ISSUES The

2009 Hospital Outpatient Prospective Payment System

The Centers for Medicare & Medicaid Services' (CMS) hospital outpatient prospective payment system (OPPS) final rule for 2009 went into effect Jan. 1, 2009. The OPPS final rule included a 3.6 percent annual update to payments under the OPPS. Hospitals that fail to report quality data will receive a 1.6 percent update. Here is a summary of the significant changes.

Drugs and biologicals. For 2009, reimbursement for separately paid drugs without pass-through status was reduced from average sales price (ASP)+5 percent to ASP+4 percent. In its final rule, CMS called ASP+4 percent a transitional payment to ASP+2 percent.

Drugs and biologicals with pass-through status are reimbursed at the same rate as physician offices: ASP+6 percent. The following anticancer and supportive care drugs have pass-through status in 2009: Fosaprepitant injection (J1453); Injection, IVIG privigen, 500 mg (J1459); Bendamustine injection (J9033); Ixabepilone injection (J9207); Vantas implant (J9225); Nelarabine injection (J9261); Temsirolimus injection (J9330); Romiplostim injection (C9245); Gadoxetate disodium injection (C9246).

Radiopharmaceuticals and brachytherapy sources. As required by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), CMS continues to reimburse therapeutic radiopharmaceuticals and brachytherapy sources provided in hospital outpatient departments based on individual hospital's charges adjusted to cost until Dec. 31, 2009.

IVIG. CMS no longer reimburses for services for intravenous infusion of immunoglobin prior to administration; therefore, in 2009 code G0332 is eliminated. In 2008, this code was reimbursed $37.71.

Drug administration payments. CMS consolidated six APCs into five in an effort to improve the APCs "clinical and resource homogeneity." As a result, payments for many chemotherapy administration services were substantially increased, while payments for other drug administration services were reduced. Table 1 (page 10) compares 2008 and 2009 reimbursement rates for these services.

Radiation therapy. While payments for several radiation therapy APCs increased in 2009; payment

continued on page 8

Table 2. 2009 MPFS Payment for Drug Administration Services[1] (see

Code	Description
96360	Hydration IV infusion, initial, 31 minutes to 1 hour
96361	Hydration IV infusion, add-on
96365	Therapeutic/prophylactic/diagnostic IV infusion, initial, up to 1 hour
96366	Therapeutic/prophylactic/diagnostic IV infusion, add-on
96367	Therapeutic/prophylactic/diagnostic, additional sequential IV infusion, up to 1 hour
96368	Therapeutic/diagnostic, concurrent infusion
96369	Therapeutic/prophylactic subcutaneous infusion, up to 1 hour
96370	Therapeutic/prophylactic subcutaneous infusion, additional hour
96371	Therapeutic/prophylactic subcutaneous infusion, reset pump
96372	Therapeutic/prophylactic subcutaneous or intramuscular
96373	Therapeutic/prophylactic/diagnostic injection, intra-arterial
96374	Therapeutic/prophylactic/diagnostic injection, IV push
96375	Therapeutic/prophylactic/diagnostic injection, add-on
96401	Chemotherapeutic, anti-neoplastic, sequential or intramuscular
96402	Chemotherapeutic, hormonal, anti-neoplastic, sequential or intramuscular
96405	Chemotherapy, intralesional, up to 7
96406	Chemotherapy, intralesional over 7
96409	Chemotherapy, IV push, single drug
96411	Chemotherapy, IV push, additional drug
96413	Chemotherapy, IV infusion, 1 hour
96415	Chemotherapy, IV infusion, additional hour
96416	Chemotherapy, prolong infusion with pump
96417	Chemotherapy, IV infusion, each additional sequential
96420	Chemotherapy, intra-arterial, push technique
96422	Chemotherapy, intra-arterial, infusion, up to 1 hour
96423	Chemotherapy, intra-arterial, infusion, each additional hour
96425	Chemotherapy, infusion method
96440	Chemotherapy, intracavitary
96445	Chemotherapy, intracavitary
96450	Chemotherapy, into CNS
96521	Refill/maintain, portable pump
96522	Refill/maintain pump/reservoir system
96523	Irrigation drug delivery device
96542	Chemotherapy injection

[1]Rates shown are national averages, not adjusted for geographic variations in cost.

