2013 Oncology Code Update

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Another year come and gone and still more code changes, new regulations, and nearly 3,000 pages of rules and guidelines to digest and incorporate into our hospitals, physician practices, and programs. In brief, here's what every community cancer center needs to know.

NEW AND REVISED CODES

Each year new codes are added, deleted, and revised. There are also updates to coding guidelines. All of these changes mean that community cancer centers must revise charge tickets, fee schedules, and other medical coding and financial documents to ensure that procedures are accurately charged. The following are key changes to CPT® procedure codes affecting oncology providers for calendar year (CY) 2013. Remember that new codes are effective Jan. 1, 2013, and cannot be reported during the final months of CY 2012.

One significant change is the widespread revision throughout the *CPT® Manual* to eliminate the word "physician" or to add the term "other qualified healthcare professional" to existing code descriptions. All of the office and outpatient visit codes and hospital inpatient and observation care codes were revised with the exception of discharge day management (codes **99238-99239**). This verbiage change ensures that non-physician practitioners can charge for services rendered in their own name and NPI number.

The 2013 *CPT Manual* also includes a clarification regarding the determination of new versus established patients for coding purposes:

When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician.

This means that if a mid-level provider working for an oncology practice evaluates a patient in the hospital and the patient is subsequently seen after discharge by an oncology physician of the same practice in the office, the office visit will be considered an established patient encounter.

There is a new code for target delineation for stereotactic body radiotherapy (SBRT), but this code will not be billed by the radiation oncologist. The code may be reported once per course of treatment by the pulmonary specialist who actively participates in computer planning and treatment management for thoracic SBRT:

- **32701:** Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment.

According to the 2013 *CPT® Manual:*

Target delineation involves specific determination of tumor borders to identify tumor volume and relationship with adjacent structures (e.g., chest wall, intraparenchymal vasculature, and atelectatic lung) and previously placed fiducial markers, when present. Target delineation also includes availability to identify and validate the thoracic target prior to treatment delivery when a fiducial-less tracking system is utilized.

One code revision affects radiation therapy. The code for removal of tongs or halo (**20665,** Removal of tongs or halo applied by another physician) has been revised for 2013 to reflect removal by another "individual" rather than another physician.

In the same manner as previously described, the physician venipuncture codes **36400-36410** have been revised to state they require the skill of "a physician or other qualified healthcare professional."

In addition, stem cell codes **38240, 38241,** and **38242** have been revised, and new code **38243** has been added. There has also been a change in terminology from bone marrow transplant to "hematopoietic progenitor cell (HPC) transplant." Hematopoietic cell transplantation (HCT) refers to the infusion of HPCs obtained from bone marrow, peripheral blood apheresis, and/or umbilical cord blood. These codes now report:

- **38240:** Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor
- **38241:** Autologous transplantation
- **38242:** Allogeneic lymphocyte infusions
- **38243:** Hematopoietic progenitor cell (HPC); HPC boost.

Table 1. New Hematology & Oncology Codes for 2013

CODE	DEFINITION
C9294	Injection, taliglucerase alfa, 10 units
C9295	Injection, carfilzomib, 1 mg
C9296	Injection, ziv-aflibercept, 1 mg
J1744	Injection, icatibant, 1 mg
J7315	Mitomycin, ophthalmic, 0.2 mg

Table 2. Hematology & Oncology Drug Codes with Revised Verbiage for 2013

CODE	DEFINITION
J9280	Injection, mitomycin, 5 mg
J1561	Injection, immune globulin, (Gamunex-C/Gammaked), non-lyophilized (e.g., liquid), 500 mg
J1569	Injection, immune globulin, (Gammagard liquid), non-lyophilized (e.g., liquid), 500 mg

Table 3. Deleted Codes Replaced with New HCPCS Codes

2012 CODE (DELETED)		2013 CODE (NEW)	
Q2046	Injection, aflibercept, 1 mg	**J0178**	Injection, aflibercept, 1 mg
Q2047	Injection, peginesatide, 0.1 mg (for ESRD on dialysis)	**J0890**	Injection, peginesatide, 0.1 mg (for ESRD on dialysis)
C9279	Injection, ibuprofen, 100 mg	**J1741**	Injection, ibuprofen, 100 mg
J8561	Everolimus, oral, 0.25 mg	**J7527**	Everolimus, oral, 0.25 mg
Q2045	Injection, human fibrinogen concentrate, 1 mg	**J7178**	Injection, human fibrinogen concentrate, 1 mg
J1680	Injection, human fibrinogen concentrate, 100 mg		
C9289	Injection, asparaginase erwinia chrysanthemi, 1000 IU	**J9019**	Injection, asparaginase (erwinaze), 1000 IU
J9020	Injection, asparaginase, 10,000 units	**J9020**	Injection, asparaginase, not otherwise specified, 10,000 units
C9287	Injection, brentuximab vedotin, 1 mg	**J9042**	Injection, brentuximab vedotin, 1 mg

