Centers for Medicare & Medicaid Services
Special Open Door Forum: Radiation Oncology Model
Moderator: Jill Darling
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Coordinator: Welcome and thank you for standing by. I would like to inform all participants that your lines have been placed on a listen-only mode until the question and answer session of today's call. Today's call is being recorded. If anyone has any objections you may disconnect at this time. I would now like to turn the call over to Jill Darling. Thank you. You may begin.

Jill Darling: Thanks (Amanda) good morning and good afternoon everyone. Welcome to today's Special Open Door Forum on the Radiation Oncology Model. I'm Jill Darling in the CMS Office of Communications and welcome. We appreciate your patience in waiting. We're waiting to get more folks and we know that this is a really high level model. So we were just waiting for more folks to get on so again thank you.

Before we get into today's presentation I have one brief announcement. This Special Open Door Forum is open to everyone but if you are a member of the press you may listen in but please refrain from asking questions during the Q&A portion of the call. If you do have any inquiries please contact CMS at press@cms.hhs.gov. And now I will hand the call over to Marcie O'Reilly.

Marcie O'Reilly: Thank you Jill. Excuse me folks. As soon as that happened I got a tickle in my throat. Okay sorry about that. Welcome and as Jill said - excuse me. Sorry I don't - that's good timing for a tickle in the throat.

As Jill said this is a Special Open Door Forum to just talk provide a high level overview of the Radiation Oncology model. This is just the first of many presentations that we'll be making available to you over the course of the

model performance period. I'll tell you more about the next Webinar which is scheduled for next week towards the end of this presentation.

There is a set of slides that I will be following during this. If you got the announcement through the open door forum or have found it on our website. I think there's a link to the slides there and you can follow through. And I'll make sure to remind myself to say what slide I'm on - when periodically so we don't get all get on different slides.

So on Slide 2 if you've heard any CMS presentations before we always start off with some disclaimers that-- letting you know that this presentation was current at the time it was published or uploaded to the Web and that we take and that Medicare policy changes so we provide force document links so they can be updated as things are changing.

And this presentation is prepared for-- as a service to our participants and that this presentation itself is a general summary of the model. It's not - doesn't substitute for the regulation or the final rule as you know it.

And I also want to just say that there's information here that you may question. We've heard - we've had - we've got some feedback from our participants or our stakeholders asking for some changes to the model. The information in here we've - we're obliged to provide you information that's consistent with what is published in the final rule. So I just want to start off with that. That that's why this information is the way it is because it does match what's in the final rule.

On Slide 3 it just - this is a short agenda. We're going to talk about the model design elements and why we design the model the way we did. I want to go over what the differences between what was proposed and what was finalized

based on public comment received and then the next steps for getting you the information you need and you getting us information that we need. That's what we call the onboarding process.

So if we go to Slide 5 a lot of this information you heard before when we did the Special Listening Session for the notice of proposed rulemaking last summer. But the RO model will test whether prospective site neutral episode based payments for radiation therapy services or episodes of care reduce Medicare program expenditures while preserving or enhancing quality of care for our Medicare beneficiaries.

As you know this model requires participation by physician group practices, freestanding radiation therapy centers, and hospital outpatient departments that operate in one or more of the randomly selected CBSAs or Core Based Statistical Areas. And we - those - you can figure out if you're in a CBSA by knowing the ZIP Code that you provide services in. And we'll talk about the ZIP Code lookup tool here in a few minutes.

Participants provide services for one or more of the 6 selected cancer types that we'll talk about and that you provide 20 or more episodes in the most recent calendar year. If you're providing less than that we'll talk about an opt out availability in a future slide here.

The models are designed to cover the professional and technical radiation therapy services that occur in, a 90-day episode. And it is a prospective, site-neutral payment with an annual retrospective payment reconciliation process. And we'll go over some more of that in a couple slides forward.

