ISSUES The

ACCC's Advocacy Efforts Pay Off for Hospitals and Practices

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Under the final 2007 hospital outpatient prospective payment system (HOPPS) rule, Medicare will continue to pay for drugs and biologicals at ASP+6 percent. In its proposed rule, the agency had looked to cut payment to ASP+5 percent. ACCC submitted extensive comments, testimony, and data from member institutions showing how the proposed HOPPS reduction to ASP+5 percent would *not* cover the cost of many anticancer drugs.

Under the final rule, radiopharmaceuticals will be paid at charges adjusted to cost, using hospital specific cost-to-charge ratios.

Another positive step forward is the significant changes the Centers for Medicare and Medicaid Services (CMS) made to payment policies for drug administration services. Starting this year, hospitals will receive separate payment for second and subsequent hours of drug administration services. (Up to now, CMS has packaged payment for additional hours into payment for the first hour.) See the coding column on page 8 for more information on this change.

Despite extensive advocacy efforts, ACCC was less successful in its efforts to obtain separate payment for pharmacy handling costs at hospitals. As in the 2006 rule, CMS again concluded that ASP+6 percent was sufficient payment for *both* pharmacy acquisition and handling costs. ACCC will continue to work with the agency and other stakeholders to demonstrate that, in fact, pharmacy handling costs are not included in hospitals' charges for drugs, and thus are not included in Medicare's payment rates.

On the physician office side, Congress convened on Dec. 8 and passed a bill of tax break extenders and trade packages that also included a rollback of the 5 percent cut to the physician fee schedule that was scheduled to go into effect on Jan. 1, 2007. This move came after ACCC and other organizations submitted extensive testimony stating that "physicians cannot sustain their current levels of services" if the predicted payment reduction went into effect. Also included in the package was a bonus payment for quality reporting that will begin on July 1, 2007, and continue to the end of the year. The exact quality reporting measures were not included in the bill.

Turn to page 9 for a look at some of the practical implications these changes have for providers.

A Snapshot of Radiotherapy Reimbursement

In 2007 radiotherapy reimbursement rates will rise by an average of 3 percent at hospitals and decline by about 6 percent at freestanding radiation treatment centers, according to an analysis by American Medical Accounting & Consulting, Inc.

Starting this year, CMS includes new codes that, for the first time, support stereotactic radiosurgery with linear accelerators in freestanding centers. In other words, freestanding radiation treatment centers can now bill for treating brain and spine lesions with stereotactic radiotherapy or radiosurgery, and for treating other types of lesions with stereotactic body radiosurgery.

Positron emissions tomography (PET) and PET/computed tomography (CT) services have been re-assigned from their previous new technology APCs to new, lower-paying APCs. Concurrent PET/CT received the New Technology APC 1511 with a payment rate of $950, reduced from the current rate of $1250. PET is assigned to APC 308, with a payment of $855.43.

Deadline Looms for National Provider Identifier!

Starting May 23, 2007, healthcare providers covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) must submit claims using only their national provider identifier (NPI).

Every covered healthcare provider must obtain and use the HIPAA mandated NPI. Even providers that do not conduct electronic transactions and are not covered by HIPAA may be required by health plans or employers to obtain one. (Small health plans have an extra year, until May 23, 2008, to be NPI-compliant.)

There is no cost to obtain an NPI, and providers can apply online at: *https://nppes.cms.hhs.gov* or obtain a paper application by calling 800.465.3203. For more information, go : *www.cms.hhs.gov/NationalProvIdentStand/.*

PHOTOGRAPH/BIG STOCK PHOTO

A Coding Primer for Hospitals in 2007

by Mary Lou Bowers, MBA, and Barbara Constable, RN, MBA

Overall, many of the "proposed" changes for the 2007 Hospital Outpatient Prospective (HOPPS) Payment System did not, in fact, go into effect. Instead, when the Centers for Medicare & Medicaid Services (CMS) released the final HOPPS rule on Nov. 1, 2006, the healthcare community was pleasantly surprised to see that the agency had decided to continue data collection, tabling many of the proposed changes until 2008. In the end, hospital outpatient departments received an overall 3.4 percent market basket update to Medicare payment rates for services this year.

