The Challenges of Coding and Billing for New Technology

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Disclaimer

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Objectives of this Presentation

Discuss the development of new CPT® and HCPCS codes

Understand the process for pricing new codes

Educate on processes for utilizing new codes and payer acceptance

Discuss new technology, equipment and trends

Understand how to apply appropriate coding and payer requirements
Methodology

**MPFS**
- Each individual code assessed for appropriate pricing
  - Work
  - Expenses
  - Risk
- Adjusted for geographic location
- Fee for service system

**HOPPS**
- Codes assigned to Ambulatory Payment Classification (APC)
- Payment applied to APC
- Adjusted for geographic location and cost reporting
- Prospective payment system
MPFS Equation

- **Work**: Relative time and intensity of service
- **Practice Expense (PE)**: Costs of maintaining practice, i.e. rent, supplies, equipment
- **Malpractice (MP)**: Costs of malpractice insurance
- **Geographic Practice Cost Index (GPCI)**: Adjusts for geographic variation in costs
- **Conversion Factor (CF)**: Converts to dollar amount
HOPPS Equation

Payment based on complexity of service:
- CF
- CF x APC relative weight

Geographic adjustment:
- 60% labor related
- 40% non-labor related

= Payment

Measures relative resources of services:
- APC
- Hospital wage index

Special Exceptions:
- If the patient is exceptionally costly
  - Payment + High cost outlier
- If a rural SCH
  - Payment x 1.071
- If a cancer or children's hospital eligible for transitional outpatient payment
  - Payment + Transitional outpatient payment; final payment determined at cost settlement

- Developed, maintained, and copyrighted by the American Medical Association (AMA)
- Identify medical services and procedures furnished by physicians and other health care professionals
- Uniform language to describe services reported to public and private insurers
CPT® Categories

- **Category I**  Five-digit codes corresponding with a procedure or service
- **Category II**  Alphanumeric tracking codes
  - Report performance measurements
  - Not required to be reported
- **Category III**  Provisional codes for new and developing technology, procedures, and services
  - Typically end in “T”
  - May be experimental, investigational and non-covered
Healthcare Common Procedure Coding System (HCPCS)

- Two principle subsystems:
  - **Level I** Comprised of the AMA's CPT® codes
  - **Level II** Alphanumeric codes representing medical items, supplies and procedures/services not described by CPT®
    - Outpatient hospital care, drugs, sources, ambulance services, etc.
    - Developed and maintained by the CMS HCPCS Workgroup
      - All payers represented, including private insurers
Code Updates

• Updated to account for additions, deletions and revisions
  – HCPCS Level II updated quarterly
    • Process involving application, public meetings and CMS HCPCS Workgroup
    • Anyone can submit an application
  – CPT® updated annually with implementation January 1 of each year
    • Process involving specialty organizations, committees and CMS
Relative Value Scale Update Committee (RUC)

- Physician panel representing various medical specialties
  - 31 member committee including 21 members appointed by national medical specialty societies
- Regularly reviews medical services to accurate value
- Makes recommendations to CMS on resources required to perform a medical service
  - Time
  - Supplies/equipment
  - Expertise
Terminology

Bundling
Invoice Pricing
Carrier Pricing
Packaging
Conditional Packaging
Comprehensive APC Payment
Bundling Versus Packaging

**Bundled:** Service is considered inclusive of another service and not separately billable

*Example: Simulation & CT*

**Packaged:** Item not separately paid, but typically required to be reported

*Example: Respiratory Motion Management (HOPPS)*
Invoice Pricing

• Each Medicare contractor determines how many invoices are necessary to determine the reimbursement amount
• Reimbursement will be made based on acquisition cost
• Examples:
  – Expendable sources
  – Radiopharmaceuticals
  – Fiducial markers

Radium 223 (Xofigo) Invoice Required

Claims with a date of service of September 1, 2014 or after, Noridian will begin requiring submission of the invoice price for payment for Radium 223 (Xofigo). This radiopharmaceutical should be billed with A9699 when billing from the Medicare Physician Fee Schedule on a CMS-1500 Claim Form or electronically.

