



March 26, 2018

Tiffany Swygert
Director, Division of Outpatient Care
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Comprehensive Ambulatory Payment Classification Methodology

Dear Ms. Swygert,

The American Society for Radiation Oncology (ASTRO), the American College of Radiology (ACR), the American Brachytherapy Society (ABS) and the American Association of Physicists in Medicine (AAPM) wish to thank you and your team for taking the time to meet with us regarding our shared concerns regarding the Comprehensive Ambulatory Payment Classification (C-APC) methodology.

As discussed during our meeting, ASTRO, ACR, ABS and AAPM have committed significant time and resources to the analysis of the C-APC methodology and its impact on radiation oncology reimbursement. Radiation oncology requires component 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).

Cancer treatment is complex, as patients are often treated concurrently with different modalities of radiation therapy, combined with other specialty modalities, and often at different sites of service. The CMS C-APC methodology does not account for this complexity and fails to capture appropriately coded claims, resulting in distorted data leading to inaccurate payment rates that will jeopardize access to certain radiation therapy services if continued and expanded.

C-APC Methodology

CMS' comprehensive APC methodology is a classification for the provision of a primary service and all adjunctive services provided to support the delivery of the primary service. CMS makes payment for all other items and services reported on the hospital outpatient claim as being integral, ancillary, supportive, dependent, and adjunctive to the primary service and representing components of a complete comprehensive service. Payments for adjunctive services are packaged into the payments for the primary services. This results in a single prospective payment for each of the primary, comprehensive services based on the costs of all reported services at the claim level.

While we appreciate the efficiencies that this methodology is designed to render, it has the unintended consequence of not recognizing concurrent or overlapping services. This methodology is particularly challenging when services unrelated to the primary service code or multiple encounters of the same primary service appear on the same claim. This is common practice for hospitals that typically issue monthly claims.

Repetitive Billing

CMS' MLN Matters Publication MM4047 addresses the Frequency of Billing to Fiscal Intermediaries (FIs) for Outpatient Services. The publication states "*repetitive Part B services furnished to a single individual by providers who bill FIs should be billed monthly (or at the conclusion of treatment).*" The publication goes on to address radiation therapy services. See below:

Revenue codes usually reported for chemotherapy and radiation therapy are not on the list of revenue codes that may only be billed monthly. Therefore, hospitals may bill chemotherapy or radiation therapy sessions on separate claims for each date of service.

However, because it is common for these services to be furnished in multiple encounters that occur over several weeks or over the course of a month, hospitals have the option of reporting charges for those recurring services on a single bill, as though they were repetitive services. If hospitals elect to report charges for recurring, non-repetitive services (such as chemotherapy or radiation therapy) on a single bill, they must also report all charges for services and supplies associated with the recurring service on the same bill.

Cervical Brachytherapy

Brachytherapy for the treatment of cervical cancer is just one example that demonstrates how the C-APC methodology does not fully account for the complexities of cancer care. The standard of care for the nonsurgical curative management of cervical cancer includes concurrent chemotherapy with external beam radiation therapy (EBRT) and brachytherapy. Brachytherapy is a surgical procedure to introduce radioactive elements directly into or adjacent to the tumor. Patients who receive this specific combination of treatment experience high quality outcomes, including longer survival times and lower mortality rates. The effectiveness of this multimodality approach to cervical cancer hinges on evidence that optimal treatment is achieved when all chemotherapy and radiation therapy (both EBRT and brachytherapy) is completed within 56 days or 8 weeks.¹ Exceeding this period results in decreased local tumor control and survival for the patient with each day of delay.²

Delivery of brachytherapy for cervical cancer results in cancer control rates as high as 100 percent for stage IB, 96 percent for stage IIB, and 86 percent for stage IIIB patients. However, an analysis of the National Cancer Data Base indicated that of 7,654 patients diagnosed with curative cervical cancer, the use of brachytherapy declined from 98 percent to 86 percent between 2004 and 2011. The median survival time was 70.9 months for those treated with brachytherapy compared to 47.1 months for those treated with other modalities.³

¹ Song MD, Suisui, et al. (January 15, 2013) The Effect of Treatment Time in Locally Advanced Cervical Cancer in the Era of Concurrent Chemoradiotherapy. *Cancer*, 325-331.

