Radiation Oncology Model Billing Guide

March 2022

Contents

Disclaimer: This document describes the RO Model billing process and is current as of the date of publication. It assumes that the first model PY will begin January 1, 2023.

1. Introduction

This Radiation Oncology (RO) Model Billing Guide consolidates key information for health care administrators, medical coders, billing and claims processing personnel, and other medical administrative staff who are responsible for submitting claims during the model performance period. The RO Model makes prospective, episode-based payments to RO participants; for RO participants, this necessitates important changes to the way they bill for many radiotherapy (RT) services. Note that this guide does not describe the pricing methodology.

To prepare for RO Model billing, readers should have:

- Determined that they are an RT provider or RT supplier eligible for and selected to participate in the RO Model
- Determined their RO participant type (Professional participant, Technical participant, or Dual participant)
- Registered in the RO Administrative Portal (ROAP) to retrieve their RO participant-specific adjustments for case mix and historical experience, when available[1]

In addition to this guide, the RO Model website features important resources and updates, including:

- Slides and a recording from the August 24, 2021, Coding, Billing, and Pricing Methodology webinar
- A frequently asked questions (FAQ) document
- Links to the Specialty Care Models to Improve Quality of Care and Reduce Expenditures Final Rule (CMS-5527-F), which includes high-level RO Model billing instructions

Disclaimer

This document describes the RO Model billing process and is current as of the date of publication. Medicare policy changes frequently, so links to the source documents have been furnished in this guide for your reference. The guide was prepared as a service to the public and is not intended to grant rights or impose obligations. It might contain references or links to statutes, regulations, or other policy materials. The information furnished is intended only to be a general summary. It is not intended to take the place of either the written law or regulations.

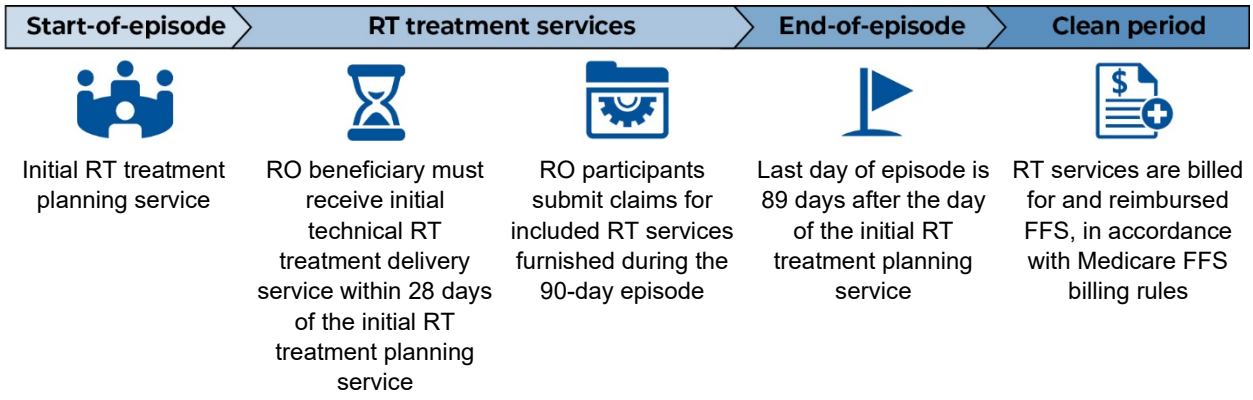
The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law. It assumes that the first performance year (PY) will begin January 1, 2023.

2. Summary of the RO Model Billing Process

In the RO Model, RO participants will bill 90-day RO episodes, using RO Model-specific Healthcare Common Procedure Coding System (HCPCS) codes to receive episode payments. RO participants will also submit encounter-like (no-pay) claims for included RT services furnished during the 90-day episode. Exhibit 1 shows a timeline of the RO Model billing process.

[1] Registration begins with retrieving your RO Model ID to access ROAP. To obtain your RO Model ID, please contact the Help Desk at 1-844-711-2664 (Option 5) or at RadiationTherapy@cms.hhs.gov. Please note that the RO participant-specific adjustments in ROAP are assuming that PY1 started in 2022. These adjustments will be updated to reflect PY1 starting in 2023.

Exhibit 1. RO Model billing timeline



[1] RO participants can submit the EOE claim with a date of service as early as Day 28 if the RO participant is certain the treatment plan is complete. The last day of the episode is still 89 days after the day of the initial RT treatment planning service.

CMS = Centers for Medicare & Medicaid Services; EOE = end-of-episode; FFS = fee-for-service; HCPCS = Healthcare Common Procedure Coding System; PC = professional component; SOE = start-of-episode; TC = technical component; RT = radiotherapy.

As shown in Exhibit 1, for eligible RT patients (RO beneficiaries), the RO Model is changing the billing process in two ways:

1. **RO participants will use RO Model-specific HCPCS codes to receive payment.** For the 15 cancer types included in the RO Model, the first claim submitted by RO participants for an RO episode is the start-of-episode (SOE) claim. This claim includes an RO Model-specific HCPCS code and V1 modifier, and it represents 50 percent of the episode payment. To receive the remaining 50 percent, RO participants must submit an end-of-episode (EOE) claim with the same RO Model-specific HCPCS code and the V2 modifier. RO episodes span 89 days after the date of the initial RT treatment planning service indicated on the professional SOE claim.

2. **RO participants will continue to submit claims for the RO Model Bundled/Packaged HCPCS codes.**
    a. **Encounter-like (no-pay) claims**. Once the SOE claim has been adjudicated and the RO participant has received an 835 remittance, RO participants will submit encounter-like (no-pay) claims for included RT services furnished during the 90-day episode. For line items that contain included RT services and included modalities for included cancer types, the remittance will indicate $0 payment—these are considered encounter-like (no-pay) claims and are used for RO Model evaluation, monitoring, and reconciliation.
    b. **Fee-for-service (FFS) claims.** The Centers for Medicare & Medicaid Services (CMS) will reimburse FFS for line items for RT services for non-included cancer types (such as liver cancer), for RT services that are not included in the RO Model (such as brachytherapy), or in certain other situations that might require a GB modifier or B1 condition code (see Appendix H).
    c. **Billing after the RO episode.** In the 28 days after the EOE (referred to as the "clean period"), all RT services are billed and reimbursed FFS, in accordance with Medicare FFS billing rules.

For RO participants that have billing questions after reviewing this Billing Guide, Appendix I provides detailed responses to billing questions that have been asked through the RO Model Help Desk.

3. RO Model Billing Process by Claim Form

An RO episode consists of two components, the **professional component (PC)**, which covers RT services that may be furnished only by a physician, and the **technical component (TC)**, which covers RT services not furnished by a physician (such as the provision of equipment, supplies, and personnel, and any costs related to RT services). The RO Model includes three types of RT providers and RT suppliers:

- **Physician group practices (PGPs)** furnish professional RT services. A PGP that does not own RT machines and only furnishes and bills for the PC would always be a Professional participant.
- **Freestanding radiation therapy centers**, a type of PGP with the machines to deliver RT, can furnish both professional and technical RT services. These centers are Dual participants when they furnish and bill for both the PC and TC for an RO episode. In rare situations, a freestanding radiation therapy center may furnish and bill for only the TC of an RO episode, and in that case would be a Technical participant. Therefore, PGPs can potentially be any of the three RO participant types depending on which component or components they are furnishing for a given episode.
- **Hospital outpatient departments (HOPDs)** furnish only technical RT services. HOPDs are always Technical participants.

Payment for the PC will be made through the Medicare Physician Fee Schedule (MPFS). Payment for the TC will be made through the MPFS or Outpatient Prospective Payment System (OPPS), depending on whether the RO participant furnishing the TC is a freestanding radiation therapy center (MPFS) or an HOPD (OPPS). When billing under the RO Model, RO participants paid according to the MPFS will complete the 837P or Health Insurance Claim Form (CMS-1500) as they normally would for Medicare patients, with some modifications. RO participants paid according to the OPPS will complete the 837I or UB-04 Uniform Bill (CMS-1450) as they normally would, with some modifications. Instructions 1 and 2 below describe the required RO Model billing modifications.

3.1. Instruction 1: RO Model Billing for 837P or CMS-1500

Professional participants and Dual participants paid according to the MPFS complete the 837P or CMS-1500 as they normally would for Medicare FFS patients, with the modifications described in Exhibit 2. Exhibit 3 shows an example CMS-1500 claim form for a PGP that is a Professional participant, highlighting the fields that are specifically impacted by the RO Model. Exhibit 4 shows an example CMS-1500 claim form for a freestanding radiation therapy center that is a Dual participant.

Exhibit 2. 837P or CMS-1500 RO Model billing for Professional participants and Dual participants

Important

For Professional participants or Dual participants that (1) elected the low volume opt-out for a PY, or (2) for Professional participants that are referring patients to an RT supplier or RT provider who is ineligible for the RO Model or has elected the low volume opt-out, please review the billing instructions in Appendix H.

Step	Description	Notes
1	Submit a claim with a professional RO Model-specific HCPCS code and an SOE modifier (V1) for the PC (and technical RO Model-specific HCPCS code for Dual participants)	• For the diagnosis code for FL 21, enter an ICD-10-CM diagnosis code associated with the included cancer type that is consistent with the RO Model-specific HCPCS code entered in FL 24D. (CMS prefers RO participants to list the ICD-10-CM diagnosis code for the included cancer type in the primary diagnosis code position. However, the claims system considers all ICD-10-CM diagnosis codes on the claim, including the other diagnosis codes listed in FL 21.) • For the date of service (FL 24A) for the PC, which also represents the beginning of the 90-day episode, enter the date of the initial RT treatment planning service. (This date will be the same as the date on the encounter-like [no pay] claim that includes HCPCS codes 77261, 77262, or 77263 for the initial RT treatment planning service.) – **Dual participants**: For the date of service (FL 24A) for the technical RO Model-specific HCPCS code, enter the date when the first RT treatment delivery service was furnished for this episode. • In the procedures, services, or supplies field (FL 24D), enter the professional RO Model-specific HCPCS code for the included cancer type and the V1 SOE modifier indicating that this is an SOE claim. – **Dual participants**: Also, in FL 24D, enter the technical RO Model-specific HCPCS code for the included cancer type and the V1 SOE modifier indicating that this is a claim for the start of the TC. Dual participants may submit the professional and technical RO Model-specific HCPCS codes on the same claim. • In the diagnosis pointer field (FL 24E), enter a value of A if the included cancer type's ICD-10-CM diagnosis code is listed first in FL 21. Otherwise, use the value that corresponds to the cancer type's ICD-10-CM diagnosis code position in FL 21. • In the charges fields (FL 24F and FL 28), enter at least 50 percent of the trended national base rate for the PC for the cancer type. If the RO beneficiary is being treated for multiple included cancer types, the RO participant may select which RO Model-specific HCPCS code to submit (FL 24D). – **Dual participants**: Also, in the charges fields (FL 24F and FL 28), enter at least 50 percent of the trended national base rate for the TC for the cancer type.

Step	Description	Notes
		• In the days or units field (FL 24G), enter 1. • In FL 32, enter the address of the physical location where the PC services were furnished. (The claims system will first look at FL 32 to see if the service location is in a participating ZIP Code. The system will then look at FL 21 for an included ICD-10-CM diagnosis code associated with an included cancer type. If such a code is present, the system will expect to find an RO Model-specific HCPCS code and related information in FL 24.) – **Dual participants**: Also, in FL 32, enter the address of the physical location where the TC services were furnished. • CMS will use standard Medicare procedures to process claims for RO beneficiary cost-sharing. Generally, a 20 percent coinsurance will apply to SOE and EOE claims. Coinsurance will not be applied to encounter-like (no-pay) claims. • Populate all other claim fields as they would be for a typical FFS claim.
2a	During the 90-day episode, submit encounter-like (no-pay) claims for included RT services as you normally would	• In the charges fields (FL 24F and FL 28), enter the usual FFS charges. During the 90-day episode, the Medicare Administrative Contractor (MAC) will send the RO participant an 835 remittance with "CARC: 234 — This procedure is not paid separately" for included RT services that involve included modalities for an included cancer type. These submissions are referred to as encounter-like (no-pay) claims. RO participants may submit encounter-like (no-pay) claims in bulk or on the dates of service. • RT services for cancer types, treatments, or modalities that are not included in the RO Model will continue to be billed and paid FFS.
2b	If applicable, submit FFS claims for scenarios requiring lines with the GB modifier	See Appendix H for information on how to submit claims for scenarios such as: • Included RT services furnished for a non-included cancer type. • Included RT services furnished by an RO participant that did not initiate the PC of the RO episode. – **Dual participants**: Included RT services furnished by an RO participant that did not initiate the TC of the RO episode
3	Submit a claim with the same RO Model-specific HCPCS code and an EOE modifier (V2) for the PC (and TC for Dual participants)	• Submit the EOE claim after the RT course of treatment is completed (with a date of service no earlier than 28 days after the SOE for the PC) if, to the best of your knowledge, the treatment plan is complete. (Any RT services furnished by the RO participant after the EOE claim is submitted will not be paid separately during the remainder of the 90-day RO episode.) • For the date of service (FL 24A), enter the date that the last included RT service was furnished. • In the procedures, services, or supplies field (FL 24D), enter the same professional RO Model-specific HCPCS code as submitted for the SOE claim along with the V2 EOE modifier indicating that this is an EOE claim. – **Dual participants**: Also enter the same technical RO Model-specific HCPCS code as submitted for the SOE claim and the V2 EOE modifier. Again, both professional and technical HCPCS codes can be included on the same claim. • In the charges field (FL24F), enter at least 50 percent of the trended national base rate for the same professional RO Model-specific HCPCS code as submitted for the SOE claim. – **Dual participants**: Also enter at least 50 percent of the trended national base rate for the same technical RO Model-specific HCPCS code as submitted for the SOE claim. • For other fields, use the same values as used for the SOE claim.

Step	Description	Notes
4	During the 28-day clean period after the EOE, submit FFS claims for included RT services as you normally would	• These claims are billed in accordance with Medicare FFS billing rules, are not subject to episode payments, and do not require the GB modifier. • If included RT services are furnished after the 28-day clean period, a new RO episode may be initiated, requiring a new SOE claim (Step 1).

Exhibit 3. CMS-1500: Example claim for a PGP that is a Professional participant

This exhibit shows an example PC claim form for a PGP that is a Professional participant, highlighting the fields that are specifically impacted by the RO Model. This example is the SOE claim for the PC of a lung cancer episode.

Please note: The claims systems will first look at FL 32 to see if the service location address is located in a participating ZIP Code. The system will then look at FL 21 for an included ICD-10-CM diagnosis code associated with an included cancer type. If so, the system will expect an RO Model-specific HCPCS code and related information to be included in FL 24.

Field Locators to Note:

FL 21: ICD-10-CM Diagnosis Code. In this example, the ICD-10-CM diagnosis code is for lung cancer.

FL 24A: Date(s) of Service. The date this beneficiary's initial RT treatment planning service was furnished. This also indicates Day 1 of the 90-day episode.

FL 24D: HCPCS Code and Modifier. The professional RO Model-specific HCPCS code for lung cancer, and the V1 SOE modifier, indicating that this is an SOE claim.

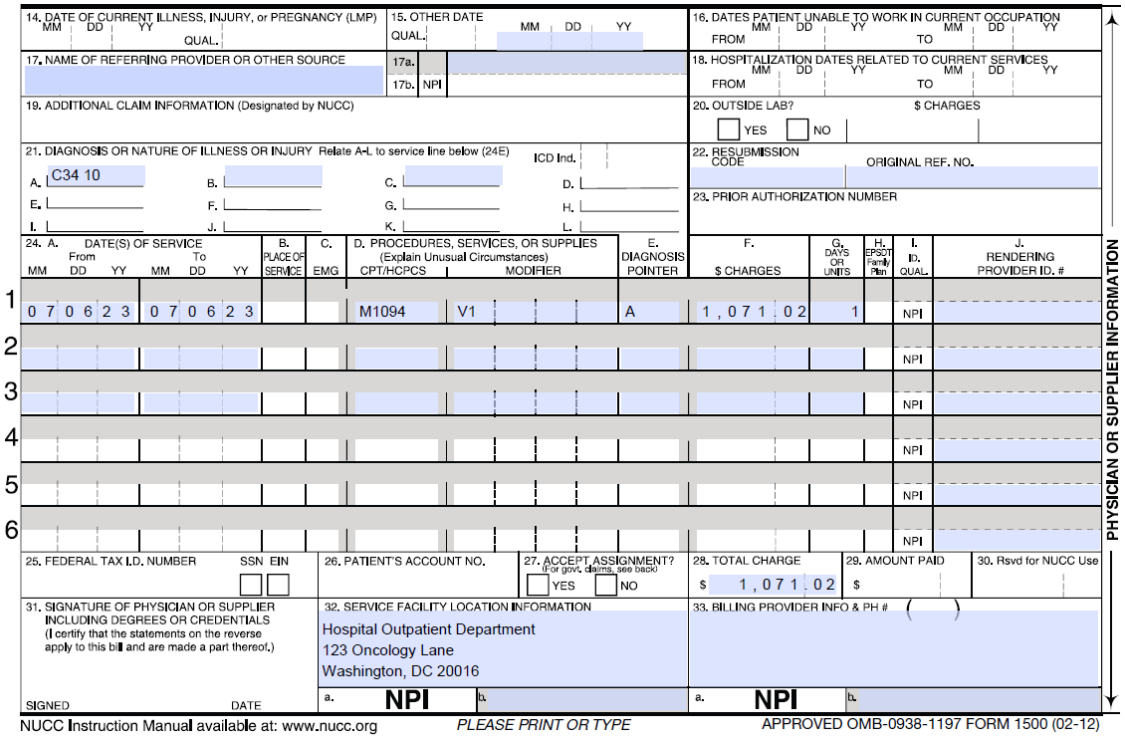
FL 24E Diagnosis Pointer. Points to the position of the ICD-10-CM diagnosis code for lung cancer in FL 21.

