Documentation & Coding for Radiation Oncology
Part 1

2017 Radiation Oncology Conference for Therapists & Dosimetrists
September 7 - 9, 2017
Conference & Event Center
Niagara Falls
Contact Information

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Disclaimer

This presentation was prepared as a tool to assist attendees in learning about documentation, charge capture and billing processes. It is not intended to affect clinical treatment patterns. While reasonable efforts have been made to assure the accuracy of the information within these pages, the responsibility for correct documentation and correct submission of claims and response to remittance advice lies with the provider of the services. The material provided is for informational purposes only.

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Objectives of this Presentation

1. Stress Importance of Compliance
2. Educate Attendees on Applying Proper Coding
3. Emphasize Utilization of Current Reference Materials
4. Allow Interactive Discussion for Questions & Advice
Acronyms

- **CMS** Centers for Medicare & Medicaid Services
- **MAC** Medicare Administrative Contractor
- **NCD** National Coverage Determination
- **LCD** Local Coverage Determination
- **CPT** Current Procedural Terminology
- **APC** Ambulatory Payment Classification
- **HOPPS** Hospital Outpatient Prospective Payment System
- **MPFS** Medicare Physician Fee Schedule
- **RVU** Relative Value Unit
- **PE** Practice Expense
- **MP** Malpractice
- **CF** Conversion Factor
- **RUC** Relative Value Scale Update Committee
- **NCCI** National Correct Coding Initiative
- **MUE** Medically Unlikely Edit
- **OIG** Office of Inspector General
Billing & Coding Overview

Authoritative Guidance

Legislative Updates

Medicare Program

Hot Topics
Billing Scenarios

- Hospital Outpatient
  - Technical Services
    - UB04
  - Physician Services (-26)
    - CMS 1500

- Freestanding Facility
  - Global Billing
    - Pro & Tech Services
      - CMS1500
  - Split Billing
    - Physician Services (-26)
      - CMS 1500
    - Technical Services (TC)
      - CMS 1500
### Payment Systems

#### MPFS

<table>
<thead>
<tr>
<th>CPT</th>
<th>Modifier</th>
<th>2017 Payment</th>
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<tbody>
<tr>
<td>77280</td>
<td>Global</td>
<td>$278.86</td>
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<tr>
<td></td>
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<td>77290</td>
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<td>77295</td>
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<td></td>
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<td></td>
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<td>$225.74</td>
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<tr>
<td>77301</td>
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<td>$1,568.70</td>
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<tr>
<td></td>
<td>26</td>
<td>$420.97</td>
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#### HOPPS

<table>
<thead>
<tr>
<th>CPT</th>
<th>APC</th>
<th>2017 Payment</th>
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<tbody>
<tr>
<td>77280</td>
<td>5611</td>
<td>$117.53</td>
</tr>
<tr>
<td>77290</td>
<td>5612</td>
<td>$311.43</td>
</tr>
<tr>
<td>77295</td>
<td>5613</td>
<td>$1,065.79</td>
</tr>
<tr>
<td>77301</td>
<td>5613</td>
<td>$1,065.79</td>
</tr>
</tbody>
</table>

Services in the same APC group are paid at the same rate.

In a hospital setting the physician is paid based on MPFS for the professional component.
Claims Submission

**HOPPS on UB04**
- Series or Recurring Accounts
- Physician = Attending MD
- Revenue Code

**MPFS on CMS1500**
- Daily, weekly, etc.
- Physician = MD providing service/supervision
- Address should match the physical location services rendered
- Place of Service Code
- 26/TC modifiers
- Q6 Modifier for Locum Tenens
Authoritative Guidance

- Federal Register
- Centers for Medicare & Medicaid Services (CMS)
- American Medical Association & CPT® Manual
- OIG Compliance Standards
- Commercial Payer Policies
Federal Register

- Document actions of Federal agencies and forum for public review and comment
- Publications include: Presidential Documents, Rule & Regulations, Proposed Rules and Notices

Hospital Outpatient Prospective Payment System (HOPPS)  
Medicare Physician Fee Schedule (MPFS)
Proposed vs. Final Rule

Proposed Rule:
- CMS plans, goals, solutions to problems and proposed rulemaking
- Opportunity for public to make comments

Final Rule:
- Final legal effect after consideration of comments
2017 Final Rule Highlights

