2005 OPPS Rule: What Your Hospital Should Know

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On Nov. 2, 2004, the Centers for Medicare & Medicaid Services (CMS) released the 2005 hospital outpatient department prospective payment system (OPPS) final rule. The final rule provides for a 3.3 percent inflation update in payment rates for outpatient services. The inflation update—together with payment increases for certain "preventive services," such as breast and colorectal exams, and revised payment for drugs and biologicals—will increase projected Medicare payments to hospitals for outpatient services to $24.6 billion compared to projected payments of $23.1 billion in 2004.

With the final rule just released, ACCC is already thinking about 2006 when more changes to the hospital reimbursement system are due to take effect. As soon as CMS releases its third-quarter average sales price (ASP) pricing data, ACCC will poll hospitals to see how the published prices compare with prices hospitals actually pay to acquire these drugs. We encourage hospitals to provide this information as expeditiously as possible to better assess whether hospitals will be able to continue providing the necessary treatments for their patients under ASP.

Here are highlights of how provisions in the final 2005 OPPS rule will affect cancer care.

■ ***Drugs, Biologicals, and Radiopharmaceuticals.*** In 2005 reimbursement for *many* of the anticancer drugs commonly used in the hospital outpatient setting declines 6 to 9 percent (see Table 1, page 12). For the most part, this reduction was expected and can be attributed to the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), which mandated that the payment floor for the average wholesale price (AWP) for single-source drugs drop from 88 percent of AWP in 2004 to 83 percent in 2005.

Except for radiopharmaceuticals, payment rates for existing drugs with continuing pass-through status in calendar year 2005 will be based on ASP + 6 percent. Should these data not be available, CMS states it will use the product's wholesale acquisition cost (WAC) or 95 percent of AWP as of May 1, 2003.

In a change to existing policy, radiopharmaceuticals are to be considered "drugs" beginning in 2005. With this change, radiopharmaceuticals are subject to payment floors and ceilings, exclusion from outlier payments, and application of the $50 packaging threshold. If a new radiopharmaceutical that is assigned a payment code on or after Jan. 1, 2005, were approved for pass-through status, payment will be established at 83 percent of AWP.

In 2005 drugs, biologicals, and radiopharmaceuticals with median costs of more than $50 per day will continue to receive separate payments. Payments for drugs, biologicals, and radiopharmaceuticals without pass-through status and whose median cost is *less* than the $50 threshold will continue to be bundled (or "packaged") into the procedures with which they are billed—with one important exception. Injectable and oral forms of antiemetics that prevent nausea and vomiting *will be paid separately* in 2005, regardless of whether the drug exceeds the $50 threshold.

■ ***Drug Administration Payments.*** Payments for drug administration increase in 2005 (see Table 2, page 13).

CMS is beginning a two-year data collection project to set drug administration payment rates for 2007 and beyond. Hospitals will continue to be paid according to existing APCs, but in 2005 CMS requires hospitals to report the associated current procedural terminology (CPT) codes for each procedure (see Table 2). For example, the first hour of chemotherapy would be billed using a CPT code (96410), and reimbursement

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2005 OPPS at a Glance

- "New" drugs (C9399) paid at 95 percent of AWP until a payment code is assigned.
- Sole-source drugs paid at 83 percent of AWP.
- Innovator multiple-source drugs will be paid no more than 68 percent of AWP.
- Generic drugs paid at no more than 46 percent of AWP.
- Orphan drugs paid at 88 percent of AWP or 106 percent of ASP. Payment rates will be based on a quarterly comparison of the most recent available ASP and AWP.
- Drugs with continuing pass-through status will be paid at a rate equivalent to ASP + 6 percent.
- Antiemetics that prevent nausea and vomiting are excluded from the $50 bundling threshold.
- Chemo administration (Q0081, Q0083, and Q0084) uses new crosswalks to CPT codes.

will be the equivalent of the existing APC payment. If applicable, the hospital would then bill a second hour of chemotherapy (96412) for data collection purposes only. Hospitals will *not* be paid for this additional code. Still, hospitals must take care to code correctly for drug administration services they provide to ensure that CMS has accurate data when it calculates 2007 drug administration payments.

