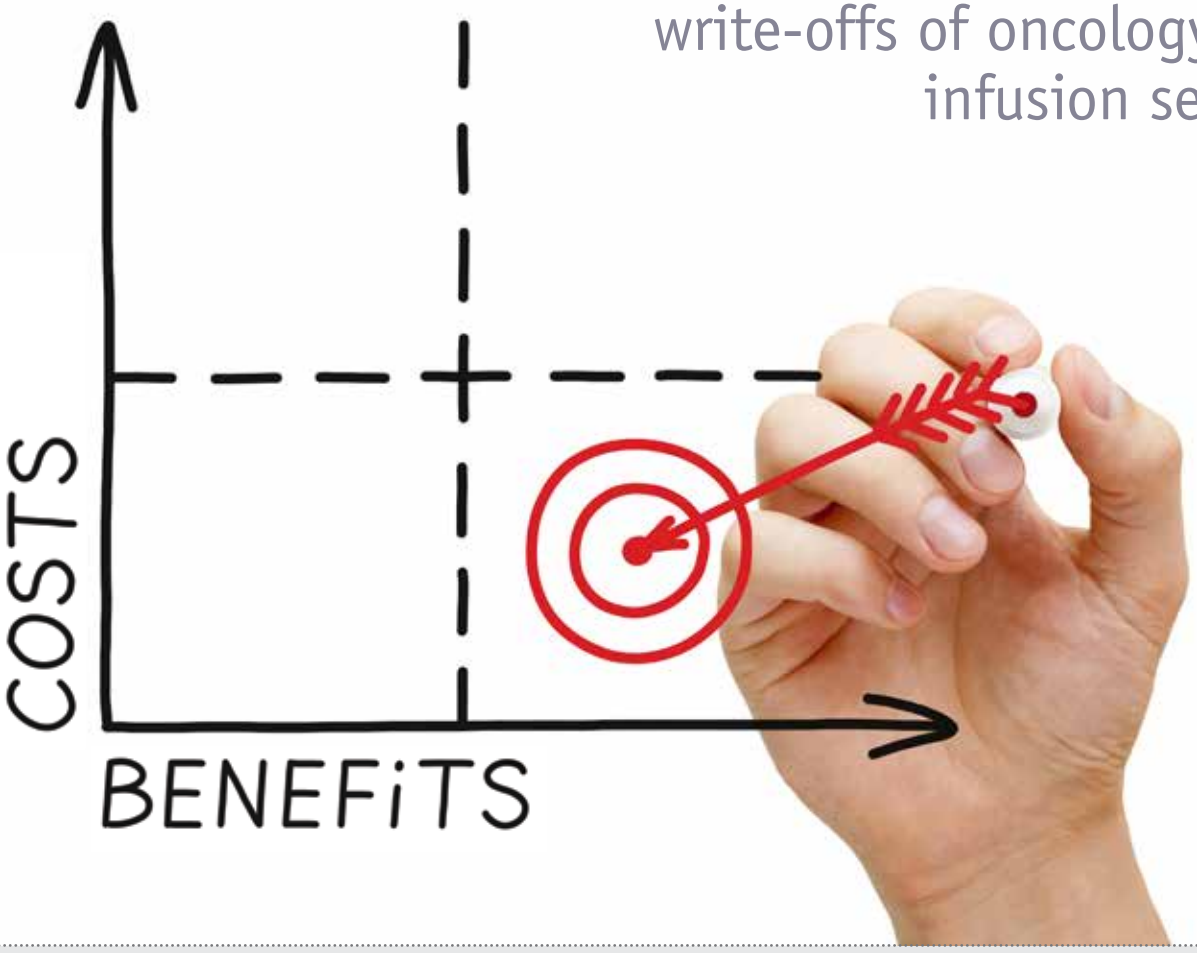
Improving Profitability & Service

A business case for managing financial write-offs of oncology drug infusion services



IN BRIEF Today, hospital administrators are constantly tasked with finding new ways to improve their program's bottom line. Often, the focus is on increasing revenue; however, opportunities also exist on the expense management side. Through a case study, we will illustrate how improving processes in outpatient infusion services may significantly improve a hospital's financial performance.