These procedures include:

- Physician monitoring of multiple physiologic parameters
- Physician verification of cell processing
- Evaluation of the patient during as well as immediately before and after the HPC or lymphocyte infusion
- Physician presence during the infusion with associated direct physician supervision of clinical staff
- Management of uncomplicated adverse events (e.g., nausea, urticaria).

While management of these uncomplicated effects is not separately charged, post-transplant infusion management of significant adverse reactions is reported separately using the evaluation and management, prolonged services, or critical care codes.

Last, incidental hydration and the infusion of medications concurrently with the transplant infusion are not separately reported. The new coding instructions add:

However, hydration or administration of medications (e.g., antibiotics, narcotics) unrelated to the transplant are separately reportable using modifier 59.

There is also a new HCPCS Level II code that will only be reported in Ambulatory Surgical Centers (ASCs):

- **G0458:** Low dose rate (LDR) prostate brachytherapy, composite rate.

Effective Jan. 1, 2013, ASCs will report this single HCPCS code for LDR prostate brachytherapy performed in an ambulatory surgical center, instead of codes **77778** (Complex interstitial source application) and **55875** (Transperineal placement of needles into prostate) for the components of the procedure. This new code provides for a single reimbursement for the facility service; the physician(s) performing the procedure will continue to report the respective procedure code(s) for the portion of the service performed.

According to CMS in the 2013 final rule:[1]

We are finalizing our proposal, without modification, to establish the CY 2013 ASC payment rate for LDR prostate brachytherapy services based on the OPPS relative payment weight applicable to APC 8001 when CPT codes 55875 and 77778 are performed on the same date of service in an ASC. ASCs will use the corresponding HCPCS Level II G-code (G0458) for proper reporting when the procedures described by CPT codes 55875 and 77778 are performed on the same date of service, and therefore receive the appropriate LDR prostate brachytherapy composite payment. When not performed on the same day as the service described by CPT code 55875, the service described by CPT code 77778 will continue to be assigned to APC 0651. When not performed on the same day as the service described by CPT code 77778, the service described by CPT code 55875 will continue to be assigned to APC 0163.

Table 1 (page 11) lists the new codes established for hematology and oncology drugs. Drug codes with revised verbiage for CY 2013 are in Table 2 (above). Table 3 (above) shows codes that were deleted and replaced with new HCPCS codes.

During CY 2012, two new Q codes (**Q2048** and **Q2049**) were created for liposomal doxorubicin, which is used to treat ovarian and other cancers. The new codes were created to distinguish between Doxil® **(Q2048),** which was in short supply, and Lipodox® **(Q2049),** an imported drug that the FDA allowed on a temporary basis during the Doxil shortage. The Doxil code **(Q2048)** will be deleted along with code **J9001,** which was used for Doxil prior to creation of the Q codes. Doxil will now be reported with new HCPCS code **J9002.** Note that the Lipodox code **(Q2049)** has not been deleted. Also, code **J9000,** which represents non-liposomal doxorubicin, has not been revised or deleted.

While it is important to know these changes so that community cancer centers can code correctly for services provided, the existence of a procedure or supply code *does not* guarantee reimbursement. Instead, payment for a service depends on the patient's insurance policy, medical necessity, and other determining factors.

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HOSPITAL REGULATORY UPDATE

On Nov. 2, 2012, the Centers for Medicare & Medicaid services (CMS) released its final rule updating the Medicare Hospital Outpatient Prospective Payment System (HOPPS or OPPS) for CY 2013.[1] This final rule was published in the Nov. 15 *Federal Register,* and affects more than 4,000 hospital outpatient departments and 5,000 Medicare-participating ASCs. The rates and policies set in the CY 2013 final rule increase payment rates for outpatient hospital departments by 1.8 percent and ASC payment rates by 0.6 percent.

