THE ISSUES

Medicare Reform on Capitol Hill

In an important victory for the oncology community, the 17 House and Senate conferees charged with reconciling differences between the House and Senate Medicare bills have agreed to several provisions designed to restore Medicare reimbursement to drugs and biologics provided in the hospital outpatient setting.

The tentative agreement calls for reimbursement for sole-source drugs and biologics at 88 percent of average wholesale price (AWP) in 2004 and 83 percent of AWP in 2005. In 2006 reimbursement rates would be established by a different methodology yet to be determined.

Under the agreement, multi-source drugs in the hospital outpatient setting will be reimbursed at 68 percent of AWP and generic drugs at 46 percent of AWP. Newer drugs that do not have a Medicare payment code, or C-code, will be reimbursed at 95 percent of AWP.

These numbers will provide much needed relief to America's hospitals, which today are struggling to treat patients with reimbursement rates far below costs.

The conferees agreed with ACCC's argument that bundling the payment for drugs that cost less than $150 per encounter with their administration payment meant that many of these "cheaper" drugs were not reimbursed at all. The conferees propose dropping the bundling threshold from $150 per encounter to $50 per encounter. Under the new agreement, if hospitals bill correctly, they are likely to be paid for some of the more frequently-used antiemetic drugs.

The conferees continue to work on the controversial issue of functional equivalence.

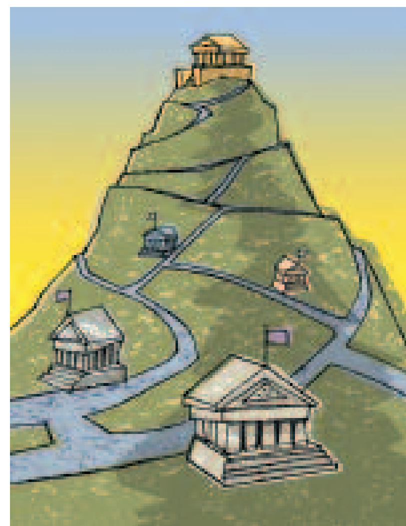
Finally, the conferees accepted the acquisition study language proposed by ACCC. The study should reveal where or even if pharmacy costs are being reimbursed.

Each of these provisions is now part of the final Medicare prescription drug coverage bill, but Congress must still pass the legislation for the provisions to become law. And, with a $400 billion price tag, members of Congress are giving the bill only a 50-50 chance of passage.

...and Meanwhile Back at CMS

ACCC submitted comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule on the hospital outpatient prospective payment system (OPPS), which was published in the *Federal Register* on August 12, 2003. CMS is expected to issue the final rule in early November.

"The rates proposed for 2004 would continue a highly inadequate level of payment for yet another year, raising serious questions about the financial viability of cancer treatment in the hospital outpatient setting and, more importantly, about patient access to care and the quality of care they receive," according to ACCC's comments. The overall effect of the proposed rates would cause payments for cancer care to fall another $7 million in 2004. The CMS proposals for 2004 also would cause large reductions in radiation oncology services and would impose complex new billing requirements on hospital clinics.



Medicare's rates are forcing major changes in the delivery of cancer care. Some ACCC members report that they are restricting patient access to cancer drugs by not including a drug in their formularies if it does not qualify for separate payment under Medicare. Other hospitals report substituting drugs on which they will lose less money if they consider them to be clinically equivalent or better, even where a physician may not agree that the substituted drug is the most appropriate one for an individual patient.

In brief, ACCC urged CMS to make fundamental modifications to the proposed rule, stating that 1) all drugs should continue to have separate ambulatory payment classifications (APCs); 2) CMS data and methodology need significant improvement; and until such time, 3) all drugs should continue to be paid at 95 percent of AWP; and 4) CMS should recognize and reimburse for pharmacy service costs.

In its comments, ACCC also highlighted the problems with the deep reductions for radiation oncology services proposed by CMS and made several alternative recommendations.