Table 1. 2009 OPPS Payment for Select Radiation Therapy Services

APC	Description	2008 Rate	2009 Rate	Percent Change 2008-2009
0300	Level I Radiation Therapy	$90.63	$93.88	3.6%
0301	Level II Radiation Therapy	$141.19	$152.05	7.7%
0303	Treatment Device Construction	$183.94	$188.16	2.3%
0304	Level I Therapeutic Radiation Treatment Preparation	$99.21	$114.70	15.6%
0305	Level II Therapeutic Radiation Treatment Preparation	$250.16	$255.69	2.1%
0310	Level III Therapeutic Radiation Treatment Preparation	$863.82	$892.90	3.4%
0312	Radioelement Applications	$542.29	$430.66	-20.6%

Source: Health Policy Alternatives

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related article on page 8)

Non-Facility			Facility		
2008	2009	2009 vs. 2008	2008	2009	2009 vs.2008
$60.56	$56.62	-6.50%	N/A	N/A	N/A
$18.28	$16.59	-9.25%	N/A	N/A	N/A
$73.89	$68.89	-6.77%	N/A	N/A	N/A
$23.61	$22.00	-6.83%	N/A	N/A	N/A
$38.09	$34.62	-9.09%	N/A	N/A	N/A
$22.09	$20.56	-6.94%	N/A	N/A	N/A
$158.82	$149.67	-5.76%	N/A	N/A	N/A
$16.00	$15.87	-0.80%	N/A	N/A	N/A
$71.22	$72.49	1.78%	N/A	N/A	N/A
$20.57	$20.92	1.71%	N/A	N/A	N/A
$18.28	$18.03	-1.36%	N/A	N/A	N/A
$57.89	$54.46	-5.93%	N/A	N/A	N/A
$25.52	$23.80	-6.72%	N/A	N/A	N/A
$64.75	$67.44	4.16%	N/A	N/A	N/A
$40.75	$36.79	-9.73%	N/A	N/A	N/A
$135.21	$84.39	-37.58%	$27.80	$28.85	3.77%
$153.87	$116.49	-24.29%	$39.61	$41.84	5.62%
$119.21	$111.80	-6.21%	N/A	N/A	N/A
$68.18	$63.84	-6.36%	N/A	N/A	N/A
$161.49	$147.51	-8.66%	N/A	N/A	N/A
$36.18	$33.54	-7.30%	N/A	N/A	N/A
$175.20	$160.85	-8.19%	N/A	N/A	N/A
$79.60	$73.57	-7.57%	N/A	N/A	N/A
$112.36	$107.84	-4.02%	N/A	N/A	N/A
$186.25	$173.84	-6.66%	N/A	N/A	N/A
$80.36	$77.54	-3.51%	N/A	N/A	N/A
$182.82	$171.31	-6.29%	N/A	N/A	N/A
$346.59	$597.97	72.53%	$127.97	$132.36	3.43%
$335.55	$285.28	-14.98%	$119.97	$116.85	-2.60%
$282.22	$208.10	-26.26%	$95.22	$88.00	-7.58%
$140.92	$126.95	-9.91%	N/A	N/A	N/A
$112.36	$107.84	-4.02%	N/A	N/A	N/A
$27.42	$25.25	-7.94%	N/A	N/A	N/A
$176.34	$134.17	-23.92%	$46.47	$45.44	-2.20%

for radioelement applications was reduced by more than 20 percent (see Table 1, page 7).

Prostate saturation biopsy pathology services. This year, four new, specific codes were created to report these services. In other words, CPT 88305 (Level IV, Surgical pathology, gross and microscopic examination) has been replaced with four new codes:

- G0416: Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1-20 specimens. APC 1505. Payment rate: $350.
- G0417: Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 21-40 specimens. APC 1507. Payment rate: $550.
- G0418: Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 41-60 specimens. APC 1511. Payment rate: $950.
- G0419 Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, greater than 60 specimens. APC 1513. Payment rate: $1,150.

Clinic visits. To make it easier for hospitals to determine which codes to use for clinic visits, CMS modified its definitions for "new" and "established" patients. Under the final rule, an "established" patient is defined as a patient registered as an inpatient or outpatient within the last three years.

