'Average' Medicare Fees for Infusion Fall Short for Some Physicians

BY JOYCE FRIEDEN

Associate Editor, Practice Trends

WASHINGTON — The new system for infusion therapy payments under Medicare shows how difficult it is to base payment on "average" prices, Rep. Nancy Johnson (R-Conn.) said at a conference sponsored by Elsevier Oncology.

"An 'on average' payment system always means some people are below the average, and the question is, are you below average on every drug?" Ms. Johnson said. "Well, then you'd be out of business. I've gotten letters from people who are closing up shop to Medicare patients. That's a very, very serious problem."

Under the new payment system for infusion therapy, providers have a choice: They can either buy their drugs from vendors that Medicare selects in a competitive bidding process, or they can buy drugs from any vendor and accept Medicare's payment of 106% of the average sales price (ASP). The ASP is determined by data supplied to Medicare by manufacturers and updated every quarter.

Several audience members complained that 106%—also called ASP plus 6%—was nowhere near enough for them to make any profit on the drugs. "I can't purchase any single drug and make any kind of margin on it," a woman from Alaska said at the meeting. "We send everybody to the hospital [for treatment]. We cannot treat a single person. There's one drug I lose $400 on every time a patient walks in the door."

Rep. Johnson said there seemed to be "pockets" of the country where too many drugs had such negative margins, "but we can't see any logic yet. Is it certain size practices? Is it certain regions of the country? We need your information, because in the end we want something that pays for drugs in a reasonable and fair process."

One problem with determining the ASP is that it includes prices received by large-group buyers who get big discounts, as well as others who get 'prompt pay' discounts, Rep. Johnson noted. "Those may be too harsh. That may mean that the little guy who is below the average can't make it."

A big problem with the payment system for drugs is that it is tied to the sustainable growth rate, a target percentage that Medicare sets each year for allowable growth in the Medicare budget, she said. If spending goes above the target, the budget must be cut the following year to make up for it. Rep. Johnson is sponsoring H.R. 3617, which would repeal the sustainable growth rate altogether and replace it with a payment increase based on the Medicare Economic Index.

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That bill is important because increasing payments to physicians is essential for moving toward a pay-for-performance system, she said. "You can't move ahead on pay-for-performance when you're going to cut reimbursement."

Another area of reimbursement concern was Medicare's oncology demonstration program. Last year, the program paid physicians $130 for each chemotherapy infusion visit as long as participating physicians filled out paperwork stating whether they are following practice guidelines with that particular patient.

This year, the program is paying $23 per evaluation and management visit, explained Dr. Peter Bach, senior advisor to Dr. Mark McClellan, administrator of the Centers for Medicare and Medicaid Services. The new system "deemphasizes chemotherapy, removes the incentive for infusions over other treatments such as oral chemo, and it … creates a longitudinal record. The payment for each event is $23 rather than $130, but obviously the number of events is far greater," he said.

Audience members did not like the changes. "CMS's demonstration project is flawed and extremely burdensome, and $23 is appalling," said Sharon A. Van Marter, practice administrator at Syracuse (N.Y.) Hematology/Oncology. "It's very nice that [overall Medicare payment rates] have been frozen at 2005 levels," but because the $130 payment is gone, "we're now looking at a 17% decrease because that isn't there."

Dr. Bach reminded audience members that the project is voluntary. On the whole, "I'm hearing two signals: One is, 'It's not enough money—we're losing money every time we [do it],' and the other is onslaughts of e-mail from carrier medical directors and practices saying that they have thousands of claims queued up and carriers aren't ready to pay them," he said. "I can't reconcile those two things. Why do something where you're going to be losing money?"

Because, replied conference chair Dr. Lee Schwartzberg, "you're throwing us a carrot—$23 every time we do it. We don't think the time relationship is right, but it's 23 more dollars. We're losing money across the system. This is the only opportunity that's been given."

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Infusion Practices Can Boost Revenue Despite Pay Limits

BY JOYCE FRIEDEN

Associate Editor, Practice Trends

WASHINGTON — In spite of poor Medicare reimbursement, physicians who use infusion therapy can take steps to make their practices more profitable, Steven M. Coplon said at a conference sponsored by Elsevier Oncology.

