Medicare Payments for Cancer Care: What Can Be Expected in 2007

On November 1, the Centers for Medicare & Medicaid Services (CMS) announced some important changes that will affect how oncologists are reimbursed for services provided to Medicare beneficiaries. (This article is current as of December 15, 2006. Any updates on the physician fee schedule published in the interim can be found on www.jopasco.org.) The *Journal of Oncology Practice* has highlighted those provisions that will have the most significant impact on office-based oncology practices and in hospital outpatient departments (see “CMS Issues. . .” sidebar), and has also talked to oncologists around the country (see “A Growing Challenge. . .” sidebar) to find out how they are preparing to move forward during this time of change and some uncertainty.

Freeze on Physician Fee Schedule Conversion Factor and Payment Increase for Quality Reporting

In early December, Congress passed legislation to avert the 5% reduction in physician payments, which was scheduled to take effect January 1, 2007. The conversion factor will remain at \$37.8975 for the duration of the year.

In the same legislation, Congress also established an increase of 1.5% for reporting of quality measures through the CMS Physician Voluntary Reporting Program (PVRP). This 1.5% increase would be applied to services rendered July 1, 2007 through December 31, 2007. Details concerning implementation of this provision are forthcoming, and ASCO will be working with CMS to assure smooth execution of the law.

Increased Recognition of Physician Work in Evaluation and Management

CMS has increased the physician work relative value units (RVUs) for many evaluation and management (E&M) services, including those services most commonly performed by oncologists. For example, payments for level 3 and level 4 established patient office visits, as well as level 4 consultations, will go up in 2007 (Table 1). As E&M services comprise a

significant proportion of services provided by oncologists, CMS estimates that these changes will result in an increase in overall payments for oncology—perhaps as much as 3%.

ASCO played a pivotal role in working with both the AMA and CMS to encourage adoption of higher work values for E&M codes that more accurately reflect the physician's role in managing treatment for today's Medicare beneficiaries. While CMS ultimately adopted the AMA's recommendations for higher work RVUs, the agency has applied a 0.8994 multiplier that will effectively discount Medicare payments for these codes to achieve budget neutrality across the fee schedule.

Effects of a Revised Practice Expense Methodology on Drug Administration Services

Certain drug administration services, including chemotherapy infusions, will experience slight decreases in payments as CMS transitions to a new methodology for assigning practice expenses to individual services. CMS estimates that this change will have no significant effect on payments to oncologists and hematologists in 2007, and will mean a 1% decrease when fully phased-in in 2010.

In the past, CMS has used a top-down methodology that starts with survey data on the practice expenses of each specialty. In the case of oncology, that method uses data from an approved practice expense survey sponsored by ASCO. In the new methodology, CMS will no longer use the survey data for “direct” costs (ie, clinical staff, supplies, and certain equipment). Instead, CMS will use the estimated code-level costs for direct expenses as determined by the AMA/Specialty Society Relative Value Update Committee (RUC).

Practice expense RVUs have two components: direct and indirect expenses. CMS will continue to refer to ASCO's practice expense data in allocating indirect costs (eg, administrative staff costs and practice overhead).

Imaging Payments Undergo Further Reductions

Medicare will continue the policy introduced in 2006 that reduces payments for second and subsequent imaging procedures

Table 1. Changes in RVUs for Key Evaluation and Management and Drug Administration Services From 2006-2007

