September 16, 2019

Atrium Health (GA, NC, SC)

Avera Health (IA, MN, NE, ND, SD)

Central Florida Health (FL)

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Hartford Healthcare (CT)

Kaiser Permanente, Southern California Permanente Medical Group (CA)

SSM Health (IL, MO, OK, WI)

University of Pittsburgh Medical Center (PA, NY)

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

Re: CMS-5527-P — Medicare Program; Specialty Care Models to Improve Quality of Care and Reduce Expenditures: Radiation Oncology Model.

Dear Ms. Verma,

The Provider Roundtable (PRT) submits the following comments on the Specialty Care Models to Improve Quality of Care and Reduce Expenditures: Radiation Oncology Model, as published in the *Federal Register*.

The Provider Roundtable (PRT) includes representatives from 13 different health systems, serving patients in 19 states. PRT members are employees of hospitals. As such, we have financial interest in fair and proper payment for hospital services by CMS, but do not have any specific financial relationship with vendors.

The members collaborated to provide substantive comments with an operational focus that we hope CMS staff will consider during the annual OPPS policymaking process. We appreciate the opportunity to provide our comments to CMS. A full list of the current PRT members is provided in **Attachment A.**

Please feel free to contact me at 765-298-2110 or via email at: *trinker@ecommunity.com*.

Sincerely,

Terri Rinker, MT (ASCP), MHA (Chair)
PRT Chair and
Revenue Cycle Director
Community Hospital Anderson
Anderson, IN

Radiation Oncology Model

CMS proposes the creation and testing of a new payment model for radiation oncology, the "RO Model," with the intent of promoting quality and financial accountability for 90-day episodes of care centered on Radiation Therapy (RT) services. The RO Model would examine whether prospective episode-based payments to physician group practices (PGPs), hospital outpatient departments (HOPDs), and freestanding radiation therapy centers would reduce Medicare expenditures while preserving or enhancing beneficiaries' quality of care. CMS anticipates that the proposed RO Model would also benefit Medicare beneficiaries by encouraging more efficient care delivery and incentivizing higher value care across episodes of care.

The proposed performance period spans five calendar years, beginning in 2020, and ending December 31, 2024. The intent is to capture all episodes that finish within the performance period, so data collection, episode payments, and reconciliation would continue into calendar year 2025.

The PRT understands that CMS initiatives tie quality of care to payment methodologies, but the Proposed Rule infers that CMS beneficiaries are not receiving quality care when RT services are provided. The PRT is concerned with this inference and requests additional information from CMS based on the proposal.

- ***The PRT asks CMS to provide clarification and data that explain why the agency believes there are quality issues with the treatment provided to patients receiving RT.***

CMS notes that there are studies indicating that shorter periods of more intense RT are just as successful for treating malignancies, compared to longer time frames with lower doses. Each clinical scenario is different, however, and there may be reasons why a physician determined, planned, and ordered less intensity and therefore more treatment sessions, for a specific patient. The PRT believes that CMS should evaluate the specifics of a clinical scenario that goes "outside" the expected parameters as part of the agency's data analysis.

- ***The PRT recommends that CMS evaluate the episodes where study data indicate that a shorter course of RT is recommended but, based on the physician's clinical decision-making and an individual patient's needs, a longer course is prescribed and delivered.***

CMS proposes the inclusion of 17 types of cancer that are commonly treated with RT. In addition, the proposal includes beneficiaries who meet certain criteria, including having a diagnosis of at least one of the cancer types included in the model and receiving RT services from a participating provider or supplier in one of the selected CBSAs.

The PRT is concerned about instances presented by patients who have multiple cancers at one time and one cancer type meets the criteria of the RO Model but the other does not. We are concerned about the effect this situation will have on the data CMS is specifically targeting by attempting to determine the appropriate utility of the number of RT treatments being provided. If one of the patient's diagnoses is not on the list, and a longer treatment cycle is the standard, how will CMS know when the treatment for the individual diagnosis was completed?

