Issues

New CMS Rule Heartening for Oncology Practices in 2004

Good news for oncology practices—at least in 2004. The Association of Community Cancer Centers (ACCC) has determined that office-based medical oncology practices are likely to see little change in 2004 in the revenue they receive for treating Medicare patients.

Despite this relative stability (practices should see somewhere between a 1 percent loss to a 7 percent increase), the sources of practice revenue will change significantly.

Most practices are likely to see a considerable decline (12 to 14 percent) in revenue from drugs because of a decrease in reimbursement rates for oncology drugs from 95 to 85 percent of average wholesale price (AWP). At the same time, because reimbursement for drug administration procedures was increased substantially, practices can expect to see between a 50 to 90 percent growth in revenue realized from procedures.

While these results may at first seem heartening—especially given the dire predictions being made throughout the fall of 2003—reimbursement to medical oncologists will see a dramatic drop in 2005. This reduction in reimbursement in 2005 is because Medicare plans to eliminate its one-time 32 percent increase in reimbursement for drug administration at the end of 2004.

The Centers for Medicare & Medicaid Services (CMS) published the AWP reform interim final rule in the Federal Register on Jan. 6, 2004. The rule's supporting data files can be accessed at: www.cms.hhs.gov/regulations/pfs/2004fc/1372fc/1372fc.asp. The physician fee schedule is also out, and can be accessed at the same web site.

ACCC is concerned that this regulation may adversely affect patient access to care in the physician office setting in 2005. To this end, ACCC is working with other cancer organizations and advocacy groups to minimize the impact of the legislation and protect patient access.

Hospitals Stand Tall Under New Medicare Law

The Medicare Prescription Drug, Improvement and Modernization Act (DIMA) was signed into law by President Bush on Dec. 8, 2003 and will vastly improve cancer care in the hospital setting in 2004. Initial analysis of oncology-related drug regimens provided in select hospital-based cancer programs shows that hospitals may see a 30 percent increase in reimbursement if they provide the exact same oncology services in 2004 as they did in 2003. The initial analysis was performed by ELM Services, Inc., an oncology consulting company in Rockville, Md.

ACCC asked for the preliminary analysis to make its members aware of the potential changes in reimbursement in the hospital-based cancer program setting. ACCC and the cancer community worked very hard in 2003 to correct the underpayment for therapies under the hospital outpatient prospective payment system (HOPPS).

"This initial analysis is very promising for hospital-based cancer programs," said Christian Downs, ACCC deputy executive director. "It breathes new life into cancer programs around the country, many of whom were concerned about patient access if they remained under the same rates as in 2003," he added.

For more information about ELM Services' preliminary analysis of oncology-related drug regimens provided in

selected hospital-based cancer programs, contact George Silberman at: gsilberman@elmservices.com.

The law includes numerous provisions that will affect cancer care in this country in the coming years. The legislation is the culmination of some six years of work to revamp the current Medicare program and put in place a prescription drug benefit for seniors. ACCC would like to thank all of its members and the community for helping ensure these provisions were in the final piece of legislation.

CMS Demonstration Project Includes Oral Anticancer Drugs

CMS has yet to make final its plans on implementing the $500 million demonstration project that will cover Medicare Part B drugs for approximately 50,000 patients. The demonstration project is the result of two distinct legislative objectives: a $100 million House proposal that focused on oral anticancer drugs, and a $1.7 billion Senate proposal that sought to have Medicare cover all self-injectable drugs, with a particular focus on multiple sclerosis medications.

While CMS has not made any final determinations of the drugs that will be covered under this project, the agency is up against a tight time frame for implementing the program. CMS has only 90 days from the law being enacted to have the project up and running. The demonstration project is part of the new Medicare reform law and gives the agency until early March to implement the demonstration.

The final demonstration project will include oral and self-injectable medications that can be substituted for Medicare Part B drugs given by a physician. While these oral and self-injectable replacements will be covered by Medicare during this demonstration project, the drugs will reflect the cost-sharing provisions included in the Medicare Part D prescription drug benefit. The agency has stated that not all eligible drugs will be included in the project, and it is holding an open-door forum to discuss, among other aspects of the project, what drugs will be included.

CMS has not yet determined the amount of money that will be distributed to oral anticancer medications versus self-injectable multiple sclerosis drugs and other drugs. The agency is working with congressional staff members to clarify the intent of the legislation regarding disbursement of the $500 million allotment.