MPFS

- Conversion Factor change, slight increase
- RVUs adjusted for several Rad Onc codes
- Moderate sedation values removed from several codes = decrease work RVUs
- Office space & rental equipment rental charge changes for lessors to lessees

HOPPS

- 1.7% increase in reimbursement payments
- Simulation and Planning APCs restructured
- IORT codes new C-APC w/ SRS codes
- APC changes to simulation and planning codes
- Provider-based Department designation changes
2018 Proposed Rule Highlights

MPFS
- Conversion Factor change, slight increase
- Malpractice RVU update
- New physician code for superficial radiation therapy
- New code for spacer gel placement
- Planning to revamp E/M guidelines
- Nonexcepted PBDs paid at 25% HOPPS rate

HOPPS
- 1.75% increase in reimbursement payments
- SRS C-APC no longer using modifier CP
- Brachy insertion code edits to ensure brachy TX code is billed on same claim
- PSI LDR brachy composite APC deleted and codes in C-APC
- Supervision changes in CAHs and rural hospitals <100 beds
MPFS Proposed Rule CY 2018

Medicare Program: Revisions to Payment Policies under Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program

Conversion Factor Update

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) put into law April 16, 2015
  - CF to increase 0.5% each year through 2019
  - CF 0% increase 2020 – 2025, additional payments based on Quality Payment Program (MIPS)
  - 2026 and beyond payments on participation in APMs
    - 0.75% update for qualifying APMs
    - 0.25% update for non-qualifying APMs
- Proposed Conversion Factor for 2018 = $35.9903
  - Increase from 2017
Calculating Conversion Factor

- Budget neutrality factor to maintain budget within +/- $20 million
- Target Recapture Amount accounts for misvalued codes

**TABLE 38: Calculation of the Proposed CY 2018 PFS Conversion Factor**

<table>
<thead>
<tr>
<th>Conversion Factor in effect in CY 2017</th>
<th>35.8887</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update Factor</td>
<td>0.50 percent (1.0050)</td>
</tr>
<tr>
<td>CY 2018 RVU Budget Neutrality Adjustment</td>
<td>-0.03 percent (0.9997)</td>
</tr>
<tr>
<td>CY 2018 Target Recapture Amount</td>
<td>-0.19 percent (0.9981)</td>
</tr>
<tr>
<td>CY 2018 Conversion Factor</td>
<td>35.9903</td>
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</tbody>
</table>
MPFS Payment

- **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
MPFS Payment Impact Table

- Radiation Oncology one of few specialties seeing proposed increase in charges for CY 2018

<table>
<thead>
<tr>
<th>Specialty</th>
<th>(B) Allowed Charges (mil)</th>
<th>(C) Impact of Work RVU Changes</th>
<th>(D) Impact of PE RVU Changes</th>
<th>(E) Impact of MP RVU Changes</th>
<th>(F) Combined Impact**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation Oncology and Radiation Therapy Centers</td>
<td>$1,784</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

** Column F may not equal the sum of columns C, D, and E due to rounding.
Direct Practice Expense

• Practice expense (PE) accounts for the resources provided by the physician and practitioner such as office rent and personnel wages, but exclude expense for malpractice
  – Direct = clinical labor, medical supplies and medical equipment
  – Indirect = administrative labor, office expenses and all other expenses

• Errors found CY 2017 final Direct PE values for 19283 & 19286
  – Corrections made to the RVUs
Malpractice RVUs

- CY 2016 review MP RVUs yearly to better represent mix of specialties billing codes
- MP premium data collected all 50 states, must include 35-state minimum per specialty to be considered or crosswalked to similar specialty
- Radiation Oncology premium data only available from 23-states – threshold not met
  - Requires crosswalk to similar specialty to set RVUs
  - Similar although slightly lesser than diagnostic radiology
Rad Onc MP RVUs

- CMS is seeking comments in the appropriateness of this and other crosswalks. Table 8 reflects the proposed MP RVU values for diagnostic radiology and the crosswalk value for radiation oncology.

