THE ISSUES

Uproar over Mammography Screening Recommendations

On Nov. 16, 2009, the U.S. Preventive Services Task Force released recommendations on mammography screening, which were published in the *Annals of Internal Medicine.* The Task Force recommended against routine screening mammography in women aged 40 to 49, and biennial screening mammography for women aged 50 to 74 years. The Task Force also did not recommend teaching breast self-examination, and concluded that the current evidence is insufficient to assess the benefits/harms of clinical breast examination beyond mammography in women 40 and older. The recommendations unleashed immediate controversy and confusion.

The American Cancer Society (ACS), the American College of Obstetrics and Gynecology (ACOG), the American Society of Breast Surgeons, and M.D. Anderson Cancer Center, among others, openly disagreed with the Task Force's recommendations. These organizations and others have stated that they will not change their screening guidelines.

However, the National Breast Cancer Coalition, a patient advocacy organization, "commended" the revised screening recommendations.

The U.S. Preventive Services Task Force, an independent panel of experts in primary care and prevention, systematically reviews evidence and develops recommendations for clinical preventive services, according to the Agency for Healthcare Research and Quality (AHRQ).The Task Force issuing the mammography screening recommendation did not include a surgeon, medical oncologist, radiation oncologist, or palliative medicine physician.

Responding to the uproar, on Wed., Nov. 18, HHS Secretary Kathleen Sebelius issued a statement acknowledging the confusion and concern created by the Task Force's screening recommendations. "The U.S. Preventive Task Force is an outside independent panel of doctors and scientists who make recommendations. They do not set federal policy and they don't determine what services are covered by the federal government…. The Task Force has presented some new evidence for consideration but our policies remain unchanged," Sebelius said. "Indeed, I would be very surprised if any private insurance company changes its mammography coverage decisions as a result of this action."

HHS policies may "remain unchanged;" however, visitors to HHS's lay-oriented healthfinder website searching under "Get Tested for Breast Cancer" (*www.healthfinder.gov/prevention/PrintTopic.aspx?topoicID=9*) are told that "The recommendation for when to get a mammogram has recently changed:

- Women ages 50 to 74 need a mammogram every 2 years.
- If you are younger than 50 or older than 74, talk with your doctor about whether you need a mammogram."

New Cervical Cancer Screening Guidelines

On Nov. 20, 2009, ACOG released new evidence-based guidelines on cervical cancer screening. These guidelines state that women should have their first cervical cancer screening at age 21 and can be rescreened less frequently than previously recommended. The guidelines were published in the December issue of *Obstetrics & Gynecology.*

ACOG now recommends that women from ages 21 to 30 be screened every two years instead of annually, using either the standard Pap or liquid-based cytology. Women age 30 and older who have had three consecutive negative cervical cytology test results may be screened once every three years with either the Pap or liquid-based cytology. Women with certain risk factors may need more frequent screening, including those who have HIV, are immunosuppressed, were exposed to diethylstilbestrol (DES) in utero, and have been treated for cervical intraepithelial neoplasia (CIN 2 or CIN 3) or cervical cancer.

2010 Final HOPPS Rule

The Centers for Medicare & Medicaid Services (CMS) hospital outpatient prospective payment system (HOPPS) final rule for 2010 went into effect Jan. 1, 2010. Most hospitals will receive an inflation update of 2.1 percent in their payment rates, with an update of 0.1 percent for hospitals that do not participate in quality reporting. Highlights of the 2010 HOPPS rule follow.

Reimbursement for drugs, biologicals, and radiopharmaceuticals

- Non-pass-through drugs, biologicals, and radiopharmaceuticals are reimbursed at ASP+4 percent. The final rule adopts a modified proposal to redistribute pharmacy overhead costs.
- Pass-through drugs are reimbursed at ASP+6 percent.
- The packaging threshold for 2010 is $65 per day.
- CMS ends the exemption to the packaging threshold for 5-HT3 antiemetics.
- CMS will continue to use the full set of CPT codes for drug administration services. CMS will include all separately payable drug administration add-on codes on the bypass list of CY 2010 and keep the

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ILLUSTRATION/ISTOCKPHOTO

five-level APC structure for payment of drug administration services in the OPPS for CY 2010.

