



Radiation Oncology Model Listening Session

Moderated by: Nicole Cooney
August 22, 2019 1:30 pm ET

Table of Contents

Announcements & Introduction.....	2
Presentation.....	2
Background on Radiation Therapy & Model	3
Rationale for Proposed Radiation Oncology (RO) Model	3
Goal of Proposed RO Model	4
Overview of Proposed RO Model.....	4
Proposed MODEL Design – Course of Treatment and Included Services	5
Proposed Model Design – Payment Strategy Overview: 4 Steps	5
Proposed RO Model Payment, Discounts, and Withholds.....	6
Feedback Session	7
Additional Information	26

This transcript was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This transcript was prepared as a service to the public and is not intended to grant rights or impose obligations. This transcript may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

CPT Disclaimer -- American Medical Association (AMA) Notice:
CPT codes, descriptions and other data only are copyright 2018 American Medical Association. All rights reserved.



Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen-only mode until the feedback session.

This call is being recorded and transcribed. If anyone has any objections, you may disconnect. I will now turn the call over to Nicole Cooney. Thank you. You may begin.

Announcements & Introduction

Nicole Cooney: Thank you. Good afternoon, everyone. I'm Nicole Cooney from the Provider Communications Group here at CMS, and I'm with my colleague, Joanna Pahl, and we'll be your moderators today. I'd like to welcome you to this Medicare Learning Network Listening Session on the Radiation Oncology Model. The Proposed Radiation Oncology Model is an innovative payment model that would improve the quality of care for cancer patients receiving radiotherapy treatment and reduce provider burden by moving toward a simplified and predictable payment system.

During today's session, our experts will briefly cover the major provisions from the rule and address your clarifying questions to help you formulate your written comments for formal submission. Please note, feedback received during this listening session is not a substitute for your formal comments on the rule. You can see the proposed rule for information on submitting these comments by September 16th, 2019.

Before we get started, you received a link to the presentation in your confirmation email. The presentation is available at the following URL go.cms.gov/npc, as in National Provider Call. Again, that URL is go.cms.gov/npc. Today's event is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in, but please refrain from asking questions during the feedback session. If you have inquiries, contact press@cms.hhs.gov.

At this time, I'd like to turn the call over to Marcie O'Reilly from our Center for Medicare and Medicaid Innovation. Marcie?

Presentation

Marcie O'Reilly: Thank you, Nicole. Thanks for joining us today. I'm Marcie O'Reilly, as Nicole said, and I'm joined here at the table with two of my colleagues, Genevieve Kehoe and Claire Kihn, who will be assisting me and answering your questions. Last month, CMS and The Center for Medicare and Medicaid Innovation proposed the Radiation Oncology Model. The Radiation Oncology Model is included in the Medicare Program Specialty Care Models to Improve Quality of Care and Reduce Expenditures Notice of Proposed Rulemaking. This proposed rule, CMS-5527-P can be downloaded from the Federal Register and as Nicole said public comments can be submitted through 5pm Eastern on September 16th. There are links further back in the presentation that will take you to the rule.

We'll be moving on to the next slide. For your convenience, we've provided a few of the most commonly used acronyms used in the NPRM. Slide 3 provides a list of the topics that we will be covering today.



Background on Radiation Therapy & Model

And we're now in slide 4. And I want to start with a little background on Radiation Therapy and the models. Radiation Therapy is a common treatment for cancer, and most radiation oncologists provide time-limited specialty services for patients with cancer, meaning they usually do not manage all of the patient's care needs. So, this is important to note, that this is the reason that this model is not a total cost of care model. There are multiple forms of Radiation Therapy listed here on the slide, and we'll talk about which ones are included and not included a little bit later in the presentation.

And services for Radiation Therapy are generally provided in a free-standing Radiation Therapy center, which is a type of physician office and the Hospital Outpatient Departments setting. Since 2014, CMS has been exploring potential ways to test an episode-based payment model for RT services. In December of 2015, Congress enacted the Patient Access and Medicare Protection Act, which requires the Secretary of Health and Human Services to submit to Congress a report on the development of a potential episodic alternative payment model for RT services.

The report, which is available on the Innovation Center website, was provided to Congress in November of 2017. The report identified three key reasons why Radiation Therapy is ready for payment and service delivery reforms: the lack of site neutrality for payment, incentives that encourage volume of services over the value of services, and identified coding and payment challenges. We believe that RO model addresses each of these issues.

Rationale for Proposed Radiation Oncology (RO) Model

We've moved on the slide 5. As per site neutrality under Medicare Fee-For-Service, RT services furnished in a free-standing Radiation Therapy center are paid under the Medicare Physician Fee Schedule or PFS at the non-facility rate, including payment for the professional and technical aspects of the services.

For RT services furnished in an outpatient department of a hospital, the facility services are paid under the Hospital Outpatient Prospective Payment System and the professional services are paid under the PFS. These payment systems determine payment rates for the same services in different ways, which creates site of service payment differentials. This difference in payment rate may incentivize Medicare providers and suppliers to deliver RT services in one setting over another, even though the actual treatment and care received by Medicare beneficiaries for a given modality is the same in both settings.

As per aligning payments to quality and value rather than volume, incentives built into the current payment system promote volume of services over the value of the services provided under both the OPPOS or Outpatient Prospective Payment System and the Physician Fee Schedule, entities and physicians that furnish RT services are typically paid incrementally. The more service they provide, the more claims that can be submitted to Medicare for payment.

These incentives are not always aligned with what is clinically appropriate for the beneficiary. For example: for some cancer types, stages, and beneficiary characteristics, a shorter course of radiation treatment with more radiation per fraction or treatment may be clinically appropriate. This model design encourages adherence to nationally recognized evidence-based clinical guidelines when clinically appropriate.



As for the coding and payment challenges, CMS has examined RT services and their corresponding Fee-For-Service codes as part of the CMS MIPS value codes initiative, based on their high volume and increasing use of new technologies. CMS is determined that they were difficulties in coding and setting payment rates appropriately for these services. These difficulties have led to changes to the valuations for these services under the Physician Fee Schedule, and coding complexities across both payment systems.

The Patient Access and Medicare Protection Act, which had us do the report to Congress, also froze inputs into the payment rates for certain RT feeds – RT delivery and related imaging services in 2017 and 2018, and excluded those same services from being considered under the MIPS value code initiative for that same period. Section 51009 of the Bipartisan Budget Act of 2018 extended these policies through 2019.

****Clarification: First sentence of the above paragraph should read:**

The Patient Access and Medicare Protection Act, which had us do the report to Congress, also froze inputs into the payment rates for certain RT delivery and related imaging services in 2017 and 2018, and excluded those same services from being considered under the mis-valued code initiative for that same period.

Goal of Proposed RO Model

We've moved to slide 6. So, the aim of this alternative payment model would be to test whether prospective site-neutral episode based or bundled payments to physician group practices, Hospital Outpatient Departments, and free-standing Radiation Therapy centers for Radiation Therapy episodes of care would reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. If finalized, this patient-centric and provider-focused Radiation Oncology Model would, in addition to improving the quality of care for cancer patients receiving RT services, would reduce provider burden by moving toward a simplified and predictable payment system.

