



August 26, 2016

Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1656-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-1656-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 14, 2016 *Federal Register* notice regarding the 2017 Medicare Hospital Outpatient Prospective Payment System (HOPPS) proposed rule. The AAPM will provide comments regarding proposed reassignment of the special medical radiation physics consultation code (CPT 77370); and existing and newly proposed comprehensive APCs that includes stereotactic radiosurgery (CPT 77371 and 77372), insertion of tandem and ovoids for brachytherapy (CPT 57155), breast brachytherapy catheter placement (CPT 19298) and other brachytherapy related surgical codes (CPT 55920, 58346, 31643).

Since the inception of the comprehensive APC methodology, the AAPM has commented concerns around the accuracy of claims data, as there is a great deal of discrepancy around how hospitals submit these claims. The AAPM is also uncertain as to whether the rates associated with C-APCs adequately or accurately reflects all of the procedures and costs associated with those APCs. This is of particular concern as CMS continues to expand the number of packaged and bundled services. Preliminary claims data analysis suggests that the comprehensive APCs may result in significant Medicare payment reductions for complex radiation oncology treatments.

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.

CPT 77370 SPECIAL MEDICAL RADIATION PHYSICS CONSULTATION

CMS proposes to reduce the number of clinical APCs for Therapeutic Radiation Treatment Preparation from 4 to 3 levels by consolidating Level 1 & Level 2 treatment preparation codes into clinical APC 5611 *Level 1 Therapeutic Radiation Treatment Preparation*. CMS proposes to reassign the special medical radiation physics consultation code (CPT 77370) from current APC 5612 to APC 5611, which results in a significant payment decrease of more than 30%.

The special medical physics consultation ensures that patients with the most complex clinical situations receive safe and effective care. Clinical examples include radiation dose to the fetus of a pregnant patient receiving radiation therapy, dose to critical structures from multiple courses of radiation therapy, radiation dose to an implanted medical device and how the device would be impacted, or integration of multiple treatment courses using multiple image modalities and image sets. This is significantly more effort and intensity than the continuing medical physics consultation code (CPT 77336) and therefore does not belong in the same clinical APC. Furthermore, this reduction of 30% is significant and we fear it may limit patient access to the essential review of a qualified medical physicist for the complicated patients who need it the most.

The AAPM recommends that CMS maintain CPT 77370 Special medical radiation physics consultation code in APC 5612 *Level 2 Therapeutic Radiation Treatment Preparation* in 2017.

COMPREHENSIVE APC 5627 LEVEL 7 RADIATION THERAPY

The AAPM engaged The Moran Company to conduct an analysis of comprehensive APC 5627 *Level 7 Radiation Therapy* and related stereotactic radiosurgery codes 77371 and 77372 based on 2014 claims data.

77371 Radiation treatment delivery, stereotactic radiosurgery, complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based

77372 Radiation treatment delivery, stereotactic radiosurgery, complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based

In the 2017 proposed rule, CMS maintains CPT 77371 and 77372 single session cranial stereotactic radiosurgery (SRS) in Comprehensive APC 5627 *Level 7 Radiation Therapy*. The two SRS procedures included in C-APC 5627 must be in the same APC due to statute. These two procedures, while clinically similar, are not resource similar (see Table 1). Based on normal HOPPS configurations of APCs, these procedures would not generally be included within the same APC.

Table 1: C-APC 5627 (2016—2014 final claims)

HCPCS	Total Claim Count	Geometric Mean Cost of Claims	Geometric Mean Costs of J1 Services	Geometric Mean Cost of Other Services
77371 SRS multisource	5,260	\$10,240	\$7,870	\$1,543
77372 SRS linear based	3,916	\$5,306	\$2,972	\$1,932

Based on resource use, these procedures are very close to a two times rule violation. When SBRT procedures (CPT 77373) are removed from the simulation of the C-APC, it does produce a two times rule violation (see Table 2). The occurrence of SBRT and SRS procedures on the same claim represent clinical scenarios in which two distinct neoplasms are being treated with different radiation therapy modalities, single session SRS and multi session SBRT. These treatments can occur in a relatively short time period meaning parts of each can be on the same outpatient hospital claim.

