Radiation Oncology (RO) Model: Coding, Billing, and Pricing Methodology Webinar

Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services

Medicare Program; Specialty Care Models to Improve Quality of Care and Reduce Expenditures Final Rule, and Calendar Year 2022 Outpatient Prospective Payment System/Ambulatory Surgical Center Payment System Notice of Proposed Rulemaking (CMS-1753-P)

Date: August 24, 2021

Time: 2:30–4:00 p.m. ET

Disclaimer

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

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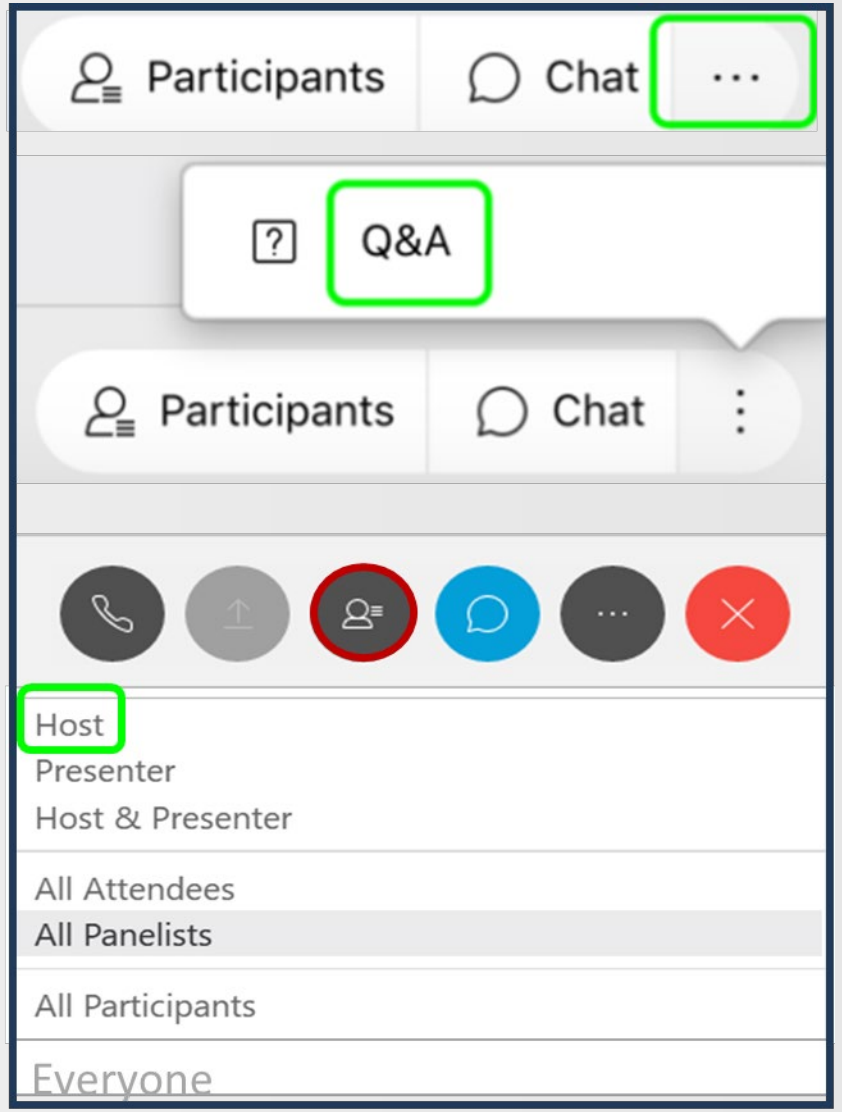
Note

This webinar is designed for staff at participating hospital outpatient departments, physician group practices, and freestanding radiation therapy centers who are supporting their organization in registration and participation in the RO Model.

Webinar Logistics: WebEx

- All lines are muted upon entry
- To ask a question during Q&A, use the Q&A feature to type a question to speakers
- To note technical issues, use the Chat feature and chat the Host
- Closed captioning is available for today's event
- A recording and slides will be available on the RO Model website within a few days at https://innovation.cms.gov/innovation-models/radiation-oncology-model
- Slides, a recording, and a transcript will also be posted to RO Connect (search term "Coding, Billing, Pricing")
- A post-event survey will pop-up at the end of today's event



Agenda

2:30–2:35 p.m. ET	Welcome	Jessica McNab (Mathematica)
2:35–2:40 p.m. ET	Coding, Billing, and Pricing Methodology Overview	Marcie O'Reilly (CMMI)
2:40–3:35 p.m. ET	Coding and Billing Process	Marcie O'Reilly (CMMI)
3:35–3:40 p.m. ET	Pricing Methodology	Marcie O'Reilly (CMMI)
3:40–3:45 p.m. ET	Duplicate Services, Incomplete Episodes, and Reconciliation	Marcie O'Reilly (CMMI)
3:45–3:55 p.m. ET	Q&A	Marcie O'Reilly (CMMI)
3:55–4:00 p.m. ET	Wrap-Up	Jessica McNab (Mathematica)

Learning System Activities and Resources

Timing	Topics
July	RO Model 101 Refresher and Portal Overview webinar and Portal Overview resource
	Quality Measure and Clinical Data Element Collection and Submission Guide and clinical data elements templates ("data collection materials")
	Technical Files
	Frequently Asked Questions (FAQs)
August 24	Coding, Billing, and Pricing Methodology webinar
August 31 *new date*	Coding, Billing, and Pricing Methodology office hours
September	RO Model Requirements webinar
	Implementation Guide
	Index of Resources
	FAQs
October	Clinical and Quality Reporting Requirements webinar
	Clinical and Quality Reporting Requirements office hours
November	Evidence-Based Protocols webinar
December	QPP, APM, MIPS webinar

Note: Timing and topics are subject to change based on ongoing trends of RO participant needs

Speakers

Marcie O'Reilly

Team Lead, RO Model, CMS Innovation Center, CMS

Ms. O'Reilly joined CMMI in 2014. She has spent the last 4+ years designing the proposed Radiation Oncology (RO) Model. She is currently leading the rulemaking and implementation teams for the RO Model. Prior to the RO Model, Marcie participated in the design of the Home Health Value-Based Purchasing Model (HHVBP) and then led the implementation of HHVBP with required participation in nine states. Before that, she was on the design and implementation teams for the Medicare Care Choices Model. She came to CMMI with 25 years of healthcare provider experience. Marcie has a Bachelor of Science in Nursing from the University of Maryland. She started her nursing career at the University of Maryland Cancer Center.

Jessica McNab

Task Lead, RO Model Learning System, Mathematica

Ms. McNab is the task lead for the RO Model Learning System. She supports RO Model implementation and optimization by developing shared learning opportunities for RO participants. Before the launch of the RO Model, Ms. McNab provided task leadership for the learning systems for ACOs Phase 2 Next Generation Model, as well as for the Maternal and Infant Health Task of Core Set. Before joining Mathematica, she worked as a quality manager at an integrated delivery system, Spectrum Health.

Coding, Billing, and Pricing Methodology Overview

RO Model Billing Requirements

- RO participants must submit claims under the existing Medicare claims systems in accordance with the RO Model billing instructions as described in the Final Rule, Medicare Program; Specialty Care Models to Improve Quality of Care and Reduce Expenditures (42 CFR Part 512 - § 512.260)
- In addition to submitting claims in accordance with the RO Model guidance for purposes of episode payment, RO participants will submit RO Model encounter data (“no-pay” claims) for all radiotherapy (RT) services furnished during the episode for purposes of reconciliation, monitoring, and evaluation

Reminder

A link to the Final Rule can be found on the RO Model website:

https://innovation.cms.gov/innovation-models/radiation-oncology-model

Included Cancer Types and Modalities

CMS is removing liver cancer from the included cancer types and proposing to remove brachytherapy from the included modalities*

Included cancer types

1. Anal cancer
2. Bladder cancer
3. Bone metastases
4. Brain metastases
5. Breast cancer
6. Cervical cancer
7. CNS tumors
8. Colorectal cancer
9. Head and neck cancer
10. Lung cancer
11. Lymphoma
12. Pancreatic cancer
13. Prostate cancer
14. Upper GI cancer
15. Uterine cancer

Included modalities*

1. 3-dimensional conformal RT
2. Intensity-modulated RT
3. Stereotactic radio surgery
4. Stereotactic body RT
5. Proton beam therapy
6. Image-guided RT

*See proposal in the CY 2022 OPPS/ASC Payment System NPRM.