The PRT also has concerns about what happens when a patient is diagnosed with metastasis(es). Each site that is being treated with RT includes a planning event, which would trigger a new episode of care under the RO Model if the parameters are met (i.e., 90-day episode has been completed and there has been a 28 day "clean period"). However, cancer does not respect time frames any more than it respects people. For metastases identified during an episode of treatment, an additional planning session will be required for the new site. The resources that will be expended are the same as those for the initial planning session, since the plan and delivery must be individualized for each site. CMS does not describe how this type of scenario would be handled, from a claims processing perspective.

The PRT notes that higher levels of radiation are involved with multiple sites of treatment, whether the multiple sites were known at the beginning of treatment or if metastasis/additional sites were identified during treatment.

- ***The PRT recommends that CMS exclude all multiple cancer scenarios from the RO Model.***

- ***The PRT further recommends that all new technology payments and payments for routine costs made for research studies be explicitly excluded from the RO Model.***

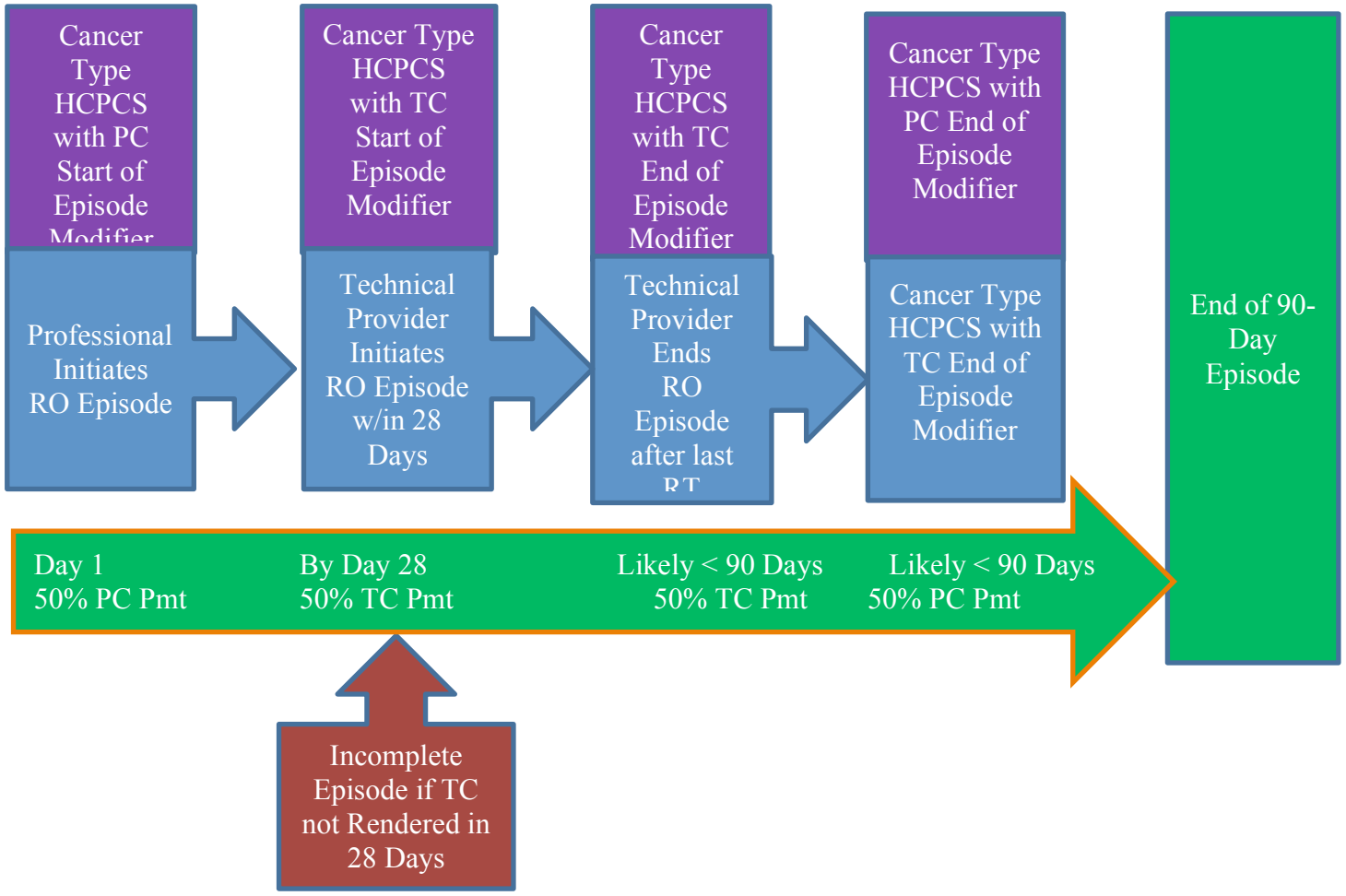
The PRT appreciates CMS' acknowledgement that the RO Model could overlap with other agency models and programs. The PRT also appreciates CMS' acknowledgement that some sort of accounting would be included to ensure that data are only counted once and only one payment is made. CMS does not provide clarification regarding how this accounting resolution would be handled, however.

