Adapting to Changes in Medicare for 2011

National Audiocall
Tuesday, December 21, 2010
Topics

• The 2011 Medicare Physician Fee Schedule
• The 2011 Hospital Outpatient Prospective Payment System
• Medicare incentive programs
• Oncology coding and billing updates
• Other topics
Medicare’s Physician Fee Schedule (MPFS)
Fee Schedule Highlights

• A number of technical updates to the 2011 fee schedule
  – Phasing-in of AMA’s Physician Practice Information Survey (PPIS)
  – Rebasing of the Medicare economic index (MEI)
  – Sustainable growth rate and conversion factor updates
Fee Schedule Highlights

• AMA’s PPIS data on practice expenses being phased in over 4 years and 2011 is 2\textsuperscript{nd} year.
  – ASCO successful in retaining Gallup survey data
  – Oncology still vulnerable to negative impacts because of updates to other specialties
  – Those updates must balance due to budget neutrality

• Estimated impact for oncology is -2\% in 2011
Fee Schedule Highlights

- MEI is a component of the SGR formula
- Used to measure physician practice costs in a “weighted” way
- CMS increasing relative values for practice expense and malpractice
- Estimated impact for oncology is +2% in 2011
Sustainable Growth Rate (SGR)

• Estimated 23% cut for 2010 was held off by multiple Congressional actions throughout the year
  – The Physician Payment and Therapy Relief Act of 2010 extended the 2.2 percent update (from June to November) until December 31st
Earlier this month, Congress passed a one-year patch to SGR (Medicare and Medicaid Extenders Act of 2010 or MMEA) – Signed by President Obama on 12/15/10

New SGR fix expires 12/31/11
  – Congress is expected to work on a permanent solution to the ongoing SGR crisis in 2011
  – Congress is expected to also finalize a funding mechanism for items left out of the SGR Patch

ASCO has met with incoming leadership for the 112th Congress on these and other issues
• Physician fee schedule update will be 0%
• Changes to relative value units (RVUs) used to calculate fee schedule rates must be budget neutral
  – To make these changes budget neutral, the conversion factor must be adjusted for 2011
• CMS is currently developing the 2011 MPFS to implement the 0% update and RVU changes
  – “We expect all 2011 claims to be processed timely, in compliance with the new legislation”
MMEA

- Also extends the existing 1.0 floor on the physician work geographic practice cost index (GPCI) through 12/31/11
  - Will be reflected in the revised 2011 MPFS
“Carry Over” Pricing Policy

• Final rule outlined new “carry over” policy
• Carry over of previous quarter’s data will occur when manufacturers do not submit ASP data in a timely fashion
  – Timely is 30 days after end of quarter
  – Being applied only to multisource drugs
• Policy to be used when missing data could cause significant changes in ASP payment
  – increase of 10% or greater
ASP & AMP

• CMS has not yet implemented mechanism proposed for substituting AMP-based reimbursement methodology for ASP in certain situations
  – MMA directed OIG to make periodic comparisons of each drug’s ASP to its AMP
  – CMS is directed to adopt AMP when ASP exceeds this benchmark by a threshold percentage set by CMS and if ASP exceeds AMP by the threshold, CMS is directed to substitute 103% of AMP for 106% of ASP
ASP & AMP

• CMS did not finalize its proposal regarding AMP-based pricing
  – Delay appears to arise from pending litigation and rulemaking regarding AMP
Drug Overfill

- CMS clarified that “intentional overfill” of drug is not covered by Medicare
- Overfill is defined as the amount of product in excess of FDA labeled amount
- Since excess does not represent a cost to provider, it is not reimbursable
- CMS stresses the lack of coverage not the use
Self-Referral Requirements

• New disclosure requirement for advanced imaging services
  – Magnetic resonance imaging (MRI)
  – Computed tomography (CT)
  – Positron emission tomography (PET)

• Effective January 1, 2011

• Specifically relates to physician self-referral law (or Stark Law)
Self-Referral Requirements

• Physicians are required to provide a list of 5 suppliers who perform the imaging service in a 25-mile radius of physician’s office
• If less than 5 suppliers exist, must list all suppliers in radius
• If no suppliers exist in the radius, physician is required to inform patient that services are available elsewhere
Self-Referral Requirements

