MEDICARE DEMANDS SUPERVISION FEE REFUNDS IN INDIANA

Recent payment denials, retrospective audits, and demands for refunds of outpatient chemotherapy supervision fees may jeopardize the future of outreach clinics in Indiana. Ft. Wayne Oncology & Hematology, Inc., a group practice comprised of four oncologists, received a final letter from the Indiana state Medicare intermediary, Blue Cross and Blue Shield, that it must refund $75,000 in chemotherapy supervision fees charged over the past 2-1/2 years. The ruling is based on a long-standing Medicare regulation which states that only one entity—the entity that owns or leases the space in which outpatient chemotherapy is delivered and pays the employees—can charge for the office visit, administration, supervision, and drug charges for chemotherapy.

The attorney for the Ft. Wayne oncologists, Alice Gosfield, was able to obtain an injunction and is negotiating an appeal. Gosfield is not "challenging the constitutionality of Medicare's rules and regulations," she says. Her argument is that the oncologists in Ft. Wayne can document that they were "directly involved" in the care of patients. It is her intention to prove that the intensity of the physicians' services is equivalent to an "office visit" and, as a result, Medicare is only entitled to the difference between supervision fees and office visit charges. If she is successful, the Ft. Wayne group will reduce the amount it must refund by as much as $45,000.

Indiana Community Cancer Care (ICCC), which operates 18 outreach clinics in the state, also underwent a Medicare audit in November. According to an ICCC spokesman, various strategies that they are examining to offset their inability to charge supervision fees include charging comprehensive office visit fees instead of intermediary or limited office visit fees for all patients, including follow-up patients. Another possibility is to try to get a new code created that parallels current radiation therapy patient management codes.

According to Indiana-based physicians and the state medical society, no other medical specialty that charges similar supervision fees is being subjected to Medicare audits. Moreover, Gosfield says that the extent of the problem in Indiana is probably "out of kilter" with the rest of the universe, because of the large number of satellite clinics that physicians and hospitals operate within the state. However, these recent actions by the Indiana Medicare intermediary could impact hospital-based oncology practices throughout the country.

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Indiana-based medical oncologists had a strategy meeting in mid-December to discuss ways to counteract the decrease in reimbursement that the loss of supervision billing creates.

One way in which outpatient-based cancer programs are attempting to improve reimbursement is to lease space from the hospital and to pay the employees directly. This is the type of arrangement that the Indiana Regional Cancer Center in Indianapolis negotiated with Community Hospitals of Indianapolis. The Ft. Wayne group is also discussing such an arrangement with its affiliated hospital.

However, physicians must be "very careful" in structuring such arrangements, says Douglas Mancino, a partner with the law firm of McDermott, Will & Emery, Los Angeles, and an expert on physician/hospital joint ventures and leasing arrangements.

Mancino notes that there are strict Medicare rules governing leased department arrangements. Moreover, he warns, many providers do not adequately "think through the reimbursement implications" of such an arrangement. Although physicians who lease outpatient space from a hospital and operate as a private practice are entitled to be reimbursed for the technical component of charges (facility, equipment, employees, supplies, etc.) and will receive a higher level of reimbursement for their professional fees (supervision, office visits, consultations, etc.), Mancino says that they will also be "subject to the reimbursement risks related to office-based practices."

Those risks can be considerable. HCFA is currently studying the adequacy of reimbursement for chemotherapy administered in physicians' offices, but there is no guarantee that significant, beneficial changes will be made. Furthermore, Statewide Mutual Insurance, the Medicare intermediary in Ohio, is "unilaterally denying payment for the supplies needed to administer chemotherapy in physicians' offices," according to Dale Cowan, M.D. As a result, Cowan says, many physicians in the Cleveland area are being forced to "refer their patients to outpatient clinics for chemotherapy treatment" despite the fact that, as a result, Medicare's costs are increased three-fold.

