A QUANTUM LEAP FROM FEE FOR SERVICE TO VALUE BASED REIMBURSEMENT

Radiation Oncology Coding, Billing, Documentation and Compliance Seminar

Ocean Room • Salisbury, MA.

June 3, 2016

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Warning: Reimbursement policies vary widely from insurer to insurer and reimbursement policies of the same third party payor may vary in different sections of the United States. As reimbursement policies are subject to change, AMAC® will endeavor, on a periodic basis, to review and revise, as necessary, all pertinent reimbursement information. Therefore, the information contained herein (while accurate at the time of print) may not be accurate at the time of use. Prior to submission of a claim for reimbursement, the user should contact the third party payor (i.e., Medicare, Medicaid or private payer) to verify applicable codes and reimbursement levels.

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Code descriptions and billing scenarios are references from and credited to the AMA CPT-4 current procedural terminology, Healthcare Common Procedure Coding System (HCPCS), AMA case studies, CMS local and national coverage determinations (LCD, NCD). DRG guidelines will determine inpatient reimbursement for Medicare recipients. Only the specific services performed by the healthcare provider should be billed. The physician must order, perform, document all procedures, staff must document all ordered procedures by physician. Operative or procedure reports should be detailed, dictated, signed, and placed in the medical chart.
DISCLOSURE

• AMAC® currently works with many cancer centers, societies, physicians, insurance companies and manufacturers as it relates to medical record documentation, regulations, reimbursement and coding.
• Our presentation will address current events and changes and will not address any specific manufacturers.
• Computed values presented in this presentation are based on an average geographical payment rate, average cancer center/department with an average patient mix.
• Please support your societies: ACR, ABS, ACHE, AHA, ASRT AHIMA, HBMA, HFMA, MGMA SROA, SATRO

Current Reimbursement Landscape

• Affordable Care Act
  o Continuous attempts to repeal
    • A federal judge ruled Thursday, May `12th that certain ObamaCare payments have been funded illegally, handing a major victory to House Republicans
  o Legislation to repeal individual and employer mandates
  o Narrow networks for providers and services
  o Inconsistent enrollment
  o Medicaid expansion
  o United Healthcare will opt out 3rd largest payor
  o Aetna Cigna will not
Current Reimbursement Landscape

"We've been very clear with the administration about the serious challenges facing consumers and health plans in this Exchange market."

Marilyn Tavenner
CEO, America's Health Insurance Plans

- 800,000 consumers had to find new insurance
- 23 non-profit insurance co-ops closed
- Insurance companies were paid only 13% of what they were owed for 2014
- People enroll during the law's special enrollment periods and then drop their insurance after they receive health services (Aetna)

2016 Pivotal Year

Phasing Out
- PQRS
  - 2016 last year to report
- Meaningless Use (EHR)
- Value Based Modifier
- Fee for Service
- Utilization incentives

Transitioning In
- MACRA
  - pay for value
- Merit-based incentive payment system
  - measure physicians on:
    - Quality, Cost, Technology, Practice Improvement
- Episodes of Care
ACA- Fast Facts

- In 2015, 12.7M people enrolled in health insurance through federal or state exchanges
- In 2015, 5.6M were returning customers
- 61% of returning customers chose a new plan
- CDC estimates uninsured rate has decreased to 9.1%
- Proposal for 2017 marketplace plans requires insurers to notify patients 30 days prior to the effective date of a change in provider status

Source: HHS and Health Care Billing and Management Association

AMA Urges DOJ to Block Insurance Mergers

- The American Medical Association (AMA) urged the Justice Department to block mergers for Anthem /Cigna and Aetna/Humana
  - Concerned about anticipated price increases;
  - Urged government not to settle for divestitures.
- Warned the Justice Department that these mergers will give insurers too much power in the marketplace
- Physicians anticipate poor reimbursement
  - hinder physicians’ ability to invest in practice infrastructure
  - hinder acquisition of new technology, training, staffing
  - impacting access to patient care and quality
- Antitrust Division of the Justice Department will review
Accountable Care Organizations (ACO)

Fifty-six percent (56%) of Medicare ACOs (May) said in a recent survey that they likely would leave the Medicare Shared Savings Program (MSSP)—which hosts the vast majority of Medicare ACOs—if proposed rules making them ineligible for a key alternative payment model (APM) designation are finalized.

