

August 30, 2019

Seema Verma, Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1717-P  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Re: Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; CMS-1717-P

Dear Administrator Verma:

The American Association of Physicists in Medicine<sup>1</sup> (AAPM) is pleased to submit comments to the Centers for Medicare and Medicaid Services (CMS) in response to the August 9, 2019 *Federal Register* notice regarding the 2020 Medicare Hospital Outpatient Prospective Payment System (HOPPS) and Ambulatory Surgical Center (ASC) proposed rule.

The AAPM provides the following recommendations:

- Discontinue Comprehensive APC payment policy for all brachytherapy insertion codes. Alternatively, modify the C-APC methodology to pay for “J1” brachytherapy insertion device and make separate payment for related planning and preparation services in addition to the C-APC payment effective January 1, 2020.
- Discontinue Comprehensive APC payment policy for Single Session Cranial Stereotactic Radiosurgery codes 77371 and 77372. Alternatively, continue separate payment for the 10 planning and preparation services in effect and add IMRT planning code 77301 effective January 1, 2020.
- Exempt all radiation therapy services from the CMS proposal to apply a minimum required level of General Supervision for hospital outpatient therapeutic services furnished by all hospitals and critical access hospitals (CAHs).
- Discontinue the CT and MRI cost centers effective January 1, 2020.
- Oppose prior authorization for procedures and services under “traditional” Medicare Part B services provided in a hospital outpatient department.

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<sup>1</sup> 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, MRI, 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.

## 1. Comprehensive APC Methodologies for Surgical Insertion Codes for Brachytherapy

Since the inception of the Comprehensive APC (C-APC) methodology, the AAPM has commented on concerns around the claims data used for ratesetting due to significant variations in clinical practice and billing patterns across the hospitals that submit these claims. We met with CMS staff in February 2018 and in our 2019 HOPPS proposed rule comment letter we provided an alternative payment methodology for the C-APCs related to surgical insertion codes for brachytherapy treatment. **To date, the Agency has not addressed these concerns and the impact on Medicare beneficiary access to brachytherapy in the hospital outpatient setting is evident.**

Despite the consensus of clinical evidence of improved outcomes using brachytherapy, there is a decline in its use for many cancer patients, including cervical cancer patients. According to the CMS HOPPS Cost Statistics File, the utilization of insertion of tandem and ovoids for clinical brachytherapy treatment (CPT 57155) has significantly decreased since the inception of the C-APC payment methodology in 2017 (see Table 1).

Table 1: CPT 57155 Total Claims Frequency

2015 Final Rule	2016 Final Rule	2017 Final Rule	2018 Final Rule	2019 Final Rule	2020 Proposed Rule
2461	2490	1440	1729	1604	1416

The AAPM remains concerned that the rates associated with C-APCs do not accurately or fully reflect the services and costs associated with the primary procedure. The current C-APC methodology is of particular concern as CMS continues to expand the number of packaged and bundled services. Given the complexity of coding, serial billing for cancer care, and potentially different sites of service for the initial surgical device insertion and subsequent treatment delivery or other supportive services, the AAPM continues to oppose the current comprehensive APC payment methodology for cancer care.

To further illustrate our concerns with the current C-APC payment methodology, we compared hospital outpatient reimbursement for CPT 57155 insertion of tandem and ovoids for clinical brachytherapy under the “traditional” clinical APC methodology and the current C-APC methodology. In our analysis, we included only typically utilized radiation oncology procedures and did not include other bundled items related to surgery. Under the clinical APC methodology, estimated 2020 reimbursement is \$17,785 (see Table 2).

Table 2: Estimated 2020 Medicare Reimbursement for CPT 57155 Under Clinical APC Payment Methodology

CPT Code	CPT Descriptor	Units	2020 Proposed Reimbursement	2020 Proposed Reimbursement Per Episode of Treatment
77263	Physician treatment planning, complex	1	0.00	0.00
77470	Special treatment procedure	1	547.14	547.14
77370	Special medical physics consult	1	128.45	128.45
77336	Continuing medical physics	1	128.45	128.45
77295	3D planning (DVH of target and normal tissues)	5	1,260.81	6,304.05
77300	Basic radiation dose calculation	5	128.45	642.25
77290	Simulation, complex (contour volumes)	5	339.20	1,696.00
57155	Insert Tandem and Ovoids	5	461.52	2,307.60
77332	Treatment device	5	128.45	642.25
77771	HDR brachytherapy 2-12 channels	5	754.19	3,770.95
77790	Supervision, handling, loading of radiation source	5	0	0
C1717	Ir-192 HDR source	5	323.65	1,618.25
				<b>\$17,785.39</b>

Under the current C-APC payment methodology, a hospital's estimated reimbursement would depend on how often the hospital files a claim. The examples below assume a total of 5 insertion of tandem and ovoids for clinical brachytherapy (CPT 57155) and 5 HDR brachytherapy treatment (CPT 77771), with 2 treatments per week over a 3-week period. This HDR brachytherapy treatment utilizes an Iridium-192 HDR source (HCPCS C1717), which is separately paid in addition to the C-APC payment.

