ISSUES The

Compendium Update:
Changes to USP DI Drug Information

Starting July 2007 one of the recognized drug compendia, the United States Pharmacopeia's *USP DI Drug Information for the Health Care Professional*, will be succeeded by Thomson Healthcare's *DrugPoints®*. *DrugPoints* will use a new rating system for indications. The three-tier rating system will include three evidence-based rating categories for FDA-labeled and off-label indications. Indications will be assigned one rating from each of the three categories:

- Efficacy (Class I – III, with I being Effective and III being Ineffective)
- Strength of Recommendation (Class I - III, with I being Recommended and III Not Recommended)
- Strength of Evidence (Category A - C).

According to Thomson, these rating will provide clinicians a "sound basis from which to make informed, evidence-based prescribing decisions specific to the patient's indication." The three-tier rating system in *DrugPoints* will be consistent across all Thomson Healthcare Core Drug Information products, including *DrugPoints* and *DRUGDEX®*.

Important to note is that there will not be a one-to-one correlation between the *USP DI* Acceptance Rating and the *DrugPoints* ratings. For example, an indication with a *USP DI* rating of Accepted could have an Efficacy rating of Effective or Evidence Favors Efficacy, and a Strength of Recommendation rating of Recommended, Recommended in Most Cases, or Recommended in Some Cases.

Thomson points out that *DrugPoints* will contain the indications that meet the following criteria:

- All FDA-approved indications regardless of rating
- Indications with a Strength of Recommendation rating of Recommended (Class I)
- Indications with the following ratings:
  1. Effective or Evidence Favors Efficacy + Recommended in Most Cases (Class IIa)
  2. Effective or Evidence Favors Efficacy + Recommended in Some Cases (Class IIb) **IF** Strength of Evidence = A or B.

As part of the transition from *USP DI* to *DrugPoints*, more than 14,000 indications were reconciled across the two products and those *USP DI* off-label indications were reviewed and assigned the appropriate ratings in *Drug Points.*

ACCC's Reimbursement Committee will review the new ratings and change the Association's own *Compendia-based Drug Bulletin* as appropriate.

ACCC Supports Increased Funding for Nursing Programs

ACCC has joined more than 40 other advocacy organizations, signing on to a letter to members of Congress to support $200 million to be spent on the Nurse Reinvestment Act and other nursing related programs within the Department of Health and Human Services. There is a clear shortage in nurses and nurse faculty in the United States and these programs may help to alleviate some of these problems. ACCC is committed to ensuring quality care for all our patients, and we hope this effort will help in that goal.

PHOTOGRAPH/COMSTOCK

ACCC Responds to CMS' Proposal for ESAs

ACCC has submitted comments to the Centers for Medicare & Medicaid Services (CMS) regarding the agency's proposed decision about the Medicare National Coverage Determination (NCD) for Erythropoiesis Stimulating Agents (ESAs). ACCC believes that CMS should *not* limit access to ESAs for proven FDA indications and compendia listings. In addition, ACCC did not agree with CMS' decision to enforce clinical limitations on ESA usage, both dosage and time limits, when that decision should be made by both the physicians and FDA. As stated in ACCC's comments: "When label indications are followed, ESAs can be very beneficial to patients, increasing their quality of life."

ACCC indicated its belief that CMS made an error in including anemia of myelodysplastic syndrome (MDS) in the non-covered category. "As a result of the proposal by CMS, more patients with MDS and chemotherapy-induced anemia will require blood transfusions, which may take them out of the community setting where they are receiving chemotherapy. This will put a serious strain on the nation's blood supply…It will also add an additional strain on hospital resources, with hospitals having to utilize more space and personnel to administer the transfusions."

