

AAPM MEETS WITH CMS REGARDING COMPREHENSIVE APC PAYMENT METHODOLOGY

AAPM in conjunction with ACR, ASTRO and ABS met with CMS officials on February 26th to discuss concerns regarding the Comprehensive Ambulatory Payment Classification (C-APC) payment methodology and its impact to brachytherapy and stereotactic radiation therapy reimbursement under the Medicare Hospital Outpatient Prospective Payment System (HOPPS). AAPM participants included PC Vice-Chair James Goodwin and PEC Chair Jonas Fontenot.

CMS defines a C-APC as a classification for the provision of a primary service and all adjunctive services and supplies provided to support the delivery of the primary service. CMS continues the C-APC payment policy methodology of including all covered outpatient department services on a hospital outpatient claim reporting a primary service that is assigned to status indicator "J1 or "J2." Under this policy, CMS calculates a single payment for the entire hospital stay, defined by a single claim, regardless of the date of service span.

Meeting participants explained that radiation oncology requires component or serial coding to account for the multiple steps that comprise the process of care (consultation; preparing for treatment; medical radiation physics, dosimetry, treatment devices and special services; radiation treatment delivery; radiation treatment management; and follow-up care management). Adding that cancer treatment is complex, as patients are often treated concurrently with different modalities of radiation therapy for different disease sites and often at different sites of service. Participants explained that the existing C-APC methodology does not account for these complexities and fails to capture appropriately coded claims, resulting in distorted data leading to

inaccurate payment rates that jeopardize access to certain radiation therapy services.

Dr. Peter Orio explained that brachytherapy catheter/ applicator insertion and treatment delivery take place on the same date of service or different dates of service, with delivery spanning a range of dates, single or multiple insertions, single or multiple HDR treatments per insertion, and different levels of complexities in planning and delivery. He advised CMS that these complexities make traditional clinical APCs the most accurate and appropriate way to pay separately for these services under HOPPS.

Dr. Michael Kuettel described the differences in the amount of time used to plan, prepare and treat a patient using stereotactic radiosurgery (SRS) based on the modality of treatment. He advised CMS that these distinctions are not captured in the C-APC methodology. Additionally, the SRS claims may include charges for stereotactic body radiation therapy (SBRT). Patients being treated for brain metastases (with SRS) may concurrently or consecutively be treated with SBRT for cancer in another site, lung cancer for example. The C-APC methodology is not designed to differentiate which charges are linked to which major procedure, as such the methodology does not appropriately capture charges for these services. He recommended that CMS continue separate payment for the planning and preparation codes associated with single session SRS.

The Medicare HOPPS proposed rule will be published in late June/early July. We hope that meeting discussions and follow-up data provided to CMS will prompt changes to the C-APC payment methodology for these services in 2019. ■