Preventive Services. The final rule implements provisions required by MMA for preventive services in hospital outpatient departments. These include the "Welcome to Medicare Physical" for new beneficiaries, which will provide baseline information to the physician on the patient's health status, allow for early detection and treatment of diseases, and provide an opportunity to refer the patient to other Medicare-covered services. When this examination is provided in an outpatient department, Medicare will pay the hospital approximately $78 for the use of the facility. The fee does not include payment for the physician's professional services, which will be paid separately under the Medicare Physician Fee Schedule.

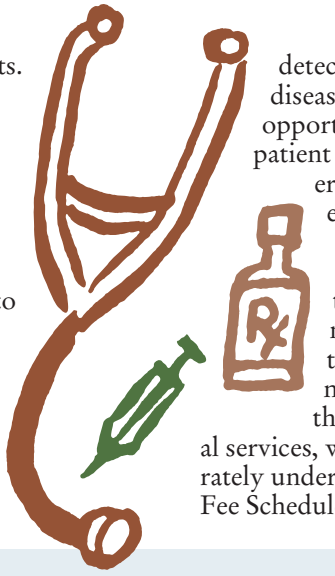

Table 1.
A Comparison of 2004 and 2005 OPPS Medicare Payment Amounts for Drugs Commonly Used in Cancer Treatment

Commercial Name/Chemical Name	HCPCS	HCPCS Units	2004 Rate[1]	2005 Rate[2]	Dollar Difference	Percentage Change
Alimta/petmetrexed injection	J9305	10 mg	$46.31	$40.54	-$5.77	-12%
Aloxi/palonosetron hcl injection	J2469	25 mcg	$30.78	$18.22	-$12.56	-41%
Anzemet/dolasetron mesylate (oral)	Q0180	10 mg	$67.09	$63.28	-$3.81	-6%
Aranesp/darbepoetin alfa	Q0137	1 mcg	$3.88	$3.66	-$0.22	-6%
Avastin/bevacizumab injection	J9035	10 mg	$65.31	$57.08	-$8.23	-13%
Camptosar/irinotecan injection	J9206	20 mg	$135.00	$127.33	-$7.67	-6%
Doxil/doxorubicin hcl liposome injection	J9001	10 mg	$364.49	$343.78	-$20.71	-6%
Elitek/rasburicase injection	J2783	0.5 mg	$105.54	$107.01	+$1.47	+1%
Eloxatin/oxaliplatin	J9263	0.5 mg	$84.51	$81.61	-$2.90	-3%
Erbitux/cetuximab injection	J9055	10 mg	$54.72	$49.64	-$5.08	-9%
Ethyol/amifostine	J0207	500 mg	$419.59	$395.75	-$23.84	-6%
Faslodex/fulvestrant	J9395	25 mg*	$81.57	$79.65	-$1.92	-2%
Gemzar/gemcitabine hcl	J9201	200 mg	$112.09	$105.73	-$6.36	-6%
Herceptin/trastuzumab	J9355	10 mg	$53.85	$50.79	$-3.06	-6%
Hycamtin/topotecan	J9350	4 mg	$739.80	$697.76	-$42.04	-6%
Kytril/granisetron hcl injection	J1626	100 mcg	$17.18	$16.20	-$0.98	-6%
Neulasta/pegfilgrastim	J2505	6 mg	$2,596.00	$2,448.50	-$147.50	-6%
Neupogen/filgrastim injection	J1440	300 mcg	$172.20	$162.41	-$9.79	-6%
Plenaxis/abarelix injectable suspension	J0128	10 mg	$89.72	$68.62	-$21.10	-24%
Procrit/non-esrd epoetin alfa injection	Q0136	1,000 units	$11.76	$11.09	-$0.67	-6%
Rituxan/rituximab	J9310	100 mg	$464.20	$437.83	-$26.37	-6%
Taxol/paclitaxel	J9265	30 mg	$79.04	$79.04	$0.00	0%
Taxotere/docetaxel	J9170	20 mg	$331.53	$312.69	-$18.84	-6%
Velcade/bortezomib injection	J9041	0.1 mg	$29.71	$28.38	-$1.33	-4%
Vidaza/azacitidine	C9218	1 mg	$4.52	$3.96	-$0.56	-12%
Zofran/ondansetron	Q0179	8 mg	$0.00	$26.12	N/A	N/A
Zevalin/In-111 Ibritumomab tiuxetan	C0182	per dose	$2,565.55	$2,419.78	-$145.77	-6%
Zevalin/Yttrium-90 Ibritumomab tiuxetan	C1083	per dose	$22,210.19	$20,948.25	-$1,261.94	-6%
Bexxar/I-131 tositumomab, dx	C1080	per dose	$2,565.55	$2,241.00	-$324.55	-13%
Bexxar/I-131 tositumomab, tx	C1081	per dose	$22,210.19	$19,422.00	-$2,788.19	-13%

