ISSUES The

ACCC Gets Key Wins in Proposed HOPPS Rule

On Jul. 1, 2009, the Centers for Medicare & Medicaid Services (CMS) issued the proposed Hospital Outpatient Prospective Payment System (HOPPS) rule for calendar year 2010. The proposed rule was published in the July 20 *Federal Register,* and CMS accepted comments until Aug. 31, 2009. The final rule will be issued by Nov. 1, 2010. The Association of Community Cancer Centers (ACCC) is pleased that several proposals in the 2010 HOPPS proposed rule appear to reflect the work of ACCC and its partners:

Reimbursement for separately payable drugs and biologicals without pass-through status. In the proposed rule, CMS has finally recognized—after years of data from ACCC and other stakeholders—that pharmacy overhead services are not being adequately reimbursed. The agency proposes to make payment for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals without pass-through status at ASP+4 percent. The payment rate of ASP+4 percent is based on the cost of separately payable drugs and biologicals calculated from hospital claims and costs reports (ASP -2 percent) with an adjustment for pharmacy overhead cost achieved by reallocating $150 million from packaged drugs and biologicals to separately payable drugs and biologicals without pass-through status. CMS acknowledges that some flaws are inherent in its rate-setting system, admitting that "the current method of converting billed charges to costs has the potential to 'compress' the calculated costs to some degree." On a less positive note, the agency did not adopt the methodology recommended by ACCC and the APC Panel to establish more appropriate payments. ACCC has been calling for payment of at least ASP+6 percent.

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In comments to the proposed rule, ACCC expressed appreciation for the fact that CMS has finally recognized the flaws in the ASP system and the lack of proper reimbursement. ACCC continues to assert that the amount allocated for pharmacy overhead is still too low, and that CMS should be allocating more funds to cover those services, thereby further raising the ASP+ number. ACCC continues to work with CMS in order to achieve the most accurate reimbursement rates possible.

Physician supervision. Another "win" for ACCC and its partner, the Oncology Nursing Society (ONS), are the proposed physician supervision requirements outlined in the 2010 HOPPS proposed rule. For 2010 CMS proposes that non-physician practitioners, specifically physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives, may directly supervise all hospital outpatient therapeutic services that they may perform themselves in accordance with their State law and scope of practice and hospital-granted privileges, provided that they con-

CMS Proposes Coverage of PET Scans to Determine Cervical Cancer Treatment

In a coverage decision memo released Aug. 13, CMS proposes to cover positron emission tomography (PET) scans for beneficiaries diagnosed with cervical cancer in order to determine the best therapy.

According to the agency, the available evidence is adequate to determine that the results of FDG PET scans for beneficiaries diagnosed with cervical cancer "are used by the treating physician to make meaningful changes in therapeutic management and improve health outcomes, and thus are reasonable and necessary."

As reported in the Aug. 17, *BNA Health Care Daily Report*, CMS proposes to cover only one FDG PET for beneficiaries who have "biopsy proven cervical cancer" when the beneficiary's treating physician determines that the FDG PET study is needed to determine the location and/or extent of the tumor for specific therapeutic purposes. CMS proposed the scans could be used only "to determine whether or not the beneficiary is an appropriate candidate for an invasive diagnostic or therapeutic procedure; to determine the optimal anatomic location for an invasive procedure; or to determine the anatomic extent of tumor when the recommended anti-tumor treatment reasonably depends on the extent of the tumor."

The agency is now accepting public comments on the proposed coverage decision. The proposed decision memo is available online at: *https://www.cms.hhs.gov/mcd/viewdraftdecisionmemo.asp?id=232.*

tinue to meet all additional requirements, including any collaboration or supervision requirements as specified in the regulations.

CMS further proposes to define "direct supervision" for on-campus hospital outpatient services to mean that the physician or nonphysician practitioner must be present in the hospital or on-campus provider-based department of the hospital and immediately available to furnish assistance and direction through the performance of the procedure. This proposal is in contrast to the current definition that requires the physician to be present in the on-campus provider-based department.

