

# ClinicalOncology

Advances in Cancer Care

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news

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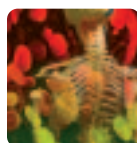
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**CONTINUING EDUCATION**

**Designing Strategies To Prevent Cancer Chemotherapy Errors,**

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## High Rate of Errors Found In Pediatric Chemotherapy for ALL

A new study has answered a long-standing question that many dread asking: How often do medication errors occur in administration of chemotherapy for pediatric patients?

In the study, which looked at prescribing, dispensing and parenteral administration of outpatient chemotherapeutic agents in children treated for acute lymphoblastic leukemia (ALL), Seattle researchers found that one or more errors occurred in nearly 10% of the 172 medications evaluated. Most of the errors were not serious, but some may have placed patients at risk for either relapse or overdose-related complications, the physician-pharmacist research team reported in a recent online edition of *Cancer* (10.1002/cncr.22131).

see *CHEMO ERRORS*, page 4 ►

## Opioids Can Disrupt Sleep and Contribute To Depression, Pain

ATLANTA—Patients with cancer-related pain are often advised to take opioids at bedtime to reduce pain and improve sleep. According to a new study, however, opioids can disrupt nocturnal sleep patterns, which may actually contribute to depression and pain.

“There may be selected times of the day when it is better to take these medications for optimizing pain control and minimizing adverse effects on sleep,” said lead study investigator Katherine Parker, PhD, RN. Dr. Parker is Edith F. Honeycutt Professor in the Nell Hodgson Woodruff School of Nursing at Emory University in Atlanta. “We are currently exploring this issue.”

Currently, it is estimated that between 30% and 80% of cancer patients experience sleep disturbances, which can adversely affect quality of life and functional status.

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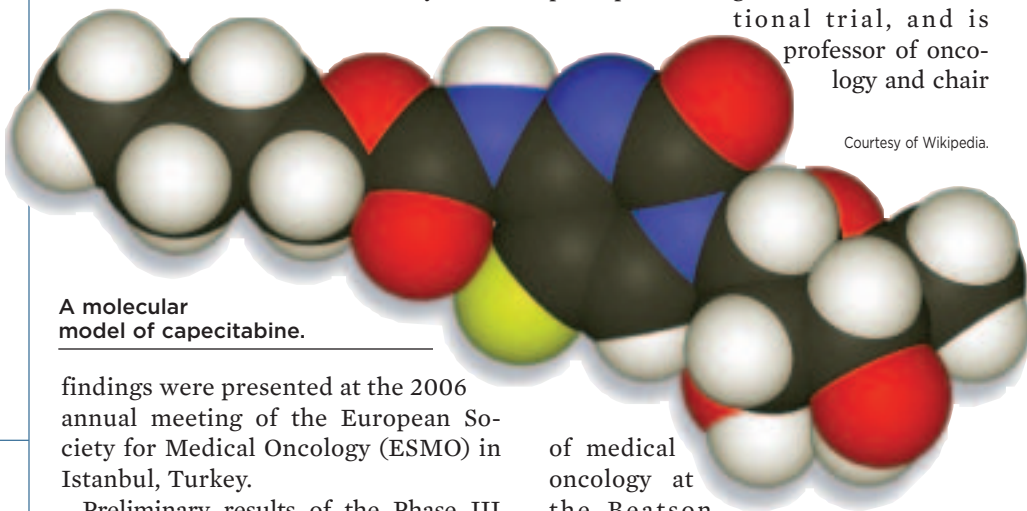
For Treatment of Colon Cancer ...

## Capecitabine/Oxaliplatin Shown Equal to FOLFOX

Capecitabine plus oxaliplatin provides equal survival benefit as FOLFOX4, according to results of a recent international study. The

to standard chemotherapy can benefit patients with colon cancer, according to Jim Cassidy, MD. He is the European principal investigator for the multinational trial, and is professor of oncology and chair

Courtesy of Wikipedia.



A molecular model of capecitabine.

findings were presented at the 2006 annual meeting of the European Society for Medical Oncology (ESMO) in Istanbul, Turkey.

Preliminary results of the Phase III clinical trial also suggested that the addition of bevacizumab (Avastin, Genentech)

of medical oncology at the Beatson Oncology Center in Glasgow, Scotland.

see *CAPE/OX*, page 22 ►

## Expect Significant Reimbursement Changes Beginning January 2007

### Medicare Will Drastically Revamp RVU and SGR

Next year's Medicare reimbursement changes will be significant. Although it is unlikely that there will be any changes in payment for drugs themselves, medical oncologists will be affected by both the Relative Value Unit (RVU) regulatory changes and the Sustained Growth Rate (SGR) legislation.

The biggest impact for oncologists is likely to come from the SGR legislative action, or lack thereof. Many clinicians

are concerned by the negative response from the Republicans, who had been stalwart in their support of physician payment increases in the past. This response came as a result of attacks made by American Medical Association (AMA) ads during the recent campaign season. Many involved in healthcare fear that legislators will not make the changes that affect physicians necessary

see *REIMBURSEMENT*, page 13 ►

**NEW PRODUCTS**

For more information on these products see page 21.



