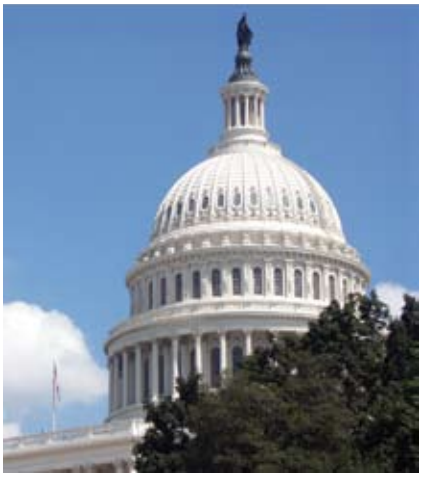
ISSUES

CMS Releases Proposed HOPD Rule

On August 8, 2006, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule for Medicare payment for hospital outpatient services in calendar year (CY) 2007. In brief, here are some of the major changes in the proposed hospital outpatient department (HOPD) rule.

Payment increases tied to reporting of quality measures. Hospitals would receive $32.5 billion in CY 2007 under the proposed rule. CMS estimates that hospitals will receive an overall average increase of 3.0 percent in Medicare payments for outpatient department services. All payment rate increases would be tied to the reporting of quality measures. Specifically, hospitals that report quality measures for purposes of the update in the inpatient prospective payment system (IPPS) would also receive a full update on outpatient payments. Those hospitals that are required to report quality measures for inpatient services in order to receive the full IPPS update, but fail to do so, would receive the outpatient payment update minus 2.0 percentage points. In conjunction with the quality measurement proposal, CMS is soliciting public comments on other, potentially more effective approaches to promote the use of high-quality services and avoid unnecessary costs.



PHOTOGRAPH/BIG STOCK PHOTOS

Drugs and Biologicals. The rule sets the payment for acquisition and overhead costs of certain separately payable drugs and biologicals at the manufacturer's average sales price (ASP) plus 5 percent, a reduction from the current rate of ASP plus 6 percent. Drugs and biologicals with pass-through status would be paid at the rate established under the Competitive Acquisition Program (CAP), if the drug is covered by CAP, or ASP plus 6 percent. CAP rates vary by drug, but often are less than ASP plus 6 percent.

CMS is proposing to pay separately for drugs, biologicals, and radiopharmaceuticals costing $55 or more per day, consistent with the previous $50 threshold but updated for inflation. The rule proposes to continue to exempt from this bundling policy certain anti-emetic drugs used by cancer patients to counteract side effects of treatment. Payments for other drugs would continue to be "bundled" into payments for their associated procedures.

Imaging. The rule proposes significant payment cuts for PET and PET/CT scans. Payments would be reduced from $1,150 for PET and $1,250 for PET/CT in 2006 to $865 for both procedures in 2007. The proposed rule also continues to pay separately for FDG (a glucose analog). These cuts were mandated in the Deficit Reduction Omnibus Reconciliation Act of 2005 (DRA).

Brachytherapy. The rule calls for separate payment for brachytherapy sources based on their source-specific median costs, as reflected in claims data. Payment would be on a per unit source basis rather than on a per day basis, to recognize the high variability of treatment costs.

Administration payments. The proposed rule would improve payments for costs associated with administering drugs to beneficiaries in the outpatient department. Currently, hospitals receive the same payment for each type of drug infusion, whether it takes an hour or five hours to administer. CMS is proposing to revise the APC payment structure for drug administration services, allowing hospitals to be paid separately for additional hours of infusion, in addition to their payment for the initial hour of infusion.

Clinic visits. To match the levels of effort for physician services, the rule proposes to increase from three

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Proposed Update to Physician Fee Schedule

CMS released the proposed physician fee schedule update for FY 2007 on August 8, 2006. Payment rates for physicians would fall 5.1 percent in 2007, unless Congress steps in to delay the cuts. Congress is likely to stop the anticipated 5.1 percent across-the-board reduction, by passing stopgap measures similar to what it has done in the past. In order to offset this decrease, lawmakers would have to appropriate $13 billion over the next five years. That money, as has been done in the past, may come at the expense of other healthcare programs.