The rule estimated that as few as 30,000 physicians could qualify initially for APM payments, which are seen as more lucrative and requiring less-burdensome quality reporting under MACRA compared with the Merit-based Incentive Payment System (MIPS) track.

• The concerns of existing ACOs led Andy Slavitt, acting administrator of the Centers for Medicare & Medicaid Services (CMS), to emphasize repeatedly in recent weeks that the agency is seeking feedback on the APM stipulations in the rule.

• Slavitt said at a recent congressional hearing that CMS plans to examine all of its existing payment models "to see where we can make changes to them so that the participants in them can qualify." HFMA

Merit-based incentive payment system (MIPS) in 2019

• AMA outlined 10 principles it would like the CMS to consider while making the payment transition

• The currently separate programs must be carefully assessed, revised, aligned and streamlined into a coherent and flexible system that is truly relevant to high-value care

• Current programs cannot just be combined
MIPS

- Eligible providers will be rated in four performance categories (VBM Measure Quality, VBM Resource Use, Meaningful Use and Clinical Practice Improvement) which will derive a “MIPS score” from 0-100
- In 2019, the range of positive or negative payment adjustments is 4 percent
- Payment adjustment factors will be in the form of a percentage on the Medicare Part B FFS services billed in 2019.
- MIPS scores will be publicly available on the Physician Compare website.

MIPS

- The current weighting in year 1 is the following:
  - Quality (50%)
  - Resource Use (10%)
  - Clinical Practice Improvement Activity (CPIA) (15%)
  - Advancing Care Information (ACI) (25%)
Medicare Access & CHIP Reauthorization Act (MACRA)

- Signed into law 4.16.2015; to begin in 2019
- Considered by many to be the most significant change in payment policy since the introduction of the resource based relative value system (RBRVS) in 1992.
- Two options for payments:
  - Merit based payment system
  - Alternative payment models

The 2019 adjustments will be based on 2017 data so very little APMs will be used.

Hospitals which employ physicians and/or are parties to professional service contracts with physicians and/or physician groups (PHYSICS) will need to review existing contracts to determine what changes are necessary. Physician collections from Medicare Part B payments are a key component of these contracts and compensation methodologies may need to be adjusted accordingly.
APMs new ways to pay health care providers for care given to Medicare beneficiaries

• From 2019-2024, pay some participating health care providers a lump-sum incentive payment.
• Increased transparency of physician-focused payment models.
• Starting in 2026, offers some participating health care providers higher annual payments.

EHR Hardship Exception

• CMS is extending the application deadline for the Medicare EHR Incentive Program hardship exception process that reduces burden on clinicians, hospitals, and critical access hospitals (CAHs).
• The new deadline for Eligible Professionals, Eligible Hospitals & CAHs is July 1, 2016.
• CMS is extending the deadline so providers have sufficient time to submit their applications to avoid the 2017 payment adjustment.
H.R.3940 - Meaningless Use Hardship Relief Act of 2015

- Grants broad relief to eligible professionals (EPs) and other providers from the 2015 EHR Incentive (Meaningful Use) Program due to the delay in publication of the Meaningful Use final modifications rule.
  - But in the final law, "flexibility in applying the hardship exception for meaningful use for the 2015 EHR reporting period for 2017 payment adjustments."
- Amends the meaningful use statute to allow for a blanket exception for EPs in 2015.
- Signed into law 1/5/2016
- The new law did not address portions of meaningless use such as quality measures, reporting periods, and the pass-fail construct.

Medicare Electronic Health Records Incentive Program 2017 Payment Adjustment

- New, streamlined hardship applications reduce the amount of information that eligible professionals (EPs), eligible hospitals, and CAHs must submit to apply for an exception.
- "Flexibility": Result of PAMPA (Patient Access and Medicare Protection Act) which established that the Secretary may consider hardship exceptions for "categories" rather than individually on a “case by case” basis; e.g., “unforeseen circumstances” category.
  
  [https://www.congress.gov/114/bills/s2425/BILLS-114s2425enr.pdf](https://www.congress.gov/114/bills/s2425/BILLS-114s2425enr.pdf)
S.2425 Patient Access and Medicare Protection Act (PAMPA) 12-28-15

Revises Medicare physician fee schedule payment for radiation treatment delivery and related imaging services (HCPCS codes G6001-G6017) by mandating that CMS apply the same code definitions, work relative value units (RVUs) and direct inputs for the practice expense RVUs in 2017 and 2018 as apply in 2016.

