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Highlights of the 2011 HOPPS Final Rule

In the final HOPPS rule, payment rates for 2011 reflect a 2.35 percent increase. This update includes a 0.25 percentage point reduction required by the Patient Protection and Affordable Care Act. Hospitals that fail to meet the quality data reporting requirements will receive an update that is reduced by 2.0 percentage points. CMS projects that total Medicare payments to hospital outpatient departments will be approximately $39 billion in 2011.

In brief, here are changes from the HOPPS final rule that went into effect on Jan. 1, 2011.

Drugs, biologicals, and radiopharmaceuticals. CMS continues to use the same methodology and policies to establish payment for drugs, biologicals, and radiopharmaceuticals in 2011 as the agency used in 2010. The good news: the payment rate for separately payable drugs, biologicals, and radiopharmaceuticals without pass-through status increased to average sales price (ASP)+5 percent in 2011.

Pass-through status for drugs and biologicals. CMS continues pass-through status in 2011 for 31 drugs and biologicals. These products will be reimbursed at ASP+6 percent, equivalent to the rate these drugs and biologicals will receive in the physician's office setting in 2011.

Payment for therapeutic radiopharmaceuticals. CMS finalized its proposal to continue to reimburse all nonpass-through, separately payable therapeutic radiopharmaceuticals at the same rate as nonpass-through drugs and biologicals based on ASP information, if available, for a "patient-ready" dose and updated on a quarterly basis for products for which manufacturers report ASP data.

Packaging and "bundling". CMS increased the packaging threshold for drugs and biologicals from $65 per day to $70 per day. The agency also will continue packaging payment for all contrast agents and diagnostic radiopharmaceuticals regardless of their per day costs for 2011.

Payment for drug administration services. For CY 2011, CMS continues to use the full set of Current Procedural Terminology (CPT) codes for reporting drug administration services and continues to pay separately for the same set of drug administration codes under the 2011 OPPS as were paid separately in the 2010 OPPS. Table 1 on page 8 compares 2011 and 2010 HOPPS payment rates for drug administration services.

Physician supervision. CMS identified a set of services with a significant monitoring component that can extend for a sizable period of time, that are not surgical, and that typically have a low risk of complication after assessment at the beginning of the service, as "nonsurgical extended duration therapeutic services."

CMS considered four criteria when identifying the list of services that would apply: 1) the service must be of extended duration, frequently extending beyond normal business hours; 2) the service must have a substantial monitoring component typically conducted by auxiliary staff; 3) the service must have a low risk of requiring the physician's or appropriate nonphysician practitioner's immediate availability after initiation of the procedure; and 4) the service is not primarily surgical in nature.

The proposed list of nonsurgical extended duration therapeutic services includes several drug administration services, but CMS did not include chemotherapy or blood trans-

ACCC Efforts Pay off—Drug Reimbursement in HOPD Increases for 2011

On Nov. 2, 2010, the Centers for Medicare & Medicaid Services (CMS) released the hospital outpatient prospective payment system (HOPPS) final rule for 2011. In the final rule, the agency increased reimbursement for drugs and pharmacy services to ASP+5 percent from the 2010 rate of ASP+4 percent. ACCC has advocated for an increase for the past three years, ever since reimbursement began to decrease in 2007. While ACCC had hoped to keep reimbursement at ASP+6 percent—the payment rate in the HOPPS proposed rule released July 2, 2010—the one percent increase shows that ACCC's meetings with CMS staff and testimony before the APC Panel have finally succeeded.

Introducing an Exciting New ACCC Community Resource in 2011!

Here's an exciting new ACCC-member benefit. In January 2011 ACCC is preparing to launch a new community web portal to replace our current *ACCCExchange* listserve.

Why change?

- ACCC's current listserve looks outdated and does not allow easy access to archived information or building and sharing of profiles.
- ACCC's current listserve does not allow multiple communities. For example, administrators or oncology pharmacists cannot start their own community.
- ACCC's current listserve does not allow a Resource Library, in which members generate content and share documents.

Why change NOW?

In its recent survey, ACCC members shared their "wish list." Five of the "Top 10 Wish List Items" related to community building. ACCC members told us they want:

1. Community areas where they can share information with colleagues of like-minded interests.
2. An archive of posted listserve messages, easily searchable by topic.
3. The ability to post and edit their personal profile.
4. A place where they can build a professional network.
5. The opportunity to find an expert and ask questions directly.

ACCC will launch its new web portal called MYNETWORK to help members connect with colleagues, share interests, and stay current.

Look for an email alert with more detailed information.

fusions in the list because, as stated in the proposed rule, the agency believes that these services require the physician's or nonphysician practitioner's recurrent physical presence to evaluate the patient's condition in the event it is necessary to redirect the service. (See page 13 for more.)

In the CY 2012 HOPPS rulemaking cycle, CMS will propose to establish an independent review process that will allow for an assessment of the appropriate supervision levels for individual hospital outpatient therapeutic services.