<table>
<thead>
<tr>
<th>Specialty Code</th>
<th>Medicare Specialty Name</th>
<th>Non-Surgical Risk Factor</th>
<th>Surgical Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>Diagnostic Radiology</td>
<td>2.82</td>
<td>2.82</td>
</tr>
<tr>
<td>92</td>
<td>Radiation Oncology</td>
<td>2.82</td>
<td>2.82</td>
</tr>
</tbody>
</table>
Values of Codes Specific to Rad Onc

- Potentially misvalued
  - Radiation Therapy Planning (CPT® codes 77261, 77262, and 77263)

- New code proposed for physician work
  - Superficial Radiation Treatment Planning and Management (HCPCS code GRRR1)

- New code for use in CY 2018
  - Peri-Prostatic Implantation of Biodegradable Material (CPT code 55X87)

- New CPT® Code for Preparation of Breast Tumor Cavity for IORT
Radiation Therapy Planning

- CPT® codes 77261, 77262, and 77263 identified through high screening tool
  - Code 77263 most utilized, per the RUC time decrease of 15-minutes
  - The RUC Recommend change in work RVUs
    - 77263 = 3.14, 77262 = 2.00 & 77261 = 1.30
    - CMS considering work RVUs with time change factored in
      - 77263 = 2.60, 77262 = 1.66 & 77261 = 1.08
- Seeking comments on which values to finalize
SRT Planning and Management

- Superficial Radiation Treatment (SRT) code 77401 includes
  - Clinical treatment planning
  - Treatment devices
  - Isodose planning
  - Physics consultation
  - Radiation treatment management
- CY 2015 comments concerning physicians not being paid accurately for planning and treatment management
HCPCS code GRRR1

• CMS is proposing code GRRR1 to account for professional planning and management associated with SRT – once per course
  – Would encompass codes 77261, 77300, 77316, 77332 and 77427
  – Proposed work RVU value = 7.93
• Proposing staff inputs to be “RN/LPN/MTA” not radiation therapists, stated they do not typically perform this work
• Seeking comments on labor values and clinical work vs. physician work of services & how much face-to-face time spent by practitioner with patient for management of SRT
Implanted Biodegradable Material

• New code for CY 2018 – 55X87 Peri-prostatic implantation of biodegradable material
  – Code for hospitals, physicians and FSCs
• Related to product SpaceOAR Gel
• CPT® Panel deleted code 0438T in 10/2016
• Proposed work RVU for 55X87 = 3.03
• 30-minute decrease in time from current value
• CMS considering work RVU of 2.96 due to time
• Full code number and definition to be released by AMA August 2017
Prep of Breast Tumor Cavity for IORT

• New code CY 2018 – details to be released by AMA

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Descriptor</th>
<th>Current Work RVU</th>
<th>RUC Work RVU</th>
<th>CMS Work RVU</th>
<th>CMS Time Refinement</th>
</tr>
</thead>
<tbody>
<tr>
<td>192X1</td>
<td>Preparation of tumor cavity with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with partial mastectomy</td>
<td>NEW</td>
<td>3.00</td>
<td>3.00</td>
<td>No</td>
</tr>
</tbody>
</table>
E/M Guidelines

• Longstanding stakeholder comments that 1995 & 1997 E/M guidelines are outdated and administratively burdensome

• CMS stated history and physical exam are the most outdated of the guidelines given current clinical practices, technology advances and the use of EHRs in

• Any collaborative reform would be multi-year process among stakeholders and CMS

• Seeking comments how to adjust and focus beginning with history and physical exam

• Distinctions in medical decision making (MDM) and time most important factors per CMS in distinguishing E/M levels
  – Updates to MDM also likely needed
Nonexcepted Off-Campus PBDs

- Nonexcepted provider-based departments (PBDs) are outside 250 yards of main building of hospital and started billing services on or after 11/2/15
- CY 2017 paid under MPFS 50% of HOPPS rate for services performed
- CY 2018 proposing 25% of HOPPS rate, also seeking comments whether should be 40%
- Bill for treatments and IGRT using G-codes through 12/31/18 on UB04 w/”PN” modifier on every line item
- Following hospital supervision and facility guidelines
AUC Advanced Diagnostic Imaging

- Appropriate Use Criteria (AUC) program proposed delay until 1/1/19
  - Radiation Oncologists ordering advanced diagnostic imaging must follow the AUC program

- Ordering physician must consult AUC through Clinical Decision Support Mechanism (CDSM)
  - Assists ordering physician in making the appropriate treatment decision for the patient, based on their specific clinical condition
Billing for Advanced Imaging

• CMS proposing G-codes to describe specific CDSM used by ordering physician and reported by furnishing physician and imaging facility

• Each claim will be required to document the following three items for each billed service:
  – Which qualified CDSM was consulted by the ordering professional;
  – Whether the service ordered would adhere to specified applicable AUC, would not adhere to specified applicable AUC, or whether specified applicable AUC were not applicable to the service ordered;
  – The NPI of the ordering professional (if different from the furnishing professional)

• CY 2019 test period, claims still paid if codes not reported correctly.

