



Documentation & Coding for Radiation Oncology Part 1

AAMD Regional VI Meeting
November 3 – 4, 2017
Double Tree Suites
Columbus, Ohio

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This presentation was prepared as a tool to assist attendees in learning about documentation, charge capture and billing processes. It is not intended to affect clinical treatment patterns. While reasonable efforts have been made to assure the accuracy of the information within these pages, the responsibility for correct documentation and correct submission of claims and response to remittance advice lies with the provider of the services. The material provided is for informational purposes only.

Efforts have been made to ensure the information within this document was accurate on the date of presentation. Reimbursement policies vary from insurer to insurer and the policies of the same payer may vary within different U.S. regions. All policies should be verified to ensure compliance.

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Objectives of this Presentation

- Stress Importance of Compliance
- Educate Attendees on Applying Proper Coding
- Emphasize Utilization of Current Reference Materials
- Allow Interactive Discussion for Questions & Advice

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Acronyms

- **CMS** Centers for Medicare & Medicaid Services
- **MAC** Medicare Administrative Contractor
- **NCD** National Coverage Determination
- **LCD** Local Coverage Determination
- **CPT®** Current Procedural Terminology
- **APC** Ambulatory Payment Classification
- **HOPPS** Hospital Outpatient Prospective Payment System
- **MPFS** Medicare Physician Fee Schedule
- **RVU** Relative Value Unit
- **PE** Practice Expense
- **MP** Malpractice
- **CF** Conversion Factor
- **RUC** Relative Value Scale Update Committee
- **NCCI** National Correct Coding Initiative
- **MUE** Medically Unlikely Edit
- **OIG** Office of Inspector General

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Billing & Coding Overview

Authoritative Guidance

Legislative Updates

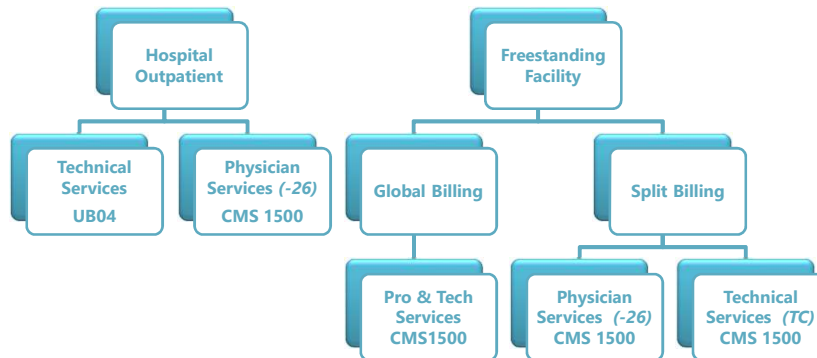
Medicare Program

Hot Topics

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Billing Scenarios



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Payment Systems

MPFS

CPT	Modifier	2017 Payment
77280	Global	\$278.86
	TC	\$241.89
	26	\$36.97
77290	Global	\$525.41
	TC	\$442.87
	26	\$82.54
77295	Global	\$499.57
	TC	\$273.83
	26	\$225.74
77301	Global	\$1,989.67
	TC	\$1568.70
	26	\$420.97

HOPPS

CPT	APC	2017 Payment
77280	5611	\$117.53
77290	5612	\$311.43
77295	5613	\$1,065.79
77301	5613	\$1,065.79

Services in the same APC group are paid at the same rate

In a hospital setting the physician is paid based on MPFS for the professional component

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Claims Submission



HOPPS on UB04

- Series or Recurring Accounts
- Physician = Attending MD
- Revenue Code



MPFS on CMS1500

- Daily, weekly, etc.
- Physician = MD providing service/supervision
- Address should match the physical location services rendered
- Place of Service Code
- 26/TC modifiers
- Q6 Modifier for Locum Tenens

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Authoritative Guidance

- Federal Register
- Centers for Medicare & Medicaid Services (CMS)
- American Medical Association & CPT® Manual
- OIG Compliance Standards
- Commercial Payer Policies

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Federal Register

- Document actions of Federal agencies and forum for public review and comment
- Publications include: Presidential Documents, Rule & Regulations, Proposed Rules and Notices



