OPPS on Capitol Hill

Since August 2000 many hospital-based cancer programs have struggled with implementation of the hospital outpatient prospective payment system, or OPPS. Unfortunately, it looks as if the struggle will continue into 2002. Several key pieces of the system remain up in the air and will continue to challenge program administrators during the coming year.

First, some hospitals have complained that when new drugs come on the market and Medicare has not assigned a specific code to the drug, the hospital is not able to bill for the drug. When Medicare finally issues a code for the drug, the hospital is not able to go back and secure reimbursement.

ACCC has been working with industry and the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) to fix this problem, but the undertaking has been slow and tedious. Even if this issue is resolved, providers can still count on having a difficult time billing Medicare under the hospital OPPS. Communication among providers and fiscal intermediaries has been inadequate and so has CMS's fine-tuning of the system.

Even more threatening than not being able to bill for certain new drugs is the potential for across-the-board reductions in the actual amount reimbursed for giving the drug. This issue revolves around the pass-through pool for drugs under the hospital OPPS system. When Congress created the original hospital OPPS system, it earmarked a certain percentage of funds to address the issue of drug reimbursement. Lawmakers pegged reimbursement to 95 percent of the average wholesale price (AWP), the same amount as in the office setting, but they added one special caveat.

This caveat, simplified, said that if it looked like Medicare was going to overspend the funds in this pool, then Medicare could apply a pro-rata reduction across the board to all drugs reimbursed under the program. Because of various factors, CMS has said it will apply this pro-rata reduction in 2002.

Initial analysis by ACCC indicates that this cut would translate into reimbursement rates of AWP minus 24 percent for sole-source drugs, AWP minus 29 percent for multi-source drugs, and AWP minus 41 percent for generic drugs.

While hospitals will do significantly better under the new APCs on radiation and chemotherapy administration, the loss on drugs will cause additional problems, further weakening this portion of the safety net that currently provides 30 percent of chemotherapy.

ACCC has been working hard to prevent or minimize these cuts. Hospital-based cancer programs need to follow this issue closely.

—Christian G. Downs M.H.A., J.D.

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PHOTOGRAPH BY WASHINGTON DC CONVENTION AND VISITORS ASSOCIATION/ILLUSTRATION BY EYEWIRE

PHOTOGRAPH BY JON GOELL

Hospitals and practices should prepare for reductions in Medicare chemotherapy reimbursement.

Prepare for Cuts In Drug Reimbursement

In a slightly different version of the AWP problem, some members of Congress and several government agencies continue to raise concerns about the "margin" between AWP and the price the provider actually pays for a cancer drug. These policymakers are concerned that providers are overcharging the Medicare program and that the AWP system needs to be changed.

Providers, on the other hand, have offered ample evidence that any "margin" on drugs is plowed back into the practice to cover the cost of actually *giving* the drug. In fact, studies by ACCC have indicated that even at AWP minus 5 percent hospitals are losing money when they administer chemotherapy to patients.

From an office practice perspective, the most critical issue is increasing the practice expense—reimbursement for chemotherapy administration—to a level that will minimize any impact in the reduction in drug reimbursement. For hospitals, increasing reimbursement for the ambulatory payment classifications (APCs) for chemotherapy administration and providing a pharmacy code are essential.

Provider groups such as ACCC, the American Society of Clinical Oncology (ASCO), US Oncology, and the Oncology Nursing Society have been working hard to educate policymakers on the complexities of the issue. Yet, the forecast for 2002 is still unclear. Many believe that AWP in its current form is not sustainable given the political pressure to change. Various methodologies to change AWP have been tried, including calibrating drug reimbursement using average manufacturers' price (AMP), but these methods focus almost exclusively on the drug reimbursement side and not on the practice expense part of the equation.

At the moment hospitals are not part of the House Commerce Committee bill since the pass-through legislation requires CMS to gather data and develop a plan for payment of drugs under the APC system.

Still, hospitals and practices need to prepare for some form of reduction in drug reimbursement, even if we do not yet know the extent of the reduction. At the same time, providers should also check their private insurance contracts to make sure they do not contain clauses that tie their drug payments to Medicare reimbursement rates.

As the New Year starts, providers need to think strategically. More precisely, providers should ask: How will this issue affect my ability to give care? How should my organization respond to the economic and managerial changes these issues will present? How can I involve my organization in the legislative and regulatory process?

