DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUL 27 2007

TO: Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson Daniel R. Levinson
Inspector General

SUBJECT: Review of Selected Physician Practices' Procedures for Tracking Drug Administration Costs and Ability To Purchase Cancer Drugs at or Below Medicare Reimbursement Rates (A-09-05-00066)

The attached final report summarizes the results of our reviews of 12 selected physician practices in the specialties of hematology, hematology/oncology, and medical oncology.

Medicare Part B reimburses physician practices for costs associated with the administration and purchase of a limited number of outpatient prescription drugs and biologicals (collectively referred to as drugs). Reimbursement of drug administration costs is based on a fee schedule for procedure codes. Pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, the Centers for Medicare & Medicaid Services (CMS) adjusted the fee schedule, effective January 1, 2004. In addition, CMS implemented new procedure codes, effective January 1, 2005. The MMA also established a new methodology for Medicare Part B reimbursement of the purchase of most covered drugs. Effective January 1, 2005, reimbursement, which is based on payment codes, is generally set at 106 percent of the manufacturer-reported average sales price. Industry groups representing oncologists have expressed concerns that the MMA's adjustments to Medicare Part B reimbursement may not adequately cover the costs associated with the administration and purchase of drugs.

Our objective was to consolidate the results of our reviews of the 12 selected physician practices. Those reviews determined whether the 12 practices (1) had procedures to track, by procedure code, the costs associated with administering drugs to cancer patients and (2) were able to purchase drugs (related to 15 selected payment codes) for the treatment of cancer patients at or below the MMA-established reimbursement rates from April 1 through June 30, 2005.

Eleven of the twelve practices reviewed did not have procedures to track, by procedure code, the costs associated with administering drugs to cancer patients. Federal regulations and guidance do not require physician practices to track the costs of resources used to provide drug administration services. However, without procedures for tracking these costs by procedure code, the

11 practices could not determine whether Medicare reimbursement for each code was sufficient to cover the costs of providing the services.

Nine of the twelve practices reviewed could generally purchase drugs related to the 15 selected payment codes for the treatment of cancer patients at or below the MMA-established reimbursement rates from April 1 through June 30, 2005. Specifically, these practices paid prices below the reimbursement rates for the majority of payment codes related to the drugs purchased. The remaining three practices paid prices above the reimbursement rates for at least half of the payment codes related to the drugs purchased.

We recommend that CMS consider the results of our review in any future evaluations of Medicare Part B reimbursement of costs associated with the administration and purchase of drugs for the treatment of cancer patients.

In its comments on our draft report, CMS agreed with our recommendation.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov. Please refer to report number A-09-05-00066 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF SELECTED PHYSICIAN PRACTICES' PROCEDURES FOR TRACKING DRUG ADMINISTRATION COSTS AND ABILITY TO PURCHASE CANCER DRUGS AT OR BELOW MEDICARE REIMBURSEMENT RATES

Daniel R. Levinson
Inspector General

July 2007
A-09-05-00066

Office of Inspector General

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The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Medicare Part B reimburses physician practices for costs associated with the administration and purchase of a limited number of outpatient prescription drugs and biologicals (collectively referred to as drugs).

- Medicare reimbursement of drug administration costs is based on procedure codes. The reimbursement amount for each procedure code is based on a fee schedule, which is intended to reflect the costs of the resources needed to furnish each physician service. Pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, the Centers for Medicare & Medicaid Services (CMS) adjusted the fee schedule, effective January 1, 2004. In addition, CMS implemented new procedure codes, effective January 1, 2005.

- Medicare reimbursement of drug purchases is based on payment codes. The MMA established a new methodology for Medicare Part B reimbursement of most covered drugs. Effective January 1, 2005, reimbursement is generally set at 106 percent of the average sales price. Each quarter, CMS uses the manufacturer-reported average sales prices to calculate the reimbursement amount for each payment code.

Industry groups representing oncologists have expressed concerns that the MMA's adjustments to Medicare Part B reimbursement may not adequately cover the costs associated with the administration and purchase of drugs. Specifically, one industry group has stated that, although the reimbursement amounts for drug administration costs have increased, reimbursement still falls short of covering all essential medical services provided to cancer patients. In addition, three industry groups have stated that reimbursement amounts for drug purchases are lower than the prices that practices pay for some cancer drugs.

OBJECTIVE

Our objective was to consolidate the results of our reviews of 12 selected physician practices in the specialties of hematology, hematology/oncology, and medical oncology. Those reviews determined whether the 12 practices:

- had procedures to track, by procedure code, the costs associated with administering drugs to cancer patients and

- were able to purchase drugs (related to 15 selected payment codes) for the treatment of cancer patients at or below the MMA-established reimbursement rates from April 1 through June 30, 2005.

SUMMARY OF RESULTS

Procedures for Tracking Drug Administration Costs

Eleven of the twelve practices reviewed did not have procedures to track, by procedure code, the costs associated with administering drugs to cancer patients. Federal regulations and guidance do not require physician practices to track the costs of resources used to provide drug administration services. However, without procedures for tracking these costs by procedure code, the 11 practices could not determine whether Medicare reimbursement for each code was sufficient to cover the costs of providing the services.