• List must be presented each time one of the services is referred
  – Not just at the initial service
  – Can be mailed/e-mailed if verbally notified
• Must be written in a “manner sufficient to be reasonably understood by all patients”
• List must include suppliers’ name, address and phone number
Self-Referral Requirements

• In final rule, CMS noted that documentation in the medical record should include some reference that notice was given to patient
• CMS suggests the supplier list be reviewed annually for accuracy
• Again, effective January 1, 2011
Timely Filing of Medicare Claims

• Previous time limit for submission of claims was a minimum of 1 calendar year from the date of service to the maximum of 4 years and 3 months after the date of service

• CMS implementing changes to the time limits for filling Medicare claims based on statutory language from the Affordable Care Act (ACA)
  – Applies to both Part A & Part B
Timely Filing of Medicare Claims

• Claims for services on or after January 1, 2010 must be filed within 1 calendar year after the date of service

• Claims for services performed during the last 3 months of 2009 must be filed no later than December 31, 2010
  – For services performed before October 1, 2009, have up to 4 years from date of service to submit claim
Medicare’s Hospital Outpatient Prospective Payment System (HOPPS)
HOPPS Highlights

• Drug payments
  – Continue standard packaging methodology
    • Drugs costing less than $70 per day are packaged into ambulatory payment classification (APC)
    • Drugs costing more than $70 are reimbursed separately
  – Separately billable drugs paid at ASP+5%
  – Only 5-HT3 antiemetic product exempt from standard packaging methodology is palonosetron hydrochloride
HOPPS Highlights

• Continue to use CPT codes to report drug administration services
  – CMS established five APCs and payment based on APCs

• No change to new vs. established patient definition
  – New patient has not been registered as an inpatient or outpatient of hospital within past 3 years
HOPPS Highlights

• Ongoing discussion about supervision requirements

• Under direct supervision CMS clarified that supervising physician or non-physician practitioner (NPP) must be “immediately available”
  – CMS not defining “immediately available” but referenced as physically present and interruptible
HOPPS Highlights

• Direct supervision required for chemotherapy services

• Hydration and therapeutic/diagnostic/prophylactic administrations considered nonsurgical extended duration therapeutic services
  – Require direct supervision during initiation period followed by general supervision for duration of service
HOPPS Highlights

- CMS expects documentation of transition from direct supervision to general supervision
- Should be documented “prominently in progress notes or in the medical record”
Medicare Incentive Programs
2011 Physician Quality Reporting System (formerly PQRI)

- Voluntary reporting program that provides incentive payment to eligible professionals (EP) who satisfactorily report data on quality measures for covered Physician Fee Schedule services furnished to Medicare Part B beneficiaries
  - Includes Railroad Retirement Board and Medicare Secondary Payer
  - Medicare Part C/Medicare Advantage beneficiaries are not included in claims-based reporting of individual measure or measures groups
Incentive Payments

- Incentive payments are available until 2014.
  - 2011: 1% of total estimated Medicare Physician Fee Schedule allowed charges
  - 2012 – 2014: 0.5% of allowed charges
- Additionally, for reporting years 2011 – 2014, EPs can earn an additional 0.5% by, more frequently than is required to qualify for or maintain board certification status, participating in a maintenance of certification program and successfully completing a qualified maintenance of certification program practice assessment
Penalties

• Beginning in 2015, EPs who do not satisfactorily report Physician Quality Reporting System measures will be subject to payment adjustments
  – 2015: -1.5% payment adjustment
  – 2016 and beyond: -2% payment adjustment
Selecting Measures

• When selecting measures for reporting consider:
  – Clinical conditions usually treated
  – Types of care typically provided – e.g. preventive, chronic, acute
  – Settings where care is usually delivered
  – Quality improvement goals for your practice for 2011

• CMS notes: Eligible professionals should not choose individual measures that do not or infrequently apply to services provided to Medicare patients by the eligible professional/practice.
2011 Measures

• 194 individual measures
  – 571 page document on CMS website
  – 5 measures have been retired
    • 114, 115, 136, 139, 174

