2015 Radiation Oncology Coding Update – What You Need to Know

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December 2, 2014
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2015 Coding Changes for Radiation Oncology

Five Areas for Coding Changes in 2015

- Radiation Treatment Delivery
  - Twelve Deletions, – Three Additions
- IMRT Treatment Delivery
  - One Deletion, - Two Additions
- Image Guided Radiation Therapy
  - Three Deletions, One Change and – One Addition
- Teletherapy and Brachytherapy Isodose Planning
  - Teletherapy – Three Deletions, - Two Additions
  - Brachytherapy – Three Deletions, - Three Additions
- Specific Modifier for Distinct Procedural Services
  - Four Additions
2015 Coding Changes for Radiation Oncology

- Radiation Treatment Delivery Coding Changes – HOSPITAL ONLY
- Previously all treatment delivery codes were based on the cost of equipment – with technology changes this is no longer the case
- IMRT – 6-10 MeV is typical for today
- Old treatment delivery codes – 12 codes (77402-77416) – three levels will be deleted beginning January 1, 2015
- Three new codes will make up the entire selection for level of service
  - Simple – 77402
  - Intermediate – 77407
  - Complex – 77412
- MeV no longer contributes to the complexity
- No longer separated by # of sites, blocking, wedges
- ALL criteria must be met

- Treatment Area – Per the AMA CPT 2014:
  - "A treatment area is a contiguous anatomic location that will be treated with radiation therapy. Generally, this includes the primary tumor organ or the resection bed and the draining lymph node chains, if indicated.
  - Breast cancer patient with a single treatment area (breast alone or the breast and adjacent supraclavicular fossa, and internal mammary nodes)."
  - Radiation to more than one discontinuous anatomic location – multiple bone mets in separate sites (e.g., femur and cervical spine) – each distinct and separate anatomic site to be irradiated is a separate treatment area.
Radiation Treatment Delivery Coding Changes – Free Standing (physician owned) Centers

- Per the Federal Register Final Rule (10/31/14) “Due to the significant code restructuring and potential for changes in payment, some specialty societies representing providers of radiation treatment services have requested that we delay implementation of the new code set.

- The coding changes for CY 2015 involve significant changes in how radiation therapy services and associated image guidance are reported.

- We are maintaining the inputs for radiation therapy codes at the CY 2014 levels. (Note: Due to budget neutrality adjustments and other system-wide changes, the payment rates may change.) Since the code set has changed and some of the CY 2014 codes are being deleted, we are creating G-codes as necessary to allow practitioners to continue to report services to CMS in CY 2015 as they did in CY 2014 and for payments to be made in the same way. All payment policies applicable to the CY 2014 CPT codes will apply to the replacement G-codes.

<table>
<thead>
<tr>
<th>CY 2014 CPT Code</th>
<th>CY 2015 HCPCS Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>76950</td>
<td>G6001</td>
<td>Ultrasonic Guidance for placement of radiation therapy fields</td>
</tr>
<tr>
<td>77421</td>
<td>G6002</td>
<td>Stereoscopic X-ray Guidance</td>
</tr>
<tr>
<td>77402</td>
<td>G6003</td>
<td>Radiation treatment delivery – up to 5 MeV Single treatment area, simple or no blocks</td>
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<tr>
<td>77403</td>
<td>G6004</td>
<td>Radiation treatment delivery – 6-10 MeV Single treatment area, simple or no blocks</td>
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<td>77404</td>
<td>G6005</td>
<td>Radiation treatment delivery – 11-19 MeV Single treatment area, simple or no blocks</td>
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<tr>
<td>77406</td>
<td>G6006</td>
<td>Radiation treatment delivery – 20 MeV or greater Single treatment area, simple or no blocks</td>
</tr>
<tr>
<td>77407</td>
<td>G6007</td>
<td>Radiation treatment delivery – up to 5MeV 2 separate treatment areas, use of multiple blocks</td>
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<tr>
<td>77408</td>
<td>G6008</td>
<td>Radiation treatment delivery – 6-10 MeV 2 separate treatment areas, use of multiple blocks</td>
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</table>
### Radiation Treatment Delivery Coding Changes — Free Standing (physician owned) Centers