Status Quo

Here's a brief update on oncology-specific issues that did *not* change from 2006 to 2007.

Drugs and biologicals continue to be reimbursed at ASP+6 percent. This was a significant change from the proposed rule in which CMS had stated that "had they followed the methodology employed for establishing payment rate for drugs and biologicals, the rate would have been set at ASP+5 percent."

IVIG (intravenous immune globulin). In 2007, hospital outpatient departments will continue to code G-0332 (pre-administration related services for IVIG, per infusion encounter) and receive a $75 payment to cover the cost of obtaining and mixing IVIG. CMS will continue to collect data and is awaiting results of two federal studies underway that will provide more information on IVIG supply, demand, and pricing.

Anti-emetics. CMS continues to exempt certain anti-emetics from the bundling rule, providing a separate payment for all drugs listed in Table 1 on page 9.

Clinic visits. CMS decided *not* to implement the proposed G-codes for clinic visits (see "The Future of Proposed Clinic Visit G-Codes Uncertain"), so hospital outpatient cancer centers should continue using CPT codes to bill.

New in 2007

And now, here's a look at what *has* changed for 2007.

Bundling threshold increased. Starting Jan. 1, 2007, drugs, biologicals, and radiopharmaceuticals having a per day cost less than $55 will remain packaged in CY 2007. These costs are based on ASP data and hospital claims data used for the CY 2007 final rule

Brachytherapy coding changes. Table 2 on page 9 provides the list of all the separately payable brachytherapy sources for 2007. Note C2632 (brachytherapy solution, iodine I-125, per mCi) was replaced with A9527 (iodine I-125, sodium iodide solution, therapeutic, per mCi). Hospitals are required to report the assigned HCPCS codes in order to receive payment for the brachytherapy source; device edits are *not* needed to ensure appropriate payment for brachytherapy procedures. The 2007 payment rates for brachytherapy sources are based on 2005 hospital claims data.

Administration codes. Based on provider feedback about the burdens of tracking two different sets of codes for payers, CMS decided not to implement the full set of C-codes this year. Instead, CMS adopted an additional 13 of the 33 codes and kept the temporary code C8957 (intravenous infusion for therapy/diagnosis; initiation of prolonged infusion, more than 8 hours, requiring the use of portable or implantable pump) until a permanent code is assigned. Table 3 on page 10 provides a list of the current administration codes, including the new add-on codes that allow providers to bill for up to five additional hours.

In its final rule, CMS also provided clarification to submitted comments, including:

- Providers can only bill one IV push code per drug. In other words, if the same drug is pushed twice during the treatment regimen, bill only one IV push code.
- Providers can only bill one initial hour of infusion. (One comment proposed to bill separately and receive payment for the first hour of therapeutic infusion and hydration infusion when provided in the same encounter. In the final rule, however, CMS responded that this scenario would "not be consistent" with CPT coding principles.)
- Payers will not be reimbursed for concurrent codes this year. While CMS intends to gather data for future payment, the agency continues to argue that reimbursement is already packaged (or bundled) into 2007 payments.

The Future of Proposed Clinic Visit G-Codes Uncertain

While CMS reviewed several different coding models based on staffing interventions, staff time spent with the patient, resource intensity point scoring, and severity acuity point scoring related to patient complexity, the agency concluded that all models were either "too complex" or "provided significant potential for up-coding."

