BRIDGE ONCOLOGY

BRIDGE ONCOLOGY RESPONSE · CPT 77407 · CY 2027 MEDICARE PAYMENT

ASTRO's 77407 Fix Moves Money Around. It Doesn't Close the Gap.

Bridge Oncology's response to ASTRO's November 16, 2026 letter to CMS: Request for Meeting & Technical Correction to CY 2027 MPFS Practice Expense RVUs for Radiation Treatment Delivery Codes

THE BOTTOM LINE

ASTRO's goal, closing the payment gap between hospitals and freestanding cancer centers, is the right one. **Its fix is not.**

ASTRO's request would not add a single new dollar for freestanding radiation centers. It takes money from the most complex treatments (CPT 77412) to raise a mid-level code (CPT 77407), and even then freestanding centers would still be paid less, relative to hospitals, than they were in 2026. It also rests on a hospital payment increase that came from 340B policy, not from evidence that treatment got more expensive.

With the final rules taking effect January 1, 2027, one workable fix is left: **raise freestanding 77407 up to the 77412 rate instead of averaging 77412 down, and bring the hospital rate to the level where the two codes already match.** Both codes get paid the same in both settings, and no one's most complex care is cut.

BY THE NUMBERS

36% One-year jump in the hospital rate for 77407, 2026 to 2027	**$0** New money ASTRO's fix brings to freestanding centers	**18–23%** Cut to 77412, the most complex treatment, under ASTRO's fix	**100%** Freestanding-to-hospital parity under the Bridge fix
9.7% Increase in the freestanding rate for the same treatment	**78.7% → 63.5%** Freestanding pay as a share of hospital pay, 2026 to 2027	**68–72%** Where ASTRO's fix leaves 77407 vs. hospital, still below 2026	**7.5%** Non-drug hospital increase funded by the 2027 340B drug cut

Background in plain English

- **The codes.** Radiation treatment delivery is billed in three levels: 77402 (simplest), 77407 (middle) and 77412 (most complex, equipment-heavy). All three were restructured for 2026, so they are essentially new codes with little claims history.
- **Two payment systems.** Medicare pays hospital outpatient departments under the OPPS and freestanding (community, physician-owned) centers under the Physician Fee Schedule (MPFS).
- **The link between them.** Since 2026, CMS has used the ratios between the hospital (OPPS APC) weights to divide a fixed pot of freestanding money among the three codes. The hospital data sets each code's *share* of the pot. It does not set the *size* of the pot.
- **What changed for 2027.** CMS moved 77407 from APC 5622 into APC 5623 alongside 77412, so both carry the same hospital weight of 5.3604. The hospital rate for 77407 jumped 36%. The freestanding rate rose about 10%.

77407 payment	Hospital (OPPS)	Freestanding (MPFS)	Freestanding as % of hospital	Gap per treatment
2026	$394.05	$310.15	78.7%	$83.90
2027 final rule	$535.88 (+36.0%)	$340.32 (+9.7%)	63.5%	$195.56

The per-treatment gap more than doubled in one year. Source: ASTRO letter, page 1; year-over-year changes calculated by Bridge Oncology.

What ASTRO is asking for

ASTRO argues that because 77407 and 77412 now sit in the same hospital group, they should get the same freestanding practice expense (PE) RVU. It says CMS should have carried the final APC reassignment into the 2027 MPFS, as it did with its March 2026 correction notice, and that the 2027 Addendum B values (10.36 for 77407 and 14.42 for 77412) should be corrected before January 1, 2027. ASTRO calls this a technical correction. It gets the problem wrong.