Table 2: C-APC 5627 without SBRT (77373) (2016—2014 final claims)

HCPCS	Total Claim Count	Geometric Mean Cost of Claims	Geometric Mean Cost J1 Services	Geometric Mean Cost Other Services	Absolute Difference Total Claim Geometric Mean Cost	Percent Difference Total Claim Geometric Mean Cost	Absolute Difference J1 Geometric Mean Cost	Percent Difference J1 Geometric Mean Cost	Absolute Difference Other Services Geometric Mean Cost	Percent Difference Other Services Geometric Mean Cost
77371	5,220	\$10,192	\$7,890	\$1,518	(\$48)	-0.5%	\$20	0%	(\$24.60)	-1.6%
77372	3,388	\$4,818	\$3,028	\$1,530	(\$488)	-9.2%	\$56	2%	(\$401.77)	-20.8%

SBRT is included in a traditional APC 5626 *Level 6 Radiation Therapy*, but becomes packaged into the C-APC 5627 rates under the comprehensive APC methodology, and occurrences of SBRT on C-APC claims are then not included in rate setting for SBRT. These clinical scenarios in actual claims are distorting rates in both APCs, and may be distorting payment for these claims, if no payment is allowed for SBRT due to the claim status as a comprehensive claim. With more than 500 claims inclusive of both SRS and SBRT, this is a significantly frequent occurrence that was never intended to be captured in the comprehensive APC concept.

In the 2016 HOPPS proposed rule, CMS recognized that the planning and preparation codes for SRS could be spread out over several days. This raised the problem of hospitals not being able to ensure that the set of codes related to the index procedure could be captured in the C-APC methodology. CMS identified some, but not all, planning and preparation codes, instructed hospitals that they would be separately paid in 2016 and 2017, and calculated the C-APC 5627 rate without these codes (as shown in Table 1 and Table 3 below).

- CT localization (CPT 77011 and 77014)
- MRI imaging (CPT 70551, 70552 and 70553)
- Clinical treatment planning (CPT 77280, 77285, 77290 and 77295)
- Physics consultation (CPT 77336)

In addition, the AAPM commented that IMRT planning (CPT 77301) has become more common in single fraction radiosurgery treatment planning, and the omission from the list of planning and preparation codes subject to separate payment in 2016 and 2017 was inappropriate.

The inclusion of planning and preparation codes on claims for SRS are shown in Table 3. For 77372, 15% of the claims have no planning and preparation codes on the same claim with the 77372, materially reducing the cost for these procedures that would likely be included in rate setting if they were present on the claim. Also, note the low volume occurrence of multiple SRS codes or units in the SRS claims.

Table 3. Planning and Preparation Codes Assigned Separate Payment from C-APC 5627 (2016—2014 final claims)

Primary HCPCS	Secondary HCPCS	Total Claim Count	Percent Claims with Planning and Preparation Codes	Geometric Mean Cost of Planning and Preparation Codes
77371		5,200	99%	\$1,489
77371	77371	14	100%	\$1,954
77371	77372	*	*	\$319
77372		3,172	85%	\$967
77372	77372	158	85%	\$1,187

The difference in time on a single claim between planning/preparation codes and the SRS treatment is shown in Table 4. The patterns in time show a relatively dramatic difference in the spread of these two SRS procedures. The much wider spread for 77372 explains the exclusion of these procedures from 15% of claims, and illustrates the problem for the C-APC methodology to capture related cost by treating the claim as reflective of an episode of care. CMS’s two-year experiment with separate payment for these services will not offer any solution within the C-APC methodology for how best to overcome the problem of this work being spread over several days, of related procedures falling on the same claim, or the prevention of hospitals splitting of claims (inadvertently or by design).

Also important to understand, is that the planning and preparation code sets are used in a wide range of radiation therapy procedures and are not, in themselves, identifiable to any one radiation therapy procedure. In the case of the >500 SRS claims that include SBRT codes, it is not possible to determine which planning and preparation codes were related to SRS vs SBRT. Planning and preparation codes on the SRS claim could be related either to SBRT or to other distinct procedures that appear on a subsequent claim. It is also possible that these procedures on the claim are related to the SBRT procedure, while the SRS planning and preparation codes may have appeared on a prior claim.

