THE ISSUES

Mid-West Copes with Historic Flooding, ACCC Expresses Concern, Support

The Association of Community Cancer Centers (ACCC) expresses it concerns and support for the well-being of all those affected by the historic flooding in the Mid-West. Governor Chet Culver said about 36,000 Iowans have been left homeless because of the historic flood.

As this issue goes to press, the disaster recovery process was underway at ACCC member Mercy Medical Center in Cedar Rapids. Mercy employees reported back to their regularly scheduled work shifts at 3 p.m. Saturday, June 14. Mercy contracted with a professional disaster recovery team, who took on the continuing tasks of pulling up carpet, removing wall coverings, and disposing of the remaining sandbags that line the perimeter of the facility. All 176 patients were safely transported from Mercy Medical Center in Cedar Rapids on June 13 to hospitals and/or nursing homes throughout the region. In many cases, family members accompanied their loved ones who were part of the evacuation process. St. Luke's Hospital in Cedar Rapids provided nearly 2,000 tetanus shots to the public.

Govenor Chet Culver said about 36,000 Iowans have been left homeless because of the historic flood.

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CMS Recognizes New Compendia for Decisions on Covering Cancer Drugs

In June the Centers for Medicare & Medicaid Services (CMS) announced that it will recognize two new sources of information for determining which drugs may be covered under Medicare Part B to treat cancer patients:

1. The National Comprehensive Cancer Network (NCCN) *Drugs & Biologics Compendium*™
2. Thomson Micromedex's *DrugDex*® compendium.

CMS also considered a request to add Thomson Micromedex's *DrugPoints*®. After review, however, the agency determined that *DrugPoints*, which is a summary of *DrugDex*, did not successfully address the regulatory criteria. Thus CMS is *not* adding *DrugPoints* to the list of approved compendia.

ACCC supports the addition of recognized, quality, evidence-based compendia, because it may mean increased patient access to treatment with anti-cancer chemotherapy drugs. The *American Hospital Formulary Service Drug Information* (*AHFS-DI*) and the Thomson Micromedex *DrugDex* compendia are recognized for Medicare Part B, Medicare Part D, and Medicaid. NCCN's *Drugs & Biologics Compendium* is currently recognized only for Medicare Part B.

In related news, ACCC, along with Covance Market Access Services Inc., surveyed oncology practices on behalf of the Pharmaceutical Research and Manufacturers of America (PhRMA) and Biotechnology Industry Organization (BIO) about the role of off-label use of anticancer therapies in patient care. The survey was mailed in June.

CMS Developing Proposed Regulations for PQRI

Proposed rules for Medicare physician quality reporting tied to bonuses for 2009 were expected to be published the first week in July, a CMS official said during a May 28 teleconference on the Physician Quality Reporting Initiative (PQRI). After publication, the agency said the public will have an opportunity to comment on how the program will look in the future.

In 2007 PQRI included 74 individual measures; that number increased to 119 in 2008. Two of the new measures are non-clinical, dealing with whether the provider has and uses electronic health records and electronic prescribing. Both the 2007 and 2008 programs offered

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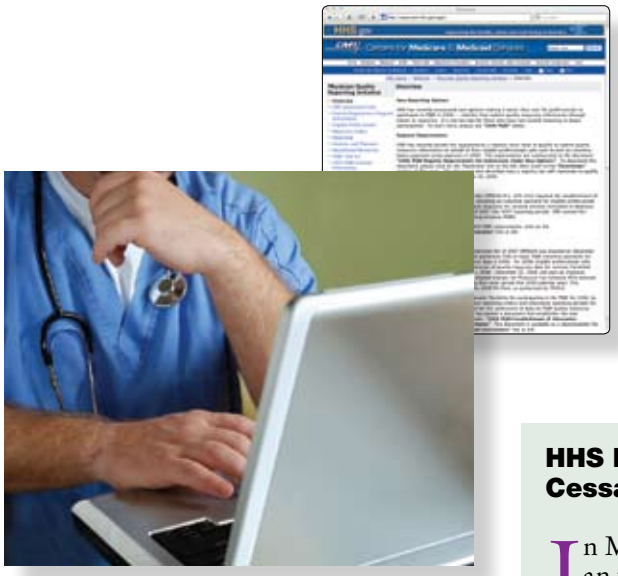

providers a chance to receive a monetary bonus amounting to 1.5 percent of their allowable Medicare charges. For 2007, however, the award was subject to a per measure cap. This cap was removed in 2008. The 2007 reward is expected to be sent to providers who participated in mid-July.