[1]Final 2004 payment rate data taken from Hospital OPPS Payment Reform for Calendar Year 2004, Addendum B (July 2004 Update)
[2]Final 2005 payment rate data taken from Hospital OPPS Rule for 2005, available online at *www.cms.gov/providers/hopps/2005fc/1427fc.asp*
*Final 2004 payment rate based on per 50 mg

Table 2. A Comparison of 2004 and 2005 OPPS Medicare Drug Administration Payment Amounts

APC	CPT	Description	2004 APC Payment	2005 APC Payment	Percent of Change
116	96400	Chemotherapy, sc/im	$43.63	$63.35	+45%
116	96405	Chemotherapy, intralesional (≤ 7 lesions)	$43.63	$63.35	+45%
116	96406	Chemotherapy, intralesional (>7 lesions)	$43.63	$63.35	+45%
116	96408	Chemotherapy, intravenous; push technique	$43.63	$63.35	+45%
116	96420	Chemotherapy, intra-arterial; push technique	$43.63	$63.35	+45%
116	96440	Chemotherapy, intracavitary (thoracentesis)	$43.63	$63.35	+45%
116	96445	Chemotherapy, intracavitary (peritoneocentesis)	$43.63	$63.35	+45%
116	96450	Chemotherapy, into CNS	$43.63	$63.35	+45%
116	96542	Chemotherapy injection	$43.63	$63.35	+45%
116	96549	Chemotherapy, unspecified	$43.63	$63.35	+45%
117	96410	Chemotherapy, infusion method (intravenous)	$165.65	$168.29	+2%
117	96414	Chemotherapy, infusion method add-on	$165.65	$168.29	+2%
117	96422	Chemotherapy, infusion method (intra-arterial)	$165.65	$168.29	+2%
117	96425	Chemotherapy, infusion method (more than 8 hours)	$165.65	$168.29	+2%
120	36680	Insert needle, bone cavity	$104.29	$111.80	+7%
120	90780	IV infusion therapy, 1 hour	$104.29	$111.80	+7%

Source: Table assembled by Health Policy Alternatives, Inc., from the 2005 Final Hospital OPPS Rule. *Federal Register*, Vol. 69, No. 219. Nov. 15, 2004. Table 33 and Addendum A.

ACCC Is Instrumental in Getting a 30-Day Extension on Proposed NCD

On Nov. 19, 2004, CMS announced that it was extending by 30 days (to Dec. 31, 2004) the due date for public comments to its draft decision memo for anticancer chemotherapy for colorectal cancer. CMS is expected to publish its final decision by Jan. 31, 2005. The national coverage determination (NCD) decision memo would require beneficiaries to be included in a listed clinical trial in order for Medicare to provide coverage for medically necessary non-compendia off-label uses for colorectal cancer treatments.

On Feb. 12, 2003, CMS opened a NCD review of oxaliplatin for colorectal cancer to evaluate when the drug is "reasonable and necessary" in the Medicare population. Over the course of an almost two-year period, the scope of the NCD has been modified and the number of colorectal drugs targeted has been expanded. On Nov. 1, 2004, CMS released a draft NCD decision memo. It allowed only 30 days for stakeholders to provide comments on a proposed NCD that introduces many important and clinically complex issues.

