THE ISSUES

Preliminary Results from ACCC's Survey on Hospital Outpatient Department Drug Reimbursement

ACCC recently surveyed its hospital pharmacy members to determine if proposed 2007 Medicare payments of average sales price (ASP) +5 percent will be sufficient to cover the drug reimbursement and related pharmacy costs in the hospital outpatient setting. Preliminary results show that for five of the eight oncology and supportive care drugs surveyed, the answer is no: A majority of respondents indicate that their costs will be greater (by more than $100) than the proposed ASP+5 percent Medicare payments. According to results thus far, a majority of respondents said that the cost of the following drugs combined with the pharmacy-related overhead will be more than the estimated 2007 Medicare payments:

- *Neulasta* (pegfilgrastim), increments of 6 mg, estimated payment of $2,142—74 percent indicated their Medicare payments would not cover their costs.
- *Taxotere* (docetaxel) 80 mg vial, increments of 20 mg, estimated payment of $1,178—68 percent indicated their Medicare payments would not cover their costs.
- *Velcade* (bortezomib) 3.5 mg, increments of 0.1 mg, estimated payment of $1,043—56 percent indicated their Medicare payments would not cover their costs.
- *Eloxatin* (oxaliplatin), 100 mg, increments of 0.5 mg, estimated payment of $1,694—56 percent indicated their Medicare payments would not cover their costs.
- *Aranesp* (darbepoetin), 200 mcg, increments of 1 mcg, estimated payment of $600—50 percent indicated their Medicare payments would not cover their costs.

For the remaining three drugs in ACCC's survey, 37 to 42 percent of survey respondents indicated that their drug costs combined with the pharmacy-related overhead would be higher than the estimated 2007 payments.

- *Herceptin* (trastuzumab), 440 mg, increments of 10 mg, estimated payment of $2,402—42 percent indicated their Medicare payments would not cover their costs.
- *Rituxan* (rituximab), 500 mg, increments of 100 mg, estimated payment of $2,326—37 percent indicated their Medicare payments would not cover their costs.
- *Avastin* (bevacizumab), 400 mg, increments of 10 mg, estimated payment of $2,254—37 percent indicated their Medicare payments would not cover their costs.

ACCC has urged its hospital members to assess how their own pharmacy costs compare to Medicare's estimated payments for 2007. ACCC collected data to submit to the Centers for Medicare & Medicaid Services (CMS) and to Congress. Go to ACCC's website *www.accc-cancer.org* or email ACCC's policy coordinator at *mfarber@accc-cancer.org* to learn more.

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PHOTOGRAPH/JUPITER IMAGES

Guilty Until Proven Innocent

As the number and types of targeted therapies continue to grow, insurers are developing increasingly strict reimbursement guidelines that providers must follow before they will be paid. In other words, insurers are monitoring provider compliance and withholding payment until providers *prove* that they are following the appropriate rules and regulations for these high-cost treatments. Or, as one practice administrator from North Carolina told *Oncology Issues*, "Insurers used to do business with providers using the 'honor system.' Now some insurers have adopted the stance that we [oncology providers] are guilty until proven innocent."

The executive director of an ACCC-member practice in Virginia confirmed this practice, saying that his insurance carriers would approve the use of the drug Abraxane only *after* his physicians submitted their written notes showing that other drugs had failed to help the cancer patient.

Demanding written proof of drug compliance has several negative consequences for oncology practices:

- Slowing payments at a time when oncology practices are struggling to stay financially solvent

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New Head for CMS

Effective October 15, the U.S. Department of Health and Human Services Secretary Mike Leavitt named Leslie Norwalk as acting administrator for the Centers for Medicare & Medicaid Services (CMS). Norwalk has served as deputy administrator for the agency that oversees $740 billion in federal spending on Medicare and Medicaid. She replaces Mark McClellan, MD, PhD, who resigned from CMS on Sept. 5.

- Requiring administrative changes and additional work, including staff time, the cost of which must come out of the provider's bottom line
- Crippling efforts to transition to an electronic claims filing system.

In fact, this last practice comes into direct conflict with the goals of the Health Insurance Portability and Accountability Act (HIPAA), which established electronic claims filing as the new standard. By requiring written information, such as pathology reports, insurers leave providers with no option but to continue to generate and submit paper claims. The North Carolina practice administrator had this to say, "…when payers require pathology reports or other proof of appropriate testing at the time of claims submission, it flies in the face of HIPAA."

