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Lilly Oncology

Reimbursement Update

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Lilly Oncology is pleased to offer this newsletter as part of our commitment to patient access to care. For more information about the topics discussed in this issue, please contact Rick Ford, Director of Reimbursement Consulting for AccessMED, at 913-744-6001.

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This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of the written law or regulations or local payer guidelines. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

CMS Releases Proposed Medicare Part B Changes for 2010

The Centers for Medicare and Medicaid Services has released its annual proposed rule containing changes under consideration for Medicare Part B in 2010. The proposed rule, "Medicare Program: Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010," appears in the July 13, 2009 *Federal Register*.ⁱ

Proposed Reimbursement Changes for 2010

The proposed rule covers a wide range of Part B coverage and reimbursement topics, including the following:

Professional Fees, Chemotherapy Administration, and Other Part B Services: Changes in reimbursement have been proposed for these types of services, which are reimbursed under the Medicare Physician Fee Schedule (MPFS). Under MPFS, each service (generally described by a CPT code) is assigned a geographically-adjusted resource-based relative value unit (RVU), which is multiplied by a dollar conversion factor to calculate the allowable for the service. For example, if the geographically-adjusted RVU for a service is 5.0 and the conversion factor is \$30, then the allowable for that service would be \$150.

CMS adjusts RVUs each year based on measured changes in work complexity, practice expense and malpractice expense or to protect budget neutrality within the Part B program. The conversion factor is updated annually.

Table 1 illustrates the impact of proposed RVU changes in 2010 for a sampling of CPT codes. In this illustration, assuming no change in the conversion factor, payment for the selected chemotherapy administration services would decrease next year, while payment for the selected office visits would rise.

Table 1: Impact of 2010 Proposed Changes to Relative Value Units for Selected Procedures

CPT Code	Description	2009 Transitioned Non-Facility Total RVU ⁱⁱ	2010 Proposed Non-Facility RVU ⁱⁱⁱ	% Change in 2010
96409	Chemo, iv push, single drug	3.10	2.43	-22%
96413	Chemo, iv infusion, 1 hr	4.09	3.14	-23%
96415	Chemo, iv infusion, add'l hr	0.93	0.71	-24%
96417	Chemo iv infusion, each add'l sequential infusion	2.04	1.51	-26%
99205	Office/outpatient visit, new (Level 5)	4.96	5.49	11%
99213	Office/outpatient visit, est (Level 3)	1.70	1.91	12%

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Answers That Matter.

2010 Medicare Part B Proposals *continued from Page 1*

The conversion factor (\$36.0666 in 2009) cannot be assumed to remain unchanged, however. The proposed rule outlines a 21.5% decrease in the conversion factor for 2010, to \$28.3208 per RVU.^{iv}

This significant decrease is the result of a formula that was designed to help maintain budget neutrality within the Part B program by controlling rising costs attributable to increases in the volume of services that physicians provide. The formula (known as the Sustainable Growth Rate, or SGR) has mandated an annual reduction in physician payment that has been unacceptable to Congress, which has intervened every year since 2004 to override the reduction in the conversion factor.^v Congressional action later this year, including the ongoing health care reform debate, may again alter the scheduled reduction in the conversion factor for 2010.

Part B Drugs: The proposed rule does not discuss any changes to the Part B drug fee schedule payment methodology for physicians in 2010. Medicare's policy of reimbursing physicians for Part B-covered drugs is unchanged by the proposed rule and should remain at Average Sale Price plus 6 percent, with quarterly updates to the drug fee schedule.

Coding Changes: CMS is proposing to bar the use of CPT codes that describe office, outpatient or inpatient consultations. CMS would require Part B providers to report consultations using other CPT codes that describe office, outpatient or hospital visits (evaluation and management services).^{vi}

This proposal is of significance because the consultation codes are currently reimbursed at higher rates than general evaluation and management (E&M) services. Historically, the higher payment was due in part to increased documentation requirements imposed by CMS. For example, both the referring and the consulting physicians were required to document the request for consultation, and the consulting physician was required to provide a written consultation report to the referring physician. These documentation requirements do not apply to general E&M codes.

