Questions and Answers from Special Open Door Forum: Radiation Oncology Model- October 8, 2020

1. Trying to understand this statement about what can be excluded besides low volume? Are extreme rural areas able to be excluded or not?
    a. The reason we chose CBSAs as the geographical unit of selection was that they generally do not include extreme rural areas. We know that from some of the questions that we received and investigating that there are a lot of different definitions of rural that people are using. So again if you think you're rural but you're on that list, you may not be as rural as the definition of OMB's definition of the CBSAs and the only the low-volume opt out is really the only, unless you're excluded because you're in that Pennsylvania Rural Health Model.
2. When it comes to ROAP it seems that a couple things are not available yet. Can you walk through some of the things that we need to submit to get various adjustment data for the claims data from you?
    a. Again, to get that information you need to ascertain your Model ID by contacting the Helpdesk with your TIN or CCN and a primary contact-- first, last name and email address. That information will be verified in ROAP and you would log in to there and it will take you to your page. Every participant has their own home in ROAP and on there will be where the case mix and historical experience adjustments are and it will also tell you whether you're eligible to opt out. And there will be a button there for you to say that you are attesting your intent to opt out the first year. In addition to that, there is the Data Request and Attestation form that you would download and fill out and choices of what level of the claims data you want and then that you're testing that you're going to be a good data custodian to protect that bene level data.
        i. I'm in that Model now and I don't see those options to - when I click on them I don't get any other options to move forward.
            1. The Helpdesk can walk you through the steps too. They're not only there to answer questions and policy related questions. They can also direct it - you step-by-step into the portals.
3. I was the lucky one to be included in the RO Model but I do have a very unique situation. We are a small rural hospital with one treatment machine. We do not have a CT simulor on site or do the treatment planning. So we see the patient as a consult. We send them to a freestanding facility. They perform the CT Sim and the treatment planning so they do the professional side of the codes. Our hospital never sees that part. Does the episode have to come from the same tax ID? In our setting in the treatment plan, professional code is billed under one tax ID and the first treatment delivery code is billed under a separate tax ID but our ZIP Code. So would are unique situation make us exempt from the APM right now? We never see the code because it's a professional and it's also built under a different - it goes through a third-party vendor called the Clearinghouse. So this code isn't treated as like a global code because it's strictly professional. And I'm just wondering if there will be a specific modifier that will go through this or because of this unique situation the payment will be delivered to the participating ZIP Code which is St. Clair, us. But how would we determine that payment slip split between a Pro C and a Tech C with two separate tax IDs.

a. Yes, that is a unique situation and I have heard something similar to this. Yes, I think it might even be your scenario - your actual scenario and we've been thinking about this. So I would love to follow-up with you offline on that. I couldn't begin to answer all of that on - in the next 16 minutes and I wouldn't want to take the time away from all the other people with questions but I will be glad to follow-up with you personally.

4. On Slide 15, you've included Brachytherapy except for surgical. And I wanted to point out that on your HCPCS list you have 55920 and 57155 surgical procedures that are only performed in an outpatient hospital and ambulatory surgery centers. So those surgical procedures that are GYN procedures 55920 and 57155 were included. And the third issue is the proton beam therapy that was included in the modalities where a standard radiation center that has one Linac most of the equipment costs about $5 million. And in a proton center the equipment runs between $30 million and $100 million. So those centers will go out of business if they're included in the Model.
    a. Could you send an email to the helpdesk and outline that a little so that we - I don't miss - not have the right information because of my notetaking it would be appreciated.
5. In the current scenario, we have two centers and one of the centers is not in the Model ZIP Code area. So were trying to extrapolate how to correctly account for those. For example, we may be taking one of our linear accelerators down so a patient may start treatment in the center that is included but complete treatment in the center that is not included in the Model. So is there any rhyme or reason, is it based on where the treatment originates for those case payments.
    a. So the episode would be triggered based on a first treatment well, at the time the treatment planning service is delivered or furnished. If the patient changes locations that we will in our billing guidelines tell you how to go through that. And I don't want to speak incorrectly on the fly right now but we will be - get providing you that information on how you would handle that situation.
6. I think for prostate Brachytherapy for our center we're freestanding so we bill globally for all of our external beam radiation therapy. However, we do prostate Brachytherapy in a hospital setting where we are basically a physician group practice at that point because we're providing the professional services and the hospital's billing for the technical component. Typically, what we do for our prostate patients is if we're going to do a combination therapy we will start with prostate Brachytherapy and then four weeks later we will simulate and start external beam radiation therapy. So in that particular situation how does that work?
    a. Okay so that would be the start of the episode when that is provided in the hospital in the first Brachy services.
        i. So if we do prostate Brachytherapy we're a PGP. So we're going to get paid at the PGP rate and that's going to be the start of that episode. And then when that patient comes back in four weeks we're getting - now they're getting external beam radiation therapy for five weeks in a freestanding radiation center but we're only going to get paid at the PGP rate, is that correct?
            1. One of things we're also doing is since we are getting a lot of Brachytherapy related questions. We're going to be doing a