In meetings with CMS earlier this year, ACCC and ONS advocated the use of the State scope of practice law rather than the direct supervision requirement instituted in the 2009 final HOPPS rule. ACCC is pleased that CMS has accepted this suggestion. In comments to the proposed rule, ACCC recommended that CMS institute this proposal.

PHOTOGRAPH/PHOTODISC

Additional Highlights of the Proposed HOPPS Rule

In its proposed rule, CMS projects a market basket update of 2.1 percent for outpatient departments and estimates total payments of $31.5 billion under the HOPPS in 2010. Other highlights include:

Drugs and biologicals with pass-through status. CMS proposes to pay for pass-through drugs and biologicals at ASP+6 percent. Pass-through contrast agents, diagnostic radiopharmaceuticals, therapeutic radiopharmaceuticals, and implantable biologicals would also be reimbursed at ASP+6 percent. CMS proposes that the pass-through status of the following six drugs will expire on Dec. 31, 2009:

- C9354 Veritas collagen matrix, cm2
- C9355 Neuromatrix nerve cuff, cm
- J1300 Eculizumab injection
- J3488 Reclast injection
- J9261 Nelarabine injection
- J9330 Temsirolimus injection

CMS proposes to continue pass-through status for 31 drugs in 2010. For a complete list, see ACCC's analysis of the proposed rule available at: *www.accc-cancer.org*.

Non-pass-through drugs, biologicals, and radiopharmaceuticals with HCPCS codes but without HOPPS hospital claims data. CMS proposes to continue to use wholesale acquisition cost (WAC) or 95 percent of average wholesale price (AWP) to establish the initial payment rate for new non-pass-through drugs and biologicals and radiopharmaceuticals.

340B program. The agency did not follow the APC Panel's recommendation to exclude data from hospitals participating in the 340B program from its rate-setting calculation for drugs. CMS proposes to continue to apply the same reimbursement rates to 340B hospitals as non-340B hospitals.

Packaging threshold. CMS proposes to increase the packaging threshold for 2010 from $60 to $65 for packaged drugs. The agency also proposes to end the exemption to the packaging threshold for 5-HT3 antiemetics. For 2010 CMS proposes to package payment for all 5-HT3 antiemetics, except palonosetron hydrochloride, consistent with its estimated per days costs from 2008 claims data.

CMS proposes to make packaging determinations on a drug-specific basis, rather than a HCPCS code-specific basis, for those HCPCS codes that describe the same drug or biological but different dosages. If the estimated cost per day for the drug is greater than $65, all HCPCS codes for the drug are separately paid. If the estimated cost per day is less than or equal to $65, all HCPCS codes would be packaged.

Therapeutic radiopharmaceuticals. CMS proposes to provide payment for separately payable therapeutic radiopharmaceuticals that have ASP information submitted through the existing ASP process at ASP+4 percent. If ASP information is not available, CMS proposes that payment be based upon mean unit cost from hospital claims data.

Proposed coding and payment for drug administration services. The agency proposes to continue to use the full set of CPT codes for drug administration services, but make minor reconfigurations of the APCs to account for changes in HCPCS code-specific median costs resulting from updated CY 2008 claims data and the most recent cost report data, and the CY 2010 drug payment proposal. (A comparison of 2009 and proposed 2010 drug administration payment rates is available on the Members-only section of ACCC's website at: *www.accc-cancer.org.*)

Brachytherapy sources. For 2010 CMS proposes to pay for brachytherapy sources based on median unit costs derived from the claims data for brachytherapy sources. The agency would assign future new HCPCS codes for new brachytherapy sources to their own APCs, with prospective payment rates set based on its consideration of external data and other relevant information regarding the expected costs of the sources to hospitals.

Of particular interest, CMS proposes to reassign CPT code 0182T, high dose rate electronic brachytherapy, per fraction from new technology APC 1519 (New Technology – Level IXX, $1700 to $1800) to APC 313 (Brachytherapy) with a proposed payment rate of $746.68.

Payment reduction for failure to report quality measures. Hospitals that fail to report quality data for outpatient services face a 2 percent reduction in their payment update factor. For the 2011 update, CMS proposes that hospitals that want to change their participation status must submit a form by March 2010. For the 2011 payment determination, CMS proposes to continue requiring hospitals to submit data on the existing 11 Hospital Outpatient Quality Data Reporting Program measures and does not propose to add any new measures.

