ABSTRACT

Myelosuppression is a significant complication of cytotoxic cancer therapy that places patients at higher risk for neutropenia and anemia. Supportive care to treat patients with cancer who develop neutropenia and anemia has advanced considerably in the past several years. New treatments are improving patient quality of life, and proactive treatment of patients at high risk permits chemotherapy to be given as scheduled. Yet despite the widespread acceptance of these treatments and their inclusion in evidence-based guidelines, reimbursement policies in the United States often undercompensate healthcare providers. Furthermore, data have shown that cost and reimbursement issues may be the cause of underuse or nonuse of growth factors. In this review, the current status of reimbursement issues in neutropenia and anemia, in addition to the implications of coding and the importance of documentation with regards to this essential element of cancer treatment, are discussed.


Healthcare reimbursement in the United States has changed drastically in the past several decades. Today, Medicare is the largest healthcare program in the United States in terms of expenditures and beneficiaries, accounting for approximately $4 of every $10 in revenue collected by 4800 US hospitals and 875000 physician practices. Originally, Medicare omitted outpatient prescription drug benefits, but in 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (Public Law 108-173) was signed into law. With the anticipated implementation of Part D of the Medicare Modernization Act (MMA) on January 1, 2006—informally known as Medicare Part D—the healthcare industry is once again preparing for adherence to an evolved set of reimbursement rules (Figure 1).

The 2003 passage of MMA also was intended to address oncology services (annual costs of cancer-related treatment account for 20% of all healthcare costs), particularly imbalances in reimbursement. Medicare traditionally has undercompensated for the administration of chemotherapy and the treatment of its ensuing side effects, such as anemia and neutropenia. It is well established that chemotherapy-induced anemia and neutropenia may adversely impact optimal cancer treatment by causing chemotherapy delays or dose reductions. Yet, despite the high incidence of anemia and neutropenia and the undisputed data supporting the benefits of supportive care on patients’ overall quality of life, high costs and reimbursement requirements restrict patient management practices and have resulted in undertreatment and delayed treatment of these comorbidities. Current reimbursement issues in the supportive care setting—with a focus on Medicare—are explored in this article. Although reimbursement for supportive care may involve third-party insurers, criteria differ widely by payer and location; thus, a full discussion is beyond the scope of this article and third-party issues are touched upon only briefly.

This discussion focuses on 2 of the most common and distressing symptoms that occur in patients with cancer: neutropenia and anemia.

EVIDENCE-BASED GUIDELINES

Prophylactic use of growth factors, pegfilgrastim or filgrastim, beginning with the first cycle of chemotherapy has been shown in clinical trials to be the most effective way to reduce the incidence of febrile neutropenia in nonmyeloid malignancies. The new National Comprehensive Cancer Network (NCCN) guidelines recognize the benefits of growth factor treatment in conjunction with a chemotherapy regimen as a preventive measure against neutropenia in patients with a 20% or greater risk of developing this condition. The NCCN guidelines also recommend pharmacologic intervention with erythropoietic therapy in those patients at high risk of chemotherapy-associated anemia. Are current reimbursement policies barriers to implementing these evidence-based practice guidelines?

CURRENT STATUS OF REIMBURSEMENT FOR SUPPORTIVE CARE

NEUTROPENIA

Studies indicate that pegfilgrastim and filgrastim are safe and efficacious for the treatment of chemotherapy-induced neutropenia. Pegfilgrastim and filgrastim are reimbursed under the Medicare Hospital Outpatient Prospective Payment System or the Medicare Part A Prospective Payment System as specifically defined by outpatient or inpatient administration.

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that neutropenic sepsis is the most common life-threatening complication of chemotherapy.

