PQRI Measures Released

The Centers for Medicare & Medicaid Services (CMS) announced April 3, 2007, detailed specifications for the 74 measures included in the 2007 Physician Quality Reporting Initiative (PQRI). The following specific cancer-related quality measures are included:

- Chemotherapy for stage III colon cancer patients
- Chronic lymphocytic leukemia: baseline flow cytometry
- Hormonal therapy for stage IC-III, ER/PR positive breast cancer
- Multiple myeloma: treatment with bisphosphonates
- Plan for chemotherapy documented before chemotherapy administered
- Radiation therapy recommended for invasive breast cancer patients who have undergone breast conserving surgery.

Three additional cancer-related quality measures relate specifically to melanoma: 1) patient medical history; 2) complete physical skin examination; and 3) counseling on self-examination. One measure—baseline cytogenic testing performed on bone marrow—relates to myelodysplastic syndromes and acute leukemias, and a final measure relates to myelodysplastic syndromes alone: documentation of iron stores in patients receiving erythropoietin therapy.

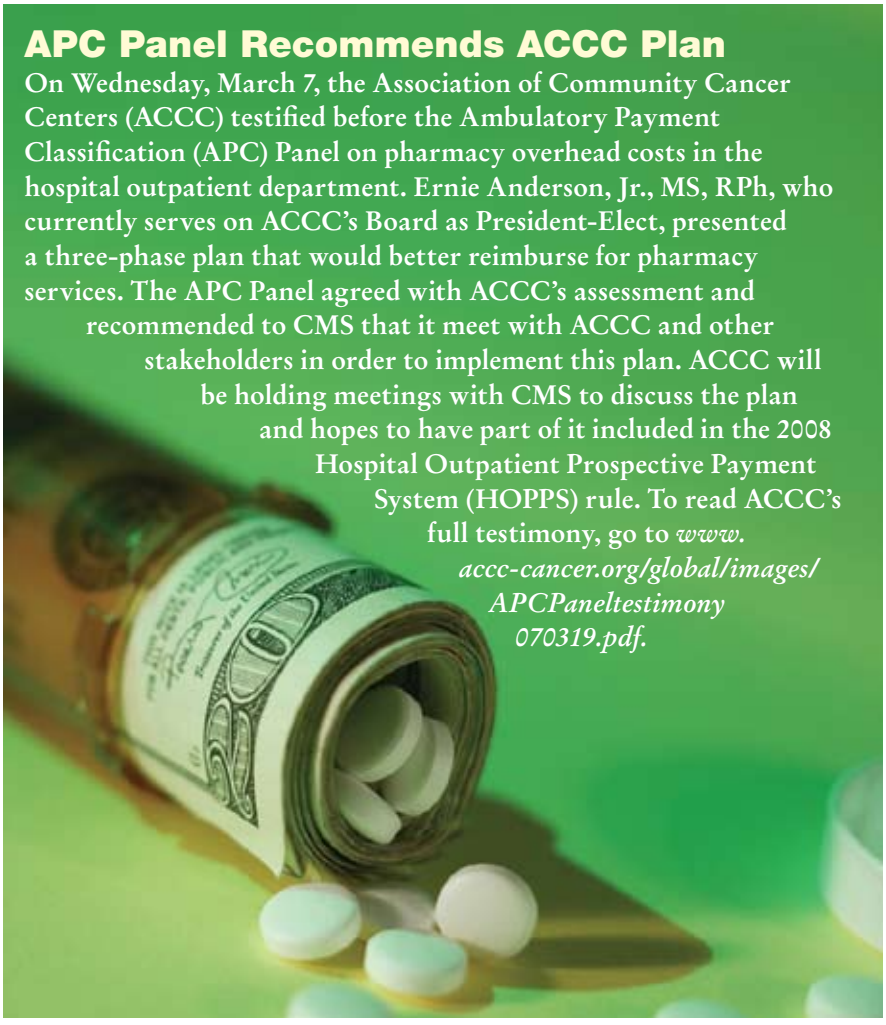
Providers are already raising concerns about the reporting and collection process.