The full comments are available on ACCC's website at: *www.accc-cancer.org/pubpol/pdf/ESA_comments_may07.pdf.*

ACCC Joins SGR Forum in Capitol Hill

On June 5 ACCC, the American Medical Association, and other advocacy groups, joined representatives from congressional offices and CMS to discuss flaws in the sustainable growth rate (SGR) methodology, the current system for determining physician reimbursement under Medicare. The policy discussion explored options for changing the current system and controlling expenditures. Estimates have ranged from $100 billion to more than $200 billion for revising the current system.

A representative from the office of Texas Congressman Michael C. Burgess announced a bill that would phase out the SGR by 2010 and replace it with the Medicare Economic Index. This option has been estimated to cost more than $250 billion.

ACCC continues to participate in efforts to modify the Medicare physician payment formula. We look forward to working with Congress and CMS to find a solution this year.

CMS Proposes Measures against Fraud in Medicare Advantage, Part D Drug Plans

As part of an effort to combat scams in Medicare Advantage plans and Part D prescription drug plans, CMS recently proposed more stringent oversight requirements and streamlined arrangements for fraud penalties. The CMS proposal would clarify provisions relating to contract determinations, including new steps to help expose potential fraud or misconduct through mandatory self-reporting. Also included in the CMS proposal: changes to streamline the process relating to intermediate sanctions and contract determinations (including non-renewals) and clearer rules for imposing civil money penalties.

Published in the May 25 *Federal Register*, public comments will be accepted until July 24. A final rule is expected to be released later this year.

Prostate Cancer Awareness and Advocacy

Spotlight on the National Prostate Cancer Coalition

Founded in 1996, this organization is dedicated to ending the devastating impact of prostate cancer on men, families, and society by focusing on three core areas: awareness, outreach, and advocacy.

Awareness. Building a network of partners that includes former New York City Mayor Rudy Giuliani, NASCAR, and Major League Baseball, the National Prostate Cancer Coalition has developed and implemented several effective awareness campaigns, including *Do It for Dad*, *Take a Swing against Prostate Cancer*, and *Prostate Cancer Awareness Month*.

Outreach. The National Prostate Cancer Coalition manages the only national mobile prostate cancer screening clinic, the *Drive Against Prostate Cancer*. The program reaches out to at-risk and underserved communities by offering free, complete, and confidential screenings. So far, the program has screened over 45,000 men.

Advocacy. The National Prostate Cancer Coalition works to increase federal funding for prostate cancer research, by partnering with top-notch organizations representing high-risk groups, such as African Americans and veterans. The organization's program, *Spring Training*, is a two-day federal advocacy training event that brings patients, survivors, their families, and healthcare professionals together to learn about important public policy issues related to prostate cancer. The program is designed to influence Congress on specific legislative priorities relevant to prostate cancer.

Advocates receive a day of orientation and training, followed by a networking dinner with coalition staff. The following day, advocates meet with elected officials and their staff members on Capitol Hill. Learn more at *www.fightprostatecancer.org.*

Medicare Patients at Risk

Some physicians plan to reduce the number of Medicare and Medicaid patients they see if payments are cut, according to a recent study by the AMA. Starting next year, the government will cut Medicare payments to physicians by about 10 percent. Over nine years, payment cuts are expected to total about 40 percent while the government estimates that the cost of caring for patients will increase 20 percent. Here are some key findings from the survey of nearly 9,000 physicians:

- If payments are cut by 10 percent in 2008, 60 percent of physicians said that they will limit the

number of new Medicare patients they treat, and 40 percent of physicians report that they will limit the number of established Medicare patients they treat.
- If payments are cut by 40 percent by 2015, 77 percent of physicians said that they will limit the number of new Medicare patients they treat, and 68 percent of physicians report that they will limit the number of established Medicare patients they treat.
- If payments are cut by 10 percent in 2008, more than half of physician respondents said they would reduce their practice staff, and 14 percent said they would get out of Medicare patient care altogether.
- If payments are cut by 40 percent by 2015, 77 percent of physicians will cut staff and 59 percent would stop providing patient care to Medicare beneficiaries.
- Other potential practice changes include: deferring the purchase of new medical equipment or technology; referring complex cases; discontinuing rural outreach; and shifting services and care to hospitals.