In addition, the rule contained a significant change from prior policy: as proposed, the rule bases relative payment weights on geometric mean costs rather than median costs. CMS believes that basing payments on mean costs better reflects average costs of services and aligns the metric used for rate-setting for the OPPS with the IPPS (Inpatient Prospective Payment System).

The final rule also made several changes to the quality reporting program for outpatient hospital departments. While CMS did not add any new measures to those finalized for the CY 2014 payment determination, it did confirm the removal of one measure, deferred data collection for a second measure, and suspended data collection for a third measure. Finally, the rule strengthened the operations of the Quality Improvement Organizations (QIOs), making them more responsive to beneficiary complaints regarding quality of care.

Outpatient Supervision

There was no change to the outpatient supervision requirements for radiation oncology. At present, radiation oncology services require direct supervision, which CMS lists as the default supervision level for outpatient therapeutic services. There was no change to the definition or requirements of direct supervision (immediately available, interruptible, and able to provide direction and assistance) in the final rule.

CMS did not alter hospital outpatient supervision guidelines for infusion center services in this final rule, but a Sept. 24, 2012, document titled *CMS' Preliminary Decisions on the Recommendations of the Hospital Outpatient Payment Panel on Supervision Levels for Select Services*[2] states that CMS intends to adopt recommendations from the Hospital Outpatient Payment Panel to update the supervision level of the following services from direct supervision to general supervision:

- **36000:** Introduction of needle or intracatheter vein
- **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
- **96360:** Intravenous infusion, hydration; initial, 31 minutes to 1 hour
- **96361:** Intravenous infusion, hydration; each additional hour
- **96521:** Refilling and maintenance of portable pump
- **96523:** Irrigation of implanted venous access device for drug delivery systems.

Last, CMS again issued instructions to contractors to not enforce the direct supervision requirement in Critical Access Hospitals (CAHs) for CY 2013 and will continue to expand this non-enforcement to include small rural hospitals with 100 or fewer beds. CMS states: "Regarding the enforcement instruction, as we discussed in the CY 2013 OPPS/ASC proposed rule, we will extend the enforcement instruction one additional year through CY 2013. This additional year, which we expect to be the final year of the extension, will provide additional opportunities for stakeholders to bring their issues to the [Hospital Outpatient Payment] Panel, and for the Panel to evaluate and provide us with recommendations on those issues."

Brachytherapy

CMS will continue paying for LDR prostate brachytherapy services performed in the hospital outpatient department using the composite APC methodology implemented for previous years. The final CY 2013 median cost for composite APC **8001** is approximately $3348.00. In addition, CMS finalized the proposal to reimburse brachytherapy sources at prospective payment rates based on their source-specific geometric mean costs for CY 2013. A comment received and published in the final rule relating to brachytherapy states:[1]

COMMENT: One commenter requested that CMS add a new C-code and APC for a high-activity cesium-131 brachytherapy source, which is designed to generate isotropic emission of therapeutic radiation and to be used primarily for the treatment of head and neck and eye cancer.

RESPONSE: We appreciate the commenter informing us of a new high-activity cesium-131 source. However, our evaluation process of new sources for addition to our set of codes is beyond the scope of this rulemaking. As we state elsewhere in this final rule with comment period, and in previous rules, such as the CY 2012 OPPS/ASC final rule with comment period (76 FR 74163), we ask parties to submit recommendations to us for new HCPCS codes to describe new brachytherapy sources consisting of a radioactive isotope, including a detailed rationale to support recommended new sources. We suggest to the commenter to send its recommendation for this new brachytherapy source, along with the detailed rationale to support the new source, to the address provided at the end of this section. We will continue to add new brachytherapy source codes and descriptors to our systems on a quarterly basis.

Other Radiation Oncology Issues

APCs **0664** and **0667** for proton beam treatment delivery will undergo a 4 percent and 56 percent payment reduction, respectively. APC **0664** includes the codes for simple proton therapy (codes **77520** and **77522**) and APC **0667** includes the codes for intermediate **(77523)** and complex **(77525)** proton treatments. While several commenters indicated that the decrease in the cost of APC **0667** can be attributed to inaccurate coding and incorrect cost reporting from one facility, CMS has updated the payment rates based on data received from all providers. This change means that simple proton therapy treatment will pay approximately $1169.00 per treatment, while intermediate and complex proton treatments will only reimburse about $702.00 per treatment in CY 2013.

