Coding Frequently Asked Questions - What We Really Want To Know
April 6, 2019

Presenter

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FACHE
CEO and Chairman of the Board
Disclaimer

• When a third-party payer is involved, the determination of reimbursement for services is the decision of the individual insurance company based on the patient’s policy and the third-party payer guidelines. No guidance can adequately address reimbursement issues for the hundreds of insurance payers that exist. Efforts have been made to ensure the information was valid at the date of presentation. Reimbursement policies vary from insurer to insurer and the policies of the same payer may vary within different U.S. regions. All policies should be verified to ensure compliance. Therefore, it is essential that each payer be contacted for their individual requirements.

• The websites listed in this presentation are current and valid as of the date of this presentation. However, webpage addresses and the information on them may change or disappear at any time and for any number of reasons. The attendee is encouraged to confirm or locate any URLs listed here that are no longer valid.

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Objectives

Provide examples of commonly asked radiation oncology coding and reimbursement questions

Discuss coding, billing and documentation issues affecting radiation oncology

Review the need to ensure coding compliance for quality, value and reimbursement
Signature Requirements

Is the timing of signatures important as long as the document is signed at some point?

CMS States:

All entries in the medical record must be dated, timed, and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided.
**Signature Requirements**

Source: Medicare Program Integrity Manual

3.3.2.4 - Signature Requirements (Rev. 751; Issued: 10-20-17; Effective: 11-20-17; Implementation: 11-20-17)

Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead should make use of the signature authentication process. The signature authentication process described below should also be used for illegible signatures.

- If the signature is illegible, MACs, ZPICs and CERT shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.
- If the signature is missing from an order, MACs and CERT shall disregard the order during the review of the claim (e.g., the reviewer will proceed as if the order was not received).
- If the signature is missing from any other medical documentation (other than an order), MACs and CERT shall accept a signature attestation from the author of the medical record entry.

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**Signature Attestation Statement**

Providers will sometimes include an attestation statement in the documentation they submit. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.

Should a provider choose to submit an attestation statement, they may choose to use the following statement:

“I, [print full name of the physician/practitioner], hereby attest that the medical record entry for [date of service] accurately reflects signatures/notations that I made in my capacity as [insert provider credentials, e.g., M.D.] when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.”

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Reminder

Note: The MACs and CERT shall NOT consider attestation statements where there is no associated medical record entry. Reviewers shall NOT consider attestation statements from someone other than the author of the medical record entry in question (even in cases where two individuals are in the same group, one should not sign for the other in medical record entries or attestation statements). Reviewers shall consider all attestations that meet the above requirements regardless of the date the attestation was created, except in those cases where the regulations or policy indicate that a signature must be in place prior to a given event or a given date. For example, if a policy states the physician must sign the plan of care before therapy begins, an attestation can be used to clarify the identity associated with an illegible signature. However, such attestation cannot be used to "backdate" the plan of care.

Bundling Versus Packaging

What is the difference and does it really matter?

VS.
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)*

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Set-Up Simulation

Is it appropriate to bill the initial Set-Up Simulation in every case?
Set-Up Simulation

Professional & Technical

77280 Simple simulation of a single treatment area

77285 Intermediate simulation two separate treatment areas

77290 Complex simulation of three or more treatment areas, particle beam, rotation or arc therapy, complex or custom blocking, brachytherapy simulation, hyperthermia probe verification, or any use of contrast material

• AMA indicates contiguous sites should be considered a single treatment area

Utilization Guidelines

• Documentation must support the date of service and complexity
• Simulation process may include use of treatment devices, which are separately coded
• Acquisition of CT images does not define level of service
• Physician signature required for all documentation
• Billable multiple times during course; however, once per day