The road to a set of national facility-specific codes remains rocky. In Sept. 2004, CMS conducted a retrospective study using clinic and emergency guidelines established by the American Hospital Association (AHA) and the American Health Information and Management Association (AHIMA). Originally scheduled to review 12,500 visits, the study was aborted after only 750. The contractor in charge of the study identified a number of elements in the guidelines that "were difficult for coders to interpret, poorly defined, nonspecific, or regularly unavailable in the medical records." In

turn, CMS advised that hospitals' internal guidelines should be changed to follow the intent of the CPT code descriptors. In other words, hospital guidelines should be designed to reasonably relate the intensity of hospital resources used to the different levels of effort represented by the codes.

Bottom line: CMS continues to await the development of a national set of facility-specific codes and guidelines.

Hospitals Table 1: Anti-emetics Exempt from $55 Packaging Requirement

HCPCS Code	Drug Name
J1260	Dolasetron mesylate
J1626	Granisetron HCl injection
J2405	Ondansetron HCl injection
J2469	Palonosetron HCl
Q0166	Granisetron HCl, 1 mg oral
Q0179	Ondansetron HCl, 8 mg oral
Q0180	Dolasetron mesylate, oral

Source: HOPPS and CY 2007 Payment Rates: Final Rule, Table 25, page 469.

Hospitals Table 2: Separately Payable Brachytherapy Sources for 2007

HCPS Code	Description	2007 APC	2005 Median Cost
C1716	Brachytherapy source, gold 198, per source	1716	$36.83
C1717	Brachytheraoy source, HDR iridium 192, per source	1717	$142.58
C1718	Brachytherapy source, iodine 125, per source	1718	$36.33
C1719	Brachytherapy source, non-HDR iridium 192, per source	1719	$23.14
C1720	Brachytherapy source, palladium 103, per source	1720	$48.82
C2616	Brachytherapy source, yttrium-90, per source	2616	$10,586.86
A9527	Iodine I-125, sodium iodide solution, therapeutic, per mCi	2632	$20.41
C2633	Brachytherapy source, cesium-131, per source	2633	$90.84
C2634	Brachytherapy source, high activity, iodine-125, greater than 1.01 mCi (NIST), per source	2634	$32.68
C2635	Brachytherapy source, high activity, palladium-103, greater than 2.2 mCi (NIST), per source	2635	$54.57
C2636	Brachytherapy linear source, palladium-103, per 1 mm	2636	$39.51

Source: HOPPS and CY 2007 Payment Rates: Final Rule, Table 30, page 562.

A 2007 Coding Primer for Physicians

by Mary Lou Bowers, MBA, and Barbara Constable, RN, MBA

PHOTOGRAPH/BIG STOCK PHOTO

Unlike the hospital side of the equation where CMS decided *not* to implement several proposed changes and payment cuts, the final rule for the 2007 Physician Fee Schedule included several significant changes for oncology practices. The final rule also included an updated five-year plan for the physician fee schedule. Here are some common questions about these changes, which went into effect Jan. 1, 2007.

Q. *Overall, how does reimbursement look for 2007?*

A. Thanks to a last minute "fix" by Congress, the conversion factor for 2007 remains the same as for 2006—$37.8975. CMS and the Relative Value Update Committee (RUC) also adjusted the relative value units (RVUs) for 2007. Overall, medical oncology practices can expect to see about a 2 percent payment increase this year. Payment for services provided by radiation oncologists is likely to remain static; estimates range from a 0 to 1 percent overall increase for these services.

Q. *How might these changes affect my practice's bottom line?*

A. In brief, here's how these adjustments may affect your daily operations.

E&M (evaluation and management) codes. Changes to these codes were mixed. For example, some of the most commonly billed physician visit codes (99213, 99214) increased 9 to 13 percent, which results in payment increases of $6.72 to $7.47 respectively. Other E&M codes have payment reductions as high as 6.5 percent (99211) and 5.3 percent (99203). Table 4 on page 11 compares 2006 and 2007 payments for all E&M services provided in a physician's office.