Infusion services typically include chemotherapy, blood transfusions, antibiotic injections, and pain management pump refills. High-volume services may be provided by a fully dedicated infusion department; infusion services may also be offered on an "as-needed basis" in the emergency room or on an inpatient unit.

Further, insurance may dictate where a patient will receive infusion services. Occasionally, private practice medical oncologists may make the decision to treat patients with private insurance—often equated with higher reimbursement—and "shift" patients with inadequate reimbursement, such as Medicare and non-insured patients, to the hospital setting. This cost-shifting can have unfortunate financial consequences for a hospital-based outpatient infusion department.

A myriad of other factors, including rising drug costs, decreased reimbursement, and stricter documentation requirements for payment, can also contribute to financial losses for hospital-based outpatient infusion services. These losses can rapidly grow out of

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Outpatient infusion departments provide comprehensive, skilled nursing services to patients who are undergoing diagnostic procedures or invasive treatments. In addition to chemotherapy administration, services may also include:

- Antibiotic therapy
- Hydration and electrolyte replacement therapy
- Transfusions of blood products
- Injections of recombinant growth factors
- Immunosuppressant therapy
- Antiviral or antifungal therapy
- Therapeutic phlebotomies
- Refill of pain pumps
- Placement of PICC or midline catheters
- Access of implanted ports
- Wound care.

Physicians can also use infusion center space to perform procedures such as simple tissue biopsies or bone marrow biopsies. In addition to a general trend towards increasing the scope of services, other factors, including a weak economy, an aging Medicare population, and longer, more complex infusions, have caused many outpatient infusion centers to extend their hours of operation.

In our case study, all of these factors were behind the hospital's decision to open a dedicated outpatient infusion department in March 2005. The infusion department grew, providing extensive services for a diverse patient population, including patients with cancer, Crohn's disease, multiple sclerosis, rheumatoid arthritis, infections, hematologic diseases, and chronic renal failure. Patient services included chemotherapy, antibiotic therapy, hydration and electrolyte therapy, transfusions of blood products, injections of recombinant growth factors, immunosuppressant therapy, refilling pain pumps, and accessing implanted ports. The outpatient infusion department was staffed by registered nurses, nursing assistants, and phlebotomists, and supported by pharmacists.

In May 2009 infusion services expanded again with a move into a newly-constructed cancer center, increasing patient capacity from 7 to 12 private chairs with hours of operation from 7:00 am to 7:00 pm, Monday-Friday. The outpatient infusion department was deliberately positioned adjacent to the office space of a large private practice medical oncology group. With this change, hospital-based infusion service volumes grew from 4,233 visits in 2009 to 5,472 in 2010. This increased volume trend continued in 2011.

Identifying & Resolving Challenges

Although the hospital's infusion department was financial viable, an internal review conducted at the time of the move into the new cancer center showed that the service line had a significant amount of write-offs—about $1.2 million annually. This finding led the hospital to create an Infusion Task Force (ITF) Committee, chaired by a hospital-employed oncology pharmacist. Committee members included: the oncology administrator, the director of Charge Capture & Compliance, the infusion director, the infusion supervisor, and the director of Patient Registration. The ITF Committee's goal: to improve the operational performance of the infusion service line and provide a guiding hand in the continual management of the service line. The committee identified multiple strategies to address the issue of write-offs, implement programmatic efficiencies, and improve quality of care. The following steps were taken:

- Create a process to review non-formulary medications (see Figure 1, page 22).
- Analyze write-offs to identify coding and process errors and less costly alternatives to reduce future write-offs.