ACCC's entire comments are on its web site at *www.accc-cancer.org.* Here are some highlights:

- *Ensure adequate payment rates for drugs and biologics and other pharmacy costs.* ACCC specifically calls for CMS to eliminate the $150 threshold and make a separate APC payment for all drugs previously eligible for separate payments. Prior to implementation of the

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hospital OPPS, hospitals received reasonable cost reimbursement for all drugs actually used in treating their Medicare patients. But for the pro rata reduction imposed in 2002, in the first two years of the new system, hospitals would have received adequate reimbursement for cancer drugs through the pass-through provision. Beginning in 2003, however, CMS began using flawed data from initial experience under the OPPS to set rates for drugs rolling off the pass-through. In addition, CMS has chosen to bundle payment for 162 drugs, including 46 cancer drugs in 2003 (with 42 proposed to be bundled in 2004), with their administration codes and eliminate separate payment for these drugs.

- *Recognize and reimburse non-drug pharmacy costs.* In addition to the cost of the drugs themselves, outpatient cancer centers incur substantial pharmacy service costs in the delivery of drugs to their patients. CMS has frequently suggested that the non-drug pharmacy costs are reimbursed in the chemotherapy and other drug administration payments, but ACCC disputes this assertion and strongly urges CMS to re-examine the issue of non-drug pharmacy costs, including the possibility of conducting additional research to determine both their magnitude and how they appear on the cost report. With this additional information, CMS could create an appropriate OPPS payment policy. In the interim, payment at 95 percent of AWP should be continued to recognize these costs. To the degree that payments for outpatient drugs fall below 95 percent of AWP, CMS must make other provisions, such as a percentage add-on to drug or drug administration APC payments.

- *Analyze payment rates and billing requirements for drug administration.* ACCC does not believe that the OPPS payment rates for these administration procedures include all of the appropriate costs for both the procedure and the packaged drugs. The current APC rates do not even cover the cost of the procedure itself. One factor in the low rates may be the small number of hospital claims that are used to set the rates.

ACCC urged CMS to analyze this issue thoroughly and explain how its rates could possibly be correct. As stated in ACCC's comments, administering treatment in an outpatient cancer center is much more complicated than removing a pre-measured dose from a pharmacy shelf and administering it to the patient. These chemotherapy administration costs are substantial and their appropriate reimbursement is critical to ensuring that patients continue to have access to the safest and most efficacious chemotherapy available.

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- *Assign C-codes faster.* ACCC continues to be concerned that CMS' pass-through application process is needlessly denying patients access to the breakthrough therapies that could save their lives. Congress created the pass-through payment system specifically to help ensure that Medicare beneficiaries would have access to the newest therapies available in hospital outpatient departments. Because CMS cannot reimburse for products until a code is issued, the agency set up an expedited process for issuing temporary C-codes until such time as a permanent J-code could be assigned.

ACCC finds it especially troubling that it can take up to seven months after the Food and Drug Administration has approved a product for CMS to assign a C-code and start reimbursing for it. During this delay, hospitals must either absorb the cost associated with providing the new breakthrough drug or device or not provide it until the code is assigned. Because of the detrimental impact of these delays on Medicare beneficiaries' access to care, ACCC requested that CMS consider beginning the C-code process earlier and make retroactive payments, at the option of a hospital to bill for such payments. This is another way that CMS could improve the current system and ensure that Medicare beneficiaries have access to advancements in care in a timely manner.

And On the Private Practice Side

On Oct. 10, 2003, ACCC submitted comments to CMS on the Payment Reform for Part B Drugs, the Medicare proposal affecting oncology practices nationwide.

"ACCC fears that inadequate payment rates in physician offices could lead to widespread delays for beneficiaries needing care… Accordingly, we urge CMS to proceed cautiously in implementing these reforms and to put patients first throughout this process." The full text of ACCC' comments is available at *www.accc-cancer.org*.

ACCC believes the proposed reductions in payments for drugs are excessive and proposed increases

in practice expense relative value units (RVUs) for drug administration and other related services are insufficient. The potential reductions in payments under the four options from CMS range from $4.1 billion over 10 years to $27.6 billion over 10 years. While ACCC supports revision of the Medicare payment system to more closely align Medicare payment amounts to the cost of drugs *and* the costs of drug administration, it voiced concerns that the extent of the drug payment cuts is so severe that it will negatively impact cancer patients nationwide.

In its comments, ACCC urged CMS to revise whichever option it selects to correct for these problems and to issue another proposed rule, giving interested parties a full opportunity to make meaningful comments before the final rule.