- If a hospital submits claims on a monthly basis, the approximate payment would be \$6,045 (1 complexity adjustment C-APC 5415 and 5 C1717 brachytherapy sources).
- If a hospital submits bi-weekly claims, the approximate payment would be \$8,609 (1 complexity adjustment C-APC 5415; 1 C-APC 5414 and 5 C1717 brachytherapy sources).
- If a hospital submits weekly claims, the approximate payment would be \$13,036 (2 complexity adjustment C-APC 5415; 1 C-APC 5414 and 5 C1717 brachytherapy sources).
- If a hospital submits claims on a daily basis, the approximate payment would be \$14,441 (5 C-APC 5414 and 5 C1717 brachytherapy sources)

Under any C-APC scenario, a hospital would not yield adequate reimbursement for a course of cancer treatment.

In our 2019 HOPPS proposed rule comment letter, the AAPM proposed a modified C-APC methodology for the surgical codes related to brachytherapy that mirrors the current CMS payment policy for single-session cranial stereotactic radiosurgery codes 77371 and 77372, which allows separate payment for specified preparation and planning codes. Yet for 2020, CMS proposes to continue the flawed C-APC payment methodology for the surgical insertion codes for brachytherapy treatment (see Table 3).

Table 3: Comprehensive APCs Related to Brachytherapy Insertion Codes

<b>C-APC</b>	<b>CPT Codes</b>
5091 <i>Level 1 Breast Surgery</i>	19499 Unlisted breast procedure
5092 <i>Level 2 Breast Surgery</i>	19298 Breast brachytherapy button & tube catheter placement
5093 <i>Level 3 Breast Surgery</i>	19296 Breast brachytherapy balloon 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
5375 <i>Level 5 Urology Services</i>	55875 Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy
5414 <i>Level 4 Gynecological Procedures</i>	57155 Insertion uterine tandem and/or vaginal ovoids 58346 Insertion of Heyman capsules for clinical brachytherapy
5415 <i>Level 5 Gynecological Procedures</i>	55920 Placement needles/catheters into pelvic organs and/or genitalia (except prostate) for radioelement application

As noted, the episode of care for cancer is complex, especially as it relates to brachytherapy treatment. Most brachytherapy insertion procedures and brachytherapy treatments occur on the same day or within the same week and therefore the services should appear on the same claim. However; in other cases, the needles or catheters are surgically placed prior to the brachytherapy treatment delivery, which often consists of multiple fractions over several days or weeks and therefore may appear on different claims. Furthermore, brachytherapy surgical insertion procedures may be provided in the outpatient setting but brachytherapy treatment or other supportive services occur at another site of service outside of the hospital setting (e.g., freestanding cancer center). This is common for the breast brachytherapy catheter codes (19296 and 19298) and certain GYN brachytherapy procedures. Regarding CPT 19296, the breast catheter is always placed after a partial mastectomy, typically days after the surgical procedure. The catheter may be placed in the outpatient department or another site of service such as a physician office. The patient may then receive brachytherapy treatment delivery at another site of service, including a hospital outpatient department, freestanding cancer center or ambulatory surgical center. Similarly, with CPT 57155, the tandem and ovoids may be placed under anaesthesia in the hospital outpatient setting, after which the patient is transported to a nearby freestanding center, where the treatment preparation, treatment planning, and treatment delivery services are performed.

Furthermore, brachytherapy procedures may be provided concurrently with external beam radiation therapy delivery services. Such services, which are not supportive to the brachytherapy procedure, would not be paid separately if they appear on the same claim as the J1 code under the C-APC methodology.

The current Comprehensive APC payment methodology for brachytherapy does not accurately reflect the true cost of providing the procedures.