However, there has always been a disconnect between how the term *consultation* is interpreted by many physicians and by CMS. To eliminate this difficulty, CMS has proposed to stop accepting the consultation CPT codes beginning January 1, 2010 and would consider a consultation as a general E&M service instead. As a result, payment for the consultation codes would cease, but the RVUs for E&M services would increase. The increases shown in Table 1 for codes 99205 and 99213 are partially due to this proposed change.

Physician Quality Reporting Initiative: The PQRI incentive bonus for 2010 would remain at 2% of estimated allowed charges *for all covered professional services furnished under the PFS*, not just those charges associated with the reported quality measures. The 2% incentive payment applies to items and services covered under the Medicare Physician Fee Schedule, such as E&M services, chemotherapy administration, surgical procedures, and radiology procedures. It does not apply to other items and services covered by Part B under different payment methodologies, such as drugs, clinical lab services, durable medical equipment or prosthetic devices.^{vii}

The reporting period for claims-based reporting would be limited to calendar year 2010. (In 2009, there were two reporting periods – calendar year 2009 and a six-month period that includes dates of service July 1 through December 31, 2009.) CMS proposes to eliminate the six-month reporting period in 2010 for claims-based reporting, but is asking for comments on whether it should continue to be offered. The six-month reporting period would continue to be available to physicians and practices using registry-based reporting. CMS is also considering accepting data extracted from qualified electronic health record (EHR) products for a limited subset of PQRI measures.^{viii}

Claims-based reporting may be restricted or eliminated after 2010 in favor of registry-based and EHR-based reporting. CMS is seeking comments on the impact of reducing the availability of claims-based PQRI reporting.

Most PQRI measures available in 2009 would remain available for reporting in 2010. However, two measures that may be of particular interest to oncologists will be eliminated. Measure 143 (Oncology: Medical and Radiation - Pain Intensity Quantified) and Measure 144 (Oncology: Medical and Radiation – Plan of Care for Pain) are proposed for deletion due to difficulties in analyzing the data reported.^{ix} On the other hand, a new measure reporting the documentation of cancer stage has been proposed to be added.^x

E-Prescribing Incentive Program – This incentive program would continue in 2010 and would provide an incentive payment for successful e-prescribers equal to 2% of their total estimated allowed charges for all professional services furnished between January 1 and December 31, 2010. As with PQRI, eligible professionals would be able to choose whether to submit data on the electronic prescribing measure through claims, a qualified registry, or a qualified EHR product.^{xi}

Re-Implementation of the Competitive Acquisition Program (CAP): CMS is proposing changes to the Competitive Acquisition Program (CAP) in hopes of attracting participants and re-implementing the program. The CAP is a “just-in-time” delivery model for drugs covered by Medicare Part B that are provided “incident to” a physician’s service, and is an alternative to the traditional “buy and bill” model of drug purchasing.