Overview of Proposed RO Model

Page 7 - Slide 7: an overview of the Proposed RO models. The proposed model would take significant steps towards making those prospective cancers specific episode-based payment in a site-neutral manner, that would cover radiotherapy services for 90-day period or episode, for 17 cancer types. The model is modality agnostic, meaning most types of radiotherapy are included in the bundled payment amount.

CMS proposes to include 3D conformal radiotherapy, intensity-modulated radiotherapy, stereotactic radiosurgery, stereotactic body radiotherapy, proton beam therapy, and brachytherapy. The Radiation Oncology Model would require participation from RT providers and suppliers that furnish RT services within randomly selected Core-Based Statistical Areas or CBSAs. The CBSAs selected for the model would contain approximately 40% of all eligible Medicare fee-for-service RT episodes nationally.

Since most people don't know which CBSA they live in but do know their ZIP code, CBSAs will be crosswalked to zip codes, and a list of zip codes that would require participation in the model will be posted on RO model website when the final rule displays. So, when a rule comes out, the list will be on the website. And I just want



to clarify, I said live and we're talking about in this model not live but where the RT services are provided, so it's the service location ZIP code on the claim, not the billing zip code.

There are some exclusions to required participation, which includes providers and suppliers furnishing RT services only in Maryland, Vermont, and the territories, as well as hospitals participating in or eligible to participate in the Innovation Centers Pennsylvania Rural Health Model. Additionally, ambulatory surgery centers, critical access hospitals, and PPS-Exempt Cancer Hospitals are excluded from participation in the RO model.

Participants' specific payment amounts would be determined based on a set of proposed national base rates, trend factors, and adjustments for each participant's case mix, historical experience, and geographic location, and we'll go in a little bit more detail on that in a few minutes.

The national base rates were constructed using episodes between-- that were initiated between 2015 and 2017 during which the majority of the technical services were provided in Hospital Outpatient Departments. For the purposes of establishing a national base rate for the PC, or professional component, and the technical component of each episode for each cancer type, episodes were triggered by occurrence of a treatment planning service, followed by a radiation treatment delivery service, within 28 days of the treatment planning service. This 5-year model, which would qualify as an advance APM and a MIPS APM under the Quality Payment Program, is currently projected to begin either January 1, 2020, or April 1, 2020, and it will end December 31st, 2024.

Proposed MODEL Design – Course of Treatment and Included Services

Slide 8. We proposed that the RO model would include most RT services furnished in Hospital Outpatient Departments and free-standing Radiation Therapy centers. Services furnished within an episode of RT usually follow a standard clearly defined process of care and generally include a treatment consultation, treatment planning, technical preparation and special services or simulation, treatment delivery, and treatment management which are also categorical terms used to generally describe RT services and their codes.

We have proposed to exclude initial consultations for the 90-day episode. These consultations, usually identified by E/M codes, would continue to be billed for Fee-For-Service. Again, this model is modality agnostic, meaning that most types of radiotherapists are included in the payment; however, on the last square on the slide, we do mention some of the services that would be excluded from the bundled payment.

Proposed Model Design – Payment Strategy Overview: 4 Steps

On slide 9, this slide talks about how the payment calculations were developed and how claims would be processed. So first, we start out creating a set of national base rates for those professional and technical components of 17 included cancer types, yielding 34 different national base rates. The episode file provided on the RO model website was provided so that you could calculate the national base rates and basically replicate our math.

Each year, a trend factor will be applied to the 34 national base rates, to update those amounts to reflect the current trends in the OPSS and PFS rates for RT services. Therefore, the final national base rates for 2020 will



not be available until those payment rules are finalized. Those rates will be then adjusted by applying a discount factor, which is the set percentage by which CMS reduces an episode payment amount after – I'm sorry - but before the other CMS standard adjustments are applied. The adjustment payment – then we would adjust the payments by taking out the withholds, when we discussed that there is a quality withhold, which is 2% for the professional component, and a patient experience withhold which is 1% for the technical components, and an incorrect payment withhold which is for both the professional and technical component rate.

****Correction: The third paragraph in the above paragraph should read:**

Those rates will be then adjusted by applying a discount factor, which is the set percentage by which CMS reduces an episode payment amount after the trend factor and model adjustments have been made but before the other CMS standard adjustments are applied.

Then we're utilizing the standard claim system, and the geographic adjustment sequestration and beneficiary call sharing processes that are in place today will remain in effect for these payments. Again, the model episode payments will be split into the professional component payment – tongue tied- the professional component payment and technical component payment. This position reflects the fact that RT professional technical services are sometimes furnished by separate providers and suppliers.

We have developed 34 RO model specific HCPCS Codes. One for the PC of each included cancer type, and one for the TC of each included cancer type. One of these codes, along with one of two modifiers to indicate the start of an episode or the end of the episode, would be required on each claim. 50% of the bundled payment would be paid upon submission of the start of episode claim and the other 50% upon completion of the episode and submission of the end of episode claim.

Proposed RO Model Payment, Discounts, and Withholds

Slide 10 provides a schematic showing the proposed discounts and withholds. The discount factor, or the set percentage by which CMS reduces an episode payment amount, would reserve savings from Medicare and reduce beneficiary cost-sharing. The discount factor for the professional component would be 4% and the discount factor for the technical component would be 5%.

Again, we proposed withhold 2% of the total episode payments for both professional and technical components for each cancer type. This would reserve money to address overpayments that may result from two situations. One; duplicate RT services and two; incomplete episodes. We were proposing a withhold for these two circumstances in order to decrease the likelihood of CMS needing two payments from you.

The quality withhold would be 2%, and that for the patient experience would be 1%, starting in performance year 3. Model participants would have the ability to earn back a portion of the quality and patient experience withholds based on clinical data reporting, quality measure reporting, and performance, and the beneficiary-reported Consumer Assessment of Healthcare Providers and Systems or CAHPS Cancer Care Radiation Therapy Survey.



During the model, the CAHPS survey will be administered by CMS beneficiaries at no cost to the model participants. During the annual reconciliation process, described in the rule, that will occur each summer, we will calculate the amount of the incorrect withhold the participant may receive back, or if they owe CMS money for incomplete episodes not covered by this withhold amount. At this time, we'll also calculate an aggregate quality score to determine how much of the quality and patient experience withhold amounts the participant would earn back.

In the next few slides, there are some important dates and helpful links, and I'm not going to read each of those to you, and particularly the links to the rule itself, and in just a few minutes, we'll start taking your questions and feedback, and we may ask you a question in response to understand your question better; and please note that we can provide you with information that's included in the NPRM, we may not provide information that is not included in the NPRM. Also, we may take a few minutes to respond, so that we can provide you the actual location of information in the NPRM.