TREATMENT OF CERTAIN RADIATION THERAPY SERVICES

Radiation treatment delivery and related imaging services identified under subsection (b)(11) will not be considered as potentially misvalued services for 2017 and 2018.

• It also requires the Secretary to submit a report to Congress on the development of an episodic alternative payment model for Medicare payment for radiation therapy services furnished in non-facility settings.

MODELS IN RADIATION ONCOLOGY APM

One current society suggestion Bone mets

➢ Palliative Care - History repeats itself like Aetna of old (bundling)
  ➢ Simple and Complex bone mets
  ➢ Simple would be standard bone mets
  ➢ Complex would be re-treatment
  ➢ 10 or fewer fractions
  ➢ Base rate is paid, then additional monies after completion of treatment then a small amount if the patient is followed up properly (additional monies for unusual cases) SBRT would be carved out
A QUANTUM LEAP FROM FEE FOR SERVICE TO VALUE BASED REIMBURSEMENT

ACTION PLAN

- READ THE RULES – they change yearly
- Understand and track your costs
  - Staff and supplies and other soft & hard costs
- Understand your treatments
  - Will the third party payor recognize and pay for physician ordered services
- Begin to work with Physician and Department managers
  - Understand the rules of the APM & MBPS
- Administration needs the data

BUNDLING ISSUES
The past several years CMS has been packaging, bundling services and procedures and assigning rates to “new” procedure codes that represent many procedures in the past. This is very important as many CDM departments do not have the knowledge to set new bundled procedure codes appropriately.

Hospitals are struggling in identifying procedures that have been either bundled, made into composite or comprehensive (CAPC). This has resulted in large losses in hospital income.

This can be corrected by increasing the charge amount and reporting costs correctly.

Please DO NOT use a multiplier on updated or new CPT/HCPCS codes, BUNDLED or PACKAGED codes or incomplete billing of C-APC (comprehensive APCs).

Multiplier - when a provider takes the Medicare allowable or APC rate, for example, and multiplies it times a factor such as 2 or 3 to obtain a “charge” amount.

Previous year’s examples show hospitals still have not fixed their own problems:

77338 – IMRT MLCs, this replaced “MULTIPLE” 77334s.

Federal register 2012 final rules: “We recognize that it is peculiar that the estimated cost for CPT code 77334, which represents the cost of a single device, would be greater than the estimated cost for CPT code 77338, which represents the cost of all devices in a single IMRT plan of treatment”.
Treatment Devices (77332-77334 & 77338)

- **77338** – Multileaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan
  - Do not report 77338 more than once per IMRT plan
  - For Immobilization in IMRT treatment see 77332-77334
  - Do not report 77338 in conjunction with **77385 or G6016**
- This is only for MLCs used for IMRT, “ONLY”!

<table>
<thead>
<tr>
<th></th>
<th>Final 2015 Payment</th>
<th>Final 2016 Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>$223.51</td>
<td>$224.28</td>
</tr>
<tr>
<td>Technical</td>
<td>$284.95</td>
<td>$288.77</td>
</tr>
<tr>
<td>Hospital APC</td>
<td>$314.43</td>
<td>$291.77</td>
</tr>
</tbody>
</table>

CHARGE MASTERS (Hospitals)

77338 - $7,200 - $12,000 (this includes multiple 77334s)
Most hospitals charge $200-$500

- Prior to 2010 this is what was charged below in an example:
  77334 X 8 units = $7,200 (77334 X1 unit = $900)
### REIMBURSEMENT DECLINES DUE TO NEW CODES OPPS

