

# AFROC



ASSOCIATION OF FREESTANDING RADIATION ONCOLOGY CENTERS

*Our Voice in Washington*

## The Source

November 2005

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### THIRD SUCCESSFUL AFROC EVENT HELD IN CONJUNCTION WITH ASTRO MEETING

For the third successive year, AFROC held a reception and reimbursement and regulatory update at the start of the ASTRO meeting.

About 80 AFROC members and non-members had a chance to meet and socialize over food and wine before sitting down to hear a legislative and regulatory update on issues of particular interest to those involved with freestanding radiation oncology centers. Among other topics, Diane explained how the AFROC survey contributed significantly to the proposed increases in radiation oncology RVUs (see the September issue of *The Source* for details). The Q&A session that followed gave attendees a chance to voice their views and have their questions answered.

AFROC will hold a similar event on Sunday, November 5, 2006 at the start of the ASTRO meeting in Philadelphia, PA. Watch this space for further details.

### Watch Your Mailbox 2006 Dues Invoices are in the mail.

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.

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

## LEGISLATIVE NEWS

### 2006 CODING CHANGES

The following changes will take effect on January 1, 2006:

#### NEW CODES

**77421** Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy

(Do not report 77421 in conjunction with 77432, 0083T)

**77422** High energy neutron radiation treatment delivery; single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking

**77423** High energy neutron radiation treatment delivery; 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator (s)

#### REVISED CODES

**77412** Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle electron beam (eg., electron or neutrons); up to 5 MeV

**77413** Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle electron beam (eg., electron or neutrons); 6-10 MeV

**77414** Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle electron beam (eg., electron or neutrons); 11-18 MeV

**77416** Radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle electron beam (eg., electron or neutrons); 20 MeV or greater

#### **DELETED CODES**

None in 2006

#### **Reconciliation May (May Not?) Include Physician Payment Update**

Although Hurricane relief consumed much of the September Congressional agenda, the leadership is now refocusing on reconciliation legislation to find savings of \$35 to \$50 billion from mandatory programs over the next five years.

Many in Congress are looking at reconciliation as a possible vehicle for legislation to address the physician payment issue. Such legislation would either freeze physician payment levels or provide physicians with a one percent update. Under the current Sustainable Growth Rate (SGR) system, physicians are scheduled for a payment decrease of over 4% in 2006.

At this stage, neither the House Ways and Means nor the House Energy and Commerce version of the budget reconciliation package includes a physician fee schedule update provision. However, on Tuesday, October 25, 2005, the Senate Finance Committee approved a reconciliation package that included a one percent increase in physician payments for 2006.

Once both the Senate and House pass budget reconciliation measures, the provisions will be reconciled in

conference committee, which likely will take place in early November. Physicians groups remain optimistic that a payment increase will be included in the final legislation. We will keep you posted of further developments.

#### **Kickback Claims Can (Can't?) Be Brought by Private Parties?**

The United States Court of Appeals for the Eleventh Circuit recently held that a violation of the anti-kickback statute can form the basis for a whistleblower action under the False Claims Act ("McNutt").<sup>1</sup> The McNutt case involved a medical services company that allegedly paid kickbacks disguised as rental payments and commissions to pharmacists for patient referrals to the company. The court had little trouble dispensing with the issue, holding that the defendants knowingly submitted false claims for reimbursement because they knew their conduct violated the anti-kickback statute and they knew that compliance with the anti-kickback statute was required for payment.

What makes this case interesting is that it is contrary to the conclusion reached by a federal district court in the southern district of New York in 2002 ("Barmak").<sup>2</sup> In Barmak, the district court noted that the anti-kickback statute does not provide for a private right of action; rather, the Department of Justice has exclusive jurisdiction to enforce the statute. The court refused to allow a whistleblower to use the FCA as a vehicle for pursuing a violation of the anti-kickback statute. The recent Eleventh Circuit decision, coupled with an earlier similar decision in the Fifth Circuit,<sup>3</sup> indicates that the Government is winning the battle on expanding the FCA to cover claims attributable to kickback violations, and thereby opening another fertile area for whistleblower suits, including suits by disgruntled employees and competitors.

<sup>1</sup> United States ex rel. McNutt v. Haleyville Medical Supplies, Inc., 2005 WL 2179164 (11<sup>th</sup> Cir. Sept. 9, 2005).

<sup>2</sup> United States ex rel. Barmak v. Sutter Corp. and Orthologic Corp., 2002 WL 987109 (S.D.N.Y.).

