May 2007

Lilly Oncology
Reimbursement Update

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Clinical Nurse Specialists, Nurse Practitioners, and Physician Assistants have new options for billing Medicare for professional services provided to hospital inpatients after CMS makes a long-overdue update to the agency's claims processing guidelines for Part B contractors.

***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 Brenda Morrow, Vice President of Payer Policy for AccessMED, at (866) 663-3969.**

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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.

MG44088

Medicare Changes Billing Guidelines for Non-Physician Practitioners (NPPs)

Clinical nurse specialists (CNSs), nurse practitioners (NPs), and the employers of physician assistants (PAs) may now be able to bill Medicare Part B for services provided in both hospital inpatient and outpatient settings. New guidelines published by the Centers for Medicare and Medicaid Services (CMS) instruct Medicare Part B contractors to begin paying claims for services provided in these settings effective April 26, 2007.

The new guideline replaces an outdated policy that may have caused contractors to assume that payment for inpatient services provided by NPPs was included in the payment that Medicare made to the hospital. However, the Balanced Budget Act of 1997 excluded the professional services of NPs, CNSs, and PAs from hospital inpatient services and made them separately payable.

Thus, when professional services are provided by an NPP to a hospital inpatient:

- An NP or CNS who has a Medicare provider number may provide a bill to his or her Medicare Part B contractor directly on the CMS-1500 claim form.
- The employer of a PA (including a hospital that employs a PA) may provide a bill to the Part B contractor for services provided by the PA, also on the CMS-1500 claim form. (Medicare does not allow PAs to bill directly for the services they provide.)
- If an NP or CNS who is not a hospital employee reassigns payment to a hospital, the hospital may provide a bill to the Part B contractor for the professional services of the NP or CNS on the CMS-1500 claim form.

Hospitals that have not previously billed separately for services provided by NPPs should contact the Part B contractor that has jurisdiction for the hospital's geographic location for further instructions on using the CMS-1500 claim form. Hospitals may seek to continue to bill their fiscal intermediaries for the facility fee associated with the provision of an NPP's professional service in the hospital setting.

When an NP or CNS reassigns payment to a hospital (or employs a PA), Medicare pays the hospital for the NPP's professional services at 85% of the Medicare Part B physician fee schedule. (NPPs who bill directly receive the same rate.) Hospitals, NPPs, and employers authorized to bill Medicare directly for the services of NPPs must accept assignment on their claims.

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Non-Physician Practitioner Billing

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CMS has instructed the Part B contractors to identify and process any claims submitted by NPs, CNSs, or the employer of a PA that have been denied since January 1, 2006.

The Part B contractors must also reopen claims with dates of service prior to January 1, 2006 (retroactive to January 1, 1998) that were denied because the claim indicated a hospital inpatient or outpatient place of service.

Contractors will not do this automatically, however. The CNS, NP, or employer of the PA must ask the contractor for a re-determination in order to receive payment for these earlier dates of service.

CMS guidelines relative to this change are contained in Change Request 5221 (Transmittal 1168), located on the CMS website at http://www.cms.hhs.gov/transmittals/downloads/R1168CP.pdf. ◆

CMS Discontinues Coverage for BBBD Brain Tumor Treatment

CMS has issued a National Coverage Decision instructing all Medicare contractors to deny coverage for osmotic blood brain barrier disruption as part of a treatment regimen for brain tumors. Claims for this treatment with dates of service March 20, 2007 and after will be automatically denied.

The NCD defines BBBD as follows:

"*The blood brain barrier (BBB) of the central nervous system is characterized by tight junctions between vascular endothelial cells, which prevent or impede various naturally occurring and synthetic substances (including anti-cancer drugs) from entering brain tissue. The BBB may be partly responsible for the poor efficiency of chemotherapy for malignant primary or metastatic brain tumors.*

"The BBBD is the disruption of the tight junction between the endothelial cells that line the capillaries of the brain accomplished by osmotic disruption, bradykinin or irradiation. Theoretically, disruption of the BBB may, in the treatment of brain tumors, increase the concentration of chemotherapy drugs delivered to the tumor and may prolong the drug-tumor contact time.

"Osmotic disruption of the BBB is the most common technique used. Chemotherapeutic agents are given in conjunction with barrier disruption. The BBBD process includes all items and services necessary to perform the procedure, including hospitalization, monitoring, and repeated imaging procedures."

CMS has determined that BBBD is not reasonable and necessary when it is used as part of a treatment regimen for brain tumors.

The decision to deny claims for BBBD applies only to the BBBD treatment itself. It does not change coverage of anti-cancer chemotherapy for brain tumors.

An extensive explanation of the methods and assessment used by CMS to reach this decision can be found on the CMS website at http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=188.◆