Understanding Current Billing & Coding Rules & Preparing for What's on the Horizon

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AAMD Region IV/Roswell Park Conference

Revenue Cycle, Inc.

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Your Expert Oncology Resource

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Objectives

Coding Changes Impacting CY 2015

- Current Coding Variances Freestanding vs. Hospital
- Initial Simulation and IMRT Planning
- New Code and Edits 4th Qtr. 2015

Reviewing Possible & Known Changes for CY 2016

- Proposed Rule Items (MPFS & HOPPS)
- AMA Coding Changes for 2016
- Future of MPFS Reimbursement

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
    - True for 2015, proposed to 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

Coding Changes Impacting 2015

Radiation Therapy Code Revisions

Not all of the newly introduced radiation therapy AMA CPT codes for 2015 were adopted for MPFS use in 2015

- The timing of the release of new codes by the AMA and RUC is created an issue for CMS
- Postponement until 2016 will allow for proper valuation and review of impact on stakeholders
- Deleted 2014 codes for treatment delivery, planning and IGRT deleted; however, new G-codes used for some of the new replacement and/or revised codes for 2015

Radiation Therapy Code Revisions

- For CY 2015 the new isodose planning codes implemented effective January 1, 2015
- The following table details the crosswalk from the deleted code to the new CY 2015 code

CY2014 CPT	CY2014 Descriptor	CY2015 CPT	CY2015 Descriptor
77305	Teletx isodose plan simple	77306	Teletx isodose plan simple
77310	Teletx isodose plan intermed	No new code for 2015	
77315	Teletx isodose plan complex	77307	Teletx isodose plan cplx
77326	Brachy isodose calc simp	77316	Brachy isodose plan simple
77327	Brachy isodose calc interm	77317	Brachy isodose plan intermed
77328	Brachy isodose calc compl	77318	Brachy isodose plan complex
77014*	CT for therapy guide	77014*	CT for therapy guide

*CPT code 77014 was not deleted by the AMA, but they did indicate it cannot be reported for IGRT for hospitals. For CY 2015 in freestanding centers, it will still be used as currently used for CY 2014

Radiation Therapy Code Revisions

Table 27: Radiation Therapy G-Codes Replacing CY 2015 CPT Codes

CY 2014 CPT Code[2]	CY 2015 HCPCS Code	Long Descriptor
76950	G6001	Ultrasonic guidance for placement of radiation therapy fields
77421	G6002	Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy
77402	G6003	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: up to 5MeV
77403	G6004	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 6-10MeV
77404	G6005	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 11-19MeV
77406	G6006	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks: 20 MeV or greater
77407	G6007	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; up to 5MeV
77408	G6008	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 6-10MeV
77409	G6009	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 11-19MeV
77411	G6010	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 20 MeV or greater
77412	G6011	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5MeV
77413	G6012	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10MeV
77414	G6013	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19MeV
77416	G6014	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20MeV or greater
77418	G6015	Intensity modulated treatment delivery, single or multiple fields/arcs,via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session
0073T	G6016	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
0197T	G6017	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

Treatment Codes

CY2014 Codes	AMA New Codes Hospitals CY2015*	CMS Final Codes FSC CY2015**	CY2016 Codes***
77401	**77401**	77401	**77401**
77402	**77402**	G6003	**77402**
77403	Deleted	G6004	-
77404	Deleted	G6005	-
77406	Deleted	G6006	-
77407	**77407**	G6007	**77407**
77408	Deleted	G6008	-
77409	Deleted	G6009	-
77411	Deleted	G6010	-
77412	**77412**	G6011	**77412**
77413	Deleted	G6012	-
77414	Deleted	G6013	-
77416	Deleted	G6014	-
77418	**77385 or 77386**	G6015	**77385 or 77386**
0073T	**77385**	G6016	**77385**

*Codes used by hospitals for Medicare patients unless directed differently by commercial payor.
**Codes used by freestanding cancer centers for Medicare patients unless directly differently by commercial payor.
***Codes per 2016 proposed rules to be used by hospitals and freestanding cancer centers unless directed differently by payors.

Image Guidance

CY2014 Codes	AMA New Codes Hospitals	CMS Final Codes CY2015 FSC & Physicians	CY2016 Codes
76950	77387	G6001	77387
77421	77387	G6002	77387
0197T	77387	G6017	77387
77014*	77387	77014	77387 or 77014

*77014 was not deleted, per AMA it is no longer billable for IGRT by hospitals. May still be reported for treatment planning CTs as appropriate per center.

In hospital, for IGRT report 77387, for treatment planning report 77014-TC.

For physicians and freestanding cancer centers, report the corresponding G-codes or 77014 for IGRT when supported.

What happened to the sim w/IMRT?

- AMA/Specialty Society Relative Value Scale Update Committee (RUC) sets values and makes recommendations to CMS to implement changes to values of codes at time of proposed and final rule.
- Meet each year to re-valuate codes for upcoming changes
- When valuing IMRT tx plan code 77301, included the time of the radiation therapist, supplies common to simulation and the time of the CT Simulator
- Same thing happened with Tx Planning CT & applicator devices for HDR in FSC
- The RUC values only impact MPFS – do not affect HOPPS!

Direct PE Inputs for MPFS ONLY!

