



Office of External Affairs

FACT SHEET

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Contact: CMS Office of External Affairs
(202) 690-6145

2006 ONCOLOGY DEMONSTRATION PROGRAM: IMPROVED QUALITY OF CARE FOR CANCER PATIENTS THROUGH MORE EFFECTIVE PAYMENTS AND EVIDENCE- BASED CARE

Background

CMS seeks to encourage quality care in all facets of cancer treatment and care by encouraging best practices.

In 2005, CMS initiated a one-year demonstration project for cancer patients undergoing chemotherapy. The demonstration focused on measuring patient outcomes in three areas of concern often cited by patients undergoing chemotherapy: controlling pain; minimizing nausea and vomiting; and reducing fatigue. We established three categories of G codes that physicians used to report these symptoms in 2005. Practices reporting data on all three factors qualified for an additional payment of \$130 per encounter for chemotherapy administration.

Following extensive discussions with various groups representing the interests of oncologists and advocates for patient care, as well as our review of the initial results and implementation of this demonstration, we have decided to continue the demonstration project for CY 2006. However, we are making substantial revisions in the G-codes for reporting to take a further step toward encouraging quality care and promoting evidence-based best practices that have been proven to lead to improved patient outcomes. These revisions reflect substantial input from many stakeholders, including oncology groups, patient advocates, interested members of Congress, and many others.

The 2005 demonstration started us down the road of measuring some important outcomes for cancer patients: their symptoms while undergoing chemotherapy. The 2006 oncology demonstration will take a more comprehensive approach to supporting care that has been shown to lead to better outcomes for cancer patients, including the care provided to patients during periods when they are not receiving chemotherapy. We are providing new support to determine whether and how oncology practices follow evidence-based practice guidelines that are well established for cancer care. We will eliminate the CY 2005 G- codes specific to the general assessment of patient symptoms, while

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maintaining our focus on quality cancer care, including the management of debilitating symptoms when they occur, to assure the best possible quality of life for cancer patients.

2006 Oncology Demonstration:

The oncology demonstration, applicable to services furnished in 2006, will build on the use of G-codes to gather more specific information relevant to the quality of care for cancer patients, including their treatments; the spectrum of care they receive from their doctors; and whether or not the care represents best practice. The project will emphasize evidence-based practice guidelines that have been shown to lead to better patient outcomes as the source for standard of care, permitting us to monitor and encourage quality care to cancer patients. Reporting will no longer be specific to chemotherapy administration services, but instead will be associated with physician evaluation and management (E & M) visits for established patients with cancer, visits that are frequent and essential to assuring quality of care and life for patients.

The demonstration is available to office-based hematologists/oncologists who provide an E & M service of level 2, 3, 4, or 5 to an established patient (as reported under the American Medical Association's Current Procedural Terminology (CPT)), when the service is delivered to a patient with a primary diagnosis of cancer belonging to one of the following thirteen major diagnostic categories: cancer of the breast (invasive), colon, rectum, prostate, lung (both small cell and non-small cell), stomach, esophagus, pancreas, ovary, head and neck, as well as chronic myelogenous leukemia, multiple myeloma, and non-Hodgkin's lymphoma. E & M services furnished by hematologists/oncologists for patients with other cancers as the principal diagnosis will not qualify under the demonstration.

To qualify for the oncology demonstration payment of \$23, the physician must submit one G code from each of the following three categories when an E & M of level 2, 3, 4, or 5 is billed:

1. the primary focus of the evaluation and management service;
2. the current disease state; and
3. whether current management adheres to clinical guidelines.

The physician will be asked to identify the primary focus of the visit from one of several categories, including for instance, supervision of therapy and attendant toxicity management, palliation and pain control, or surveillance for disease recurrence. The physician will report the status of the patient's cancer, for example, characterizing the extent of spread of the cancer as best understood clinically at that time. Lastly, the physician will be asked to report whether the patient's management adheres to physician developed guidelines for the management of patients with that type and extent of cancer, as documented in the guidelines published by either the National Comprehensive Cancer Network or the American Society for Clinical Oncology. In terms of the guidelines, the physician may report that the guidelines are being followed, or are not followed, for example, where there was an alternative treatment due to patient preference, or where the physician did not agree with the guidelines.

