



FLORIDA SOCIETY OF CLINICAL ONCOLOGY FAX BLAST SPECIAL FAX BLAST – MEDICARE UPDATE – July 3rd, 2008

IMPORTANT MEDICARE UPDATE: - (Source: Bobbi Buell)

As you may know may now, Congress left for the Fourth of July break without changing the Medicare law that would cause a **10.6% reduction starting TODAY (July 1)**. **What Medicare is going to do is freeze your claims for 10 days. This will delay the cut until Congress comes back in session and does something about the current fee problem.** All claims with dates of service prior to July 1 will be processed. ANY delay in claims processing can be a disaster in oncology as the denial rate for ESAs is so high (an estimated 40-45% according to a sample of 1500+ physicians) that cash is already an issue.

In an unrelated event, CMS published the **2009 PROPOSED fee schedule rules**. **These include an estimated 5.4% decrease which may be voided by the Congressional fix to this year's fee schedule.**

Medicare Frozen Solid July 1

CMS, without any official documentation so far, has stated to the press that it will delay paying doctors starting **July 1, 2008 to give Congress more time to block a scheduled 10.6 percent fee cut**. As you may know, Congress had a scheduled vacation for July 4th and we wouldn't want them to miss out on that. **The decision by the Centers for Medicare and Medicaid Services doesn't block or freeze the cut.** It's up to Congress to decide that. All they are doing is not paying claims, which they can do because of the 14-day window.

To give the vacationing Congress more time to act, the agency has instructed its contractors not to process any physician or non-physician Medicare claims for health care services given **during the first 10 business days of July**. Claims for services received on or before June 30 will be processed as usual. If Congress does not act before the ten days, the 10.6% cut will then be implemented.

Almost every year, Congress finds a way to avoid such cuts. But last week, in a particularly heated round of finger-pointing, the Senate fell just **one vote short of the 60 needed to proceed to legislation that would have stopped the cut**. Democrats insisted on cutting the Medicare Advantage ("MA") program, which is an issue for both parties and for providers. As you may know, Medicare now pays per patient more for MA patients than for regular Medicare patients. The Bush administration and Republicans like Medicare Advantage (another Medicare oxymoron) because it lets the elderly and disabled choose private insurance companies in lieu of traditional Medicare Parts A, B, and D. President Bush will veto any bill that contains MA cuts. The Democrats think that government payments to the private insurers are too generous. This has created a bloody battle with Medicare providers being caught in the middle

Because the current situation has received a lot of press, Congress will most likely get to work on this upon their return. The stalemate may be broken by the possible return of Senator (and cancer patient) Ted Kennedy (D-MASS) to the Congress. We may then get a 1.1% increase for 18 months. That would mean .6% more over the last six months for the rest of the year and an increase next year of 1.1%. **Yet, if nothing gets passed before the CMS 10-day freeze is over, we may see retroactive adjustments, which may not be received for months. This is bad news for cash-poor cancer practices.**

Medicare Releases PROPOSED 2009 Fee Schedule

The proposed rule includes a **projected update to the fee schedule conversion factor of negative 5.4 percent under a formula specified in the Medicare law**. Obviously, if Congress changes the update factor in the upcoming session, this will not

occur. But, we all know that anything can happen.

From what we see right now (and is subject to change), the Oncology highlights proposed in the rule include the following (but this is not inclusive of the whole proposal):