Again our participants are physician group practices identified by a single TIN and furnish the professional component of the radiation therapy services and

then hospital outpatient departments which are identified by a CCN and then freestanding radiation therapy services that are also identified by a TIN. And then when we talk about the information you provide to the Helpdesk that information is important.

More on Slide 7, another - it's just another way of portraying what the high level overview of the Model. But I just - I really want to point out the information in the bottom left corner that, you know, the payments in the Radiation Oncology Model cover. They include RT services furnished during an eligible episode and can point out that it is not a total cost of care model. Your payments for within this model are only for the radiation therapy services provided during that episode and that the episode paid in two installments, half of the payment at the start of the episode and 50% when the treatment has ended.

As we go to Slide 8 this just tells you why we qualify as an Advanced APM and that's because we require the use of CEHRT. There's the inclusion of quality measure performance as a determination of payment for professional services and then there's a—that-- APM entity is their financial risk. And this also qualifies as an MIPS APM. And again we'll go into a lot more detail on some of these things next week on the RO Model 101 Webinar.

So if we go to Slide 10 we're going to talk - we're talking about the rationale for why the model was designed the way it was. As you know there in radiation therapy services there's been what we call a site of service payment differential where the same services provided in a hospital outpatient department are paid differently when provided in the community setting.

We would like to - we envision this model to empower patients and doctors by encouraging physicians to provide high quality, nationally-recognized,

evidence-based care and by supporting innovative approaches to improving quality, accessibility and affordability by removing the current fee-for-service payment incentives. And ultimately too we want to make sure that we're improving our beneficiary experience.

We're going to move in now to the summary of the changes from the proposed rule to final rule. Again these were - we got several thousand comments on the proposed rule and reviewed all of those to fine-tune the model design. First and foremost, on Slide 12 we wanted to note that we lowered the required participation from 40% of eligible Radiation Oncology episodes to 30%.

And on Slide 13 the model performance period and then the proposed rule we had planned for the model to - we proposed a start date of either January 1 or April 1, 2020 but with the onset of the PHE and we delayed it until January of this coming year, 2021. And I just want to reiterate that we've heard your concerns about the start date of the model and we have shared your concerns with CMS leadership. And if any changes are made to the RO Model we will have to go through the rulemaking process.

On Slide 14 we removed one of the 17 cancer types. Kidney cancer is no longer in the model, leaving us with 16 cancer types. Those 16 cancer types are listed on that slide. Of all of the included, the modalities that we propose to include, we kept them all in the model with the exception of intraoperative radiotherapy. That's no longer included that if you're providing that service that would be done fee-for-service.

New technology, we got a lot of questions during the comment period about how will we handle new technology because we didn't have any proposals about it so we're not really - we didn't finalize something, but we did put a note of clarification in the final rule that says that as new technologies are

identified by and presented to CMS in the process to get HCPCS codes established, once those HCPCS are established and if we think it should be included in the Radiation Oncology Model we would have to propose that in future rulemaking. So in the meantime any of those new codes until ever decided to be in RO Model would be paid for fee-for-service.

Slide 17-- so we proposed and finalized four quality measures -- and they are listed here on the slide -- Oncology Medical Radiation Plan of Care for Pain, the Preventive Care and Screening for Depression, Advanced Care Plan, and Treatment Summary Communication for Radiation Oncology.

The first reporting period would be for Performance Year one so it would be all patients in 2021 but would be reported into our data portal in March 2022. We also propose that and finalize that we would be collecting clinical and saving data for five cancer types.

I just want to specifically note we have a request for information on the RO Model website that lists the actual data elements that our panel of experts has suggested that we should be collecting but we want to get more – broader feedback. So I think it - in the – it’s like a three-page document. It’s very short. If you could read that and send your comments to the RO Model Helpdesk and all the instructions for that are in that document. And also when you submit that information to let us know if you’d like to be involved in an actual conversation as opposed to just getting your written comments and again that information is in there. And again, that document's on our website.