FL 24F: Charges. The charge amount is at least half of the trended national base rate for the professional RO Model-specific HCPCS code for lung cancer.

FL 24G: Days or Units. Number of days or service units.

FL 28: Total Charge. Sum of charges listed in FL 24F.

FL 32: Service Facility Location. The physical address where the PC of the RO episode was furnished. In this example, the PGP is a Professional participant furnishing included RT services in an HOPD that is physically located in a ZIP Code within a Core-Based Statistical Area (CBSA) selected for participation in the RO Model.



All other fields should be completed per the usual Medicare billing guidelines. HCPCS codes and charges for individual services may not appear on the same claim as RO Model-specific HCPCS codes.

Exhibit 4. CMS-1500: Example claim for a freestanding radiation therapy center that is a Dual participant

This exhibit shows an example claim form for both the PC and TC for a freestanding radiation therapy center that is a Dual participant. Dual participants can submit the professional and technical RO Model-specific HCPCS codes on the same claim. This example is an SOE claim for both the PC and TC of an RO episode for breast cancer.

Field Locators to Note:

FL 21: ICD-10-CM Diagnosis Code. In this example, the ICD-10-CM diagnosis code is for breast cancer.

FL 24A: Date(s) of Service. Line 1 lists the date this beneficiary's initial RT treatment planning service was furnished. This also indicates Day 1 of the 90-day episode. Line 2 lists the date of service that corresponds with the first RT treatment delivery service furnished in this episode. The date of service for the TC must be within 28 days of the date of service for the PC.

FL 24D: HCPCS Code and Modifier. Line 1 lists the professional RO Model-specific HCPCS code for breast cancer. Line 2 lists the technical RO Model-specific HCPCS code for breast cancer. Both lines contain the V1 SOE modifier indicating that this is an SOE claim.

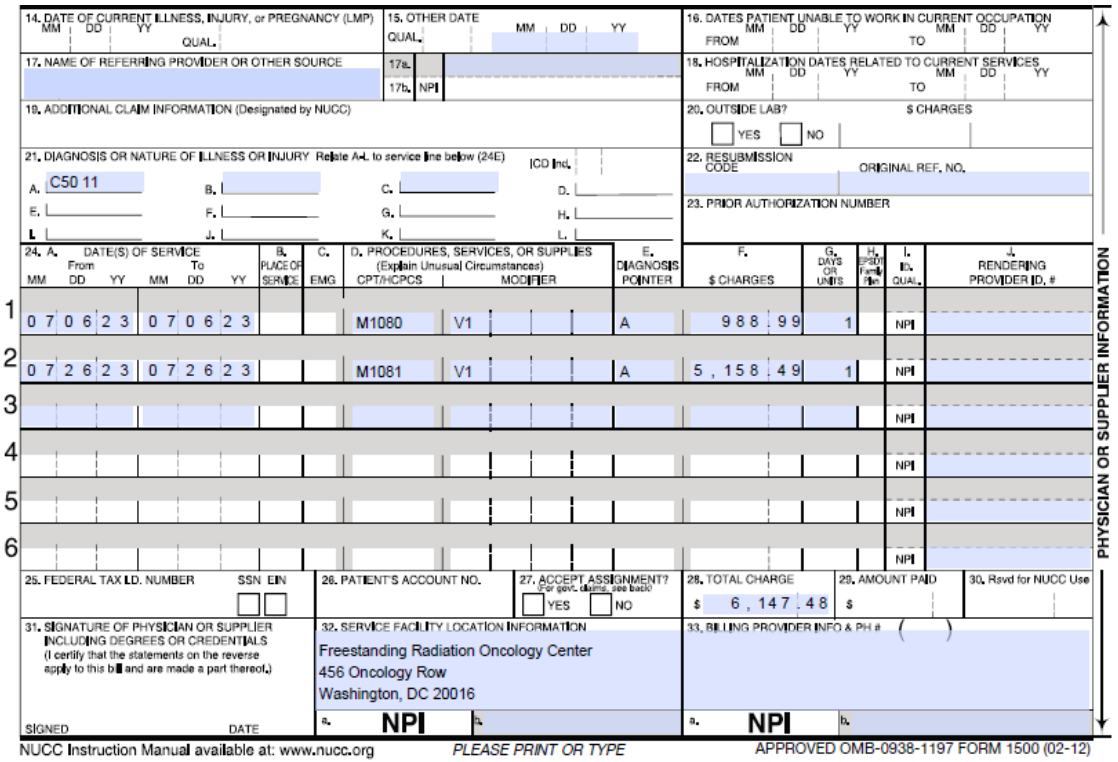
FL 24E: Diagnosis pointer. Points to the position of the ICD-10-CM diagnosis code for breast cancer in FL 21.

FL 24F: Charges. Line 1 charge is at least half of the trended national base rate for the professional RO Model-specific HCPCS code for breast cancer. Line 2 charge is at least half of the trended national base rate for the technical RO Model-specific HCPCS code for breast cancer.

FL 24G: Days or Units. Number of days or service units.

FL 28: Total Charge. Sum of charges listed in FL 24F.

FL 32: Service Facility Location. Physical address of the freestanding radiation therapy center where the PC and/or TC of the RO episode was furnished.



14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. C50 11 B. C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07 06 23	07 06 23			M1080	V1	A	988.99	1		NPI	
2 07 26 23	07 26 23			M1081	V1	A	5,158.49	1		NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $ 6,147.48
29. AMOUNT PAID $
30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
Freestanding Radiation Oncology Center
456 Oncology Row
Washington, DC 20016
a. NPI b.
33. BILLING PROVIDER INFO & PH # ( )
a. NPI b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

All other fields should be completed per the usual Medicare billing guidelines. HCPCS codes and charges for individual services may not appear on the same claim as RO Model-specific HCPCS codes.

3.2. Instruction 2: RO Model Billing for 837I or CMS-1450

RO participants paid according to the OPPS complete the 837I or CMS-1450 as they normally would for Medicare FFS patients, with the modifications described in Exhibit 5. Exhibit 6 shows an example CMS-1450 claim form for an HOPD that is a Technical participant, highlighting the fields that are specifically impacted by the RO Model.

Exhibit 5. 837I or CMS-1450 RO Model billing for Technical participants that are HOPDs

Important

For Technical participants that (1) elected the low volume opt-out for a PY or (2) were referred to by an RT supplier or RT provider who is furnishing the PC and is ineligible for the RO Model or has elected the low volume opt-out, please review the billing instructions in Appendix H.

Step	Description	Notes
1	Submit a claim with a technical RO Model-specific HCPCS code and an SOE modifier (V1) for the TC	• In FL 1, enter the address of the physical location where the TC was furnished. (The claims systems will first look at FL 1 to see if the service location address is in a participating ZIP Code. The system will then look at all fields in FL 67 for an included ICD-10-CM diagnosis code associated with an included cancer type. If such a code is present, the system will expect to find an RO Model-specific HCPCS code and related information in FL 43-47.) • In the type of bill field (FL 4), list codes 0131 or 0132, although 0132 is preferable. CMS links the episode to the claim via the modifier and not the bill type. • In the statement covers period field (FL 6), list from dates and through dates that are the same as those in FL 45 (date of first RT treatment delivery service). • In the HCPCS code field (FL 44), enter the technical RO Model-specific HCPCS code for the included cancer type and the V1 SOE modifier indicating that this claim is for the start of the TC. • For the service date (FL 45), enter the date when the first RT treatment delivery service was furnished for this episode. • In the service units field (FL 46), enter 1. • In the total charges field (FL 47), the charges entered may be a nominal amount (for example, $0.01). • For the principal diagnosis code in FL 67, enter an ICD-10-CM diagnosis code that is consistent with the RO Model-specific HCPCS code entered in FL 44. (CMS prefers RO participants to list the ICD-10-CM diagnosis code for the included cancer type in the primary diagnosis code position. However, the claims system considers all ICD-10-CM diagnosis codes on the claim, including the other diagnosis codes listed in FL 67.) • CMS will use standard Medicare procedures to process claims for RO beneficiary cost-sharing. Generally, a 20 percent coinsurance will apply to SOE and EOE claims. The hospital outpatient coinsurance for each bill will be capped at the inpatient deductible amount. Coinsurance will not be applied to encounter-like (no-pay) claims. • Populate all other claim fields as they would be for a typical FFS claim.

Step	Description	Notes
2a	During the 90-day episode, submit encounter-like (no-pay) claims for included RT services as you normally would	• In the type of bill field (FL 4), list the usual type of bill code, but do not use 0130 for these services unless you did so before RO Model implementation. • In the total charges field (FL 47), enter the usual FFS charges. During the 90-day episode, the MAC will send the RO participant an 835 remittance with "CARC: 97 — The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835" for included RT services that involve included modalities for an included cancer type. These submissions are referred to as encounter-like (no-pay) claims. RO participants may submit encounter-like (no-pay) claims in bulk or on the dates of service. • RT services for cancer types, treatments, or modalities that are not included in the RO Model will continue to be billed and paid FFS.
2b	If applicable, submit FFS claims for scenarios requiring the B1 condition code or claim lines with the GB modifier	• See Appendix H for information on how to submit claims for scenarios such as included RT services furnished for a non-included cancer type and the patient has a history of an included cancer type.
3	Submit a claim with the technical RO Model-specific HCPCS code and an EOE modifier (V2)	• Submit the EOE claim after the RT course is completed (with a date of service no earlier than 28 days after the SOE for the PC) if, to the best of your knowledge, the treatment plan is complete. (Any RT services furnished by the RO participant after the EOE claim is submitted will not be paid separately during the remainder of the 90-day RO episode.) • In the type of bill field (FL 4), list codes 0131 or 0134, although 0134 is preferable. • In the statement covers period field (FL 6), list from dates and through dates that are the same as those in FL 45 (date of last RT treatment delivery service). • In the HCPCS code field (FL 44), enter the same RO Model-specific HCPCS code as submitted for the SOE claim along with the V2 EOE modifier indicating that this is an EOE claim. • For the service date (FL 45), enter the date that the last included RT service was furnished. • In the total charges field (FL 47), the charges entered may be a nominal amount (for example, $0.01). • For other fields, use the same values as used for the SOE claim.
4	During the 28-day clean period after the EOE, submit FFS claims for included RT services as you normally would	• These claims are billed in accordance with Medicare FFS billing rules, are not subject to episode payments, and do not require the GB modifier or B1 condition code. • If included RT services are furnished after the 28-day clean period, a new RO episode may be initiated, requiring a new SOE claim (Step 1).

Exhibit 6. CMS-1450: Example claim for an HOPD that is a Technical participant

This exhibit shows an example TC claim form for an HOPD that is a Technical participant, highlighting the fields that are specifically impacted by the RO Model. This example is the SOE claim for the TC of the lung cancer episode depicted in the PC example (Exhibit 3).

Please note: The claims systems will first look at FL 1 to see if the service location address is located in a participating ZIP Code. The system will then look at FL 67 for an included ICD-10-CM diagnosis code associated with an included cancer type. If so, the system will expect an RO Model-specific HCPCS code and related information to be included in FL 43–47.

Field Locators to Note:

FL 1: Service Facility Location. Address of the HOPD's physical location; that is, the service location where the TC of the RO episode was furnished.

FL 4: Type of Bill. For the SOE claim with a V1 modifier, list codes 0131 or 0132 (0132 is preferable); for the EOE claim with a V2 modifier, list codes 0131 or 0134 (0134 is preferable).

FL 6: Statement Period. "From" and "Through" dates are the same as the service date in FL 45.

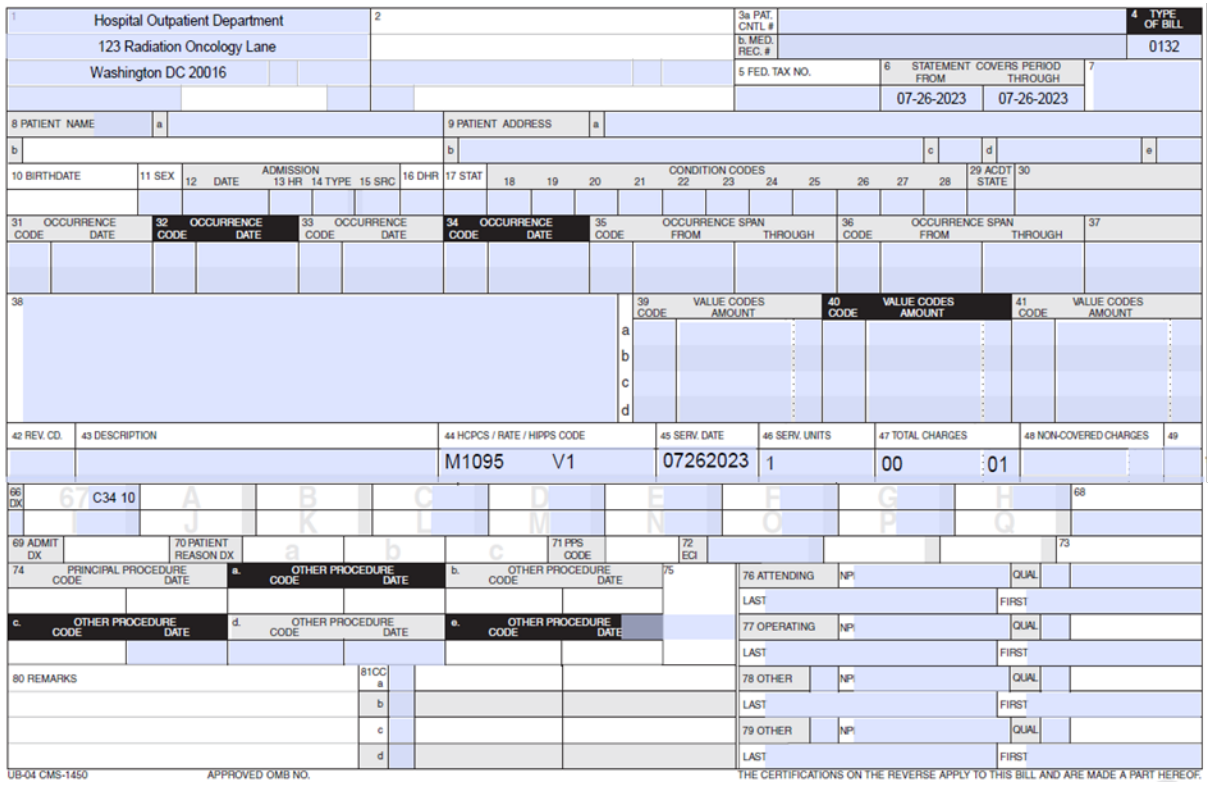
FL 44: HCPCS Code and Modifier. The technical RO Model-specific HCPCS code for lung cancer and the V1 SOE modifier indicating that this is an SOE claim.

FL 45: Service Date. The date of service that corresponds with the first treatment delivery service furnished in this episode.

FL 46: Service Units. Should always equal "1" for this type of claim.

FL 47: Total Charges. Any amount, but the suggested nominal amount is $0.01.

FL 67: ICD-10-CM Diagnosis Code. In this example, the ICD-10-CM diagnosis code is for lung cancer.



All other fields should be completed per the usual Medicare billing guidelines. HCPCS codes and charges for individual services may not appear on the same claim as RO Model-specific HCPCS codes.

4. Duplicate Services, Incomplete Episodes, and Reconciliation

In calculating the episode payment, CMS includes a 1 percent incorrect payment withhold, which reserves money for the purpose of reconciling any duplicate RT services and incomplete episodes during reconciliation. Duplicate RT services and incomplete episodes can result in RO participants earning back only a part of their incorrect payment withhold, or RO participants might owe CMS.

4.1. Duplicate Services

Duplicate services can be (1) an included RT service furnished to a single RO beneficiary by an RO Model-eligible RT provider or RT supplier (or both) that did not initiate the PC or TC for that RO beneficiary for the episode, or (2) an included RT service furnished to an RO beneficiary by an RT provider or supplier that does not operate in a participating ZIP Code but otherwise is not excluded from the RO Model. The RT service is a duplicate RT service even if the RT provider or RT supplier did not furnish the included RT service in a participating ZIP Code. An included RT service furnished to a single RO beneficiary by an RT provider or RT supplier operating in a participating ZIP Code but excluded from participation in the RO Model is not considered a duplicate RT service.

The RO beneficiary would remain under the care of the RO participant that initiated the PC or TC, and in many circumstances, the duplicate RT service would be a different modality than what is furnished by the RO participant. The RO participant(s) that bill the SOE and EOE claims would receive the episode payments, and the RT provider and/or RT supplier furnishing one or more duplicate RT services would bill claims using the GB modifier or B1 condition code to indicate that they should be paid FFS. In this case, the episode payment would be reconciled against the Incorrect Payment Withhold during the annual reconciliation process (see below).

