



August 23, 2017

Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1676-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Revisions to Payment Policies under the Medicare Physician Fee Schedule for CY 2018; Proposed Rule; CMS-1676-P

Dear Administrator Verma,

The American Association of Physicists in Medicine (AAPM)¹ is pleased to submit comments to the Centers for Medicare and Medicaid Services (CMS) in response to the July 21, 2017 *Federal Register* notice regarding the 2018 Medicare Physician Fee Schedule (MPFS) proposed rule.

The AAPM appreciates that 2018 CMS proposals have minimal impact to radiation oncology procedures and services and provides the following recommendations.

- AAPM supports the RUC-recommended and CMS approved relative value units (RVUs) for radiation therapy planning codes 77261, 77262, 77263; and new peri-prostatic implantation of biodegradable material code 55X87.
- AAPM opposes the CMS proposed code description and related work RVU for new superficial radiation treatment planning and management code GRRR1. AAPM recommends that the newly proposed service be subject to the AMA Current Procedural Terminology (CPT) Editorial Panel and Relative Value Scale Update Committee (RUC) processes.
- AAPM supports the CMS proposal to implement the Appropriate Use Criteria (AUC) program on January 1, 2019. In addition, we support the one-year transition period where claims will be paid regardless of whether the correct information is provided on the claim.

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.

I. 2018 Proposed Relative Value Units (RVUs)

For 2018, CMS is proposing to accept the RUC-recommended work RVUs based on the understanding that the RUC generally considers the kinds of concerns CMS has historically raised regarding appropriate valuation of work RVUs. AAPM agrees with this proposal. We believe that while the CPT/RUC process is rigorous, it does result in fair and equitable valuation of services.

AAPM supports the CMS proposal to accept the RUC-recommended work RVUs in the 2018 MPFS proposed rule.

A. Therapeutic Radiology Treatment Planning Codes (77261, 77262, 77263)

CPT 77263 *Therapeutic radiology treatment planning; complex* was identified through a screen of high expenditure services across specialties as a potentially misvalued code. CPT codes 77261 and 77262 were also included for review. For 2018, CMS is proposing the RUC-recommended work RVUs of 1.30 for CPT 77261, 2.00 for CPT 77262, and 3.14 for CPT 77263.

In the proposed rule, CMS notes concerns regarding the RUC-recommended work RVUs given the decreases in service times as recommended by the RUC and reflected in the survey data compared to the current values. CMS considers alternative RVUs based on a crosswalk to a code with the same intraservice time and similar total time to CPT 77263.

The use of direct crosswalks based only on time comparison or ratios of time inappropriately discount the variation in technical skill, judgment, and risk inherent to procedures. CMS considered a crosswalk to CPT code 96111 that describes developmental testing, which is typically used for evaluating individuals with suspected developmental disorders. CPT code 96111 describes evaluation, interpretation and reporting. It does not include treatment planning. As such, the crosswalk to CPT code 96111 is inappropriate. We believe that the RUC undertook a rigorous and valid analysis to ensure the accuracy of the recommended values. AAPM urges CMS to accept the RUC-recommended values for the Therapeutic Radiology Treatment Planning codes.

AAPM supports the RUC-recommended and CMS approved work relative value units of 1.30 for CPT 77261, 2.00 for CPT 77262, and 3.14 for CPT 77263. We do not support the CMS alternative valuation for these codes.

B. Peri-Prostatic Implantation of Biodegradable Material (55X87)

In October 2016, the CPT Editorial Panel deleted Category III code 0438T and created a new CPT code 55X87 *Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed*. For 2018, CMS is proposing the RUC-recommended work RVU of 3.03 for CPT 55X87.

In reviewing the RUC recommendations, CMS noted a decrease in preservice time (30 minutes) compared to the current value. AAPM disagrees that there is a decrease in preservice time compared to the current preservice time. The current Category III code 0438T was not surveyed and there no physician time inputs in the database.

AAPM supports the RUC-recommended and CMS approved work relative value unit of 3.03 for the new peri-prostatic implantation of biodegradable material code 55X87. We do not support the CMS alternative valuation for 55X87.

In addition, *CMS seeks comments related to whether equipment item EQ250 portable ultrasound includes probes.* The EQ250 ultrasound unit, portable (\$29,999) does not include an intracavitary probe, the probe necessary to perform this procedure. Both the portable unit and the intracavitary probe should be included as direct practice expense inputs for this procedure.

C. Superficial Radiation Treatment Planning and Management (GRRR1)

In the 2015 MPFS, CMS finalized language limiting the codes that could be reported with superficial radiation therapy (SRT) delivery. At that time, the CPT Panel considered and ruled out potential reporting of other radiation therapy services with CPT code 77401, but did determine that a physician evaluation and management code may be reported, when performed, if CPT 77401 is billed alone.

Based on stakeholder comments, CMS proposes to make separate payment for the professional planning and management associated with superficial radiation treatment using HCPCS code GRRR1 *Superficial radiation treatment planning and management related services, including but not limited to, when performed, clinical treatment planning (for example, 77261, 77262, 77263), therapeutic radiology simulation-aided field setting (for example, 77280, 77285, 77290, 77293), basic radiation dosimetry calculation (for example, 77300), treatment devices (for example, 77332, 77333, 77334), isodose planning (for example, 77306, 77307, 77316, 77317, 77318), radiation treatment management (for example, 77427, 77431, 77432, 77435, 77469, 77470, 77499), and associated evaluation and management per course of treatment.* CMS intends for this code to describe the range of professional services associated with a course of SRT, including services similar to those not otherwise separately reportable under CPT guidance and the NCCI manual. For 2018, CMS is proposing a work RVU of 7.93 for HCPCS code GRRR1.