• Handout: “2011 Physician Quality Reporting System Measures for Consideration by Oncology Providers”
<table>
<thead>
<tr>
<th>Measure #69: Multiple Myeloma: Treatment with Bisphosphonates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ELIGIBLE PATIENTS</strong> (Denominator)</td>
</tr>
<tr>
<td>All patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission</td>
</tr>
<tr>
<td>ICD-9 diagnosis code: 203.00, 203.02 AND CPT E/M service codes: 99201-99205, 99212-99215</td>
</tr>
<tr>
<td><strong>MEASURE CODING</strong> (Numerator)</td>
</tr>
<tr>
<td>Intravenous Bisphosphonate Therapy Prescribed or Received CPT II 4100F: Bisphosphonate therapy, intravenous, ordered or received</td>
</tr>
<tr>
<td>Intravenous Bisphosphonate Therapy not Prescribed or Received for Medical Reasons CPT II 4100F 1P: Documentation of medical reason(s) for not prescribing bisphosphonates (e.g., patients who do not have bone disease; patients with dental disease; patients with renal insufficiency)</td>
</tr>
<tr>
<td>Intravenous Bisphosphonate Therapy not Prescribed or Received for Patient Reasons CPT II 4100F 2P: Documentation of patient reason(s) for not prescribing bisphosphonates (e.g., patient declined, economic, social religious, other patient reason)</td>
</tr>
<tr>
<td>Intravenous Bisphosphonate Therapy not Prescribed, Reason Not Specified CPT II 4100F 8P: Bisphosphonate therapy, intravenous, not ordered or received, reason not otherwise specified</td>
</tr>
</tbody>
</table>
• EPs may choose to report on measures groups if all of the measures within the group are applicable to services provided to Medicare patients by the EP

  - Measures groups include: diabetes mellitus; chronic kidney disease; preventive care; rheumatoid arthritis; perioperative care; back pain; hepatitis C; ischemic vascular disease; community-acquired pneumonia; asthma; coronary artery bypass graft; heart failure; coronary artery disease; HIV/AIDS
Submission of Quality Data

• Claims
• Qualified registry
• Electronic health record
• Group practice reporting options
### Reporting Mechanisms for Individual Measures: CLAIMS

<table>
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<tr>
<th>Reporting Period(s)</th>
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<td>1/1 – 12/31/11 or 7/1 – 12/31/11</td>
<td>Report at least 3 Physician Quality Reporting System measures (or 1-2 measures if fewer than 3 apply); And Report each measure for at least 50%* of applicable Medicare Part B FFS patients seen during the reporting period</td>
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*revised
What is a registry?

- Captures and stores clinical related data submitted to the registry by the eligible professional (or group practice)
- Registry submits information on Physician Quality Reporting System individual measures or measures groups to CMS on behalf of EPs/group practices
- Registries provide CMS with calculated reporting and performance rates at the end of the reporting period
Registries

• CMS qualifies registries annually
  – Current list of *Qualified Registries for 2010 PQRI Reporting* is available at
    http://www.cms.gov/PQRI/Downloads/Qualified_Registries_Phase4_eRxPQRI_06282010_FINAL.pdf
  • Contact information for the registries is included
  – Registries vary in the measures they can report
    – all measures, specific measures, measures groups
### Reporting Mechanisms for Individual Measures: REGISTRY

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<td>Report at least 3 Physician Quality Reporting System measures; And Report each measure for at least 80% of applicable Medicare Part B FFS patients seen during the reporting period</td>
</tr>
</tbody>
</table>
EHR Submission

• CMS qualifies EHR vendors annually
• Using a qualified EHR, EPs submit raw clinical data to CMS and measures are calculated by CMS
  – List of Qualified EHR Vendors for the 2011 Physician Quality Reporting and eRx Incentive Programs will be available at
    www.cms.gov/PQRI/20_AlternativeReportingMechanisms.asp#TopOfPage
Reporting Mechanisms for Individual Measures: EHR

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*measures with a 0% performance rate will not be counted (new)
Group Practice Reporting

• To participate, a group practice must:
  – Submit self-nomination letter to CMS. Information is posted on the Group Practice Reporting Option section of the Physician Quality Reporting website
  – Meeting certain technical and other requirements
  – Be selected to participate
GPRO I

- Self-nominated groups with 200 or more eligible professionals
- Complete pre-populated data collection tool for an assigned set of Medicare beneficiaries
  - 26 total measures
  - Access to tool no later than first quarter of 2012
GPRO II – New for 2011

• Group practices with 2 – 199 eligible professionals

• CMS will select approximately 500 groups meeting the eligibility requirements
  – Reported via claims (unless only applicable measures group(s) is registry-only)
  – No data collection tool – report individual measures using claims or registry reporting, or measures groups
How to Participate in GPRO in 2011