Ability To Purchase Drugs at or Below Medicare Reimbursement Rates

Nine of the twelve practices reviewed could generally purchase drugs related to the 15 selected payment codes for the treatment of cancer patients at or below the MMA-established reimbursement rates from April 1 through June 30, 2005. Specifically, these practices paid prices below the reimbursement rates for the majority of payment codes related to the drugs purchased. The remaining three practices paid prices above the reimbursement rates for at least half of the payment codes related to the drugs purchased.

RECOMMENDATION

We recommend that CMS consider the results of our review in any future evaluations of Medicare Part B reimbursement of costs associated with the administration and purchase of drugs for the treatment of cancer patients.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In its comments on our draft report, CMS agreed with our recommendation. We have included CMS's comments as Appendix E.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicare Part B reimburses physician practices for costs associated with the administration and purchase of a limited number of outpatient prescription drugs and biologicals[1] (collectively referred to as drugs). Covered drugs include injectable drugs administered by a physician; certain self-administered drugs, such as oral anticancer drugs and immunosuppressive drugs; drugs used in conjunction with durable medical equipment; and some vaccines.

Medicare Reimbursement of Drug Administration Costs

Medicare Part B reimburses physician practices for costs associated with the administration of drugs based on procedure codes. The reimbursement amount for each procedure code is based on a fee schedule. Reimbursement under the fee schedule is based on national uniform relative value units (RVU), which are intended to reflect the costs of the resources needed to furnish each physician service.

For each service on the fee schedule, there are three RVUs: (1) physician work, which includes the physician's time, skill, and training; (2) practice expense, which includes rent, utilities, equipment, supplies, and salaries of nurses, technicians, and administrative staff; and (3) malpractice expense, which includes the costs of obtaining professional liability coverage. The Centers for Medicare & Medicaid Services (CMS) adjusts these RVUs for geographic differences in practice costs and then multiplies the adjusted RVUs by a dollar amount (the conversion factor) to determine the reimbursement amounts. The RVUs, geographic practice cost indexes, and conversion factor are published every year in the Federal Register.

Pursuant to section 1848(c)(2)(H)(i) of the Social Security Act, as added by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, CMS used a survey from a physician specialty organization when determining the practice expense RVUs for certain drug administration services on the fee schedule. Specifically, CMS used a 2002 survey from the American Society of Clinical Oncology (ASCO), which collected from oncology practices such data elements as office expenses; nonphysician payroll expenses, including fringe benefits and the costs of administrative personnel; the costs of medical materials and supplies; and depreciation, leases, and rent on medical equipment individually valued at $1,000 or more.[2] Based on the revised RVUs, CMS adjusted the fee schedule for drug administration services, effective January 1, 2004. In addition, CMS implemented new procedure codes, effective January 1, 2005.

[1]Biologicals are medicinal compounds prepared from living organisms and their products.

[2]We did not review the results of ASCO's survey.

Medicare Reimbursement of Drug Purchases

Medicare Part B reimburses physician practices for drug purchases based on payment codes, which are part of the Healthcare Common Procedure Coding System. Each payment code has a fixed CMS-assigned billing unit. Each time a physician practice submits a bill for a covered drug, it must specify the number of billing units administered to the patient. For example, if a billing unit for a given payment code is 50 milligrams and a physician practice administers 100 milligrams, the practice should bill for two billing units.

One payment code can cover numerous national drug codes (NDC), which represent drugs that may be manufactured by more than one company in different package sizes and strengths.[3] Each NDC is a unique three-segment number that identifies the labeler/vendor, product, and package size. The package size and/or strength denoted by an NDC may not equal the billing unit for the related payment code. Because of these complexities, CMS publishes a payment code/NDC crosswalk that identifies all NDCs associated with each payment code, as well as the number of billing units for each NDC.

Section 1847A of the Social Security Act, as added by the MMA, established a new methodology for Medicare Part B reimbursement of the purchase of most covered drugs. Effective January 1, 2005, reimbursement is generally set at 106 percent of the average sales price (ASP) that manufacturers report. The ASP is a manufacturer's sales of a drug to all purchasers in the United States in a calendar quarter divided by the total number of units of the drug sold by the manufacturer in that quarter. The ASP calculation includes the following specific price concessions: volume discounts, prompt-payment discounts, cash discounts, free goods that are contingent on any purchase requirement, chargebacks, and most rebates. However, the ASP calculation does not include sales at a nominal charge or other sales excluded from the determination of "best price" in the Medicaid drug rebate program.

The MMA requires drug manufacturers to report quarterly to CMS the ASP for each drug covered by Medicare Part B. The manufacturers report the ASP separately for each NDC. Each quarter, CMS uses the manufacturer-reported ASPs for sales that occurred two quarters earlier to calculate the reimbursement amount for each payment code.

Industry Group Concerns

Industry groups representing oncologists have expressed concerns that the MMA's adjustments to Medicare Part B reimbursement may not adequately cover the costs associated with the administration and purchase of drugs. Specifically, the Community Oncology Alliance (COA) has stated that, although the reimbursement amounts for drug administration costs have increased, reimbursement still falls short of covering all essential medical services provided to cancer patients. In addition, COA, ASCO, and the American Society of Hematologists have stated that reimbursement amounts for drug purchases are lower than the prices that practices pay for some cancer drugs.

