CMS gives radiation therapy providers a break — but bigger changes may be coming

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Billing

CMS is letting radiation oncologists bill some E/Ms with superficial radiation therapy (SRT) that had previously been bundled. But those providers should look out: this may be a preliminary step before CMS puts in new regulations that may shake up their reimbursement.

Transmittal 4267, issued March 27 but effective as of January 1 of this year, explicitly allows therapists to bill E/M existing patient Levels 1 through 3 (**99211, 99212,** and **99213**) in conjunction with superficial radiation treatment delivery (up to 200 kV) if the work described involved "radiation therapy planning," "radiation treatment device construction," and "radiation treatment management when performed on the same date of service as superficial radiation treatment delivery."

CMS had issued an earlier transmittal making this change, but revised it with the March 27 transmittal to reflect that "billing with modifier **25** (significant, separately identifiable E/M services) may be necessary if National Correct Coding Initiative (NCCI) edits apply," and to correct the E/M levels that would be permitted. This would seem to be good news for therapists who performed significant work besides the technical work normally associated with **77401** (Radiation treatment delivery, superficial and/or ortho voltage, per day).

Ann Hubbard, director of health policy for the American Society for Radiation Oncology (ASTRO), which works closely with CMS and the American Medical Association's CPT Editorial Panel on coding and other issues, thinks this may be a clarification suggested by a passage in the 2019 physician fee schedule final rule. That rule noted that, while the 2016 National Correct Coding Initiative (NCCI) manual "stated that radiation oncology services may not be separately reported with E/M codes this NCCI edit is no longer active"; nonetheless "stakeholders have stated that MACs have denied claims for E/M services associated with SRT based on the NCCI policy manual language" despite the edit's deactivation.

CMS also noted in the fee schedule rule that it had been contemplating adding a new G-code to cover some of the services they had not previously allowed to be billed separately with 77401, including "associated E/M." Deepak Kapoor, M.D., chairman and CEO of Integrated Medical Professionals (IMP) and past president and current health policy chairman of the Large Urology Group Physicians Association (LUGPA), wonders whether another shoe will soon drop at CMS.

"We're not sure of CMS' rationale, but based on what we know is brewing, it's reasonable to presume that this has something to do with the creation of radiation oncology bundles," says Kapoor.

Kapoor notes that back in February a transmittal CMS issued and then withdrew — a CMS spokesperson told the publication *Inside Health Policy* it had been "inadvertently posted" — suggested the agency was setting up a bundled payment radiation oncology demonstration model that might be mandatory in certain regions. HHS Secretary Alex Azar had also talked about such a model.

"We expect something will come over the summer months [about the demo] that will be more formalized," says Hubbard. "ASTRO did recommend a voluntary model; we know Azar is interested in a mandatory one."

Advocates for radiation oncologists have been struggling to get ahead of other changes the agency has proposed for their specialty. For example, rates at independent radiology centers that had been frozen for years were going to be allowed to fall in 2019. These wound up being held in place by an amendment to the Bipartisan Budget Act of 2018 (PBN blog 3/8/18).

"This was needed because in the original freeze, there was a proviso that required creation of an alternative payment model for radiation," says Kapoor. "As that wasn't done at the time, had the freeze expired, changes to reimbursement would have taken effect that would have had a devastating effect on outpatient radiotherapy treatments, particular for patients with breast and prostate cancer."

Radiation oncologists are vulnerable to payment interventions. In recent Comparative Billing Reports (CBR) CMS has ascribed a 10.3% improper payment rate to radiation oncology services in general, and experts think the agency is taking aim at the popular and high-paying radiation therapy code **77301** (Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications) to decrease such payments (PBN 1/31/19). — *Roy Edroso (redroso@decisionhealth.com)*

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CMS Transmittal 4257/Change Request 11137: www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4267CP.pdf

BACK TO TOP