Inclusion of treatment devices in the simulation process typically increases the complexity. Simulation without the inclusion of devices or with any pre-made devices (e.g., blocks, immobilization) is considered simple. The addition of custom immobilization devices or tangential ports is an indicator of complex level of simulation. The typical course of radiation therapy will require between one and three simulations. However, no more than one simulation should be reported on any given day. Frequency in excess of three simulations should be supported by documentation in the medical record.
Simulation Bundling

NCCI Policy Manual:

Modifier indicator “1” for 77290 & 77280

Modifier 59 only appropriate when:

• Initial brachytherapy simulation in the morning
• Followed by a verification simulation for the afternoon BID treatment

IMRT Simulation

• Simulation and CT guidance not separately billable with IMRT planning code, CPT® 77301
  • PE RVUs included with 77301 for MPFS
  • Bundled for HOPPS per Medicare Claims Processing Manual
• Continue to document simulation and CT guidance procedure
• Treatment devices are considered separately billable
• Review commercial payer policies for instructions

Medicare Claims Processing Manual
“Payment for the services identified by CPT codes 77014, 77280, 77285, 77290, 77295, 77306 through 77321, 77331, and 77370 are included in the APC payment for CPT code 77301 (IMRT planning). These codes should not be reported in addition to CPT code 77301 when provided prior to or as part of the development of the IMRT plan.”
Documentation

- Date of service
- Simulation area(s)
- Position
- Treatment devices
- Imaging
- Photographs
- Markings

Administration of Contrast

- No separate charge for injection
- Contrast is separately billed (HOPPS)
- May require informed consent for contrast administration
Respiratory Motion Management

Professional and Technical

**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

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 isocenter 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 all 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 reported as a separate claim line or 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).

Documentation

- Date of 3D or IMRT planning
- Images acquired
- Fusion of data sets
- Mapping of field based on target and organs at risk

<table>
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<tr>
<th>Patient Name</th>
<th>Smith, Jane</th>
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<tr>
<td>MR No.</td>
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<tr>
<td>3/1/2017</td>
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<td>May 1, 2018</td>
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<td>Referring Physician</td>
<td>Dr. Brown</td>
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Respiratory Motion Management Simulation

Jane Smith has agreed to proceed with a course of radiation therapy to her lower left side. Due to potential tumor and critical structure motion, a DRR image was acquired during the simulation performed on 4/25/2018. Once the images were acquired, the DRR data was retrospectively binned according to the respiratory phase to create a DRR image demonstrating the respiratory movement. From this data set, a ITV was reconstructed and transferred to the contouring workstation for region-volume definition.

The CT and reconstructed image sets were used to contour the GTV and an ITV was then created to account for the motion of the target. I reviewed these contours in the axial, sagittal and coronal planes to confirm target motion was encompassed. The ITV was then generated using a 3mm margin. Following target delineation, an IMRT treatment plan was generated to deliver a dose of 60Gy in 3 fractions. Critical structures included the heart, spinal cord, normal lung tissue, femoral arteries and contralateral breast.

Continuously authorized by J. Brown, MD 3/1/2018 2:00 PM
Stereotactic Treatment Delivery

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

G0339 and G0340 remain for MPFS until further review

Utilization Guidelines

• Billable once per day regardless of the number of sessions or lesions
• If performed on same date as a different treatment modality, only one is billable
• Covered diagnoses may vary from payer to payer
• SBRT cannot be utilized as boost
The radiation oncologist remains available throughout SBRT treatment to manage the execution of the treatment and to make real-time adjustments in response to patient motion, target movement, or equipment issues to ensure accuracy and safety.

Payer Guidelines

1. Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT): cranial lesions are distinct disciplines that utilize externally generated high dose focusing radiation in certain cases to inactivate or eradicate a defined target in the head without the need to make an incision. This target is defined by high-resolution stereotactic imaging. The process of care involves the radiation oncologist and/or neurosurgeon and physicist. For a subset of tumors involving the skull base, the multidisciplinary team may also include a head and neck surgeon with training in stereotactic radiosurgery. SRS/SBRT are typically performed in a single session, using a rigidly attached stereotactic guiding device, other immobilization technology and/or a stereotactic image-guidance system, but can be performed in a limited number of sessions up to a maximum of five.