Included and Excluded Services

Included services

Treatment planning

- Determining treatment modality, parts of the body that must be radiated, and plan for RT (e.g., RT Planning)

Technical preparation and special services

- Technical preparation to confirm radiation dosing is accurate, machine is prepared, and treatment aids are constructed (e.g., RT Aids)

Treatment delivery

- Radiation delivered to patient in one or more sessions (e.g., RT Delivery)

Treatment management

- Patient monitoring and treatment adjusted according to outcomes (e.g., RT Management x 5 Treatments)

Excluded services (to be billed FFS)*

- Initial consultation (typically billed using E&M service)
- Experimental and low volume treatments (neutron beam, hyperthermia)
- General imaging not related to radiation prep
- RT furnished in any setting other than a HOPD or freestanding RT center
- Radiopharmaceuticals
- Intra-operative RT
- Brachytherapy services*

*See proposal in the CY 2022 OPPS/ASC Payment System NPRM.

Episode Length

- If an RO beneficiary is not treated with RT from an RO participant within 28 days of initial treatment planning service, then the requirements for triggering an episode will not be met, and the incomplete episode policy takes effect
- The 28 days after an episode has ended is the “clean period” during which time an RO participant will bill RT services furnished to an RO beneficiary in accordance with Medicare fee-for-service rules
- If clinically appropriate, an RO participant may initiate another episode for the same RO beneficiary after the 28-day clean period has ended

RO Model Prospective Payment

Prospective payments furnished for certain RT services furnished during a 90-day episode of care for 1 of 15 included cancer types

Payments cover included RT services furnished during an episode

Episode payments are split into two components:

- Professional component
- Technical component

Episode payments are made in two installments:

- 50% at the start of the episode
- 50% at the end of the episode (no sooner than day 28 of the episode)

Episode Payments Based on RO Model-Specific HCPCS Codes

Participant-specific professional episode payment

A payment made by CMS to a **Professional participant** or **Dual participant** for the provision of the Professional component of RT services to an RO beneficiary during an episode

Participant-specific technical episode payment

A payment made by CMS to a **Technical participant** or **Dual participant** for the provision of the Technical component of RT services to an RO beneficiary during an episode

RO Model-Specific HCPCS Codes and National Base Rates (Excerpt)

RO Model-Specific Placeholder Codes	Professional or Technical	Included Cancer Type	National Base Rate
M1076	Professional	Bone Metastases	$1,446.41
M1077	Technical	Bone Metastases	$6,194.22
M1078	Professional	Brain Metastases	$1,651.56
M1079	Technical	Brain Metastases	$9,879.40
M1080	Professional	Breast Cancer	$2,059.59
M1081	Technical	Breast Cancer	$10,001.84
M1094	Professional	Lung Cancer	$2,231.40
M1095	Technical	Lung Cancer	$12,142.39

Coding and Billing Process

Billing Process Overview

1. RT supplier and RT provider determines RO Model eligibility and RO participant type
2. RO participant determines whether a patient is an eligible beneficiary
3. RO participant submits billing claims for RO beneficiaries

Step 1. Determining RO Participant Eligibility

RO Participant Must	
• **Be one of the following types of RT provider or RT supplier**: ✓ **HOPD** (as identified by CCN) ✓ **PGP** (as identified by TIN) ✓ **Freestanding RT Center** (as identified by TIN) • **Furnish RT services in a ZIP Code** located in a CBSA randomly selected for inclusion in the RO Model	• **NOT** be a hospital participating in the PA Rural Health Model* • **NOT** be a hospital participating in the Community Transformation track of the CHART Model* • **NOT** be furnishing RT services solely in MD, VT, or U.S. Territories • **NOT** be any of the following: ✓ Ambulatory Surgical Centers ✓ Critical Access Hospitals ✓ PPS-exempt cancer hospitals

*See proposal in the CY 2022 OPPS/ASC Payment System NPRM.

Low Volume Opt-Out

- Entities that would otherwise be required to participate in the RO Model may opt out for a given performance year if they have <20 episodes or RO episodes (depending on the performance year) across all CBSAs selected for participation in the most recent year with claims data available (2 years prior to the applicable performance year)
  - A new Tax Identification Number or CMS Certification Number that results from a merger, acquisition, or other business relationship is not eligible for the low volume opt-out if the entities involved have furnished 20 or more episodes of RT services as a combined total across all CBSAs selected for participation in the most recent year with claims data available*

*See proposal in the CY 2022 OPPS/ASC Payment System NPRM.

Step 2. Determining Beneficiary Eligibility

An RO beneficiary…

- Receives RT services for at least 1 of 15 included cancer types
- Has traditional Medicare fee-for-service as the primary payer
- Is eligible for Medicare Part A and enrolled in Medicare Part B
- Is NOT enrolled in a Medicare health plan or Program of All-Inclusive Care for the Elderly plan
- Is NOT exercising the Medicare hospice benefit
- Is NOT covered under United Mine Workers at the time of the episode
- Is NOT deceased prior to the start of the episode

Note:

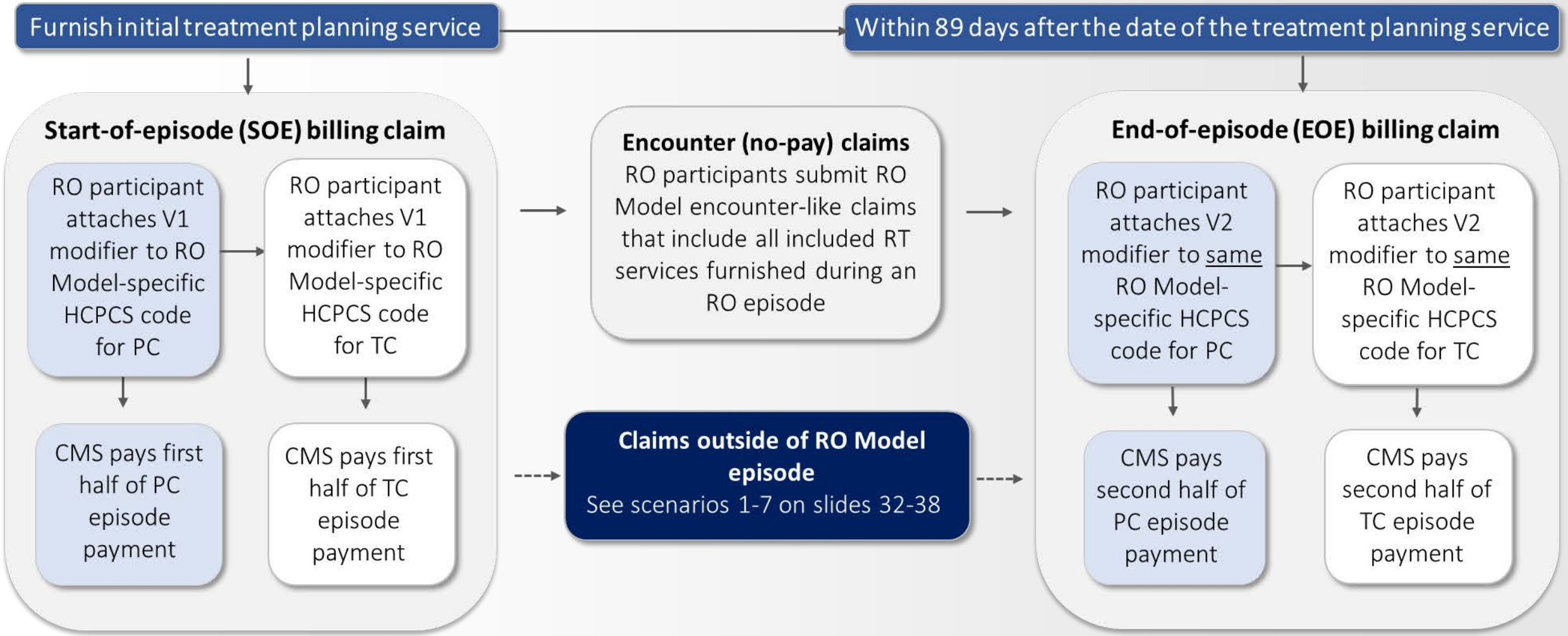
- Part D coverage is not a requirement for beneficiary eligibility
- Beneficiaries enrolled in a clinical trial for RT services (except Proton Beam Therapy) for which Medicare pays routine costs would also be included in the RO Model, if the above also apply

