

PREPARING FOR



“How prepared do you feel for 2005?”

This was the first question posed at the Head Nurse/Practice Manager Conference October 15-17, 2004. Answers among the group of OA members varied from, “Not at all prepared,” “Somewhat prepared,” and very prepared.” The goal of this conference was for members to leave armed with strategies to better plan for legislative reimbursement changes in 2005. The networking, expert speakers and open discussions all contributed to the success of this program. As a service to all members, we are pleased to feature summaries of the reimbursement and clinical presentations from the conference.

Maximizing Reimbursement in Your Practice

PRESENTED BY PATRICIA DIBENEDETTO, RN, BSN

The evolution of oncology reimbursement continues to pose challenges. The reimbursement for pharmaceutical agents and the administration of such has changed in 2004 and will continue to change in 2005 and beyond. This year we have seen a dramatic reduction in reimbursement for drugs and conversely a significant payment increase for the administration of these agents, essentially creating a revenue neutral year. The Center for Medicare and Medicaid Services (CMS) plans to decrease oncology reimbursement from 800 million dollars in 2004 to 340 million by 2006. In

2004, CMS allowed payment of multiple chemotherapeutic agents given by push method on the same day; reimbursed drugs at 80-87% AWP, and reimbursed newly approved drugs at 95% AWP. There was a temporary increase of 32% for administration codes of chemotherapeutic as well as therapeutic infusions in 2004.

With 2005 soon upon us, more changes are ahead. Drug reimbursement in 2005 will be based on the 3rd Quarter Average Selling Price (ASP) + 6%, administration codes will be decreasing to 29% of current 2004 rates, and new temporary G-codes will be instituted for administration of drugs (see p. 26 for details). Keeping up with the changes in the dynamics of reimbursement will be crucial for maximizing reimbursement in your practice. Oncology Associates and I will keep you updated and current with these changes as they occur.

New Solutions to Old Problems: CINV

PRESENTED BY DR. REGINA CUNNINGHAM, PHD, RN, AOCN

Chemotherapy induced nausea and vomiting (CINV) continues to represent a substantial problem for patients. Over the past three decades, research has increased our understanding of the neurobiologic mechanisms involved in emesis. This knowledge has led to the development, testing and approval of a variety of new

antiemetic agents. Despite this, many patients continue to experience CINV. Recent studies have indicated that nurses and physicians often underestimate the incidence of both acute and delayed CINV in patients who are receiving both moderately and highly emetogenic chemotherapy. The largest disparity between professionals' perceptions and patients' actual experiences were in the setting of delayed nausea and emesis (defined as hours 25-120 after chemotherapy). These data provide important insights about the problem of delayed CINV.

Delayed CINV can be lessened when good control is achieved during the acute (first 24 hours after receiving chemotherapy) phase of therapy. Maximizing control during the initial and early courses of therapy is important in influencing symptoms response; conversely, inadequate control during this period may predict problems through the entire chemotherapy trajectory.

Current classes of antiemetics include dopamine receptor antagonists, corticosteroids, benzodiazepines, cannabinoids, 5-HT₃ receptor antagonists and NK-1 receptor antagonists. Two new agents were approved by the Food and Drug Administration in 2003. Aprepitant (Emend Merck, Whitehouse Station) is the first neurokinin (NK)-1 receptor antagonist to become available. Aprepitant acts by blocking the ability of substance P (a neurotransmitter involved in inducing CINV)