Slide 18, we had proposed that we were going to require the submission of some additional administrative data through annual Web based surveys but we have clarified and finalized in the Final Rule that that reporting will be optional. It's - oh and the second half of the bundled payment as you know, as

I said earlier, the model is split into two payments, one at the beginning of the episode and one at the end of the 90-day episode.

We heard from stakeholders through the public comment period that in the cases, for example if you're doing, you know, one treatment, one fraction for bone meds, you didn't really think you needed to have to wait 90 days, it would impede cash flow. So we took into consideration that and we have made a, that those second payment can be billed as early as day 28 of the episode as long as you're certain that it is the end of treatment and you won't be doing additional treatments and if you do do additional treatments recognize that that second payment that you got covers everything else in that 90-day period. And again we'll go over this stuff in a lot more in-depth in our RO Model 101.

APM incentives-- We had proposed and finalized that the APM incentive will only be applied to the professional component of the payments. But we did make a change to the MIPS adjustments. We had originally proposed to waive all quality adjustments for all RO Model payments for all participant types. But upon listening to comment we have altered it to allow the MIPS payment adjustments for the professional component of the payment.

We're now on Slide 22. The national base rates that were in the medical facilities rulemaking were based on episodes that occurred between 2015 and 2017 to calculate those payment rates. And with the, you know, the rule coming out later we updated that to be 2016 through 2018 so that the - that was more current.

On Slide 23 we talk about the efficiency factors, what you learned of in the proposed rule. We gave it what we think was a better name in the final rule and it's now the blend factor. But what this is, is that we - that historically

inefficient participants will get a certain - well all participants will get a certain percentage of the national base rate and a certain - and then a blend of blended with a percentage of what they historically made fee-for-service. So that's why we're calling it a blend. So for example, in the first year of the model all participants get 90% of what they made under fee-for-service and just 10% of their payment is based on the national base rates. And so that - so those percentages are laid out on the slide and again we'll go through this in a lot more detail. And the RO Model 101 has stayed the same. We just changed the name.

And then the discount factors were dropped by 1/4% each. And, you know, as we explained in the rule that this is all part of the, you know, there's a way that evaluations determines that they can detect change as a result of the Model and there's a balance between the size of the Model and the discounts and the lowering the, you know, the lower the discounts, the more participants generally would need to be in the Model. But we were able to strike a very close balance here that gave you some relief on the number of participants that were in.

Oh, sorry I'm looking at one slide and reading another. On Slide 25 the withhold amounts. We kept the 2% quality withhold but we reduced the incorrect payment withhold to 1%. And then we will in Performance Year three we'll reevaluate whether that 1% is adequate or even still needed based on, you know, how payment - incorrect payments play out during those first two years of the model. Our hope was to help - that was one of the other things to help with the cash flow with reducing that incorrect payment based on public comments on that issue.

We did not propose a hardship exemption in the proposed rule but we asked that people give us ideas for what one might look like. We did not get a lot -

much feedback, if any, on that. So we're still taking that into consideration and are monitoring for any unintended consequences and we would consider a hardship exemption in future rulemaking. But in the meantime we did, in lieu of a hardship exemption, we have - and this the slide should say it's not just stop-loss policy, but it was a stop-loss policy and a low volume opt out options that we've given.

So we - whoops. We have applied - we're going to be applying a stop-loss limit of 20% for certain RO participants. Those participants would qualify for the stop-loss if they had fewer than 60 episodes of eligible RT services during the 2016 through 2018 and were providing services as of the effective date of the final rule which is the effective date of the current final rule is November 30.

So if you were - if you're new after that this stop-loss does not apply to you, like if you're a new practice after that. But it does apply to anyone who's a current participant practicing radiation therapy provider or supplier.

And then we also have established an annual opt-out for low volume entities. And this is for any participant that furnishes less than 20 episodes within one or more of the selected CBSAs and with - according to the most recent year of claims data. So low volume opt-outs will be assessed each year so when you go into the radiation oncology portal before the start of each Model it will tell you if we have determined that you had less than 20 episodes in the last year and you can choose to opt-out.