The screen shots on this slide and next are from the AMA RBRVS DataManager/PE Inputs

77301 - RADIOTHERAPY DOSE PLAN IMRT

Direct Practice Expense Inputs For 2015

	Clinical Labor Inputs		Clinical Staff Time						CMS Profiled As	
Staff Type	Description	Compensation Per Minute	Pre Non Facility	Intra Non Facility	Post Non Facility	Pre Facility	Intra Facility	Post Facility	In Office	Out of Office
L037D	RN/LPN/MTA	0.37	2	6	2				Y	N
L050C	Radiation Therapist	0.5	0	48	0				Y	N
L107A	Medical Dosimetrist/Medical Physicist	1.07	0	65	0				Y	N
L152A	Medical Physicist	1.52	10	255	0				Y	N

Medical Supply Direct Inputs MPFS

77301 - RADIOTHERAPY DOSE PLAN IMRT

Medical Supply Direct Inputs

Supply Code	Description	Quantity In Office	Quantity Out of Office	Cost In Office	Cost Out of Office
SA048	pack, minimum multi-specialty visit	1		$1.14	
SA063	tray, catheter insertion (w-o catheter)	1		$4.14	
SB022	gloves, non-sterile	2		$0.17	
SD024	catheter, Foley	1		$7.82	
SD096	markers, radiographic, multi-modality	4		$8.00	
SK058	paper, photo printing (8.5 x 11)	20		$9.00	
SL001	acetone	6		$0.08	

Medical Equipment MPFS

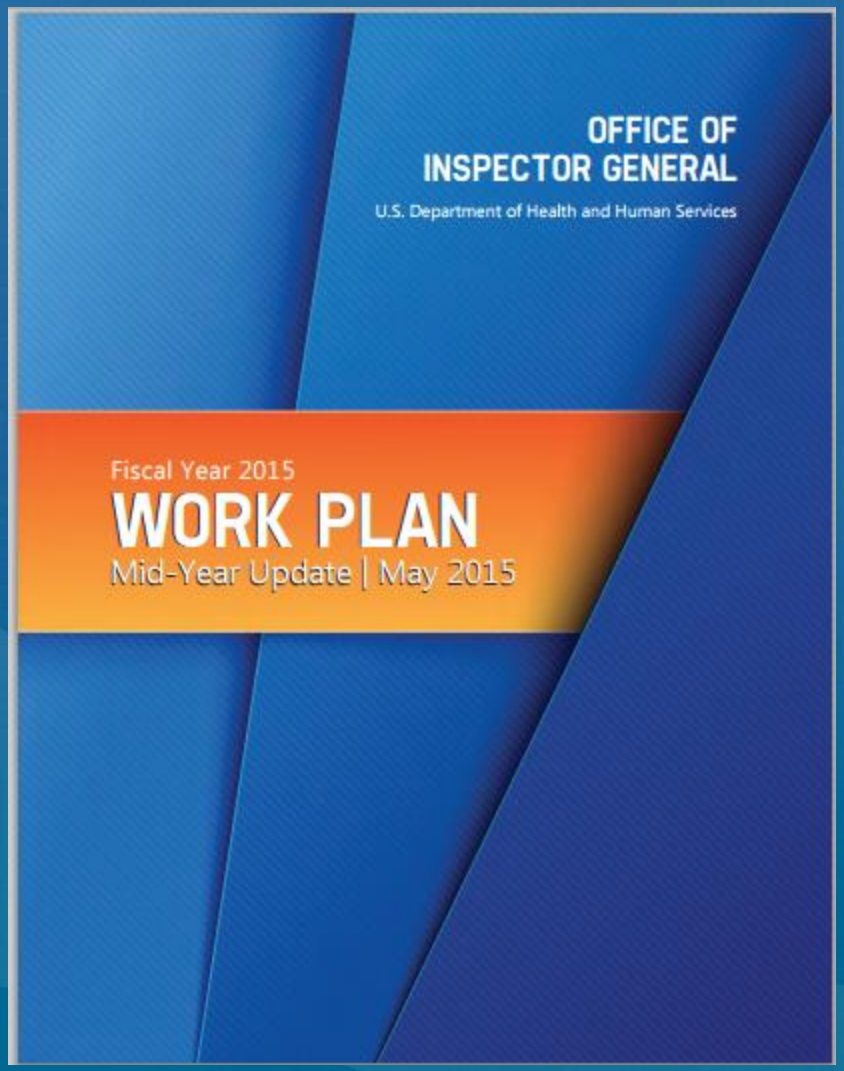
77301 - RADIOTHERAPY DOSE PLAN IMRT

Equip Code	Description	Medical Equipment: Equip In Use In Office (Min)	Equip In Use Out of Office (Min)	Equip Cost In Office	Equip CostOut of Office	Equip Useful Life (Yrs)	Purchase Price
ED033	treatment planning system, IMRT (Corvus w-Peregrin	330		$438.3100		5	$350,545.00
ED031	printer, dye sublimation (photo, color)	15		$0.1300		5	$2,322.50
ED050	PACS Workstation Proxy	255		$2.5200		5	$2,501.00
ER005	IMRT CT-based simulator	47		$173.6300		5	$975,000.00
ER006	IMRT physics tools	15		$4.4600		5	$78,600.00
ER014	chamber, Farmer-type	47		$0.1700		7	$1,169.38
ER028	electrometer, PC-based, dual channel	47		$1.0500		5	$5,675.00
ER030	film dosimetry equipment-software (RIT)	60		$7.1700		5	$30,840.00
ER050	phantom, solid water calibration check	47		$0.2600		10	$2,109.50
ER089	IMRT accelerator	47		$379.3300		7	$2,641,783.00

What about the sim in a hospital?