<sup>3</sup> United States ex rel. Thompson v. Columbia/HCA Healthcare Corp., 125 F.3d 899 (5<sup>th</sup> Cir. 1997).

### **New Members**



*Please join us in welcoming our newest member -*

*Autis C. Speights, MBA who is Executive Director of Turville Bay MRI & Radiation Oncology Center in Madison, Wisconsin.*

### **Congress Considers Gainsharing Arrangements**

House Ways and Means Subcommittee on Health Chair Nancy Johnson (R-CT) appears to be interested in introducing "gainsharing" legislation and recently held a hearing to examine the potential impact of gainsharing arrangements on hospitals, physicians, suppliers and patients.

Gainsharing is an arrangement between hospitals and physicians under which the hospital provides a physician a share of any reduction in the hospital's cost for patient care attributable to the physician's efforts. Example of such physician efforts can include use of best practices or increased/decreased use of certain devices and technologies. Currently gainsharing is prohibited unless the hospital receives approval from the Department of Health and Human Services.

During the Subcommittee hearing on October 7, 2005, Lewis Morris, Chief Counsel, Office of Inspector General (OIG), Department of Health and Human Services (HHS) stated that gainsharing is best assessed and implemented on a case-by-case basis. Morris stated that while gainsharing promotes reductions in hospital costs by aligning physician incentives with those of the hospital, the OIG continues to be wary of gainsharing because these arrangements implicate the Civil Monetary Penalty (CMP), Federal anti-kickback statutes, and may have self-referral or "Stark" law implications.

Mr. Morris went on to echo concerns expressed by Ranking Members Pete Stark (D-CA) regarding patient care under gainsharing arrangements, stating that these arrangements could incite physicians to rush patients out of the hospital setting, withhold or promote certain devices or technologies during patient care, and "cherry-pick" patient populations. Mr. Morris stated that in response to these concerns, the OIG evaluates gainsharing proposals based on three basic standards: accountability and transparency, quality controls, and fraud and abuse safeguards.

This renewed interest in gainsharing legislation comes in part as a result of recommendations earlier this year from the Medicare Payment Advisory Commission (MedPAC). In March MedPAC recommended that Congress allow HHS to oversee gainsharing arrangements between physicians and hospitals, potentially deterring physicians from establishing physician-owned specialty hospitals. Hospital groups appear largely supportive of gainsharing arrangements finding that the partnering of physicians' and hospitals' goals leads to better patient outcomes and increased efficiency. However, patient groups and device manufacturers remain skeptical questioning whether gainsharing encourages the least costly care rather than the most appropriate, long-term solution. During the October hearing, these concerns were reiterated by Congressman Ramstad (R-MN) who also stated that gainsharing could significantly reduce the development and implementation of new and advanced technology, devices and services that might improve long-term outcomes but could be seen as more costly in the short-term.

Nevertheless, Chairwoman Johnson appears confident that gainsharing is an appropriate way to control health care costs and committed to further promoting the concept. As a legislative starting point, it is thought that the Subcommittee might consider a national demonstration project.

### **HHS Waives Application of Stark Law In States Impacted by Hurricane**

The Department of Health and Human Services (HHS) has granted a waiver from the Stark Law for areas affected by Hurricane Katrina. The states affected include not only Louisiana, Mississippi, and Alabama but also Texas, Florida, Colorado, Georgia, North Carolina, Oklahoma, Tennessee, West Virginia, Utah and Arkansas. The waiver will allow hospitals and other DHS providers to furnish financial support to physicians to the extent necessary to ensure that sufficient health care items and services are available to meet the needs of Medicare, Medicaid and SCHIP enrollees. The waiver is subject to a "good faith" requirement.

### **Director of NCI Named Acting Director of FDA**

When Lester Crawford unexpectedly announced his resignation from the Commissioner of the Food and Drug Administration (FDA) on September 30, 2005, President Bush quickly named Andrew von Eschenbach, current director of the National Cancer Institute, acting Commissioner of the FDA.

Originally, Von Eschenbach announced he would be running both the NCI and FDA simultaneously, although after concerns regarding conflict of interest and feasibility were raised by both Congress and the public, the NCI Director announced a temporary leave of absence from the institute.

Von Eschenbach comes to the FDA with a known interest in increasing cancer drug availability. Many are speculating that his work at the FDA with regard to cancer treatments will be aggressive, pointing to his focus on epidemiological versus clinical data while at the NCI. However, it remains unclear whether the acting Commissioner would support marketing of unproven drugs to willing and able candidates, as many conservative groups are currently advocating.