4.2. Incomplete Episodes

Incomplete episodes can occur in four scenarios:

1. The TC is not initiated within 28 days following the Professional participant or Dual participant furnishing an initial RT treatment planning service to the RO beneficiary. (If all RT services are furnished to a beneficiary in a nonparticipating ZIP Code, even if the initial RT treatment planning service was furnished in a participating ZIP Code, the episode would be incomplete.)
2. The RO beneficiary stops meeting any of the eligibility criteria or triggers any of the exclusion criteria before the TC of an episode initiates.
3. Traditional Medicare stops being an RO beneficiary's primary payer before all included RT services in the RO episode have been furnished. (For example, this could occur if a beneficiary switches to Medicare Advantage or a private payer during the RO episode.)
4. The RO beneficiary switches their RT provider or RT supplier before all RT services in the RO episode have been furnished.

4.3. Annual Reconciliation

Reconciliation is the process of calculating reconciliation payments or repayment amounts for incomplete episodes and duplicate RT services, as well as quality reconciliation amounts and stop-loss reconciliation amounts. CMS conducts annual reconciliation for each RO participant for the previous PY to calculate

payments due to the RO participant and payments owed to CMS under the RO Model's withhold policies. The reconciliation process includes a review of incomplete episodes, duplicate RT services, any stop-loss reconciliation amount due, as well as the amount of the quality and patient experience withholds RO participants can earn back based on clinical data element (CDE) reporting, reporting of and performance on quality measures, and the beneficiary-reported Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Cancer Care Radiation Therapy Survey.

During annual reconciliation, CMS will review all claims for RT services for each RO beneficiary with dates of service during the 90-day episode to determine if a given episode qualifies as incomplete or if duplicate RT services occurred, as stipulated in the final regulations (Specialty Care Models Rule [85 FR 61114]). CMS will then reconcile the episode payments for the PC and TC that were paid to the RO participant(s) with what the FFS payments would have been for those RT services using encounter-like (no-pay) claims.

CMS calculates the total duplicate RT services amount by adding all FFS amounts for duplicate RT services furnished during each episode initiated in the PY. The duplicate RT services amount is capped for each episode and will not be more than the RO participant-specific professional episode payment amount or RO participant-specific technical episode payment amount received by the RO participant for an RO episode, even if the duplicate RT services amount exceeds the RO participant-specific professional episode payment amount or the RO participant-specific technical episode payment amount.

For all incomplete episodes initiated in the PY, CMS determines the total incomplete episode amount by calculating the difference between (1) the sum of the participant-specific episode payment amounts paid to the RO participant for all incomplete episodes that occurred during the PY, and (2) the sum of all FFS amounts that would have been paid to the RO participant in the absence of the RO Model for any included RT services furnished during the incomplete episodes, as determined by encounter-like (no-pay) claims. The difference is what CMS owes the RO participant, or what the RO participant owes CMS, for the incomplete episodes.

Any portion of the withholds that is earned back will be distributed in an annual lump sum after the reconciliation process. When an RO participant owes CMS money (reconciliation repayment) or CMS owes the RO participant money (reconciliation payment), the RO participant shall not collect beneficiary coinsurance on these amounts. Each RO participant will receive a reconciliation report that provides details underlying whether repayment is due to CMS or a payment is due to the RO participant. RO participants will have 45 days to submit a timely error notice to CMS if they believe there is an error in the reconciliation.

4.4. True-Up Reconciliation

True-up reconciliation is the process of calculating additional reconciliation payments or repayment amounts for incomplete episodes and duplicate RT services identified after the initial reconciliation and after an additional 12-month claims run-out for all RO episodes initiated in the applicable PY. CMS conducts a true-up reconciliation for each PY. Initial reconciliation will occur approximately eight months after the end of the PY (for example, in August PY2 for PY1), and true-up will be completed approximately a year after the initial reconciliation (for example, in August PY3 for PY1). True-up timing addresses the issue of delayed claims for included RT services for RO beneficiaries. The true-up does not include the quality reconciliation payment amount or the patient experience reconciliation amount.

4.5. Cases of Hospice or Death

An RO episode is included in, and paid for under, the RO Model if the RO beneficiary dies after the TC of an RO episode has been initiated, or if the RO beneficiary elects the Medicare hospice benefit after the initial treatment planning service, provided that the TC is initiated within 28 days following the initial treatment planning service. Each RO participant will receive both installments of the episode payment under such circumstances, regardless of whether the RO beneficiary dies or elects the Medicare hospice benefit before the relevant course of RT treatment has ended.

If an RO beneficiary selects the Medicare hospice benefit during an RO episode and continues their RT plan of care, the RO Model allows for RO Model payments to continue (in addition to the Medicare hospice per diem). The Medicare hospice agency will not be responsible for the cost of RT services in this case.

To prevent Coordination of Benefits issues, the EOE date for the RO episode must be prior to or on the date of death, or the day before electing the hospice benefit. In these cases, RO Model claims can be submitted prior to the calculated EOE. In other words, in cases of hospice election, the date of service for the EOE (V2) claim must be before the date of the Medicare hospice election, and in cases where the RO beneficiary dies, the date of service on the EOE (V2) claim must be equal to or prior to the date of death.

If the RO beneficiary elects the Medicare hospice benefit or dies after the initial treatment planning service but prior to the first treatment delivery service is furnished (i.e., before the TC of an RO episode has been initiated), this would be an incomplete RO episode and would be handled during reconciliation if the SOE claim was already submitted and adjudicated. These episodes would not be included in CDE reporting.

Appendix A. Cancer Types and Modalities Included in the RO Model

Included cancer types	Included modalities
1. Anal cancer	**1.** Three-dimensional conformal RT
2. Bladder cancer	**2.** Intensity-modulated RT
3. Bone metastases	**3.** Stereotactic radiosurgery
4. Brain metastases	**4.** Stereotactic body RT
5. Breast cancer	**5.** Proton beam therapy
6. Cervical cancer	**6.** Image-guided RT
7. Central nervous system (CNS) tumors	
8. Colorectal cancer	
9. Head and neck cancer	
10. Lung cancer	
11. Lymphoma	
12. Pancreatic cancer	
13. Prostate cancer	
14. Upper gastrointestinal cancer	
15. Uterine cancer	

Appendix B. Included Cancer Types and Corresponding ICD-10-CM Diagnosis Codes

Cancer Type	ICD-10-CM Diagnosis Codes
Anal Cancer	C21.xx
Bladder Cancer	C67.xx
Bone Metastases	C79.51
Brain Metastases	C79.3x
Breast Cancer	C50.xx, D05.xx
Cervical Cancer	C53.xx
CNS Tumors	C70.xx, C71.xx, C72.xx
Colorectal Cancer	C18.xx, C19.xx, C20.xx
Head and Neck Cancer	C00.xx, C01.xx, C02.xx, C03.xx, C04.xx, C05.xx, C06.xx, C07.xx, C08.xx, C09.xx, C10.xx, C11.xx, C12.xx, C13.xx, C14.xx, C30.xx, C31.xx, C32.xx, C76.0x
Lung Cancer	C33.xx, C34.xx, C39.xx, C45.xx
Lymphoma	C81.xx, C82.xx, C83.xx, C84.xx, C85.xx, C86.xx, C88.xx, C91.4x
Pancreatic Cancer	C25.xx
Prostate Cancer	C61.xx
Upper GI Cancer	C15.xx, C16.xx, C17.xx
Uterine Cancer	C54.xx, C55.xx

Appendix C. RO Model-Specific HCPCS Codes with Trended National Base Rates for 2022 (updated November 2021)[2]

Assigned HCPCS code	Professional or technical	Short descriptor	Type of service	Effective date	Paid by MPFS	Paid by OPPS	Trended national base rate	Trended national base rate divided by 2
M1072	Professional	ROM Rad Therapy Anal, PC	6	1-Jan-22	Yes	No	$2,980.42	$1,490.21
M1073	Technical	ROM Rad Therapy Anal, TC	6	1-Jan-22	Yes	Yes	$17,517.57	$8,758.79
M1074	Professional	ROM Rad Therapy Bladder, PC	6	1-Jan-22	Yes	No	$2,677.14	$1,338.57
M1075	Technical	ROM Rad Therapy Bladder, TC	6	1-Jan-22	Yes	Yes	$14,069.06	$7,034.53
M1076	Professional	ROM Rad Ther Bone Mets, PC	6	1-Jan-22	Yes	No	$1,387.57	$693.79
M1077	Technical	ROM Rad Ther Bone Mets, TC	6	1-Jan-22	Yes	Yes	$6,299.37	$3,149.69
M1078	Professional	ROM Rad Ther Brain Mets, PC	6	1-Jan-22	Yes	No	$1,583.75	$791.88
M1079	Technical	ROM Rad Ther Brain Mets, TC	6	1-Jan-22	Yes	Yes	$10,127.96	$5,063.98
M1080	Professional	ROM Rad Therapy Breast, PC	6	1-Jan-22	Yes	No	$1,977.98	$988.99
M1081	Technical	ROM Rad Therapy Breast, TC	6	1-Jan-22	Yes	Yes	$10,316.98	$5,158.49
M1082	Professional	ROM Rad Therapy Cervical, PC	6	1-Jan-22	Yes	No	$2,916.15	$1,458.08
M1083	Technical	ROM Rad Therapy Cervical, TC	6	1-Jan-22	Yes	Yes	$14,094.75	$7,047.38
M1084	Professional	ROM Rad Therapy CNS, PC	6	1-Jan-22	Yes	No	$2,455.26	$1,227.63
M1085	Technical	ROM Rad Therapy CNS, TC	6	1-Jan-22	Yes	Yes	$15,434.87	$7,717.44
M1086	Professional	ROM Rad Ther Colorectal, PC	6	1-Jan-22	Yes	No	$2,408.14	$1,204.07

[2] See RO Model-Specific HCPCS Codes with Trended National Base Rates for 2022 - November 2021 (XLS).

Assigned HCPCS code	Professional or technical	Short descriptor	Type of service	Effective date	Paid by MPFS	Paid by OPPS	Trended national base rate	Trended national base rate divided by 2
M1087	Technical	ROM Rad Ther Colorectal, TC	6	1-Jan-22	Yes	Yes	$12,646.72	$6,323.36
M1088	Professional	ROM Rad Ther Head/Neck, PC	6	1-Jan-22	Yes	No	$2,984.45	$1,492.23
M1089	Technical	ROM Rad Ther Head/Neck, TC	6	1-Jan-22	Yes	Yes	$18,223.47	$9,111.74
M1094	Professional	ROM Rad Therapy Lung, PC	6	1-Jan-22	Yes	No	$2,142.03	$1,071.02
M1095	Technical	ROM Rad Therapy Lung, TC	6	1-Jan-22	Yes	Yes	$12,477.92	$6,238.96
M1096	Professional	ROM Rad Therapy Lymphoma, PC	6	1-Jan-22	Yes	No	$1,655.34	$827.67
M1097	Technical	ROM Rad Therapy Lymphoma, TC	6	1-Jan-22	Yes	Yes	$8,239.84	$4,119.92
M1098	Professional	ROM Rad Therapy Pancreas, PC	6	1-Jan-22	Yes	No	$2,381.51	$1,190.76
M1099	Technical	ROM Rad Therapy Pancreas, TC	6	1-Jan-22	Yes	Yes	$14,129.15	$7,064.58
M1100	Professional	ROM Rad Therapy Prostate, PC	6	1-Jan-22	Yes	No	$3,245.53	$1,622.77
M1101	Technical	ROM Rad Therapy Prostate, TC	6	1-Jan-22	Yes	Yes	$21,101.22	$10,550.61
M1102	Professional	ROM Rad Ther Upper GI, PC	6	1-Jan-22	Yes	No	$2,560.84	$1,280.42
M1103	Technical	ROM Rad Ther Upper GI, TC	6	1-Jan-22	Yes	Yes	$15,233.16	$7,616.58
M1104	Professional	ROM Rad Therapy Uterus, PC	6	1-Jan-22	Yes	No	$2,628.76	$1,314.38
M1105	Technical	ROM Rad Therapy Uterus, TC	6	1-Jan-22	Yes	Yes	$14,777.08	$7,388.54

Appendix D. RO Model Bundled/Packaged HCPCS Codes

HCPCS	HCPCS description	Category
77014	Computed tomography guidance for placement of radiation therapy fields	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77021	Magnetic resonance guidance for needle placement	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77261	Radiation therapy planning	Treatment Planning
77262	Radiation therapy planning	Treatment Planning
77263	Radiation therapy planning	Treatment Planning
77280	Set radiation therapy field	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77285	Set radiation therapy field	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77290	Set radiation therapy field	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77293	Respirator motion mgmt simul	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77295	3-d radiotherapy plan	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77299	Radiation therapy planning	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77300	Radiation therapy dose plan	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77301	Radiotherapy dose plan imrt	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77306	Telethx isodose plan simple	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77307	Telethx isodose plan cplx	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77321	Special teletx port plan	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77331	Special radiation dosimetry	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77332	Radiation treatment aid(s)	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77333	Radiation treatment aid(s)	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77334	Radiation treatment aid(s)	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77336	Radiation physics consult	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77338	Design mlc device for imrt	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77370	Radiation physics consult	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77371	Srs multisource	Radiation Treatment Delivery

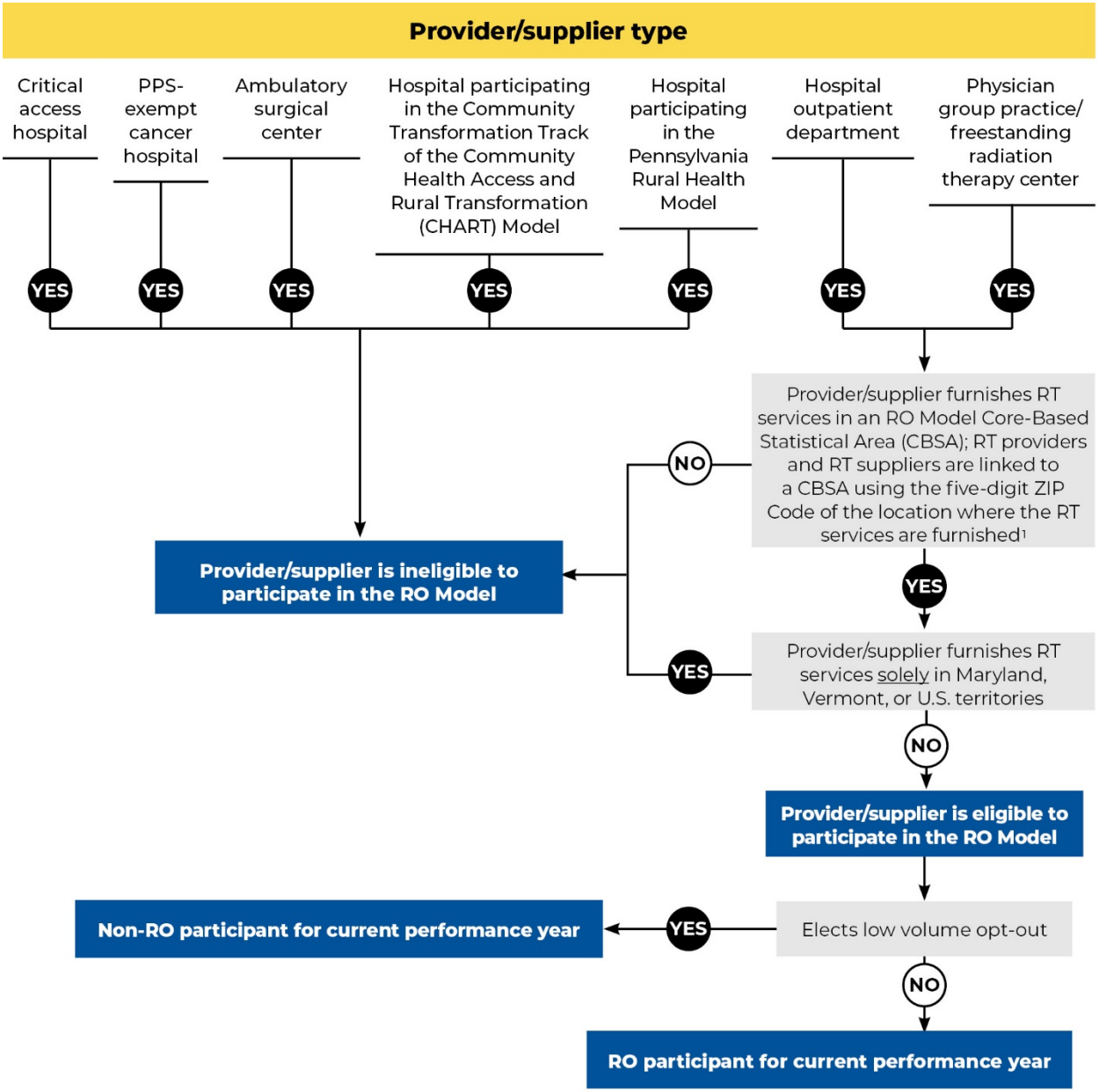
HCPCS	HCPCS description	Category
77372	Srs linear based	Radiation Treatment Delivery
77373	Sbrt delivery	Radiation Treatment Delivery
77385	Ntsty modul rad tx dlvr smpl	Radiation Treatment Delivery
77386	Ntsty modul rad tx dlvr cplx	Radiation Treatment Delivery
77399	External radiation dosimetry	Medical Radiation Physics, Dosimetry, Treatment Devices, Special Services
77402	Radiation treatment delivery	Radiation Treatment Delivery
77407	Radiation treatment delivery	Radiation Treatment Delivery
77412	Radiation treatment delivery	Radiation Treatment Delivery
77417	Radiology port images(s)	Radiation Treatment Delivery (Guidance)
77427	Radiation tx management x5	Treatment Management
77431	Radiation therapy management	Treatment Management
77432	Stereotactic radiation trmt	Treatment Management
77435	Sbrt management	Treatment Management
77470	Special radiation treatment	Treatment Management
77499	Radiation therapy management	Treatment Management
77520	Proton trmt simple w/o comp	Radiation Treatment Delivery
77522	Proton trmt simple w/comp	Radiation Treatment Delivery
77523	Proton trmt intermediate	Radiation Treatment Delivery
77525	Proton treatment complex	Radiation Treatment Delivery
G0339	Robot lin-radsurg com, first	Radiation Treatment Delivery
G0340	Robt lin-radsurg fractx 2-5	Radiation Treatment Delivery
G6001	Echo guidance radiotherapy	Radiation Treatment Delivery (Guidance)
G6002	Stereoscopic x-ray guidance	Radiation Treatment Delivery (Guidance)
G6003	Radiation treatment delivery	Radiation Treatment Delivery
G6004	Radiation treatment delivery	Radiation Treatment Delivery
G6005	Radiation treatment delivery	Radiation Treatment Delivery
G6006	Radiation treatment delivery	Radiation Treatment Delivery
G6007	Radiation treatment delivery	Radiation Treatment Delivery
G6008	Radiation treatment delivery	Radiation Treatment Delivery
G6009	Radiation treatment delivery	Radiation Treatment Delivery
G6010	Radiation treatment delivery	Radiation Treatment Delivery
G6011	Radiation treatment delivery	Radiation Treatment Delivery
G6012	Radiation treatment delivery	Radiation Treatment Delivery
G6013	Radiation treatment delivery	Radiation Treatment Delivery
G6014	Radiation treatment delivery	Radiation Treatment Delivery
G6015	Radiation tx delivery imrt	Radiation Treatment Delivery
G6016	Delivery comp imrt	Radiation Treatment Delivery
G6017	Intrafraction track motion	Radiation Treatment Delivery (Guidance)

Appendix E. Eligibility Flowcharts for RO Participants and RO Beneficiaries

RT providers and RT suppliers will first need to determine their own eligibility to participate in the RO Model (Exhibit 7) and then determine whether a Medicare beneficiary is an eligible RO beneficiary (Exhibit 8). RO participant eligibility is not static. PGPs, HOPDs, and freestanding radiation therapy centers that are not currently eligible for RO participation could later become eligible if they begin meeting all the RO Model's participation criteria during the model performance period. For example, a PGP that furnishes professional RT services only at an HOPD that is not located in a participating ZIP Code begins furnishing its services at an HOPD located in a participating ZIP Code. This PGP would become an RO participant when it furnishes included RT services at the RO Model-participating HOPD. This is only one example of many situations in which an RT provider or RT supplier could become eligible for the RO Model.

