Recommendations
2025-2026 Linear Accelerator Workgroup

The linear accelerator (LINAC) workgroup met three times in 2025: October 22, November 18, and December 10. The group consisted of radiation oncologists, medical physicists, radiation technologists and oncology center administrators. Their review addressed the areas specified in the workgroup charge.

At the conclusion of their work, they recommended a complete revision of the LINAC need methodology and the establishment of a new policy. Overall, these recommendations aim to ensure that the state has sufficient LINACs going forward. In particular, the recommended changes reflect the state's growing population, increases in cancer cases, and expansion of LINAC treatment beyond oncology.

If approved, the State Health Coordinating Council (SHCC) will consider the T&E Committee's recommendations for inclusion in the Proposed 2027 SMFP.

Recommendations for the 2027 SMFP

Recommendation 1: Use facility-level deficits as the basis for projecting need.

The current methodology projects a need only when the overall utilization in the service area shows a deficit of LINACs. This approach can disadvantage high-utilization facilities in the same service area as facilities that have very low utilization. Use of facility-level deficits will project a need for the service area if a single facility in the service area has high utilization. However, anyone can apply for a CON for a LINAC; it is not limited to the facility that triggered the need determination.

Recommendation 2: Use the North Carolina Health Service Areas (HSA) as LINAC service areas.

The current 28 service areas were established when the state had far fewer LINACs than are currently available. It also required periodic revision to examine changes in utilization patterns based on the patients' county of residence and location of treatment. Although LINACs exist in only about half of the 100 counties, they are relatively well distributed across the state. Thus, it is no longer necessary to consider these factors. The HSAs shown in Appendix A of the SMFP provide stability over time and allow a wider geographic area for the siting of new LINACs than the current service areas.

Recommendation 3: Use population growth in HSAs to project utilization three years beyond the reporting year.

Many methodologies in the SMFP include a growth factor when projecting needs. The LINAC methodology should be updated to include population growth in the HSA when projecting need. The three-year projection period is based on the anticipated time required to develop a new LINAC.

<u>Recommendation 4</u>: Retain the 6,750 Equivalent Simple Treatment Visit (ESTV) threshold for projecting needs.

The workgroup agreed to retain the 6,750 ESTV threshold after consideration of other options for measurement of utilization and use of other thresholds.

Table 1 projects what the needs might be under the new methodology but using the 2026 SMFP data. The 2026 SMFP shows four need determinations: one was based on methodology calculations; the other three were based on petitions. The Adjusted Projected Deficit/Need shows how the placeholders for 2026 need determinations and CONs issued for LINACs still in development would reduce the calculated needs.

Table 1. Projected and Adjusted Need Determinations

Health Service Area	Adjusted Planning Inventory	Projected Deficit/Need	Adjusted Projected Deficit/Need*
I	21	1	1
II	21	1	0
III	23	11	9
IV	30	2	0
V	18	1	1
VI	19	2	1
Total		**18**	**12**

<u>Recommendation 5</u>: Approve Policy TE-6.

The workgroup reviewed the proposed policy first developed by the Agency in 2024. They generally favored a policy of this nature, but recommended several changes that are reflected in the final version below:

Proposed Policy TE-6: Plan Exemption for Linear Accelerators (LINAC)

A hospital with a cancer/oncology program that does not have an existing or approved linear accelerator (LINAC) may apply for a LINAC pursuant to the provisions in this Policy. The hospital shall demonstrate in its certificate of need (CON) application that:

1. the cancer/oncology program provides coordinated services for the diagnosis, treatment, and care of people with cancer, using a multidisciplinary approach to patient care including, but not limited to, surgeons, medical oncologists, and oncology specialty providers.
2. the cancer/oncology program is located on the main campus of the hospital or a campus that operates under the main hospital's license; and
3. the cancer/oncology program has been in operation at least three full Federal fiscal years at the time of application; and
4. the cancer/oncology program served a total of at least 200 newly diagnosed patients in the past two full Federal fiscal years; and
5. the cancer/oncology program has not been denied certification or accreditation due to deficiencies in quality of care; and

6. within one year of acquisition of the approved LINAC, the cancer/oncology program is eligible to apply for accreditation by one of the following nationally recognized organizations: American College of Radiology (ACR)-Radiation Oncology Practice Accreditation (ROPA); American College of Radiation Oncology (ACRO); or the American Society for Radiation Oncology (ASTRO)-APEx.
7. the application conforms to Policy GEN-5.

The performance standards in 10A NCAC 14C .1903 are not applicable.

Recommendation 6: Adopt recommended weights for 2026 CPT coding recategorization.