Outpatient Radiation Therapy Takes a Hit from Medicare

The proposed OPPS rule from CMS features draconian cuts in reimbursement for radiation oncology services in a wide range of services from basic external beam radiation therapy to complex IMRT. Based on the proposed rates and CMS data on the frequency of services, the proposed payment rates are estimated to decrease total payments to hospitals for outpatient radiation oncology services by more than $174 million (see Table 1).

Such reductions in payment could slow the adoption of and limit the access to these valuable new technologies. In addition, patients in rural communities would be hurt the most, because they would need to go to large university or research institutions to receive cancer treatment with the latest technology.

Radiation treatments most affected by the proposed rule include:

- *APC 301 Level II Radiation Therapy* includes four CPT codes for radiation therapy (77412, 77413, 77414, and 77416). The codes are for complex treatment delivery.

CMS proposes a payment rate of $115.84 for APC 301, which is a 30 percent reduction from the 2003 payment rate of $164.73. Based on four quarters of 2002 claims data from CMS, ACCC estimates that this proposal will reduce total payments for APC 301 (external beam radiation therapy) by more than $155 million. External beam radiation therapy is the most commonly provided type of radiation therapy, and approximately 50 to 60 percent of cancer patients are treated with this type of radiation at some time during their disease.

Most patients receive external beam therapy five times a week over several weeks, and an entire course of treatment usually lasts from one to eight weeks, depending on the type of cancer and the goal of treatment. The proposed payment reduction of approximately $49 per treatment will have a significant cumulative effect over an entire course of therapy. ACCC estimates that hospitals will lose between $1,500-$2,000 per course of therapy unless CMS restores the payments to the 2003 levels.

A payment reduction of 30 percent is too much for a cancer center to absorb in a single year.

Additionally, when hospitals purchase or lease capital equipment they must usually sign multi-year contracts. So, even if a hospital decided to terminate the service, it would be stuck with a financial commitment. More seriously, termination of the service could affect patient access, especially in rural and inner city areas.

- *High Dose Rate (HDR) Brachytherapy (APC 313)* includes four CPT codes for remote afterloading HDR brachytherapy (77781, 77782, 77783, and 77784).

CMS proposes a payment rate of $712.59 for APC 313 brachytherapy, which is a 35 percent reduction from the 2003 payment rate of $1,097.06. ACCC maintains that this payment rate will be insufficient to cover the costs of the procedures and will jeopardize patient access to this therapy. Based on four quarters of 2002 claims data from CMS, ACCC estimates that this proposal

Table 1: Proposed Cuts in 2004 OPPS Rule for Radiation Oncology

2004 APC	2004 Title	2002 Volume (Q1–Q4)	2003 Payment Rate	2004 Proposed Payment Rate	Impact of Change (Payment Difference X Volume)
301	Level II Radiation Therapy	3,177,215	$164.73	$115.84	-$155,334,041
313	Brachytherapy (high dose rate)	11,336	$1,097.06	$712.59	-$4,358,352
412	IMRT Treatment Delivery	101,958	$400.00	$286.82	-$11,539,606
413	IMRT Treatment Plan	5,820	$875.00	$327.74	-$3,185,053
	Total Impact				**-$174,417,052**

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will reduce total payments for APC 313 by more than $4 million.

ACCC believes that the faulty payment rate proposed for 2004 for APC 313 can largely be attributed to hospital billing errors. After reviewing the 2002 hospital billing data used by CMS to establish the payment rates in the proposed rule, ACCC found that for more than 55 percent of the brachytherapy cases, a claim was not submitted for the source. Hospitals apparently were confused about the appropriate use of code C1717 (HDR Ir-192) and did not code appropriately for the Iridium source.

■ *Intensity Modulated Radiation Therapy (IMRT) (APCs 412 and 413)* includes IMRT treatment planning and IMRT treatment delivery.

Under the 2003 OPPS, IMRT treatment planning (code 77301) is assigned to APC 712 New Technology Level VII with a payment rate of $875. For 2004, CMS proposes to move this procedure to APC 413 IMRT Treatment Plan with a payment rate of $327.74. If enacted, the proposed rate constitutes a 62.5 percent reduction in payment.