We encourage you submit your formal comments on [regulations.gov](https://www.regulations.gov) and we encourage you to be as specific as possible. If you do not agree with the proposal, please submit an alternative. Also, please tell us about the proposals that you like as well. I'm going to turn it over to Joanna now.

Feedback Session

Joanna Pahl: Thank you, Marcie. We will now take your feedback. As a reminder, this event is being recorded and transcribed. In an effort to hear as much feedback as possible, each caller will have a maximum of three minutes to provide input. There may be questions today that we cannot answer because CMS must protect the rulemaking process and comply with the Administrative Procedure Act. We appreciate your understanding. It is also important to note that verbal comments on today's call do not take the place of submitting formal comment on the rules, as outlined on slide 12 of today's presentation. All right. Dorothy, we are ready to start Q&A.

Operator: To provide feedback, press star followed by the number one on your touchtone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset to assure clarity. Once your line is open, state your name and organization. Please note, your line will remain open during the time you are providing your feedback, so anything you say, or any background noise, will be heard in the conference. Please hold while we compile the roster. Please hold while we compile the roster.

Your first feedback comes from the line of Valerie Rinkle.

Valerie Rinkle: Hello. I'm wondering because I noted on page 78 of the model that CMS says that it will maintain the list of ICD-10 diagnosis codes by cancer type throughout the course of the model, but on the list that is published right now secondary malignant neoplasm codes that are used for metastasized disease are not on the list published, and usually these patients don't receive radiation treatment, so that's why I assume these metastasized cancers are excluded purposely, is that correct?

Marcie O'Reilly: Just let me pull up that. Are you talking about the list that we included in the actual NPRM?

Valerie Rinkle: Yes.



Marcie O'Reilly: Okay. So, we don't have the exact ICD-9s and 10s listed there but we will be providing because we're also now looking at all that ICD-10 codes that are proposed for 2020 to be effective. We will reconcile this list and it will be – will be there.

Valerie Rinkle: But you didn't have this list on your website, right?

Marcie O'Reilly: Hold on one second.

Nicole Cooney: We're pulling the website up right now.

Marcie O'Reilly: We do not have the list of ICD-9s and 10s that were used to formulate the cancer types on the website, but we did say in the rule that we would be putting the list up when the final rule publishes.

Nicole Cooney: Thank you for your feedback.

Operator: Your next feedback comes from the line of Anne Hubbard.

Anne Hubbard: Hi. Good afternoon. This is Anne Hubbard from ASTRO and I wanted to ask about the mandatory point of the model. At ASTRO, we're very concerned about the fact that the model is planned to be mandatory from the outset, given the fact that other models the agency has rolled out have been either voluntary or phased into mandatory overtime. Has the agency given any consideration to considering the RO model for a phase-in or for more of a limited mandatory requirement?

Marcie O'Reilly: Hi, Anne. We have not, since that we're – we have not at this point, but we would appreciate you to, in detail, propose how you would like to see that option when you submit your public comments – your formal comments.

Anne Hubbard: Sure thing. We'll do. Thank you.

Operator: Your next feedback comes from the line of Carl Guiden.

Carl Guiden: Actually, the question I was going to ask was answered or asked by the person in front of me. So, I am fine.

Operator: Your next feedback comes from the line of Amy Rinkle.

Amy Rinkle: Hello. I'm with Valorize Consulting, and my question is when new technologies and treatments modalities that are not included in the list of model modalities, that come online during the model period, be subject to the payment models?

Marcie O'Reilly: Anything that it's not in the proposed rule and then —thus finalized would have to go through future rulemaking, so we were going to include other modalities that aren't listed now. We would propose that, and you would have an opportunity to comment on that. Thank you.

Nicole Cooney: Thank you.



Amy Rinkle: Thank you.

Operator: Your next feedback comes from the line of Parashar Patel.

Parashar Patel: Hi. Thank you. Parashar Patel from ViewRay. We're generally supportive of the framework that CMS has proposed. We'll be submitting specific comments on specific topics. One point of clarification, does the 90-day episode always end at 90 days, or does it end at the last treatment and when the provider submits a claim with the last treatment then the payment is made at that time, or does the providers have to wait until the 90 days are actually over?

Marcie O'Reilly: Yes, you would have to – we have it set up, so you would wait to the 90-day episode to be complete, so that is truly a 90-day episode.

Parashar Patel: So even if the treatment was done in 6 or 8 fractions for example over the course of 2 weeks, the provider has to wait the full 90-days to get the second half of the payment?

Marcie O'Reilly: That is correct.

Parashar Patel: Okay. Thank you.

Operator: Your next feedback comes from the line of Derek Hall.

Derek Hall: Hi, there. Yes, this is Derek Hall with Summa Health System. Just – I guess my first question was, I didn't see a lot of language in the proposed rule that kind of talks about model overlap, so patients that would be BPCI advanced or MSSP and/or part of this initiative as well, so I guess not expecting an answer on the call today, but just my request is that – that in the final rule that there be a little more detail around how those programs would interact that I've seen in previous final rules that have dropped. And I'm surveying the room to see if we have any other questions here. Any other questions here? And that was our only I guess question/comment. Thank you.

Marcie O'Reilly: I just want to clarify you did see the overlap section starting on page 3 – 534. You're just asking for more detail on how that rule will roll out. Okay. Thank you.

Derek Hall: I am. Yes, absolutely.

Marcie O'Reilly: Thanks for the clarification.

Operator: Your next feedback comes from the line of Darrin Kistler.

Darrin Kistler: Yes, thank you. Darrin Kistler of the University of Kansas. So, what was the rationale for including all of proton therapy except for those that are in a randomized clinical trial, when it's such a small percentage of overall radiation treatments, and really is more of a tertiary procedure patients referred for that specialty care?

Marcie O'Reilly: We included it just in the vein of our modality-agnostic theme.



Darrin Kistler: It's just – there's hundreds and thousands of linear accelerators across the country, and only a small group of proton facility, so and we'll put that in our comments, but I just liked clarification on that.

Marcie O'Reilly: Please do, and we did include in that section some of the rationale of why we included it based on some of the studies and MedPAC reports and other reports and things like that, so, but, yes, please, if you do not agree with that, please submit an alternative.

Darrin Kistler: Okay. And just as a follow-up question and kind of unrelated, but, and I haven't read every detail on the page, but what happens when a patient comes back with a new problem in that same 90 days, is that included in that same bundled payment? I mean, like a secondary metastatic site which is resulting in two courses of treatment or based on the same diagnosis, so...?

Marcie O'Reilly: Yes, that would be the same episode.

Darrin Kistler: Okay.

Marcie O'Reilly: Thank you.

Operator: Your next feedback comes from the line of Gregg Franklin.

Gregg Franklin: Hello. I'm with the New Mexico Cancer Center. Just a quick question more about new technologies, and I know people have mentioned a few of them, but more specifically for those, let's say practices that want to maybe in the future purchase new technology, whether it be proton or some other new technologies, there be a – given that you're putting those new technologies into the current bundled for our – let's say particular practice we might have – we have a history of treating with just linear accelerators, and so our case rate will be based on our current case rate, the question is, if we were to get new more expensive technologies, how we incorporate that in, I mean, it would seem like possibly doing a multi-year like let's say Fee-For-Service payment, say before they're included, the bundled payment would be a more appropriate way in my mind of trying to incorporate new technologies? Thank you.

