



# RO Model – Process and Procedure

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Policy

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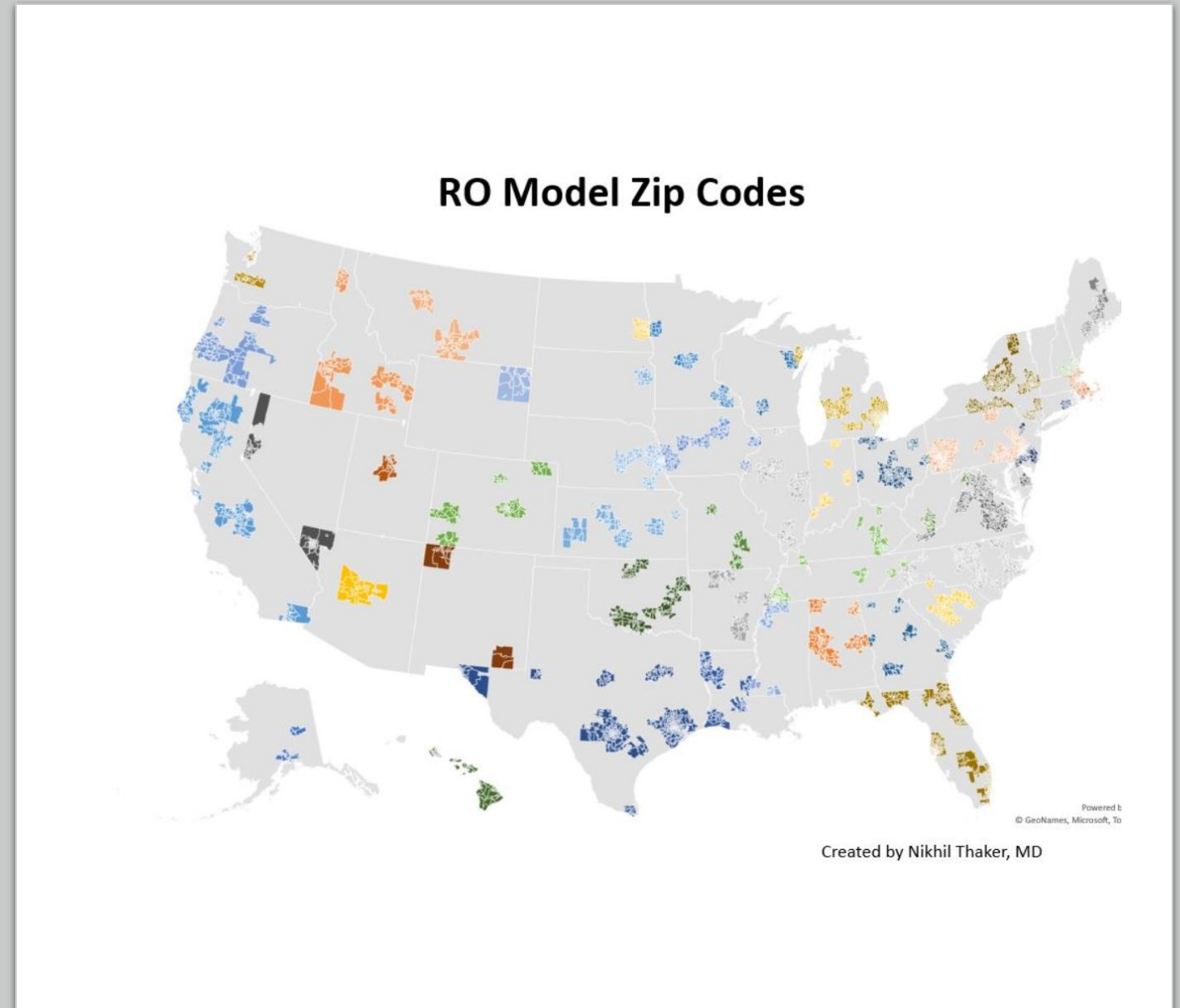
# Agenda

- RO Model Participation Requirements & Exemptions
- Model Episode Construct
- Billing & Coding
- Reconciliation and True Up
- ASTRO Concerns



# Mandatory participation

- **30% of all RO episodes in eligible geographic areas will be included in the model.**
- **\$230 million in savings over 5 years (2021-2025)**
- **Exemption for practices with fewer than 20 Medicare FFS episodes in prior year**
- **500 group practices**
- **450 hospital outpatient departments**
- **20% of participants are in rural zip codes**



# How do I know if I'm a RO Model Participant?

- Check RO Model Zip Code List:  
<https://innovation.cms.gov/innovation-models/radiation-oncology-model>
- RO Model ID
  - CMS Help Desk – 1-844-711-2664, option 5
  - Provide your TIN or CCN number and name of primary contact
- ROAP – Radiation Oncology Administrative Portal (**coming soon**)
  - Data including case mix and historical experience
  - Performance reports
  - Data Request Forms – claims, episode and participant
  - Attestation of CHERT and PSO
- Radiation Oncology Connect (**coming soon**)
  - Document sharing and other resources.