Among the quality measures under consideration for 2012 and subsequent years are:

- Adjuvant chemotherapy is considered or administered within 4 months of surgery to patients under age 80 with American Joint

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Committee on Cancer (AJCC) III colon cancer
- Adjuvant hormonal therapy for patients with breast cancer
- Needle biopsy to establish diagnosis of cancer precedes surgical excisions/resection.

Proposed PFS Brings Cuts to Medical Oncology and Radiation Oncology

The Medicare Physician Fee Schedule (PFS) 2010 proposed rule, released Jul. 1, 2009, will reduce payments to cancer care providers, with especially steep cuts projected for radiation oncology. Table 1 below shows the projected impact of 2010 PFS proposals on physicians involved in cancer care. The proposed 2010 PFS was published in the July 13, *Federal Register.* The agency's comment period ended Aug. 31, 2009.

For 2010, CMS predicts the sustainable growth rate (SGR) formula will decrease the conversion factor by 21.5 percent. However, as in the past, Congress is likely act to prevent this cut from taking effect.

The agency proposes to remove physician-administered drugs from the SGR calculation beginning in 2010 and retrospectively to the 1996/1997 base year. CMS says this proposal would "eliminate the disproportionate impact that the large past increases in the costs attributable to physician-administered drugs would otherwise have upon future PFS updates."

Highlights of the 2010 PFS proposed rule include:

PE RVU changes. CMS proposes to complete the four-year transition from a top-down methodology to a bottom-up methodology for calculating PE RVUs in CY 2010. In 2010, PE RVUs would be calculated based entirely on the current methodology.

The agency proposes to adopt a new data source for the PE RVUs. CMS proposes to use data from the American Medical Association (AMA) Physician Practice Information Survey (PPIS) in place of the AMA's Socioeconomic Monitoring Survey (SMS) data and supplemental survey data to calculate PE RVUs for all Medicare-recognized specialties that participated in the PPIS for 2010. In general, this proposal would increase payments for primary care physicians and reduce payments for some specialties.

According to Health Policy Alternatives, Inc., the impact of these proposed PE RVU changes would mean an overall reduction of about 5 percent for hematology/oncology; 17 percent for radiation oncology; and 10 percent for radiology.

Change in the utilization rate for equipment priced over $1 million. CMS proposes to increase the equipment usage assumption rate for calculating PE RVUs from the current 50 percent usage rate to a 90 percent usage rate for equipment priced over $1 million. This proposal would reduce the costs of that equipment attributed to each procedure in which it is used.

CMS calculates that the proposed change in utilization rate would have a "significant" effect on total Medicare payments to Independent Diagnostic Testing Facilities (IDTFs) and radiation oncologists. Payments to IDTFs would be reduced by 2 percent and payments to radiation oncologists would be reduced by 5 percent.

Consultation services. CMS proposes to eliminate the use of all inpatient and office/outpatient consultation codes, except for telehealth consultation. Instead of a consultation code, physicians would bill an initial hospital care or initial nursing facility care code for their first visit to the hospital or nursing facility. The agency also proposes to create a modifier to distinguish the admitting physician of record who oversees the patient's care from other physicians who may furnish specialty care.

Physician resource use measurement and reporting program. In 2009, as required by MIPPA, CMS implemented a Physician Feedback Program that uses Medicare claims and other data to provide confidential feedback reports to physicians. In phase I of the program, CMS disseminated approximately 230 reports to physicians in 12 different geographic locations. Although oncologists were not included in phase I of the program, prostate cancer is listed as one of the "high cost, high volume, or both" priority conditions that CMS states it intends to finalize in the CY 2010 PFS final rule. For phase II, CMS proposes to add reporting to groups of physicians and to add quality measurement information as a context for interpreting comparative resource use.

E-prescribing incentive program. CMS would continue implementation of the e-prescribing incentive program created by MIPPA and the ARRA. In 2010, successful e-prescribers are eligible for an incentive payment equal to 2 percent of the total estimated allowed charges for all covered professional services furnished during the 2010 reporting period.