Providers report procedures using Current Procedural Terminology (CPT) codes. The Centers for Medicare and Medicaid Services (CMS) adopted a new categorization of CPT codes that became effective for procedures performed beginning on January 1, 2026. The methodology calculations assign a weight to each CPT code based on the relative LINAC resources required. Many procedures are weighted 1.0 (i.e., the number of procedures equals the number of ESTVs). Those that take more time receive higher weights. The weights are then applied to the number of procedures reported to calculate the ESTVs used in the need determination methodology.

This new categorization will not affect the 2027 SMFP because the reporting year ended on September 30, 2025. It will, however, affect the data the Agency receives early in 2027 for inclusion in the 2028 SMFP. The workgroup examined the new categorizations and recommended weights. Attachment 1 shows *the current and revised CPT code categorization and their associated weights used in the need determination methodology. The new categorization will be incorporated into the 2027 hospital License Renewal Application and the Registration and Inventory form.*

Recommendation 7: Reconvene the workgroup early in 2027 to review the impact of new CPT code categorization on need determination calculations.

In addition to new categorizations, CMS established expectations regarding how procedures should be reported. CMS expects that about 35% of the total LINAC procedures will be reported in Level 3. Currently, over 90% of procedures in North Carolina are reported using CPT codes that will be in Level 3 under the new coding scheme. Application of the new weights, even if NC providers follow the CMS expectations, will substantially increase the number of ESTVs reported.

Until data is received early in 2027, it is not possible to know how the new CPT categorization and anticipated changes in reporting may affect need determination calculations. Therefore, the staff recommends reconvening the workgroup to examine these effects and consider adjustments to the 6,750 ESTV threshold and other issues that may be pertinent.

It may also be necessary to examine the first full year of reporting under the new CPT categorization - the 2026-2027 reporting year. Data will be available for examination early in 2028. The Agency will review the data and determine whether to consult the workgroup at that time.

Attachment 1: Current and 2026 CPT Code Categorization and Recommended Weights

CURRENT METHODOLOGY				RECOMMENDED		
CPT Code	**Description**	**Weight**		**CPT Code**	**Description**	**Weight**
Simple Treatment Delivery				***Simple Treatment Delivery***		
77401	Radiation treatment delivery	1.0		77402	Level 1 (Simple)	1.0
77402	(<=5 MeV)	1.0				
77403	(6-10 MeV)	1.0				
77404	(11-19 MeV)	1.0				
77406	(>=20 MeV)	1.0				
Intermediate Treatment Delivery				***Intermediate Treatment Delivery***		
77407	(<=5 MeV)	1.0		77407	Level 2 (Intermediate)	1.0
77408	(6-10 MeV)	1.0				
77409	(11-19 MeV)	1.0				
77411	(>=20 MeV)	1.0				
Complex Treatment Delivery				***Complex Treatment Delivery***		
77412	(<=5 MeV)	1.0		77412	Level 3 (Complex)	2.0
77413	(6-10 MeV)	1.0				
77414	(11-19 MeV)	1.0				
77416	(>= 20 MeV)	1.0				
77418	Intensity modulated radiation treatment (IMRT) delivery	1.0				
Other				**Other**		
77372	Stereotactic radiosurgery (SRS), complete, 1 session	3.0		77372	SRS cranial one session (fraction) complete LINAC	4.0
77373	Stereotactic body radiation therapy (SRT)	3.0		77373	SRT multisession up to 5 (fractions 2-5)	4.0
	Total body radiation	2.5		*	Total/hemi-body radiation	3.0
	Hemibody radiation	2.0		*	Total skin radiation	3.0
	Limb salvage irradiation	1.0			no code	
Specialty Treatments				***Specialty Treatments***		
	Intraoperative radiation therapy (total weight)	10.0		*	Intraoperative radiation therapy (including patient transport) **	6.0
	Pediatric patient under anesthesia (total weight)	1.5		*	Patient under anesthesia (if anesthetized in LINAC vault)**	0.5
77417	Additional field check radiographs	0.5			deleted-no longer recorded	
Gamma Knife, Proton/Neutron				**Gamma Knife, Proton/Neutron**		
77371	SRS - Gamma Knife	3.0		77371	SRS cranial cblt (Gamma Knife)***	
	Proton/neutron radiation therapy	2.0		77520	Proton trt (simple, int, cmplx) ***	

* Procedures are in methodology but do not have separate CPT codes.

** For example, if the LINAC performed 200 Complex (77412) procedures, 3 of which were performed while the patient was undergoing surgery, include them in the total 200 procedures under 77412. Also report the 3 intraoperative procedures in this section.

*** No weights are provided because these procedures are not in the methodology.