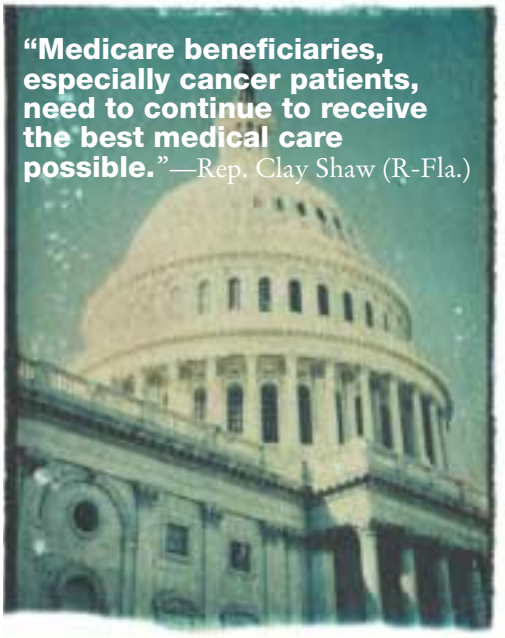
Rep. Clay Shaw Speaks at ACCC's National Meeting

"The current payment that Medicare provides for outpatient cancer drugs is not adequate, and we need to change it," said Representative Clay Shaw (R-Fla.), a senior Republican on the House Ways and Means Committee and a keynote speaker at ACCC's recent 29th Annual National Meeting.

He was referring to the *Beneficiary Access to Care Act of 2003* (H.R. 1032), which he recently reintroduced, and which now has four sponsors. Rep. J.D. Hayworth (R-Ariz.), Rep. Dave Camp (R-Mich.), and Rep. Mark Foley (R-Fla.) have joined Rep. Shaw in supporting this bill that addresses the January 1 cuts in Medicare drug reimbursement and is aimed at protecting patient access to cancer care in the hospital outpatient setting. Specifically, this legislation would ensure that sole-source and innovator multi-source drugs are reimbursed at 83 percent of AWP in the hospital outpatient setting and would require that CMS revise the data and methodology it uses to establish these reimbursement rates.



Shaw hopes that H.R. 1032 will be included in a more comprehensive Medicare prescription drug bill that the House will consider sometime this spring. He urged providers at ACCC's conference to speak in support of H.R. 1032 at congressional visits scheduled during the meeting.

"When Medicare started in 1965, we didn't have the wonder drugs that we have today that preserve and enhance life well beyond what we thought even possible," Shaw said. "Medicare has not kept pace with innovation and has to be brought into the 21st century."

"Medicare beneficiaries, especially cancer patients, need to continue to receive the best medical care possible. Hospital outpatient departments are a critical part of the cancer care delivery system and provide a significant portion of the nation's cancer care," Shaw said.

Shaw also pointed out that the fiscal 2003 spending bill signed by President Bush will halt the scheduled 4.4 percent cut to the physician fee schedule under Medicare and will increase physician payments by 1.6 percent in 2003.

"Doctors cannot be paid at such low levels and be expected to serve our Medicare patients," Shaw said. He added that he will continue to watch the situation and to push for corrections to the fee schedule so doctors can continue to provide health care services to seniors.

In his opening remarks, Rep. Shaw spoke about his family's experience with cancer and his own recent diagnosis and treatment for lung cancer. Shaw reported that he had a "clean bill of health" from his doctors at the H. Lee Moffitt Cancer Center and Research Institute in Tampa, Fla.

"I was lucky and blessed to have had access to one of the finest cancer institutions in the nation," said Shaw, who added that he was extremely thankful and would like to help those who are less fortunate than he.

Shaw also said that it was his personal goal to take the lead in Congress to raise awareness and support for lung cancer research funding. He pointed out that funding for lung cancer research is about $1,200 per patient per year, lower than any other major site of cancer. Breast cancer research, for instance, is funded at $11,000 per patient per year, prostate cancer at $8,000, and colon cancer at $3,000.

"If we can send a man to the moon and bring him back safely, we can certainly conquer cancer," Shaw concluded.

Update on Single Drug Pricer

ACCC's analysis of the newest release of the Single Drug Pricer (SDP), an index that establishes the fee schedule for each of the approximately 400 drugs covered by Medicare Part B, indicates that reimbursement for the majority of oncology and supportive care drugs given in physician offices will *not* change in the second quarter of 2003.