• Potential participants must
  – Meet group practice definition
  – Have billed Medicare B between 1/1 – 10/29/10
  – Self-nominate between 1/3 – 1/31/11
  – Provide group practice’s TIN
  – Agree to attend/participate in mandatory training sessions and kick-off meeting

• Reporting requirements vary by size of group practice/# of eligible professionals
Resources

- CMS
  - www.cms.gov/PQRI
- QualityNet Help Desk
  - Feedback report availability and access
  - PQRI-IACS registration questions
  - PQRI-IACS login issues
  - Program and measure-specific issues
    - 866-288-8912 (7:00 a.m. – 7:00 p.m. M-F CST)
    - gnetsupport@sdps.org
    - TTY 877-715-6222
Electronic Prescribing (eRx) Incentive Program

• eRx is the transmission of prescriptions through electronic media and takes place between a prescriber, dispenser, pharmacy benefit manager or health plan

• Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorized the eRx Incentive Program beginning in 2009 to promote adoption and use of eRx systems
  – Provides incentives for eligible professionals and group practices who are “successful electronic prescribers” and *payment adjustments* for those who are not
2011 eRx Incentive Program

• For successful claims-based reporting in 2011, a single code should be reported (numerator)
  – G8553 – At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system

• For a patient visit including one of the following codes on the same claim (denominator)
  – 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109
Successful Individual ePrescriber & Incentive Eligible

• Must generate and report one or more eRxs associated with a denominator-eligible patient visit for a minimum of 25 unique visits per year
• Each visit must be accompanied by the eRx G-code attesting that during the visit at least one prescription was electronically prescribed
• At least 10% of the eligible professional’s Medicare Part B charges must be comprised of the codes in the denominator of the measure to be incentive eligible
Incentive Payments

• For reporting years 2011 and 2012, successful e-prescribers can qualify to earn an incentive payment equal to 1% of allowed PFS charges
  – NOTE: Incentive payment is not available to eligible professionals receiving 2011 incentive from Medicare EHR incentive program)

• For reporting year 2013, incentive payment is 0.5% of allowed PFS charges

• Beginning in 2012, eligible professionals who are NOT successful e-prescribers may be subject to a payment adjustment
eRx Penalties

- Per legislation, beginning in 2012 payment adjustments will occur for not being a successful electronic prescriber
  - 2012: -1% payment adjustment (reduction in payment for Part B covered professional services)
  - 2013: -1.5% payment adjustment
  - 2014: -2% payment adjustment
eRx Payment Adjustments

• 2012 payment adjustment will be determined as follows
  – Reporting period: January 1 – June 30, 2011
  – Reporting mechanism: Claims
  – Eligible professional must have submitted at least 10 electronic prescriptions during the reporting period (1/1 – 6/30/11)
Hardship Exemption

• CMS may, on a case-by-case basis, exempt eligible professionals from the eRx payment adjustment if compliance would result in a significant hardship
  – The eligible professional practices in a rural area with limited high speed internet access, or
  – The eligible professional practices in an area with limited available pharmacies for electronic prescribing

• This exemption is subject to annual renewal
Hardship Exemption

• To request a hardship exemption for 2012 payment adjustment
  – An eligible professional must report the appropriate hardship G-code on at least 1 claim before 6/30/11
  – G8642 – the eligible professional practices in a rural area without sufficient high speed internet access and requests a hardship exemption
  – G8643 – the eligible professional practices in an area without sufficient available pharmacies for electronic prescribing and requests a hardship exemption
Payment Adjustment Concerns

• In a letter to HHS, more than 100 provider organizations – including ASCO – have urged the Secretary to revise the policy for how CMS will calculate physician penalties
  – The letter opposes CMS’s decision to base 2012 penalties on e-prescribing activities in the first six months of 2011 and 2013 penalties on activities in all of 2011
  – Also requests CMS to recognize additional exemptions including one that would allow an eligible professional who is certified as a “meaningful user” of an EHR to forego reporting on e-prescribing measures and be exempt from penalties
ARRA and HITECH: What are They?


