



AMERICAN ASSOCIATION *of* PHYSICISTS IN MEDICINE
Advancing the Science, Education & Professional Practice of Medical Physics

MEDICAL PHYSICS ECONOMICS UPDATE

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DISCLAIMER

- *Jonas Fontenot has no conflicts to declare.*
- *Wendy Smith Fuss is a consultant for the AAPM.*
- *The comments in this presentation are not intended to express a political opinion.*



THE AAPM PROFESSIONAL ECONOMICS COMMITTEE

■ Purpose

- Monitor and analyze the activities of entities that influence reimbursement for medical physics services, advise the Association on the formal positions it should take on related issues, and provide information to the membership and other organizations.

■ Activities/ Responsibilities

- Review the proposed actions of CMS and other reimbursement agencies
- Review guidelines that relate to the use of CPT codes and their implementation
- Ensure coordination between the activities of the AAPM and those of related organizations
- Work with related organizations to develop consistent responses to proposals and issues of mutual concern
- Provide information to the membership through existing channels within the AAPM
- Provide information to other organizations regarding reimbursement for professional medical physics services.

Members

Jonas Fontenot (chair)
Michele Ferenci (vice-chair)
Blake Dirksen
Jim Goodwin
Brent Parker
George Sherouse
Christopher Waite-Jones
Jerry White
Sam Einstein
Dongxu Wang
Russel Tarver
Amy Wexler
Richard Martin
Wendy Smith Fuss





OUTLINE

- Overview of Payment Systems
- The Radiation Oncology Alternative Payment Model
- COVID-19 Impact on Health Policy
- Additional Slides



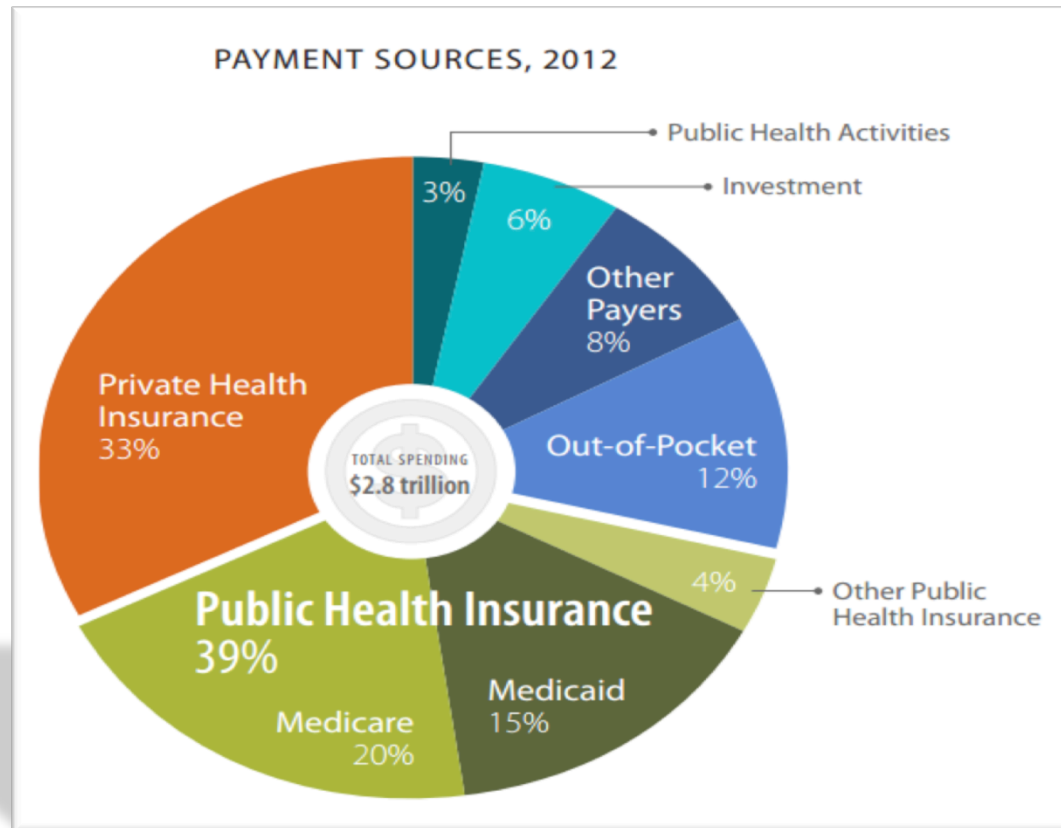


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OVERVIEW OF PAYMENT SYSTEMS



WHO PAYS FOR HEALTHCARE?



