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American College of Gastroenterology Comments Regarding CPT Drug Administration Code Workgroup Recommendations

Presented by Thomas F. Fise, *Executive Director, and Mark H. Rayder, Vice President, Public Policy*

Thank you for the opportunity to present the views of the American College of Gastroenterology at this *CPT Public Session for Discussion of Drug Infusion Administration.*

As the CPT Drug Administration Code Workgroup is aware, the American College of Gastroenterology (ACG) primarily represents the interests and concerns of clinical gastroenterologists. As such, payment for the administration of complex infusions, such as infliximab, is the coding issue of greatest importance to the College's members under the purview of this workgroup.

Many gastroenterologists use infliximab infusions to treat patients with moderate to severe ulcerative colitis or Crohn's disease who do not respond to standard therapies. These can be very debilitating diseases. Patient conditions are complicated and they often are weak and ill. Administering the biologic infliximab, a monoclonal antibody, is laborious and has serious risks and complications associated with it, most notably, infusion reactions and hypotension. The infusion process is similar in complexity, often more so, to that of many high toxicity chemotherapeutic agents. Nevertheless, administration of infliximab is reimbursed at a level consistent with saline infusions, CPT codes 90780 and 90781, rather than at the oncologic rate, which is more consistent with the sophistication of infusion, frailty of the patient and costs associated with drug storage.

ACG, in comments to the Center for Medicare and Medicaid Services (CMS), has repeatedly called for the agency to address this fundamental inequity in the payment system that allows for reimbursement to be based on diagnosis or the specialty performing the service instead of the complexity level of the work being performed. Of course, Section 303 (J) of the Medicare Prescription Drug and Modernization Act of 2003 (MMA) requires the Health and Human Services Secretary to address this very issue, and to do so "promptly." So, we applaud the efforts by the Workgroup, within the context of the CPT Editorial process, to come to a consensus on this issue which affects so many of the physician specialties.

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That being said, we are disappointed that the proposal put forth by the American College of Rheumatology (also known as Option R) is not included for consideration as one of the options under the Workgroup proposals. ACG supports this proposal because it is the only one that provides for coding complex infusions as a function of the medication infused *and* also provides for this remedy in the most simple, direct and expeditious manner in order to benefit patients and physician practices in 2005.

From ACG's perspective, it is most important to get the coding right, and both Option R and the Workgroup's Option B proposal respect the complexity of biologicals, such as infliximab, vis-à-vis chemotherapeutic agents. The Option B proposal accomplishes this through a three-tiered coding system. In order to do so, however, the RUC process must be engaged, which will delay implementation until the release of the 2006 Medicare Physician Fee Schedule. Unfortunately, addressing the drug infusion coding issue cannot be divorced from the larger problems inherent in the total drug infusion reimbursement equation, namely, the sliding level of reimbursement for the purchase of the actual drugs. Today, from an economic standpoint, it is difficult for our members to provide office-based infusion services to their Medicare patients because the total reimbursement barely covers the cost of the drug and qualified nursing staff. This does not even consider basic overhead costs, such as saline bags, infusion chairs, and drug storage. Once the Medicare transitional payments for infusion services drop from 32 percent this year to only 3 percent in 2005, gastroenterologists will most likely be losing money on providing this service to Medicare patients. Patients, too, will be hurt in this scenario, as they are forced to seek infusion services at hospitals instead of in the office of their treating physician.

Again, ACG would like to identify itself with the Option R proposal put forth by the American College of Rheumatology, a proposal that recognizes the immediate need for reimbursement relief and its impact on patient care. The College is also in alignment with the ultimate outcome of Option B and its respect for the complexity of administering biologicals, however, we have serious reservations about the extended timetable associated with following this proposal.