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In the News

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HCFA Releases Proposed Fee Schedule for RBRVS

The new resource based relative value scale (RBRVS) system of payment for physician services under Medicare will effectively reduce the conversion factor by 16 percent by the time of full fee schedule implementation in 1996, according to proposed regulations published in the June 5, 1991, *Federal Register.* Despite a legislative mandate to keep the program budget neutral, the Health Care Financing Administration (HCFA) has justified the decrease by saying that utilization will rise as a result of the new fee schedule. The medical community, most notably the American Medical Association (AMA) is up in arms about the proposal. And, at *Oncology Issues* deadline, Louis Sullivan, M.D., Secretary of HHS, was due to testify at a special hearing of the Senate Finance Committee as to why the proposed regulations breach the budget neutrality mandate.

Little can be said about the effect of the proposed fee schedule on oncology services, because the RVUs for oncology-specific services are not expected to be completed until mid-September. Moreover, revised visit codes by the American Medical Association's CPT Committee have yet to be completed. However, a number of the changes in HCFA's proposed rules will have an impact ON oncologists. (See the accompanying story for details about ACCC's response to the proposed fee schedule.) Those proposed changes include:

- A limit on the payment for drugs to 85 percent of the average wholesale price (AWP) as published in the *Red Book* and similar price listings. In addition, HCFA is proposing separate price limits for high-volume drugs.
- Chemotherapy administration codes will only be paid for when they are coded by a physician or staff outside of a hospital setting. The professional component of chemotherapy management is currently being surveyed for RBRVS as part of the Harvard Phase III study. These vignettes will reflect the range of chemotherapy management professional services including, office, outpatient, and hospital settings. This will allow recognition of the professional component of chemotherapy administration in all practice settings.
- Payments for chemotherapy injections will no longer be paid for separately from the visit charge or other physician service rendered in conjunction with the injection. However, HCFA will continue to pay separately for chemotherapy infusions (CPT 96410, 96412, 96414, 96422, 96423, 96425) and the administration of chemotherapy agents into specialized body cavities (CPT 96440, 96445, 96450).
- Payments will be limited to 50 percent of the "practice expense" component of the relative value unit (RVU) when services that HCFA deems to be "office-based" are performed in an outpatient department. (The 50 percent reduction will not apply to the physician work or malpractice components of the total RVU for the service.) HCFA plans to develop a national list of services that it determines should be performed in an office setting.
- HCFA plans to institute a separate fee schedule allowance for a limited number of expensive, disposable supplies furnished in an office setting (lumbar puncture trays, venous access catheters, thoracentesis trays, cystoscopy trays, surgical trays, catheter insertion trays, and bone marrow aspiration trays). HCFA may include other office supplies if respondents to the proposed rule provide a "specific rationale" as to why the supply should not be considered a routine office expense.
- Payment differentials for carrier-unique local modifier codes will be eliminated. Only modifiers for which HCFA establishes a national payment policy will be allowed.
- HCFA plans to decrease fee schedule payments to new physicians for the first four years of their practice, from 80 percent for the first year of practice to 95 percent for the fourth year. These limits will apply to all physicians, whether they are in solo or group practice. The only exception will be primary care physicians practicing in rural areas designated as HMSAs by the Public Health Service Act.
- The proposed rules will eliminate most local carrier codes and place limits on the future use of local codes by requiring carriers to acquire prior approval from HCFA, instituting an annual review of all local codes, and by establishing national HCPCS codes for new services that are not deemed to be appropriate for inclusion in the CPT.
- HCFA will eliminate local, equipment-specific codes for radiation therapy treatments. New codes will be used that are based on the actual energy level furnished to the patient, rather than the capability of the equipment.
- The professional component of services rendered by radiation physicists in a hospital setting will be eliminated (CPT-4 procedure codes 77336, 77370, 78990, 79900).
- A pre-operative visit period of 30 days and a post-operative visit period of 90 days will be included in a global fee for surgeons. This fee will also cover post-operative medical and/or surgical care due to complications.
- Taking into account expected changes in payments and volume responses to RBRVS, HCFA predicts that physicians practicing in Hawaii and New Hampshire will experience the largest decrease in payments, relative to the national average, in the first year of RBRVS (3 percent), while physicians practicing in Minnesota will experience the largest increase in payments (6 percent). By 1996, physicians in Florida and Nevada will be the biggest losers (a decrease of 4 percent), while physicians in Mississippi will be the winners (an increase of 7 percent).

Some Insurers Change Policies to Exclude BMT Coverage

In a number of states, third-party payors are inserting exclusions in their insurance contracts that deny coverage of autologous bone marrow transplantation (ABMT) for breast cancer, according to Karen Antman, M.D., Dana-Farber Cancer Institute, Boston. During a forum on emerging treatments for breast cancer at the National Cancer Institute in June, Antman expressed her concern about such a trend. During the panel/audience discussion in which Antman brought this trend to the attention of forum participants, an insurance company representative warned that "if insurance companies must drop experimental exclusions [from their policies] due to litigation, they will be forced to write specific exclusions in their contracts." But Williams Peters, M.D., head of the BMT program at Duke University Medical Center, Durham, NC, warned that inserting "specific contract exclusions could backfire," pointing to the extremely bad

publicity that would be likely to follow such an action.