- The RUC does not set values for codes in a hospital
- Codes are placed in APCs and reimbursed all the same in the same APC
- 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

OIG 2015 Mid-Year Work Plan Update



Effective as of May 2015 for Hospitals

"NEW Intensity-modulated radiation therapy We will review Medicare outpatient payments for intensity-modulated radiation therapy (IMRT) to determine whether the payments were made in accordance with Federal rules and regulations. 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. Prior OIG reviews have identified hospitals that have incorrectly billed for IMRT services. To be processed correctly and promptly, a bill must be completed accurately. (CMS's Medicare Claims Processing Manual, Pub. No. 100-04, ch. 1, § 80.3.2.2.) In addition, certain services should not be billed when they are performed as part of developing an IMRT plan. (CMS's Medicare Claims Processing Manual, Pub. No. 100-04, ch. 4, § 200.3.2) (OAS; W-00-15-35740; various reviews; expected issue date: FY 2016)"

Current & Retired Payor LCDs

Noridian Healthcare Solutions, LLC Local Coverage Determination L24318, Revision Effective Date: For services performed on or after 01/01/2015

"Use of Simulation-Aided Field Setting in IMRT (CPT 77280-77295)

Simulation-aided field setting complex (77290) during a course of IMRT is appropriate for the initial set up of the patient where an immobilization device may be constructed, isocenter(s) and volume of interest are determined, and CT or other imaging is obtained for subsequent reconstruction of target(s) and critical structure(s). CT and other imaging are separately coded (e.g. 77014), when necessary and performed. Also, a simple simulation (77280) may be appropriately provided and claimed once during a course of IMRT, either as a separate or at the time of the first fraction, where the record documents the simulation is for the purpose of field verification, and occurs on a separate day from and after 77290."

First Coast Service Options, Inc., Local Coverage Determination L28892, Revision Effective Date: For services performed on or after 01/01/2015

"Use of Simulation-Aided Field Setting in IMRT (CPT Code 77290)

Simulation-aided field setting complex (CPT code 77290) during a course of IMRT is appropriate for the initial setup of the patient where an immobilization device may be constructed, isocenter(s) and volume of interest are determined, and CT or other imaging is obtained for subsequent reconstruction of target(s) and critical structure(s). Documentation should include patient positioning and immobilization device, target verification, possible utilizing radiographic studies and a description of the physician's work."

WPS Current Rad Onc LCD

Included in Attachments - Billing and Coding Guidelines for Radiation Oncology Including Intensity Modulated Radiation Therapy (IMRT) LCD Determination ID Number L30316

The following list of codes should not be reported on the *same date of service* as IMRT planning (77301). They may, however, correctly be used, as needed, for medically necessary simulation and treatment planning during the course of IMRT treatment (i.e. with code G6015).

CPT Code	CPT Code Descriptor
77280	Therapeutic radiology simulation-aided field setting, simple
77285	Therapeutic radiology simulation-aided field setting, intermediate
77290	Therapeutic radiology simulation-aided field setting, complex

AMA CPT Assistant November 2009

IMRT Planning (Code 77301)

Before IMRT treatment planning, the patient undergoes a procedure known as simulation, which is a process that physically aligns the patient for treatment and is reported in this instance, by code 77290 Therapeutic radiology simulation-aided field setting; complex. In almost all cases of IMRT, a custom immobilization device is constructed for the patient to ensure that the daily set-up of the patient is precisely reproducible each day of treatment, and this is reported with code 77334, Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts). Thereafter, a 3-D image acquisition (CT, MRI, PET) of the target region and surrounding areas occurs, and either the CT alone or multiple fused image sets are utilized for the planning set. The physician then contours the visible abnormality or target area that is seen on each slide of the image set. The 3-D summation of these contours defines the gross tumor volume (GTV). A margin is drawn around the GTV by the physician to include the volume of tissue at risk for microscopic spread of the disease (ie, to include disease that is not visible on imaging studies). This larger volume is called the clinical target volume (CTV). Another margin is then added by the physician beyond the CTV to create the planning target volume (PTV), and this additional volume is necessary to account for potential patient movement and random set-up error. Nearby normal structures that could possibly be damaged by radiation are known as organs at risk (OAR), which are also individually contoured by the physician.

CMS Billing of Packaged Codes

Medicare Claims Processing Manual Chapter 4 Part B Hospital Section 10.4 Packaging

A. Packaging for Claims Resulting in APC Payments

If a claim contains services that result in an APC payment but also contains packaged services, separate payment for the packaged services is not made since payment is included in the APC. However, charges related to the packaged services are used for outlier and Transitional Corridor Payments (TOPs) as well as for future rate setting.

Therefore, it is extremely important that hospitals report all HCPCS codes consistent with their descriptors; CPT and/or CMS instructions and correct coding principles, and all charges for all services they furnish, whether payment for the services is made separately paid or is packaged.

This is why hospitals continue to bill for the treatment planning CT and IGRT even though there is no separate payment. Only if the code or rule states a code is bundled, then the codes are not reported (e.g. IGRT with IMRT tx).

Packaged is not the same as bundled!

What are options for hospitals?

Hospitals have an internal decision to make

Option 1 = If payor LCD states initial simulation is appropriate for course of IMRT, could be supported to bill for the service.

Option 2 = Due to OIG review and physicians unable to bill for initial simulation (even if employed by or work in hospital) and/or no payor LCD stating appropriate to bill for initial simulation, document work provided but only bill for treatment planning CT and immobilization device(s).

HDR Insertion Codes Include Device

- In FSC & for physicians the following codes are bundled into another service
  - Treatment planning CT (77014) bundled into initial simulation (77280 – 77290)
  - Initial simulation (77280 – 77290) bundled into IMRT plan (77301)
  - HDR applicator device (77332) bundled into insertion (57155 & 57156)
- When the physician inserts the tandem & ovoids or vaginal cylinder the device code (77332) is part of the insertion code for physicians and freestanding cancer centers
- Hospitals can still bill for the device code

HDR Applicator/Device Packaged into Placement Code 57155 MPFS ONLY!