GAO REPORT RELEASED

On Nov. 1, 2001, the U.S. General Accounting Office (GAO) issued a report on the practice expense payments that oncologists receive in the office-based setting under Medicare. The GAO concluded that while some practice expenses were improperly calculated and do not reflect some indirect costs and supply expenses, oncologists' overall payments in 2001 are 8 percent higher than they would have been under the old charge-based payment system. The GAO recommended a few changes for calculating some oncology practice expenses, but overall concluded that under the new resource-based payment structure, "oncology's practice expense payments, compared to their estimated practice expenses, are about the same as the average for all physicians."

ASCO disagreed with the study results, and the American Medical Association has questioned any recalibration. While no specific number is mentioned in the report, both GAO and CMS leaders told the House Commerce Committee that their best estimate was an increase of $50 million in practice expense (versus a "savings" of $1 billion).

GAO's results complicate oncologists' efforts to educate Congress about the fact that their practice expense payments are particularly inadequate for certain office-based services, such as chemotherapy administration. The report also comes at a time when Congress is contemplating reducing drug acquisition payments for the office-based setting.

PHOTOGRAPH BY PHOTODISC

Entitled "Medicare Physician Fee Schedule: Practice Expense Payments to Oncologists Indicate Need for Overall Refinements," the GAO report was

mandated by Congress under Section 213 of the Balanced Budget Refinement Act of 1999. Congress directed the GAO to examine the resources necessary to provide safe and effective outpatient cancer therapy, including the adequacy of the practice expense relative value units associated with such care.

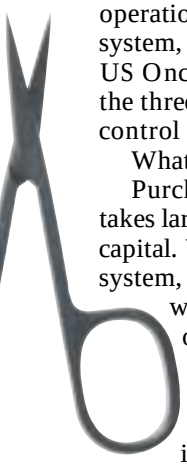
US Oncology Adopts New Strategy to Promote Expansion

US Oncology announced Oct. 1, 2001, that it was restructuring by providing its core services to the oncology market through a non-physician practice management (PPM) model. Three service lines will be offered: pharmacy management services (purchasing, inventory, staffing, and on-site admixture), outpatient cancer center operations (facility development, construction, and management of diagnostic and radiation treatment services), and clinical research (Phase I-IV clinical trials and drug development services).

In the past, when practices affiliated with US Oncology or its predecessor companies, they sold their non-medical assets (furniture, fixtures, equipment, accounts receivable, and good will) to US Oncology, which managed their financial and business operations in return. Under the new system, practices may affiliate with US Oncology, contract for any of the three service lines, and maintain control of their own operations.

What's in it for US Oncology?

Purchasing oncology practices takes large amounts of capital. Under the new system, the money that would have previously been spent on acquisition of the non-medical assets of an affiliating practice can go directly into practice market development activities, such as cancer center development, delivery of on-site pharmacy services, and expansion of its Phase I-IV clinical research.



US Oncology still expects to open 12 to 15 new cancer centers a year and add 60 to 80 new oncologists to its network annually. It also plans to add 12 to 15 PET installations each year. The company will continue to offer physicians assistance with practice coverage, recruitment, practice marketing, managed care contacting, and other services. The resource networks for nurses will remain in operation as will a number of management councils on which physicians, nurses, pharmacists, and radiation therapists are represented.

US Oncology currently treats more than 15 percent of all newly diagnosed cancer patients in the country, and last year accrued 4,000 patients to about 100 research protocols, representing approximately 9 percent of all adult accruals to clinical trials. It is affiliated with more than 850 physicians in more than 450 locations in 27 states and operates 75 cancer centers that have a total of 112 linear accelerators and 12 PET units.

Service Line vs. Earnings Models

US Oncology will offer currently affiliated practices the option of 1) staying with the present earnings-based model that allows physicians to concentrate solely on patient care while US Oncology manages the business aspects of their practice, or 2) maintaining ownership of their practice and contracting for services from US Oncology through the new *service line structure*. The service line structure continues US Oncology's support of its key services, including access to capital for development of integrated cancer center and diagnostic services.

US Oncology will continue to support the earnings model for existing affiliated practices, while offering the service line structure to new practices. "Both models allow the network to grow and offer its services to a broader network of oncologists across the U.S.," said Lloyd K. Everson, M.D., vice chairman of US Oncology. "In addition, both models align the incentives of the network with its oncology practices and cancer centers by building on its strengths to further offer enhanced access to cancer care for patients with cancer."

If all practices currently affiliated with US Oncology convert to the service line structure, the transition will cost the company $60 million in restructuring charges, a $390 million write-off of intangible assets and good will (a non-cash transaction charge), and an annual net drop in operating earnings of $53 million as it terminates the existing management service agreements and converts to a new set of contract service agreements.

