HOW ONE SMALL ONCOLOGY PRACTICE *is Surviving*

by Ruben Sierra, MD, PFPM, CAPPM, and Rindi Baze

Since the implementation of the Medicare Modernization Act (MMA) of 2003, Columbia Basin Hematology Oncology—like other oncology practices across the country—has faced constant challenges while adjusting to the mandated changes. Our practice has been able to survive and continue to provide chemotherapy services only by changing how we do business and by improving our practice efficiency to the highest levels possible. Here is our story.

A Rapid Reaction Approach

Our first step was to create a high-level team that continually reviews Columbia Basin Hematology Oncology's standards of practice. This integral "rapid reaction team" is chaired by the managing partner and includes the office manager, the nurse manager, and the head of the billing department. Our team meets on an "as needed" basis to address changes with Medicare payments as soon as they occur.

Every three months, the team reviews practice policies to sustain or even improve practice efficiency. This review process is complex, multidirectional, and time-consuming. Initially, the team reviewed *all* the services provided by the practice, finding that many services—while important—were very cost inefficient. While we had known this information for several years, in the past our practice was able to "subsidize" these services because of adequate Medicare reimbursement. In other words, even though our practice took a loss on certain services, overall we were in a strong enough financial position to provide these non-cost-effective services in our office. Everything changed under average sales price (ASP).

Desperate Times, Desperate Measures

Once Medicare started paying for drugs at ASP+6 percent, our practice could no longer afford to subsidize the cost of these services. Medicare reimbursement for many of our services was now below the actual cost of providing the services. In several situations, Medicare reimbursement equaled only 20 percent of our cost. But the real "losers" were our cancer patients. Patient convenience had been the driving factor in providing these services in our office, and our patients were negatively affected when they were told our practice could no longer afford to provide the following:

- Blood transfusions
- Therapeutic phlebotomies
- Peripheral blood drawing
- IV antibiotic therapy
- Some non-urgent hydrations.

Our practice worked with its patients over a period of time to educate them as to why our office could no longer offer these services. We also provided referrals to outside sources that would provide these services.

At the same time as the practice was downsizing its service line, the team was also looking closely at the practice's chemotherapy protocols. To maximize efficiency, the decision was made to unify, as much as possible, the common chemotherapy protocols. For example, in colorectal cancer there are many treatment options for the practitioner to choose from, including: FOLFOX-4; FOLFOX-6; FOLFOX-6, modified; IFL; IROX; FOLFIRI; CAPOX; CAPIRI; 5FU/FA; and Avastin added to any of the above treatment protocols. By choosing *one* front-line therapy for advanced disease and adjuvant

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therapy, our practice was able to concentrate its acquisition efforts on specific drugs. The next step was to familiarize nursing staff with these drug regimen choices and work with billing staff to obtain the best possible purchase price.

To more fully capture and be reimbursed for *all* the services our practice was providing, we implemented an electronic medical records system (EMR) for the infusion unit. Although this move required a financial investment during lean times, the EMR improved our documentation and charge capture, and allowed us to collect quality care data.

Our goal was to continue to provide the best therapy in the most cost-efficient method. While our efforts were largely successful, the hours of staff time required to implement these changes were not reimbursed by *any* payers.

An "All Star" Team

Each quarter when the Centers for Medicare & Medicaid Services (CMS) releases ASP+6 percent drug prices, our rapid response team is in motion, analyzing the data and following up with a report and recommendations for the practice.

Our nurse manager plays a critical role in our rapid response team. She keeps track of the costs for anticancer drugs and supplies and also manages the practice's inventory. Each week she contacts every vendor and procures the best prices available at that time. If the rapid response team has determined that certain drugs are being reimbursed below our cost, she immediately gets on the phone with suppliers to see if the practice can acquire the drugs at a better price. She also advises the managing partner about special pricing on drugs, supplies, and equipment.

For a small office that does not have a large cash flow, keeping the drugs and supplies inventory down to the minimum is absolutely critical. At the same time, it is also necessary to have these drugs and supplies available when they are needed for our patients. To help in this effort, our nursing team developed and uses many standard orders that have increased our practice's efficiency. Some of the protocols include standard orders for the management of:

- Anemia
- A variety of infections
- Blood/platelet transfusions
- Dehydration
- Diarrhea
- Mucositis
- Nausea/vomiting
- Neutropenia
- Neutropenic fever
- Thrombocytopenia

At the end of each day, our nurse manager reviews all the infusion unit "super bills" to ensure that all charges have been captured. She also plays a key role in reviewing policies

Who We Are

Columbia Basin Hematology Oncology, PLLC, is a medical oncology practice located in Kennewick, Wash., employing four medical oncologists, one nurse practitioner, 10 nurses, and 24 office staff. In the past seven years, the practice has had more than 75,000 patient encounters, not including infusion visits through its chemotherapy unit. Medicare accounts for 46 percent of the practice's payer mix.

The practice's infusion unit consists of 12 chemotherapy units. Services provided include oncology and hematology consults, chemotherapy treatment, central line maintenance, IV therapy, and patient education.

