American Association of Physicists in Medicine
One Physics Ellipse
College Park, MD 20740-3846
(301) 209-3350
Fax (301) 209-0862
http://www.aapm.org

August 20, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1612-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for CY 2015 Proposed Rule; CMS-1612-P

Dear Administrator Tavenner,

The American Association of Physicists in Medicine[1] (AAPM) is pleased to submit comments to the Centers for Medicare and Medicaid Services (CMS) in response to the July 11, 2014 *Federal Register* notice regarding the 2015 Medicare Physician Fee Schedule (MPFS) proposed rule.

AAPM has significant concerns regarding the proposed reductions to radiation oncology and freestanding radiation therapy centers in the 2015 MPFS. Cuts of this magnitude could harm cancer care, especially in rural areas, and will negatively impact Medicare beneficiary access to life-saving treatments. Since for many facilities fixed investments of buildings and capital equipment have already been made based on certain *pro forma* revenue assumptions that CMS proposes to change suddenly, it is almost certain that a cut of this scope and depth in projected operational revenue will immediately and directly result in reductions of expenditures for non-physician clinical labor, of which the Medical Physicist is the highest incremental cost. AAPM is deeply concerned that the loss of substantial necessary Medical Physicist work under the proposal can be expected to result in a decrease in both quality and safety of the radiation services delivered to the patients insured by CMS, an outcome that AAPM would prefer to see avoided.

I. Radiation Treatment Vault

CMS proposes to remove the radiation treatment vault as a direct practice expense input from multiple radiation treatment delivery codes (i.e., 77373, 77402-77416, 77418), producing a significant negative impact on freestanding radiation therapy centers. CMS suggests that the costs associated with the treatment vault are already accounted for in the indirect practice expense methodology. We do not believe that the cost of the vault is already properly included in the indirect practice expense.

[1] The American Association of Physicists in Medicine (AAPM) is the premier organization in medical physics, a broadly-based scientific and professional discipline encompassing physics principles and applications in biology and medicine whose mission is to advance the science, education and professional practice of medical physics. AAPM represents over 7,000 medical physicists.

The proposed rule would reclassify treatment vault costs as indirect but CMS does not propose to increase the radiation oncology indirect practice expense used to determine radiation oncology practice expense relative value units (RVUs). AAPM believes that the radiation oncology practice expense per hour is understated due to errors introduced when the American Medical Association (AMA) Physician Practice Information Survey (PPIS) data was incorporated in the MPFS. The indirect practice expense per hour for radiation oncology is currently understated and impacts all radiation oncology services. If CMS does implement this proposal, it will be important to allocate a higher cost per square foot for the radiation treatment vault than that of the remaining square footage of the facility.

AAPM considers a radiation treatment vault to be a direct practice expense. A linear accelerator treatment vault is not primarily "a room" in the sense that an imaging room is primarily a room. The vault is customized and machine-specific, the accelerator cannot operate without it, they are not interchangeable, and the relative cost of its shielding function is much greater for a vault than for an imaging room. An imaging room is a room with shielding, while in a vault, the room is the shield. For a typical 500 square foot linear accelerator treatment room the incremental cost of the concrete shielding alone, over and above typical medical building costs, is in excess of $1M, clearly an extraordinary difference. The vault is inarguably intrinsic to the linear accelerator. Further, the radiation treatment vault must be constructed or modified for the linear accelerator and necessary in order to safely and effectively operate the equipment. The linear accelerator cannot be operated in the absence of the shielded vault. The vault requires a significant investment as well as shielding design expertise from a Medical Physicist.

Further, we understand that the radiation treatment delivery codes, which represent 50 percent of radiation oncology allowed charges, were recently revalued and the interim final RVUs will be published in the 2015 MPFS final rule. We fear that the impact of this proposal along with revaluation of these codes could lead to more severe impacts to practice expense RVUs. Therefore, AAPM concurs with the American Society for Radiation Oncology (ASTRO) recommendation to delay a final policy decision on the radiation treatment vault until after the 2015 radiation oncology coding changes are implemented.

> ***The AAPM recommends that CMS maintain the costs associated with a radiation treatment vault as part of the direct practice expense for all radiation oncology treatment delivery codes but supports a delay on this policy decision until after the 2015 radiation treatment delivery changes are implemented.***

II. Medical Equipment Maintenance Costs

CMS is soliciting comment on the medical equipment maintenance factor assumption. AAPM believes that the current maintenance factor of 5 percent used to determine the equipment costs per minute is inadequate for radiology and radiation oncology medical equipment. Maintenance costs for highly specialized and complex equipment used for radiology and radiation oncology is typically about 10 percent of the purchase price.

