CMS Deputy Administrator
Talks about the Future of Cancer Care

Acting deputy administrator Herb B. Kuhn of the Centers for Medicare & Medicaid Services (CMS) gave attendees at ACCC's 15th Annual Oncology Presidents' Retreat in Arlington, Va., on Jan. 26 and 27, an in-depth look at transformations in the way the agency conducts its business. "Our mission is changing," said Kuhn, "from indemnity insurer—simply paying the bills—to trying to help people stay well, prevent complications, and avoid unnecessary healthcare costs."

One change is greater focus by CMS on prevention. "We had been spending less than 5 percent of our budget on prevention, which meant less effective healthcare." With new benefits coming forward, such as Medicare reimbursement for certain screenings and a medical physical, that is beginning to change, said Kuhn.

At the same time, as a means to maximize value of Medicare payments, CMS is moving toward integrating quality and payment systems. One such effort is the Premier Hospital Quality Improvement Demonstration, launched in October 2003 by CMS and the Premier Inc. healthcare alliance. According to Kuhn, second-year results from this hospital value-based purchasing demonstration project released January 25 show substantial improvement in quality of care, leading to incentive payments totaling almost $8.7 million to 115 top-performing hospitals. Hospitals participating in the Premier Hospital Quality Improvement Demonstration reported significant improvement in quality of care across five clinical focus areas measured by more than 30 nationally standardized and widely accepted quality indicators. This value-based purchasing project is part of an overall shift in Medicare to pay that is based on value, not volume of services. Demonstrations to assess quality measures, such as the Premier Hospital Quality Improvement Demonstration, as well as the Physician Voluntary Reporting Program, are a "great way for CMS to field test ideas before applying them nationally," said Kuhn.

CMS Deputy Administrator Herb Kuhn spoke of "better dialogue" with the physician community.

As part of the agency's focus on provider quality initiatives, CMS is working on a bonus payment program for physicians that will start mid-year 2007. Mandated by the Tax Relief and Health Care Act of 2006 (TRHCA), the program will offer an additional 1.5 percent in payments to physicians who report on performance. The program is slated to begin in July 2007 for providers who will report quality data under the physician fee schedule. Quality reporting under TRHCA is voluntary; however, physicians who report on measures for services furnished from July 1-Dec. 31, 2007, will receive a bonus in 2008. While quality measures under this program are still being determined, Kuhn announced that the Ambulatory Care Quality Alliance had considered five cancer measures and adopted four. One is related to radiation oncology and the other three, community oncology.

In response to a question, Kuhn indicated that quality measures for the program would be posted by April at the latest. For more information, see "Update: Physician Quality Reporting Initiative (PQRI)" on page 10.

MACs at-a-Glance

Medicare Administrative Contractors (MACs) have arrived. CMS awarded the first performance-based contract to integrate and provide Medicare Part A and Part B services to Noridian Administrative Services, LLC. The contract award for Region 3, worth $29 million in 2007, includes the states of Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming. As with Region 3, all states in a specific MAC are geographically contiguous.

The Medicare Modernization Act (MMA) of 2003 mandated four primary objectives for the MACs:

- Financial management and administrative cost savings
- Improved allocation of the claims processing workload throughout the United States
- Consistency in claims processing activities and decisions across a wider service area
- The ability to deliver "better" service through open competition.

The new MACs must interface with existing CMS contracted entities that perform medical review or benefit integrity work, including agreements with beneficiary contract centers, qualified independent contractors, quality improvement organizations, recovery audit contractors, enterprise data centers, and program safeguard contractors.

Noridian Administrative Services now has the opportunity to be a successful "model" for future MACs. The company has spent the past six months implementing improved and streamlined contract processes and testing of its implementation approaches. Pioneering the MAC movement, Noridian Administrative Services is likely to make some errors; however, any errors and challenges will provide a benchmark

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Brown Bagging **The Saga Continues**

Oncology Issues has recently learned that some ACCC member institutions are once again dealing with growing problems related to "brown bagging," a scenario where oncology drugs are shipped not to the physician but to third-party pharmacies or to the patients themselves. Patients must then bring the drugs to their physicians. This practice of "brown bagging" creates so many quality control and patient care problems that most providers believe the practice should be abandoned entirely. In the past, brown bagging was mainly seen in the physician practice setting, but more and more insurers are trying to carry this practice over into the hospital setting. For some hospitals, "just saying no" to brown bagging may even mean terminating contracts with certain insurers. Here's what our member institutions are saying about this controversial practice.

We have been approached more times in the last two weeks with requests to bring in medications for our hospital to mix than we have in the last 12 months. Many employers are placing more of the burden for the cost of medications onto their beneficiaries. A concept called "co-insurance" is pervasive. This practice requires the beneficiary to pay a certain percent of charges (often 10 percent), in addition to their deductibles and co-pays. The co-insurance is potentially very high and beneficiaries are looking for ways to minimize their out-of-pocket expense. Payers may offer them alternatives, such as shipping the medication with their standard prescription plan co-pay and asking the patients to find a provider to mix the drug. This scenario is financially very attractive—especially for VA beneficiaries.

