

Shortcomings and flaws in Medicare coding that affect oncologist practices

As we have reported, on January 1, 2005, according to the provisions of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, the reimbursement structure for community oncology practices will change dramatically.

Medicare will switch drug reimbursement from average wholesale price to a system based on average selling price. At the same time, the reimbursement for essential medical services (ie, payment for the administration of chemotherapy, nursing care, patient monitoring, and other essential cancer care) is scheduled to decrease by 29 percentage points—from a 32% increase in reimbursement for services to just 3%. If not addressed, these changes will substantially decrease payment for cancer care.

There are significant shortcomings and flaws in the Medicare Part B coding system, which has not maintained a level of reimbursement commensurate with essential cancer care services required to treat seniors covered by Medicare. The true cost of administering quality cancer care to Medicare patients—quality in terms of being on a par with that given to all other cancer patients—is not reflected in the reimbursement codes used to bill Medicare for services performed.

These are the conclusions of a task force of experienced cancer practice administrators and consultants convened by the Community Oncology Alliance to provide Congress and the Centers for Medicare & Medicaid Services (CMS) with specific data and recommendations on this vital issue. Some of the spe-

cific findings of the task force include the following:

- There is typically a time lag (up to 18 months) in the issuance of J codes for new cancer drugs. This lag results in payment delays that place financial pressure on cancer practices.
- Medicare does not reimburse for standard-of-care services that are an essential part of quality, modern-day cancer care. These services include patient and family education, nutrition counseling, and psychosocial counseling. They are not just “nice to provide” services; they are often critical services that enhance outcomes and minimize costly and debilitating hospitalization. Some of these services are bundled into existing codes but at levels below cost.
- Codes for certain medical services that are still performed, and in many cases have become more complex, have been eliminated. For example, this year MMA eliminated code 99211 which covered patient care services provided on the same day as chemotherapy administration. These are real services provided to cancer patients that are not covered in other codes.
- Administrative costs to bill Medicare have increased dramatically and have added to the overall cost of maintaining a cancer clinic. There has been no corresponding increase in existing codes or creation of new codes to cover these increased costs.
- The costs associated with pharmacy management/inventory, waste, and other direct drug and supply costs are not adequately reimbursed.
- The “bundling” of the cost of services performed and supplies utilized into just a few codes for cancer care has artificially lowered reimbursement because increases in individual component costs are not reflected in these bundled codes.
- Extensive coordination of care, including chemotherapy planning (eg, drug regimen dosing), triage of acute care, clinical trial oversight,

and health maintenance for the patient by the medical team, is not covered in Medicare coding.

- Additional overhead cost required to maintain rural satellite clinics is not covered by current coding.
- According to the report of the task force, the codes that Medicare uses to reimburse community cancer clinics need to be redefined and expanded. Codes need to realistically include all the essential cancer care services required by seniors covered by Medicare. The 29 percentage point decrease in the transitional payment for cancer care services, scheduled to start January 1, 2005, is unjustifiable until coding issues are addressed. Community cancer clinics cannot continue to operate, especially facilities in rural areas, if costs exceed reimbursement.

The report by the Community Oncology Alliance task force puts forth recommendations on coding

changes, some that CMS can make now under administrative authority and under the mandate and spirit of MMA. Their report has been provided to CMS and their findings presented to members of Congress. Members of the task force have also testified to a committee of the American Medical Association.

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A copy of the report can be obtained from the COA Web site, www.communityoncology.org. For questions or further information on the task force, contact Dianne Kube at dianne.kube@att.net.