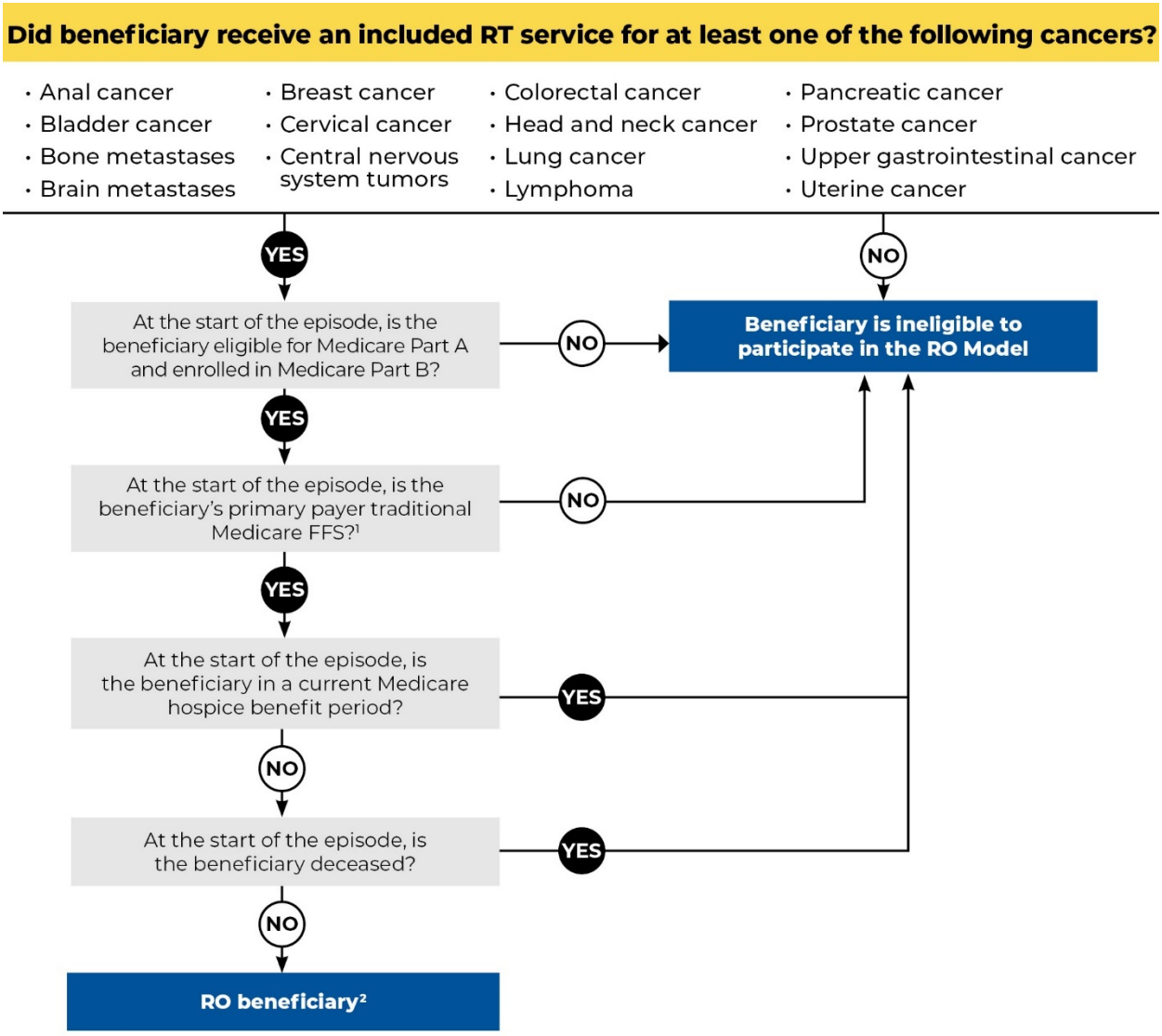
RO beneficiary eligibility assessments occur at the time an RO participant furnishes the initial RT treatment planning service that triggers an RO episode. If, after this initial service, the beneficiary's case changes so that the beneficiary no longer meets the RO Model eligibility requirements, CMS will usually consider this to be an incomplete episode.

Exhibit 7. Determining RO participant eligibility



[1] Participation in the RO Model is required for all RT providers and RT suppliers furnishing services in randomly selected CBSAs. CMS uses RT providers' or RT suppliers' service location ZIP Codes, which are found on claims submitted to CMS, to link them to CBSAs selected under the RO Model. If an RO participant has a service location in a participating ZIP Code and one in a nonparticipating ZIP Code that operates under the same taxpayer identification number or CMS Certification Number, only the location in the participating ZIP Code would be expected to follow RO Model requirements. Conversely, if an entity that initially does not furnish included RT services in one of the randomly selected CBSAs begins to furnish such services at a later date, the entity will be required to participate in the RO Model.

Exhibit 8. Determining RO beneficiary eligibility



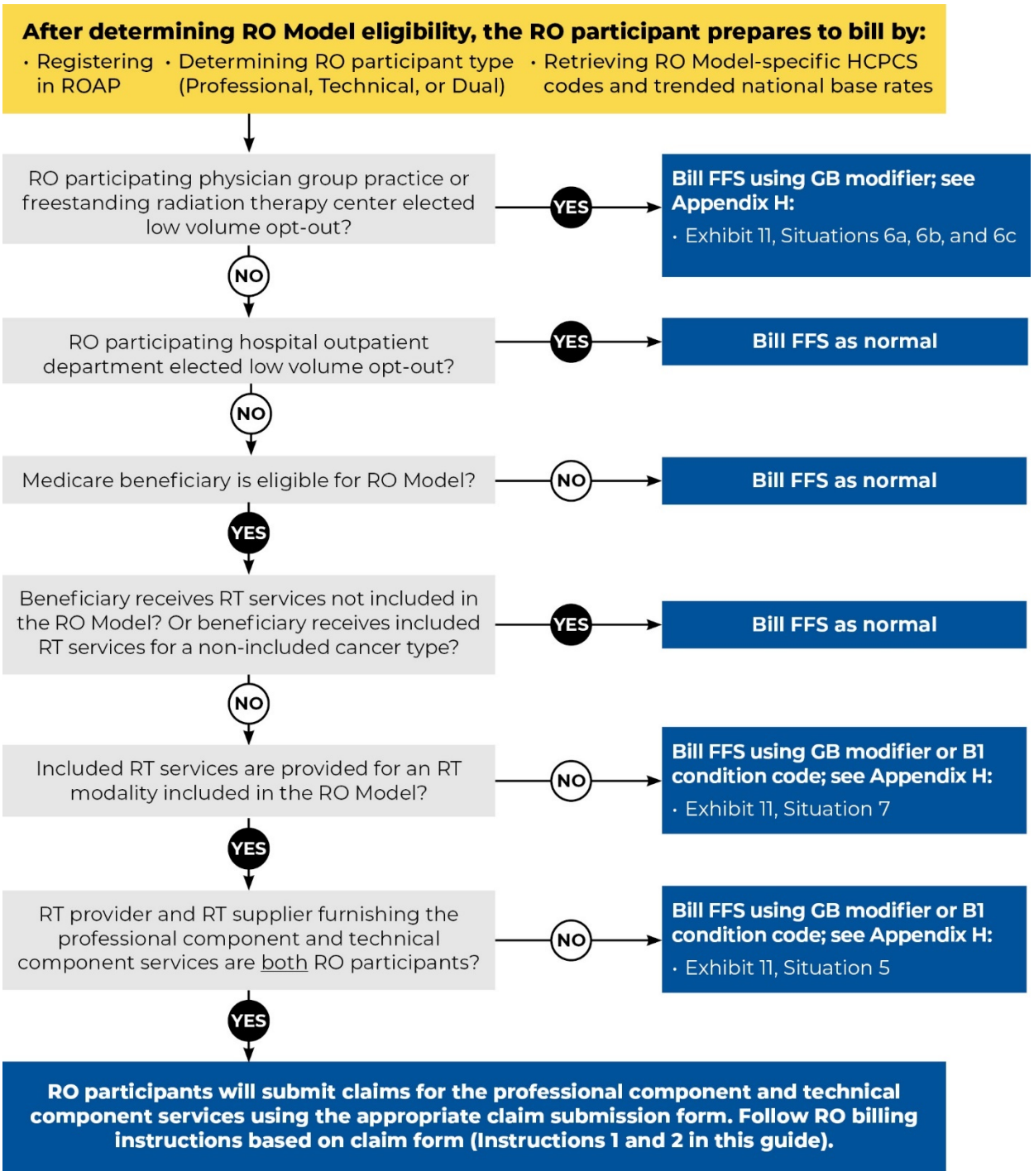
[1] Beneficiary is not enrolled in a Program of All-Inclusive Care for the Elderly plan or in a Medicare Advantage or other managed care plan and is not covered under United Mine Workers.

[2] Medicare beneficiaries enrolled in a clinical trial for included RT services for which Medicare pays routine costs would also be included in the RO Model as long as the additional participation criteria apply, with the exception of federally funded, multi-institution, randomized controlled clinical trials for proton beam therapy.

Appendix F. RO Model Billing Decision Flowchart

Exhibit 9 offers guidance on determining whether RT services furnished to a Medicare beneficiary should be billed under the RO Model and how to bill such services.

Exhibit 9. RO Model billing decision flowchart



Appendix G. 835 Remittance Information for RO Model Billing Errors

Exhibit 10 lists the claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) that will appear on 835 remittances when billing errors are found on claims from RO participants.

Exhibit 10. 835 CARCs and RARCs for PC and TC billing errors

Billing errors in claims for PC	CARCs	RARCs
Claim is not paired with a V1 SOE modifier	4	
Date of service is later/greater than October 3, 2027 (*RO participants will be paid FFS after this date*)	4	
Claim is not paired with a V2 SOE modifier that uses a return to provider (RTP) error message	4	
Provider is ineligible to participate in the RO Model	5, 16	M77, MA114
GB modifier is used on a claim that includes the RO Model-specific HCPCS code	16	M20
HCPCS codes are not specific to the RO Model	16	M20
Patient is ineligible to participate in the RO Model	16	M76
HCPCS codes are not specific to the RO Model and are missing an RO Model-approved ICD-10-CM code in a diagnosis position	16	M76
Date-of-service charge is less than the fee amount	16	M76
RO participant billed SOE RO Model-specific HCPCS codes with a V1 modifier more than once every 118 days from the SOE (*Also comes with Medicare Summary Notice: 16.29)	97*	M86
Claim does not have an RO Model-specific HCPCS with an SOE V1 modifier in the paid history with a date of service 28 to 100 days before the date of service for the RO Model-specific HCPCS code with the EOE modifier	234	N83
Billing errors in claims for TC	**CARCs**	**RARCs**
Claim has a date of service later/greater than October 3, 2027 (*RO participants will be paid FFS after this date*)	4	
Claim is not paired with one facility/Technical RO Model-specific HCPCS code and a V1 SOE modifier	4	
Claim is not paired with facility/Technical RO Model-specific HCPCS code and EOE V2 modifier	4	
GB modifier is used on a claim that includes the RO Model-specific HCPCS code	16	M20
Date-of-service charge is less than the fee amount	16	M76
Claim includes a B1 condition code	16	MA114
Claim uses more than one facility/Technical RO Model-specific HCPCS code line per claim	16	N519
Claim does not include the same RO Model-specific HCPCS code with an SOE V1 modifier in paid history with a date of service 80 to 100 days before the date of service for the RO Model-specific HCPCS code with the EOE modifier	234	N83

Appendix H. Billing FFS Using GB Modifier and B1 Condition Code

In certain scenarios (Exhibit 11), an RO participant will bill FFS with a GB modifier or B1 condition code when furnishing RT services included in the RO Model:

- **GB modifier** for professional (carrier/supplier) claims for included RT services—that is, claims submitted using the 837P or CMS-1500 and paid under the MPFS.
  - The **GB modifier** should be used for all claim lines on a claim that should be paid FFS.
- **B1 condition code or GB modifier** for institutional (HOPD) claims for included RT services—that is, claims submitted using the 837I or CMS-1450 and paid under the OPPS.
  - The **B1 condition code** should be used when all included RT services furnished on a claim should be paid FFS.
  - The **GB modifier** should be used on claim lines when only some included RT services on a claim should be paid FFS.

The RO participant will be paid FFS for these services as long as the appropriate modifier or condition code is used.

Exhibit 11. Situations requiring FFS billing with GB modifier or B1 condition code

Situation	Approach to billing FFS
Situation 1: An included RT service is furnished to a single RO beneficiary by an eligible RT provider or eligible RT supplier (or both) that did not initiate the PC or TC for that RO beneficiary during the 90-day RO episode.	• **837P or CMS-1500** (for PGP or freestanding radiation therapy center): Bill FFS using the HCPCS codes for the included RT services and the GB modifier. • **837I or CMS-1450** (for HOPD): Bill FFS using the HCPCS codes for the included RT services and the B1 condition code.
Situation 2: A patient ages into Medicare during their current treatment plan.	• **837P or CMS-1500** (for PGP or freestanding radiation therapy center): Bill FFS using the HCPCS codes for the included RT services and the GB modifier. • **837I or CMS-1450** (for HOPD)**:** Bill FFS using the HCPCS codes for the included RT services and the B1 condition code.
Situation 3: An RO participant is furnishing included RT services for a non-included cancer type and the patient has a history of an included cancer type (ICD-10-CM diagnosis codes for both cancer types are on the claim).	• **837P or CMS-1500** (for PGP or freestanding radiation therapy center): Bill FFS using the HCPCS codes for the included RT services and the GB modifier. • **837I or CMS-1450** (for HOPD): Bill FFS using the HCPCS codes for the included RT services and the B1 condition code.
Situation 4: An RO participant is furnishing included RT services to a patient receiving proton beam therapy through a federally funded, multi-institution, randomized controlled clinical trial.	• **837P or CMS-1500** (for PGP or freestanding radiation therapy center): Bill FFS using the HCPCS codes for the included RT services and the GB modifier. • **837I or CMS-1450** (for HOPD)**:** Bill FFS using the HCPCS codes for the included RT service and the B1 condition code.

