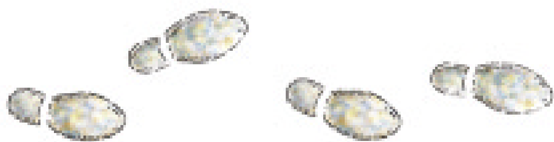
Life *Under* APCs

A Reimbursement Primer for Hospital Oncology Programs

BY MARY LOU BOWERS

The Way We Were...

In 2000 the ambulatory payment classification (APC) system went into effect. As hospital programs struggled to implement this new payment system, the oncology service line suffered drastic reimbursement cuts in 2002 and 2003—specifically with regards to chemotherapy delivery, even though radiation oncology was still profitable. Hospitals were being reimbursed as low as 50 to 60 percent of Average Wholesale Price (AWP) for some cancer drugs. When Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), that was signed into law on Dec. 8, 2003, it helped to remedy this underpayment.



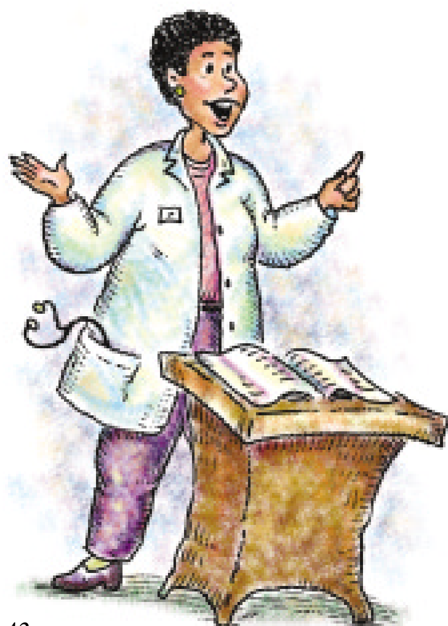
The Way We Are...

On the hospital side, MMA changes the payment structure for drugs. MMA classifies drugs into three categories:

1. Hospitals will be paid *no less than* 88 percent of AWP in 2004 and *no less than* 83 percent of AWP in 2005 for **sole-source** (FDA-approved) drugs.
2. **Innovator multiple-source** (brand name drugs whose patent has expired) will be paid *no more than* 68 percent of AWP.
3. **Noninnovator multiple-source** (generic) drugs will be paid *no more than* 46 percent of AWP.

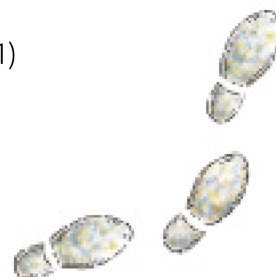
Payments are made by classification and for each individual drug. This means no bundling—at least until 2006!

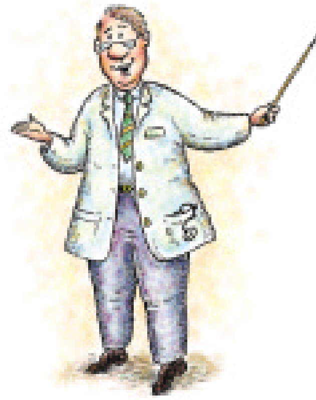
As of April 1, 2004, the old HCPCS codes will indicate that a generic drug was used, and hospitals will need to use the new HCPCS codes when submitting claims for brand-name multisource drugs.



Good news: In the end, MMA is likely to increase overall reimbursement for hospital outpatient medical oncology services by 30 percent—if patient volume and services remain unchanged.

Bad news: CMS reduced the payment structure for brachytherapy procedures and dramatically reduced reimbursement for radiation oncology. External beam treatment delivery (APC 301) was reduced from $165 to $116. IMRT delivery was reduced from $400 to $294. Radiopharmaceuticals: CMS is working on determining the payment for Bexxar by May 1, 2004. Until such a payment is established, Bexxar will be paid "parallel to another radiopharmaceutical" (Zevalin) in the amount of $2,250.





To achieve a healthy bottom line, hospital oncology programs need to keep their chargemaster up-to-date, code correctly, bill for every service provided, and appeal denials. Avoid the traps with these tips:

7 Tips

1. Monitor your drugs costs, especially your highest cost drugs. For hospitals, AWP is set under the single drug pricer (SDP) based on prices in the May 1, 2003, *Red Book.*

2. Use a J9999 (miscellaneous chemotherapy drug) code for new drugs, biologicals, and radiopharmaceuticals without HCPCS codes, which are paid at 95 percent of AWP, until CMS develops a billing mechanism for these drugs. Your billing department will also need a record that these drugs were administered, so they can go back and bill after CMS puts the payment mechanism in place.