Side by side: ASTRO's request vs. the Bridge fix

	ASTRO's request	Bridge Oncology's fix
Diagnosis	A calculation error at CMS	A flawed code structure plus a hospital rate inflated by policy dollars
Who acts	CMS, on the freestanding fee schedule	CMS on hospital rates now; the AMA CPT Editorial Panel on the codes
New money for freestanding centers	None. The pot is fixed, so dollars only move between codes	Freestanding 77407 rises ~$133 per treatment (+39%) without cutting another code
Effect on 77412 (most complex care)	Cut of roughly 18% to 23%	No cut
Effect on 77402	Cut of roughly 3% to 9%	No cut
Freestanding 77407 vs. hospital	Rises only to about 68% to 72%, still below 2026's 78.7%	100%: real site neutrality, in dollars
Durability	Locks a provisional, one-year grouping into fee schedule values	Fixes the code definitions themselves, which only the CPT Panel can do
What it signals	Pays Level 2 and Level 3 the same everywhere, quietly admitting the split is broken, but leaves the flawed code in place	Names that problem and fixes it at the source

Where ASTRO's letter goes wrong

1. It treats a 340B-funded payment decision as cost evidence

ASTRO's argument depends on hospital data being “routinely updated, auditable” cost information. But ASTRO's own Table B shows the move to APC 5623 was a grouping decision, not a cost finding. In the proposed rule the codes carried different weights: 4.3106 for 77407 and 6.1752 for 77412. The final rule merged them into one blended weight of 5.3604. The hospital data never showed the two treatments cost the same. CMS chose to pay them the same.

And the dollars behind that weight were inflated. In the 2027 hospital rule, CMS cut payments for drugs bought through the 340B program and, to keep the hospital system budget neutral, raised payments for all non-drug services, including radiation, by 7.5%. That is a redistribution of drug dollars, not a finding that radiation costs more. No hospital cost-report trend produces a 36% rise in one year, and the letter never explains it.

2. It confuses the codes' values relative to each other with their dollar level

ASTRO's letter itself states that the family's share of PE and malpractice RVUs is held constant. The hospital link sets how the three codes relate to each other, not how much the family is paid. Equalizing 77407 and 77412 therefore only moves dollars inside the family: 77407 goes up only as far as 77412 and 77402 come down. ASTRO calls the request a correction, but never says its own proposal cuts 77412.

3. The 2026 utilization trend makes the outcome worse, and shows the code is unstable

Bridge Oncology's claims data review shows 77407 falling from about **75%** of treatment delivery volume in Q1 2026 to **65%** in Q2 and **60%** in Q3.

- **CMS's 18% figure for 77412 is out of date.** As volume leaves 77407 for 77412, a growing share of complex cases would be paid at the lower, blended rate.
- **The cut lands on more patients over time.** In every scenario we modeled, the most complex, capital-heavy freestanding treatments lose roughly a fifth of their practice expense value.
- **A code whose share moves 15 points in two quarters is not a stable resource category.** Coding behavior is still settling, which points to a problem with how the code is defined, not how it is valued.

4. Its argument about first-year data cuts against its own request

ASTRO tells CMS that a value relationship drawn from the first year of a new code family "is not a reliable basis" for setting values. Yet the 2027 APC 5623 assignment rests on the same immature data, plus reallocated 340B dollars. ASTRO wants one provisional relationship thrown out and an equally provisional one locked in.

5. It blames the fee schedule for a gap the hospital side created

The gap widened because the hospital rate for 77407 rose 36% while the freestanding rate rose about 10% inside a fixed pool. A budget-neutral fee schedule that links relative values, not dollars, can never keep up with hospital rates pushed up from a separate pot of money. Asking freestanding centers to chase that number with dollars taken from their own 77412 payments is not site neutrality.

6. It shows the coding problem without naming it

If 77407 and 77412 share a hospital group and also get equal freestanding PE RVUs, Medicare would pay Level 2 and Level 3 treatment delivery the same everywhere. That amounts to admitting the 77407/77412 split no longer reflects a real difference in resources. CMS cannot delete a CPT code. Asking CMS to equalize the RVUs leaves the flawed code in place and makes freestanding centers absorb the result.

