Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

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To cite this article: (1992) Highlights from ACCC's 18th Annual Meeting, Oncology Issues, 7:2, 18-19, DOI: 10.1080/10463356.1992.11905057

To link to this article: https://doi.org/10.1080/10463356.1992.11905057

Highlights From ACCC's 18th Annual Meeting

The Association of Community Cancer Centers held its 18th Annual National Meeting in Washington, DC, on March 11–14. This year's meeting included special sessions on new technology, leadership effectiveness, RBRVS and oncology practices, and national issues affecting reimbursement and patient care. Following are a few of the highlights from the meeting.

ACCC Honors Jerry Boyd

Exciting opportunities in cancer research and treatment are being "limited by the failure of the White House and Congress to provide adequate support for the National Cancer Act," according to Jerry Boyd, Contributing Editor, *The Cancer Letter*. Boyd, who received the ACCC's annual award for Outstanding Contributions to Cancer Care, contended that government has "paid no heed to emotional pleas from patients or to mechanisms, such as the bypass budget, for funding the National Cancer Act. Congress is not paying attention to its own creation," he said.

Jerry Boyd

If there is to be "fundamental change," Boyd warned, it will demand a "massive educational effort. But if we all do our jobs, cancer can be a disease that our grandchildren and future generations won't have to worry about."

FDA Plans To Revise Concept Paper

FDA's goal in issuing the concept paper, "Drug Company Supported Activities in Scientific or Educational Contexts," has been "seriously misrepresented," said Ann Witt, Acting Director of the Drug Marketing, Advertising and Communication Division of the Agency. "The purpose of the policy is to describe activities that *can* be supported by drug companies," she contended. "FDA has no right to regulate medical education, but it does have the responsibility to regulate prescription drug promotion."

According to Witt, the concept paper was a result of FDA's concern about prescription drug promotion that has been presented in the guise of news, marketing research, and in medical education. "We recognize that much of the funding of medical education is legitimate and should be protected," Witt said.

Nevertheless, she warned of the danger of "subtle" forms of drug promotion. "The medical community must make sense of a staggering amount of information; it needs a balanced source of information regarding those products, and we need to maintain a balance of those sources," she maintained.

After receiving a number of comments on the draft paper from both the medical community and the pharmaceutical industry, Witt said that the FDA is likely to alter some of its initial proposals, including:

- Allowing independent programs to be repeated.
- Permitting conferences that focus on a single drug product.
- Not holding pharmaceutical companies responsible for the content of conferences they sponsor if they are truly independent or for correcting inaccurate information presented at those conferences.

Witt also noted that "if appropriate accrediting organizations, such as AACME, can develop appropriate monitoring procedures for the programs they accredit," FDA will rely on those organizations to "monitor the programs and to inform FDA of any violations."

Payment, Technology Impact Site of Care

New payment regulations under RBRVS and technological advances are shifting patients from the inpatient to the outpatient setting, from the outpatient to the office setting, and could create a "schism that fragments previously cohesive multidisciplinary cancer programs," said James L. Wade, III, Director of Oncology at Decatur (IL) Memorial Hospital.

James L. Wade III

Specific, new technologies that are decreasing admissions and lengths of stay, according to Wade, include the use of carboplatin instead of cisplatin; the introduction of growth factors; the widespread adoption of the antiemetic, ondansetron; and the ability to more effectively avoid mucositis through "early recognition and treatment of its viral component. "All four of these advances are shifting patients from the inpatient to the outpatient setting," he noted and, thus, impact hospital/physician relations.

Wade also predicted that physician payment under RBRVS will result in "significant decreases in physician fees unless they shift their practices to an office setting." According to Wade, there are approximately 100 oncologists in Illinois; three-quarters of which practice in an outpatient setting and previously received chemotherapy administration fees. "Unless new arrangements are made between hospitals and physicians, physicians' will shift their practices to an office setting to make up for those lost revenues," he warned.

In addition, other government regulations are "attacking our common

ground," he said. "Conflict of interest regulations, few and narrow safe harbors for physician/hospital joint ventures, and threats to the tax-free status of institutions" are all affecting hospital/physician relations. "Together, we need to develop the best quality care we can," he said. "Medical oncologists must be willing to work with hospitals in areas such as quality improvement and cost control; to help distinguish the hospital's cancer program from its competition; and to guide hospitals into beneficial areas such as clinical research, the adoption of new technologies, and strategies for enlarging the hospital's service base, such as satellite clinics."

HCFA Considers Changes To RBRVS

The Health Care Financing Administration (HCFA) will continue to fine-tune Medicare's Resource-Based Relative Value Scale (RBRVS) system of physician payment, according to Kathleen Buto, Director of HCFA's Bureau of Policy Development. To date, HCFA is examining a number of issues, including:

Kathleen Buto

- The use of transition fees instead of the actual fee schedule amount for procedures that are not crosswalked.
- Alternative ways to cost-out technical components across the fee schedule.
- Whether HCFA should continue to pay the Average Wholesale Price (AWP) for drugs or revert to a policy of AWP minus 15 percent.
- The appropriateness of instituting payment differentials for physicians in teaching hospitals.
- Developing guidelines to ensure that appropriate, concomitant care is recognized by Medicare carriers.
- Broadening exclusions from the payment differential for new physicians beyond the current exclusion for rural physicians.
- Instituting a payment differential for hospital-based radiation oncology vs. freestanding facilities.

However, Buto was confident that the main goals of the RBRVS system will be accomplished; namely, to eliminate variations in payment among physician specialties for performing the same service; the creation of a fee structure in which there is less ability to justify random increases in procedures; increased payment for cognitive services, at the expense of procedures; and the protection of Medicare beneficiaries through strict balance billing limitations.

E&M Downcoding Prevalent Among Oncologists

Recent data show that oncologists are coding about "50 percent of all outpatient office visits as Level III visits," said Joseph Bailes, M.D., Chairman of ASCO's Clinical Practice Committee. That means that, most likely, oncologists are "downcoding to avoid the documentation requirements" of Level IV and V visits," he explained. Such a practice, he warned, is "detrimental to your practice and to oncology as a whole."

Joseph Bailes, M.D.

Downcoding is particularly risky in this, the initial year of the new visit codes, Bailes noted, because those coding practices will be used as the basis for monitoring the future coding patterns of oncologists.

Moreover, he explained that "HCFA expects a higher level of coding from some specialties." In fact, Bailes maintained that oncologists are "more likely to be audited for coding all patient encounters as Level III visits, rather than appropriate Level IV and V visits. Carriers are more likely to believe that physicians are upcoding Level II visits, instead of downcoding higher level visits." As a result, he urged oncologists not to attempt to "crosswalk" between the previous visit codes and the new evaluation and management codes. "Approach each visit as an isolated encounter," Bailes advised.

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