CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2256	**Date: February 15, 2019**
	Change Request 11177

SUBJECT: Continued Analysis Calls for Prospective Bundled Payments for Radiation Oncology (RO) Model

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to continue conference calls to complete the development of final business requirements for timely implementation of the prospective bundled payment for Radiation Therapy (RT) services provided to Medicare beneficiaries with specific cancer diagnoses and provided by participants in the RO Model.

EFFECTIVE DATE: July 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: February 20, 2019 for BR 4; July 1, 2019

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

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I. GENERAL INFORMATION

A. Background: This Change Request (CR) will allow for the continuation of discussions and development of business requirements for the implementation of the Prospective Bundled Payments for Radiation Onocology (RO) Model.

B. Policy: CMS is proposing to make bundled payments for all included Radiation Therapy (RT) services, instead of using Medicare Fee-for-Service (FFS) payments for services provided in the randomly selected Core-Based Statistical Areas (CBSA) to beneficiaries who have both Medicare Part A and B, and for whom traditional FFS Medicare coverage is their primary insurance during the RO Model episode. CMS is proposing an episode as the 90-day period of time initiated on the date of service when the initial treatment planning service is furnished and subsequent billing of a professional RO Model-specific Healthcare Common Procedure Coding System (HCPCS) code with a start of episode modifier. The RO Model would make prospective lump sum payments using the existing CMS claims processing systems to participants. These payments would cover all RT services needed within the 90-day period; participants would be expected to report no-pay claims for services provided during the episode.

CMS is proposing to pay the full participant-specific professional and technical episode payment amounts in two installments. We would pay the first half of the payment for the Professional Component (PC) of the episode when a participant furnishes the PC of the episode and bills one of the new RO Model-specific HCPCS codes and modifiers developed specifically for the RO Model. We would pay the second half of the payment for the PC of the episode at the end of the episode (generally, but not exclusively, 89 days after the date when treatment planning occurs) when the same model-specific HCPCS code is billed with a modifier indicating that the episode has ended. These PC episode payments would be made through the Medicare Physician Fee Schedule (MPFS) and would only be paid to radiation oncologists (as identified by their National Provider Identifiers (NPIs) and their respective Tax Identification Numbers (TINs)). We would use the new RO Model-specific HCPCS code (and modifiers, as appropriate) for the PC of each of the 17 cancer types that we propose for inclusion in the model.

Professional participants would be required to bill a new RO Model-specific HCPCS code with the V1 modifier for the PC once the treatment planning service is furnished and when the RO Model beneficiary, in consultation with his or her radiation oncologist, determines to move forward with a course of RT. We developed a new HCPCS code for the PC of each of the 17 cancer types that CMS is proposing for inclusion in the model. The two payments for the PC of the episode would cover all professional services of the radiation treatment for the episode. CMS will pay the second half of the payment for the PC of the episode at the end of the episode when the same RO Model-specific HCPCS code is billed with the V2 modifier indicating that the episode has ended. Payment for the PC would be made through the MPFS.

CMS will pay the first half of the payment for the Technical Component (TC) of the episode when a participant has agreed to furnish the TC of the episode bills a new RO Model-specific HCPCS code and modifier. CMS will pay the second half of the payment for the TC of the episode at the end of the episode when the same RO Model-specific HCPCS code is billed with the V2 modifier indicating that the episode has ended. Similar to the PC, we developed a new HCPCS code (and modifiers, as appropriate) for the TC

of each of the 17 cancer types that CMS is proposing for inclusion in the model. Payment for the TC would be made through either the MPFS or Outpatient Prospective Payment System (OPPS), as both freestanding radiation therapy centers and Hospital Outpatient Departments (HOPDs) would participate in the RO Model and furnish the TC.

The TC of the episode would not be paid until the PC of the episode has been initiated. This requires the radiation oncologist that furnishes the PC of the episode to indicate to the technical participant that the PC of the episode has been initiated. The TC of the episode would begin on or after the date that the PC of the episode is initiated and would last until the PC of the episode concludes. Accordingly, the TC of the episode may be up to 90 days long but could be shorter due to the time between planning (professional initiation) and when treatment begins (technical initiation). For both the PC and TC end-of-episode claims, participants would include information on all RT services furnished during the episode.

Following the 90-day episode period, participants would be eligible to bill RT services as fee-for-service for the same beneficiary for 28 days before a new episode can be triggered. Following the 28-day clean period, participants would be eligible to initiate another episode for the same beneficiary if clinically appropriate. We would monitor use of services outside of the 90-day episode.

If a beneficiary dies or enters hospice after both PC and TC of the episodes have been initiated, the provider gets full payment even if the beneficiary does not finish treatment. In these scenarios, to prevent Coordination of Benefits (COB) issues, the end of episode date must be prior to or on the date of death or the day before electing the hospice benefit. In these cases, model claims can be submitted prior to the calculated end of episode.

If a claim is submitted with a RO Model-specific HCPCS code for a site of service that is located within one of the randomly selected CBSAs as identified by zip code, but the CMS Certification Number (CCN) or TIN is not on the participant list, the claim should be paid using the rate assigned to that RO Model-specific HCPCS code (without Payment Model Adjustments (PMA)).

CMS shall provide further billing instructions to participants through sub regulatory channels of communication, including the Medicare Learning Network (MLN Matters) publications and model-specific webinars.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
11177.1	Contractors shall participate in eight one-hour conference calls to finalize the business requirements for the Prospective Bundled Payments for Radiology (RO) Model Implementation CR.	X	X			X	X		X	STC, VDC
11177.2	Contractors shall review updated draft business requirements as the conference calls progress, and submit language for updated business requirements, as well as outstanding comments and questions, as needed.					X	X		X	

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
11177.3	Contractors should not submit minutes for the calls to ECHIMP.	X	X			X	X		X	STC, VDC
11177.4	Contractors shall submit email contacts for call participants to Marcie.Oreilly@cms.hhs.gov within 5 days of issuance of the CR.	X	X			X	X		X	STC, VDC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Marcie OReilly, 410-786-9764 or Marcie.OReilly@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0