WHO DETERMINES HOW MUCH IS PAID?

- The Centers for Medicare & Medicaid Service (“CMS”)
 - Department of US HHS
 - Sets Medicare policy (but does not implement it)
 - Defines rates at which we are paid
- Third party private payors
 - Negotiate with care providers to set rates
 - Usually based on some multiple of the Medicare rate

MEDICARE STRUCTURE

- Medicare Part A
 - Hospital Inpatient
- Medicare Part C
 - Managed Care (Medicare Advantage)
- Medicare Part D
 - Prescription Drugs
- Medicare Part B
 - Physician Payment
 - Freestanding Cancer Centers
 - Hospital Outpatient Departments & Clinics
 - Ambulatory Surgical Centers

WHICH PARTS PAY FOR MEDICAL PHYSICS?

- Radonc and radiology procedures are generally outpatient, so covered under Part B
- Part B has three different payment systems
 - Medicare Physician Fee Schedule Payment System (MPFS)
 - Hospital Outpatient Prospective Payment System (HOPPS)
 - Ambulatory Surgical Center Payment System (ASC)
- Each system has a different method for determining reimbursement rates, but all use the same set of billing codes
- All billing is fee-for-service

WHICH PARTS PAY FOR MEDICAL PHYSICS?

- Depends on the type and location of service
- Reimbursement has two components
 - “Professional” covers physician payment
 - “Technical” cover non-physician labor, equipment, *etc.*

Setting	Technical	Professional
Hospital	HOPPS	MPFS
Freestanding	MPFS	MPFS

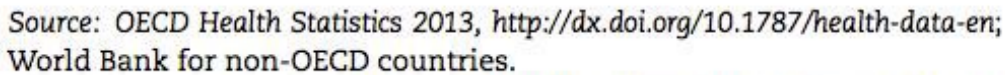
- Hospital – essentially a 24-hour care facility with inpatients
- Freestanding – physician’s office, specialty center, *etc.*

HOPPS RATESETTING

- Under the **Hospital Outpatient Prospective Payment System**, technical charges are CPT code-specific, but are then binned into Ambulatory Payment Classifications (APCs) for payment
- Payment is based on what hospitals previously charged

MPFS RATESETTING

- Under the **Medicare Physician Fee Schedule** (also known as free-standing) technical charges are CPT code-specific, built around coding of patient encounters
- There is a process by which AMA recommends the payment for each code

StatLink

ALTERNATIVE PAYMENT MODELS

- Brainchild of the CMS Innovation Center
- Purpose: **“To test whether episode-based payments reduce expenditures while preserving or enhancing quality of care”**
- There are 2 AP models in the current PR, more to come
 - **Radiation Oncology**
 - End Stage Renal Disease
 - Why these? Perceived systematic problems/abuses
 - Radiation Oncology’s IMRT boom is coming home to roost



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RADIATION ONCOLOGY ALTERNATIVE PAYMENT MODEL



RADIATION ONCOLOGY APM (RO-APM)

- Radiation Oncology Alternative Payment Model
- A grand experiment in insurance methodology
- Pays PC and TC at a *flat rate* for a 90 day episode of care
- Limited to 17 most common “cancer types”
- Site neutral
- Includes *protons* and some brachytherapy

RO-APM INCLUDE SERVICES

- Included services
 - Treatment planning
 - Dose planning
 - Medical physics & dosimetry
 - Treatment devices
 - Special services
 - Treatment delivery
 - Treatment management

RO-APM INCLUDED MODALITIES

- Included modalities
 - External beam radiotherapy
 - 3D conformal radiotherapy
 - Intensity modulated radiotherapy
 - Stereotactic radiosurgery
 - Stereotactic radiotherapy
 - Intraoperative radiotherapy
 - Image-guided radiotherapy
 - Brachytherapy
 - Proton beam radiotherapy
 - CMS may exclude PBT clinical trials