Under Medicare's system for infusion-drug reimbursement, "essential services are underreimbursed or not reimbursed at all," said Mr. Coplon, chief executive officer of The West Clinic, a Memphis, Tenn., oncology practice. "But the cost of drugs, staff, facilities, and malpractice insurance all continue to increase."

To stay in business, practices must look more closely at the revenue they get for their services, he said. For example, "on one drug regimen [given frequently to Medicare patients], we're making $24 on $7,061 worth of investment. Even Sam Walton, when he started Wal-Mart, worked on a higher margin than that."

One way to boost revenue is to raise the amount the practice brings in from private payers, he continued. "Negotiate it to the best of your ability; go for every code you can possibly think of. Get creative," he advised. "If they're willing to say yes, you can make up for a lot of these margins you're losing on the Medicare book of business."

Another strategy: Diversify. Instead of just providing drug, chemotherapy, administrative, and laboratory services at an oncology practice, why not add radiology, pain management, palliative care, gynecologic oncology, and hospitalist care? Within each service, of course, are different subsets—radiation oncology can include CT, PET, PET/CT, and MRI, he noted.

Roberta L. Buell, vice president of provider services and reimbursement at P4 Healthcare, Sausalito, Calif., said practices should consider if their billing procedures are "optimal." In an optimal practice, "80% of receivables should be less than 90 days overdue," Ms. Buell said. "And if your practice is more than 50% Medicare, you should be doing much better than that." Also, be aware of your practice's "chair turn" per day and see if it can improve.

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Medicare Proposes Noncoverage of Charité Spinal Disk

BY ALICIA AULT

Associate Editor, Practice Trends

Medicare might not pay for implantation of the Charité artificial spinal disk if a proposed coverage decision becomes final in May.

According to the Centers for Medicare and Medicaid Services proposal, the evidence is not adequate to conclude that disk replacement with the Charité "is reasonable and necessary."

CMS is accepting comments through April and will make a final decision May 6. The agency said it found few data in patients older than 65 and that the results of the pivotal Charité study "are unconvincing as a demonstration of net health benefit."

Several specialty societies—including the North American Spine Society, the Scoliosis Research Society, and the Spine Arthroplasty Society—have commented, mostly saying that the jury is still out on older patients. The American Association of Neurological Surgeons and the Congress of Neurological Surgeons said the surgeon should decide what is best, adding that not enough data on patients older than 60 years existed "to demonstrate that this procedure is inappropriate for elderly patients."

The Charité was approved by the Food and Drug Administration last November, but it has not been widely adopted and is rarely being paid for by insurers. So far, 176 procedures have been covered by insurers; Medicare has paid for a few cases as well, said Dr. Richard Toselli, worldwide vice president for research and development at DePuy Spine Inc. of Raynham, Mass., manufacturer of the Charité disk.

The disk is indicated for 18- to 60-year-old patients with degenerative disk disease at one level, either L4/L5 or L5/S1. It has not been studied in patients older than age 60.

CMS began its coverage review at the request of Dr. Richard Deyo, an internist and professor of medicine and health services at the University of Washington, Seattle. In an interview, Dr. Deyo said he was concerned about the safety of the Charité in older patients partly because osteopenia and osteoporosis are contraindications.

Dr. Deyo also said the Charité had shown in trials only that it was not inferior to a type of fusion—Bagby and Kuslich (BAK) cages with iliac crest bone graft—a procedure he called "largely discredited."

The disk is not intended to be implanted in patients older than age 65, so Medicare's proposal did not come as a great surprise, Dr. Toselli said in an interview.

DePuy Spine is hoping that Medicare will pay for Charité implantation in its disabled beneficiaries, he said. Medicare has 42 million beneficiaries; about 6.5 million are younger than age 65 and disabled.

A split coverage decision would not be unprecedented. A CMS spokesman said the agency has in the past covered procedures or therapies for subgroups of the Medicare population, or has imposed restrictions on the prescribing or use of a device or therapy.

In its Charité proposal, however, CMS said the data did not seem to support using the disk in the disabled, either. ■