Composite APCs for brachytherapy, imaging, and other services. In 2009, CMS continues to use the composite APCs it created in 2008 for extended assessment and management, low-dose-rate (LDR) prostate brachytherapy, cardiac electrophysiologic evaluation and ablation, and mental health services. This year, the agency expanded the use of composite APCs to cover three families of imaging services: 1) ultrasound, 2) CT and CTA, and 3) MRI and MRA. While acknowledging that for several of the more commonly reported cancer diagnoses more than half of patients receive more than two imaging procedures, the agency said this variability would "balance out" when hospitals also provide imaging services to patients with non-cancer diagnoses.

Highlights of the 2009 Physician Fee Schedule

The final Medicare Physician Fee Schedule (MPFS) rule implemented the payment rates for 2009 and made adjustments to physician payments that were required by MIPPA. The conversion factor for 2009 is $36.0666, 5.3 percent less than the 2008 level of $38.0870. Although MIPPA required CMS to increase the conversion factor by 1.1 percent, this change is offset by MIPPA's requirement to apply the budget neutrality adjuster for the work relative value units (RVUs) to the conversion factor. In 2008, the work RVUs were reduced by 11.94 percent to adjust for increases in the total number of work RVUs created during the five-year review. MIPPA requires this budget neutrality adjustment to be applied to the conversion factor instead of to the work RVUs. This change spreads the effect of the adjustment among all services reimbursed under the physician fee schedule, not just those with physician work RVUs. As a result, the conversion factor for all services is reduced, but the work RVUs have been increased. The impact on each specialty varies.

- Hematology/Medical Oncology: total Medicare payments are reduced by 1 percent.
- Radiation Oncology: total Medicare payments are reduced by 3 percent.
- Radiology: total Medicare payments remain the same.

Drug administration services. Payments for most drug administration services were reduced in 2009 (see Table 2, pages 6-7).

Imaging services. When two or more diagnostic imaging services in the same coding family are furnished to the same patient in the same session, CMS reduced payment for the technical component of the second and subsequent procedures by 25 percent. CMS finalized its proposal to add 10 procedures to the list: 1) CPT 70336; 2) CPT 70554; 3) CPT 75557; 4) CPT 75559; 5) CPT 75561; 6) CPT 75563; 7) CPT 76776; 8) CPT 76870; 9) CPT 77058; and 10) CPT 77059. See ACCC's website, *www.accc-cancer.org* for more.

Prostate Saturation Biopsies. CMS finalized its proposal to create four new G-codes for prostate saturation biopsy, a service that is currently reported with CPT code 88305 (see Table 3).

For more information about the Physician Quality Reporting Initiative (PQRI), potentially misvalued services, independent diagnostic testing facility (IDTF) regulations, and the e-prescribing initiative, visit ACCC's website, *www.accc-cancer.org.*

Table 3. 2009 MPFS Codes and Payment Rates for Prostate Saturation Biopsies

Code	Description	Payment (global, non-facility)
G0416	Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1-20 specimens	$634.41
G0417	Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 21-40 specimens	$1,232.76
G0418	Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 41-60 specimen	$2,115.67
G0419	Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, > 60 specimens	$2,511.32

Oncology Code Update **2009**

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

With each New Year come changes to procedure codes, diagnosis codes, and government regulations. Here is a summary of additions, deletions, and regulatory issues that will impact the specialties of radiation and medical oncology in calendar year (CY) 2009.

New Codes and Updated Descriptors

For oncology physicians, facilities, and cancer programs, the following new CPT® procedure codes and HCPCS Level II codes for CY 2009 are of interest. Remember, the existence of a code does not guarantee reimbursement; payment for a service depends on the patient's insurance policy, medical necessity, and other determining factors.

Procedure code 61793. This code: Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), one or more sessions, has been deleted effective Jan. 1, 2009, and replaced with the following code series:

- 61796: Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion.
- +61797: Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple. (List separately in addition to code for primary procedure.)
- 61798: Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion.
- +61799: Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex. (List separately in addition to code for primary procedure.)
- +61800: Application of stereotactic headframe for stereotactic radiosurgery. (List separately in addition to code for primary procedure.)
- 63620: Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion.
- +63621: Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion. (List separately in addition to code for primary procedure.)