# Exemptions

- Low-Volume Opt-Out
  - 20 or fewer RT episodes across all CBSAs selected for participation in the most recent year with available claims data
  - CMS will notify practices that qualify for the opt-out 30-days prior to the beginning of the performance year
  - Practices that wish to opt-out must attest to their intention to opt-out
- Centers in MD, VT, US Territories, ASCs, CAHS, PPS-Exempt Cancer Hospitals and Penn Rural Health Model Participants are exempt



# RO Participants

- **Professional Participant** = PGPs, identified by a single TIN, that deliver only the professional component of radiation therapy services at either a freestanding or Hospital Outpatient Department (HOPD)
- **Technical Participant** = HOPDs or freestanding center, identified by a single CCN or TIN, which delivers only the technical component of radiation therapy services.
- **Dual Participant** = A RO participant, identified by a single TIN, that delivers both the professional and technical radiation therapy services through a freestanding radiation therapy center.



# Medicare FFS Beneficiaries

- Any Medicare FFS beneficiary receiving radiation therapy for at least one identified cancer type.
- Medicare FFS beneficiaries participating in clinical trials for radiation therapy services, excluding PBT trials
- RO Participants must notify Medicare beneficiaries that they are participating in the RO Model by providing a written notice.
  - Beneficiaries have the right to refuse sharing clinical data. In those cases the participant must notify CMS.
- Medicare FFS beneficiaries are responsible for 20% of the cost of care



# Cancer Types

- Anal Cancer
- Bladder Cancer
- Bone Metastases
- Brain Metastases
- Breast Cancer
- Cervical Cancer
- CNS Tumors
- Colorectal Cancer
- Head and Neck Cancer
- Liver Cancer
- Lung Cancer
- Lymphoma
- Pancreatic Cancer
- Prostate Cancer
- Upper GI Cancer
- Uterine Cancer







# Included Services & Modalities

## Services

- Treatment planning
- Dose planning
- Radiation physics and dosimetry
- Treatment devices
- Special services
- Treatment delivery
- Treatment management

## Modalities

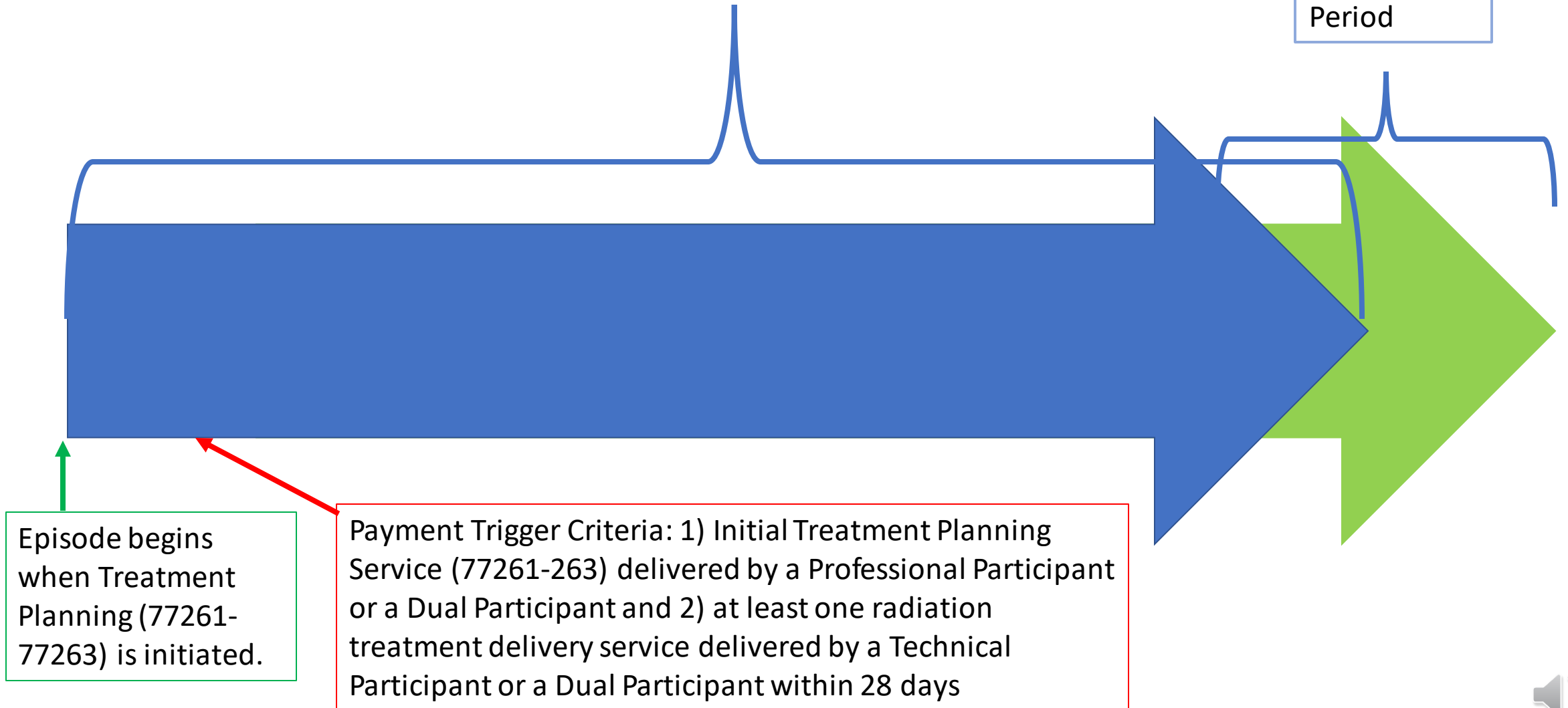
- 3-D Conformal Radiotherapy
- IMRT
- SRS
- SBRT
- PBT
- IGRT
- Brachytherapy



