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## **Summary of Proposed Changes in Medicare Fee Schedule**

On July 1, 2009, the Centers for Medicare & Medicaid Services (“CMS”) released its proposed changes in the Medicare physician fee schedule for 2010. The notice will be published in the Federal Register on July 13, 2009, with a period for public comment. This is a summary of the provisions in the notice of greatest interest to oncologists.

### **Conversion Factor Update**

CMS estimates that, under the sustainable growth rate (“SGR”) methodology in the Medicare statute, the conversion factor for 2010 will be reduced by 21.5% compared to 2009 unless Congress enacts overriding legislation. CMS also estimates reductions of 5% to 6.5% in the conversion factor for each of the several succeeding years under the current law and administrative policies.

CMS notes that it currently includes physician-administered drugs in the SGR methodology although it is not required to do so. It also states that expenditures for physician-administered drugs have increased by about 22% a year in the 1997-2005 period while expenditures for all services in the SGR (including drugs) have increased only 6% a year.

In the notice, CMS proposes to exclude physician-administered drugs from the SGR methodology both prospectively and retroactively to the SGR’s base year. The notice states, however, that CMS may choose not to finalize this proposal depending on “new policy developments, new information or changed circumstances.” CMS states that this change would not reduce the projected 21.5% reduction in the conversion factor for 2010 but that it would reduce the number of subsequent years in which there would be reduction in the conversion factor. The change would also make it less expensive for Congress to increase payments to physicians by revising the SGR methodology, since the CMS proposal would increase the payments to some extent without legislation.

### **Practice Expense Relative Values**

One of the major components in calculating payment amounts under the fee schedule is the relative value for practice expenses. For most specialties, the physician fee schedule currently uses a five-year average of practice expense data from the American Medical Association’s Socioeconomic Monitoring Survey (“SMS”) as a basis for estimating practice expenses associated with each CPT code. That survey was discontinued in 1999. For a few specialties, including medical oncology and radiation oncology, CMS uses supplemental surveys sponsored by the specialties involved. The data from the various surveys are adjusted to 2005 by using the Medicare Economic Index to make them comparable.

The AMA conducted a new survey in 2007-08 called the Physician Practice Information Survey (“PPIS”). CMS is proposing to use the PPIS to adjust the practice expense relative values for 2010 instead of the SMS. Although CMS currently uses five years of SMS data, it plans to use the single PPIS survey. In addition, although the supplemental surveys were required by CMS to meet certain precision criteria, CMS plans to use the PPIS even if it does not meet those criteria.

CMS is also proposing to change the utilization rate for expensive equipment. Currently, the methodology assumes that equipment is used 50% of the time, and CMS is proposing to increase that assumption to 90% for equipment costing more than \$1 million. As a result, the calculated cost per procedure for using such equipment would decrease, and thus the Medicare payment amount would decrease. CMS states that the only specialty significantly affected by this change is radiation oncology, although independent diagnostic testing facilities would also be significantly adversely affected.

CMS estimates that the change in methodology for practice expense relative values would result in a decrease in payments to oncologists of about 5%. The decrease to radiation oncologists is estimated at 17% (of the 17%, CMS states that 5% is due to the change in the assumed utilization rate for expensive equipment).

CMS also states that it is asking the AMA's Relative Value Update Committee to review the practice expense assumptions regarding supply costs and the useful life of renewable sources for several high dose radiation therapy and placement codes.

### **Malpractice Relative Value Units**

A small factor in the payment amount for physician services is the relative value for malpractice insurance costs. CMS is proposing to use new data on the costs of malpractice insurance to compute the malpractice relative values. The current relative values are based on data for the twenty largest specialties, but the new data relate to all specialties for which information is available – a total of 44, including medical oncology.

When the current malpractice relative values were implemented in 2000, CMS set the malpractice relative values for codes used by oncologists by using malpractice cost data for hematologists. Based on that data, medical oncology was assigned a risk factor of 1.21. (The lowest possible risk factor was designated as 1.00.)

