CMS Proposes Significant Change to Chemo Administration Coding for Hospitals

Starting January 1, 2005, hospital-based cancer programs may see significant changes in how chemotherapy (and nonchemotherapy) administration is coded. Proposed changes to the Hospital Outpatient Prospective Payment System (HOPPS) will transition the coding used for these services from their current Level II, Healthcare Common Procedural Coding System (HCPCS) codes to Level I, Current Procedural Terminology (CPT) codes. The Centers for Medicare & Medicaid Services (CMS) proposed the change from HCPCS codes to CPT codes in an effort to document the administrative components of these services. Under the CMS proposal while codes will be changed in 2005, reimbursement amounts will continue to reflect the HCPCS methodology. (See Table 1, which includes the 2005 proposed administration reimbursement rates.)

For 2005, CMS is proposing to use the CPT codes for drug administration and to "crosswalk" the CPT codes into ambulatory payment classification codes (APCs) that reflect how the services would have been paid under Q0081, Q0083, and Q0084. (See Table 2, which represents several of the most common services and the proposed crosswalks.)

Although hospitals would bill the CPT codes and include the charges for each CPT code on the claim, payment would be made on a "per visit basis" without consideration for multiple units of the service provided. Facilities would code and bill for each additional hour of chemotherapy (or nonchemotherapy) administration, but receive payment only for the first hour. (See Table 3 for an example of the proposed coding changes and reimbursement for a lung cancer patient receiving a regi-

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Table 1: 2005 Proposed Changes in Drug Administration Payments

Current HCPCS	Proposed APC	Final 2004 APC Payment	Proposed 2005 Payment	Percent of Change
Q0081	120	$104.29	$110.93	6.4%
Q0083	116	$43.63	$62.31	42.8%
Q0084	117	$165.65	$165.60	0%

Source: Health Policy Alternatives, Inc.

Table 2: 2005 Proposed Crosswalk for Drug Administration Codes

Description	Current HCPCS	Proposed CPT Code	Proposed APC	Maximum Units
Chemotherapy, sc/im	Q0083	96400	116	1
Chemotherapy, push	Q0083	96408	116	1
Chemotherapy infusion, first hour	Q0084	96410	117	1
Chemotherapy infusion, each additional hour	N/A	96412	N/A	0
IV infusion therapy,	Q0081	90780	120	1
IV infusion therapy, each additional hour	N/A	90781	N/A	0

Source: Excerpted from 69 Federal Register. *50521 (Aug. 16, 2004).*

Table 3: A Snapshot of Proposed Reimbursement Changes for a Lung Cancer Patient Receiving a Regimen of Paclitaxel and Carboplatin, as well as Pre-treatment and Post-treatment Hydration

Current HCPCS	Proposed CPT Code	Description	Units	Charge	Payment
Q0084	96410	Chemotherapy, first hour	1	$300.00	$165.60
N/A	96412	Chemotherapy, each additional hour	4	$400.00*	N/A
Q0081	90780	IV therapy, first hour	1	$200.00	$110.93
N/A	90781	IV therapy, each additional hour	1	$100.00	N/A
		TOTAL		**$1,000.00**	**$286.53**

**The $400 charge is based on $100 per additional hour or 4 units of 96412.*
Table assembled for ACCC by ELM Services, Inc., Rockville, Md., www.elmservices.com.

men of paclitaxel and carboplatin, as well as pre-treatment and post-treatment hydration.)

CMS intends to use CPT data collected in 2005 and 2006 to design a payment methodology for administration costs in the hospital outpatient setting in 2007 and beyond. If this coding change is adopted for 2005, hospital-based cancer centers will need to train staff to code and bill correctly for *all* services even though there would be no separate payment in 2005. Currently no cost data exist for these CPT codes in the hospital outpatient setting.

Just as private medical oncology practices have used CPT codes to accurately document their administration costs, hospital outpatient departments making the change from the current HCPCS codes to CPT codes will more accurately capture the services they provide. During the next two years, accurate reporting of *all* payable charges, as well as *all* packaged charges, will be critical to the determination of future reimbursement for hospital outpatient departments, assuming CMS finalizes its proposal.

Note that CMS might be considering other approaches, including a simpler idea proposed by ACCC. This approach would use the new 2006 CPT codes for drug administration services as adopted by the American Medical Association (AMA) CPT Editorial Panel and implement them in 2005 via G-codes as CMS has done in the physician office setting.

Physician Practices: How Bad Could It Be?

The impact that the proposed 2005 Medicare physician fee schedule will have on physician practices has generated much anxiety within the physician community. CMS estimates that the combined impact of changes made to Medicare drug and physician fee schedule payments for oncology/hematology practices to be -8 percent. In other words, total reimbursement for all services provided in the physician office from 2004 to 2005 will decline by 8 percent.