Step 3. Billing Components and Claims

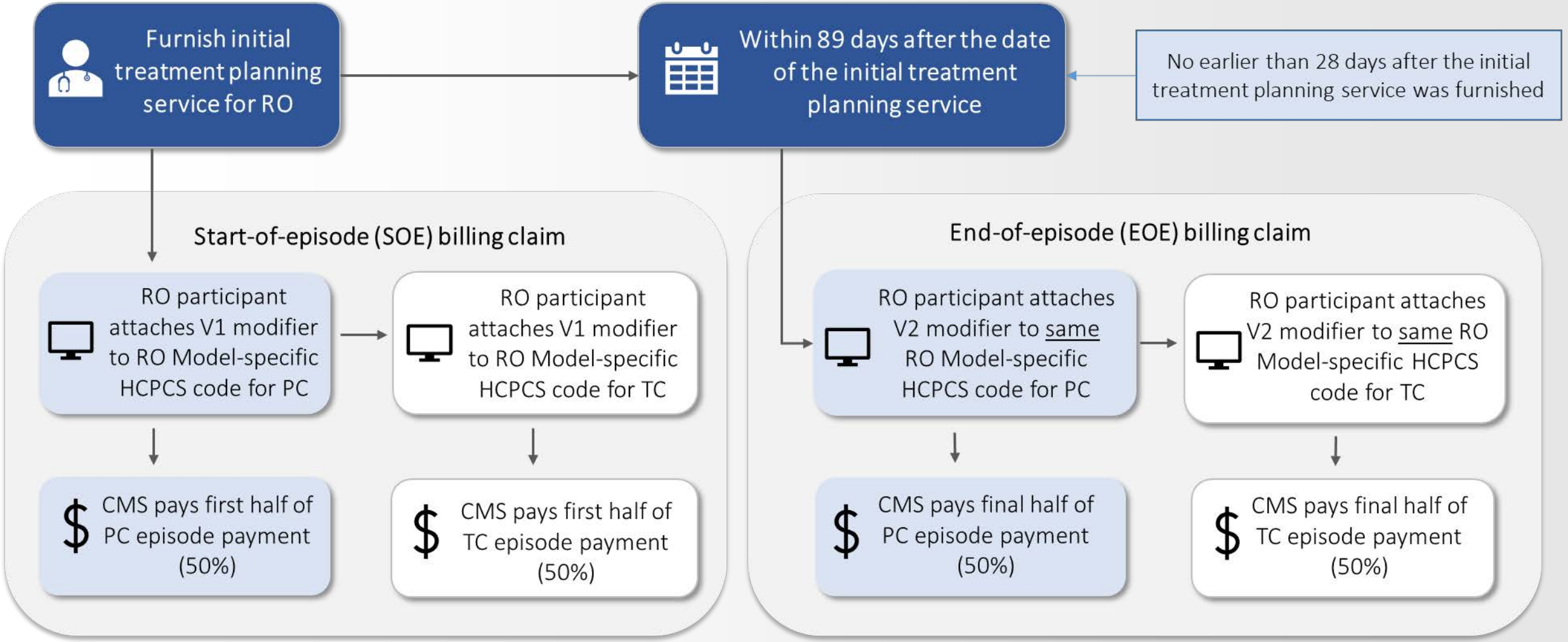
RO participants will need to submit claims for the Professional and/or Technical components of care using the appropriate claim submission form.

RO participant type	Component		Appropriate claim submission form			
	Professional	Technical	CMS-1500	837P	CMS-1450 (UB-04)	837I
 Dual participant	✓	✓	✓	✓		
 Professional participant	✓		✓	✓		
 Technical participant		✓			✓	✓

Billing Process Overview



RO Model Episode Billing Timeline



Billing Process: Professional Component Services

1. **Professional participants and Dual participants are required to bill an RO Model-specific HCPCS code and a modifier** indicating the start of an episode (SOE modifier) for the PC once the treatment planning service is furnished.
2. **CMS pays the first half of the payment for the PC of the episode to the Professional participant or Dual participant** upon submission of a claim with an RO Model-specific HCPCS code and SOE modifier (V1).
3. **The Professional participant provides the Technical participant** with a signed and dated radiotherapy prescription and the final treatment plan. This will inform the Technical participant of when the episode began and allow it to determine the date for end-of-episode (EOE).
4. **When the RO episode is complete, the Professional participant or Dual participant** bills the same RO Model-specific HCPCS code that initiated the episode, this time with an EOE modifier (V2).
5. **The EOE claim can be submitted and paid as early as day 28 of the 90-day episode** if the Professional participant is certain the treatment plan is complete.
6. **CMS pays 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 is made through the MPFS.

Professional Component: Start-of-Episode Billing

RT provider or RT supplier:

- ✓ Is eligible to participate in the RO Model
- ✓ Determined it is a Professional participant or Dual participant

Beneficiary:

- ✓ Is eligible for the RO Model
- ✓ SOE begins within RO Model performance period (01/01/22 – 10/03/26)*

File claim with RO Model-specific HCPCS code (labeled "Professional") and **V1 (SOE) modifier**

Actions that must be completed

- Verify provider/supplier is eligible
- Verify beneficiary is eligible
- Enter a Date of Service between 01/01/22 and 10/03/26
- **Use RO Model-Specific HCPCS code**
- Include a RO Model approved ICD-10 code on the claim
- **Enter a V1 Modifier**
- Bill SOE RO Model-Specific PC HCPCS code with modifier V1 **only one time** every 118-day period from the SOE for the same beneficiary
- Verify RO Model-Specific HCPCS code does not have a charge less than fee amount

Claims that do not follow these actions will trigger a Return to Provider with an error message from the Medicare Administrative Contractor

*See proposal in the CY 2022 OPPS/ASC Payment System NPRM.

Professional Component: End-of-Episode Billing

Confirm that beneficiary is eligible for the RO Model at the end of service

File claim with the **same** RO-specific PC HCPCS code and **V2 (EOE) modifier**

<u>Actions that must be completed</u>

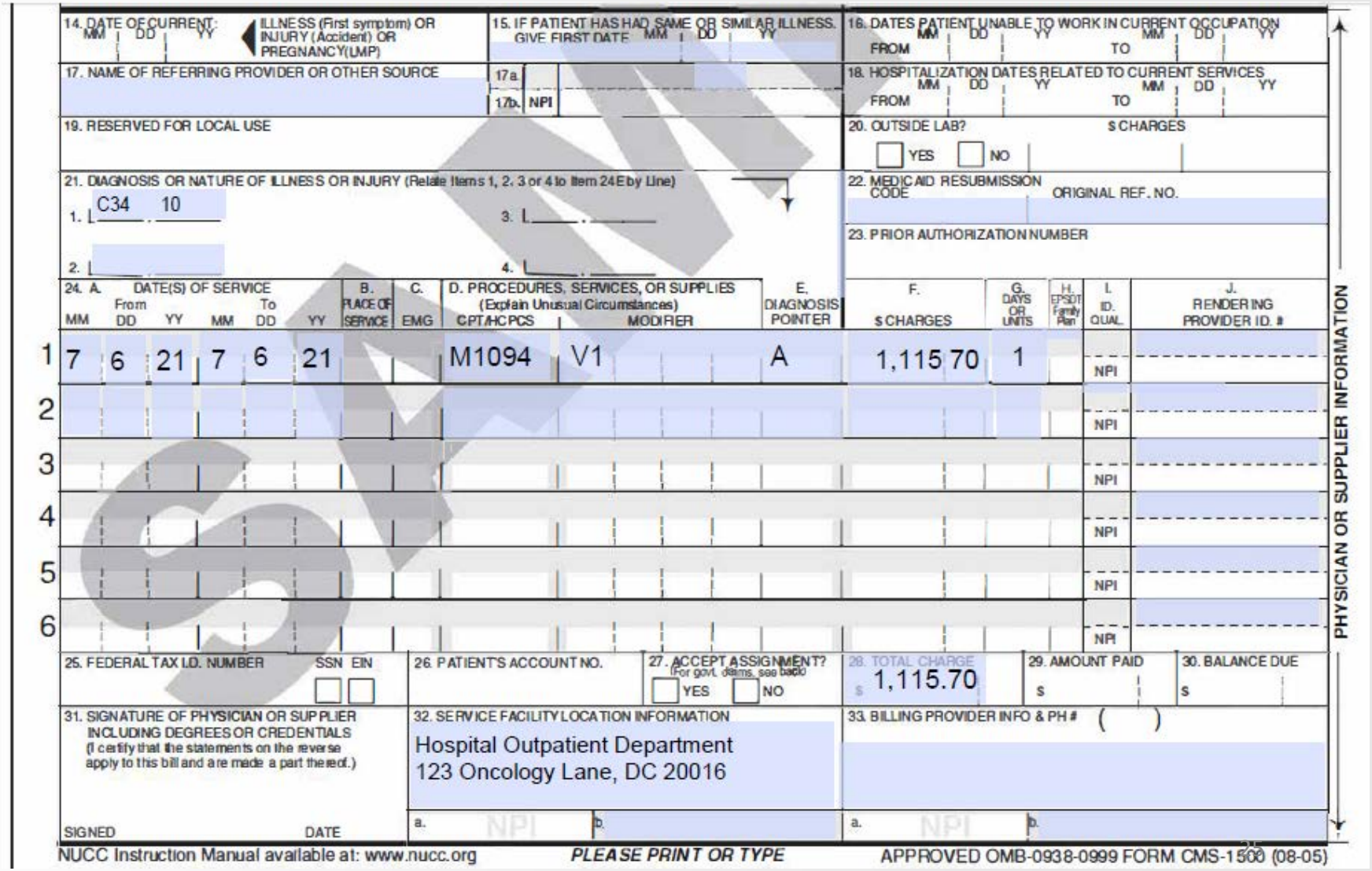
- The Date of Service for the same RO Model-specific HCPCS code, with an EOE V2 modifier, should be **equal to day 28 through 90** of the RO episode
- Enter a **V2 EOE modifier** for the same RO Model-specific HCPCS code used at SOE
- Verify RO Model-Specific HCPCS code does not have a charge less than the fee amount