Based on the new data, the specialties of medical oncology and hematology/oncology have a risk factor of 1.76. By comparison, hematology is 1.59 and internal medicine is 1.72 for physicians who do not do surgical procedures.

Although the risk factor for oncology has increased, risk factors for other specialties apparently increased more because the malpractice relative value units for codes used by oncologists have decreased. The principal chemotherapy administration codes currently have malpractice relative values of 0.06 to 0.08, but under the proposal those relative values would decline to 0.01. CMS estimates that the change in the malpractice relative values will result in a decrease in Medicare payments to oncologists of about 1%.

### **Net Effect on Codes Used by Oncologists**

As indicated above, CMS estimates that oncologists would experience a reduction in Medicare payments of about 6% as a result of the change in the practice expense and malpractice relative values. Relative values for the chemotherapy administration codes would decrease while relative

values for visit codes would increase. The following table compares the proposed relative value units (“RVUs”) to the 2009 relative values and to the 2010 relative values that would exist after completion of the ongoing four-year transition to the revised methodology that was adopted by CMS effective in 2007:

Code	Proposed RVUs	2009 RVUs	Percent Change	2010 RVUs Under Current Rules	Percent Change
96409 – Chemotherapy by push	2.43	3.10	-22%	3.05	-20%
96413 – First hour of chemotherapy infusion	3.14	4.09	-23%	3.92	-20%
96415 – Each subsequent hour of infusion	0.71	0.93	-24%	0.90	-21%
99213 – Level 3 visit with established patient	1.91	1.70	+12%	1.72	+11%
99214 – Level 4 visit with established patient	2.83	2.56	+11%	2.57	+10%
99232 – Level 2 subsequent hospital care	1.98	1.85	+7%	1.87	+6%

### **Geographical Adjustments**

In 2008, CMS raised the possibility of revising the current configuration of payment areas (“localities”) and discussed several alternative structures. In the notice, CMS summarizes the comments received and states that it has decided against any changes at this time.

Currently, the Medicare statute sets a floor of 1.0000 on the geographic practice cost index for physician work. This floor expires at the end of 2009, and as a result 54 out of the 89 localities will experience a decrease in payment amounts compared to amounts that would be paid by having the floor in effect.

## **Consultation Codes**

In the notice, CMS reviews the long-standing issue of when a consultation code can be billed, particularly in light of ambiguous language regarding transfer of care and the differences between the CPT guidance and Medicare policy. CMS also states that payment is higher for a consultation code than for a new patient visit (or hospital admission) even though, in CMS's view, the work is clinically similar. CMS states that the extra payment is for the written report required for a consultation, but it states that a formal written report is no longer required and that written documentation is required for all visits.

CMS is therefore proposing to eliminate payment for all consultation codes (except telehealth consultation G-codes) effective January 1, 2010. The revision would be made in a budget-neutral manner by redistributing the relative value units from the consultation codes to the codes for new and established patient visits and initial hospital and initial nursing facility visits. (CMS does not state why the relative values are being redistributed in part to the codes for established patients. Encounters with established patients are presumably not now being billed as consultations.) Physician work relative values for outpatient visits would increase about 6% and those for initial hospital and nursing facility visits would increase about 2%.

In the case of hospital admissions, a new modifier would be created to identify the admitting physician. This change would permit both the admitting physician and a specialty physician to bill an initial hospital visit on the same day, which is not permitted under current Medicare policy.

## **Accreditation Standards for Advanced Diagnostic Imaging Services**

Legislation enacted in 2008 (MIPPA) limits Medicare payment for the technical component of advanced diagnostic services (MRI, CT, nuclear medicine, PET) to accredited suppliers, effective in 2012. Oncology practices furnishing such services will need to be accredited. CMS plans to approve accreditation organizations by January 1, 2010.

The proposed regulations do not include specific standards but instead identify topics for which the accreditation organization must establish standards that satisfy CMS. Topics include: qualifications of non-physician personnel, qualifications of medical directors and supervising physicians, and procedures to ensure quality and safety.

