

# Radiation Oncology Viability in Hospitals and Freestanding Clinics

Computing your bottom line is the way to make an informed choice BY DOROTHY KNIGHT, M.P.M.



**H**ospital administrators may want to evaluate which health care model—a hospital-based program or a freestanding facility—will provide their institution with the best “bottom line” in revenue for radiation oncology services. Some consultants advocate for the freestanding model. However, administrators should withhold judgment until they have gathered a variety of financial data and reimbursement information—including current ambulatory payment classification (APC) payment rates—and base their decision on these numbers.

## What is a Hospital-Based Program?

The Centers for Medicare and Medicaid Services (CMS) clearly defines the rules that allow an institution to qualify for provider-based status. First, the governance for the radiation oncology department has to be the same as other departments throughout the hospital. Second, the facility cannot be any further than 35 miles from the main campus, or the main campus and the off-site radiation oncology center must provide services to 75 percent of the same market.

If a hospital was grandfathered in under Medicare's outpatient prospective payment system (OPPS) in August 2000, the hospital will need to send CMS the appropriate paperwork by October 2002 in order to maintain provider-based status.

Regardless of whether a hospital can, or will, make a change in its current radiation oncology program, a financial comparison between hospital-based programs and freestanding centers can be a worthwhile endeavor.

## Getting Started

To understand the impact on the bottom line of a hospital-based versus a freestanding radiation oncology center, hospitals must first know the following information:

1. The hospital's 2002 Medicare Fee Schedule for its geographic region. This information can be downloaded from CMS's web site (<http://www.cms.hhs.gov/>).
2. The 2002 APC Payment Rates. The published payment rates are unadjusted geographically. A hospital will need to adjust the national rate by its wage and labor adjustment to clearly reflect the actual payment for its region. The APC payment rates are listed in the Feb. 28, 2002 *Federal Register*, Addendum B.
3. The hospital's 2001 Radiation Procedure Volumes identified by CPT code and/or HCPCS code.
4. The hospital's 2001 Radiation Oncology Payer Breakdown. This breakdown identifies which services/procedures are covered by which insurance companies, as

well as how much the insurance companies will pay for each service/procedure.

Hospitals must also have a clear understanding of the new payment methodology for devices, which went into effect April 2, 2002, as well as an understanding of their negotiated contract rates for non-Medicare patients—either a percentage of charges or negotiated fee schedule rates.

## Technical and Professional Service Revenues

Freestanding payments for professional and technical service revenues are taken directly from the 2002 Medicare fee schedule for a particular region. Hospital-based payments for technical services are taken directly from Addendum B of the Feb. 28, 2002, *Federal Register*. These payment rates are not adjusted by region. Professional revenues are taken directly from the 2002 Medicare fee schedule, which is broken down by region. If there is more than one fee schedule for the state, be sure to use the correct regional schedule.

Typically, revenues for technical services in a hospital-based model are higher than those of a freestanding center. The reasoning behind this payment mechanism is that the overhead in hospitals is higher than in the freestanding center.

Accordingly, revenues for professional services in a hospital-based model are generally lower because the radiation oncologist is not responsible for the overhead component of the payment. Usually, the hospital pays for such items as the building, staff, and supplies. However, if the radiation oncologist is paying rent for office space, examining rooms, and other overhead items, then the radiation oncologist can bill as an office instead of an outpatient department of the hospital and be paid for that overhead component.

Alternatively, freestanding centers can receive the additional overhead portion of the payment since they are incurring the overhead costs.

As shown in Table 1, freestanding centers receive no reimbursement for technical services related to new patient consults, new patient visits, established patient visits, interdisciplinary conferences, and critical care.

In the hospital-based model, the hospital can bill for the services provided by nurses, social workers, and/or nutritionists using the appropriate visit codes listed in the Feb. 28, 2002 *Federal Register*, Addendum B. As an example, a hospital's unadjusted payment amount for codes 99201-99202 and 99211-99212 is \$44.29. For codes 99204-99205 and codes 99214-99215, the unadjusted payment is \$70.25. Typically, the patient has three to five clin-

ic visits per radiation therapy course for services provided by the nurse, social worker, or nutritionist. In the hospital-based model, the physicians are not required to be present in the clinic, but can be in the hospital making rounds or meeting with referring physicians.