Claims that do not follow these actions will trigger a Return to Provider with an error message from the Medicare Administrative Contractor

Professional Component: Example Claim from a PGP that is a Professional Participant

Field Locators to Note:

FL 21: ICD-10 Diagnosis Code
FL 24A: Date(s) of Service
FL 24D: HCPCS Code & Modifier
FL 24E: Diagnosis pointer
FL 24F: Charges
FL 24G: Days or Units
FL 28: Total Charge
FL 32: Service Facility Location Information



Billing Process: Technical Component Services

1. **Technical participants or Dual participants that furnish the TC of an episode must bill** an RO Model-specific HCPCS code with a SOE modifier (V1).
2. **The PC will provide the Technical participant with a signed and dated radiation prescription and the final treatment plan** to inform the Technical participant of when the episode began and allow it to determine the date for the EOE. The submission and payment of TC claims is not dependent on the submission of PC claims. If the TC claim with the SOE modifier (V1) is received first, the claims system will estimate the first day of the episode.
3. **CMS pays the first half of the payment for the TC of the episode** when the Technical participant or Dual participant furnishes the TC of the episode and bills for it using an RO Model-specific HCPCs code with a SOE modifier (V1).
4. **When the RO episode is complete, the Technical participant or Dual participant** bills the same RO Model-specific HCPCS code that initiated the episode, this time with an EOE modifier (V2).
5. **The EOE claim can be submitted and paid as early as day 28 of the 90-day episode** if the RO participant is certain that the treatment plan is complete.
6. **CMS pays 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. Payment for the TC is made through the MPFS or OPPS.

Technical Component: Start-of-Episode Billing

RT provider or RT supplier:

- ✓ Is eligible to participate in the RO Model
- ✓ Determined it is a Technical participant or Dual participant

Beneficiary:

- ✓ Is eligible for the RO Model
- ✓ Started an episode with a Professional participant

File claim with RO Model-specific HCPCS code (labeled "Technical") and **V1 (SOE) modifier**

Actions that must be completed

- Enter a Date of Service between 01/01/22 and 10/03/26*
- File claim with one RO Model-specific TC HCPCS code and V1 SOE modifier
- Use only one Technical V1 RO Model-specific HCPCS line per claim
- For claims paid thru MPFS, verify RO Model-Specific HCPCS code does not have a charge less than the fee amount
- For claims paid thru OPPS, a token charge can be applied to the RO Model-specific HCPCS code

Claims that do not follow these actions will trigger a Return to Provider with an error message from the Medicare Administrative Contractor

*See proposal in the CY 2022 OPPS/ASC Payment System NPRM.

Technical Component: End-of-Episode Billing

Confirm that Beneficiary is eligible for the RO Model at the end of service

File claim with the **same** RO-specific TC HCPCS code and **V2 (EOE) modifier**

Actions that must be completed

- Enter Technical RO Model-specific HCPCS and EOE modifier V2
- Use only one Technical V2 RO Model-specific HCPCS code line per claim
- For claims paid thru MPFS, verify RO Model-Specific HCPCS code does not have a charge less than the fee amount
- For claims paid thru OPPS, a token charge can be applied to the RO Model-specific HCPCS code

Claims that do not follow these actions will trigger a Return to Provider with an error message from the Medicare Administrative Contractor

Technical Component: Example Claim for a HOPD that is a Technical Participant

Form sections to note:

FL1: Service Facility Location Information

FL 4: Type of Bill

FL 6: Statement Period

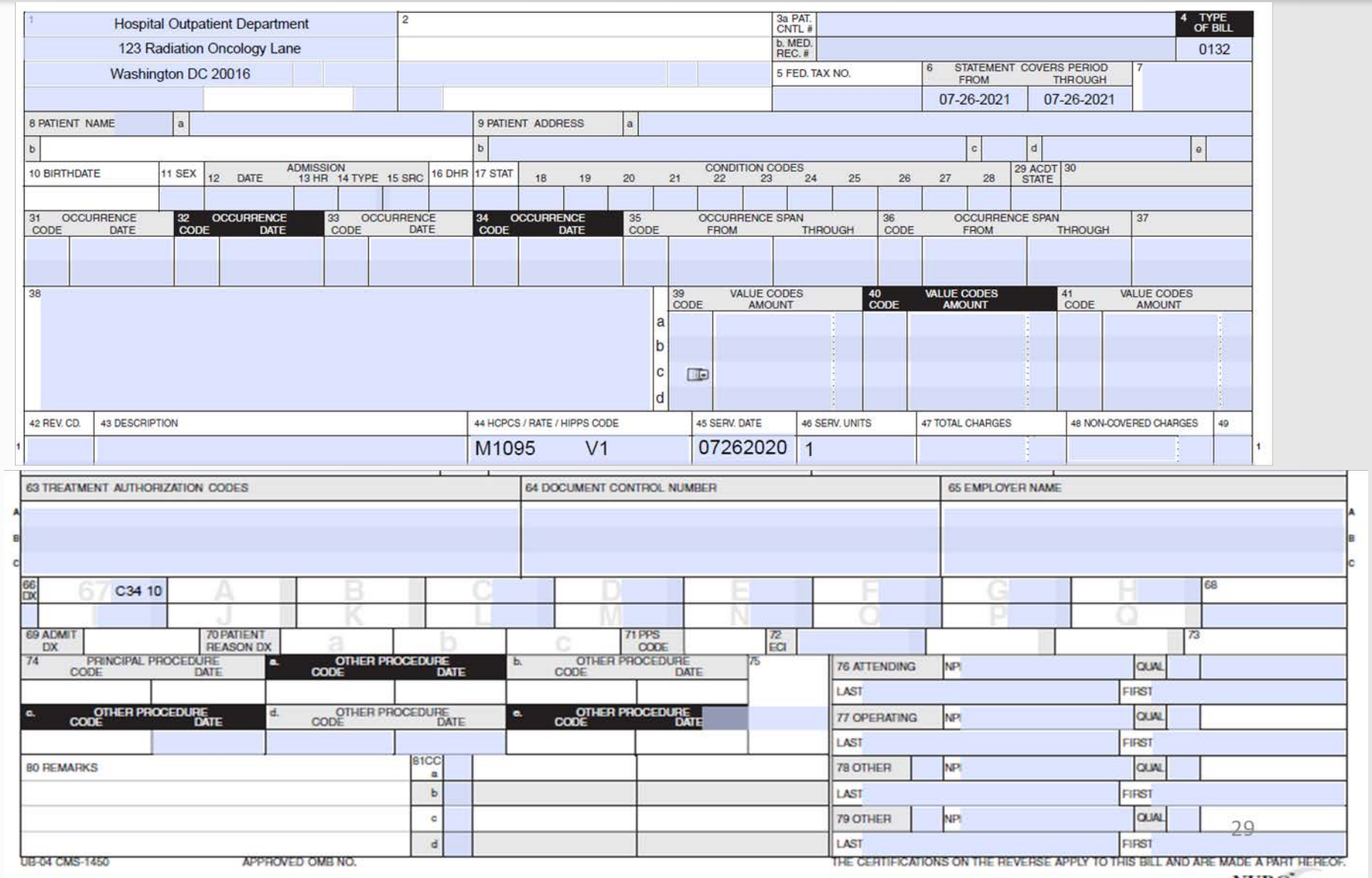
FL 44: HCPCS Code & Modifier

FL 45: Service Date

FL 46: Service Units

FL 47: Total Charges

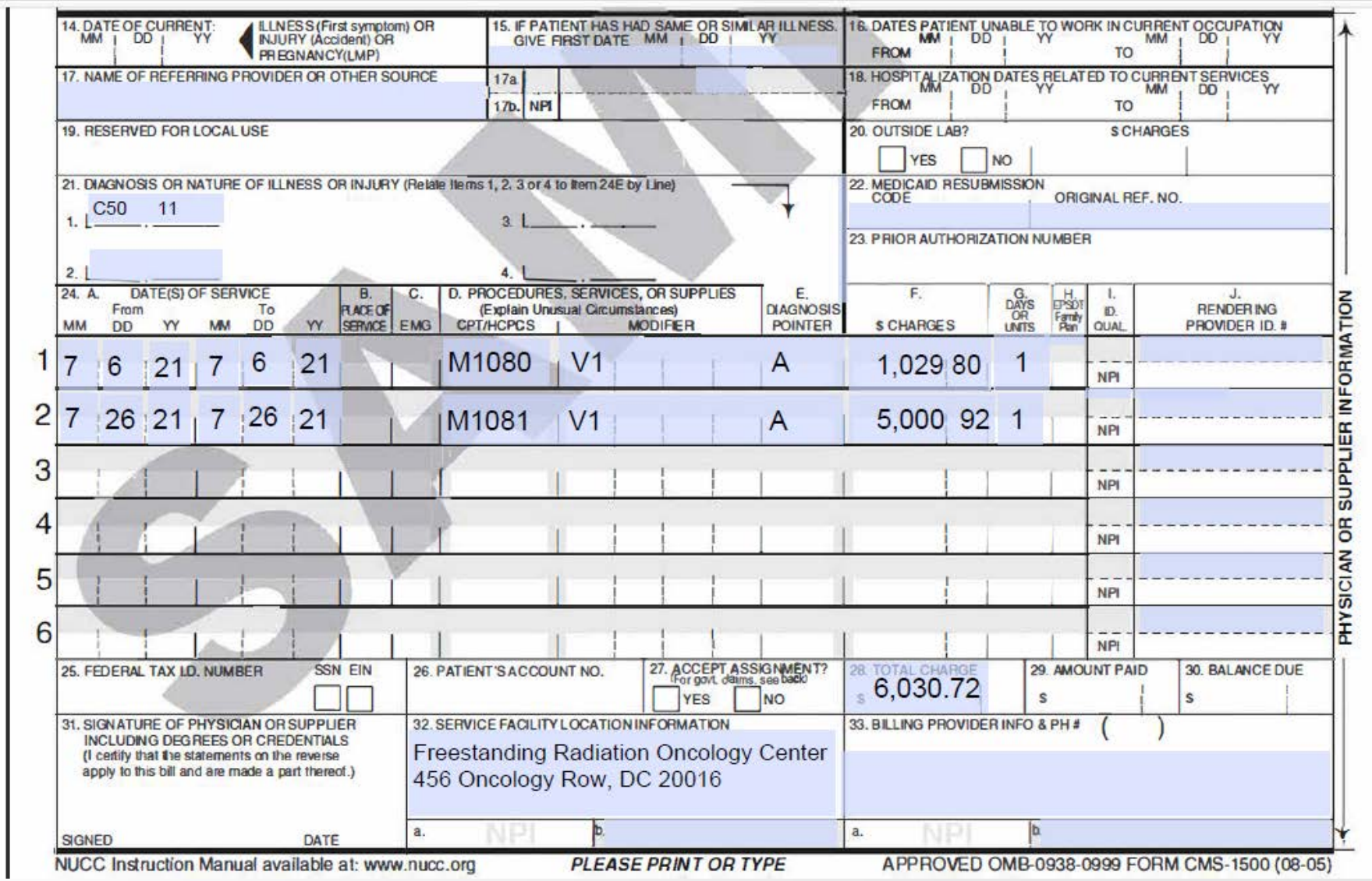
FL 67: ICD-10 Diagnosis Code



Professional and Technical Components: Example Claim for a Freestanding Radiation Therapy Center

Field Locators to Note:

FL 21: ICD-10 Diagnosis Code
FL 24A: Date(s) of Service
FL 24D: HCPCS Code & Modifier
FL 24E: Diagnosis pointer
FL 24F: Charges
FL 24G: Days or Units
FL 28: Total Charge
FL 32: Service Facility Location Information



14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. C50 11
2.
3.
4.
22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	7	6	21	7	6	21			M1080	V1	A	1,029 80	1		NPI	
2	7	26	21	7	26	21			M1081	V1	A	5,000 92	1		NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $ 6,030.72
29. AMOUNT PAID $
30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
Freestanding Radiation Oncology Center
456 Oncology Row, DC 20016
a. NPI b.
33. BILLING PROVIDER INFO & PH # ( )
a. NPI b.
PHYSICIAN OR SUPPLIER INFORMATION
NUCC Instruction Manual available at: www.nucc.org
PLEASE PRINT OR TYPE
APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

In Cases of Hospice and/or Death, Skilled Nursing Facility Stay

- An RO episode is included in, and paid for under, the RO Model if the RO beneficiary dies after the Technical component of an RO episode has been initiated, or if the RO beneficiary elects the Medicare hospice benefit after the initial treatment planning service, provided that the Technical component is initiated within 28 days following the initial treatment planning service
- Each RO participant will receive both installments of the episode payment under such circumstances, regardless of whether the RO beneficiary dies or elects the Medicare hospice benefit before the relevant course of RT treatment has ended
- RO beneficiaries in a skilled nursing facility will be eligible to receive included RT services without those services being subject to consolidated billing rules

Situations Requiring Fee-for-Service Billing with Modifier (1)

RO participants may experience the following situations:

1. An included RT service is furnished to a single RO beneficiary by an eligible RT provider or eligible RT supplier (or both) that did not initiate the PC or TC for that RO beneficiary
2. A patient ages into Medicare during their current treatment plan
3. Treatment is being furnished for a non-included cancer type and patient has a history of an included cancer type
4. Patients receiving PBT through a clinical trial
5. RO participant is furnishing services in conjunction with an excluded RT provider or RT supplier
6. RO participants who have opted out of the RO Model (3 scenarios)
7. Professional and Dual participants furnishing included RT services for an excluded modality (e.g., Brachytherapy*, IORT)

In these scenarios, the eligible RT provider or RT supplier will bill FFS using the appropriate code:

- **B1 condition code or GB modifier** for institutional claims for included RT services
- **GB modifier** for physician claims for included RT services

*See proposal in the CY 2022 OPPS/ASC Payment System NPRM.

Situations Requiring Fee-for-Service Billing with Modifier (2)

Situation 1: An included RT service is furnished to a single RO beneficiary by an eligible RT provider or eligible RT supplier (or both) that did not initiate the Professional component or Technical component for that RO beneficiary within the 90-day RO episode

- Physician group practice or freestanding radiation therapy center –> Bill fee-for-service, using the HCPCS code for the included RT service(s) and the **GB modifier**
- Hospital outpatient department –> Bill fee-for-service, using the HCPCS code for the included RT service(s) and the **B1 condition code**

Situation 2: A patient ages into Medicare during their current treatment plan

- Physician group practice or freestanding radiation therapy center –> Bill fee-for-service, using the HCPCS code for the included RT service(s) and the **GB modifier**
- Hospital outpatient department –> Bill fee-for-service, using the HCPCS code for the included RT service(s) and the **B1 condition code**

Situations Requiring Fee-for-Service Billing with Modifier (3)

Situation 3: Included RT services furnished for a non-included cancer type and the patient has a history of an included cancer type (ICD-10 codes for both are on the claim)

- Physician group practice or freestanding radiation therapy center –> Bill fee-for-service, using the HCPCS code(s) for the included RT service(s) and the **GB modifier**
- Hospital outpatient department –> Bill fee-for-service, using the HCPCS code(s) for the included RT service(s) and the **B1 condition code**

Situation 4: An RO participant is furnishing included RT services to a patient receiving proton beam therapy through a clinical trial

- Physician group practice or freestanding radiation therapy center –> Bill fee-for-service, using the HCPCS code(s) for the included RT service(s) and the **GB modifier**
- Hospital outpatient department –> Bill fee-for-service, using the HCPCS code(s) for the included RT service(s) and the **B1 condition code**
- Follow all other Medicare billing guidelines to indicate that the beneficiary is participating in a clinical trial

Situations Requiring Fee-for-Service Billing with Modifier (4)

Situation 5: A Professional participant is furnishing services in conjunction with an excluded RT provider or RT supplier (examples: PPS-exempt hospital; service locations in Maryland or Vermont; PA Rural Health Model participant)

- Physician group practice or freestanding radiation therapy center –> Bill fee-for-service, using the HCPCS code(s) for the included RT service(s) furnished in an excluded service location and the **GB modifier**

Situations Requiring Fee-for-Service Billing with Modifier (5)

Situation 6a: A Dual participant furnishing included RT services is eligible for the low volume opt-out and has chosen to opt out of the RO Model

- Freestanding radiation therapy center –> Bill fee-for-service (FFS), using the HCPCS code for the included RT service(s) and the **GB modifier**

Situation 6b: An RO participant furnishing the Professional component or Technical component of RT services has not opted out of the RO Model, but the entity furnishing the corresponding component for all RO episodes has chosen to opt out.