## **Authorized Compendia and Coverage of Off-Label Uses**

The MIPPA legislation requires that any compendium recognized by CMS as authoritative for purposes of Medicare coverage must have a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests, effective January 1, 2010. To implement the requirement for a publicly transparent process, CMS is proposing that the compendium must post the materials used in its evaluation process on its website.

CMS is also proposing that the compendia would be required to publish the names of the individuals who have substantively participated in the development of compendia recommendations, along with transcripts of meetings and records of votes. The compendia would

need to have a process to disclose the financial and non-financial conflicts of individuals involved in making recommendations, as well as their immediate family members. CMS states that the four compendia have already adopted conflicts disclosure policies similar to its proposal. Disclosures would have to remain available for at least five years.

### **Payment for Part B Drugs**

The Medicare statute allows CMS to substitute a payment method based on the widely available market price (“WAMP”) of a drug or 103% of its average manufacturer price (“AMP”) instead of 106% of the manufacturer’s average sales price (“ASP”) if ASP exceeds the AMP or WAMP by a specified threshold. CMS is proposing to continue that threshold at 5%.

### **Competitive Acquisition Program**

CMS notes that the Competitive Acquisition Program for drugs (“CAP”) was put on hold for 2009 because of contractual issues with the bidders. In the notice, CMS is proposing several changes in the CAP to make it more attractive:

- Under the current rules, the payment rates to the CAP vendor are initially set by inflating its bid by the producer price index to the midpoint of the three-year contract term and are then revised only annually based on information about what the CAP contractor actually paid for drugs. The initial inflation adjustment can result in payments exceeding 106% of ASP in the first year of the contract, which is ordinarily not permitted. CMS is proposing to eliminate the initial inflation adjustment and instead to update the payment amounts quarterly based on the CAP vendor’s actual expenditures for drugs. All payment amounts would be capped at 106% of ASP.
- CMS is proposing to shorten the list of drugs available through the CAP. Under the 2006-08 contract, 180 drugs were available from the CAP vendor. CMS is proposing to remove the low-cost drugs and otherwise shorten the list. High-cost oncology drugs would continue to be on the CAP list.
- CMS is proposing to drop Alaska, Hawaii, and the Territories from the area served by the CAP due to logistical problems in serving those places.
- CMS is proposing to allow physicians to maintain small quantities of the CAP vendor’s drug on its premises. This would be permitted only if the physician uses an electronic drug inventory management device. The CAP vendor would electronically authorize access to its drugs in response to a physician’s order for a specific patient. CMS indicates that a bidder for a CAP contract could limit its bid to supplying physicians who use an electronic inventory management system.
- CMS has reiterated its policy of allowing physicians to transport CAP drugs between offices of the practice if both the physician and the CAP vendor agree and the arrangement is permitted by state law. Under the proposal, any agreement allowing transportation must include requirements that the drugs are not subjected to conditions that will jeopardize their integrity, stability, and/or sterility while being transported.

## **Physician Quality Reporting Initiative (PQRI)**

The PQRI is an ongoing program in which physicians can earn an incentive payment by submitting specified quality measures data. The bonus payment for physicians participating in the PQRI in 2010 will be 2% of the Medicare physician fee schedule payments. Physicians can continue to choose between claims-based reporting and registry-based reporting.

CMS is proposing to discontinue two oncology-related quality measures – #143 (“Oncology: Medical and Radiation – Pain Intensity Quantified”) and #144 (“Oncology: Medical and Radiation – Plan of Care for Pain”). CMS states the reason for their retirement is that they are “analytically challenging.” A new oncology-related quality measure proposed for 2010 is “Cancer Stage Documented.”

By the end of 2009, CMS plans to post a list of qualified registries on its website. The list would be supplemented by the summer of 2010. CMS is proposing that physicians who want to submit through a registry would need to enter into a formal legal arrangement with a registry, including a business associate agreement under the HIPAA privacy rules.