Cowan, who is a member of the American Society of Clinical Oncology's (ASCO's) subcommittee on CPT coding, also notes that there is a fundamental difference in how Medicare and physicians interpret CPT codes for chemotherapy administration. Medicare's position is that the 965 code is "purely a technical administration fee code," Cowan says, "while physicians are maintaining that it also covers professional administration fees."

Another coding-related reimbursement problem that Gosfield is addressing on behalf of the Ft. Wayne oncologists is Blue Cross and Blue Shield's interpretation of proper coding for services performed in an outpatient hospital setting. In a recent newsletter, the intermediary stated that "in accordance with the federal TEFRA regulations, reductions in Medicare-approved amounts will take place for services which are performed in an outpatient hospital setting, under circumstances where the patient's condition is one which could have been treated in a doctor's office setting." It goes on to advise providers in Indiana to use an XO

modifier originally created to report that the services provided in the outpatient setting were for the treatment of an illness, diagnosis, or condition that could not be treated in the doctor's office setting. The intermediary further states that the XO modifier should be used with all chemotherapy administration (905) CPT Codes. However, the XO modifier is an "emergency room visit" code which effectively reduces reimbursement by 40 percent of prevailing charges under the TEFRA regulations. Gosfield is arguing that using an emergency room visit code when a service is provided in an outpatient hospital setting constitutes fraud.

Another part of the ongoing reimbursement squeeze is the recent implementation of Medicare's 60 percent rule, which is applicable to certain professional services provided in an outpatient setting, including clinics and cancer centers. This rule decreases the amount of reimbursement to 60 percent of prevailing charges for the same services provided in a private office setting, including office visits and consultation fees.

The rule change is being enforced in most states. This "double-whammy" on oncologists who practice in a hospital-based outpatient setting could jeopardize the future of hospital-based outpatient cancer programs.

The ACCC is monitoring the situation in Indiana and advises member programs to review the appropriateness of supervision fee charges.

NRC PROCEEDS WITH MISADMINISTRATION REPORTING RULES

The Nuclear Regulatory Commission (NRC) is proceeding with the revision of its current misadministration reporting requirements in the face of widespread criticism of the proposed rules by the medical community.

At a meeting of the Quality Assurance Subcommittee of the Advisory Committee on the Medical Uses of Isotopes, representatives of concerned medical associations voiced their dismay with the proposed rules, declaring that in several areas, the NRC is "attempting to tell physicians how to practice medicine," according to Juliana Simmons, M.D., Washington (DC) Hospital Center, ACCC's representative at the meeting.

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Simmons says that "good quality assurance programs" within hospitals, rather than reporting incidents to the NRC, is key.

Meeting participants, including representatives of the American College of Radiology (ACR) and the American Association of Physicists in Medicine (AAPM) suggested that forming a commission, composed of medical experts, would be a "much more sensible approach," Simmons reports.

Moreover, she says that members of the subcommittee were told that the revised misadministration reporting guidelines, which require reports to be filed if a patient receives a 10 percent higher dose than intended, will not give a true picture of quality of care.

"In some treatment settings, a 10 percent increase in dosage would have little or no adverse effect," Simmons says. "However, a three to five percent increase in dosage in other settings could be life-threatening but, under the proposed 10 percent NCR guideline, would not be reportable incidents."

Simmons warns that another possible effect of the NRC's proposed actions is that state regulatory agencies, which often follow the lead of NRC, could apply similar regulations across the board, governing not only cobalt treatments, but linear accelerators as well.

The NRC will publish final rules in the *Federal Register* this spring, followed by a 90-day comment period. Concerned ACCC members are advised to watch for the notice and to carefully examine the final proposed rules.

MEDICAL SOCIETY REPS MEET IN HOUSTON

A meeting of state medical society representatives and concerned cancer-related associations met in Houston on January 14 to discuss the feasibility of creating a federation of state medical societies.