As in the previous year, claims cost data for the IMRT device (code **77338**) illustrates an average reported cost of $293.00; as a result, CMS will continue to assign this code to APC **305,** with a final rule geometric mean cost of approximately $297.00.

During CY 2012, CMS packaged the payment for intraoperative radiation therapy (IORT) services into the payment for the principal surgical procedure performed during the same operative session. After review, CMS agrees that codes **77424** and **77425** should be separately reimbursed, but do not qualify for a new technology APC. As a result, these codes will be assigned to APC **0065** (Level I Stereotactic Radiosurgery) with a geometric mean cost of approximately $1006.00.

Packaged Services

CMS continues to package image guidance procedures under the OPPS in 2013 and assigns these codes a status indicator of "N" (items and services packaged into APC rates). This policy affects codes:

- **76950:** Ultrasonic guidance for placement of radiation fields
- **76965:** Ultrasonic guidance for interstitial radioelement application
- **77014:** CT guidance for placement of radiation fields
- **77417:** Therapeutic radiology port films
- **77421:** Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy.

While hospitals will continue to bill for these packaged services separately, there will be no separate payment for radiation therapy image guidance in 2013.

The final rule includes the following comment and response:[1]

COMMENT: One commenter asked that CMS reinstate separate payment for radiation oncology guidance procedures because these services are vital to the safe provision of radiation therapy and unconditionally packaging payment for them may discourage hospitals from providing them.

RESPONSE: As we stated in the CY 2012 OPPS/ASC final rule with comment period (76 FR 74188), we recognize that radiation oncology guidance services, like most packaged services, are important to providing safe and high quality care to patients. However, we continue to believe that hospitals will invest in services that represent genuinely increased value to patient care. We will continue to pay separately for innovative technologies if a device meets the conditions for separate payment as a pass-through device or if a new procedure meets the criteria for payment as a new technology APC.

CMS continues to stress that hospitals should report all HCPCS codes that describe packaged services provided, unless the CPT Editorial Panel or CMS provide other guidance. CMS stated that failure to report codes for packaged services makes it difficult to track utilization patterns and resource costs.

Table 4. Hematology & Oncology Drugs that Lost Pass-Through Status Effective Dec. 31, 2012

CY 2013 HCPCS CODE	CY 2013 LONG DESCRIPTOR	CY 2013 SI*	CY 2013 APC
J0597	Injection, C-1 esterase inhibitor (human), Berinert, 10 units	K	9269
J0897	Injection, denosumab, 1 mg	K	9272
J1290	Injection, ecallantide, 1 mg	K	9263
J1557	Injection, immune globulin (Gammaplex), intravenous, non-lyophilized (e.g., liquid), 500 mg	K	9270
J1741	Injection, ibuprofen, 100 mg	N	N/A
J3385	Injection, velaglucerase alfa, 100 units	K	9271
J7183	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO	K	1352
J8562	Fludarabine phosphate, oral, 10 mg	K	1339
J9043	Injection, cabazitaxel, 1 mg	K	1339
J9302	Injection, ofatumumab, 10 mg	K	9260
J9307	Injection, pralatrexate, 1 mg	K	9259
J9315	Injection, romidepsin, 1 mg	K	9265
Q2043	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion	K	9373

Table 5. Hematology & Oncology Drugs With Pass-Through Status in 2013

CODE	DEFINITION
C9292	Injection, pertuzumab, 10 mg
C9293	Injection, glucarpidase, 10 units
C9294	Injection, taliglucerase alfa, 100 units
C9295	Injection, carfilzomib, 1 mg
C9296	Injection, ziv-aflibercept, 1 mg
J9042	Injection, brentuximab vedotin, 1 mg
J9019	Injection, asparaginase (erwinaze), 1000 IU
J0131	Injection, acetaminophen, 10 mg
J0178	Injection, aflibercept, 1 mg
J0490	Injection, belimumab, 10 mg
J0638	Injection, canakinumab, 1 mg
J1572	Injection, immune globulin, (Flebogamma/Flebogamma dif), intravenous, non-lyophilized (e.g., liquid), 500 mg
J7180	Injection, factor XIII (antihemophilic factor, human), 1 IU
J9179	Injection, eribulin mesylate, 1 mg
J9228	Injection, ipilimumab, 1 mg

Payments to Cancer Hospitals

Since the inception of the OPPS, Medicare has paid designated cancer hospitals for covered outpatient hospital services. There are 11 cancer hospitals that meet the classification criteria. The Affordable Care Act (ACA) states that if the cancer hospitals' costs are determined to be greater than the costs of other hospitals paid under the OPPS, the Secretary shall provide an appropriate adjustment to reflect these higher costs. Section 3138 of the Act also requires that this adjustment be budget-neutral.

