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**Housekeeping**

- Participants are on mute
- Questions will be addressed throughout and after the webinar via the WebEx question panel
- Participants will be emailed a PDF copy of the presentation following the webinar
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Objectives

Basic Review of HOPPS and MPFS

MPFS
- Final Rule Items
- Final Payment Rates

HOPPS
- Final Rule Items

Coding Changes Impacting CY 2016
- New Brachytherapy Codes
- Provider Based Department Changes
- Codes 77295 and 77300 in 2016
- Review Simulation and IMRT

Q&A
HOPPS and MPFS Payment Systems

**HOPPS**
- Payments based on costs
- Adjusted by a wage index
- Grouped into APC’s
- Example: Tx Devices
  - 77332, 77333 and 77334
    - Historically the same payment rate under HOPPS
    - Will change in 2016

**MPFS**
- Codes have RVUs
- CF is applied to all RVUs
- GPCI’s
- Codes can be split into Global, TC, 26 payment
- Example: Tx Devices
  - 77332, 77333, 77334
    - Historically different payment rates under MPFS
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
Annual Updates to Rules

- Stay up to date
- Stay informed
- Get involved

Hospital Outpatient: Hospital Billing Technical Charges

Physician/Facility: Physician Practicing in a Hospital Setting & Freestanding Facilities

http://www.gpoaccess.gov/index.html

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Proposed vs. Final

Proposed

CMS’s plan, intent, thoughts for rules, regulations and reimbursement for upcoming year

Final

Determined after consideration and debate occurs based on comments received

Proposed Rules + Consideration of Comments = Final Rule
2016 Final

MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)
MPFS Final Highlights

- Conversion Factor = $35.8279
  - Update Factor = 0.5% (1.0005)
  - Budget Neutrality Factor of -0.02% (0.9998)
  - Target Recapture Amount = -0.77% (0.9923)
- Estimated Impact on Total Allowed Charges by Specialty
  - Radiation Oncology = -2%
  - Radiation Therapy Centers = -1%
- Misvalued codes - will seek recommendations from RUC and other interested stakeholders
  - Misvalued codes identified through high expenditure by specialty screen
    - 77263, 77334 & 77470
  - Target recapture amount
    - Means to establish annual target reductions in PFS expenditures related to adjustments due to misvalued codes
MPFS Final Highlights cont.

- Radiation Treatment and Related Image Guidance Services
  - G-codes will continue in CY 2016!
  - Brachytherapy code changes will be implemented for CY 2016
  - Equipment Utilization Rate for Linear Accelerators
    - Updating the default utilization rate assumption for linear accelerators used in radiation treatment services from 50 to 70%
  - Superficial Radiation Treatment Delivery
    - CMS considering creating a code to describe total work associated with the superficial course of treatment
    - Seeking additional information and alternative descriptions for a code for future rule makings
    - Finalizing update of equipment item ER045 “orthovoltage radiotherapy system” with a change by renaming it “superficial radiation therapy system” and updating the price from $140,000 to $216,000
MPFS Final Highlights cont.

• Incident-to Changes
  – Billing Physician as the Supervising Physician
    • Incident to services require direct supervision of the auxiliary personnel providing the service by the physician or other practitioner
    • CMS finalizing revision of the regulations specifying the requirements for which physicians or other practitioners can bill for incident to services
    • The physician who bills for service billed to Medicare must also be the physician or other practitioner who directly supervised the service
    • Additionally Auxiliary personnel who have been excluded or revoked from Medicare cannot provide incident to services to Medicare, Medicaid or any other federally funded health care programs by OIG
• Locum Tenens Physicians
  – Finalized revision of definition of locum tenens physician to remove the reference to “stand in the shoes.” CMS believes definition of locum tenens is clear without it
Conversion Factor (CF) Update

• The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) put into law April 16, 2015
  – Repealed sustainable growth rate (SGR)
  – Revised and established PFS updates for several years
  – Established a Merit-based Incentive Payment System (MIPS)
• CY 2016 CF proposed to be $36.1096 & finalized at $35.8279
  – 0.5% increase over CY 2015 CF of $35.9335, but…
  – Decrease of Budget Neutrality Factor
  – Decrease of Target Recapture Amount
Calculating Conversion Factor

- Budget Neutrality keeps CMS budget in expected range, factor subtracted from CF of 2015 + the 0.5% update factor
- Target Recapture Amount
  - Factor applied if due to misvalued codes in previous years, expenditure reduction does not meet the 1% target
  - Pathology had high number of misvalued codes that are now impacting reimbursement for all specialties in 2016

**TABLE 60: Calculation of the CY 2016 PFS Conversion Factor**

| Conversion Factor in effect in CY 2015 | 35.9335 |
| Update Factor | 0.5 percent (1.005) |
| CY 2016 RVU Budget Neutrality Adjustment | -0.02 percent (0.9998) |
| CY 2016 Target Recapture Amount | -0.77 percent (0.9923) |
| CY 2016 Conversion Factor | 35.8279 |
MPFS Equation