CPT Code	Descriptor	2006 Total RVUs	2007 Total RVUs*	% Change
Evaluation and management				
99211	Level 1 established office of outpatient visit	0.57	0.53	-7.0
99212	Level 2 established office of outpatient visit	1.02	0.97	-4.9
99213	Level 3 established office of outpatient visit	1.39	1.57	+12.9
99214	Level 4 established office of outpatient visit	2.18	2.38	+9.2
99215	Level 5 established office of outpatient visit	3.17	3.22	+1.6
99241	Level 1 office consultation	1.33	1.28	-3.8
99242	Level 2 office consultation	2.43	2.36	-2.9
99243	Level 3 office consultation	3.24	3.23	-0.3
99244	Level 4 office consultation	4.57	4.74	+3.7
99245	Level 5 office consultation	5.91	5.88	-0.5
99291	Critical care, first 30-94 minutes	6.78	6.76	-0.3
99292	Critical care, each additional 30 minutes	3.01	3.02	+0.3
Nonchemotherapy drug administration				
90760	IV infusion, hydration; initial, up to 1 hour	1.67	1.62	-3.0
90761	; each additional hour	0.53	0.50	-5.7
90765	IV infusion, for therapy, prophylaxis, or diagnosis; initial, up to 1 hour	2.04	1.98	-2.9
90766	; each additional hour	0.68	0.64	-5.9
90767	; additional sequential infusion, up to 1 hour	1.12	1.05	-6.3
90768	; concurrent infusion	0.65	0.60	-7.7
90772	Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular	0.49	0.51	+4.1
90774	Therapeutic, prophylactic, or diagnostic injection; IV push, single or initial substance/drug	1.52	1.51	-0.7
90775	; each additional sequential IV push of a new substance/drug	0.71	0.69	-2.8
Chemotherapy drug administration				
96401	Chemotherapy administration, subcutaneous or intramuscular; nonhormonal antineoplastic	1.39	1.54	+10.8
96402	; hormonal antineoplastic	1.21	1.12	-7.4
96409	Chemotherapy administration, IV push, single or initial substance/drug	3.23	3.16	-2.2
96411	; each additional substance/drug	1.87	1.82	-2.7
96413	Chemotherapy administration, IV infusion; up to 1 hour, single or initial substance/drug	4.56	4.38	-3.9
96415	; each additional hour	1.03	0.98	-4.9
96416	Chemotherapy administration, IV infusion, initiation of prolonged chemotherapy infusion (more than 8 hours), requiring portable or implantable pump	4.90	4.74	-3.3
96417	; each additional sequential infusion	2.23	2.15	-3.6
96521	Refilling and maintenance of portable pump	4.04	3.85	-4.7
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic	2.92	2.91	-0.3
96523	Irrigation of implanted venous access device for drug delivery systems	0.74	0.73	-1.4

NOTE. National average payment amounts can be calculated by multiplying total RVUs by the Medicare physician conversion factor. To find payments specific to your locality, check your Medicare carrier's Web site.

Abbreviations: RVUs, relative value units; CPT, Current Procedural Terminology; IV, intravenous.

* Total RVUs are calculated as the sum of the physician work RVU, nonfacility practice expense RVU, and professional liability RVU for each service. The 2007 RVUs in this table reflect a 0.8994 multiplier applied by Centers for Medicare & Medicaid Services to achieve budget neutrality in light of overall increases to RVUs from the 5-year review.

CMS Issues Final Hospital Outpatient Payment Rule for 2007

By Christian Downs, JD, MHA

On November 1, 2006, CMS issued the Medicare hospital outpatient prospective payment system (OPPS) final rule for 2007. The final rule includes several policy changes that will affect providers of cancer care, including significant changes to coding and payment for drug administration services. In the final rule, CMS abandoned its proposed payment changes for drugs and radiopharmaceuticals and will continue to pay for these therapies using the same methodologies as in 2006. The final rule will go into effect on January 1, 2007.

Payment for Drugs, Biologic Products, and Radiopharmaceuticals

In 2007, Medicare will reimburse separately billable drugs in the hospital outpatient setting at their average sales price (ASP) plus 6%. CMS acknowledged that it received many comments that its proposed rate of ASP plus 5% for drugs without pass-through status was too low to reimburse hospitals for the costs of acquiring and handling drugs. Drugs with pass-through status will be reimbursed at ASP plus 6% as well, except for drugs that are available through the Competitive Acquisition Program for physicians' offices, which will be reimbursed at the Competitive Acquisition Program rate.

CMS finalized its proposal to pay separately for drugs costing more than \$55 per day. This is an increase of \$5 from the current level of \$50. CMS will continue to pay separately for antiemetic drugs, regardless of their daily cost.

CMS also decided to continue to reimburse radiopharmaceuticals at hospitals' charges, adjusted to cost using hospital-specific cost-to-charge ratios. Medicare will pay separately for brachytherapy sources, but will base payment on source-specific median costs and will pay on a per unit basis rather than a per day basis.

Pharmacy Handling Costs

As in 2006, CMS concludes that ASP plus 6% is sufficient payment for both pharmacy acquisition and handling costs and will not make a separate payment for handling costs. CMS remains convinced that pharmacy handling costs are included in hospitals' charges for drugs, and thus are included in Medicare's payment rates, but the agency will continue to work with stakeholders to study these costs.