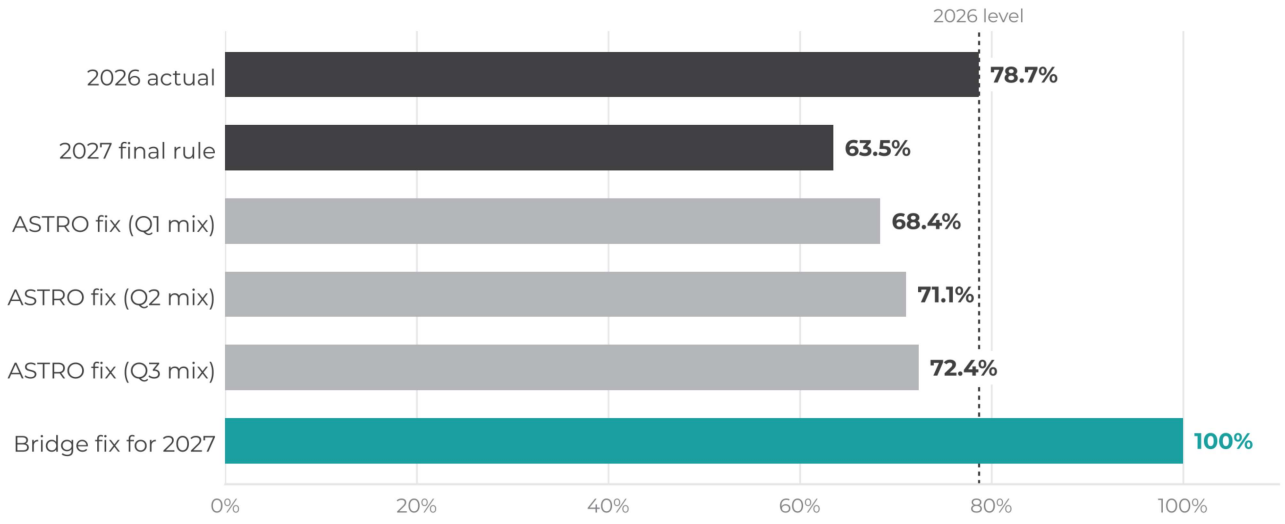
What ASTRO's fix actually does

Because the freestanding pot is fixed, every dollar 77407 gains comes out of 77412 and 77402. Bridge Oncology modeled ASTRO's fix at three real 2026 utilization mixes.

Scenario (77402 / 77407 / 77412 share)	77402 PE RVU	77407 PE RVU	77412 PE RVU	77407 rate	% of hospital
2027 final rule (current)	2.96	10.36	14.42	$340	63.5%
ASTRO fix, Q1 mix (7 / 75 / 18)	2.71 (−8.5%)	11.16 (+7.8%)	11.16 (−22.6%)	~$367	68.4%
ASTRO fix, Q2 mix (7 / 65 / 28)	2.81 (−5.0%)	11.59 (+11.9%)	11.59 (−19.6%)	~$381	71.1%
ASTRO fix, Q3 mix (7 / 60 / 33)	2.86 (−3.2%)	11.81 (+14.0%)	11.81 (−18.1%)	~$388	72.4%
Bridge fix for 2027	**2.96 (no cut)**	**14.42 (+39.2%)**	**14.42 (no cut)**	**~$474**	**100%**

Family PE pool held constant per CMS methodology for ASTRO scenarios. Utilization mix from Bridge Oncology claims data review. Dollar figures are estimates, not CMS-published rates. See methodology.

77407 freestanding payment as a share of the hospital rate



Even at the most favorable mix, ASTRO's fix leaves 77407 well below its 2026 level. Only the Bridge fix reaches parity.

Even in the most favorable ASTRO case:

- Freestanding 77407 stays roughly **$148 to $169 below** the hospital rate per treatment, close to double the 2026 gap of $84.
- 77412, the most complex treatment, loses about a fifth of its practice expense value: roughly **$86 to $107 less per treatment**, from an estimated $474 today.

Timing: where the structural fix belonged

The structural fix should have happened during the 2027 rulemaking cycle, either before CMS issued the proposed rule or during the comment period after it (proposed rule in July 2026, comments due August 31). That was the window to:

- take the 77407/77412 split to the AMA CPT Editorial Panel and restructure the family so each level reflects a real difference in resources;
- keep 340B-funded increases out of the hospital rates that the freestanding fee schedule tracks; and
- set hospital and freestanding rates together, so neither setting outran the other.