[3]The Food and Drug Administration requires registered drug establishments to provide information related to all drug products intended for commercial distribution for use in creating a universal product identifier for human drugs.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to consolidate the results of our reviews of 12 selected physician practices in the specialties of hematology, hematology/oncology, and medical oncology. Those reviews determined whether the 12 practices:

- had procedures to track, by procedure code, the costs associated with administering drugs to cancer patients and

- were able to purchase drugs (related to 15 selected payment codes) for the treatment of cancer patients at or below the MMA-established reimbursement rates from April 1 through June 30, 2005.

Scope

To select the 12 physician practices, we identified those practices in the 50 States and the District of Columbia whose Medicare-allowed amounts for certain drugs totaled $50,000 or more each in 2003 (the most recent paid claims data available to us at the start of our reviews). To ensure that we selected physician practices of various sizes, we divided the practices into two groups: the "large practices" group, consisting of practices with Medicare-allowed amounts in excess of $5 million each, and the "other practices" group, consisting of practices with Medicare-allowed amounts of $50,000 to $5 million each. We then eliminated from our review physician practices included in a prior Office of Inspector General review.[4] In addition, to ensure nationwide coverage, we selected three practices in each of the four regions designated by the U.S. Census Bureau (western, midwestern, northeastern, and southern regions). The three practices in each region included one practice from the "large practices" group and two practices from the "other practices" group. The 12 practices were located in 12 States.

The 15 payment codes selected for review represented 15 of the 43 drugs that COA and the American Society of Hematologists had identified as drugs that physician practices could not purchase at or below the MMA-established reimbursement rates. The 43 drugs accounted for approximately $2.1 billion of the $4.5 billion in total 2004 Medicare Part B expenditures for drugs administered by practices in the specialties of hematology, hematology/oncology, and medical oncology.[5] The 15 selected payment codes represented more than 99 percent of the $2.1 billion.

Because meeting our objective did not require an understanding or assessment of the selected physician practices' overall internal control structures, we did not perform such a review. We limited our review of internal controls to obtaining an understanding of whether the 12 practices

[4]The prior review, "Adequacy of Medicare Part B Drug Reimbursement to Physician Practices for the Treatment of Cancer Patients" (A-06-05-00024, September 26, 2005), which was mandated by the MMA, evaluated the adequacy of the MMA-established reimbursement rates from January 1 through March 31, 2005.

[5]The $2.1 billion represents the total 2004 Medicare-allowed amounts for 40 of the 43 drugs identified by the industry groups. There were no 2004 Medicare data for the remaining three drugs.

had procedures to track drug administration costs by procedure code. For any practice that indicated that it tracked costs by procedure code, we did not evaluate the adequacy of the tracking procedures or the sufficiency of reimbursement. We also did not review CMS's methodology for calculating drug administration reimbursement rates.

We conducted our fieldwork at the 12 practices' offices from August 2005 through May 2006. (See Appendix A for a map showing the practices' locations.)

Methodology

To determine whether the selected practices had procedures to track drug administration costs by procedure code, we interviewed representatives from each practice and obtained documentation related to accounting for drug administration services. We also reviewed applicable Federal laws, regulations, and guidance.

To determine whether the selected practices were able to purchase drugs at or below the MMA-established reimbursement rates, we:

- identified all NDCs associated with the 15 selected payment codes, as reported by CMS in the payment code/NDC crosswalk;[6]

- reviewed invoices to identify the drug purchase quantity, size, and price for all NDCs related to the selected payment codes;

- converted the quantity purchased for each identified NDC into billing units for the selected payment codes;

- calculated the average purchase price related to each selected payment code at the CMS-assigned billing unit level;

- reviewed drug rebate agreements and other documentation related to rebates and purchase discounts;

- calculated the average net purchase price related to each selected payment code by subtracting any rebates or discounts (excluding prompt-payment discounts) associated with the drug purchase;[7] and

[6]Although some drugs purchased under the identified NDCs could have been billed under more than one payment code, we treated the drugs as if they were billed using the selected payment codes. This method had no impact on our analysis because the per-unit reimbursement for the selected payment codes was the same regardless of which payment code was billed.

[7]We did not include prompt-payment discounts in our calculations of average net purchase prices because we believe that the decisions to take such discounts are physician practice business decisions. When invoice prices included prompt-payment discounts, we added the discounts back into the purchase prices.

- compared the average net drug purchase price related to each selected payment code with the second quarter 2005 MMA-established reimbursement rate published by CMS on September 16, 2005.

Between December 2005 and June 2006, we issued a restricted report to each of the 12 practices and CMS.

We conducted this review in accordance with generally accepted government auditing standards.

RESULTS OF REVIEW AND RECOMMENDATION

Eleven of the twelve practices reviewed did not have (nor were they required to have) procedures to track, by procedure code, the costs associated with administering drugs to cancer patients. In addition, 9 of the 12 practices reviewed could generally purchase drugs related to the 15 selected payment codes for the treatment of cancer patients at or below the MMA-established reimbursement rates from April 1 through June 30, 2005.