Situation	Approach to billing FFS
	• Follow all other Medicare billing guidelines to indicate that the beneficiary is participating in a clinical trial.
Situation 5: A Professional participant is furnishing services in conjunction with a non-included RT provider or RT supplier (such as, a PPS-exempt cancer hospital, a service location in Maryland or Vermont, or a participant in the Pennsylvania Rural Health Model or Community Health Access and Rural Transformation [CHART] Model).	• **837P or CMS-1500** (for PGP or freestanding radiation therapy center): Bill FFS using the HCPCS codes for the included RT services furnished in a non-included service location, along with the GB modifier.
Situation 6a: A Dual participant furnishing included RT services is eligible for the low volume opt-out and has chosen to opt out of the RO Model.	• **837P or CMS-1500** (for freestanding radiation therapy center): Bill FFS using the HCPCS codes for the included RT services and the GB modifier.
Situation 6b: An RO participant furnishing the PC or TC of RT services has not opted out of the RO Model, but the entity furnishing the corresponding component for all RO episodes has opted out.	• **837P or CMS-1500** (for PGP or freestanding radiation therapy center that has not opted out of the RO Model): Bill FFS using the HCPCS codes for the included RT services and the GB modifier. • **837I or CMS-1450** (for HOPD that has not opted out of the RO Model): Bill FFS using the HCPCS codes for the included RT services and the B1 condition code or GB modifier.
Situation 6c: An RO participant furnishing the PC or TC of RT services has not opted out of the RO Model. However, an entity furnishing the corresponding component has opted out of the RO Model, and another affiliated entity furnishing the corresponding component has not opted out of the RO Model.	• The RO participant would bill FFS using the HCPCS codes for the included RT services and the GB modifier or B1 condition code in partnership with the entity that opted out. • RO participants would bill RO Model-specific HCPCS codes for RO episodes in partnership with other RO participants.
Situation 7: A Professional participant or Dual participant is furnishing included RT services for an included cancer type using a non-included RT modality (such as, brachytherapy, intraoperative radiation therapy, or any other modality not listed in the included cancer types and modalities in Appendix A).	• **837P or CMS-1500** (for PGP or freestanding radiation therapy center)**:** Bill FFS using the HCPCS codes for the included RT services that use a non-included modality, along with the GB modifier. See Exhibit 12 for example CMS-1500.
Situation 8: An RO participant has a patient who has two cancer types: brain metastases (included in the RO Model) and liver cancer (not included in the RO Model). The RO participant is treating the non-included cancer (liver cancer) with included RT services, and ICD-10-CM diagnosis codes for both cancer types are on the claim.	• **837P or CMS-1500** (for PGP or freestanding radiation therapy center): For the non-included cancer type, bill FFS using the HCPCS codes for the included RT services and the GB modifier. • **837I or CMS-1450** (for HOPD): For the non-included cancer type, bill FFS using the HCPCS codes for the included RT services and the B1 condition code (when all included RT services furnished on a given claim should be paid FFS) or the GB modifier (when only some included RT services on a claim should be paid FFS).

Situation	Approach to billing FFS
Situation 9: An RO participant has a patient who has two cancer types: brain metastases (included in the RO Model) and liver cancer (not included in the RO Model). The RO participant is treating both the liver cancer and the brain metastases with included RT services.	• **837P or CMS-1500** (for PGP or freestanding radiation therapy center): For the non-included cancer type, bill FFS using the HCPCS codes for the included RT services and the GB modifier. For the included cancer type, use the HCPCS codes for the included RT services, but do not use the GB modifier (claims will be processed as encounter-like [no-pay] claims). • **837I or CMS-1450** (for HOPD): For the non-included cancer type, bill FFS using the HCPCS codes for the included RT services and the B1 condition code (when all included RT services furnished on a given claim should be paid FFS) or the GB modifier (when only some included RT services should be paid FFS). For the included cancer type, in addition to submitting claims with the RO Model-specific HCPCS and SOE and EOE modifiers to receive the episode payment, separately use the HCPCS codes for the included RT services, but do not use the B1 condition code or GB modifier (claims will be processed as encounter-like [no-pay] claims).

Exhibit 12. CMS-1500: Example claim for a Professional participant or Dual participant billing the PC for an excluded modality (brachytherapy)

This exhibit shows an example claim form for a Professional participant or Dual participant billing the PC for an excluded modality, specifically brachytherapy. The HCPCS codes specific to the delivery of brachytherapy will not be subject to RO Model billing edits. However, because the RT services associated with the PC are included in the RO Model—and are, therefore, subject to RO Model billing edits—Professional participants and Dual participants will need to apply the GB modifier for those RT services to signal the system to pay FFS for all included RT services related to brachytherapy. As shown in this example, the codes for treatment planning (HCPCS 77261) and treatment management (HCPCS 77427) include the GB modifier, and the brachytherapy-specific code (HCPCS 77316) does not. The same rules would apply to any other modalities excluded from the RO Model, assuming they are furnished in a service location included in the RO Model and for an included cancer type.

Field Locators to Note:

FL 21: ICD-10-CM Diagnosis Code. In this example, the ICD-10-CM diagnosis code is for breast cancer.

FL 24A: Date(s) of Service. Follow the usual Medicare billing guidelines.

FL 24D: HCPCS Code and Modifier. Lines 1 and 2 contain the HCPCS codes for treatment planning and treatment management. Both lines contain the GB modifier to signal the system to pay FFS for these services. Line 3 contains the HCPCS code for brachytherapy and does not contain the GB modifier because this service is excluded from the RO Model.

FL 24E: Diagnosis Pointer. Follow the usual Medicare billing guidelines.

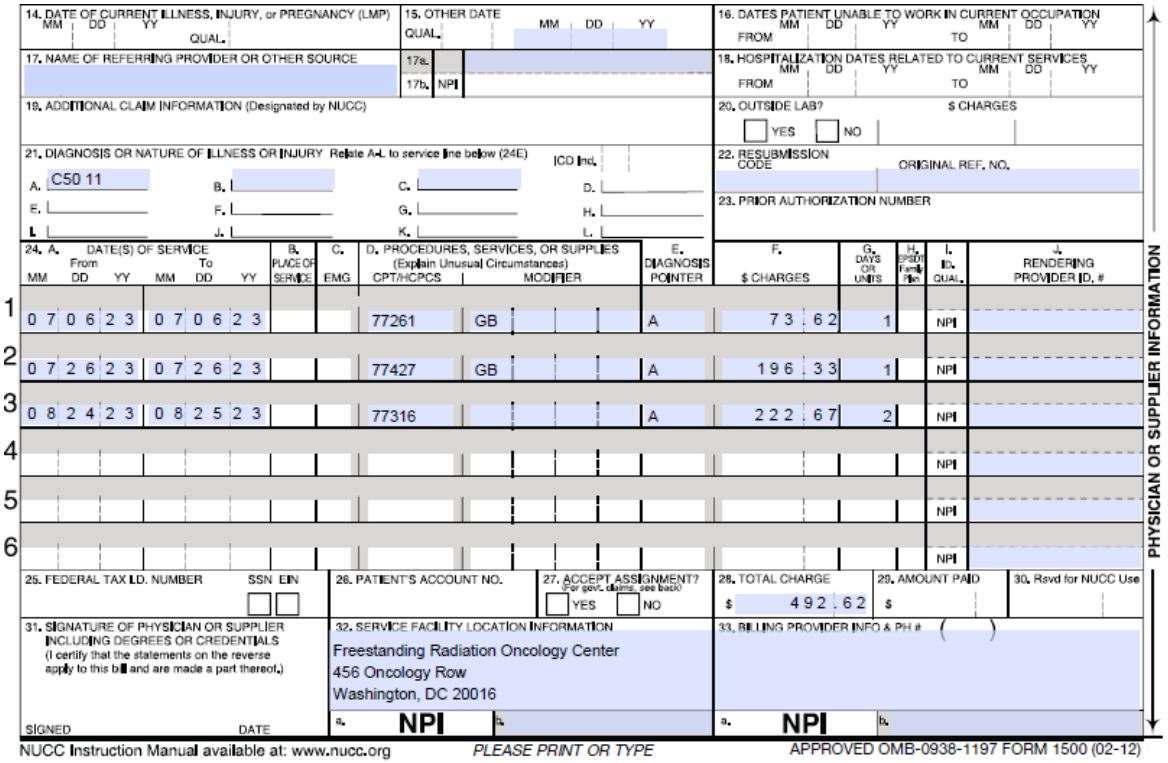
FL 24F: Charges. Follow the usual Medicare billing guidelines.

FL 24G: Days or Units. Follow the usual Medicare billing guidelines.

FL 28: Total Charge. Follow the usual Medicare billing guidelines.

FL 32: Service Facility Location Physical address of the freestanding radiation therapy center where the RT services were furnished.

All other fields should be completed per the usual Medicare billing guidelines.



14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. C50 11 B. C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07 06 23	07 06 23			77261	GB	A	73 62	1		NPI	
2 07 26 23	07 26 23			77427	GB	A	196 33	1		NPI	
3 08 24 23	08 25 23			77316		A	222 67	2		NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO
28. TOTAL CHARGE $ 492 62
29. AMOUNT PAID $
30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
Freestanding Radiation Oncology Center
456 Oncology Row
Washington, DC 20016
a. NPI b.
33. BILLING PROVIDER INFO & PH # ( )
a. NPI b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Appendix I. Questions and Answers

	Question	Answer
	1. Start of episode	
a.	When does an RO episode start? I understand that the initial V1 modifier is to be attached to the first professional charges. Does this have to be at the time of the order for simulation or planning directive? Could it be attached at the CT Simulation time? What determines the start of the episode—the date the clinical treatment plan is billed or the date it is signed off on?	An RO episode starts when a Professional participant or Dual participant furnishes the initial RT treatment planning service to an RO beneficiary. This is the date the initial RT treatment planning service is furnished, not when the bill is submitted to CMS. HCPCS codes 77261, 77262, or 77263 are the only codes that can be used to trigger an episode. The Professional participant or Dual participant also submits a separate claim with a professional RO Model-specific HCPCS code for an included cancer type. The claim should have an SOE modifier (V1) and a date of service that is the same as that of the initial RT treatment planning service. This signals to CMS the start date of an RO episode. No other HCPCS codes can be included on claims with RO Model-specific HCPCS codes.
b.	Which technical RT service can trigger the start of the TC of an episode?	An RT treatment delivery service needs to be furnished to the RO beneficiary within 28 days of the initial RT treatment planning service. Included RT treatment delivery services are labeled as such on the RO Model Bundled/Packaged HCPCS codes list. At the time of the first RT treatment delivery service, a Technical participant or Dual participant also submits a claim with a technical RO Model-specific HCPCS code for an included cancer type. The claim should have an SOE modifier (V1) and a date of service that is the same as that of the first RT treatment delivery service. This signals to CMS the start date of the TC of the RO episode. (A Dual participant may submit the technical RO Model-specific HCPCS code on the same claim as the professional RO Model-specific HCPCS code.)
c.	Who can start an RO episode? Can only radiation oncologists start an RO episode? Is a radiation oncologist the only provider who can trigger the SOE? If a neurologist sees a gamma knife beneficiary and submits a professional claim, would this initiate an episode, or would it have to be the radiation oncologist?	There are no requirements regarding the type of clinician who can initiate an RO episode. Any physician billing under a taxpayer identification number (TIN) that is an RO participant can trigger an RO episode. The physician does not need to be a radiation oncologist. However, treatment planning services, which trigger the start of an episode, are typically performed by a radiation oncologist.

	Question	Answer
d.	If a Professional participant bills the code 77263 on January 1, 2023, but the hospital does not bill the first treatment (dated January 5, 2023) for 6 months because it has 12 months to bill, at what point is the episode considered incomplete for the Professional participant?	The determination of whether an episode is incomplete is not based on when the claim is submitted. The determination of whether an episode is incomplete is made during reconciliation in August of the year following the PY. The episode would not be considered incomplete until reconciliation. However, CMS encourages RO participants to submit claims in a timely manner.
e.	If, after an SOE RO Model-specific HCPCS code is billed on the professional side, a patient decides to get treated elsewhere, are we allowed to go back and remove the RO Model-specific HCPCS code entered and send the payment back to CMS? Or do we have to wait to do it during the reconciliation process?	If the RO participant realizes soon after submitting the SOE claim that the patient is going elsewhere, the RO participant should retract the RO Model claim and rebill it as FFS. Otherwise, the beneficiary will pay a large coinsurance on the first half of the episode payment installment, along with paying the 20 percent coinsurance on the new provider's FFS bills. Use the same process to retract RO Model claims as you would to retract regular Medicare FFS claims.
f.	What happens if two physicians bill a treatment planning code for the same Medicare patient? What if a physician bills for the beginning of an episode, and then another physician bills a treatment planning code for the same patient?	The SOE will be based on the SOE claim (with the RO Model-specific HCPCS code and V1 modifier) that was submitted and adjudicated first. If an SOE claim dated for the other treatment planning service is submitted, it will be rejected, even if the date of service on that claim is earlier than the date on the first SOE claim submitted. The claim for the other treatment planning service itself will be treated as a duplicate service and reconciled with the episode payment during annual reconciliation.
g.	For the technical (hospital) claims with just an RO Model-specific HCPCS code and V1 or V2 modifier, wouldn't it be better/more appropriate to have an OPPS SOE claim with the M1075 with V1 modifier and charge amount of $2,500, so when CMS pays the claim, the adjudication information could be something like the following? • Total claim amount: $2,500 • 50 percent of approved episode amount: $2,200 • OPPS payment: $1,800 • Beneficiary coinsurance amount: $400 • Contractual adjustment CO45 amount: $300	For claims that signal the start and end of the episode (that is, claims that include RO Model-specific HCPCS codes and V1 or V2 modifiers), HOPDs that bill through OPPS and file claims using the CMS-1450/UB-04 or 837I claim form may apply any charge amount on the claim. CMS suggests a token charge of $0.01.

	Question	Answer
h.	How do we handle correcting claims? For example, if we forget to submit the SOE claim or EOE claim with the new RO Model-specific HCPCS code with V1 or V2, should we submit a corrected claim as soon as we discover the error, or do we have to wait and go through the incorrect payment process?	Corrections to claims for RT services included in the RO Model may be submitted in the same manner as a correction for any other claim. You should not wait until the annual reconciliation or "true-up" to correct claims, as that will not occur until potentially 18 to 30 months after the service has been furnished, and individual claims are not re-adjudicated during the reconciliation process. By submitting corrections as soon as you are aware of them, beneficiaries will then pay the correct coinsurance. Beneficiary coinsurance is not recalculated during the reconciliation process.
i.	What happens if qualifying RO beneficiaries are accidentally billed as regular FFS and not with an SOE claim, per the RO Model? Will Technical participants or Professional participants be penalized? Will they be given the opportunity to correct the billing? Will there be an audit or true-up period to correct any issues with billing?	If a Professional participant or Dual participant furnishes an initial RT treatment planning service in a participating ZIP Code for an included cancer type to a Medicare beneficiary who is eligible for the RO Model, but CMS has not yet adjudicated an SOE claim for the beneficiary (that is, a claim with an RO Model-specific HCPCS code and V1 modifier), the claim will be returned to the participant with a message that the service is covered under a demonstration. Once the RO participant submits the SOE V1 claim, the episode will begin, and the treatment planning bill can be resubmitted for processing as an encounter-like (no-pay) claim. The same is true for Technical participants who furnish RT treatments to the beneficiary but have not yet submitted a technical SOE V1 claim for CMS adjudication. For any RO Model service, if an error is discovered in a timely way, the claim should be corrected in the same manner as would be done currently for correcting FFS claims.
	2. End of episode	
a.	We had to delay furnishing RT to a breast cancer patient who was hospitalized between the first RT treatment and the remaining treatments, which made her RT treatments extend past the 90 days of the episode period. How do I bill for these services?	If treatment for a cancer type included in the RO Model (either the original episode's cancer or a new cancer that occurred during the episode) extends past the initial 90-day episode into the 28-day clean period, these services will be paid FFS. No special modifiers or codes are needed on claims for RT services furnished during the clean period.
b.	The EOE (V2) modifier is to be placed at the last technical treatment charge. Does this mean the last treatment? Or the last technical charge? Such as the Physics QA as they close out the course?	The TC EOE claim (with the technical RO Model-specific HCPCS code and V2 modifier) should be submitted when the final technical RT service, with an HCPCS code included on the RO Model Bundled/Packaged HCPCS codes list, is furnished to the Medicare patient. The only exception to this is if the patient elects the Medicare hospice benefit. In such cases, the date of service for the RO Model-specific HCPCS code on the EOE claim should be at least one day prior to hospice election, even if the patient continues to receive RT services while receiving hospice care.

	Question	Answer
c.	Gamma knife services and palliative care are included in the RO Model and occur during one treatment session. How do we enter the V1 and V2 modifiers for both the PC and TC reimbursement in claims?	The professional RO Model-specific HCPCS code on the SOE claim with the V1 modifier should have the same date of service as when the initial treatment planning service was furnished, which starts the episode. The technical RO Model-specific HCPCS code on the SOE claim with the V1 modifier should have the same date of service as when the first (and only) RT treatment was furnished. The professional and technical RO Model-specific HCPCS codes on the EOE claims with the V2 modifier should be submitted, and have a date of service, at least 28 days after the episode start date. The date of service on the EOE claims does not have to be the same as the actual date the service was furnished. However, the actual date of service on an encounter-like (no-pay) claim must reflect the actual date the service was rendered.
d.	What physician do we bill the EOE claim to? Is it the last physician to do the final treatment summary notes or the physician who does the end of treatment note?	If all the physicians are billing under the same participating TIN, it does not matter which physician's name is on the claim. You should put the same physician National Provider Identifier (NPI) on the claim that would be appropriate if you were billing the last service on an FFS basis.
	3. Episode payment	
a.	Do I need to wait until the end of the 90-day RO episode to submit the EOE claim to receive the second half of the episode payment?	An EOE claim can be submitted as early as Day 28 of the 90-day episode if the RO participant is certain, to the extent possible, that the treatment plan is complete. Any included RT services furnished after the EOE claim is submitted will not be paid separately during the remainder of the 90-day RO episode.
b.	Are the RO episode payments that go to a Professional participant for the PC dependent on also receiving the SOE claim from the Technical participant for the TC?	CMS can adjudicate the PC SOE claim without the TC SOE claim having been submitted. If a TC EOE claim is not submitted with a date of service within 28 days of the PC SOE claim (or if a TC claim is never submitted), this will be an incomplete episode, and the Professional participant's episode payment will be reconciled to FFS in the annual reconciliation process.
c.	If a TC SOE claim is submitted before CMS receives a PC SOE claim, will the TC SOE claim be paid?	If the TC SOE claim is submitted first, CMS will adjudicate and pay the claim (first installment of the TC episode payment) and tentatively set the start of the episode based on the TC SOE claim's date. However, the actual SOE will be modified to the date of service included on the PC SOE claim. If a PC SOE claim is never received, this will be an incomplete episode, and the Technical participant's episode payment will be reconciled to FFS based on the encounter-like (no-pay) claims during the annual reconciliation process.

