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September 2, 2015

Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1631-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 Proposed Rule; CMS-1631-P

Dear Administrator Slavitt:

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 15, 2015 *Federal Register* notice regarding the 2016 Medicare Physician Fee Schedule (MPFS) proposed rule.

AAPM has significant concerns regarding the proposed reductions to radiation oncology and freestanding radiation therapy centers in the 2016 MPFS rule. Cuts of this magnitude could harm cancer care, especially in rural areas, and will negatively impact Medicare beneficiary access to life-saving treatments. For many facilities, fixed budgets for physical plant and capital equipment have been made based on long-term *pro forma* revenue projections that CMS proposes to substantially change in the short-term. It is almost certain that a cut of this scope and depth in projected operational revenue will immediately and directly result in reductions of expenditures for non-physician clinical labor, which includes the Medical Physicist. AAPM is deeply concerned that the loss of substantial necessary Medical Physicist work under the proposal can be expected to result in a decrease in both the quality and safety of the radiation services delivered to the patients insured by CMS.

[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. Radiation Treatment Delivery and Image Guidance

For 2016, CMS proposes a revised set of codes that describe radiation treatment delivery and image guidance services (see below):

- 77402 Radiation treatment delivery, >1 MeV; simple
- 77407 Radiation treatment delivery, >1 MeV; intermediate
- 77412 Radiation treatment delivery, >1 MeV; complex
- 77385 IMRT, includes guidance and tracking, when performed; simple
- 77386 IMRT, includes guidance and tracking, when performed; intermediate
- 77387 Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed

CMS did not accept the AMA RUC recommendation to include 2 minutes for "dose output and performance verification" to the equipment inputs for treatment delivery codes 77402, 77407, 77412, 77385 and 77386. This activity is a critical step in the process of care and is performed on the following equipment:

- Laser Diode (ER040)
- Radiation Treatment Vault (ER056)
- Power conditioner (ER102)
- IMRT Linear Accelerator (ER089)
- Water Chiller (ER065)

The AAPM recommends that CMS add two (2) minutes to equipment inputs ER040, ER056, ER102, ER089 and ER065 included in radiation treatment delivery codes CPT codes 77402, 77407, 77412, 77385 and 77386.

In addition, CMS deleted the Intercom (EQ139) from treatment delivery codes 77402, 77407, 77412, 77385 and 77838. This intercom is a direct practice expense input as it provides safety monitoring of the patient as a part of radiation treatment delivery. This equipment is separate from the typical department intercom.

The AAPM recommends that CMS include an Intercom (EQ139) as a direct practice expense input for radiation treatment delivery codes CPT codes 77402, 77407, 77412, 77385 and 77386.

The new treatment delivery codes proposed for 2016 include an IMRT linear accelerator (ER089) as the previous generations of a low energy linear accelerator are no longer commercially available. CMS notes in the proposed rule that because the invoices used to price the capital equipment included "onboard imaging," the cost of that equipment is already reflected in the price per minute associated with the capital equipment. Therefore, CMS did not include onboard imaging as a separate item in the proposed direct practice expense inputs for these codes. We understand that the invoice data for ER089 IMRT linear accelerator submitted to the AMA RUC Practice Expense Committee did not include the cost of onboard imaging. Onboard imaging is a significant capital equipment cost associated with radiation treatment delivery.

The AAPM recommends that CMS include the cost of onboard imaging as a direct practice expense equipment cost associated with CPT codes 77385, 77386 and 77387.

II. Equipment Utilization Rate for Linear Accelerators

CMS proposes to adjust the equipment utilization rate assumption for the IMRT linear accelerator (ER089) to account for a significant increase in usage. Instead of applying the default 50 percent assumption, CMS is proposing to use a 70 percent assumption based on the recognition that the item is now being typically used to provide more intensive services, and that would increase its overall usage in comparison to the previous assumption.

Given the magnitude of payment reductions proposed for freestanding radiation therapy centers, we think that CMS should delay implementation of the 70% equipment utilization rate specific to IMRT linear accelerators (ER089) for one year until 2017. Should the Agency decide not to delay the implementation of the equipment utilization rate change, we recommend extending the phase-in period to four years to mitigate the significant payment cuts caused by this policy.

The AAPM recommends that CMS delay the 70% equipment utilization rate specific to IMRT linear accelerators (ER089) until January 1, 2017. If implementation is not delayed, we request that the equipment utilization rate specific to IMRT linear accelerators (ER089) be phased-in over a four year period (i.e., 2016-2019).

AAPM believes that this proposal will have a negative impact on rural and medically underserved freestanding radiation therapy centers, which typically provide a lower volume of radiation treatment services. Payment cuts of this magnitude could impact patient access to cancer care in these settings. We think that rural and medically underserved freestanding radiation therapy centers should be permanently exempt from the 70% equipment utilization rate.

The AAPM recommends that CMS permanently maintain the 50% equipment utilization rate for the IMRT linear accelerator (ER089) in rural and medically underserved freestanding radiation therapy centers.

III. New Practice Expense Equipment Inputs

CMS added new equipment inputs to the CMS practice expense database, which includes a power conditioner and HDR brachytherapy treatment vault (see below).