Work RVU * Work GPCI + PE RVU * PE GPCI + MP RVU * MP GPCI * Conversion Factor

Physician work provided per service
Practice expense, overhead etc. for service
Malpractice is professional liability insurance
Used to convert RVUs into $$$

GPCI = Geographic Practice Cost Index (adjusts each different type of RVU) for a particular locality in the country
## MPFS Payment Impact Table

<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</td>
<td>$1,776</td>
<td>0%</td>
<td>-2%</td>
<td>0%</td>
<td>-2%</td>
</tr>
<tr>
<td>Radiation Therapy Centers</td>
<td>$52</td>
<td>0%</td>
<td>-2%</td>
<td>0%</td>
<td>-1%</td>
</tr>
</tbody>
</table>

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

Proposed conversion to AMA CPT codes was not finalized, G-codes continued, this will decrease the overall negative impact from what was proposed.
# Global RVU Changes Snapshot

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>DESCRIPTION</th>
<th>TOTAL NON-FACILITY RVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2015 RVU Totals</td>
</tr>
<tr>
<td>77263</td>
<td>Radiation therapy planning</td>
<td>4.64</td>
</tr>
<tr>
<td>77280</td>
<td>Set radiation therapy field</td>
<td>7.59</td>
</tr>
<tr>
<td>77290</td>
<td>Set radiation therapy field</td>
<td>14.29</td>
</tr>
<tr>
<td>77295</td>
<td>3-d radiotherapy plan</td>
<td>13.68</td>
</tr>
<tr>
<td>77300</td>
<td>Radiation therapy dose plan</td>
<td>1.77</td>
</tr>
<tr>
<td>77301</td>
<td>Radiotherapy dose plan imrt</td>
<td>54.29</td>
</tr>
<tr>
<td>77306</td>
<td>Telethx isodose plan simple</td>
<td>4.07</td>
</tr>
<tr>
<td>77307</td>
<td>Telethx isodose plan cplx</td>
<td>7.97</td>
</tr>
<tr>
<td>77316</td>
<td>Brachytx isodose plan simple</td>
<td>5.22</td>
</tr>
<tr>
<td>77318</td>
<td>Brachytx isodose complex</td>
<td>9.87</td>
</tr>
<tr>
<td>77332</td>
<td>Radiation treatment aid(s)</td>
<td>2.31</td>
</tr>
<tr>
<td>77334</td>
<td>Radiation treatment aid(s)</td>
<td>4.26</td>
</tr>
<tr>
<td>77338</td>
<td>Design mlc device for imrt</td>
<td>14.15</td>
</tr>
<tr>
<td>77427</td>
<td>Radiation tx management x5</td>
<td>5.22</td>
</tr>
<tr>
<td>77431</td>
<td>Radiation therapy management</td>
<td>2.86</td>
</tr>
<tr>
<td>77432</td>
<td>Stereotactic radiation trmt</td>
<td>11.71</td>
</tr>
<tr>
<td>77435</td>
<td>Sbrt management</td>
<td>17.67</td>
</tr>
<tr>
<td>77470</td>
<td>Special radiation treatment</td>
<td>4.36</td>
</tr>
<tr>
<td>77778</td>
<td>Apply interstit radiat compl</td>
<td>24.43</td>
</tr>
<tr>
<td>G6002</td>
<td>Stereoscopic x-ray guidance</td>
<td>2.1</td>
</tr>
<tr>
<td>G6012</td>
<td>Radiation treatment delivery</td>
<td>6.37</td>
</tr>
<tr>
<td>G6013</td>
<td>Radiation treatment delivery</td>
<td>7.17</td>
</tr>
<tr>
<td>G6015</td>
<td>Radiation tx delivery imrt</td>
<td>11.19</td>
</tr>
<tr>
<td>G6016</td>
<td>Delivery comp imrt</td>
<td>11.16</td>
</tr>
</tbody>
</table>

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## 2015 - 2016 MPFS Global Compare

<table>
<thead>
<tr>
<th>Type</th>
<th>2015 Course Collections - CF = $35.9335</th>
<th>2016 Course Collections - CF = $35.8279</th>
<th>2015 - 2016 Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015 Global - CF = $35.9335</td>
<td>2016 Global - CF = $35.8279</td>
<td>Global</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>GLOBAL % Change</td>
</tr>
<tr>
<td>2D</td>
<td>$4,961.34</td>
<td>$5,222.63</td>
<td>$261.29</td>
</tr>
<tr>
<td>3D w/IGRT 35 fxs</td>
<td>$16,948.39</td>
<td>$18,303.76</td>
<td>$1,355.36</td>
</tr>
<tr>
<td>IMRT 42 fxs</td>
<td>$25,839.78</td>
<td>$23,652.86</td>
<td>-$2,186.92</td>
</tr>
<tr>
<td>SRS - Linac</td>
<td>$5,039.67</td>
<td>$5,123.03</td>
<td>$83.36</td>
</tr>
<tr>
<td>SBRT Linac 5 Fractions</td>
<td>$10,848.32</td>
<td>$11,014.21</td>
<td>$165.89</td>
</tr>
<tr>
<td>Prostate - HDR</td>
<td>$5,066.98</td>
<td>$5,304.32</td>
<td>$237.34</td>
</tr>
<tr>
<td>Prostate - LDR</td>
<td>$3,364.09</td>
<td>$3,157.15</td>
<td>-$206.94</td>
</tr>
<tr>
<td>GYN T&amp;O - HDR</td>
<td>$5,138.13</td>
<td>$5,309.34</td>
<td>$171.21</td>
</tr>
<tr>
<td>GYN Cyl 1 Chan HDR</td>
<td>$4,750.05</td>
<td>$5,137.00</td>
<td>$386.95</td>
</tr>
<tr>
<td>GYN Multi Chan HDR</td>
<td>$6,258.54</td>
<td>$6,593.41</td>
<td>$334.87</td>
</tr>
</tbody>
</table>
Potentially Misvalued Codes