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These new neurosurgery codes do not affect hospital reimbursement for Medicare patients. They are *not* paid under the Outpatient Prospective Payment System (OPPS), and they will not be billed by radiation oncologists. These new codes do impact medical record documentation, since not only the number of intracranial and spinal lesions must be recorded, but the complexity (size and location) of each lesion must also be documented in the patient medical record. In addition, the American Medical Association (AMA) has issued code sequencing guidelines and specified quantity limits when reporting the add-on (each additional lesion) codes.

HDR brachytherapy codes. This section has been re-structured with the deletion of procedure codes 77781-77784. These codes have been replaced with the following:

- 77785: Remote afterloading high dose rate radionuclide brachytherapy, 1 channel
- 77786: Remote afterloading high dose rate radionuclide brachytherapy, 2-12 channels
- 77787: Remote afterloading high dose rate radionuclide brachytherapy, more than 12 channels.

AMA deleted procedure codes 77781-77784 because the descriptors of these codes no longer accurately described the provision of high dose rate brachytherapy. Also, the new codes have redefined the differences between the parameters of each service level.

New temporary procedure code 0197T. A new Category III procedure code has been established for cardiac, respiratory, and/or motion tracking performed during a single radiation treatment fraction. Although this code is effective

Jan. 1, 2009, it is not included in the 2009 Edition of the *CPT® Manual*. Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g., 3D positional tracking, gating, 3D surface tracking) each fraction of treatment should now be billed using the following code: 0197T. This new temporary procedure code has not yet been further defined, but based on the code descriptor this is

Table 1. 2009 OPPS Payment for Drug Administration Services

2008 Code	2009 Code	Description
90760	96360	Hydration IV infusion, initial
+90761	+96361	Hydration IV infusion, each additional hour
90765	96365	Therapeutic/prophylactic/diagnostic IV infusion, initial
+90766	+96366	Therapeutic/prophylactic/diagnostic IV infusion, each additional hour
+90767	+96367	Therapeutic/prophylactic/diagnostic sequential IV infusion
+90768	+96368	Therapeutic/prophylactic/diagnostic concurrent IV infusion
90769	96369	Therapeutic/prophylactic subcutaneous infusion, up to 1 hour
+90770	+96370	Therapeutic/prophylactic subcutaneous infusion, each additional hour
90771	96371	Therapeutic/prophylactic subcutaneous infusion, reset pump
90772	96372	Therapeutic/prophylactic subcutaneous or intramuscular
90773	96373	Therapeutic/prophylactic/diagnostic injection, intra-arterial
90774	96374	Therapeutic/prophylactic/diagnostic injection, IV push
+90775	+96375	Therapeutic/prophylactic/diagnostic injection, IV push, sequential new drug
+90776	+96376	Therapeutic/prophylactic/diagnostic injection, IV push, sequential same drug
90779	96379	Unlisted therapeutic/prophylactic/diagnostic IV or intra-arterial injection or infusion
	96401	Chemotherapy, subcutaneous or intramuscular, non-hormonal antineoplastic
	96402	Chemotherapy, subcutaneous or intramuscular, hormonal antineoplastic
	96405	Chemotherapy, intralesional, up to 7
	96406	Chemotherapy, intralesional over 7
	96409	Chemotherapy, IV push, single drug
	96411	Chemotherapy, IV push, sequential drug
	96413	Chemotherapy, IV infusion, 1 hour
	96415	Chemotherapy, IV infusion, additional hour
	96416	Chemotherapy, prolonged infusion with pump
	96417	Chemotherapy, IV infusion, each additional sequential drug
	96420	Chemotherapy, intra-arterial, push technique
	96422	Chemotherapy, intra-arterial, infusion, up to 1 hour
	96423	Chemotherapy, intra-arterial, infusion, each additional hour
	96425	Chemotherapy, prolonged infusion with pump
	96440	Chemotherapy, intracavitary, pleural with thoracentesis
	96445	Chemotherapy, intracavitary, peritoneal with peritoneocentesis
	96450	Chemotherapy, into CNS, including spinal puncture
	96521	Refill/maintain, portable pump
	96522	Refill/maintain, implantable pump/reservoir system
	96523	Irrigation drug delivery device
	96542	Chemotherapy intraventricular via reservoir
	96549	Chemotherapy, unspecified

a technical-only service that will be reported once per treatment fraction when the elements of the code definition have been met.

