[Commenter’s Letterhead]

September 27, 2019

**VIA ELECTRONIC FILING TO**

***http://www.regulations.gov***

Honorable Seema Verma

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-1715-P

P.O. Box 8016

Baltimore, MD 21244-8016

**RE: [CMS-1715-P] Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies**

Dear Administrator Verma,

On behalf of [commenter], I write to bring to CMS’s attention an issue within the CY 2020 Physician Fee Schedule that is impacting our ability to provide top quality care to our cancer patients. [Commenter] is a [type of provider - physician group / hospital / clinic / etc.] that utilizes surface guided radiation therapy (SGRT), an advanced imaging technology, in the treatment of various types of cancer patients as part of radiation therapy treatment course.

CMS’s reimbursement policies for the use of SGRT have created access and reimbursement issues for our patients who rely on coverage by Medicare as well as other third party payers, in order to obtain access to life-saving treatments. SGRT is billed using HCPCS code G6017, *Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (eg,3d positional tracking, gating, 3d surface tracking), each fraction of treatment*, or CPT code 77387 *Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed*. To date, CMS has not assigned payment amounts for either of these codes. The result of these CMS policies in [commenter]’s clinical practice is confusion and inconsistency when obtaining reimbursement for the use of SGRT technology – not just from the Medicare program, but also from third party payers that incorporate payment rates from CMS’s Medicare physician fee schedule. Such policies have the effect of hindering access to new and innovative technologies, to the detriment of the cancer patients we serve.

In the CY 2020 MPFS proposed rule, CMS has proposed to maintain the status quo of this confusion surrounding SGRT reimbursement by not establishing reimbursement for code G6017 or publishing the AMA RUC’s recommendations for code 77387, even though CMS has the ability to address this issue. We request that CMS alleviate this concern affecting cancer treatment providers as well as the patients across the country by publishing the RUC’s recommendations for code 77387 and establish reimbursement for code G6017 when finalizing the MPFS for CY 2020.

[Commenter]’s use of SGRT has yielded clinical benefits to our patients with breast, intracranial, head and neck, extremity, and other cancers, as supported by established clinical guidelines and peer-reviewed literature. Surface imaging is a non-radiographic, noninvasive technology for continuous localization of patients during radiation therapy. SGRT uses non-invasive surface imaging to reduce localization uncertainty during irradiation. Stereo vision technology is used to set-up and continuously monitor the patient’s surface during treatment while comparing it to a reference position in 3D, allowing us to monitor a patient’s position in real time during the course of radiation therapy treatment. Studies have shown that SGRT can potentially replace the use of skin marks for positioning abrogating the need for permanent and unpleasant tattooing of patients. During treatment, stereo cameras and computer software monitor the patient’s exact position by tracking the skin surface to make sure the radiation is precisely targeted. If the patient moves, the radiation can be automatically paused until the patient is back in position. SGRT enables a reduction of initial setup variability, provides verification of immobilization continuously during treatment including at non-coplanar linac gantry angles, and provides dynamic surface information for use in gated and breath-hold treatment techniques, all of which can permit reductions in the margins required to account for target localization uncertainty. By using SGRT we more accurately deliver the maximum dose of radiation therapy to tumors while minimizing toxicity to normal tissue (including any surrounding vital organs), which reduces the risk of side effects. For example, when treating left breast cancer (breast cancer is the most common type of cancer in the U.S.), one study showed that SGRT, in conjunction with DIBH (Deep Inspiration Breath Hold), effectively prevented radiation-induced abnormalities in blood flow to the heart. Of the breast cancer patients treated, 0% showed these abnormalities after six months. This compares to a previous study without SGRT technology and DIBH, where 27% of patients showed new abnormalities in blood flow to the heart 6 months after radiation therapy. Ancillary benefits from surface imaging include the ability to use immobilization techniques that confer greater comfort to patients, a reduction in imaging dose through reduced radiographic localization requirements, improvements to the efficiency and safety of clinical workflows, and limiting the anesthesia needed during pediatric cancer treatment cases.

[Any additional thoughts by commenter]

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[Commenter] appreciates your consideration of our comments. If you have any questions, you can reach me at [email], or you may contact [alternate name and email].

Regards,

[Name of Signer]