The Complexities of Oncology Billing: Get What you Deserve

Please stand by. The webinar will begin shortly.

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The Complexities of Oncology Billing: Get What you Deserve

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Elaine Kloos, RN, NE-BC, MBA

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Teri U. Guidi, MBA, FAAMA

Teri Guidi is the President and CEO of Oncology Management Consulting Group. With more than 30 years of experience in oncology management, Ms. Guidi is expert in the areas of strategic planning, reimbursement, program development, and market assessment. She has worked with health networks, hospitals, private practices, and the pharmaceutical industry. Recent projects have included strategic and business planning, joint venture development, hospital/physician alignment, educational programs, and program assessments. She has held positions at institutions ranging from NCI-designated comprehensive cancer centers to large teaching hospitals in integrated health systems to small community hospitals. She has served as Executive Director and System Vice President of cancer service lines, and as Vice President of a health system-owned medical oncology practice. Ms. Guidi's experience spans all areas of outpatient oncology including infusion services, radiation oncology, clinical trials, and tumor registry. Among her major areas of interest are financial analysis and profitability reporting.

Ms. Guidi is a frequent speaker at national and regional professional conferences, with numerous publications on a wide variety of oncology-related topics. She serves on the Editorial Boards of *Oncology Issues* and *Oncology Practice Management*, on several professional society committees, and served two terms on the American College of Surgeons Commission on Cancer. Ms. Guidi received her Master's Degree in Business Administration from the Carroll School of Management at Boston College in 1995 and earned Fellowship in the American Academy of Medical Administrators in 1999.

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Elaine Kloos, RN, NE-BC, MBA

Elaine Kloos is Senior Consultant with Oncology Management Consulting Group and brings over 25 years of experience in the healthcare field. Ms. Kloos also has over 18 years of expertise in Oncology Administration and Women's Breast Health Services with specific areas of focus in clinical service line development, comprehensive breast care centers, strategic planning, facility design and project management. As a Registered Nurse, Ms. Kloos adds significant clinical expertise to the OMC Group and is very well versed in clinical operations, patient satisfaction, radiation oncology equipment selection, new program development as well as JCAHO, ACoS, ACR and ACRO accreditation processes. She has served as a Cancer Service Line Director and Vice President for numerous healthcare systems and community based hospitals. Ms. Kloos' oncology experience includes inpatient medical and GYN oncology, radiation oncology, outpatient chemotherapy infusion, medical and GYN oncology physician practices, comprehensive breast centers, high-risk breast cancer and high-risk colon cancer programs, clinical research, community outreach, and cancer registry. Among her major areas of proficiency are revenue cycle analysis of the oncology service line (both medical oncology and radiation oncology), strategic planning, market analysis and positioning, operational efficiency, new program development and facility design.

Ms. Kloos is board certified as a Nurse Executive by the American Nurses' Association. She is active in multiple national organizations including the Association of Cancer Executives, the Oncology Nursing Society and the Association of Community Cancer Centers. Ms. Kloos serves on the Board of Directors for the Association of Cancer Executives and is the current Treasurer and active on the Vendor Relations Committee. Ms. Kloos received her Nursing Degree from the University of Tennessee, a Bachelor of Science degree in Healthcare Administration from Auburn University and a Master's Degree in Business Administration from Louisiana State University.

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Agenda

- The front end
- The middle
- The back end
- Questions

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Why?

- In virtually all cases, outpatient oncology services can be profitable.
- The processes in the revenue cycle are also important to support pay-for-quality and other new reimbursement models.

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The Front End

- Payers make all kinds of rules – know what they are!
  - Read their policies regularly
  - Educate staff and physicians on the rules
  - If possible, hardwire rule checks into your systems
- Update your charge master/superbill at least quarterly
- Verify insurance at every visit (at least monthly)
- Obtain and check pre-certifications/pre-authorizations for every visit

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The Front End (2)

- Educate and assist patients at the beginning and at any change point about their financial responsibilities
- Utilize all available drug replacement options
- Ensure that all required orders are complete before the start of any visit
- Collect co-pays and deductibles at every visit

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Front End (3)

- Drugs are billed using HCPCS codes. New drugs can be billed by practices with a non-specific code, but hospitals have to wait for a temporary code. When the drug gets a permanent “J” code, the billing unit definition often changes.

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The Front End (4)

- Radiation: Hospital IGRT codes are packaged (no payment but reportable) for Medicare; however, IGRT codes are not reportable for IMRT,SRS or SBRT for Medicare patients. Other payers are covering IGRT for all modalities but usually require prior authorization.
- Professional IGRT codes are billable and payable for Medicare except with SRS/SBRT. Ensure prior auth is obtained for professional IGRT except for Medicare for any modality.
- 77014 (CBCT) is bundled into simulation codes and should not be billed.