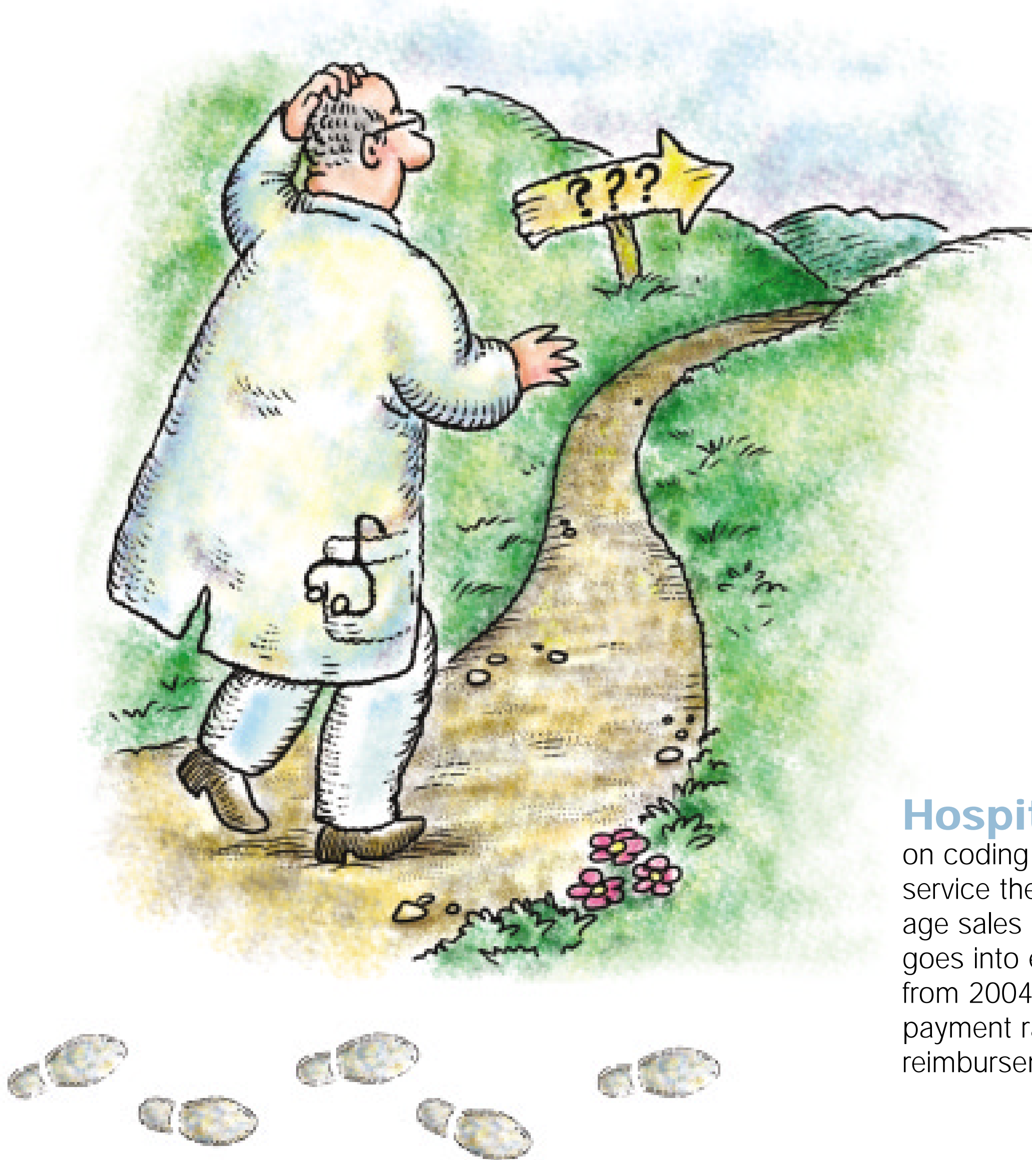
3. Keep in mind that nine pass-through drugs that were paid on or before Dec. 31, 2002, including oxaliplatin 5 mg, received separate APCs and were moved to sole source.

4. Be aware that drugs for which pass-through payment was first made on or after Jan. 1, 2003, and were approved for sale as of April 1, 2003, will be paid at 85 percent of AWP.

5. Remember that the multiple technique code Q0085 (chemotherapy by both infusion and other) was eliminated in 2004 and replaced with two codes: Q0084 and Q0083. In 2004 these two codes pay $76.74 less than Q0085.

6. Remember that non-chemotherapy infusion provided *with* another Status T (surgical code or diagnostic radiology) procedure will be reimbursed only at 50 percent of its payment amount.

7. Bill for the seeds in addition to the procedure in all brachytherapy, including HDR. To do so for HDR, determine the cost of source replacement and spread this amount over the expected users.



Hospitals must focus on coding correctly and for every service they provide *today*. The average sales price (ASP) methodology goes into effect in 2006, and the data from 2004 and 2005 will establish payment rates under this new reimbursement system.

Practical Habits

1. Update your chargemaster. Charge correctly and for every service provided.
2. Request edit changes for clinic visit services provided during radiation treatment.
3. Train your radiation staff how to code and bill properly. It's more important now than ever!
4. Stay educated and up-to-date about reimbursement changes.

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