	Question	Answer
d.	Often, a patient has an initial visit and a clinical treatment plan is written, but then the patient does not return to start RT treatment until a month later (that is, after 28 days). If the physician submits the SOE claim when the clinical treatment plan is furnished, and the hospital submits its first RT treatment claim with dates of service after 28 days from the date of the clinical treatment plan, when will the physician receive payment?	If the physician is associated with a Professional participant or Dual participant, the physician should submit a claim containing a professional RO Model-specific HCPCS code and an SOE modifier (V1), with a date of service that is the same as the date of the treatment planning service. Once the claim is adjudicated, the RO participant will receive the first half of the PC episode payment according to the date of the SOE. If an SOE claim for the TC (that is, the first RT treatment) does not have a date of service within 28 days of the SOE for the PC, this would be an incomplete episode. If the Professional participant or Dual participant is aware that the treatment did not begin within 28 days, they would bill an EOE claim, and then the episode would be reconciled based on services included on the encounter-like (no-pay) claims. The incomplete episode would be reconciled during annual reconciliation. As part of this process, CMS would calculate the difference between (1) the sum of the participant-specific episode payment amounts paid to the RO participant for the incomplete episode during the PY and (2) the sum of all FFS amounts that would have been paid to the RO participant in the absence of the RO Model for any included RT services furnished during the incomplete episode, as determined based on encounter-like (no-pay) claims. The difference is what CMS owes the RO participant, or what the RO participant owes CMS, for the incomplete episode. The Technical participant would bill for all included RT services furnished to the patient as FFS using the B1 condition code or GB modifier and would be paid within the usual time frame.
e.	What happens to payment if my patient opts out of being an RO participant?	Patients are not RO participants. If you are an RO participant, any of your patients who are Medicare beneficiaries and who meet RO Model eligibility requirements are RO beneficiaries. Medicare beneficiaries may not opt out of the RO Model if they receive RT services from an RO participant. However, beneficiaries may elect to see an RT provider or RT supplier who is not participating in the RO Model. RO beneficiaries may also choose not to share their Medicare claims data with RO participants.
f.	Will payments be different for each provider in a PGP?	No. Payments are made to RO participants at the RO Model ID level. RO Model IDs are determined at the TIN or CMS Certification Number (CCN) level. So payments to PGPs are made at the TIN level.

	Question	Answer
g.	If a Medicare patient decides to discontinue RT in the middle of the RO episode (for reasons other than death or hospice), how is the RO episode paid? What happens if a Medicare patient receives the RT treatment planning and simulation services but does not end up being treated as planned?	These scenarios are examples of an incomplete episode. If either occurs before CMS adjudication of an SOE claim, the RO participant may bill for the services furnished as FFS using the GB modifier or B1 condition code. If these scenarios occur after CMS has adjudicated the SOE claim, the encounter-like (no-pay) claims submitted by the RO participant will be used to reconcile incomplete episodes to FFS during annual reconciliation. As part of this process, CMS will calculate the difference between (1) the sum of the participant-specific episode payment amounts paid to the RO participant for the incomplete episode that occurred during the PY and (2) the sum of all FFS amounts that would have been paid to the RO participant in the absence of the RO Model for any included RT services furnished during the incomplete episode, as determined by encounter-like (no-pay) claims. The difference is what CMS owes the RO participant, or what the RO participant owes CMS, for the incomplete episode.
h.	What happens if the RO beneficiary elects the Medicare hospice benefit during the RO episode?	An RO episode is included in, and paid for as a complete episode under, the RO Model if the RO beneficiary elects the Medicare hospice benefit after the initial treatment planning service, provided that the technical component is initiated within 28 days following the initial treatment planning service. In other words, if an RO beneficiary selects the Medicare hospice benefit during an RO episode after both the PC and TC of the episode have been initiated, and the beneficiary continues their RT plan of care, the RO Model allows for RO Model episode payments to continue (in addition to the Medicare hospice per diem). The RO Model allows this so as not to dissuade RO participants from making a hospice referral when needed. In cases of hospice election, the date of service for the EOE with V2 claim must be before the date of the Medicare hospice election to prevent Coordination of Benefits issues. These RO Model claims can be submitted prior to the actual end of episode. These episodes would be included in CDE reporting. If the RO beneficiary elects the Medicare hospice benefit after the initial treatment planning service but prior to the first treatment delivery service is furnished, this would be an incomplete RO episode and would be handled during reconciliation if the SOE claim was already submitted and adjudicated. You should bill for the EOE with a date before the day of hospice election. These episodes would not be included in CDE reporting.

	Question	Answer
	4. RO Model-specific HCPCS codes	
a.	What charges should I list on the SOE and EOE claims that have the professional RO Model-specific HCPCS codes?	For professional claims (paid through the MPFS, using an 837P or CMS-1500), the RO Model-specific HCPCS code should not have a charge less than the fee amount. The fee amount is one-half the PC trended national base rate for the included cancer type. This is the same amount that you should put on both the SOE claim with the V1 modifier and EOE claim with the V2 modifier.
b.	What charges should I list on the SOE and EOE claims that have the technical RO Model-specific HCPCS codes?	For HOPD claims (paid through the OPPS, using a CMS-1450/UB-04 or 837I claim form), the total charges you put in FL 47 for an RO Model-specific HCPCS code can be a nominal amount, such as $0.01. For professional claims (paid through the MPFS, using an 837P or CMS-1500), the RO Model-specific HCPCS code should not have a charge less than the fee amount. The fee amount is one-half the TC trended national base rate for the included cancer type. This is the same amount that you can put on both the SOE claim with the V1 modifier and EOE claim with the V2 modifier.
c.	Do we use the new RO Model-specific "M" HCPCS codes for all patients? How do we bill payers that are not part of this project? Do we use the existing RT HCPCS codes for non-RO Model payers and for Medicare if we are submitting claims for diagnoses other than the 15 included cancer types?	The new RO Model-specific HCPCS codes should be used on Medicare claims for Medicare beneficiaries who (1) meet the eligibility criteria to be an RO beneficiary and (2) are being treated with an RT service included in the list of RO Model Bundled/Packaged HCPCS codes for any of the 15 included cancer types. The claims with these new RO Model-specific HCPCS codes, together with a V1 or V2 modifier code, are used to signal the start and end of an RO episode. Use existing HCPCS codes (that is, the RO Model Bundled/Packaged HCPCS codes) for both Medicare beneficiaries who do or who do not meet these criteria to bill for RT services, the same as you typically would use them under traditional FFS billing. If an RT service is included in an RO episode, it will not be paid FFS separately in most cases. Also continue to use the existing HCPCS codes to bill for RT services for other payers, per their instructions.
d.	Are the M codes sent on every claim?	No, the RO Model-specific HCPCS codes with the V1 and V2 modifiers are only sent on claims that signal the start and end of an episode. During a 90-day episode (after the SOE claim has been adjudicated), submit FFS claims as you normally would for RT services, with the usual HCPCS codes. For RT services included on the list of RO Model Bundled/Packaged HCPCS codes, your MAC will process these as encounter-like (no-pay) claims.

Question		Answer
5. RO Model-specific HCPCS code modifiers		
a.	We would like to start building out the modifiers to identify patients who will be in this model. Could you furnish a list of modifiers for the RO Model?	Only three modifiers and one condition code are used in the RO Model: the V1 and V2 modifiers that appear on claims to indicate the start and end of an episode, respectively; the GB modifier (for MPFS and OPPS claims) used on claim lines for included RT services that should be paid FFS; and the B1 condition code (for OPPS claims) used to indicate that the entire claim should be paid FFS, instead of being subject to RO Model claims edits. These three modifiers and the condition code are existing elements in the Medicare claims system and thus should not be new to your vendor.
b.	Why doesn't physician billing have the option to use the B1 condition code for claims in which all the lines would be FFS?	Physician claims and claims from freestanding radiation therapy centers are submitted on a different claim form (CMS-1500) and processed by a different Medicare claims system (MCS) than are HOPD claims, which are processed by the Fiscal Intermediary Standard System (FISS). These systems use different codes and rules for processing claims. The B1 condition code is put in a field on the header of an institutional claim processed by FISS and applies to all lines on the claim. MCS does not use condition codes. MCS uses modifiers at the claim-line level to adjust payment for different claim lines.
6. 90-day RO episode period: Included services (encounter-like [no-pay] claims)		
a.	After an episode's SOE claim is submitted, should an RO participant continue to enter CPT/HCPCS codes for RT services as usual? When is the earliest an organization can submit an encounter-like (no-pay) claim?	In addition to billing the RO Model-specific HCPCS codes with the V1 and V2 modifiers to receive the first and second halves of the episode payment, RO participants shall submit encounter-like (no-pay) claims that include the CPT or HCPCS codes for all included RT services furnished during the RO episode. Encounter-like (no-pay) claims should not be submitted until after the SOE (V1) claim has been adjudicated. RO participants should submit RO Model Bundled/Packaged HCPCS codes using the same claim forms as for FFS claims. However, CMS will process these claims as encounter-like (no-pay) claims. CMS will use the encounter data for evaluation, RO Model monitoring, and annual reconciliation. Encounter-like (no-pay) claims do not require any special charges or fees, condition codes, type-of-bill codes, or revenue codes. In other words, put the same codes on an encounter-like (no-pay) claim for included RT services as for an FFS claim for a service not included in the RO Model.

	Question	Answer
b.	Can no-pay codes be submitted on the same claim as the beginning- or ending-episode HCPCS codes for the RO Model payment? Does a Professional participant also submit the treatment planning code with the SOE claim? Or is that a separate claim? For encounters related to the SOE, would we need to send two claims for one encounter: one for the SOE claim with the RO Model-specific HCPCS code and V1 modifier, and a second with the 77XXX codes related to treatment planning?	On SOE or EOE claims with RO Model-specific HCPCS codes, no other HCPCS codes can be included. If this occurs the claim will be returned. CMS will look for the initial RT treatment planning code in the encounter-like (no-pay) claims after the SOE claim has been adjudicated. The dates of service should match on the claim for the initial RT treatment planning service and on the claim with the professional RO Model-specific HCPCS code with V1 modifier. Encounter-like (no-pay) claims should be submitted after an RO episode has been established via the adjudication of an SOE claim with the RO Model-specific HCPCS code and the V1 modifier. The initial RT treatment planning service should be submitted separately from the SOE (V1) claim.
c.	For encounter-like (no-pay) claims, should the billed amount be reduced to zero, or can the procedures be billed with their standard fee?	For RT encounter-like (no-pay) claims, RT services included on the list of RO Model Packaged/Bundled HCPCS codes are billed as usual, with their standard charges or fees listed on the claim. The Medicare processing system will recognize services with the RO Model Packaged/Bundled HCPCS codes that are billed during an RO episode and process them as encounter-like (no-pay) claims. Encounter-like (no-pay) claims do not require any special charges, condition codes, type-of-bill codes, or revenue codes. In other words, put the same information, including the charge amount, on an encounter-like (no-pay) claim for included RT services as for an FFS claim for a service not included in the RO Model.
d.	Should an encounter-like (no-pay) claim contain only services that are included in the RO Model? For example, if a Medicare patient has a computerized tomography scan or brachytherapy during an RO episode, are those services included or not included in the encounter-like (no-pay) claim? If a Medicare patient is treated in the emergency room during an RO episode, does this service go on a separate claim? How do I bill if an RO beneficiary receives chemotherapy and RT services on the same day?	Once the professional SOE claim is adjudicated, included RT services and other services may appear on the same bill, or they may be split into separate bills. • For RT services on the claim that are included in the RO Model, your MAC will process them as encounter-like (no-pay) claims. • For RT services on the claim that are included in the RO Model and should be paid FFS, either apply the GB modifier code to the claim service line items (MPFS or OPPS) or apply the B1 condition code to the claim (OPPS). • For non-included RT services (such as chemotherapy) on the claim, bill for them as usual to receive FFS payment. Your MAC will process them as usual according to Medicare FFS payment rules.

	Question	Answer
	Our hospital bills for RT services on a monthly basis, so at the end of each month, a claim is sent to CMS for the care furnished at our cancer center for the month. On occasion, this results in RT, lab, transfusion, and chemotherapy charges all being listed in the same monthly services claim. After the RO Model begins, do we need to split these non-RT charges off to their own claim—so they aren't listed on the RO Model bundled services claim—to make sure these other services will be paid FFS? We do cycle billing (we drop one claim per month for all of a patient's visits). We usually include the radiation and medical oncology charges on the same claim. Can we continue to do that?	
e.	How frequently should RO participants submit encounter-like (no-pay) claims? Should the frequency of encounter-like (no-pay) claims mimic the frequency of SOE and EOE claims? Currently, we bill for RT services monthly. Can we continue to do this? Do encounter-like (no-pay) claims have to include the entire episode of care, or can we bill for these claims on a date-of-service basis, as we currently do? Can we submit more than one encounter-like (no-pay) claim for a patient (one every 30 days)?	The RO Model does not change the existing requirements for the frequency of billing for RT services. Once the professional SOE claim is adjudicated, multiple encounter-like (no-pay) claims may be submitted for a patient. These claims may be submitted in the same way, on the same claims, and in the same time frame as Medicare FFS claims. RO participants may submit their encounter-like (no-pay) claims as frequently as they choose, as long as they start submitting them after the SOE claim has been adjudicated. RO participants may follow their normal billing cycle. RO participants may submit RT services claims (FFS paid and no-pay) in bulk or one at a time.
f.	Simulation and planning charges have a technical component to them, and the majority of time they take place on a date before the first treatment. Since the SOE RO Model-specific HCPCS code for the technical side will not be entered until the first day of treatment, are we expected to hold the simulation and planning technical charges until after the SOE RO Model-specific HCPCS code for the technical side has been paid?	Yes, you should not submit the encounter-like (no-pay) claims with the technical simulation and planning codes until after the first RT treatment delivery service is furnished and CMS has adjudicated a claim with a technical RO Model-specific HCPCS code, the V1 modifier, and a date of service that is the same as the date of the first RT treatment delivery service. Included RT treatment delivery services are labeled as such on the RO Model Bundled/Packaged HCPCS codes list.

	Question	Answer
g.	Regarding the bill-hold language, do we need to hold claims throughout the billing process, or can any changes or remittance of claims be taken care of on the back end?	The RO Model does not change existing billing frequency requirements for RT services. Once the SOE claim is adjudicated, multiple encounter-like (no-pay) claims can be submitted for an RO beneficiary. These claims can be submitted in the same way, on the same claims, and in the same time frame as Medicare FFS claims were submitted prior to RO Model implementation. RO participants may submit RT services claims (FFS paid and no-pay) in bulk or one at a time. RO participants may follow their normal billing cycle. Similarly, if you need to make an adjustment to a claim (for example, to correct a diagnosis or date of service), you would do so in the same manner as with regular Medicare FFS claims. The only change to billing timing is that RO participants should not bill an EOE claim with the V2 modifier until at least 28 days after the SOE. This allows for the RO participant to be more confident that this will not be an incomplete episode. Please note that there will be no adjustments to individual claims as part of the reconciliation or true-up process.
h.	For the RO Model, what is the required value for ANSI 837P claims to send BHT06 for encounters?	RO participants will be submitting encounter-like (no-pay) claims for RT treatments that are included in the RO Model and fall within an episode period. These are not encounter claims per se, but they are claims that look like typical FFS claims that will not be paid separately from the episode's payment (which is paid through special SOE and EOE claims with RO Model-specific HCPCS codes and V1/V2 modifiers). Encounter-like (no-pay) claims for the RO Model are submitted on the same claim forms as FFS claims and do not require any special charges, condition codes, type-of-bill codes, revenue codes, or other codes. In other words, you would put the same codes on an encounter-like (no-pay) claim for included RT services as you would if this were a paid FFS claim for a service not included in the RO Model. The encounter-like (no-pay) claims for RT treatments referenced in the RO Model differ from the 837PX12 Health Care Encounters. Populate the BHT06 field in the 837PX12 per normal Medicare FFS billing rules.
i.	Our understanding is that the professional RO Model-specific HCPCS code needs to be adjudicated before a practice can continue to bill additional professional CPT code claims. Do we also need to wait for the technical RO Model-specific HCPCS code claim to be adjudicated before we can bill our "normal" radiation treatment claims?	If the RO participant is a Dual participant, it can begin submitting claims for both professional and technical RT services after CMS adjudicates the professional SOE claim (with a professional RO Model-specific HCPCS code and V1 modifier).