On the positive side, CMS proposes expanding the preventative care services covered by Medicare. For example, Medicare beneficiaries may now receive a colorectal cancer screening exam without having to pay the Part B deductible.

Under the proposed rule, beneficiaries' Part B premiums will increase to $98.40 a month.

to five the number of payment levels for visits to a hospital clinic or emergency department, with payment rates established based on historical hospital claims data. As a result, the maximum payment for clinic visits would increase from $92 to $133, while the maximum payment for emergency department visits would increase from $244 to $345. CMS plans to seek public input on guidance for hospitals about the proper use of the new codes.

Medicare Administrative Contractors (MACs). The proposed rule would begin the transition from the current policies for administering Medicare fee-for-service claims (including hospital claims for outpatient services) using fiscal intermediaries and carriers to the new Medicare Administrative Contractors (MACs). Under the existing structure, providers are permitted to choose the fiscal intermediaries that process both their inpatient claims under Medicare Part A and their outpatient claims under Part B. The proposed rule would require hospitals to file their claims with the intermediary with jurisdiction over the hospital's geographic location until a MAC replaces the intermediary. The MAC would then handle all hospital claims, as well as Part B claims from physicians, laboratories, and other suppliers.

Ambulatory surgical centers (ASCs). The proposed rule would greatly expand the list of surgical procedures for which Medicare pays an ASC facility fee by adding 14 surgical procedures to the current list of Medicare-approved ASC services. CMS would specify procedures excluded from payment of an ASC facility fee for safety reasons. In addition, ASC facility fees would not be paid for procedures that require active medical monitoring and care at or beyond midnight following the procedure. Payment rates would be set using the relative payment weight determined for a particular surgical procedure multiplied by a conversion factor.

For more information about the proposed rule, log onto ACCC's website at *www.accc-cancer.org*.

CAP Falls Flat

As of July 10, only 307 physicians, operating in 664 practice locations, had enrolled in Medicare's Competitive Acquisition Program (CAP), according to CAP vendor BioScrip. Just 22 were listed as oncologists. The majority were classified as allergists/immunologists or ophthalmologists. The expected target was 1,500 to 2,000 physicians.

In his written testimony, Richard Friedman, chief executive officer of BioScrip, said that unless more physicians enroll, his company "cannot keep investing in CAP where it will not recognize the return on investment." Bioscrip, a specialty pharmacy company in Elmsford, N.Y., dedicated 90 staff members to the business, based on the projected enrollment of 2,000 physicians.

ILLUSTRATION/FRANK RENLIE

Final Rule for Hospital Inpatient Payment System (IPPS)

On Aug. 1, CMS released the hospital IPPS final rule for FY 2007. In the final rule, an incremental, three-year transition in the diagnosis-related group (DRG) system will be used, as opposed to phasing it in by 2008, as was originally proposed. Under the new rule, hospitals will receive payments based on specific costs, as opposed to a charge-based system. The DRG weighting factors, which are changing from charge-based to cost-based, will be fully implemented in FY 2009.

Overall, rates to hospitals will increase by 3.4 percent in FY 2007 for hospitals that report quality data. Hospitals that report quality data will receive the full market basket increase, while those who do not report data will receive 2 percentage points less than the full market basket increase. This provision was mandated in the Deficit Reduction Act of 2005.

In addition, CMS made a clarification in CAP for Part B drugs, by stating that physicians will no longer be responsible for tracking CAP drugs to ensure patient delivery. This provision should prove to be less burdensome on CAP physicians.

The final rule appeared in the August 18, 2006, *Federal Register* and will be effective for discharges on or after October 1, 2006. Log onto ACCC's website (*www.accc-cancer.org*) for a listing of select DRG codes and how their payments are projected to change under this new rule.

ACCC Joins Access to Medical Imaging Coalition

The Association of Community Cancer Centers has joined the Access to Medical Imaging Coalition. The purpose of the coalition is to support HR 5704, the Access to Medicare Imaging Act introduced by Rep. Joe Pitts (R-Pa.) and S 3795. The bills call for a two-year moratorium on the cuts in payments for Medicare medical imaging services. They also call for a Government Accountability Office study to analyze the impact that the Deficit Reduction Act cuts may have on patient access.

