Life After AWP

A Reimbursement Primer for Oncology Professionals

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The Way We Were...

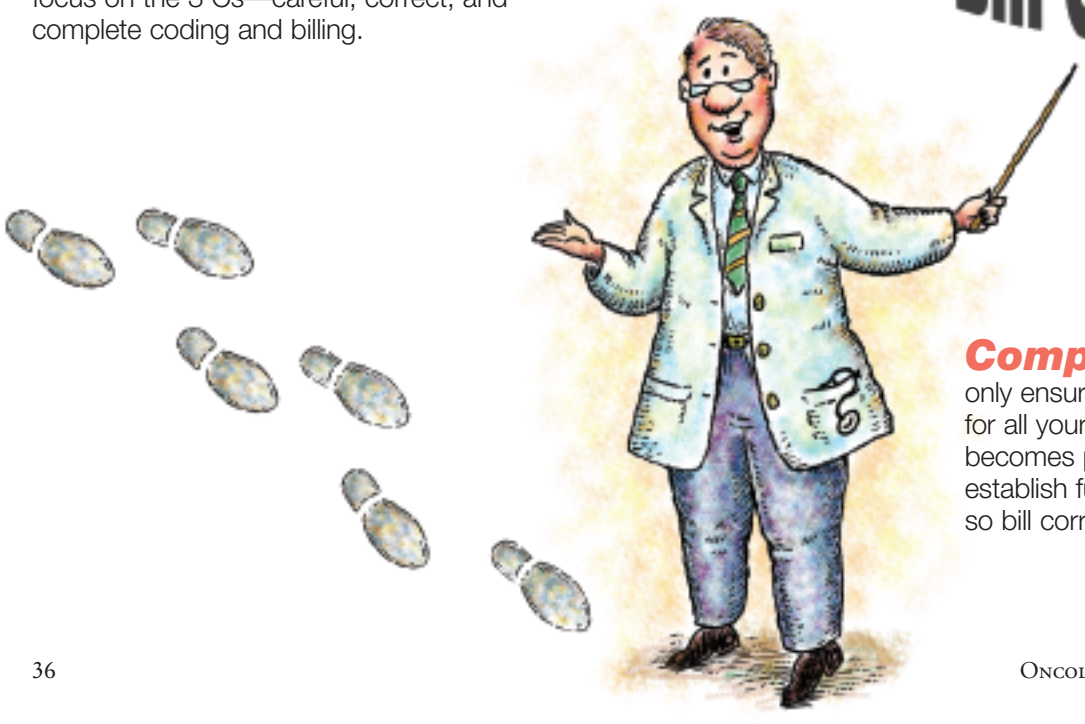
Average wholesale price (AWP) reimbursement for practices began in 1992. With AWP came a margin on drug reimbursement and underpayment for services performed. For years, the Centers for Medicare & Medicaid Services (CMS) threatened to take away the drug margin without adjusting reimbursement for practice expenses. The problem was brought to light by a 2001 GAO study verifying drug overpayments and corresponding underpayments for administration costs, and Congress was forced to act. On Dec. 8, 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) was signed into law, phasing out AWP and moving to ASP (average sales price).

Under ASP, CMS will use drug costs submitted by manufacturers to set drug payment rates more closely aligned with true acquisition costs.

In 2004 reduced drug payments are offset by a temporary 32 percent increase in practice administration payments. In 2005 this increase drops to 3 percent. It disappears entirely in 2006.

With the elimination of the drug margin and the shift to reimbursement based on the actual services performed, practices must focus on the 3 Cs—careful, correct, and complete coding and billing.

Bill Correctly



Complete billing not only ensures you are getting paid for all your services *today*, it also becomes part of the data used to establish future payment rates—so bill correctly!

To ensure economic survival, oncology practices must bill for *every* service they provide. Practices can start by following these simple steps:

8 Steps

1. Read the CPT Book and analyze each code available and bill every payor for every service you perform.

2. When utilizing single dose vials, be sure to bill (and document) for the entire vial if the remainder is thrown away—not just the amount the patient receives.

3. Review how you calculate your chair time. When do you start billing? How do you round times? Is chair time correctly documented in your medical records?