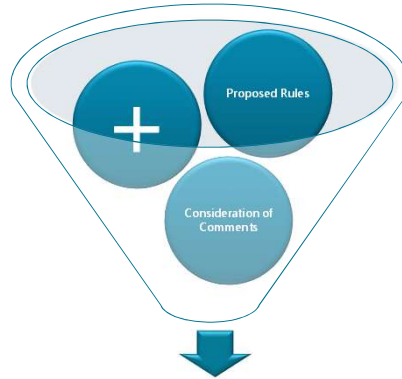
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Proposed vs. Final Rule

Proposed Rule:

- CMS plans, goals, solutions to problems and proposed rulemaking
- Opportunity for public to make comments



Final Rule:

- Final legal effect after consideration of comments

FINAL RULE

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2017 Final Rule Highlights

MPFS

- Conversion Factor change, slight increase
- RVUs adjusted for several Rad Onc codes
- Moderate sedation values removed from several codes = decrease work RVUs
- Office space & rental equipment rental charge changes for lessors to lessees

HOPPS

- 1.7% increase in reimbursement payments
- Simulation and Planning APCs restructured
- IORT codes new C-APC w/ SRS codes
- APC changes to simulation and planning codes
- Provider-based Department designation changes

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2018 Proposed Rule Highlights

MPFS

- Conversion Factor change, slight increase
- Malpractice RVU update
- New physician code for superficial radiation therapy
- New code for spacer gel placement
- Planning to revamp E/M guidelines
- Nonexcepted PBDs paid at 25% HOPPS rate

HOPPS

- 1.75% increase in reimbursement payments
- SRS C-APC no longer using modifier CP
- Brachy insertion code edits to ensure brachy TX code is billed on same claim
- PSI LDR brachy composite APC deleted and codes in C-APC
- Supervision changes in CAHs and rural hospitals <100 beds

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HOPPS Proposed Rule CY 2018



FEDERAL REGISTER

Public Inspection :: Tomorrow's Documents Today

0 Sign in Sign up

PR Public Inspection :: Proposed Rule

Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs

<https://www.federalregister.gov/documents/2017/07/20/2017-14883/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment>

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Final Rule Update

- **HOLD THE PRESSES!**
 - The final rules are coming out as we speak!
 - We are in the process of digesting the information
 - I will highlight some of the changes

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HOPPS Payment Rates

- Proposing 1.75% (**1.35%**) increase to Outpatient Department (OPD) fee schedule
 - Based on 2.9% (**2.7%**) increase for inpatient services paid under inpatient prospective payment system (IPPS), Proposed multifactor productivity (MFP) adjustment -0.4% (**-0.6%**) & Proposed Affordable Care Act adjustment of -0.75% (**-0.75%**)
- Payments in CY 2018 are expected to be ~\$70 billion, increase of ~5.7 (**5.8**) billion from CY 2017 OPPS payments
- Proposed Conversion Factor (CF) to increase 1.75% from CY 2017 to equal \$76.483 (**\$78.636**) (\$74.953 for hospitals that fail to meet the Hospital OQR Program requirements
- Proposing to continue 2.0% (**2.0%**) reduction for hospitals failing to meet outpatient quality reporting requirements

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Additional Payment Adjustments

- Rural adjustment of 7.1% (**7.1%**) to the OPPS payments to certain rural sole community hospitals (SCHs), including essential access community hospitals (EACHs)
 - Excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy
- Ambulatory Surgical Center (ASC) payment proposed to increase by 1.9% (**1.2%**) that meet quality reporting under ASCQR program
- Cancer Hospital Payment Adjustment
 - Beginning CY 2018 the 21st Century Cures Act requires this weighted average PCR be reduced by 1.0 percentage point
 - Proposed target PCR of 0.89 (**0.88**) would be used to determine the CY 2018 cancer hospital payment adjustment to be paid at cost report settlement

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Standardizing APC Payment Weights (Finalized)

- APCs group services which are considered clinically comparable to each other with respect to the resources utilized and the associated cost
- Ancillary services or items which are necessary components of the primary service are packaged into the APC rates and not separately reimbursed
- Code G0463, clinic visit, proposed to be used as standardization for weighting APCs, assigned a weight of 1.00 again in CY 2018