At *Oncology Issues* deadline, Rodger Winn, M.D., University of Texas, M. D. Anderson Hospital and Tumor Institute, and an organizer of the meeting, said that participants would discuss the role that such a federation could play in relation to all issues affecting medical oncology. Winn says that current reimbursement problems throughout the United States for state-of-the-art cancer treatment has been a driving force behind the notion of forming a federation. He also cites the failure of various organizations' attempts to hold fruitful discussions about reimbursement problems with staff members of the Health Care Financing Organization (HCFA).

A report on the outcome of the meeting will appear in the Spring issue. In the meantime, questions about the meeting may be directed to Rodger Winn, M.D., 713/792-8515.

HCFA OUTLINES OUTPATIENT DRUG AMENDMENT PLANS

The outpatient drug amendment to the Medicare Catastrophic Health Act, due to be implemented in January 1991, will not only require major changes in the way freestanding, hospital-based, and physician-owned pharmacies do business with Medicare patients, but it will provide the Health Care Financing Administration (HCFA) with the means of monitoring private physicians' prescribing practices.

At a public briefing in Baltimore, MD, in late November, HCFA staff reported that the Agency currently is developing a drug benefit payment system that will use electronic, point-of-sale technology and provide the Agency with a national outpatient drug data base.

The most serious implication for private physicians involves HCFA's plans to perform quality of care evaluations of their prescribing patterns based on the information they accrue in the national data base. Physicians' prescribing pat-

terns for Medicare patients will be audited for excessive prescribing, exeecessive use of restricted prescriptions, fragmented prescribing of maintenance-type drugs, and possible adverse drug interactions. However, the accuracy of such quality of care evaluations has been seriously questioned because, at this point in time, HCFA has no plans to include either Medicare Part A or Part B diagnostic, procedural, or drug prescription information in the national data base on which the evaluations will be based.

HCFA will also be auditing up to 25 percent of participating pharmacies annually to deter fraud and abuse. The Agency will be looking for such deviations as an excessive number of drug bills, higher-than-average drug costs, high utilizations by a beneficiary, a low rate of generic billing, high ingredient costs, and an atypical number of beneficiaries. HCFA believes that the audits will force participating pharmacies to be more price sensitive and to rely more heavily on generic drug prescriptions.

HCFA's preliminary plans are to contract with three to five designated "drug processing centers" throughout the country. These centers will enroll pharmacies and provide bill processing and payment, drug utilization review, and training and technical assistance. They will also track beneficiary eligibility, drug coverage, availability of generic substitutes, potential adverse drug interactions, and approve pricing. Participating pharmacies will be required to purchase the necessary hardware/software at their own expense in order to access the national data base. HCFA plans to release "requests for proposals" for potential contracting organizations this fall.

Frank Derville, deputy director, bureau of program operations, HCFA, said at the briefing that the agency expects 700 million claims for 34 million beneficiares to be processed during the first year of the program. Derville also said that the new benefit will affect 55,000 retail pharmacies, as well as pharmacies based in nursing homes, hospital outpatient departments, mail order companies, and physicians' private/group practices. Medicare patients who patronize non-participating pharmacies will have to pay in advance and then file a paper claim for Medicare reimbursement. However, HCFA predicts that only 10 percent of claims during the first year will involve paper claim processing by the contracting centers.

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Cavan Redmond, project manager, ELM Services, Inc., contributed to this report.

BRODER APPOINTED NCI DIRECTOR

The Reagan Administration has appointed Samuel Broder, M.D., director of the Division of Cancer Treatment's Clinical Oncology Program and deputy director of the Institute, as the new director of the National Cancer Institute (NCI).

Broder has been a clinical cancer investigator and scientist manager at NCI for his entire career. His predecessor, Vincent DeVita, M.D., has widely praised the selection of Broder as his replacement.

Members of president-elect George Bush's transition team participated in the selection of Broder to ensure that Broder will be retained under the new Administration. ■