While oncology providers agree that pre-testing is appropriate—particularly with targeted therapies where the indication requires a particular test—some insurance companies seem to be carrying this practice too far. "We all know the requirements, and we shouldn't get paid if we are not following the rules," one practice administrator agreed. "What's changed is *how* insurers are guaranteeing compliance."

The practice administrator went on to talk about a major insurer that recently conducted a "random" audit of certain patient records in her practice. When she did some research, she found that all of the records being audited belonged to breast cancer patients who had received Herceptin as part of their treatment. The audit required extensive staff time on the part of the practice. (Of course, this staff time was *not* reimbursed by the insurer.) In an effort to expedite the process and save time and resources, the practice administrator asked the insurer exactly what information they required.

"We submitted tons of paperwork for the audit. And since no one would tell us exactly what information to send, we sent what we thought was a reasonable subset of records. Because of the way the request was made, we may not have sent copies of the pathology reports in each instance," the practice administrator said. "In the end, those pathology reports were exactly what the insurer was looking for. The insurer used the absence of proof of pre-testing to implement stringent new guidelines."

"And our providers *had* conducted the appropriate tests," the practice administrator concluded. "If the insurer had simply been upfront about the audit, it would have saved everyone time and effort, and their results would have been more accurate."

The ACCC members interviewed for this article see this insurer practice continuing well into the future. In fact, one practice administrator had this prediction, "I wouldn't be surprised to see certain drugs, like growth factors, as next on the pre-test list."

Spotlight on the Susan G. Komen Breast Cancer Foundation

PHOTOGRAPH/ISTOCKPHOTO

The Susan G. Komen Breast Cancer Foundation recently announced the availability of $13 million in funding for the launch of its new *Focused Areas of Study Grant Program*. This new program is designed to attract high-caliber, innovative research proposals addressing key questions in four specific areas of breast cancer.

Ductal carcinoma in situ. The Foundation is currently accepting applications for basic, clinical, and translational research initiatives that examine initiation, progression, and invasion, as well as underlying biological processes for each. It will consider proposals ranging from $300,000 to $1.5 million for a funding period of two to three years.

Experimental model systems. Proposals in this category should catalyze the development and refinement of laboratory methods that are surrogates of human biology. Funding may be granted to proposals of merit for the development of tools that facilitate the testing and generation of hypotheses that advance the understanding of breast cancer initiation, growth, progression or metastasis. Proposals ranging from $300,000 to $1.5 million for a funding period of two to three years will be considered.

Biomarker identification and validation. Proposals should demonstrate the potential to catalyze the next generation of breakthroughs in the understanding of breast cancer causation, progression, metastatic, and recurrent disease. Priority will be given to applicants that address key challenges or barriers pertaining to the validation of breast cancer biomarkers. Proposals will be accepted ranging from $300,000 to $3 million for a funding period of two to three years.

Environmental research method. Proposals in this category should address current environmental research challenges in laboratory or clinical settings relevant to breast cancer. Preference may be given to proposals that address specific challenges pertaining to research methodology, measurement standards and assessment instruments, research focusing on mammary-specific models, or projects demonstrating potential to enhance clinical application or utility. Proposals will be accepted ranging from $300,000 to $5 million for a two- to five-year period.

For information on the Komen Foundation's Focused Areas of Study grants, contact Chandini Portteus at 972.855.4393 or apply online at *www.komen.org/focusedgrants*.

The $13 million designated for the new *Focused Areas of Study Grant Program* is supplemental to the Foundation's annual investment in research through its Research Award Grants Program. In fiscal 2005, the Komen Foundation's Research Award Grants Program distributed more than $54.8 million to fund a total of 247 investigator-initiated scientific research grants. Since the Komen Foundation's inception in 1982, it has invested more than $630 million in breast cancer research, education, screening, and treatment programs.

Proposed 2007 Hospital Outpatient Department (HOPD) Rule

Improve your charge capture and educate your staff on coding changes *today*

by Linda Gledhill, MHA, and Barbara Constable, RN, MBA

PHOTOGRAPH/COMSTOCK

For hospitals, 2007 will be all about "quality care," with payment increases tied to mandatory reporting of identified quality measures. The proposed 2007 hospital outpatient department (HOPD) rule expanded quality measures to include hospital outpatient departments. Hospitals that are currently required to report quality data for inpatient services will now need to include outpatient department data when reporting on the 21 Hospital Quality Alliance (HQA) approved clinical quality measures. Hospitals that do *not* include the outpatient data will have their payments reduced by 2 percent. In other words, the Centers for Medicare & Medicaid Services (CMS) has suggested deducting 2 percentage points from the proposed 3.4 percent inflation update.

