ASSOCIATION of CANCER EXECUTIVES

ACE update

2010 Vol. 10 / No. 6
December–January

CMS 2010 Final Rule – Brighter Outlook for Radiation Oncology Than Proposed in July

By Sally Eggleston, MBA, RTCT
Revenue Cycle, Inc.

On October 30, 2009 the DHS's Centers for Medicare and Medicaid Services (CMS) published the 2010 Final Rule for both the HOPPS (Hospital Outpatient Prospective Payment System) and the MPFS (Medicare Physician Fee Schedule). The provisions of both of these rules are effective January 1, 2010.

2010 Final Rule HOPPS

CMS did not deviate much from the Proposed Rule published in July for the majority of radiation oncology procedure codes in regards to payment for the hospital outpatient setting. CMS will continue with the packaging of all image guidance procedures such as CPT® codes 77421 Stereoscopic Imaging, 77417 Port Films, 77014 CT Guidance and 76950 Ultrasound Guidance. Even with image guidance being packaged, the payment for IMRT treatment delivery in the hospital setting has increased substantially to cover the costs of daily image guidance. The table below outlines the historical and current payment rates for IMRT with 77421 Stereoscopic Imaging, one form of IGRT.

The Composite APC 8001, combining payment for hospitals when a prostate seed implant is performed, will continue with the payment rate increasing a small amount to $3,084.00. CMS did finalize a change in APC grouping and payment for 0182T Electronic Brachytherapy from new technology APC 1519 to APC 0313 which includes a payment rate

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Payment for:	CY 2006	CY 2007	CY 2008	CY 2009	CY 2010
Radiation Tx – IMRT (CPT 77418)	$319	$336	$348	$411	$421
IGRT Guidance (CPT 77421)	$75	$67	N/A	N/A	N/A
Total Payment for IMRT & IGRT	$394	$403	$348	$411	$421

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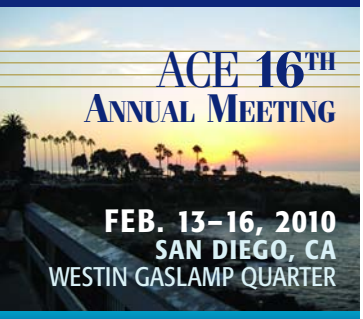

President's Message

Patrick A. Grusenmeyer, ScD
ACE President; Senior Vice President, Cancer and Imaging Services, Christiana Care Health System

Transition Forward

As I write this, the New Year and a new decade have just begun. I start the year a little cautious after our experiences over the past 18 months, with the economy and the stock market experiencing their worst period since the great depression, the bursting of the housing bubble, the highest unemployment rate in two decades, the United States fighting two wars, record federal budget deficits, and the continuing decreases in reimbursement for medical care. At times, it can feel like we are under siege.

The new good news is that 2010 may bring improvement in many areas. The economy is improving, although slowly. The stock market has had an impressive rebound since its low in March 2009, and housing prices have stabilized in many areas of the country, though unemployment remains high. The withdrawal of U.S. forces from Iraq continues on schedule, but Afghanistan could be a long slog.

2010 will be an interesting year for U.S. healthcare. Healthcare reform was painfully making its way through a divided Congress. Just recently, Massachusetts elected a new Republican Senator, which will be a game changer on Capitol Hill. Regardless of whether one favors or opposes the current healthcare bill, to live in the richest country in the world, in which 15% of its population is uninsured and essentially without access or extremely limited access to healthcare is, in my view, unacceptable. In addition, according to a study by Harvard researchers published in *Health Affairs* in June 2009, 60% of bankruptcies are caused by medical costs. Furthermore, the growing cost of healthcare, in dollars, and as a percent of gross domestic product is unsustainable. Healthcare needs reform. It is not equitable and it is not sustainable.

As we have seen though, reforming a system that encompasses almost one fifth of the U.S. economy (i.e. one fifth of all jobs) and a system that is utilized by most of the population, many who fear losing something in the process of reform, is extremely difficult. Let us hope there is the political will on both sides of the aisle to fix the system.