Under the 2003 OPPS, IMRT treatment delivery (code 77418) is assigned to APC 710 New Technology Level V with a payment rate of $400. For 2004, CMS proposes to move this procedure to APC 412 IMRT Treatment Delivery with a payment rate of $286.82. This proposal constitutes a 28 percent payment reduction.

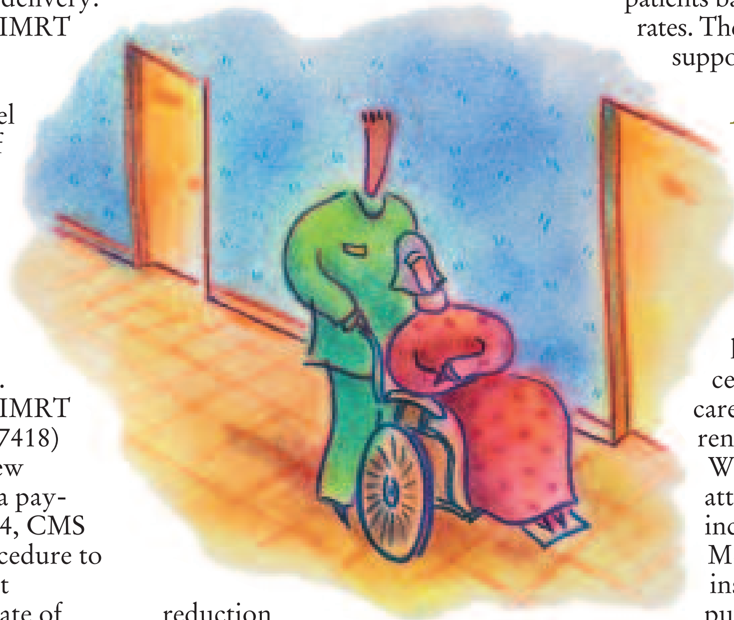
Based on four quarters of 2002 claims data from CMS, ACCC estimates that the two payment reductions will reduce total payments for IMRT by more than $14 million.

ACCC believes the cause of the low payment rates may be errors in the coding of IMRT. Hospitals have had considerable confusion about the G-codes initially created by CMS and the transition to the new CPT codes in 2002. In some cases, ACCC believes hospitals are miscoding IMRT planning as IMRT treatment and vice versa.

On the positive side, most of the codes used in planning and simulation were given a 4 to 7 percent increase. Permanent prostate seed implants received an 8 to 10 percent increase, and stereotactic radiosurgery did not change dramatically.

Inadequate Reimbursement Threatens Patient Access

Alabama. The Cancer Center of Southern Alabama in Mobile has already begun to calculate the substantial losses from the payment cuts for its radiation oncology services, according to John R. Russell, M.D. An analysis by the facility suggests a $500,000 reduction in payments for APC 301 Level II Radiation Therapy, which is an estimated $48.89 reduction per treatment.



Over the last year, the facility has seen a growth in HDR charges due to the rise in patients undergoing intravascular brachytherapy and MammoSite breast treatment. For HDR therapy, the facility calculates a $90,000 loss for 230 patients. The annual source replacement cost is greater than $40,000.

The analysis for IMRT reimbursement is also a concern. Our review suggests a loss of more than $100,000. Although this practice has a relatively low percentage of IMRT patients, the proposed reduction is especially difficult in view of the requirements for high-salaried employees most of whom are in short supply nationally.

California. In Los Angeles, chemotherapy treatment is being threatened. One large hospital has closed its doors to chemotherapy outpatients, so a cancer patient must now be admitted for an overnight stay in order to receive chemotherapy treatment. A second hospital not only discontinued its outpatient chemotherapy but also had to restrict chemotherapy admissions to those patients with other ailments besides chemotherapy-related ones.

A number of hospitals operated by a large health care organization are restricting treatments for cancer patients based on reimbursement rates. They have stopped using many supportive care cancer drugs.

Kansas. One hospital with a Medicare patient population of about 60 percent is reviewing all its drug contracts to see if it can afford to continue providing those drugs to its patients. The hospital is especially concerned about its supportive care drugs since they are currently not reimbursed at all. While the hospital is attempting to cost-shift by increasing charges to non-Medicare patients, private insurance companies are pushing back and refusing to make up the difference for the loss on Medicare patients.