The warning signs were in the proposed rule: 77407 and 77412 sat in different hospital groups with weights of 4.3106 and 6.1752, and the final rule merged them. The final rules take effect January 1, 2027, and a CPT code restructuring cannot be completed in time for 2027.

The right fix: match up, don't average down

1. **Raise freestanding 77407 to the 77412 rate.** Set 77407's PE RVU at 14.42, equal to 77412, instead of averaging the two inside the family pool as ASTRO proposes. 77412 and 77402 take no cut.
2. **Bring the hospital rate to where the codes already match.** Lower the APC 5623 hospital payment to the freestanding 77412 level, a level that reflects cost without the 340B reallocation, so 77407 and 77412 are paid the same amount in both settings.
3. **Fix the codes for 2028 and beyond.** The AMA CPT Editorial Panel should delete 77407 and restructure the treatment delivery family. One-time or policy-funded hospital payment movements should be kept out of the fee schedule's relative values. CMS cannot delete a CPT code; that step was never CMS's to make.

77407, per treatment	Hospital (OPPS)	Freestanding (MPFS)	Freestanding as % of hospital	Cut to 77412
2026	$394.05	$310.15	78.7%	None
2027 final rule	$535.88	$340.32	63.5%	None
ASTRO's fix	$535.88	~$367 to $388	68% to 72%	18% to 23%
Bridge fix for 2027	**~$474**	**~$474**	**100%**	**None**

THE RESULT

Under the Bridge fix, freestanding 77407 rises by about **$133 per treatment (+39%)**, the hospital rate comes down about 12% from the 2027 final rule, and the site-of-service gap **closes completely**. The hospital rate would still be about 20% above its 2026 level.

Questions reporters may ask

Doesn't ASTRO's fix at least help 77407?

Yes, by about 8% to 14%, but only by cutting 77412 and 77402 out of the same pool of dollars. Freestanding centers as a whole get nothing new, and the hospital gap stays far wider than in 2026.

Isn't it just consistent to give two codes in the same hospital group the same rate?

It is consistent on paper. But if Medicare pays Level 2 and Level 3 the same everywhere, the honest conclusion is that the codes no longer describe different resources. The fix is to repair the codes, not to average them inside a fixed pot.

Why should hospital rates come down rather than freestanding rates simply going up?

The freestanding fee schedule is budget neutral by law. It cannot match a hospital rate lifted by money moved from 340B drug payments. Aligning hospital rates with cost is the only path to equal payment in dollars.

Methodology and sources

The ASTRO scenarios hold the 2027 final freestanding (MPFS) PE pool for the treatment delivery family constant at each utilization mix and redistribute it in proportion to the final 2027 hospital (OPPS) relative weights (77402: 1.3005; 77407 and 77412: 5.3604). The quarterly utilization mix (77402 / 77407 / 77412 of 7 / 75 / 18 in Q1, 7 / 65 / 28 in Q2 and 7 / 60 / 33 in Q3 2026) is based on Bridge Oncology's claims data review. The Q1 share for 77412 is consistent with CMS's figure of about 18% early in 2026. As a sensitivity check, if 77412 is held at 18% at the Q3 mix, the result is similar (77407 +9.6%, 77412 −21.3%, 77407 at about 69.6% of the hospital rate).

Dollar figures scale ASTRO's reported 2027 freestanding rate of $340.32 by the change in PE RVUs and ignore the small malpractice component; the 77412 dollar estimate applies the same scaling. The Bridge fix sets 77407's PE RVU equal to 77412's (14.42), giving about $474; the hospital figure is the rate that would equal it. All are estimates, not CMS-published rates.

Sources: ASTRO letter to CMS, November 16, 2026 (Tables A and B and the 77407 OPPS v. MPFS table); CY 2027 OPPS and MPFS final rules; trade press coverage of the CY 2027 OPPS final rule's 340B provisions (Healthcare Financial Management Association, Fierce Healthcare, American Hospital Association).