<table>
<thead>
<tr>
<th>CY 2014 CPT Code</th>
<th>CY 2015 HCPCS Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>77409</td>
<td>G6009</td>
<td>Radiation treatment delivery – 11-19 MeV 2 separate treatment areas, use of multiple blocks</td>
</tr>
<tr>
<td>77411</td>
<td>G6010</td>
<td>Radiation treatment delivery - 20MeV 2 separate treatment areas, use of multiple blocks</td>
</tr>
<tr>
<td>77412</td>
<td>G6011</td>
<td>Radiation treatment delivery – up to 5 MeV 3 or more treatment areas, custom blocking, electron beam</td>
</tr>
<tr>
<td>77413</td>
<td>G6012</td>
<td>Radiation treatment delivery – 6-10 MeV 3 or more treatment areas, custom blocking, electron beam</td>
</tr>
<tr>
<td>77414</td>
<td>G6013</td>
<td>Radiation treatment delivery – 11-19 MeV 3 or more treatment areas, custom blocking, electron beam</td>
</tr>
<tr>
<td>77416</td>
<td>G6014</td>
<td>Radiation treatment delivery – 20 MeV or greater 3 or more treatment areas, custom blocking, electron beam</td>
</tr>
<tr>
<td>77418</td>
<td>G6015</td>
<td>Intensity modulated treatment delivery, single or multiple fields, per session</td>
</tr>
<tr>
<td>0073T</td>
<td>G6016</td>
<td>Compensator-based beam modulation treatment delivery of inverse planned treatment – 3 or more compensators</td>
</tr>
<tr>
<td>0197T</td>
<td>G6017</td>
<td>Intra-fraction localization and tracking of target or patient motion, each fraction.</td>
</tr>
</tbody>
</table>

### 2015 Coding Changes for Radiation Oncology

**Radiation Treatment Delivery Coding Changes**

- CPT 77401 – Radiation treatment delivery, superficial and/or ortho-voltage
- Do not report this code for energies equal to 1 MeV – must be below
- You will no longer report the following codes for this service
  - Clinical Treatment Planning – 77261, 77262, 77263
  - Treatment Devices – 77332, 77333, 77334
  - Teletherapy Codes – 77306, 77307
  - Brachytherapy Isodose Planning – 77316, 77317, 77318
  - Weekly Physics – 77336
  - Weekly Management – 77427
- You may report the appropriate level of service for Evaluation and Management services (992xx).
2015 Coding Changes for Radiation Oncology

Image Guided Radiation Therapy
- The following CPT codes are deleted beginning January 1, 2015
  - Stereoscopic X-ray guidance – 77421 – FSC’s – G6002
  - Ultra-sonic guidance – 76950 – FSC’s – G6001
  - Intra-fraction localization – 0197T – FSC’s – G6017
- In addition you will no longer report CBCT code 77014 for IGRT services
  - Really no use for code – will be around for 1 more year – cannot bill anyway
- New Code – 77387 will be reported for all IGRT services, any modality and will include intra-fraction localization (gating) – this code as both a TC and -26 component.
- DO NOT report 77387TC with IMRT or SRS/SBRT treatment delivery codes
  - Only the technical component of this code is bundled with IMRT and SRS
  - The professional component (-26) may be reported with IMRT and SRS
  - It is NOT bundled with conventional XRT – report both TC and -26
  - Hospitals will have continued ‘packaging’ of this service, but should continue to report

HOSPITAL ONLY!