# Episode Length and Trigger

## 90-Day Episode of Care

28 Day Clean  
Period



Episode begins when Treatment Planning (77261-77263) is initiated.

Payment Trigger Criteria: 1) Initial Treatment Planning Service (77261-263) delivered by a Professional Participant or a Dual Participant and 2) at least one radiation treatment delivery service delivered by a Technical Participant or a Dual Participant within 28 days





# Payment Methodology

1. National Base Rates
2. Application of a Trend Factor
3. Geographic Adjustment
4. Case Mix, Historical Experience & Blend
5. Discount Factor
6. Withholds for Incorrect Payments and Quality Measures Performance
7. Co-Insurance
8. Sequestration

How and when will I know  
what my PC and TC Rates are?





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**Dec. 2020 for Case Mix, Historical Experience Adjustment, and Trend Factor**



# Billing and Coding

- RO Model specific Cancer Type HCPCS Code
- Start of Episode – SOE – V1 modifier
- End of Episode – EOE – V2 modifier
- Practices must still submit encounter claims data for all radiation therapy services included on the RO Model HCPCS list
- **More to come in RO Model Billing Guide**



# Claims Processing – Professional and Dual Participants

- Start of Episode (SOE)
  - Professional participants and Dual participants bill a new RO Model HCPCS code and a V1 modifier that indicate treatment planning has taken place.
  - The first half of the episode payment for the PC services is made through the PFS.
- End of Episode (EOE)
  - Professional participants and Dual participants bill the same RO Model HCPCS code with a V2 modifier.
  - The EOE claim may be submitted as early as day 28 of the 90-day episode.
  - Any RT services delivered after the EOE is submitted during the 90-day period will not be paid.
  - Any RT services delivered after the 90-day episode, during the 28-day clean period will be paid FFS.



# Claims Processing – Technical and Dual Participants

- Start of Episode (SOE)
  - Technical and Dual participants that provide the technical component of an episode will bill a new RO Model HCPCS code with a V1 modifier for the first half of the episode payment.
  - The Professional participant will provide the Technical participant with a signed and dated prescription and the final treatment plan, indicating that the PC component of the episode has been initiated. The TC of the episode begins on or after the date that the PC component is initiated.
  - The submission and payment of TC claims is not dependent on the submission of PC claims.
  - The first half of the payment will be paid to HOPDs via the OPPS or Freestanding Centers via the PFS





# Claims Processing – Technical and Dual Participants

- End of Episode (EOE)
  - Technical and Dual participants that provide the technical component of an episode will bill the same RO Model HCPCS code with a V2 modifier for the second half of the episode payment.
  - The EOE claim may be submitted by the Technical participant or Dual participant as early as day 28 of the 90-day episode.
  - Any RT services delivered after the EOE claim is submitted during the 90-day period will not be paid.
  - If the patient requires additional RT services after the 90-day period, during the 28-day clean period, will be paid FFS.