### **OIG Finds that Medical Oncologists Can Purchase Drugs for Allowed Amounts**

The Office of the Inspector General (OIG) of the Department of Health and Human Services recently issued a report that found that medical oncologists generally can purchase cancer drugs for the "Average Sales Price +6%" which is allowed under current law. The OIG report was required by the Medicare Modernization Act, which substantially lowered the Medicare payment amounts for chemotherapy and other drugs furnished by physicians in

their offices. The report can be accessed at <http://www.oig.hhs.gov/oas/reports/region6/60500024.htm>.

### **CMS Announces Voluntary Quality Reporting Program for Physicians**

On October 28, 2005, Dr. Mark McClellan announced via teleconference that CMS will soon institute a voluntary quality reporting system for physicians and practitioners reimbursed under Medicare Part B. The program will collect information from physicians on a voluntary basis using 36 evidence-based measures that are the result of collaboration between the agency and a group of physician representatives and quality organizations. Members of the group included the National Quality Forum, National Council on Quality, Rand Corporation, the AMA Physician Consortium and individual specialty groups such as AMA, ACP, ACS, AAFP, etc. The program will not involve any financial incentive for participation at this time.

As the program is structured, data collection on the 36 measures will be achieved through the use of newly created G-codes that will be submitted during the regular claims process along with general claims info such as the ICD-9 and CPT codes for each patient service. Once the data is received from the physician, CMS will analyze the data and provide each physician with individualized feedback and suggestions on actions the physician may take to improve quality and efficiency of care. Each individual physician will be able to view his personal feedback information, as well as the submitted data, via a "Quality Net Exchange" website. Although physicians will not have access to other providers' information, CMS intends to compile peer averages to be used as a reference tool for physicians via the website. Data submitted by physicians will not be made public; it will be used only by CMS for purposes of providing feedback on quality and efficiency.

Submission of a particular G-code will take place during the regular claims submission process after a physician has submitted a patient's relevant ICD-9 and CPT codes. The claims system will use those codes to identify patients that are eligible for additional quality data collection and prompt participating physicians for a G-code. For instance, if one of the measures used is measurement of a diabetic patient's hemoglobin at a certain level, once a patient is identified as eligible for that measure, a physician would be advised he or she should enter an additional quality G-code. He or she would then input one of the following four codes:

1. Patient has a hemoglobin level less than or equal to XXXX.
2. Patient has a hemoglobin level higher than XXXX.
3. Patient is an exception and is not eligible for data

collection.

4. Patient has not been with the physician for a minimum 6 month period.

Once the G-code is selected, CMS will store that information and analyze a collection of all the submitted data to provide feedback.

At this time, CMS will not be offering any financial incentive for participating in the voluntary reporting program. The benefits to the physician will be the ability to gain individualized feedback on care and take steps to enhance the quality of patient care provided. CMS claims that the project will also provide the physician with an opportunity to become familiar with and perfect the data submission process before further anticipated quality enhancement programs may take effect.

Dr. McClellan indicated that he expects that any further action on a pay for performance initiative will be through legislative action and will be linked to improving physician payment rates. In outlining the goals of the voluntary program, Dr. McClellan highlighted 3 main benefits of the current voluntary project:

1. It will assist in improvement of fee for service payment rates by better assessing quality and efficient care.
2. It can promote recognition of all the services a beneficiary receives for treatment of a condition, particularly for those patients with chronic conditions.
3. It will further promote the adoption of electronic data collection and advancement of the use of electronic health records.

Finally, CMS indicated that the initial program will be based upon a set of 36 evidence-based clinical measures (most of which are process-type measures) used to assess quality and provide feedback to individual physicians. Trent Haywood and the staff at CMS will continue to move forward with developing additional measures for individual specialties in cooperation with various provider groups, and those measures may be used in addition to the 36 general measures in the near future.

The complete set of 36 quality measures that CMS has chosen for the program should be available on the CMS website later today or over the weekend, along with a more detailed description of the program and instructions on how it will work. Registration for the program is expected to begin in the early part of December, and the actual collection of data will likely occur with the launch of the Quality Net Exchange website in January of 2006. More information on the program will be made available as the registration date approaches.



**AFROC will hold its 18th Annual Conference on  
June 5 and 6, 2006 at the Grand Hyatt in Washington, DC**



## The Votes Are In

*Thanks to all of you who sent in your ballots.*

*Your 2005/2006 Board of Directors are:*

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