Table 4. Average difference in days between Planning and Preparation Services on Same Claim with SRS procedure (2016—2014 final claims)

HCPCS	Mean Number of Days Between SRS Procedure CPT 77371	Mean Number of Days Between SRS Procedure CPT 77372
77011 CT scan for localization	2.10	4.52
77014 CT scan for therapy guide	1.15	8.43
77551 MRI brain stem without dye	0.03	13.39
77553 MRI brain stem with dye	0.36	10.32
77552 MRI brain stem with and without dye	0.17	8.85
77280 Set radiation therapy field, simple	3.23	2.61
77285 Set radiation therapy field, intermediate		22.00
77290 Set radiation therapy field, complex	4.32	9.24
77295 3D radiotherapy plan	0.21	4.32
77736 Radiation physics consult	0.04	1.43

The necessity for adjunctive planning and preparatory therapeutic radiology procedures results in different patterns of performance of these procedures over time, resulting in the potential for the “episode of SRS” to be spread out over a time period that may not be captured by a single claim. This procedure spread means that related cost may be left out of the C-APC during rate setting, as related claims cannot be used in the methodology, and the claims used may not represent an accurate or comprehensive capture of the related cost that should be included, given the intent of the C-APC methodology. This procedure spread also means that hospitals could split claims by date to capture payment for the planning and preparation codes when they occur on different dates. Hospitals are not equipped to hold claims to ensure that all related procedures are reported on a single claim.

The C-APC methodology is also capturing costs for other therapeutic radiology procedures often delivered during the same time span as the SRS procedures, but treating different lesions (e.g., presence of SBRT procedures on same claims with SRS procedures). This reporting of two separate treatments for two different problems (primary and secondary neoplasms) during the same time span is not an uncommon clinical scenario. Handling of SBRT claims in rate setting for SRS distorts costs for the SRS C-APC and removes important SBRT data from rate setting for the SBRT APC.

The current comprehensive APC methodology is not suited to single-session stereotactic radiosurgery (CPT 77371 and 77372). The AAPM has long-standing concerns about this policy. The AAPM believes that the recent experience with bundling related to this comprehensive APC has been unnecessarily complex and clearly has caused both confusion and inaccuracy in coding for stereotactic radiosurgery procedures. The AAPM is concerned that the existence of a variety of claim durations and claim processes will continue to lead to incorrect coding and inconsistent reimbursement.

While planning and preparation are generally included on a single day for one of the procedures (CPT 77371), these procedures are spread out over time for the other procedure (CPT 77372). Therefore, a Composite APC is not a good fit.

While the traditional APC provides a better representation from a clinical similarity perspective, the failure of most claims to generate sufficiently correctly coded single claims for rate setting purposes, excludes most of the relevant cost from rate setting, providing a rate that would be much too low. The only procedure that generates close to representative single claims volume under the traditional method is CPT 77372. Because most CPT 77371 claims include planning and preparation codes on the same day, there are no correctly coded claims used for rate setting for this procedure that dominates the volume in the APC.

The legislative mandate requiring that single-session SRS procedures 77371 and 77372 be in the same APC makes it difficult to identify an alternative solution to resolve the multitude of issues. No existing rate setting mechanism is responsive to the above problems. A number of mandatory edits could improve the C-APC methodology for SRS with modification for a different type of complexity adjustment but this would increase complexity and could potentially lead to more errors in coding. Another option would be to expand the by-pass code list, which may improve results for the traditional APC but may have implications for other radiation oncology procedures.

If CMS continues the comprehensive APC methodology for single session cranial radiosurgery, the AAPM suggests that CMS consider additional edits to adapt the comprehensive APC methodology for single-session stereotactic radiosurgery procedures 77371 and 77732 to include:

- Introduce an edit to exclude SBRT procedures (CPT 77373) from rate setting for C-APC 5627, and an edit to exclude SRS procedures (CPT 77371 and 77372) from rate setting for traditional APC 5626. This will prevent the major distortions and treat these procedures as separate for rate setting purposes.
- Introduce an edit to allow separate payment for SBRT (CPT 77373) when it appears on C-APC 5627. This will prevent underpayment when two separate interventions are proximal in time for the patient's benefit.
- Expand the list of planning and preparation procedures related to CPT 77371 and 77372 and continue to exclude these services from C-APC 5627. This will preserve separate payment for these procedures that cannot be accurately linked in time to one or more radiation therapy procedures, and will avoid the problems hospitals have in tracking related procedures that occur over time for reasons of clinical practice.

As CMS addresses more complex comprehensive APC configurations, the assumption that a patient is being treated in the outpatient hospital setting for a single problem represented on a single claim is not representative of complex oncology care. When complex interventions are introduced for patients with metastatic or other very severe/complex conditions, treatment for multiple conditions may be observed more often and spread out over several days. If rate setting always targets the average situation (e.g., single conditions treated on a claim), hospitals that treat the poorest and most seriously ill patients will not realize payment that captures their actual costs of care.

