Medicare Reimbursement Changes Likely Influenced Changes in Prostate Cancer Treatment

Atlanta 2008/04/07 -Financial pressures from Medicare reimbursement changes may have caused physicians to switch from providing hormonal-induced castration to providing surgical castration for men with prostate cancer. That is the finding of a new study published in the May 15, 2008 issue of CANCER, a peer-reviewed journal of the American Cancer Society. The study suggests that factors other than evidence-based medicine may have a significant influence on treatment decisions.

Androgen deprivation, using either medical castration with leutenizing hormone-releasing hormone (LHRH) agonists or by surgical castration, is a standard treatment for prostate cancer patients. The two approaches have been shown to be equally effective, but the trends in their use among Medicare patients have changed dramatically in recent years. In the late 1990s and early 2000s, LHRH treatment increased considerably, while surgical castration decreased. But in 2003, the trend reversed, and LHRH treatments waned while surgical castrations increased.

To determine whether changes in Medicare reimbursements may be linked this switch in prostate cancer treatment, J. Stephen Jones, M.D. and colleagues at the Cleveland Clinic examined publicly available data from Medicare. They found that total allowed charges for medical castration peaked in 2003 at $1.23 billion. After the Medicare Modernization Act was instituted in 2004, total allowed charges for medical castration in 2005 dropped 65 percent from the 2003 peak.

Dr. Jones and his team noted that in situations where there are no financial incentives or disincentives to prescribe a treatment, practice patterns usually change slowly. However, in this case, the change occurred in the very same years as the Medicare reimbursement changes.

While other factors—such as changes in perception of the effectiveness of different types of castration or changes in prostate cancer disease demographics—could have had an effect, “the most plausible explanation of the change in practice is the change in reimbursement,” the authors wrote. In support of their conclusion, they pointed out that only one of the LHRH agonists—called triptorelin—increased in use after institution of the Medicare Modernization Act. This drug was also the only LHRH agonist which maintained its reimbursement rate after the Medicare act was enacted.

The authors concluded that their findings suggest that financial pressures most likely contributed to prescription practices of androgen deprivation among physicians treating Medicare patients. They urged practitioners and individuals involved in financial decisions regarding health care reimbursement in particular to take note of these findings.

In an accompanying editorial, Dr. Gerald W. Chodak of the Midwest Prostate and Urology Health Center in Chicago wrote, “changing a recommendation to a patient from an LHRH agonist to surgical castration solely for economic reasons is ethically inappropriate. However, asking urologists to take a financial loss while treating patients also is inappropriate.” He recommended that physicians be completely honest with patients, making sure they are aware of the choices and the factors affecting a particular recommendation.

Article: “Androgen deprivation falls as orchiectomy rates rise after changes in reimbursement in the US Medicare population.” Christopher J. Weight, Eric A. Klein, and J. Stephen Jones. CANCER; Published Online: April 07, 2008 (DOI: 10.1002/cncr23421); Print Issue Date: May 15, 2008.

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