United Healthcare Tests New Payment Method for Oncology

United Healthcare is working with five oncology practices participating in a one-year pilot program to test its new cancer care payment model. The study focuses on best treatment practices and patient outcomes for patients with breast, colon and lung cancers. The participating practices are located in Dayton Ohio; Forth Worth, Texas; Kansas City, Missouri; Marietta, Georgia; and Memphis, Tennessee. Under this pilot program the oncologist is reimbursed for the standard treatment period on the first day he/she sees the patient. What are not included in the payment are the chemotherapy drugs which are covered at the manufacturer’s cost. Office visits, chemotherapy administration and ancillary services are still paid on a fee-for-service basis.

Lee N. Newcomer, M.D., Senior Vice President of Oncology for United Healthcare states, “By paying medical oncologists for a patient’s total cycle of treatment, rather than the number of visits and the amount of chemotherapy drugs given, this program promotes better, more-patient-centric, evidence-based care with no loss of revenue for the physician.”

Medicare Tests Anti-Fraud Software for Payments in 10 States

Beginning in July, 2011 Medicare will begin testing software to detect fraudulent claims in 10 states with the highest fraud rates. As part of the Small Business Lending Act passed on September 27, 2010, Medicare is required to use software similar to that used by credit card companies to detect fraudulent charges. If, following the first year of operation, the program is deemed successful it will be expanded to ten more states.
In The News

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Coding and Compliance Tips by Lori Shore

Physicians Exempt from Red Flags Regulations
President Obama is expected to sign the Red Flags Program Clarification Act of 2010 passed by the Senate on November 30th and the House on December 7th by years’ end. The Act redefines “creditor” to exclude physicians from the Federal Trade Commission definition. Originally scheduled to be implemented in 2008, Red Flags Rules have been postponed on several occasions while opposition by physician groups was addressed.

Congress Reaches a One-Year “Doc Fix”
The Medicare and Medicaid Extenders Act of 2010 (H.R. 4994) has averted the 25% decrease in physician payments related to the Sustainable Growth Rate (SGR) scheduled for January 1, 2011 for a one-year period. This will not; however, affect the 8.2% decrease to the conversion factor due to value changes in Relative Value Units (RVUs).

The new CPT code changes may seem few for radiology but they are sure to have a big impact on reimbursement. Most notably is the bundling of CT abdomen and pelvis done during the same session. Code 74176 is to be used when CT of both the abdomen and pelvis are done during the same session without contrast. Code 74177 is used when both studies are done during the same session with contrast. All other scenarios when both CT of the abdomen and pelvis are done during the same session are billed with the new code 74178.

Codes 74150-74170 and 72192-72194 are still valid codes for situations where only one area is studied.

The ACR and RBMA continue to argue for the correction of the non-facility practice RVUs for the new bundled CT abdomen/pelvis codes as undervalued.

There were significant changes to CPT coding for interventional radiology for 2011. Vessels were bundled into territories for revascularizations of 3 regions; iliac, tibial-peroneal and femoral-popliteal. A hierarchy was also created with stent placements most highly valued followed by atherectomy then angioplasty. These procedures are to be coded based on the hierarchy within the territory.

There are only 3 codeable vessels in the iliac and tibial-peroneal territories and all vessels in the femoral-popliteal are considered a single vessel for coding purposes. If you code these procedures it is advisable to refer to the narrative section in the CPT book.