Part B Insider (Multispecialty) Coding Alert

ONCOLOGY REIMBURSREMENT: Tough Times Could Be Ahead For Oncologists In 2006

Demonstration project, add-on payment both due to phase out

Most physicians face a drastic 4.3 percent cut in 2006 unless Congress or the **Centers for Medicare & Medicaid Services** acts. But oncologists have it much, much worse.

In addition to that sharp pay cut, oncologists stand to lose several current revenue streams. The chemo- therapy demonstration project, in which oncologists receive $130 per day to ask patients about pain, nausea and fatigue, is set to end in January. And a 3 percent "add-on" to drug administration payments is also set to end next year.

Add to that bargain-basement drug payments with no sign of relief, and you have a nightmare scenario for oncologists: payments in freefall.

"I don't think we know anything right now, any more than we knew anything this time last year or the year before," says **Judy Stone** with **Carolina Hematology/Oncology** in Charlotte, NC.

Either CMS or Congress could still decide to add more money to oncologists next year or extend the demonstration project, notes **Joseph Bailes**, an oncologist and co-chair of the **American Society for Clinical Oncology's** government relations task force. He hopes that policymakers will recognize the true cost of providing services associated with chemotherapy and reimburse providers for that cost. ASCO is continuing to educate CMS and Congress on oncologists' service costs.

Know Your Costs

Most practices are just starting to get a handle on their costs and revenues to service Medicare patients, adds Bailes. Practices are figuring out how to understand their costs and provide services effectively at the rates Medicare pays. You need to have "a good handle on your practice economics," and find the lowest rates for drugs, Bailes advises. And if you can't find drugs at the rate Medicare pays, then let CMS know.

"I know my business this year much better than I've ever than I've ever known it before," says Stone. "I know, by regimen, what my costs are." She knows, based on Medicare payment formulas, "which drugs are my winners and which drugs are my losers." That roster can change from week to week as manufacturers change prices and the quarterly Average Sales Price numbers don't keep up.

Providers "need to make certain they know how to use all the infusion codes," adds Bailes. The new administration codes took effect this year as G-codes, and it's taken providers this long just to get the hang of them. But next year, those codes will turn into CPT Codes and private insurers will start recognizing them, making them even more important to use properly.

"Practices are going to have to start finding ways they can buy the drugs less expensively, through whatever programs they can come up with," says Fredericksburg, VA-based consultant **Melanie Witt**. "In some cases it will be doable and in some cases it won't."

Providers also have the option next year to use the much-criticized Competitive Acquisition Program for drugs, in which a vendor provides drugs to physicians and bills Medicare directly. The proposed version of the CAP would have required physicians to decide far in advance which patient needed which drug on which date, but Bailes hopes the final version

will be better.

Stone says she's looking for any methods to help patients obtain help and support affording chemotherapy. She uses an online system in North Carolina called the **Medication Assistance Program,** which allows users to type in a patient's income, demographics and drug regimen, and then obtain a list of resources for the patient. Ask your state's health department if it offers any similar programs.

Some chemotherapy practices are already turning away patients who can't afford their 20 percent copayment, but Stone says that could be a mistake. It's not patient-friendly, and it also may choke off future referrals.