- ***The PRT requests that CMS clarify how the overlapping RO Model and program accounting would be operationalized, so that providers that participate in multiple programs and models have a clear understanding of the process.***

Outlining Basic ROM Billing and Payment Procedures as Described by CMS

The PRT has several questions concerning the claim, coding, billing, and payment processes CMMI intends for the RO Model. We believe it is very important, in keeping with CMS' "Patients over Paperwork Initiative," to eliminate or reduce administrative burden wherever and whenever possible with respect to the ROM. Below is a depiction of the PRT's understanding of the episode timeframe and billing procedures, derived from the information outlined in the Proposed Rule.

As this graphic illustrates, CMS proposes unique HCPCS Level II codes for each of the 17 cancer types divided by the professional and technical components. CMS also proposes modifiers for the initiation of an episode and for the end of treatment delivery, which will often occur prior to the 90-day episode. The beginning of an episode is triggered by a professional participant billing one of the treatment planning codes 77261-77263 ,with the applicable cancer type HCPCS level II code, and the episode initiation modifier. A complete episode is defined as at least one RT delivery code billed by a technical or dual participant within 28 days of the planning codes and episode HCPCS code and initiation modifier. An episode ends 90 days after episode initiation and is followed by a 28-day clean period.



The PRT is concerned about specific considerations related to the 90-day episodic billing time frame. CMS assumes that RT services would be completed within the 90-day episodic period and a new episode would not begin until at least 28 days have elapsed. While we agree that this is the most common scenario, that there are times when extenuating circumstances (particularly an inpatient [IP] admission) cause the outpatient RT services to begin *after* the 28-day window. In this case, the planning session occurs, and the patient may begin RT treatment during the IP stay.

For example, our member institutions have experienced cases when the decision is made to treat the malignancy with RT, but the patient has a family vacation planned (e.g., trip to Europe) and the dates cannot be changed without huge financial impact to the beneficiary and his or her family. After consulting with the physician, the decision is made to go ahead with the RT planning, and initiate the treatment when the beneficiary returns from the trip. Depending on the length of the trip, and when the beneficiary schedules the first treatment, therapy could occur after the 28-day window.

From an operational standpoint, the PRT is concerned, if the treatment does not begin within the 28-day period, but the physician plans to treat the patient with RT therapy, that there may be no "trigger" to begin an episode of care. The physician has already done the planning session and an order was provided to the technical provider. There may not be a reason for another planning

session to occur, but the physician orders that the treatment should begin. This case would be paid under the fee-for-service methodology, since there would be no "triggering event" based on the description in the Proposed Rule.

Another operational concern for hospital billing processes is tracking the date of the original planning session by the provider. If the treatment starts on day 26, for example, the treatments may not be completed prior to completion of the original 90-day episode. The technical provider will report the initiation HCPCS code and then the services for each treatment, as is current billing practice. Based on our understanding of the proposal, the episode closes on the 90th day following the date of the reported planning service. In this scenario, however, the technical provider would not attach the HCPCS code for the end of treatment at the end of the 90-day episode. The final HCPCS code will not be reported until the technical component is completed – which could be outside the 90-day episode triggered by the planning services, is generated by the clinical department, and is unknown to the billing staff.