ACCC is concerned about CMS's goals and intentions. The agency's rush to national coverage decision-making could lead to unintended consequences for Medicare patients with cancer and could set a precedent on a broad range of issues in the future. ACCC was active in seeking additional time to allow for a full and open dialogue between our members and CMS. The 30-day extension to Dec. 31, 2004 reflected ACCC's focused efforts. This extension helped ensure that CMS makes a fully informed decision on coverage issues that have the potential to significantly alter physicians' recommended treatment and Medicare beneficiaries' access to cancer therapies.

ACCC is also concerned that the views of our members—key stakeholders—have not yet been adequately represented. On Dec. 8, ACCC convened a conference call of key stakeholders and healthcare experts to discuss the consequences of NCD. Feedback from this call was incorporated into ACCC's comments to the NCD proposal, which were submitted on Dec. 31.

Radiation Oncology in 2005

Reimbursement for radiation oncology services will increase in a number of areas:

- Most technical charges will increase between 5 to 9 percent.
- Overall reimbursement for intensity-modulated radiation therapy (IMRT) will increase by about 4 percent (see Table 3).
- Reimbursement for IMRT planning, however, decreases.
- Overall reimbursement for external beam radiation therapy will increase by about 6 percent. (CPT 77295, 3-D simulation, increases by 8 percent.)

On the down side, reimbursement for brachytherapy isodose planning (CPT 77326) and radiation physics consultation (CPT 77370) are each reduced 51 percent from $200.60 in 2004 to $97.48 in 2005.

In 2005 CMS intends to compensate providers for the "acquisition

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costs of seeds." All brachytherapy sources will be paid based on the hospital's charge for each device adjusted to cost. In other words, hospitals must use the contract price they pay for the seeds and then mark up the charge using the hospital's departmental cost-to-charge (CCR) ratio. Remember to use the CCR from the department supplying the seeds and make sure it is taken from the latest settled cost report filed with Medicare. *Do not* use the most recent CCR or the hospital's CCR because Medicare requires hospitals to use the relevant department's CCR.

ACCC Submits Nomination to Medicare Coverage Advisory Committee

ACCC recently submitted its nomination of James C. Chingos, MD, to the Medicare Coverage Advisory Committee (MCAC). Dr. Chingos is ACCC treasurer and medical director at the Cape and Islands Regional Cancer Center at the Davenport-Mugar Cancer Center in Hyannis, Mass. He is responsible for the planning and implementation of cancer care programs and activities at 23 entities, including two non-profit community hospitals.

MCAC reviews and evaluates medical literature and technology assessments relating to medical items and services that are or may be eligible for coverage by the Medicare program. The committee consists of 100 members representing all medical specialties, biostatistics, public health, epidemiology, and other health professions.

Heads Up! New J-Codes Assigned

Effective Jan. 1, 2005, three anti-cancer drugs were given permanent J-codes:

The permanent J-code for Aloxi (palonosetron hcl injection) is now J2469. When billing Aloxi using J2469, the billing unit is 25 mcg (0.25 mg dose). Aloxi is indicated for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of moderately emetogenic chemotherapy and acute nausea and vomiting associated with initial and repeat courses of highly emetogenic chemotherapy.

The permanent code for Avastin (injection, bevacizumab) is now J9035. When billing Avastin using J9035, the billing unit is 10 mg. Physician practices: when J9035 becomes effective, there will be no C-code overlap. Avastin, used in combination with intravenous 5-fluorouracil-based chemotherapy, is indicated for first-line treatment of patients with metastatic carcinoma of the colon or rectum.

The permanent code for Velcade (injection, bortezomib) is J9041. When billing Velcade using J9041, the billing unit is 0.1 mg. Velcade is indicated for treatment of multiple myeloma.