Providers must enter the name and dose of the radiopharmaceutical along with the invoice price in Item 19 of the CMS-1500 Claim Form or the electronic equivalent. Claims without this information will be denied as unprocessable.
Carrier Pricing

- Medicare contractors given authority to determine reimbursement for specific services
- Contractors establish RVUs and payment
  - May require submission of documentation
  - Rate may or may not be published
- Examples:
  - Proton treatment delivery (MPFS)
  - Cobalt based SRS (MPFS)
  - Gating & intrafraction tracking (MPFS)
Conditional Packaging

- Services defined as:
  - Major services
  - Ancillary or supportive
- Ancillary services may be packaged when reported with another code but paid separately when reported alone
- Packaging based on Status Indicator (SI) assigned to code by HOPPS
- Example:
  - Stereotactic headframe removal
  - LDR treatment delivery
Comprehensive APC Payment

- All-inclusive payment for certain procedures
- Includes services that are typically packaged and not typically packaged
- Each code reported on claim form, but paid as single value for entire procedure
- Example:
  - IORT
  - SRS
Proceed With Caution

• New technology may lead to:
  – Coding changes
  – Documentation changes
  – Non-covered services
  – Contracting with payers
Hydrogel

- 0438T - Transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance.
  - **Physician:**
    - No RVUs assigned to Category III Code
    - Carrier priced, but may be non-covered
  - **Hospital Outpatient:**
    - Assigned to APC 5374
  - Effective 2017 gel is no longer billable in hospital or freestanding center/office setting
  - AMA changes to code remove statements to bill for supply gel separately
Hydrogel Update

• Look for a new CPT Category I code with revised descriptor to replace Category III code 0438T, Transperineal placement if biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance.

Fractionated SRS

- Stereotactic radiosurgery (SRS) delivered in 2–5 fractions
- Requires coding changes regardless of equipment

77371 Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based

77372 Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based

77373 Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions
Coding Guidelines

• As stated in the MLN Matters® MM8572 dated December 27, 2013

Fractionated SRS treatment is any SRS delivery service requiring more than a single session of SRS treatment for a cranial lesion, up to a total of no more than five fractions, and one to five sessions (but no more than five) for non-cranial lesions. CPT code 77373 is to be used for any fraction (including the first fraction) in any series of fractionated treatments, regardless of the anatomical location of the lesion or lesions being radiated. Fractionated cranial SRS is any cranial SRS that exceeds one treatment session. Fractionated non-cranial SRS is any non-cranial SRS, regardless of the number of fractions but never more than five. Therefore, CPT code 77373 is the exclusive code (and the use of no other SRS treatment delivery code is permitted) for any and all fractionated SRS treatment services delivered anywhere in the body, including, but not limited to, the cranium or head. 77372 is not to be used for the first fraction of a fractionated cranial SRS treatment series and must only be used in cranial SRS when there is a single treatment session to treat the patient’s entire condition.
Treatment Devices

• Existing code set utilized
  – Immobilization devices
  – Beam modifying devices
• May or may not be considered billable
  – Reusable & non-customized
  – Disposable
  – Bundled with other devices or services
Treatment Devices

77332 Simple (simple block, simple bolus)

• Examples: pre-made electron block, bolus, asymmetric jaw

77333 Intermediate (multiple blocks, stents, bite blocks, special bolus)

• Examples: Bite block, customized bolus

77334 Complex (irregular blocks, special shields, compensators, wedges, molds or casts)

• Examples: Aquaplast masks, alpha cradles, Vac-Lok™, wedges, compensators
Brachytherapy Devices

- Billable once per course
- Typically billed as simple (CPT® 77332); however, there are instances where complex would be appropriate
- Vaginal cylinder and Tandem & Ovoid (Ring) included in placement code PE for MPFS
- Prostate template included in PE for LDR treatment delivery