Other grammatical changes for 2009. In addition to deleting and adding codes for 2009, some minor grammatical changes have been made to the following codes:

- 19296: Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy
- +19297: Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (List separately in addition to code for primary procedure.)
- 77305: Teletherapy, isodose plan (whether hand or computer calculated); simple (1 or 2 parallel opposed unmodified ports directed to a single area of interest)
- 77310: Teletherapy, isodose plan (whether hand or computer calculated); intermediate (3 or more treatment ports directed to a single area of interest)
- 77326: Brachytherapy isodose plan; simple (calculation made from single plane, 1 to 4 sources/ribbon application, remote afterloading brachytherapy, 1 to 8 sources)
- 77407: Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; up to 5 MeV
- 77412: Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5 MeV
- 77427: Radiation treatment management, 5 treatments
- 77431: Radiation therapy management with complete course of therapy consisting of 1 or 2 fractions only
- 77432: Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of 1 session)
- 77435: Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions
- 77750: Infusion or instillation of radioelement solution (includes 3-month follow-up care)
- 0073T: Compensator-based beam

2008 Rate	2009 Rate	Difference	Percent Change
$114.64	$73.67	-$40.97	-35.74%
$25.13	$24.89	-$0.24	-0.96%
$114.64	$128.62	$13.98	12.19%
$25.13	$24.89	-$0.24	-0.96%
$25.13	$36.13	$11.00	43.77%
Packaged	Packaged	N/A	N/A
$114.64	$73.67	-$40.97	-35.74%
$25.13	$36.13	$11.00	43.77%
$51.22	$24.89	-$26.33	-51.41%
$25.13	$24.89	-$0.24	-0.96%
$51.22	$36.13	-$15.09	-29.46%
$51.22	$36.13	-$15.09	-29.46%
$51.22	$36.13	-$15.09	-29.46%
Packaged	Packaged	N/A	N/A
$16.21	$24.89	$8.68	53.55%
$51.22	$36.13	-$15.09	-29.46%
$51.22	$36.13	-$15.09	-29.46%
$51.22	$36.13	-$15.09	-29.46%
$51.22	$73.67	$22.45	43.83%
$105.38	$128.62	$23.24	22.05%
$105.38	$73.67	-$31.71	-30.09%
$149.34	$187.96	$38.62	25.86%
$51.22	$36.13	-$15.09	-29.46%
$149.34	$187.96	$38.62	25.86%
$51.22	$73.67	$22.45	43.83%
$105.38	$128.62	$23.24	22.05%
$149.34	$187.96	$38.62	25.86%
$51.22	$73.67	$22.45	43.83%
$149.34	$187.96	$38.62	25.86%
$149.34	$187.96	$38.62	25.86%
$149.34	$187.96	$38.62	25.86%
$149.34	$187.96	$38.62	25.86%
$114.64	$187.96	$73.32	63.96%
$114.64	$128.62	$13.98	12.19%
$36.24	$39.92	$3.68	10.15%
$51.22	$128.62	$77.40	151.11%
$16.21	$24.89	$8.68	53.55%

modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensator convergent beam modulated fields, per treatment session.

While these are minor changes to the grammar or structure of the code descriptor, oncology entities should update internal documents to reflect the current code definition when necessary.

HCPCS code G0332. With regard to infusion center coding updates, one of the most significant changes is the elimination of HCPCS code G0332: Services for intravenous infusion of immunoglobulin prior to administration (this service is to be billed in conjunction with administration of immunoglobulin), for all sites of service. CMS believes that the pre-administration costs are now included in the reimbursement for the IVIG product and separate payment for pre-administration is no longer warranted.

S3711: Circulating tumor cell test. This is a new HCPCS Level II national Blue Cross code. In general, only BCBS payers accept the S series of HCPCS codes; however, cancer centers should review other payer policies to ascertain their acceptance of this code.