CMS based its projections for an 8 percent decline on those high-volume drugs for which it has validated average sales price (ASP) submission. The initial 8 percent decline was based on manufacturer data submitted in the first quarter of 2004. These numbers will likely change between now and the final rule, because ASP reimbursement for the first quarter 2005 will be based on third quarter 2004 manufacturer drug data submissions.

At a special session at ACCC's 21st National Oncology Economics Conference held Oct. 6-9, 2004, a panel of physicians in private practice reported potential reductions in the range of 15 to 17 percent. Others in the cancer community have predicted a similar reduction.

Ultimately, the magnitude of the "hit" depends on the individual practice and its current financial profile. In other words, a practice's mix of drugs, its purchasing agreements, and its practice-specific costs (i.e., overhead, staffing, capital expenses, employee compensation, profit-sharing arrangements) will all affect how the practice fares in 2005.

As we go to press, the final rule has not been released. While the rule is expected to be published on Nov. 1, 2004, with second-quarter ASP data, third-quarter ASP data will not likely be available until December 2004.

On the legislative front, H.R. 5144, the "Norwood Bill," limits the extent of the Medicare cuts in 2005 and 2006 by establishing payments and floors for drug reimbursement and minimum payment amounts for drug administration services. At press time, Congress had not acted on this bill.

The Bottom Line for Hospitals in 2005

CMS estimates that HOPPS payment rates by 2005 would have overall a positive effect for every category of hospital with the smallest increases accruing to hospital-based cancer centers (about 0.7 percent). The impact of this proposed rule, however, will depend on a number of factors, most significant of which are the mix of services furnished by a particular hospital and the impact of the wage index changes on the hospital.

Hospital outpatient departments can expect a 5 percent decline in Medicare drug payments in 2005, based on an analysis conducted for ACCC by Health Policy Alternatives, Inc., in Washington, D.C. Two-thirds of the 67 cancer and supportive care drugs included in the proposal will experience a reduction in payment rates. This reduction can be attributed to the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), which reduces payment for single source drugs from 88 percent of average wholesale price (AWP) in 2004 to 83 percent of AWP in 2005.

Based on drug payment rates in the proposed rule and assuming no change in drug utilization, total 2005 payment from Medicare is expected to be $831,336,370. In 2004 total payment for these drugs was $877,277,184.

PHOTOGRAPH/COMSTOCK.COM

New Drug Administration Codes for Practices

CMS will implement new oncology codes based on AMA recommendations. The changes include 19 new and updated codes, including a new code "that will reflect the higher resource costs associated with infusing a second cancer drug," CMS administrator Mark McClellan said in an Oct. 12 letter to House Ways and Means/Health Subcommittee Chairman Nancy Johnson (R-Conn.).

"Oncologists and other physicians will also be able to bill Medicare for more than one administration of a nonchemotherapy drug, as they can currently do for chemotherapy drugs," the letter stated.

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Other new codes will reimburse for the staff costs of pharmaceutical preparation, as well as "physician work supervision" of the preparation. CMS is also clarifying the billing process for managing significant adverse reactions.

The changes go into effect Jan.1, 2005, and the new codes will be included in the CPT book in 2006. As such, for 2005 each of these new codes will be issued HCPCS G-codes.

Because the actual relative value units (RVUs) for each of the drug administration codes are unknown at this time, only CMS is able to calculate new Medicare reimbursement rates. In addition, the financial impact of these proposed coding changes and the recommended practice expense inputs cannot yet be assessed. Based solely on the new work RVUs and the inputs provided, however, drug administration payments to cancer providers may *not* be significantly different from the 2005 proposed physician fee schedule.

While ACCC is hopeful that the total 2005 payments for cancer drugs and their administration will be an amount that is adequate enough for cancer patients to continue receiving treatment in their communities, the potential impact of the MMA on overall reimbursement remains a mystery. Also unknown is whether any potential increases generated by the newly created administration codes will offset the statutory-based reduction of the transitional payment from 32 percent in 2004 to 3 percent in 2005. If the new drug administration payments do not cover the costs of providing the services and/or if drug reimbursement under average sales price (ASP) +6 percent is less than what physicians actually pay to acquire the drugs, the effect on community cancer centers and their patients will be dramatically adverse.

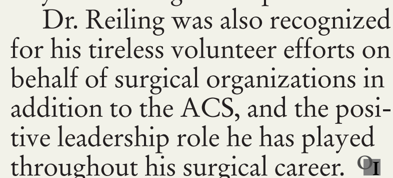
ACCC Board Member Honored

The Board of Regents of the American College of Surgeons (ACS) presented Richard B. Reiling, MD, FACS, of Charlotte, N.C., with the College's 2004 Distinguished Service Award on Thursday, October 14, at its 90th Annual Clinical Congress in New Orleans, La.