**The AAPM recommends that CMS discontinue the Comprehensive APC payment policy in 2020 for all brachytherapy insertion codes. CMS should revert to status indicator “T” for CPT codes 19296, 19298, 19499, 20555, 31643, 41019, 43241, 55875, 55920, 57155 and 58346.**

**Alternatively, CMS could continue to pay for “J1” brachytherapy insertion codes under the C-APC payment methodology but exclude and make separate payment for designated preparation and planning services in addition to the C-APC payment.**

**The AAPM identified a list of twenty-eight (28) codes proposed for separate payment in addition to the C-APC payment for the brachytherapy insertion codes effective January 1, 2020 (see below).** Not all planning and preparation codes would be utilized for each brachytherapy insertion procedure code listed in Table 3 above. This recommendation mirrors the current CMS payment policy for single-session cranial stereotactic radiosurgery codes 77371 and 77372, which allows separate payment for specified preparation and planning codes.

- 10035 Placement of soft tissue localization device (egg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including image guidance; first lesion
- 32553 Placement of interstitial devices for radiation therapy guidance (egg fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple
- 49411 Placement of interstitial devices for radiation therapy guidance (egg fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvis (except prostate), and/or retroperitoneum, single or multiple
- 55874 Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance
- 55876 Placement of interstitial device(s) for radiation therapy guidance, prostate, single or multiple
- 76000 Fluoroscopy, up to 1 hour physician or other qualified health care professional time
- 76872 Ultrasound, transrectal
- 76873 Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning
- 77280 Therapeutic radiology simulation-aided field setting; simple
- 77285 Therapeutic radiology simulation-aided field setting; intermediate
- 77290 Therapeutic radiology simulation-aided field setting; complex
- 77295 3-dimensional radiotherapy plan, including dose-volume histograms
- 77300 Basic radiation dosimetry calculation
- 77301 Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications



- 77306 Teletherapy isodose plan; simple, include basic dosimetry calculation(s)
- 77307 Teletherapy isodose plan; complex, include basic dosimetry calculation(s)
- 77316 Brachytherapy isodose plan; simple, include basic dosimetry calculation(s)
- 77317 Brachytherapy isodose plan; intermediate, include basic dosimetry calculation(s)
- 77318 Brachytherapy isodose plan; complex, include basic dosimetry calculation(s)
- 77321 Special teletherapy port plan
- 77331 Special dosimetry, only when prescribed by treating physician
- 77332 Treatment devices; simple
- 77333 Treatment devices; intermediate
- 77334 Treatment devices; complex
- 77336 Continuing medical physics consultation
- 77338 Multi-leaf collimator devices for IMRT
- 77370 Special medical radiation physics consultation
- C9728 Placement of interstitial devices for radiation therapy/surgery guidance (e.g., fiducial markers, dosimeter), for other than the following sites (any approach); abdomen, pelvis, prostate, retroperitoneum, thorax, single or multiple

As noted above, CMS identifies a list “brachytherapy insertion codes” defined in Table 3. The AAPM has concerns regarding two (2) of the codes (CPT 43241 and 19499) because these codes are not used exclusively for brachytherapy but may be used for other radiation oncology related or non-radiation oncology related procedures.

- 43241 Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube catheter
- 19499 Unlisted procedure breast

**The AAPM recommends that CMS remove CPT 43241 and 19499 from the list of brachytherapy insertion codes, as they are not used exclusively for brachytherapy treatment.**

## **2. Comprehensive APC Methodologies for Stereotactic Radiosurgery**

In the 2020 proposed rule, CMS maintains CPT 77371 and 77372 single session cranial stereotactic radiosurgery (SRS) in Comprehensive APC 5627 *Level 7 Radiation Therapy*.

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 primary “J1” procedure could be captured in the C-APC methodology. CMS identified some, but not all, planning and preparation codes, and continues separate payment in 2020 for the 10 codes listed below. We understand that CMS calculates the C-APC 5627 rate without including the cost associated with these codes.

- 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 has previously 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, 2017, 2018, 2019 and 2020 is inappropriate.

**The AAPM supports continued separate payment for the ten (10) planning and preparation codes related to CPT 77371 and 77372. Further, the AAPM recommends that IMRT planning code 77301 be added to list of separately paid planning and preparation codes related to stereotactic radiosurgery codes 77371 and 77372 effective January 1, 2020.**

We believe hospitals are not appropriately coding for SRS and stereotactic body radiation therapy (SBRT) services. CMS's continued 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.

Further, the C-APC methodology is also capturing costs for other therapeutic radiation oncology procedures, often delivered during the same time span as the SRS procedures, which treat different lesions (e.g., presence of SBRT procedures on same claims with SRS procedures). This reporting of two separate treatments areas 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.

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 or weeks. 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.

**The AAPM urges CMS to eliminate the Comprehensive APC payment policy for single-session stereotactic radiosurgery code 77371 and 77372.** CMS should work with stakeholders to develop a more appropriate payment methodology for these services.