57155 - INSERT UTERI TANDEM/OVOIDS

Direct Practice Expense Inputs For 2015

		Medical Equipment					
Equip Code	Description	Equip In Use In Office (Min)	Equip In Use Out of Office (Min)	Equip Cost In Office	Equip CostOut of Office	Equip Useful Life (Yrs)	Purchase Price
EF021	table, brachytherapy treatment	70	0	$4.3100	$0.0000	15	$28,900.00
EF027	table, instrument, mobile	122	0	$0.1700	$0.0000	15	$634.00
EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)	122	0	$1.7000	$0.0000	7	$4,322.50
EQ032	IV infusion pump	122	0	$0.7700	$0.0000	10	$2,384.45
EQ137	instrument pack, basic ($500-$1499)	77	0	$0.1700	$0.0000	4	$500.00
EQ170	light, fiberoptic headlight w-source	70	0	$0.5500	$0.0000	5	$1,992.92
EQ292	Applicator Base Plate	70	0	$1.2100	$0.0000	5	$4,382.00
ER084	T&O Applicator Set	77	0	$19.8400	$0.0000	4	$57,652.00
ER062	stirrups (for brachytherapy table)	70	0	$0.7200	$0.0000	10	$3,876.00

HDR Applicator/Device Packaged into Placement Code 57156 MPFS ONLY!

57156 - INS VAG BRACHYTX DEVICE

Direct Practice Expense Inputs For 2015

		Medical Equipment					
Equip Code	Description	Equip In Use In Office (Min)	Equip In Use Out of Office (Min)	Equip Cost In Office	Equip CostOut of Office	Equip Useful Life (Yrs)	Purchase Price
EF021	table, brachytherapy treatment	43	0	$2.6400	$0.0000	15	$28,900.00
EQ170	light, fiberoptic headlight w-source	43	0	$0.3300	$0.0000	5	$1,992.92
EQ292	Applicator Base Plate	43	0	$0.7400	$0.0000	5	$4,382.00
ER085	Vag Applicator Set	50	0	$6.2800	$0.0000	4	$27,553.00
ER062	stirrups (for brachytherapy table)	43	0	$0.4400	$0.0000	10	$3,876.00

New HCPCS Code for 10/1/15

- Use of gel spacer to position the rectum's anterior wall away from prostate has received FDA approval.
- Current billing thru 9/30/15
  - Unlisted CPT® code 45999 (unlisted procedure, rectum)
  - Gel reported as A4649 (surgical supply; miscellaneous)
- New Code effective 10/1/15

Table 1 – New Separately Payable Procedure Code Effective October 1, 2015

HCPCS Code	Short Descriptor	Long Descriptor	OPPS SI	OPPS ASC	Effective Date	2015 Medicare National Avg. Payment
C9743	Bulking/spacer material impl	Injection/implantation of bulking or spacer material (any type) with or without image guidance (not to be used if a more specific code applies)	S	0310	10/01/2015	$1,038.12

•HCPCS code C9743 reported in hospital only as C-codes are not billable in office settings.
•Gel reported as A4649, not separately reimbursed. Gel is packaged into placement code as is any imaging used to place gel.

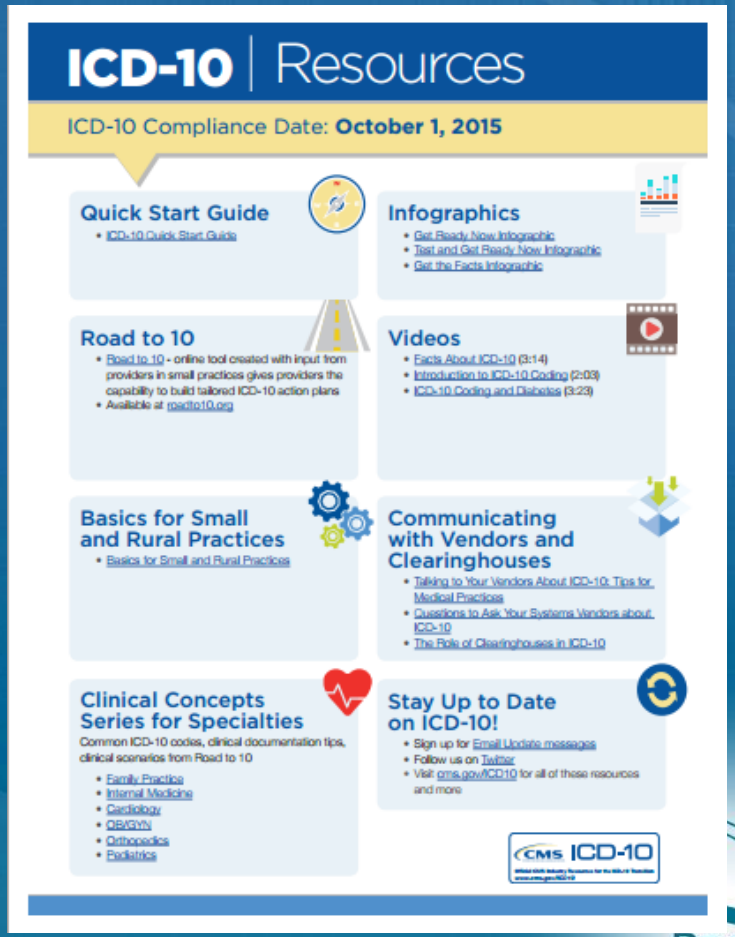
New Hospital Edits & MUEs eff. 10/1/15

Column 1	Column 2	Modifier Indicator 0=not allowed 1= allowed 9= not applicable
77014	77387	1
77301	77387	0
77371	77385	0
77371	77386	0
77372	77385	0
77372	77386	0
77373	77385	0
77373	77386	0
77386	77334	1
77386	77385	1
77402	77401	0
77407	77401	0
77412	77401	0
77432	77387	0
77435	77387	0

HCPCS/CPT Code	Outpatient Hospital Services MUE Values
C1715	45

ICD-10 Resources for Countdown

- CMS has provided a resource flyer available on CMS website.
- https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10ResourcesFlyer20150817.pdf



Additional ICD-10 Resources

- MLN Matters Number SE1408 *Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) – A Re-Issue of MM7492.*

Table A – Institutional Providers			
Bill Type(s)	**Facility Type/Services**	**Claims Processing Requirement**	**Use FROM or THROUGH Date**
13X	Outpatient Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
85X	Critical Access Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM

What will happen in 2016 and beyond?