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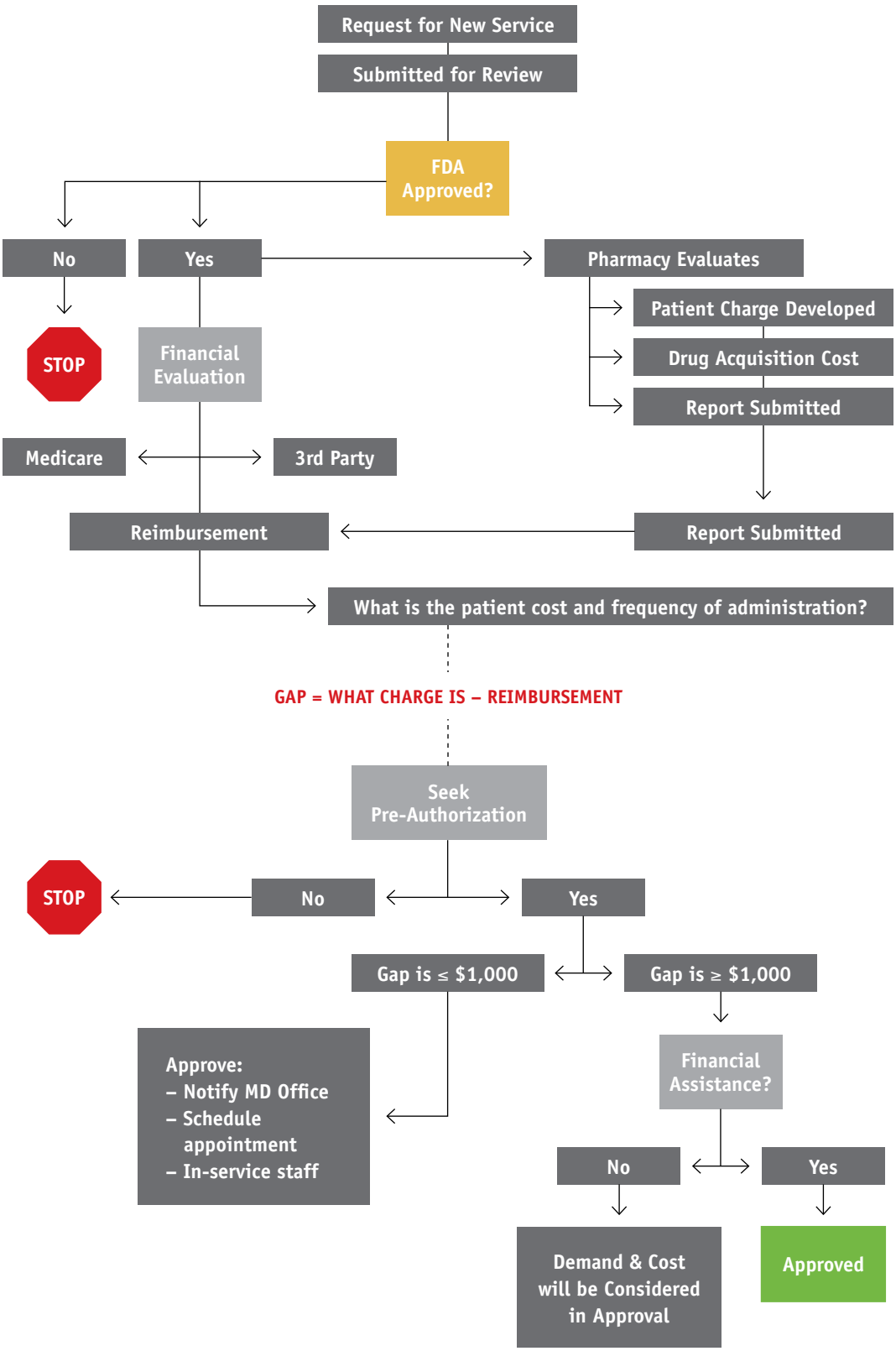
control or even go unnoticed by busy hospital administration. For example, if not actively managed, infusion write-offs can silently grow to significant levels that adversely affect a cancer program's bottom line. Developing strategies to proactively address the issue of write-offs can help community cancer centers safeguard against such financial losses and, in turn, improve the program's financial performance.

The idea of developing a centralized process to improve reimbursement for outpatient infusion services is not new. In 2011 Norris Cancer Hospital, University of Southern California, created an in-house authorization center to monitor and improve reimbursement.[1] Detailed in a 2011 article in the *American Journal of Health System Pharmacy*, this model is just one example of how a facility can identify opportunities to improve reimbursement or, at the very least, minimize loss.