As beneficiaries receive plan changes from their payers, I believe we will see many more requests for brown bagging. It is becoming critically important for providers to have a consistent response to this unsafe practice.

North Carolina ACCC Member Institution

Presently, the only medications that our patients are bringing in after having the prescription filled at another pharmacy are non-chemotherapy medications—usually supportive care drugs. However, our hospital does not allow any brown bagging. In addition to issues related to the integrity of the product being administered, our oncology pharmacist has also raised the potential issue of drug counterfeiting.

Brown bagging also raises concerns related to safe chemotherapy transport. Within the past two years, there has been increased focus on the safe handling of hazardous and chemotherapy drugs within the professional community. If the professionals can't "get it right," what are the implications to brown-bagged medicines?

Our hospital does not administer any drug that didn't come from us.

New York ACCC Member Institution

We recently had the brown-bagging issue arise relative to an IVIG dose, and determined that our hospital cannot accept brown-bagged drugs delivered by patients or even by their doctor's office. Instead our hospital is requiring delivery directly from the distributor, and only after they've consulted with our pharmacy regarding their shipping and quality standards.

Florida ACCC Member Institution

Our compliance officer and our JCAHO expert at our outpatient cancer center have determined that the brown bagging practice, which is growing, does not meet the requirements of the Joint Commission for control of medications we administer.

Idaho ACCC Member Institution

Our hospital does not accept brown-bagged drugs that are delivered by patients or their physician office. Our nurses are not even allowed to hook up a pump for a patient if the medication was mixed from an infusion company and not our own pharmacy."

Ohio ACCC Member Institution

Our hospital does not allow brown bagging from the patients or other locations for the exact reason JCAHO cites: we would be assuming responsibility for the drug administered without full control of what is being administered.

Louisiana ACCC Member Institution

The quality control and product integrity issues of brown bagging transcend all sites and modalities of therapy delivery. Whether it is happening in the hospital or in the physician practice, brown bagging cannot be allowed. And it is our responsibility to communicate this message to the medical directors of insurance companies and intermediaries.

Indiana ACCC Member Institution

Bottom line: even hospitals with anti-brown bagging policies are seeing some cancer patients showing up for appointments with their medications. When patients are told that the hospital cannot administer these drugs, it is upsetting for patients *and* providers.

ACCC and *Oncology Issues* will continue to monitor this issue and report on any future findings.

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for subsequent MACs to improve the formula for success as the other regions roll out.

CMS expects the transfer of workload in all regions to be completed by October 2009. To evaluate the performance of each MAC, the agency will establish operational standards that will focus on three main criteria:

1. Enhanced provider customer service
2. Increased payment accuracy
3. Improved provider education and training that will lead to correct claims submission and cost savings resulting from efficiencies and innovation.

Specifically, the standards will measure accuracy, consistency, and timeliness. If the standards are not met, CMS can terminate and/or transfer functions from one MAC to another at any time during the five-year contract period.

CMS is encouraging participation during the development process and has solicited review from providers and others in the oncology field that would encourage specific feedback and suggested innovations to modernize business processes and the technology platform. In addition, the agency held three comment periods during Cycle One, has hosted various Open Door Forum update conferences, and is sending periodic emails to those who have signed onto the Open Door Forum listserv.

Information to help providers stay current and participate in the MAC initiative is available through your existing Medicare carrier/fiscal intermediary, as well as at the following websites: *www.FedBizOpps.gov* and *www.cms.hhs.gov/MedicareContractingReform/.*

Update: Physician Quality Reporting Initiative (PQRI)

According to CMS, physicians and other practitioners will *not* have to enroll in a new Medicare reporting program in order to receive their bonus payment. Instead, the reporting of measures of quality of care will take place through G-codes and *Current Procedural Terminology* Category II codes, as part of the claim submission process. Covered services are those under the Medicare physician fee schedule, and include anesthesia services and the technical component for diagnostic services, a CMS representative said during a CMS Open Door forum held in January 2007. Excluded are claims for clinical laboratory services and Part B drugs.

As reported previously, PQRI offers an additional 1.5 percent in payments to those practitioners who report quality information for services furnished from July 1-Dec. 31. The money will be paid out in 2008, and eligible claims must be sent to CMS by February 2008.

The agency will send further information through the normal communication channels, "outreach teams," and will post a "frequently asked questions" document on its website. The agency will regularly update its website with information relating to the program. For more information, visit *www.cms.hhs.gov/PQRI.*

ACCC Supports Oncology Nurses

The Association of Community Cancer Centers has voiced its support for S. 646, a bill to increase the nursing workforce. In a letter to Senator Norm Coleman, co-sponsor of the bill, ACCC acknowledged the severe shortage of nursing professionals and applauded the Senator's effort to help address this critical issue. ACCC expressed support for the "distance learning program," measures to expand opportunities for nursing faculty, and proper funding for nursing programs currently in place within the Department of Health and Human Services.

