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Advances in Cancer Care

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I.V. Busulfan Superior To Oral in Treatment Of Lymphoma Patients

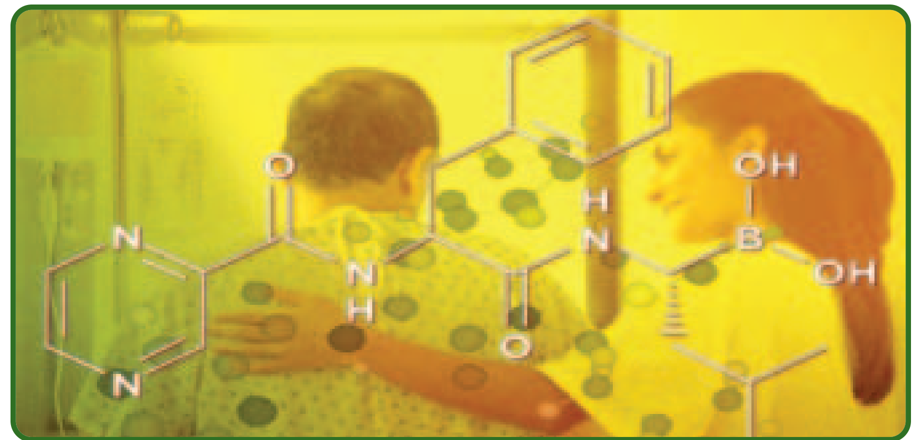
ORLANDO, FLA.—Intravenous busulfan is better tolerated and more effective than the oral form in high-dose chemotherapy following autologous stem cell transplantation (SCT) for lymphoma.

A previous retrospective analysis had lent strong support to the hypothesis that oral busulfan delays drug-related toxicity. However, this current retrospective study found a highly statistically significant advantage (P=0.008) for intravenous busulfan over oral busulfan in relapse-free survival (RFS) over 18 months of follow-up. The latter study was presented at the 2006 annual meeting of the American Society of Hematology.

see I.V. BUSULFAN, page 10 ▶

In Multiple Myeloma …

Bortezomib Phase 3 Promise Holds Up in Clinical Treatment



ORLANDO, FLA.—Bortezomib is equally effective in an everyday clinical setting as it was in the randomized trials that led to its approval last year. The results of a Phase 3b trial were presented recently at the 2006 annual meeting of the American Society of Hematology.

The trial showed that bortezomib, when administered to patients with relapsed or refractory multiple myeloma, can be significantly effective. The

see BORTEZOMIB, page 9 ▶

Bioethics

In Patients of All Ages…

Pediatric Protocols Yield Greater Treatment Success

The national pediatric cancer cooperative groups allow 94% to nearly 98% of American children (<15 years of age) the opportunity to participate in clinical trials, regardless of race or ethnicity, according to W. Archie Bleyer, MD. However, less than 25% of adolescents (those between the ages of 15 and 19 years) are being enrolled in any cooperative group sponsored by the National

see TWO WORLDS, page 4 ▶

How Will It Affect Your Practice?

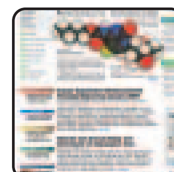
The Impact of the CMS 2007 Final Rule

January is a time for reflection, renewal and change. Looking back to 2006 for guidance on 2007 changes of codes and rules can help map out a plan for your practice in the new year. In our last article, “Expect Significant Change Beginning in 2007” (*Clinical Oncology News* November/December 2006, page 1), we looked at the future and at the impact of the sustained growth rate. This article focuses on the *real impact* the final rule brings to oncology practices and provides tips on planning for the year ahead.

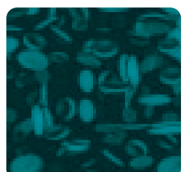
The 2007 final rule released by the Centers for Medicare & Medicaid Services (CMS) implements changes in the work and practice expense relative value units

see FINAL RULE, page 30 ▶

Updated Web site
See details of our redesigned Web site, www.clinicaloncology.com
See page 32.



FROM THE bench TO THE bedside
Erythropoiesis-Stimulating Proteins: Optimizing Therapy, Minimizing Resources, brought to you by Amgen
See page 20.



BILLING AND REIMBURSEMENT

FINAL RULE

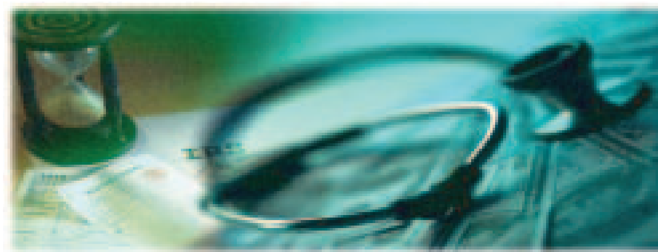
continued from page 1

(RVUs), the Deficit Reduction Act (DRA) adjustments for imaging services payments and includes a 5% reduction in the Medicare physician fee schedule.

The work and practice expense RVU changes alone result in a 3% increase in allowable charges for hematology-oncology, and a 1% increase for radiation oncology. However, when incorporating the 5% reduction and changes in imaging services, CMS estimates combined impact of these changes leads to a 2% reduction of allowed charges for hematology-oncology and a 5% reduction for radiation oncology, despite increases in the work and practice expense.