CMS has concluded that cancer hospitals are more costly than other hospitals paid under the OPPS. CMS estimates that on average, the OPPS payments to the 11 cancer hospitals are approximately 67 percent of reasonable costs, whereas, CMS estimates the OPPS payments to other hospitals are approximately 91 percent of reasonable costs.

For CY 2013, CMS will continue to provide additional payments to cancer hospitals so that the hospital's payment-to-cost ratio (PCR) with the payment adjustment is equal to the weighted average PCR for the other OPPS hospitals using the most recent submitted or settled cost-report data.

Infusion Center Issues

For CY 2013 CMS will pay for both pass-through drugs and biologicals and for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals without pass-through status at ASP+6 percent. CMS will also continue to include antiemetic drugs in the drug packaging rules. These drugs will be paid separately only if their average cost per day is greater than $80, which is the 2013 OPPS drug packaging threshold. Currently, the only 5-HT3 antiemetic that meets the criteria for separate payment is palonosetron HCl (code **J2469**).

In the 2013 OPPS Final Rule, CMS provides the following comments on 5-HT3 antiemetics:[1]

We continue to believe that the use of these antiemetics is an integral part of an anticancer treatment regimen and that OPPS claims data demonstrates their increasingly common hospital outpatient utilization. As we stated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60488), we no longer believe that a specific exemption to our standard drug payment methodology is necessary to ensure access to the most appropriate antiemetic products for Medicare beneficiaries. We continue to believe that our analysis conducted in the CY 2010 OPPS/ASC proposed rule on 5-HT3 antiemetics (74 FR 35320), along with the historical stability in prescribing patterns for these products and the availability of generic alternatives for several of these products, allows us to continue our policy of not specifically exempting these products from the OPPS drug packaging threshold.

CMS also finalized its proposal to provide payment for blood clotting factors under the same methodology as other separately payable drugs and biologicals under the OPPS (ASP+6 percent) and to continue payment of an updated furnishing fee (to be posted on the CMS website at a later date).

CMS announced that a total of 23 medicines and biological substances, including the hematology and oncology drugs in Table 4, page 17, are losing their pass-through status effective Dec. 31, 2012. Once pass-through status expires, the drug will be paid separately only if the estimated cost per day is greater than the OPPS packaging threshold of $80. Status Indicator N means that the charge will be packaged into the reimbursement for the primary service that day. Status indicator K indicates that this drug is a non-pass-through drug subject to payment at the APC allowance.

CMS has granted or will continue pass-through status to 26 drugs and biologicals in CY 2013, including the hematology and oncology drugs in Table 5, left.

References

1. CMS. 2013 Medicare OPPS Final Rule. Available online at: *www.gpo.gov/fdsys/pkg/FR-2012-11-15/pdf/2012-26902.pdf*. Last accessed Dec. 4, 2012.
2. CMS. Preliminary Decisions on the Recommendations of the Hospital Outpatient Payment Panel on Supervision Levels for Select Services. Available online at: *www.cms.gov/Regulations-and-Guidance/Guidance/FACA/Downloads/Prelim-Supervision-Decisions092412.pdf*. Last accessed Dec. 3, 2012.

PHYSICIAN PRACTICES & FREESTANDING CENTERS

The Medicare Physician Fee Schedule (MPFS) specifies payment rates to physicians and other providers, including freestanding radiation oncology centers, for more than 7,000 healthcare services and procedures, ranging from simple office visits to complex surgery. The 2012 MPFS final rule was posted to the CMS website on Nov. 2, 2012, and was published in the Nov. 16 *Federal Register*.[1] All payments and policies are effective Jan. 1, 2013.

Conversion Factor

The conversion factor is updated on an annual basis according to a formula specified by statute, which is designed to rein in the growth in outlays for physician services. The formula requires CMS to adjust the conversion factor up or down depending on how actual expenditures compare to a target rate called the Sustainable Growth Rate (SGR).

The SGR is a formula that was adopted in 1997 under the Balanced Budget Act. If actual expenditures exceed the expenditures allowed by the formula, the conversion factor update is reduced. Congress has taken a series of legislative actions to avoid reductions to MPFS rates since 2003; however, a long-term solution is critical. There is currently a substantial difference between target and actual spending that must be accounted for through future reductions to MPFS rates.