*Treatment devices (77332-77334)*

Treatment devices may include the use of certain templates, molds, or other apparatus that may be required for specific clinical circumstances. Pre-manufactured, commercially available devices are simple devices.
Respiratory Motion Management

- **77293** Respiratory motion management simulation (list separately in addition to code for primary procedure)
  - “Primary Procedure” is either 77295 or 77301 and will be billed on same date of service
  - Packaged for HOPPS

Complete documentation is essential when reporting an add-on code. Documentation should include both the medical necessity of reporting CPT code +77293 as well as that the work the code describes was done. The documentation needs to be more extensive than just part of the simulation note since it is part of the isodose planning process. Physicians should work with their staff to ensure that proper documentation has been completed. Since the work that is included in +77293 occurs over several days, and it involves the therapists, the dosimetrist, the physicist, and the physician, the information that could support the code would appear in several documents. The simulation note would also document physician review of respiratory motion management set-up and use at the time of simulation. The treatment plan document would indicate that the physician created an ITV that covered the target volume in all phases of respiratory motion. Add-on codes are to be reflected as a separate claim line on electronic claim submission. Add-on codes should be listed separately in addition to the primary procedure code. This code is only charged once per 3-D or IMRT plan and should be reported on the same day as the primary planning code (77295 or 77301).
Field-in-Field

Noridian Healthcare Solutions, LLC Intensity Modulated Radiation Therapy (IMRT) (L34080) LCD states:

“Note also, traditional “field-in-field technique,” which is neither MLC nor compensator-based, is not considered IMRT but rather external beam therapy.”
In addition…

- Payers instruct one treatment device is billable per “port”
- Payers may also define “port” within published guidelines
  - Retired Radiation Therapy Services LCD

“Port, Portal:
These words are synonymous and refer to the site, on the skin, where the radiation beam enters the body. Field, often used as a synonym for port, will not be used in this policy.”
Conformal Arcs

Radiation Oncology Including Intensity Modulated Radiation Therapy (IMRT) (L34652) LCD states:

B. Treatment Delivery
IMRT treatment delivery can be accomplished through a variety of technologies. The most common approach utilizes a multi-leaf collimator (MLC) to modulate the intensity of the beam. Various forms of MLC technology include fixed gantry types such as static MLC (step and shoot) where the leaves do not move when the beam is on and dynamic MLC (sliding window) where they move during treatment. There are also moving gantry technologies including fan-beam therapy that uses a binary collimator to deliver slice-by-slice treatment and intensity modulated arc therapy, in which the gantry rotates while moving MLCs create non-uniform dose to the planning target volume during individual arc segments. A different technical solution for IMRT is to use a solid compensator with varying thickness filters to modulate the beam. The basic requirement for all forms of IMRT treatment delivery is that the technology must accurately produce the calculated dose distribution described by the IMRT plan.

IMRT uses non-uniform and customized fluence distributions in treatment delivery. Delivery and planning of IMRT may require the use of a multi-leaf collimator (MLC) with leaves that project to a nominal 1cm or less at the treatment unit isocenter. The MLC may be in a dynamic (DMLC) or segmented mode (SMLC) (mean segments per gantry position or 'steps' required to meet IMRT delivery is 5) to create the 3-dimensional, intensity-modulated dose distribution. These processes maybe called segmental, binary or step and shoot.

The use of a MLC to produce simple one-dimensional ramp intensity distributions is excluded because the inverse planning process is not expected to produce these intensity patterns.

Other planning and delivery methods include:
- Conformal Arc
- Intensity Modulated Arc
- Electronic forward planned compensator
- Inverse planned IMRT Solid Compensators
Adaptive Planning

What is your definition of adaptive planning?
Coding Challenges

• Overuse of codes per payer instructions
• Exceed quantity benchmarks set by Medicare
• Process does not meet published code requirements
  – “Significant Change”
  – Required QA
  – Medical Necessity
• Work performed but no CPT® code
Published Guidance...