What's important to know is you need to look at that along with -- and I'll go into a lot more detail on this next week too -- is and you out to look at that your eligibility to opt-out as well as what your payment rates would be

because some people who had a low-volume last year could do better under the model financially then they would have if they opted out.

All right that is a summary of the things that we tweaked through the public comment process and finalized. If we move on to the on boarding information-- on Slide 30, there's a link to the ZIP Code list that's on the RO Model website.

So the first thing, if you haven't already done it, which I bet most of you already have, is look and see if the site of service, the site - the ZIP Code for the site of your service location is on that ZIP Code list. If it is, you are - have been randomly selected to participate in this model.

But I want to say for the people in Pennsylvania you also want to look at – clink on the link for the Pennsylvania Rural Health Model because any hospital outpatient departments that are eligible to participate in that Model are also excluded. So, again, for Pennsylvania folks you want to look at both lists.

Okay, so here is where we have an ask of you so that you can get your information, particularly your payment, your participant-specific payment adjustments and your - whether you find out whether you are eligible to opt out or not is you need access to the Radiation Oncology Administrative Portal which we call ROAP for short R-O-A-P. And we're on actually Slide 31 but to get into ROAP you need to have your Model ID.

So we need you to call or email the Helpdesk with that information. But I want to - I just want to say because TINs, your tax ID numbers are considered personally identifiable information you cannot send them and you should not send them through email. We prefer - we want you to call the Helpdesk, give

them your TIN and also we need you to supply the first and last name of a primary contact and their email address. This is - this person doesn't have to be the primary contact forever but it's going to be that first person that needs to log in to ROAP.

To make sure all of your information is secure we pre-populate the ROAP with an email, a first name, last name and email associated with that Model ID. Once that first person logs in they can change - they can add four other primary points of contact, they can add a legal contact. They can add multiple primary contacts.

So but this first one that we need is just whoever's going to be the first one to log in to ROAP. So and then if you're a CCN or a hospital outpatient department you can do this via email but you're more than welcome to call the Helpdesk too.

And again that Model ID number will not only get you into ROAP but that's the first portal that you need to get into. But eventually you'll be wanting to get into our Secured Data Portal and then our Connect site will be another platform of information for our participants.

On this slide: radiationtherapy@cms.hhs.gov is the email box and the phone number is 844-711-2664 with Option 5.

If you go to Slide 33: Step 2 registering in ROAP-- there's a, ROAP is live. You can get – go in there right after we get off the call here if you've already obtained your Model ID and given the primary contact information. But you can click on the link in the slide here or on the RO Model Web page. There is a link as well as a user's guide that gives you some step-by-step instructions on how to if you're having trouble with registration.

I also want to say that if you've used any of the CMS Enterprise portals in the past and have - you can use that information to log in to ROAP as long as that - and again that email matches what we have in ROAP.

So if you go in today because you've already provided us with your - we've already provided you with your Model ID and we have your contact information you can get in right away. If you call the Helpdesk right after this call as I hope you do, they're waiting for you guys to start calling in after today or after this presentation, it's going to take a couple days for us to add the primary contact into ROAP so we'll ask you to wait a couple days to login. And again this is all for the reasons to keep your information secure.

Some of the things that you can do in the ROAP the - is update your participant information and contacts, download and submit a data request attestation form which we'll talk about a lot next week which is basically if you want to take - or request claims data to see how we - so if you - what claims data we used to calculate your participant specific - participant specific rates you would fill out this form and upload it - download it from ROAP. You'd upload it back in. And then once we have verified the validity of that form we would be uploading the claims data into the Secure Data Portal.

This ROAP doesn't have any bene level data in it but the secure data portal does and that's why we have - that's the segregation there. There'll still be other operational things that you will do in ROAP over the course of the model. Each year you'll have to, for QPP purposes, validate your individual practitioner lists and attest to some of the things that are model requirements. And once we start providing performance reports you would download them from this portal.