Among the changes proposed:^{xii}

1. **Quarterly Reimbursement Update for CAP Vendors:** Adjustments to the drug reimbursement paid by CMS to CAP vendor(s) would occur quarterly, rather than annually. In general, quarterly reimbursement updates would be calculated by CMS based on the CAP vendors’ reasonable net acquisition cost (RNAC) data. However, reimbursement for a drug under the CAP program would never exceed the ASP+ 6% payment limit that applies to physicians who purchase Part B drugs under the “buy and bill” model.
2. **A Shorter List of Approved CAP Drugs:** Low-cost, frequently-utilized drugs such as corticosteroid injections would be removed from the approved CAP drug list so that physicians participating in CAP could purchase and keep a supply of these drugs on hand. Thus, the approved CAP drug list would be narrowed to higher-cost items. CMS provides a list of drugs that are being considered for inclusion on the CAP drug list for the next contract period and is seeking comments on specific drugs that should be added to this list. The proposed list includes 53 drugs, down from about 180 drugs in the original CAP program. Of these 53 drugs, 15 are chemotherapy drugs included in the J9xxx series of HCPCS codes.
3. **Easier Method for Adding Approved Drugs:** Participating CAP physicians and approved CAP vendors would have the ability to submit a request to CMS to add drugs or biologicals to the list of drugs furnished by the requesting vendor if there is sufficient demand and if the drug has therapeutic uses that are similar to other drugs already available through CAP.
4. **Leeway to Request Removal of an Approved Drug:** A vendor would be able to request permanent removal of a HCPCS code from its CAP drug list for which NDCs are not available due to situations outside the vendor’s control, such as changes in drug distribution methods, changes in agreements between manufacturers and distributors and/or pharmacies regarding who may purchase certain drugs, and direct distribution arrangements. CMS approval of the drug deletion would apply only to the vendor(s) that request the deletion. If a deletion is approved, participating CAP physicians who are affected by the decision would have the option of remaining with the CAP vendor and purchasing the affected drug via the “buy and bill” model. They would also have the option to switch vendors, if more than one approved CAP vendor is available.
5. **A Smaller Geographic Coverage Area:** The geographic area served by the CAP program would be temporarily restricted to the 48 contiguous states and the District of Columbia during the next round of CAP vendor contracting. During the next CAP participation period (unscheduled at this time), the CAP program would not be available to physicians in Alaska, Hawaii or any U.S. Territory. According to CMS, these are areas associated with low physician participation, long shipping times, and high shipping costs.

6. *Permitting CAP Drug Stock at the Physician's Office:* Under the original CAP program, participating physicians could not maintain a stock of a CAP drug in their offices due to CMS concerns about program integrity and drug diversion. CMS is now proposing to allow CAP vendors to utilize electronic transactions to furnish CAP drugs from nominal quantities of CAP vendor-owned stock located at a physician's office in response to specific prescription orders.
7. *Expanding the List of Qualified CAP Participants:* Under the original CAP program, only physicians were eligible to participate in CAP. CMS is proposing to expand eligibility to practitioners such as Nurse Practitioners, Clinical Nurse Specialists, Physician Assistants, and others who legally prescribe drugs that are typically covered "incident to" a physician's service.
8. *Allowing Physician Transport of CAP Drugs Between Practice Locations:* Under the original CAP program, CAP drugs could only be shipped directly to participating physicians, and those physicians could not transport drugs from one location to another. CMS is proposing to allow transportation between locations, subject to voluntary agreements between the physician and the CAP vendor. Transportation by the physician would also be subject to State and Federal laws and regulations and product liability requirements.

CMS is accepting comments from the public on these and other proposed changes to the Medicare Part B program through August 31, 2009.^{xiii} Guidelines for submitting comments are contained in the July 13, 2009 *Federal Register*, which can be viewed on the Web at <http://edocket.access.gpo.gov/2009/pdf/E9-15835.pdf>. After the comment period ends, CMS will develop the final version of the 2010 rule, which is typically published in the *Federal Register* in November of each year. ♦

End Notes

ⁱ Federal Register, July 13, 2009, pages 33520 - 33825: <http://edocket.access.gpo.gov/2009/pdf/E9-15835.pdf>

ⁱⁱ CMS PFS Relative Value File, 2009 - RVU09C, PPRRVU09.xls: <http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=descending&intNumPerPage=10>

ⁱⁱⁱ Federal Register, July 13, 2009, pages 33791 and 33796

^{iv} *Ibid.*, page 33651

^v *Ibid.*, page 33649, column 3

^{vi} *Ibid.*, page 33551 - 33554

^{vii} *Ibid.*, page 33559, column 2

^{viii} *Ibid.*, page 33561, column 1

^{ix} *Ibid.*, page 33574, Table 16

^x *Ibid.*, page 33581, Table 19

^{xi} *Ibid.*, page 33594, Column 1

^{xii} *Ibid.*, pages 33623 - 33633

^{xiii} *Ibid.*, page 33520