RO-APM CANCER TYPES

- | | | |
|--|---|---|
| 1. Anal Cancer
\$2,968 PC / \$16,006 TC | 7. CNS Tumors
\$2,463/\$14,193 | 13. Lymphoma
\$1,662/\$7,444 |
| 2. Bladder Cancer
\$2,637/\$12,556 | 8. Colorectal Cancer
\$2,369/\$11,589 | 14. Pancreatic Cancer
\$2,380/\$13,070 |
| 3. Bone Metastases
\$1,372/\$5,568 | 9. Head and Neck Cancer
\$2,947/\$16,708 | 15. Prostate Cancer
\$3,228/\$19,852 |
| 4. Brain Metastases
\$1,566/\$9,217 | 10. Kidney Cancer
\$1,550/\$7,656 | 16. Upper GI Cancer
\$2,500/\$12,619 |
| 5. Breast Cancer
\$2,074/\$9,740 | 11. Liver Cancer
\$1,515/\$14,650 | 17. Uterine Cancer
\$2,376/\$11,221 |
| 6. Cervical Cancer
\$3,779/\$16,955 | 12. Lung Cancer
\$2,155/\$11,451 | |

RO-APM METHODOLOGY

- The trigger event is a PC charge for clinical treatment planning (77261-77263) *and* a new PC APM HCPCS code with SOE modifier
- A TC charge for a treatment code and a TC APM HCPCS code with SOE modifier must be posted within 28 days
- Professional episode end is signaled by PC APM HCPCS code with EOE modifier
- Technical episode end is signaled by TC APM HCPCS code with EOE modifier
- 90 day APM episode is followed by a 28 day “clean period” which is FFS

RO-APM METHODOLOGY

- Half of the payment is made at the SOE
- The other half is paid at the EOE
- There is an annual reconciliation to assess:
 - Duplicate services and/or incomplete episodes
 - Compliance with quality metrics (AQS)
 - Starting PY3, performance on patient surveys

RO-APM IMPACTS

- Proposal is likely to move forward in some way
 - Approximately 40%(?) of RT episodes will be included
 - No impact on programs not required to participate
 - Only traditional Medicare plans are included
 - Likely represents 20-40% of patient volume at most programs
- Lots of unknowns
 - Mandatory vs voluntary
 - Number of participating practices (if mandatory)
 - Timing
 - Ratesetting methodology

RO-APM IMPACTS

- There is no specific revenue for 77370 or 77336
- There is no direct link from payment to any specific procedure
- The change in billing/coding does not apply to all patients in your department, only the ones who are “eligible” for the APM
 - So... Do you use a separate process track? Or manage APM patients just the same as FFS?
- The RO-APM experiment is for a fixed period of five years



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COVID-19 IMPACTS



COVID-19 IMPACTS

- In the event of a declared Public Health Emergency (PHE), the Secretary of Health and Human Services (HHS) has authority to temporarily waive or modify application of certain Medicare requirements
 - HHS Secretary declared PHE on January 31, 2020
 - President Trump declared a national emergency on March 13, 2020
- CMS released two 2020 Medicare Physician Fee Schedule Public Health Emergency Interim Final Rules with Comment
 - Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (March 30, 2020)
 - Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program (April 30, 2020)

COVID-19 IMPACTS & TELEHEALTH

- CMS now pays for more than 80 additional services when furnished via telehealth
 - Includes initial inpatient visits, emergency department visits, initial and subsequent observation services
- Expansion of telehealth establishes three distinct categories of service for use during COVID-19 Public Health Emergency
 - Applies to traditional Medicare & Medicare Advantage beneficiaries
 - Private payers and state Medicaid plans operate under their own payment policies and are not obligated to follow CMS policy

COVID-19 IMPACTS & TELEHEALTH

Medicare Telehealth Visits

- New or Established Patients
- Requires interactive audio and video telecommunications for real-time communication between physician and patient
 - Video chats like Apple FaceTime and Facebook Messenger video chat, Google Hangouts video or Skype are acceptable to provide telehealth
 - Facebook Live, Twitch, TikTok and similar video communications applications are not to be used to provide telehealth
- CPT codes 99201-99215
 - Paid at same Medicare rate as regular, in-person visits

COVID-19 IMPACTS & TELEHEALTH

- Medicare Virtual Check-in Visits
 - New or Established Patients
 - Patients have brief check-in with provider via a broad range of communication methods
 - Telephone (no video requirement), audio/video, text messaging, email, use of patient portal
 - Services may only be reported if they do not result in a visit, including a telehealth visit
 - HCPCS codes G2010 and G2012
 - Paid at same Medicare rate as regular, in-person visits