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THE ONCOLOGY BUSINESS INSTITUTE

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TOBI – an Exciting Collaboration

The Oncology Business Institute is a landmark collaboration of the **Oncology Management Consulting Group** of Pennsylvania and **Oncology Metrics** of Texas. TOBI brings together OMC Group's decades of national experience in developing, running and advising successful hospital cancer centers and Oncology Metrics' unparalleled expertise in data collection and benchmark analysis.

What is The Oncology Business Institute?

TOBI is a membership organization dedicated to providing administrators of hospital outpatient cancer centers with the information they need to ensure maximum performance through comparative benchmarking, networking, and education.

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Finally, hospital and oncology administrators alike have a dedicated source that properly addresses the complex nuances of outpatient oncology and the differences in program size and scope. For more information, call or email TOBI: 215-766-2065, resources@TOBImember.com or visit our website at www.TOBImember.com

TOBI will enable you to:

- Establish realistic and attainable production expectations
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- Monitor financial metrics for strategic decision making
- Network with top performing centers
- Share best practices with peer centers





CMS 2010 Final Rule

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of $777.55, a decrease of $972.45 for CY 2010. CMS also finalized their proposal to adopt the prospective payment methodology for brachytherapy sources. This same proposal has been finalized numerous times in the past few years but has been overturned legislatively each and every year so it will remain to be seen whether or not there is any change to this ruling in the future. The majority of radiation oncology procedure codes will see an increase in payment for 2010 with some specialty procedures and external beam codes that fall into APC 0304 seeing a reduction. Some of the commonly utilized procedure codes, the 2010 payment rates and variance to 2009 payment rates can be seen in the table at right.

CPT Code	Descriptor	APC	PAYMENT RATE 2010	PAYMENT RATE 2009	VARIANCE 2009–2010
77280	Simple Simulation	0304	$102.94	$114.70	($11.76)
77290	Complex Simulation	0305	$266.32	$255.69	$10.63
77295	3D Simulation	0310	$927.34	$892.90	$34.44
77300	Basic Dosimetry	0304	$102.94	$114.70	($11.76)
77334	Complex Treatment Device	0303	$190.62	$188.16	$2.46
77338	IMRT Treatment Device	0303	$190.62	$188.16	$2.46
77301	IMRT Planning	0310	$927.34	$892.90	$34.44
77418	IMRT Treatment Delivery	0412	$421.22	$410.83	$10.39
77336	Continuing Weekly Physics	0304	$102.94	$114.70	($11.76)

2010 MPFS

Medicare law requires CMS to adjust the MPFS payment rates annually based on an update formula, which includes application of the Sustainable Growth Rate, or SGR that was adopted in the Balanced Budget Act of 1997. This formula has yielded negative updates every year beginning in CY 2002, although CMS was able to take administrative steps to avert a reduction in CY 2003, and Congress has taken a series of legislative actions to prevent reductions in CYs 2004-2009. For CY 2010 CMS finalized the conversion factor to be $28.406 which would be 21.2% reduction. On December 16, 2009 the House approved an amendment to HR 3326 that would freeze the 21.2% reduction until March 1, 2010. This amendment was then approved by the Senate on December 19 and signed into law by President Obama on December the 21, 2009. The language in this bill is specific only to the conversion factor so all other 2010 changes outlined in the PFS final rule will be effective January 1, 2009. With this temporary fix lasting only 60 days into 2010 it is paramount that some further adjustment to the SGR or permanent fix be implemented soon.

In the 2010 Proposed Rule, radiation oncology was scheduled to see a 19% reduction in RVU's that would have severely impacted the technical component of services delivered in freestanding radiation oncology centers. The cuts were attributed to two main issues, the Physician Practice Information Survey (PPIS) and a change in the equipment utilization. The PPIS survey increased the PE/HR (practice expense per hour) ratio for radiation oncology and resulted in a pro-

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CMS 2010 Final Rule

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"CMS did recognize that some specialties would experience significant payment reductions."

posed 12% decrease for the radiation oncology specialty. CMS was also proposing changing the allocation of equipment costs for calculating PE RVUs from 50% to 90%. With the assistance of ASTRO, ACRO, Radiation Therapy Alliance and many other groups, several studies and comments were sent to CMS regarding these cuts. In response to comments received on the proposed rule, CMS performed additional analyses of summary data supplied by the AMA, the supplement survey, and cardiology, urology and radiology groups. This analysis indicated that while the PE/HR for these specialties differs between the data sources reviewed, these differences did not validate commenter conclusions that the PPIS data is invalid and CMS continues to believe that the PPIS is the most appropriate data source available for the development of resource-based PE RVUs. However, CMS did recognize that some specialties would experience significant payment reductions with the use of the PPIS data. Given the magnitude of these payment reductions CMS agreed with suggestions to transition to the new PE RVUs developed using the PPIS data and provide a four year transition period. This modification of the proposed rule combined with the removal of therapeutic equipment from the equipment utilization reduction resulted in only a 5% reduction in payment for radiation oncology disbursed over a four year period.