- High expenditure screening tool identified codes which may be potentially misvalued.

**TABLE 8: List of Potentially Misvalued Codes Identified Through High Expenditure by Specialty Screen**

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Short Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>31575</td>
<td>Diagnostic laryngoscopy</td>
</tr>
<tr>
<td>77263</td>
<td>Radiation therapy planning</td>
</tr>
<tr>
<td>77334</td>
<td>Radiation treatment aid(s)</td>
</tr>
<tr>
<td>77470</td>
<td>Special radiation treatment</td>
</tr>
</tbody>
</table>

- Codes have not been reviewed since 2009 or earlier and have a significant impact on PFS payments at a specialty level, >$10 million allowed charges.
Radiation Treatment and Related Image Guidance Services

- 2016 G-codes continue for treatment delivery and imaging MPFS only!
- Brachytherapy coding changes in 2016 will be implemented
- 3 areas impacting coding and reimbursement in 2016
  - Image guidance
  - Equipment utilization rate assumptions for linear accelerators
  - Superficial radiation treatment services
Treatment Delivery Coding in CY 2016

• Implementation of AMA codes delayed again for MPFS
  – Treatment delivery and image guidance codes will continue to be reported with CMS created G-codes
• CMS indicated new IMRT tx codes were good based on diagnosis compared to single code to encompass all IMRT services.
• The overall high potential impact to reimbursement for IMRT courses major reason for delay.
• Seeking more information and input to value codes in future
• CMS is engaging market research to develop independent estimates on utilization of linear accelerators and image guidance used to deliver radiation treatments to patients
• CMS to review how to collect data from hospital based systems to assist in establishing rates for txs and other technical services
Before accurate rates can be developed following changes needed, per CMS

“Developing a code set that recognizes the difference in costs between kinds of imaging guidance modalities;

Making sure that this code set facilitates valuation that incorporates the cost of imaging based on how frequently it is actually provided; and

Developing treatment delivery codes that are structured to differentiate payment based on the equipment resources used.”

Table on following slide outlines the G-codes to use for MPFS
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>77014 (IGRT)</td>
<td>77014</td>
<td>Computed tomography guidance for placement of radiation therapy fields</td>
</tr>
<tr>
<td>77401</td>
<td>77401</td>
<td>Radiation treatment delivery, superficial and/or orthovoltage, per day</td>
</tr>
<tr>
<td>76950</td>
<td>G6001</td>
<td>Ultrasonic guidance for placement of radiation therapy fields</td>
</tr>
<tr>
<td>77421</td>
<td>G6002</td>
<td>Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy</td>
</tr>
<tr>
<td>77402</td>
<td>G6003</td>
<td>Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 MeV</td>
</tr>
<tr>
<td>77403</td>
<td>G6004</td>
<td>Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 6-10 MeV</td>
</tr>
<tr>
<td>77404</td>
<td>G6005</td>
<td>Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 11-19 MeV</td>
</tr>
<tr>
<td>77406</td>
<td>G6006</td>
<td>Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 20 MeV or greater</td>
</tr>
<tr>
<td>77407</td>
<td>G6007</td>
<td>Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; up to 5 MeV</td>
</tr>
<tr>
<td>77408</td>
<td>G6008</td>
<td>Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 6-10 MeV</td>
</tr>
<tr>
<td>77409</td>
<td>G6009</td>
<td>Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 11-19 MeV</td>
</tr>
<tr>
<td>77411</td>
<td>G6010</td>
<td>Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 20 MeV or greater</td>
</tr>
<tr>
<td>77412</td>
<td>G6011</td>
<td>Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 MeV</td>
</tr>
<tr>
<td>77413</td>
<td>G6012</td>
<td>Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 MeV</td>
</tr>
<tr>
<td>77414</td>
<td>G6013</td>
<td>Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 MeV</td>
</tr>
<tr>
<td>77416</td>
<td>G6014</td>
<td>Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 MeV or greater</td>
</tr>
<tr>
<td>77418</td>
<td>G6015</td>
<td>Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session</td>
</tr>
<tr>
<td>0073T</td>
<td>G6016</td>
<td>Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensator convergent beam modulated fields, per treatment session</td>
</tr>
<tr>
<td>0197T</td>
<td>G6017</td>
<td>Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (eg, 3D positional tracking, gating, 3D surface tracking), each fraction of treatment</td>
</tr>
</tbody>
</table>
# Reimbursement Snapshot of TXs 2016