"Most of these [measures] are reasonable, but how does this [initiative] get managed through Medicare's billing system?" asks Patrick Grusenmeyer, ScD, FACHE, vice president, cancer program, Helen F. Graham Cancer Center, Christiana Care Health System in Newark, Del. "Who gets penalized and how does Medicare know who are the patient's physicians—especially if a referral was not made to a medical oncologist—if, for example, a stage III colon cancer patient does not receive chemo? The surgeon? The medical oncologist? The radiation oncologist? If the patient was seen by a medical oncologist and did not get chemo, then chemo was probably either not appropriate or the patient refused. Do physicians qualify for the added reimbursement simply by reporting the information regardless of whether the services were provided? PQRI is still a bit murky to me."

Medical oncologist Edward Braud, MD, also expressed concerns: "Depending on the makeup of a practice—any of these measures could be important. However, I don't understand how CMS will collect from billing data when a patient was first diagnosed with melanoma, CLL, or MDS. Certainly, with a G-code you can state that a treatment plan is done with the first dose of chemotherapy, but what about patients who start treatment two months before they start Medicare benefits? How do you document back to CMS that we recommended radiation post lumpectomy? PQRI has left a number of questions unanswered." Braud

APC Panel Recommends ACCC Plan

On Wednesday, March 7, the Association of Community Cancer Centers (ACCC) testified before the Ambulatory Payment Classification (APC) Panel on pharmacy overhead costs in the hospital outpatient department. Ernie Anderson, Jr., MS, RPh, who currently serves on ACCC's Board as President-Elect, presented a three-phase plan that would better reimburse for pharmacy services. The APC Panel agreed with ACCC's assessment and recommended to CMS that it meet with ACCC and other stakeholders in order to implement this plan. ACCC will be holding meetings with CMS to discuss the plan and hopes to have part of it included in the 2008 Hospital Outpatient Prospective Payment System (HOPPS) rule. To read ACCC's full testimony, go to *www.accc-cancer.org/global/images/APCPaneltestimony070319.pdf.*



PHOTOGRAPH/COMSTOCK

practices at the Springfield Clinic in Springfield, Ill.

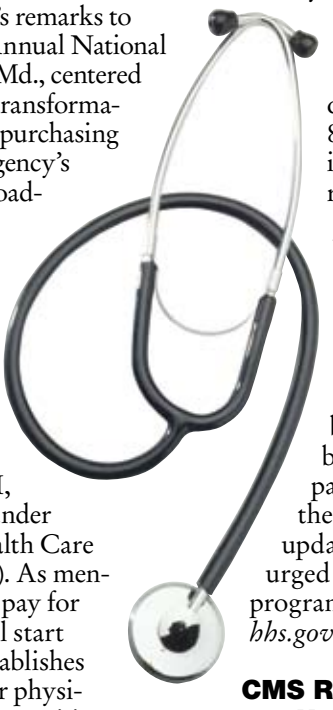
The 2007 PQRI quality measures relate to important processes of care that are linked to improved healthcare quality outcomes. They are evidence- and consensus-based measures that reflect the work of national organizations involved in quality measure development, consensus endorsement, and adoption. These organizations include the American Medical Association Physician Consortium for Performance Improvement, the National Committee for Quality Assurance, the National Quality Forum, the AQA Alliance, and other physician and non-physician professional organizations. The professional organizations are also assisting CMS in providing PQRI education and assistance to their members.

The specifications have been posted well in advance of the statutory deadline of July 1, 2007. This move was to help eligible professionals identify measures applicable to their practices and prepare for submission of quality data in advance of the July 1, 2007 start date of the program. CMS anticipates a small number of additional specification changes, which may expand the applicability of the measures to additional eligible professionals.