Administration codes. In 2007, practices will see payment reductions from between 0.5 percent to 7.2 percent for most administration services. Only three codes experience payment increases this year: 90772

continued on page 12

Hospitals Table 3. Current Administration Codes and Payments

2006 HCPCS Code	2007 HCPCS Code	Description	2006 Payment	2007 Payment
N/A	90760	Intravenous infusion, hydration; Initial, up to 1 hour	N/A	$111.20
N/A	90761	(Add-on code) each additional hour, up to 8 hours	N/A	$24.25
C8950	90765	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	$120.77	$111.20
C8951	90766	(Add-on code) each additional hour, up to 8 hours	N/A	$24.25
N/A	90767	(Add-on code) additional sequential infusion, up to 1 hour	N/A	$24.25
N/A	90768	(Add-on code) concurrent infusion	N/A	No payment
90772	90772	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	$ 23.31	$24.25
90773	90773	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intra-arterial	$47.82	$48.82
C8952	90774	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); IV push	$47.82	$48.82
N/A	90775	(Add-on code) therapeutic, prophylactic, or diagnostic injection (specify substance or drug)	N/A	$48.82
90779	90779	Unlisted therapeutic, prophylactic, or diagnostic intravenous, intra-arterial injection, or infusion	$8.14	$11.12
96401	96401	Chemotherapy anti-neoplastic, subcutaneous, or intramuscular	$68.37	$48.82
96402	96402	Chemotherapy hormonal anti-neoplastic, subcutaneous, or intramuscular	$68.37	$48.82
96405	96405	Chemotherapy administration; intralesional, up to and including 7 lesions	$68.37	$48.82
96406	96406	Chemotherapy administration; intralesional, more than 7 lesions	$68.37	$48.82
C8953	96409	Chemotherapy administration; intravenous push technique, single or initial substance/drug	$68.37	$97.41
N/A	96411	(Add-on code) chemo IV push, additional drug	$67.65	$97.41
C8954	96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug	$189.04	$152.75
C8955	96415	(Add-on code) chemo infusion, each additional hour	N/A	$48.82
96416	96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemo infusion (more that 8 hours), requiring use of a portable or implantable pump	$189.04	$152.75
N/A	96417	(Add-on code) chemo infusion, each additional sequential infusion, (different substance/drug)	N/A	$48.82
96420	96420	Chemotherapy administration, intra-arterial; push technique	$68.37	$97.41
96422	96422	Chemotherapy administration, intra-arterial; infusion technique, up to one hour	$189.04	$152.75
96423	96423	(Add-on code) chemotherapy administration, intra-arterial; infusion technique, each additional hour up to 8 hours (List separately in addition to code for primary procedure)	N/A	$48.82
96425	96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	$189.04	$152.75
96440	96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	$68.37	$152.75
96445	96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	$68.37	$152.75
96450	96450	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture	$105.28	$152.75
96521	96521	Refilling and maintenance of portable pump	$113.20	$111.20
96522	96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)	$113.20	$111.20
96523	96523	Irrigation of implanted venous access device for drug delivery systems	N/A	$31.36
96542	96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	$68.37	$48.82
96549	96549	Unlisted chemotherapy procedure	$68.37	$11.12
C8957	C8957	Prolonged IV infusion, requiring pump	N/A	$152.75

Source: The Pritchard Group, LLC, Rockville, Md.