Offices should note, however, that in the second quarter SDP Pricing, a few drugs commonly used in oncology practices did have an increase in reimbursement:

- Anzemet® (J1260), from $14.24 in January 2003 to $16.45 in April 2003
- Ethyol (J0207), from $427.34 to $452.97
- Navelbine® (J9390), from $99.28 to $104.31
- Venofer® (J1755), from $13.07 to $13.20.

PHOTOGRAPH BY PICTUREQUEST.COM

Also of note, doxorubicin (J9000) decreased from $50.96 in January 2003 to $42.82 in April.

Since payment discrepancies among carriers have been common, the Centers for Medicare and Medicaid Services (CMS) established the SDP to standardize the amount that carriers should reimburse providers for pharmaceuticals. These discrepancies in drug payment rates exist, in part, because there are at least three published sources for average wholesale price (AWP) of drugs, each of which has different publication dates.

Under the SDP, a single carrier (Palmetto GBA) will determine the AWP for drugs, based on drug manufacturer data published in the Red Book and the First Data Bank. Palmetto GBA is the Medicare carrier for Ohio, West Virginia, and South Carolina. It also administers Trailblazers, the Medicare carrier for Texas, Colorado, New Mexico, Maryland, Delaware, Northern Virginia, and the District of Columbia. The company processes national Medicare claims for the Railroad Retirement Board, rural home health agencies in the South and Midwest, and is the regional claims processing contractor for durable medical equipment in 14 southern and southwestern states.

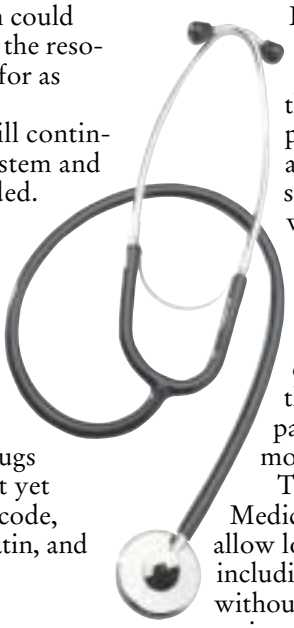
After Palmetto establishes the AWP for each drug, CMS will set payment rates based on 95 percent of the AWP allowance, e.g., the SDP. Hospital outpatient drugs (except blood clotting factors) and drugs billed to durable medical equipment regional carriers (DMERCs) will not be covered under the SDP, but will be reimbursed through APCs and DRGs.

Beginning in January 2003, Medicare began reimbursing 100 percent of the SDP price. SDP prices will be updated on a quarterly basis, every January 1, April 1, July 1, and October 1. AWP increases in February 2003 and March 2003 will not be reflected in the SDP file until the third quarter update in July.

CMS released a Program Memorandum on Dec. 4, 2002, announcing the creation of the SDP. ACCC is continuing to analyze the Program Memorandum, but two issues are worth noting. First, if a quarterly update is not made available for any reason, carriers must continue to use the previous quarter's price list, which, in turn, may impact the carrier's ability to pay for new drugs or drugs for which prices may have increased. Second, if regional offices/carriers believe that a drug list price is inappropriately low or inadequate, they will not be allowed to reimburse subscribers at the price they think is fair or which they have used in the past. Substitutions can be made only after a joint memorandum from CMS, which could delay such corrections (or the resolution of other problems) for as long as six months.

CMS has said that it will continue to evaluate the SDP system and will make changes as needed.

Visit *http://www.cms.hhs.gov/providers/drugs* to download the HCPCS pricing in an Excel spreadsheet. Also available on the CMS web site is a listing of the SDP for NOC (not otherwise classified) drugs. NOC drugs are those drugs that do not yet have an assigned HCPCS code, such as Neulasta, Oxaliplatin, and Faslodex.



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Bush Proposal Seeks New Medicare Drug Plan

On March 3, President Bush outlined a plan for Medicare reform by proposing comprehensive drug coverage for millions of Medicare patients, but only if they switch to subsidized private insurance plans. The Administration hopes that propelling seniors into private insurance will control the costs of the new benefits.