CPT 57155 INSERT TANDEM AND/OR OVOIDS FOR BRACHYTHERAPY

The AAPM engaged Direct Research LLC to conduct an analysis of 2015 claims data of newly proposed comprehensive APCs that include surgical codes provided in conjunction with brachytherapy.

CMS proposes assignment of CPT 57155 Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy to newly proposed comprehensive APC 5414 *Level 4 Gynecologic Procedures*. CMS created a complexity adjustment when two or more insertions (57155 + 57155) are provided and assigned 5715E to C-APC 5415 *Level 5 Gynecologic Procedures*.

CPT 57155 describes the insertion of uterine tandem and/or vaginal ovoids prior to brachytherapy treatment delivery. The typical patient receives 4 to 6 fractions, often provided twice a week for 2 to 3 weeks. Two tandem and ovoid insertion procedures (CPT 57155) would never occur on the same day but may occur more than once in a week (e.g., 5 day claim reporting period). The overwhelming majority of 57155 cases are for HDR brachytherapy where the treatment is always the same day as the applicator insertion (2015 CPT codes 77785, 77786, 77787; 2016 codes 77770, 77771 77772).

According to 2015 claims data analysis, 63% of CPT 57155 claims included a HDR brachytherapy treatment delivery code and 37% of claims did not include a HDR brachytherapy code (CPT 77785 or 77786 or 77787). Inaccurate and miscoded claims should not be used for rate setting. Claims that include HDR brachytherapy appear accurate as billing occurs on the same day as the surgical insertion of tandem and/or ovoids (CPT 57155), which is the normal process of care. The geometric mean cost of claims with brachytherapy is \$3,464 and \$2,017 for claims without brachytherapy, a difference of \$1,447.

The current 2016 payment is \$1,861 and the proposed 2017 comprehensive APC payment is \$2,074. The proposed C-APC 5414 payment of \$2,074 clearly reflects miscoded claims without HDR brachytherapy and these should be eliminated from rate setting.

According to data analysis of 5715E, 95% of claims include HDR brachytherapy treatment delivery indicating that the majority of claims were accurately coded. The geometric mean cost of claims with brachytherapy is \$8,094 and \$4,530 for claims without brachytherapy, a difference of \$3,564. The proposed C-APC 5415 payment of \$4,168 is inappropriate and does not reflect the costs associated with HDR brachytherapy treatment delivery.

This 2015 claims data analysis supports our position that comprehensive APCs may result in significant Medicare payment reductions for complex procedures like brachytherapy where surgery to place catheters/needles/devices and brachytherapy treatment delivery is most frequently provided on the same day as surgical insertion or subsequent to device placement surgery. We are not confident that the current comprehensive APCs rate setting methodology adequately or accurately reflects all of the procedures and costs associated with those APCs.

The current comprehensive APC methodology is not suited to insertion of uterine tandem and/or vaginal ovoids for brachytherapy (57155) due to the complexity of treatment and varying hospital claims reporting process.

A correctly coded claim (CPT 57155 and CPT 77785 or 77786 or 77787) could be considered for composite APC payment, which will reflect payments based on accurate hospital coding. CMS states that an advantage to the composite APC model is that they are able to use data from correctly coded multiple procedure claims to calculate payment rates for the specified combinations of services. CMS could establish a composite APC defined as one unit of CPT 57155 Insert tandem and/or ovoids provided on the same day as one unit of HDR brachytherapy treatment delivery defined by CPT 77785 or 77876 or 77787. CMS set precedent in 2008 by establishing the first radiation oncology composite APC 8001 for Low Dose Rate Prostate Brachytherapy (CPT 55875 and 77778) and we support this methodology for CPT 57155 done in conjunction with HDR brachytherapy.

Alternatively, CMS could establish a new type of Comprehensive APC(s) that bases payment on correctly coded claims, which accurately captures the cost of one surgical device insertion procedure (J1=57155) and one associated HDR brachytherapy treatment delivery code (S=77785 or 77786 or 77787). When two surgical device insertion codes are on the same claim then CMS could establish a separate C-APC payment for two surgical device insertion procedures and two associated HDR brachytherapy treatment delivery codes. The Agency could introduce code edits to ensure that correct coding is reflected in the C-APC payment methodology.

