CMS Proposes Payment Decreases to Treatment Delivery Codes that Utilize a Treatment Vault

CMS proposes to reallocate the costs of a radiation treatment vault, which yields a negative impact of 4% for radiation oncology and 8% for freestanding radiation therapy centers under the 2015 Medicare Physician Fee Schedule (MPFS) proposed rule.

In previous rulemaking, CMS indicated that they included the radiation treatment vault as a direct practice expense (PE) input for several recently reviewed radiation treatment codes for the sake of consistency with its previous inclusion as a direct PE input for some other radiation treatment services, but that they intended to review the radiation treatment vault input and address whether or not it should be included in the direct PE input database for all services in future rulemaking. Specifically, CMS questioned whether it was consistent with the principles underlying the practice expense methodology to include the radiation treatment vault as a direct cost given that it appears to be more similar to building infrastructure costs than to medical equipment costs. Moreover, CMS indicates that it is difficult to distinguish the cost of the vault from the cost of the building. In response to this action, CMS received comments and invoices from stakeholders who indicated that the vault should be classified as a direct cost. However, upon review of the information received, CMS believes that the specific structural components required to house the linear accelerator are similar in concept to components required to house other medical equipment such as expensive imaging equipment. In general, the electrical, plumbing, and other building specifications are often unique to the intended functionality of a given building, including costs that are attributable to the specific medical equipment housed in the building, but do not represent direct medical equipment costs in our established practice expense methodology. Therefore CMS believes that the special building requirements indicated for the radiation treatment vault to house a linear accelerator do not represent a direct cost in the practice expense methodology, and that the vault construction is instead accounted for in the indirect PE methodology, just as the building and infrastructure costs are treated for other MPFS services including those with infrastructure costs based on equipment needs.

Radiation oncology treatment delivery codes affected by the CMS proposal to remove the radiation treatment vault include:

- 77373 SBRT delivery
- 77402 Radiation treatment delivery
- 77403 Radiation treatment delivery
- 77404 Radiation treatment delivery
- 77406 Radiation treatment delivery
- 77407 Radiation treatment delivery
- 77408 Radiation treatment delivery
- 77409 Radiation treatment delivery
- 77411 Radiation treatment delivery
- 77412 Radiation treatment delivery
- 77413 Radiation treatment delivery
- 77414 Radiation treatment delivery
- 77416 Radiation treatment delivery
- 77418 IMRT radiation treatment delivery

AAPM opposes the CMS proposal and will provide comments to CMS by the September 2nd deadline. In addition, AAPM is working with ASTRO and other stakeholders to have Members of Congress weigh-in on the proposal. Given that a number of radiation treatment delivery codes are slated for change and revaluation effective January 1, 2015, and the impact will not be known until later this year, Congress may request that CMS not address this issue until after 2015.

Another major provision of the 2015 proposed rule calls for notice and comment rulemaking for setting values for physician services, on which pay codes are based. CMS has been working with the American Medical Association’s CPT Editorial Panel and Relative Value Scale Update Committee (RUC) to change the process for receiving information on new and revised codes under the misvalued code policy in order to allow all misvalued code revisions to go through notice and comment rulemaking before being adopted. If finalized as proposed, the new process would ensure that by 2016, changes to the rates for particular services (except for those that are entirely new services never before valued under the MPFS) are effective only after CMS has responded to public comment.

Lawmakers from both parties and in both chambers have been urging CMS to make public the process of setting values for physician services. The lawmakers are pushing the measure on behalf of specialists who were surprised by reimbursement cuts to their services in recent years. Those specialists include gastroenterologists, orthopaedic surgeons, nephrologists, urologists, diagnostic radiologists and pain specialists.

For decades, CMS approved the vast majority of values for physician services that were recommended by the American Medical Association's RUC. However, primary physicians and several former CMS administrators argued that the RUC undervalued primary care services and overvalued high-end specialties. In 2011, CMS suddenly changed course, accepting nearly 30 percent fewer RUC recommendations compared to previous years. CMS had historically accepted about 90 percent of the RUC’s physician payment recommendations, and in 2011 that acceptance rate dropped to about 60 percent.

Creating notice and comment rulemaking may erode the influence of the RUC. Congress is responding to specialty physicians who can no longer depend on CMS to approve RUC recommendations, but it’s also true that using notice and comment rulemaking further erodes the RUC’s influence because it puts a greater emphasis on the process at CMS, even if the RUC isn’t the intended target of the change.

AAPM will submit written comments to CMS and they will be posted to the website in late August. The MPFS final rule will be published by November 1, 2014.