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Comprehensive APCs (C-APCs) **(Finalized)**

- C-APC's package payments for ancillary and secondary items, services and procedures into the most costly primary procedure under HOPPS at the claim level
- No new C-APCs for CY 2018 proposed, but some changes and updates to existing one
 - C-APC SRS Treatment Course
 - Brachytherapy Insertion Procedures

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C-APC Stereotactic SRS

- C-APC 5627 (Level 7 Radiation Therapy) Stereotactic Radiosurgery (SRS), created in CY 2015
- CY 2012 Law required code 77371 (Cobal-60-based) & 77372 (LINAC-based) SRS treatments paid same amount
- Intention of the SRS C-APC was the inclusion of simulation and planning services into the treatment delivery code and all reported together on the same claim
- Differences in billing patterns between the different forms of SRS created an issue when valuing the reimbursement for the C-APC
- CMS developed the modifier "CP" to identify services ancillary to the treatment delivery code, but were reported on a different claim than the treatment delivery code itself

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C-APC Stereotactic SRS cont.

- "CP" modifier required in CY 2016 & 2017 on services billed not on same claim, but 30 days prior to tx delivery and not one of 10 removed codes
 - "CP" modifier ends 12/31/17, not to be used in CY 2018
- Due to billing patterns varying per SRS modality, 10 codes removed from C-APC and paid separately from SRS tx (70551, 70552, 70553, 77011, 77014, 77280, 77285, 77290, 77295, and 77336)
 - CMS proposing to continue paying 10 codes separately, reassess the re-bundling back into APC in future rulings

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Brachytherapy Insertion Procedures

- CY 2017 several brachy C-APCs introduced
 - Comments indicated insertion codes and HDR tx codes rarely billed on claim together, concerns on ratesetting
 - CMS commented they do not exclude claims billed incorrectly, would assess claims going forward
- Analysis for CY 2018 supported many insertion codes billed without corresponding brachy tx code
 - Many of claims did not include the treatment delivery code 77750 – 77799 along with insertion code 57155, 20555, 31643, 41019, 43241, or 55920
 - CMS proposing new coding edits, insertion code required to be reported with tx delivery code

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Deletion of Composite APC

8001

- CMS is proposing to delete composite APC 8001 (LDR Prostate Brachytherapy Composite)
- Proposing to assign HCPCS code 55875 SI "J1" and to a C-APC 5375 (Level 5 Urology and Related Services)
- CMS would require 55875 (needle insertion) & 77778 (LDR tx) to be billed on same claim per edits
 - Code 77778 and all other ancillary codes on the same claim as the surgical insertion would be packaged into the placement code and not separately reimbursed (**comments considered and the edit was not finalized, do not need to report on same claim**)

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Brachytherapy Insertion Codes


Edits (No Edits were finalized – No reporting changes)

- CMS is proposing to create a series of edits which will tie the brachytherapy insertion codes to the brachytherapy treatment delivery codes
- Each insertion code has a status indicator of J1 – each is part of a C-APC and all ancillary services are billed as appropriate and per edits, but not all paid
- CMS proposing to require the insertion codes listed in Table 5 from HOPPS proposed rule must be billed on same claim as the treatment delivery code

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TABLE 5.—PROPOSED BRACHYTHERAPY INSERTION PROCEDURES ASSIGNED TO STATUS INDICATOR "J1"	
HCPCS Code	Long Descriptor
19296	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy
19298	Placement of radiotherapy after loading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance
19499	Unlisted procedure, breast
20555	Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)
312643	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of catheter(s) for intracavitary radioelement application
41019	Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application
43241	Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube catheter
55875	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy
55920	Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application
57155	Insertion of uterine tandem and/or vaginal ovoids for clinical Brachytherapy
58346	Insertion of Heyman capsules for clinical brachytherapy

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APC 2 Times Rule Exceptions

(Finalized)