CMS is asking for comments on the congressionally mandated demonstration project that involves Medicare Part B drugs. To help the agency develop the demonstration, CMS is asking for comments on the following:

- What drugs will be covered under the demonstration project
- What drugs do these new drugs "replace"
- How are these drugs taken: on a regular basis or episodic
- What is the estimated cost per beneficiary per year
- How many Medicare beneficiaries might be eligible for this coverage
- How are these drugs best provided —mail order, retail, or both
- How can CMS most effectively identify and recruit beneficiaries to participate in this demonstration
- What are the best outreach vehicles.

Comments can be sent directly to Jody Blatt via e-mail at: jblatt@cms.hhs.gov or via mail to Ms. Jody Blatt, Medicare Demonstrations Program Group, Centers for Medicare & Medicaid Services, Mail Stop C4-17-27, 7500 Security Boulevard, Baltimore, MD 21244.

The demonstration project is being seen as a "stop-gap" measure that allows self-administered drugs to be distributed to Medicare patients well before the legislation covering self-administered drugs goes into effect in 2006. The focus of this project is to examine how self-administered drugs can be distributed, and how costs can be managed.

ACCC will continue to monitor this project and will submit periodic updates as information becomes available.

New Codes for Orphan Drugs

In its final rule, CMS determined that in 2004 it will pay for nine single-indication orphan drugs at 88 percent of AWP as established in the April 1, 2003, single drug pricer:

- J9015, aldesleukin, per vial
- J0256, alpha 1-proteinase inhibitor, injection, 10 mg
- Q2019, basiliximab, injection, 20 mg
- J7513, daclizumab parenteral, 25 mg
- J9160, denileukin diftitox, 300 mcg
- J9300, gemtuzumab ozogamicin, 5 mg
- J9216, interferon, gamma 1-b, 3 million units
- J2355, oprelvekin, injection, 5 mg
- J3240, thyrotropin alpha, injection, 0.9 mg.

Based on information that the agency received regarding the widely available market prices for imiglucerase and alglucerase, these two therapies will be paid at 94 percent of AWP (J1785, imiglucerase, injection, per unit; J0205, alglucerase, injection, per 10 units).

New Codes for Cancer Drugs

CMS granted product-specific HCPCS codes for the following drugs, effective Jan. 1, 2004.

- J9098 cytarabine liposome, 10 mg
- J9178 epirubicin HCl, injection, 2 mg
- J9263 oxaliplatin, injection, 0.5 mg
- J9395 fulvestrant, injection, 25 mg
- Q0137 darbepoetin alfa, injection, 1 mcg.

New CPT Code and Payment Rates for RFA of Bone Tumors

The American Medical Association (AMA) has assigned a new Current Procedural Terminology (CPT) code, 20982, for radiofrequency ablation (RFA) of bone tumors.

Following the AMA's action, Medicare issued new National Unadjusted Payment Rates for both facility- and non-facility-based radiofrequency ablation treatment of bone tumors. The AMA CPT code and the Medicare payment guidelines became effective on Jan. 1, 2004.

The newly published Medicare National Unadjusted Payment Rates set payment levels for physician services of $4,262.87 per procedure for non-facility-based radiofrequency treatment of bone tumors, and $408.47 for physician services for facility-based treatment. Reimbursement is lower for facility-based treatment because the physician uses the hospital's imaging and RFA equipment. Physicians in radiology and oncology practices that have purchased the company's radiofrequency ablation products for use outside of the hospital's setting are eligible for the non-facility reimbursement.

Prior to the assignment of the new CPT code, physicians and hospitals relied on miscellaneous or general "Series 99" codes to file reimbursement claims. The newly assigned CPT code provides an industry standard procedure billing and coding process for RFA of bone tumors.

CPT code 20982 covers percutaneous radiofrequency ablation of bone tumors (e.g., osteoid osteoma and metastasis), including computed tomography (CT) guidance. The AMA CPT codes are applicable to government and private payer health insurance systems.

Providers to Be Assigned a National Provider Identifier

Providers to Be Assigned a National Provider Identifier

Healthcare providers will be required to use a unique national provider identifier (NPI) for filing and processing all healthcare claims by May 23, 2007, according to a final rule published in the Jan. 23, 2004 Federal Register. Providers will be assigned one NPI for all healthcare transactions, whether federal, such as Medicare; state-administered, such as Medicaid; or private. The NPI will replace so-called legacy identifiers. Providers currently use several identifiers, depending on the destination of data.