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

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

MPFS Proposed Highlights

- Proposed CY2015 CF $36.1096
- Estimated impact on total allowable change by specialty
  - Radiation Oncology -3%
  - Radiation Therapy Centers -9%
- Potentially misvalued codes
  - Potentially misvalued codes identified through high expenditure by specialty screen
    - 31575 , 77263, 77334 and 77470
- RVUs for new codes
  - CY 2016 will have significant number of codes valued which do not appear in the proposed rule but will be present in the final rule expected by the first of November.
  - Future years (exception of entirely new services) all codes changes CMS does not receive from the RUC by the February 10th deadline, will still be released in the proposed rule for the subsequent year. CMS will not wait until the final rule to release any codes changes or creation of G-codes for the coming year
  - New or revised codes are not subject to the phase-in over 2 years changes to RVUs that other codes will be subject to when estimated change is 20% or more

MPFS Proposed Highlights cont.

- Malpractice RVUs
  - Proposing to review on annual basis, rather than every 5 years and use average of 3 most recent years of available data instead of one
  - Implement process similar to valuation of practice expense (PE) RVUs
- 10 and 90 day global periods
  - CMS must develop method to gather information needed to value surgical services and data collection to begin no later than January 1, 2017
  - Seeking comment on most efficient means of gathering data and what kind of data to gather
- Proposed elimination of Refinement Panel and instead publish the proposed rates for all interim final codes in the PFS proposed rule for the subsequent year
  - Panel was designed to assist with the review of comments presented by stakeholders on CPT® codes with interim final work RVUs for a year and develop final work values for subsequent year
- New Work RVUs proposed
  - Accepted without refinement (accepted values presented by the RUC) (code 7778A was not on list, possible omission)
    - 31626 , 77387, 7778B , 7778C, 7778D and 7778E
  - Accepted with refinement
    - 77385, 77386, 77402, 77407 and 77412

MPFS Proposed Highlights cont.

- Radiation Treatment and Related Image Guidance Services
  - Seeking comment on 3 additional issues related to valuation of codes
  - Image Guidance Services
  - Equipment Utilization Rate for Linear Accelerators
  - Superficial Radiation Treatment Delivery
- Incident-to Changes
  - Billing Physician as the Supervising Physician
- PQRS
  - Alignment with other quality reporting programs
  - Proposed requirements for individual and group practice reporting
  - PQRS Measure proposed for removal 0386/194 - Effective Clinical Care – Oncology: Cancer Care Stage Documented
- Locum Tenens Physicians
  - Propose to revise 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
  - Set to increase 0.5% from CY 2015 final six months of $35.9335
  - Applied Budget Neutrality Factor of 0.9999
  - Could change pending comments and final adjustments to RVUs etc.

MPFS Payment Impact Table

Table 45: CY 2016 PFS Proposed Rule Estimated Impact on Total Allowed Charges by Specialty					
(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact**
Radiation Oncology	$1,769	0%	-3%	0%	-3%
Radiation Therapy Centers	$52	0%	-9%	0%	-9%

Global RVU Changes Snapshot

Service Description		TOTAL NON-FACILITY RVUs		
HCPCS	DESCRIPTION	2015 RVU Totals	2016 Proposed RVU Totals	Diff
77263	Radiation therapy planning	4.641	4.86	**0.22**
77280	Set radiation therapy field	7.59	8.14	**0.55**
77290	Set radiation therapy field	14.29	15.35	**1.06**
77295	3-d radiotherapy plan	13.68	14.59	**0.91**
77300	Radiation therapy dose plan	1.77	1.88	**0.11**
77301	Radiotherapy dose plan imrt	54.29	58.38	**4.09**
77306	Telethx isodose plan simple	4.07	4.35	**0.28**
77307	Telethx isodose plan cplx	7.97	8.49	**0.52**
77318	Brachytx isodose complex	9.87	10.58	**0.71**
77321	Special teletx port plan	2.58	2.75	**0.17**
77332	Radiation treatment aid(s)	2.31	2.44	**0.13**
77334	Radiation treatment aid(s)	4.26	4.53	**0.27**
77338	Design mlc device for imrt	14.15	15.11	**0.96**
77385	Ntsty modul rad tx dlvr smpl	-	7.74	**7.74**
77386	Ntsty modul rad tx dlvr cplx	-	11.66	**11.66**
77387	Guidance for radiaj tx dlvr	-	5.85	**5.85**
77412	Radiation treatment delivery	-	5.93	**5.93**
77427	Radiation tx management x5	5.22	5.44	**0.22**
77432	Stereotactic radiation trmt	11.71	12.25	**0.54**
77435	Sbrt management	17.67	18.49	**0.82**
77470	Special radiation treatment	4.36	4.63	**0.27**
77778	Apply interstit radiat compl	24.43	25.89	**1.46**
99204	Office/outpatient visit new	4.64	4.64	**0.00**
99214	Office/outpatient visit est	3.03	3.02	**(0.01)**

So Why the Negative Impact?