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
<th>2015 Final Payment Rate (CF $35.9335)</th>
<th>2016 Final Payment Rate (CF$35.8279)</th>
<th>Variance</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>77401</td>
<td>Radiation treatment delivery</td>
<td>$ 20.84</td>
<td>$ 24.72</td>
<td>$ 3.88</td>
<td>18.6%</td>
</tr>
<tr>
<td>G6004</td>
<td>Radiation treatment delivery</td>
<td>$ 125.77</td>
<td>$ 145.46</td>
<td>$ 19.69</td>
<td>15.7%</td>
</tr>
<tr>
<td>G6008</td>
<td>Radiation treatment delivery</td>
<td>$ 173.92</td>
<td>$ 201.35</td>
<td>$ 27.43</td>
<td>15.8%</td>
</tr>
<tr>
<td>G6012</td>
<td>Radiation treatment delivery</td>
<td>$ 228.90</td>
<td>$ 265.13</td>
<td>$ 36.23</td>
<td>15.8%</td>
</tr>
<tr>
<td>G6013</td>
<td>Radiation treatment delivery</td>
<td>$ 257.64</td>
<td>$ 265.48</td>
<td>$ 7.84</td>
<td>3.0%</td>
</tr>
<tr>
<td>G6015</td>
<td>Radiation tx delivery imrt</td>
<td>$ 402.10</td>
<td>$ 347.53</td>
<td>$ (54.57)</td>
<td>-13.6%</td>
</tr>
<tr>
<td>G6016</td>
<td>Delivery comp imrt</td>
<td>$ 401.02</td>
<td>$ 346.46</td>
<td>$ (54.56)</td>
<td>-13.6%</td>
</tr>
</tbody>
</table>
Image guidance

• On-board imaging calculated as part of capital expense of treatment machines, could not accurately calculate separately for image guidance codes per the RUC data.

• Time value of image guidance was accepted as correct, 16 minutes total at time of treatment.
  – 3 mins pre-service, 10 mins intraservice and 3 mins post service

• The RUC assumed the most used imaging code was 77014, when setting values for 77387 it used these values
  – Most used imaging code was 77421 with lower RVUs

• CMS did not agree with imaging bundled into IMRT txs and then allowing imaging to be billed with 3D txs. Creates issues with the hierarchy of codes; 3D would be higher than IMRT if it was accepted

• As a result, image guidance codes for 2016 are 77014 and G-codes
Equipment Utilization Rate for Linear Accelerators

- Capital equipment cost is the primary determining factor in payment rates for treatment delivery.
- Estimated Cost = # mins of equipment use x per minute cost of equipment
- CMS has two default equipment usage assumptions 50% and 90% – Rad Onc default calculation
  - Typical business hours10 hrs/day x 5 days/week = 50 hour work week, 50% of that = 25 hrs/week that linacs are used for treatment
  - CMS claims data supports single linac used 11.2 hrs/day or 7 out of 10 business hrs/day, not 5 of 10 hrs/day
  - A 45% aggregate time increase in utilization over current default
Equipment Utilization Rate for Linear Accelerators cont.

- Treatment times had issues
  - The RUC stated IMRT is 60 mins/treatment
  - Data and public info said IMRT is 5-30 mins/treatment
- CMS adjusting utilization for Rad Onc from 50% to 70% over 2 years
  - CMS calculated utilization to be higher, but limiting the increase to only 70%, rather than the 90% used for Diagnostic Radiology
  - Increase to 60% in 2016 and increase to 70% in 2017
  - Increase in utilization = decrease in Practice Expense (PE) RVUs = potential decrease in payment for treatments
- This is reason for overall negative impact in 2016
Superficial Radiation Treatment Delivery

- CMS did not make major changes as requested per comments. Feedback was conflicting.
- Considering creating a code to describe the work associated with code 77401 due to all other codes bundling into tx.
  - CMS is seeking input.
- CMS did finalize equipment is now named “superficial radiation therapy system”
- Equipment pricing raised from $140,000 to $216,000.
Incident to Changes

- CMS finalizing changes to incident to definition and guidelines.
- Incident to services continue to require direct supervision of auxiliary personnel providing the service by physician or NPP.
- CMS adjusting language to include supervising is billing physician:
  - "To be certain that the incident to services furnished to a beneficiary are in fact an integral, although incidental, part of the physician’s or other practitioner’s personal professional service that is billed to Medicare, we believe that the physician or other practitioner who bills for the incident to service must also be the physician or other practitioner who directly supervises the service. It has been our position that billing practitioners should have a personal role in, and responsibility for, furnishing services for which they are billing and receiving payment as an incident to their own professional services."
- Statement matches attestation statement on back of CMS1500 claim form.
Incident to Changes cont.