In addition to the two current methods of claims-based and registry-based reporting, CMS is proposing to add a third alternative of submission through electronic health records (“EHR”), pending its final conclusions on whether this is a feasible method of submitting quality measures data. In 2010, EHR reporting would be available only for a limited subset of the PQRI quality measures, and the subset does not include any of the cancer treatment measures. CMS indicates that it may significantly limit the use of claims-based reporting after 2010, relying instead on reporting through registries and EHR.

Beginning in 2010, PQRI payments can be made to group practices based on the group’s submissions of quality data as a whole, rather than based on the actions of individual physicians in the group. If the group qualifies for the 2% bonus, individual physicians in the group cannot also qualify for the bonus. In 2010, this option will be limited to groups having at least 200 professionals eligible to participate in the PQRI. Groups would be required to report on 26 quality measures related to high-cost chronic conditions and preventive care.

CMS will post on [www.medicare.gov](http://www.medicare.gov), as part of the Physician and Other Health Care Professionals Directory, the names of physicians who satisfactorily submitted PQRI data for 2009. This will be continued with respect to the 2010 PQRI. In the case of group practices that participate in the 2010 PQRI, their performance rates will also be published.

## **Physician Resource Use Measurement and Reporting Program**

In 2009, CMS implemented phase I of its Physician Feedback Program, which it has now renamed the Physician Resource Use Measurement and Reporting Program. Under the program, information is provided confidentially to physicians in selected cities and specialties comparing the resource costs for the physician’s patients compared to a larger group of patients. For phase I, the program focuses on costs for the following conditions: (1) congestive heart failure; (2) chronic obstructive

pulmonary disease; (3) prostate cancer; (4) cholecystitis; (5) coronary artery disease with acute myocardial infarction; (6) hip fracture; (7) community-acquired pneumonia; and (8) urinary tract infection. In response to comments, CMS has added diabetes to the list.

CMS is proposing to expand the program. Reports would be provided not only to individual physicians but also to groups of physicians, such as group practices or physicians practicing in a facility or system. CMS is also proposing to add confidential reporting regarding quality measures, such as the PQRI measures.

### **Transition to Value-Based Purchasing Program**

As required by law, CMS is developing a plan to transition Medicare payments for physician services to a value-based purchasing program. CMS is preparing a report to Congress, which is due May 1, 2010, and is seeking further comment on the content of the report.

### **Incentives for Electronic Prescribing**

Under the E-Prescribing Incentive Program, which began this year, successful e-prescribers can earn a 2% bonus in 2010, as they can in 2009. Claims-based reporting is the only reporting mechanism available in 2009, but CMS is proposing that registry- and EHR-based reporting will be available in 2010, as in the PQRI program.

Currently, a physician reports one of three G-codes to participate in the program – (a) all prescriptions were electronically prescribed, (b) no prescriptions were generated in the visit, or (c) some or all of the prescriptions were not electronically prescribed because the pharmacy’s system was not able to receive the data or because a controlled substance was involved. CMS is proposing that only one code would be used in 2010, and the code would be reported if at least one prescription was electronically prescribed. A physician would be considered to be a successful e-prescriber and eligible for the bonus if the code is reported at least 25 times during 2010. CMS’s rationale is that once a physician has undertaken the expense of installing an electronic prescribing system and has used the system to some extent, the physician is likely to use it generally.

As in the case of the PQRI, there will be an option for group practices of 200 or more professionals to participate as a group, rather than as individual physicians. A group would have to participate in the PQRI program to participate as a group in the Electronic Prescribing Incentive Program.

### **Signature Requirement for Lab Tests**

The notice contains a discussion, including a request for comments, on CMS’s policy on when a physician signature is required to order a clinical laboratory test. CMS states that a physician signature is not required on the paperwork sent to a laboratory (what CMS calls a “requisition”). The order for the test, however, must be documented by a written order signed by the physician in the patient’s medical record.