PQRI. For 2010, the Medicare statute authorizes an incentive payment equal to 2 percent of the estimated total charges for all covered

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Table 1. Cumulative Effect on Total Medicare Payments*

Specialty	Allowed Charges (million)	Combined Impact
Hematology/Oncology	$1,888	-6 percent
Radiation Oncology	$1,799	-19 percent
Radiology	$5,254	-11 percent

*These calculations are based on all of the 2010 PFS proposals (with the exception of the cut to the conversion factor) taking effect.

Source: Health Policy Alternatives

professional services furnished during the reporting period.

Quality measures. CMS proposes retiring seven 2009 PQRI quality measures. Two of these, Oncology: Medical and Radiation—Pain Intensity Quantified and Oncology: Medical and Radiation—Plan of Care for Pain, are proposed for retirement because they are too analytically challenging.

The agency proposes making nine measures currently reportable through claims-based reporting or registry-based reporting, reportable only through registry-based reporting, including:

- Melanoma: Follow-Up Aspects of Care
- Melanoma: Continuity of Care – Recall Systems
- Melanoma: Coordination of Care.

CMS also proposes adding 22 new measures—16 of which would be registry-only measures.

Currently, physicians report quality measures through claims-based reporting or registry-based reporting. CMS proposes to allow eligible professionals to choose to report data on PQRI quality measures through claims, to a qualified registry, or through a qualified electronic health record (EHR) product.

The agency has proposed a process for making incentive payments to group practices based on the determination that the group practice, as a whole, satisfactorily reports on PQRI quality measures for 2010.

Imaging accreditation. CMS proposes to implement a requirement under MIPPA that beginning Jan. 1, 2010, suppliers of the technical component of advanced imaging services need to be accredited. The agency outlines the criteria and process it will use to select accreditation organizations and standards to be applied to imaging suppliers. The CMS-designated accreditation organization would apply standards that set qualifications for non-physician medical personnel who provide the technical component of such advanced imaging (e.g., diagnostic MRI, CT, nuclear medicine, and PET).

Drug compendia. The proposed rule implements MIPPA's requirement that "[o]n or after January 1, 2010, no compendia may be included on the list of compendia under this subparagraph unless the compendia had a publicly transparent process for evaluating therapies and for identifying potential conflicts of interest." CMS proposes "that a compendium could meet this standard by publishing materials used in its evaluation process on its Web site." All currently listed compendia will be required to comply with these requirements by Jan. 1, 2010, to remain on the list of recognized compendia.

Proposed coding and payment for drug administration services. Using the 2009 conversion factor and excluding any adjustments for geographic variations in cost, reimbursement for nearly all administration codes would be reduced between 7 and 25 percent. A comparison of 2009 and proposed 2010 drug administration payment rates is available on the Members-only section of ACCC's website at: *www.accc-cancer.org.*

In its comment letter to CMS, ACCC voiced its concern and called for elimination of or reductions to the massive cuts to medical and radiation oncology under the proposed PFS. The Association called on CMS to work with Congress on a permanent fix to the SGR formula. ACCC will continue to work with its partners to ensure patient access to quality care.

Medicare Rule Puts Some Damper on Lab Tests

A new ACCC survey reveals that Medicare's "date of service" rule for laboratory testing may discourage some hospitals from sending out samples for advanced molecular diagnostic testing. Under current rules, if a hospital sends a specimen away to the lab for advanced molecular diagnostic testing within 14 days of blood draw or tissue biopsy, the lab must bill the hospital, which in turn must bill Medicare. However, if the hospital waits until day 15 or later to send off the specimen, the lab can bill Medicare directly.

To assess whether this arrangement discourages hospitals from ordering advanced molecular diagnostic tests, ACCC recently surveyed its membership. The main finding: One-third of respondents indicate that Medicare's "date of service" rule does cause a reimbursement problem with their Medicare Administrative Contractor (MAC). Some hospitals delay sending out the sample for testing, and many report an increased administrative burden and increased patient waiting time for results. Nine percent have reduced the number of outside laboratory tests ordered due to reimbursement challenges.