In the freestanding center, the services provided by the nurse, social worker, or nutritionist are *not* covered under Medicare. Effective January 2002, nutritionists that qualify can obtain a provider number for Medicare Part B services, but coverage is only for extremely limited diagnoses. Physicians are required to be present when Medicare patients are being treated in freestanding centers.

### The Bottom Line

Although some consultants say freestanding centers are better overall to the bottom line, the benefits of providing radiation oncology services in a freestanding (versus a hospital-based setting) are not as clear-cut. To make an informed decision, every hospital and freestanding center must examine its particular situation and financial data and make its own calculations. You may be surprised by the numbers.

Using information from the Nov. 30, 2001, *Federal Register*, we compared the net radiation oncology revenue of a freestanding center to a hospital-based program:

<b>Freestanding Center</b>	Net radiation oncology revenue: \$9,090,623
<b>Hospital-Based Program</b>	Net radiation oncology revenue: \$10,670,413

In this case, the hospital-based program received almost

\$1.6 million of additional net revenue over the freestanding center.

The professional revenues used in this computation came directly from the physician fee schedule for a Midwest city. The example compared a hospital-based facility with approximately 135 patients per day with a freestanding center, and did not include any brachytherapy, stereotactic, or other high technological services.

The example conservatively estimated that 50 percent of the patient population was covered by Medicare. For non-Medicare patients, we assumed payment at 20 percent above the Medicare payment, another conservative estimate. The hospital-based model for non-Medicare patients is usually a percentage of the actual charges. Conversely, in the freestanding center, the non-Medicare revenues are typically a fee schedule based directly on the region, and are usually 10 to 15 percent above the Medicare payment.

Keep in mind the importance of collecting co-payments. Under the APC payment system, co-payments are now a higher percentage of the actual cost of the service. So, if hospitals are not collecting co-payments, they are losing out.

Freestanding programs that can meet the criteria for becoming a hospital-based program may benefit from running similar computations to see if they can increase their revenue by making such a change. Hospitals expanding an existing facility or building a new facility should also carefully weigh the financial decision of providing radiation oncology services in a hospital-based program versus a freestanding clinic. ☐

*Dorothy Knight, M.P.M., is chief operating officer of Digestive Disease Associates in Baltimore, Md.*

Table 1. A Comparison of Billable Professional and Technical Services by Health Care Model

Code	Description	HOSPITAL-BASED		FREESTANDING	
		Professional	Technical	Professional	Technical
99241-99245	New Patient Consult	Y	Y	Y	N
99201-99205	New Patient Visit	Y	Y	Y	N
99211-99215	Established Patient	Y	Y	Y	N
G0175	Interdisciplinary Conference		Y	N	N
99291	Critical Care	Y	Y	Y	N
77280	Simulation Simple	Y	Y	Y	Y
77285	Simulation Intermediate	Y	Y	Y	Y
77290	Simulation Complete	Y	Y	Y	Y
77295	Simulation 3-D	Y	Y	Y	Y
77300	Dosimetry-Basic	Y	Y	Y	Y
77305	Isodose Planning Simple	Y	Y	Y	Y
77310	Isodose Planning Intermediate	Y	Y	Y	Y
77315	Isodose Planning Complex	Y	Y	Y	Y
77331	Special Dosimetry	Y	Y	Y	Y
77332	Treatment Device Simple	Y	Y	Y	Y
77333	Treatment Device Intermediate	Y	Y	Y	Y
77334	Treatment Device Complex	Y	Y	Y	Y
77336	Weekly Physics		Y		Y
77401-77406	Radiation Tx Delivery Simple		Y		Y
77407-77411	Radiation Tx Delivery Intermediate		Y		Y
77412-77416	Radiation Tx Delivery Complex		Y		Y
77417	Port Films		Y		Y
77427	Weekly Management	Y		Y	
77470	Special Procedure	Y	Y	Y	Y