PROCEDURES FOR TRACKING DRUG ADMINISTRATION COSTS

Based on our interviews and accounting documentation at the 12 practices reviewed, 11 practices did not have procedures to track costs associated with administering drugs to cancer patients. Although most practices had procedures to track overall practice costs, only one practice had procedures to track drug administration costs by procedure code (shown as practice 9 in the table on the following page and in Appendixes B, C, and D). This practice estimated its costs for each procedure code by applying what it believed was CMS's methodology for computing drug administration reimbursement rates. Representatives of another practice stated that they had the capability but chose not to allocate drug administration costs by procedure code (practice 5).

Federal regulations and guidance do not require physician practices to track the costs of resources used to provide drug administration services. However, without procedures for tracking these costs by procedure code, the 11 practices could not determine whether Medicare reimbursement for each code was sufficient to cover the costs of providing the services.

Although the 11 practices were unable to demonstrate the sufficiency of Medicare reimbursement, all 11 practices, as well as the practice that tracked costs by procedure code, identified costs that they believed Medicare did not reimburse or adequately reimburse. These costs included patient support services, such as chemotherapy teaching sessions, provided by nonphysician personnel; supplies, such as needles and intravenous tubing; drug mixing equipment, such as chemotherapy hoods; preinfusion and postinfusion procedures performed by nurses; and drug storage and inventory costs. Based on our review of the ASCO survey questionnaire, information related to several of these costs was available to CMS in determining practice expense RVUs and reimbursement amounts for drug administration services.

Appendix B presents additional information on the reimbursement issues identified by the 12 practices.

ABILITY TO PURCHASE DRUGS AT OR BELOW MEDICARE REIMBURSEMENT RATES

Nine of the twelve practices reviewed could generally purchase drugs related to the 15 selected payment codes for the treatment of cancer patients at or below the MMA-established reimbursement rates from April 1 through June 30, 2005.[8] Specifically, these practices paid prices below the reimbursement rates for the majority of payment codes related to the drugs purchased. The remaining three practices paid prices above the reimbursement rates for at least half of the payment codes related to the drugs purchased.

The table below summarizes the results for all 12 practices. Appendix C shows the MMA-established reimbursement rate and the average net purchase price, by practice, for each of the 15 selected payment codes. Appendix D shows the percentage differences between these reimbursement rates and purchase prices.

Number and Percentage of Payment Codes Related to Drugs Purchased at or Below the MMA-Established Reimbursement Rates

Practice Number	Number of Payment Codes Related to Drugs Purchased	Number of Payment Codes Related to Drugs Purchased at or Below MMA Reimbursement	Percentage of Payment Codes Related to Drugs Purchased at or Below MMA Reimbursement
1	12	10	83.33%
2	6	5	83.33%
3	15	12	80.00%
4	14	11	78.57%
5	14	11	78.57%
6	9	7	77.78%
7	10	7	70.00%
8	13	9	69.23%
9	12	8	66.67%
10	6	3	50.00%
11	9	4	44.44%
12	9	4	44.44%

Based on our analysis, we determined that there were no significant differences in our results due to practice size or location.

[8]During the quarter, only 1 of the 12 practices purchased drugs related to all 15 payment codes. The 11 other practices purchased drugs related to 6 to 14 of the 15 payment codes.

RECOMMENDATION

We recommend that CMS consider the results of our review in any future evaluations of Medicare Part B reimbursement of costs associated with the administration and purchase of drugs for the treatment of cancer patients.

