Part B Insider (Multispecialty) Coding Alert

Drug Reimbursement: 2 Hopes For Saving Drug Payments In 2005

New codes or new legislation could rescue practices

It's going to take a minor miracle to save oncologists and other specialties from the drug payments axe.

"If all the cuts that are scheduled to go through do go through, it'll make it extremely difficult," says **Ris Marie Cleland** with **Oplinc Oncology** in Lawton, OK. "There will be a disruption in care for patients" and a reduction in patient access. Not only are drug payments being slashed to rock-bottom levels, but a 32 percent add-on payment for drug administration is dropping to just 3 percent in 2005 and nothing in 2006.

CMS did increase the relative value units for drug administration codes themselves, and those increases are permanent, notes Cleland.

CMS insists that oncologists will see only an 8 percent decrease in their drug revenues in 2005, and rheumatologists will see only a 6 percent drop. But urologists will lose 36 percent of their Medicare drug revenues, and Ob/Gyn physicians will lose 18 percent of drug payments.

"I can't figure out how they get to 8 percent actually," gripes Cleland. But she notes that the impact will differ greatly for different providers depending on their patient population and the types of drugs they use. If you happen to provide drugs that are targeted for deeper cuts, then you're in for a rougher time.

"Our numbers are looking like it's going to be closer to a 20 percent cut," says **Elaine Towle**, practice administrator with **New Hampshire Oncology-Hematology** in Hooksett, NH. Her practice is using "a couple of different modeling methods," including a survey tool distributed by the **American Society for Clinical Oncology**.

Senate Bill, New Codes Could Help Providers

A pending bill in the Senate would rescue physicians from steep cuts. Sen. **Deborah Stabenow** (D-MI), introduced the Ensuring Quality and Access to Cancer Care Act , which would extend this year's 32 percent add-on payment into 2005. Cleland says she's hopeful that this bill could save oncologists from having to rethink their practices.

Meanwhile, CMS is talking to the **American Medical Association** and the **Physicians Regulatory Issues Team** about ways to add to drug administration payments, and the groups have raised some important issues. For example, if extra payments rely on current codes for chemotherapy and non-chemotherapy administration, can these take into account the expense and difficulty involved in administering highly toxic non-chemotherapy drugs? Or are new or revised CPT Codes required?

Also, the physician advisers asked, does current coding for chemotherapy administration include all the support services that oncology practices provide? Or do cancer management codes need to be revised?
Any additions CMS makes to drug administration payments are exempt from budget-neutrality requirements.

The CPT Editorial Panel established a workgroup that will report back at its August 2004 meeting. Meanwhile, ophthamologists, urologists and other specialists raised questions about their drug reimbursements. CMS may make some coding changes through the use of G-codes so physicians can receive adequate reimbursement by 2005.

Until now, Medicare has reimbursed physicians for Part B drugs using average wholesale prices - industry-generated, artificially inflated figures that have been the source of more scandals than the voting on American Idol. In the MMA,

Congress shifted to a methodology based on average sales price, defined as the average price, net of rebates or discounts, for all sales of a drug in the United States.

Starting in 2005, Medicare will reimburse Part-B drugs at 106 percent of the ASP. In 2006 and beyond, physicians may choose between using the ASP system and obtaining medications through a CMS-administered competitive-bidding program.

Drug manufacturers have been supplying CMS with drug pricing data on a quarterly basis, starting in January 2004. CMS comes up with the average by dividing the total amount sold with the number of units sold. Medicare will still pay for influenza, pneumococcal and hepatitis B vaccines according to 95 percent of AWP.

For a single-source drug, the payment should be the lesser of 106 percent of ASP or 106 of wholesale price. If a drug is widely available for 5 percent less than the ASP, the HHS Secretary can disregard the ASP data, and starting in 2006, the drug doesn't even have to be available for 5 percent less.