Table 1. Tracking Your Drug Costs

Drug Name	HCPCS Code	Practice Cost[1] December 2005	Practice Cost[1] March 2006	2004[2] ASP+6% (Payment in dollars)	2005[3] ASP+6% (Payment in dollars)	2005[4] ASP+6% (Payment in dollars)	Dollar[5] Difference	Percentage Change
Drug A								
Drug B								
Drug C								

[1]Dollar amount the practice paid to obtain the drug.
[2]Based on 4th quarter 2004 data supplied by drug manufacturers.
[3]Based on 3rd quarter 2005 data supplied by drug manufacturers.
[4]Based on 4th quarter 2005 data supplied by drug manufacturers.
[5]Subtract most current practice cost from most current ASP+6 percent reimbursement payment.

to eliminate waste and misuse of practice resources.

Our office manager and the head of the billing department are also integral members of the practice's rapid response team. For example, the billing department pre-approves all chemotherapy regimens and any other therapy provided at the infusion unit. Billing staff have "immersed" themselves into the Medicare policies and have greatly increased their understanding of these complex rules and regulations. In fact, the billing staff's ability to procure 100 percent of "approved" therapies is astonishing. Much of their success rests on their ability to interact efficiently with our oncology nurses and providers. Bottom line: our billing department provides another layer of supervision to ensure that all our charges are captured and paid.

Using all available resources, including the practice's EMR system and Lynx machine, the nurse manager and billing department are able to create all the critical reports needed to understand the practice's true cost of doing business. On a regular basis, the nurse manager and the head of the billing department compile useful statistics, which are then shared with the office manager and the managing partner. The managing partner, in close collaboration with the office manager, has the responsibility of capturing, analyzing, and presenting the data to the entire practice.

The team established strict—but realistic—office-wide benchmarks, which are reviewed every three months. An in-depth financial report is generated twice a year.

Current infusion benchmarks include: 100 percent of correct super bills; 100 percent correct orders, 100 percent documentation of treatment; and 0 percent waste. Our oncology nursing staff has taken the lead in ensuring our practice meets these benchmarks.

The practice's financial benchmarks target our accounts receivable (AR) time. The goal is to achieve an AR time of less than 40 days. (While 30 days would, of course be better, it is not a realistic benchmark for our complex oncology/hematology practice.) Our most recent average AR was 36 days. A second, equally important financial benchmark is for net collections to be at 100 percent.

Medicine: Science, Art, and *Business*?

Today, more than ever in the history of medicine, oncologists must realize that their practices are, in fact, a business. As with any business, you cannot make decisions, such as what therapy to give a patient, without knowing your cost and your profitability—if any. The dedicated and talented cancer care team at Columbia Basin Hematology Oncology compiles a large amount of data, which allows us to analyze and improve practice efficiency. (See Tables 1, 2, and 3.) Among other trends, we use this data to:

- Understand our costs per hour, per day, and per provider
- Track the cost and reimbursement of our chemotherapy protocols
- Monitor the cost and reimbursement of our supportive therapies, including anti-emetics, growth factors, and anti-osteoclast drugs.

Practices that hope to survive in today's restrictive reimbursement climate must be able to gather and analyze data—both the cost of doing business *and* quality outcomes data. Looking ahead, it is clear that insurers (both public and private) are looking to link reimbursement to quality care data. So if your practice is not gathering this information, you had better start *now*.

Most oncologists chose the journey of medical school, residency, and fellowship because they love to take care of patients. They enjoy the challenge of looking cancer (the mortal enemy) in the eye and trying to defeat that enemy every minute, every hour, and every day of their professional lives. As soon as today's oncologists commit themselves to a private practice, the reality hits home: medicine is not only a science and an art, it's a business. And we are faced with the difficulty of reconciling our science, art, and business in an ethical, honest, humane, and fair manner.

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Table 2. Tracking Your Costs, Charges, and Charge Capture

PRACTICE COSTS

Protocol	Drug Administration Costs[1]	Chemotherapy Drug Costs[2]	Supportive Care Drug Costs	Facility Fees (Overhead)	Total Practice Costs
Protocol A					
Protocol B					
Protocol C					

PRACTICE CHARGES

Protocol	Administration Charges[1]	Chemotherapy Drug Charges	Supportive Care Charges	Total Charges
Protocol A				
Protocol B				
Protocol C				

MEDICARE REIMBURSEMENT

Protocol	Medicare Payment for Drug Administration[1]	Medicare Payment for Chemotherapy Drug(s)[3]	Medicare Payment for Supportive Care Drug(s)[3]	Total Medicare Payment
Protocol A				
Protocol B				
Protocol C				

[1] Dollar amount based on administration hours.
[2] Dollar amount the practice paid to obtain the drug.
[3] Based on most current ASP data supplied by drug manufacturers.

Table 3. Tracking Your Medicare Charges and Payments

PRACTICE CHARGES

	Chemotherapy Drug(s)	E&M Services[1]	Demonstration Project[2]	Total Charges
Protocol A				
Protocol B				
Protocol C				

PRACTICE PAYMENTS

	Chemotherapy Drug(s)	E&M Services[1]	Demonstration Project[2]	Total Charges
Protocol A				
Protocol B				
Protocol C				

[1]Includes services carried out at hospitals (i.e., admitting and then seeing an inpatient cancer patient, being called in for a consultation).
[2]Administrative and physician work related to CMS' cancer quality demonstration project, which requires physicians to submit one G-code from each of three categories: E&M visits, practice guideline adherence, and disease site.