Intensity Modulated Radiation Therapy
- CPT 77418 – IMRT treatment delivery is DELETED – FSC’s – G6015
- CPT 0073T – Compensator based IMRT is DELETED – FSC’s – G6016
- Two new codes:
  - 77385 – IMRT treatment delivery, Simple
    - Report this level of service for compensator based IMRT
    - Do not report 77338 (IMRT treatment device) for compensator IMRT – continue to report 77334
  - 77386 – IMRT treatment delivery, Complex
  - Both include IGRT – IGRT is not separately billable
- NOTE – For breast IMRT the treatments and planning MUST be full IMRT (multiple angles) not modulated field in field treatments.
2015 Coding Changes for Radiation Oncology

Teletherapy and Brachytherapy Isodose Plans

- Teletherapy Isodose Planning
  - 77305, 77310 and 77315 – DELETED
  - Two New Codes
  - 77306 – Teletherapy Isodose plan – simple
  - 77307 – Teletherapy Isodose plan – complex
    INCLUDES DOSIMETRY CALCULATIONS
  - Brachytherapy Isodose Planning
    - 77326, 77327 and 77328 – DELETED
    - Three New Codes
    - 77316 – 1-4 sources or 1 channel
    - 77317 – 5-10 sources or 2-12 channels
    - 77318 - >10 sources or >12 channels
    INCLUDES DOSIMETRY CALCULATIONS

You can longer report CPT 77300 with any isodose plan – all calculations are included in the reporting of the planning code.

Specific Modifiers for Distinct Procedural Services

- CMS will establish four (4) new HCPCS modifiers to define subsets of the -59 modifier (used to describe a “Distinct Procedural Service”)
- Effective Date – January 1, 2015 – Change Request 8863, Transmittal 1422

BACKGROUND

Currently the -59 modifier is used to indicate that a code represents a service that is separate and distinct from another service with which it would usually be considered bundled.

Many providers incorrectly consider the -59 modifier for bypassing of the National Correct Coding Initiative (NCCI) – it is the MOST widely used modifier.

The -59 modifier is associated with considerable abuse and high levels of manual audit activity resulting in reviews, appeals and even civil fraud and abuse cases.
2015 Coding Changes for Radiation Oncology

Specific Modifiers for Distinct Procedural Services

- The -59 modifier is both commonly used and commonly abused.
- According to CERT data from 2013 a projected $2.4 billion in MPFS payments were made on lines with modifier -59, with a $320 million dollar error rate.
- Facility payments, primarily OPPS projected $11 billion was billed on lines with a -59 modifier with projected error of $450 million.
  - A projected total for one year of $770 million
- The Primary Issue with the -59 modifier is that it is defined for use in a wide variety of circumstances, such as a use to identify different encounters, anatomic sites, and distinct services.
- CMS believes that more precise coding options coupled with increased education and selective editing is needed to reduce the errors associated with this overpayment.

POLICY

- Four New HCPCS Modifiers to identify subsets of Distinct Procedural Services.
- These new modifiers define specific subsets of the -59 modifier.
- CMS states that the -59 modifier should not be used when a more descriptive modifier is available.
  - XE – Separate Encounter – A Service That Is Distinct Because It Occurred During a Separate Encounter.
  - XP – Separate Practitioner - – A Service That Is Distinct Because It Was Performed By A Different Practitioner.
  - XU – Unusual Non-Overlapping Service – The Use Of A Service That is Distinct Because It Does Not Overlap Usual Components Of The Main Service.
2015 Coding Changes for Radiation Oncology

- CMS will continue to recognize the -59 modifier in many instances, but may selectively require a more specific – X{EPSU} modifier for billing certain codes at higher risk for incorrect billing.
  - Example: Some NCCI code pairs may be identified as payable only with the –XE separate encounter modifier but not the -59 modifier or other –X{EPSU} modifiers.
- The –X{EPSU} modifiers are more selective versions of the -59 modifier so you would NOT include both modifiers on the same line.
- As a default CMS will initially accept either the -59 modifier or the more selective –X{EPSU} modifier as correct coding, although they are encouraging a rapid migration to the more selective modifiers.
- At present there are no published national edits in place identifying those codes that will require the –X{EPSU} modifiers – however contractors are not prohibited from requiring their use when necessitated by local program integrity and compliance needs.