PHOTOGRAPH/PHOTODISC

CMS Update at ACCC's 33rd Annual National Meeting

CMS is "an active purchaser of care for beneficiaries," said Terrence Kay, acting director for the Hospital Ambulatory Policy Group, Center for Medicare Management, at CMS. Kay's remarks to attendees at ACCC's Annual National Meeting in Baltimore, Md., centered on CMS's in-progress transformation into a value-based purchasing (VBP) program. The agency's quality improvement roadmap has as its goals to improve quality and avoid unnecessary costs, as well as to promote innovation and the evidence base for effective use of new technologies.



Kay also updated attendees on the PQRI, a program mandated under the Tax Relief and Health Care Act of 2006 (TRCHA). As mentioned previously, this pay for reporting program will start in July 2007. PQRI establishes a financial incentive for physicians and other health practitioners to participate in a voluntary quality reporting program. Eligible professionals who successfully report data for a designated set of quality measures may earn a bonus payment, subject to a cap, of 1.5 percent of total allowed charges for covered Medicare physician fee schedule services provided during the reporting period of July 1, 2007 to December 31, 2007.

Kay said that both private practice and hospital-based physicians, including physicians that are hospital employees, can participate in the 2007 PQRI. And not just physicians are eligible, Kay said. Among the other healthcare professionals who can report on quality measures under the 2007 PQRI program are nurse practitioners, clinical nurse specialists, physician assistants, clinical social workers, clinical psychologists, registered dietitians, nutritional professionals, physical therapists, and occupational therapists.

Participants do not have to register to participate in the 2007 PQRI. Providers will report the services provided using G-codes that are currently under development. CMS is working with the AMA to develop the CPT category 2 codes that will match each quality measure under the PQRI. According to Kay, the agency will provide detailed specifications that will link CPT codes and ICD-9 codes with each quality measure. The 1.5 percent bonus will be paid for "successful" reporting of quality measures. If the quality measure is reported 80 percent of the time, it is considered "successful" reporting, Kay said.

The PQRI 1.5 percent bonus payment is subject to a cap, Kay said. The payment applies to physician fee schedule services. The PQRI will include claims submitted by February 2008. The bonus will be a one-time payment that will arrive in the summer of 2008. To stay updated on the PQRI, Kay urged attendees to check the program's website at *www.cms.hhs.gov/PQRI*.

CMS Releases Proposed 2008 Hospital Inpatient Rule

On April 13, CMS released a proposed rule that it said continues the transition to a more accurate payment system for hospital inpatient care, an effort begun last year. Overall, the proposed rule would increase payments to more than 3,500 acute care hospitals by $3.3 billion, according to CMS's press release. The agency also said that the inpatient rates for operating expenses will rise by 3.3 percent in fiscal 2008 for the hospitals that report quality data to the government.

Payment reforms include a proposal to restructure the inpatient diagnosis related groups (DRGs) to account for the severity of a patient's condition. The proposed rule would create 745 new severity-adjusted DRGs, replacing the current 538 DRGs, with payments increasing for hospitals with sicker patients and decreasing for hospitals with less ill patients. These changes reflect recommendations from the Medicare Payment Advisory Commission.

The proposed rule would implement a provision of the Deficit Reduction Act of 2005, moving to end higher Medicare payments for care of hospital-acquired conditions, including infections. Further, the proposed rule would create five new quality measures, including 30-day mortality for Medicare patients with

pneumonia and four measures related to surgical care improvement, bringing to 32 the total number of measures that hospitals would need to report in fiscal year 2008 to qualify for the full market basket (inflation index) pay update in 2009.

Comments on the proposed inpatient prospective payment system (IPPS) rule are due on June 12, and the final rule, which will be effective beginning Oct. 1, will be published later in the summer, CMS said.

The proposed rule is available at: *www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-P.pdf.*

CMS Proposes Changes to Clinical Trial Policy

A revised national coverage determination (NCD) that would place various requirements on clinical research studies in order for Medicare to pay the costs of participating beneficiaries was released by CMS on April 10.