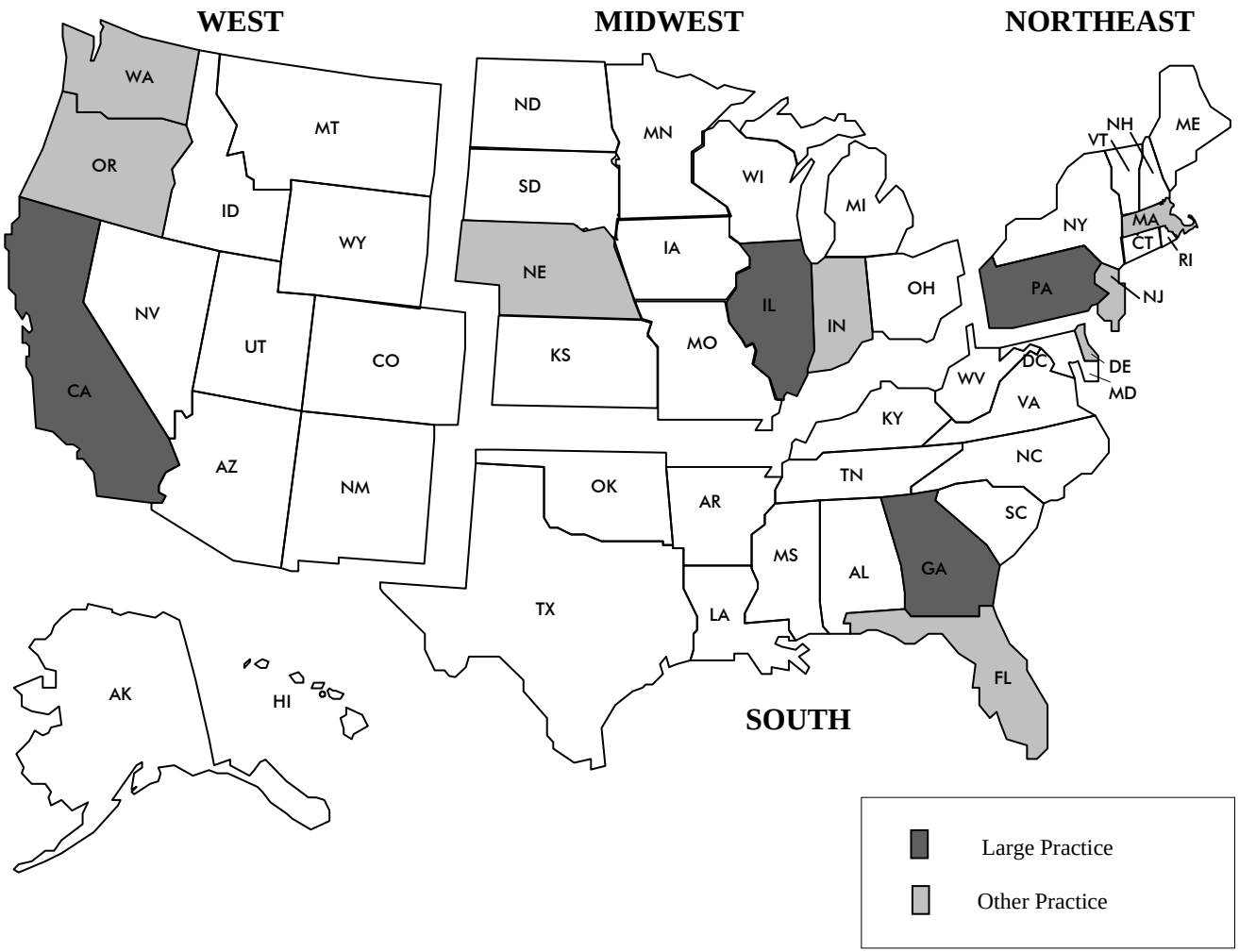
CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In its comments on our draft report, CMS agreed with our recommendation and provided information on CMS's implementation of the Competitive Acquisition Program. This voluntary program allows physicians to obtain Medicare Part B drugs without purchasing them. We have included CMS's comments as Appendix E.

APPENDIXES

APPENDIX A

LOCATIONS OF THE 12 PHYSICIAN PRACTICES REVIEWED



REIMBURSEMENT ISSUES IDENTIFIED BY THE 12 PHYSICIAN PRACTICES

PRACTICE 1

Representatives from Practice 1 identified drug administration costs that they believed were not reimbursed, or adequately reimbursed, by Medicare: patient support services, such as nutritional and financial counseling, and huber needles.

PRACTICE 2

A representative from Practice 2 identified costs that she believed were not reimbursed by Medicare. The procedures she listed as not reimbursed included mixing of chemotherapy drugs, port flushing during chemotherapy, and disposal of chemotherapy waste. The supplies she listed as not reimbursed included:

- bacteriostatic sodium chloride (30 ml);
- bacteriostic water (30 ml);
- heparin lock flush (30 ml);
- huber needles;
- dressing change kits;
- intravenous tubing;
- betadine lotion;
- sterile gloves;
- disposable syringes/needles (10 cc, 20 cc, 30 cc, and 60 cc);
- surgical sponges (4 × 4) and tape;
- alcohol pads;
- catheters (22G × 1"); and
- surgical tray/bone marrow biopsies.

PRACTICE 3

Representatives from Practice 3 identified costs that they believed were not reimbursed, or adequately reimbursed, by Medicare: patient support services (chemotherapy teaching sessions and advice/phone calls) and preinfusion and postinfusion procedures performed by nurses (evaluating the patient, establishing and discontinuing venous access, and educating the patient and family before discharge).

The representatives also identified issues with the drug administration codes, stating that the G code for "port flush" is allowed only when no other service is provided that day and that no code is available for concurrent chemotherapy administration.

In addition, representatives identified items that they believed were not adequately reimbursed and should be covered as part of the reimbursement rates for drug purchases:

- the cost of maintaining inventory;
- nonbillable drug loss for drugs that become outdated while on the shelf;

- medical supplies and labor to perform admixture of drugs;
- the biosafety cabinet to perform admixture of drugs (annual certification);
- specialized products for daily decontamination of the biosafety cabinet;
- safety garb worn during admixture of drugs (specialized gowns and gloves);
- specialized containers for disposing of contaminated supplies (e.g., needles);
- disposal of toxic waste; and
- purchases of brand-name drugs far exceeding average sales prices when generic supplies run out.

PRACTICE 4

Representatives from Practice 4 identified costs that they believed were not reimbursed, or adequately reimbursed, by Medicare: patient and family education, nutrition and psycho/social counseling, chemotherapy planning (drug regimen, dosing, etc.), triage of acute care, and clinical trial oversight.

In addition, representatives identified items that they believed were not reimbursed as part of the reimbursement rates for drug purchases:

- billing and reimbursement processing (either internal or outsourced);
- billing for patients without secondary insurance;
- pharmacists and mixing technicians (for the preparation of chemotherapy drugs);
- pharmacy management/inventory, waste, and other direct drugs and supplies;
- electronic medical record system purchase, development, and maintenance;
- staff documentation of infusion-related activity in medication administration records;
- space and carrying costs of inventory;
- administrative staff; and
- costs to bill Medicare.