- PGP or freestanding radiation therapy center that has not opted out of the RO Model –> Bill FFS, using the HCPCS code(s) for the included RT service(s) and the **GB modifier**
- HOPD that has not opted out of the RO Model –> Bill FFS, using the HCPCS code for the included RT service and the **B1 condition code or GB modifier**

Situation 6c: An RO participant furnishing the Professional component or Technical component of RT services has not opted out of the RO Model, but an entity furnishing the corresponding component has chosen to opt out of the RO Model and another affiliated entity furnishing the other component has not opted out of the RO Model.

- RO participants would bill FFS for included RT services in partnership with an entity that chose to opt out
- RO participants would bill RO Model-specific HCPCS for RO episodes in partnership with other RO participants

Using B1 Condition Code vs. GB Modifier on HOPD Claims

An RO Model participant has a patient that has two cancer types, brain metastases (included in the RO Model) and liver cancer (not included in the RO Model)

Scenario 1

- The RO participant is treating the liver cancer, a cancer type not included in the Model, with an included RT service
- The included RT service should be paid fee-for-service instead of through the episode payment
- The **B1 Condition Code** should be used when all included RT services furnished on a given claim should be paid fee-for-service
  - For example, when included RT services are furnished for a non-included cancer type and the patient has a history of an included cancer type, as indicated by the list of ICD-10 codes included on the claim

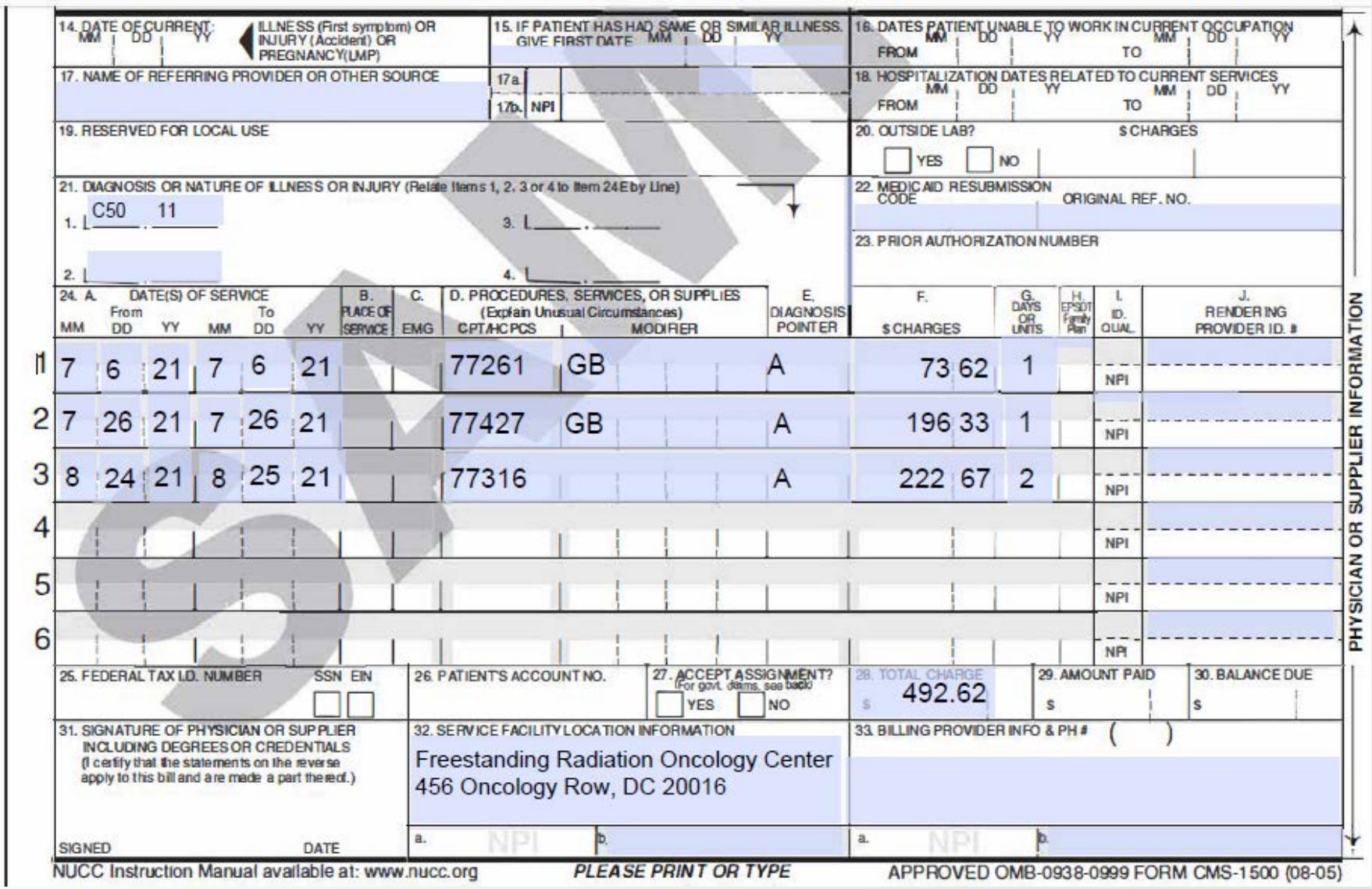
Scenario 2

- The RO participant is treating both the liver cancer and the brain metastases with included RT services
- The **GB modifier** should be used when some included RT services on a claim should be paid fee-for-service
  - For example, when treatment is being furnished for an included cancer type and a non-included cancer type during the same 90-day episode
  - In this case the included RT services for the non-included cancer type would need to include the GB modifier

Professional or Dual Participant Billing Professional Component for an Excluded Modality (e.g., Brachytherapy)

Field Locators to Note:

FL 21: ICD-10 Diagnosis Code
FL 24A: Date(s) of Service
FL 24D: HCPCS Code & Modifier
FL 24E: Diagnosis pointer
FL 24F: Charges
FL 24G: Days or Units
FL 28: Total Charge
FL 32: Service Facility Location Information



14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. C50 11
2.
3.
4.
22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	7	6	21	7	6	21			77261	GB	A	73 62	1		NPI	
2	7	26	21	7	26	21			77427	GB	A	196 33	1		NPI	
3	8	24	21	8	25	21			77316		A	222 67	2		NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $ 492.62
29. AMOUNT PAID $
30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
Freestanding Radiation Oncology Center
456 Oncology Row, DC 20016
a. NPI b.
33. BILLING PROVIDER INFO & PH # ( )
a. NPI b.
PHYSICIAN OR SUPPLIER INFORMATION
NUCC Instruction Manual available at: www.nucc.org
PLEASE PRINT OR TYPE
APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Encounter-Like (No-Pay) Claims

- In addition to the start-of-episode and end-of-episode claims, all RO participants must submit RO Model encounter data on no-pay claims for all included RT services identified on the RO Model Packaged/Bundled HCPCS Codes list within a given 90-day episode
- The encounter data will be used for annual reconciliation of incomplete episodes and duplicate RT services, the RO Model evaluation and monitoring (such as understanding how the utilization of RT services changes over time),, and other CMS research
- These claims can be submitted by RO participants once a start-of-episode claim has been adjudicated, using their typical coding and billing schedules and processes for Medicare services

Professional Component Billing Errors

.	Error	Error Messages	
Start-of-Episode	Provider ineligible to participate in RO Model	CARC: 5 CARC: 16	RARC: M77 RARC: MA114
	Patient is ineligible to participate in RO Model	CARC: 16	RARC: M76
	Date of Service later/greater than 10/03/26	CARC: 4 (*RO participants will be paid FFS after this date*)	
	HCPCS codes not specific to the RO Model	CARC: 16	RARC: M20
	HCPCS codes not specific to the RO Model and without an RO Model approved ICD-10 in a diagnosis position	CARC: 16	RARC: M76
	Claim not paired with a V1 SOE modifier	CARC: 4	
	RO participant billed SOE RO Model-specific PC HCPCS codes with modifier V1 more than one time per every 118-day period from the SOE	CARC: 97 MSN: 16.29	RARC: M86
	Date of Service charge less than the fee amount	CARC: 16	RARC: M76
	GB modifier used on a claim that includes the RO Model-specific HCPCS code	CARC: 16	RARC: M20
End-of-Episode	Claim does NOT have an RO Model-specific HCPCS with a SOE V1 modifier in paid history with a Date of Service 28 to 100 days prior to the Date of Service of the RO Model-specific HCPCS with the EOE modifier	CARC: 234	RARC: N83
	Claim is not paired with a V2 SOE modifier with RTP error message	CARC: 4	
	Claim has a Date of Service charge less than the fee amount	CARC: 16	RARC: M76