Fiscal 2008 Budget Plan Would Cut Medicare, Medicaid Funding by $101 Billion

President Bush's fiscal 2008 budget proposal released Feb. 5 calls for major cuts to Medicare providers and reduces Medicare and Medicaid funding by about $101 billion over five years. For example, the proposed budget would reduce the full market basket update for *all* provider groups. For providers already dealing with rising healthcare costs and shortfalls in Medicare and Medicaid reimbursement, these proposed cuts could be catastrophic.

Bush's proposal also contained a number of Medicaid reimbursement reforms, including a plan to make high-income beneficiaries pay more for their prescription drug coverage in the form of higher premiums.

Congress does not have to abide by the recommendations in this proposal. In the past, Congress often has altered certain aspects of a President's budget before final passage. ACCC will continue to monitor the budget process and update its members when more information is available.

March is National Colorectal Cancer Awareness Month!

The Colon Cancer Alliance (*www.ccalliance.org*) is a non-profit organization comprised of colon and rectal cancer survivors, their families, caregivers, and people genetically predisposed to the disease, and the medical community. The organization is dedicated to patient support, advocacy, and education. The Colon Cancer Alliance offers a toll-free helpline (877.422.2030), an online support community, and a peer-to-peer support network Buddy Program. The Colon Cancer Alliance also offers educational resources to patients and families affected by colorectal cancer. The organization is the official patient support partner of the National Colorectal Cancer Research Alliance.

Coding for E&M Services: 101

by Barbara Constable, RN, MBA

The Centers for Medicare & Medicaid Services (CMS) wants to compensate physicians for the quality of care they provide to patients. Evaluation and Management (E&M) documentation is the pathway that translates a physician's patient care work into the claims and reimbursement process. Careful documentation of services provided is the foundation for correct coding.

As a result of a five-year review of the Resource-Based Relative Value Scale (RBRVS) for E&M services, the Relative Value Update Committee (RUC) recommended an increase in the work RVUs for 28 E&M services, while the work RVUs for 7 services remained unchanged. For example, in 2007, the work RVUs for CPT code 99204 (mid-level office visit, new patient) increased 15 percent; the work RVUs for 99213 (mid-level office visit, established patient) increased by 37 percent; for 99221 (initial hospital, inpatient) the work RVU increased by 41 percent.

To help ensure that you are coding for *all* the services your physicians provide, coders and billers should refer to the two quick references listed below.

Principles of Documentation

CMS has developed seven general principles of medical documentation:[1]

1. The medical record should be complete and legible.
2. Documentation of each patient encounter should include:
   - Reason for encounter, relevant history, physical examination findings, and prior test results
   - Assessment, clinical impression, or diagnosis
   - Plan for care
   - Date and legible identity of the observer.
3. If not documented, the rationale for ordering diagnostic tests must be "easily inferred."
4. Past and present diagnoses should be accessible to treating and consulting physicians.
5. Appropriate health risk factors should be identified.
6. The patient's progress, responses to and changes in treatment, and revision of diagnosis should be documented.
7. Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) codes reported on the health insurance claim form should be supported in the medical record.

Seven Components for E&M

CMS has also identified seven key components for E&M services. When billing for physician services, coders and billers must understand that the first three components: *history*, *examination*, and *medical decision making* are key to selecting the appropriate level of the E&M service.

1. History
2. Examination
3. Medical decision making
4. Counseling
5. Coordination of care
6. Nature of presenting problem
7. Time.

When visits consist primarily of counseling or coordination of care, time is the controlling factor for determining level of service. Keep in mind that performance and documentation of one of these key components at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level.

Documentation of History. In this first of three key components, the level of the E&M services is based on four types of history: chief complaint; history of present illness; review of systems; and past, family and/or social history.

Examination. Under this key component, the levels of E&M services are based on four types of progressively more complex examinations: problem-focused, expanded problem focused, detailed, and comprehensive.

Medical decision making. Coders and billers should use the following four levels of service to describe this third key component: straightforward, low complexity, moderate complexity, and high complexity. Each of the four levels is based on an established progression of elements.

To help coders and billers understand the level of service for each of these three components, CMS has developed definitions and specific documentation guidelines that are available online at: *www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf.*

When coding new patient visits, the three key component areas must be at the same level to bill for that service. In other words, to bill at the highest level of service, the medical record must document that all three key components were carried out at the highest level of service. If the three components are not at the same level, the coders and billers must bill the entire visit at the next lowest service level documented. Established patient visits require two of the three key components to be on the same level to code a visit. In other words, if two of the three components are high-level services and the third is a mid-level service, the entire visit can be coded as a high-level office visit.

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References

[1]Centers for Medicare & Medicaid Services. *1997 Documentation Guidelines for Evaluation and Management Services*. Available online at: *www.cms.hhs.gov/MLNProducts/Downloads/MASTER1. pdf.* Last accessed on Feb. 23, 2007.