Dr. Reiling is Medical Director of the Presbyterian Cancer Center in Charlotte, N.C., and serves on the Association of Community Cancer Centers' Executive Committee as secretary.

The American College of Surgeons bestowed its highest honor on Dr. Reiling, who was recognized for "his dedicated service to the College, his service on College committees, his contributions to the profession of surgery as a gifted surgeon, and his distinctive service to the surgical community as a distinguished professor."

Dr. Reiling was also recognized for his tireless volunteer efforts on behalf of surgical organizations in addition to the ACS, and the positive leadership role he has played throughout his surgical career.



The State of Radiation Oncology

In 2004 both IMRT and brachytherapy were hit hard with reimbursement cuts. While the 2005 proposed hospital outpatient rule from CMS alleviates some of these cuts by raising payment for IMRT delivery from $294.11 to $307.78, physics planning is proposed to drop from $850 to $811.91. Physics planning is a critical component of IMRT delivery that involves using sophisticated computer programs to design and control radiation dose distributions. In particular when hospital cancer programs are first adding IMRT, physics planning for the treatment is often more time and labor intensive.

The 2005 proposed rule also suggests combining two codes for stereotactic radiosurgery, GO242 (procedure) and GO243 (planning), into one code. Furthermore, in a Physicians, Nurses, and Allied Health Professionals Open Door Forum convened on Oct. 18, 2004, CMS indicated that it is considering replacing code CPT 79900 (administration of therapeutic radiopharmaceuticals) with HCPCS Q3001. To ensure adequate and correct reimbursement, hospital billers and coders will need to be alert to any such coding changes.

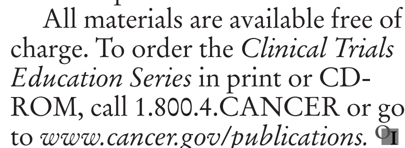
The volatile reimbursement environment may make it more challenging for smaller community-based hospitals that have just added or are planning to add leading-edge cancer treatments such as IMRT and high-dose rate (HDR) brachytherapy. Still, when *Oncology Issues* interviewed a number of its member organizations, the community cancer programs we talked with are completely invested in providing the radiation oncology services that benefit their patients.

New Clinical Trials Education Series from NCI

In September, the National Cancer Institute (NCI) launched its new *Clinical Trials Education Series (CTES),* a complete collection of resources including new materials that healthcare professionals can use to discuss clinical trials with peers, patients, and community groups.

The new *Clinical Trials Education Series* consists of 13 adult education resources, including workbooks, slide presentations, booklets, brochures, videos, and Web-based courses, to help potential trial participants learn about treatment and prevention options.

All materials are available free of charge. To order the *Clinical Trials Education Series* in print or CD-ROM, call 1.800.4.CANCER or go to *www.cancer.gov/publications.*



The Association of Community Cancer Centers extends a special note of thanks for the supporters of its 21st National Oncology Economics Conference

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PHOTOGRAPH/PHOTODISC

ACCC and *Physician's Weekly* Launch **Oncology-Only News Service**

As part of its ongoing effort to provide its members and the entire cancer-care community with essential medical, clinical, and practice management news, the Association of Community Cancer Centers (ACCC) has announced a collaboration with *Physician's Weekly*, LLC (PW) in a pilot program of a new information service to serve the specific needs of oncologists and other cancer care health professionals.

Physician's Weekly, working in close association with ACCC medical experts, will produce a special two-part series to be published in January and February 2005. Content will be presented using the unique *Physician's Weekly* news poster format and will include news and information on:

- The impact of recent legislation on cancer drug pricing, administration, and reimbursement
- Current clinical approaches to specific areas of cancer care
- Opinions of nationally recognized oncology researchers and thought leaders
- Information on new and emerging therapies, diagnostics, and preventive measures
- Notices of coming ACCC programs and events.

The special issues will be distributed to more than 1,500 of the leading U.S. hospitals and academic centers already a part of the PW service network, as well as all 670 ACCC institutions/group practices.

Please note: ACCC and *Physician's Weekly* will be contacting each of our 670 Delegate Representatives at member institutions and oncology group practices to encourage them to display these special *Physician's Weekly* issues in a prominent location within their respective institutions. Each ACCC Delegate Representative will receive an oak-frame medical wall board in which to place the poster-size oncology news page.

A survey of all Delegate Representatives will accompany the second issue, allowing readers to express their views on the pilot issues and suggest topics for future issues. All recipients will also be invited to join—free of charge—the *Physician's Weekly* cancer care news service network. In order to offer this as a free service, funding support will be provided through industry sponsorships.