Contractor Instructions

- Notice of the release will be via the established MLN Matters list serv.
- Contractors will post this article, or a direct link to this article on their Web sites and include information about it in listserv messages within one week of the availability of the provider education article.
Updates for Reimbursement for 2015

**New NCCI Edit for Brachytherapy procedures:**
- CPT 77790 – Supervision, handling, loading of radiation source is no longer billable with the following brachytherapy codes
  - 77761 – Intracavitary radiation source application, simple
  - 77762 – Intracavitary radiation source application, intermediate
  - 77763 – Intracavitary radiation source application, complex
  - 77776 – Interstitial radiation source application, simple
  - 77777 – Interstitial radiation source application, intermediate
  - 77778 – Interstitial radiation source application, complex

It may still be reported with the following Brachytherapy procedure:
- 77789 – Surface application of radiation source

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**Medicare Physician Fee Schedule:**
- CMS announced on Oct. 31 that it would back off the proposed cuts to radiation oncology until 2016. In the final rule for CY 2015 it is estimated that radiation oncologists will NOT see a change in total allowed charges beginning January 1, 2015.
- This will be true for payment rates for global payments (professional and technical) in the freestanding centers and professional payments in the hospital outpatient environment.
- Projections estimate a 1% increase in estimated total allowed charges which is better than the 6% cuts proposed in July.
- CMS also announced they would retain the value of the vault as a direct practice expense input. They will study the issue and how to relate to practice expense and address in CY 2016.
OIG Work Plan for 2015

Medicare Part A and B

- Quality of Care: Planned work will examine settings in which OIG has identified gaps in program safeguards intended to ensure medical necessity, patient safety, and quality of care. We will also continue our focus on access to care, including beneficiary access to durable medical equipment, prosthetics, orthotics, and supplies in the context of new programs involving competitive bidding.

- Oversight of Payment and Delivery Reform: OIG will consider work examining the transition from volume- to value-based payments and the soundness and effectiveness of the payment structures, care coordination, and administration of these new payment models. Work expected to begin in 2015 and beyond includes examinations of data and metrics to document and measure quality and performance.

Hospitals

Medicare oversight of provider-based status

- We will determine the extent to which provider-based facilities meet CMS’s criteria. Provider-based status allows facilities owned and operated by hospitals to bill as hospital outpatient departments. Provider-based status can result in higher Medicare payments for services furnished at provider-based facilities and may increase beneficiaries’ coinsurance liabilities. In 2011, the Medicare Payment Advisory Commission (MedPAC) expressed concerns about the financial incentives presented by provider-based status and stated that Medicare should seek to pay similar amounts for similar services. (OEI; 04-12-00380; expected issue date: FY 2015).
Comparison of provider-based and free-standing clinics

- We will review and compare Medicare payments for physician office visits in provider-based clinics and free-standing clinics to determine the difference in payments made to the clinics for similar procedures and assess the potential impact on the Medicare program of hospitals’ claiming provider based status for such facilities. Provider-based facilities often receive higher payments for some services than do freestanding clinics. The requirements to be met for a facility to be treated as provider based are at 42 CFR § 413.65(d). (OAS; W-00-14-35724; W-00-15-35724; expected issue date: FY 2015).

Outpatient evaluation and management services billed at the new-patient rate

- We will review Medicare outpatient payments made to hospitals for evaluation and management (E/M) services for clinic visits billed at the new-patient rate to determine whether they were appropriate and will recommend recovery of overpayments. Preliminary work identified overpayments that occurred because hospitals used new-patient codes when billing for services to established patients. The rate at which Medicare pays for E/M services requires hospitals to identify patients as either new or established, depending on previous encounters with the hospital. According to Federal regulations, the meaning of “new” and “established” pertains to whether the patient has been seen as a registered inpatient or outpatient of the hospital within the past 3 years. (73 Fed. Reg. 68679 (November 18, 2008).) (OAS; W-00-14-35627; expected issue date: FY 2015).
Hospitals

Bone marrow or stem cell transplants

- We will review Medicare payments to hospitals for bone marrow or stem cell transplants to determine whether the payments were made in accordance with Federal rules and regulations. Bone marrow or peripheral blood stem cell transplantation includes mobilization, harvesting, and transplant of bone marrow or peripheral blood stem cells and the administration of high-dose chemotherapy or radiotherapy before the actual transplant. When bone marrow or peripheral blood stem cell transplantation is covered, all necessary steps are included in coverage. (CMS’s Medicare Claims Processing Manual, Pub. No. 100-04, Ch. 3, § 90.3.) Bone marrow or stem cell transplants are covered under Medicare only for specific diagnoses. Procedure codes must be accompanied by the diagnosis codes that meet specified coverage criteria. Prior OIG reviews have identified hospitals that have incorrectly billed for bone marrow or stem cell transplants. (OAS; W-00-14-35723; expected issue date: FY 2015).