The identifier was mandated by Congress in the administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA). CMS released the final rule Jan. 22, 2004 and its effective date is May 23, 2005, at which time providers may begin to apply for their NPIs. HHS has already released rules on healthcare privacy, transactions and code sets, and security. The compliance dates for the privacy and TCS rules have passed. The security rule compliance date is April 21, 2005.

Special Payments for Small Rural Hospitals Extended

CMS added a two-year extension of special payments for small rural hospitals that have fewer than 100 beds, as mandated by DIMA.

Small rural hospitals, in addition to only 11 comprehensive cancer centers, children's hospitals, and sole community hospitals, were receiving additional payments from CMS during the transition from a reasonable cost reimbursement system to the current outpatient prospective payment system.

The additional funding, which was scheduled to end Jan. 1, 2004 for all but children's and the 11 cancer hospitals, was reinstated by Congress. This payment structure will now expire Dec. 31, 2005.

This provision allows small rural hospitals to be reimbursed at rates more aligned with the payments they received prior to the implementation of the OPPS. CMS estimates that approximately 1,150 small rural hospitals and 600 sole community hospitals will benefit from this extended exemption.

Any comments regarding the CMS OPPS interim final rule, including the rural hospital provision, are due to the agency by March 8, 2004.

CMS Now Accepting Electronic Comments on Proposed Rules

Comments on proposed Medicare and Medicaid regulations can now, for the first time, be submitted electronically via the Internet. By early 2005, CMS aims to have all comments available on its web site.

In a release, CMS said the new electronic process will begin with the rule proposing changes to the prospective payment system (PPS) for long-term care hospitals, which was published Jan. 30 in the Federal Register.

CMS said that in addition to comments on proposed or final regulations, the new CMS system will be open for comments on other documents, such as policy notices soliciting public comment and notices asking for other information, including nominations for advisory committees.

The agency said that individuals who send in electronic comments will get an automatic reply confirming that their comments were received before the comment period closed. Such a confirmation is "not in place for comments received by hand or through the mail."

CMS will also put the electronic comments on its web site for public review after the comment period closes, "including any personally identifiable or confidential business information included in a comment." CMS said it

will continue to consider written comments delivered either by hand or through the mail to the addresses identified in the published rules.

According to CMS, the comment record, or docket, usually stays open for comments at least 30 days for Medicaid regulations, and 60 days for Medicare regulations, though some comment periods may differ.

The agency said it generally limits the number of days it publishes regulations and notices in the Federal Register to the fourth Friday of each month.

Also, CMS said that at the beginning of each quarter, it puts on its web site the Quarterly Provider Update, which identifies the regulations and notices CMS intends to publish during the quarter in the Federal Register.

To comment electronically, visit www.regulations.gov or the link to the new CMS system provided in CMS' published rules.

Attention Healthcare Providers!

The National Cancer Institute (NCI) is developing new education materials for women who receive abnormal Pap test results that are subsequently found to be non-cancerous. The booklet is about cervical changes that are not cancer.

NCI is looking for physicians, physician assistants, and nurse practitioners who discuss abnormal Pap test results with patients. Participants will be asked to review the materials and participate in a one-hour telephone interview. Participants will be paid for their time.

For more information and to see if you qualify, call NCI's toll-free number at 888.249.0029.

Cancer Deaths Continue to Decline in the U.S.

Death rates continue to drop for the deadliest three cancers in men—lung, colon, and prostate—and for breast and colon cancer in women, according to the latest American Cancer Society (ACS) statistics.

The decline in deaths is due to new treatments and wider use of tools for finding cancer early, when it is most treatable, the report said.

But more U.S. women are dying from lung cancer, the annual report shows, and more people are dying of obesity-related cancers, such as some types of liver and esophageal cancer.

The report, Cancer Facts & Figures 2004, published Jan. 15, estimates that 1.37 million Americans will be diagnosed with cancer in 2004, and 563,700 will die of the disease. This works out to about 1,500 Americans a day.

Colon cancer death rates fell to 20.8 per 100,000 people per year in the latest year available, 2000. That number compares with 20.9 per 100,000 in 1999 and 22.6 in 1995. Breast cancer deaths fell from 30.6 per 100,000 in 1995 to 26.7 in 2000.

Cancer has long been the second leading cause of death after heart disease, accounting for about a quarter of all U.S. deaths.