Based on the proposal, CMS has not changed the billing requirements other than adding the HCPCs codes and modifiers for initiation and termination. While billing for the services will stay the same, we do not see that CMS has addressed this possible scenario. We realize this may not happen on a regular basis for any one specific hospital, but it does happen for all hospitals at varying rates, depending on their volume of treatment delivery.

- ***The PRT urges CMS to proactively address the scenario described above, which impacts both hospitals and the payment structure.***

The PRT appreciates and strongly agrees with CMS' proposal regarding episodes in which a patient expires or is transferred to hospice care; in these cases, CMS would provide full episode payment and not consider these two scenarios as incomplete episodes.

Billing Individual Radiation Oncology Services Following HIPAA Transaction Sets

While the Proposed Rule states that participants will bill individual encounters following typical RT coding and billing, the PRT wishes to emphasize that the billing instructions CMS releases must be *extremely clear* for participants and communicated in a variety of way. As CMS realizes, not everyone read the Final Rule. Since this is a mandatory requirement for selected participants, it is critically important to ensure that the information is complete and accurate in order to provide robust data for CMS analysis.

Therefore, we ask that CMS clarify in its billing instructions that all ROM participants will be required to continue billing individual patient encounters using HIPAA-mandated transaction code sets (i.e., CPT and HCPCS Level II codes) for professional/dual participant services on 1500/837P claims and hospital outpatient participant services on UB04/837I. This is critical for participants to follow usual and typical coding and billing; it is also important for CMS to understand the types, frequency, and fractionation of RT delivered to beneficiaries treated under the Model. This information is vital to allow comparison between the participant and control groups and episodes.

As CMS knows, HIPAA transaction set requirements under the Administrative Simplification Act (ASA) require that services are billed following claim and code sets; in addition, this is

important for hospital outpatient departments that are required to properly complete annual Medicare and Medicaid cost reports. Charges must meet the requirements of the Provider Reimbursement Manual Part 1 Section 2202.4, which mandate that charges be related consistently to the cost of the services and uniformly applied to all patients, whether Medicare, Medicaid, or commercial patients. The ROM cannot alter these requirements because doing so could undermine the validity of the hospital cost reporting process. Therefore, we urge CMS to be very clear with future billing instructions.

- ***The PRT requests that CMS clarify, in its billing instructions, that all ROM participants will be required to continue billing individual patient encounters using HIPAA-mandated transaction code sets.***

Impact on Secondary and MediGap Payers

Another reason it is important for all participants to follow usual coding and billing pursuant to HIPAA transaction sets relates to beneficiary's secondary and MediGap insurance. CMS does not address this topic in the Proposed Rule. Nonetheless, we expect that CMMI will define new claim adjustment reason codes (CARC) and remittance advice reason codes (RARC) so this insurance, when secondary to Medicare, will not process co-payments for individual services. Instead, they will process applicable co-payments associated with each of the professional, dual, and technical episode payments when made and explained on the remittance advice from Medicare.

We ask that CMS verify and explain this process in the Final Rule to enable participants to better understand these important operational issues.

- ***The PRT requests that CMS provide very specific billing instructions and clarifications to providers that individual patient encounters using HIPAA-mandated code sets for professional and technical services are still required.***

- ***The PRT requests that CMS verify and explain the process for communication to secondary and MediGap insurance (i.e. CARC/RARC codes) to ensure all participants have a clear understanding of the operational process for reimbursement.***

Timing of Episode Payments

The PRT is concerned about timely payment and cash flow for ROM participants. CMS should clarify that the final episode payment is made to participants based on billing the end of episode modifier and cancer type HCPCS code, which signify the end of delivery.

In addition, CMS must clarify that the agency does not intend to require the full 90-days elapse before providing the end of episode payment to either the professional or technical participants. Waiting until the end of the 90-day episode will create a significant cash flow hardship for treatments that end in a much shorter time frame (e.g., SRS or SBRT) due to hypofractionation and efficient delivery of care. CMS can determine the episode's initiation (from the professional or dual participant reporting of the initial HCPCS codes and modifier) and when delivery is completed by observing the technical components billed within the episode and the end of

treatment HCPCS codes and modifier. CMS can establish the 90-day episode based on these data elements and enforce a 90-day episode while allowing payment to be made at the end of treatment delivery. This will avoid unnecessary delay in payment when services end significantly earlier than the 90-day episode.