ACCC members can review an in-depth analysis of the final rule as well as listen to an audio summary on the Members-only section of ACCC's website, *www.accc-cancer.org*.

Highlights of the 2011 MPFS Final Rule

In the final Medicare Physician Fee Schedule (MPFS) released on Nov. 2, 2010, CMS discusses several changes that will have a significant effect on payment for cancer care. An in-depth analysis of the rule can be found on ACCC's website at: *www.accc-cancer.org*. In brief, the MPFS final rule that went into effect on Jan. 1, 2011 will:

- Reduce physician payment rates in 2011 by an additional projected 10.1 percent, in addition to the 23 percent reduction that was scheduled to go into effect in December 2010, under the sustainable growth rate (SGR) formula.
- Continue the second year of a four-year transition to practice expense (PE) relative value units (RVUs) calculated using Physician Practice Information Survey (PPIS) survey data.
- Change the utilization rate for determining PE RVUs for diagnostic imaging equipment priced over $1 million and expand the list of services to which the higher equipment utilization rate assumption applies.
- Identify and revise potentially misvalued services under the PFS.
- Expand the imaging multiple procedure payment reduction (MPPR) policy by increasing the reduction from 25 percent to 50 percent and extending it to multiple imaging services provided not only within the same family of codes, but across such families, as well as add four additional CT Current Procedural Terminology (CPT) codes to the policy.
- Create a refined process for regularly updating the prices for equipment and supplies under the MPFS and discuss use of prices from the General Services Administration (GSA) medical supply schedule to update inputs for high-cost supplies.
- Rebase and revise the Medicare Economic Index (MEI).
- Address ASP issues, including ASP-based reimbursement rates for biosimilars, carry-over ASPs, partial quarter ASP data, treatment of overfill in the ASP calculation, and Widely Available Market Price (WAMP) / Average Manufacturer Price (AMP) substitution for ASP.
- Change the policy regarding requisitions for clinical laboratory tests.
- Implement changes to the Physician Quality Reporting Initiative (PQRI) and the Physician Resource Use Measurement and Reporting (RUR) Program under the Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act or 2010 (HCERA).

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Table 1. HOPPS Drug Administration Rates (2011 compared to 2010)