Implantable biologicals and brachytherapy

- CMS will consider implantable biologicals seeking pass-through status beginning on or after Jan. 1, 2010, under the device process only.
- Brachytherapy sources will be paid on a prospective payment basis.
- CPT code 0182T (HDR electronic brachytherapy) is assigned to APC 0313. CMS does not create a new Level II HCPCS code for single-fraction electronic brachytherapy.

Imaging

CMS will continue to pay for all multiple imaging procedures within an imaging family performed on the same date of service using the multiple imaging composite methodology.

Physician supervision

CMS finalized the proposal to allow certain non-physician practitioners (NPPs) to directly supervise all hospital outpatient therapeutic services that they may perform themselves within their state scope of practice and hospital-granted privileges, provided that they meet all additional requirements, including any collaboration or supervision requirements. NPPs may not supervise diagnostic services.

The agency finalizes its proposal to require that all hospital outpatient diagnostic services provided directly or under arrangement, whether provided in the hospital, in a provider-based department of a hospital, or at a nonhospital location, follow the physician supervision requirement for individual tests as listed in the Medicare Physician Fee Schedule Relative Value File.

Quality reporting

CMS supports the addition of cancer quality measures for CY 2012 and beyond. The agency will publicly report HOP QDRP data on Medicare's Hospital Compare website (*www.hospitalcompare.hhs.gov*) in 2010 with some modifications in the periods of time to be reported.

ACCC's detailed analysis of the 2010 HOPPS rule is available on the members-only section of the Association's website at: *www.accc-cancer.org*.

2010 Medicare PFS Final Rule

The Physician Fee Schedule (PFS) final rule for CY 2010 went into effect Jan. 1, 2010. Table 1 shows the effect of the final rule on Medicare payments to physicians involved in cancer care. Highlights of the 2010 PFS include:

- Office-administered Part B drugs are removed from the calculation of the sustainable growth rate (SGR) beginning in 2010.
- The final physician payment rate update for CY 2010 is -21.3 percent. As in past years, it is expected that Congress will step in and "fix" these payment cuts.
- Consultation codes are eliminated, while work relative value units for new and established hospital office visits and for initial hospital and nursing facility visits are increased. Beginning Jan. 1, 2010, providers will use existing E/M services codes when providing consultation services.
- CMS increases utilization rate assumption for magnetic resonance imaging (MRI) and computed tomography (CT) equipment over $1 million from 50 percent to 90 percent and phases in new RVUs over four years. CMS ***does not apply*** this assumption to therapeutic equipment such as Gamma Camera and intensity-modulated radiation therapy.
- Proposals to simplify PQRI and e-Prescribing Program reporting requirements are implemented.
- CMS finalizes proposed accreditation requirements for suppliers of the technical component of advanced imaging services.

ACCC's in-depth analysis of the 2010 PFS rule is available on the members-only section of ACCC's website at: *www.accc-cancer.org*.

Final NCD on PET for Cervical Cancer

On Nov. 10, 2009, CMS released the final National Coverage Determination (NCD) on positron emission tomography (PET) for cervical cancer. The agency will cover only one FDG PET for staging for beneficiaries who have biopsy proven cervical cancer when the beneficiary's treating physician determines that the FDG PET study is needed to determine the location and/or extent of the tumor for the following therapeutic purposes related to the initial treatment strategy:

- To determine whether or not the beneficiary is an appropriate candidate for an invasive diagnostic or therapeutic procedure; or
- To determine the optimal anatomic location for an invasive procedure; or
- To determine the anatomic extent of tumor when the recommended anti-tumor treatment reasonably depends on the extent of the tumor.

The NCD notes that "CMS may find it appropriate to exclude coverage for diagnosis of cervical cancer since this disorder is initially diagnosed by biopsy." View the NCD at: *https://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?from2=viewdecisionmemo.asp&id=232&*.

Table 1. Impact of Final 2010 PFS*

Specialty	Final Rule Allowed Charges (millions)	Combined Impact Full	Combined Impact Transitional
Hematology/Oncology	$1,897	-6%	-1%
Radiation Oncology	$1,809	-5%	-1%
Radiology	$5,056	-16%	-5%

*Prior to application of the conversion factor Source: Health Policy Alternatives