For more information go to *http://www.cms.hhs.gov/pqri*.

HHS Announces 12 Demonstration Sites for EHR Incentive

Twelve communities in the states of Alabama, Delaware, Florida, Georgia, Maine, Louisiana, the Maryland/D.C. area, Oklahoma, Pittsburgh, South Dakota, Virginia, and Wisconsin were selected to participate in a Medicare demonstration project offering incentives to physicians for using electronic health records to improve patient care. The 12 communities were selected in a competitive process because they demonstrated that their programs are already ahead of the curve when it comes to electronic health records (EHRs), said Department of Health and Human Services (HHS) Secretary Michael O. Leavitt at a June 10 news conference.

In year one of the five-year demonstration project, physicians will receive financial incentives based on the effectiveness of their EHR use. In year two, financial incentives will be given only to physicians who use EHRs to measure how they are doing against various quality standards. Similar to year one, the more effectively physicians measure their progress and meet those standards, the greater the financial incentives. In the remaining three years of the demonstration project, "payments will be based on actual performance on the clinical quality measures, rather than just reporting," according to a statement from HHS. "An added payment will be offered each year based on EHR functionalities used by the practice. Payments may total up to $15,000 per physician or $75,000 per practice during each of these three years. Total payments under the demonstration project may be up to $58,000 per physician or $290,000 per practice over five years." For more information go to *http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/2008_Electronic_Health_Records_Demonstration.pdf.*

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HHS Releases New Smoking Cessation Guidelines

In May 2008 HHS released an update to its 1996 Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence*. The update contains revised and improved recommendations to providers and clinicians so that they can better assist patients to quit smoking. The most effective method for smokers to end addiction to tobacco products: combining FDA-approved pharmacotherapies and counseling, according to the revised guidelines. Among the recommendations issued in the 2008 updated guidelines:

- Clinicians, in their offices and in the hospital, should ask their patients if they smoke and offer counseling and other treatments to help them quit.
- If tobacco users are unwilling to make an attempt to quit, clinicians should use the motivational treatments that have been shown to be effective in promoting future attempts to quit.
- Individual, group, and telephone counseling are effective, and their effectiveness increases with treatment intensity. Counseling should include two components: practical counseling and social support.
- Tobacco cessation treatments are highly cost-effective relative to other clinical interventions. Providing coverage for these treatments increases quit rates. Insurers and purchasers should ensure that all insurance plans include the counseling and medication treatments that have been found to be effective in the 2008 guideline update.
- Counseling treatments have been shown to be effective for adolescent smokers and are now recommended. Additional effective interventions and options for use with children, adolescents, and young adults need to be determined.

The 2008 guidelines update is available online at: *http://www.surgeongeneral.gov/tobacco/default.htm.* Copies are also available by calling 800.358.9295.

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Gaps and Challenges in Quality Measures

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With the public comment period open on the proposed 2009 Medicare Physician Fee Schedule, including the proposed 2009 Physician Quality Reporting Initiative (PQRI) program, now is a good time to look at the "pipeline" of cancer quality measures from the lead developer, the AMA-Physician Consortium for Performance Improvement® (PCPI). Some AMA-PCPI measures are already in the PQRI, notably for oncology: measure #72 (Chemotherapy for Stage III Colon Cancer) and measure #73 (Plan for Chemotherapy Documented).

ACCC is concerned that quality measures are not reflecting all modalities of treatment in currently accepted clinical practice. A review of the AMA-PCPI oncology measure set reveals some gaps or inconsistencies in measures for chemotherapy patients. Few of the quality measures for patients receiving chemotherapy include oral therapy. The number of IV-restricted measures is at odds with the increasing availability of anti-cancer oral drugs. AMA-PCPI measures that are not inclusive of oral drugs include:

- #4, Plan for Chemo Documented (Oncology)
- #8, Pain Intensity Quantified (Oncology and Radiation Oncology)
- #9, Plan of Care for Pain (Oncology and Radiation Oncology)
- #10, Pathology Report (Oncology and Radiation Oncology).