The Ambulatory Care Quality Alliance (AQA) and HQA have formed a new steering committee. Over the next year, the committee will work closely with CMS to develop unique quality measures for outpatient departments. The committee will also focus on price and quality "transparency" in an effort to provide consumers with quality information for making healthcare decisions.

Improving Charge Capture

With less than two months left in CY 2006, community cancer centers should be taking a look at *how* they update their chargemaster and identifying ways for refining, improving, or streamlining this process. Updating the way you submit and capture charges should be a team effort, and here are a few tips to help you get started.

Your clinical team should bring to the table technology trends, material and labor needs, and clinical information on your market competitors. Your marketing department should be responsible for providing information on patient population, disease trends, a review of market prices, and assistance in transparency pricing. The financial team should contribute up-to-date information on payer contracts and payer mix. Taken together, this information should provide your cancer program with a "snapshot" of the upcoming year.

Improving charge capture is challenging and labor intensive for many community cancer centers—particularly those that do not have a clear plan for integrating and implementing upcoming reimbursement changes. Some cancer programs may want to consider bringing in outside experts to identify key areas for improvement. Oncology consultants, for example, can help develop and implement a chargemaster with competitive pricing. Bottom line: accurate chargemasters and effective claims processes are key and need to be reviewed and updated throughout the year.

Drug Administration

In the 2007 proposed HOPD rule, CMS will continue to use the CY 2006 OPPS drug administration coding structure. This method combines CPT codes with several C-codes and does *not* use the concepts of initial, sequential, and concurrent drug administration currently in place in private physician offices. One significant change: CMS proposes to now pay for additional hours of infusion, both therapeutic and chemotherapy. In previous years, these additional hours had been "packaged" in with the first hour's payment.

Table 1 shows the proposed administration coding system for therapeutic infusion, push technique, and chemotherapy infusion, including 2006 payment

Table 1: Proposed 2007 Drug Administration Coding

C-Code	Description	2006 Payment Rates	2007 Proposed Payment Rates
C8950	IV Therapeutic Infusion, 1st hour	$120.77	$112.94
C8951	IV Therapeutic Infusion, hours 2-8 each	no payment	$25.49
C8952	Therapeutic Push Technique	$47.82	$48.99
C8953	Chemotherapy Push Technique	$68.37	$97.84
C8954	Chemotherapy Infusion, 1st hour	$189.04	$154.86
C8955	Chemotherapy Infusion, hours 2-8 each	no payment	$48.99
C8957	Infusion greater than 8 hours	$113.20	$154.86

Source: The Pritchard Group, LLC, in Rockville, Md.

Table 2: Proposed 2007 Clinic Visit G-codes and Payment Rates

HCPCS Code	Description	Current CPT	Payment
GXXX1	Level 1 Hospital Clinic Visit	99201, 99211	$49.93
GXXX2	Level 2 Hospital Clinic Visit	99202, 99212, 99213, 99241, 99242	$62.12
GXXX3	Level 3 Hospital Clinic Visit	99203, 99214, 99243	$83.67
GXXX4	Level 4 Hospital Clinic Visit	99204, 99215, 99244	$105.50
GXXX5	Level 5 Hospital Clinic Visit	99205, 99245	$130.38

Source: The Pritchard Group, LLC, in Rockville, Md.

rates and proposed payment rates for 2007. (Note: under the proposed rates for 2007, all treatments would have to be longer than 1 hour and 31 minutes to reach 2006 payment levels.)

Facility Clinic Visits

In the proposed HOPD rule, CMS indicated that the current CPT codes (99201-99245) reflect the activities of physicians and do not "describe the range and mix of services provided by hospitals during visits of clinic and emergency department patients and critical care encounters." The agency continues to recommend that each hospital develop guidelines that accurately represent the intensity of hospital resources used for each charge level. For FY 2007, CMS is proposing to use HCPCS codes to describe hospital clinic and emergency department and critical care visits.

For clinic visits, CMS has proposed a set of five new G-codes to replace CPT clinic visit codes for new patients, established patients, and consultations (see Table 2). The specific G codes have not been published as yet, but Table 2 illustrates the proposed assignments and payment rates. CMS also indicates that the G-codes may be recognized by other payers.

In addition to the clinic visit G-codes listed in Table 2, CMS has proposed 12 additional new G-codes: five for general emergency room visits, five for special emergency room visits, and two critical codes.

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