PRACTICE 5

Representatives from Practice 5 identified costs that they believed were not reimbursed, or adequately reimbursed, by Medicare:

- facilities/building costs and rent;
- billing and charge capture expenses;
- inventory storage, including robotic storage units;
- drug mixing;
- drug safety checks;
- insurance verifications;
- preauthorizations;
- verification of all phases of drug administration;
- hiring and training;
- needles and tubing;
- lab analysis;

- receptionists and file clerks;
- answering patient toxicity questions;
- protective equipment;
- chemotherapy pumps and chairs;
- chart preparation;
- computer programming for new procedure codes;
- accidental spillage or breakage;
- loss of drugs past expiration;
- unapproved drug uses; and
- uncaptured drug usage.

PRACTICE 6

A representative from Practice 6 stated that Medicare reimbursement for more expensive drugs was inadequate because it did not compensate for cashflow issues, such as decreasing drug manufacturer rebates and other expenses. These other expenses related to the time that staff spent entering billing codes into the billing system and maintaining inventories.

PRACTICE 7

Representatives from Practice 7 identified drug administration costs that they believed were not reimbursed, or adequately reimbursed, by Medicare: patient support services, such as chemotherapy teaching sessions and advice/phone calls, and preinfusion and postinfusion procedures performed by nurses.

PRACTICE 8

A representative from Practice 8 stated that Medicare reimbursement for drug administration was inadequate to cover costs related to the time that staff spent searching for the lowest drug prices and performing preinfusion and postinfusion procedures.

PRACTICE 9

Representatives from Practice 9 identified drug administration costs that they believed were not reimbursed by Medicare: pharmacy services for mixing drugs, nursing assistance in patient training and phone contacts, chemotherapy hoods, and treatment rooms that were required to comply with Occupational Safety & Health Administration standards and other space requirements.[1]

[1]Practice 9 had procedures to track drug administration costs by procedure code. We did not evaluate the adequacy of the tracking procedures or the sufficiency of reimbursement.

PRACTICE 10

A representative from Practice 10 stated that Medicare reimbursement for needles and intravenous setups was inadequate and believed that Medicare should reimburse for these expenses separately.

PRACTICE 11

Representatives from Practice 11 stated that Medicare did not adequately reimburse for patient support services, such as after-hours advice/phone calls, and the supplies used to treat patients.

PRACTICE 12

Representatives from Practice 12 stated that Medicare reimbursement was inadequate to cover the general costs of practice operations, such as supplies and fixed costs, and costs associated with time spent to educate patients about their treatment and discuss their concerns.

APPENDIX C

MEDICARE REIMBURSEMENT RATES AND AVERAGE NET PURCHASE PRICES FOR 15 SELECTED PAYMENT CODES

(April 1 Through June 30, 2005)

	Medicare Reimbursement Rate for Each Payment Code (A – O)														
	A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**	**M**	**N**	**O**
	$9.806	$16.120	$439.813	$277.145	$226.658	$257.634	$323.682	$20.717	$428.074	$5.393	$1,212.831	$0.246	$3.944	$1.848	$5.539
Practice Number	**Average Net Purchase Price for Drugs Related to Each Payment Code**														
1	$9.936	$12.752	$434.497	$210.702	$151.790	$194.977	$311.688	-	-	$4.777	-	$0.554	$1.872	$1.050	$3.798
2	9.110	-	-	271.899	151.800	-	-	-	-	-	-	0.603	1.980	1.711	-
3	9.757	12.689	439.944	202.215	151.802	256.682	311.686	$19.364	$408.260	4.947	$1,342.590	0.451	1.928	1.308	4.371
4	7.192	12.621	445.706	199.835	189.580	256.546	318.184	27.418	422.388	4.901	-	0.619	1.932	1.007	4.366
5	7.162	12.290	438.796	224.795	210.560	259.250	311.686	20.654	433.422	5.158	-	0.575	1.786	1.369	3.881
6	-	13.848	439.945	214.232	-	-	317.234	-	-	4.950	-	0.549	2.000	1.172	4.000
7	8.529	18.133	441.067	271.815	151.789	-	309.893	-	-	4.901	-	1.210	1.990	-	4.440
8	7.950	14.958	442.225	244.784	127.626	258.294	317.609	27.419	-	4.950	-	0.688	2.101	1.238	5.497
9	9.740	12.167	439.951	200.260	151.800	262.950	314.803	-	-	5.716	-	0.557	1.992	1.144	4.000
10	9.829	-	436.583	-	151.823	-	-	-	-	-	-	1.379	-	2.060	3.870
11	10.296	14.387	445.708	-	-	261.856	-	-	-	6.930	-	1.100	1.961	1.631	4.600
12	9.979	-	445.707	-	163.569	-	318.183	-	-	4.901	-	1.223	2.053	1.919	6.190
	Number of Practices With Average Net Purchase Prices at or Below Medicare Reimbursement Rate for Each Payment Code														
	7	8	3	9	10	3	9	2	2	8	0	0	11	9	10
	Number of Practices With Average Net Purchase Prices Above Medicare Reimbursement Rate for Each Payment Code														
	4	1	8	0	0	4	0	2	1	2	1	12	0	2	1