4. Collect your full copayments. If possible, talk to patients about payment arrangements *before* you provide services.

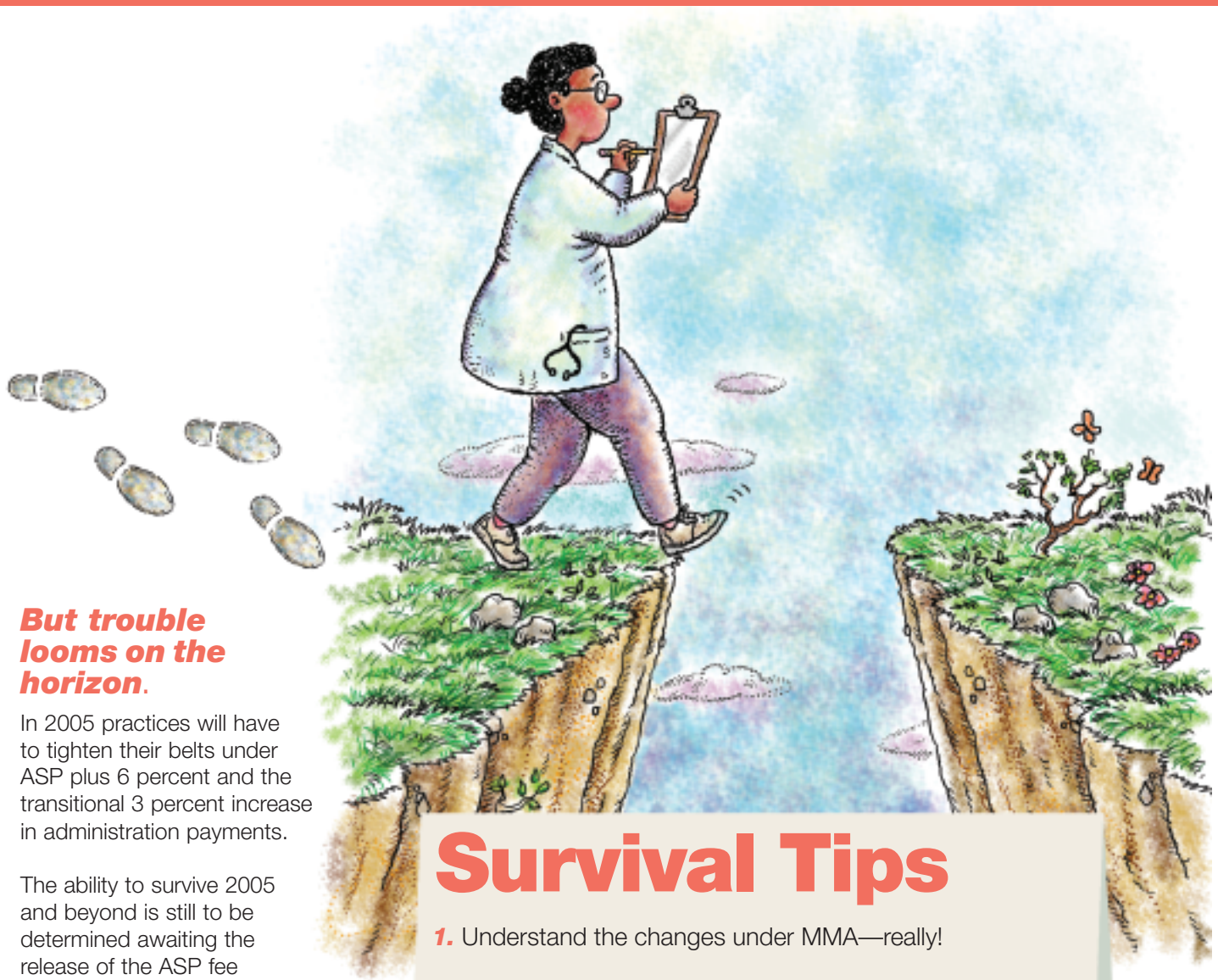
5. Make sure your practice is updating your fee schedule and submitting claims using the revised relative value units (RVUs) for codes 90780-90781 and 96400-96549.

6. Remember that Level 1 office visits on the same day as chemotherapy are now *included* in the administration payment.

7. Level 2 to Level 5 office visits can now be billed *separately* on the same day as chemotherapy. Just be sure you include a modifier "25" to indicate a separate, identifiable service. (Codes 99212-99215 require face-to-face physician time.)

8. Keep-in-mind that chemotherapy administration (96408) intravenous push technique can now be billed once per day for *each* drug administered.

In the end, practices will be kept whole in 2004 under MMA, if they offer the same services as in 2003 and their patient volume remains the same.



But trouble looms on the horizon.

In 2005 practices will have to tighten their belts under ASP plus 6 percent and the transitional 3 percent increase in administration payments.

The ability to survive 2005 and beyond is still to be determined awaiting the release of the ASP fee schedule and accurate definition of "actual sales price." In the meantime, practices need to prepare.

Survival Tips

1. Understand the changes under MMA—really!
2. Educate and train your entire staff and physicians. Ultimately, your key to survival rests with the 3 Cs—careful, complete, and correct coding and billing.
3. Monitor your drug costs. Are you receiving the best possible price?
4. Review all your private payor contracts. Be sure you are reimbursed adequately for your drug costs *and* the services you perform.
5. Your billers and coders are more important than ever. Be sure you give them the tools and training to do a good job!
6. Drug margins are in the past! Moving forward, we must now ensure adequate reimbursement for our services.
7. Network and join local and national oncology organizations. As we saw on the hospital side, if the system is "broke," we can work toward a fix—but only by joining together with a united voice for our patients and quality care!

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