- CMS identified 12 APCs in which the 2 times rule violation was found – one specific to radiation oncology
 - APC 5611 (Level 1 Therapeutic Radiation Treatment Preparation) and includes HCPCS codes 77280, 77299, 77300, 77316, 77331, 77332, 77333, 77336, 77370 and 77399
- 2 times rule does not allow the codes to be assigned to an APC where the highest costing code is more than 2 times that of the lowest costing code
- When a 2 times rule violation is identified, CMS and the HOP Panel will reassign codes or create a new APC
- CMS stated all 12 APC meet exception criteria for CY 2018, no changes proposed

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Brachytherapy Sources (Finalized)

- CMS is proposing to use costs derived from CY 2016 claims data to set the proposed CY 2018 payment rates
 - Base the payment rates for brachytherapy sources on the geometric mean unit costs for each source
- Brachytherapy sources, unless otherwise noted, are assigned status indicator (SI) "U"
 - Codes with SI "U" are not packaged into C-APCs
- Sources with no claims data assigned SI "E2" (Items and Services for Which Pricing Information and Claims Data Are Not Available)

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Therapeutic Radiopharmaceuticals (Finalized)

- New drugs, biologicals and radiopharmaceuticals are granted pass-through status by Medicare
 - Establishes transitional payment until enough data is acquired to determine if the new agent is to be paid separately or packaged into an APC
- Therapeutic radiopharmaceuticals with pass-through status paid at average sales priced (ASP) +6%
 - If no data, then paid whole acquisition cost (WAC) +6% or 95% of average wholesale price (AWP)
- If pass-through status has expired, a rate is established per CMS and packaging and bundling guidelines

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Packaging Policies (Finalized)

- Due to frequency of billing for low-cost drug administration codes, CMS is proposing to include in packaging policies
- Proposing admin codes in APCs 5691 & 5692 to be packaged when performed with another separately payable service
 - Drug admin should be separately paid when reported alone
- Conditional packaging could impact rad onc departments who provide hormone injections i.e. Lupron with code 96372 (therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular)

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~~If performed with another service, may not be~~



Supervision of Therapeutic Services

- Since CY 2009 CMS has clarified that direct supervision is required for hospital outpatient therapeutic services covered and paid by Medicare in a hospital or provider-based department
- Stakeholders in critical access hospitals (CAHs) and rural hospitals with 100 or fewer beds have consistently requested nonenforcement of direct supervision due to insufficient staffing and inability to recruit physicians and nonphysician practitioners to practice in rural areas

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Proposed Supervision Changes cont. (Finalized)

- Stakeholders called out radiation oncology specifically in finding someone to supervise who is not from emergency dept. or nonphysician practitioner
- CMS is proposing for CY 2018 and 2019 to reinstate nonenforcement of direct supervision for outpatient therapeutic services for CAHs and small rural hospitals having 100 or fewer beds.
- CMS believes this will provide these specific locations more time to comply with the supervision requirements of therapeutic services.
- All parties will have time to submit specific services to be evaluated for the recommended change in supervision level to the Advisory Panel on the Hospital Outpatient Payment

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Comment Period & Final Rules

- Deadline for submitting comments was September 11, 2017
 - Electronic submission is encouraged by CMS, <http://www.regulations.gov>.
- Final 2018 Rules will be released in late November

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Medicare Program Overview

Health insurance managed by the Federal government

- Medicare Administrative Contractors (MACs)
- Claims Processing
- Rules & Regulations
- Program Integrity

"The MACs serve more than 1.5 million health care providers enrolled in the Medicare FFS program. Collectively, the MACs process more than 1.2 billion Medicare FFS claims annually, 210 million Part A claims and more than 1 billion Part B claims, and paid \$367 billion in Medicare benefits." Source: CMS.gov

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Medicare Administrative Contractors

Companies awarded a bid to be the Medicare provider for a specific region of the country

- Enroll health care providers in the Medicare program and educate providers on Medicare billing requirements
- Answer provider and beneficiary inquiries
- Publish guidelines and coverage for services within Local Coverage Determinations (LCDs)
- Central point of claims processing for Part A and B
- 10 year term, then re-bid process begins


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**AAMD Region VI Meeting
November 3 – 4, 2017
Columbus, Ohio**



