



American Association of Physicists in Medicine

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August 26, 2015

Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1633-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Proposed Rule; CMS-1633-P

Dear Administrator Slavitt:

The American Association of Physicists in Medicine¹ (AAPM) is pleased to submit comments to the Centers for Medicare and Medicaid Services (CMS) in response to the July 15, 2015 *Federal Register* notice regarding the 2016 Medicare Hospital Outpatient Prospective Payment System (HOPPS) proposed rule. The AAPM will provide comments on comprehensive APCs and proposed payment for APC 5641 *Brachytherapy* and APC 5622 *Level 2 Radiation Therapy*.

COMPREHENSIVE APC PROPOSAL

CMS continues the comprehensive payment policy implemented on January 1, 2015, which applies to several radiation oncology services including intraoperative radiation therapy (IORT), breast brachytherapy catheter placement and single session cranial stereotactic radiosurgery (SRS) procedures assigned to C-APCs 5093 *Level 3 Breast/Lymphatic Surgery and Related Procedures* and 5631 *Single Session Cranial Stereotactic Radiosurgery*.

In general, AAPM supports the concept of C-APCs but suggests that CMS focus on clinically coherent services as the basis for C-APCs. For example, C-APC 5093 *Level 3 Breast/Lymphatic Surgery and Related Procedures* contains services that are not clinically relevant to each other (see table below). C-APC 5093 includes procedures that treat breast

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. Medical physicists contribute to the effectiveness of radiological imaging procedures by assuring radiation safety and helping to develop improved imaging techniques (e.g., mammography CT, MR, ultrasound). They contribute to development of therapeutic techniques (e.g., prostate implants, stereotactic radiosurgery), collaborate with radiation oncologists to design treatment plans, and monitor equipment and procedures to insure that cancer patients receive the prescribed dose of radiation to the correct location. Medical physicists are responsible for ensuring that imaging and treatment facilities meet the rules and regulations of the U.S. Nuclear Regulatory Commission (NRC) and various State regulatory agencies. AAPM represents over 7,000 medical physicists.

cancer with different radiation therapy technology (i.e. IORT and brachytherapy) and other services for breast repair and/or reconstruction. In a hospital outpatient system moving toward episodes of care, it may be more appropriate to consider C-APCs based on clinical conditions (e.g. early stage breast cancer) or similar types of technology (e.g. radiation therapy for the treatment for early stage breast cancer). In addition to being clinically coherent, all procedures in a C-APC should also be similar in resource costs. Additional levels of a C-APC may be required to achieve both of these objectives.

APC 5093 Level 3 Breast/Lymphatic Surgery and Related Procedures

HCPCS Code	Short Descriptor
19296	Placement breast catheter for radiation following partial mastectomy
19298	Placement of breast brachytherapy catheters (multiple tube and button type) for radiation at the time of or subsequent to partial mastectomy
19325	Enlarge breast with implant
19342	Delayed breast prosthesis following mastopexy, mastectomy or in reconstruction
19357	Breast reconstruction
77424	IORT treatment delivery by x-ray
77425	IORT treatment delivery by electrons

We also note that this C-APC 5093 will not apply in the Ambulatory Surgery Center payment system. This difference in payment based on site of service may provide incentives related to reimbursement levels rather than patient process of care. We recommend that this C-APC apply to both HOPPS facilities and ASC facilities.

Last year AAPM commented that choosing a bundling benchmark such as “on the same claim” is not a good foundation for a comprehensive payment procedure set. A “per claim” approach leads to confusion, variation in the payments to different facilities based on their claim process and induces incentives for claim timing not in the best interests of payment reform or patient care.

AAPM thinks that C-APC 5631 *Single Session Cranial Stereotactic Radiosurgery* is a good example of a comprehensive APC that includes similar clinical services, however, the comprehensive payment does not reflect similar resource costs. An underlying assumption of the C-APC policy is that the hospital is reporting all services related to the primary service on a single claim. This assumption may not apply to radiation oncology services as was evidenced by your recent stereotactic radiosurgery claims analysis. As noted in the 2016 HOPPS proposed rule, CMS identified differences in billing patterns between SRS procedures delivered using Cobalt-60 based and LINAC based technologies, which has led to one technology receiving additional payment for pre-planning and preparation services that were not typically billed on the same claim as the primary service (i.e. SRS treatment delivery).