### **3. Supervision of Outpatient Therapeutic Services in Hospitals and Critical Access Hospitals**

CMS is proposing to change the generally applicable minimum required level of supervision for hospital outpatient therapeutic services from Direct Supervision to General Supervision for services furnished by all hospitals and critical access hospitals (CAHs).

CMS reports that stakeholders have consistently requested that CMS continue the nonenforcement of the direct supervision requirement for hospital outpatient therapeutic services for CAHs and small rural hospitals having 100 or fewer beds. Stakeholders stated that some small rural hospitals and CAHs have insufficient staff available to furnish direct supervision. These stakeholders noted that it is particularly difficult to furnish direct supervision for critical specialty services, such as radiation oncology services, that cannot be directly supervised by a hospital emergency department physician or nonphysician practitioner because of the volume of emergency patients or lack of specialty expertise.

As defined, General Supervision means that the procedure is furnished under the physician's overall direction and control, but that the physician's presence is not required during the performance of the procedure. This proposal would ensure a standard minimum level of supervision for each hospital outpatient service furnished incident to a physician's service in accordance with the statute.

CMS states that they have not learned of any data or information from CAHs and small rural hospitals indicating that the quality of outpatient therapeutic services has been affected by requiring only general supervision for these services. CMS notes that it is important to remember that the requirement for general supervision for outpatient therapeutic services does not preclude these hospitals from providing direct supervision for outpatient therapeutic services when the physicians administering the medical procedures decide that it is appropriate to do so. Many outpatient therapeutic services involve a level of complexity and risk such that direct supervision would be warranted even though only general supervision is required.

CMS is seeking public comments on whether specific types of services, such as radiation therapy, should be excluded from this proposal.

The sophistication and complexity of radiation therapy technology has increased exponentially in the past few decades. As radiation treatments have become more targeted and precise, they have also required increasingly complex equipment and processes. The work of ensuring treatment accuracy and patient safety throughout a prescribed course of treatment has also become more



demanding in expertise and attention. Due to the complexity of radiation therapy, radiation oncology providers need to be immediately available during treatment planning and delivery.

Radiation therapy utilizes high doses of ionizing radiation. Under General Supervision, the use of therapeutic levels of radiation dose poses an inherent danger and could cause serious harm to patients due to the irreversible nature of radiation treatment delivery.

Direct Supervision should be maintained for all radiation therapy services and procedures to ensure patient safety and maintain high quality cancer care.

**The AAPM recommends that all radiation therapy services be exempt from the CMS proposal to apply a minimum required level of General Supervision for hospital outpatient therapeutic services furnished by all hospitals and critical access hospitals (CAHs). The AAPM believes that radiation therapy requires a minimum level of Direct Supervision in all hospitals, including critical access hospitals.**

#### **4. CT & MRI Cost Centers**

In the 2014 HOPPS final rule, CMS finalized a policy of creating new cost centers and distinct cost-to-charge ratios (CCRs) for implantable devices, magnetic resonance imaging (MRIs), computed tomography (CT), and cardiac catheterization. However, in response to the 2014 HOPPS proposed rule, commenters reported that some hospitals currently use an imprecise “square feet” allocation methodology for the costs of large moveable equipment like CT scan and MRI machines. They indicated that while CMS recommended using two alternative allocation methods, “direct assignment” or “dollar value,” as a more accurate methodology for directly assigning equipment costs, industry analysis suggested that approximately only half of the reported cost centers for CT scans and MRIs rely on these preferred methodologies. In response to concerns from commenters, CMS finalized a policy for the 2014 HOPPS to remove claims from providers that use a cost allocation method of “square feet” to calculate CCRs used to estimate costs associated with the APCs for CT and MRI. Further, CMS finalized a transitional policy to estimate the imaging APC relative payment weights using only CT and MRI cost data from providers that do not use “square feet” as the cost allocation statistic. CMS stated that this policy would sunset in 4 years to provide a sufficient time for hospitals to transition to a more accurate cost allocation method and for the related data to be available for rate setting purposes. Therefore, beginning in 2018, CMS would estimate the imaging APC relative payment weights using cost data from all providers, regardless of the cost allocation statistic employed. In both the 2018 HOPPS final rule and the 2019 HOPPS proposed rule, CMS extended the transition policy for 1 additional year and continues to remove claims from providers that use a cost allocation method of “square feet” to calculate CT and MRI CCRs. For 2020, CMS is proposing to use all claims with valid CT and MRI cost center CCRs, including those that use a “square feet” cost allocation method, to estimate costs for the APCs for CT and MRI.