To value this code, CMS is including the physician work and work time associated with radiation management-related services that they think would be typical for a course of SRT treatment. CMS is not proposing to include inputs related to radiation physics consultation, described by CPT 77336, as they think that a typical course of SRT would not require this service, and the typical practitioner providing SRT would not be performing a physics consultation.

In response to the proposed G-code, CMS does not share the specific methodology used to determine the components of the G-code, nor how it achieved the 7.93 RVU valuation. The methodology should be transparent and detailed in the proposed rule.

Further, the AAPM is concerned that the wording of the proposed code does not explicitly make clear the role of the Qualified Medical Physicist (QMP) in the delivery of this broad service. It is

crucial that any course of treatment involving external beam radiation therapy be subject to a quality management process provided by a QMP. The QMP services typically include, but may not be limited to: calibration and performance testing of the equipment, technical consultation at simulation as to optimal patient positioning; choice of treatment beam energy and appropriate applicators; confirmation that the treatment plan and dosimetry calculation are performed accurately and in accordance with the written prescription; supervision of technical details of the treatment delivery; and timely review of the patient records at the presumed end of treatment to assure that the entire prescription has been accurately fulfilled in its entirety and appropriately documented. These services are generally captured and billed in radiation therapy using CPT 77336 *Continuing medical physics consultation*. It is not clear whether these QMP services are meant to be bundled in GRRR1, in which case some language to that effect is missing from the proposed code and one presumes also is missing from the valuation, or whether it is intended that 77336 be billed separately as a matter of routine, in which case some clarifying language to that effect would be welcome. It would be an unfortunate, and AAPM presumes unintended, consequence if silence in the description of GRRR1 as to the role of the services of a Qualified Medical Physicist was to undermine the provision of those vital services to patients receiving superficial radiation therapy.

The AAPM cannot support the G-code description of work as currently proposed. As proposed GRRR1 includes multiple services in one code that would be highly valued. The proposed payment would be the same if one or multiple services are provided. This current G-code descriptor should be broken into smaller components.

AAPM opposes the CMS proposed code description and related work RVU of 7.93 for new superficial radiation treatment planning and management code GRRR1. AAPM recommends that the newly proposed service be subject to the AMA Current Procedural Terminology (CPT) Editorial Panel and Relative Value Scale Update Committee (RUC) processes.

II. Malpractice RVUs

For 2018, CMS is proposing malpractice RVUs developed using the most recent data available. CMS collects malpractice insurance premium data from all 50 states, the District of Columbia and Puerto Rico in order to update the malpractice RVUs for each specialty. Rate filings must be available from at least 35 states to establish the minimum amount of premium data necessary to establish a malpractice RVU rate.

CMS crosswalks specialties for which there is not sufficient premium data to similar specialties, in order to establish malpractice RVUs. The most recent data for radiation oncology was only available from 23 states, and does not meet the CMS 35-state threshold. Therefore, CMS proposes to crosswalk the risk factor for diagnostic radiology to radiation oncology to establish the malpractice RVUs. *CMS seeks comments on the methodology to develop 2018 malpractice RVUs.*

While AAPM agrees with the crosswalk to diagnostic radiology for the calculation of malpractice RVUs for the specialty of radiation oncology, we are concerned that CMS was unable to collect radiation oncology specific malpractice data from at least 35 states. In 2015, when a similar analysis was performed, radiation oncology malpractice data was collected from 41 states. It is troublesome

that data could not be collected from at least 35 states, given the number of radiation oncology practices across the country. AAPM urges CMS to reevaluate the process for collecting malpractice insurance premium data, so that information that is more accurate is available for future rate setting.

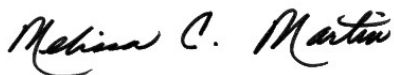
III. Appropriate Use of Diagnostic Imaging

The Protecting Access to Medicare Act of 2014 establishes a program to promote the use of Appropriate Use Criteria (AUC) for advanced diagnostic imaging services. CMS is proposing that ordering professionals must consult specified applicable AUC through qualified clinical decision support mechanisms (CDSMs) for applicable imaging services furnished in an applicable setting, paid for under an applicable payment system and ordered on or after January 1, 2019. The Medicare AUC program is proposed to begin with an educational and operations testing year in 2019, which means physicians would be required to start using AUCs and reporting this information on their claims. During this first year, CMS is proposing to pay claims for advanced diagnostic imaging services regardless of whether they contain information on the required AUC consultation.

AAPM supports the CMS proposal to implement the Appropriate Use Criteria (AUC) program on January 1, 2019. In addition, we support the one-year transition period where claims will be paid regardless of whether the correct information is provided on the claim.

Appropriate payment for medical physics services, radiology and radiation oncology procedures is necessary to ensure that Medicare beneficiaries continue to have full access to diagnostic imaging and high quality cancer treatments. We hope that CMS will consider these issues for the 2018 Physician Fee Schedule final rule. Should CMS staff have additional questions, please contact Wendy Smith Fuss, MPH at (561) 637-6060.

Sincerely,



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