² Petereit MD, Daniel G., et al. (1995) The Adverse Effect of Treatment Prolongation in Cervical Carcinoma. *International Journal of Radiation Oncology Biology Physics*, Volume 32, No. 5, 1995, 1301-1307.

³ Petereit MD, Daniel G., et al. (March 20, 2015) Brachytherapy: Where Has It Gone? *Journal of Clinical Oncology*, Volume 33, No. 9, 980-983.

In the United States, the most commonly used regimens are 45Gy EBRT to the pelvis (possibly with a sidewall boost) with concurrent cisplatin-based chemotherapy and either 5.5 Gy per fraction for **five** fractions (for patients treated with concurrent chemotherapy who have had either a complete response or have <4 cm of residual disease) or 6 Gy for **five** fractions (for patients with tumors >4 cm after EBRT).⁴

In summary, the standard of care for a cervical cancer patient will be external beam radiation therapy/5 brachytherapy insertions/chemotherapy all completed within 56 days of treatment start.

Charge Capture:

Let's look at CMS 2018 HOPPS rates for cervical cancer. We assume that the hospital bills CMS monthly for the cervical cancer treatment, which is standard practice in the field.

The primary service (J1) in the case of cervical cancer is CPT Code 57155. That service is assigned to APC 5414 with a 2018 payment rate of \$2,272.61.

APC	HCPCS	Group Title	Short Descriptor	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
5414		Level 4 Gynecologic Procedures		J1	28.9004	\$2,272.61	.	\$454.53

All the radiation delivery, planning and preparation, etc. are considered adjunctive services and designated with status indicator S. Those charges will appear on the same bill as the J1 service (CPT Code 57155).

HCPCS	SI	APC	Payment Rate	Single Frequency	Total Frequency	Minimum Cost	Maximum Cost	Median Cost	Geometric Mean Cost
57155	J1	54140	\$2,272.61	1719	1729	\$600.56	\$16,316.39	\$3,079.38	\$3,013.71
77470	S	5623	\$522.28	41039	57294	\$91.53	\$2,116.61	\$443.11	\$442.63
77370	S	5611	\$125.35	26766	34844	\$35.03	\$797.28	\$172.27	\$172.34
77771	S	5624	\$714.06	5687	11435	\$151.64	\$3,074.26	\$715.92	\$730.89

Planning and Preparation codes									
HCPCS	SI	APC	Payment Rate	Single Frequency	Total Frequency	Minimum Cost	Maximum Cost	Median Cost	Geometric Mean Cost
77290	S	5612	\$323.07	111404	140318	\$87.82	\$1,851.20	\$392.67	\$393.94
77295	S	5613	\$1,186.60	72804	96841	\$239.99	\$5,269.28	\$1,136.40	\$1,129.38

⁴ National Comprehensive Cancer Network. Cervical Cancer (Version 1.2017). <https://www.tri-kobe.org/nccn/guideline/gynecological/english/cervical.pdf> Accessed March 21, 2018.

77336	S	5611	\$125.35	646839	657097	\$30.49	\$584.58	\$135.66	\$132.25
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2018 NFRM Final Rule CPT Cost Stats 10.27.17

Packaged Services	
76942	N
77417	N
99151-99157	N

The brachytherapy sources will also appear on the bill. However, sources have a status indicator designation of “U” and are separately paid.

Brachy Source								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C1717	Brachytx, non-str,hdr ir-192		U	2646	3.7462	\$294.59	.	\$58.92

For purposes of this analysis and our recommendations, we are using the CMS 2016 mean data for CPT Code 57155. CPT Code 57155 currently has a status indicator of J1, thus including other services in the mean data. As such, the 2016 mean data for CPT Code 57155, which had a status indicator T at the time, reflects costs associated with just the insertion.

2016 Mean*
\$797.17

*2016 FR CPT Cost Stats 2015-12-16

As discussed above, the current standard of practice for cervical cancer is five fractions (insertions) of (1) brachytherapy:

HCPCS	SI	Geometric Mean Cost	UoS	
57155	J1	\$797.17	5	\$3,985.85
77470	S	\$442.63	1	\$442.63
77370	S	\$172.34	1	\$172.34
77771	S	\$730.89	5	\$3,654.45
77290	S	\$393.94	5	\$1,969.70
77295	S	\$1,129.38	5	\$5,646.90
77336	S	\$132.25	1	\$132.25

\$16,004.12

and (2) external beam radiation therapy. Again, assuming the hospital is billing monthly, that external beam cost, based on CMS 2018 mean data file, will be greater than **\$25,000**.