Radiation Oncology Including Intensity Modulated Radiation Therapy (IMRT) LCD:
“In those uncommon circumstances, where there is a **substantial change** in either patient anatomy or tumor conformation and where a second CT dataset is required to produce an accurate, efficacious and safe "cone-down" plan, a second 77295 charge may be appropriate. When the physician deems this to be the case, the medical necessity for the second 77295 simulation must be documented.”

CPT Assistant, November 2009:

**Coding Tip**

Code **77301** is used to describe planning for a defined imaging set that portrays the treatment target(s). Use of code **77301**, subsequent to the initial plan within a defined treatment course only occurs in unusual circumstances if the patient needs a new imaging set due to dramatic change in the external contour of the patient (eg, weight loss) or significant change in the contour of the target (eg, tumor shrinkage). In addition, in the unusual case that a second and unrelated anatomical area is in need of an IMRT treatment, a second code (**77301**) could also be reported.
Required QA

Patient Specific IMRT Treatment Verification

The accepted methodology to perform the computer plan distribution verification aspect of the treatment planning process is to deliver the plan to an extended phantom that contains 2D film in planes that correspond to planes in the IMRT plan that can be compared. Since there are literally thousands of beamlets used in delivering IMRT dose patterns, delivering these plans to such a phantom will indicate any deviations from the physician's (radiation oncologist) prescription and corrective action can be taken before the patient is treated.

6. The monitor units (MUs) generated by the IMRT treatment plan must be independently checked before the patient's first treatment.

7. Documentation of fluence distributions re-computed in a phantom is required, or an equivalent methodology consistent with Patient Specific IMRT Treatment Verification described above.
Unlisted Codes

Used for reporting and tracking of services and procedures until specific code is established

- **77299** Unlisted procedure, therapeutic radiology clinical treatment planning
- **77399** Unlisted procedure, medical radiation physics, dosimetry & treatment devices
- **77499** Unlisted procedure, therapeutic radiology clinical treatment management
MRI for Treatment Planning

• Per the AMA guidelines, if the MRI is done for treatment planning purposes, it should be captured with the unlisted MRI imaging CPT® code. If the scan is performed for diagnostic purposes, the appropriate MRI Diagnostic CPT® code would be utilized.

**Question:** What is the appropriate CPT code to report for the professional and technical components of a MRI study performed for treatment planning?

**Answer:** If a localization exam is formally interpreted and reported separately from the treatment planning process, it is appropriate to report a diagnostic MRI code of the specific anatomical site studied for the professional component (PC). The unlisted procedure code 76498, Unlisted magnetic resonance procedures (eg, diagnostic, interventional), for the technical component (TC) when the MRI study is performed for treatment planning. The professional component of an MRI diagnostic study is reported when the radiation oncologist consults with the radiologist to determine the extent of the disease on the MRI planning localization study to draw the appropriate targets and avoid surrounding structures.
Protons

Adaptive Aperture or MLC

Pencil Beam Scanning

Stereotactic
Proton Coding

• New technology, but supports existing CPT® codes
  – Treatment devices: 77332, 77333, 77334 or 77338
  – Treatment planning: 77321, 77295 or 77301

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ASTRO Model Policies

PROTON BEAM THERAPY (PBT)

PBT is one of the acceptable forms of external beam radiation therapy that may be used to administer Stereotactic Body Radiation Therapy (SBRT) or Stereotactic Radiosurgery (SRS). Separate ASTRO Model Policies for SBRT\(^6\) and SRS\(^7\) include technology descriptions and a list of indications for which SBRT or SRS should be covered. When PBT is used to administer SBRT or SRS, the delivery and management codes relevant for SBRT or SRS apply, and the same clinical indications apply as for those treatment strategies.
Intrafraction Tracking

Gating

Position Management

Tracking

G6017 77387
Coding

Physician & Freestanding

- **G6017** - Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g., 3D positional tracking, gating, 3D surface tracking), each fraction of treatment
- Carrier Priced

Hospital Outpatient

- **77387** - Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed
- Packaged
Questions