Hospitals

Oversight of pharmaceutical compounding

- We will determine the extent to which Medicare’s oversight of Medicare-participating acute care hospitals addresses recommended practices for pharmaceutical compounding oversight. Pharmaceutical compounding is the creation of a prescription drug tailored to meet the needs of an individual patient. Most hospitals compound at least some pharmaceuticals onsite. Medicare oversees the safety of pharmaceuticals compounded at Medicare-participating hospitals through the accreditation and certification process. This work is particularly important in view of a 2012 meningitis outbreak resulting from contaminated injections of compounded drugs. (OEI; 01-13-00400; expected issue date: FY 2015).
Other Providers

Billing and Payments

Diagnostic radiology—Medical necessity of high-cost tests

- We will review Medicare payments for high-cost diagnostic radiology tests to determine whether the tests were medically necessary and to determine the extent to which use has increased for these tests. Medicare will not pay for items or services that are not “reasonable and necessary.” (Social Security Act, § 1862 (a)(1)(A).) (OAS; W-00-13-35454; W-00-14-35454; various reviews; expected issue date: FY 2015).

Imaging services—Payments for practice expenses

- We will review Medicare Part B payments for imaging services to determine whether they reflect the expenses incurred and whether the utilization rates reflect industry practices. For selected imaging services, we will focus on the practice expense components, including the equipment utilization rate. Practice expenses may include office rent, wages, and equipment. Physicians are paid for services pursuant to the Medicare physician fee schedule, which covers the major categories of costs, including the physician professional cost component, malpractice insurance costs, and practice expenses. (Social Security Act, § 1848(c)(1)(B).) (OAS; W-00-13-35219; W-00-14-35219; various reviews; expected issue date: FY 2015).
Other Providers

Physicians—Place-of-service coding errors

- We will review physicians’ coding on Medicare Part B claims for services performed in ASCs and hospital outpatient departments to determine whether they properly coded the places of service. Prior OIG reviews determined that physicians did not always correctly code nonfacility places of service on Part B claims submitted to and paid by Medicare contractors. Federal regulations provide for different levels of payments to physicians depending on where services are performed. (42 CFR § 414.32.) Medicare pays a physician a higher amount when a service is performed in a nonfacility setting, such as a physician’s office, than it does when the service is performed in a hospital outpatient department or, with certain exceptions, in an ASC. (OAS; W-00-13-35113; W-00-14-35113; various reviews; expected issue date: FY 2015).

Prescription Drugs

Part B payments for drugs purchased under the 340B Program

- We will determine how much Medicare Part B spending could be reduced if Medicare were able to share in the savings for 340B-purchased drugs. We will calculate the amount by which ASP-based payments exceed 340B prices and estimate potential savings on the basis of various shared-benefit methodologies. Previous OIG work revealed that some Medicaid State agencies have developed strategies to take advantage of the discounts on 340B drugs. The 340B Program requires drug manufacturers to provide discounted outpatient drugs to approximately 10,000 covered entities, including tribal health centers, children’s hospitals, and tuberculosis clinics. Medicare Part B reimburses for almost all covered outpatient drugs (including those purchased by 340B entities) on the basis of the ASP, regardless of the amount paid for the drug. Medicare Part B providers that purchase drugs under the 340B program can fully retain the difference between the ASP-based payment amount and the 340B purchase price. (OEI; 12-14-00030; expected issue date: FY 2015).
Prescription Drugs

