

# AFROC



ASSOCIATION OF FREESTANDING RADIATION ONCOLOGY CENTERS

*Our Voice in Washington*

## The Source

June/July 2006

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### 120 Members Have Paid Their Dues for 2006.

#### Have you?

AFROC is the only organization that solely focuses on the regulatory, legislative, and socioeconomic issues of freestanding radiation oncology centers and is **your only voice in Washington**. Your continued participation is critical to its future and to the future of your freestanding radiation center.

Invoices for 2006 dues have been mailed. It is estimated that 95% of your dues can be taken as a business expense.

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AFROC's website  
[www.afroc.org](http://www.afroc.org)

## LEGISLATIVE NEWS

### Possible Physician Fee Freeze Under Consideration

As in recent years, it is again likely that Congress will freeze Medicare physician fee payments at the current rate. If Congress does not act on a freeze, physician would be facing a payment cut next year of 4.6 percent.

Several House Republicans have expressed support for freezing the Medicare payment rate at its current level. The cost for another one-year fix would be approximately \$10.8 billion. Members of the House are looking for ways to offset the costs of such a freeze. Although the Senate continues to look at a "pay for performance" system, it is more likely that it will again move a simple reimbursement freeze for yet another year. To pay for the fix, the Senate may propose using the funds from the Medicare Part D prescription drug plan's stabilization fund. The White House and

## Save the Date

***In conjunction with the  
ASTRO Conference in Philadelphia,  
you are invited to attend a  
Reception, Reimbursement and Legislative Update  
by Diane Millman, JD  
and a  
Q&A period  
on Sunday, November 5, 2006  
from 6:00 to 8:00 p.m.***

**Watch this space for further details.**

House Republicans are strongly opposed to using the \$10 billion stabilization fund to offset costs of other spending proposals, such as the SGR freeze.

### **Ways & Means Committee to Discuss ICD-10 Coding Implementation**

The House Ways & Means Committee is considering legislation that would change the codes used in hospitals and physicians' offices.

Currently, doctor's offices use 13,000 ICD-9 codes. The proposed legislation would overhaul diagnosis coding and provide 120,000 ICD-10 codes, which hospitals and physicians' offices must implement by October 2009. In late May, the Ways & Means Health Subcommittee added the October 2009 deadline to the markup of H.R. 4157, the health information technology ("HIT") bill.

The House Energy & Commerce Committee is also working on legislation that would affect diagnostic coding. Their proposal does not include a final implementation date but does include a section on required pilot testing of new codes. The Senate's HIT bill does not include an ICD-10 clause.

Many supporters of the ICD-10 codes believe that such a change is essential and that the data and deadline required by the legislation is realistic. However, opponents of the coding change, state that the October deadline is unreasonable, especially when accounting for the other changes required in the next three years, such as the National Pay Identifier and the Electronic Claims Attachments. Critics feel that requiring so many drastic changes in a short time burdens providers financially and could increase the rates of error.

Ways & Means Health Subcommittee Chairwoman Nancy Johnson (R-CT) has stated she believes that the changes in coding are overdue and will ultimately help combat fraud within the health care system.

### **Imaging Coalition Gaining Support to Stop Payment Cuts**

On May 10, 2006, a broad coalition, including AFROC, secured the support of 44 House Republican lawmakers to delay scheduled Medicare payment cuts to medical imaging services. Members of the coalition, the "Access to Medical Imaging Coalition," include the American College of Radiology, the National Electrical Manufacturers Association (NEMA), US Oncology, and a number of other groups and associations. The House members supporting the coalition sent a letter to House Speaker Dennis Hastert (R-IL) requesting that Congress reexamine Medicare cuts made under the Deficit Reduction Act, which was enacted in February of 2006 that impact providers performing imaging services, possibly including CT simulation and a number of imaging services used in conjunction with radiation treatment.

Under current law, Medicare payment for imaging services in non-hospital settings is to be limited to the amounts paid in outpatient hospital departments. Imaging took one-third of the Medicare cuts enacted in the Deficit Reduction Act yet comprise only 10 percent of the overall total reimbursement. According to the coalition and to the lawmakers who sent the letter, the payment cuts were inserted into the Deficit Reduction Act without any public deliberation by either chamber, and without an analysis of their potential impact on patient care.

The coalition is circulating a legislative proposal that would provide a two year delay in payment cuts at a cost of approximately \$1.5 billion and require a Government Accountability Office report on the current payment system for imaging services. AFROC will continue to update you on these efforts as new developments occur.

### **New Noridian IMRT Coverage Policy Released**

Effective June 15, 2006, Noridian Administrative Services, LLC, a Medicare Part B Fiscal Intermediary, released a new coverage policy for Intensity Modulated Radiation Therapy

for Alaska, Arizona, Colorado, Hawaii, Iowa, Nevada, North Dakota, Oregon, South Dakota, Washington and Wyoming. According to the release, coverage is provided under the following criteria:

1. Important dose limiting structures adjacent to, but outside the PTV, are sufficiently close and require IMRT to assure safety and morbidity reduction.
2. An immediately adjacent volume has been irradiated and abutting portals must be established with high precision.
3. Gross Tumor Volume (GTV) margins are concave or convex and in close proximity to critical structures that must be protected to avoid unacceptable morbidity.
4. Only IMRT techniques would decrease the probability of grade 2 or grade 3 radiation toxicity as compared to conventional radiation in greater than 15% of radiated similar cases.

Under the Noridian policy, IMRT is indicated for primary brain tumors, brain metastasis, prostate cancer, lung cancer (with special provision for organ motion), pancreas cancer and other upper abdominal sites (with special provision for organ motion), spinal cord tumors, head and neck cancer, adrenal tumors,

pituitary tumors and situations in which extremely high precision is required. Indications include some left breast tumors due to risk to immediately adjacent cardiac and pericardial structures, though it would only rarely if ever be medically necessary for tumors of the right breast.