Among other changes, the clinical research policy (formerly known as the clinical trial policy) proposes five requirements:

1. Adding FDA post-approval studies and coverage with evidence development (CED) to studies that would qualify under this policy
2. Requiring all studies to be registered on the NIH website *www.ClinicalTrials.gov* before enrollment begins
3. Requiring studies to publish their results
4. Paying for investigational clinical services if they are covered by Medicare outside the trial or required under an CED through the NCD process
5. Expanding the "deeming" agencies to all Department of Health and Human Services (DHHS) agencies, the Veterans Administration, or the Department of Defense. (Deeming agencies are agencies that can "deem" whether a trial has met the general standards outlined in the policy.)

"This new decision will signal our continued support to provide access to services for beneficiaries by facilitating participation in the full range of qualified, scientifically sound research projects," CMS Acting Administrator Leslie V. Norwalk said in a statement released by CMS.

CMS said that the new name reflects a broader policy. "Many researchers have a very narrow definition of 'clinical trial' and, as such, many studies that CMS would like to support may not be included under the former title."

The proposed NCD opens a 30-day comment period. CMS will review all the public comments and suggestions received and incorporate them into a final NCD. CMS is expected to publish the final NCD no later than 60 days after the end of the comment period. The revised policy will be effective with the publication of the final NCD.

CMS Proposal for Linking Medicare Payments to Hospital Performance

On March 22, CMS released details of a proposed program that would link Medicare reimbursements for hospitals to performance. The program would begin on Oct. 1, 2008.

"CMS's hospital payment policy moving forward will focus on purchasing value for the Medicare program, so that hospitals will receive differential payments as a function of their performance," the agency said in its Options Paper for the value-based purchasing (VBP) program. The draft described a "performance assessment model" that CMS proposes to use to score a hospital's performance. It includes:

- Methods for computing a performance score and translating the score into an incentive payment
- Options regarding the basis and allocation of VBP incentive payments
- The proposed selection criteria for performance measures and candidate measures for fiscal 2009 and beyond
- Options for transitioning from the current "Reporting Hospital Quality Data for Annual Payment Update" program
- A proposed redesign of the data submission and validation infrastructure to support the VBP program requirements
- Public reporting of performance results.

CMS offers two options for the hospital P4P program. It could begin in 2009 or be phased in over a three-year period starting in 2009, CMS staff said in a public listening session held on April 12.

Required by the Deficit Reduction Act to begin in fiscal 2009, valued-based purchasing (VBP), which links payment more directly to performance, is a key policy mechanism

continued on page 12

Deadline Extended for National Provider Identifier (NPI)

According to CMS, healthcare providers that have been making a "good faith effort to comply with NPI provisions" may implement contingency plans that could include accepting legacy provider numbers on Health Insurance Portability and Accountability Act (HIPAA) transactions in order to maintain operations and cash flow. Each covered entity will determine the specifics of its contingency plan, and the contingency plan cannot extend beyond May 23, 2008—the existing deadline for small healthcare plans.

If a complaint is filed against a covered entity, the agency said, it will evaluate the entity's "good faith efforts" to comply with the standards and would not impose penalties on covered entities that have deployed contingencies to ensure the smooth flow of payment.

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that CMS is adopting to transform from passive payer to active purchaser. Most of the measures used in the current Reporting Hospital Quality Data for Annual Payment Update will be used in the VBP program. CMS expects to complete the final VBP design in June and to prepare a final report in July.

The "phased approach" would unroll between fiscal years 2009 and 2011. In 2009, the incentive payment would be based on reporting. In 2010, half would be based on reporting and half on performance. In 2011, 100 percent of the incentive payment would be based on performance.

The second option would allow all of the incentive payment to be based on performance in 2009. Measures reported under the Reporting Hospital Quality Data for Annual Payment Update in fiscal 2008 would provide the basis for determining a hospital's "attainment" score. Measures reported in fiscal 2007 would provide baseline data for calculating improvement scores.