In this article we offer another model to improve the financial performance of a hospital infusion service line, including the processes used, the challenges faced, and relevant case studies. Because financial information is disclosed in this article, the name and location of the hospital has been de-identified. We hope that by sharing our experience we can help shed light on opportunities for other facilities to improve their own financial performance.

Figure 1. Process to Review Non-Formulary Medications



- Develop a proactive process to review non-covered or poorly-reimbursed medications and services.

New Drug or Service Request Form

Now, physicians requesting new or non-formulary infusion services are required to complete an Outpatient Infusion Services: New Drug or Service Request form (see pages 24-25). This form summarizes the treatment and/or medication, including indications, dose, frequency, side-effects, adverse effects, and implications for nursing. Medications that require cardiac monitoring and medications without FDA-approved indications are excluded from infusion services. With this form, the physician provides clinical evidence that the new or non-formulary treatment or medication will be equal to or better than any current treatment on formulary. If no formulary alternative exists, then the clinical evidence will include the studies that brought the treatment or medication to market. As efficiency of service and quick follow-up are important customer service goals, the ITF Committee developed a process that would allow most requests to be resolved within five business days.

Here's how the process works. Once the request form is completed by the infusion department supervisor, the ITF Committee is responsible for circulating the application through pharmacy, registration, and fiscal coding. The ITF Committee has three options for approval of new and non-formulary medications:

- Medication remains non-formulary and non-approved. The fiscal impact is too excessive or the cost of treatment outweighs any potential gains. The patient can pay out-of-pocket or be referred to an assistance program.
- Medication is reviewed on a case-by-case basis.
- Medication is added to the formulary. The benefits of providing the medication or treatment outweigh the cost and therefore support stocking the medication in the hospital pharmacy.

To help with this process, the ITF Committee created the key role of "gatekeeper." This staff person is responsible for monitoring infusion service processes that could potentially lead to write-offs. The gatekeeper identifies these cases, triggers the review process, and communicates with the ordering physician on non-formulary requests. Before the gatekeeper role was implemented to pre-review cases, physicians could order and schedule infusion services without regard for write-off potential.

Analyzing Write-offs

In addition to reviewing non-formulary medications, the ITF Committee initially met monthly to review and analyze infusion service write-offs. Standing agenda items include:

- Retrospective review of write-offs
- Outstanding requests for new drugs
- Changes in reimbursement
- Medication alerts.

Once the process flowed efficiently and results were being realized, the committee began to meet every other month. During each meeting, the ITF Committee reviews the most recent write-off report, which also includes an itemized break down of potential cases at risk of being a write-off (see Table 1, page 26). Specifically, these potential cases are claims for services that were "kicked back" from the hospital's medical necessity filter system, but have not yet been submitted to the payer. The report includes the patient name, medical record number, date of service, medication administered, referring physician, and the comment section for the cause of the "kick back." With advanced notice of potential write-offs, the ITF Committee can proactively address the issue, and identify patterns and opportunities to make improvements.

When the ITF Committee first began meeting, a write-off report was typically 12-pages long, and it was just not practical to address all items at once. Initially, the committee chose to focus on a few high-dollar write-offs each month even though these occurred much less frequently than low-dollar write-offs. When tabulated, these few cases comprised the bulk of the write-offs and often were more easily addressed. Once write-off issues were fixed, the committee monitored them closely to ensure they did not re-emerge. The ITF Committee continued to address these more costly write-offs; over time, write-offs were reduced to less than $100,000 a year.

The ITF Committee used this retrospective review to compare alternate generic drugs and drugs on formulary and review the coding of these drugs. Then, depending on the issue, the most appropriate committee member was tasked with discussing the write-off and alternatives with the prescribing physician. The gatekeeper ensured that, once identified, future cases would either meet the documentation requirement or follow the agreed on corrective action plan. Over time, this process significantly decreased the number of write-offs in reports.

Non-Covered or Poorly Reimbursed Drugs & Services

The ITF Committee developed a "fast track" process to proactively review non-covered or poorly-reimbursed infusion services.