Title XIII: The Health Information Technology for Economic and Clinical Health (HITECH) Act

Centers for Medicare & Medicaid Services
- Managing incentive program through Medicare and Medicaid to promote EHR usage

Office of the National Coordinator (ONC)
- Established groups to certify EHRs; incentive program requires use of certified EHRs.
The Medicare Incentive Program

Carrot and stick approach

- Largest possible incentive is $44,000 over 5 years
  - Early adopters get larger incentive
  - Biggest annual payments in first years

- Must demonstrate meaningful use of EHRs to receive incentive.

Bonus payments available 2011-2016

Penalties begin in 2015 and do not end:
- 1 percent in 2015
- 2 percent in 2016
- 3 percent in 2017
The Medicaid Incentive Program

- Voluntary for states to implement.
- Greater level of assistance – Up to $63,750 over six years.
- No penalties.
- First year payment ($21,250) can support adopting, implementing and upgrading EHRs.
- Later years require that physician demonstrate meaningful use, using same definition as Medicare, though each state can have additional measures.
- EPs must have a 30 percent Medicaid patient load to qualify (no CHIP, no “secondary”).
- Can only receive incentive from a single state, even if licensed in and seeing Medicaid patients from multiple states.
Can You do Both?

NO

Physicians must register to receive incentive payments from either Medicare or Medicaid.

However, CMS will allow a one-time switch between the incentive programs, but only for a payment year before 2015.
HITECH, PQRI, & eRx

• If an eligible provider opts to receive incentives under Medicare
  – May collect PQRI and HITECH incentives
  – May NOT collect eRx incentives

• If an eligible provider opts to receive incentives under Medicaid
  – May collect PQRI, HITECH, and eRx incentives
EPs practicing predominantly in HPSAs get 10% higher payments.

<table>
<thead>
<tr>
<th>Year*</th>
<th>Yearly incentive payments for EHR adoption based on year of first use**</th>
<th>Yearly Payment Penalties if not using a EHR***</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$18,000.00</td>
<td></td>
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<tr>
<td>2012</td>
<td>$12,000.00 $18,000.00</td>
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<td>2013</td>
<td>$ 8,000.00 $12,000.00 $15,000.00</td>
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<td>2014</td>
<td>$ 4,000.00 $ 8,000.00 $12,000.00 $12,000.00</td>
<td>-1%</td>
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<tr>
<td>2015</td>
<td>$ 2,000.00 $ 4,000.00 $ 8,000.00 $ 8,000.00</td>
<td>-2%</td>
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<td>2016</td>
<td>$ 2,000.00 $ 4,000.00 $ 4,000.00 $ 4,000.00</td>
<td>-3%</td>
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<td>2017</td>
<td>$ 2,000.00 $ 4,000.00 $ 4,000.00 $ 4,000.00</td>
<td>-4%</td>
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<tr>
<td>2018</td>
<td>$ 2,000.00 $ 4,000.00 $ 4,000.00 $ 4,000.00</td>
<td>-5%</td>
</tr>
<tr>
<td>2019</td>
<td>$ 2,000.00 $ 4,000.00 $ 4,000.00 $ 4,000.00</td>
<td>Variable</td>
</tr>
<tr>
<td>Total Payments</td>
<td>$44,000.00 $44,000.00 $39,000.00 $24,000.00</td>
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</tbody>
</table>
Hospital-based physicians (anyone who provides 90% or more of his/her services in an inpatient hospital or emergency room setting) are not eligible for either program, and will not be subject to payment penalties (exception for those in rural health clinics and federal qualified health centers).

CMS estimates that about 14 percent of physicians are hospital-based and will not be eligible for EHR incentive.
Basic Structure of CMS’ Program

- Incentive payments provided to eligible providers who adopt certified EHR technology and achieve meaningful use
Two Sides to the Program

Health IT Vendors

• Design EHR technologies that meet the standards and certification criteria
• Submit EHR technologies to an ONC-Authorized Testing and Certification Body (ONCATCB), which tests and certifies EHR technologies for use

Health Care Providers

• Demonstrate meaningful use of certified EHR technology to qualify for the Medicare and Medicaid EHR incentive programs
Meaningful Use : HITECH Act

• The Recovery Act specifies 3 major components
  – Use of certified EHR in a meaningful manner (Stage 1)
  – Use of certified EHR technology for electronic exchange of health information to improve quality of health care (Stage 2)
  – Use of certified EHR technology to submit clinical quality measure (CQM) and other measures (Stage 3)
Demonstrating “Meaningful Use”

• Annual attestation to CMS that you:
  – Are using certified EHR technology (with technology specified)
  – Have met each of the 15 core meaningful use objectives; and 5 of the 10 “menu” objectives
    • Have accurately and completely reported the associated HIT functionality measures – one for each objective
  – Have accurately and completely reported 6 quality measures using your EHR to generate values (electronic reporting from EHR starting in 2012)
  – Reporting period is 90 days in first year; one year thereafter
How will Payments Work?

