He Said, She Said!

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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
The following slides include:

- Real questions, conversations and discussions
- Real answers, guidance and recommendations
- Reminders on coding guidance and regulations
Clinical treatment planning is part of the dosimetry planning process, it even has planning in the name of the code. Why can’t I bill it when I sign the plan?

She Says…

Clinical Treatment Planning represents:
- Integration of the overall medical condition and extent of disease
- Development of a plan of therapy for the complete course
- Coordination with other therapeutic modalities
- Review of complex testing and imaging
- Occurs at the initiation of the course of treatment
Clinical Examples in Radiology

“Phase II – Preparing for Treatment – Treatment planning, simulation, dosimetry Treatment Planning (77261-77263)

It is during the treatment planning phase that the radiation oncologist will determine the appropriate type of treatment. As noted in the ASTRO/ACR Guide to Radiation Oncology Coding, treatment planning is a cognitive process that includes determining the disease-bearing areas, identifying type and method of delivery, specifying area to be treated, selecting treatment techniques, and specifying dose and duration of therapy. Information obtained during the initial consultation and additional test results are used. Imaging studies and laboratory tests are used to determine the treatment volume and critical structures in close juxtaposition to the treatment area.”

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“Once the documentation for clinical treatment planning, which includes a written prescription or intent along with a note documenting the thought process and work, is complete the patient proceeds to the next step in treatment preparation: simulation.”

ASTRO

“Clinical treatment planning codes (CPT codes 77261-77263) are the professional charges for the physician to integrate the patient’s overall medical condition and extent of disease and to formulate a plan of therapy for the patient. The term “clinical treatment planning” should not be confused with CPT codes that describe dosimetry isodose plans, which occur later in the process of care (e.g., teletherapy isodose plan (CPT codes 77306-77307), 3-D radiotherapy plan (77295), IMRT plan (77301) and brachytherapy isodose plan (77316-77318)).”


He Says…

It sounds like some of the same information the doctor puts in the consultation note, can’t I just use that?
 Requires documentation of:

- Work performed in development of the plan of care
- Key factors supporting level of service
- Separate from work utilized to code E/M
- May be performed on same date as E/M

Noridian Healthcare Solutions

Intensity Modulated Radiation Therapy (IMRT) L34080
“Clinical treatment planning includes interpretation of special testing, tumor localization, treatment volume determinations, treatment time/dosage determinations, choice of treatment modality(ies), selection of appropriate treatment devices, and other procedures such as concurrent or sequential chemotherapy or surgery. A separate charge for Clinical Treatment Planning may be appropriately claimed at the appropriate level of service (77261, 77262 or 77263), when based on separately-documented work itemizing the specific services provided. Review of records, pathology reports, and/or imaging studies are typically part of the basis for claiming either a higher-level E/M service preceding treatment planning, or as a component of this code, but this same work should not be counted as a basis for both services.”
Noridian Healthcare Solutions

“Radiation Therapy documentation Requirements

Documentation of clinical treatment planning written, signed and dated by physician that includes some or all of the following elements:

- Diagnosis and extent of disease
- Treatment site
- Target anatomical structures
- Identification of any organs at risk or adjacent to treatment fields
- Intent of treatment
- Specialized tests interpreted to determine target volume
- Treatment modality and interaction with chemotherapy, if applicable
- Planning considerations and justification for modality and technique planned

Use of anesthesia or specific patient-related immobilization challenges”

Documentation

- Treatment area
- Orders
- Intent for treatment
- Goals & dose constraints
- Medical necessity
Timing of signatures is not important as long as the document is signed at some point, right?

Payers require services to be signed or authenticated by the person(s) responsible for the care of the beneficiary.

Missing or delayed signatures may result in:

- Non-compliance with payer guidelines
- Non-billable services due to timing
- Questions related to required supervision or participation
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, ZIPCS 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.

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.”
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.

He Says...

Can we just remove the date and time from our signatures, so you can’t tell when it was signed?
Published guidelines require electronic signatures to include the date and time of the signature. Timing of approvals are also necessary to support physician orders and services such as IGRT.

Code of Federal Regulations
Title 21

PART 11 — ELECTRONIC RECORDS; ELECTRONIC SIGNATURES
Subpart D—Electronic Records
Sec. 11.50 Signature manifestations.

(a) Signed electronic records shall contain information associated with the signing that clearly indicates all of the following:
(1) The printed name of the signer;
(2) The date and time when the signature was executed; and
(3) The meaning (such as review, approval, responsibility, or authorship) associated with the signature.
(b) The items identified in paragraphs (a) (1), (a) (2), and (a) (3) of this section shall be subject to the same controls as for electronic records and shall be included as part of any human readable form of the electronic record (such as electronic display or printout).
The patient has multiple metastatic brain lesions that need to be treated. If we treat each lesion on a separate day can it be considered SRS?

