THE ISSUES

ACCC Survey Reveals Need for Medicare Payment Adjustment to Adequately Capture Pharmacy Service Costs

An ACCC survey of hospital oncology pharmacists reveals that pharmacy handling and overhead costs may account for approximately 30 percent of total drug costs. In stark contrast, CMS is proposing to pay hospitals only 2 percent to cover these costs in 2006.

ACCC's survey findings are similar to those included in the June 2005 Medicare Payment Advisory Commission (MedPAC) report, which suggested pharmacy service overhead costs make up 26 to 28 percent of total pharmacy costs. MedPAC is an independent advisory council that reports to Congress.

"To reach a reasonable compromise, ACCC is proposing that CMS implement a pharmacy service and handling add-on of at least 8 percent of average sales price (ASP)," said Deborah Walter, ACCC senior director of Policy and Government Affairs. "Based upon our extensive data analysis, increasing the add-on percentage from 2 percent to 8 percent would protect beneficiary access to drug therapy in the hospital setting, while increasing projected total Medicare payments to hospitals by less than 1 percent (0.33 percent)."

ACCC and members of its OPEN (Oncology Pharmacy Education Network) Advisory Board have shared these findings with Congressional Hill staff and CMS officials. Discussions have focused on the importance—and need—of an add-on adjustment that will ensure hospital pharmacies can continue to provide high-quality care to patients. ACCC has also been working very closely with other pharmacy associations and hospital groups to develop a more unified message on the necessary reforms

"I am deeply concerned that the effect of this proposed reimbursement policy—coupled with CMS's proposal to reduce payments by 50 percent to hospitals for select multiple diagnostic imaging procedures and cut reimbursement for administering drug therapies—could slowly dismantle multidisciplinary cancer care, which is certainly not CMS's intent," said Jeanne Musgrove, member of ACCC's Governmental Affairs Committee. "Hospitals cannot continue to sustain these hits. It is critical to establish reimbursement rates that ensure hospitals are appropriately reimbursed for the services they provide," she added. Musgrove is cancer services director at Piedmont Medical Center in Rock Hill, S.C.

The survey results are available on ACCC's website at: *www.accc-cancer.org.*

PHOTOGRAPH/GETTY IMAGES

Caution! Invalid Chemo Codes

ILLUSTRATION/ARTVILLE

As of Oct. 1, 2005, the diagnosis code V58.1, encounter for chemotherapy, is no longer a valid code. The ICD-9-CM now requires you to use a fifth digit with this code. The new codes are:

- V58.11, encounter for antineoplastic chemotherapy
- V58.12, encounter for immunotherapy for neoplastic condition.

The FDA defines immunotherapies as Bacille Caimette-Guerin (BCG), interferon-alfa, interleukin-2, and the monoclonal antibodies. Use code V58.12 with these agents. V58.11 should be used with cytotoxic chemotherapy treatments. This is an initial interpretation of the ICD-9-CM committee, look for a more complete list of the immunotherapy agents on your carrier/intermediary website.

ACCC Submits Comments to CMS on 2006 Proposed HOPPS Rule

On Sept. 16, ACCC submitted its comments to CMS regarding proposed changes to the hospital outpatient prospective payment system (HOPPS) and calendar year 2006 payment rates. The comments are a culmination of issues that have been discussed with Congress, CMS, and others. ACCC urged CMS to protect cancer patients' access to quality care in the most appropriate setting by providing appropriate reimbursement for cancer treatments under HOPPS. Toward that end, ACCC urged CMS to increase the add-on payment for pharmacy handling costs to at least 8 percent of ASP (see above) and make an appropriate fixed-rate add-on payment to reimburse pharmacy service costs for packaged drugs. In addition, ACCC urged CMS to:

- Revise the coding and payment policies for drug administration services to make separate payment

continued on page 10

for additional hours of infusion services and to allow hospitals to bill for more than one initial service code in a single day
- Develop and implement a quality improvement demonstration project for cancer care provided in hospital outpatient departments, similar to the demonstration project implemented in physician offices in 2005
- Rethink the proposal with respect to multiple diagnostic imaging services in the same family performed during the same session
- Continue to study the economies of providing multiple diagnostic imaging services and implement a reduction of no more than 25 percent for these services in the meantime
- Begin working with stakeholders to develop a future rate-setting methodology that accounts for all the costs of providing radiopharmaceuticals
- Postpone implementation of the proposed C-codes for pharmacy overhead charges and study the issue in greater depth
- Issue proposed coding guidelines for evaluation and management services to help hospitals bill appropriately for cancer therapy support services
- Reconsider the proposed rates for the brachytherapy APCs.

