



Friday, November 9, 2012

Following Elections, Congress Seeks to Address Fiscal Cliff During Lame Duck

On November 6, President Barack Obama was reelected for a second term, winning 50 percent of the popular vote and 303 of the 270 electoral votes needed to secure victory over challenger Mitt Romney. In the Senate, Democrats picked up two additional seats for the 113th session, holding a 53 to 45 majority over Republicans (with Independents holding the remaining two seats). Meanwhile, Republicans retained their majority in the House with a 233 to 195 majority.

Democrats' continued control of the White House and the Senate is anticipated to stave off GOP attempts to repeal or replace the Affordable Care Act (ACA). However, there is a possibility that certain key components of the law could be altered or pushed back as part of upcoming budget talks in Congress. In addition, certain obstacles to the law's implementation remain, such as some Republican governors' vows not to execute its Medicaid expansion and health insurance exchanges and the possibility that the GOP could successfully chip away portions of its federal funding next year. These actions could have considerable impact on the law's success; for example, not expanding eligibility for Medicaid coverage would substantially impact the ACA's ability to cover the uninsured.

With the start of the lame duck session next week, lawmakers will have sizeable work to do in preventing the fast-approaching "fiscal cliff" at the end of the year. Unless Congress intervenes, on January 1 Bush tax cuts, unemployment benefits for the long-term jobless, payroll tax cuts and other tax breaks will expire; automatic defense and domestic reimbursement cuts under the Budget Control Act (BCA) will take effect; and the 27 percent payment cut to physicians under Medicare's Sustainable Growth Rate (SGR) will occur, amounting to \$7 trillion in tax increases and spending cuts over a decade.

While Republican and Democratic leaders in the House and Senate agree that the drastic funding cuts must be averted, they are differing in their approaches to such a solution, with how to address taxes being the major sticking point. House Speaker John Boehner (R-OH) has insisted that any new tax revenue needs to come from a broad tax overhaul, which would take months to work out.

His recommendation is to agree to a deficit-lowering "down payment" plan in the lame ducks session that could serve as a "catalyst for major solutions" next year. Senate Majority Leader Harry Reid (D-NV), meanwhile, continues to push for a complete deficit-lowering plan by the end of the year, supporting tax rate increases on upper-income earners as a major revenue source. Due to the limited lame duck timeframe and continued partisan divide on taxes and other issues, a two-step process similar to that suggested by Rep. Boehner is thought to be more likely.

No matter the scope of the talks, major cuts to Medicare and Medicaid will be on the table in budget discussions, as well as various ideas offered in bipartisan budget lowering proposals in recent years such as raising Medicare premiums on wealthy seniors, establishing new co-pays for some services such as home health visits, instituting a surcharge on certain supplemental Medicare policies and gradually raising Medicare eligibility from age 65 to 67.

With the prevailing parties still in power in the White House, Senate and House and anticipated continued challenge in reaching across the aisle to enact major change, it is anticipated that lawmakers will seek payment cuts from various sources, including health care providers, rather than pursue a path of fundamental reform that would have been more likely had the Congressional and Presidential balances of power changed. The US Oncology Network will continue to advocate during the lame duck session for an SGR fix and important cancer care delivery funding on behalf of the physicians we represent and the patients we serve.

CMS Releases Final Rule for 2013 Medicare Physician Fee Schedule

Medical Oncology Cut Converted into 2% Increase & Cuts to Radiation Oncology Significantly Reduced

On November 1, the Centers for Medicare and Medicaid Services (CMS) posted the Final Rule for the 2013 Medicare Physician Fee Schedule (MC-PFS). It is important to note that proposed cuts to medical oncology were reversed and converted into a 2% increase and the drastic proposed cuts to radiation oncology were significantly reduced. *(Continued on page 2)*

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CMS Releases Final Rule for 2013 Medicare Physician Fee Schedule (*cont'd*)

The changes to these proposed cuts followed a concerted effort by the oncology community to push back on these drastic cuts, including The US Oncology Network [comments](#) on the proposed cuts and [letters](#) by members of both chambers of Congress calling for a reversal to these significant radiation oncology cuts. Additionally, the final rule creates new codes for transitional care management that may present an opportunity for Network practices to bill Medicare for new services in managing the care of patients during the 30 days following a hospital or LTC facility discharge.

The CMS estimates of specialty impacts created by the 2013 MC-PFS include the following:

Specialty	HEMATOLOGY/ ONCOLOGY	RADIATION ONCOLOGY
Allowed Charges (mil)	\$1,909	\$1,988
Impact of End of PPIS Transition	-1%	-4%
New and Revised Codes, MPPR, New Utilization and Other Factors	3%	2%
Updated Equipment Interest Rate Assumption	1%	-3%
Transitional Care Management	-1%	-1%
Input Changes for Certain Radiation Therapy Procedures	0%	-1%
TOTAL	2%	-7%

The changes in the 2013 MC-PFS Final Rule from the reimbursement cuts CMS originally proposed in July of this year include:

- Radiation Oncology: -7 % (versus -15% in the proposed rule)
- Hematology/Oncology: +2 % (versus -1% in the proposed rule)

A summary analysis of the some of the rule's impacts on community oncology is below.