Still, if all the existing practices convert to the service line structure, the company will receive $160 million from the sale of assets back to the practices. It will use the funds to repay some $140 million in debt.

When US Oncology first announced the new plan its stock dropped because many people thought it was attempting to divest itself of its practices in the face of a possible cut in the average wholesale price for oncology drugs under Medicare. The company has spent the last few months explaining its goals. US Oncology officials told *Oncology Issues* that they expect their stock to recover in the near future as more people understand "the positive strategic growth implications" of their plans and begin to see successful addition of practices and cancer centers.

The verdict is still out whether US Oncology and oncology practices will benefit from the switch.

"Over time I think physicians will find affiliation with US Oncology more attractive than before because the arrangement will allow them to retain their local autonomy, while gaining access to the ability to provide leading-edge care for their patients," said Dale E. Fuller, M.D.,

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IMRT: The Hidden Costs

PHOTOGRAPH BY PHOTODISC

Intensity modulated radiation therapy (IMRT) with its tight beam margins and high curative doses may be the future of radiation oncology. The clinical value of the process has been proven, and cancer centers around the world are scrambling to include it in their treatment arsenals. Be aware, however, of hidden costs that may make its use impractical.

The most obvious cash outlay is for the equipment itself, and most institutions have figured this item into their budget. The Cadillac of IMRT machines lists between $1 million and $1.7 million; but if an institution's linear accelerator is new enough, a multileaf collimator can be added or retrofitted to the existing equipment, and costs can be significantly reduced.

What most oncology practices don't count on is the price of both the software *and* the personnel that make the hardware usable.

A treatment planning system for an IMRT machine can cost anywhere from $170,000 to $375,000, depending on the capability needed. Even more expensive are the additional staff members that must be hired. The problem is not training, it's time. While the current staff of the clinic can be taught to run the IMRT system with no difficulty, IMRT treatment planning takes so long that extra personnel are needed to keep the facility's regular caseload current.

Planning an ordinary 2-D radiation oncology treatment takes about an hour. If 3-D treatment is used, at least another half hour is added. After the physicist or dosimetrist receives the dose request from the attending physician and reviews the CT scans, it doesn't take long to plan how to fractionate that dose through a maximum of 6 to 8 different radiation ports around the tumor, maintaining limited doses to surrounding critical structures, and define how the treatment ports should look.

IMRT is also planned from CT scans. These studies can provide at least 100 different views of the malignant lesion, and the IMRT software program must deal with every one of them before a final IMRT treatment plan is completed. It takes a minimum of 2.5 to 3 hours. Although IMRT patients should only represent around 15 percent of a clinic's caseload, planning the treatment takes so long that dedicated personnel are needed for this task if the clinic is to function efficiently for the other 85 percent of its patients. Since the average salary for a dosimetrist is around $70,000 and a physicist usually earns more, staffing is a big ticket item.

The other hidden costs include more sophisticated immobilization devices (which are necessary because IMRT treatment margins are calculated in millimeters instead of the usual centimeters), training costs, and the cost of the increased maintenance these highly precise machines require to maintain their specifications.

Medicare reimburses for IMRT under codes 77301 for planning and 77418 for delivery. These are the only two codes that can be billed for an IMRT procedure. Clinics offering IMRT cannot additionally bill Medicare for a 3-D charge, an isodose charge, or calculations as they can for other complex 3-D procedures.

Other points to consider when evaluating IMRT include:

- Not all software that claims to be able to calculate a plan for IMRT can truly and reliably do so.
- Not all multileaf collimators are capable of delivering true IMRT.
- Not all patients with problems needing curative radiation therapy gain additional benefit from the use of IMRT, so evidence-based guidelines defining situations in which the use of IMRT is appropriate must be developed.

Each institution that uses IMRT must examine the available space and financial needs of its existing facility, determine how much money will be needed for start-up and maintenance costs, and compare these figures to the reimbursement available in its area before it can formulate a master plan to make IMRT a profitable, as well as a life-saving, venture.

F.A.C.R., a radiation oncologist with St. Paul Medical Center in Dallas, Tex., who is familiar with US Oncology.

Not nearly as optimistic about the restructuring of US Oncology is Judy Stone, the administrator of an oncology practice in Texas once aligned with an oncology-specific PPM (not US Oncology). During the time her practice was owned/managed by the PPM, the "hands on" level of medical oncology expertise they needed never developed, and the promised "economies of scale" never proved out, according to Stone.

Stone believes physicians are independent by nature. "If losing control of the physician population is key to PPM failure, US Oncology is in jeopardy. My fear is that US Oncology may eventually fall prey to this same experience, and the consequences could be far-reaching."