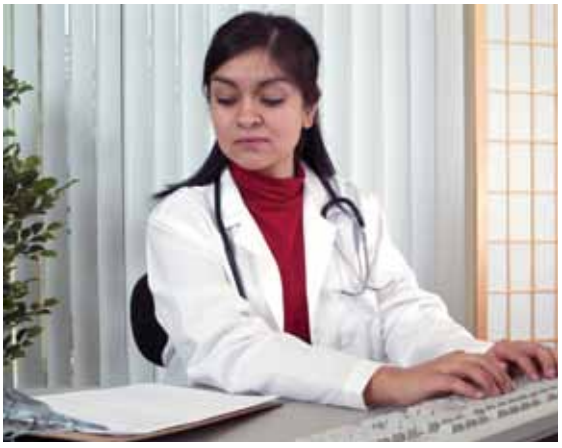
A Senate bill (S. 1220) sponsored by Sens. Arlen Specter (D-Pa.) and Ron Wyden (D-Ore.) requires that "certain complex diagnostic laboratory tests performed by an independent laboratory after a hospital outpatient encounter or inpatient stay during which the specimen involved was collected shall be treated as services for which payment may be made directly to the laboratory."

A similar bill (H.R. 1699) was introduced in the House in March by Reps. Jason Altmire (D-Pa.) and Tim Murphy (R-Pa.). ACCC supports both bills.

The vast majority of ACCC survey respondents (92 percent) are not aware of legislative efforts to eliminate the date of service rule. A majority of survey respondents (58 percent) express willingness to work with ACCC on its advocacy efforts concerning this issue and write their congressional representatives to support the legislative effort.

Reimbursement Check-Up

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



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When the going gets tough, the tough review their reimbursement! During economically challenging times, reviewing services billed, payments received, and the revenue cycle process to ensure appropriate reimbursement is more important than ever.

That said—this is not the time for "creative coding" or "CPT surfing." In other words, don't sit down and leaf through your coding manual to find code descriptors for potential undiscovered reimbursement. However, the presence of an economic slowdown can be a catalyst for reviewing current patient care processes and determining if additional billable services are being provided. The following is a list of services that may be overlooked when claims are filed. This is not a comprehensive list, but represents commonly performed services that may not be consistently billed by physicians, hospitals, and cancer programs.

Tobacco Cessation Counseling

Effective March 22, 2005, Medicare Part B initiated coverage for two levels of smoking cessation counseling. Medicare limits this coverage to patients who are competent and alert at the time services are provided, and:

- Use tobacco, and
- Have a disease or adverse health effect found by the U.S. Surgeon General to be linked to tobacco use, or
- Who are taking certain therapeutic agents whose metabolism or dosage is affected by tobacco use as based on FDA-approved information.

Medicare covers two attempts at quitting each year, and each attempt may include a maximum of four intermediate or intensive sessions. (The patient and physician determine the intensity of the session.) This means that Medicare covers a maximum of eight sessions in one year, but healthcare professionals should charge only one unit of a smoking cessation service per date of service. The following codes report these services:

- **99406**: Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
- **99407**: Intensive, greater than 10 minutes.

A minimal counseling service, defined as 3 minutes or less in duration, bundles into other services performed by the physician or facility and is not separately charged.

The counseling service described by these codes includes a physician or qualified nonphysician healthcare professional counseling the patient face-to-face, separate from any other service performed on the same date. There must be a behavior change intervention, not just a review of the patient's smoking status. CMS recommends that healthcare providers use its online resources as part of their counseling efforts (*http://www.smokefree.gov* and *http://www.cms.hhs.gov/SmokingCessation/*).

In addition, smoking and tobacco-use cessation counseling claims are reported with the correct diagnosis code that reflects the condition the patient has that is adversely affected by the use of tobacco or the condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by the tobacco use. For example:

- **305.1:** Tobacco use disorder; tobacco dependence; tobacco abuse.

Tobacco use disorder is reported when the patient uses tobacco in a way that is damaging to his or her health or when there is tobacco dependence:

- **V15.82**: History of tobacco use
- **989.84**: Toxic effects of tobacco
- **E866.8**: Accidental poisoning, other specified substances.