- Revising last sentence from what was proposed to state,
  - “that the physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) treating the patient more broadly.”

- Also stating the following,
  - “that only the physician or other practitioner under whose supervision the incident to service(s) are being provided is permitted to bill the Medicare program for the incident to services.”
Incident to Changes cont.

- Auxiliary personnel who have been excluded from Medicare, Medicaid and all other federally funded health care programs by the OIG cannot provide services under incident to (direct supervision) of the physician.
- "As a condition of Medicare payment, auxiliary personnel who, under the direct supervision of a physician or other practitioner, provide incident to services to Medicare beneficiaries must comply with all applicable federal and state laws. This includes not having been excluded from Medicare, Medicaid and all other federally funded health care programs."
**PQRS**

  - MACRA authorizes the end of the PQRS in 2018 and beginning of a new program, which may incorporate aspects of the PQRS, the Merit-based Incentive Payment System (MIPS)
- EPs in critical access hospitals (CAH), billing under Method-II (CAH-IIs) no longer excluded from PQRS
  - ALL reporting mechanisms available, including the claims-based reporting mechanism.
- EPs who practice in RHCs and/or FQHCs would not be subject to the PQRS payment adjustment.
- To meet the criteria for the 2017 PQRS payment adjustment, CMS added the following requirement: "Of the measures reported, if the EP sees at least 1 Medicare patient in a face-to-face encounter, as defined that term in the proposed rule, the EP would report on at least 1 measure contained in the PQRS cross-cutting measure set."
- Telehealth visits WILL NOT be accepted as face-to-face encounters for the cross-cutting measure set requirement.
CY 2016 Reimbursement Rates with $35.8279 CF

MPFS NON-FACILITY
MPFS Simulation

- 2015 Final Payment Rate (CF $35.9335)
- 2016 Final Payment Rate (CF $35.8279)
MPFS Treatment Devices

$77332
$77332-TC
$77332-26
$77333
$77333-TC
$77333-26
$77334
$77334-TC
$77334-26
$77338
$77338-TC
$77338-26

2015 Final Payment Rate (CF $35.9335)
2016 Final Payment Rate (CF $35.8279)

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MPFS Stereotatic Treatment Delivery - SRS & SBRT

$1,600.00
$1,400.00
$1,200.00
$1,000.00
$800.00
$600.00
$400.00
$200.00
$

2015 Final Payment Rate  (CF $35.9335)
2016 Final Payment Rate  (CF$35.8279)
MPFS Physician Treatment Management

- 77427
- 77431
- 77432
- 77435

$100.00
$200.00
$300.00
$400.00
$500.00
$600.00
$700.00

2015 Final Payment Rate (CF $35.9335)
2016 Final Payment Rate (CF $35.8279)
MPFS Image Guidance

$20.00 $40.00 $60.00 $80.00 $100.00 $120.00 $140.00

77014 77014-TC 77014-26 G6001 G6001-TC G6001-26 G6002 G6002-TC G6002-26 G6017

2015 Final Payment Rate (CF $35.9335)
2016 Final Payment Rate (CF $35.8279)

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Brachytherapy Isodose Planning

2015 Final Payment Rate (CF $35.9335)  2016 Final Payment Rate (CF $35.8279)
2016 Final Rule

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (HOPPS)
HOPPS Final Highlights

• Payment rates
  – Decrease payment rates under OPPS for outpatient departments -0.3%
  – CY 2016 HOPPS conversion factor $73.725
  – Rural sole community hospitals (SCHs) and essential access community hospitals (EACHs) – continue 7.1% payment adjustment.
  – Cancer Hospital Payment Adjustment – continue to provide payment-to-cost ratio (PCR) = 0.92 for each cancer hospital
  – Hospitals which fail to meet the Hospital Outpatient Quality Reporting (OQR) Program requirements are subject to additional 2% point reduction from Outpatient Department (OPD) fee schedule

• Outlier Payments
  – To ensure aggregate outlier payments = 1.0% the following is finalized
    • 1.75 multiple threshold, $3,250 final fixed-dollar threshold
HOPPS Final Highlights cont.

• APC Changes Finalized
  – Changes based on following principals
    • Improved clinical homogeneity;
    • Improved resource homogeneity;
    • Reduced resource overlap in APCs within a clinical family; and
    • Greater simplicity and improved understanding of the structure of the APCs.

• Changes to C-APC for SRS procedures
  – Finalized change C-APC from 0067 to C-APC 5627 (Level 7 Radiation Therapy), Clinical Family RADTX
  – Finalized removal of some ancillary codes from C-APC for CY 2016 & CY 2017

• LDR Composite APC not changing
HOPPS Final Highlights cont.