Marcie O'Reilly: At this time, we believe that this is another reason why we're doing the trend factor and trending rates to the current year payment rate, so at this point that's how we are handling that. If you have better suggestions, which you just mention one. Please submit those with a little detail when you submit your formal comment.

Gregg Franklin: Thank you.

Operator: Your next feedback comes from the line of Brad Robert.

Brad Robert: Yes, just a quick question on the Core-Based Statistical Area and ZIP codes, if a provider has multiple locations, how is that handled? Is it just one ZIP code location?

Marcie O'Reilly: Participation would be either participants will be identified by their TIN or their CCN, so if your locations had different TINs, then that would take care of it. That TIN service location which is within the ZIP



code. If for example: you are a TIN with 20 service locations and some service locations are within a selected CBSA or ZIP code and some are not, they would be billing differently. One would be – the ones in the ZIP codes would be following the RO model and the ones not in the ZIP code would be carrying on business as it is today, and this is all part of our ability to generalize results among the country with the evaluation.

Brad Robert: Thank you.

Marcie O'Reilly: Thank you.

Operator: As a reminder, to remove yourself from the queue, if your question has been answered or your feedback has been provided, press the pound key. To remove yourself from the queue, please press the pound key. Your next feedback comes from the line of Samantha Ross.

Samantha Ross: Hi. I'm calling from CommonSpirit Health. Just a clarification question. You mentioned in the rule a clean period, so after the 90 days, you can't trigger another episode for a short period of time. Are any billings that are included in the model during that clean period just regular Medicare Fee-For-Service billing?

Marcie O'Reilly: That's correct. You interpreted what we said in the NPRM correctly. Anything provided during that 28-day period, you would be able to bill Fee-For-Service.

Samantha Ross: And then additional – are there any drugs or anything included in the model as well?

Marcie O'Reilly: Drugs are not included. Only Radiation Therapy [crosstalk] service.

Operator: Your next feedback comes from the line of Lora Markley.

Lora Markley: Hi. This is Lora Markley from the U.S. Oncology Network. This is aligned in regards to the claim submission. So, once a member has been identified and the billing is done, how is that going to show up on the member's EOB, and then for the crosswalk to a Medigap payer with all of the withholds, how is that going to work when the member has still the 20% portion that they're responsible for, and will it be done timely so that there's no timely filing component?

Marcie O'Reilly: All right. Let me start with the first one and then you said three and now I don't remember what order you said them in. So, the first one was – can you just repeat? Can we do it one at a time?

Lora Markley: Sure. Sorry. So, in relationship to members who are identified and put into the model with the billing in the bundled payments that we are to receive, how is that going to reflect under the member's EOB?

Marcie O'Reilly: I cannot verbatim tell you how it will be reflected but there, we have MSN messages and things developed, and after the model is finalized, if it's finalized, we will be doing a billing webinar and putting out an MLN Matters article and things going all of this, so we will be able to go into that in much more detail.

Lora Markley: Okay. And then the second part and maybe answer with your response just now, but with members that have the Medigap secondary and with this model, they're still responsible for their 20% co-



insurance. So, the crosswalk to the Medigap payers, and then with all of the withhold amounts in the reconciliation, how will that work?

Marcie O'Reilly: And I mean it will still be a responsibility therefore and I would assume we would just, and I don't know this. We didn't put this in the rule because it was just operational stuff that we have to work out. So, I think I don't necessarily understand what the – I understand the question, but I don't understand why you're asking the question. So, either you can give me more detail now and I can take it back. You can provide it as a formal comment or if you want to give me a little more detail on this specific question through our radiationtherapy@cms.hhs.gov mailbox, we may be able to help there too.

Lora Markley: Okay. I'll submit it through the email address with the various components and example. Thank you.

Operator: Your next feedback comes from the line of Wendy Smith.

Wendy Smith: Hi. This is Wendy Smith with Health Policy Solutions. What happens in the case of when a patient begins the episode in a Free-standing Cancer Center as an outpatient but is later admitted to the hospital, and they receive some or all of their treatment delivery as inpatient, and similarly, what if the patient begins the Radiation Therapy in inpatient setting and then discharged from the hospital midcourse treated in a non-facility setting to complete their treatment?

Marcie O'Reilly: Question one: that would be considered an incomplete episode, so and the claim system, we have built business rules in there to be able to recognize those types of scenarios, and again, we'll go through that in more detail when the billing seminars happen. The opposite situation is that when they continue the treatment that was started in the hospital in the outpatient setting, you will have the ability to fill those Fee-For-Service. Because they're not starting the episode in either of our settings.

Wendy Smith: Okay, great. Can I ask a follow-up question about incomplete episode? I'm just a little confused about the incomplete episode of care. So, in the first situation, would the PC or the dual participant receive 50% of the PC payment at the start of the episode, but since the treatment was furnished in the hospital setting, so how does CMS recoup these incomplete episodes of payments. I guess that's what I'm interested in. I mean, if you have some situation where they're constantly getting paid for an incomplete episode then do you recoup those monies during the reconciliation process?

Marcie O'Reilly: We would look to see during the reconciliation process if the amount with the 2% that was withheld from the original payments would cover that, and then we wouldn't have to recoup anything, and we would apply that to all your cases for the year and then it would be based on aggregate amount, but we will be doing a lot of work to reconcile claims that are submitted as model claims with – claims that are submitted Fee-For-Service for any of these types of reasons, but it will all happen after the reconciliation process.

Wendy Smith: Okay. Thank you.

Operator: Your next feedback comes from the line of Jonas Fontenot.

Jonas Fontenot: Hi. This is Jonas Fontenot with Mary Bird Perkins Cancer Center. My question is, how will CMS handle a situation where the initial treatment – clinical treatment planning trigger is provided in a



physician office or free-standing Radiation Therapy Center, but subsequent treatment deliveries are provided in the ASC setting?

Marcie O'Reilly: That is like an example of an incomplete episode. So, if you would bill the professional the PC of code for that diagnostic category and then services are provided in the Ambulatory Surgery Center, they will – the Ambulatory Surgery Center will bill as they normally did, and we would reconcile this during the reconciliation process.



Jonas Fontenot: Thank you.

Operator: Your next feedback comes from the line of Gerald White.

Gerald White: Jerry White, Colorado Associates in Medical Physics. How will you process if GYN Oncologist provides the surgical service CPT 57155 to insert a tandem and ovoids for cervical cancer, but the radiation oncologist provides the initial clinical treatment plan, who will receive the PC payment for the treatment course? Does the GYN Oncologist receives any payment for the surgical portion of the treatment?