- Delay of the use of the updated AMA CPT codes and using G-codes for one year – significant changes

2015 HCPCS Code	2015 Total RVU	2016 HCPCS Code	2016 Proposed Total RVU	2015 – 2016 Diff
77014	3.28	77387	5.85	2.57
G6002	2.1	77387	5.85	3.75
G6003	4.52	77402	3.85	-0.67
G6007	7.19	77407	6.65	-0.54
G6011	7.69	77412	5.93	-1.76
G6015	11.19	77385	7.4	-3.79
G6015	11.19	77386	11.66	0.47
G6016	11.16	77385	7.4	-3.76

Potentially Misvalued Codes

- Statutory category, *"codes that account for the majority of spending under the physician fee schedule",*

Table 8:Proposed Potentially Misvalued Codes Identified Through High Expenditure by Specialty Screen	
Code	Short Descriptor
31575	Diagnostic laryngoscopy
77263	Radiation therapy planning
77334	Radiation treatment aid(s)
77470	Special radiation treatment

- Codes have not been reviewed since 2009 or earlier and have a significant impact on PFS payments at a specialty level. This review is meant to assess any changes in the physician work and update the direct PE inputs.

Radiation Treatment and Related Image Guidance Services

- 2015 AMA codes adopted by HOPPS delayed one year by MPFS
- 2016 the changes take effect
  - Treatment delivery codes & Image guidance codes
- Review of changes and establishing values CMS found 3 specific areas seeking comment
  - Image guidance
  - Equipment utilization rate assumptions for linear accelerators
  - Superficial radiation treatment services.

Image guidance

- The RUC assumed most reported IGRT code for CY 2013 was 77014, wrong it was 77421!
- 2016 values recommended for 77387 = values of 77014
  - CMS seeking comments on correct work time for 77387
- 77014 continue as valid code 2016 for Tx planning CT
  - CPT & the RUC to determine fate of 77014 in future
- CMS considered 77387 as pro only, no technical component
  - Reconsidered, adopting CPT guidelines
    - 77387 billed TC & -26 for 3D
    - 77387 billed -26 only for IMRT

Equipment Utilization Rate for Linear Accelerators

- Current equipment time utilization rate default of 50%
  - 25 hours/week out of 50 hr work week linac used for tx
- CMS feels too low, based on data and the RUC stated lower-dose linacs obsolete and no longer manufactured
- New linacs used to used to furnish all levels and types of EBRT, performing more service than when default rate set
- CMS assumes most linacs are phasing out as of CY 2013
  - 2013 – 2016 majority of remaining to be replaced by single linear accelerator

Equipment Utilization Rate for Linear Accelerators cont.

- CMS proposing change 50% utilization rate to 70%
- Data suggests cancer centers open at least 11 hours/day
  - Treating patients for most of it
  - Utilization is believed to be higher than 70%, but not proposing to adjust higher
- 2-year phase in of RVUs
  - 60% utilization for CY 2016 values
  - 70% utilization for CY 2017 values
- Seeking empirical data of capital equipment costs & util. rates

Superficial Radiation Treatment Delivery

- Changes made in 2015 to CPT code 77401
- Several services no longer billable with code, no review by the RUC prior to changes
- Stakeholder comments sent to CMS include
  - Radiation Therapists no longer treating superficial pts.!
  - Majority patients treated by physicians!
    - Asking for physician work to be added to 77401
    - Asking for nurse time to be added and radiation therapist removed
- Equipment pricing raise from $140,000 to $216,000

Incident to Changes

- Comments due to questions received about who to bill under
- Per CMS incident-to services require direct supervision of the auxiliary personnel providing the service by the physician or other practitioner
- CSM response, for question who to bill under
  - *"…the physician or other practitioner who bills for incident to services must also be the physician or other practitioner who directly supervises the auxiliary personnel who provide the incident to services."*

Incident to Changes cont.

- *"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. This is consistent with the requirements that all physicians and billing practitioners attest on each Medicare claim that he or she "personally furnished" the services for which he or she is billing."*

Incident to Changes cont.

- "*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.*"
- 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

PQRS

- CMS proposing alignment with other quality reporting programs
  - Medicare Electronic Health Record (EHR) Incentive Program for Eps
  - Physician Value-Based Payment Modifier (VM)
  - Medicare Shared Savings Program
- According to CMS >1.25 million professionals were eligible to participate in 2013 PQRS, Medicare Shared Savings Program and Pioneer ACO Model
- Assumes 1.25 million eligible professionals will participate in PQRS in 2016
- PQRS has never reached 100% participation, in 2013 641,654 (51%) EPs participated, expect increase in 2016, estimate 70% or approx. 875,000 EPs
- CMS outlined several proposed payment requirements for 2018 PQRS Payment Adjustment for Individuals and Group Practices

PQRS Measure Proposed for Removal

- CMS is proposing to remove PQRS measure 0386/194, Effective Clinical Care, Oncology: Cancer Care Stage Documented
- CMS indicated the clinical concept does not add clinical value to PQRS because documenting cancer stage is a basic standard of care documented early in patient's care before treatment options are discussed.