Technologies that are used to perform SRS/SBRT include linear accelerators, particle beam accelerators, and multi-source Cobalt-60 units. In order to enhance precision, various devices may incorporate robotics and real-time imaging.

To qualify for SRS/SBRT a high dose should be delivered in a single fraction or in 2-5 fractions. 500 cGy (5 Gray) in a single dose is considered the minimum dose for SRS. A more typical dose would be 150-250 cGy (15-25 Gray) if given in one fraction.

In general, SRS/SBRT is not indicated for cancers that are widely disseminated, unless evidence can be provided to justify the expectation of a meaningful clinical benefit, as well as evidence of a dosimetric advantage for SRS/SBRT over other forms of radiation therapy.
Multiple Lesions

ASTRO Coding Guidance

**Coding Question:** It is my understanding that in order to treat two sites with SBRT you need to keep the treatments to five or less. If the physician has two plans and two separate lesions, but treats these on alternate days that total more than five fractions, can we bill SBRT charges?

**Coding Answer:** CPT instructions for CPT code 77373 (SBRT treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions) include the possibility of treating multiple sites of disease in one treatment course. Therefore, if the sum of the treatment days for all of the sites treated during a single course of therapy exceeds five, it is not appropriate to charge CPT code 77373 for SBRT delivery.

Multiple Lesions Cont.

**Coding Question:** In the hospital setting, using a robotic modality, if a patient presents with three brain metastases that require separate single-fraction treatment plans (related to clinical issues such as treatment time or integral dose), is it appropriate to charge the SRS treatment code (77372) and the weekly management code (77432) per treatment plan (i.e. charging 77372/77432 with each treatment delivery)? In addition, can each treatment plan (77295) be charged separately? Or should the hospital bill 77373 and the corresponding SBRT weekly management (77435) and just a single treatment plan (77295), regardless of the number of treatment plans generated and treated?

**Coding Answer:** If the intent is to treat three lesions separately but within the context of a single episode of care, then the appropriate codes would be 77373 for SBRT delivery, 77435 for SBRT physician management, and a single instance of 77295 for 3-D planning. If these are discrete episodes of care with separate consultation notes, separate CT scans, separate clinical treatment plans, and separate end-of-treatment notes, then 77372, 77432, and 77295 may be charged for each episode of care.
Documentation Requirements

- Medical necessity
- Frequency of treatment
- Patient’s functional status and performance status
- Why SBRT is the treatment of choice
  - Lower risk to normal tissue or disease recurrence
  - Advantage of treatment over other techniques
  - Dosimetric evidence of reduced normal tissue toxicity or tumor control
- Procedure note for each treatment fraction

Proceed With Caution

- New technology may lead to:
  - Coding changes
  - Documentation changes
  - Non-covered services
  - Contracting with payers
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 77384 is used to describe planning for a defined imaging set that portrays the treatment target(s). Use of code 77384, 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 (77384) 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 CT 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 (MU’s) 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

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

77799 Unlisted procedure, clinical brachytherapy

79999 Unlisted radiopharmaceutical therapeutic procedure

Interview/Include your staff to illustrate you are all a portion of a coding team.
Radiation Oncology 3D on the Horizon

Review of Outpatient 3-Dimensional Conformal Radiation Therapy Planning Services

3-Dimensional Conformal Radiation Therapy (3D-CRT) is a radiation therapy technique that allows doctors to sculpt radiation beams to the shape of a patient's tumor. A 3D-CRT plan is provided in its treatment plan for planning and delivery. Hospitals bills Medicare for developing a 3D-CRT treatment plan using Current Procedural Terminology (CPT) codes. Automated pretreatment edits prevent additional payments for repeat radiation therapy planning services if they are billed on the same date of service as the 3D-CRT treatment plan. However, Medicare allows additional payments if they are billed on a different date of service (e.g., 1 day before). For a form of radiation similar to 3D-CRT, Medicare requires added payments for separate direct radiation planning services when they are billed on a different date of service. We will determine the extent of potential savings to Medicare if it had implemented the same requirements for 3D-CRT planning services.