Medicare Part B Monthly Premium Increases in 2006

CMS Administrator Mark B. McClellan, MD, PhD, announced that the Medicare Part B monthly premium will be $88.50 in 2006, an increase of $10.30 from the current $78.20 premium. The 2006 premium is roughly the same amount that CMS actuaries have been projecting since early this year. Though premiums are rising, most Medicare beneficiaries will see significantly lower out-of-pocket healthcare costs in 2006 because of the savings in drug costs from the new Medicare prescription drug benefit. Also, about one-fourth of beneficiaries can receive assistance that pays for their entire Part B premium, and about one-third of beneficiaries can receive assistance for their Part D premium.

Spotlight on PanCAN

PanCAN (the Pancreatic Cancer Action Network) is a national patient advocacy organization for pancreatic cancer—the fourth leading cause of cancer death in the United States.

Founded in 1999, PanCAN's mission is threefold: finding a cure for pancreatic cancer; advancing research, effective treatments, prevention programs, and early detection methods; and providing patient support services. To fulfill these objectives, PanCAN awards annual research grants, advocates on the state and national level for increased research funding and prevention initiatives, and educates the public through a wide variety of activities, including National Pancreatic Cancer Awareness Month (November), PALS (Patient and Liaison Services), and an annual Pancreatic Cancer Symposium.

For more information about this patient advocacy group, log onto PanCAN's website at: *www.pancan.org.*

Update on Part D Drug Benefit

Medicare's Part D prescription drug benefit starts Jan. 1, 2006. This new optional Medicare benefit will be provided by prescription drug plans (PDPs) or through Medicare Advantage plans. PDPs will offer *only* prescription drug coverage. Medicare Advantage prescription drug plans (MA-PDs) will offer both healthcare coverage and prescription drug coverage.

In September 2005, CMS announced that ten companies had been awarded contracts to provide Medicare prescription drug plans nationwide. The 10 national prescription drug plan (PDP) organizations are Aetna, Connecticut General Life (Cigna), Coventry, Medco, MemberHealth, PacifiCare, SilverScript (Caremark), UniCare, United Healthcare and WellCare. CMS approved additional sponsors to provide PDPs regionally, ranging from 11 to 20 companies in each of the 34 PDP regions. Medicare Advantage drug plan sponsors were also announced. Just as Medicare Part B has some variation by region, Medicare Part D has regional variation as well.

In October 2005, the Medicare PDPs began marketing to consumers. The enrollment period for Medicare beneficiaries to sign up for a Medicare Part D prescription drug plan is between Nov. 15, 2005 and May 15, 2006. For those who join a plan by Dec. 31, 2005, Medicare Part D coverage will begin on Jan. 1, 2006. For those who join after that date, coverage will be effective the first day of the month *after* the month they join. In most instances, beneficiaries who do not join by May 15, 2006, will have to wait until November 15, 2006 to join and will likely pay a penalty.

A *Toolkit for Health Care Professionals: Medicare Prescription Drug Coverage* is available on the CMS website at *www.cms.hhs.gov/medlearn/drugcoverage.asp.* This includes fact sheets, brochures, and reproducible artwork that helps explain the Part D benefit to patients.

In general, Part D drugs will include most prescription drugs or biologicals used for medically accepted indications that are not currently covered under Medicare Part B. Some drugs may be covered under either Part B or Part D, for example, methotrexate. Whether a drug is covered under Part B or Part D depends on how the drug is dispensed or administered by the individual. This means that a drug typically covered under Part B will be covered under Part D when the drug is dispensed by a pharmacy and self-administered by the patient. The same drug administered in a

continued on page 12

physician's office would be covered under Part B.