PERCENTAGE DIFFERENCES BETWEEN MEDICARE REIMBURSEMENT RATES AND AVERAGE NET PURCHASE PRICES

(April 1 Through June 30, 2005)

PRACTICE 1

Payment Code	Medicare Reimbursement Rate	Average Net Purchase Price	Percentage Difference[1]
A	$9.806	$9.936	–1.33%
B	16.120	12.752	20.89%
C	439.813	434.497	1.21%
D	277.145	210.702	23.97%
E	226.658	151.790	33.03%
F	257.634	194.977	24.32%
G	323.682	311.688	3.71%
H	20.717	-	-
I	428.074	-	-
J	5.393	4.777	11.42%
K	1,212.831	-	-
L	0.246	0.554	–125.20%
M	3.944	1.872	52.54%
N	1.848	1.050	43.18%
O	5.539	3.798	31.43%

PRACTICE 2

Payment Code	Medicare Reimbursement Rate	Average Net Purchase Price	Percentage Difference
A	$9.806	$9.110	7.10%
B	16.120	-	-
C	439.813	-	-
D	277.145	271.899	1.89%
E	226.658	151.800	33.03%
F	257.634	-	-
G	323.682	-	-
H	20.717	-	-
I	428.074	-	-
J	5.393	-	-
K	1,212.831	-	-
L	0.246	0.603	–145.12%
M	3.944	1.980	49.80%
N	1.848	1.711	7.41%
O	5.539	-	-

[1]Percentage difference = $\frac{\text{reimbursement rate – average net purchase price}}{\text{reimbursement rate}} \times 100$

PRACTICE 3

Payment Code	Medicare Reimbursement Rate	Average Net Purchase Price	Percentage Difference
A	$9.806	$9.757	0.50%
B	16.120	12.689	21.28%
C	439.813	439.944	–0.03%
D	277.145	202.215	27.04%
E	226.658	151.802	33.03%
F	257.634	256.682	0.37%
G	323.682	311.686	3.71%
H	20.717	19.364	6.53%
I	428.074	408.260	4.63%
J	5.393	4.947	8.27%
K	1,212.831	1,342.590	–10.70%
L	0.246	0.451	–83.33%
M	3.944	1.928	51.12%
N	1.848	1.308	29.22%
O	5.539	4.371	21.09%

PRACTICE 4

Payment Code	Medicare Reimbursement Rate	Average Net Purchase Price	Percentage Difference
A	$9.806	$7.192	26.66%
B	16.120	12.621	21.71%
C	439.813	445.706	–1.34%
D	277.145	199.835	27.90%
E	226.658	189.580	16.36%
F	257.634	256.546	0.42%
G	323.682	318.184	1.70%
H	20.717	27.418	–32.35%
I	428.074	422.388	1.33%
J	5.393	4.901	9.12%
K	1,212.831	-	-
L	0.246	0.619	–151.63%
M	3.944	1.932	51.01%
N	1.848	1.007	45.51%
O	5.539	4.366	21.18%

PRACTICE 5

Payment Code	Medicare Reimbursement Rate	Average Net Purchase Price	Percentage Difference
A	$9.806	$7.162	26.96%
B	16.120	12.290	23.76%
C	439.813	438.796	0.23%
D	277.145	224.795	18.89%
E	226.658	210.560	7.10%
F	257.634	259.250	–0.63%
G	323.682	311.686	3.71%
H	20.717	20.654	0.30%
I	428.074	433.422	–1.25%
J	5.393	5.158	4.36%
K	1,212.831	-	-
L	0.246	0.575	–133.74%
M	3.944	1.786	54.72%
N	1.848	1.369	25.92%
O	5.539	3.881	29.93%

PRACTICE 6

Payment Code	Medicare Reimbursement Rate	Average Net Purchase Price	Percentage Difference
A	$9.806	-	-
B	16.120	$13.848	14.09%
C	439.813	439.945	–0.03%
D	277.145	214.232	22.70%
E	226.658	-	-
F	257.634	-	-
G	323.682	317.234	1.99%
H	20.717	-	-
I	428.074	-	-
J	5.393	4.950	8.21%
K	1,212.831	-	-
L	0.246	0.549	–123.17%
M	3.944	2.000	49.29%
N	1.848	1.172	36.58%
O	5.539	4.000	27.78%

PRACTICE 7

Payment Code	Medicare Reimbursement Rate	Average Net Purchase Price	Percentage Difference
A	$9.806	$8.529	13.02%
B	16.120	18.133	–12.49%
C	439.813	441.067	–0.29%
D	277.145	271.815	1.92%
E	226.658	151.789	33.03%
F	257.634	-	-
G	323.682	309.893	4.26%
H	20.717	-	-
I	428.074	-	-
J	5.393	4.901	9.12%
K	1,212.831	-	-
L	0.246	1.210	–391.87%
M	3.944	1.990	49.54%
N	1.848	-	-
O	5.539	4.440	19.84%

PRACTICE 8

Payment Code	Medicare Reimbursement Rate	Average Net Purchase Price	Percentage Difference
A	$9.806	$7.950	18.93%
B	16.120	14.958	7.21%
C	439.813	442.225	–0.55%
D	277.145	244.784	11.68%
E	226.658	127.626	43.69%
F	257.634	258.294	–0.26%
G	323.682	317.609	1.88%
H	20.717	27.419	–32.35%
I	428.074	-	-
J	5.393	4.950	8.21%
K	1,212.831	-	-
L	0.246	0.688	–179.67%
M	3.944	2.101	46.73%
N	1.848	1.238	33.01%
O	5.539	5.497	0.76%