- Brachytherapy Sources
  - CMS finalizing proposal to continue to set the payment rates for brachytherapy sources using established prospective payment methodology, which is based on geometric mean costs

- Stereotactic Radiotherapy codes will be removed from ASC covered list
  - Codes 77371, 77372 and 77373 will be removed from the ASC covered ancillary services list for CY 2016 and subsequent years

- Final Hospital OQR Measure for CY 2018 and subsequent years
  - OP-33: External Beam Radiotherapy (EBRT) for Bone Metastases (NQF #1822)

- Initial Simulation and IMRT courses
  - CMS addressed whether or not the initial simulation is billable for an IMRT course in a hospital setting
APC Restructuring

- Finalized restructuring of APCs into 9 individual clinical families and based on the following principles:
  - Improved clinical homogeneity;
  - Improved resource homogeneity;
  - Reduced resource overlap in APCs within a clinical family; and
  - Greater simplicity and improved understanding of the structure of the APCs.

- APCs also renumbered to provide consecutive APC numbers within a clinical family.

- Every code in same APC is reimbursed the same amount, regardless of complexity or modality.
Comprehensive APCs (C-APC) for SRS

- Services which are as integral, ancillary, supportive, dependent, and adjunctive to the primary service and reported on the same claim as SRS treatment codes 77371 (Cobalt-60 based) or 77372 (Linac based) is packaged and not separately reimbursed.

- All ancillary services are reported on the claim to assist in cost reporting for the service in setting C-APC future payments, but not separately reimbursed.

- Upon review of CY 2014 claims data for SRS procedures and the codes ancillary to 77371 and 77372 - issues identified which can and do impact the C-APC for SRS.

- Changes made to C-APC – removing codes to be reimbursed separately.
Cobalt-60 vs. Linac Variances

• Analysis of CY 2014 claims revealed that billing practices for Cobalt-60 based vs. Linac based technologies varied
• SRS delivery with Cobalt-60 typically had all services (specifically imaging, simulation, treatment plan and physics services) related to the procedure billed on the same date and claim as the treatment itself.
• Linac based services were found to have services such as imaging, simulation, treatment plan and physics services reported on different dates of service and separate claims.
  – Services such as simulation and planning reported up to a month prior to Linac based SRS tx on different claim forms
• Regulation passed in 2013 requires both 77371 and 77372 be reimbursed the same amount. Changes finalized to account for possible increased reimbursement of linac based services performed over multiple dates vs. Gamma Knife which are performed on single date.
C-APC Changes 2016 & 2017

- CMS removing some services from the C-APC and provide payment to these separately, even when billed with the SRS treatment code which has a status indicator of “J1” in CYs 2016 & 2017
- The following codes will be removed from the SRS C-APC and reimbursed separately (up to 30 days prior to tx only), when reported on the same or claim 30 days prior as the SRS treatment code 77371 or 77372
  - CT localization (HCPCS codes 77011 and 77014);
  - MRI imaging (HCPCS codes 70551, 70552, and 70553);
  - Clinical treatment planning (HCPCS codes 77280, 77285, 77290, and 77295);
  - Physics consultation (HCPCS code 77336)
- Modifier “CP” to be reported on above codes when billed for services related in the preparation and delivery of SRS treatment, both Cobalt-60 and Linac based, but only when performed on different date than treatment
- After collection of data, plan to repackage codes back into C-APC in 2018
HCPCS Code Updates for CY 2016

• AMA did provide CMS with new codes for CY 2016 on time!
  – So no G-codes were created for HOPPS and new HCPCS codes will be implemented 1/1/16, no delay
• Several codes are slated for deletion in 2016
  – HDR brachytherapy codes and electronic brachytherapy code
• New codes released by AMA on September 1, 2015
• New codes will be covered in upcoming section
Hospital OQR Measure for CY 2018

- CMS finalized new Hospital Outpatient Quality (OQR) Reporting Measure for CY 2018 and subsequent years specific to Radiation Oncology
- NQF# 1822, OP-33: External Beam Radiotherapy (EBRT) for Bone Metastases
  - 2009 Task Force organized by ASTRO assessed existing recommendations for palliative care in order to better address and evaluate any lack of guidelines
  - Established 4 sets of recommendations for treating bone metastases in previously un-irradiated patients
- Goal is to reduce the rate of EBRT overuse and promote patient safety
Hospital OQR Bone Mets cont.

- Designed to address concerns with unnecessary exposure to EBRT for bone pain and reduce overuse of EBRT services, also address treatment gaps in the variations of courses used to treat the similar patients.

- Measure to address all patients (all payors) using following dosing schedules:
  - 30 Gy over course of 10 fractions
  - 24 Gy over course of 6 fractions
  - 20 Gy over course of 5 fractions
  - Single 8 Gy fraction

- Measure is not open to following patients:
  - Patients who have had previous radiation to the same site;
  - Patients with femoral axis cortical involvement greater than 3 cm in length;
  - Patients who have undergone a surgical stabilization procedure;
  - Patients with spinal cord compression, cauda equina compression, or radicular pain.
Initial Simulation with IMRT Course

- Physicians and freestanding cancer centers cannot bill for initial simulation with course of IMRT in 2015.
- In 2016 hospitals cannot bill for initial simulation with course of IMRT.
- CMS requested by commenters to address questions about billing for initial simulation with IMRT course for hospitals.
- CMS cited two sources/transmittals to support their stance that the initial simulation is not billable.
  - Medicare Claims Processing Manual
  - NCCI Edits Policy Manual
Initial Simulation with IMRT Course cont.