#### Hospital Dollars lost due to AMA changes with new codes

<table>
<thead>
<tr>
<th>CPT Procedure Codes</th>
<th>UNITS BILLED</th>
<th>2014 TOTAL FOR THIS PROCEDURE</th>
<th>2015 TOTAL FOR THIS PROCEDURE</th>
<th>2016 TOTAL FOR THIS PROCEDURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>77307 (77315) plus 4 dose calculations</td>
<td>50</td>
<td>$769.97</td>
<td>$38,498.50</td>
<td>$113.12</td>
</tr>
<tr>
<td>77321 plus 1 dose calculation</td>
<td>50</td>
<td>$246.02</td>
<td>$21,301.00</td>
<td>$314.33</td>
</tr>
<tr>
<td>77316 (77326) plus one dose calculation</td>
<td>5</td>
<td>$229.30</td>
<td>$1,146.50</td>
<td>$113.12</td>
</tr>
<tr>
<td>77317 (77327) plus one dose calculation</td>
<td>50</td>
<td>$426.02</td>
<td>$19,170.90</td>
<td>$314.43</td>
</tr>
<tr>
<td>77318 (77328) plus one dose calculation</td>
<td>30</td>
<td>$426.02</td>
<td>$12,780.60</td>
<td>$314.43</td>
</tr>
<tr>
<td>77290 prior to IMRT</td>
<td>150</td>
<td>$311.37</td>
<td>$46,705.50</td>
<td>$311.37</td>
</tr>
<tr>
<td>77770 (77785) plus one dose calculation</td>
<td>50</td>
<td>$848.45</td>
<td>$42,422.50</td>
<td>$842.51</td>
</tr>
<tr>
<td>77771 (77786) plus one dose calculation</td>
<td>25</td>
<td>$848.45</td>
<td>$21,112.25</td>
<td>$842.51</td>
</tr>
<tr>
<td>77772 (77787) plus one dose calculation</td>
<td>10</td>
<td>$848.45</td>
<td>$8,484.50</td>
<td>$842.51</td>
</tr>
<tr>
<td>TOTAL</td>
<td>211,721.25</td>
<td>$163,839.20</td>
<td>$110,774.60</td>
<td>$10,774.60</td>
</tr>
</tbody>
</table>

Total loss for 2015 and 2016 for the above codes |

$211,721.25 AMAC 2016 |

$47,882.05 AMAC 2016 |

$100,946.65 AMAC 2016
A QUANTUM LEAP FROM FEE FOR SERVICE TO VALUE BASED REIMBURSEMENT

REIMBURSEMENT DECLINES DUE TO NEW CODES MPFS

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>77307 (77315) plus 4 dose calculations</td>
<td>$210.64</td>
<td>$183.62</td>
<td>$135.11</td>
<td>$184.15</td>
<td>$140.09</td>
</tr>
<tr>
<td>77321 plus 1 dose calculation</td>
<td>$130.04</td>
<td>$151.28</td>
<td>$43.48</td>
<td>$151.55</td>
<td>$44.07</td>
</tr>
<tr>
<td>77316 (77326) plus one dose calculation</td>
<td>$80.42</td>
<td>$72.59</td>
<td>$114.99</td>
<td>$73.45</td>
<td>$117.16</td>
</tr>
<tr>
<td>77317 (77327) plus one dose calculation</td>
<td>$104.78</td>
<td>$163.89</td>
<td>$95.58</td>
<td>$149.64</td>
<td>$95.66</td>
</tr>
<tr>
<td>77318 (77328) plus one dose calculation</td>
<td>$140.96</td>
<td>$196.49</td>
<td>$151.28</td>
<td>$203.38</td>
<td>$151.55</td>
</tr>
<tr>
<td>77390 prior to IMRT</td>
<td>$80.96</td>
<td>$80.55</td>
<td>$432.64</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>77770 (77785) plus one dose calculation</td>
<td>$106.21</td>
<td>$198.82</td>
<td>$106.00</td>
<td>$198.35</td>
<td>$101.75</td>
</tr>
<tr>
<td>77771 (77786) plus one dose calculation</td>
<td>$201.75</td>
<td>$351.07</td>
<td>$201.95</td>
<td>$355.02</td>
<td>$198.84</td>
</tr>
<tr>
<td>77772 (77787) plus one dose calculation</td>
<td>$286.76</td>
<td>$552.75</td>
<td>$248.11</td>
<td>$566.93</td>
<td>$287.97</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$1,342.52</td>
<td>$2,269.47</td>
<td>$1,323.96</td>
<td>$2,199.74</td>
<td>$1,244.92</td>
</tr>
</tbody>
</table>

Total loss for 2015 and 2016 for the above codes | N/A | N/A | $18.56 | $69.73 | $97.60 |

Hospital Example
FINAL 2015 Compared to Final 2016

<table>
<thead>
<tr>
<th>YEAR</th>
<th>APC Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015 (FINAL)</td>
<td>$5,149,732</td>
</tr>
<tr>
<td>2016 (FINAL)</td>
<td>$5,193,074</td>
</tr>
</tbody>
</table>