PRACTICE 9

Payment Code	Medicare Reimbursement Rate	Average Net Purchase Price	Percentage Difference
A	$9.806	$9.740	0.67%
B	16.120	12.167	24.52%
C	439.813	439.951	–0.03%
D	277.145	200.260	27.74%
E	226.658	151.800	33.03%
F	257.634	262.950	–2.06%
G	323.682	314.803	2.74%
H	20.717	-	-
I	428.074	-	-
J	5.393	5.716	–5.99%
K	1,212.831	-	-
L	0.246	0.557	–126.42%
M	3.944	1.992	49.49%
N	1.848	1.144	38.10%
O	5.539	4.000	27.78%

PRACTICE 10

Payment Code	Medicare Reimbursement Rate	Average Net Purchase Price	Percentage Difference
A	$9.806	$9.829	–0.23%
B	16.120	-	-
C	439.813	436.583	0.73%
D	277.145	-	-
E	226.658	151.823	33.02%
F	257.634	-	-
G	323.682	-	-
H	20.717	-	-
I	428.074	-	-
J	5.393	-	-
K	1,212.831	-	-
L	0.246	1.379	–460.57%
M	3.944	-	-
N	1.848	2.060	–11.47%
O	5.539	3.870	30.13%

PRACTICE 11

Payment Code	Medicare Reimbursement Rate	Average Net Purchase Price	Percentage Difference
A	$9.806	$10.296	–5.00%
B	16.120	14.387	10.75%
C	439.813	445.708	–1.34%
D	277.145	-	-
E	226.658	-	-
F	257.634	261.856	–1.64%
G	323.682	-	-
H	20.717	-	-
I	428.074	-	-
J	5.393	6.930	–28.50%
K	1,212.831	-	-
L	0.246	1.100	–347.15%
M	3.944	1.961	50.28%
N	1.848	1.631	11.74%
O	5.539	4.600	16.95%

PRACTICE 12

Payment Code	Medicare Reimbursement Rate	Average Net Purchase Price	Percentage Difference
A	$9.806	$9.979	–1.76%
B	16.120	-	-
C	439.813	445.707	–1.34%
D	277.145	-	-
E	226.658	163.569	27.83%
F	257.634	-	-
G	323.682	318.183	1.70%
H	20.717	-	-
I	428.074	-	-
J	5.393	4.901	9.12%
K	1,212.831	-	-
L	0.246	1.223	–397.15%
M	3.944	2.053	47.95%
N	1.848	1.919	–3.84%
O	5.539	6.190	–11.75%

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

JUN 15 2007

TO: Daniel R. Levinson,
Inspector General

FROM: Leslie V. Norwalk, Esq.
Acting Administrator

SUBJECT: Office of Inspector General's Draft Report: "Review of Selected Physician Practices' Procedures for Tracking Drug Administration Costs and Ability to Purchase Cancer Drugs at or Below Medicare Reimbursement Rates (A-09-05-00066)

Thank you for the opportunity to review and comment on the Office of Inspector General's (OIG) draft report entitled, "Review of Selected Physician Practices' Procedures for Tracking Drug Administration Costs and Ability to Purchase Cancer Drugs at or Below Medicare Reimbursement Rates." We appreciate the OIG's continuing efforts to examine this important issue.

The OIG report examines physician practices' awareness of their drug administration costs and compares Medicare reimbursement with physicians' average purchase price in the second quarter 2005 for 15 selected drugs furnished by hematology, hematology/oncology, and medical oncology practices. The OIG study found that in second quarter of 2005 physician practices in these specialties could generally purchase drugs for the treatment of cancer at less than the Medicare payment rates, although they had difficulty identifying drug administration costs. Nine of the twelve practices reviewed could generally purchase drugs for the treatment of cancer patients at or below the average sales price (ASP) reimbursement rates. Specifically, these practices paid prices below the reimbursement rates for the majority of payment codes related to the drugs purchased. Furthermore, the report confirmed earlier work conducted by the OIG that found, regardless of practice size, physician practices could generally purchase drugs at less than the ASP reimbursement amount. The report provides additional evidence of the adequacy of Medicare payment for Part B drugs used in cancer treatment under the ASP payment methodology.

For those physicians who wish to obtain Part B drugs and biologicals for Medicare beneficiaries without purchasing them, the Centers for Medicare & Medicaid Services (CMS) has implemented a Competitive Acquisition Program (CAP). Under this voluntary program, the physician obtains the drugs at no cost from an approved CAP drug vendor and the vendor is paid directly by Medicare at competitively bid rates.

OIG Recommendation

The OIG recommends that CMS consider the results of their review in any future evaluations of Medicare Part B reimbursement of costs associated with the administration and purchase of drugs for the treatment of cancer patients.

CMS Response

As recommended, we will consider the results of the OIG review in any future evaluations of Medicare Part B reimbursement of costs associated with the administration and purchase of drugs for the treatment of cancer patients.

Thank you very much for your work on this report.