On Jan. 1, 2013, Congress once again stepped in with a "doc fix" preventing an overall reduction of 26.5 percent to the conversion factor used to calculate payment for services provided by more than 1 million physician and qualified midlevel providers. In addition, payments to primary care specialties will increase and payments to select other specialties will decrease due to several changes in how CMS calculated payments for CY 2013.

The largest payment increase for primary care specialties overall will result from a new payment for managing a beneficiary's care when the beneficiary is discharged from an inpatient hospital, a skilled nursing facility, an outpatient hospital observation, partial hospitalization services, or a community mental health center. Payments to primary care specialties also will increase due to redistributions from changes in payments for services furnished by other specialties. Remember that because of the budget-neutral nature of this system, increases in payments for one service result in decreases in payments for other services.

Radiation Oncology Updates

CMS finalized its proposal to adjust intra-service procedure time assumptions for IMRT delivery (code **77418**) from 60 to 30 minutes and SBRT delivery (code **77373**) from 90 to 60 minutes. However, CMS adjusted other direct practice expense inputs for these services, which results in 2013 interim RVUs of 11.92 for **77418** and 37.30 for **77373** with decreases from 2012 payment rates of 14.7 percent and 20.5 percent, respectively. According to the final rule:[1]

Because the physician work associated with these treatments is reported using codes distinct from the treatment delivery, the primary determinant of PE RVUs for these codes is the number of minutes allocated for the procedure time to both the clinical labor (radiation therapist) and the resource-intensive capital equipment included as direct PE inputs.

It has come to our attention that there are discrepancies between the procedure time assumptions used in establishing nonfacility PE RVUs for these codes and the procedure times made widely available to Medicare beneficiaries and the general public.

Specifically, the direct PE inputs for IMRT treatment delivery (code 77418) reflect a procedure time assumption of 60 minutes. Information available to Medicare beneficiaries and the general public indicates that IMRT sessions typically last between 10 and 30 minutes.

The direct PE inputs for SBRT treatment delivery (code 77373) reflect a procedure time assumption of 90 minutes. In 2012, information available to Medicare beneficiaries and the general public states that SBRT treatment typically lasts no longer than 60 minutes.

Table 6. 2013 Procedure Code Recommendations & RVU Assignments

HCPCS CODE	CY 2012 WORK RVU	AMA RUC/HCPAC Recommended Work RVU	CY 2013 Interim Final Work RVU	Agree/Disagree with AMA RUC/HCPAC Recommended Work RVU	CMS Refinement to AMA/HCPAC Recommended RVU
38240	2.24	4.00	3.00	Disagree	No
38241	2.24	3.00	3.00	Agree	No
38242	1.71	2.11	2.11	Agree	No
38243	New	2.13	2.13	Agree	No

Table 7. Combined 2013 Total Allowed Charge Impact by Specialty*

SPECIALTY	IMPACT END OF PPIS TRANSITION	NEW & REVISED CODES, MPPR, NEW UTILIZATION & OTHER FACTORS	UPDATED EQUIPMENT INTEREST RATE ASSUMPTION	TRANSITIONAL CARE MANAGEMENT	INPUT CHANGES FOR CERTAIN RADIATION THERAPY PROCEDURES	TOTAL (CUMULATIVE IMPACT)
Hematology Oncology	-1%	3%	1%	-1%	0%	2%
Radiation Oncology	-4%	2%	-3%	-1%	-1%	-7%
Radiation Therapy Centers	-5%	4%	-5%	-1%	-1%	-9%