- However…codes 77301 and 77295 will continue to be reimbursed the same amount in 2016! A 3D course of treatment does not have the simulation bundled into the planning.
- The final geometric mean cost of the services described by CPT code 77301 is approximately $1,125.
- CMS stated “if the clarification of our coding guidance for IMRT planning services results in a significant change in the geometric mean cost of services described by CPT code 77301 in future years, we will consider an alternative APC assignment for the code other than APC 5614.”
CODING CHANGES IMPACTING 2016
Coding Changes Impacting CY 2016

• New Brachytherapy Codes
  – Codes deleted for 2016
  – New codes effective in 2016
• Provider Based Department Changes
  – New law changes Provider Based Departments in future
• Codes 77295 and 77300 in 2016
• Initial Simulation and IMRT courses in 2015
Code Changes in 2016

- AMA deleted several codes in brachytherapy for 2016
- CMS accepted code deletions and new codes for both HOPPS and MPFS
  - Also added new brachytherapy codes
- HCPCS code effective October 1, 2015 for gel spacer still applies in 2016, but has reimbursement changes
Radionuclide Brachytherapy Codes

- Codes 77785, 77786 & 77787 deleted in 2016
- New codes added - Skin Surface HDR Radionuclide Treatments
  - 77767 – Remote afterloading high dose rate radionuclide skin surface brachytherapy; includes basic dosimetry, when performed; lesion diameter up to 2.0 cm or 1 channel
  - 77768 - Remote afterloading high dose rate radionuclide skin surface brachytherapy; includes basic dosimetry, when performed; lesion diameter over 2.0 cm and 2 or more channels, or multiple lesions
Radionuclide Brachytherapy Codes cont.

- Codes 77785, 77786 & 77787 deleted in 2016
- New codes added - Interstitial or Intracavitary HDR Radionuclide Treatments
  - 77770 - Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy; includes basic dosimetry, when performed; 1 channel
  - 77771 - Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy; includes basic dosimetry, when performed; 2 to 12 channels
  - 77772 - Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy; includes basic dosimetry, when performed; over 12 channels
Interstitial LDR Brachytherapy Txs

- Codes 77776 & 77777 deleted in 2016
- Changes to code 77778
  - 77778 - Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed
- Code 77790 not billed with code 77778; work of code 77790 is not factored into 77778
- When using <10 sources for any procedure, report 77799 since codes 77776 & 77777 deleted
Electronic Brachytherapy Treatments

- Code 0182T deleted
- New codes - Electronic Brachytherapy Treatments
  - 0394T - High dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry, when performed
  - 0395T - High dose rate electronic brachytherapy, interstitial or intracavitary treatment, per fraction, includes basic dosimetry, when performed
- When reporting codes 0394T or 0395T the following codes cannot be reported: 77261-77263, 77300, 77306 – 77307, 77316 – 77318, 77332 – 77334, 77336, 77427, 77431, 77432, 77435, 77469, 77470, 77499, 77761 – 77763, 77770 – 77772, 77778 and 77789
Spacer Gel HCPCS Code Prostate Pts.

- C9743 - Injection/implantation of bulking or spacer material (any type) with or without image guidance (not to be used if a more specific code applies); hospitals only
- 45999 - Unlisted procedure; physicians and freestanding/offices only
- Gel billed as A4649 - Surgical supply; miscellaneous
  - Hospital packaged into placement
  - Offices paid at invoice cost

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>C9743</td>
<td>Bulking/spacer material impl</td>
<td>0310</td>
<td>$1,038.12</td>
<td>5374</td>
<td>$2,243.49</td>
<td>116%</td>
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</table>
Provider Based Department Changes

- Bipartisan Budget Act of 2015 signed into law 11/2/15
- SEC. 603. Treatment of Off-campus Outpatient Departments of a Provider references 42 CFR 413.65 - Requirements for a determination that a facility or an organization has provider-based status within the law.
- MedPAC (Medicare Payment Advisory Commission) concerned that CMS pays varying payments based on location or designation of an entity for the same services and hospitals are acquiring practices to increase payments
  - Procedure in office/freestanding cancer center paid under MPFS
  - Procedure in hospital setting, pay facility fee under HOPPS and professional fee under MPFS, typically results in higher amount paid than just for procedure in an office
  - Procedure in ASC reimbursement is less than if receives same service in a hospital
Provider Based Department Changes cont.

- Bipartisan Budget Act of 2015, Section 603, effective January 1, 2017 when a service is provided in an off-campus outpatient department of a hospital, unless they were billing as a dept. of the hospital prior to January 1, 2017, CMS will reimburse services under either the MPFS or ASC fee schedule.
- Off-campus departments billing for services prior to 1/1/17 are exempt, but CMS could change or adjust future rules to add further limitations.
- Hospitals will be required to report as requested per the HHS Secretary info appropriate to implement means of collecting data, which may include use of a modifier or code.
On-campus vs. Off-campus

On-campus vs. off-campus, what’s the difference?