Stereotactic treatment delivery and management codes were developed to include all lesions. If all lesions cannot be treated in a single session, follow published guidelines for coding instructions.
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

CMS MM8572

“CPT code 77371 is to be used only for single session cranial SRS cases performed with a Cobalt-60 device, and CPT code 77372 is to be used only for single session cranial SRS cases performed with a linac-based device. The term “cranial” means the pathological lesion(s) that are the target of the radiation is located in the patient’s cranium or head. The term “single session” means that the entire intracranial lesion(s) that comprise the patient’s diagnosis are treated in their entirety during a single treatment session on a single day. CPT code 77372 is never to be used for the first fraction or any other fraction of a fractionated SRS treatment. CPT code 77372 is to be used only for single session cranial linac-based SRS treatment.”
“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.”

**Coding Question:** In the hospital setting, using a robotic modality, if a patient presents with three brain metastasis 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.
I need to treat a lung patient with two separate lesions for a total of 5 fractions per lesion. If I treat them on separate days can we still bill it as SBRT?

Stereotactic treatment delivery and management codes define a total number of fractions per course. If the course exceeds the maximum number of fractions conventional codes are appropriate.
WPS

Stereotactic Body Radiation Therapy L34647

“SBRT may be fractionated (up to 5 fractions). Each fraction requires an identical degree of precision, localization and image guidance. Since the goal of SBRT is to intensify the potency of the radiotherapy by completing an entire course of treatment within an extremely accelerated time frame, any course of radiation treatment extending beyond five fractions is not considered SBRT and is not to be billed using these codes.”

ASTRO

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.
As long as I get a new CT data set, I can bill a second 77295 or 77301, right?

He Says...

A second 3D conformal plan or IMRT plan is billable when a significant change in the target or patient anatomy supports the medical necessity for a new plan.

Documentation:
- New image data set
- Significant changes
- Medical necessity for new plan

She Says...
WPS

Radiation Oncology Including Intensity Modulated Radiation Therapy (IMRT) L34652

“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 (e.g., weight loss) or significant change in the contour of the target (e.g., 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.
Since we acquire the 4DCT during simulation, is the information in the simulation note sufficient to bill CPT® 77293?

Respiratory Motion Management Simulation is a multistep process requiring documentation throughout the procedure.

Documentation:
- Order/medical necessity
- Acquisition of 4DCT and work during simulation
- Recommend summary note of use of 4DCT during planning phase dated on plan date
The rules and coding won’t matter once we go to a set payment rate per diagnosis.
Not likely, the Alternative Payment Model (APM) will come with a new set of codes, modifiers and rules to follow.

What We Know Now

“CMS is proposing to make bundled payments for all included Radiation Therapy (RT) services, instead of using Medicare Fee-for-Service (FFS) payments for services provided in the randomly selected Core-Based Statistical Areas (CBSA) to beneficiaries who have both Medicare Part A and B, and for whom traditional FFS Medicare coverage is their primary insurance during the RO Model episode.”
Key Details

- 90 day episode of care bundle
- Initiated by the clinical treatment planning service
- Prospective lump sum payments utilizing the existing CMS claims processing systems
- Participants expected to report no-pay claims for services provided during episode
- 17 cancer types

Payments

2 payment installments

- First half of payment for professional component when new RO Model-specific HCPCS codes and modifiers are reported
- Second half at end of episode (89 days after the clinical treatment planning date) and when new RO Model-specific HCPCS codes and modifiers are reported
HCPCS Codes & Modifiers

Developed new HCPCS code for each of the 17 cancer types

V1 modifier - used when clinical treatment planning is furnished

V2 modifier – used when episode has ended

Follow Up

“Following the 90-day episode period, participants would be eligible to bill RT services as fee-for-service for the same beneficiary for 28 days before a new episode can be triggered. Following the 28-day clean period, participants would be eligible to initiate another episode for the same beneficiary if clinically appropriate. We would monitor use of services outside of the 90-day episode.”
Next Steps

Watch for publication of proposal and key program details

Provide comments and feedback

Watch for further CMS instructions and learning opportunities
Reminder

- Use the correct rules
  - Physician, Freestanding, Hospital Outpatient, Provider Based Department,…
  - State or Jurisdiction
  - Payer
- Understand what constitutes authoritative guidance
- Consider differences related to practice patterns, equipment and documentation

Coding Guidance

- Federal Register
- Centers for Medicare & Medicaid Services (CMS) Publications
- Commercial Payer Policies
- American Medical Association & CPT® Publications
- OIG Compliance Standards
- Standards of Practice
- Opinions of specialty organizations