Marcie O'Reilly: So, as we talked about incomplete episodes, we also talked about duplicate services for one of the reasons we have the incorrect payment withhold, so that would be reconciled during the duplicate services if two different parties provided the professional component.

Jerry White: It will be noted, there are two different tasks though. The gynecological oncology surgeon inserts the tandem and ovoids as surgical procedure as part of the brachytherapy procedure. But the radiation oncologist does the actual brachytherapy, so something like two physicians are billing for the same thing. There are two different services by different physicians as part of the episode of care.

Marcie O'Reilly: I'm going to have to think through that one. Thank you. But thanks for bringing that to our attention and any other – any situations like that that you don't think that we covered in our scenarios and the rules.

Jerry White: I'll submit similar parallel situations with some comments. I suspect there are other similar situations.

Marcie O'Reilly: Yes. Thank you.

Operator: Your next feedback comes from the line of Tom Eichler.

Tom Eichler: Good afternoon. Tom Eichler here in Richmond, Virginia Radiation Oncologist and I'm also with ASTRO Health Policy. My question is, the RO model qualifies as an advanced APM, but in the proposed rule CMS estimates almost 20% of practices would not qualify for the bonus and would fall under the category of MIPS APMs. My question is, is the agency planning to make it mandatory for these practices that don't qualify to be in the RO model or in the APM; it seems like they're set up to fail?

Marcie O'Reilly: Thank you for that comment, and I think we've received that comment from you guys at ASTRO too, and we are looking into that, but right now it is set up to be just as you explained.

Tom Eichler: Okay. Thank you.

Operator: Your next feedback comes from the line of John Strasser.



John Strasser: I had two questions. One is about the incomplete issue. If the patient goes through more than 50% of the course but stops early, does that still count incomplete, or is there some sort of threshold to being close to complete that would qualify for the second payment; and then the second question has to do with the withholds, particularly with the quality withhold. I thought that MACRA and MIPS sort of prospective of the stuff we're doing now qualifies for like two years from now. So, it sounds like we're going to be penalized and having to wait for that funds for stuff that we've already earned, so that's kind of confusing, I guess.

Marcie O'Reilly: Part one of your question that would – that – you would get both payments; you would just bill because we don't know here why you – how many treatments that they were supposed to get. So only time it's considered is incomplete or duplicate services if they stop getting treated by one provider or supplier and got started treatment with another, but if you did the majority of it and you billed the first one you can bill the second half of the payment.

John Strasser: Okay.

Marcie O'Reilly: And the second question.

Joanna Pahl: Can you repeat your second question for us, please?

John Strasser: I guess most of us are participating in MIPS right now are prospectively reporting and that's a positive adjustment if we get this base of maybe 1.5%, but then there's going to be this withhold on this – on top of that it seems like we're getting a little bit penalized for things upfront by having to withhold the upfront is happening as opposed to later – for future years. Why are we being punished upfront on this if we're doing the work and we've done it already this year and we're doing it and we're then going to this program, shouldn't the quality piece be for the future year, or the year after, and so why would we be having a withhold upfront?

Marcie O'Reilly: The withhold upfront was designed to qualify as an advanced APM; if we did not do the withhold, then for the first year of the model, it would not be considered advance APM for the Quality Payment Program rules.

John Strasser: And would we...?

Marcie O'Reilly: Go ahead.

John Strasser: Would we still be receiving our bonus that we've earned like we participated in 2018 and we qualified for the bonus, will that be added on to those payments for if we're forced into this model?

Marcie O'Reilly: We state in the NPRM that the MIPS adjustments would not be applied to any RO model claims...

John Strasser: Because there is a cost for us to do – there is a cost for us for filing this data right now. So, it's not a revenue-neutral thing for us to participate in MIPS today. It is efforts in terms of time spent and then if we get required to participate in this model, we're not getting any of that bonus for the work we actually did. That doesn't seem really fair, I would say.



Marcie O'Reilly: And I encourage you to submit that comment. That's a very good comment, to submit.

Joanna Pahl: I'm sorry. You've exceeded the time limit. Thank you for your input. We need to move on to the next caller.

Operator: Your next feedback comes from the line of Andrew Ross.

Andrew Ross: Yes, this is Andrew Ross with Ohio Health. We had two questions; one being the most important about data availability. I know you looked at evaluating 2015, 2017 claims data to develop this model. Will we receive any of that RM storable data upfront prior to model began, so we can take a look at our previous care patterns and understand where we can implement care redesign?

Marcie O'Reilly: Yes, in the NPRM, we do let you know that upon submission of a data request and attestation form, we will send you all the claims data for your particular practice for that time period. It would be the same data that we use to calculate your participant specific amount.

Andrew Ross: Do you know when we're expected to receive that. I know you mentioned that we'll receive information on specific payment amounts in the fall, assuming that's after final proposed rule. What about the data? Is that similar time period or is there a different time period for that?

Marcie O'Reilly: You will, as soon as the model is finalized and you fill out that DRA, we can start submitting – giving you that data. As for the payment amount, the specific ones, per the rule we cannot give them to you any later than 30 days prior to the start of the model of the performance year.

Andrew Ross: Okay. So, once the model is finalized and we can find out if we're a participant, we can submit a DRA and start that process right away...

Marcie O'Reilly: You sure can. Yes.

Andrew Ross: And then my second question is, if we are not a participant but we're selected as a comparator, is there any requirement for like the HCPCS Code to trigger an episode or anything like that, if your comparator as supposed to be a participant?

Marcie O'Reilly: No, and you will not know if you're in the comparison group.

Andrew Ross: Got it. Thank you.

Operator: Your next feedback comes from the line of Carrie Salter.

Carrie Salter: Hi. This is Carrie Salter from UAB. I had two quick questions. One, just clarification on actually the total amount of funds that the provider would be eligible for, so there's a 4% withhold, the 2% CMS withhold and the 2% quality, so if you meet your quality metrics, I think I've read in the proposal that you would get partial payment if you meet quality metrics. Can you clarify so that our max payment would be somewhere close to 96% possibly or 98%?



Marcie O'Reilly: So, could earn the 2% of the quality, the entire 2% of the quality withhold back, if you perform well on the pay-for-performance measures and you submit the data for the one pay-for-reporting thing, and then the other part of that goes into that aggregate quality scores if you submit the clinical data elements that we will be asking for. So, you could potentially earn all 2% back, so that would up your payments and then if you don't have any incomplete episodes or things like that, you could get that other 2% back too, so you would – and your math is right, up to 98% back or 96.

Carrie Salter: Okay. Thank you for that clarification and one quick question regarding the TIN. We have several JVs and we actually bill under the same professional TIN; however, if one of our sites is not in the PSA, and the technical components then is billed and not included in the mandatory bundle, would the professional services only then be included in those sites where we have joint ventures? Or would it cause that site to also be included in the technical fee billing as well?

Marcie O'Reilly: If the entity providing the technical services is providing them in a location not in one of the CBSAs, they would be billing Fee-For-Service, and just the TIN who's billing the professional service would bill, if they're only billing the professional service that's the portion of the payment that they would get.