New HCPCS drug codes. For 2009, the following drugs received new codes:

- J0641: Injection, levoleucovorin calcium, 0.5 mg
- J1453: Injection, fosaprepitant, 1 mg
- J1459: Injection, immune globulin, (Privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg (replaces deleted code Q4097)
- J1930: Injection, lanreotide, 1 mg
- J7186: Injection, antihemophilic Factor VIII/Von Willebrand factor complex (human), per factor VIII i.u. (replaces deleted code Q4096)
- J8705: Topotecan, oral, 0.25 mg
- J9033: Injection, bendamustine HCl, 1 mg
- J9207: Injection, ixabepilone, 1 mg
- J9330: Injection, temsirolimus, 1 mg.

Table 2. 2009 HCPCS Codes Designating Different Doses of the Same Drug

J1470	Gamma globulin, IM, 2 cc, injection
J1480	Gamma globulin, IM, 3 cc, injection
J1490	Gamma globulin, IM, 4 cc, injection
J1500	Gamma globulin, IM, 5 cc, injection
J1510	Gamma globulin, IM, 6 cc, injection
J1520	Gamma globulin, IM, 7 cc, injection
J1530	Gamma globulin, IM, 8 cc, injection
J1540	Gamma globulin, IM, 9 cc, injection
J1550	Gamma globulin, IM, 10 cc, injection
J1560	Gamma globulin, IM, > 10 cc, injection
J8521	Capecitabine, oral, 500 mg
J9062	Cisplatin 50 mg, injection
J9080	Cyclophosphamide 200 mg, injection
J9091	Cyclophosphamide 1.0 gm, injection
J9092	Cyclophosphamide 2.0 gm, injection
J9094	Cyclophosphamide lyophilized, 200 mg
J9095	Cyclophosphamide lyophilized, 500 mg
J9096	Cyclophosphamide lyophilized, 1.0 gm
J9097	Cyclophosphamide lyophilized, 2.0 gm
J9110	Cytarabine HCl, 500 mg
J9140	Dacarbazine 200 mg, injection
J9260	Methotrexate sodium injection, 50 mg
J9290	Mitomycin 20 mg, injection
J9291	Mitomycin 40 mg, injection
J9375	Vincristine sulfate 2 mg, injection
J9380	Vincristine sulfate 5 mg, injection
Q0165	Prochlorperazine maleate 10 mg, oral
Q0168	Dronabinol 5 mg, oral
Q0170	Promethazine HCl 25 mg, oral
Q0172	Chlorpromazine HCl 25 mg, oral
Q0176	Perphenazine 8 mg, oral
Q0178	Hydroxyzine pamoate 50 mg

HCPCS code J1750. Codes J1751 (injection, iron dextran 165, 50 mg); J1752 (injection iron dextran 267, 50 mg); and Q4098 (injection, iron dextran, 50 mg) have been deleted and replaced with a more generic HCPCS code: J1750 Injection, iron dextran, 50 mg.

HCPCS code J9182. The code for etoposide, 100 mg was deleted effective Jan. 1, 2009, although the following code remains active: J9181, injection, etoposide, 10 mg.

Administration procedure codes. In order to relocate the therapeutic, diagnostic, and prophylactic drug administration procedure codes to the same section as the chemotherapy administration codes, AMA re-numbered all of these infusion and injection procedures. The code descriptors did not change for 2009. See Table 1 (pages 10-11) for these code updates.

Hospital Regulatory Update

The Centers for Medicare & Medicaid Services (CMS) provided clarification of the regulations regarding physician supervision of services performed in a hospital outpatient department. First, the agency explained that diagnostic services performed in a hospital outpatient department must be provided under the supervision of a physician. The required level of supervision for an exam is that which is indicated in the Medicare Physician Fee Schedule (MPFS), unless the local Medicare contractor has provided separate written instructions. This guideline applies to outpatient departments within the hospital (on-campus), as well as remote departments (off-campus).

For therapeutic services provided in the hospital outpatient department, direct physician supervision is required. Direct supervision means that the physician must be present in the outpatient department where the services are performed, be trained on the procedure, and be able to assist hospital staff, direct the procedure, and provide immediate patient care, as necessary. This rule also applies both to on-campus and off-campus departments.