- ***The PRT urges CMS to clarify that payment to providers will not be held until the end of the 90-day episode if the RT treatment ends prior to the end of 90 days.***

Avoiding Incomplete Episodes for Professional Participant Services Rendered in Excluded Providers

The PRT wants to prevent unnecessary incomplete episodes and avoid administrative burden to professional participants. CMS discusses several provider types that will be excluded from the ROM, including all participants in Maryland and Vermont; the Pennsylvania Rural Demonstration; and excluded PPS hospitals like Critical Access Hospitals, cancer, or children's PPS-exempt hospitals.

We also understand that the TINs under which radiation oncologist professional groups bill will be excluded. For example, any professional groups located in Maryland will be excluded. However, there are professional groups whose TINs may not be exclusively associated with an excluded provider (i.e., they have a unique and separate TIN) and yet practice in a provider type that is excluded. CMS needs a way to ensure which episodes are included and what episodes are not included in the ROM even for a ZIP Code that has been selected for the Model.

CMS did not discuss this situation in the Proposed Rule. Nor does it detail how a radiation oncologist from a TIN and ZIP Code selected for the ROM, and that furnishes the professional planning and simulation services in an excluded provider will be protected from having a large volume of incomplete episodes. During the CMS Listening Session, the agency stated that it would establish a modifier for professional participants to use in order to indicate the services are delivered by an excluded provider.

We request that CMS consider an alternative to a new modifier that does not require any changes in how professionals bill their radiation oncologist services. We recommend that CMS use the location of services in item number 32 and the NPI in item 32a, which is mandated on the 837P/1500 claim to exclude the services from the ROM. CMS will know the NPIs and addresses of all the excluded providers, and this information will be on all participant claims, as it is a HIPAA transaction set requirement for all professional claims. CMS will be able to exclude the claims based on the address and NPI of the location of service. This process is preferable because it does not require any change in billing for radiation oncologists.

To better communicate excluded providers, CMS could publish online an explicit list of excluded providers including their names, addresses, and NPIs to ensure there's no confusion about excluded providers. The PRT believes that it is important for professional participants to have a CMS-approved list that clearly indicates what providers are excluded despite the fact that they are located within a ZIP Code selected for the ROM.

This information would also emphasize that, should any of the professionals furnish services at a location included in the ROM and their TIN/ZIP Code is not otherwise excluded, the participant

would be required to report the HCPCS Level II code for the cancer type and the appropriate modifier(s).

If CMS believes it must require the use of a new modifier to signify services in an excluded provider, we request that the agency allow the modifier to be reported with the usual RT planning, simulation, and management CPT and HCPCS codes rather than ask for the cancer type HCPCS code to be reported.

- ***The PRT recommends that CMS utilize the information already required by HIPAA transaction sets (NPI, names and addresses) for professional claims in order to determine if a provider is excluded, rather than creating a new modifier and additional operational burden for RT professionals.***

Accuracy and Calculation of National Base Rates

The PRT is concerned about how CMS calculated the base rates in the ROM, due to CMS' use of comprehensive APCs for certain RT services and the propensity for hospitals to use monthly or repetitive service claims for radiation oncology services. We ask CMS to clarify whether it attributed correct per-encounter APC payment rates for services, or use a single C-APC payment for a month's worth of services.

Hospital providers continue to exercise an option to bill individual radiation oncology encounters on a single monthly claim rather than billing each encounter on separate claims. This results in a single C-APC payment for an entire month of services rather than a C-APC payment for each encounter. This is not accurate payment and is solely due to hospitals not understanding the claims-based packaging methodology.

We ask CMS to confirm that it applied APC payment rates to individual dates of services for radiation oncology services to calculate the base rates even when hospitals billed using a single monthly claim. Furthermore, we believe it is important for CMS to explicitly instruct hospitals to bill each encounter on unique claims to avoid inappropriate claim-based packaging rules when the C-APC payment rates are intended to be per encounter/visit.