CMS will continue to adapt AMA-PCPI measures under its PQRI. In turn, the PQRI can be viewed as a test lab for permanent reimbursement codes. For example, PQRI #73 recognizes chemotherapy planning (efforts to obtain a permanent CPT code for such services have so far been unsuccessful). Still, if PQRI leads to permanent recognition of such management services, it is important to include *all* treatment regimens—IV, oral, and radiation.

The AMA-convened PCPI has already made available for implementation more than 200 physician performance measure descriptions and specifications for 31 clinical topics and conditions—from diabetes to melanoma to oncology preventive care and screening. To make matters more confusing, the development of performance indicators is also underway by accrediting agencies such as The Joint Commission and the National Commission on Quality Assurance (NCQA), as well as the National Quality Forum (NQF), a not-for-profit membership organization whose goals are to develop and implement a national strategy for healthcare quality measurement and reporting.

And there's more. In September 2004 the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), America's Health Insurance Plans (AHIP), and the Agency for Healthcare Research and Quality (AHRQ), joined together to lead an effort for determining how to most effectively and efficiently improve performance measurement, data aggregation, and reporting in the ambulatory care setting. This combined effort is called the AQA alliance.

Ideally, all performance indicators are founded on evidence-based, clinically derived guidelines for specific medical conditions. Typically, they entail an instrument for prospective data collection on treatment of individual patients that can be used to measure physician performance over time.

More on PQRI #73

One of the challenges of the PQRI program is meeting all the reporting requirements. PQRI measure #73, plan for chemotherapy documented before chemotherapy is administered, requires an appropriate diagnosis code, a CPT code for chemotherapy administration, and a CPT code for E/M service.

If your organization and/or billing structure does not allow you to submit both of these CPT codes, you cannot submit this PQRI measure.

Please note, G8373 was the correct code for this measure in 2007. In 2008 coding has changed to CPT II codes. For measure #73, report as follows:

- **Chemotherapy Plan Documented, CPT II 0519F:** Planned chemotherapy regimen, including at a minimum: drug(s) prescribed, dose, and duration, documented prior to initiation of a new treatment regimen
- **Chemotherapy Plan not Documented, CPT II 0519F-8P:** Plan for chemotherapy not documented, reason not otherwise specified.

A list of oncology-related measures for the 2008 PQRI program is available on ASCO's website at *www.asco.org/pqri*.

Although many community cancer centers have been successful in billing the PQRI oncology indicators for employed physicians, many hospitals are still struggling with the program even after almost a year.

"Our billing and coding departments are having fits trying to be able to bill and report correctly," writes Matt Sherer, MBA, MHA, former service line director at the Regional Cancer Center, Singing River Hospital, in Pascagoula, Miss. "We were not trying to even report on all of the items available for oncology. We had selected only five. These were the five we felt we could meet and report. Up to this point, we have not been successful." Mr. Sherer reports that his former institution continues to look for ways it can report the information without it "being such a manual and tedious project."

Vascular Access Procedures

by Cindy C. Parman, CPC, CPC-H, RCC

When a blood sample is obtained and sent for laboratory testing, the procedure is essentially the same, regardless of the technique used to obtain the specimen. However, code assignment and reimbursement vary depending on the access technique, bundling guidelines, and/or packaging rules for the blood draw service.

Venipuncture

During venipuncture, a nurse, phlebotomist, technician, medical assistant, or other healthcare specialist punctures the patient's vein and obtains a blood sample for analysis. In general, a 5 ml to 25 ml sample of blood is adequate, depending on what blood tests have been requested. This procedure is reported with code **36415:** collection of venous blood by venipuncture.

Procedure code 36415 is located in the surgical section of the *CPT® Manual*, and documentation should include the date blood was drawn, the site accessed, the condition of the access site, name and discipline of the individual who obtained the sample, and any patient complaints or concerns (e.g., pain, erythema, inflammation). Note, procedure code 36415 is *not* bundled or packaged into drug administration on the same service date.