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Front End Examples

- Drug without permanent code, 100 mg vial, bill 1 vial, reimbursed at $1,230. When J code was assigned it was 1 mg, reimbursed at $12.30. Someone failed to correct the CDM for 6 months. 15 treatments were billed at 1 unit instead of 100 units = $18,266.50 in missed revenue
- When CMS ruled that hospital IGRT codes are not reportable for IMRT, SRS or SBRT, it was added to the claim scrubber. But 30% of patients were on insurance plans that would pay for it. Every one not billed left $40 on the table. $40 x 60 patients x 20 treatments = $48,000.

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Front End Example (2)

- One center tracked their financial counselor numbers for one year:
  - $92,000 in receipts from co-pay assistance programs
  - $55,000 in receipts from foundations
  - $993,000 in cost of drugs replaced
  - $233,000 in receipts for patients who were helped to enroll in insurance programs

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The Middle for Infusion

- Never mix drug before lab results and assessment indicate it is appropriate
- Document, document, document
  - For each hydration, injection and infusion:
    - Document all start and stop times, route, and dose administered
    - Document waste of any "single dose vial" if it cannot be used for another patient

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Middle for Infusion Example

- Infusions are billed according to the duration. For 15 minutes or less, a “push” is billed. For over 15 minutes up to 90 minutes, one “hour” is billed – which pays better than a “push.”
- For drugs that are labelled as “single dose vials,” unused contents (if not usable for another patient) can be wasted and billed.

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Middle for Infusion Example 1

- RNs round times to nearest 5 minutes. 16 patients per day received pushes and infusions. Half of those pushes actually took 16-18 minutes. One quarter of the infusions were ordered for 90 minutes but actually took a little longer.
- 16 daily time rounding “errors” = 8 pushes that could have been billed as an hour, 4 drug 91+ minute infusions that could have been billed as 2 hours. Over the course of a year, that’s 2,000 pushes instead of IV hours and 1,000 missed IV hours per year = $88,130.00 in missed revenue.

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Middle for Infusion Example 2

- Pharmacy is unaware that they can bill for waste from single dose vials
- 2,668 annual infusion visits, 10% chart audit
- Total of $2,017.93 in missed waste revenue
- Annualized to $20,164.18 in missed revenue

The Middle for Radiation

- Document, document, document
  - Each billable code must have a physician order, documentation of medical necessity as well as physician involvement.
  - Ensure codes that have a professional and technical component are billed on the same date of service.
- Be aware of NCCI Procedure-to-Procedure(PTP) edits and Medically Unlikely (MUE) edits

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Middle for Radiation Example

- OMC Group has had clients that virtually had almost no physician documentation except for a consult note. This places almost all charges (professional and technical) at risk for repayment due to no medical necessity documentation.
- Unless clinically indicated as a “true” clinical emergency, don’t hurry up the steps and processes for simulation and treatment planning.

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The Middle for Everything

- Don’t have clinical staff choosing codes! Hire a certified coder to code from the source documentation.
- Double check charges entered by an electronic system against documentation
- Reconcile pharmacy charges daily including SDV waste
- Perform an end of treatment review for all radiation charges to ensure no codes were missed.

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The Back End

- Periodically check conversions from charges to claims.
  - Some IT systems don't transfer codes properly.
- Never automatically accept a claim scrubber rejection.
  - Some scrubbers delete codes unnecessarily that could have been billed with a modifier attached.
- Reconcile EOBs/Remittances at the line item level.
- Never automatically accept an unpaid item.
  - Often items would have been paid with a modifier or another diagnosis.
- Appeal all unpaid items that are appropriate for appeal
  - If you don't ask, you certainly won't receive.

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Back End Examples

- Blue Cross was 30% of the payer mix. They denied one drug 32 times as “not covered” because the diagnosis didn’t match policy. Billing wrote it all off when in fact the actual diagnosis was payable if the EMR system had updated them properly. This resulted in over $18,000.00 in missed revenue.
- When CMS retroactively allowed 77300 with 77295, the hospital failed to back bill, leaving over $80,000.00 on the table.

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Add It All Up

Example	Results
Financial Counselor	$1,373,000
Charge Master	$18,000
IGRT	$48,000
Infusion Time	$88,000
Drug Waste	$20,000
Diagnosis Coding	$18,000
Retro Billing	$80,000
TOTAL	**$1,645,000**

- Now ***THAT*** should pay for those coders and financial counselors!

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Questions

- Any questions not addressed here may be emailed to solutions@oncologymgmt.com
- OMC Group will compile questions and answers and distribute to webinar registrants

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Thank You!

Sincere thanks to all of you for joining us today. We hope that you will keep OMC Group in mind when consulting needs arise in the future.

Financial and Market Analyses	**New Center Development**	**Hospital/ Physician Integration**	**Strategic Planning**
Implementation and Interim Leadership	**Performance and Financial Benchmarking**	**Operational Assessments**	**Revenue Cycle Reviews**

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