Carrie Salter: But the professional compound, would still be regulated under the RO model?

Marcie O'Reilly: Yes, the professional component service location within the location.

Carrie Salter: Okay. All right. Thank you.

Marcie O'Reilly: You're welcome.

Operator: Your next feedback comes from the line of Amar Rewari.

Amar Rewari: Hi. This is Amar Rewari with Associates in Radiation Medicine. My question is related to the lack of the advanced APM bonus on the technical side. When the proposal to wave the 5% bonus on the TC, combined with the 5% discount, put those practices that are mandated to be in the model at a considerable competitive disadvantage, compare their peers, I mean, they won't be able to maintain and upgrade existing technology or invest in new technology to be able to compete effectively on quality of care and outcomes.

Marcie O'Reilly: Those peers would not be getting that 5% either. So, this was all for site neutrality.

Amar Rewari: I'm saying the peers who aren't in the model, so 40% of the practices in the model won't be getting the TC bonus, while the 60% that aren't in the model, that qualified for the advanced APM outside of this model still would be getting those bonus payments?

Marcie O'Reilly: I don't know of any model that a Radiation Therapy provider would qualify – that there's any APMs out there for you - them to qualify for an APM incentive bonus.



Amar Rewari: And then the second part to that, particularly for practices that are in dual eligible environments, that combination of the 4%, plus the 5% discount, without the 5% bonus on the technical component, that's a pretty significant discount for those practices. Have you guys taken that to account for the dual eligible?

Marcie O'Reilly: Well yes, we have, because that is really, if you read the rules, a lot of the reasons why we have proposed this is that there's no incentive to – providing- professional component and you provide services in both locations, that you wouldn't start steering patients to the free-standing center away from the Hospital Outpatient Departments so that the technical 5% would be there. Does it make sense?

Amar Rewari: No, it makes sense. It's just, often times if you can't pick and choose depending on what your hospital contracts are, sometimes you have a free-standing center, sometimes you have a hospital-based department like my practice where dual eligible, but it's not out of choosing. We don't direct care to one or the other based on payment. We do it because of that's where the location of those hospital contracts are, so it would really hit us hard in those and because of that.

Marcie O'Reilly: Please, please, send us that as a comment.

Amar Rewari: Thank you.

Operator: Your next feedback comes from the line of Donna Royster.

Donna Royster: Hello, Marcie. I wanted to ask questions about when we initiate the first code, the 77261 through 63 and say it's on a 10-day whole-brain treatment and we submit that last code that says that this is for end-of-treatment, we have to wait the 90 days before we get paid.

Marcie O'Reilly: You know, I need to think about that one because that so much of the question was asked before. Now you have me doubting myself on the correct answer. I need to get back on that one.

Donna Royster: Yes. I'd appreciate it. Because when I was reading, I was going to say I think some of us on the call would need to know that because that's going to affect our revenue coming in, if we do like a 10-day course and we have everything submitted and we have the end of treatment code, and then we're waiting either for the 90-day episode to end, or if we submit the code, then we get payment within the regular 14-day turnaround for Medicare with the clean claims.

Marcie O'Reilly: Right and I need to go back and look through all the business rules that are being program now to the claim system and that might be an easy answer when you like but I don't want to give you false information on the phone.

Donna Royster: Right. And maybe that will be answered on some of the billing webinars that come out in the future.

Marcie O'Reilly: Oh, it'll absolutely be covered there.

Donna Royster: Okay. Thank you, Marcie.

CPT only copyright 2018 American Medical Association. All rights reserved.



Operator: Your next feedback comes from the line of Monica Vanderwerf.

Monica Vanderwerf: Hi. Monica Vanderwerf from Radiation Medical Group and San Diego CyberKnife. So all of the separate adjustments of professional and technical – I'm assuming there's also sequestration, that was my first question, and then you also spoke about drugs being excluded and being paid at Fee-For-Service, what about like fiducials or like the transperineal biomaterial base or items like that, would that be Fee-For-Service as well?

Marcie O'Reilly: I don't know all the codes for all of those things. If those codes are not listed on the list of the package bundled codes in the table provided in the rule, then they would be billed Fee-For-Service. We do have radioisotopes in the table and if any of them are there, if those codes are specifically there, then they would be included in the bundle. And the other – your first question was about sequestration. Yes, sequestration is the fact I mentioned that at the, early on in the presentation.

Monica Vanderwerf: Thank you.

Operator: Your next feedback comes from the line of Teri Bedard.

Teri Bedard: Hi. This is Teri Bedard with Revenue Cycle, and it's not uncommon for us to treat multiple diagnoses at the same time that are different diagnoses, and I know you talked a little bit earlier about if they're the same, but what if it was a lung cancer and a bone or brain metastases they're both part of that 90-day period. How do we account for those different diagnoses that may be treated in that episode of care? Do we select only one, pick one, or we pick both, is there a way to represent if that changes, and a different diagnosis is added during that 90-day period that maybe didn't start at the beginning of that 90-day period?

Marcie O'Reilly: Good question. You would – when we did the pricing, we did look at all the scenarios out there, and how many and how many times that kind of scenario occurs, and it's built into our pricing, so you would, if you had a breast cancer with a bone mets or a lung cancer with a bone mets, you would pick – you have the choice to pick the RO model specific HCPCS Code for that, and for the diagnosis that you choose lung you just make sure you have to have the ICD-9 codes on the claim to support it.

Marcie O'Reilly: Go ahead.

Teri Bedard: Okay. Also, kind of building on the last question that somebody had asked. If there is not a diagnosis that's on here like skin but one is, you would bill the CMS Fee-For-Service in the model at the same time simultaneously as well?

Marcie O'Reilly: That's correct.

Teri Bedard: Okay. All right. Thank you very much.



Operator: Your next feedback comes from the line of Leonela Torres.

Leonela Torres: Hi. I'm Leonela Torres from Weill Cornell Medicine. My question is in regards to what if the beneficiary becomes a beneficiary in the middle of treatment; so we've already started treatment, they had a previous payer and now become a Medicare beneficiary in the middle of treatment, would that be considered an incomplete episode since we've already billed the 77261 through 63 already to previous payer?

Marcie O'Reilly: You will be able to bill that patient Fee-For-Service for the remainder of the course. When we go over the billing guidelines, you'll see that there are specific codes that you can put – you'll be able to put on the claim to indicate that this patient for a reason like that is not eligible for the model, and is eligible for Fee-For-Service payments.

Leonela Torres: And then my secondary question is in regards to the LCDs. So if I'm reading your policy correctly, you wanted the removal of ICD-10 codes from LCDs within the first year of the model being live, and correct me if I'm wrong about that, and so would we be still subjected to the policies of the LCDs if they would no longer be active?

Marcie O'Reilly: The first part, I don't recall anything about removing ICDs from the LCDs but what we were saying in the rule is that they will not – the MACs will not be applying the LCDs to the RO model payments, but we expect our participants to if, in the Fee-For-Service world, if that modality wouldn't be covered in your area then we expect you to still follow those, and then we will be monitoring for that.

