PHYSICAL EXAMINATION

On examination, the patient appears to be a thin Caucasian woman. Karnofsky performance status is 90%. Vital signs are as follows: blood pressure, 160/98 mm Hg; pulse, 110 beats/minute; respiratory rate, 20 breaths/minute; temperature, 37°C; and oxygen saturation, 96% on room air. She is awake, alert, and oriented to person, place, and time. Pupils are equal round and reactive to light and accommodation. Extraocular muscle movements are grossly intact. The sclerae are anicteric and conjunctivae are pink and moist appearing. The oropharynx is clear and poor dentition is noted. The sclerae are anicteric and conjunctivae are pink and moist appearing. The oropharynx is clear and poor dentition is noted. The neck is without lymphadenopathy. The lungs are clear bilaterally, and heart examination reveals a sinus tachycardia without a murmur. The abdomen is diffusely tender to palpation and is most intense in the suprapubic region. Bowel sounds are hypoactive and no peripheral edema is noted. Neurologic examination is within normal limits.

TREATMENT PLAN

The treatment plan for this patient is cisplatin 30 mg/m² intravenously (IV) weekly with concurrent pelvic radiation therapy daily.

TREATMENT COURSE

The patient was treated in the outpatient setting without difficulty until her second week of treatment, when she developed severe diarrhea and abdominal cramping. She was found to have Clostridium difficile colitis and was treated in the hospital with IV metronidazole. She was noted to have a hemoglobin of 10 g/dL and complained of a lack of energy and overwhelming fatigue. Then she received 2 units of packed red blood cells. During her fourth week of therapy, her hemoglobin was 8 g/dL. She reported minimal vaginal spotting. Iron studies were within normal limits. The oncology provider ordered darbepoetin alfa 200 µg every 2 weeks after the fourth week of chemotherapy; however, Medicare denied coverage for this medication.
because of inadequate documentation. Subsequent treatment delays as a result of pain, anemia, dehydration, elevated serum creatinine, and constipation occurred during the chemotherapy. The patient continued to require packed red blood cell infusions.

**DISCUSSION**

Medicare allows reimbursement of epoetin alfa or darbepoetin alfa for chemotherapy-induced anemia if the hemoglobin is less than 11 g/dL, and the patient is symptomatic if the treatment occurs in a physician office or hospital. There is currently no reimbursement for self-administered growth factor, even if the hemoglobin meets the reimbursement criteria. This requires that clinicians carefully document and monitor hemoglobin levels, presenting symptoms, and medication administration to allow proper reimbursement. There is no routine reimbursement for prophylactic use of these agents to prevent symptoms of anemia, including weakness, fatigue, dyspnea, or dizziness. This often deters the clinician, as it requires that the clinician appeal for use based on medical necessity.

The Centers for Medicare and Medicaid Services considered the American Society of Clinical Oncology and the National Comprehensive Cancer Network guidelines when developing their reimbursement policies. These guidelines require that patients being treated with these growth factors be monitored routinely to allow assessment of response. Clinicians should be encouraged to utilize a symptom assessment tool to allow proper coding of symptoms to facilitate reimbursement. If the patient is experiencing symptoms or has a hemoglobin that is trending down, a routine letter of medical necessity could be developed that would facilitate documentation of medical necessity. This case study also reiterates the importance of careful documentation by the healthcare provider for justification of supportive care medications.

**REFERENCE**