The AAPM opposes assignment of CPT 57155 to comprehensive APC 5414 and assignment of 5715E to comprehensive APC 5415 as the proposed payments do not accurately include the costs of HDR brachytherapy and other related preparation and planning services.

The AAPM recommends that CMS maintain the existing traditional APC methodology or establish a new Composite APC or a modified Comprehensive APC(s) based on correctly coded claims, defined by CPT 57155 Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy billed in conjunction with a HDR brachytherapy treatment delivery code CPT 77785 or 77786 or 77787.

OTHER NEWLY PROPOSED COMPREHENSIVE APCs

In the 2017 proposed rule, CMS proposes to create 25 new C-APCs. CMS is converting many traditional APCs to comprehensive APCs. The C-APC policy applies to surgical services provided prior to or during brachytherapy treatment delivery for multiple types of cancer (see Table 5). The episode of care for cancer is complex, especially as it relates to brachytherapy treatment. Often the needles or catheters are surgically placed prior to the brachytherapy treatment delivery, which often consists of multiple fractions over several days or weeks.

Table 5: Newly Proposed C-APC Expansion for Brachytherapy-Related Surgical Codes

C-APC	CPT Codes
5091 <i>Level 1 Breast/ Lymphatic Surgery</i>	19499 Unlisted breast procedure
5092 <i>Level 2 Breast/ Lymphatic Surgery</i>	19298 Breast brachytherapy button and tube catheter placement
5113 <i>Level 3 Musculoskeletal Procedures</i>	20555 Placement needles/catheters into muscle and/or soft tissue for subsequent interstitial radioelement application
5153 <i>Level 3 Airway Endoscopy</i>	31643 Diagnostic bronchoscope, catheter placement
5165 <i>Level 5 ENT Procedures</i>	41019 Placement needles/catheters into head and/or neck region for radioelement application
5302 <i>Level 2 Upper GI Procedures</i>	43241 Upper GI endoscopy, catheter placement
5341 <i>Level 1 Abdominal/ Peritoneal /Biliary and Related Procedures</i>	55920 Placement needles/catheters into pelvic organs and/or genitalia (except prostate) for radioelement application
5414 <i>Level 4 Gynecologic Procedures</i>	57155 Insertion uterine tandem and/or vaginal ovoids 58346 Insertion of Heyman capsules for clinical brachytherapy

Many of the newly proposed comprehensive APC payments do not accurately reflect the costs associated with brachytherapy treatment delivery (CPT 77761-77787) and related radiation oncology preparation and planning procedures. According to data analyses conducted by Direct Research, the geometric mean cost of brachytherapy is not adequately or accurately reflected in some 2017 proposed C-APC payment rates (see Table 6 below). Some of the surgical services in Table 6 related to brachytherapy have low total claim volume or a minimal number of claims with brachytherapy delivery (CPT 19298, 20555, 41019, 43241, 58346).

Further, all of the newly proposed comprehensive APCs and related brachytherapy surgical codes do not include a complexity adjustment with the exception of 5715E assigned to C-APC 5415 *Level 5 Gynecologic Procedures*.

CMS's rules for a complexity adjustment are highly restrictive. CMS only takes "J1" codes into consideration when trying to find code combinations for a complexity adjustment. Because brachytherapy treatment delivery codes have an S status indicator, CMS does not consider whether adding brachytherapy to a claim boosts the costs enough to assign it to another higher paying APC.

Table 6: Claims With and Without Brachytherapy Treatment Delivery (2015 Claims Data)

Same claims, claims with significant use of brachytherapy, split by presence of brachytherapy on the claim.