But as of tomorrow, again I was saying, that one of the first things you're going to be able to find out in the ROAP is whether you can opt out and what your historical experience and case mix adjustments are. So they will be updated every year in the model.

And all right, talked about the determining your opt out. Again you will use the say - for the secure portal. I mentioned that just a second ago. But all that information's repeated here on the slide.

The one thing I did not mention is the Secure Data Portal is where you will eventually upload your quality measure data and your clinical data elements data. And, again, the reason this is in the secure portal is that clinical data elements is at the beneficiary levels but we want that to be secure.

We're on Slide 34, the last one before we start taking questions. There's a link at the top for the RO Model website. And then what's available now on there is a the copy of the final rule or link to the final rule, the fact sheet, that ZIP Code list I mentioned.

There's a copy of the beneficiary letter that participants can modify to-- with their practice level information to send to beneficiaries once the Model starts. The request for information for the clinical data elements-- I'm going to put a plug-in for that again.

Again, the clinical data elements are going to be used to help us in the - during the course of the model to either refine elements of the model and/or hopefully as you guys know there's not a lot of great quality measures out there for radiation, specific radiation therapy. And we'd like to be able to use this information working with our stakeholders to develop some usable measures in the future.

There's information about the upcoming Webinar. RO Model 101 is scheduled for next week, next Thursday, and then we'll be doing a high level model billing overview two weeks after that. And the - that information will be posted shortly.

And other things that will be coming to the Model website-- the access to the portals. Actually, ROAP is there now as of today. The Secure Data Portal there's nothing in there yet until - so we haven't given you – we haven't had you log into that yet.

And the Connect site if you participated in any other RO Models, the Connect site is like, I don't like to say it's a social media like platform, where participants can have chats with each other. It'll be a place where we keep all of our Webinar registrations and things like that and any of like documents that come in. There might be journal articles there. It's, there's - like I said there's a - it's a really good opportunity for participants to share good ideas that they've - their innovations so it's really a place to share innovation.

The FAQs were posted last week. And again, those FAQs are based on what is in the final rule. As soon as CM announces, does their next HCPCS, you know, when they release them to the public with the RO Model specific HCPCS codes would be on there and we will put them on the website.

The trended national base rates again those will be done once the PFS and OPPS rules rate setting is finalized. We use those to do the trend at national base rates. We'll be doing a billing guide that is a little bit more detailed than Webinar and that will be coming. And then a quality measure and clinical data analytic collection guide will be coming, forthcoming.

So I know that was a lot in a half an hour but I wanted to leave room for questions. And like I said there's some opportunity for more detailed information next Thursday. So (Amanda) if you'd like to start taking questions.

Coordinator: We'll now begin our question and answer session. If you'd like to ask a question please press Star 1. Please unmute your phone and record your name slowly and clearly when prompted. Your name is required to introduce your question. Again that's Star 1 if you'd like to ask a question. Our first question comes from (Kirsten Pope). Your line is open.

(Kirsten Pope): Hi. Thanks for taking my call. I just am trying to understand a certain of this statement about what can be excluded besides low volume? Is extreme rural areas able to be excluded or not? And what's it meant like the…

((Crosstalk))

Marcie O'Reilly: 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 there is not any other - there - the only the low-volume opt out is really the only, unless you're excluded because you're in that Pennsylvania Rural Health Model.

(Kirsten Pope): Okay thank you.

Coordinator: Thank you. Our next question comes from (Brad Robert). Your line is open.

(Brad Robert): Yes, thank you for taking my call. 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?

Marcie O'Reilly: 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 as - and there's 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.

So those are just the - those are the first things you need. Did I answer your question?

(Brad Robert): If I can speak again I guess 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.

Marcie O'Reilly: When you click on what? Well you know what, let's if we want can you - 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.

(Brad Robert): Thank you.

Coordinator: Thank you. Our next question comes from (April Haller). Your line is open.

