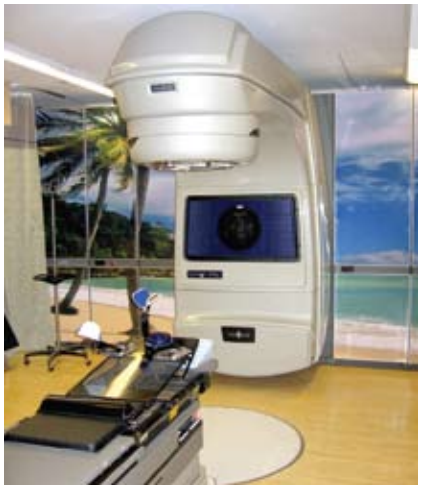

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IMRT delivers radiation to tumors while avoiding exposure to normal tissue.

ASTRO vs CMS: The battle for radiation oncology services

Bryant Furlow

The Centers for Medicare and Medicaid Services (CMS) announced a 7% overall reduction to radiation oncology services under its 2013 Medicare Physician Fee Schedule (MPFS). The cuts, which take effect January 1, 2013, will amount to an approximately 9% reduction in radiotherapy.

As steep as the new cuts will be, they come as a relief to many. The original proposal called for reductions of more than twice that much for some external-beam radiotherapies. It represented an estimated $300 million reduction in services, potentially triggering staff reductions and even closing some radiotherapy clinics, thereby limiting access to services for many rural patients.[1]

Concerted lobbying efforts of organizations, including the American Society for Radiation Oncology (ASTRO), rallied sufficient bipartisan congressional opposition to the proposal to convince 130 members of Congress from 43 states to voice concern to CMS. ASTRO president Michael Steinberg, MD, of the David Geffen School of Medicine at UCLA, in Los Angeles, California, described the original proposal's reductions as draconian and served as a warning about the pressure on federal agencies to control health care costs. The 2013 MPFS, first published in the *Federal Register* in July 2012, was part of a $2 billion reassessment of overvalued medical services.

Steinberg told *Oncology Nurse Advisor* that the revaluations of radiation therapies had been based partly on anecdotal information from patient education information sheets. "They were a bit of a surprise," he said before the final cuts were announced. "We feel CMS has not adhered to the rigorous process they've used in the past," a reference to the American Medical Association's Relative Value Scale assessment process. The original proposal would have resulted in longer travel times for patients and longer waits to start radiotherapy, Steinberg said.

He expressed relief when the final 2013 MPFS showed less-dramatic reductions in services, but hinted at continuing concern over the use of anecdotal information to set reimbursement values for oncology services. "ASTRO appreciates the diligence and efforts of CMS to more accurately rate procedures and looks forward to continuing to work closely with CMS to ensure fair and accurate methods to determine rate codes through sound data and rigorous analytical methodology," Steinberg added.

IMPACT GREATEST ON IMRT AND SBRT

More than 50% of the originally proposed changes would have come from reductions in the permitted-time allocations for two radiation-oncology services: intensity-modulated radiation therapy (IMRT) and stereotactic body radiotherapy (SBRT). Permitted-time allocations, the amount of time a procedure is presumed to require, would have dropped from 90 minutes to 60 minutes for SBRT and from 60 minutes to 30 minutes for IMRT (reductions of 28% and 40%, respectively).

IMRT is indeed disproportionately reimbursed, cautioned Benjamin Falit, MD, of the Yale School of Medicine, in New Haven, Connecticut, because costs have dropped faster than reimbursement rates over recent years.[2] IMRT and SBRT might be wrongly valued under existing rules, Steinberg acknowledges. But determining exactly how and by how much should be carefully undertaken using standard Relative Value Scale methodologies.

A JOINT RESPONSE

The newly announced cuts are just the latest reductions in federal reimbursements for radiation oncology, Steinberg is quick to add. Radiotherapy fees have already been cut 4 years in a row.[1]

In a recent survey of almost 600 ASTRO members, responses suggested that the proposed cuts to radiation oncology in the original 2013 MPFS would have dramatically affected the availability of radiation therapy nationwide, with some clinics predicting new

ASTRO [and others] wrote to CMS urging reconsideration of the proposed cuts.

limits on access for Medicare patients, and others consolidating or even closing their practices.[3] Many clinics, particularly in rural areas, indicated they would have postponed purchases of new equipment or imposed staff reductions.[3] The American Cancer Society's Cancer Action Network, Susan G. Komen for the Cure Advocacy Alliance, Lance Armstrong Foundation, the National Coalition for Cancer Survivorship, and ASTRO wrote to CMS in September 2012, urging reconsideration of the proposed cuts.[4]

"The level of cuts aimed at radiation oncology is double that of any other specialty," the letter noted.[4] "New technology and improved techniques have led to improved outcomes and these inappropriate cuts will stymie that achievement. Cuts of this magnitude will harm cancer care, particularly in rural areas, and could lead many treatment centers to close their practices."[4]

SAFETY ISSUES

ASTRO published a white paper on IMRT safety in 2011, following a *New York Times* report on serious radiotherapy accidents in the United States and a report in *The Lancet Oncology* on radiotherapy calibration and radiation dose errors in several countries.[5-8] The IMRT safety white paper emphasized the importance of interdisciplinary coordination in dose and delivery planning, the use of quality-assurance checklists, and the right of any member of the radiotherapy team to call a time out to double-check or review any facet of the plan or delivery of IMRT. Time pressure is a major concern, the white paper warned, because last-minute changes to treatment plans can involve skipped quality-assurance steps and lead to dosing errors.

But reimbursement cuts take the field in the wrong direction when it comes to safety, caution Steinberg and others. "A number of years ago, when IMRT was put into the fee schedule for 2002-2003, and practice expense calculations were much more rudimentary, they cut the number of radiation therapists required for IMRT delivery from 2 to 1," Steinberg said. "With the safety issues involved in the significant complexity of IMRT, that needs to be fixed as well. One therapist on a machine makes no sense, that's not considered safe by anyone's standards."

The proposed cuts would have made things even worse. The field can't have cuts like this and keep delivery safe. "I'm not here to say if you do this, safety will go down the drain," Steinberg adds. "I'm saying, we're going to do it safely and you have to resource and reimburse it so it can be safe."

Hospitals use IMRT primarily for more complex tumors. But some experts suspect that widespread and sometimes allegedly inappropriate self-referrals of patients for IMRT by stand-alone urology-based radiology practices equipped with IMRT systems may have played a role in the CMS revaluation of IMRT procedures.[2] Such self-referral by stand-alone clinics for relatively simple prostate tumor treatment can be very profitable, because the planning involved is much less time-consuming than planning for more complex head-and-neck or lung tumors.

"Some have said that," Steinberg acknowledged. "I don't know this to be the case, that CMS used draconian IMRT cuts to address self-referral. We think self-referral is a very significant issue, and allows a certain type of perverse economic incentive to put a barrier in front of patient choice, and to increase the cost of the system. But these kinds of cuts are a blunt instrument." ■

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