Table 3. A Comparison of 2004 and 2005 Reimbursement Amounts for IMRT

CPT Code		Frequency	2004 Payment	2005 Payment	Dollar Change	Percent Change	Total 2004 Payment	Total 2005 Payment
99215	Office visit for established patient	1	$82.07	$79.65	-$2.42	-3%	$82.07	$79.65
76370	CT guidance	1	$91.35	$97.90	+$6.35	+7%	$91.35	$97.70
77301	IMRT Planning	1	$850.00	$813.57	-$36.43	-4%	$850.00	$813.57
77300	Radiation dosimetry planning, basic	6	$91.35	$97.48	+$6.13	+6%	$548.10	$584.88
77334	Treatment devices, complex	6	$157.33	$163.67	+$6.34	+4%	$943.98	$982.02
77418	IMRT delivery	42	$294.11	$309.20	+$15.09	+5%	$12,352.62	$12,986.40
77417	Port films	16	$42.57	$43.87	+1.30	+3%	$681.12	$701.92
77336	Continuing physics consultation	8	$91.35	$97.48	+$6.13	+6%	$730.80	$779.84
TOTAL PAYMENT							$16,280.04	$17,023.28
DOLLAR DIFFERENCE								$743.24
PERCENT CHANGE								+4.4%

Table assembled by ELM Services, Inc., Rockville, Md., *www.elmservices.com.*

2005 Physician Fee Schedule: What Your Practice Should Know

PHOTOGRAPH/COMSTOCK.COM

For more than a year, oncology practices across the country have been anxiously anticipating the new reimbursement methodology mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). Starting Jan. 1, 2005, Part B drugs and biologicals are now paid using the average sales price (ASP) methodology. First quarter 2005 payment rates are based on third quarter 2004 data submitted to CMS from drug manufacturers. Table 4 on page 16 shows 2005 payment rates for drugs commonly used in physician offices for cancer treatment.

One-Year Demonstration Project. On Nov. 1, 2004, CMS announced that $300 million is earmarked for a quality of care one-year demonstration project beginning in January 2005. The demonstration project will pay participating physicians who furnish chemotherapy in the office an additional $130 per patient encounter per day. Physicians who treat patients in the hospital setting do *not* qualify for this additional payment.

To qualify for the extra payment, practitioners must assess and document the severity of a patient's status with respect to nausea and/or vomiting, pain, and fatigue. At the start of each chemotherapy session, physicians will be required to use 12 new G-codes (G9021-G9024 for nausea/vomiting; G9025-G9028 for pain; and G9029-G9032 for fatigue) to document the specified services related to these three factors. This payment increase is above any increase in the new and revised drug administration codes that CMS is implementing in 2005.

The demonstration project is intended to measure and improve the quality of care provided to Medicare patients and offset a portion of the physician payment shortfall brought about by reductions in drug and administration payments.

Drug Administration Payments. The transitional payment for drug administration dropped to 3 percent in 2005. Table 5 on page 16 compares the 2004 payment rates, which included a 32 percent transitional payment, to the 2005 rates. The transitional payment will be phased out in 2006.

CMS accepted several changes to drug administration codes recommended by the Physicians' Current Procedural Terminology (CPT) Editorial Board. CMS has also accepted changes to work relative value units (RVUs) and practice expense inputs for 18 new and revised codes from the AMA/Specialty Relative Value Scale Update Committee (RUC). Because new permanent codes will not be included in the CPT until 2006, CMS developed temporary codes to allow physicians to be paid for these services in 2005. These include three new categories for drug administration services: infusion for hydration; nonchemotherapy therapeutic/diagnostic injections and infusions other than hydration; and chemotherapy administration (other than hydration), which includes infusions and injections. The infusion of substances such as monoclonal antibody agents or other biologic response modifiers will now be reported under the chemotherapy codes, instead of the nonchemotherapy infusion codes. There are also new codes in both the chemotherapy and nonchemotherapy sections for reporting the additional sequential infusion of different substances or drugs. Go to ACCC's web site (*www.accc-cancer.org*) for a list of these new codes.

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2005 Physician Practice Reimbursement at a Glance

- Most drugs paid at ASP + 6 percent. Drug payments will be updated quarterly
- $130 per patient encounter for physicians participating in one-year demonstration project
- Transitional administration payment reduced from 32 percent in 2004 to 3 percent in 2005
- Chemotherapy administration billed using 18 new/revised G codes
- A supplying fee of $24 per prescription was established for immunosuppressive drugs and oral antiemetic and anticancer drugs.