The 2018 Medicare HOPPS payment for cervical brachytherapy treatment is \$2,272.61, which is:

- **\$13,731.51 less than average cost** for the brachytherapy portion of the treatment; and
- **\$40,000 less than the average cost** for brachytherapy and external beam radiation therapy (partial treatment).

Recommendations:

We recognize that CMS is committed to the C-APC methodology and support CMS policies that promote efficiency and the provision of high quality care. However, the methodology used to create C-APCs lacks the appropriate charge capture mechanisms; as it is currently applied it grossly undervalues cancer treatments, particularly brachytherapy.

Based on our analysis, we urge CMS to consider allowing brachytherapy to be subject to the traditional APC payment methodology.

If CMS insists on the continued use of the C-APC methodology, we recommend that the Agency move brachytherapy for cervical cancer treatment to C-APC 5416 Level 6 Gynecologic Procedures. This C-APC is reimbursed at \$6,286.92, which is closer to the actual cost of treatment delivery as noted above. Additionally, we would request that CMS allow the planning and preparation services to be paid in addition to the C-APC payment. This is a similar approach that the Agency has taken with the methodology used for the SRS C-APC, in which the planning and preparation codes are separately paid. Finally, we ask that CMS recognize the multimodality process involved in the treatment of cervical cancer by allowing separate payment for the external beam radiation therapy services that occur during a course of care. We believe that these changes will result in more appropriate reimbursement and address concerns regarding access to appropriate care.

In summary, we recommend:

- (1) Reverting to traditional APC methodology for brachytherapy and radiation therapy services
- (2) If CMS insists on C-APC methodology, the agency should:
 - a. Include in the C-APC 57155, 77470, 77370, 77771 and bundled services (e.g. port films, IGRT, supervision, handling loading of source, moderate sedation)
 - i. Assign to C-APC 5416 Level 6 Gynecologic Procedures
 - ii. Eligible for complexity adjustment
 - b. Separate payment for planning and preparation services, similar to the SRS policy
 - c. Separate payment external beam radiation therapy (EBRT)
 - d. Continue separate payment brachytherapy sources
- (3) Align CMS' Repetitive Billing Instructions with HOPPS Methodology

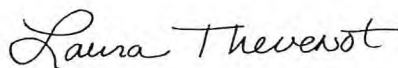
We believe these changes to the HOPPS methodology will begin to remedy the egregious underpayment for cervical cancer care. **We also note that similar issues exist for other brachytherapy insertion procedures, and we urge the Agency to work with the undersigned societies to remedy those payment disparities as well.**

Stereotactic Radiosurgery

Separately, we recognize that CMS is required, by statute, to pay CPT code 77371 *Stereotactic Radiosurgery (SRS), Multi-source Cobalt-60 Based* and CPT Code 77372 *Stereotactic Radiosurgery, Linear Accelerator Based* at the same HOPPS rate. We appreciate CMS' decision to make separate payment for the 10 planning and preparation codes adjunctive to SRS treatment beginning in 2016. By making this separate payment, the Agency recognized that there are differences in the amount of time used to plan, prepare and treat a patient using SRS based on the modality of treatment. Since these distinctions cannot be resolved with the existing methodology, we urge the Agency to make permanent separate payment for the planning and preparation codes associated with this C-APC.

We appreciate the opportunity to meet about the C-APC methodology. Should you have any questions on the items addressed in this letter, please contact Anne Hubbard, ASTRO Director of Health Policy, at 703-839-7394 or anne.hubbard@astro.org; Pam Kassing, ACR Senior Economic Advisor, at 800-227-5462, ext. 4544 or pkassing@acr.org; or Wendy Smith Fuss, Health Policy Solutions on behalf of AAPM and ABS, at 904-844-2487 or Wendy@healthpolicysolutions.net.

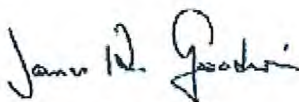
Sincerely,



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