Technical Component Billing Errors

	Error	Error Messages	
Start-of-Episode	Claim has a Date of Service later/greater than 10/03/26	CARC: 4	
	Claim is not paired with one Facility/Technical RO Model-specific HCPCS code and a V1 SOE modifier	CARC: 4	
	Claim uses more than one Facility/Technical RO Model-specific HCPCS line per claim	CARC: 16	RARC: N519
	Claim includes a B1 Condition Code	CARC: 16	RARC: MA114
	GB modifier used on a claim that includes the RO Model-specific HCPCS code	CARC: 16	RARC: M20
End-of-Episode	Claim is not paired with Facility/Technical RO Model-specific HCPCS and EOE V2 modifier	CARC: 4	
	Claim does not include the same RO Model-specific HCPCS with a SOE V1 modifier in paid history with a Date of Service 80 to 100 days prior to the Date of Service of the RO Model-specific HCPCS with the EOE modifier	CARC: 234	RARC: N83
	Claim uses more than one Facility/Technical RO Model-specific HCPCS line per claim	CARC: 16	RARC: N519

Pricing Methodology

Reminder

The RO Model Payment Calculator Workbook can be found on the RO Model website: https://innovation.cms.gov/media/document/ro-model-cms-pricing-workbook

Pricing Process Overview

Site-neutral 90-day episode payments for RT, followed by a 28-day clean period

National base rate

- Establishes national base rates using three-year baseline period*
- Calculates amounts by included cancer type for both PC and TC

Trend factor

- Accounts for volume and payment trends outside of the RO Model under OPPS and MPFS
- Uses recent claims data to calculate the volume of RT services and corresponding payment rates of nonparticipants (HOPDs and freestanding RT centers)

Adjustments

- **Case mix:** Addresses differences in RO participants' beneficiary populations (e.g., sex and age)
- **Historical experience:** Addresses differences in RO participants' historical care patterns

PY1 Blend: 90% of PY1 episode payment determined by what RO participant received historically under FFS

Claims processing

- Apply participant-specific adjustment, discounts, and withholds
- Apply geographic adjustment, sequestration and beneficiary cost-sharing

50% of bundle paid at the start of an episode, 50% paid at the end of treatment (no sooner than day 28 of episode)

*See proposal in the CY 2022 OPPS/ASC Payment System NPRM.

The Blend – Historical Payment and the National Base Rate

Historically Inefficient

- If the RO participant's historical payments for RT services were higher than the national average, the blend in performance year 1 will be 90% of the RO participant's historical payments and 10% of the national base rate

PY1	PY2	PY3	PY4	PY5
90/10	85/15	80/20	75/25	70/30

Historically Efficient

- If the RO participant's historical payments for RT services were lower than the national average, the blend for the model performance period is fixed at 90% of the RO participant's historical payments and 10% of the national base rate

PY1	PY2	PY3	PY4	PY5
90/10	90/10	90/10	90/10	90/10

Discounts and Withholds

Discounts and Withholds	Professional Component	Technical Component
Discount Rate*	3.5%	4.5%
Incorrect Payment Withhold	1%	1%
Quality Withhold*	2%	n.a.
Patient Experience Withhold	n.a.	1% (beginning in PY3)

*See proposal in the CY 2022 OPPS/ASC Payment System NPRM.

Application of Discounts, Withholds, and RO Participant-Specific Adjustments

Two scenarios for applying discounts, withholds, and RO participant-specific adjustments:

- An entity has previously been identified as an RO participant:
  - National base rate x (Combination of discounts, withholds, adjustments, and blend) -> Geographic adjustment, sequestration, and beneficiary cost-sharing

- An entity has not previously been identified as an RO participant:
  - National base rate x (Combination of just discounts and withholds) -> Geographic adjustment, sequestration, and beneficiary cost-sharing

- RO participant list updated quarterly in the claims systems
  - New RO participants will receive adjustments to their payments once they have sufficient historical data
  - In addition, RO participants with < 60 episodes in the last 3 years of data will not receive a case mix adjustment or historical experience adjustment

Duplicate RT Services, Incomplete Episodes, and Reconciliation

Duplicate RT Services and Incomplete Episodes

Incomplete episodes or duplicate RT services can result in RO participants either being owed money or owing money to CMS because of overpayments

Duplicate RT service
Any included RT service furnished to a single RO beneficiary by an RT provider or RT supplier that: 1. Is not excluded from participating in the RO Model, and did not initiate the PC or TC of the episode -or- 2. Is not operating in an included CBSA, but otherwise not excluded from the RO Model

Incomplete episode
1. TC is not initiated within 28 days following PC 2. RO beneficiary stops meeting any of the eligibility criteria or triggers any of the exclusion criteria before the TC of an episode initiates 3. Traditional Medicare stops being an RO beneficiary's primary payer before all included RT services in the RO episode have been furnished 4. RO beneficiary switches RT provider or RT supplier before all RT services in the RO episode have been furnished

Annual Reconciliation

- Professional participants and Dual participants will have their incorrect episode payment amount added to their quality reconciliation amount
  - The quality reconciliation amount is determined by multiplying the participant's Aggregate Quality Score against the quality withhold. This process will apply to Technical participants starting in performance year 3.
- The initial annual reconciliation could occur as early as August the year following a performance year
- Each RO participant receives a reconciliation report that indicates the reconciliation payment amount they are due or the repayment amount owed to CMS
- RO participants have 45 days to submit a timely error notice to CMS if they believe there is an error in the reconciliation calculation

Stop-Loss Limit

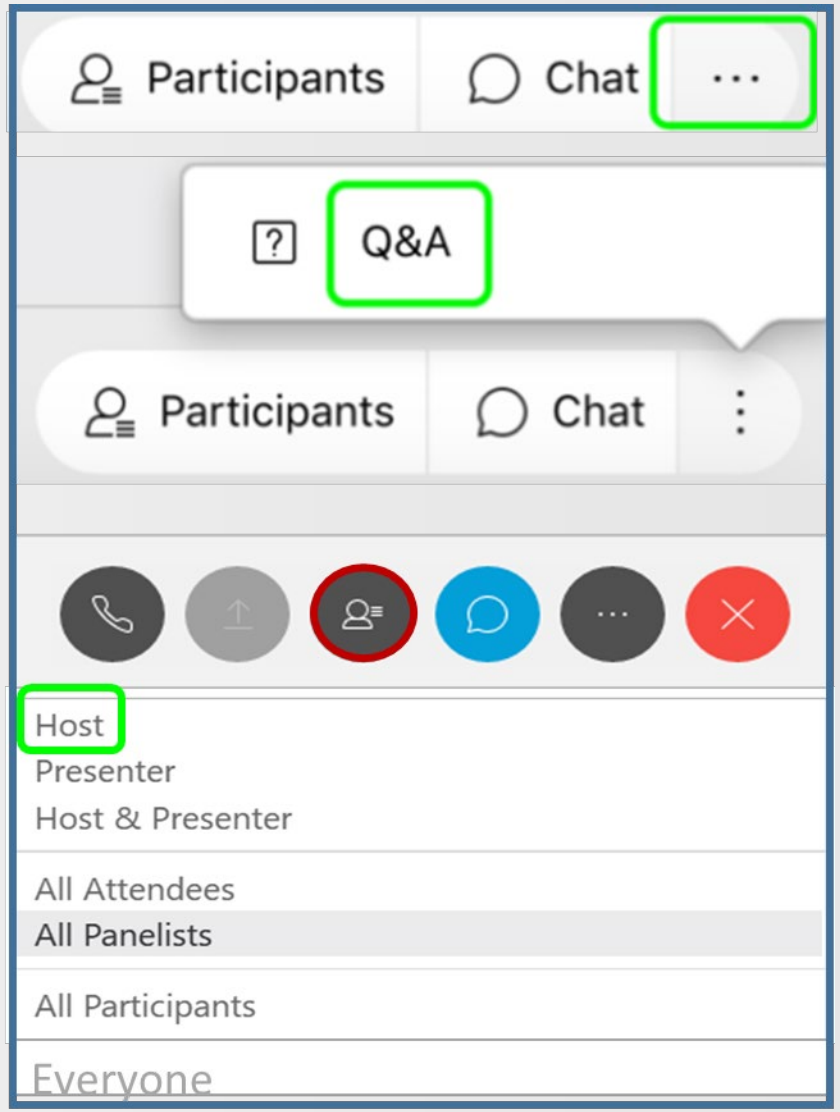
- As proposed in the NPRM, the stop-loss reconciliation amount is the amount owed to RO participants for the loss incurred under the RO Model, who:
  - Have < 60 episodes during the baseline period
  - Were furnishing included RT services before the start of the RO Model performance period in CBSAs selected for participation*
- Under this stop-loss limit, CMS would use no-pay claims to determine what these RO participants would have been paid under fee-for-service compared with the payments they received under the RO Model, and pay these RO participants retrospectively for losses in excess of 20% of what they would have been paid under fee-for-service
- Payments under the stop-loss policy would be determined at the time of reconciliation

*See proposal in the CY 2022 OPPS/ASC Payment System NPRM.