HOPPS Proposed Highlights

- Payment rates – overall 0.2% decrease in OPPS payments to providers taking into account all proposed changes
  - $73.929 Conversion Factor proposed for CY 2016 equating to a 2.0% reduction from CY 2015
  - Continue 2% adjustment for hospitals who fail to meet the hospital outpatient quality reporting requirements
  - Cancer Hospital Payment Adjustment – continue to provide payment-to-cost ratio (PCR) = 0.90 for each cancer hospital
  - Proposed wage index - 0.1% increase for urban hospitals and -0.4% decrease for rural hospitals
- Wage Index – Frontier States to continue with 1.000, if when calculating the wage index the value were to be below 1.000
- Outlier Payments – Increase in Fixed Dollar Threshold
- Proposed Hospital OQR Measure for CY 2018
  - OP-33: External Beam Radiotherapy (EBRT) for Bone Metastases (NQF #1822)
  - To address concerns associated with unnecessary exposure to radiation a new Web-based quality measure for CY 2018 payment determination and subsequent years is proposed

HOPPS Proposed Highlights cont.

- APC Restructuring
  - Proposed restructure of OPPS APC grouping for nine APC clinical families
  - Renumber APCs to provide consecutive numbering of APCs within each clinical family of APCs to improve clinical and resource homogeneity
  - HCPCS code G0463 (Clinical Visit) proposed to move from APC 0634 to APC 5012
  - Propose to use APC 5012 for APC relative payment rates as previously did with APC 0634
    - G0463, hospital outpatient clinic visit, is the most common hospital code reported
- Changes to C-APC for SRS procedures
  - Reviewing claims data identified variances in codes and way services are billed for SRS Gamma Knife based vs. Linac based
  - Proposing to change C-APC from 0067 to C-APC 5631
  - During a review of CY 2014 claims CMS identified services billed differently for Gamma Knife (77371) SRS procedures vs. Linac (77372) based SRS procedures
  - Remove the codes from the geometric mean cost calculation for CY 2016 and CY 2017 and allow for separate reimbursement of each code. Also propose to utilize a special modifier (which has yet to be released) to assist with data collection applied to each of the following codes when reported for an SRS procedure

HOPPS Proposed Highlights cont.

- New HCPCS Codes for HOPPS
  - The AMA did provide to CMS, on time, the new code changes for 2016; therefore no new G-codes were established for these changes. Contained within Addendum B is a listing of the new codes. The following table indicates there are new codes which will be released by the AMA August 31, 2015 for implementation January 1, 2016 by HOPPS. The full code and long description is not listed in this table.
  - CPT® codes 77776 and 77777 used for LDR interstitial treatment and HDR treatment codes 77785, 77786 and 77787 are deleted for 2016. Additionally the electronic brachytherapy code 0182T is also deleted for 2016
  - The new codes will be for HDR, electronic and radionuclide, and establish a difference in those for skin treatment vs. other areas

HOPPS Payments

- After last few years of increases, proposed decrease in overall payments for hospitals of 0.2%
- Continue 2% adjustment for hospitals who fail to meet the hospital Outpatient Quality Reporting (OQR) requirements
- Proposed continue for Frontier States a wage index of 1.000 if the otherwise applicable wage index (including reclassification, rural and imputed floor, and rural floor budget neutrality) is less than 1.000.

Payment for Hospital Outpatient Visits

- Proposing to continue with current policy for code G0463 adopted in CY 2014 in utilization of code
- Propose to move from APC 0634 to APC 5012 (Level 2 Examinations and Related Services) with other clinically similar and resource similar codes
- Proposing to use CY 2014 claims data to develop pricing as this is first year of data for code

HCPCS Code	Short Descriptor	2015 APC	2015 Nat. Avg. Payment	2016 Proposed APC	2016 Proposed Nat. Avg. Payment	Variance
G0463	Hospital outpt clinic visit	0634	$96.22	5012	$102.19	6%

APC Restructuring

- Proposed Restructuring of APCs to improve clinical and resource homogeneity among the APC groupings
- CMS has proposed to restructure the APCs for these clinical families based on the following principles previously outlined within the CY 2015 OPPS proposed rule:
  - 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.

Addendum Q1.-Proposed APC Crosswalk (from CY 2015 APC to CY 2016 APC)		
2016 APC Title	2015 APC Number	2016 APC Number
Level 1 Therapeutic Radiation Treatment Preparation	0304	5611
Level 2 Therapeutic Radiation Treatment Preparation	0456	5612
Level 3 Therapeutic Radiation Treatment Preparation	0305	5613
Level 4 Therapeutic Radiation Treatment Preparation	0310	5614
Level 1 Radiation Therapy	0300	5621
Level 2 Radiation Therapy	0301	5622
Level 3 Radiation Therapy	0412	5623
Level 4 Radiation Therapy	0667	5624
Level 5 Radiation Therapy	0666	5625
Single Session Cranial Stereotactic Radiosurgery	0067	5631
Brachytherapy	0313	5641
Brachytx, non-str, HA, I-125	2634	2634
Brachytx, non-str, HA, P-103	2635	2635
Brachy linear, non-str,P-103	2636	2636
Brachytx, stranded, I-125	2638	2638
Brachytx, non-stranded,I-125	2639	2639
Brachytx, stranded, P-103	2640	2640
Brachytx, non-stranded,P-103	2641	2641
Brachytx, stranded, C-131	2642	2642
Brachytx, non-stranded,C-131	2643	2643
Brachytx cesium-131 chloride	2644	2644
Brachytx, non-str, Gold-198	1716	1716
Brachytx, non-str, HDR Ir-192	1717	1717
Brachytx, NS, Non-HDRIr-192	1719	1719
Brachytx, stranded, NOS	2698	2698
Brachytx, non-stranded, NOS	2699	2699

APC Restructuring cont.