(April Haller): Thank you. So 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.

So my question is one, 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…

Marcie O'Reilly: Yes.

(April Haller): …separate tax IDs?

Marcie O'Reilly: 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.

(April Haller): Okay thank you.

Coordinator: Thank you. Our next question comes from (James Hugh). Your line is open.

(James Hugh): Hello. This is (Jim Hugh). I wanted to thank you very much for having this presentation today. One statement I wanted to make right off the bat, our software systems, we work with hundreds of cancer centers all over the US. We will not have software ready by January of 2021.

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. Thank you.

Marcie O'Reilly: Thank you. I would just suggest could you specifically send an email to - that was a lot of information and I think I wrote those codes down fast enough. But 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.

((Crosstalk))

(James Hugh): No problem at all. I'll go ahead and email that as soon as this is over. Thank you.

Marcie O'Reilly: Thanks.

Coordinator: Thank you. Our next question comes from (Kristi Rogers). Your line is open.

(Kristi Rogers): Yes-- 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 or…

Marcie O'Reilly: 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.

(Kristi Rogers): Okay good. Okay. All right, thank you.

Marcie O'Reilly: You're welcome.

Coordinator: Thank you. Our next question comes from (Robert). Your line is open.

(Robert Peterman): Oh thank you. This is (Robert Peterman). (Jim) I want to thank you for chiming in there. I had a similar question as well. So 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 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?

Marcie O'Reilly: Well when you say - and I don't want to get into a lot of detail here but when you say hospital is that hospital inpatient or hospital outpatient?

(Robert Peterman): It's a hospital outpatient.

Marcie O'Reilly: Okay. Okay so that would be the start of the episode when that is provided in the hospital in the first Brachy services.

(Robert Peterman): But do see how that would be a problem? 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?

Marcie O'Reilly: Again similar answer, I don't want to give you the wrong answer because I'm thinking on the fly but I do know we have this situation discussed and we've discussed it many times. And one of things we're also doing is since we do get - are getting a lot of Brachytherapy -related questions. We're going to be doing a Brachytherapy kind of, you know, scenarios and how they should be handled. So I will be - we will - keep your eye out for that.

(Robert Peterman): Okay but let me just follow it up real quick because I think maybe you…

Marcie O'Reilly: (Unintelligible).

((Crosstalk))

(Robert Peterman): …can answer it. If you go to the slide that (Jim) referenced which was Slide 15 it says Brachytherapy except for surgical and electronic. So would prostate Brachytherapy be excluded?

Marcie O'Reilly: Only if that code - the code is not included on our included CPT list. And it shouldn't say all surgical. It should say some surgical.

(Robert Peterman): And what it says is on that slide you have the slide right, it says…

Marcie O'Reilly: Yes I'm looking at it right now.

(Robert Peterman): …Brachytherapy. Yes it say Brachytherapy except for surgical and electronic.

Marcie O'Reilly: Right.

(Robert Peterman): Well that's - so I would think prostate Brachytherapy is a surgical Brachytherapy case correct?

Marcie O'Reilly: Again I'd have to look at the CPT codes that would be billed.

(Robert Peterman): Okay thank you.

Coordinator: Question comes from (Wendy). Your line is open.

(Wendy): Hi there. 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?

Marcie O'Reilly: You have the option on that Data Request and Attestation form to request it on a, you know, an ongoing basis, a quarterly basis or whatever, and that you would be – we would be pulling it - the data that's relevant to whatever the use is that you're going to be using it for.

(Wendy): Okay thank you.

Coordinator: Thank you. Our next question comes from (Carol Prince). Your line is open.

(Carol Prince): Yes I apologize if someone has asked this question before. 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?

Marcie O'Reilly: Absolutely. If you go to the Radiation Oncology medical - Radiation Oncology Model website on the CMMI website you - there - they are posted on there.

(Carol Prince): Okay thank you.