Drug Administration Services

For 2007, CMS will implement three significant changes to payment policies for drug administration services in the hospital outpatient setting. First, CMS will make separate payment for second and subsequent hours of drug administration services. Until recently, CMS has packaged payment for additional hours into payment for the first hour. Second, CMS has organized the drug administration codes into new ambulatory payment classifications (APCs) with new payment rates. Although payment codes for the first hour of administration have been reduced, payments for any treatment administration lasting 2 hours or longer will be increased. Third, CMS will use all of the Current Procedural Terminology (CPT) codes for drug administration instead of the current mix of CPT codes and C-codes.

CMS did not implement the APC Panel's recommendations to pay for a second IV push of the same drug or to issue clarifications regarding billing for biologic response modifiers. CMS will continue to make a \$75 payment for preadministration services associated with IVIG.

E&M Services

As proposed, CMS will implement new APCs for E&M services. For 2007, CMS replaced the three current APCs for hospital clinic visits with five new APCs. CMS did not finalize its proposal to create new G-codes for E&M services, but instead will use the current CPT codes for these services. CMS will continue to work on refining the draft American Hospital Association/American Health Information Management Association guidelines for billing for these services.

Imaging Procedures

As proposed, CMS will not reduce payment for second and subsequent imaging procedures in 2007. CMS will assign PET and PET/CT services to new, lower-paying APCs from their current new technology APCs. Concurrent PET/CT will be assigned to New Technology APC 1511 with a payment rate of \$950, reduced from the current rate of \$1,250. PET will be assigned to APC 308, with a payment of \$855.43.

Christian Downs, JD, MHA, is executive director of the Association of Community Cancer Centers, Rockville, Maryland.

Table 2. Example of Imaging Payment Determination for Services Subject to Multiple Imaging Reduction and Hospital Outpatient Cap

CPT Code	Payment Rate for Technical Component (\$)	25% Multiple Imaging Reduction (\$)	Hospital Outpatient Cap Rate (\$)	Final Payment for Technical Component (\$)
7XXX1	341.89	256.42	316.55	256.42
7XXX2	552.86	414.65	391.83	391.83

NOTE. Adapted from Table 9 in the *Federal Register* December 1, 2006. "Medicare Program; Revisions to Payment Policies, Five-Year Review of Work Relative Value Units, Changes to the Practice Expense Methodology Under the Physician Fee Schedule, and Other Changes to Payment Under Part B; Revisions to the Payment Policies of Ambulance Services Under the Fee Schedule for Ambulance Services; and Ambulance Inflation Factor Update for CY 2007."

in the same family. The technical component of such imaging services will be paid at 75% of the full payment rate.

In 2007, CMS will institute a cap on the technical component of imaging services including positron emission tomography (PET), computed tomography (CT), and magnetic resonance imaging (but not mammography) at the hospital outpatient payment rate. In other words, the technical component for imaging services performed in the office may not be higher than the technical component for imaging services performed in the hospital outpatient department. CMS has implemented this provision in response to a mandate in the Deficit Reduction Act of 2006.

For services where both reductions might apply, CMS will determine payments by first applying the multiple imaging rule and then applying the hospital outpatient cap. Table 2 presents an illustration of how payments will be determined in this circumstance. Note that these reductions only apply to the technical component of imaging. Payment policy for the physician's interpretation of imaging studies remains untouched.

Intravenous Immune Globulin Preadministration Payment Continued

In 2006, CMS introduced an additional payment associated with "preadministration" services related to intravenous immune globulin (IVIG) in response to reports that IVIG was difficult and time-consuming for physicians to acquire. CMS continues to express concern about IVIG access and availability and has therefore decided to extend its temporary payment for preadministration services related to IVIG for another year. Oncologists will receive approximately \$71 when they bill for IVIG preadministration using the Medicare code G0332, defined as "preadministration-related services for intravenous infusion of immunoglobulin, per infusion encounter." (This service is to be billed in conjunction with administration of IVIG.)

Medicare will also continue to pay separately for IVIG (at their average sales price plus 6%) and appropriate drug administration codes associated with its infusion.

Fate of Oncology Demonstration Uncertain

To date, CMS has not committed to a continuation of the 2006 Oncology Demonstration Project, stating that an extension "remains under consideration." The voluntary demonstration project enabled physicians to bill \$23 when reporting the primary focus of visit, disease state, and adherence to clinical guidelines issued by ASCO and the National Comprehensive Cancer Network (NCCN), in conjunction with E&M services. In 2006, this demonstration was estimated to provide an additional \$150 million in Medicare payments to oncologists. ASCO testified before Congress in July 2006 and has strongly urged both Congress and the Administration to continue the program.