HCPCS	Claims			Geometric mean cost			2015 actual payment			2017 calculated payment		
	Total	No brachy therapy	With brachy therapy	Total	No brachy therapy	With brachy therapy	Total	No brachy therapy	With brachy therapy	Total	No brachy therapy	With brachy therapy
57155	1289	479	810	\$ 2,834	\$ 2,017	\$ 3,464	\$ 1,915	\$ 599	\$ 2,693	\$ 2,093	\$ 2,063	\$ 2,111
43241	344	336	*	\$ 1,635	\$ 1,596	*	\$ 1,481	\$ 1,429	*	\$ 1,361	\$ 1,361	*
19296	343	295	48	\$ 5,544	\$ 4,519	\$ 19,486	\$ 7,026	\$ 7,050	\$ 6,875	\$ 6,475	\$ 6,455	\$ 6,597
19499	286	197	89	\$ 2,564	\$ 1,434	\$ 9,282	\$ 5,634	\$ 2,710	\$ 12,108	\$ 2,469	\$ 2,481	\$ 2,442
5715E	212	11	201	\$ 7,854	\$ 4,530	\$ 8,094	\$ 7,763	\$ 2,546	\$ 8,048	\$ 4,097	\$ 4,064	\$ 4,099
31643	160	96	64	\$ 1,721	\$ 924	\$ 4,379	\$ 2,641	\$ 1,442	\$ 4,440	\$ 1,215	\$ 1,207	\$ 1,226
55920	91	25	66	\$ 5,928	\$ 2,434	\$ 8,305	\$ 5,668	\$ 2,964	\$ 6,692	\$ 3,130	\$ 2,937	\$ 3,203
19298	60	52	*	\$ 5,177	\$ 4,681	*	\$ 7,274	\$ 7,230	*	\$ 4,334	\$ 4,302	*
41019	28	21	*	\$ 3,618	\$ 3,350	*	\$ 2,916	\$ 2,512	*	\$ 4,307	\$ 4,331	*
58346	17		17	\$ 7,623		\$ 7,623	\$ 9,136		\$ 9,136	\$ 1,955		\$ 1,955
20555	*	*	*	*	*	*	*	*	*	*	*	*

The current comprehensive APC methodology is not appropriate for some brachytherapy-related surgical codes, including CPT 55920, 58346 and 31643 as the payment is inadequate and does not account for the costs of brachytherapy treatment delivery or other services associated with treatment preparation and planning. Further, these codes are not subject to additional payment through a complexity adjustment.

CPT 19298 PLACEMENT OF BREAST BRACHYTHERAPY CATHETER

CMS proposes to reassign CPT 19298 from current C-APC 5093 *Level 3 Breast/Lymphatic Surgery and Related Procedures* to newly proposed C-APC 5092 *Level 2 Breast/Lymphatic Surgery and Related Procedures*, which yields a 41.8% payment reduction from 2016 payment of \$7,558 to proposed 2017 payment of \$4,395.

CPT 19298 Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes image guidance

CPT 19298 describes the placement of multiple button and tube type catheters into the breast for brachytherapy treatment delivery at the time of or subsequent to partial mastectomy. The typical patient receives 10 fractions of brachytherapy over a 5-day period.

Historically, both breast brachytherapy catheter placement codes 19296 and 19298 have been assigned to the same APC, as they are similar clinically and with regard to resource cost. Table 7 confirms that CPT 19296 and 19298 have similar geometric mean and median costs based on 2015 claims.

Table 7: Geometric Mean and Median Cost of Breast Brachytherapy Catheter Codes (2015 Claims Data)

HCPCS	SI	APC	Payment Rate	Single Frequency	Total Frequency	Median Cost	Geometric Mean Cost
19296	J1	5093	\$6,696.89	337	338	\$5,617.22	\$5,884.93
19298	J1	5092	\$4,394.99	59	60	\$5,135.50	\$5,171.52

The C-APC 5092 proposed payment of \$4,395 for CPT 19298 is less than what this procedure was paid under the traditional APC prior to assignment to a comprehensive APC in 2015 (see Table 8 below). The 2017 proposed payment is inaccurate and inappropriate and does not cover the costs associated with the surgical placement of the breast brachytherapy catheter and all of the other codes included on the claim.

Table 8: 2011-2015 APC Payment for Breast Brachytherapy Catheter Codes (2015 Claims Data)

HCPCS	Descriptor	2011 Payment	2012 Payment	2013 Payment	2014 Payment
19296	Breast interstitial radiation treatment, delayed (expandable)	\$4,407.45	\$4,394.13	\$4,562.00	\$4,846.71
19298	Placement afterloading brachytherapy catheters (tube/button) into breast	\$4,407.45	\$4,394.13	\$4,562.00	\$4,846.71

The AAPM recommends that CMS maintain the current assignment of CPT 19298 Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes image guidance in C-APC 5093 Level 3 Breast/ Lymphatic Surgery and Related Procedures in 2017.

We hope that CMS will consider these issues during the development of the 2017 HOPPS final rule. Should CMS staff have additional questions, please contact Wendy Smith Fuss, MPH at (561) 637-6060.

Sincerely,



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President, AAPM



Blake Dirksen, M.S.
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