U.S. Health Spending at New Heights

Healthcare spending in the United States reached $1.6 trillion in 2002, a growth rate of 9.3 percent, United Press International (UPI) reports.

CMS issued this annual report, which showed 2002 spending—the most recent yearly statistics available — surpassed $1.4 trillion in 2001.

For the sixth year in a row, health spending grew at an accelerated rate, and the growth is 5.7 percentage points faster than the growth of the overall economy, UPI reports.

Health spending per person averaged $5,440 in 2002, up $419 from 2001.

Prescription drug costs continued to lead the spending increase, rising by 15.3 percent. Hospital expenditures were up for the fourth consecutive year, increasing by 9.5 percent and spending on physician services was up 7.7 percent.

Private payers funded more than half of the national expenditures with the public sector—Medicare and Medicaid—accounting for 46 percent of health payments, UPI reports.

Medicare Billing for Prostate Seed Implants in 2004

by Kimberly Partlow, MS, CMD

The Centers for Medicare & Medicaid Services (CMS), in its final hospital outpatient prospective payment system rule issued Jan. 7, 2004, included changes in reimbursement for prostate seed brachytherapy implants. Since this procedure is now also reimbursed when performed in an ambulatory surgery center and competition for this procedure is certain, hospitals must bill correctly to maintain their revenue levels. Here are answers to some frequently asked questions.

Q *When does the new Medicare policy go into effect and how long will it last?*

A The new policy was effective starting Jan. 1, 2004, and will continue until Dec. 31, 2006.

Q *Does a hospital still need to use HCPCS codes G0256 and G0261 for prostate seed brachytherapy implants?*

A No. As of Jan. 1, 2004, hospitals should no longer use these codes, at least until Dec. 31, 2006, at which time a new Medicare rule should be issued indicating the next change.

Q What code(s) should the hospital use to report this procedure?

A You should now use the same code as for other complex nonprostate brachytherapy implants— CPT code 77778.

Q In 2003 the cost of the seeds was bundled into the procedure code. What code should the hospital use in 2004 to bill for seeds?

A In 2004 bill the seeds separately. If you use iodine, then bill APC 1718 and HCPCS C1718. If the hospital uses palladium, then bill APC 1720 and HCPCS C1720.

Q *Medicare had a provision for outlier payments with these sources. Does this provision still apply?*

A No. In the updated Medicare OPPS rule, these types of sources are excluded from outlier payments.

Q *Should the hospital account for the number of seeds used?*

A Yes. The hospital will need to have appropriate documentation indicating the number of sources ordered and the number implanted at the time of the procedure.

Q *Are CPT codes 77778 and the seeds codes (C1718 and C1720) the only codes the hospital can use to bill for this procedure now?*

A No. A hospital can use a variety of other codes for billing in addition to these codes. Bill for prostate seed implants the same way you bill for other non-prostate brachytherapy implants. These other CPT codes include, but are not limited to: 77295, for three-dimensional simulation; 77328, for complex isodose planning; 77332, for treatment devices; 77331, for special dosimetry; and 77370, for special physics consultation. Some carriers allow 77336, for continuing physics consultation.

Q *Our physicians use real-time ultrasound during the procedure. Is this service reimbursable, or part of the implant procedure CPT 77778?*

A No. Ultrasound guidance is a distinct and separate procedure and is reimbursable using HCPCS 76965.

Q *Should all these HCPCS codes be billed on the day of the procedure?*

A No. Several codes are billed preimplant; one set of codes are billed the day of the procedure; and some codes are billed post-implant. The exact codes will vary slightly depending on your facility and which procedures you actually perform.

Q *Where can I find the appropriate codes and the documentation necessary for billing?*

A You can review the local medical review policy (LMRP) for your state. The LMRP will detail the information your provider will need for documentation for the codes billed and valid ICD-9 codes to support medical necessity.

Q *We have a template we received from a hospital in another state. Can we just use those codes?*

A While you can use the template as a guideline for setting up your own codes, LMRP's vary and your codes should be based on your state's guidelines.

Since the codes for prostate seed implants have now been unbundled, your facility should review its chargemaster and ensure that all the procedure codes necessary to report this procedure are correctly documented. Centers performing other types of implants should have few problems training their staff or updating the chargemaster. If prostate seed implants are the only brachytherapy procedure used at your facility, however, you will have to revise the chargemaster with updated codes and make staff aware of the additional billing necessary for accurate reimbursement.