If CMS applied a single C-APC payment for an entire month of services, we ask that CMS rectify its calculation of the payment rates or make an appropriate adjustment for the participant when making the case-mix and historical trend adjustments.

- ***The PRT requests that CMS confirm whether the methodology to calculate the base rates was based on individual dates of services for radiation oncology services or a single C-APC payment for an entire month of services when the claim was a series/recurring claim.***

- ***The PRT recommends that CMS explicitly instruct hospitals to bill each encounter on unique claims to avoid inappropriate claim-based packaging rules.***

- ***The PRT requests that CMS rectify its calculation of the payment rates if the methodology applied a single C-APC payment for an entire month of services, or to make an appropriate adjustment for the participant when making the case-mix and historical trend adjustments.***

Proposal to Apply Coinsurance

Medicare FFS beneficiaries are generally required to pay 20 percent coinsurance for services furnished under the OPPS and MPFS payment methodologies. While this policy would apply under the ROM (i.e., beneficiaries would pay 20 percent of the bundled PC and TC payments), the timing and amount of the coinsurance would be different.

The Proposed Rule notes that, depending on the choice of modality and number of fractions ordered and administered by the RO participants, the coinsurance amount of the bundled rate may be higher than what a beneficiary or secondary insurer would otherwise pay under Medicare FFS. CMS recommends that providers implement a "multiple installment payment plan" for beneficiaries who do not have secondary insurance coverage. CMS also notes that the RO providers should inform patients of the installment plan availability only during the actual billing process.

The PRT has no objection to an "installment plan," since providers already have programs in place where financial counsellors work with patients on payment plans that fit their individual situations. The delay created by the requirement to delay discussing this option with the patient "until the course of the actual billing process" conflicts with CMS' price transparency proposal that patients know their financial responsibilities *prior* to receiving services.

The first question from a patient/beneficiary regarding services is usually "How much will I owe?" followed by the response, "I can't pay that in a lump sum." CMS should not dictate when this discussion occurs; this should be left to providers to address the patient's concerns when they arise.

- ***CMS should eliminate the requirement that hospital operational processes wait "until the course of the actual billing process" because it will increase hospitals' administrative burden and increase cost to create new plans specifically for the ROM.***

Beneficiary Protections

CMS is proposing to require professional participants and dual participants to notify RO beneficiaries that they are participating in CMS' ROM, and provide written notice to each beneficiary during the initial treatment planning session. CMS intends to provide a notification template that will include information regarding beneficiary cost-sharing responsibilities and a beneficiary's right to refuse having his or her data shared. Beneficiaries who refuse to have their data shared would notify their respective RO participant, and the RO participant must notify CMS in writing within 30 days of being made aware that the beneficiary's decision.
CMS acknowledges there will be additional administrative burden on operationalizing this model. The PRT is concerned that this model increases patients' costs of care, and increases administrative burden in order to provide "quality care."

The PRT makes the following recommendations that would be beneficial to CMS, providers, and, ultimately, beneficiaries:

- ***The PRT recommends that CMS not implement the ROM for payment purposes prior to gathering data to fully understand its impact. Instead, CMS should require reporting of the newly created HCPCS codes and modifiers and assess the claims data prior to implementing a prospective payment methodology. CMS data collection is from 2015 through 2017 and does not represent all of the current practices.***

- ***The PRT also recommends that CMS not withhold payments due to incomplete episodes during the test period. Rather, we recommend that CMS utilize the new HCPCS codes and modifiers as informational for the initial and ending services for the 90-day periods and evaluate the data over a three-year period. This would, at a minimum, identify specific scenarios for application of the ROM, allow time for CMS to assess the appropriateness of including multiple cancer site treatment within the ROM, and determine if it is best for the beneficiary and program to exclude these scenarios from the ROM; and provide data to the public for public comments. This time frame would also allow identification of additional key operational issues that can be addressed prior to implementing a payment methodology change.***

CMS proposes that the Quality initiative portion of the ROM would link the payments to quality measures that involve clinical data reporting and patient experience. In addition, ROM participants must annually certify their intent to use Certified Electronic Health Record Technology (CEHRT) and bear more than a nominal amount of financial risk.