CMS notes that stakeholders have raised concerns regarding using claims from all providers to calculate CT and MRI CCRs, regardless of the cost allocations statistic employed. Stakeholders

noted that providers continue to use the “square feet” cost allocation method and that including claims from such providers would cause significant reductions in the imaging APC payment rates.

According to data from the American College of Radiology (ACR), approximately half of all hospitals paid under the HOPPS had CT and/or MRI cost centers that were reporting CCRs using the preferred methods (“dollar value” or “direct assignment”). Hence current rates have declined based on using partial data. These data show that hospitals have either been unable or unwilling to make the changes CMS regulations mandated.

The change required to create standard cost centers for CT and MRI is complex and hospitals are unable to respond. The CCRs for selected CT and MRI procedures show a significant number of CCRs that are close to zero. These near zero CCRs indicate that even when hospitals create standard cost centers, they are likely unable to accurately re-allocate many costs that are already allocated across hospital departments to new CT and MRI departmental cost centers. For these hospitals, the CCRs probably reflect allocations of staffing and dedicated departmental expenses, while the costs of equipment, some costs associated with space (e.g., lead in walls), other administrative costs have been spread across all hospital departments and have not been moved. The presence of these near zero CCRs will contribute to underestimated costs used in rate setting, pulling rates for CT and MRI procedures down below their actual cost and further eroding payment accuracy. No other high cost technologies are treated in this manner. Hospitals have standard accounting practices for high cost moveable equipment and it is inconsistent and burdensome to expect hospitals to account CT and MRI in a different manner than they deal with other types of equipment.

Further, the use of separate CT and MRI CCRs creates unintended consequences on the technical component of CT and MRI codes in the Medicare Physician Fee Schedule (MPFS). If this policy is finalized, the resulting reductions in hospital payments would also affect the physician office practice setting. This is because the HOPPS technical payments would fall below the payment rates in the MPFS causing further cuts as mandated by the Deficit Reduction Act of 2005 (DRA). The DRA mandates that the MPFS technical payments be paid at the MPFS rate or HOPPS rate, whichever is the lower.

**The AAPM recommends elimination of CT and MRI standard cost centers effective January 1, 2020.** The evidence demonstrates that the CCRs for CT and MRI are incorrect and causing inadequate payments for CT and MRI services.

## **5. Prior Authorization for Certain Hospital Outpatient Procedures**

CMS believes that prior authorization is an effective method for controlling unnecessary increases in the volume of covered outpatient services. Beginning July 1, 2020, CMS proposes a prior authorization process for five categories of services: blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty and vein ablation.

In a recent June 2019 Request for Information, CMS asked for feedback from stakeholders on the burdens of prior authorization as part of the Agency’s Patients Over Paperwork initiative. The

Regulatory Relief Coalition told CMS that prior authorization requirements imposed by Medicare Advantage plans “pose the single greatest administrative burden for physicians caring for Medicare patients.”

The American Society for Radiation Oncology (ASTRO) recently surveyed members regarding the burden associated with prior authorization. ASTRO conducted a nationwide web survey of its members in late 2018, and the group says the findings “make clear that restrictive prior authorization practices cause unnecessary delays and interference in care decisions for cancer patients.”

About 30% of the providers who responded said the average length of treatment delay their patients see due to prior authorization is between one and three days, 32% said the delay is between four and five days and 31% said the average delay their patients see due to prior authorization is more than five days. These findings are cause for alarm given research linking each week of delay in starting cancer therapy with a 1.2% to 3.2% increased risk of death.

ASTRO reported that most requests submitted by the radiation oncologist are initially approved, and nearly two-thirds of providers who responded to the survey said most denials they receive during the process are overturned on appeal.

CMS Administrator Seema Verma recently said prior authorization shouldn't interfere with the practice of medicine or delay patient care. We agree with Administrator Verma. **The AAPM opposes prior authorization for procedures and services under “traditional” Medicare Part B services provided in a hospital outpatient department.**

Prior authorization impedes delivery of cancer care. Patients deserve the ability to receive the cancer care that is prescribed by their provider. Prior authorization is an effort to decrease Medicare expenditures at the expense of patients. **The AAPM recommends that CMS carefully consider health care delays and the resulting impact on beneficiaries' health when evaluating any prior authorization requirements.**

We hope that CMS will consider these issues during the development of the 2020 HOPPS final rule. Should CMS staff have additional questions, please contact Wendy Smith Fuss, MPH at (904) 844-2487.

Sincerely,



Cynthia H. McCollough, Ph.D., FAAPM, FACR, FAIMBE  
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