In the past, Congress has stepped in and "fixed" proposed cuts, and Congress' own advisory committee on Medicare, MedPAC, has already recommended that Congress stop next year's 10 percent cut and update payments 1.7 percent, in line with practice cost increases.

Report Says Medicare, Medicaid Could Save Billions by Heeding Recommendations

A new compendium of never-acted-on recommendations made to CMS and other government health agencies was released May 31 by the Department of Health and Human Services (HHS) Office of Inspector General (OIG). As reported in the June 4 BNA *Health Care Daily*, the report includes a listing of "priority" recommendations that the OIG has made to CMS that would, according to OIG estimations, save the Medicare and Medicaid programs at least $6.3 billion. Some of the savings that could be achieved had yet to be determined, the OIG noted, meaning that the recommendations could yield even greater savings for the programs. Areas where the programs could save money include oxygen equipment and pharmaceuticals reimbursement.

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Outcomes, Outcomes, and Outcomes

BY DALE FULLER, MD

Editor's Note: The opinions expressed in this editorial represent the opinions of the author and do not represent the opinions of the Association of Community Cancer Centers. Anyone interested in submitting a counterpoint editorial on this topic should contact the managing editor at: mmarino@accc-cancer.org.

In the real estate business, the three most important elements of success are said to be: "location, location, and location." In the opinion of this writer, those of us in the field of radiation oncology need to take a break from our headlong rush to acquire the very latest in technology—with all of the associated bells and whistles—and take a hard look at what should be the three most important measures of success in our field: outcomes, outcomes, and outcomes.

Take a moment with me to reflect on the evolution of radiation oncology in the last 50 years or so. Short distance cobalt machines (both vertically mounted and isocentric), and later 80 cm cobalt machines that offered better dosing at greater depths, brought cancer patients relief from the dose limiting skin reactions related to ortho-voltage X-ray treatment in the late 1950s. After a few "detours" in the beam voltage race—Van de Graf units, constant potential X-ray machines, and betatrons, to name some—radiation oncology equipment and technology continued to improve.

And thus began the race among hospitals offering radiation treatment services. The end goal: acquiring the "newest, latest, and greatest" equipment. At the start of this "race," only a thousand or so facilities offered radiation therapy. Today the number of venues that offer these services has virtually exploded. More important, there has been a corresponding growth in the sophistication of their equipment. In addition to hospital-based programs, today's cancer patients can receive radiation treatment at freestanding cancer centers and physician practices.

But let's get back to the "race." With the advent of linear accelerator technology, almost all of the recent growth has been in the refinement of the operating systems and accessories attached to these sophisticated linear accelerators. Today, these refinements and accessories allow us to treat our cancer patients using 3D, IMRT, IGRT, and other radio-surgery options of increasing complexity. The downside to this explosion of technology is the expense—for patients, providers, and payers. And yet most hospitals still choose to participate in this costly race. Why? Perhaps for fear that if they do not lead the technology pack, they will lose patients to their competitors.

In my opinion, the incentive for the purchase of new radiation oncology technology has been revenue preservation.

More troubling is the lack of reported and measured outcomes, which means that outcomes from these newer technologies can only be "inferred." In the absence of outcomes data, the radiation oncology community has forged ahead with its buying spree—based, most of the time, on what I perceive as "professional intuition." Bottom line: marketing has supplanted accountability for clinical outcomes in this race.

But it wasn't always this way. The move from ortho-voltage to

cobalt and mega-voltage therapy brought outcome enhancements that were readily apparent early on. For example, the skin sparing afforded by this new technology reduced an acute toxicity in patients. Another measurable outcome: mega-voltage radiation allowed escalated dosing of the tumor, resulting in the ablation of more cancers.

