

# The push toward quality & efficiency – Leaders, get on board!

– Sally Eggleston, RT, MBA

PQRI, Nursing Home Compare, Health Outcomes Survey, Hospital Quality Initiatives, Packaging – these buzz words are more prevalent than ever and are pointing physicians and facilities down one road; consistent quality care, delivered efficiently with proven technologies warranted for each individual patient.

While it is easy to see the emphasis on “quality” in several of the buzz words above, it is not quite so glaring in the “packaging” that we are seeing occur in hospital outpatient departments (HOPPS). The packaging of Image Guidance Radiation Therapy procedures in the hospital outpatient setting may well be a great example of the future of Medicare payment processes. As of January 1, 2008, Centers for Medicare & Medicaid Services (CMS) packaged all image guidance procedures in the hospital outpatient setting and considered these procedures to be ancillary and dependent in relation to a number of services. The image guidance services that are provided in delivering radiation oncology services were included in this packaging. Arguing that these procedures are not ancillary and dependent to another service was very difficult since, in cancer facilities, such image guidance procedures as stereoscopic imaging, CT guidance, port films and ultrasound are performed prior to treatment and/or planning. But argue we did, as hospitals, physicians, oncology specialty organizations, corporations as well as individuals’ voiced concern regarding this packaging to no avail – resulting in the continuation of packaging through 2009.

CMS declares that the Medicare program is a value-based purchaser and they firmly believe that packaged payments cause hospitals to carefully consider whether the purchase of, or the use of technology, is appropriate for an individual patient’s needs. They trust that new technologies known to improve the quality of care will increase in utilization whether or not the payment is packaged. While CMS stressed that they did not believe that beneficiary access to care would be harmed by packaging of these image guidance services, comments from some clinicians stating that they no longer utilize image guidance, would make a person believe otherwise. CMS created packaging with the idea that it would generate incentives for hospitals and their physician partners to work together to

establish appropriate protocols that will eliminate unnecessary services where they exist and institutionalize approaches to providing necessary services more efficiently.

There are those words again; “efficient,” “protocols,” “incentives,” and “institutionalize”. The reimbursement atmosphere is changing and leaders in cancer programs across the country must be prepared for these changes. Avoiding buying that new accelerator or CT scanner, because the return on investment is not what it once was, should not be the answer. Working jointly with physicians to determine the appropriate protocols, working with technical staff to maximize efficiencies and ensuring appropriate documentation, charge capture, billing and reimbursement for procedures is no longer something to schedule for the next quarterly meeting but requires immediate attention. While the *Journal of the National Cancer Institute* did publish in November 2008, that both incidence and death rates from all cancers combined decreased statistically significantly in men and women, overall there are still many patients to be treated.

Hospital outpatient departments did get a reprieve for 2009 when it was discovered that several of the radiation oncology codes from the bypass list that did not meet the empirical criteria to determine appropriate APC payments for the packaging were included and affected payment determination. As a result of the changes to the bypass list, the median cost for APC 0412 (IMRT Treatment) increased by more than nine percent compared to the median costs used to calculate the proposed CY 2009 OPPS payment rates. Packaging payment for IGRT guidance services increased the payment rate for IMRT, by approximately \$50. Table 1 shows the historical payments from 2006 to 2009 for IMRT and one of the IGRT codes (stereoscopic imaging).

**Table 1**

	CY 2006	CY 2007	CY 2008	CY 2009
Payment for Radiation Tx-IMRT (CPT 77418)	\$319	\$336	\$348	\$411
Payment for IGRT Guidance (CPT 77421)	\$75	\$67	N/A (pkgd pmt)	N/A (pkgd pmt)
Total payment for IMRT & IGRT	\$394	\$403	\$348	\$411

While the increase in payment does counterbalance the loss of payment for this particular image guidance code, hospitals are still bemoaning the loss of individualized payment for procedures. CMS reminded us in the Final Rule for HOPPS 2009 that the history of technology development shows that technologies do not necessarily result in the forecasted improvements over existing technologies. Often a period of some years of broad use is necessary to assess effectively whether the new technology improves, harms or yields no improvement in patient health and quality of life. In the field of oncology, especially radiation oncology, the advances in technology have been vast and numerous and every facility wants new technology due to its clinical significance, but we have also been lured with the superb ROIs. The days of purchasing based upon having the latest technology with the highest payment appear to be over; we must embrace those buzz words and work jointly and efficiently to provide high quality care with the preeminent technology that is appropriate for the individual patient. **H**

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#### References

- ▶ <http://www.cms.hhs.gov/center/quality.asp>
- ▶ Department Of Health And Human Services, Centers for Medicare & Medicaid Services, 42 CFR Parts 410, 416, and 419 (CMS-1404-FC); (CMS-3887-F); (CMS-3835-F-1) RIN 0938-AP17; RIN 0938-AL80; RIN 0938-AH17 Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2009 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2009 Payment Rates
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**Sally Eggleston, RT, MBA**, is Director of Business Development for Revenue Cycle, Inc., which is headquartered in Austin, Texas..