The 2006 demonstration meets our objective of having oncology payments increasingly focused on patient-centered care, rather than chemotherapy administration. In the 2006 demonstration, data collection and payments are linked to E&M provided by physicians to patients, rather than chemotherapy administration that may occur in the absence of an involved visit between doctor and

patient. This demonstration also meets the objective of helping us learn to what extent Medicare beneficiaries are being treated in a manner that yields the best outcomes, understand clinical cancer scenarios where there is not clinical consensus among physicians on the relevance of specific guidelines, and ensure that due emphasis is placed on a multi-disciplinary, comprehensive approach to palliation and end of life care. Also, by focusing on evidence based practices, there is the potential that unnecessary services and tests will be reduced, lowering program costs and yielding better quality of life for Medicare beneficiaries with cancer.

The information requested should be readily available to the treating physician at the time of the patient visit, in that it is fundamental to providing high quality care that the primary objective of a visit is established and communicated to the patient, that the disease status is understood, and that the current management is understood within the context of what are widely endorsed practices. Oncologists are well versed in the recommendations and guidelines disseminated by their physician-run specialty organizations. We do not believe, therefore, that it will be a significant burden for oncologists to perform the additional work to provide the information required for this demonstration. There is an expectation that physicians communicate with their patients, as part of their visit and as frequently as necessary, the same information that is being submitted to CMS as part of this demonstration. Specifically, it is essential to good patient care that patients are aware of the purpose of each of their visits, their current disease status, and whether their management is consistent with the management recommended in practice guidelines.

Practices reporting data on all three categories to Medicare will qualify for an additional payment of \$23 in addition to the E & M visit.

As with the 2005 demonstration, participation in this demonstration is voluntary and occurs on a claim by claim basis.

To facilitate the collection of this information, we have established new G-codes to be reported by participants. Additional information on the G-codes and other details of the demonstration will be made available through our website at www.cms.hhs.gov.

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CANCER DIAGNOSES INCLUDED IN 2006 ONCOLOGY DEMONSTRATION

Breast cancer
Chronic myelogenous leukemia
Colon cancer
Esophageal cancer
Gastric cancer
Head and neck cancer.
Multiple myeloma
Non-Hodgkin's lymphoma
Non-small cell/small cell lung cancer
Ovarian cancer
Pancreatic cancer
Prostate cancer
Rectal cancer

AREAS OF INQUIRY FOR 2006 ONCOLOGY DEMONSTRATION

I. Primary focus of the visit: Physicians will choose one G code corresponding to each of the below 6 codes)

- 1) Work-up, evaluation, staging (at time of diagnosis, recurrence, or contemplated change in therapy)
- 2) Treatment decision making occurring after disease is staged or restaged, counseling about treatment, or supervising or coordinating active therapy, or managing toxicity of therapy. To distinguish from treatment that is palliative: therapies considered in this category are those given with the intent of prolonging life, prolonging disease free survival, or increasing the chance of cure.
- 3) Disease surveillance (meaning that there is no current evidence of disease and no ongoing therapy to prevent recurrence, but future treatment would be contemplated for disease recurrence)
- 4) Expectant management of patient with existing disease (meaning that there is disease present, and future treatment would be pursued if disease recurred, but no active therapies being given or coordinated).
- 5) Supervising, coordinating, or managing palliative therapy or end-of-life care. Treatments and activities included may include management of both chemotherapy and other treatments such as radiotherapy, when those treatments are not expected to prolong life or lead to cure, but are expected to increase quality of life or reduce/manage complications from the patients' cancer.
- 6) Other

II. Guideline adherence: Physicians will report if their care complies with professional guideline

- 1) Management adherent to guidelines
- 2) Management differs from guidelines as a result of patient enrollment on clinical trial or institutional protocol
- 3) Management differs from guidelines because the treating physician disagrees with guideline recommendations
- 4) Management differs from guidelines because the patient, after being offered treatment consistent with guidelines has opted for alternative treatment or management (including no treatment).
- 5) Management differs from guidelines for reasons associated with patient comorbid illness or performance status not factored in to guideline recommendations.
- 6) Patient's condition not addressed by available guidelines

III. Condition Codes: These are specific to the type of cancer and will be clarified in instructions before the Demonstration becomes effective.