CMS proposes the use of a separate portal and a new website for data collection and quality measure reporting. This adds additional operational burden. With all the quality data reporting that providers already submit, the mechanism for reporting and especially the site for reporting should be the same. It is an unnecessary burden to continue to require providers to report the same types of information (many times duplicative information) through different mechanisms.

- ***The PRT recommends that CMS delay implementation to allow providers to thoroughly review the quality measures.***

- ***The PRT encourages CMS to simplify quality reporting using the current quality reporting mechanisms instead of creating yet another process for reporting quality data.***

Payment Withhold Based on Quality Reporting

One of the PRT's primary concerns about the ROM is the proposed quality and patient experience withholding of payment adjustments, which is connected to our broader concern about the calculation of payment rates under the model. CMS stated in the Proposed Rule that it would notify ROM participants of their unique payment rates, and publish the national base payment rates no later than 30 days prior to the start of the performance year in which those payments would be made.

CMS' calculations to create the national base rates (using claims data that CMS possesses, but providers do not), and the additional eight steps involved in calculating the participant-specific payment rates, are challenging for providers to replicate on their own. Notifying participants of their expected payment rates just 30 days prior to the start of the performance year leaves

participants insufficient time to conduct financial impact analyses and prepare accordingly. The PRT submits that, even if the delayed implementation date of April 1, 2020 is confirmed, the time frame does not allow providers enough time to prepare.

Even if CMS published the national base rates at an earlier date, which would allow some providers more time to do their own calculations and estimate their base payment rates, many participants will not have the resources to replicate CMS' calculations without additional information and detail. CMS does propose to create a data-sharing process by which participants could request a claims data file on their patient population. This will enable participants to review CMS' calculations of their participant-specific episode payment amounts and reconciliation payment amounts. However, in the Rule, CMS discusses sharing these data in the context of the model 5-year period and 30 days prior to the performance year start. It appears that the data-sharing proposal would not be timely enough to mitigate this problem.

Understanding their reimbursement is key for providers that are trying to operationalize the ROM and ensure its success. Operational changes will need to be made for coding, billing, and data collection (including quality data), which will add another reporting portal and requirements for clinical data that goes beyond the four measures CMS proposed for a certain sub-set of disease sites. At a time when participants will be trying to integrate all of the necessary administrative changes, they will be unsure of what they will be paid.

Our second concern deals with the length of time it takes to earn back the quality or patient experience withholding. If finalized as proposed, reconciliation will occur annually, with the first performance year (2020) reconciliation process occurring in August 2021. CMS then proposes a true-up process to calculate additional payments/repayments for incomplete episodes and duplicate services identified after claims runout that will occur in August 2022. This means that providers that delivered a service in January of a performance year would wait until August of the following year to recoup their patient experience hold, or quality withhold—and potentially will have to wait until the August after that (two years after the actual performance year) for other withholds, due to claims run-out.

That is a long time for providers to wait, and they are waiting just to potentially recoup the withhold—not earn a bonus, even if they earned a high Aggregate Quality Score. We believe that alternatives that provide timely recoupment of the withhold for participants, especially for the first performance year, would improve the ROM and reduce the burden on participants.

The proposed quality withhold, combined with the discount factors, may represent a significant cut for some providers, elevating their financial risks and reducing their margins. A solution whereby the withhold is only applied to the following performance year's payments would help providers with financial planning, ensure that providers are not waiting up to 20 months to recoup their quality payment, and not penalize providers that deliver high-quality care. Those who have the highest quality scores would thus not see their payments reduced in the future, only those who failed to perform will face future payment withholds. Applying the withhold to the next performance year rather than returning some amount of money that was withheld from all of the previous performance year's payments would help reduce some of providers' financial exposure.

- ***The PRT recommends that CMS allow providers adequate time to prepare for the***

ROM, provide their payment rates earlier than a month prior to implementation, and consider alternatives to the quality withhold as proposed (such as applying a withhold to the next year's payments), in order to reduce provider burden and enable a smoother implementation of the ROM.