Annual, lump-sum payment on a rolling basis

– CMS estimates 15-45 days for payment to arrive after verification that EP demonstrated meaningful use.
– Payment from a single payment contractor for Medicare. State for Medicaid.
– EP to designate a single tax ID number where payment should be sent.
– All reporting and payment done at the level of the individual National Provider Identifier.
Registering for the Incentives

• Registration begins in January, 2011 at the EHR Incentive Program website
  • [http://www.cms.gov/EHRIncentivePrograms/](http://www.cms.gov/EHRIncentivePrograms/)

• Requirements include
  • Name
  • NPI
  • Business address and phone
  • Taxpayer ID number for incentive payments
  • Medicare or Medicaid program selection
    • State selection for Medicaid providers
How to begin

1. Confirm that NPI information is complete and accurate in the PECOS system
2. Have and use a certified EMR
   - Confirm that your vendor has applied for certification
     • You will need your vendor’s HHS ONC certification number when you apply for funding
3. Become a meaningful user
   - Designate a staff member to become the HITECH and Meaningful Use expert and communicate with your EMR vendor
   - Review the Core Set and Menu Set with providers to begin planning to integrate them into your practice
   - Develop a timeline for meeting the Meaningful Use requirement
4. Set a target date for submitting your attestation
If you don’t have an EMR yet…

• Start researching vendors and set up demonstrations
• Get your practice organized to select an application
• Set a timeline for implementation
Medicare Incentive Program Resources

• Medicare EHR Incentive Program, Physician Quality Reporting System and e-Prescribing Comparison
Oncology Coding and Billing Updates
CPT Coding Changes

• Minimal coding changes to chemotherapy codes
• Parenthetical note for 96523 has been revised
  – Reference to bill 36591 for collection of blood specimen
CPT Coding Changes

• Deletion of 96445 and addition of 96446
  – 96445  Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis
  – 96446  Chemotherapy administration into pleural cavity via indwelling port or catheter

• Deletion of 96445 and addition of 96446 made to reflect the current practice of intraperitoneal chemotherapy
HCPCS Coding Changes

• Lots of changes in the chemotherapy section (J9000 series)
• Effective January 1, 2011
• New Codes
  – J9302 Injection, ofatumumab, 10 mg
  – J9307 Injection, pralatrexate, 1 mg
  – J9315 Injection, romidepsin, 1 mg
  – J9351 Injection, topotecan 0.1 mg
• New code and new amount
HCPCS Coding Changes

• Deleted codes – Effective January 1, 2011
  – J9062  Cisplatin, 50 mg
  – J9080  Cyclophosphamide, 200 mg
  – J9090  Cyclophosphamide, 500 mg
  – J9091  Cyclophosphamide, 1 gram
  – J9092  Cyclophosphamide, 2 gram
  – J9093  Cyclophosphamide, lyophilized, 100 mg
  – J9094  Cyclophosphamide, lyophilized, 200 mg
HCPCS Coding Changes

• Deleted codes (cont.)
  – J9095  Cyclophosphamide, lyophilized, 500 mg
  – J9096  Cyclophosphamide, lyophilized, 1.0 gram
  – J9097  Cyclophosphamide, lyophilized, 2.0 gram
  – J9110  Injection, cytarabine, 500 mg
  – J9140  Dacarbazine, 200 mg
  – J9290  Mitomycin, 20 mg
  – J9291  Mitomycin, 40 mg
HCPCS Coding Changes

• Deleted codes (cont.)
  – J9350 Injection, topotecan, 4 mg
  – J9375 Vincristine sulfate, 2 mg
  – J9380 Vincristine sulfate, 5 mg
ICD-9 Coding Changes

• See handout
Other Topics
Home health services

• Effective 1/1/11, a physician who certifies a patient as eligible for Medicare home health services must see the patient
  – Law also allows a non-physician practitioner (NPP) to see the patient, when the NPP is working for or in collaboration with the physician
  – Face-to-face encounter must occur within 90 days prior to start of home health care or within 30 days after the start of care