Column Definitions:
1. Impact of End of PPIS Transition: This column shows the estimated CY 2013 impact on total allowed charges of the changes in the RVUs due to the final year of the PPIS transition.
2. Impact of New and Revised Codes, Updated Claims Data, MPPR on the TC of Ophthalmology and Cardiovascular Diagnostic Tests and Other Factors: This column shows the estimated CY 2013 impact on total allowed charges of the changes in the RVUs, due to new and revised codes, proposed multiple procedure payment reduction for the TC of cardiovascular and ophthalmology diagnostic tests furnished on the same day and other final policies that resulted in minimal redistribution of payments under the PFS, the use of CY 2011 claims data to model payment rates, and other factors.
3. Impact of Updated Equipment Interest Rate Assumption: This column shows the estimated CY 2013 impact on total allowed charges of the changes in RVUs resulting from our update to the equipment interest rate assumption as discussed in section III.A.2.f of this Final Rule with comment period.
4. Impact of Discharge Transitional Care Management Services: This column shows the estimated CY 2013 combined impact on total allowed charges of the changes in the RVUs resulting from CMS policy to recognize new CPT codes that pay for post-discharge transitional care management services in the 30 days following an inpatient hospital, outpatient observation or partial hospitalization, skilled nursing facility (SNF), or community mental health center (CMHC) discharge as discussed in section III.H.1 of this Final Rule with comment period.
5. Impact of Input and Price Changes for Certain Radiation Therapy Procedures: This column shows the estimated CY 2013 combined impact on total allowed charges of the changes in the RVUs resulting from CMS policy to adjust inputs on certain radiation therapy procedures.
6. Cumulative Impact: This column shows the estimated CY 2013 combined impact on total allowed charges of all changes from the policies in this Final Rule with comment period in the previous columns.

We believe medical societies and practitioners strive to offer their cancer patients accurate information regarding the IMRT or SBRT treatment experience. Therefore, we believe that the typical procedure time for IMRT delivery is between 10 and 30 minutes and that the typical procedure time for SBRT delivery is under 60 minutes.

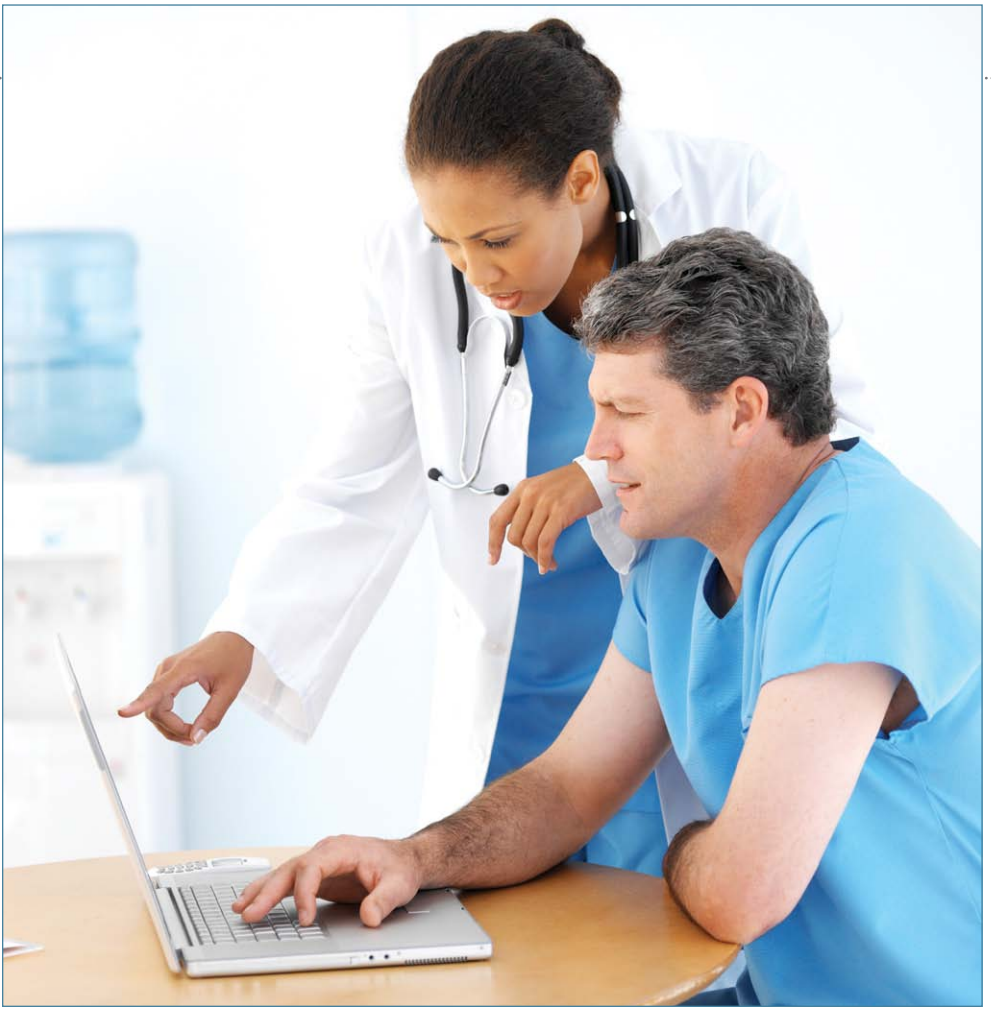
While we generally have not used publicly available resources to establish procedure time assumptions, we believe that the procedure time assumptions used in setting payment rates for the Medicare PFS should be derived from the most accurate information available. In the case of these services, we believe that the need to reconcile the discrepancies between our existing assumptions and more accurate information outweighs the potential value in maintaining relativity offered by only considering data from one source.