Oklahoma. Two more hospitals serving communities with a large number of retirees have closed their chemotherapy infusion centers and are now sending patients to their nearest physician office for treatment. In more than one case, patients with adverse reactions have had to be transferred by ambulance and admitted to the hospital for emergency care.

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Coding and Billing for Technical Services in the Physician Office

by Carolyn Travers

In the past, technical services were usually provided in the hospital setting and professional services in the physician office. Today, that scenario is not necessarily true. Lower reimbursement rates and rising health care costs are driving both private practice physicians and hospitals to capture as much revenue as possible. Physicians, administrative staff, and billers need to be ready should a practice decide to move from providing professional services only to providing both professional and technical components. Here are some tips to help you make a smooth transition.

First, contact your insurance carriers to learn the steps required for changing the location of technical services. For example, you may need to submit a form or statement about the change prior to submitting any claim forms. Medicare requires your practice to submit a CMS 855R form for reassignment and change of location.

You will need to update Superbills/encounter forms to reflect the additional services rendered (e.g., chemotherapy administration, chemotherapy drugs, and labs). You will also need to update your chargemaster about the appropriate pricing structure.

Before initiating the new services, staff should be fully trained on the new processes and procedures for which they are now responsible. For instance, the front desk staff or the receptionist will now need to verify medical insurance information rather than rely on information from hospital personnel. The appropriate, credentialed staff should handle billing services. To do their job correctly, billing personnel will need to be very familiar with chemotherapy billing.

While many physicians prefer to do their own coding, billers need to be familiar with ICD-9-CM, CPT, and HCPCS codes for each treatment. The physician and/or nurse need to alert billers to changes in diagnosis, and the biller should understand the importance of making such necessary changes. Often, especially at the start of the transition, the practice's biller simply serves as a data entry person. If your practice wants to be reimbursed accurately and in a timely manner, your biller must have the proper training and tools.

Once staff are educated about their new responsibilities, be sure to develop a policy/procedure manual for all staff involved in patient encounters. At the very least, the manual should include processes for registration, scheduling, verification of benefits, preauthorization of services, charge capture entry, and verification of charges.

Verification of benefits is a critical step because it provides the amount of the patient co-pay. Collecting the patient co-payment is easiest at the time of the patient's appointment.

Preauthorization of services is usually required for commercial and managed care carriers. These carriers tend to have very rigid rules regarding chemotherapy services and will not pay your claim if proper preauthorization is not obtained *prior to* rendering the service. You need to develop a form that shows the type of treatment ordered by the physician, the diagnosis/ICD-9-CM code, carrier name, pertinent patient identification information, frequency of all drugs and labs ordered, and the beginning date of treatment and projected discharge date.

The ordering physician must sign this form. You should obtain written authorization by whatever means are acceptable to the carrier. Also, you should keep the authorization in the appropriate files and ensure the information is given to your biller for claims submission.

Your practice should have a mechanism in place for alerting the biller to *all* diagnosis changes. This step is especially critical when coding for chemotherapy services. Your biller should have the local medical review policies (LMRPs) and drug compendia readily available when billing for chemotherapy services. Quite often the billing instructions in the LMRP supersede the drug compendia and/or national guidelines. Using these tools effectively will help eliminate claims processing delays and ensure a better revenue stream for your practice.

Your practice's billers will need to refer to the patient chart and/or chemotherapy flow sheets when billing for some services. For example, the encounter form may indicate hydration therapy intravenous infusion (codes 90780 and/or 90781) and chemotherapy IV infusion (codes 96410, 96412, or 96414) performed on the same day. Billing for these services and the drugs is determined by the delivery of services. If the services were delivered simultaneously, Medicare will not reimburse for the hydration. If the records indicate the services were delivered sequentially or as a separate procedure, Medicare will reimburse for each delivery as long as you append the hydration with a modifier 59. The method of administration/delivery can only be verified by referencing the patient records.

If your practice makes the decision to provide technical services to its patients, remember that each staff member—from the front desk staff to the back-end staff—plays a critical role in making this transition as smooth and as successful as possible.

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