Brachytherapy scenarios and how they should be handled. Keep your eye out for that.

7. The question around the beneficiary level data if you request it, so would you get the baseline data and then how often would you be updating that data for use to be downloaded?
    a. You have the option on that Data Request and Attestation form to request it on a quarterly basis. We would be pulling the data that's relevant to whatever the use is that you're going to be using it for.
8. I didn't get a copy of the slide set and only had a phone number to call in. Is there a way that I can get a copy of the slide set?
    a. Absolutely. If you go to the Radiation Oncology medical - Radiation Oncology Model website on the CMMI website you - there - they are posted on there.
9. We'll have the trend factor and the case rate mix index once the 1734, 1736 OPPS and MPFS final rules are released in November. Is that correct?
    a. You will have the trended national base rates after that. The case mix and historical adjustments we have already.
10. Do both the technical and professional organizations start the global period with the V1 modifier or just one?
    a. Because we pay, the payments are separated between a professional component and a technical component if you're a PGP that only provides the professional you would still be one modifier for the professionals HCPCS code for that cancer type. If you're technical and you're only doing the technical you would do the same. You'd build the technical one with a V1 modifier. If you are a freestanding and you're providing both professional and technical that first claim would have - you can put the V1 modifier on the - you could put the professional HCPCS and the technical HCPCS with the V1 modifier on the same claim.
        i. And then if a patient is admitted and received radiation during the admission do we still combine the charges?
            1. No, if radiation is delivered inpatient and is billed under the hospital inpatient system that is not included in our episode. So our episode would start after they receive their first treatments in a freestanding or outpatient department.
                a. And then if a patient receives treatment planning during an inpatient admission how do we start the global treatment period?
                    i. We will have that included in our billing training,
11. Many of practices are really struggling right now with the COVID pandemic with resources extremely tied up trying to just keep patient care flowing. And this is a just as a comment, just a huge disruption to us trying to figure out how to get into this Model in under 90 days. And even from listening to the questions today it's very clear that there are many scenarios that we just don't even have answers on. The second comment is along the lines of ASTRO. I was involved in helping to craft some of the responses but I think ASTRO had many committees put together with really thought out suggestions for the Model that really represented, you know, thought within the field to make the Model actually work for the participants. And it seems like that none of these recommendations were really ever taken.

And I’m very worried after talking with other people around the country about how practices may really find some financial jeopardy. Last comment is most of us rely on EMRs to do all of our billing and all of our work. And our vendors have zero support for helping us to get into this Model. They release their updates typically once a year and there's no penalty to these vendors to at least help us in any way for getting us in the Model. So there’s a lot of frustration out here. We all feel that 90 days is really a very difficult window for CMS to be pushing particularly in the setting of the pandemic and a lot of uncertainty in finances at practices. So I don’t know if there's a way you can comment on is a thought about whether this is going to be extended.

    a. We have heard and we have received very similar comments about the concern about the start of the model and the prep time and if you didn’t hear me say this I will reiterate it is that we have elevated this to CMS leadership. And the model team will do whatever we're instructed to do and it would have to go through rulemaking is the other thing that I said. But we are - we’ve heard you and we are listening to you.

12. That question about the start date was mine. I will just say you mentioned that it will require rulemaking. Is it not something that you could do through say an interim final rule without or with comment, just something that’s a little bit of a faster vehicle than the general proposed and final rulemaking?

    a. Yes, I mean when we say rulemaking that could be any of the variations of rulemaking.