• Documentation must include
  – That the physician or NPP saw the patient
  – How the patient’s clinical condition supports homebound status and need for skilled services

• MLN article coming soon…
Provider Enrollment, Chain and Ownership System (PECOS)

• All Medicare providers must have an active Medicare enrollment record
  – You do not have an active enrollment record if
    • You enrolled in Medicare prior to implementation of PECOS and/or
    • You have not submitted any updates or changes to your Medicare enrollment information in the past 6 (or more) years
PECOS

• If you do not have an enrollment record in PECOS
  – Your information may not be current and payment accuracy could be affected
  – You may not be able to receive incentive payments from Medicare for meaningful use of certified electronic health records
  – You need an approved enrollment record to continue to refer or order items or services for your Medicare patients (effective date pending)
PECOS

• There are two ways to enroll
  1. Use internet-based PECOS and send your enrollment application to the Medicare carrier or A/B MAC
     • Be sure you have a National Provider Identifier (NPI)
     • Create a User ID and password in the National Plan and Provider Enumeration System (NPPES)
     • [http://www.cms.gov/MedicareProviderSupEnroll](http://www.cms.gov/MedicareProviderSupEnroll) for more information
PECOS

• There are two ways to enroll
  2. Fill out the appropriate paper Medicare provider enrollment application(s) (CMS-855I and, if appropriate, CMS-855R as well) and mail the applications and necessary documentation to the Medicare carrier or A/B MAC.

• Forms are available at http://www.cms.gov/cmsforms/cmsforms/list.asp
HIPAA Transaction Standards and Code Sets: 5010 and ICD-10

• All covered entities (including providers, clearinghouses, health plans) must transition to the latest version of the HIPAA electronic transaction standards and code sets

• Two important deadlines:
  – 1/1/12 – 5010 version of electronic transaction standards will replace the current 4010
  – 10/1/13 – the International Classification of Diseases 9th Revision, Clinical Modification (ICD-9-CM) will be replaced by ICD-10-CM
HIPAA Version 5010

• HIPAA requires update from 4010 to 5010 beginning 1/1/11 and full implementation on 1/1/12
  – 5010 is necessary for the implementation of ICD-10 on 10/1/13

• 5010 requires considerable changes in content of electronic claims submission and data returned to you in response to electronic inquiries
  – Will require changes to software, systems, and some procedures that will be used to bill Medicare and other payers
HIPAA Version 5010

- These are national standards and apply to transactions with ALL payers, not just Medicare
- Start having conversations with your software vendor, billing service, clearinghouse and key health plans about upgrading to 5010
  - Implementation plans, timelines
  - Testing schedules
- Software vendors are especially important – they are not “covered entities” so are not legally responsible for compliance
  - Are costs included in maintenance agreements? Or an additional cost?
ICD-10

• 10/1/13 – ICD-9 will be replaced by ICD-10
  – To accommodate the ICD-10 code structure, version 4010 of the transaction standards must be upgraded to 5010 by 1/1/12

• ICD-10 consists of two parts
  – ICD-10-CM for diagnosis coding
  – ICD-10-PCS for inpatient procedure coding

• CPT will continue to be used for coding outpatient procedures

• ICD-10 will affect everyone covered by HIPAA – not just those who submit Medicare or Medicaid claims
ICD-10 CMS Compliance Timeline

1/1/10 – payers and providers begin internal testing of 5010 standards for electronic claims

1/1/11 – payers and providers begin external testing of 5010; CMS begins accepting 5010 claims; 4010 claims continue to be accepted

1/1/12 – all electronic claims must use Version 5010; 4010 claims are no longer accepted

10/1/13 – claims for services after this date must use ICD-10 codes for medical diagnosis and inpatient procedures; CPT codes will continue to be used for outpatient services
CMS Says…

• “These transition dates are definite. The US Department of Health and Human Services established the deadlines in two final regulations issued on January 16, 2009 and confirmed them on March 5, 2009. HHS does not plan to extend the deadlines.”
Transition to 5010 and ICD-10

• Talk with your vendors – software, billing service, clearinghouse – and payers
  – Vendors should have products and services ready well in advance of the compliance deadlines to allow adequate time for testing to avoid disruptions to cash flow
Transition to 5010 and ICD-10