Coordinator: Thank you. Our next question comes from (Jordan Johnson). Your line is open.

(Jordan Johnson): Hey thanks so much for taking this call. Just a quick question about like and to answer the physicians whoever asked the question about Brachytherapy inside the final rule that it's actually a duplicative service if you roll Brachy into EBRT that's initiated at the first - that's just based on the final rule that they've published so far. So it's a duplicate of service for continuation.

But my question is 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?

Marcie O'Reilly: You will have the trended national base rates after that. The case mix and historical adjustments we have already.

(Jordan Johnson): Got it. Thank you so much. I was just wondering if we had that published data. I know in the initial data it was the historical data from 2016 to 2017 or 2015 to 2017 and I was wondering if that same historical data was going to be published for 2016 to 2018 now that everything shifted right one year?

Marcie O'Reilly: You're asking about the episode file I think (Jordan)?

(Jordan Johnson): Correct yes ma'am.

Marcie O'Reilly: Okay got you. Okay.

Coordinator: Does that conclude the question?

(Jordan Johnson): Yes ma'am.

Marcie O'Reilly: Yes.

(Jordan Johnson): That's fine.

Coordinator: Thank you. The next question comes from (Joseph). Your line is open.

(Justin Zeller): Is that (Justin Zeller)?

Coordinator: Yes I apologize. Your line is open.

(Justin Zeller): Oh, okay. I had a couple questions. Do both the technical and professional organizations start a global period. Would that be one modifier?

Marcie O'Reilly: Could you repeat that? You kind of cut out a little bit.

(Justin Zeller): Do both the technical and professional organizations start the global period with the V1 modifier or just one?

Marcie O'Reilly: 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.

(Justin Zeller): Okay. And then if a patient is admitted and received radiation during the admission do we still combine the charges?

Marcie O'Reilly: No-- the radiation - 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.

(Justin Zeller): And then if a patient receives treatment planning during an inpatient admission how do we start the global treatment period?

Marcie O'Reilly: Let me - I - like can't tell you that off the top of my head. But we will have that included in our billing training, I promise you.

(Justin Zeller): Okay.

Marcie O'Reilly: It's just two weeks away so or three weeks away.

Coordinator: Thank you. Our next question comes from (John). Your line is open.

(John): Hi. Is that me?

Coordinator: Yes.

(John): Hello?

Marcie O'Reilly: Sure.

(John): I wasn't sure which line - there could be multiple (John)'s. I had a couple of quick comments and questions. First of all 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 that 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.

I know (Jim Hugh) gave a very good comment about potentially you're going to see a lot of practices close. And I think that's a real threat if the payment cuts are as substantial as some of us are modeling. Thank you.

Marcie O'Reilly: Thank you (John). I don't know if you heard in the beginning that, you know, we have heard and we've received very similar comments about the concern about the start of the model and the prep time and that we - I just - well 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 is, you know, we'll do whatever we're instructed to do and what - but 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.

(John): I've got to tell you it doesn't feel like it. We all feel like we're hitting a brick wall at this point.

Marcie O'Reilly: Yes I understand.

Coordinator: Thank you. The next question…

Jill Darling: (Amanda) we'll take one more question please.

Man: Yes.

Coordinator: Thank you. Our last question comes from (Shira Hollander). Your line is open.

(Shira Hollander): I'll actually give everyone back their time. 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?

Marcie O'Reilly: Yes I mean when we say rulemaking that could be any of the variations of rulemaking.

(Shira Hollander): Okay thank you.

Marcie O'Reilly: So that those are all options.

Coordinator: Thank you. That was our last question.

Marcie O'Reilly: Okay right on time 3 o'clock. Thank you everyone. And I hope we will be talking with you again on the 15th, next Thursday. And please call the Helpdesk with your info, to get your info and submit your questions. We're - we are always open to feedback and want to answer questions. Thank you again.

Coordinator: Thank you. That concludes today's conference. Thank you for participating. You may disconnect at this time.

End