• After CY 2019, claims not paid if codes not reported correctly
  – Joint effort by ordering and furnishing physicians and facilities needed
AUC Outliers

- Providers ordering advanced diagnostic imaging services for the following will be required to follow AUC program initially:
  - Coronary artery disease (suspected or diagnosed)
  - Suspected pulmonary embolism
  - Headache (traumatic and non-traumatic)
  - Hip pain
  - Low back pain
  - Shoulder pain (to include suspected rotator cuff injury)
  - Cancer of the lung (primary or metastatic, suspected or diagnosed)
  - Cervical or neck pain
Submitting Comments

• Use file code CMS-1676-P
• No later than 5 pm EST September 11, 2017
• Electronic submission is encouraged by CMS, http://www.regulations.gov.
  – Follow the instructions under the “submit a comment” tab.
Medicare Program Overview

Health insurance managed by the Federal government

- Medicare Administrative Contractors (MACs)
- Claims Processing
- Rules & Regulations
- Program Integrity

“The MACs serve more than 1.5 million health care providers enrolled in the Medicare FFS program. Collectively, the MACs process more than 1.2 billion Medicare FFS claims annually, 210 million Part A claims and more than 1 billion Part B claims, and paid $367 billion in Medicare benefits.” Source: CMS.gov
Medicare Administrative Contractors

Companies awarded a bid to be the Medicare provider for a specific region of the country

• Enroll health care providers in the Medicare program and educate providers on Medicare billing requirements
• Answer provider and beneficiary inquiries
• Publish guidelines and coverage for services within Local Coverage Determinations (LCDs)
• Central point of claims processing for Part A and B
• 10 year term, then re-bid process begins
<table>
<thead>
<tr>
<th>MAC</th>
<th>States Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cahaba GBA <a href="http://www.cahabagba.com">www.cahabagba.com</a></td>
<td>Alabama, Georgia, Tennessee</td>
</tr>
<tr>
<td>Palmetto GBA <a href="http://www.palmettogba.com">www.palmettogba.com</a></td>
<td>North Carolina, South Carolina, Virginia (except areas noted as Novitas), West Virginia</td>
</tr>
<tr>
<td>First Coast Service Options <a href="http://www.medicare.fcso.com">www.medicare.fcso.com</a></td>
<td>Florida, Puerto Rico, Virgin Islands</td>
</tr>
<tr>
<td>WPS Government Health Administrators <a href="http://www.wpsgha.com">www.wpsgha.com</a></td>
<td>Indiana, Iowa, Kansas, Michigan, Missouri, Nebraska</td>
</tr>
<tr>
<td>CGS <a href="http://www.cgsmedicare.com">www.cgsmedicare.com</a></td>
<td>Kentucky, Ohio</td>
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</table>

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CMS Publications

National Coverage Determination (NCD)

Local Coverage Determination (LCD)
National Coverage Determination (NCD)

- Determination by the Secretary of the Department of Health and Human Services whether or not an item or service is covered nationally

- Examples:
  - Hyperthermia for Treatment of Cancer (110.1)
  - Smoking and Tobacco-Use Cessation Counseling (210.4)

- In absence of an NCD, Medicare contractors may establish an LCD
Local Coverage Determination (LCD)

• Carrier, fiscal intermediary or MAC develop and/or adopt LCDs to define whether a particular service will be covered
• Developed when no NCD is published or in need of further definition
• May include:
  – CPT® and HCPCS coding instructions
  – ICD-10 codes
  – Documentation requirements
  – Associated articles with additional instructions
Retired LCDs

- Policies remain active when there is evidence of significant problems with performance, billing and/or coding
- Correct claims submission is expected with or without an active LCD

Why are LCDs Retired?

LCDs are retired due to lack of evidence of current problems, or in some cases because the material is addressed by a National Coverage Determination (NCD), a coverage provision in a CMS interpretative manual or an article. Most LCDs are not retired because they are incorrect. The guidance in the retired LCD may be helpful in assessing medical necessity. Where providers have adjusted their billing and coding practices to correspond to the guidance in LCDs, they will want to be very careful in departing from these practices just because the LCD is retired.
Find Your Policies

QUESTIONS