Despite such concerns, US Oncology believes that this newly announced strategy will enhance the performance of the company and positively position its practices for the future.

For more discussion, go to *www.accc-cancer.org*.

PHOTOGRAPH BY PHOTODISC

New Billing Codes Specific to Oncology in 2002

by Roberta L. Buell, M.B.A.

Every January coders are faced with a flurry of new codes. If your cancer center is in a hospital, you must update your charge description master and charge sheets for new codes. If you are in an office-based cancer center, it is time to update your Superbill. To assist you, here are the new codes specific to oncology to be used in all settings on Jan. 1, 2002. For CPT HCPCS Levels I and II, these codes must be used after March 31, 2002. Remember that the codes listed below are not the only new codes for the coming year. They have been selected for their applicability to oncology. Be advised that no coding list takes the place of buying new coding books every year.

ICD-9-CM (Effective Oct.1, 2001) DIAGNOSIS CODES

- 602.3—Dysplasia of the prostate
- 793.80—Unspecified abnormal mammogram
- 793.81—Mammographic microcalcification
- 793.89—Other abnormal findings on radiological examination of the breast
- V10.53—Personal history of malignant neoplasm, renal pelvis
- V70.7—Examination of participant in clinical trial (change from V70.5). (This code must be used on *hospital* claims for Medicare-approved clinical trials starting Jan. 1, 2002).
- V83.01—Asymptomatic hemophilia A carrier
- V83.02—Symptomatic hemophilia A carrier.

CPT (HCPCS Level I) Codes

Probably the most important development in oncology coding in the AMA's new *CPT* is the change of the bone marrow codes from the laboratory section to the surgery section. The new codes are:

- 38220—Bone marrow aspiration
- 38221—Bone marrow biopsy, needle or trocar.

While there are no carrier guidelines for these procedures to date, we believe that for these codes the multiple procedure rule can apply for Part B and perhaps for hospital outpatients. If this reasoning holds true, the biopsy should be sequenced first on the bill with the aspiration second and –51 applied (38220-51). It can mean that the aspiration will be paid at 50 percent of the allowable. Fortunately, the RBRVS (Medicare fee schedule) relative values are slightly higher than in 2001. This change may be to accommodate the deletion of the tray (A4550) from Part B payment. Billing for E & M codes the same day as these codes may require modifier –25 on the E & M code. You should check your December 2001 carrier or fiscal intermediary guidelines to verify this information.

There are also new codes for home infusion procedures (99551-99569). These codes include the visit, all solutions, and supplies. All drugs are excluded and can be billed separately. These codes are not covered by Medicare for physician or hospital outpatient services.

HCPCS Level II Codes

- G0202—Mammogram, bilateral, screening, direct digital imaging
- G0204—Mammogram, bilateral, diagnostic, direct digital imaging
- G0206—Mammogram, unilateral, diagnostic, direct digital imaging
- G0231—PET scan for recurrence of colorectal cancer, whole body, gamma cameras only
- G0232—PET scan for recurrence of lymphoma, whole body, gamma cameras only
- G0233—PET scan for recurrence of melanomas, whole body, gamma cameras only
- G0234—PET scan regional or whole body, for solitary pulmonary nodule following CT or for initial staging of pathologically diagnosed NSCLC; gamma cameras only
- G0236—Digitization of film radiographic images with computer analysis for lesion detection and further physician review for interpretation, diagnostic mammography
- G0242—Multi-source photon stereotactic radiosurgery (Cobalt multi-source beams) plan (further description may be needed)
- G0243—Multi-source photon stereotactic radiosurgery (Cobalt multi-source beams) delivery (further description may be needed)
- J1755—Iron sucrose, 20 mg
- J7193—Factor IX (Anti-hemophilic factor, purified, non-recombinant) per IU
- J7195—Factor IX (Anti-hemophilic factor, purified, recombinant) per IU
- J9017—Arsenic trioxide, per 1 mg
- J9300—Gemtuzumab ozogamicin (Mylotarg™), per 5 mg.

Some of the transfusion codes have been changed from Q-codes to P-codes. The new codes are:

- P9045—Infusion, albumin (human), 5%, 250 ml
- P9046—Infusion, albumin (human), 25%, 20 ml
- P9047—Infusion, albumin (human), 25%, 50 ml
- P9048—Infusion plasma protein fraction (human), 5%, 250 ml
- P9050—Granulocytes, pheresis, each unit

HCPCS Level II Modifiers

- GY—Item or service statutorily non-covered
- GZ—Item or service not reasonable or necessary.

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