The Noridian policy further indicates that IMRT may be necessary in some gynecologic tumors where its high precision is especially necessary to avoid immediately adjacent structures such as bowel or where there is a special need to avoid marrow. It may also be necessary in some lymphomas, malignant lymph nodes or sarcomas where anatomic location gives rise to a need for special care to avoid adjacent structures. Since these are likely to be only a relatively small fraction of gynecologic tumors, lymphomas, malignant nodes or sarcomas, in each case particular care is required to document the necessity for IMRT.

The Noridian policy also sets forth special guidelines for billing clinical treatment planning, simulation-aided field setting, treatment devices and special treatment procedures performed in conjunction with IMRT. The following is a summary of the key points:



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## **CMS Issues Final Rule on Medicare Enrollment Procedures for Suppliers and Providers**

On Friday, April 21, 2006, the Centers for Medicare and Medicaid Services (“CMS”) released its final rule on the new Medicare enrollment procedures for suppliers and providers. The new regulations are effective June 20, 2006.

### *Initial Enrollment*

As with all previous enrollees, suppliers and providers must continue to submit an application to CMS via form CMS 855. New enrollees will be required to provide a National Provider Identifier (“NPI”) from the National Plan and Provider Enumeration System. Currently, the deadline for obtaining an NPI is May 23, 2007.

CMS is also implementing stricter standards for enrollment. If CMS notifies an applicant that their application is incomplete, the applicant must submit all the information requested within 60 days, or CMS can deny Medicare enrollment. Applicants can apply for an extension. If CMS rejects an application, applicants cannot appeal the decision but must submit a new application, complete with all necessary documents.

Under the final rule, CMS has the authority to perform site visit inspections to ensure that the applicant is equipped and compliant with Medicare’s requirements for participation. These site visits are separate from survey and certification visits.

New enrollees may submit claims retroactively once the enrollment process is complete.

### *Reporting Changes to Medicare*

Generally, any changes to enrollment must be submitted to Medicare within 90 days while changes in ownership (CHOWs) must be submitted within 30 days. Should a provider or a

supplier undergo a CHOW, both parties must complete and submit enrollment applications **before** the completion of the CHOW. If either party fails to do so, the current owner may be subject to fines even after the other party takes ownership. If the new owner fails to submit a CMS 855 within 30 days of CHOW, CMS has the authority to deactivate the current Medicare billing number.

At no time other than CHOW or reassignment is it legal to sell or transfer a Medicare billing number under the final rule.

### *Periodic Validation of Enrollment Information*

Providers and suppliers must resubmit an enrollment application every five years to ensure accuracy of information. If a supplier or provider is currently receiving payment from Medicare but has never completed a CMS 855 enrollment application, they will be required to do so now or within 60 days of notification from CMS. The application will require new documentation and information not previously sought. Applicants are strongly encouraged to begin this process before being notified by CMS.

### *Enrollment Requirements*

Suppliers and providers must certify that they are compliant with all state and federal licensure laws and not employing any debarred or excluded personnel at any time during the CMS 855 application process. Application certification also ensures that the applicant is compliant with all Medicare laws, regulations, and program instructions, federal anti-kickback rules, and the Stark law. Enrollees must be compliant with all of these regulations before receiving payment.

Under the final rule, CMS requires that each application be signed by an individual who has a financial and legal stake in the supplier or provider. The signatory also must own or have controlling interest in the supplier or provider. Once CMS approves the initial application, the supplier or provider may appoint a “designated official” to sign any future applications or

amendments to prior submitted information. The final rule defines a “delegated official” as a “W-2 managing employee of the provider or supplier who is enrolling in, or currently enrolled in, the Medicare program, or be an individual with ownership or control interest in the provider or supplier.”

#### *Denial of Enrollment*

CMS has broadened its authority to deny Medicare enrollment under the final rule. Denial may occur any time CMS deems a supplier or provider noncompliant to Medicare regulations. Denied applicants can appeal the decision, but the provider or supplier cannot reapply for Medicare enrollment until the appeals process is complete. If CMS denies an enrollment application, CMS can review all locations owned by the supplier or provider for possible revocation of enrollment.

#### *Revocation and Deactivation of a Medicare Billing Number*

The final rule also establishes authority to CMS to revoke a supplier or provider’s Medicare billing number. Loss of the billing number becomes affective within 30 days of CMS notification. If CMS revokes the provider or supplier’s billing number because of the

employment of a debarred or excluded individual, the provider or supplier may regain their billing number if they prove to CMS that the employee no longer works for the provider or supplier. Providers and suppliers may appeal the revocation of a Medicare billing number. The regulations explaining the appeals process for denials and revocations will be submitted in a separate final rule. Providers and suppliers will not receive payment from Medicare during a pending appeal. CMS has the authority to review the files of associated providers and suppliers if the Medicare billing number is revoked.

If a provider or supplier’s file remains inactive for twelve consecutive months, or fails to provide updated enrollment information within 90 days (or 30 days for change of ownership), CMS has the authority to deactivate the Medicare billing number under the final rule. Providers and suppliers whose billing numbers are deactivated for not submitting updated information must complete a new enrollment application complete with all necessary documentation.



*Save the Date*

**The 19th Annual AFROC Conference**

**will be held**

**on May 12-14, 2007 at the**

**Grand Hyatt**

**Washington, DC**



*The  
Source*

June/July 2006

1875 Eye Street, NW  
Twelfth Floor  
Washington, DC 20006-5409  
Phone: 888-334-4542  
Fax: 202-466-5938  
Email: [sgell@ppsv.com](mailto:sgell@ppsv.com)

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