Physician's Weekly is a weekly one-page medical news publication for office- and hospital-based physicians. The new oncology-related edition will feature articles by oncology experts and healthcare journalists, written in a lively, jargon-free style designed to meet overwhelming demands for the attention of the busy clinician.

Now in its twenty-first year of continuous publication, *Physician's Weekly* is written for both hospital- and office-based physicians in all medical specialties. Newly introduced this year are specialty editions for surgery and emergency medicine. *Physician's Weekly* also provides continuing medical education programs through the poster medium and its website, *www.physweekly.com*. OI

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Tips for Coding E&M Services

by Carolyn Travers

Under the current OPPS, here are tips for coding and billing in some common scenarios.

Scenario A

The patient has a scheduled appointment to see the doctor with no chemotherapy or injections planned.

Consultation. The patient must be referred for the consultation by another physician or an appropriate source. The consultant physician must communicate in writing to the requesting physician. This written report must document the consulting physician's opinion and all services ordered and rendered to the patient. These services must be documented in the patient's medical record.

Confirmatory consultation. Medicare defines a confirmatory consultation as one in which the consulting physician's Evaluation and Management (E&M) services are being sought "for opinion and/or advice only." You must document the consultation in the medical record.

Follow-up visit. You must document follow-up visits in the patient's medical record. When the patient has already seen the physician on the date of service, the hospital may *not* bill an additional E&M service for vitals, weight, and nursing assessment provided during the course of the follow-up appointment.

Scenario B

The patient has a scheduled appointment to see the doctor for either a consult or follow-up visit with no chemotherapy or injections planned. During the course of the hospital visit, the patient is unexpectedly given chemotherapy or injection on the same date of service. The patient also has vitals, weight, and a nursing assessment done.

If the patient sees the physician for a consultation or follow-up, and then unexpectedly receives chemotherapy/injection administration and drugs, the hospital *can* bill for the chemotherapy/injection administration and drugs. These services must be medically necessary and must be documented in the medical record.

Each time you use a drug, you bill for the drug using either the appropriate C or J drug code. In 2004, you can also bill for drugs that have received FDA approval on or after January 1, 2004, but have not yet been issued a C-code, using C9399. (For more on this instruction, see CMS transmittal 188 dated May 28, 2004 with an effective date of January 1, 2004.) You must include the National Drug Code (NDC), the quantity of the drug administered expressed in the unit of measure applicable to the drug or biological, and the date the drug was furnished to the beneficiary.

You may bill for all injections that you give on the same day.

Remember, because you are billing a separate E&M service on the same date of service as the scheduled physician visit, you must use a modifier -25 to indicate a significant, separately identifiable service.

Since this is a hospital-based environment and the patient has already seen the physician on this date of service, the hospital may *not* bill an additional E&M service for vitals, weight, and nursing assessment.

Scenario C

The patient has a scheduled appointment to see the doctor for either a consult or follow-up visit with no chemotherapy or injections planned.

The patient sees the physician today and has vitals, weight, and a nursing assessment done and is scheduled for chemotherapy the next day.

To code and bill in this scenario, adhere to the consultation or follow-up E&M service rules explained above. Document and bill for the administration and chemotherapy services on the actual date that the chemotherapy services are provided. Since this is a hospital-based setting and the patient has already seen the physician on this date of service, you *cannot* bill an additional E&M service for vitals, weight, and nursing assessment.

Scenario D

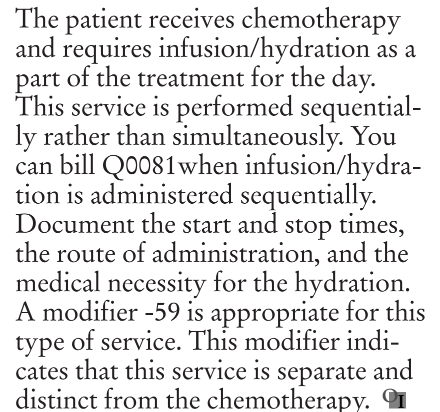
Patient is scheduled for chemotherapy or injection but *not* to see the physician; however, due to an additional medical issue a physician is consulted.

All chemotherapy or injection services must be medically necessary and documented in the patient's medical record. You must also document the additional medical issue in the patient's medical record, select the appropriate level of service, bill for all services rendered, and add the modifier -25.

The hospital can bill either a Q0083 (if delivered by SQ, IM, or push) *or* Q0084 (if delivered by IV). You can also bill for both the Q0083 *and* the Q0084 if all methods are used.

Scenario E

The patient receives chemotherapy and requires infusion/hydration as a part of the treatment for the day. This service is performed sequentially rather than simultaneously. You can bill Q0081when infusion/hydration is administered sequentially. Document the start and stop times, the route of administration, and the medical necessity for the hydration. A modifier -59 is appropriate for this type of service. This modifier indicates that this service is separate and distinct from the chemotherapy.



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