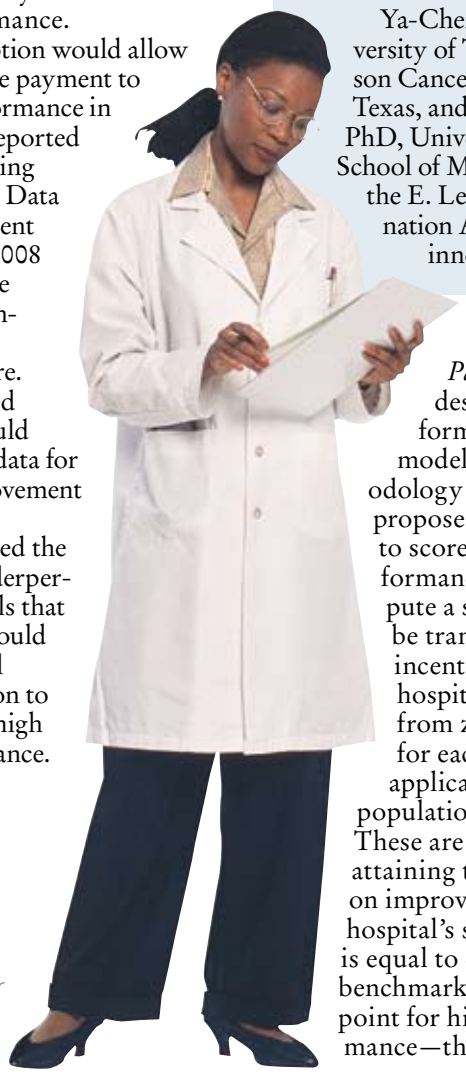
CMS has crafted the VBP so that "underperforming" hospitals that have improved would receive a financial reward, in addition to those that attain high levels of performance.

In its *Options Paper,* CMS also describes the "performance assessment model" as the methodology that the agency proposes to use in order to score a hospital's performance and to compute a score that would be translated into an incentive payment. The hospital would receive from zero to 10 points for each measure that is applicable to its patient population and service mix. These are based on either attaining the score, or based on improvement. If the hospital's score on a measure is equal to or greater than the benchmark—the reference point for high level of performance—the hospital receives 10 points and its full incentive payment. To receive points, a hospital must achieve a minimum level of performance, known as the attainment threshold.

Scoring based on improvement is based on the scale between the hospital's score from the prior year and the benchmark.

The overall performance score is determined by aggregating the scores across the measures for which the hospital has a minimum number of cases. This score is translated into the payment using what is known as an exchange function.

The full *Options Paper* is available online at: *www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalVBPOptions.pdf.*



A Medicare pay-for-performance (P4P) program for hospitals could begin in 2009.

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PHOTOGRAPH/COMSTOCK

Lance Armstrong Foundation Supports Cancer Research and Community-Based Initiatives

The Lance Armstrong Foundation recently awarded more than $4.1 million in grants to support cancer survivorship research projects, the basic and clinical research of testicular cancer, and community-centered cancer survivorship initiatives across the country.

Survivorship research. Cancer survivorship research studies funded by the Foundation will explore 1) quality of life among African-American head and neck cancer survivors, 2) chronic pain in cancer survivors, 3) the prevention of diabetes in prostate cancer survivors, and 4) cancer survivors' intentions to work following diagnosis and treatment.

Ya-Chen Shih, PhD, University of Texas M.D. Anderson Cancer Center, Houston, Texas, and Jens Ehmcke, PhD, University of Pittsburgh School of Medicine, received the E. Lee Walker Imagination Award for their innovative approaches to cancer survivorship research. This award honors Walker, former chairman of the Foundation's board of directors.