CMS further stated that only physicians can provide physician supervision of therapeutic procedures. The final rule states: "Therefore, it would not be in accordance with the law and regulations for a non-physician practitioner to be providing the physician supervision in a provider-based department, even if a nurse practitioner's or a physician assistant's professional service was being billed as a nurse practitioner or a physician assistant service and not a physician service."

New status indicators. CMS created new status indicators for CY 2009, including status indicator "R" for blood and blood products, and status indicator "U" for brachytherapy sources. In addition, brachytherapy sources will continue to be paid at charges-adjusted-to-cost for 2009. Lastly, CMS indicated that it is considering implementing a new HCPCS code for high activity Cesium; this new code may be added in a 2009 quarterly update.

Bundling and packaging. The drug threshold price for OPPS services is $60 in CY 2009. Anti-emetic drugs continue to be exempt from this rule. Busulfan (code J8510) will also be paid separately in 2009 even though its average cost has fallen to $57 per day.

Drug reimbursement. Drugs that are above the threshold price will be paid at the average sales price (ASP) plus 4 percent, which is a decrease from ASP+5 percent in 2008. Note, the drug payment rate under the Medicare Physician Fee Schedule (MPFS) remains at ASP+6 percent for 2009.

In 2008 CMS began paying for multiple HCPCS codes designating different doses of the same drug. (Previously only the lowest dose code was paid.) For CY 2009, CMS is adding a number of additional drug codes to this group that were not recognized last year, including codes for gamma globulin and a number of chemotherapy agents (see Table 2).

Drug administration services. In CY 2009, these services are reported using five APC groups, instead of the six APCs reimbursed in CY 2008. Despite requests from commenters, CMS declined to unpackage code 96368 (concurrent therapeutic infusion), and this service will *not* be separately reimbursed in CY 2009.

Clinic visits. Hospitals will continue to report clinic visit services in 2009 using the same set of CPT procedure codes that were in place for 2008. Additionally, CMS is instructing hospitals to continue to use their own internal visit classification guidelines for 2009. However, for purposes of code assignment, CMS revised the definitions of new and established patients. A new patient is now defined as an individual who has not been registered as an inpatient or outpatient of the hospital within three years prior to the current visit. An established patient is one who has been registered as an inpatient or outpatient within the past three years. Previously, the definition was based on whether the patient had a medical record number assigned within the prior three years. For example, patients are now considered to be new patients if they have a medical record number assigned during an emergency department visit five years ago but have not received any services from the hospital since that time.

Other coding changes. HCPCS Level II codes C9725 (endorectal applicator) and C9726 (breast applicator) have been reclassified from New Technology APCs to regular APCs. Code C9725 is classified to APC 0148 (rather than 0164, as originally proposed), and C9726 is classified to APC 0028. For 2009, proton beam therapy will be assigned to APC 0664 (codes 77520 and 77522) and APC 0667 (codes 77523 and 77525). The 2009 payment rates for these proton therapy APCs are significantly lower than the rates listed in the proposed rule for OPPS, due to new Medicare cost reports submitted by two facilities that perform this service.

Guidance services. Despite a recommendation from the APC Panel that radiation therapy guidance services should be paid separately, CMS declined to unpackage the image guidance used in image-guided radiation therapy (IGRT). However, the agency notes that payment for the common combination of codes 77418 (IMRT) and 77421 (IGRT guidance) has increased from $348 in 2008 to $411 in 2009, even though the guidance remains packaged.

CMS also declined to change CT guidance for placement of radiation therapy fields (77014) from unconditionally packaged to conditionally packaged or unpackaged. The agency indicated that if this service were conditionally packaged, hospitals would have an incentive to provide it on a different day from other services in order to receive payment.

Physician Practice and Freestanding Center Regulatory Update

CMS received approximately 4,100 public comments in response to the proposed MPFS. Here are highlights of the major changes.

Procedure code 77371. A significant practice expense change affects code 77371: Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion(s) consisting of one session); multi-source Cobalt 60 based. In CY 2009, this code will be "carrier priced" in the freestanding setting, which means that each individual Medicare contractor will independently determine reimbursement for this code.