CMS did finalize the discontinuance of payment for both inpatient (99251-99255) and outpatient (99241-99245) consultations for Jan. 2010. In lieu of a consultation code the physician may bill either a New Patient Visit (99201-99205) or an Established Patient Visit (99211-99215) dependent upon on the description of the visit being performed and documented. CMS does not have the authority to determine which services will be recognized and paid by other third party payers. Some payers may choose to adopt the CMS policy of not paying for inpatient or outpatient consultations subsequent to the MPFS final rule. In cases where other payers do not adopt this policy, physicians and their billing personnel will need to take into consideration that Medicare will no longer recognize consultation codes submitted on bills, whether those bills are for primary or secondary payment. Billing professionals will need to pay close attention to whether or not Non-Medicare payors adopt the non-payment for consultations & and process both primary and secondary claims accordingly.

While radiation oncology was definitely spared some major cuts in 2010 under the MPFS and the payments under HOPPS have increased for the majority of codes, the specialty is still in danger of cuts in the near future. With such an upward trend of utilization of costly procedures prescribed by radiation oncologist the specialty is a target for decreased reimbursement.

Fortunately, radiation oncology was spared some major cuts in 2010 under the MPFS while payments under HOPPS have increased for the majority of codes. However, with an upward trend toward utilization of costly procedures prescribed by radiation oncologists the specialty is a target for decreased reimbursement in the very near future. ■

President's Message

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"ACE is fortunate to have Joy Soleiman as our incoming president."

Our challenge in cancer care will be to maintain services, provide excellent clinical care and customer service to our patients with diminishing resources. Not an easy process, but as we like to say around my cancer center, if it were easy, anybody could do it.

We have added an exciting new service for ACE members this year. The first **Hot Topics** conference call took place on January 13 and featured authors Dr. Lowell Schnipper and Dr. Neal Meropol discussing ASCO's Guidance Statement on the Cost of Cancer Care. We had 30 members dial in for the call. Thanks to the authors and to Membership Committee co-chairs Strode Weaver and Nancy Harris for making this possible. Watch for upcoming Hot Topics conference calls.

This will be my last ACE President's column. It has been an honor to serve as your President and I thank you for trusting me with that responsibility. ACE is fortunate to have **Joy Soleiman** as our incoming president. She brings an energy, enthusiasm and commitment to ACE and to cancer care that will serve the organization well.

ACE should end the year in a better financial position than it began, important for the continued operations of the organization. I would like to thank the ACE Board of Directors and Standing Committees for their hard work over the past year. On behalf of the ACE leadership, I also want to thank our corporate sponsors and the Annual Meeting exhibitors for their solid support, as well as the entire ACE membership for their continued interest and participation.

The ACE 16th Annual Meeting and Oncology 101 program (February 13–16 in San Diego, California) is fast approaching and the ACE Education Committee has put together a great slate of presentations. Be sure you are registered. I look forward to seeing you in San Diego. ■

HONI's "Industry Insiders" – *Q&A with ACE Board*

Ed. Note: ***Hematology & Oncology New & Issues*** *(HONI) is featuring the ACE Board of Directors in a monthly "Industry Insiders" column, which we are pleased to reprint here.*

Submitted by **Colleen Jernigan, PhD, RN, AOCN,** *ACE Board Member; UTMD Anderson Cancer Center*

Q: How important is customer service to the community-based oncology practice in today's economic environment, and who are the practice's customers?

A: Providing exceptional customer service should be a significant concern for any healthcare provider regardless of size, location, or specialty. Community-based oncology programs however, are in a unique position today to see an increase in volume based on the current economic changes. Patients and families who once considered treatment in regional centers are now reconsidering the expenses involved and are deciding to receive treatment closer to home. Creating and fostering an on-going environment focused on exceeding customer expectations is a worthy goal for all providers but especially for community practices that will likely see an increase in patient volume and revenue.

