

## Planning for New CMS Rules



*Integrated Oncology Consulting Solutions  
And Cancer Care Center Planning*

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The CMS proposed rules for 2013 have arrived. For cancer program administrators in the late 80s and early 90s, new rules just meant a change in the chargemaster. Their finance department made changes in the billing programs and work continued as usual. There were no RAC audits, few OIG investigations and Stark I and II were not implemented until the early 1990s. Drugs were reimbursed at cost plus. Happy days!

Things are certainly different in 2013. While only 16 percent of the U.S. population is covered by Medicare, the program is responsible for 40 percent of hospital inpatient stays and 35-55 percent of the average hospital's revenue. Since cancer is a disease of aging, Medicare is responsible for 60-70 percent of revenues related to cancer care. Changes proposed by CMS each year are critical to a cancer program's survival. Each year when the proposed rules are released, there are a plethora of webinars and presentations related to their effect on cancer care. Calculations of the changes for both hospitals and physician practices are necessary to determine the impact on oncology services. New equipment decisions are based on their ability to have a positive return on investment. Physician practices decide if they can afford to stay in private practice. Hospitals determine if they need to cut staff or services.

Physician reimbursement has the potential of being cut each year, typically through the conversion factor. Fortunately, through legislation, this reduction has routinely been avoided. The Medicare Sustainable Growth Rate (SGR), the method CMS uses to control Medicare physician spending, is once again delayed. Since SGR was enacted in 1997, Congress has suspended or adjusted it to protect physician revenues. But failure to adjust SGR in the future will decimate physician practices by decreasing revenues to unsustainable levels.

Medscape reports that this year, the Moran Group conducted a study on behalf of ION Solutions and The Community Oncology Alliance. Findings showed a 20 percent increase in oncology clinics closing and an increased incidence of sending patients to hospitals for chemotherapy.<sup>1</sup>

Cancer program or physician practice administrators must carefully review the proposed fee schedule each year before implementation to determine the impact on the program or practice. This review includes not just specific E&M codes or procedure codes, but also other changes. This year there are new packaging rules for HOPPS and the extent of the changes will have a significant impact on the financial viability of a program and practice.

Another major change this year is the Physician Supervision Rules for Critical Access and Rural Hospitals. Revenue Cycle Inc. recently disseminated the rule in its entirety, but the following is the proposed change for physician supervision:

*For CY 2014, we anticipate allowing the enforcement instruction to expire, such that all outpatient therapeutic services furnished in hospitals and CAHs would require a minimum of direct supervision unless the service is on the list of services that may be furnished under general supervision or is designated as a nonsurgical extended duration therapeutic service. (To download the list of services available on the CMS Website, visit <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CY2013-OPPS-General-Supervision.pdf>)*

While CMS previously exempted Critical Access and Rural hospitals from enforcement, the exemption is proposed to expire in 2014. This should come as no surprise since CMS has stated for the past two years that they intend to allow the exemption to expire. Many hospitals have plans in place to address this change. Without last minute resurrection, it may significantly impact the care patients receive in rural settings. CMS stated that they have had few requests or comments on the Physician Supervision Rule but are willing to consider them throughout the year on all regulations. An annual review only when the proposed rules are published is not enough. New codes or changes in approved drugs can occur at any time. CMS publishes the ASP (Average Sales Price) quarterly for payments and it is critical to review the changes in drug reimbursement each quarter. The Oncology Group has found that many hospitals do not routinely review ASP changes quarterly, which leads to drug charges that are incorrect. These incorrect charges may leave revenue on the table or result in overcharges to Medicare . . . neither of which is appropriate.

Cancer care providers need to voice how the changes are affecting them. Hospital and physician providers must let CMS and legislators know about the impact that changes will have on the quality of cancer care they provide to patients. Providers can send comments to CMS independently or through a professional organization—ASCO, ASTRO, ACRO, ACCC, ONS—and they must do it every year.

Once the new rules are finalized, it is critical to ensure the appropriate reimbursement for services provided. The right reimbursement starts with the staff. Appropriate coding for procedures, compliance with the rules put in place by CMS or other payors for specific treatments and correct billing will assure appropriate payment.

If reimbursement is decreasing, costs must be reviewed. The greatest costs are:

1. Equipment (especially for radiation oncology)
2. Drugs
3. Salaries and benefits

Equipment and drug costs may not be manageable without a strong internal or external negotiator or a Group Purchasing Organization (GPO). The cost of drugs should be considered in the decision to use a particular treatment regimen, especially when bio equivalents are available with similar results at a lower cost. This benefits the practice, hospital and the patient as the patient's co-pays and out-of-pocket costs increase proportionally to the cost of the drug or service. A strong drug replacement program can significantly enhance revenue streams and is a viable part of revenue protection and enhancement.

Personnel costs can be reduced, if necessary. At no time should quality care be in jeopardy, but it is important to assure the appropriate level of staff to provide the care needed. For example, using a Medical Tech/Aide in infusion or radiation versus an RN or therapist for rooming patients and doing vital signs can reduce costs.

With the constantly changing reimbursement environment, it is imperative that program and practice administrators stay current and use available resources to secure a sustainable future for their patients, communities, physicians and staff.

The Oncology Group and Revenue Cycle Inc. can assist your program or practice to assure that you are receiving fair payment for your work product. We can provide an evaluation of staffing compared to national benchmarks and will make recommendations for change. For more information about our services, please contact us at [info@theoncologygroup.com](mailto:info@theoncologygroup.com) or 512.583.8815.

1. Cancer Clinics Closing: Community Oncology 'Near Crisis'. *Medscape*. Jun 27, 2013.