CMS also finalized the proposal to review procedure code **77336,** continuing physics consultation, as a potentially misvalued code due to changes in technology, knowledge required, and effort expended. The AMA RUC will review this service and provide recommendations to CMS on its valuation, and the AAPM will submit information on practice expense inputs and other data to support the revaluation of this code. In addition, CMS finalized the proposal to review and make adjustments to procedure codes with stand-alone procedure time assumptions used in developing PE RVUs, including the following radiation oncology codes:

- **77280-77290:** Therapeutic radiology simulation-aided field setting
- **77301:** Intensity modulated radiotherapy plan
- **77338:** MLC devices for IMRT
- **77372:** SRS radiation treatment delivery
- **77373:** SBRT radiation treatment delivery
- **77402-77416:** Radiation treatment delivery
- **77418:** IMRT treatment delivery
- **77600:** Hyperthermia, externally generated
- **77785-77787:** HDR brachytherapy administration.

Another area that will have a negative impact on radiation oncology reimbursement surrounds CMS' decision to finalize its proposal to replace the current interest rate assumption of 11 percent with a "sliding scale approach" based on current Small Business Administration (SBA) maximum interest rates for different categories of loan size. In addition, this final rule reviews the CMS initiative to bundle payments and provide a single allowance for an entire course of treatment. Specifically, this rule states:

Additionally, we have had representatives of specialty groups such as radiation oncologists volunteer to work with us to



create a bundled payment for their services. If we were to engage in a bundling project for radiation therapy, we would want to do more than provide a single episode payment for normal course of radiation therapy that aggregates the sum of the individual treatments. Radiation therapy has many common side effects that can vary based on the type of cancer the patient has and how it is being treated. Common side effects associated with radiation therapy include fatigue, skin problems, eating problems, blood count changes, emotional issues such as depression, etc. If we were to engage in a bundling project that includes radiation therapy, we would be interested in exploring whether it could also include treating and managing the side effects that result from radiation therapy in addition to the radiation therapy itself. Such an episode-based payment would allow Medicare to pay for the full course of the typical radiation therapy as well as the many medical services the patient may be receiving to treat side effects.

Although CMS has not adopted a bundled reimbursement for any oncology services to date, government and non-government payers continue to explore this option.

Medical Oncology Updates

Procedure codes **38240, 38241, 38242,** and **38443** were reviewed by the CPT Editorial Panel for CY 2013; the recommendations and RVU assignments can be found in Table 6, page 19.

CMS states that it will continue to maintain 5 percent widely available market price (WAMP) and average manufacturer price (AMP) thresholds, which have been stable at the current rate since CY 2005. As noted in the proposed rule, available data are limited and there is no information that would prompt CMS to believe different thresholds are necessary.

Transitional Care Coordination Codes

The MPFS final rule replaces a proposed HCPCS Level II code with the transitional care management codes created by the American Medical Association and effective Jan. 1, 2013. These two new codes require a face-to-face visit with the beneficiary within 7 to 14 days of discharge by the physician who will coordinate all of the beneficiary's care for 30 days following hospital or other inpatient stay. The goal of this care is to prevent hospital readmissions by monitoring all patient medical conditions, and the intent is to benefit primary care physicians through an estimated 7 percent overall payment increase.

Summary

Based on reimbursement changes associated with this final rule, radiation therapy centers will see an estimated overall decrease of 9 percent, primarily as a result of the PPIS (Physician Practice Information Survey) transition discussed above and a change in the interest rate assumption used to calculate practice expense. Radiation oncologists (professional services) will experience an approximate 7 percent decrease for the same reasons as those listed for radiation therapy centers.

Table 7, left, shows the combined 2013 total allowed charge impact by specialty listed by CMS. Note: these percentages do *not* include the potential cost factor reduction. OI

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References

1. CMS. 2013 Medicare Physician Fee Schedule Final Rule. Available online at: *www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf*. Last accessed Dec. 4, 2012.