Billing and Payments

- We will determine whether Part B payments for immunosuppressive drugs that were billed with a service code modifier “KX” met Medicare documentation requirements. Medicare claims for immunosuppressive drugs reported with the KX modifier may not always meet documentation requirements for payment under Part B. Medicare Part B covers Food and Drug Administration (FDA)-approved immunosuppressive drugs and drugs used in immunosuppressive therapy when a beneficiary receives an organ transplant for which immunosuppressive therapy is appropriate. (Social Security Act, § 1861(s).) Since July 2008, suppliers that furnish an immunosuppressive drug to a Medicare beneficiary annotate the Medicare claim with the KX modifier to signify that the supplier retains documentation of the beneficiary's transplant date and that such transplant date preceded the date of service for furnishing the drug. (CMS’s Medicare Claims Processing Manual, Pub. No. 100 04, Ch. 17, § 80.3.) (OAS; W-00-14-35707; W-00-15-35707; various reviews; expected issue date: FY 2015).

Payments for outpatient drugs and administration of the drugs

- We will review Medicare outpatient payments to providers for certain drugs (e.g., chemotherapy drugs) and the administration of the drugs to determine whether Medicare overpaid providers because of incorrect coding or overbilling of units. Prior OIG reviews have identified certain drugs, particularly chemotherapy drugs, as vulnerable to incorrect coding. Providers must bill accurately and completely for services provided. (CMS's Claims Processing Manual, Pub. No. 100-04, Ch. 1, § § 70.2.3.1 and 80.3.2.2.) Further, providers must report units of service as the number of times that a service or procedure was performed. (Chapter 5, § 20.2, and Ch. 26, § 10.4.) (OAS; W-00-12-35576; W-00-13-35576; W-00-14-35576; various reviews; expected issue date: FY 2015).
Physicians

Place-of-service coding errors

- We will review physicians’ coding on Medicare Part B claims for services performed in ASCs and hospital outpatient departments to determine whether they properly coded the places of service. Prior OIG reviews determined that physicians did not always correctly code nonfacility places of service on Part B claims submitted to and paid by Medicare contractors. Federal regulations provide for different levels of payments to physicians depending on where services are performed. (42 CFR § 414.32.) Medicare pays a physician a higher amount when a service is performed in a nonfacility setting, such as a physician’s office, than it does when the service is performed in a hospital outpatient department or, with certain exceptions, in an ASC. (OAS; W-00-13-35113; W-00-14-35113; various reviews; expected issue date: FY 2015).

Impact of Final Rule – MPFS and Facility

CY 2015 PFS Final Rule with Comment Period Estimated Impact Table:
Impacts of Work, Practice Expense, and Malpractice RVUs

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Allowed Charges (Millions)</th>
<th>CY2014 Impact of Work RVU Changes</th>
<th>Impact of PE RVU Changes</th>
<th>Impact of MP RVU Changes</th>
<th>Combined Impact</th>
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</thead>
<tbody>
<tr>
<td>HEMATOLOGY/ONCOLOGY</td>
<td>$1,811</td>
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<td>0%</td>
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<td>Radiation Oncology</td>
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<td>Radiation Therapy Centers</td>
<td>$57</td>
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<td>0%</td>
<td>0%</td>
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Impact of Final Rule with Comment Period on CY 2014 Payment for Selected Procedures Physicians

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<tr>
<th></th>
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<td>77427</td>
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<tr>
<td>99203</td>
<td>Visit new</td>
<td>$77.02</td>
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<td>$73.08</td>
<td>$73.03 0%</td>
<td>$84.95 -21%</td>
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Current 2014 Conversion Factor – 35.8228
January 1 – March 31 payments based on CY 2015 Conversion Factor of 35.8013 -22% Subject to change
April 1 – December 31 payments based on CY 2015 Conversion Factor of 28.2239 after comment period

Hospital Outpatient Payment for SRS and IORT

Hospital Reimbursement:
- Promotes greater packaging of payments rather than separate payments for each individual service.
  - CPT codes are assigned to Ambulatory Payment Classifications (APC’s) based on clinical resource use similarity. All APC’s are reimbursed at the same rate.
  - Services considered ancillary along with their costs are ‘packaged’ into the primary service.
  - Packaged services do not receive separate payment.
  - Example – imaging is not separately paid when reported with treatment delivery.
**Stereotactic Radiosurgery (SRS) - APC**