		2010			2011				
Code	**Description**	**SI**	**APC**	**Rate**	**SI**	**APC**	**Rate**	**Difference 2010-2011**	**% Change 2010-2011**
90471	Immunization admin	S	0436	$25.61	S	0436	$26.35	$0.74	2.89%
90472	Immunization admin, each addl	S	0436	$25.61	S	0436	$26.35	$0.74	2.89%
90473	Immune admin oral/nasal	S	0436	$25.61	S	0436	$26.35	$0.74	2.89%
90474	Immune admin oral/nasal addl	S	0436	$25.61	S	0436	$26.35	$0.74	2.89%
96360	Hydration iv inf, init	S	0438	$75.50	S	0438	$75.58	$0.08	0.11%
96361	Hydrate iv inf, add-on	S	0436	$25.61	S	0436	$26.35	$0.74	2.89%
96365	Ther/proph/diag iv inf, init	S	0439	$126.47	S	0439	$128.44	$1.97	1.56%
96366	Ther/proph/dg iv inf, add-on	S	0436	$25.61	S	0436	$26.35	$0.74	2.89%
96367	Tx/proph/dg addl seq iv inf	S	0437	$37.35	S	0437	$36.88	-$0.47	-1.26%
96368	Ther/diag concurrent inf	N			N			NA	NA
96369	Sc ther inf, up to 1 hr	S	0439	$126.47	S	0439	$128.44	$1.97	1.56%
96370	Sc ther inf, addl hr	S	0437	$37.35	S	0437	$36.88	-$0.47	-1.26%
96371	Sc ther inf, reset pump	S	0436	$25.61	S	0436	$26.35	$0.74	2.89%
96372	Ther/proph/diag inj, sc/im	S	0436	$25.61	S	0436	$26.35	$0.74	2.89%
96373	Ther/proph/diag inj, ia	S	0437	$37.35	S	0437	$36.88	-$0.47	-1.26%
96374	Ther/proph/diag inj, iv push	S	0437	$37.35	S	0437	$36.88	-$0.47	-1.26%
96375	Ther/proph/diag inj add-on	S	0437	$37.35	S	0437	$36.88	-$0.47	-1.26%
96376	Tx/pro/dx inj new drug add-on	N			N			NA	NA
96379	Ther/prop/diag inj/inf proc	S	0436	$25.61	S	0436	$26.35	$0.74	2.89%
96401	Chemo, anti-neopl, sq/im	S	0437	$37.35	S	0437	$36.88	-$0.47	-1.26%
96402	Chemo hormone antineopl sq/im	S	0437	$37.35	S	0437	$36.88	-$0.47	-1.26%
96405	Chemo intralesional, up to 7	S	0437	$37.35	S	0437	$36.88	-$0.47	-1.26%
96406	Chemo intralesional over 7	S	0439	$126.47	S	0439	$128.44	$1.97	1.56%
96409	Chemo, iv push, sngl drug	S	0439	$126.47	S	0439	$128.44	$1.97	1.56%
96411	Chemo, iv push, addl drug	S	0438	$75.50	S	0438	$75.58	$0.08	0.11%
96413	Chemo, iv inf, 1 hr	S	0440	$219.42	S	0440	$205.86	-$13.56	-6.18%
96415	Chemo, iv inf, addl hr	S	0437	$37.35	S	0437	$36.88	-$0.47	-1.26%
96416	Chemo prolong inf w/pump	S	0440	$219.42	S	0440	$205.86	-$13.56	-6.18%
96417	Chemo iv inf each addl seq	S	0438	$75.50	S	0438	$75.58	$0.08	0.11%
96420	Chemo, ia, push technique	S	0438	$75.50	S	0438	$75.58	$0.08	0.11%
96422	Chemo ia inf up to 1 hr	S	0440	$219.42	S	0440	$205.86	-$13.56	-6.18%
96423	Chemo ia inf each addl hr	S	0438	$75.50	S	0438	$75.58	$0.08	0.11%
96425	Chemotherapy, inf method	S	0440	$219.42	S	0440	$205.86	-$13.56	-6.18%
96440	Chemotherapy, intracavitary	S	0439	$126.47	S	0439	$128.44	$1.97	1.56%
96445	Chemotherapy, intracavitary	S	0440	$219.42	D			-$219.42	-100.00%
96446*	Chemo tx admn prtl cavity	S			S	0439	$128.44		
96450	Chemotherapy, into CNS	S	0440	$219.42	S	0440	$205.86	-$13.56	-6.18%
96521	Refill/maint, portable pump	S	0439	$126.47	S	0439	$128.44	$1.97	1.56%
96522	Refill/maint pump/resvr syst	S	0439	$126.47	S	0439	$128.44	$1.97	1.56%
96523	Irrig drug delivery device	Q1	0624	$41.23	Q1	0624	$43.58	$2.35	5.70%
96542	Chemotherapy injection	S	0438	$75.50	S	0438	$75.58	$0.08	0.11%
96549	Chemotherapy, unspecified	S	0436	$25.61	S	0436	$26.35	$0.74	2.89%
C8957	Prolonged iv inf, req pump	S	0440	$219.42	S	0440	$205.86	-$13.56	-6.18%
G0008	Admin influenza virus vaccine	S	0350	$25.61	S	0350	$26.35	$0.74	2.89%
G0009	Admin pneumococcal vaccine	S	0350	$25.61	S	0350	$26.35	$0.74	2.89%

SI = Status indicator
*= New code for 2011
Source: Health Policy Alternatives

See Table 2 at right for the estimated cumulative effect of the MPFS final rule on total Medicare payments to physicians involved in cancer care.

ACCC members can review an in-depth analysis of the final rule as well as listen to an audio summary on the Members-only section of ACCC's website, *www.accc-cancer.org*.

Table 2. Estimated Impact of Final 2011 MPFS

Specialty	Allowed Charges (in millions)	Combined Impact	
		Full	Transitional
Hematology and Oncology	$1,912	0%	-2%
Radiation Oncology	$1,939	-1%	-7%
Radiology	$5,052	-10%	-14%

Source: Health Policy Alternatives

CMS to Hold Listening Session on Outpatient Imaging Efficiency Measures

As reported in the Nov. 30, 2010, *BNA Health Care Daily Report*, CMS will hold a Jan. 31 listening session to solicit input from stakeholders to identify additional potential imaging efficiency measures for use in the Hospital Outpatient Quality Data Reporting Program (HOP QDRP). In 2010, the agency adopted four claims-based imaging measures, including mammography follow-up rates, abdomen CT use of contrast material, and thorax CT use of contrast material. The agency added three additional imaging efficiency measures in 2011.

According to CMS, public reporting of imaging efficiency measures is important because of the health risks and financial implications associated with the use of imaging procedures. In its notice, the agency said that "research shows that a significant portion of imaging services received by patients may be inappropriate; and immoderate use of diagnostic imaging also contributes to inflated medical technology costs."

Potential topics for consideration in the listening session will include:

- Other imaging procedures that would be appropriate candidates for imaging efficiency measures
- Data sources appropriate for imaging efficiency measures, e.g. claims data, chart abstracted data, EHRs, use of registries
- Other settings appropriate for imaging efficiency measures, in addition to outpatient hospitals
- Development of imaging measures using a diagnosis- or condition-based approach versus measures developed using a procedure-specific basis.

For information on how to register for this listening session and instructions on how to submit written comments, go to: *http://edocket.access.gpo.gov/2010/pdf/2010-29995.pdf.*