Avastin from Genentech



Revlimid from Celgene



Taxotere from Sanofi-Aventis

## REIMBURSEMENT

continued from page 1 ▼

as part of the appropriations bill. However, actions taken just before recess suggest a different result.

### Pleasure Now, Pain Later?

Both the House and Senate have bills in committee that would make a two- or three-year repair, but each have some ugly results for 2009 and beyond. The bills in play contain increases for 2007 and 2008 of between 0.5% and 2.7%. Some of the changes include bonus payments for quality information reporting and utilization management participation. Concerns have been raised that tying physician fee increases to performance indicators will lead to decreased patient access to care providers. Friends of the physician community have indicated they are working to protect physicians from SGR impacts and end the annual angst that legislators and physicians face regarding practice fee limitations.

If this SGR issue sounds familiar, it should. The current SGR was put into law in the Balanced Budget Act (BBA) of 1997, and was intended to restrain growth of Medicare payments to physicians. The intention was to contain medical inflation around that of non-medical services, and control cost of physician services to meet the SGR spending target. This has left physicians with two problems. Medical inflation has been higher than non-medical inflation, so costs have increased faster than payments. Patient demand for care—both novel and traditional treatments—has grown exponentially. Physicians are penalized for the growth in demand, the new technology and the drugs—all items over which they have no control.

### 5.1% Reimbursement Cut Across the Board in 2007

The current law requires a 5.1% cut across the board in 2007 payment for each procedure code. Congress must act to reverse this action. Since 2003, as part of the appropriations bill, Congress has acted on an annual basis to give minor increases, after 2002 had seen a 5.4% decrease. From 2003 through 2005, Congress acted to create a 1.6% increase, followed by increases of 1.5% each of the next two years. In 2006, Congress eliminated a 4.45% scheduled decrease resulting in no change in reimbursement. If the planned SGR schedule were enacted, physician payments would have decreased 34% since 2001, while the AMA shows increased costs for physicians of 41%. We will continue to be on this precipice each year, because it is unlikely that our legislators will bite the bullet and fix the SGR. Each year the fix is in the \$1



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billion range; Congress cannot face the \$1 trillion deficit a permanent repair would cost.

### The Good News

The second major reimbursement item should have a positive effect on medical oncologists' practices. The RUC (Resource Utilization Committee) of the AMA has recommended significant changes to the physician fee schedule RVUs. These changes have been accepted by the Centers for Medicare and Medicaid Services and will be published as part of the Physician Fee Schedule for 2007. The final rule was issued on November 2, 2006.

The changes positively impact the Evaluation and Management (E&M) codes. CMS gave an example of the change as follows: The work component for RVUs associated with an intermediate office visit, the most commonly billed physician's service, will increase by 37%. The work component for RVUs for an office visit requiring moderately complex decision making and for a hospital visit also requiring moderately complex decision making will increase by 29% and 31% respectively. Both these services rank in the top 10 most frequently billed physician services among more than 7,000 types of service paid under the physician fee schedule.

The proposed rule, which was published on June 16, 2006, revised RVUs for more than 400 services. The goal was to modernize the physician work component—that is, the time and work required of the physician to provide the service that includes the treatment itself and the assessment, risk analysis and decision making involved in the physician's determination of the treatment to be given. CMS data show that the physician work component of Medicare payments is approximately \$35 billion, and comprises more than 50% of the total Medicare payments made under the fee schedule to physicians.

The impact of this change is required by the BBA to be budget neutral. That means that it cannot increase or decrease payments by more than \$20 million. CMS estimates that the impact will be \$4 billion. This difference requires that CMS make an adjustment to the implementation. CMS has proposed an application that can be applied by Medicare only and which will allow payment by insurers of the new structure in its

entirety. Medicare will cut some of the high RVU procedures payments to accommodate the E&M code upgrades. This should mean about a 4% increase for oncology in 2007.

### Changes to RVU, Too

Along with the RVU update, CMS has proposed changing its practice expense calculations. Practice expense includes the personnel, supply and overhead costs of running a practice. Each procedure is then allocated a portion of this expense. Practice expense was increased significantly when the drug administration codes were updated in 2005. Medical malpractice is not computed as part of practice expense. CMS estimates that it spends \$30 billion or 45% of its overall payments to support practice expense.

The new methodology would be consistent across specialties, use data collected by specialty societies and reviewed by the RUC and is easier to understand. It would eliminate the "non-physician work pool" that has been problematic for oncologists, who have a highly trained and compensated non-physician staff as compared to many other specialties, and replace it with a standard practice expense methodology. The change would be implemented over four years to lessen the impact on budget neutrality, ensuring continued patient access and ease in reporting for physicians.

These issues will have the greatest impact on your practice reimbursement for 2007. Although the continuation of the current demonstration project will be extremely important, it clearly is not as controversial as the SGR exception will be, and therefore is less likely to be changed in the upcoming year. Remember, the RVU change will have a positive impact beyond Medicare. The final rule should be available by the time you are reading this, for your practice manager to evaluate.

—Mary Lou Bowers

**Ms. Bowers**, a member of the **Clinical Oncology News** advisory board, is president and CEO of **The Pritchard Group**, which specializes in oncology practice management and reimbursement consulting.

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