Port or PICC Access

In some cases, a separate venous access is not required to obtain the blood sample. For patients with an existing implanted port or peripherally inserted central catheter (PICC), these specimens can be obtained directly from the vascular access device. Depending on the type of port or catheter, this service may be reported using one of two codes:

- **36591:** Collection of blood specimen from a completely implantable venous access device.
- **36592:** Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified.

The type of existing catheter differentiates these specimen collection codes. Code 36591 is collection from an implanted port, and code 36592 is collection from a peripherally-inserted line. Guidelines published by the American Medical Association (AMA) in the *CPT® Manual* state that these codes are *not* separately reported when any other service is performed on the same date. As a result, the only time these port/PICC draw codes will be paid is when they are the sole procedure performed for the patient on a particular service date.

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Hospitals billing under the Outpatient Prospective Payment System (OPPS) will continue to report "packaged" services, including both of these specimen collection codes. While code 36592 will never be separately paid in the hospital outpatient department, code 36591 is a "special packaged" code and will be reimbursed when it is the only service performed for the patient that day.

Port Flush

Patients who receive drug administration through an implanted port may require maintenance procedures, such as 'flushing' of the port, between drug administration cycles. The capture of this charge and reporting of this code may be an area of confusion for hospitals and physician practices. The code for the port flush service is **96523:** irrigation of implanted venous access device for drug delivery systems.

This code was established for reporting irrigation required for implanted venous access devices for drug delivery systems when these services are provided on a separate day from the injection or infusion services. A notation in the *CPT® Manual* states that code 96523 is *not* charged if any other services are provided to the patient on the same service date.

While this service will never be separately paid in the hospital outpatient department, code 96523 is another "special packaged" code that will be reimbursed when it is the sole service performed for the patient that day. For all sites of service, flushing of a

vascular access port prior to or after drug administration is considered to be part of the administration service and not separately charged.

HCPCS code **J1642:** injection, heparin sodium, (heparin lock flush), per 10 units, may also be assigned for the heparin used to perform the port flush. Individual payer guidelines will determine whether there is separate reimbursement for the heparin; it is often considered to be a supply charge rather than a drug charge.

Port Declot

When a patient has a port in place for an extended period of time, the port or catheter may become obstructed. Catheter obstruction is typically defined as the inability to infuse fluid, sluggish flow, and/or the inability to withdraw blood samples. In this situation, providers may need to declot the implanted vascular device using a thrombolytic agent (e.g., Alteplase).

This procedure necessitates the use of a thrombolytic agent that is introduced through a syringe and then slowly instilled into the device or catheter. This service may consist of a single bolus of thrombolytic agent, or repeat instillation of a thrombolytic agent until the clot has been resolved. The correct code to charge for this declotting procedure is **36593:** declotting by thrombolytic agent of implanted vascular access device or catheter.

In addition to the procedure code, the HCPCS Level II code for the thrombolytic agent should also be reported. Existing codes for these agents include:

- **J2997:** Injection, alteplase recombinant, 1 mg
- **J3364:** Injection, urokinase, 5000 IU vial
- **J3365:** Injection, IV, urokinase, 250,000 IU vial
- **J2995:** Injection, streptokinase, per 250,000 IU.

In general, this service must be linked to appropriate diagnosis codes, such as 996.74 (complications due to vascular device) and E878.8 (surgical operation and other surgical procedures as the cause of abnormal reaction of patient, or of later complication, without mention of misadventure at the time of operation).

If the declotting service is performed with saline or a non-thrombolytic substance, however, code 36593 is *not* reported. The infusion of saline or a bolus of non-thrombolytic substance is included in other services performed on the same day and not separately charged.

As you can see, a variety of port maintenance procedures are performed for individual patients. Cancer programs must ensure that these services are reported to payers based on the nature of the service ordered, performed, and documented in the medical record. Authoritative guidelines for the charging of these services are included in the *CPT® Manual* and apply to Medicare and all other third-party insurers.

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References

CPT® Manual, 2008. Available online at: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3756.pdf* *http://www.cms.hhs.gov/OutpatientCodeEdit/Downloads/AttachmentBReleaseFinal.pdf.* Last accessed June 2, 2008.