Colorectal Cancer Screening Deductible Waived

Effective January 1, 2007, Medicare has waived beneficiary deductible requirements for covered colorectal cancer screening services, though copayments will still apply. Affected services include flexible sigmoidoscopy (G0104), colonoscopy (G0105 and G0121), and barium enemas (G0106 and G0120). The Deficit Reduction Act mandated waiver of deductibles for colorectal cancer screening services to create an incentive for more beneficiaries to take advantage of this important preventive benefit.

Looking Ahead

One goal of the Medicare Modernization Act (MMA) in 2003 was establishing more accurate payments for chemotherapy drugs and services, but balance in Medicare payments for these services has not yet been achieved. ASCO continues to advocate for balanced payment reform and supports proposals that address issues including payment for "underwater" drugs, payment for comprehensive cancer care planning and a fix for the yearly conversion factor reductions. As a new Congress convenes in January, ASCO members are encouraged to contact and educate their senators and representatives about these important issues.

DOI: 10.1200/JOP.0713501

A Growing Challenge: Delivering High-Quality Care With Fewer Resources

With payments from Medicare scaled back so significantly, oncologists today find themselves needing to relinquish old habits as they think in financial terms about every aspect of their practices. They need to seriously weigh expenditures in areas including:

- Staffing and employee benefits
- Treatment patterns and possible drug alternatives
- Participation in clinical trials
- Adoption of electronic medical records
- Their own compensation

Many oncologists would love not to have to think so deeply about financial questions. They would much rather devote their energies to patient care, and often, to research to advance the level of that care.

Here we present ways in which three oncology practices approach these matters:

Edward Balaban, DO, Sewickley Medical Oncology Hematology Group, University of Pittsburgh Cancer Institute, Pittsburgh, Pennsylvania

“These changes seem to be coming at a record clip. We spend considerable time figuring out the impact and how we may have to change. We haven’t had to do anything drastic yet because of the demonstration project. But that could change at the drop of a hat.”

“Like most practices, we’ve begun discussions with our community hospital about chemotherapy being delivered there,” says Dr Balaban. “Logistically and financially, the hospital isn’t ready for it. The conversations are ongoing.”

“Since our practice is attached to the University of Pittsburgh, we may be able to send some patients to a large tertiary center there. That means sending people who don’t feel comfortable downtown into the city.”

He foresees that oncologists who are used to prescribing certain drugs and drug combinations may soon need to consider costs in ways they never before have. “With drugs of equivalent efficacy, we may be able to tailor our treatments to contain costs.”

“What really worries us is reaching the day that we have to dole out various therapies, and, while trying to give optimal treatment, having to forego an additional drug or two that has become unaffordable. We haven’t reached that day yet. I hope we never do.”

Peter M. Townley, MD, Oncology Hematology West, Omaha, Nebraska

“Congress didn’t understand all the services that we provide when they drafted the Medicare Modernization Act,” says Peter M. Townley. “Now it’s a struggle to provide those services.”

“We are very dedicated to the clinical trials process as a way of advancing cancer care for our patients. We see these trials as invaluable and can’t imagine the practice of oncology without them. However, the real costs to a practice are not inconsequential. In fact, many smaller practices or new practices may not be able to offer this option to their patients.”

“It’s much more cumbersome and costly to do the same job we did years ago,” Dr Townley says. “Practice expenses keep rising despite cuts in reimbursement. The oncologist struggles to provide the newest treatment options available to a patient population of underinsured and uninsured patients. Because of this, practices have to utilize far more resources such as social services, financial services, and counseling for their patients. Processes such as these increase the cost of delivering high-quality cancer care, yet the practice has no other options.”

John M. Rainey, MD, Louisiana Oncology Associates, Lafayette, Louisiana

Dr Rainey has four partners. “In November, we plan to discuss our finances in anticipation of the 5.1% reduction and the possible loss of the demonstration project.”

Among the topics to be covered: how much charity care the practice can afford, staffing issues, and probable salary reductions for physicians.

“We’ve already tightened up by reducing our drug inventory,” he says “Today we treat lots of elderly patients with Medicare only. Should those patients now be funneled to the hospital? Do we send flex nurses home once the peak hours of treatment are completed or ask our regular nurses to work harder? The only areas left to cut are salaries and personnel.”

“This is a bad dream. Physicians are not bankers or finance managers. Over the next several months, we will attempt to develop several financial scenarios pending what CMS decides for its payment schedules. We lose a lot of sleep worrying if we can keep the doors open.”

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