COVID-19 IMPACTS & TELEHEALTH

- Medicare E-Visits
 - New or Established Patients
 - Communication between an established patient and provider through use of an online patient portal
 - Patient must initiate the initial inquiry through patient portal
 - Communications may take place over a 7-day period
 - CPT codes 99421-99423
 - Three time-based E/M codes specific to this service

COVID-19 IMPACTS & TELEHEALTH

- Physicians may use CPT 99441-99443 for *Telephone Evaluation and Management Services* for new or established patients on an interim basis
- Codes will be reimbursed by CMS for E/M visits provided via audio-only telephone at the same rate as if the service had been provided in person
 - CMS clarified this policy in April 30, 2020 rule based on reports that many Medicare beneficiaries did not have access to video communication systems
- CMS crosswalks CPT codes 99212, 99213 and 99214 to CPT codes 99441, 99442, and 99443, respectively
 - Payments retroactive to March 1, 2020



COVID-19 IMPACTS & SELECTION OF E/M LEVELS

- Office/Outpatient Evaluation and Management (E/M) level selection furnished via telehealth can be based on Medical Decision Making (MDM) or Time
 - Time defined as all of the time associated with E/M on the day of the encounter
- Requirements regarding documentation of history and/or physical exam in the medical record have been removed

COVID-19 IMPACTS & PLACE OF SERVICE

- Providers are instructed to apply the CPT telehealth modifier -95 *Synchronous Telemedicine Service Rendered via Real-time Interactive Audio and Video Telecommunication System* to claim lines that describe services furnished via telehealth
 - Modifier -95 indicates that the service was delivered during the COVID-19 PHE
- Providers report the place of service (POS) code based on the location in which they would have normally provided the service



COVID-19 IMPACTS & TELEHEALTH

- CMS acknowledges that hospitals still provide some administrative and clinical support for services that are provided via telehealth
- When telehealth services are furnished by a physician who ordinarily practices in the hospital outpatient department to a patient located at home or other site (e.g. nursing facility), CMS will permit the hospital to bill and be paid the originating site facility fee amount for those telehealth services
- Hospitals may also bill the facility fee if the physician is at a distant site and the patient is located in the hospital outpatient department
- CMS requires documentation in the medical record of the reason for the visit and the necessity of the visit

COVID-19 IMPACTS & RADIATION ONCOLOGY TREATMENT MANAGEMENT

- Telehealth flexibilities are broadened to include radiation oncology on-treatment visits (OTVs) under CPT 77427 *Radiation Treatment Management, 5 treatments* to ensure both care teams and patients are protected from exposure to the virus
- Telehealth OTV requires the provider to use an interactive audio and video telecommunications system for real-time two-way communication between provider and patient
- ASTRO advises that telehealth option should be used judiciously and only during this emergency to protect the patient or physician from exposure to COVID-19 virus

COVID-19 IMPACTS & SUPERVISION POLICY

- CMS relaxed the definition of Direct Supervision in hospitals and freestanding facilities to allow supervision to be provided using real-time interactive audio and video technology
- The remotely supervising physician must still be immediately available to provide assistance and direction
- Local regulatory requirements may still require onsite supervision



COVID-19 IMPACTS & HOSPITAL SUPERVISION POLICY

- During COVID-19 PHE, CMS allows Direct Supervision of hospital outpatient diagnostic services to be met through the virtual presence of the physician through audio and video real-time communications technology
 - Includes CPT 77014 and 77421

COVID-19 IMPACTS & SUPERVISION POLICY

- Nonphysician practitioners may order, provide directly and now supervise the performance of diagnostic tests during the COVID-19 PHE
 - Applies to diagnostic X-ray tests, diagnostic laboratory tests and other diagnostic tests
 - Applies to nurse practitioners, clinical nurse specialists, physician assistants and certified nurse-midwives
- Teaching physicians may use audio and video, real-time communications technology to interact with residents through virtual means, which would meet the requirement that they be present for the key portion of the service
 - Does not apply in the case of surgical, high-risk, interventional, or other complex procedures, services performed through an endoscope, and anesthesia services



COVID-19 IMPACTS & PRIOR AUTHORIZATION

- CMS is pausing its standard medical review policies, including Prior Authorization
- No additional details provided in the interim final rule

ADDITIONAL SLIDES AND Q&A

- Discussing either:
 - 2021 Proposed Rules
 - 2020 Final Rules
 - RO-APM Final Rule
- Go to:
 - <https://bit.ly/AAPM-ECON>