



Letters to the Editor

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■ **HCFA Oversights**
 ■ **Breast Cancer BMT Coverage**

I have read the editorial in the May/June 1996 *Oncology Issues* and am in absolute agreement with your comments.

I am the medical director of Southwest Oncology Centers, which operates three free-standing radiation oncology facilities in the state of Arizona. The problems described in your editorial have been chronic in our practice and probably in the state of Arizona. Arizona has its own answer to Medicaid, known as the Arizona Health Care Cost Containment System (AHCCCS). Patients are allowed to alter their AHCCCS program periodically during the year. Often our facility receives referred patients who are covered under a particular AHCCCS contractor and who alter their AHCCCS insurer midway through their radiation treatment course for a variety of reasons. Many times these patients do not inform our front office of this change, and treatment proceeds with the understanding that the patient is covered by his initial contractor. When that contractor is later billed for services at completion of treatment, a segment of the fees is disallowed. The claim is that the initial contractor is no longer responsible; the new contractor will not assume responsibility because it has not authorized the patient's care and management. In these cases our office is out of luck and can no longer recoup the fees for services provided. The patients are never informed that they must inform their medical care providers of the change of status.

We also have our share of Medicare HMO problems, as you elude to in your article. This happens time and time again. In particular, one problem area concerns patients who are placed on Medicare Hospice programs and who do not inform our office of this change. In years gone by, hospice organiza-

tions were strictly voluntary and offered a laudable service to the terminally ill patients. Since the advent of Medicare Hospice, however, there have developed numerous hospice organizations that eagerly accept HCFA payments but desire to offer the minimal degree of care to the dying patients. Many of our patients have been snatched up by the Medicare Hospice organizations, and no one has informed our office of this change in category. Also, many of these same patients have never been advised or encouraged to inform the treating physicians of their change of status. When Medicare is subsequently billed for services, it disallows portions of these bills from the date of Medicare Hospice enrollment. The hospice organization refuses to pay the additional charges because the patient care had not been authorized.

This is a terrible lack of concern and oversight by HCFA, as well as by the various state agencies and HMO providers.

I find the situations that I have described and that you noted in your editorial to be totally appalling with very little recourse for organizations such as those I represent.

—Franklin S. Danziger, M.D.,
 F.A.C.R.
Southwest Oncology Centers, Ltd.
Phoenix, Ariz.

The article in the March/April 1996 *Oncology Issues* regarding insurance coverage for breast cancer BMT makes one ask, "Are insurers still, in fact, denying BMT therapy for breast cancer based on the experimental treatment coverage exclusion?" The controversy surrounding insurance coverage for bone marrow or stem cell transplants for breast cancer and other solid tumors has plagued the cancer community for more than five

years. At what point in time is a therapy deemed "not experimental" and, therefore, eligible for coverage? Must it be shown to be effective after five, ten, or fifteen years? What does "effective" mean? If insurers and cancer care providers continue to base coverage decisions on what is experimental in cancer therapy, this war will continue indefinitely. Patients that have disease with an unacceptable cure rate and no effective standard therapy should be considered for investigational therapies administered under a clinical trial. This therapy is part of the patient's medical care and should be reimbursed, if the clinical trial meets specific guidelines. Both providers and payers must come to terms with this standard and work together to develop reasonable guidelines that consider the cost and effectiveness of the treatment. Otherwise,

- patients will not receive adequate treatment
- advances in cancer therapy will stagnate
- payers will continue to battle litigation
- providers will spend an inordinate amount of time advocating for coverage.

Our current experience is that payers are more interested in reducing overall reimbursement than denying coverage for BMT. Moreover, the cancer community is concerned about the lack of patient access to clinical trials because of a lack of provider choice. If and when cancer care is routinely capitulated and the provider is at risk, the payer will have no interest in denying the specifics of cancer care. As for the provider, there may unfortunately be little time or internal resources to enroll patients on clinical trials.

—Barbara A. Redmond, J.D.
 Director, Contractual and
 External Affairs
Johns Hopkins Oncology Center
Baltimore, Md.