Percentage Difference Decrease
Increase .84%
### Hospital Example

**FINAL 2015 Compared to Final 2016 with dose calculations removed for 77295 (rescinded)**

<table>
<thead>
<tr>
<th>YEAR</th>
<th>APC Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015 (FINAL)</td>
<td>$5,149,732</td>
</tr>
<tr>
<td>2016 (FINAL)</td>
<td>$5,081,056</td>
</tr>
</tbody>
</table>

**Percentage Difference**

- Decrease 1.3%

### Freestanding Physician Example 2015 Final, Final Compared to Final 2016

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Medicare Professional</th>
<th>Medicare Technical</th>
<th>Medicare Global</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015 FINAL</td>
<td>$1,146,152</td>
<td>$4,813,001</td>
<td>$5,962,766</td>
</tr>
<tr>
<td>2016 FINAL</td>
<td>$1,146,848</td>
<td>$4,804,012</td>
<td>$5,954,468</td>
</tr>
</tbody>
</table>

**Percentage difference**

- Increase .06%
- Decrease .19%
- Decrease .14%
Example 2015 Final, Final Compared to Final, Final, Final 2016 without dose calculations for 77295 (this was rescinded)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Medicare Professional</th>
<th>Medicare Technical</th>
<th>Medicare Global</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015 FINAL</td>
<td>$1,146,152</td>
<td>$4,813,001</td>
<td>$5,962,766</td>
</tr>
<tr>
<td>2016 FINAL</td>
<td>$1,120,539</td>
<td>$4,738,987</td>
<td>$5,863,187</td>
</tr>
</tbody>
</table>

Percentage difference: -2% -1.6% -1.7%

---

How can I help now?

- If two plans are performed on the same day you lose
- Verify all plans and dose with payor approved equipment and software (internal ok)
- Work closely with physicians and billing staff to understand what the payors want.
- Authorize the correct services – biggest issue in losses today
- Just because it is ordered does not mean the it will be paid
Physician Orders
(Example, the initial simulation (now CT 77014 not billable with a CT simulation 1/1/2014) is usually ordered on simulation setup sheet)

- Verification simulation: simple (a process, treatment parameters and set up, images and order to treat)
- 3-D physics plan
- 2-D physics plan
- IMRT physics plan
- 4-D Respiratory Management
- Beam modification devices (MLCs, Wedges, compensators)
- Dose calculations (second check)
- Guidance – when; _____ what; Fluoro, CBCT, US, KV/MV, transponders, 3-D surface tracking, gating
- Special/micro/in-vivo Dosimetry
- Medical Necessity
- Date of measurement ________ not for QA
- Continuing Physics (weekly, per five fractions)
- Special Physics Consult (physicist only)

Orders, Dates & Doctor Initials

6/3/16

Clinical Flow 2-D, 3-D, IMRT (any EBRT proton, neutron...)

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
</table>
| Setup  | Simulation – 77290 (laser, tattoo, immobilize, set up) Not billable w/IMRT | 77295 - 3-D 77301 - IMRT 77306, 77307, 77316, 77317, 77318 | 77300 – dose calculation Verification MU second check (or other date) | Treatment 77401, 77402, 77407, 77412 77385, 77386 G6003-G6016 ...
| Immobilization 77334 (vac-loc, alpha-crade, aquaplast, breast board-77332) | Devices –77334 MLCs, blocks, Wedges Compensator (or different date) | Please note one must have a dose verification system other than the planning system to verify each gantry angle or arc or sub-arcs by "calculation". | Verification simulation 77280 | G6001, G6002, G6017 or 77387, 77014 |
| 77470 – Special Procedure (rare) | 77300 – dose calculation Verification MU second check (or other date) | | | Devices –77334 MLCs, blocks, Wedges Compensator (or different date) |
| 77263 – Professional prescription (do not bill the 77014 here) | 77338 – IMRT MLC per IMRT plan (or different date) | | | 77338 – IMRT MLC per IMRT plan (or different date) |
EXAMPLE NOTE: Procedure: 77293

XXXXXX was simulated today using respiratory correlated 4DCT in which a marker (or breath hold with no marker) was placed on the patient and this was used to reconstruct images that represent the location of the tumor and critical structure throughout the breathing cycle. These images were imported in our treatment planning system and based on these we developed target and avoidance volumes that represent the patient during normal respiration. A treatment strategy was developed to ensure a good target coverage and normal tissue sparing in regions affected by respiratory motion.