Leonela Torres: Okay. Thank you.

Operator: Your next feedback comes from the line of Amy Lawhead.

Amy Lawhead: Just a couple quick questions and one comment. First the question related to the GYN Oncologists putting in the tandems et cetera, and I think online on slide 8 under the also excluded where it says surgical services supporting brachytherapy placement, I think those would fall in there, but you might want to just check, but that's just kind of a statement. And then second, of all for those of us who are out here who are also in the OCM model, and of course nobody's in the advanced side of that at this point in time, but if we are selected and we're in this and now we're in Advance Payment Model, does that kind of – does that overlay over the OCM, because our radiation physicians are part of the OCM? Does that make sense?

Marcie O'Reilly: We discussed that in the overlap section in the rule, but again, for the APM incentive, it's based on the RO model payment by those radiation therapists who are on the individual practitioner list. So, your medical oncologist would not be on that list and their services – their medical oncology services would not be calculated into the APM incentives. Does that make sense? Or is that how...

Amy Lawhead: I think it relates back to another question that I heard related to the 5% bonus being in advance – being in advanced, yet we're getting the 5% taken off here because the radiation oncologists are in the OCM model, and we could be advanced over there. We do get that 5% bonus for the oncology services – Radiation



Oncology services, but in this model then we would be penalized at 5%. I think that's what he was talking about as well.

Marcie O'Reilly: Can you submit that comment and that scenario specifically so we can make sure that, as someone asked, that we ledge out our overlap policies and the final rule. This would be good feedback.

****Correction: The above paragraph should read:**

Marcie O'Reilly: Can you submit that comment and that scenario specifically so we can make sure that, as someone asked, that we flesh out our overlap policies and the final rule. This would be good feedback.

Amy Lawhead: Absolutely. Thank you.

Operator: Your next feedback comes from the line of Chip Richter.

Chip Richter: Hi. Chip Richter. Just a little further clarification on the comment just a moment ago on GYN surgical services from the earlier contributor. In the example of breast IORT where the single fraction of radiotherapy is administered concurrent with a lumpectomy, will the hospital be able to bill a lumpectomy separate from the G-codes for the RO payment?

Marcie O'Reilly: Yes.

Chip Richter: Thank you.

Operator: Your next feedback comes from the line of Ashish Patel.

Ashish Patel: Hi. For radium treatment specifically, those are included in the model and that treatment episode is longer than 90-day duration, so how does that work for the episodic payment?

Marcie O'Reilly: You're saying that the treatment for that particular scenario is generally, the course of treatment is longer than 90 days?

Ashish Patel: Yes.

Marcie O'Reilly: I need to look into that one.

Ashish Patel: Okay.

Operator: Your next feedback comes from the line of Brian Vamston.

Brian Vamston: Hello. Good afternoon. Thank you. Brian Vamston with Allina Health System. I have a question regarding the risk criteria for this model. The Advanced Alternative Payment Models under the Quality Payment Program have parameters that set the amount of risk that qualifies. Please correct me if I'm wrong, but the interpretation I have been reading this is that there is no sort of downside cap, so essentially all the



responsibility of the payment if it exceeds the allowed amount will be born responsible by the provider, so essentially there is no percentage or whatever cap on the risk on the downside. Is that correct, and could you clarify if it's not?

Marcie O'Reilly: You interpreted that correctly.

Brian Vamston: Okay. Thank you. I guess that's the one area of concern regarding that cap on risk.

Marcie O'Reilly: Okay. Well I would submit your comment with ideas on how to rectify that.

Brian Vamston: Absolutely. Thank you.

Operator: Your next feedback comes from the line of K.D. Lanning.

K.D. Lanning: Hi. Can you hear me?

Nicole Cooney: Yes, we can. Maybe, speak up a little.

K.D. Lanning: All right. Thank you. My comment is really regarding the professional side of billing, so, often our physicians are providing services in the hospitals and the hospitals own the EMR systems, and so we are concerned that we may face some roadblocks obtaining the clinical data that we need to report the Quality Measures and the new clinical data that's going to be paid for reporting, and so we really – and we will include comment or make comment on this, but just wondered if there had been any thought into how the hospitals might be incentivized to help us acquire this data, because I believe that the Quality Measures are only going to be for professional or dual participants, and that the hospitals won't have to report that same data, correct?

Marcie O'Reilly: You are correct, and that would be a very good comment to submit that type of scenario for us to address the final rule.

Joanna Pahl: Thank you.

Operator: Your next feedback comes from the line Valerie Rinkle.

Valerie Rinkle: Yes. I'm following up on the prior question because in page 78 of the rule is where you published table 1 and crosswalked ICD-9 and ICD-10 diagnoses codes to the different cancer types, and my earlier question was that there are certain diagnosis codes indicative of metastasized cancers that are not on this table and so was that intentional since those patients typically do not receive Radiation Therapy?

Marcie O'Reilly: Can you give me an example of one of these ICD-10 codes? I'm feeling a little like at the mercy of you telling me they're not on there but I'm not sure which ones you're referring to.

Valerie Rinkle: Like a metastasized cancer in a different side of the body. I don't have the codes off the top of my head but let's just say that there was a metastasized cancer in the GI area. I mean, actually, it's the groin area.



Marcie O'Reilly: We do include the codes for secondary [metastases] disease as in – so they are in there. So if...

Marcie O'Reilly: ... go ahead.

Valerie Rinkle: No, you go ahead.

Marcie O'Reilly: Well I mean I'm just – I'm not a 100% sure I understand the question but so I was – if you could send a scenario...? Go ahead.

Valerie Rinkle: I heard you say to another caller that said if there are cancer diagnoses that are not on the table, they would continue to be paid Fee-For-Service, so but with metastasized cancer, you typically put the primary cancer whether it's stable or not, whether it's in remission or not, and then you have the secondary diagnoses. That's the coding rule.

Marcie O'Reilly: Right.

Valerie Rinkle: So, I'm kind of confused.

Marcie O'Reilly: I'm kind of confused too. But in general you have, I know all the codes for bone mets are there and all the codes for brain mets are there, if it's secondary malignancy of the liver, it will – it falls in the table under liver but that may not be their primary, but then that's where the other person as well maybe something else is primary and the secondary is liver. You had to choose which of the categories...

Valerie Rinkle: So, what about the secondary malignant neoplasm of respiratory and digestive organs that's not on there? C78.XX for example. I'm not a coder by training. So, I have to have my coders help me.

Marcie O'Reilly: Okay. Well I encourage you – I'm trying to look at the list and I'm trying to answer, did you say C78?

Valerie Rinkle: Yes.

Marcie O'Reilly: Okay. I encourage you to – if you find that there any codes that you think are mysteriously missing or you're wondering why they're not there, I would submit that.

Valerie Rinkle: Okay, and then a follow-up. I heard you say that it's a professional group that is starting the episode that they know because the only Radiation Therapy delivery location is an excluded location like the Pennsylvania location or one of the hospital types that are excluded, they still have to start the episode even though it's always going to be incomplete, is that what you stated?