# What if the Episode includes a Secondary Diagnosis?

- If the episode includes services for multiple cancer types those services and costs are included in the episode payment rate.
- If two or more claim lines fall within brain mets or bone mets or secondary malignancies the episode is set to the cancer type with the highest claim count.
- If there are fewer than two claim lines for brain mets, bone mets or secondary malignancies, the episode is assigned to the cancer type with the highest claim count among all other cancer types.



# How will services provided by multiple physicians at multiple sites be addressed?

- Duplicate Services
  - The PC component of RO Services are provided by more than one Professional participant or Dual participant
  - TC component of RO Services is provided by more than one Technical or Dual Participant.
  - Examples:
    - EBRT and Brachytherapy
    - Cervical cancer episode initiated by Dual Participant in community clinic referred to physician at hospital for brachytherapy
    - Prostate cancer episode initiated by Professional Participant for brachy in hospital, referred to community clinic for EBRT



# Cervical Episode

Cervical cancer episode initiated by Dual Participant in community clinic referred to physician at hospital for brachytherapy

- Dual participant initiates the episode at the community clinic with the combination treatment planning and EBRT delivery codes.
- The referral to the physician at the hospital for brachytherapy. The hospital services will bill a modifier or condition code to indicate that those services should be paid FFS.
- During the Incorrect Payment reconciliation period the FFS amounts paid for the hospital-based brachytherapy services (both the PC and the TC portion) will be taken from the 1% Incorrect Withhold amount. CMS will not deduct more than the value of the episode.



# Prostate Episode

- Prostate cancer episode initiated by Professional participant for brachy in hospital, referred to community clinic for EBRT
  - The Professional participant and Technical participant trigger the episode with the combination planning and treatment delivery codes associated with the delivery of brachy therapy with the issuance of a SOE claim. They also submit an EOE claim.
  - The community-based clinic provides the EBRT uses a designated modifier or condition code that indicated they should be paid FFS.
  - During the Incorrect Payment reconciliation period the FFS amounts paid for the EBRT services delivered by the community-based clinic will be taken from the 1% incorrect withhold for the Professional participant and Technical participant. CMS will not deduct more than the value of the episode.



# What about referrals to PPS Exempt facilities?

- PPS Exempt Cancer Hospitals are exempt from participating in the RO Model.
  - Services referred to a PPS Exempt facility will be paid FFS
  - FFS payments made to PPS Exempt facilities will not be deducted from RO Model participants during the Incorrect Payment reconciliation period.



# Reconciliation and True Up Process PY 2021



# Stop Loss Policy

RO participants with fewer than 60 episodes in the baseline period (2016-2018) do not have sufficient historical volume to calculate a reliable adjustment to their payment rates.

- CMS applies a stop loss policy to prevent these practice from significant payment shifts.
- CMS will use no-pay claims data to determine what these RO Participants would have been paid under FFS as compared to payments under the RO Model.
- CMS will pay these participants retrospectively for losses in excess of 20% of what they would have been paid under FFS. These payments are determined during reconciliation.





# Timely Error Notice and Reconsideration

- Limited to reconciliation process not the RO Model payment methodology or AQS methodology
- Timely error notice must be submitted 45 days from reconciliation report
  - CMS has 30 days to respond
- Reconsideration Review must be submitted 10 days of Timely Error response
  - Official response issued 60 days post Reconsideration Review submission