MAC	States Covered
Novitas-Solutions www.novitas-solutions.com	Arkansas, Colorado, Delaware, DC, Louisiana, Maryland, Mississippi, New Jersey, New Mexico, Oklahoma, Pennsylvania, Texas, Virginia (counties of Arlington, Fairfax & City of Alexandria)
Cahaba GBA www.cahabagba.com	Alabama, Georgia, Tennessee
Noridian Healthcare Solutions www.noridianmedicare.com	Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming, American Samoa, California, Guam, Hawaii, Nevada, Northern Marianas Islands
Palmetto GBA www.palmettogba.com	North Carolina, South Carolina, Virginia (except areas noted as Novitas), West Virginia
NGS www.ngsmedicare.com	Connecticut, Illinois, Maine, Massachusetts, Minnesota, New Hampshire, New York, Rhode Island, Vermont, Wisconsin
First Coast Service Options www.medicare.fcso.com	Florida, Puerto Rico, Virgin Islands
WPS Government Health Administrators www.wpsgha.com	Indiana, Iowa, Kansas, Michigan, Missouri, Nebraska
CGS www.cgsmedicare.com	Kentucky, Ohio

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CMS Publications

Manuals & Transmittals

National Correct Coding Initiative (NCCI)

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Medicare Claims Processing Manual

- Numerous Internet-Only Manuals (IOMs) are published and provide additional guidance
 - Chapter 1 – General Billing Requirements
 - Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPSS)
 - Chapter 12 - Physicians/Nonphysician Practitioners
 - Chapter 13 – Radiology Services and Other Diagnostic Procedures
 - Chapter 17 – Drugs and Biologicals
 - Chapter 22 – Remittance Advice
 - Chapter 23 – Fee Schedule Administration and Coding Requirements

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html?DLPage=1&DLSort=0&DLSortDir=ascending>

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National Correct Coding Initiative (NCCI)

- Developed to promote correct coding and control improper coding resulting in inappropriate payments
- Based on coding conventions defined by the CPT® Manual
- Updated Quarterly
- Practitioner versus hospital outpatient publications
- Edits include:
 - Procedure to Procedure (PTP)
 - Medically Unlikely Edits (MUE)

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/NationalCorrectCodInitEd/>

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PTP Edits

- CPT® codes listed in either Column 1 or Column 2
- Indication:
 - 0 – Rule “zero chance of getting paid” = Modifier not allowed
 - 1 – Rule “one chance of getting paid” = Modifier allowed
 - 9 – Rule no longer applicable “typically in place originally in error”

Column 1	Column 2	Effective Date	Deletion Date	Indication
77290	77336	20031001		1
77306	77300	20150101		0
77295	77300	20160101	20160101	9
77301	77290	20020101		0

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Modifiers

- Two digit designation added to the end of a CPT® code, provides additional information about the billed procedure
- Classified as either:
 - *Payment modifier*
 - *Information modifier*

- 24 – Unrelated E&M w/in global period
- 25 – E&M /procedure on same day
- 26 – Professional Component
- TC – Technical Component Only
- 58 – Staged or related procedure
- 59 – Distinct Procedural Service
- 76 – Repeat procedure or service

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X Modifiers

- XE** Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
- XS** Separate Structure, A Service That IS Distinct It Was Performed On A Separate Organ/Structure
- 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

Developed to provide greater reporting specificity in lieu of modifier 59 when possible.

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Medically Unlikely Edits (MUEs)

- Predetermined quantity allowed for a particular CPT® code on a date of service
- Published on Medicare Website
- Updated quarterly
- May be claim line or date of service edit

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MUE Adjudication Indicator (MAI)

- Assigned to each published code
- MAI levels include:
 - "1" – Adjudicated as a claim line edit
 - "2" – Per day edits based on policy
 - "3" – Per day edits based on clinical benchmarks
- Denials for MAI "1" or "3" may be appealed and paid for correctly coded and medical necessary units in excess of MUE value

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MAI of 2

MLN Matters Number: SE1422:

"An MAI of 2 indicates an edit for which the MUE is based on regulation or subregulatory instruction ("policy"), including the instruction that is inherent in the code descriptor or its applicable anatomy..."