Unfortunately, outcomes were (and are) not always so positive. Dose escalation at the tumor level also increased the dose to the surrounding uninvolved tissue, resulting in a higher incidence of injury to normal tissue. This particular outcome brought about acute toxicity and, at times, a late toxicity that sometimes took years to identify—especially if the provider was not able to follow the patient long-term.

Still, less than positive clinical outcomes present an opportunity for improvement, and that is exactly what the radiation oncology community has done. Most of the efforts to reduce acute and late toxicity have revolved around new technology that:

- Improves tumor volume definition
- Reduces normal tissue exposure
- Improves computer-based treatment planning
- Reduces patient and organ motion during treatment.

Some of the new technologies (or perhaps a better term would be "enhancements" to existing technologies) have been quite successful—*we think*. Enthusiasts in the radiation oncology community have equated these technological advances to a shift from a "shotgun approach" to an approach that allows clinicians to "pin-point" the tumor in the treatment volume. Of course, this belief presupposes that our ability to define tumor volumes within target volumes has evolved to the same degree as has the technology of our treatment equipment—something that may or may not be the case.

A definitive answer to that question brings us full circle to where I started: outcomes, outcomes, and outcomes.

In my opinion, very few reliable data are available to validate claims that one generation of radiation oncology technology or a piece of the "latest and greatest" radiation oncology equipment is truly making a statistically significant difference in the control of cancers. Even in terms of treatment-related late effects, we find very few data to document any statistically significant differences.

As clinicians, we should be able to answer outcomes questions any time they are posed. And I would go further and say that we should have available credible outcomes data from our own cancer programs—not simply outcomes data published by an academic medical center regarding their treatment of cancer patients whose characteristics may or may not match the patients we are treating at our community cancer centers.

So where do we go from here? How about improving our ability to report toxicities? The National Cancer Institute's (NCI) Common Toxicity Criteria is a well-developed schema that could be adapted to allow clinicians to report toxicities. Until the radiation oncology community starts reporting this information in a more systematic way, it is left only with an intuitive assumption that its new technology is reducing acute toxicities in patients—at least in terms of what happens below the skin level of the patient.

The good news is that the necessary outcomes data can, in fact, be recorded and compared, and registry software is available to help us in this effort. In my opinion, the collection and reporting of outcomes data *must* be carried out if the radiation oncology community is to continue to garner support—from its patients, hospital administration, and payers—for purchasing new (and increasingly expensive) radiation oncology technology. And, after all, shouldn't the decision to acquire new technology be based on the most important measurable benefit—improving and/or prolonging the lives of our cancer patients—and not on issues related to market share?

Dale Fuller, MD, is a radiation oncologist in Dallas, Tex.

Another Perspective

Let's play devil's advocate and take a brief look at the issue from the manufacturer's perspective. Someone recently opined to me, "If you're making the same product or offering the same service over an extended period of time, you're in trouble." That statement is quite possibly one of the drivers behind this "race" that the radiation oncology community finds itself in. Manufacturers feel the same need to attain and maintain a competitive advantage—the same as cancer programs. After all, what happens to their sales figures if they have no new bells and whistles to introduce at the annual trade shows? And let's be honest, all of us feel the need to sell and purchase the "latest and greatest"—regardless of whether we are talking about cars, computers, televisions, or linear accelerators.

Non-monetary recommendations in the report included those that would improve quality of care to beneficiaries, the OIG said. Among such recommendations was a new recommendation that CMS seek legislation to establish intermediate sanctions for hospitals that do not report directly to the Medicare agency patient deaths related to restraint and seclusion. The OIG reported in September 2006 (OEI-09-04-00350) that hospitals failed to report 44 of 104 documented deaths related to restraints or seclusions between 1999 and 2004.

