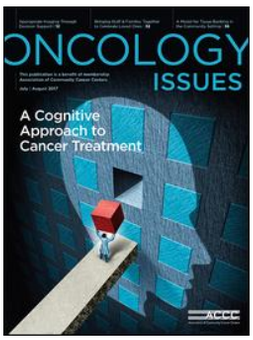

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Harvard's Phase III Results: Oncologists Respond

Oncology Issues asked three medical oncologists to voice their opinions on the results of Harvard's phase III vignettes for hematology/oncology and the future under RBRVS.

James L. Wade, III, M.D., Decatur (IL) Memorial Hospital Cancer Institute.
Judith Dernburg has accurately presented the history of how we got to where we are with the RBRVS. The real question now is "where are we with the RBRVS?" There are three points that can help orient us now and give us direction for the future.

First, chemotherapy administration codes are now defined as strictly technical, which eliminates much of the incentive that prompted oncologists to have their patients treated in an outpatient hospital-based chemotherapy suite. Such a change will hurt small rural hospitals that rely on a traveling oncologist to help sustain outpatient revenue.

Second, the phase III survey clearly shows that there is a great deal of additional work involved in the management of cancer patients, especially when they are receiving chemotherapy. For example, in Table 2, vignette "e" shows that the time component with the patient may be only 18 minutes, but the intraservice work is almost four times as long. Once the fee schedule is fully implemented in 1996, the rates will not be high enough to encompass this level of work, even for a level 5 E/M code. HCFA has agreed to abide by the phase III study results. It will either create higher levels of codes to reflect this extra work or, possibly, a chemotherapy management code that would be used in addition to the other E/M codes in all sites of service.

The phase III survey did not measure the costs of administering chemotherapy, nor was it supposed to. The law stated that technical codes would be derived from the Customary Prevailing Rate for that code in 1989. Not only have the codes mutated twice since then, but there was little uniformity in how they were used across the United States. In addition, many Medicare carriers previously used local codes for specific circumstances. Some carriers included the cost of supplies in local codes and others paid for supplies with "J" codes. When the 1989 codes were translated into the 1992 fee schedule, there was a lot lost in the translation. ASCO has demonstrated that supply costs are substantial and need to be recognized rather than ignored.

Finally, in the rules published in November 1991, a prohibition on the concurrent use of a 96408 and a 96410 appeared out of nowhere. We hope that the documentation and reasoned arguments critical of this restriction will have a favorable impact on HCFA and allow us to continue to practice with a little less hassle.

Lloyd K. Everson, M.D., The Indiana Regional Cancer Center, Indianapolis
Dernburg nicely recaps the background and current approaches for RBRVS implementation. However, she doesn't address the current system's strengths and weaknesses. RBRVS is dramatically and significantly affecting the overall development and delivery of core cancer services. In specific regard to medical oncology's professional and technical service reimbursement, there is a real question as to whether the RBRVS system compensates and reimburses physicians for the professional work that they do evaluating and managing patients.

In a private practice setting, there are at least two problems with the current RBRVS system. First, the five levels of E/M codes do not adequately compensate for an oncologist's expertise and level of consultation in evaluating and managing most levels of cancer patients and in administering chemotherapy. Second, under current regulations, drug reimbursement is not adequate; being limited to either AWP or the drug's invoice cost.

In an ambulatory care setting, the professional E/M code reimbursement formula has been a fraction of the professional charge rates in the private office setting. Under RBRVS, that rate has been increased, but the question remains as to whether that increase will equalize reimbursement between the two settings.

We must view the current concerns in oncology service reimbursement in a much larger construct. Oncology represents a microcosm of the total challenges we face in health care. It is on the forefront of advancing technology, the emerging genetic revolution, the challenges we face with the AIDS epidemic, and in emerging prevention strategies. Therefore, many of the approaches that we use in cancer care to enhance delivery of services in an integrated, multidisciplinary, and comprehensive construct will have implications for the much broader challenges we face in health care delivery.

How do we construct an integrated, multidisciplinary, and comprehensive approach to cancer care and program development? At least two key aspects of a successful delivery system include (1) a healthy financial picture, and (2) bonding of physicians and hospitals to a common vision and plan. The current RBRVS system has not resolved nor helped address these challenges in a constructive manner. It remains to be seen whether the financial incentives outlined in the RBRVS approach will bring oncologists and hospitals together or drive them apart.

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Judith Dernberg's article reflects the Hsaio study's perspective on RBRVS as it relates to oncology services. HCFA contracted with Hsaio's group to determine the physician work involved in every physician service. Three of the most critical reimbursement concerns to oncologists have centered on services that involve no "physician work" component, and therefore were not studied by Hsaio. Thus chemotherapy drugs, chemotherapy administration, and chemotherapy supplies are not discussed in this article.

Similarly, the practice expense and malpractice components of the Medicare fee schedule were not evaluated by Hsaio. Dernberg appropriately points out that these two components of the Medicare fee schedule are based on historical charges and are not resource based. This retains a reimbursement bias favoring procedures as opposed to cognitive services. To change this method of reimbursement practice expense and malpractice components would require a change in the law. It also would require a study to determine a

method to calculate proper practice expenses for each and every CPT code.

Hsaio's measurement of physician work is based on the valuation of vignettes. Medicare's policing of those same services is based on strict interpretation of the documentation requirements for the E/M code descriptors and ignores the vignettes. Though the AMA CPT Editorial Panel and HCFA have allowed the publication of brief vignettes to help physicians appropriately code their visits, these vignettes are not considered in the valuation of a coding level. The extent of history, the extent of physical examination, and the complexity of medical decision making determine if a service was properly coded. Despite the use of the vignettes to qualify physician work, they are essentially being ignored by Medicare in determining the appropriate coding for each patient intervention.

Oncologists have eagerly awaited the E/M code evaluations from the Hsaio III study. This phase of the study included chemotherapy management services, which have been inconsistently reimbursed and valued in the past. At present, "chemotherapy management" must be recognized as part of the E/M service, though it is not considered by any of the three key descriptors.

The three vignettes in Table II that include chemotherapy indicate more time as well as more intensity than similar visits without the addition of chemotherapy management. Table II only indicates the intra-service work. The total physician work would be separately calculated and is not included in this table. Chemotherapy management, including determining the appropriate chemotherapy regimen, dosing, antiemetics and fluids, would be outside the definition of intra-service work.

Though there is little available data, it seems that chemotherapy management does constitute a service that requires a reproducibly measurable amount of additional physician work. This additional physician work is not adequately reflected in the complexity of medical decision making of the E/M codes and has posed difficulties for oncologista, as well as Medicare auditors, in deciding how it could be appropriately recognized. We are hopeful that a separate chemotherapy management code can be defined and appropriately reimbursed to reflect this significant oncologic service that is not recognized by the present evaluation and management codes.

the invasive bias of the CPR system[12,13] The Harvard researchers agree with PPRC that the practice cost methodology used in the MFS legislation is not satisfactory.

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11. For example, the practice cost component of a typical office visit (CPT 99213) is $13, while practice costs for a 3-vessel CABG (CPT 33512) are $1,197—a ratio of 92 to 1. The ratio of the work component of the fee schedule is 45 to 1 or half of the practice cost ratio. A physician would have to provide 92, 15-minute office visits—a total of 23 hours of patient care—to earn practice cost revenues equal to a single 8.5 hour surgical services (including pre- and post-service visits).
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