Practices Table 4: E&M Services, a Comparison between 2006 and 2007*

CPT Code	Description	2006 Payment	2007 Payment	Payment Difference	Percentage Difference
99201	Office/outpatient visit, new	$36.76	$35.80	-$0.96	-2.6%
99202	Office/outpatient visit, new	$65.18	$62.21	-$2.98	-4.6%
99203	Office/outpatient visit, new	$97.02	$91.91	-$5.11	-5.3%
99204	Office/outpatient visit, new	$137.19	$139.79	+$2.60	+1.9%
99205	Office/outpatient visit, new	$174.33	$175.40	+$1.07	+0.6%
99211	Office/outpatient visit, established	$21.60	$20.20	-$1.41	-6.5%
99212	Office/outpatient visit, established	$38.66	$36.94	-$1.72	-4.4%
99213	Office/outpatient visit, established	$52.68	$59.40	+$6.72	+12.8%
99214	Office/outpatient visit, established	$82.62	$90.09	+$7.47	+9.0%
99215	Office/outpatient visit, established	$120.14	$121.98	+$1.85	+1.5%
99241	Office consultation	$50.40	$48.34	-$2.06	-4.1%
99242	Office consultation	$92.09	$89.26	-$2.83	-3.1%
99243	Office consultation	$122.79	$122.44	-$0.35	-0.3%
99244	Office consultation	$173.19	$179.49	+$6.30	+3.6%
99245	Office consultation	$223.97	$222.87	-$1.11	-0.5%

*Based on 2007 conversion factor of $37.8975

Practices Table 5: Administration Codes, a Comparison between 2006 and 2007*

CPT Code	Description	2006 Payment	2007 Payment	Payment Difference	Percentage Difference
90760	Hydration IV infusion, initial	$63.29	$61.50	-$1.79	-2.8%
90761	Hydrate IV infusion, add-on	$20.09	$18.98	-$1.10	-5.5%
90766	Therapeutic, prophylactic, or diagnostic IV infusion, add on	$25.77	$24.33	-$1.44	-5.6%
90767	Therapeutic, prophylactic, or diagnostic, additional sequential IV infusion	$42.45	$39.83	-$2.62	-6.2%
90768	Therapeutic or diagnostic concurrent infusion	$24.63	$22.85	-$1.79	-7.2%
90772	Therapeutic, prophylactic, or diagnostic injection, subcutaneous or intramuscular	$18.57	$19.44	+$0.87	+4.7%
90773	Therapeutic, prophylactic, or diagnostic injection, intra-arterial	$18.95	$18.30	-$0.65	-3.4%
90774	Therapeutic, prophylactic, or diagnostic injection, IV push	$57.60	$57.30	-$0.31	-0.5%
90775	Therapeutic, prophylactic, or diagnostic, injection, add-on	$26.91	$26.15	-$0.76	-2.8%
96401	Chemotherapy antineoplastic, subcutaneous, or intramuscular	$52.68	$58.32	+$5.64	+10.7%
96402	Chemotherapy hormonal antineoplastic, subcutaneous, orintramuscular	$45.86	$42.48	-$3.38	-7.4%
96405	Chemotherapy intralesional, up to 7 lesions	$113.31	$121.56	+$8.25	+7.3%
96406	Chemo intralesional over 7 lesions	$145.91	$145.13	-$0.78	-0.5%
96409	Chemotherapy, IV push, single drug	$122.41	$119.60	-$2.81	-2.3%
96411	Chemotherapy, IV push, additional drug	$70.87	$68.97	-$1.90	-2.7%
96413	Chemotherapy, IV infusion, 1 hour	$172.81	$166.06	-$6.75	-3.9%
96415	Chemotherapy, IV infusion, additional hour	$39.03	$37.17	-$1.86	-4.8%

*Based on 2007 conversion factor of $37.8975

(4.7 percent), 96401 (10.7 percent), and 96405 (7.3 percent). See Table 5 on page 11 to see how payment rates for administration services compare between 2006 and 2007.

Real world scenario. Patient X comes to your office for a scheduled visit and a chemotherapy treatment. The patient receives one therapeutic IV push medication and a two-hour chemotherapy infusion. Overall, the practice would see about a 0.4 percent payment decrease for this treatment regimen (see Table 6 below). If the conversion factor had remained at $35.9848 (as published in the final rule for the 2007 Physician Fee Schedule), the payment for this treatment regimen would have been reduced by about 5 percent.