# Advanced APM and MIPS APM

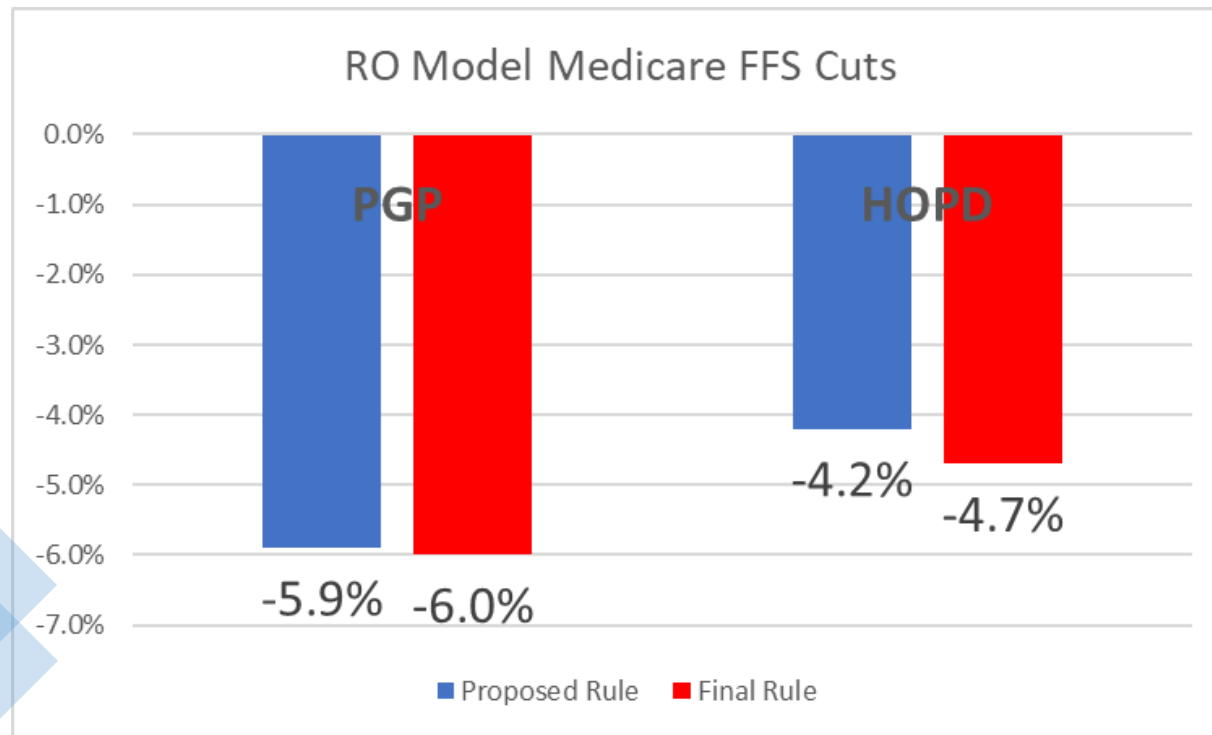
- CMS is designated the RO Model as an Advanced APM and MIPS APM
- The Agency limits the 5% bonus to the PC component only.
- Practices must meet Qualified Advanced APM Thresholds to achieve Advanced APM QP status
  - 50% of Medicare Part B payments generated through participation in an Advanced APM, **OR**
  - 35% of Medicare patients received care through an Advanced APM



## ASTRO responds to CMS Radiation Oncology Model: Implementation delay and more reforms needed

*Final rule includes mandatory participation for nearly 1,000 practices and does not allow sufficient time for transition*

21-Sep-2020 9:50 AM EDT, by American Society for Radiation Oncology (ASTRO)



- Implementation Date Set for January 1, 2021
- Mandatory for 30% of Episodes (950 practices)
- Discount Factors set at 3.75% for PC and 4.75% for TC
- Medicare FFS payment cuts
  - **6% for PGPS**
  - **4.7% for HOPDs**



# Stories from the front line

Our volume is still down from COVID, both for the current time as well as for the entire year. Revenues are way off... Our centers were already talking about laying off or reducing staff. Jan 1 start date is awfully ambitious considering the amount of training and documentation that we need to implement to meet the programs requirements.

--Massachusetts Radiation Oncologist

The proposed model is extremely complex and confusing. The amount of time and training to ensure that we have revenue personnel who are trained to accurately comply with all of these proposed changes will be extraordinary. The very burdensome requirements of the APM, coupled with the likelihood of having to operate a simultaneous and parallel FFS operation with private payors, means that we will likely need to hire a dedicated FTE to coordinate this transition.

--New Jersey Radiation Oncologist

The combination of dramatic cuts in payments and the increased requirements of documentation and data entry for this mandatory program will break us. My staff and I are stretched to the limit. This has been the worst year of my professional life. That the agency would spring this on frontline providers during a pandemic is just cruel. Practices will close. Patients will be harmed.

--Virginia Radiation Oncologist

Our volume is down 35% year over last and our supply expenses are up 14% thanks to COVID-19. Consequently, this seems like the worst possible time to implement such a radical change. With the challenges private practice's are already facing this could be disastrous for the foreseeable future, and one that we may or may not be able to survive due to the inequity imposed.

--Florida radonc practice  
administrator



# Congress Must Act to Protect Patient Access to Radiation Oncology and Drive Value-Based Care

1

Provide mandated participants more time to cope with the pandemic and adopt the model.

- Delay implementation until July 1, 2021 and after the expiration of the PHE.

2

Reduce the discount factor cuts to a level consistent with MACRA's intent and other payment models.

- Decrease the professional and technical discount factor payment cuts to 3%.





# Questions?

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