For oncology practices that provide infusion services, the projected 3% RVU increase will be offset by the decreases in RVUs for drug administration. Table 1 provides a CY 2006 to 2007 comparison summary of the most commonly used administration codes. The 2007 transitional RVUs are decreased 2% to 5% when compared to CY 2006. Code 96413 Chemotherapy 1st hour decreases 3% in 2007 and is projected to decrease 13% when fully implemented in 2011.

Table 2 provides a glimpse of the real impact to a medical oncology office that provides infusion services. The overall example consists of a level 4 office visit, a two-hour chemotherapy treatment, and a therapeutic I.V. push. In Example A the 2007 conversion factor of $35.9848 reflects that payment for that treatment in CY 2007 will be reduced 3% when compared to the reimbursement payment in CY 2006. However, Example B shows that if Congress freezes the conversion factor to remain



This article focuses on the real impact the 2007 final rule brings to oncology practices and provides tips on planning for the year ahead.

Table 1. Impact of CPT Changes Between 2006 and 2007

CPT	Description	2006 RVU	2006 Payment	2007* RVU	2007* Payment	Difference 2006 RVU	Difference 2006 Payment
90760	Hydration I.V. infusion, initial	1.67	**$63.29**	1.64	**$59.02**	-2%	**-7%**
90761	Hydration, I.V. infusion, add-on	0.53	**$20.09**	0.51	**$18.35**	-4%	**-9%**
90765	Ther/proph/diag I.V. inf, initial	2.04	**$77.31**	2	**$71.97**	-2%	**-7%**
90766	Ther/proph/diag I.V. inf, add-on	0.68	**$25.77**	0.66	**$23.75**	-3%	**-9%**
90767	Ther/proph/diag addl seq I.V. inf	1.12	**$42.45**	1.07	**$38.50**	-5%	**-10%**
90774	Ther/proph/diag initial, I.V. push	1.52	**$57.60**	1.53	**$55.06**	1%	**-5%**
96409	Chemo, I.V. push, single drug	3.23	**$122.41**	3.18	**$114.43**	-2%	**-7%**
96411	Chemo, I.V. push, addl drug	1.87	**$70.87**	1.84	**$66.21**	-2%	**-7%**
96413	Chemo, I.V. infusion, 1 hour	4.56	**$172.81**	4.41	**$158.69**	-3%	**-9%**
96415	Chemo, I.V. infusion, addl hour	1.03	**$39.03**	1	**$35.98**	-3%	**-8%**

*Payment based on 2007 conversion factor of $35.9848

Table 2.* Conversion Factors

Example A. Current Conversion Factor of $35.9848

	2006	2007	Change
Level 4	$82.62	$90.68	+10%
Chemo 1st hour	$172.81	$ 158.69	-8%
Chemo additional hour	$39.03	$35.98	-8%
Therapeutic IVP	$57.60	$55.06	-4%
Total	**$352.07**	**$340.42**	**-3%**

Example B. Conversion Factor Remained 37.8975

	2006	2007	Change
Level 4	$82.62	$95.50	+16%
Chemo 1st hour	$172.81	$ 167.13	-3%
Chemo additional hour	$39.03	$37.90	-3%
Therapeutic IVP	$57.60	$57.98	+1%
Total	**$352.07**	**$358.51**	**+2%**

***Important note: On Dec. 9, 2006, Congress passed a bill that included a reversal of the 5% reduction in the Medicare physician fee schedule. This bill is expected to be approved by President Bush. The conversion factor remains unchanged for 2007 at $37.8975.**

unchanged from last year at $37.8975, the same services would result in a 2% increase in payment.

Imaging continues to face scrutiny with more cuts occurring in the free-standing setting. The new payment policy required by the DRA of 2005 caps payment rates for selected imaging services under the physician fee schedule at the same amount paid for the same technical services when performed in the hospital outpatient setting. In light of additional cuts required by DRA, CMS will retain the multiple payment reduction of 25% and will not impose the 50% reduction at this time. When providing reimbursement, CMS will apply the multiple imaging reductions first, followed by the outpatient payment imaging cap, if applicable. Addendum F in the final rule provides a complete list of imaging codes defined by the DRA.

There are some additional changes to note when updating FY 2007 fee schedules. CMS will continue the temporary add-on payment of approximately $71 for one more year for the additional administrative costs of locating and acquiring an adequate supply of IVIG during this period of market instability.

CMS does not address the oncology "quality of care" demonstration project with payments to oncologists of $23 per patient encounter. However, CMS may very well propose to either eliminate the demonstration project or greatly scale it back for FY 2007. If the oncology demonstration survives in FY 2007, CMS officials have given strong indication that it could be eliminated for FY 2008. CMS seems to be looking for more substantive quality-of-care indicators. There is an attempt to develop the same indicators for oncology outpatient care (currently under development and scheduled for implementation in 2009) and physician offices.

As Medicare seeks ways to cut costs, relentless pressure will continually be placed on providers. Depending on your current market, if the overall 5% reduction in Medicare physician fee schedule remains for 2007, then oncology practices will see reductions from 2% to 5% or more depending on practice size, patient disease mix and location.

To guarantee patients' continuing access to quality care, all providers must strive to run the most efficient centers possible. It will be very important for each practice to evaluate their patient population, compare last year's volumes, and accurately project this year's forecast for services in developing an overall strategy for 2007.

—Mary Lou Bowers, MBA and Barbara Constable, RN, MBA

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