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<td>July 2018</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Review of Outpatient 3-Dimensional Conformal Radiation Therapy Planning Services</td>
<td>Office of Audit Services</td>
<td>Y-00-16-30812</td>
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What’s New

Payments Made by Novitas Solutions, Inc., to Hospitals for Certain Advanced Radiation Therapy Services Did Not Fully Comply With Medicare Requirements

Intensity-modulated radiation therapy (IMRT) is an advanced type of radiation procedure used to treat difficult-to-reach tumors. Novitas Solutions, Inc. (the Medicare Administrative Contractor responsible for processing Medicare payments for outpatient services in Jurisdictions H and L) incorrectly paid hospitals for IMRT services provided to nearly all of the beneficiaries associated with our review. Although most of the IMRT services directly affected hospitals were allowable, we determined that Novitas made overpayments for at least 1 service for 88 of the 131 beneficiaries in our random sample. Based on our sample results, we estimated that hospitals in Jurisdictions H and L received Medicare overpayments of at least $7.2 million for unallowable IMRT services during our audit period. The overpayments occurred because (1) Novitas’ claim processing system did not adequately prevent payments to hospitals for all incorrectly billed IMRT services and (2) hospitals were unfamiliar with or misinterpreted Medicare guidance about billing for certain IMRT services, or made clerical errors.

We made three recommendations to Novitas to recover the overpayments identified in our report. We also made two procedural recommendations to implement payment edits and to educate hospitals on properly billing for IMRT services.

Copies can also be obtained by contacting the Office of Public Affairs at Public.Affairs@oz.mhs.gov.
November 2018

- Novitas incorrectly paid hospitals for IMRT services provided to “nearly all of the beneficiaries” in the review
  - Payment dates between July 2013 – December 2015
  - Most services were allowable
  - Overpayments made for at least 1 service for 98 of the 100 beneficiaries
  - 2 beneficiaries processed correctly

Findings

- Special physics consultation without order or documentation
- Incorrect number of units billed
- Incorrect use of modifier for intermediate treatment device
- Lacking medical necessity
- Not standard of care
Recent Item

Intensity-Modulated Radiation Therapy

Intensity-modulated radiation therapy (IMRT) is an advanced mode of high-precision radiotherapy that uses computer-controlled linear accelerators to deliver precise radiation doses to a malignant tumor or specific areas within the tumor. IMRT is provided in two treatment phases: planning and delivery. Certain services should not be billed when they are performed as part of developing an IMRT plan. Prior OIG reviews identified hospitals that incorrectly billed for IMRT services. We will review Medicare outpatient payments for IMRT to determine whether the payments were made in accordance with Federal requirements.

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<td>October 2017</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Intensity-Modulated Radiation Therapy</td>
<td>Office of Audit Services</td>
<td>W-00-10-05732, various</td>
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What OIG Found

Payments for outpatient IMRT planning services did not comply with Medicare billing requirements. Specifically, for all 100 line items in our sample, the hospitals separately billed for complex simulations when they were performed as part of IMRT planning. The overpayments primarily occurred because the hospitals appeared to be unfamiliar with or misinterpreted the Centers for Medicare & Medicaid Services (CMS) guidance. In addition, the claim processing edits did not prevent the overpayments because the edits applied only to services billed on the same date of service as the billing of the procedure code for the bundled payment, and the services in our sample were billed on a different date of service.

On the basis of our sample results, we estimated that Medicare overpaid hospitals nation-wide as much as $21.5 million for complex simulations billed during our audit period. In addition, we identified $4.2 million in potential overpayments for other IMRT planning services that were not included in our sample. In total, Medicare overpaid hospitals as much as $25.8 million during our audit period.