The full report is available at: *www.oig.hhs.gov/publications/docs/compendium/Compendium2007.PDF.*

Top 10 Billing Errors in the Hospital Outpatient Department

by Carol Ware, CPC

Hospital outpatient cancer centers need to be aware of billing pitfalls and learn how to avoid or correct them to minimize delay in payment. Protecting the revenue stream through accurate coding and billing must be a priority. Here are the top 10 billing errors that occur in the hospital outpatient billing department, along with suggested solutions to avoid or correct each error.

1. Services Provided Prior to or after Coverage Effective Dates

Because insurers will indicate these as non-covered services, hospitals must implement processes to verify (or re-verify if necessary) a patient's eligibility *prior to* rendering services. Remember to document:

- The effective date of coverage
- Whether the service is allowed under the patient's plan
- The patient's level of benefits.

2. Provider Numbers Not Valid or Not Included on Claim

Implementation of the national provider identifier (NPI)—originally scheduled for May 23, 2007—will now be determined once CMS establishes that the volume of claims that include the NPI is sufficient. CMS will notify providers of the new implementation date, but may begin rejecting claims without the NPI as early as July 2007 or as late as August 2007.

3. Missing Diagnosis Codes or Diagnosis Codes Unrelated to Service Provided

For example, hospital billing staff may erroneously use the "History of" codes to indicate current diagnosis codes. The "History of" codes refer to resolved conditions; these codes should not be used if the patient is still being treated for that condition.

4. Invalid, Deleted, or Changed Diagnosis Codes

In August of each year, ICD-9-CM diagnosis codes are updated. The effective date for these changes is October 1, coinciding with the Medicare Inpatient Prospective Payment System fiscal year. Hospitals *must* update all systems by October 1 of each year to account for these changes.

5. Deleted Procedures

Here's a perfect example of why hospitals must update their systems to account for changes in procedure codes. In 2006, the Medicare Outpatient Prospective Payment System (OPPS) decided to use a combination of newly revised drug administration CPT codes and internally-created "C" codes instead of certain CPT codes that included descriptors for concurrent or sequential drug administration. However, in 2007, the OPPS uses only CPT codes for drug administration services.

6. Invalid HCPCS Codes

This mistake can occur because the HCPCS code is no longer valid or a code has been transposed. For example, J3490 "Unclassified drugs" may be transposed as J4390 or J9340. The easiest solution? Ensure that the system checks for valid HCPCS codes.

7. Incorrect Revenue Codes

Under the OPPS, some drugs are paid under separate Ambulatory Payment Classification (APC) groups and others are "bundled" in with their administration payments. Hospitals need to know which drugs are billed separately. For these separately billable products, claim forms must include revenue code 636 (drugs requiring detailed coding) instead of the 25X (general pharmacy) revenue grouping.

8. Incorrect Drug Units

Since each HCPCS code has its own unit value, billers must ensure that the appropriate number of units is listed on claim forms for the individual HCPCS code to ensure accurate payment for the volume of drug utilized.

9. Correct Coding Initiative (CCI) Edits

CMS issues the CCI edits that designate which procedures are to be bundled together and which are mutually exclusive. Hospitals may receive a denial if two or more procedures that are included on a claim are not to be coded together. When claims contain multiple procedures, hospitals should check against the CCI. It is available online at: *www.cms.hhs.gov*. Separate files are available for physician offices and hospital outpatient departments.

10. Services Deemed Not Medically Necessary

Hospitals may receive denials indicating a service or services are not medically necessary or payment is denied because coverage guidelines are not met. As a part of their regular practice, hospitals should ensure they are aware of and in adherence to payer coverage policies, or in the case of Medicare, local coverage determinations. If asked by payers, hospitals must provide medical record documentation to support their claims.

Staying current with the reimbursement environment is essential to the hospital's bottom line. To minimize coding and billing errors hospitals can:

- Confirm that the hospital charge-master is up-to-date
- Ensure that documentation of medical necessity is part of the normal protocol
- Continue to educate staff on appropriate billing and coding.

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