- Per 42 CFR 413.65, “Campus means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus.”

• Locations not on-campus are considered off-campus
  - Hospitals need to evaluate their campuses and how they defined the locations with CMS

• Remote locations of a hospital will be considered on-campus

• Any new acquisitions or off-campus locations need to be evaluated for financial impact if created after 1/1/17
New POS Code for Provider Based

- POS codes to identify services provided in on-campus outpatient hospital vs. off-campus outpatient hospital

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
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</thead>
<tbody>
<tr>
<td>POS 19</td>
<td>Off Campus-Outpatient Hospital &lt;br&gt;Descriptor: A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.</td>
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<tr>
<td>POS 22</td>
<td>On Campus-Outpatient Hospital &lt;br&gt;Descriptor: A portion of a hospital’s main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.</td>
</tr>
</tbody>
</table>
Codes 77295 and 77300 in 2016

- Effective January 1, 2016 CPT code 77300 will edit with Code 77295!
- Code 77300 would be billable with following possible scenarios
  - IMRT, IORT, SIRT, Radiopharmaceuticals & Superficial
  - Nomograms for PSI
  - Hand calculations
  - Re-calcultating dose later during course due to changes
- Code 77300 is a column 2 code to the following primary codes
  - 77295, 77306 & 77307 & 77316 – 77318
  - 77767, 77768, 77770, 77771 & 77772
  - 0394T & 0395T
Simulations & IMRT in 2015

- AMA/Specialty Society Relative Value Scale Update Committee (RUC) values and makes recommendations to CMS for values of codes at time of proposed and final rule
- Meet each year to re-value codes for upcoming changes
- When valuing CPT 77301, included radiation therapist time, supplies common to simulation and the time of the CT Simulator
- The RUC values only impact MPFS – does not affect HOPPS!
# 2015 Direct PE Inputs for MPFS ONLY

Source: AMA RBRVS DataManager/PE Inputs

## 77301 - RADIOTHERAPY DOSE PLAN IMRT

Direct Practice Expense Inputs For 2015

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>Description</th>
<th>Clinical Labor Inputs</th>
<th>Clinical Staff Time</th>
<th>CMS Profiled As</th>
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<tr>
<td></td>
<td></td>
<td>Compensation Per Minute</td>
<td>Pre Non Facility</td>
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<tr>
<td></td>
<td></td>
<td>Intra Non Facility</td>
<td>Post Non Facility</td>
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<tr>
<td>L037D</td>
<td>RN/LPN/MTA</td>
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<tr>
<td>L050C</td>
<td>Radiation Therapist</td>
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<td>0</td>
<td>48</td>
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<tr>
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<td>Medical Dosimetrist/Medical Physicist</td>
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<td>65</td>
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<tr>
<td>L152A</td>
<td>Medical Physicist</td>
<td>1.52</td>
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## 2015 Medical Supply Direct Inputs

**MPFS**

### 77301 - RADIOTHERAPY DOSE PLAN IMRT

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<thead>
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<th>Supply Code</th>
<th>Description</th>
<th>Quantity In Office</th>
<th>Quantity Out of Office</th>
<th>Cost In Office</th>
<th>Cost Out of Office</th>
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<tbody>
<tr>
<td>SA048</td>
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<tr>
<td>SA063</td>
<td>tray, catheter insertion (w/o catheter)</td>
<td>1</td>
<td></td>
<td>$4.14</td>
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<tr>
<td>SB022</td>
<td>gloves, non-sterile</td>
<td>2</td>
<td></td>
<td>$0.17</td>
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<td>SD024</td>
<td>catheter, Foley</td>
<td>1</td>
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<td>SD096</td>
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## 2015 Medical Equipment MPFS

### 77301 - RADIOTHERAPY DOSE PLAN IMRT

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<th>Equip Code</th>
<th>Description</th>
<th>Equip In Use In Office (Min)</th>
<th>Equip In Use Out of Office (Min)</th>
<th>Equip In Cost (Yrs)</th>
<th>Equip Cost Out of Office (Yrs)</th>
<th>Equip Useful Life (Yrs)</th>
<th>Purchase Price</th>
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<td>ED033</td>
<td>treatment planning system, IMRT (Corvus w-Peregrin)</td>
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<td>E5005</td>
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<td>ER006</td>
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<td>$379.3300</td>
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<td>$2,641,783.00</td>
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What About Hospitals in 2015?

- RUC does not set values for codes in a hospital
- Codes are placed in APCs and reimbursed at a rate set for the APC group
- CMS addressed this for hospitals in the 2016 Final Rule
- May 2015 OIG released mid-year work plan update
  - Includes information of review of IMRT related services
- Some payor policies indicate initial sim is billable for IMRT course
- CMS indicates to bill for services which are packaged in hospital setting
Questions?