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Final RBRVS Rules Benefit Oncologists

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single treatment area, single port or parallel opposed ports, simple blocks or no blocks, up to 5 Me, AND

- 77412—Radiation therapy delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (i.e., electron or neutron), up to 5 MeV

For each of these last three procedures, three hospitals reported payments less than RBRVS, and one reported receiving the same reimbursement as RBRVS.

- 77781—Remote afterloading high intensity brachytherapy, 5–8 source positions or catheters
  AND
- 77782—Remote afterloading high intensity brachytherapy, 9–12 source positions or catheters.

Approximately half of the respondents indicate their reimbursement is higher than RBRVS, whereas others indicate reimbursement lower than RBRVS. However, as more complex codes for Remote afterloading brachytherapy are used, specifically CPT 77783 (9–12 source positions or catheters) and 77784 (more than 12 source positions or catheters), the majority of hospitals report higher payments than the RBRVS schedule of payments.

It is obvious from the results of this limited survey that the majority of U.S. hospitals are receiving a higher reimbursement for hospital-based radiation therapy services, than the RBRVS reimbursement

Final RBRVS rules benefit oncologists

Oncologists will experience increased Medicare payments due to the Health Care Financing Administration's (HCFA's) revision to the 1993 Medicare physician fee schedule. Despite a 2.8 percent across-the-board reduction imposed because of an increased volume of total physician services in 1992, oncologists will benefit from HCFA's adoption of a number of payment changes recommended by ACCC, ASCO, and other oncology-related organizations.

Pushes and infusions

Under HCFA's policy, oncologists could not charge for a chemotherapy push and infusion during the same office visit. Effective January 1, 1993, HCFA reversed this policy and Medicare will now allow a separate chemotherapy administration payment for both procedures. However, the final rule continues to disallow payment for multiple pushes.

Chemotherapy management

Based on the results of Harvard's Phase III study of hematology and oncology vignettes, HCFA has stated that the data suggest that there is more physician work involved in chemotherapy administration than other types of physician visits. However, the Agency believes the data to be inconclusive and, therefore, it has declined to establish new chemotherapy management codes at this point in time. Leadership of ACCC and ASCO intend to continue negotiations with HCFA on this matter and remain optimistic that new codes will be created in the future.

HCFA did rule that oncologists may bill a Level I visit Evaluation and Management (E/M) code, even if they do not have face-to-face contact with the patient, as long as they are actively involved in managing the patient's chemotherapy administration. The medical record must reflect these activities (i.e., reviewing laboratory results, consultations with nursing personnel, dosage adjustments, etc.). HCFA has also stipulated that the service must be provided in the office setting and under the oncologist's direction.

Supplies

The final rule provides increased payment for specific CPT codes to reflect supply costs associated with chemotherapy administration. Data submitted to HCFA reflecting previous, separate payments by Medicare carriers for the supplies associated with chemotherapy administration convinced the Agency that a number of 1992 CPT codes did not adequately reimburse oncologists for these expenses. In specific, relative values have been increased for:

- CPT code 96408 (chemotherapy, intravenous push), resulting in an average increased payment of $2.33;
- CPT code 96410 (chemotherapy, intravenous infusion, first hour), resulting in an average increase of $5.47;
- CPT code 96420 (chemotherapy, intra-arterial push), with an increased payment of $2.71; and
- CPT code 96422 (chemotherapy, intra-arterial infusion, first hour), for an average increase of $5.39.

HCFA says these increases represent a temporary measure and that the Agency will continue to study the supply

structure in freestanding facilities. Furthermore, it is also apparent from the survey that the higher and more complex procedures receive more than RBRVS regardless of the region or hospital.

As the blending formula is gradually eliminated and hospitals convert to an RBRVS-only payment, identical to the freestanding reimbursement, the hospital financial margin for this service will be much less than under the previous compensation structure. However, the hospital setting still has two significant advantages over freestanding centers: a federal rate for inpatient capital equipment costs and cost reimbursement for outpatient capital equipment expenditures. Also, as a large entity, hospitals have the financial leverage to purchase new equipment and increase their volumes, whereas, freestanding entities rely on entrepreneurs and investors that now have to contend with the new Safe Harbor investment guidelines.

If this survey is repeated in another 5 or 10 years, other reimbursement issues, such as Ambulatory Patient Groups (APGs) will have affected the payment system for hospitals and freestanding facilities, especially as the Clinton health care reform package goes into effect. If the past decade is any gauge of the future, one can only predict further reductions in payment and more refinement in services: one that will surely affect radiation therapy.

costs associated with chemotherapy administration.

Oncologists will also see increased payments for the expensive procedure trays (lumbar puncture, thoracentesis, venous access catheters, bone marrow aspiration, catheter insertion, and surgical trays). HCFA's slight increase in the conversion factor (0.8 percent) will increase reimbursement for these items to $31.25 in 1993.

Evaluation & Management visits

The relative values for the middle and higher levels of E/M codes has been increased. Physicians successfully argued that physician work per unit of time per visit is constant. Initially, HCFA contended that the amount of work decreased as the length of the visit increased. The final rule, which now reflects work per unit of time as a constant value, results in slight payment increases for visit levels 3, 4, and 5.

Other chemotherapy changes

The relative values for specialized chemotherapy codes requiring needle placement have been increased by HCFA. CPT code 96440 (chemotherapy requiring thoracentesis) has been increased from 2.50 to 3.32; CPT code 96445 (chemotherapy requiring paracentesis) has been increased from 3.00 to 3.34; and CPT code 96450 (chemotherapy requiring lumbar puncture) has been increased from 2.25 to 2.89.

In addition, the final rule contains a new code for subarachnoid or intraventricular chemotherapy administration of single or multiple agents via a subcutaneous reservoir. The new code—96542—has been assigned a relative value of 2.70.

Finally, HCFA lowered the practice expense components for two chemotherapy codes, because limited charge data were available for these infrequently used codes in 1992. The practice expenses for CPT codes 96423 (intra-arterial infusion, after the first hour) and 96445 (chemotherapy requiring paracentesis) have both been downgraded.

Overall Changes to RBRVS

In 1992, the volume of physician services exceeded the level of total Medicare expenditures allowed by Congress. As a result, HCFA has reduced the 1993 inflation adjustment by 2.8 percent. This decrease, which is tempered by the 0.8 percent increase in the conversion factor, will result in slightly lower fee schedule amounts for most RBRVS codes this year. Overall, the conversion factor changed from $31.001 in 1992 to $32.249 in 1993.

Summary

Despite the decrease in overall relative values for Medicare physician services, the primary codes used by oncologists will provide a higher level of reimbursement for this specialty in 1993. In addition, it is hoped that future changes, such as the creation of chemotherapy management codes, will further benefit oncologists as HCFA continues to fine-tune the system. All provisions in the final rule are subject to instructions being issued to carriers from HCFA. Please contact your local carrier regarding implementation of new policies.