Q&A

Reminder: How to Submit a Question

- All lines are muted
- To ask a question, use the Q&A feature to type a question to speakers
- To note technical issues, use the Chat feature and chat the Host



Wrap-Up and Next Steps

RO Model Resources

RO Model Website:

https://innovation.cms.gov/innovation-models/radiation-oncology-model

- RO Model Portal Overview and portal manuals
- FAQs
- RO Model Payment Calculator Workbook
- RO Model Episode File (2017-2019) and Data Dictionary
- HCPCS_CD Chemotherapy Code File
- NCD Chemotherapy Codes File
- Major Procedures File
- Case Mix Regression Model File
- RO Model-Specific HCPCS Codes-August 2021
- Included Cancer ICD-10 Codes-August 2021
- Included RT Services (HCPCS Codes)-August 2021

RO Connect:

https://app.innovation.cms.gov/CMMIConnect/s/login/

All of these materials, and more!

Wrap-Up

Please complete the evaluation as you exit the event. Feedback helps us improve future activity and resources.

Thank You!

RO Model Help Desk

Please direct questions about the RO Model or upcoming events to the RO Model Help Desk:

- RadiationTherapy@cms.hhs.gov
- 1-844-711-2664, Option 5

Next Up: Coding, Billing, & Pricing Methodology office hours on August 31, from 3:00-4:00 PM ET

Appendix: Acronyms

Acronym	Definition
APM	Alternative Payment Model
3DCRT	3-Dimensional Conformal Radiotherapy
AQS	Aggregate Quality Score
ASC	Ambulatory Surgery Centers
CAH	Critical Access Hospitals
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CARC	Claims Adjustment Reason Code
CBSA	Core-Based Statistical Area
CCN	CMS Certification Number
CDE	Clinical Data Element
CHART	Community Health Access and Rural Transformation
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CNS	Central Nervous System
E&M	Evaluation and Management
EOE	end-of-episode
FAQs	Frequently Asked Questions
FFS	Fee-For-Service
HCPCS	Healthcare Common Procedure Coding System
HOPD	Hospital Outpatient Department
IGRT	Image-Guided Radiotherapy
IMRT	Intensity-Modulated Radiotherapy
MAC	Medicare Administrative Coordinator

Acronym	Definition
MIPS	Merit-Based Incentive Payment System
MPFS	Medicare Physician Fee Schedule
MSN	Medicare Summary Notice
NPRM	Notice of Proposed Rule-Making
OPPS	Outpatient Prospective Payment System
PACE	Program of All-Inclusive Care for the Elderly
PBT	Proton Beam Therapy
PC	Professional component
PCHs	PPS-Exempt Cancer Hospitals
PGP	Physician Group Practice
PPS	Prospective Payment System
PSO	Patient Safety Organization
PY	Performance Year
QPP	Quality Payment Program
RARC	Remittance Advice Remark Codes
RO	Radiation Oncology
RT	Radiotherapy
RTP	Return to Provider
SBRT	Stereotactic Body Radiotherapy
SOE	start-of-episode
SRS	Stereotactic Radio Surgery
TC	Technical component
TIN	Taxpayer Identification Number

Appendix: RO Model-Specific Placeholder Codes*

RO Model-Specific Placeholder Codes	Professional or Technical	Included Cancer Type
M1072	Professional	Anal Cancer
M1073	Technical	Anal Cancer
M1074	Professional	Bladder Cancer
M1075	Technical	Bladder Cancer
M1076	Professional	Bone Metastases
M1077	Technical	Bone Metastases
M1078	Professional	Brain Metastases
M1079	Technical	Brain Metastases
M1080	Professional	Breast Cancer
M1081	Technical	Breast Cancer
M1084	Professional	Cervical Cancer
M1085	Technical	Cervical Cancer
M1082	Professional	CNS Tumor
M1083	Technical	CNS Tumor
M1086	Professional	Colorectal Cancer
M1087	Technical	Colorectal Cancer

RO Model-Specific Placeholder Codes	Professional or Technical	Included Cancer Type
M1088	Professional	Head and Neck Cancer
M1089	Technical	Head and Neck Cancer
M1094	Professional	Lung Cancer
M1095	Technical	Lung Cancer
M1096	Professional	Lymphoma
M1097	Technical	Lymphoma
M1098	Professional	Pancreatic Cancer
M1099	Technical	Pancreatic Cancer
M1100	Professional	Prostate Cancer
M1101	Technical	Prostate Cancer
M1102	Professional	Upper GI Cancer
M1103	Technical	Upper GI Cancer
M1104	Professional	Uterine Cancer
M1105	Technical	Uterine Cancer

*See proposal in the CY 2022 OPPS/ASC Payment System NPRM.

Appendix: RO Model Bundled Healthcare Common Procedure Coding System Codes (1)*

HCPCS Code	HCPCS Description	Category
77014	Computed tomography guidance for placement of	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77021	Magnetic resonance guidance for needle placement	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77261	Radiation therapy planning	Treatment Planning
77262	Radiation therapy planning	Treatment Planning
77263	Radiation therapy planning	Treatment Planning
77280	Set radiation therapy field	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77285	Set radiation therapy field	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77290	Set radiation therapy field	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77293	Respirator motion mgmt simul	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77295	3-d radiotherapy plan	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77299	Radiation therapy planning	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77300	Radiation therapy dose plan	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77301	Radiotherapy dose plan imrt	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77306	Telethx isodose plan simple	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77307	Telethx isodose plan cplx	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77321	Special teletx port plan	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77331	Special radiation dosimetry	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77332	Radiation treatment aid(s)	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77333	Radiation treatment aid(s)	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77334	Radiation treatment aid(s)	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77336	Radiation physics consult	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services

*See proposal in the CY 2022 OPPS/ASC Payment System NPRM.

Appendix: RO Model Bundled Healthcare Common Procedure Coding System Codes (2)*

HCPCS Code	HCPCS Description	Category
77338	Design mlc device for imrt	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77370	Radiation physics consult	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77371	Srs multisource	Radiation Treatment Delivery
77372	Srs linear based	Radiation Treatment Delivery
77373	Sbrt delivery	Radiation Treatment Delivery
77385	Ntsty modul rad tx dlvr smpl	Radiation Treatment Delivery
77386	Ntsty modul rad tx dlvr cplx	Radiation Treatment Delivery
77399	External radiation dosimetry	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77402	Radiation treatment delivery	Radiation Treatment Delivery
77407	Radiation treatment delivery	Radiation Treatment Delivery
77412	Radiation treatment delivery	Radiation Treatment Delivery
77417	Radiology port images(s)	Radiation Treatment Delivery (Guidance)
77427	Radiation tx management x5	Treatment Management
77431	Radiation therapy management	Treatment Management
77432	Stereotactic radiation trmt	Treatment Management
77435	Sbrt management	Treatment Management
77470	Special radiation treatment	Treatment Management
77499	Radiation therapy management	Treatment Management
77520	Proton trmt simple w/o comp	Radiation Treatment Delivery
77522	Proton trmt simple w/comp	Radiation Treatment Delivery
77523	Proton trmt intermediate	Radiation Treatment Delivery

*See proposal in the CY 2022 OPPS/ASC Payment System NPRM.

Appendix: RO Model Bundled Healthcare Common Procedure Coding System Codes (3)*

HCPCS Code	HCPCS Description	Category
77525	Proton treatment complex	Radiation Treatment Delivery
G0339	Robot lin-radsurg com, first	Radiation Treatment Delivery
G0340	Robt lin-radsurg fractx 2-5	Radiation Treatment Delivery
G6001	Echo guidance radiotherapy	Radiation Treatment Delivery (Guidance)
G6002	Stereoscopic x-ray guidance	Radiation Treatment Delivery (Guidance)
G6003	Radiation treatment delivery	Radiation Treatment Delivery
G6004	Radiation treatment delivery	Radiation Treatment Delivery
G6005	Radiation treatment delivery	Radiation Treatment Delivery
G6006	Radiation treatment delivery	Radiation Treatment Delivery
G6007	Radiation treatment delivery	Radiation Treatment Delivery
G6008	Radiation treatment delivery	Radiation Treatment Delivery
G6009	Radiation treatment delivery	Radiation Treatment Delivery
G6010	Radiation treatment delivery	Radiation Treatment Delivery
G6011	Radiation treatment delivery	Radiation Treatment Delivery
G6012	Radiation treatment delivery	Radiation Treatment Delivery
G6013	Radiation treatment delivery	Radiation Treatment Delivery
G6014	Radiation treatment delivery	Radiation Treatment Delivery
G6015	Radiation tx delivery imrt	Radiation Treatment Delivery
G6016	Delivery comp imrt	Radiation Treatment Delivery
G6017	Intrafraction track motion	Radiation Treatment Delivery (Guidance)

*See proposal in the CY 2022 OPPS/ASC Payment System NPRM.