The Bush proposal, called "A Framework for Improving and Modernizing Medicare," offers three choices.

Under traditional Medicare, seniors would continue receiving care as they do now, with enhancements such as a discount card providing 10 to 25 percent off at pharmacies and an additional $600/year subsidy to help pay for prescription drugs. Bush is also promising coverage for unusually high drug expenses from a catastrophic illness, but his plan does not specify when such coverage would begin, although administration officials have previously suggested that beneficiaries might have to spend $4,000 to $7,000 of their own money on prescription drugs to qualify. These new benefits would be provided at no additional premium.

The second choice, called Enhanced Medicare, would give a choice of multiple insurers, with the federal government paying most of the cost and participants paying a small share. These plans would offer prescription drug benefits, full coverage of preventive benefits, protection against high out-of-pocket drug costs, and cost sharing that does not penalize participants who need the most medical care.

The third option, called Medicare Advantage, would allow low-cost coverage, including benefit packages without drugs, with fewer requirements for the providers. It would be similar to the current Medicare+Choice program, which allows a choice of private plans.

More than 80 percent of Medicare patients are in a fee-for-service plan that lets them choose their doctors and hospitals while Medicare pays the bills. Under the Bush proposal, the elderly would have the same broad choices that are available to most younger workers. However, to receive extensive drug coverage, seniors would have to join private health plans, including HMOs, other managed care plans, PPOs, or other private fee-for-service providers.

Bush will call on Congress to act on his Medicare proposal this year, said Thomas Scully, administrator of the Centers for Medicare and Medicaid Services (CMS) in a news release. He will emphasize that the options are similar to those available through the Federal Employee Health Benefits Program (FEHBP), which includes members of

Congress. The plan is expected to cost $400 billion over 10 years for a new prescription drug benefit.

MedPAC Report Details FY 2004 Payment Recommendations

As a whole, Medicare payments are adequate to cover the costs of efficient providers, according to the Medicare Payment Advisory Commission (MedPAC) in its annual report to Congress on Medicare payment policy released on March 3.

The commission recommended that the hospital inpatient prospective payment system be set at marketbasket minus 0.4 percentage points and the hospital outpatient, physician, and outpatient dialysis payment systems be set at marketbasket minus 0.9 percentage points.

For physician services, the commission recommended a 2.5 percent payment increase in 2004.

Other recommendations included zero updates for skilled nursing and home health providers, an increase to the cap on disproportionate share payments, and elimination of the differential in base rates for rural and small urban hospitals.

The report also addresses how to assess access to care for Medicare beneficiaries, payment for new technologies, and what choices of health insurance are available to Medicare beneficiaries.

With regard to payment for new technologies, MedPAC recommended that the Secretary of Health and Human Services (HHS) introduce clinical eligibility criteria for pass-through payments for drugs and biologicals under the outpatient prospective payment system (OPPS).

Although the Bush administration is citing MedPAC's recommendations as evidence that providers do not need payment increases for FY 2004, ACCC and other provider groups strongly disagree with MedPAC's conclusions. With the exception of the AARP representative at the Ways and Means health subcommittee hearing, testimony from provider organizations representing hospitals, nurses, doctors, and others all said that the MedPAC recommendations were flawed and jeopardized their fiscal health.

Health Subcommittee Chairwoman Nancy Johnson (R-Conn.) noted that she has never seen a larger disconnect between MedPAC's recommendations and the comments she has received from providers. Further, Johnson claimed that the rate of productivity used by MedPAC to determine adequate payment is "generic" and does not reflect the different circumstances facing different types of providers. She said that productivity increases within heath care now require the purchase of expensive new technologies.

One provider suggested adding the cost of new technology and uncompensated care to Medicare cost reports to help mitigate such misleading MedPAC data. Another suggested that no further reductions be made in Medicare reimbursement until state legislatures have time to address Medicaid reimbursement shortfalls. Chairwoman Johnson said she agreed with their concerns.

A representative from the American Hospital Association (AHA) claimed that MedPAC's use of two-to three-year-old cost report data does not accurately reflect current market conditions in the hospital industry. AHA said that MedPAC is unable to consider recent trends such as the nursing shortage, the increased demand for services, increasing technology costs, "skyrocketing" medical liability premiums, and the added cost of disaster preparedness. AHA further claimed that 57 percent of hospitals had negative Medicare margins in 2001, and nearly one-third had negative total margins.