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Treatment Devices

(77332-77334 & 77338)

Documentation:

• Need beam’s eye view in the medical chart of all blocks and/or MLCs on each port. One segment per gantry angle or separate documentation.

• Written description and, if possible, picture of immobilization or other beam modification devices

• Written description of all other devices; custom bite blocks, wedges (dynamic(EDW) or standard off the shelf), custom or standard bolus....

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Treatment Devices (77332-77334 & 77338)

Possible Examples:

- Custom wax bolus/bite block and a custom block/MLC = 77333-59 & 77334 (the technical is always billed on every custom device)
- Rectal balloon – 77334 (one time only) do not bill 7733X more than once per treatment course
- MLC based IMRT, initial set up, 7 fields, no boost – one 77338
- MLC based IMRT, initial set up 7 fields, boost 7 fields planned later in treatment; Bill Two 77338

IMRT Physics Plan

77301 - Intensity modulated radiotherapy plan, including dose volume histograms for target and critical structure partial tolerance specifications.

Dose plan is optimized using inverse or forward planning technique for modulated beam dose distribution. Computer plan distribution must be verified for positional accuracy based on domestic verification of the intensity map with verification of treatment set up and interpretation of verification methodology. (2016 AMA Current Procedural Terminology)

(MEDICAL NECESSITY IS AN ISSUE)
Medical Necessity Note

In this age of payor harassment it is very important that a clear and concise medical necessity note is written so that the lay people or non clinical radiation auditors or clinical staff can understand.

Please make it patient specific

Date: ___ Patient Name:____ DOB:_____ Account #:____

____ (Patient Name) ____ has prostate cancer. It was clear that there were no maneuvers that would be available to reduce the GTV, CTV or PTV to allow for an adequate and appropriate distribution other than the use of intensity modulated radiation therapy.

Because of the potential significant morbidity of treatment to the immediately adjacent bladder and rectum, IMRT was chosen to keep that risk of damage to a minimum.

It was also clear that with 3D conformal treatment, we would not have been able to shape the dose of radiation to the convex structure of the prostate gland, minimizing the dose of the immediately adjacent normal tissue, without the use of IMRT.
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770-693-6031

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770-693-6031

June 3, 2016

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**NCCI REVERSAL**

March 1, 2016; A letter from the NCCI

“I thank you for your patience regarding your inquiries about the National Correct Coding Initiative (NCCI) procedure to procedure edit with column one CPT code 77295 (3-dimensional radiotherapy plan, including dose volume histograms) and column two CPT code 77300 (Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician). We discussed with CMS (Centers for Medicare & Medicaid Services) your correspondence and the meetings between your organization and CMS and us about this edit. CMS owns NCCI and makes all decisions about its contents. CMS will delete this edit in the July 1, 2016 version of NCCI. The deletion will be retroactive to January 1, 2016, the implementation date of the edit. CMS will also revise the National Correct Coding Initiative Policy Manual for Medicare (Medicaid) Services, Chapter IX, Section F (Radiation Oncology), subsection 14 in the 2017 version of the Manual. CMS and we appreciate your assistance with the NCCI”.

**77295 3-D PLAN**

77295 - 3-dimensional radiotherapy plan, including dose-volume histograms

Trial: LUNG

Absolute

4000.00 cGy

3800.00 cGy

3530.00 cGy

3260.00 cGy

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A QUANTUM LEAP FROM FEE FOR SERVICE TO VALUE BASED REIMBURSEMENT

PLANNING CODES FOR 2-D

77306 - Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)

77307 - Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)

PLANNING NON 3-D BRACHYTHERAPY

77316 - Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)

77317 - Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)

77318 - Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)

Most providers never billed the dose calculations with the brachytherapy planning in the past as it was included in the brachytherapy plan but the decay factor calculation should have remained?
Dosimetry 77300

“Basic radiation dosimetry calculation, central axis depth dose, TDF, NSD, gap calculation, off axis factor, tissue in homogeneity factors, as required during course of treatment, only when prescribed by the treating physician.

This code may be reported any time during a course of radiation therapy in which a calculation is done, as many times as necessary. Each procedure should have the appropriate documentation in the chart”. AMA 1997.

“Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician (Do not report 77300 in conjunction with 77306, 77307, 77316, 77317, 77318, 77321)” AMA changes 2015.
Physics Special Port Plan (77321)

77321 - “Special teletherapy port plan, particles, hemi-body, total body”

77321- Special teletherapy port plan, particles, hemibody, total body
This code is used when a plan for any special beam consideration is required. The use of electrons as a portion of or as the main modality for treatment of a particular problem is an example. *AMA*

(Do not report 77300 in conjunction with 77306, 77307, 77316, 77317, 77318, 77321) *AMA*

Special teletherapy port plans are usually done in connection with a complex level of treatment. These are electron calculations and cannot be submitted for the same field with a basic radiation dosimetry calculation, which is photon. Electron beams require attention because of their characteristics in interacting with living tissue. A special teletherapy port plan calculates the dosage level of the treatment portal for the use of electrons or heavy particles when used in a portion of or as the main mode of treatment for the field of interest. *AMA*

Micro-dosimetry/Special Dosimetry (77331)

77331 Special dosimetry (eg, TLD, microdosimetry) (specify), only when prescribed by the treating physician

On the first day of treatment, the radiation oncologist ordered that solid state diode probes be used to directly measure the radiation delivered to the posterior pharyngeal wall, the mid point of the anterior neck, and the lymph nodes in the right lateral neck. These measured dose points were compared to the initial calculations performed by the medical radiologicat physicist and were found to be within 3% agreement, validating the initial calculations. Had these numbers been off by more than 5%, then an investigation of the source of error and appropriate corrections would have been performed.

It should be noted that up to this point, only the first treatment of radiation therapy has been delivered. This points out the large amount of front-end work that is done in the initial preparation of these patients prior to the actual beginning of the daily treatment delivery. *AMA* case study
Micro-dosimetry/Special Dosimetry (77331) cont...

Dosimetry is the calculation of the radiation dose to be delivered to the tumor. The physician chooses the energy level and modality of photon or electron beams to be used for each simulated port, even if only one treatment area is concerned. Once the tentative treatment fields have been determined, the dosimetry of the treatment portals can be calculated. Special dosimetry uses measuring and monitoring devices when the physician deems it necessary to calculate the total amount of radiation that a patient has received at any given point. The results determine whether to uphold or alter the current treatment plan. **AMA**

Code **77331** has both a technical and professional component. To report only the professional component, append modifier **26**. To report only the technical component, append modifier **TC**. To report the complete procedure (i.e., both the professional and technical components), submit without a modifier. **AMA**

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Physics Only Charges 77336

**77336** Continuing medical radiation physics consultation in support of therapeutic radiologist including continuing quality assurance reported per week of therapy

This code includes the overall quality control, machine calibration, film badge service, and a host of other physics related procedures that assure the radiation oncologist that the quality control functions have been appropriately carried out. These activities are also beneficial to each patient undergoing radiation treatment. This is generally reported on a weekly basis. **AMA**
1. Continuing Physics Check

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6/3/16
Physics Only Charges 77370

77370 "Special medical radiation physics consultation"
(This would be charged rarely)

77370 Special medical radiation physics consultation
The medical radiological physicist was called for a consultation
to coordinate the complex dose calculations resulting from
multiple treatment field interactions. A full consultative report
was rendered by the medical radiological physicist. The
procedure is ordered by the physician and the results are
acknowledged by the physician but the actual performance of
this service is carried out exclusively by the physicist. AMA

Physics 77370

May be medically necessary for treatment plans in which one or
more of the following techniques or factors are present.

1. Complex interrelationships of electron and photon ports. This code will not be reimbursed for
an EBRT boost for breast cancer
2. Brachytherapy
3. Analysis of special devices and blocking to protect critical organs for treatment delivery that
is not routinely required
4. Analysis of treatment areas that are abutting or overlapping with a previously treated area
5. Analysis of potential complications that a pregnant patient may experience as a result of
treatment delivery
6. Fusion of three-dimensional image sets from multiple modalities, e.g., computerized
tomography (CT), positron emission tomography (PET) and magnetic resonance imaging
(MRI)
7. Patient with a pacemaker/defibrillator/prosthesis within close proximity to treatment fields
8. SRS/SBRT
9. Patient-specific treatment circumstances that require corrective measures to solve a
discrepancy, correct a treatment error and ensure proper completion of treatment
10. Fusion and blending of multiple treatment plans including previously completed treatments
for a specific patient circumstance
11. Radioimmunotherapy (for patients previously treated with external beam and an evaluation
of a critical organ dose is required)
12. SIRT
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