

Comments and Responses Regarding Draft Local Coverage Determination: Erythropoietin Stimulating Agents (ESA)

As an important part of Medicare Local Coverage Determination (LCD) development, National Government Services (NGS) solicits comments from the provider community and from members of the public who may be affected by or interested in our LCDs. The purpose of the advice and comment process is to gain the expertise and experience of those commenting.

I would like to thank those who suggested changes to the draft Erythropoietin Stimulating Agents (ESA) LCD. The official notice period for the final LCD begins on October 1, 2007, and the final determination will become effective on December 1, 2007.

Comment: Several commenters raised concerns that the requirement for pretreatment EPO level <100 for MDS is too restrictive. NCCN guidelines state that the EPO level should be <500 in this setting.

Response: Measurement of circulating erythropoietin levels may only be helpful in anemia involving myelodysplasia. Several articles in recent books show erythropoietin levels <200 or <100 are associated with response to exogenous EPO of up to 70% whereas levels of 500 have 7% response.

Comment: A commenter noted between the stated policy of covering low-risk MDS and the ICD-9 codes listed that ICD-9 238.72 (low-risk MDS) appears to be the best fit.

Response: NGS concurs and has revised the policy.

Comment: A commenter recommended changing “glomerular filtration” to “estimated glomerular filtration rate.” It is accepted clinical practice to estimate using a regression formula.

Response: NGS agreed to change to (calculated) glomerular filtration rate. (No need to select a single way to calculate if more than one way exists.)

Comment: A commenter stated that maintaining patients within a range Hb 10-12 g/dL is not possible all of the time. CMS has recognized this in ESRD patients and requires that attempts are made by changing the dose of the ESA when the patient is above the target of Hb 12 g/dL. Payment should not be denied if appropriate adjustments are made in dosing.

Response: CMS national policy continues to state that the target range for all indications is Hb / HCT 10-12 g/dL / 30 -36%. When values rise above the target range, appropriate dose reductions must be made in order for the contractor to pay the claim(s).

A CMS Contracted Agent

Comment: A commenter stated that the Hb level at which an ESA may be started should be 12, based on physician judgment. This allows for individual patient variability as to their symptomatic response to anemia (i.e., patients are symptomatic at wide ranges of Hb). Since the goal is an Hb <12 this change in the LCD would be consistent with that goal.

Response: There is data suggesting no morbidity or mortality if the Hb/HCT is above 10 g/dL / 30%. The FDA revised labeling for ESAs states that they are to be used to prevent transfusion. For these reasons, NGS will allow initiation of ESAs only when a patient's Hb / HCT is below 10 g/dL / 30%.

Comment: A commenter stated that there is no rationale to limit chronic inflammatory states. Often, a specific diagnosis can not be made but the patient will have anemia of chronic disease (ACD) that will benefit from ESA treatment. Several specific diagnoses of ACD are not listed, i.e., vasculitis, other collagen vascular diseases, use of immunosuppressive drugs such as cyclophosphamide, chlorambucil, mycophenolate for immunologic diseases such as SLE, glomerulonephritis and transplants.

Response: We found no strong evidence to support coverage of ESAs for those indications. These patients usually have a mild anemia which does not require transfusion. Per the FDA, the purpose of ESAs is to avoid transfusions.

Comment: A commenter requested coverage for patients with hemochromatosis. If they are anemic and require transfusion, it is thus not possible to phlebotomize them in order to remove excess iron. ESAs enable one to decrease iron stores by having the individual incorporate his excess iron into red cells that are then phlebotomized. Without ESAs, the phlebotomy process is much more prolonged and the patient exposed to increased storage iron and its deleterious effects.

Response: Neither the FDA or considerable literature supports this use.

Comment: A commenter requested coverage of ESAs for females who require a hysterectomy. By using ESAs, the hemoglobin can be safely brought above 10g/dL and surgery safely performed. If brought to 12g/dL, homologous donations can be obtained and used as clinically needed.

Response: This use of ESA is not approved by the FDA. Healthy patients can have their hemoglobin safely raised with iron while waiting for elective surgery.

Comment: A commenter stated that there is a need in preoperative patients, especially in patients who refuse all blood products (e.g., Jehovah's Witnesses) to start with a higher red cell count to allow for blood loss.

Response: Modern surgical techniques (including use of cell savers) allow for much less loss of blood than in earlier days.

Comment: A commenter stated raising the Hb to a level of greater than or equal to 13 g/dL allows a patient to have surgery with little or no blood transfusions. This results in better outcomes and a decreased impact on the already strained blood supply.

Medicare

A CMS Commented About Response: Many patients on Medicare are older and have chronic diseases that would cause their Hb/HCT to be slightly low. When you raise their hemoglobin levels to 13 g/dL and above, the risk for morbidity and mortality rises. Patients with chronically low Hb/HCT do well without having the “normal” values of young healthy adults.

Comment: A commenter requested that the duration of treatment with ESA not be limited, but very based on the disease. For chronic anemia of MDS, for example, the patient may require chronic treatment for 52 weeks. In patients who require repeated sessions of chemotherapy, 12 weeks is also an artificial limitation.

Response: The LCD allows use of EPO for MDS only if there is a positive response in the initial 8 weeks. Literature suggests that if no response occurs within 8 weeks the medication should be stopped. We do not limit the time of treatment if there is a successful response.

The duration of treatment for patients receiving chemotherapy is limited per the CMS National Coverage Determination (NCD) published July 30, 2007.

Comment: A commenter requested clarification regarding the duration of treatment and target Hb / HCT for chemotherapy-induced anemia.

Response: Since the effect of chemotherapy may last for some time post infusion, based on the CMS NCD we would allow treatment for up to 8 weeks post infusions, but after that if the level drops due to the cancer diagnosis alone, EPO would not be covered. The NCD allows ESA treatment until the Hb is 10. Coverage and treatment limitations for chemotherapy –induced anemia are delineated in CMS’ NCD published July 30, 2007.