CMS is proposing to change payment for stereotactic radiosurgery treatment under C-APC 5631 by identifying any services that are differentially billed for codes 77371 and 77372 on the same claim and on claims 1 month prior to delivery of SRS services in C-APC 5631, including planning and preparation services, and removing them from the C-APC geometric mean calculation for 2016 and 2017. For any codes that CMS removes from the C-APC bundle, CMS is proposing that those codes would receive separate payment even when appearing with a “J1” procedure code (HCPCS code 77371 or 77372) on the same claim for both 2016 and 2017.

AAPM believes that the recent experience with bundling related to this composite APC has been unnecessarily complex and clearly has caused both confusion and inaccurate coding subsequent to SRS procedures. We recommend a careful re-evaluation of the process that led to the valuation of this APC, the codes that are to be included and the methodology for assuring accurate coding. CMS should convene stakeholders in 2016 to discuss the goals of this C-APC process and develop recommendations as to how those goals could be realistically achieved.

For data collection purposes, CMS proposes to require hospitals in 2016 to report a modifier identifying any adjunctive services furnished prior to an associated primary service to better estimate payments under an encounter-based comprehensive APC. AAPM supports CMS's efforts to better capture the costs of adjunctive services involved in providing primary services, however, we do not support the proposed modifier policy. The addition of an even more complex system of modifiers is unlikely to bring clarity or accuracy to the data collected or to the payment process. If CMS finalizes the modifier proposal, AAPM recommends that CMS offer additional detail on the specific items and services that are to be reported with a modifier as "adjunctive to the primary service." Without such clarification, hospitals may not consistently identify and report adjunctive services. CMS also needs to provide detail on specific exceptions for the episode of care, otherwise hospitals will likely under-report or inaccurately report the adjunctive services. This would result in flawed data for rate-setting.

Lastly, we remain concerned about the complexity adjustment policy, which does not apply to C-APC 5093 *Level 3 Breast/Lymphatic Surgery and Related Procedures* or C-APC 5631 *Single Session Cranial Stereotactic Radiosurgery*. CMS should consider a complexity adjustment methodology that could be applied to the highest level C-APC within each family of codes.

AAPM recommends that CMS reconsider the creation of comprehensive APCs based on clinical coherence, similarity of resource cost, and appropriate complexity adjustments.

AAPM does not support unbundling planning and preparation services associated with stereotactic radiosurgery codes 77371 and 77372 in C-APC 5631 *Single Session Cranial Stereotactic Radiosurgery*.

AAPM recommends that CMS not implement the modifier proposal to identify adjunctive services for comprehensive APCs.

NEW HDR BRACHYTHERAPY CODES & ASSIGNMENT TO APC 5641 AND APC 5622

CMS proposes seven (7) new High Dose Rate (HDR) Brachytherapy codes effective January 1, 2016 (see below). The new codes include the work of the basic radiation dosimetry calculation described by CPT 77300.

- 7778A Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter up to 2.0 cm or 1 channel
- 7778B Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter over 2.0 cm and 2 or more channels, or multiple lesions
- 7778C Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel
- 7778D Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 2-12 channels

- 7778E Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; over 12 channels
- 01XXT High dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry, when performed
- 02XXT High dose rate electronic brachytherapy, interstitial or intracavitary treatment, per fraction, includes basic dosimetry, when performed

Based on independent claims analysis, we understand that CMS did not include the cost of the now bundled basic radiation dosimetry calculation code (i.e. CPT 77300) when calculating the geometric mean cost of the newly proposed HDR Brachytherapy codes assigned to APCs 5641 *Brachytherapy* and 5622 *Level 2 Radiation Therapy*.

AAPM requests that CMS recalculate the geometric mean cost of the affected HDR Brachytherapy claims to determine a more accurate payment for APC 5641 *Brachytherapy* and APC 5622 *Level 2 Radiation Therapy*.

With expanded bundling of services, CMS should ensure that these costs are captured in the outpatient claims data and lead to accurate and appropriate APC payments.

We hope that CMS will take these issues under consideration during the development of the 2016 HOPPS/ASC final rule. Should CMS staff have additional questions, please contact Wendy Smith Fuss, MPH at (561) 637-6060.

Sincerely,



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



Jonas Fontenot, Ph.D.
Vice-Chair, Professional Economics Committee