CMS Establishes comprehensive APC (C-APC) for Stereotactic Radiosurgery
- Level II Stereotactic Radiosurgery APC 0067 renamed to –
- Single session Cranial Stereotactic Radiosurgery

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Desc.</th>
<th>CY 2015 APC</th>
<th>CY 2015 Payment</th>
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<td>SRS Linear Based</td>
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<td>$9,765.40</td>
<td>0067</td>
<td>$3,591.65</td>
<td>172%</td>
</tr>
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**Intra-Operative Radiation Therapy (IORT) - AP**

Intra-Operative Radiation Therapy (IORT) will be assigned to a single Comprehensive APC (C-APC)
- Level IV Breast and Skin Surgery – APC 0648
- CMS will provide a single payment for all services on the claim regardless of the span of date(s) of service.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Desc.</th>
<th>CY 2015 APC</th>
<th>CY 2015 Payment</th>
<th>CY 2014 APC</th>
<th>CY 2014 Payment</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>77424</td>
<td>Io Rad Tx Delivery – X-Ray</td>
<td>0648</td>
<td>$7,461.40</td>
<td>0065</td>
<td>$1,248.28</td>
<td>498%</td>
</tr>
<tr>
<td>77425</td>
<td></td>
<td>0648</td>
<td>$7,461.40</td>
<td>0065</td>
<td>$1,248.28</td>
<td>498%</td>
</tr>
</tbody>
</table>
Stereotactic Body Radiation Therapy (SBRT)

Two Times Rule:
- CPT 77373 was assigned to APC 0066 – Level V Radiation Therapy in CY 2014.
- CMS cross walked claims data from G codes (G0251, G0339 and G0340).
- G0251 is typically used for fractionated cranial SRS, NOT SBRT.
- ASTRO claimed it was inappropriate to group claims date in same APC.
- Inclusion of G0251 would “violate” the “two-times rule”.
  - Highest cost item or service within an APC group is more that two-times greater than the lowest cost item.
- CMS reviewed and created new criteria and granted an exception to the ‘two-times rule’ for APC 0066 as well as nine (9) other APC’s and will retain G0251 in the claims data for rate setting for CPT 77373.
  - Current CY 2015 payment rate - $1,902.48

Low-dose-rate (LDR) Prostate Brachytherapy

Composite APC (C-APC) – 8001
- APC 8001 is a composite APC for Low Dose Rate Brachytherapy when CPT codes 55875 (Transperineal needle placement, prostate) and 77778 (Application of interstitial radiation source application, simple are furnished in a single hospital encounter.
- In the proposed rules for CY2015 CMS proposed a rate of $3,504.02 for APC 8001. Almost a 10% decrease.
- In the final rule for CY 2015 CMS finalized it decision and revised its calculation based on 416 claims, not the initial 379 claims.
- The reimbursement rate for APC 8001 is $3,745 a slight increase, but still a 4% decrease.
**Insertion Uterine Tandem/Ovoids**

CPT 57155

- CPT 57155 will be moved from APC 0193 – Level IV Female Reproductive Procedures to:
- APC 0192 – Level III Female Reproductive Procedures
- This will reduce the reimbursement from $1,375.20 in CY 2014 to CY 2015 - $487.06 – 65% decrease in reimbursement.
- You are encouraged to comment to CMS about this decrease in writing asking that they re-examine APC’s 0192, 0193 and 0202 “Level V Female Reproductive Procedures for correct assignment and distribution of the codes for stability and services assigned to each APC.

**Proton Beam Therapy**

**APC Changes for CY 2015 for Proton Beam Therapy:**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Desc.</th>
<th>CY 2015 APC</th>
<th>CY 2015 Payment</th>
<th>CY 2014 APC</th>
<th>CY 2014 Payment</th>
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<td>$1,071.95</td>
<td>667</td>
<td>$1,205.27</td>
<td>-11%</td>
</tr>
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</table>
Questions?

Thank you for your participation!

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