

A photograph of the Aurora Borealis (Northern Lights) in shades of green and blue, dancing across a dark night sky. Below the lights, the dark silhouettes of mountains and a forested ridge are visible. In the foreground, a calm body of water reflects the colors of the sky. The overall scene is serene and atmospheric.

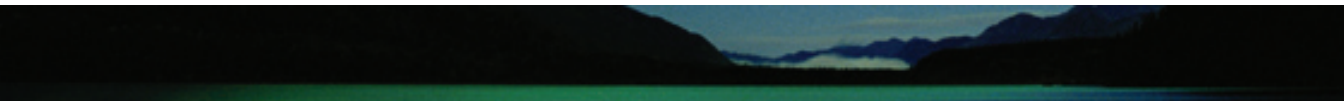
the medical ●  
**Review**

**Winter 2010**



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## New Reimbursement Method For Cancer Treatment

UnitedHealth Group Inc. is trying to change how it reimburses oncologists using a method the insurer says could improve treatment practices. It started a pilot program in October 2010 involving five physician practices across the country, focusing on breast, colon and lung cancers.

Oncologists currently buy chemotherapies and other drugs directly at wholesale prices, and then are reimbursed at higher rates based on the drug's inflated prices. Oncologists make about 60 percent of their income from selling drugs in this way, according to UnitedHealth. They may make greater profit margins from higher-priced medicines, and therefore can be incentivized to prescribe newer drugs regardless if they have been proven more effective.

As opposed to this fee-for-service method, doctors in the pilot program will be paid one upfront fee based on the expected cost of a standard treatment regimen. United said that by paying oncologists for a patient's total cycle of treatment, rather than the number of visits and the amount of chemotherapy drugs given, the program promotes better, more patient centric care with no loss of revenue for the physician.

The insurer calculates a payment to the practice based on the cost of the drugs and the resources the oncologist's office spends in managing the patient. The five medical practices in the program have between 18 and 35 oncologists on staff.

The regimens will be evaluated based on various health outcomes, emergency room visits and complications. The program is expected to be revenue-neutral at first, but stands to save money over the longer term should oncologists prescribe older drugs that have worked in their regimens as opposed to newer, higher priced treatments.





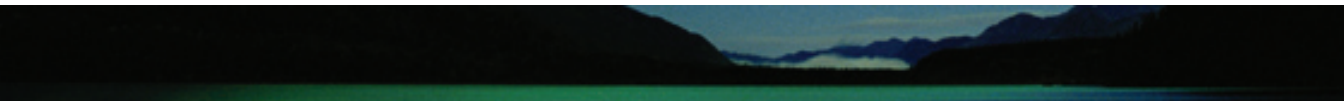
## Massachusetts Publishes Comprehensive Payment Database

In November 2010, Massachusetts health officials published the most comprehensive state database in the country listing payments drug companies and medical device makers made to health care providers in the state. The report lists \$35.7 million in payments from hundreds of companies for the six months between July 1 and Dec. 31, 2009, for speaking, consulting, food, educational programs, marketing studies, as well as charitable donations. About half of that money (\$16 million) went to physicians.

Any drug or device company doing business in the state was required to begin reporting certain payments over \$50, under a law passed two years ago that also bans the companies from providing gifts to physicians. Companies don't have to disclose funding for research aimed at answering a legitimate scientific question, but do have to report payments for marketing studies that are designed to promote a product.

Industry payments to physicians have come under increasing scrutiny because of critics' concerns that the money influences doctors to prescribe newer and more expensive medications, helping to drive up the cost of health care. But the companies and many doctors say that physicians should work closely with drug and device companies to help develop new treatments and educate their colleagues—and that it's only fair they be paid for their time.

The physician receiving the most during the six-month period is Dr. Mary Ann Asbell (Family Practice) in Cambridge, who was paid \$194,275 by Genzyme Corp. for unspecified "bona fide services." However, she is not listed currently as a licensed doctor in Massachusetts, according to the Board of Registration in Medicine as well as the ABMS. The top-paid individual was not a physician but a psychologist: Carole C. Upshur of Worcester earned \$250,000 from Allergan. The database can be found at [mass.gov/dph/pharmamed](http://mass.gov/dph/pharmamed).



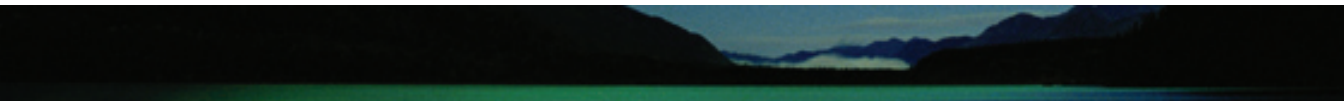


## Unnecessary Implantation Of Defibrillators

In January 2011, the Journal of the American Medical Association published a study that concluded one out of every five heart defibrillators implanted in the United States may be unnecessary, or were implanted without their doctor following the appropriate guidelines for when the devices should be used. Practice guidelines do not recommend use of an implantable cardioverter-defibrillator (ICD) for primary prevention in patients recovering from a myocardial infarction or coronary artery bypass graft surgery and those with severe heart failure symptoms or a recent diagnosis of heart failure.