Access to Medical Imaging Coalition members include both imaging companies and advocacy groups and associations, including: US Oncology, American Society of Clinical Oncology, American Society for Therapeutic Radiology and Oncology, and DMS Imaging.

The Deficit Reduction Omnibus Reconciliation Act of 2005 included approximately $2.8 billion in cuts to Medicare in-office imaging services between 2007-2010 by capping in-office imaging reimbursement at HOPD rates and cutting reimbursement for imaging studies performed on contiguous body parts. ACCC will work with the coalition to increase grassroots and government support for HR 5704.

PHOTOGRAPH/COMSTOCK

Coding For Consults

by Linda Gledhill, MHA

Q. ***How do you determine if a visit is a consultation or a new patient visit?***

A. A consultation is when a physician or nonphysician practitioner (NPP) is asked by another physician or NPP for an opinion or advice regarding management of a specific problem. A new patient is one who self refers for the initial visit *or* a previously seen patient that has not been seen in the practice for more than three years.

Q. ***Can NPPs perform consultations?***

A. Qualified NPPs may perform consultation services as long as they are within the scope of practice and licensure requirements of the state in which they practice.

Q. ***What documentation is required for a consultation service?***

A. In 2006, both the physician providing the consultation and the physician requesting the consultation must keep documentation of the reason for the consultation request. After the consultation is completed, a written report, including the consultant's opinion for treatment, must be sent to the referring physician and kept in *both* medical records.

Q. ***Can consultations be requested verbally?***

A. Yes, but both the consulting and referring provider must document the request in the patient's medical record. A simple request form is a better way to track and document consult requests.

Q. ***How do I bill when a patient requests a second opinion from my practice?***

A. In 2006, Medicare deleted 'second opinion' Confirmatory Consultation CPT codes 99271-99275. If a patient or family member requests a second opinion, it should be coded as a new patient visit using codes CPT codes 99201-99205.

Q. ***How do I code a second opinion from the patient or family member while the patient is in the hospital and under the care of another provider?***

A. Inpatient consultation requests are tricky. If the request comes from the patient or a family member but the attending physician does *not* request a consultation, the consultation requirements are not met. Instead, for patients or family members requesting a second opinion during a hospital stay, providers should bill using subsequent hospital care CPT codes 99231-99233.

If the attending physician requests a consultation, providers can use the initial inpatient consultation CPT codes 99251-99255. As with all consultation requests, providers must send a report to the physician requesting the consultation.

In 2006, CMS deleted follow-up inpatient consultations CPT codes 99261-99263, as they were difficult to understand and rarely used by providers. After the initial consultation is performed, providers should now charge using subsequent hospital care CPT codes 99231-99233.

Q. ***Can I charge for a consultation when another physician in my group requests that I see one of his or her patients?***

A. According to the Medicare manual, a consultation can be charged by another physician in the same group practice when the consulting physician or qualified NPP has expertise in a specific medical area *beyond* the requesting professional's knowledge. The manual also states that this practice should not become routine.

Q. ***Can I charge a consultation and order diagnostic tests on the same day?***

A. Yes. CMS policy states that "a physician or qualified NPP consultant may initiate diagnostic services and treatment at the initial consultation service."

Q. ***When does transfer of patient care occur?***

A. Transfer of care occurs when the consulting physician takes responsibility for managing the entire course of treatment for the patient. All subsequent visits would be billed as an established patient visit using CPT codes 99212-99215. The point where care is transferred should be documented in the patient progress notes. Consultations *cannot* be charged after a transfer of patient care occurs.

Q. ***Can a consultation be charged when time is used as the basis for the visit charge level?***

A. As with most oncology visits, time can become the deciding factor when counseling and coordination of care are needed. If counseling and coordination of care are required for a period of time that is greater than 50 percent of the CPT-suggested time that the visit would normally require, the visit level can be based on time. An example would be an 80-minute consultation where more than 40 minutes were spent counseling the patient. When using time, documentation should include the amount of time spent in counseling and verification that this time took up more than 50 percent of the visit time.

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