But before a practice can create, promote, and sustain an environment that concentrates not just on the 'science' but more importantly on the 'art' of customer service they need to first determine who their customer is. I would suggest the 'customer' is not just the patient or family member who shows up in the lobby but it includes a wide spectrum of individuals/systems to include the referring physician, community healthcare providers, regional treatment centers, and perhaps most importantly the staff within the community based oncology facility. How staff respond to one another and how the organizational values of customer service are internalized by team members has a significant impact on how patients perceive the service provided. However, excellent customer service is more than a friendly face. It is the result of an on-going organizational commitment to ensure staff do their very best to 'do it right the first time'. This means first carefully selecting staff with customer service skills, providing appropriate initial and intermittent training, and directly assessing the perceived outcomes from both internal and external customers. Maintaining a proactive approach will take a commitment as the economic slow down which will drive customers to community based practices also causes program development slow downs and staff reduction. Employees that work together collaboratively make a difference. These differences include higher employee satisfaction scores, higher retention rates, reduced patient complaints, and a more positive work environment that is recognizable by 'all' customers. It is an investment that has long term rewards for all involved. ■

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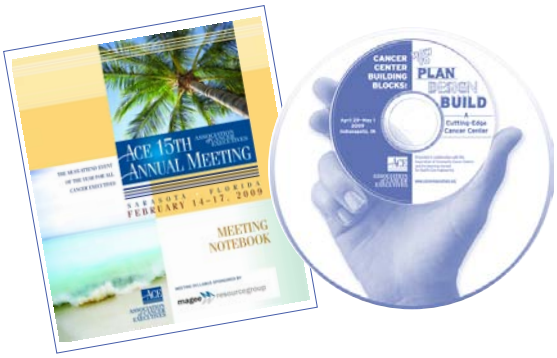

To order one or both, contact ACE HQ today.

Share Your News

Announce your organization's achievements, program changes, staff transitions and events to the entire ACE membership! Send an email with your news and press releases to: info@cancerexecutives

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ACE Update is published by
Association of Cancer Executives
2300 N Street NW, Suite 710 • Washington DC 20037
202.521.1886 • Fax: 202.833.3636
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Since November 13, 2009

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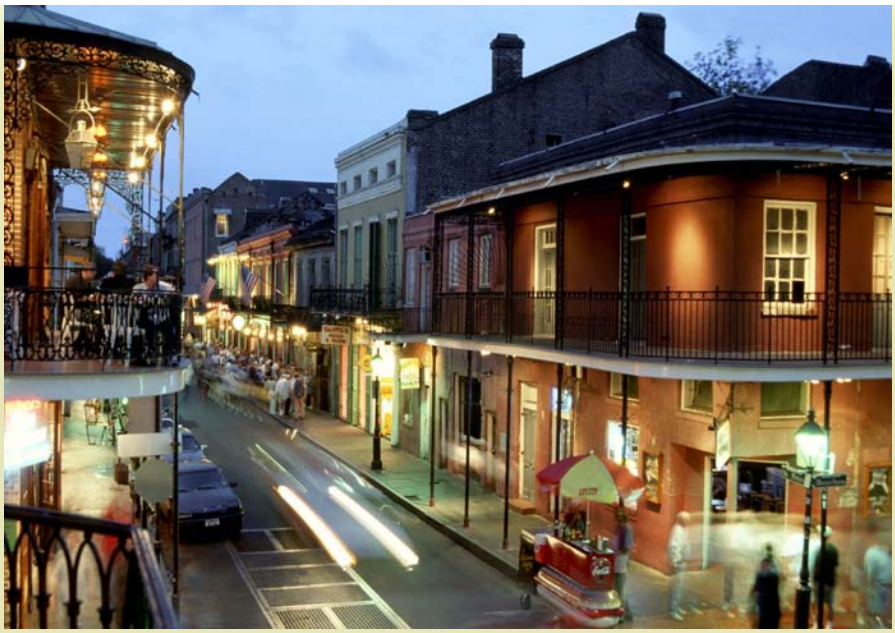

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