The retrospective study's objective was to determine the number, characteristics, and in-hospital outcomes of patients who receive a non-evidence-based ICD and examine the distribution of these implants by site, physician specialty, and year of procedure. Of 111,707 patients, 25,145 received non-evidence-based ICD implants (22.5%). Patients who received a non-evidence-based ICD compared with those who received an evidence-based ICD had a significantly higher risk of in-hospital death and any postprocedure complication. The rate of non-evidence-based ICD implants was significantly lower for electrophysiologists than non-electrophysiologists. There was no clear decrease in the rate of non-evidence-based ICDs over time with rates remaining at about 22% from 2006-2009.

Medically unnecessary ICD implantations cause significant mortality and morbidity. Additionally, there is a very large expense to ICD implantation. Although manufacturer costs are about \$30,000-\$40,000, hospital billed charges often exceed \$100,000-\$150,000 for the device itself. There are ancillary costs for the hospital stay, OR charges, hospital procedure charges as well as physician procedure charges. ICD implantations should be closely reviewed for medical necessity prior to reimbursing a claim.



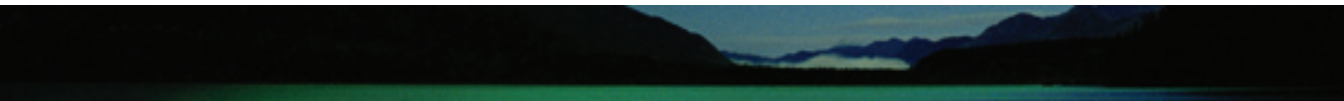


## Update OnNever Events

Wrong-site and wrong-patient procedures are more common than the medical community might care to admit, and clinicians in both surgical and non-surgical disciplines share equal responsibility for the unacceptable errors, write investigators in the October 2010 issue of the Archives of Surgery. A review of physician-reported adverse outcomes from a Colorado liability insurance database revealed 25 wrong-patient and 107 wrong-site procedures during a 6.5-year period. The wrong-patient procedures included 5 cases of significant harm, including 3 unnecessary prostatectomies resulting from a mix-up in pathology samples. Wrong-site procedures included an errantly placed chest tube that led to the patient's death from pulmonary decompensation.

The authors reviewed data on 27,370 adverse outcomes reported by physicians to the Colorado Physicians Insurance Company. Internal medicine specialists accounted for 24% of wrong-patient errors, followed by (at 8% each) family/general practitioners, pathologists, urologists, obstetrician-gynecologists, and pediatricians. Orthopedic surgeons were responsible for 22.4% of wrong-site procedures, followed by general surgeons (16.8%) and anesthesiologists (12.1%).

Errors in diagnosis were responsible for 14 of the 25 wrong-patient mistakes (56%) and for 13 of the wrong-site failures (12.1%). Errors of communication occurred in all of the wrong-patient cases and in nearly half of the wrong-site cases. As noted earlier, 1 patient died from acute respiratory failure when an internal medicine specialist placed a chest tube in the wrong side. Other wrong-site errors leading to significant harm included wrong-level spine surgery, wrong-site vascular procedures, wrong enterocolic resection, wrong-organ resection, and wrong-sided ovariectomies, eye surgeries, craniotomies, ureteric procedures, and maxillofacial surgery. Only 36% of wrong-patient cases and 2.8% of wrong-site cases caused no harm.





## Avastin Revoked By FDA

In December 2010, the FDA announced it will revoke approval of the drug Avastin to treat metastatic breast cancer after several studies suggested the drug does not extend women's lives and carries significant risks. The agency said Genentech, the maker of Avastin and a subsidiary of Roche, has 15 days to request a hearing to review the decision. The company in a statement said that it would take that step, arguing that it believes the drug does extend the lives of breast cancer patients.

The FDA approved Avastin for treatment of some breast cancers in 2008 based on a study showing that the drug delayed cancer growth by more than five months. The drug also is approved to treat colon, lung, brain and kidney cancers. In July, an FDA advisory committee voted 12-to-1 to withdraw Avastin's authorization for advanced breast cancer. The recommendation was based on two new studies that the advisers concluded had not shown that the drug extends life and indicated the drug slowed tumor growth for perhaps as little as about a month.

"None of the studies demonstrated that patients receiving Avastin lived longer, and patients receiving Avastin experienced a significant increase in serious side effects," said Janet Woodcock, director of the FDA's Center for Drug Evaluation and Research. "The limited effects of Avastin combined with the significant risks led us to this difficult decision."

Avastin is prescribed to about 17,500 breast cancer patients annually and is one of the most expensive cancer drugs on the market, costing about \$175k-\$200k/year. Breast cancer patients also would lose eligibility for a program in which Genentech caps the annual cost of the drug at about \$57,000 for women making less than \$100,000 a year.





## Bottom Line **Winter 2010**

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We're a team of highly specialized physicians delivering essential medical management solutions. Our doctors' unique brand of communication skills, coupled with the understanding of complex business principles, translates into world-class treatment for both our clients and their patients. Every day we provide innovative, proactive solutions to intricate cost containment issues, thus living up to our credo: **PHYSICIANS. TAKING CARE OF BUSINESS.**

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**U.S. community hospitals posted a 5% profit margin in 2009, earning \$34.4 billion in profit on \$691 billion in net revenue**