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Part B Insider (Multispecialty) Coding Alert

Meetings: Local Carriers Are Your Best Bet For Fixing

PPAC urges CMS to take drugs out of update formula retroactively

Least costly alternative (LCA) policies create an "unlevel playing field" across the country because some Part B carriers don't apply them, or apply them differently than others, physicians complain. And in the wake of steep cuts to drug payments, these policies make it even harder for physicians to provide badly needed drugs.

Currently, individual carriers can decide whether or how to implement LCA policies, which will only pay the price of the cheapest alternative to a particular drug, officials from the **Centers for Medicare and Medicaid Services** told the **Practicing Physicians' Advisory Council** at PPAC's March 7 meeting. Providers who want LCA policies changed in the wake of drug cuts should ask their local carriers, CMS added.

CMS admitted that one carrier had experienced "claims processing issues" as a result of problems with an LCA policy, but the problems are now resolved.

Five states don't have LCA policies at all, according to PPAC representatives. One of these states, Utah, just launched a six-month program to test if it needs such a policy. Carrier medical directors have told local physicians they're waiting for a national directive before they reform their LCA policies.

Be careful what you wish for, CMS officials noted. If the agency issued a national "least costly alternative" policy, physicians might not like it as much as their local carrier's policy.

At its March 7 meeting, PPAC also did the following:

1. **Passed** a resolution calling on CMS to require vendors in the new competitive drug acquisition program to waive copayments for patients when the physician waives the patients' copayments for other services. Physicians feared they would have to absorb the copays for their indigent patients if the drug vendors refuse to do so.
2. **Resolved** CMS should require the drug vendors to provide drugs for off-label uses when the evidence supports their use. Also, the demonstration drug prices shouldn't affect Average Sales Price levels, and physicians should be able to opt in or out of the program on a drug-by-drug basis.
3. **Recommended** CMS begin projecting the effect on Medicare beneficiaries' access to care if the physician pay cuts averaging 5 percent a year take effect from 2006 to 2011 - and that CMS develop a plan to prevent decrease in physicians' Medicare participation.
4. **Urged** CMS to use its administrative authority to remove physician-administered drugs and biologics from the physician payment update formula retroactive to 1996. CMS officials said that removing drugs from the formula going forward wouldn't prevent steep cuts, and the CMS counsel is still figuring out whether it has the authority to remove drugs retroactively.

Other meeting topics: Separately, CMS declined to expand the demonstration project for reporting pain and nausea control for chemotherapy to patients receiving other medications. CMS officials also said they will release a Medlearn Matters article resolving physicians' confusion involving observation care and hospital admissions.

An oncologist complained once again about the definition of G0353, the code for a "push" infusion or short-term infusion lasting less than 30 minutes. The descriptor currently requires that a provider be "continuously present" at the patient's

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bedside. No physician's office can afford to have a nurse sit by a patient's bedside watching an IV drip for 30 minutes, she complained. CMS officials responded that the **American Society for Clinical Oncology** is involved in the CPT Editorial Panel workgroup that is revising this code descriptor, and thus providers can expect to see some improvements.

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