- Variances >20% proposed for Rad Onc codes in 2016

HCPCS Code	Short Descriptor	2015 APC	2015 Nat. Avg. Payment	2016 Proposed APC	2016 Proposed Nat. Avg. Payment	Variance
55875	Transperi needle place pros	0162	$2,084.03	5374	$2,529.65	21%
57155	Insert uteri tnadem/ovoids	0192	$487.06	5414	$1,885.47	287%
77280	Set radiation therapy field	0304	$113.12	5612	$169.37	50%
77332	Radiation treatment aid(s)	0303	$215.54	5611	$109.98	**-49%**
77333	Radiation treatment aid(s)	0303	$215.54	5612	$169.37	**-21%**
77334*	Radiation treatment aid(s)	0303	$215.54	5613*	$297.70	38%
77370	Radiation physics consult	0304	$113.12	5612	$169.37	50%
77778	Apply interstit radiat compl	0651	$952.11	5641	$697.05	**-27%**
77762	Apply intracav radiat interm	0312	$395.77	5622	$$197.20	**-50%**

*Same APC as intermediate and complex simulation code s77285 & 77290

Comprehensive APCs (C-APC) for SRS

- Continuing packaging of services finalized for 2015
- 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
- CMS is proposing changes for CY 2016 & CY 2017!

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
- Since both 77371 and 77372 are assigned to the same C-APC, proposed to change from 0067 to 5631 in CY 2016, the costs used to set the APC rate are reflective of the data collected.

Proposed C-APC Changes 2016 & 2017

- CMS is proposing for CY 2016 and CY 2017 to remove 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”.
- The following codes are proposed to be removed from the SRS C-APC and reimbursed separately, even when reported on the same claim 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 proposed (not yet released) to be reported on above codes when performed and billed for services related in the preparation and delivery of SRS treatment, both Cobalt-60 and Linac based
- After collection of data, plan to repackage codes back into C-APC

Proposed C-APC Changes cont.

- Propose changing C-APC 0067 to C-APC 5631

HCPCS Code	Short Descriptor	2015 APC	2015 Nat. Avg. Payment	2016 Proposed APC	2016 Proposed Nat. Avg. Payment	Variance
77371	Srs multisource	0067	$9,765.40	5631	$7,347.35	**-25%**
77372	Srs linear based	0067	$9,765.40	5631	$7,347.35	**-25%**

LDR Brachytherapy C-APC 8001

- In place since 2008, proposing to continue C-APC 8001 for LDR prostate brachytherapy services
- Includes codes 55875 and 77778
  - If reported together then under C-APC payment, if performed separately then reimbursed under individual APCs – very different than other C-APCs
- In ASC continue to report G0458 (low dose rate (LDR) prostate brachytherapy services, composite rate) when services on same date of service

Proposed Hospital OQR Measure

- CMS proposed a new Hospital Outpatient Quality (OQR) Reporting Measure for CY 2018 and subsequent years specific to Radiation Oncology
- OP-33: External Beam Radiotherapy (EBRT) for Bone Metastases (NQF #1822)
  - 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

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.

WHAT WE KNOW FOR SURE IN 2016

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 by September 1, 2015
- CMS listed partial codes and short descriptors of the new codes for 2016
  - New codes will replace the deleted brachytherapy codes

NEW CPT Codes by AMA

- September 1, 2015 AMA released new and changes to CPT codes for 2016
  - HDR brachytherapy treatment codes deleted
    - 77785, 77786 and 77787 deleted
    - Replaced with brachytherapy treatment codes for skin and other than skin
  - LDR brachytherapy treatment codes deleted
    - 77776 & 77777 deleted
    - 77778 includes handling & loading (77790)
  - Electronic brachytherapy code deleted
    - 0182T deleted, replaced with new codes

HDR Brachy Treatments Skin

- New codes effective January 1, 2016
  - 77785, 77786 & 77787 deleted
  - 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

HDR Brachy Treatments Non-skin

- New codes effective January 1, 2016
  - 77785, 77786 & 77787 deleted
  - 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

LDR Brachy Treatments

- Code revision effective January 1, 2016
  - 77776 & 77777 deleted
  - 77778 - Interstitial radiation source application; complex, includes supervision, handling, loading of radiation source, when performed
    - ***Complex*** *application has greater than 10 sources/ribbons.*
    - If more than 10 sources or ribbons are not used, unlisted CPT code 77799 (unlisted procedure, clinical brachytherapy) is to be used to report the treatment

Electronic Brachy Treatment Changes

- New codes effective January 1, 2016
  - 0182T deleted
  - 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
- Following codes cannot be reported with 0394T & 0395T
  - 77261 – 77263, 77300, 77306 – 77307, 77316 – 77318, 77332 – 77334, 77336, 77427, 77431, 77432, 77435, 77469, 77470, 77499, 77761 – 77763, 77767 – 77768, 77770 – 77772, 77778 or 77789.

New Place of Service (POS) Codes

- On August 6, 2015 CMS released MM9231 *New and Revised Place of Service Codes (POS) for Outpatient Hospitals* which contains the new and revised POS codes to be implemented January 4, 2016.

New and Revised POS Codes Effective January 1, 2016		
Code		**Descriptor**
POS 19	Off Campus-Outpatient Hospital	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.
POS 22	On Campus-Outpatient Hospital	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.

Future of MPFS Reimbursement

- 2015 Conversion Factor (July – Dec) is $35.9335
- 2016 Proposed (with BN) to be $36.1096
- 2016 – 2019 single conversion factor 0.5% each year starting 2016 and subsequent years through 2019
- 2020- 2025 single conversion factor 0% each year starting 2020 and subsequent years through 2025
- Starting 2026 and subsequent years two different conversion factors, it will depend on whether or not a qualifying Alternative Payment Model (APM) participant
  - Qualifying APM participant CF update of 0.75%
  - Non-qualifying APM participant CF update of 0.25%

Questions?

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