	Question	Answer
		If the RO participant is a Technical participant, it should start submitting claims for technical RT services after CMS adjudicates the technical SOE claim (with a technical RO Model-specific HCPCS code and V1 modifier).
7. 90-day RO episode period: Non-included services		
a.	What if an RO beneficiary needs a service that is not included in the RO Model?	RO beneficiaries may continue to receive any other medically necessary services they require. Services not included in the RO Model payment will be billed and paid for as usual under the existing Medicare FFS systems.
b.	If a patient has technical services unrelated to radiation oncology on the same date as a 77000 code that is included in the RO Model, how will the non-RO Model services be paid for? Several references have been made to the "no pay" claim, but a TOB 13X UB could contain both payable and bundled services due to overlapping dates. Will there be additional requirements for nonbundled services outside the 77000 code range?	Any RT service furnished to a Medicare patient that has a HCPCS code not on the list of RO Model Packaged/Bundled HCPCS codes—that is, a non-RO Model service—will be processed and paid for as a typical FFS claim. After the professional SOE claim is adjudicated, RO participants can submit CMS-1450/UB-04 or 837I claims that have line items for services with RO Model Packaged/Bundled HCPCS codes as well as HCPCS codes for non-RO Model services. Both types of claim line services can be submitted with standard charges and modifiers. For claim lines that include an RO Model Packaged/Bundled HCPCS code, your MAC will return an 835 remittance with a $0 payment edit, which constitute encounter-like (no pay) claims.
c.	Suppose the RT services furnished for the TC of an RO episode are delivered via new technology not included in the RO Model. Are these services billed and paid FFS?	If a HCPCS/CPT code is not included in the RO Model (that is, it is not on the list of RO Model Bundled/Packaged HCPCS codes), it will be paid FFS. This list will be updated as needed to include or exclude certain codes. Per the Specialty Care Models to Improve Quality of Care and Reduce Expenditures Final Rule (CMS-5527-F) (p. 61165), to the extent that new technologies and equipment are billed under new HCPCS codes, CMS will go through rulemaking to add those new codes to the list of RO Model Bundled/Packaged HCPCS codes. CMS believes that any increased use of established codes that are included RT services will be accounted for over time with the trend factor described in Section III.C.6.d of the final rule. Until new technologies with corresponding HCPCS codes are added to the list of included services, they will be paid FFS.

	Question	Answer
8. RO episodes that straddle PYs		
a.	How do we handle Medicare patients who start RT treatment before the RO Model starts, and their RT treatment continues into the first RO Model performance period?	If the date of service on the claim for the PC (initial RT treatment planning service) occurs prior to the start of the model performance period, you would bill FFS with no modifiers for all professional RT services provided to the Medicare patient or for all technical services provided under the MPFS payment system, even if the TC of the RO episode was not furnished until after the model performance period had started. However, technical RT services furnished by an HOPD that are included in the RO Model should list the B1 condition on HOPD claims (if all services on the claim are included RT services), or the GB modifier on HOPD claim-line items (if only some services on the claim are included RT services). This will signal the OPPS payment system to pay FFS for these claims. This episode for the Medicare patient would not be included in the RO Model.
b.	For Medicare patients who receive initial RT at the end of an RO Model PY and continue receiving it in the next PY, would they be paid for under FFS, given that the RT treatment planning began in the previous PY?	RO episodes will continue across PYs. Regardless of the PY, an RO episode will still start when a Professional participant or Dual participant furnishes the initial RT treatment planning service to an RO beneficiary (HCPCS codes 77261, 77262, or 77263 are the only codes used to trigger an episode). An RO episode ends when all RT services have been furnished and RO participants have submitted a claim with the same RO Model-specific HCPCS code, plus the EOE V2 modifier, that initiated the episode.
9. Secondary payers/beneficiary cost-sharing		
a.	Is there a way to determine how much the co-pay will be for RO beneficiaries receiving care for an included cancer type?	RO beneficiaries will pay 20 percent of each of the PC and TC episode payments for their cancer type, regardless of what their total coinsurance payment amount would have been under the FFS payment system. Hospital outpatient caps are also applied per standard Medicare rules. The coinsurance amount for an RO beneficiary is based on the payment amount that results after applying the case-mix and historical-experience adjustments, withholds, discount factors, and geographic adjustments to the trended national base rates for the included cancer type billed for by the RO participant. The Payment Calculator Workbook on the RO Model website shows how beneficiary coinsurance is determined. Besides using this workbook to obtain estimates of payments you will receive for RO episodes, you can use the workbook to obtain estimates of beneficiary coinsurance for each cancer type.

	Question	Answer
10. Multiple cancer types		
One cancer type is included in the RO Model; one is not included		
a.	We are treating a lymph node metastasis from a lung cancer primary. Lymph node metastasis is not one of the included cancer types, but it would be listed first in an RT claim for the Medicare patient because it is the treating diagnosis. Because a lung cancer diagnosis code, as the primary cancer, would also be listed in the claim, would this be considered an RO Model lung cancer episode, or would we bill FFS? During an RO episode for an included cancer type in the RO Model, suppose there is a subsequent need to treat a non-included cancer type during the 90-day episode, but after completing treatment for the included cancer type. Would the RT services for treating the non-included cancer type be paid FFS, and would a modifier be required?	In the first scenario, if the RO participant is furnishing RT services only for the non-included cancer (lymph node metastasis), this would not be an RO episode. However, because a diagnosis of lung cancer (an included cancer type) would also be listed in these claims, the RO participant should bill FFS for all RT services furnished for the non-included cancer type using: • The GB modifier on MPFS claims (837P or CMS-1500) for included RT services that are for the non-included cancer • The GB modifier on OPPS claims (CMS-1450/UB-04 or 837I) if only some of the included RT services on the claim are for the non-included cancer • The B1 condition code on OPPS claims (CMS-1450/UB-04 or 837I) if all included RT services on the claim are for the non-included cancer In general, if RT services are being furnished for both an included cancer type (such as lung cancer) and a non-included cancer type (such as lymph node metastasis) within a 90-day episode of care, and the RO beneficiary has a history of the included cancer type, and thus that diagnosis code is included on the claim, the RO participant should bill FFS for any included RT services furnished for the non-included cancer type, using the GB modifier or B1 condition code. Once the SOE claim is adjudicated, the RO participant may include services for both included and non-included cancers in the same claim, using the GB modifier for included RT services furnished for the non-included cancer.
All cancer types are included in the RO Model		
b.	We are treating a Medicare patient for two included cancer types: a primary lung cancer and a secondary brain metastasis. How do we determine which cancer to start an episode for, and how do we bill for RT services for the other cancer type? How do we bill for an RT course that will treat two separate RO Model tumor groups (such as breast and brain metastases) within the same 90-day episode? Is the participant supposed to pick one of the two tumor types, or will Correct Coding Initiative edits apply?	If included RT services are being furnished to treat two (or more) included cancer types during an RO episode, the RO participant can choose the RO Model-specific HCPCS code with the highest payment amount to include on the SOE (V1) claim. The same RO Model-specific HCPCS code must be on the EOE (V2) claim. The pricing methodology was constructed such that, on average, all included RT services for each included cancer type would be covered by the episode payment. Included RT services furnished to treat both cancer types should be included on the encounter-like (no-pay) claims.

	Question	Answer
		All RT services included in the RO Model that are furnished to treat both included cancer types will be included in the episode payment for the 90-day episode period and will be processed as encounter-like (no-pay) claims.
c.	What happens if an RO participant submits an EOE claim for the primary cancer on Day 30 of the RO episode, and then the Medicare patient is diagnosed with a new RO Model cancer? For example, assume a patient is being treated for bone metastasis and completes the prescribed 10 fractions for palliation. The patient then returns for follow-up two to three weeks after treatment and has a new brain or bone metastasis. Will this start a new episode of care?	If an EOE claim has been submitted, another episode for the patient may not start until at least 118 days (that is, after the 90-day episode period plus the 28-day clean period) after the date of services on the professional SOE claim, even if RT treatment ended before 90 days. The pricing methodology was constructed such that, on average, all included RT services for each included cancer type would be covered by the episode payment. Included RT services furnished to treat both cancer types should be included on the encounter-like (no-pay) claims. All RT services included in the RO Model that are furnished to treat both included cancer types (the primary cancer and the new cancer) will be included in the episode payment for the 90-day episode period and processed as encounter-like (no-pay) claims.
11. Multiple sites of care		
a.	How do I bill for services furnished at multiple facilities? For example, RT is furnished at another site for another diagnosis (such as lung cancer) but is then referred to an HOPD for gamma knife stereotactic radiosurgery (SRS) for the treatment of brain metastases.	In the scenario described, the SRS would be considered a duplicate RT service and should be billed FFS. Consider a freestanding radiation therapy center that only furnishes SRS. The freestanding radiation therapy center often radiates the brain while another freestanding radiation therapy center furnishes the PC for both the SRS and treatment of the primary lung cancer, as well as the external beam radiation for the lung cancer. The freestanding radiation therapy center that furnishes the PC for the RT care and the TC would be considered a Dual participant, would own the RO episode, and would bill an RO Model-specific HCPCS code to receive the episode payment. The freestanding radiation therapy center that furnishes the SRS would bill FFS with existing HCPCS codes and the GB modifier. If SRS is the only modality used during the RO episode, the freestanding radiation therapy center that furnishes the SRS would submit claims with RO Model-specific HCPCS codes labeled “technical,” and the PGP or freestanding radiation therapy center that furnishes the PC of the SRS would submit claims with RO Model-specific HCPCS codes labeled “professional.”
b.	What happens when a patient is under treatment with an RO participant and needs additional treatment at the same time for an additional area?	The RO episode would start when you submit a claim with an RO Model-specific HCPCS code for lung cancer, plus the V1 modifier, for the PC (the claim should

	Question	Answer
	For example, a patient is being treated with radiation for lung cancer and has symptomatic brain metastases that need treatment during the lung episode. How will the additional brain treatment(s) be billed/paid, and how is this handled if the second treatment occurs at another practice that did not trigger the PCs and TCs of the lung episode?	contain the date when the initial RT treatment planning service was furnished). The TC would start on the date that the first RT treatment delivery service was furnished, and a claim with an RO Model-specific HCPCS code for lung cancer, plus the V1 modifier, for the TC was billed. For the 90-day episode, any RT treatments for both the lung cancer and brain metastases that are included in the RO Model—and were furnished by the initiating PC and TC participants—would be covered under the episode payment for the lung cancer. Included RT services furnished to treat both included cancer types by the initiating PC and TC participants will be processed as encounter-like (no-pay) claims. The pricing methodology was constructed such that, on average, all included RT services for each included cancer type would be covered by the episode payment. In addition, an RO participant's case-mix and historical-experience adjustments help account for the costlier beneficiary populations (such as those diagnosed with multiple cancer types) in the participant-specific episode payment amounts. In the scenario described, any included RT services for the lung or brain cancers that were furnished at a different practice—one that participates in the RO Model but did not initiate the PC or TC of the lung cancer episode—would be considered a duplicate RT service and should be billed FFS: • For duplicate professional services, use the GB modifier on all claim lines furnished by the other practice. • For duplicate technical services furnished by an HOPD, if a claim includes only duplicate services, use the B1 condition code. If a claim includes other services, use the GB modifier on all claim lines for included RT services. • For duplicate technical services furnished by a freestanding radiation therapy center, use the GB modifier on all claim lines furnished by the center.
c.	Is there a different RO Model billing requirement for a patient who goes to one center that is under the RO Model and then goes to another center that isn't part of the RO Model for other radiation services? So in this case it would be the same billing entity, both provider-based facilities, just the ZIP Codes are 150 miles away from each other. What if RT treatment begins at one location and then the Medicare patient is transferred to another facility, but the facilities are under the same tax ID/organization?	Even though the two radiation treatment centers bill under the same entity (CCN if an HOPD, TIN if a freestanding radiation therapy center), if the patient begins treatment in the center that is an RO participant (located in a participating ZIP Code) and then is transferred to the center that is not currently an RO participant (located in a nonparticipating ZIP Code) for the remaining RT services, this will be an incomplete episode. The non-RO participant will receive FFS payments for its services.

	Question	Answer
		If the patient receives most RT services from the RO participant and then some services from the non-RO participant, and the non-RO participant center is excluded from the RO Model only because it is operating in a nonparticipating ZIP Code, then those RT services will be considered duplicate RT services. The non-RO participant will receive FFS payments for its services. During annual reconciliation, CMS will reconcile any episode payments made to the initiating center against the sum of all FFS amounts that would have been paid to the RO participant in the absence of the RO Model for any included RT services furnished during an incomplete episode or for duplicate services, as determined by encounter-like (no-pay) claims.
d.	A patient starts an episode at participating Hospital "A" and under PGP "A" and completes the course of treatment/sending EOE M-codes. Within 90 days of that SOE, the patient starts a second course of treatment (diagnosis and modality included in the RO Model) at participating Hospital "B," and the professional provider is still PGP "A." • Would this second course of treatment be reported as a second SOE, generating a new episode, because the facility is different, and Hospital "B" and PGP "A" would both be paid new bundled payments? If so, during the reconciliation process, would the episode payments remain for the facility, the professional episode payment be reversed, and the reported 77xxx series CPT codes be paid FFS? • Or would this second course of treatment payment be absorbed into the original episode, and there would be no separate payment for either Hospital "B" or PGP "A"? • Or would the second course of treatment payment be absorbed into the original episode bundled payments for PGP "A," but Hospital "B" would get paid FFS?	Under this scenario, this would be treated as a single RO episode. Payment for the second course of treatment would be absorbed into the original episode payment for PGP "A," but Hospital "B's" services would be duplicate services. Hospital "B's" claims for RT services that are included in the RO Model should include the GB modifier or B1 condition so they will be paid FFS. Duplicate services will be reconciled to FFS during the annual reconciliation process. As part of this process, CMS will calculate the difference between (1) the sum of the participant-specific episode payment amounts paid to the RO participant for the episode that occurred during the PY, and (2) the sum of all FFS amounts for any included RT services furnished as duplicate services during the episode, as determined by encounter-like (no-pay) claims. The difference is what CMS owes the RO participant or what the RO participant owes CMS. Until the end of the 90-day episode period, PGP "A's" included RT services provided at either Hospital "A" or Hospital "B" would be processed as encounter-like (no-pay) claims. If RT services for the patient are still required during the 28-day clean period following the end of the original episode, both PGP "A's" and Hospital "B's" RT services would be paid FFS, with no GB modifier or B1 condition code required.

	Question	Answer
e.	Our providers work with a neurologist to provide gamma knife services to patients at a local hospital. How will both the radiation oncologist and the neurologist bill as a PC participant for the same RO episode? Is this considered a duplicate service, and one provider will bill FFS with the GB modifier? How do you determine which provider would bill FFS versus under the RO model?	If the neurologist is part of the same PGP, that is an RO participant, as the radiation oncologist, and furnishes an RT service that is included in the RO Model, the neurologist's RT service will be part of the episode payment and processed as an encounter-like (no-pay) claim. If the neurologist bills under a different TIN (that is, a TIN not affiliated with the RO-participating PGP under which the radiation oncologist bills), whoever furnishes and bills for the initial RT treatment planning service would send in an SOE claim with an RO Model-specific HCPCS code and V1 modifier (most likely the radiation oncologist). The provider who does not send in the SOE/V1 claim (most likely the neurologist) and is affiliated with a different RO participant, or is affiliated with a non-RO participant who would be a participant except for operating in a nonparticipating ZIP Code, would include the GB modifier on the claim lines with included RT services and be paid FFS for their (duplicate) RT services furnished to the Medicare patient. Duplicate services will be reconciled with episode payments during annual reconciliation based on encounter-like (no-pay) claims.
f.	Would an episode be considered incomplete if the services are provided to the patient at two different locations—both part of our health system—that share an RO Model ID? Would an episode be considered incomplete if the services are provided to the patient at two different locations—both part of our health system—that have different RO Model IDs?	If the patient is transferred from one location where RT treatment began to another location to complete RT treatment: • If both locations are RO participants under a single RO Model ID (that is, they are billing under the same TIN or CCN), this will not be an incomplete episode (nor will the services be considered duplicate services). • If one location is an RO participant, but the patient is transferred to the location that is under a different RO Model ID (and that is also an RO participant), this would be an incomplete episode, reconciled to the first location at annual reconciliation. The RO participant at the second location would add the GB modifier or B1 condition to claims to be paid FFS. • If the second location is not an RO participant, this would also be an incomplete episode, but the non-RO participant at the second location would bill as usual without the GB modifier or B1 condition code and be paid FFS. If the patient is provided most RT services where RT treatment began, but another secondary location provides additional RT services: • If the secondary location is not an RO participant but would be if it was located in a participating ZIP Code, then the secondary location would be providing duplicate services. The secondary location would bill FFS but would not need to include the GB modifier or B1 condition code.