A witness for the American Medical Association (AMA) said that Congress must change the sustainable growth rate (SGR) formula used for calculating physician payments, since the "critically flawed" formula led to a dramatic swing in reimbursement for 2003 that required an act of Congress to fix. The AMA claimed that the formula could be improved significantly by deleting gross domestic product growth and Part B drugs.

Johnson said she planned another hearing after MedPAC's June report.

Information on the March report is available at: *http://www.medpac.gov.*

New HHS Report Says Medical Litigation Crisis Deepens

Problems associated with medical litigation have significantly worsened in the past year, according to a report released on March 3 by the Department of Health and Human Services (HHS). In many states, the spiraling cost of insurance for health care providers is impairing patient access to care, as well as the cost and quality of health care. Americans pay for the cost of the runaway litigation system through higher premiums for health insurance, higher out-of-pocket payments when they obtain care, and higher taxes, the HHS report says.

HHS first published a report on the problem in July 2002, with two supplements released last year. This most recent report, entitled *Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care,* says "the crisis has only worsened, in both scope and intensity," since the earlier reports.

One-third of hospitals saw an increase of 100 percent or more in liability insurance premiums in 2002, according to a study cited by the report. And over one-fourth of hospitals reported either a curtailment or complete discontinuation of service as a result of growing liability premium expenses.

In 2001, the insurance premiums charged to specialists in the 18 states without meaningful non-economic caps had increased 39 percent. By 2003, the premiums in these states had gone up an additional 51 percent, almost double in two years.

The ill effects of a broken medical liability system have now put a total of 18 states in crisis, reports the AMA. The current liability system

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is adversely affecting patient care as shown in the following examples.

Missouri. Women with gynecological cancers in three rural Missouri towns now have to drive more than 100 miles because the only gynecological oncologist was forced to eliminate his rural outreach clinic due to increasing insurance premiums. Physicians saw their premiums increase more than 60 percent on average last year.

Connecticut. Because of a legal climate making $1 million-plus jury verdicts and settlements more common, an increasing number of Connecticut obstetricians are no longer delivering babies, and premiums for neurosurgeons and other high-risk specialists are more than $100,000.

Kentucky. High-risk specialists in Kentucky, including emergency room physicians and general surgeons, saw increases in their liability premiums last year of between 87 to 200 percent. Nearly one-quarter of the state's physicians say medical liability concerns make them consider leaving the state.

The main factor causing the crisis is the rise in mega-awards and settlements, particularly for non-economic damages. Between 1991 and 2002, the number of payments each year of $1 million or more that were reported to the National Practitioners Data Bank (NPDB) increased from 298 to 806.

The report cites evidence that reasonable limits on non-economic damages, such as California has had in effect for 25 years, can reduce health care costs by 5 to 9 percent without increasing mortality or medical complications.

President Bush has proposed a framework for improving the medical litigation system. It includes allowing unlimited compensation for "economic losses," while placing reasonable limits on non-economic damages, as has been enacted in many states, and payment of judgments over time. In addition, HHS is devoting new efforts to improving quality of care and reducing medical errors. The President's framework also calls for confidentiality provisions that would encourage communication among health care professionals to identify weaknesses and improve health care quality and patient safety. Legislation has also been introduced in Congress.

The new report can be found on the web at: *http://aspe.hhs.gov/daltcp/reports/medliab.pdf.*

Update: The NCI's CIRB Initiative

Established in August 1999, the Central Institutional Review Board (CIRB) Initiative of the National Cancer Institute (NCI) strengthens protections for research participants by providing expert reviews of research protocols and other services that ease the administrative burden of conducting cooperative group trials for local research institutions.

Meeting monthly since January 2001, the CIRB currently has 111 participating IRBs representing 126 community and university teaching hospitals. The CIRB handles all Phase III adult cooperative group protocols that originate from the NCI every year. To date, the CIRB has reviewed 47 protocols, and local IRBs (LIRBs) have used the CIRB's review process for 31 of them.