Q. *How does the reimbursement look for IMRT this year?*

A. Table 7 below compares the 2006 and 2007 payment rates for a sample IMRT treatment plan. In this particular real world scenario, the total payment for this treatment regimen was increased by about 2 percent. Note: CPT code 76370 (CT guidance) was deleted. Starting in 2007, practices should now bill using CPT code 77014 (CT guidance).

Q. *What is happening with regards to the imaging cuts?*

A. In 2007, CMS enacted the 25 percent payment reduction when more than one procedure from the same imaging family is performed during the same session on the same day. In other words, providers will be reimbursed the full amount for the highest priced procedure, and 75 percent for each additional procedure that falls under the above criteria. CMS decided not to impose a proposed 50 percent reduction on these imaging procedures at this time. Keep in mind, Congress mandated these cuts, as well as others, in the Deficit Reduction Act (DRA) of 2005.

Q. *Can you explain exactly* how *the Deficit Reduction Act affects reimbursement of imaging services?*

A. Section 5102 of the DRA includes two provisions that affect payment of imaging services under Medicare's Physician Fee Schedule. The first provision addressed payment for certain multiple imaging procedures. The second provision addressed aligning imaging payments under the Physician Fee Schedule to imaging payments under the Hospital Outpatient Prospective Payment System (HOPPS). Specifically, under the Physician Fee Schedule, the payment for certain imaging services would be equal to the technical component of those same imaging services as outlined in the HOPPS.

Reductions to multiple imaging were to be implemented first, followed by the HOPPS imaging cap, if applicable. The full list of the affected imaging procedures can be found in *Addendum F: CPT/HCPCS Imaging Codes Defined by DRA 5102(b).* Additional information about imaging changes under the Physician Fee Schedule can also be found online at: *www.cms.hhs.gov.*

Q. *Is there any good news?*

A. There are some silver linings. Drugs and biologicals continue to be reimbursed at ASP+6 percent. In addition, CMS continues to use the temporary G-code G0332 to pay for the pre-administration of IVIG (intravenous infusion immunoglobulin).

Practices Table 6: Sample Chemotherapy Regimen[1]

Service Provided	2006*	2007*	Percent of Change
Level 4 office visit	$82.62	$90.09	+9.0%
Chemotherapy administration, first hour	$172.81	$166.06	-3.9%
Chemotherapy administration, additional hour	$39.03	$37.17	-4.8%
Therapeutic IV push	$57.60	$57.30	-0.5%
Totals	**$352.07**	**$350.62**	**-0.04%**

[1]Calculated using the 2007 conversion factor of $37.8975. *Payments have been rounded up.

Practices Table 7: Sample IMRT Treatment Regimen[1]

CPT Code	Service Provided	2006 Payment*	2007 Payment*	Dollar Difference*	Percent of Change
77014	CT guidance	$162.58	$170.33	+$7.75	+4.8%
77263	Physician planning	$167.13	$154.78	-$12.35	-7.4%
77290	Pretreatment simulation	$341.84	$396.52	+$54.69	+16.0%
77301	IMRT planning (after CT imaging)	$1,532.95	$1,755.27	+$222.31	+14.5%
77334	Treatment devices (after planning)	$194.41	$180.97	-$13.44	-6.9%
77418	Daily treatment delivery	$689.73	$641.60	-$48.13	-7.0%
76950	Daily ultrasound set up	$82.62	$77.75	-$4.86	-5.9%
77417	Port films	$23.88	$21.60	-$2.27	-9.5%
77336	Continuing physics	$119.38	$101.57	-$17.81	-14.9%
77427	Weekly physician management	$172.05	$176.14	+$4.08	+2.4%
77470-59	Special treatment procedures	$554.82	$452.11	-$102.71	-18.5%
Total		**$4,041.39**	**$4,128.64**	**+$87.25**	**+2.1%**

[1]Calculated using the 2007 conversion factor of $37.8975. *Payments have been rounded up.

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