Marcie O'Reilly: No, we would say that that could happen. That again would be if you know that the tactical, the delivery service, is not going to be provided by a purchase within or within 28 days of that treatment planning service that the professional did, that will be one of the scenarios we'll cover in the billing on what kind of modifier or condition code will be put on the claim to say this patient will not qualify for this model because half of the treatment is not being provided in the model, and I apologize if I said that wrong earlier.

Valerie Rinkle: And then also...

Joanna Pahl: Sorry, we need to move on to the next caller, please. Thank you.

Operator: As a reminder, if you would like to provide feedback, press star followed by the number one on your touchtone phone. Your next feedback comes from the line of Wendy Smith.

Wendy Smith: Hi. Wendy Smith again with Health Policy Solutions. I have a couple of questions about the historical adjustment. Are you there?

Marcie O'Reilly: Yes, we're listening.

Wendy Smith: Okay. Sorry. So, I have a couple of questions about the adjustment – regarding the historical adjustment, let's say that a practice currently uses hypofractionation. Will the efficiency factor that factors into historical adjustment lead to decreased payment, because the practice is already considered efficient?

Marcie O'Reilly: Actually, people who are historically efficient will actually probably make more money under this model.

Wendy Smith: Okay, and then a follow-up question. Are the case-mix adjustment and the historical adjustment both cancer-site-specific?

Marcie O'Reilly: One for each. Or do you mean...

Marcie O'Reilly: ... So, there's a – there's a case-mix adjustment for both the technical component and the professional components, so could be different for your particular practice. Is that what you're asking?

Wendy Smith: No, I'm asking if the case-mix adjustment looks like it's cancer-site-specific, but is the historical adjustment also cancer-site-specific?

Marcie O'Reilly: They're not – none of them are cancer-site-specific. It's in the aggregates.

Wendy Smith: Okay. Thank you.

Operator: Your next feedback comes from the line of James Goodwin. James, your line is open. There is no response from that line.

Operator: Your next feedback comes from the line of Angela Thompson.

Angela Thompson: So, our question is if a patient is planned, and a particular ZIP code, and then we send them back to a satellite clinic to get treatment, how is that going to be billed through Medicare with the new rule?

Marcie O'Reilly: So, you're saying the satellite would not to be in the model or they might be in the model?



Angela Thompson: Let's say they are not in the model.

Marcie O'Reilly: That's just one of those some more scenarios where that you would recognize that the beneficiary would not qualify to be in the model because of that and we would have – we'll be telling you through the billing webinars how to code the claim, so you can get paid Fee-For-Service for that patient.

Angela Thompson: Now we have another scenario where we have an inpatient who – a patient that gets admitted for vaginal brachy procedures to see a P&O or Si-add they are hospitalized for 3 days and then they come to our unit, day #1 is done in the OR but day #2 and #3 are done in clinic where we're inserting the P&O on day #2 and #3 in the outpatient setting, but they're still inpatient. How does that get billed when you have two separate providers? You've got the Gyn/Onc surgeon who places it on day #1, and then you have the Rad/Onc provider who puts it in day #2 and #3, so it's a little bit trickier.

Marcie O'Reilly: Right, and I'm not a radiation oncologist, so I don't want to answer that question -you know-definitively, but there are probably scenarios where there would be an opportunity for those to be paid Fee-For-Service.

Angela Thompson: But what happens to the patient who passes away during their treatment?

Marcie O'Reilly: Death is included in our case-mix adjustments. So if a patient dies during treatment, they get the full first and second payment, and this is what brought my brain back to that you do not have to wait the 90 days, so the claim system will not prevent you from – for that other question that came in – prevent you from submitting your claim early, but if any treatment - further treatment is tried to be billed Fee-For-Service during that 90 days, even though you already got your second half of your payment, you would get a remittance advice that says this was already covered under a model payment or a bundled payment.

Angela Thompson: Okay. Perfect. Thank you.

Marcie O'Reilly: So that's the same for hospice, so I think we explained that in hospice, if they move into hospice during the course of treatment, they will get both payments, but they just can't be in hospice when they start the treatment.

Angela Thompson: Okay. Thank you.

Operator: Your next feedback comes from the line of Karen Laff. Karen, your line is open. There's no response from that line.

Operator: Your next feedback comes from the line of Daniel Petereit.

Daniel Petereit: Hi. Daniel Petereit, Radiation Oncologists in Rapid City South Dakota and also President of the American Brachytherapy Society. More of a comment. Will probably just put this in for the comments section. It has to do with patients who require both external beam radiation and brachytherapy. One scenario was prostate cancer, and this proven benefit for subset of those patients, and then for cervical cancer patients and to start even brought up a little bit. It's absolutely indicated in as brachytherapists were concerned that



brachytherapy kind of falling off the chart on this, and so it could be detrimental to patients having access to these critical services when appropriate.

Marcie O'Reilly: Yes, please put in that comment, but the brachytherapy for those cases where the patient only gets brachytherapy, and you remember the diagnosis categories are covered for that patient that's getting brachy just brachytherapy, that dollar amount includes if a patient had other therapies that might be more expensive. So, I think you have to take and think about that.

Daniel Petereit: Yes. I mean, that's the concern, since our patients require both external beam and brachytherapy. Then the other scenarios that's not uncommon for brachytherapist, is the external beam radiation is done in the community or a smaller facility and the brachytherapy is referred to a higher volume service or higher volume center. That's also needed to be taken into consideration as well, or we hope it would be?

Marcie O'Reilly: I think in that scenario, again that was one of you – one of the providers would get the RO model payment and the other would be paid billing Fee-For-Service.

Daniel Petereit: Okay. And not to be repetitive, but again, this is the scenario where patients requiring both external beam and brachy, I know it's probably going to finally to get brachytherapy alone, but okay. Thank you.

Nicole Cooney: Dorothy, we'll take our final question.

Operator: Your final feedback comes from the line of Deb Moore.

Deb Moore: Thank you. I was just curious as to how certain you are for the January 1, I know you also have April on there, but I think we would all prefer April, so we could be ready. Can you comment on that?

Marcie O'Reilly: I can comment that please make sure you include your comments for the start date that you prefer.

Deb Moore: One other question if I might. Can a facility apply for a – if they're selected, can they apply for delay based on extenuating circumstances?

Marcie O'Reilly: We have no provisions in the rule right now for that. I would submit that as a comment as something that we might want to consider.

Deb Moore: Thank you.

Additional Information

Nicole Cooney: Okay. Thank you everyone for your questions today. An audio recording and transcript will be available in about two weeks at go.cms.gov/npc. Again, that is go.cms.gov/npc. Again, my name's Nicole Cooney and I'm here with my colleague, Joanna Pahl and we'd like to thank all of our presenters, and also

thank all of you for participating in today's Medicare Learning Network Listening Session. Have a great day, everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect. Presenters, please hold.