Based on American Medical Association (AMA) guidance, either a physician or qualified nonphysician healthcare provider may perform these services. In the outpatient setting, the hospital may report these codes when documentation supports that qualified hospital personnel performed the counseling. If the healthcare provider performs a separately identified patient service on the same date, modifier 25 (significant, separately identifiable service) may be appended to the code. For more, see Table 1. Reimbursement for Tobacco-use Cessation Counseling, page 13.

Prolonged Services

Prolonged services codes report the provision of an extended professional service that requires face-to-face patient contact that is above and beyond the usual service. The prolonged service code is reported in addition to other physician services, including Evaluation and Management (E/M) services at any level. As a result, prolonged services codes will never be reported as "stand alone" services. Additional guidelines for

the use of these codes include:

- Report the total duration of face-to-face time spent by the physician on a given date providing prolonged service—even if the time spent is not continuous. Time spent by staff such as nurses or medical assistants or time the patient remains unaccompanied is *not* included in prolonged service time.
- Prolonged service of less than 30 minutes total duration on a given date is *not* separately reported because the work involved is included in the total work of the patient encounter or other service performed.
- Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.
- If time is considered the key or controlling factor in choosing the level of E/M service (more than 50 percent of the visit constitutes counseling and/or coordination of care), then the prolonged services codes should only be used in addition if the service has exceeded 30 minutes beyond the highest level of E/M in the appropriate category.

Here are the prolonged services codes:

+99354: Prolonged physician service in the *office* or *other outpatient setting* requiring direct (face-to-face) patient contact beyond the usual service (e.g., prolonged care and treatment of an acute asthmatic patient in an outpatient setting). First hour. (List separately in addition to code for office or other outpatient E/M service.)

+99355: Each additional 30 minutes. (List separately in addition to code for prolonged physician service.)

+99356: Prolonged physician service in the *inpatient* setting, requiring direct (face-to-face) patient contact beyond the usual service (e.g., maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient). First hour. (List separately in addition to code for inpatient E/M service)

+99357: Each additional 30 minutes. (List separately in addition to code for prolonged physician service.)

According to CMS in *MLN Matters* 5972: "Documentation, however, is required to be in the medical record about the duration and content of the medically necessary E/M service and prolonged services that you bill. Providers must appropriately and sufficiently document in the medical record that they personally furnished the direct face-to-face time with the patient specified in the CPT® code descriptors. Providers should make sure that they document the start and end times of the visit, along with the date of service." Table 2, page 13, shows reimbursement for prolonged services codes.

Follow-up Visits

According to AMA in the 2009 edition of the *CPT Manual*: "Listings for Radiation Oncology provide for teletherapy and brachytherapy to include initial consultation, clinical treatment planning, simulation, medical radiation physics, dosimetry, treatment devices, special services, and clinical treatment management procedures. They include normal follow-up care during course of treatment and for three months following its completion." As a result, the majority of payers do not allow separate reimbursement for physician follow-up visits unless the patient is post-therapy by at least 90 days or is being treated for a condition not related to the therapy.

The 90-day follow-up period covers all patient visit services for 90 days following completion of therapy. Therefore, for 90 days after completion of irradiation, payers consider patient visit codes related to treatment to be bundled into the treatment management (code **77427**). This bundling includes follow-up care for the malignancy or area under treatment, as well as follow-up services for any other medical conditions treated by the radiation oncologist (such as nausea, vomiting, skin erythema, and mucositis). Payers do not consider this to be a "global period" because that concept only applies to surgery. Instead, payers consider the follow-up care for 90 days to be an extension of the treatment management (packaged service) and not separately billed.

This AMA authoritative coding guideline:

- Applies to all insurance payers (not only to Medicare)
- Means that physicians cannot charge the visits to *any* insurance. All visits that are billed may be paid in error, even if the visits occur within the 90-day period following treatment. To avoid the possibility of refunding incorrect payment (potentially with the addition of fines and penalties), physicians should ensure that they do not generate a claim for visits that occur within the 90-day period following therapy.