For IMRT planning services billed in the 2 years after our audit period (for CYs 2016 and 2017), we identified an additional $3.7 million in potential overpayments for complex simulations and $1.7 million for other IMRT planning services. In total, Medicare overpaid hospitals as much as $5.4 million after our audit period.
Trivia - False Claims Act

Originally set up to fine those who billed the government for horses, but delivered donkeys during the Civil War.

Example 1

- Physician is coding incorrectly, but advises the biller that he will make the decisions to ensure maximum reimbursement. Biller agrees, to save her job.

- 18 USC 2 states:
  - Whoever commits an offense against the United States or aids, abets, counsels, commands, induces, or procures its commission, is punishable as a principal.

  The “helper” is as guilty as the mastermind.
Example 2

- What if you don’t know about the illegal billing at the time it occurred, but learn about it after the fact and help conceal it?
- 18 USC 3 states:
  - Whoever, knowing that an offense against the United States has been committed, receives, relieves, comforts, or assists the offender in order to hinder or prevent his apprehension, trial or punishment, is an accessory after the fact.
  
  Hiding evidence of incorrect billing can be obstruction of justice.

Radiation Oncology Example 1

**Insufficient Documentation – Missing Signatures**

A radiation oncologist billed for HCPCS 77301 and 77300, and for multi-leaf collimator devices for IMRT, therapeutic radiology simulation-aided field setting, therapeutic radiology treatment planning (complex), and IMRT treatment delivery for three dates of service. The submitted documentation included notes for three dates of service different from those billed, an unsigned and undated treatment plan, an undated histogram, a Computed Tomography (CT) scan report, an unsigned fine needle aspiration report, an unsigned operative report, and a breast Magnetic Resonance Imaging (MRI) report. There was no documentation of complex treatment devices (irregular blocks, special shields, compensators, wedges, molds, or cast), and there was no verification of treatment setup and delivery. No signature attestation statement was received from either the radiation oncologist or the radiation physicist and no other medical records were submitted despite a request for additional documentation. This claim was scored as an insufficient documentation error.
Radiation Oncology Example 2

Insufficient Documentation – Missing Order, Intent to Order, and Dosimetry Calculation

A radiation oncologist billed for HCPCS 77301, the documentation received included CT images, a cumulative dose volume histogram, a treatment plan report, and an unsigned IMRT plan summary/calculation for the date of service billed. The billing provider did not submit an authenticated copy of the treating physician’s progress notes to document the order/intent to order radiation therapy prior to billed date of service, nor did the billing provider submit an authenticated copy of the dosimetry calculation for date of service. No other medical records were submitted despite a request for additional documentation. This claim was scored as an insufficient documentation error.

Radiation Oncology Example 3

“Radiation Therapy listed among the top 10 errors by type of service, with a projected error rate of 42.7%.”

Case #3: Treatment Records, Treatment Plans, and Orders

Submitted CPT code:

- 77437: Radiation treatment management x5.

Records submitted:

- Chemotherapy records
- Lab results
- Physician’s note (not signed)
- Discharge instructions
- Upon second request, the following additional records were submitted: follow-up note; end of treatment summary; consultation note; multiple CT results; pathology results; colonoscopy results; and EGD results.

Financial Impact – Why Radiation Is a Target

- 2015 improper payment rate for radiation oncology – 9.6%
  - 0.3 % of overall Medicare FFS improper payment rate
  - $137 million projected improper payment for radiation oncology for 2015

Source: Medicare Quarterly Provider Compliance Newsletter January 2017

Lookback Period

Overpayments must be reported and returned only if a person identifies the overpayment within 6 years of the date the overpayment was received.
“Magic Words” – Use Caution

“Instead of teaching physicians to use "magic words", train them to:

▪ Document what was known at the time of the encounter - specifically.
▪ Document the “decision points” of code selection
▪ Document the sequence of events
Questions