	Question	Answer
		• If the secondary location is not an RO participant for reasons other than ZIP Code location (see RO Model exclusion criteria), the secondary location's RT services would not be considered duplicate services. The secondary location would bill FFS and would not need to include the GB modifier or B1 condition code.
12. Beneficiary eligibility changes		
a.	If a Medicare patient changes insurance coverage to a Medicare Advantage, health maintenance organization, or commercial plan during an RO Model episode of care, what do we do with the claims?	The solution depends on the timing of the switch in insurance and the SOE claim submission: • For RO beneficiaries who switch before the SOE claim is adjudicated, Professional participants and Technical participants should bill FFS, using the GB modifier or B1 condition code for any RO Model Bundled/Packaged HCPCS codes for services furnished while the RO beneficiary was in Medicare FFS. For any RT services furnished after the insurance switch, the RO participant should bill the new primary payer. • If the switch occurs after the SOE claim is adjudicated, this will be an incomplete episode. If the RO beneficiary exits traditional Medicare FFS before the end of an episode, CMS will reconcile the SOE payment against the FFS amount based on the submission of encounter-like (no-pay) claims for services furnished before the RO beneficiary switched to a new primary payer.
13. ICD-10-CM diagnosis codes		
a.	We use the ICD-10 diagnosis code Z51.0 for RT claims, and the second diagnosis in a claim is the cancer type we are treating. Will this need to change? Should an RO participant include all ICD-10 diagnosis codes (including unspecified ICD-10 codes) on claims for all 15 cancer types? When the Medicare system verifies the inclusion of RO Model ICD-10 codes, does it review all codes in the claim's FL 66 (TC), or just the diagnosis code in the first position?	CMS' claims-processing system for the RO Model includes only the ICD-10-CM diagnosis codes listed in Appendix B. The order of cancer diagnosis codes on the claim form is not critical to RO Model billing because the claims system reviews all diagnosis codes on the form. The position does not matter for either OPPS or MPFS claims. However, CMS encourages RO participants to place the ICD-10-CM diagnosis code related to the reason for the RT treatment in the first, or primary, diagnosis position.
b.	Currently, we report only the treatment site on claims for radiation therapy. For example, if a breast cancer patient is receiving radiation to the lymph nodes, we would report only the lymph nodes. But based on the information presented so far, it appears that CMS is going to require the primary cancer site as well as the treatment site. What should we do?	The RO Model does not require any changes to the reporting of ICD-10-CM diagnosis codes on claims. RO participants may continue to report the treatment site on claims using traditional Medicare FFS billing rules. However, reporting all diagnosis codes that identify the patient's condition is important for coding specificity. Providers should report to CMS all diagnoses relevant to the claim.

	Question	Answer
c.	How does the Medicare claims-processing system handle the case of an ICD-10 cancer diagnosis code on a claim that does not match the cancer type for the SOE or EOE RO Model-specific HCPCS code on the claim?	On SOE and EOE claims containing an RO Model-specific HCPCS code, the ICD-10-CM cancer diagnosis codes on the claim do not need to match the cancer type represented by the RO Model-specific HCPCS code. For example, if an SOE claim lists a diagnosis code for lung cancer in the claim's diagnosis field, but the RO Model-specific HCPCS code is for breast cancer, the claims system will still process the claim under the RO Model to start a breast cancer RO episode. However, CMS encourages RO participants to place matching diagnoses on claims.
d.	How will ICD-10 codes not in the RO Model be treated during an RO episode? Will CMS include all ICD-10 codes (including unspecified ICD-10 codes) in the claim edits for all 15 cancer types?	Claims with included RT services that have only ICD-10-CM diagnosis codes not included in the RO Model will continue to be paid FFS. The list of included ICD-10-CM diagnosis codes can be found in Appendix B.
e.	Does the diagnosis billed on the SOE/EOE claims for a Technical participant have to be the same diagnosis as the Professional participant billed for the initial treatment and planning visit?	Although the claims system does not have edits to identify that the cancer diagnosis listed on the technical SOE/EOE claims is the same as the cancer diagnosis listed on the professional SOE/EOE claims (and on the initial RT treatment planning claim), they should be the same. CMS will be monitoring RO claims for this type of situation.
14. Non-RO participant and low volume opt-out providers		
a.	If a physician is employed by a PPS-exempt cancer hospital, and the physician furnishes treatment planning services at another HOPD facility that is an RO participant, will the episode be included in the RO Model? Asked another way, can a Professional participant be non-included due to billing under a TIN at a PPS-exempt cancer hospital, or does that exclusion apply only to the TC, as determined by the HOPD's CCN?	If a physician bills for Medicare services under a PGP's TIN that participates in the RO Model, and the HOPD is also an RO participant, the episode will be included in the RO Model. The address of the site where the RT is furnished—not the billing address—determines whether an episode is included in the RO Model. In the example of a physician employed by a PPS-exempt cancer hospital who furnishes RT at an RO participant HOPD, the episode would be included in the RO Model.
b.	If a physician is an RO participant and sends a patient to an HOPD that is not an RO participant, what will be required on the hospital claim to get the regular payment under OPPS? Will the B1 condition code or GB modifier be required?	If an HOPD is not an RO participant and treats an RO beneficiary, it should bill as usual on the hospital claim to receive FFS payment under OPPS. Neither a B1 condition code nor a GB modifier code is required. Say a physician is participating in the RO Model and is furnishing the PC of RT services, and the physician bills an RO Model-specific HCPCS code with the V1 modifier when RT treatment starts (at the time of the initial RT treatment planning service). This physician later learns the TC of RT services will be furnished by a nonparticipant. In this case, the episode will be considered incomplete and will be reconciled against the FFS encounter-like (no-pay) claims for the professional services at annual reconciliation.

	Question	Answer
		If a PGP participating in the RO Model knows that all of its RO Model-eligible beneficiaries will receive the TC of RT services from a nonparticipating HOPD, the PGP should not send in an RO Model-specific SOE claim for these beneficiaries. If the site of service included on the professional claim is not in a participating ZIP Code, the claim will process as FFS without the need for a modifier.
c.	For providers who opt out, what are the billing requirements to be paid under FFS?	A PGP that opts out of the RO Model may bill FFS on an MPFS claim form (837P or CMS-1500) using the HCPCS codes for included RT services and the GB modifier. A freestanding radiation therapy center that opts out of the RO Model may bill FFS on an MPFS claim form (837P or CMS-1500) using the HCPCS codes for included RT services and the GB modifier. An HOPD that opts out of the RO Model may bill FFS on an OPPS claim form (CMS-1450/UB-04 or 837I claim form) using the HCPCS codes for included RT services and does not need a GB modifier or B1 condition code on these claims.
d.	How should I bill if the entity furnishing the TC or PC of an episode has opted out of the RO Model?	If the RO participant furnishing the PC or TC has not opted out of the RO Model, but the entity providing the corresponding component has opted out, there would never be a complete episode. Thus, the component furnished by the RO participant that has not opted out would not be eligible for the RO Model episode payment; this entity would bill its component of the included RT services as FFS, using the GB modifier or B1 condition code. If, for example, an HOPD works with more than one PGP to furnish the PC, and one eligible PGP opts out, the HOPD would bill RO Model-specific HCPCS codes in partnership with the PGP that has not opted out of the RO Model. The HOPD would bill FFS using the B1 condition code on claims that contain only included RT services furnished in partnership with a PGP that has opted out of the RO Model.
15. RT services furnished in a setting other than an HOPD or freestanding radiation therapy center		
a.	If an RO beneficiary receives RT services while living in a skilled nursing facility, how are those services billed?	RO beneficiaries in a skilled nursing facility will be eligible to receive included RT services without those services being subject to consolidated billing rules. Bill for RT services the same as if the RO beneficiary were not in a skilled nursing facility (that is, use the RO Model-specific HCPCS codes and V1 and V2 modifiers on SOE and EOE claims). Because the included RT services are not

	Question	Answer
		subject to consolidated billing, these services will be paid for under the terms of the RO Model if those furnishing both the PC and TC services are RO participants.
b.	How do I bill for RT services furnished to a Medicare beneficiary who is participating in a clinical trial?	Medicare beneficiaries enrolled in a qualifying, federally funded clinical trial for included RT services (except for proton beam therapy) for which Medicare pays routine costs are included in the RO Model, as long as they meet all eligibility criteria for Medicare beneficiaries. CMS will rely on RO participants to determine if a beneficiary is enrolled in a qualifying clinical trial. If so, the RO participants will use the existing claims process to bill CMS for clinical trials, in addition to adding the appropriate GB modifier or B1 condition code to allow the claim to be paid FFS. CMS will monitor this aspect of the RO Model closely to make sure these claims are valid.
c.	It is my understanding that there are very specific included/excluded services in an RO Model episode. Would you please advise how this will impact the 24/72-hour bundling rule?	If an RO episode begins when the Medicare beneficiary is an outpatient, and then the beneficiary is admitted to a hospital within three days of outpatient RT services being furnished, these RT services will not be packaged into the inpatient hospital's payment. Instead, they will be processed as outpatient services under the RO Model's episode payment.
16. RT modalities		
a.	What are the specific billing rules for treating an included cancer type with included RT services but with a non-included modality?	If an RO participant furnishes an RT service on the list of RO Model Packaged/Bundled HCPCS codes list to an RO beneficiary via a non-included modality, the RO participant should submit an MPFS claim (837P or CMS-1500) that includes the GB modifier on all claim lines for included RT services directly associated with the non-included modality. If both included and non-included RT services are billed on the same OPPS claim (CMS-1450/UB-04 or 837I), the GB modifier should be listed on the claim lines for included RT services furnished using the non-included modality. If all RT services billed on an OPPS claim are included services furnished via the non-included modality, the claim should contain the B1 condition code. The services with the GB modifier or B1 condition code will be paid FFS amounts. Exhibit 12 offers an example of a Professional participant or Dual participant billing the PC for brachytherapy. In the example: HCPCS codes that are included on the list of RO Model Packaged/Bundled HCPCS codes for the delivery of brachytherapy will not be subject to RO Model billing edits. However, because the RT services associated with the PC are included RT services and subject to

	Question	Answer
		RO Model billing edits, Professional participants and Dual participants will need to apply the GB modifier for those RT services to prompt the system to pay FFS for all RT services directly related to brachytherapy. The HCPCS codes for treatment planning and treatment management include the GB modifier because they are included RT services. However, the brachytherapy-specific codes do not include the GB modifier because they are not included on the list of RO Model Packaged/Bundled HCPCS codes. The same rules would apply to brachytherapy, intraoperative radiation therapy, and any other excluded modalities, assuming they are furnished in a service location included in the RO Model and for an included cancer type.
b.	We have ongoing billing submissions for accelerated partial breast irradiation. Should this be billed as stereotactic body radiation therapy or as intensity-modulated radiation therapy? How will this affect such treatments, and what is the correct treatment? Our providers perform on-table adaptive RT, which often requires billing multiple treatment plans as well as extensive additional work by the providers and clinic staff. If the treatment modality and cancer type are included in the RO Model, how should we report the additional services required to create and implement the adaptive plans? Using the adaptive course could create five or more adaptive plans, along with treatment codes. The prostate adaptive course could be replanned multiple times throughout the 40- to 44-fraction course. Would this be reimbursed at the same rate as a traditional (nonadaptive) intensity-modulated RT prostate course?	The RO Model offers modality-agnostic episode payments to RO participants. For example, if you are treating a patient who has breast cancer—an included cancer type—with any modality included in the RO Model, the payment is the same. Encounter-like (no-pay) claims should include the CPT/HCPCS code for the actual modality used. Similarly, an episode that includes adaptive RT will be paid at the same rate as treatment with nonadaptive RT techniques. RO participants' historical-experience and case-mix adjustments account for historical patterns of care and their relative cost. A patient can have only one RO Model episode active during a period, regardless of the number and type of treatment plans. RO participants should bill the RO Model-specific HCPCS code that is most appropriate for the totality of the care being furnished to the patient. All services should be included on the encounter-like (no-pay) claims. CMS will use these claims to assess possible changes to the pricing.
c.	I have a location that has a professional group in a freestanding center but performs only brachytherapy in an HOPD. In this scenario, I understand that the professional side would use the GB modifier. Are any modifiers or special billing needed on the technical/ brachytherapy side?	The Dual participant (freestanding radiation therapy center) should use the GB modifier for professional RT services that have HCPCS codes included on the RO Model Bundled/Packaged HCPCS codes list that are furnished in conjunction with the brachytherapy at the HOPD (whether or not the HOPD is an RO participant) to be paid FFS for these services. The same is true for the HOPD if it is an RO participant—it should use the GB modifier if only some services on the claim are for included RO services furnished in conjunction with brachytherapy; it should use the B1 condition code if all services on the claim are for included RO services furnished in conjunction with brachytherapy. If the

	Question	Answer
		HOPD is not an RO participant, then it will bill FFS the same as usual, with no modifier or condition code required.
17. Miscellaneous		
a.	Will RO participants be instructed to post gross charges to beneficiary accounts for individual RT services per their chargemasters?	The RO Model does not instruct hospitals on how to post gross charges or implement any other accounting procedures.
b.	Do claims with the RO Model-specific HCPCS codes or the encounter-like (no-pay) claims show up on the hospital cost report?	Claims paid based on the RO Model-specific HCPCS codes will be isolated in a new, demonstration specific Provider and Statistical Reimbursement report and will qualify for bad debt. Encounter-like (no-pay) claims will be isolated in a new, informational-only Provider and Statistical Reimbursement report and will not qualify for bad debt (because no payment or coinsurance is applied). The total hospital costs listed in the cost report will include the costs incurred rendering the services covered under the RO Model.
c.	How will this program be identified on the remittance received from CMS? Is this going to be identified on the remittance as a MIPS program, when applicable?	RO Model claims will be shown on a remittance advice in the same way and appear on the same remittance advices as other Medicare FFS claims. The SOE and EOE claims will be identifiable by the presence of RO Model-specific HCPCS codes and modifiers V1 or V2. No special remark codes will be placed on SOE or EOE claims that are paid in accordance with the rules of the RO Model. However, specific remark codes will be put on a claim that is returned to the provider or rejected due to not meeting the rules of the RO Model—for example, if a claim is submitted with two SOE claim lines on the same claim by an RO participant (that is not a Dual participant) or if the date of service does not meet certain requirements. CARCs and RARCs for SOE and EOE claims can be found in Appendix G. For claims processed as encounter-like (no-pay) claims, CARC/RARC codes will be as follows: • Professional participants, Dual participants, or Technical participants that use CMS-1500 or 837P claim forms for MPFS claims: During the 90-day episode, your MAC will send an 835 remittance with “CARC: 234—This procedure is not paid separately” and “RARC: N83—No appeal rights. Adjudicative decision based on the provisions of a demonstration project.” • Technical participants that use CMS-1450/UB-04 or 837I claim forms for OPPS claims: During the 90-day episode, your MAC will send an 835 remittance with “CARC: 97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835.”

	Question	Answer
		Claims that might otherwise be included in the episode payment but are paid FFS will be identified by the GB modifier on the line item or the B1 condition code on the claim. RO Model claims will be shown on a remittance advice in the same way and appear on the same remittance advices as other Medicare FFS claims. The RO Model does not affect how the MIPS quality adjustment is applied to Medicare claims. For services paid under the MPFS, the MIPS adjustment will be applied to RO Model claims with a professional RO Model-specific HCPCS code and V1/V2 modifier the same as it is applied to other usual professional Medicare claims.
d.	Is there or will there be any Electronic Remittance Advice (ERA) remittance examples posted to the RO Model website of how we could expect to see the payments and associated withholds come through in our files so we can prepare ahead of time for posting concerns?	RO Model claims will be shown on a remittance advice in the same way and appear on the same remittance advices as any other Medicare FFS claim. They will be identifiable by the presence of RO Model-specific HCPCS codes, modifiers (V1 or V2), and/or the CARC/RARC codes for claims processed as encounter-like (no-pay) claims. Claims that might otherwise be included in the episode payment but are paid FFS will be identified by the GB modifier on the line item or the B1 condition code on the claim.
e.	Given that the RO Model is technology agnostic for the bundled payment, how are patients handled if their ICD-10-CM diagnosis is included in the RO Model but not covered by the Local Coverage Determination (LCD) or MAC? For instance, the Local Coverage Article (A57669) does not cover proton beam therapy for right-sided breast cancer. However, in the RO Model, anyone with a diagnosis of C50.xx or D05.xx should be able to receive any combination of external beam technologies, including but not limited to proton beam therapy.	The RO Model is a payment model and is not changing any coverage rules that might apply either nationally or locally in specific MAC jurisdictions. If a service would not be covered under traditional FFS Medicare, then it should not be billed under the RO Model. To do so could be referred for fraud and abuse investigation. For more specific instructions on LCD policy under the RO Model, see the Specialty Care Models final rule (pp. 61205, 61209, 61253): “LCDs are decisions made by a Medicare Administrative Contractor (MAC) whether to cover a particular item or service in a MAC’s jurisdiction (region) in accordance with section 1862(a)(1)(A) of the Social Security Act. The MAC’s decision is based on whether the service or item is considered reasonable and necessary. The MACs will not have the ability to apply LCDs to RO Model claims because only the RO Model-specific HCPCS codes appear on the claim, and these codes are not included in any current LCDs. When we monitor utilization of RT services during the RO Model, as described in section III.C.14.a, we will use the reasonable and necessary provisions as stated in applicable LCDs as one of our monitoring tools.”

Appendix J. Glossary of Acronyms

Acronym	Definition
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CARC	claim adjustment reason code
CBSA	Core-Based Statistical Area
CCN	CMS Certification Number
CDE	clinical data element
CHART	Community Health Access and Rural Transformation
CMS	Centers for Medicare & Medicaid Services
CNS	central nervous system
CPT	Current Procedural Terminology
EOE	end-of-episode
FAQ	frequently asked questions
FL	Field Locator
FFS	fee-for-service
FISS	Fiscal Intermediary Standard System
GB	claim being re-submitted for payment because it is no longer covered under a global payment demonstration
GI	gastrointestinal
HCPCS	Healthcare Common Procedure Coding System
HOPD	hospital outpatient department
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
MAC	Medicare Administrative Contractor
MCS	Medicare claims system
MPFS	Medicare Physician Fee Schedule
OPPS	Outpatient Prospective Payment System
PC	professional component
PGP	physician group practice
PPS	Prospective Payment System
PY	performance year
RARC	remittance advice remark code
RO	radiation oncology
ROAP	Radiation Oncology Administrative Portal
RT	radiotherapy
SOE	start-of-episode
SRS	stereotactic radiosurgery
TC	technical component
TIN	taxpayer identification number