Community-centered initiatives. Examples of community-centered initiatives funded by the Lance Armstrong Foundation include projects that provide interventions to reduce fatigue, weight gain and cancer recurrence rates; projects that create personalized exercise programs for cancer survivors; and programs that provide breast cancer survivors with care packages that address their special needs and ongoing health concerns.

Since its inception, the Lance Armstrong Foundation has invested more than $18.7 million in research grants and more than $4.8 million in grants to community-based, non-profit organizations. For more information about the Foundation's grant funding, visit *www.livestrong.org.*

A Look at IGRT Reimbursement

by Kimberly Partlow, MS, CMD, RT(T)

With any new technology, understanding reimbursement for its implementation is critical to your return on investment and revenue cycle. Although image guided radiation therapy (IGRT) does not add new billing codes to radiation oncology, the technology does provide reimbursement for its daily utilization in the clinic. IGRT also provides an opportunity to increase revenue for each treatment fraction. Since initial start up may require more resource utilization in most departments, proper coding is important to maximize your revenue potential.

For now, the reimbursement outlook is good for this technology in both the hospital and the freestanding setting. Actual payments vary depending on geographic locations, cost-to-charge ratios, and contractual agreements. The combination of services delivered will also vary from patient to patient or center to center, but Tables 1 and 2 present an example of what codes one *might* bill and receive from Medicare (unadjusted for geography) for a lung cancer treatment utilizing IGRT.

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TABLE 1: Estimated Medicare Payment Rates for a Typical Lung Cancer Patient Receiving IGRT Treatment[1,2]

CPT Code	Units/ Course	Service Description	Freestanding Center (Global)	Technical Component	Professional Component	Outpatient Prospective Payment System
77014	1	CT scan for therapy guide	$173.57	$129.23	$44.34	$94.53
77280	2	Set radiation therapy field	$182.29	$145.53	$36.76	$96.72
77295	1	Set radiation therapy field	$1,144.13	$906.51	$237.62	$848.76
77300	10	Radiation therapy dose plan	$82.24	$50.02	$32.21	$96.72
77334	10	Radiation treatment aid(s)	$185.70	$120.89	$64.80	$180.90
77336	7	Radiation physics consult	$101.57	$101.57	$0.00	$96.72
77416	37	Radiation treatment delivery	$144.39	$144.39	$0.00	$137.04
77417	1	Radiology port film(s)	$21.60	$21.60	$0.00	$43.60
77421	37	Stereoscopic X-ray guidance	$137.19	$116.72	$20.46	$67.45

[1]Codes and units billed will vary. [2]Estimates do not include patient copayments.
Source: Oncology Management Group, Bucks County, Pa.

TABLE 2: Estimated Medicare Payment Rates, Including Patient Copayments, for a Typical Lung Cancer Patient Receiving IGRT Treatment[1]

CPT Code	Units/ Course	Service Description	Freestanding Center (Global)	Technical Component	Professional Component	Outpatient Prospective Payment System
77014	1	CT scan for therapy guide	$173.57	$129.23	$44.34	$94.53
77280	2	Set radiation therapy field	$364.57	$291.05	$73.52	$193.44
77295	1	Set radiation therapy field	$1,144.13	$906.51	$237.62	$848.76
77300	10	Radiation therapy dose plan	$822.38	$500.25	$322.13	$947.20
77334	10	Radiation treatment aid(s)	$1,856.98	$1,208.93	$648.05	$1,809.00
77336	7	Radiation physics consult	$710.96	$710.96	$0.00	$677.04
77416	37	Radiation treatment delivery	$5,342.41	$5,342.41	$0.00	$5,070.48
77417	1	Radiology port film(s)	$21.60	$21.60	$0.00	$43.60
77421	37	Stereoscopic X-ray guidance	$5,075.99	$4,318.80	$757.19	$2,495.65
TOTAL			**$15,512.58**	**$13,429.74**	**$2,082.85**	**$12,199.70**

[1]Codes and units billed will vary.
Source: Oncology Management Group, Bucks County, Pa.