Many cooperative group studies are open at hundreds of sites at the same time. The CIRB eliminates the necessity for hundreds of full-board IRB reviews of the same protocol and significantly reduces the administrative review burdens for LIRBs and principal investigators. The faster process makes it possible to start enrolling patients within days after opening a trial (instead of weeks and months) and makes trials for rare diseases feasible.

The CIRB is not an additional layer of bureaucracy because the CIRB and the LIRB do not duplicate each other's tasks. The CIRB's primary function is initial and continuing review of protocols and adverse events reports, while the LIRB's primary task remains consideration of local context and oversight of local study performance.

For the next 12 to 18 months, the CIRB is shifting its focus from expansion to utilization. Instead of adding more sites, it will outreach

to investigators at participating sites and focus on refining its services to LIRBs. The CIRB will then measure local utilization of the facilitated review process and assess the experience of LIRB chairs, coordinators, and principal investigators, as well as CIRB members.

For more information about the CIRB, visit *www.ncicirb.org*.

Breast Cancer: Coding for Screening, Diagnostic, and Treatment Procedures

by Linda B. Gledhill, M.H.A.

Although breast cancer is one of the most common types of cancer, coding for some of its screening, diagnostic, and treatment procedures can be confusing. Here is how to code some of the procedures related to breast cancer treatment.

Q *What ICD-9 codes can be used for mammograms? Will insurance companies cover these procedures?*

A The ICD-9 code for screening mammograms is V76.12 and the procedure code is 76092. Medicare covers one mammogram per year at 80 percent of the allowed amount, when ordered by a physician. Commercial carriers vary, depending on coverage and policy type.

Q *Is the same mammogram procedure code used for patients with breast implants?*

A No. Implants may make it difficult to see all of the breast tissue and detect an abnormality. Use the code for bilateral diagnostic mammograms (76091), and take additional views as needed.

Q *What are some of the breast cancer risk factors a physician needs to know?*

A The most common risk factors for breast cancer are a personal history of breast cancer (V10.3), a family history of breast cancer (V16.3), and hyperplasia, (611.1). However, studies are uncovering more risk factors and new codes are being added to the list.

Q *What are some of the more common symptoms of breast cancer a patient may experience and how are they coded?*

A Patients should notify their physician if they notice any of the following symptoms: a lump in their breast (611.72), pain in their breast (611.71), nipple discharge or abnormalities in the way the skin of the breast looks or feels (611.79).

Q *If a patient needs further diagnostic tests after a mammogram to determine the origin of an abnormal finding, what are some of the testing options and how are they coded?*

A Several types of biopsies may be used to determine whether a patient needs further treatment for a specific abnormal finding:

- *Fine-needle aspiration* removes fluid and cells from a breast lump for lab analysis (CPT code 10021).
- A *needle biopsy* also removes tissue to be analyzed by a lab (CPT code 19100).
- A *surgical incision biopsy* may be used to remove part of a lump, or an *excisional biopsy* may be performed to remove the entire area in question. The surgeon will code these biopsies according to the extent of the procedure.

Q *How do you code the diagnosis for breast cancer?*

A The ICD-9 code must be very specific. Coding any neoplasm requires the use of the highest level of specificity available. The diagnosis codes range from 174.0 to 174.9.

Q *How do you code for treatment?*

A ***Surgery*** is the most common treatment with options ranging from a lumpectomy (CPT code 19120-19126) to a radical mastectomy, (CPT code 19140-19240). The choice depends on the extent of the tumor.

External beam *radiation therapy* can be given in a hospital outpatient department or a private physician's office. The daily radiation treatment codes are CPT 77413-77416, usually one per day.

Implanted radioactive material can also be used to treat a tumor. This procedure is only done on an inpatient basis. Should the patient receive implants and external beam therapy at the same time, the special treatment code CPT 77470 can be used.

Chemotherapy. Each insurance carrier's formulary has a list of chemotherapy drugs it will reimburse for the treatment of breast cancer.

Q *Are there any specialty codes for patients receiving chemotherapy and radiation therapy?*

A If the patient is receiving chemotherapy and external beam treatment, the special treatment code (CPT 77470) can be used by the radiation center physician.

Q *After treatment is complete, how are follow-up mammograms coded?*

A When the patient returns for a screening mammogram after treatment for cancer, use the CPT code for high-risk patients (V76.11).

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