Billing for Prostate Brachytherapy in 2004

Administrative best practices every hospital should know

by Mary Lou Bowers, MBA, and Lynn M. Jones, MHA

The 2004 Medicare rule changes bring good news for hospital outpatient facilities that provide prostate brachytherapy services. This procedure is no longer bundled!

In 2004 providers are now reimbursed *separately* for the seeds and the procedure—with the payment amount for seeds based on their cost. These changes improve the reimbursement picture for brachytherapy because providers can now detail *all* services utilized in providing brachytherapy and cover the full cost of the procedure. However, providers must first understand exactly what they can and cannot charge when submitting claims for implantable seeds. Under the new rule, you can bill for items used to provide the treatment, including seeds, needles, and catheters.

Providers should put two immediate changes in place:

- Update your chargemaster with the correct codes for brachytherapy. In 2004 codes identifying the specific surgical and urological procedures are billed under 77778 and 55859.
- Bill for *each* seed used. Use codes C1718 (Iodine) and C1720 (Palladium). Remember, the cost of the seeds *is no longer* bundled in codes G0256 (Palladium) and G0261 (Iodine). Additionally, Medicare places *no limits* on the number of seeds allowed.

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Investigate new purchasing patterns for this procedure, particularly in regard to purchase of seeds.

Use the Appropriate Cost-to-Charge Ratio

Medicare's intent is to reimburse for the actual costs of the seeds used, and multiplying the charges submitted by an outpatient surgery center by that center's cost-to-charge ratio (CCR) equals compensation. To determine appropriate reimbursement, providers should use the latest settled cost report from the department supplying the seeds. To ensure that you are using the correct CCR, ask your finance department for the appropriate last settled cost report. Do not use the most recent CCR as there is usually a two-year time lag between this CCR and the one accepted by Medicare. Do not use the hospital's CCR because Medicare requires using the relevant department's ratio.

Table 1 shows how using the wrong CCR can result in a provider receiving an excess payment for seeds. Even if this error is unintentional, the claimant would be subject to prosecution and fines due to prohibitions against overcharging federal health programs for services.

How to Bill for Seeds

In 2004 Medicare will reimburse hospitals for the invoiced cost of

Table 1: An Example of How Your CCR Can Affect Your Payment*

Basis	CCR	Charge	Payment	Implications
Department's Last Settled CCR	0.5	$7,000	$3,500	Appropriate Payment
Department's Current CCR	0.6	$7,000	$4,200	Overpayment of $700
Hospital's Settled CCR	0.7	$7,000	$4,900	Overpayment of $1,400

* Assumes a hypothetical total cost of $3,500 for seeds for one procedure.

seeds. So, providers should bill Medicare for the number of seeds ordered. For brachytherapy, three types of seeds may be purchased: stranded, loose, and Mick®. For each patient, the number and type of seeds needed for treatment will vary.

For example, a physician may order 100 seeds for two different cancer patients—Patient X and Patient Y. Patient X may be treated with 80 stranded seeds at $30/seed, 5 loose seeds at $20/seed, and 10 Mick® seeds at $25/seed, for a total seed invoice cost of $2,750. Patient Y, however, may receive 80 stranded seeds at $30/seed, 5 loose seeds at $20/seed, and 10 Mick® seeds at $25/seed, for a total seed invoice cost of $2,725. While Medicare only pays for each seed used under two codes—C1718 (Iodine) or C1720 (Palladium)—your internal system will need to keep track of and account for the different types of seeds ordered and used in order to ensure correct reimbursement.

When purchasing seeds, the right pricing decision can impact your program's revenue per procedure. Keep in mind that your charges for seeds should *not* be based solely on your Medicare reimbursement rates. Commercial payers usually pay a percentage of charges or a negotiated or capitated rate. Often commercial payers reimburse at higher rates than Medicare, based on the contract with the hospital.

Table 2 compares two providers' reimbursement rates based on a typical payer mix. Hospital A's seed charges are $5,000 per procedure. Hospital B's seed charges are $6,000 per procedure.

Table 2 shows that making the right business decision about seed purchase can directly affect your program's bottom line. Based on the payer mix in this example, hospital B, purchasing higher priced seeds, actually experiences $532.50 more in reimbursement per procedure. Over 100 procedures, a $53,250 increase would result. Even more important—future Medicare payments will be based on 2004 and 2005 data. So purchasing the lowest priced seeds today may not be to your programs overall advantage.

Billing for Waste

Seeds are ordered based on the patient's treatment plan. You can bill up to 15 percent of the number of seeds used as waste, but the reason for the waste must be documented in the patient's treatment plan, and it must be signed by both the physicist and the physician as part of the medical record. Establishing a department "seed wastage policy" can be a good administrative policy.

In determining what to pay for seeds, consider all the process factors involved with deliverying brachytherapy. For example, while pre-loaded seeds may cost more, they can save staff time, limit exposure of staff to radiation, and save time in the operating room. Another important consideration in seed purchase is the reliability of your supplier. Delays or cancellations due to vendor delivery problems are a tremendous inconvenience to the patient and your delivery team—not to mention the lost revenue to your cancer program when you are forced to cancel an operating room because the seeds did not arrive.

In the end, you should look at the 2004 rule changes as an opportunity to better identify *all* the costs involved in delivering prostate brachytherapy to patients. Cancer programs that carefully identify their costs and bill and code correctly and accurately for all services related to providing this important therapy, should see improved reimbursement for this service in 2004.

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Table 2: A Comparison of the Cost and Reimbursement of Differently-Priced Seeds

	Payer	Charge	Percentage Paid by Insurer	Payment Received	Percentage Payer Mix	Weighted Payment
Hospital A	Medicare*	$5,000	Cost	$2,500	50%	$1,250.00
	Commercial #1	$5,000	Capitated	$3,800	10%	$380.00
	Commercial #2	$5,000	65% charges	$3,250	25%	$812.50
	Commercial #3	$5,000	80% charges	$4,000	15%	$600.00
					Total Payment	**$3,042.50**
Hospital B	Medicare*	$6,000	Cost	$3,000	50%	$1,500.00
	Commercial #1	$6,000	Capitated	$3,800	10%	$380.00
	Commercial #2	$6,000	65% charges	$3,900	25%	$975.00
	Commercial #3	$6,000	80% charges	$4,800	15%	$720.00
					Total Payment	**$3,575.00**

* Medicare uses the cost-to-charge ratio from the department supplying the seed.