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DRUG REIMBURSEMENT: Good News: You Soon Can Use 14 New Anti-Cancer Drug Codes

Bad news: New payments replace just 1/5 of what you're losing

The **Centers for Medicare and Medicaid Services** is willing to put its money where its mouth is when it comes to keeping cancer care in physicians' offices.

With cancer care providers facing half a billion dollars in cuts next year, CMS accepted the suggestions of the **American Medical Association's** Relative-Value Update Committee. Starting in January, you'll have 14 new drug administration codes, according to a letter from CMS Administrator **Mark McClellan** to House Ways and Means Health Subcommittee Chair **Nancy Johnson** (R-CT).

In particular, new codes will reimburse physicians for the extra cost of infusing a second drug. Also, "oncologists will be able to bill Medicare for more than one administration of a nonchemotherapy drug, as they can do currently for chemotherapy drugs," McClellan wrote. Payments for the new codes will also account for the time non-physician staff spend preparing medications. And CMS will recognize physician supervision of clinical staff preparing medications.

An attachment to McClellan's letter included physician work RVUs, plus staff time and medical equipment, that would go into calculating payments for the new codes. But the letter didn't actually specify what the payment amounts for the new codes would be.

The **American Society of Clinical Oncologists** called on CMS to reveal the numbers as quickly as possible, and said its "rough estimate" showed the new numbers would only boost payments to oncologists by $100 million in 2005, or a fifth of the amount oncologists stand to lose. But we won't really know how much relief the new codes offer until CMS issues its final **Physician Fee Schedule** rule, according to **Deborah Kamin**, ASCO's senior director of cancer policy and clinical affairs.

CMS Leaves Docs Codeless for Managing Drug Reactions

CMS followed the RUC's recommendation not to introduce any new codes for managing significant adverse drug reaction, McClellan said. Instead, CMS will encourage oncologists to use existing options more frequently, including billing a separate high-level evaluation and management visit, raising the level of an existing visit, billing for prolonged services, or billing for critical care.

There are a couple of problems with this approach, says coder **Christine Berger** with the **St. Louis University** Internal Medicine Dept. Carriers and intermediaries regularly put prepayment edits on critical care and downcode the claim automatically to a regular E/M visit unless they see the correct notes. Billing staff have to comb through every single critical care claim to identify and explain these downcodes, which costs more than the added reimbursement.

ASCO has told CMS that the carriers' "frequent denials" have discouraged doctors from billing for prolonged services or critical care, and CMS has asked for examples of this problem, Kamin says. She hopes CMS will go back to the carriers "with a little more explicit guidance" so the carriers will start treating these codes more consistently with CMS' wishes.

Also, Medicare bundles codes for push and subcutaneous administration of therapeutic drugs with E/M visits. So if a chemotherapy patient has an adverse reaction and you're giving her therapeutic drugs to prevent or correct that reaction, you'll lose the reimbursement for administering those drugs if the doctor bills for a separate E/M visit. Medicare will pay for chemotherapy administration separately with an E/M as long as you use the correct modifier, but not

therapeutic drug administration, explains Berger.

The new "average sales price" plan for pricing drugs will hurt doctors in areas where drugs are more expensive than the national average, Berger complains. In the end, the real victims will be patients who may not have access to the best drugs, or the best site of service, for their conditions.