I. Craig Henderson, M.D., also with the Dana-Farber Cancer Institute, contended, "BMT is not the heart of the problem, it's just a very visible modality. We need to develop an alliance [between insurers and providers] to develop a rational program," he said, pointing to the ignorance on the part of providers about the insurance industry, as well as the ignorance on the part of insurers as to what is involved in clinical research and the costs of that research.

BMT Reimbursement Survey

More than 200 bone marrow transplantations (BMTs) were not performed over the past three years because of coverage denials by third-party payors, according to a survey by the *BMT Newsletter* in January of this year. And the survey found that many more patients had their BMTs delayed while trying to appeal insurers' coverage denials or trying to raise the funds on their own. Other results of the survey, which received responses from 69 BMT centers, 4 third-party payors, and 1 HMO include:

- BMT centers more frequently experience reimbursement difficulties for autologous BMTs (71% of the centers) than for allogeneic BMTs (35%).
- Insurers most frequently deny coverage of ABMTs for breast cancer (47 of the 66 centers that perform the procedure) and ovarian cancer (32 of the 43 centers which perform the procedure).
- Other types of cancers for which centers had reimbursement problems included brain tumors (6 of 11 facilities), testicular cancer (5 of 11 centers), and multiple myeloma (6 of 10 centers).
- Seventy nine percent of the centers require pre-approval from insurers for BMTs.
- One or more patients at 40% of the BMT centers did not receive the treatment in the past three years because of an insurer's refusal to pay for it.
- Few centers reported reimbursement problems for AMBTs to treat acute leukemia,Hodgkin's disease, or non-Hodgkin's lymphomas.
- Many centers reported that they were able to reverse insurers' initial denial of coverage when the transplant physician intervened.
- Forty-nine percent of the centers have had one or more patients sue insurers for coverage of BMT expenses over the past three years.
- Responding insurers indicated that they rely on the following sources to evaluate the efficacy and experimental status of BMTs: American College of Physicians, American Medical Association, Council of Medical Specialty Societies, Food & Drug Administration, Medicare, National Cancer Institute, National Institutes of Health, Office of Technology Assessment, Peer-Reviewed medical journals, and independent consultants.

The *BMT Newsletter* is available free of charge. To add your name to the circulation list, call 708/831-1913 or write to BMT Newsletter, 1985 Spruce Ave., Highland Park, IL 60035.

ACCC Seeks Changes in Proposed RBRVS Fee Schedule

The Health Care Financing Administration's (HCFA's) proposed fee schedule for a resource based relative value scale (RBRVS) system of physician payment under Medicare proposes that, across the board, drug payments to physicians be limited to 85 percent of the Average Wholesale Price (AWP) as listed in the Red Book and other price listings. At *Oncology Issue's* deadline, the ACCC was formulating a response to that proposal, as well as other portions of the proposed regulations that would have a negative impact on cancer care. The ACCC's proposals largely concur with those of the American Society of Clinical Oncology (ASCO), which plans to submit its own proposal at the end of July.

ACCC is recommending that HCFA drop its proposal to regulate drug payments at AWP minus 15 percent from current consideration until appropriate research is completed on its impact on drug reimbursement. According to Joseph Bailes, M.D., Chairman of ASCO's Clinical Practice Committee, the proposal by ASCO will adhere to "some formula based on the AWP, but at a higher percentage."

Lee Mortenson, ACCC's Executive Director, points out that "unlike pharmacies, oncologists do not sell sundries to Medicare patients, and they cannot make up a loss generated by supplying Medicare patients with drugs by selling chocolate bars and magazines to patients; a position the Inspector General took when he proposed that pharmacies essentially take a loss on the drugs supplied to Medicaid beneficiaries, because they would acquire their other business." The ACCC agrees with Bailes' assessment that the "acquisition cost of the drug alone is not a true and complete measure of the cost of drugs and does not take into consideration ancillary costs, including wastage, breakage, exceeded expiration dates, administrative costs, bad debts, etc." And, as Bailes says, "there is no other mechanism in the proposed fee schedule for covering those ancillary costs."

ACCC notes that a June survey of oncologists indicates that "on average, each oncologist requires a drug inventory worth $10,000, and that the monthly drug charges are in excess of $10,000 per month for Medicare patients," Mortenson says. The survey also revealed that "52 percent of respondents believed the proposed rule would shift care to the hospital setting, and 62 percent indicate that they have no ability to affect the price of drugs that they purchase."

ACCC is also recommending that HCFA provide an additional comment period for oncology codes. "Our concern," Mortenson says, "is that the interim codes will go into effect and it will be difficult to get them retroactively changed."

Finally, ACCC notes that the proposed reduction in the payment formula for services performed by hospital-based physicians are "arbitrary and inappropriate." ACCC contends note that this reduced fee "presents significant difficulty for rural hospitals that support oncologists to come to their communities." And, coupled with the elimination of local codes, many oncologists may determine that it is "economically unfeasible to travel to rural communities to see small numbers of patients on a regular basis."

Comments on the proposed fee schedule must be submitted to HCFA no later than August 5th. (At *Oncology Issues* deadline, however, the AMA was seeking an extension of the comment period.) ■