Keep in mind that this guideline applies only to *professional* reporting. Hospitals can capture and report *all* medically necessary facility visits, even during the 90 days following therapy. Because hospitals do not charge for treatment management, but instead report services on a daily episodic basis, they can charge each patient service individually.

In addition, as this requirement applies only to "follow-up" visits, some exceptions permit physicians to charge for patient visits during the 90-day period following therapy.

Follow-up Visits: Exception 1

Beginning with the 2007 CMS Final Rule for physician services, published in the *Federal Register*, December 1, 2006, Medicare states: "All of the codes in the family CPT® codes [**77785** through **77787**], are currently designated as 90-day global services. CPT® codes [**77785** through **77787**] are used to treat many clinical conditions, but primarily patients with prostate cancer, breast cancer, and sarcoma. Patients with any of these conditions usually receive several treatments (2 through 10) over a 2 to 10-day period of time. Due to the increasing variability in treatment regimens, it is difficult to assign RVUs for a 'typical' patient based on a global period of 90 days."

"However, we propose, on an interim basis, to revise the work RVUs and PE inputs to reflect the removal of the postoperative visit,

Table 1. Reimbursement for Tobacco-use Cessation Counseling

Code	Descriptor	Physician Payment*	Hospital Payment*
99406	Tobacco-use cessation, 3-10 minutes	$12.98	$11.42
99407	Tobacco-use cessation, > 10 minutes	$24.89	$11.42

*Average national Medicare reimbursement

Table 2. Reimbursement for Prolonged Services

Code	Descriptor	Average Payment*
99354	Prolonged service, office, first hour	$91.97
99355	Prolonged service, office, each additional 30 min	$90.89
99356	Prolonged service, inpatient, first hour	$83.67
99357	Prolonged service, inpatient, each additional 30 min	$84.40

*Average national Medicare reimbursement

Table 3. Codes and Reimbursement for Follow-up Visits

Code	Descriptor	Physician Payment*	Hospital Payment*
99212	Established patient visit, level 2	$37.15	$68.96
99213	Established patient visit, level 3	$61.31	$68.96
99214	Established patient visit, level 4	$92.33	$89.74
99215	Established patient visit, level 5	$124.79	$113.57

*Average national Medicare reimbursement

CPT® code **99212** that is currently assigned to these services…Separate payment will be made for medically necessary post-therapy visits based on the documented level of E/M service for the post procedure encounter(s)…We [CMS] do not anticipate this change will have a significant impact on Medicare expenditures."

The removal of the 90-day global period applies *only* to high-dose-rate (HDR) treatments and *only* then for Medicare patients. In addition, while the HDR treatment no longer has a global period, the placement of tandem and/or ovoids (or other surgical applicator insertion procedures) includes a 90-day surgical global period, and subsequent applications for planned treatments may require modifier 58 (staged procedure).

Follow-up Visits: Exception 2

Although payers consider routine physician follow-up visits after radiation therapy treatment to be included in the treatment management service, physicians can charge for patient encounters for new medical conditions. For example, if the radiation oncologist treated the patient for lung cancer, mucositis and nausea while under treatment, the reimbursement for code **77427** (physician weekly treatment management) would include payment for any follow-up visits for these medical conditions. If the patient presents during the 90-day follow-up period with a complaint of dizziness, the physician would charge the visit with the "new" diagnosis of dizziness as the primary diagnosis code for the encounter.

This exception emphasizes the need for complete medical record documentation, especially the physician's notation of "chief complaint" for each patient encounter. The reimbursement impact is shown in Table 3, above.

While all healthcare entities should monitor services rendered and procedure codes charged on an ongoing basis, difficult economic times call for a more thorough analysis of billable procedures. Some of these services reimburse a small amount per encounter, but added up over a year they may constitute a significant increase in income.

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Resources

1. Centers for Medicare & Medicaid Services. *Federal Register,* December 1, 2006. (Physician Fee Schedule Final Rule). Available online at*: http://edocket.access.gpo.gov/2006/pdf/06-9086.pdf.* Last accessed Aug. 3, 2009.
2. Centers for Medicare & Medicaid Services. *MLN Matters 5972*. Available online at: *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5972.pdf*. Last accessed Aug. 3, 2009.