• Points to consider when speaking to your vendors
  – Will system upgrades or replacements be necessary to accommodate 5010 or ICD-10?
  – Will there be costs involved or will upgrades be covered by existing contracts?
  – When will upgrades or new systems be available for testing and implementation?
  – What customer support and training will the vendor provide?
  – How will their product/service accommodate both ICD-9 and ICD-10 as you work with claims for services provided before and after the transition deadlines?
Resources

• CMS - 5010
  – http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp#TopOfPage

• CMS - ICD-10
  – http://www.cms.gov/ICD10/05a_ProviderResources.asp

• MGMA Vendor and Health Plan Questions and Guidelines
Red Flag Rules

• 12/7/10 – House passed Senate bill exempting physicians from identity theft regulations known as the Federal Trade Commission’s Red Flag Rules
  – Regulations require financial institutions and credit-extending businesses to submit written identity theft mitigation and prevention strategies

• S. 3987 was presented to the President on 12/9/10 and awaits his signature
Medicare compliance

• A new Medicare Learning Network (MLN) educational product: Medicare Quarterly Provider Compliance Newsletter
  – First issue October 2010
  – Table of contents in this issue includes:
    – Services with excessive units
    – Drug codes – incorrect number of units billed
    – Physician Pharmaceutical Injectables – Incorrect Procedure Codes and/or Number of Units Billed
Medicare compliance

• Other resources
  – Provider compliance MLN articles
    • [http://www.cms.gov/MLNProducts/Downloads/ProvCmpl_Articles.pdf](http://www.cms.gov/MLNProducts/Downloads/ProvCmpl_Articles.pdf)
  – Provider compliance national educational products
ASCO RESOURCES
Electronic Health Records

- ASCO Electronic Health Record Initiatives at:  
  - [www.asco.org/ehr](http://www.asco.org/ehr)
- Social networking site  
  - [ASCOConnections.org](http://ASCOConnections.org)
- EHR Lab at 2011 ASCO Annual Meeting
The Premier, Oncology-Specific Guide to EHRs

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**CLINICAL ALERT—Leucovorin Shortage**

January 8, 2008

**Why is there a shortage of leucovorin?**

There is currently a nationwide shortage of injectable racemic leucovorin, available only as a generic drug and only from two manufacturers in the US (Kedron Laboratories and Teva Pharmaceuticals). According to the FDA and the American Society of Health-System Pharmacists (ASHP), the companies have not provided information on how long this shortage, caused by unspecified "manufacturing delays," is expected to last.

**What about using levo-leucovorin?**

Levo-leucovorin is the levo isomeric form of racemic (d,l)-leucovorin, and is the pharmacologically active isomer of leucovorin. Levo-leucovorin is available under the brand name "Fusilev" (Spectrum Pharmaceuticals). According to the FDA website, limited supplies of levo-leucovorin continue to be available (the ASHP does not list a shortage of this drug). Unlike leucovorin, levo-leucovorin is not FDA-approved for use in colorectal cancer or other malignancies (with the exception of use for rescue after high-dose methotrexate therapy in colorectal cancer). However, it has been used off-label in the treatment of malignancies, as a substitute for leucovorin, though noninferiority in terms of efficacy has not been tested either for metastatic disease or adjuvant therapy.

If clinicians and patients are considering the use of levo-leucovorin, they should note the following:

- The dose for levo-leucovorin is 50% of the usual dose of racemic leucovorin.
- Levo-leucovorin is not FDA-approved for malignancy indications (except as noted above).
- The cost of levo-leucovorin may be significantly higher than for leucovorin.
- For the time being, you may wish to check with your Medicare contractor and private insurance carriers for coverage determinations.


**What about using oral leucovorin?**

According to the ASHP, leucovorin tablets are still available. Oral leucovorin is not FDA-approved for use in treatment of malignancies (except for methotrexate rescue in colorectal cancer), although its use has been evaluated in that setting. The use of oral leucovorin may be limited by the large number of tablets needed and by the fact that oral absorption of leucovorin is saturable and highly variable.

**What about using capecitabine to substitute for the combination of SFU/leucovorin?**

Capecitabine is an oral pro-drug of SFU. For some treatment regimens, for some malignancies, substitution of capecitabine for the combination of SFU/leucovorin is supported based on high quality randomized clinical trials. However, such data are not available for all SFU/leucovorin containing regimens.
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