1) PPIS Phase-in

In 2010, CMS initiated a four year transition to the use of Physician Practice Information Survey (PPIS) data for practice expense RVUs, and 2013 is the final year of the transition. The final year of the PPIS transition results in hematology / oncology receiving an expected 1% decrease (versus 0% called for in the proposed rule) and radiation oncology receiving an expected 4% decrease (versus the 3% decrease called for in the proposed rule) due to the changes in the RVU distribution.

2) Interest Rate Assumption

As in the proposed rule, the final rule calls for a reduction in the interest rate assumptions used to establish payments for practice expenses – a change that has its largest impact on procedures such as advanced imaging and radiation therapy that are highly dependent on expensive capital equipment, CMS finalized without modification our proposal to use a “sliding scale” approach based on the current SBA maximum interest rates for different categories of loan size (price of the equipment) and maturity (useful life of the equipment). The updated interest rate assumption changes for hematology/oncology resulted in a 1% increase (consistent with that of the proposed rule) and radiation oncology resulted in a 3% decrease (also consistent with that of the proposed rule).

3) The Transitional Care Services Code

CMS created two new post-discharge transitional care services G codes developed by AMA's Chronic Care Coordination Workgroup to be used by the community physician (including oncologists) or qualified nonphysician practitioner to report the services provided to ensure the coordination and continuity of care for patients discharged from a hospital (inpatient stay, outpatient observation, or outpatient partial hospitalization), SNF stay, or CMHC. These two codes:

- split transitional care into moderately complex and highly complex care
- require communication (direct contact, telephone, electronic) with the patient or caregiver within 2 business days of discharge
- require a face-to-face visit with the beneficiary within 7-14 days of discharge. (*Continued on page 3*)

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CMS Releases Final Rule for 2013 Medicare Physician Fee Schedule (*cont'd*)

The new transitional care codes resulted in a 1% decrease to medical oncology and radiation oncology. To the extent that oncologists provide these services and bill for these newly created codes, there is an opportunity for positive impact in this area.

4) IMRT/SBRT Proposals

CMS finalized adjusting the procedure time assumption for IMRT delivery (CPT code 77418) to 30 minutes (60 minutes currently), as well as adjusting the procedure time assumption for SBRT delivery (CPT code 77373) to 60 minutes (90 minutes currently). CMS did note in the final rule that in the case of CPT code 77418, the 'accelerator, 6-18 MV' (ER010) and the 'collimator, multileaf system w-autocrane' (ER017) are used throughout the procedure and currently have no minutes allocated for preparing the equipment, positioning the patient, or cleaning the room. Since these clinical labor tasks are associated with related codes typically reported at the same time, CMS did allocate minutes to these equipment items to account for their use immediately before and following the procedure. Additionally, CMS is:

- incorporating a second radiation therapist for CPT code 77418. The second therapist will be allocated 30 minutes of service period time, consistent with the first.
- incorporating a new equipment item called "IMRT accelerator" to replace the linear accelerator (ER010) and collimator (ER017) used as current direct PE inputs for CPT code 77418 priced at \$2,641,783 in the direct PE input database.
- incorporating the radiation treatment vault (ER056) and water chiller (ER065) as direct PE inputs for both CPT codes 77418 and 77373.
- updating the price of the "laser, diode, for patient positioning (Probe)" (ER040) from \$7,678 to \$18,160.

The changes to the IMRT and SBRT procedure times and labor and equipment costs on radiation oncology results in a decrease of 1 percent (versus the 7% decrease in the proposed rule); there is no change for medical oncology in this area.

5) The Sustainable Growth Rate Formula

It is important to recognize that, absent congressional action, payments for all services to Medicare patients will be reduced by 27% in 2013 due to the operation of the Sustainable Growth Rate (SGR) formula in the absence of Congressional action to avert the SGR cuts. We continue to expect the SGR cut will be averted.

To view the Final Rule click [here](#). To view a CMS Fact Sheet on the Final Rule click [here](#).

GAO Issues Report on Imaging Self-Referral

On October 31, the Government Accountability Office (GAO) released a [report](#) finding self-referred and non-self-referred advanced imaging services, among them computed tomography (CT) and magnetic resonance imaging (MRI), increased from 2004 to 2010, with a larger increase among self-referred imaging services. The GAO undertook the study to assess self-referral's role in rising Medicare Part B expenditures, which include reimbursement for advanced imaging services, in recent years. It examines trends in self-referred and non-self-referred imaging services, how the provision of these services differs based on whether providers self-refer, and implications of self-referral on Medicare spending.

The report found that the number of self-referred MRI services rose from 2004 to 2010 by over 80 percent, compared to an increase of 12 percent for non-self-referred MRI services. The increase in self-referred CT services more than doubled during this time period, while non-self-referred CT services rose by about 30 percent. The report also found that in 2010, self-referring doctors referred about twice as many MRI or CT services as providers who did not self-refer, and concluded that Medicare paid \$109 million more in 2010 for MRIs and CTs than it would have absent self-referral incentives.

In its report, GAO recommends that CMS improve its ability to identify self-referral of imaging services, address increases in these services and monitor self-referred services to ensure they are appropriate. In response to the report, the American Association of Orthopaedic Surgeons said, "Significant technological advances have been made in our field so that patients can receive timely and accessible screenings from the comfort of their doctor's office. We believe that any restriction on this convenience would threaten the quality of care being delivered to our patients." Click [here](#) to read the report.