...CMS expects all claims reporting services in excess of the MUE for edits with an MAI of 2 will represent either clerical errors or errors in the interpretation of instructions. CMS has not identified any instances in which a higher value would be correct and payable. MACs have therefore been instructed that this subregulatory instruction is binding on the MAC for both initial determinations and redeterminations, as is all subregulatory instruction."

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MAI of 3

MLN Matters Number: SE1422:

“An MAI of 3, the most common per day edit, indicates an edit for which the MUE is based on clinical information such as

- *billing patterns;*
- *prescribing instructions; or*
- *other information...*

...In the rare instance where the provider has verified all information, including the correct interpretation of coding instructions, and still believes that the correctly coded medically necessary service exceeds the MUE, the provider should submit a clearly supported appeal.”

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HCPCS/ CPT Code	Outpatient Hospital Services MUE Values	MUE Adjudication Indicator	MUE Rationale
77261	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
77262	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
77263	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
77280	2	3 Date of Service Edit: Clinical	Nature of Service/Procedure
77285	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
77290	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
77293	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
77295	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
77300	10	3 Date of Service Edit: Clinical	Clinical: Data
77301	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
77306	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
77307	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
77316	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
77317	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
77318	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
77321	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
77331	3	3 Date of Service Edit: Clinical	Clinical: Data
77332	4	3 Date of Service Edit: Clinical	Clinical: Data
77333	2	3 Date of Service Edit: Clinical	Clinical: Data
77334	10	3 Date of Service Edit: Clinical	Clinical: Data
77336	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
77338	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
77370	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
77371	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
77372	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
77373	1	3 Date of Service Edit: Clinical	Clinical: Data
77385	2	3 Date of Service Edit: Clinical	Nature of Service/Procedure

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NCCI Policy Manual

- Published annually
- Divided into chapters by code range
- Provides additional instruction and guidance

c) **Modifier 58:** Modifier 58 is defined by the *CPT Manual* as a "staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period". It may be used to indicate that a procedure was followed by a second procedure during the post-operative period of the first procedure. This situation may occur because the second procedure was planned prospectively, was more extensive than the first procedure, or was therapy after a diagnostic surgical service. Use of modifier 58 will bypass NCCI PTP edits that allow use of NCCI-associated modifiers.

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New RAC Contracts Awarded

- October 31st CMS announced awards for Medicare Fee-for-Service Recovery Audit Contractor (RACs) contracts
 - Region 1: Performant Recovery, Inc.
 - Region 2: Cotiviti, LLC
 - Region 3: Cotiviti, LLC
 - Region 4: HMS Federal Solutions
- Perform post payment reviews to identify over and underpayments for Part A & B
- RACs paid after provider's challenge has passed second level of appeal

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IMRT Reviews

- Reviews conducted by
 - Office Inspector General (OIG)

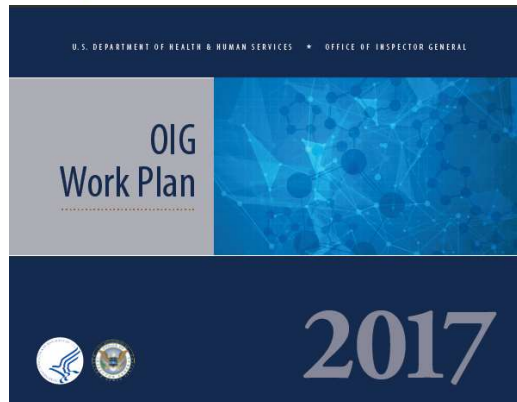
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OIG



Intensity-modulated radiation therapy (IMRT) is an advanced mode of high-precision radiotherapy that uses computer-controlled linear accelerators to deliver precise radiation doses to a malignant tumor or specific areas within the tumor. IMRT is provided in two treatment phases: planning and delivery. Certain services should not be billed when they are performed as part of developing an IMRT plan. Prior OIG reviews identified hospitals that incorrectly billed for IMRT services. We will review Medicare outpatient payments for IMRT to determine whether the payments were made in accordance with Federal requirements.

OAS: W 00 16 35733; W-00-16-35740; various reviews • Expected Issue Date: FY 2017



<https://oig.hhs.gov/reports-and-publications/archives/workplan/2017/HHS%20OIG%20Work%20Plan%202017.pdf>

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QUESTIONS

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