Conclusion

In summary, the PRT recommends that CMS:

- ***Delay implementation of the new ROM until CMS assesses the overall impact of this proposal based on provider comments, administrative burden, and the lack of time to operationalize the ROM requirements.***
- ***Allow implementing measures without payment impact to assess operational impacts and develop solutions for issues such as multiple cancers within and outside of the RO model, episodic timing of 90 days and initiation of 28 days as the SOE.***
- ***Not withhold payments due to incomplete episodes during the test period.***
- ***Provide clarification and data that indicate why CMS believes there is a quality issue with the treatment provided to patients receiving RT.***
- ***Exclude all multiple cancer scenarios in the ROM.***
- ***Explicitly exclude all new technology payments and payments for routine costs made for research studies from the ROM.***
- ***Provide very specific billing instructions and clarifications to providers that individual patient encounters using HIPAA-mandated code sets for professional and technical services is still required.***
- ***Verify and explain the process for communication to secondary and MediGap insurance (i.e. CARC/RARC codes) to ensure all participants have a clear understanding of the operational process for reimbursement.***
- ***Utilize the information already required by HIPAA transaction sets (NPI, names and addresses) for professional claims to determine if a provider is excluded, rather than creating a new modifier and additional operational burden for radiation oncology professionals.***
- ***Provide more clarity of how the overlapping model and program accounting would be operationalized to increase the understanding on the part of providers that participate in multiple CMS and/or Innovation Center programs and models.***
- ***Confirm whether the methodology to calculate the base rates was based on individual dates of services for radiation oncology services or a single C-APC payment for an entire month of services when the claim was a series/recurring claim.***
- ***Explicitly instruct hospitals to bill each encounter on unique claims to avoid inappropriate claim-based packaging rules.***
- ***Clarify that payment to providers will not be held until the end of the 90-day episode if the radiation therapy treatment ends prior to the end of 90 days.***
- ***Rectify its calculation of the payment rates if the methodology applied a single C-APC payment for an entire month of services, or to make an appropriate adjustment for the participant when making the case-mix and historical trend adjustments.***

Attachment A: Provider Roundtable Members

Jennifer L. Artigue, RHIT, CCS
Corporate Director,
Health Information Management (HIM)
Franciscan Missionaries of Our Lady Health System
Baton Rouge, LA

Kathi L Austin, CPC, COC, CCP
Director Revenue Integrity/Audit
SSM Health
St. Louis, MO

Kathy L. Dorale, RHIA, CCS, CCS-P
VP, Health Information Management
Avera Health
Sioux Falls, SD

Carole Hokeah, MS, RN, CPC, CCS, CSSGB
System Director of Revenue Integrity
Central Florida Health
Leesburg, FL

Vicki McElarney, RN, MBA, FACHE, COC *
Consultant
Craneware
New Brunswick, NJ

Diana McWaid, MS, RHIA, CDIP, CCS, CPC, CRC (Vice Chair)
Assistant Director, Education, Training
& Quality Assurance
Kaiser Permanente SCPMG
Clinical Documentation & Audit Operations
Pasadena, CA

Kathy Noorbakhsh, BSN, CPC, COC
Director, Corporate Compliance and
Revenue Analysis
University of Pittsburgh Medical Center
Pittsburgh, PA

Terri Rinker, MT (ASCP), MHA (Chair)
Revenue Cycle Director
Community Hospital Anderson
Anderson, IN

Valerie Rinkle, MPA *
Regulatory Specialist
HCPro
Medford, OR

Anna Santoro, MBA, CCS, CCS-P, RCC
Director of Revenue Integrity
Hartford Healthcare
Newington, CT

John Settlemyer, MBA, MHA, CPC
Assistant Vice President,
Revenue Management / CDM Support
Atrium Health
Charlotte, NC

Angela Simmons, CPA
Vice President,
Finance – Revenue and Reimbursement
Vanderbilt University Medical Center
Nashville, TN

Denise Williams, RN, COC *
Senior Vice President of Revenue,
Integrity Services
AHIMA ICD-10 Ambassador
REVANT SOLUTIONS
Cane Ridge, TN

* *Non-voting past PRT member*

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