CPT Code	Item Name	CMS Code	Average Price	Number of Invoices	Estimated Allowed Services (Non-Facility)
77385, 77386, 77402, 77407, 77412	Power Conditioner	ER102	$26,400	2	2,198,441
7778A, 7778B, 7778C, 7778D, 7778E	Brachytherapy treatment vault	ES052	$175,000	1	24,936

The AAPM supports the inclusion of a Power Conditioner (ER102) and Brachytherapy Treatment Vault (ES052) as direct practice expense equipment inputs.

IV. Medical Equipment Maintenance Costs

CMS is seeking comment on whether adding another item-specific financial variable for equipment costs will be likely to increase the accuracy of practice expense RVUs across the Physician Fee Schedule. AAPM believes that the current maintenance factor of 5 percent used to determine the equipment costs per minute is inadequate for radiology and radiation oncology medical equipment. Maintenance costs for highly specialized and complex equipment used for radiology and radiation oncology should be a minimum of 10 percent of the purchase price.

The AAPM supports a minimum 10% maintenance factor for highly specialized and complex radiology and radiation therapy equipment. CMS should work with stakeholders to obtain accurate data to update the adjustment factor for radiology and radiation oncology.

V. Superficial Radiation Treatment Delivery

CMS is seeking recommendations from stakeholders, regarding whether or not it would be appropriate to add physician work to CPT 77401 *Radiation treatment delivery, superficial and/or ortho voltage, per day* and remove minutes for the radiation therapists, even though physician work is not included in other radiation treatment services.

The AAPM does <u>not</u> support allocating physician work to the superficial radiation treatment delivery code 77401.

VI. Migration from Film to Digital Practice Expense Inputs

AAPM agreed with the CMS policy to migrate from film to digital practice expense inputs for radiology and radiation oncology codes. For 2016, CMS proposes to update the price of the PACS Workstation (ED050) from $2,501 to $5,557 based on submitted invoices, which reflects the "Technologists workstation." We understand that CMS did not include the costs associated with the "Rad (professional) Workstation." Both the technologist and professional workstations should be considered direct expenses within the practice expense methodology. AAPM requests that CMS update the pricing in the final rule to include <u>all</u> the costs associated with the PACS Workstation.

The AAPM requests that CMS update the price of the PACS Workstation (ED050) to include the costs associated with "Rad (professional) Workstation.

VII. Improving the Valuation of the Global Surgical Period

CMS proposes to develop through rulemaking a process for data collection to value surgical services with a 10- and 90-day global period in order to improve the accuracy of valuation and payment for the various components of global surgical packages. **AAPM believes that if CMS has concerns regarding the accuracy of surgical services with global periods, they should nominate specific surgical codes as "potentially misvalued" and have these services re-valued by the AMA RUC.**

VIII. Potentially Misvalued Services

CMS proposes 3 radiation oncology codes as "potentially misvalued" as identified by the High Expenditure Services screen, which includes CPT 77263 *Complex radiation treatment planning*; CPT 77334 *Complex treatment device*; and 77470 *Special radiation treatment procedure*. CPT Codes 77263 and 77334 have recently been reviewed by the AMA RUC and have maintained stable utilization levels in recent years. AAPM feels that an AMA RUC revaluation of recently reviewed codes is unnecessary and an administrative burden to the professional societies.

The AAPM opposes revaluation in 2016 of CPT 77263 Complex radiation treatment planning and CPT 77334 Complex treatment device as they were recently reviewed by the AMA RUC.

IX. Phase-In of Significant RVU Reductions

The Protecting Access to Medicare Act of 2014 specified that if the total RVUs for a service would otherwise be decreased by an estimated amount equal to or greater than 20 percent as compared to the total RVUs for the previous year, the adjustments must be phased-in over a two-year period. CMS is proposing to reduce a service by the maximum allowed amount (i.e. 19 percent) in the first year, and phase-in of the percent remainder of the reduction in the second year.

AAPM does not support a maximum 19% reduction in year one and the remainder of the reduction in year two. We do support 50% of the total reduction in year one and 50% of the remaining reduction in year two, which would lead to a more equitable payment system and allow physicians more time to make changes in their practices to accommodate for the reductions.

The AAPM supports 50% of the total reduction in year one and 50% of the remaining reduction in year two for existing services with RVU reductions greater than 20 percent.

X. Changes for CT Under the Protecting Access to Medicare Act of 2014

Effective for services furnished on or after January 1, 2016, the Protecting Access to Medicare Act of 2014 amends the statute by reducing payment for the technical component (TC) of the MPFS service and the hospital outpatient prospective payment system (OPPS) payment for computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association Standard XR-29-2013. CMS is proposing to establish a new "CT" modifier that would be reported with specific CPT codes, effective January 1, 2016. The AAPM supports this proposal and a payment decrease to the technical component of CT services associated with substandard equipment. However, due to the administrative burden the AAPM asks that the proposal be delayed for one year to give providers and manufactures additional time to fully prepare for this change.

The AAPM supports the CMS CT Modifier proposal with a one year implementation delay.

XI. 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. AAPM supports the use of clinical practice guidelines and appropriate use criteria from provider-led entities, for example the American College of Radiology.

The AAPM supports the appropriate use of diagnostic imaging.

Appropriate payment for medical physics services, radiology and radiation oncology procedures is necessary to ensure that Medicare beneficiaries will continue to have full access to imaging in the diagnosis of cancer and high quality cancer treatments in freestanding radiation therapy centers. We hope that CMS will take these issues under consideration for the 2016 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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