An important exception is for oral cancer drugs that are currently covered under Part B. These drugs will remain under Part B and *never* will be covered by Part D.

Also, a patient may not receive coverage for a drug under Part D if the only reason that Part B coverage was not available was because the patient filled the prescription at a pharmacy without a Medicare supplier number, required for Part B coverage. As a result, it will be important for patients to fill prescriptions that may be covered under Part B at a pharmacy with a Medicare supplier number; otherwise, the patient risks losing Medicare coverage altogether for that drug.

Update on NCI/CMS Oncology Pilot Project: Progress Is Slow, Patient Accrual Not Completed

On Sept. 20-21, the National Cancer Advisory Board convened in Bethesda, Md. to discuss a number of issues, including the status of the Centers for Medicare & Medicaid Services (CMS) and National Cancer Institute (NCI) Oncology Pilot Project.

The pilot project originated in a national coverage decision (NCD) issued on Jan. 28, 2005. As outlined in the NCD, CMS is covering the "clinical and experimental" costs of four anti-cancer drugs: oxaliplatin (Eloxatin™), irinotecan (Camptosar®), cetuximab (Erbitux™), or bevacizumab (Avastin™) in nine NCI-sponsored clinical trials. All nine trials evaluate the drugs' use in off-label indications, and the pilot project will collect and validate clinical evidence to improve the use of these new therapies.

According to Mark Clanton, MD, MPH, NCI Deputy Director for Cancer Care Delivery Systems, the six colorectal and three non-colorectal NCI/CMS collaborative clinical trials selected for launch were chosen based on each treatment's high level of off-label usage and perplexing irregularities for researchers.

Dr. Clanton indicated that the NCI/CMS partnership is intended to explore how the two agencies can align their resources and agency-specific goals to accelerate development of evidence for emerging cancer treatment regimens. He further suggested that "this can be done by having CMS collect data to make reasonable and necessary determinations for off-label cancer treatments, while NCI sponsors trials as part of a research agenda to evaluate use of new agents in off-label indications to determine safety and efficacy."

In addition, as CMS lacks the statutory authority to conduct research, the agency views the Oncology Pilot Project as an opportunity to reach its goal of becoming more evidence based. By contrast, NCI views these clinical trials as an opportunity to advance the knowledge for these drugs, as well as to serve as a potential model for additional coverage expansions in clinical trials for other anti-cancer agents by both CMS and other insurance carriers.

Almost ten months after the NCD was announced, the nine trials have yet to begin.

Physician Offices Face another Round of Steep Payment Cuts in 2006

Medicare beneficiaries' access to quality cancer care could suffer immensely from payment cuts proposed in the 2006 Medicare Physician Fee Schedule, according to ACCC's official comments submitted to CMS on Sept. 30, 2005. The proposed cuts—combined with ongoing payment reforms spurred by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)—could create significant obstacles for cancer patients and their physicians in 2006.

PHOTOGRAPH/PHOTODISC

For 2006, CMS forecasts a 5.6 percent reduction in Medicare payments for hematology and oncology services provided in physician offices. Payment cuts for drug administration services are even deeper, ranging from 6 to 7 percent. "These cuts alone could create access problems, but when combined with proposed cuts in reimbursement for drugs and their administration services at hospitals, the effects could be disastrous," according to Edward Braud, MD, chair of ACCC's Governmental Affairs Committee and a practicing physician in Springfield, Ill.

With hospitals possibly reducing or eliminating their cancer programs in the face of similar levels of payment cuts, the proposed reductions in the proposed 2006 physician fee schedule come at a time when physicians may be confronted with increased volumes of patients and greater challenges to providing quality patient care.

"We are now aware of hospitals that have reduced or eliminated their outpatient services, leaving some patients to seek care in physician offices and other patients, who need treatments that are available only in hospitals, with nowhere to turn," Dr. Braud added.

Deborah Walter, ACCC senior director of Policy and Government Affairs expressed her concerns that "the proposed payment reductions to physicians could have grave implications for patients battling cancer."