Table 4. A Comparison of 2004 and 2005 Physician Office Payment Rates for Select Cancer Therapies

Commercial Name/Chemical Name	HCPCS	HCPCS Units	2004 Rate[1]	2005 Rate[2]	Dollar Difference	Percentage Change
Alimta/petmetrexed injection	J9305	10 mg	No data	$40.54	N/A	N/A
Aloxi/palonosetron hcl injection	J2469	25 mcg	No data	$18.22	N/A	N/A
Anzemet/dolasetron mesylate (oral)	Q0180	100 mg	$64.80	$47.72	-$17.08	-26%
Aranesp/darbepoetin alfa non-esrd	J0880	5 mcg	$21.20	$17.72	-$3.48	-16%
Avastin/bevacizumab injection	J9035	10 mg	No data	$57.08	N/A	N/A
Camptosar/irinotecan injection	J9206	20 mg	$130.24	$125.58	-$4.66	-4%
Doxil/doxorubicin hcl liposome injection	J9001	10 mg	$352.06	$356.35	+$4.29	+1%
Elitek/rasburicase injection	J2783	0.5 mg	$105.54	$107.01	+$1.47	+1%
Eloxatin/oxaliplatin	J9263	0.5 mg	No data	$8.24	N/A	N/A
Erbitux/cetuximab injection	J9055	10 mg	No data	$49.64	N/A	N/A
Ethyol/amifostine	J0207	500 mg	$405.29	$417.56	+$12.27	+3%
Faslodex/fulvestrant injection	J9395	25 mg	$78.36	$80.51	+$2.15	+3%
Gemzar/gemcitabine hcl	J9201	200 mg	$111.33	$115.34	+$4.01	+3%
Herceptin/trastuzumab	J9355	10 mg	$52.01	$52.99	+$0.98	+2%
Hycamtin/topotecan	J9350	4 mg	$706.17	$739.69	+$33.52	+5%
Kytril/granisetron hcl injection	J1626	100 mcg	$15.62	$7.09	-$8.53	-55%
Neulasta/pegfilgrastim	J2505	6 mg	$2,507.50	$2,273.93	-$233.57	-9%
Neupogen/filgrastim injection	J1440	300 mcg	$158.50	$178.94	+20.44	+11%
Plenaxis/abarelix injectable suspension	J0128	10 mg	No data	$68.62	N/A	N/A
Procrit/non-esrd epoetin alpha injection	Q0136	1,000 units	$11.62	$10.18	-$1.44	-12%
Rituxan/rituximab	J9310	100 mg	$427.28	$442.01	+$14.73	+3%
Taxol/paclitaxel	J9265	30 mg	$138.28	$15.85	-$122.43	-89%
Taxotere/docetaxel	J9170	20 mg	$301.40	$297.58	-$3.82	-1%
Velcade/bortezomib injection	J9041	0.1 mg	No data	$28.38	N/A	N/A
Vidaza/azacitidine	C9218	1 mg	No data	$3.96	N/A	N/A
Zofran/ondansetron	Q0179	8 mg	$27.22	$28.66	+$1.44	+5%

[1]Final 2004 Physician fee schedule payment rate data taken from CMS Program Transmittal 75, Pub. 100-04, Medicare Claims Processing, Change Request 3105 (Jan. 30, 2004), as modified by Program Transmittal 119, Pub. 100-04, Medicare Claims Processing, Change Request 3163 (March 15, 2004) and Program Transmittal 90, Pub. 100-20, One-Time Notification, Change Request 3312 (June 25, 2004).
[2]2005 payment rate data taken from Preliminary ASP Pricing File. Available online at *www.cms.hhs.gov/providers/drugs/asp.asp*.

Table 5. A Comparison of 2004 and 2005 Physician-Office Drug Administration Payment Amounts

Code	Description	2004 Payment with 32 percent transition payment	2005 Payment with 3 percent transition payment
G0345	IV infusion therapy, 1 hour	$117.79	$64.80
G0346	IV infusion, additional hour	$33.02	$20.69
G0351	Injection, sc/im	$24.64	$19.13
G0355	Chemotherapy, sc/im	$64.07	$53.09
G0358	Chemotherapy, push technique	$154.76	$73.00
G0359	Chemotherapy, infusion method	$217.35	$177.60
G0360	Chemotherapy, infusion method additional hour	$48.30	$40.20

Table assembled by ELM Services, Inc., Rockville, Md., *www.elmservices.com*