**ANEMIA**

Anemia is a major cause of fatigue, which continues to be the most distressing and most prevalent side effect of cancer treatment today. As is the case with the treatment of neutropenia, management of chemotherapy-related anemia is associated with significant healthcare expenditures, and epoetin alfa and darbepoetin alfa are no exceptions. Among a random sample of practicing physicians in the United States, 37% reported that financial considerations had affected their decision to use erythropoietin. The authors of this assessment of erythropoietin use further stated that reimbursement policies in the United States could indeed be a major determinant of physician practice patterns. Medicare reimbursement for epoetin alfa and darbepoetin alfa is stringently defined and varies by geographic jurisdiction. For example, in Oklahoma, Louisiana, Arkansas, Missouri, and New Mexico, erythropoietic therapy is specified for the treatment of symptomatic anemia for patients with nonmyeloid malignancies with hemoglobin levels of less than 10 of epoetin alfa use, and 80% of the charges are typically reimbursed by Medicare. However, Medicare denies reimbursement for epoetin alfa if it is used as a preventative measure for anemia or a transfusion, if it is used to treat other types of anemia apart from the approved indications, or if it is self-administered.

**IMPLICATIONS OF CODING AND IMPORTANCE OF DOCUMENTATION**

Integrating evidence-based practice guidelines as a standardized approach to supportive care issues may enhance rates of reimbursement in a clinical practice by justifying medical necessity. Because Medicare reimbursement requirements are so stringent, one of the first steps oncology practices can take toward timely and maximized reimbursement is accurate billing and claims submission. The relationship between reimbursement and supportive care is complicated and requires a clear understanding of all the elements involved, including administration of International Classification of Diseases, Ninth Revision codes, Current Procedural Terminology (CPT) codes, Relative Value Units, and Medicare reimbursement guidelines. Staying up-to-date with coding guidelines as they are released is a challenge, but the effort is
Figure 2. Medicare and Coding Resources

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<thead>
<tr>
<th>Agency</th>
<th>Telephone Number</th>
<th>Web Sites</th>
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<tbody>
<tr>
<td>Medicare</td>
<td>1-800-MEDICARE</td>
<td><a href="http://www.medicare.gov">http://www.medicare.gov</a></td>
</tr>
<tr>
<td>AARP—Guide to the New Medicare Prescription Drug Coverage</td>
<td>1-888-OUR-AARP</td>
<td><a href="http://www.aarp.org">http://www.aarp.org</a></td>
</tr>
<tr>
<td>Centers for Medicare and Medicaid Services</td>
<td></td>
<td><a href="http://www.cms.hhs.gov/providers/drugs/default.asp">http://www.cms.hhs.gov/providers/drugs/default.asp</a></td>
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ICD-9 Coding

AARP = American Association of Retired Persons; ICD-9 = International Classification of Diseases, Ninth Revision.

essential to maximizing reimbursement for supportive care. Best documentation practices to ensure proper coding in supportive care are to include the diagnosis on each visit note and order sheet, being sure to include principal and primary diagnosis codes to document medical necessity. Codes must reflect the condition of the patient and indicate the reason or reasons for which the service was performed. Justification of the treatment choice or CPT code is accomplished by linking it to the patient’s specific diagnosis, symptom, or complaint. As an example, a patient who is experiencing severe fatigue, shortness of breath, has a hemoglobin level of 9.0 g/dL, and who has received a myelosuppressive chemotherapy regimen known to cause anemia would benefit from erythropoietin. Proper documentation of this symptom would assist with reimbursement. Another area of concern is in outpatient areas where nurse visits occur frequently. It is necessary when accepting verbal orders for supportive care medications to specify the indication in the actual verbal order to ensure reimbursement. In addition, change of supportive care medications because of a lack of efficacy also needs to be carefully documented to avoid denial. Unintentional or careless documentation and/or coding errors will not only result in lower rates of reimbursement, but also may result in an investigation for fraud or abuse.

CONCLUSIONS

Reimbursement issues are expected to continue to present challenges in supportive care. However, an up-to-date understanding of Medicare reimbursement guidelines and coding practices will help clinical practices to ensure reimbursement (Figure 2). Additionally, alternative solutions are available for patients without coverage or with limited coverage. Pharmaceutical company assistance programs exist to help eligible patients receive the supportive care they need. Also, the Social Security Administration may provide extra help for people with limited incomes under certain circumstances. Following evidence-based practice guidelines enables clinical nurse specialists, nurse practi-

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