> ***The AAPM supports a variable equipment maintenance factor and requests that CMS work with stakeholders to obtain accurate data to update the adjustment factor for radiology and radiation oncology.***

III. Migration from Film to Digital Practice Expense Inputs

AAPM agrees with the CMS proposal to migrate from film to digital practice expense inputs for radiology and radiation oncology codes. We concur that many of the medical supply and equipment costs associated with film technology no longer apply to typical resource inputs for digital technology. We understand that the Agency has not received appropriate pricing for the Picture Archiving and Communication System (PACS) equipment and that the costs may be variable. AAPM does <u>not</u> support the CMS proposal to assign a desktop computer (ED021) as a direct practice expense proxy for the PACS workstation.

The AAPM recommends that CMS* not *utilize the direct practice expense costs of a desktop computer (ED021) as a proxy for the PACS Workstation. AAPM encourages CMS to delay the migration from film to digital practice expense inputs until CMS is able to obtain accurate pricing for the PACS Workstation to determine the direct practice expense inputs associated with this technology.

IV. CPT 77293 Clinical Labor Input

CMS reports an error in the clinical labor type for CPT 77293 Respiratory motion management simulation. AAPM agrees that the correct labor type is a Medical Physicist (L152A) and not an Audiologist (L052A).

The AAPM recommends that CMS assign a Medical Physicist (L152A) as the appropriate clinical labor type for CPT 77293 Respiratory motion management simulation.

V. Valuing New, Revised and Potentially Misvalued Codes

CMS proposes to modify the current process to make all changes for new, revised and potentially misvalued codes that is more transparent and allows for notice and comment rulemaking beginning with the 2016 MPFS proposed rule.

AAPM is supportive of a more transparent process that allows professional societies that are not formally part of the CPT and RUC processes (like AAPM) to participate in the notice and comment period during the annual proposed rule as opposed to commenting on interim final RVUs published in the annual final rule. AAPM would strongly support the proposal if the AMA agrees to modify their CPT and RUC processes and timelines to meet the new CMS deadline. We do not support the CMS proposal to implement temporary G-codes to describe predecessor codes while the CPT code is being revalued.

The AAPM supports the CMS proposal to modify the process for valuing new, revised and potentially misvalued codes if the American Medical Association is able to modify their CPT and RUC processes and timelines to alleviate the need for temporary HCPCS G-codes.

VI. Impact of Proposed Reductions to 2015 Radiation Oncology RVUs

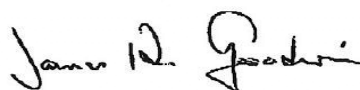
CMS continues to propose new payment policies that negatively impact the specialty of radiation oncology. Radiation Oncology and Radiation Therapy Centers are negatively affected by the proposal to remove radiation treatment vault costs from the direct practice expense of fourteen (14) radiation treatment delivery codes that yields a 4 percent reduction in payment to Radiation Oncology and an 8 percent reduction to Radiation Therapy Centers, which is compounded by other payment decreases for the past several years. AAPM is concerned regarding the viability of providing high quality radiation therapy and medical physics services in a freestanding setting.

Continued reductions to RVUs and MPFS payments will have a deleterious effect on freestanding radiation therapy centers and impact the provision of cancer care, especially in rural areas. Medicare beneficiaries deserve access to quality cancer treatment provided in freestanding and community-based cancer centers.

The AAPM recommends that CMS stabilize radiation oncology RVUs and payments in order to ensure Medicare beneficiary access to life saving cancer treatments provided in freestanding and community-based cancer centers.

Appropriate payment for medical physics services, radiology and radiation oncology procedures is necessary to ensure that Medicare beneficiaries will continue to have full access to imaging in the diagnosis of cancer and high quality cancer treatments in freestanding radiation therapy centers. We hope that CMS will take these issues under consideration for the 2015 Physician Fee Schedule final rule. Should CMS staff have additional questions, please contact Wendy Smith Fuss, MPH at (561) 637-6060.

Sincerely,



James Goodwin, M.S.
Chair, Professional Economics Committee

Blake Dirksen, M.S.
Vice-Chair, Professional Economics Committee