"Many of our members simply cannot absorb the significant cuts in payment rates for cancer services without substantial ramifications for patient care," she added. Walter hopes that CMS will carefully consider a number of recommendations that could mitigate this problem.

ACCC recommends that CMS revise the sustainable growth rate formula as needed to prevent the expected 4.3 percent cut in the conversion factor and review the practice expense relative value units (RVUs) for drug administration services as soon as the necessary data are available to ensure that these RVUs accurately reflect all of the costs associated with administration of advanced drug therapies. ACCC also looks forward to working with CMS to identify appropriate quality measures and payment incentives that will promote the delivery of high quality, patient-centered cancer care.

Coding Guidelines for **Palliative Care and Hospice**

by Linda Gledhill, MHA

Q. *How should I code the diagnosis when a patient is receiving palliative care rather than treatment to cure a disease?*

A. Diagnosis coding for palliative care visits consists of coding for the underlying disease, followed by encounter for palliative care, and the symptom being treated. For example:

162._ Lung Cancer
V66.7 Encounter for Palliative Care
286.66 Dyspnea (shortness of breath)

Q. *The physician often spends most of the visit time counseling the patient. Can we charge for these counseling services?*

A. Evaluation and Management (E&M) coding can be complicated. Many times, physicians do not complete all of the guidelines for an E&M visit, instead using the allotted time for counseling and coordinating care. In these cases, you can use the length of the patient encounter (time) to determine the appropriate visit level.

Q. *How would a physician determine the level to charge if time was used as the basis for coding the visit?*

A. E&M codes have approximate time values. If a physician must spend more than 50 percent of the time designated by these codes on counseling and coordinating care, you can base the visit level on the length of the patient encounter (time). For example, a physician spends 40 minutes with an established patient to determine the palliative care the patient should receive. Thirty minutes of this time is spent counseling and coordinating care. This patient encounter can be coded using visit level 99215.

Q. *Does the physician's time have to be spent with the patient or can the physician charge for services carried out in the office?*

A. If the patient is seen in the physician's office, the time must be spent in face-to-face interaction. If the patient is seen in the hospital as an inpatient, the physician can include time spent counseling and coordinating care on the unit.

Q. *If "time" is used to determine the level of the visit, what documentation is needed?*

A. Documentation for visits based on time is critical and must include the total amount of time spent with the patient, as well as the time spent coordinating care (more than 50 percent), and the recommendations and treatment decisions.

Q. *If the patient sees more than one physician on the same day, how do I avoid denied claims for billing more than one visit on the same day?*

A. If a medical oncologist sees the patient for an E&M visit and refers the patient to a pulmonologist for evaluation of the shortness of breath, the pulmonologist should use the reason for the consult (dyspnea) as the primary diagnosis.

Linda Gledhill, MHA, is a senior associate at ELM Services, Inc., in Rockville, Md.

Hospice Care

If the physician has determined that the patient is terminally ill and has six months or less to live, the patient can choose hospice care. Hospice care is designed to enable a patient to be as comfortable as possible and does not involve curative treatment.

Q. *How do hospice physicians bill for their visits?*

A. Hospice care is billed to Medicare under Part A and is sent to the fiscal intermediary rather than the carrier. Here are the revenue codes used to bill for hospice care:

651 Routine home care
652 Continuous home care (24 hrs)
655 Inpatient respite care
656 General inpatient care

Q. *How much does Medicare pay for hospice care?*

A. Medicare pays 100 percent of the allowed charges for these codes; however, this benefit is capped at approximately $20,000. (Payment rates vary depending on the area of the country.) The patient does not have a co-payment or deductible.

Q. *If a patient exhausts this benefit, how do you bill for physician services?*

A. Once the hospice benefit has been exhausted, you can bill any additional services to the Medicare carrier as you did prior to using the hospice benefit.

Q. *Will commercial payers cover hospice services?*

A. Many commercial carriers now have hospice benefits. These benefits may be similar to the Medicare benefit or they may be based on specific visit rates. Check with your private payers to determine specifics.