- **ASP:** No significant changes were evidenced. Medicare made official the weighted averaging that actually went into effect April 1, 2008. Additionally, they did not increase the implementation threshold for Widely Available Market Price or Average Manufacturers Price, which is that ASP must be 5% (or more) over these prices for them to be used to pay for Part B drugs. They also believe that there "complicated operational issues associated with potential payment substitutions", which is why they are cautious about using these pricing mechanisms.
- **Cancellation of G0332:** CMS believes that "market conditions for IVIG have improved". They do not believe that you are being paid less than cost for the drug, so they propose to eliminate the preadministration payment next year. This seems to be a bit out of touch with what you are actually experiencing out there.
- **Competitive Acquisition Program (CAP) Revisions:** The proposed rule contains a number of proposed refinements to the CAP, including clarifying the annual payment amount update calculation for drugs; expanding the definition of a physician for CAP purposes in terms expanding **the definition to include Non-Physician Practitioners**; easing the restriction on physicians transporting CAP drugs between their practice locations with many caveats--including making provisions in the contract with the vendor for safe transport between locations; and explaining what happens if a CAP physician or vendor is suspended from participation in the CAP.
- **MRI Multiple Payment Rule:** As you may remember, in 2006, CMS instituted the multiple procedure rule where the technical component of the second, third, etc. procedure in the same physical "family" will be reduced. Two MRIs done in cancer were added for 2009--77058 (MRI--one breast) and 77059 (MRI--both breasts).
- **Diagnostic Testing:** CMS is also proposing to "improve" the quality of diagnostic testing performed by physicians and NPPs in their offices by **requiring them to enroll as suppliers of these services and to meet certain quality and performance standards**, including applicable Federal and State licensure, health and safety requirements that currently apply to independent diagnostic testing facilities (IDTFs). **CMS is proposing to make the standards effective January 1, 2009 for newly enrolling suppliers, but to allow existing suppliers until September 30, 2009 to come into compliance.** The proposal specifically seeks public comment about whether these standards should apply to all diagnostic services or to a subset of services such as those that require more costly testing and equipment, imaging services generally, or only advanced imaging techniques.
- **E-Prescribing:** In the 2008 Final Rule, CMS amended an exemption that will limit the use of computer-generated faxes to e-prescribe drugs for Part D to instances in which temporary/transient transmission failure or communication problems preclude the use of the adopted NCPDP SCRIPT standard. This amendment is scheduled to take effect on January 1, 2009. In the 2009 Proposed Rule, CMS is proposing to add an exemption for computer-generated faxes used by pharmacies to request refills from providers that are not capable of receiving and processing refill requests using the adopted NCPDP SCRIPT standard.
- **Payment for Follow-Up Inpatient Telehealth Consultations:** Prior to 2006, follow-up inpatient consultations were approved for payment when furnished remotely using Medicare-approved telehealth services. In 2006, the CPT deleted the codes for follow-up inpatient consultations and advised practitioners to bill for these services using the codes for subsequent hospital care (99231-99233). Because the subsequent hospital care codes describe different services than follow-up inpatient consultations, CMS did not add them to the list of Medicare approved telehealth services for 2007. **For CY 2009, CMS is proposing to add new HCPCS G-codes codes specific to the telehealth delivery of follow up inpatient consultations.** The new codes will enable practitioners to bill for follow-up inpatient consultations delivered via telehealth. These codes are intended for use by physicians or NPPs who are consulted again by the patient's attending physician regarding the patient's care but who are not available for a face-to-face encounter.
- **Physician Quality Reporting Initiative (PQRI):** Right now, the does not authorize an incentive payment for the satisfactory reporting of data on quality measures for services furnished on or after January 1, 2009. So, no one knows what PQRI will pay next year. The proposed rule proposes a total of 175 measures for reporting in 2009, an increase of 56 measures from 2008. Of these, 111 are current measures, and 64 are new measures either endorsed by the National Quality Forum (NQF), adopted by the AQA Alliance (AQA), or measures currently under consideration by either. CMS is also proposing to include measures that were reviewed but not selected for the 2009 PQRI in a 2009 New Measures

Testing Process similar to 2008. No financial incentive payment would be associated with submission of these new test measures for either 2008 or 2009 (which means you are a guinea pig for no money). There will be these options for reporting:

1. **For individual measures**, CMS is proposing to require reporting of three individual measures (or less than three if only one or two are applicable to an eligible professionals) for 80 percent of applicable cases during the calendar year. Same old/ same old...
 2. **For Measures Groups**, CMS is proposing to require professionals who report for the full calendar year to report measures for 30 consecutive patients for whom all measures of one Measures Group apply, or 80 percent of patients to whom all measures of one Measures Group apply with a minimum of 30 patients. **For the July 1, 2009 - December 31, 2009** reporting period, CMS is proposing to require reporting on 80 percent of applicable patients, with a minimum of 15 patients. CMS is proposing Measures Groups for Diabetes Mellitus, Chronic Kidney Disease (CKD), Preventive Care, Coronary Artery Disease, HIV/AIDS, Coronary Artery Bypass Surgery, Rheumatoid Arthritis, Perioperative Care, and Back Pain. **Nothing in cancer yet, so your reporting period is Calendar Year 2009--just like 2008.**
 3. **Clinical Registry Data Reporting**: CMS is proposing to conduct another self-nomination process so that additional registries can potentially be approved for submitting quality measures data.
 4. **Electronic Health Record (EHR) Reporting**: If the 2008 Measure Testing Process is successful, CMS is proposing to begin accepting data from EHRs for a limited subset of the proposed 2009 PQRI quality measures starting January 1, 2009 for the CY 2009 reporting period. You will hear more about this in the coming months. Under the proposal, EHR reporting would be available only for reporting individual measures not Measures Groups. Good for those of you with EMRs/EHRs in Oncology (maybe)!
- **Proposed Changes to Physician Self-Referral and Anti-Markup Provisions**: This proposed rule proposes two alternatives to revising the anti-markup rule. The first alternative **would not require application of the anti-markup rule to diagnostic testing services provided by a physician who shares a practice with a single physician or physician organization**. In all other cases, the anti-markup rule would apply. The second alternative would clarify anti-markup provisions that were finalized in last year's final rule by providing guidance pertaining to various terms of the rule, including what would constitute the "office of the billing physician or other supplier" and other concepts such as "outside supplier." There would also be an exception to the Self-Referral laws for gain-sharing and pay-for-performance relationships among providers. That is probably a good idea because CMS wants physicians and hospitals to share some incentives
 - **Proposed Changes to Enrollment and Billing Rules**: The proposed rule includes a number of changes in enrollment and billing requirements. They are looking for comments as to whether the enrollment should be effective on the date of filing or date of enrollment or the date of first claims submission. CMS is definitely looking to NOT allow providers 27-month period of billing prior to enrollment as they do now in some cases. There is a proposal requiring that physicians and NPPs must also notify within 30 days their designated contractor of a: change of ownership, adverse legal action or change of location that would have an effect on a payment amount. Failure to comply can result in an overpayment fine (does not state whether interest and penalties will be included) from the date of the reportable change related to an adverse legal action or a change of location. **Also, the proposal states that physicians and NPPs should maintain written ordering and referring documentation for 10 years (now it is seven years)**. The proposal also includes a requirement that providers and suppliers to submit all outstanding claims within 15 days of the date notice of revocation of billing privileges has been sent. If a revocation is based upon a Federal exclusion or debarment, felony conviction, or license suspension or revocation, or if the practice location has been deemed non-operational, then the revocation will become effective on the date of the notification. CMS also discussed the future possibility of revoking Medicare billing privileges for providers with severe tax payment problems.

CMS will accept comments on the proposed rule until August 29, 2008. These comments will be included (or excluded from) a final rule to be issued by November 1, 2008. Your comments must go to the individual responsible for section of the Proposed Rule that you are commenting on.

This is just a first glance at these regulations. I will pass on more information as other interpretations come out.

Quick Links

- For the proposed regulations, go to <http://www.cms.hhs.gov/center/physician.asp>.
- There is no official Medicare release about the payment delay. For another press release, see

Additional Information from CMS:

The Questions and Answers below apply to the recent decision by the Centers for Medicare & Medicare Services to hold for up to 10 business days claims paid under the Medicare physician fee schedule (MPFS) that contain July 2008 dates of service.

Q1. Will claims containing services paid under the MPFS be held that contain both June and July dates of service?

A1. Yes, your local contractor will hold the entire claim for 10 business days.

Q2. Will claims be held that contain both services paid under the MPFS and services paid under a separate fee schedule?

A2. Yes, claims that contain both services paid and not paid under the MPFS will be held. For example, a claim with a July date containing an Evaluation and Management code and a drug code would be held.

Q3. Does the holding of claims paid under the MPFS also include anesthesia and purchased diagnostic services?

A3. Yes, contractors will hold all claims with dates of service July 1, 2008, and after that contain services paid under the MPFS, including anesthesia and purchased diagnostic services.

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