Orders and referrals. CMS believes that it is essential that providers and suppliers maintain documentation regarding the specific service ordered or referred to a Medicare beneficiary by an eligible physician or non-physician practitioner (NPP), including the national provider identifier (NPI). In addition, the ordering and referring documentation maintained by a provider or supplier must match the information on the Medicare claim form. Physicians and non-physician practitioners are required to maintain written ordering and referring documentation for seven years from the date of service. Failure to comply with the documentation requirements as specified is a reason for revocation of Medicare participation.

Doctor of Nursing Practice degree. As part of the 2009 final MPFS Rule, CMS has finalized the proposal to amend the Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS) qualifications to include the Doctor of Nursing Practice (DNP) degree. The DNP degree can be obtained without a master's degree in nursing; therefore, CMS will accept either a master's degree or the DNP to satisfy the educational requirements for NPs and CNSs. In addition, the agency indicates that it will continue to study and monitor DNP nursing programs, state legislative action, and the state boards of nursing as the DNP degree evolves.

Billing update. The final MPFS rule established an effective date of billing for physicians, NPPs, and physician and NPP organizations that would be the later of:

1. The date of filing of a Medicare enrollment application that was subsequently approved by Medicare contractor (that is, carrier, fiscal intermediary or A/B Medicare Administrative Contractor); or
2. The date a physician, NPP, or physician and NPP organization first started furnishing services at its new practice location.

In addition, this provision allows physicians, NPPs, physician or NPP organizations to retrospectively bill for services up to 30 days prior to their effective date of billing when the physician or NPP organization met all program requirements, including state licensure requirements, services were furnished at the enrolled practice location prior to the date of filing, and circumstances precluded enrollment in advance of providing services to Medicare beneficiaries. Therefore, physicians, NPPs, and physician or NPP organizations would be limited to receiving reimbursement for services for a maximum of 30 days prior to filing an enrollment application that was subsequently approved by a Medicare contractor (or 90 days if the application was delayed due to a federally-declared national disaster). Of note, incomplete enrollment applications will be denied by the Medicare contractors, defining the "date of filing" as the date that the Medicare contractor receives a signed provider enrollment application that the Medicare contractor is able to process to approval.

CMS also updated regulations to state: "The revocation of a provider's or supplier's billing privileges is effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier, except if the revocation is based on Federal exclusion or debarment, felony conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational."

Exceptions to this rule include providers revoked based on Federal exclusion, felony conviction, license suspension, or when a practice location ceases to operate. If the provider believes that the CMS contractor has made this decision in error, the provider can file an appeal. CMS also requires a revoked healthcare entity to submit all outstanding claims not previously submitted within 60 calendar days of the revocation effective date, which limits the ability of revoked suppliers to bill Medicare retrospectively.

In addition to the items listed above, this final rule also includes information on PQRI, e-prescribing, and other relevant topics.

Compendia Off-Label Indications

Separate from the final rule regulatory guidance, CMS issued Transmittal 96 to update the use of compendia as authoritative sources. CMS recognizes the following as authoritative compendia for use in the determination of a "medically accepted indication" of drugs and biologicals used off-label in an anticancer chemotherapeutic regimen:

- *American Hospital Formulary Services – Drug Information* (AHFS-DI)
- *NCCN Drugs and Biologics Compendium*
- Thomson Micromedex *DrugDex*
- *Clinical Pharmacology.*

This document also indicates that Medicare contractors shall recognize medically accepted indications as those that:

- Are favorably listed in one or more of the compendia listed above; or,
- The contractor determines from a review of the peer-reviewed literature as described above that it is a medically accepted indication, ***unless*** CMS has determined that the use is not medically accepted, or any of the listed compendia list the use as not medically necessary (or use similar language).

Cindy C. Parman, CPC, CPC-H, RCC, is a principal at Coding Strategies, Inc., Powder Springs, Ga.

Resources

1. 2009 Medicare Physician Fee Schedule Final Rule. Available online at: *www.cms.hhs.gov/physicianfeesched/downloads/CMS-1403-FC.pdf?agree=yes&next=Accept*. Last accessed 12/08/08.
2. 2009 Medicare OPPS Final Rule. Available online at: *www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/CMS-1404-FC.pdf*. Last accessed 12/08/08.
3. Medicare Benefit Policy: Transmittal 96. Available online at: *www.cms.hhs.gov/Transmittals/downloads/R96BP.pdf*. Last accessed 12/08/08.