When a physician's office contacts the hospital's outpatient infusion department to schedule a patient for a new service for non-formulary medication, the gatekeeper initiates the fast track process by filling out the Outpatient Infusion Services: New Drug or Service Request form. The gatekeeper is responsible for notifying the requesting physician of the fast track process; the ITF Committee then decides whether to approve or deny the requested service. Typically, the gatekeeper gave feedback to the referring physician; however, in some situations, it was appropriate for the pharmacist and administrator to follow up with the physician. Fortunately there was little to no physician push back; rather, physicians were understanding and supportive of the new process.

Because this review process involves a drug-based service, the ITF Committee is led by the clinical pharmacist dedicated to oncology services, with support from the cancer program administrator. Responsibilities include answering the following questions:

1. ***What is the financial cost of the new proposed service in terms of acquisition?*** This is determined based on the average wholesale price (AWP) of the new medication and the acquisition cost for the hospital to obtain the medication.
2. ***What is the cost of the service to the patient?*** This is the amount the patient must pay out-of-pocket for the medication.

(*continued on page 26*)

Outpatient Infusion Services: New Drug or Service Request

Infusion Task Force Meeting Date Presented: _____

Instructions: Fill out all areas of this form accurately and completely to avoid delays in your requests.

1. **A.** Name of requestor: _____
   B. Who took the request? _____
   C. Who will contact requestor with follow-up? _____
   D. When are we to follow-up with requestor? _____
   (Normal review time is 5 business days; however, if a prompt decision is required, indicate that here.)

2. Brief description of the service (or medication): _____

3. Drug or service provider: _____

4. Is the item on contract? ☐ Yes ☐ No If "No," who supplies the requested medication?

5. What is the indication for the medication or service? _____

6. Is this service or medication indicated for: **A.** Inpatient use? ☐ Yes **B.** Outpatient use? ☐ Yes

7. Estimated annual usage for the medication or service? _____

8. Cost of the medication or service? (May attach additional documentation to reflect actual pharmacy requisition costs, nursing infusion costs, etc.)

9. Any formulary alternatives that can be used and are in use at the cancer program? _____

10. Any other Division facilities that are currently using this medication and or service? _____

11. Recommendation of the clinical nurse coordinator of Infusion Services? ☐ Approve ☐ Deny (Indicate reason)

_____

_____

_____

12. Director's offset plan if above request approved? _____

_____

_____

13. Reimbursement:

	INPATIENT	OUTPATIENT
Anthem PPO		
Anthem HMO		
Medicare		
Medicaid		
Cigna HMO		
Cigna PPO		

CPT Code/ DRG Code: _____

APPROVALS

Pharmacy Services: _____

Administration: _____

Task Force Recommendation

☐ Approved ☐ Denied

☐ Requestor has been contacted regarding the decision of this review. Date Contacted: _____

Please note the following: If "Fast Track" is indicated, request will be examined and acted upon within 5 business days. The Committee meets on the 2nd Monday of every other month beginning with January from 3:00 pm to 5:00 pm. Please attach additional resources or references as necessary to this form if more space is needed to complete your request.

Signature Tracking for "Fast Track" Process

Pharmacy Approval: _____

Nursing Approval: _____

Finance Approval: _____

Administration Approval: _____

(Pharmacy, Nursing, Finance, and Administration must view and approve all "Fast Track" requests.)

Table 1. Sample Write-Off Report*

PATIENT NUMBER	PATIENT NAME	SERVICE CODE	ADMIT DATE	TOTAL CHARGE	PROCEDURE DESCRIPTION FROM CMS ADDENDUM B	ATTENDING PHYSICIAN NAME
123456789A	Alpha, J.	INFJ	06/23/10	$3,124	Thyrotropin injection	Adams
123456789B	Beta, M.	INFJ	07/09/10	$2,576	Iron sucrose injection	Jones
123456789C	Charlie, D.	INFJ	08/12/10	$2,273	Reclast injection	Smith

*Names, dates, and patient medical record numbers are fictitious.

(*continued from page 23*)

3. ***Who supplies the new medication if approved?*** The medication's charge information, AWP, and acquisition cost are all taken into account to make this decision.

The ITF Committee partners with a hospital-employed financial counselor to address these cases prospectively. This role became so valuable to cancer services, the financial counselor was provided dedicated space adjacent to registration and added as a member of the ITF Committee. The financial counselor compares the cost of the drug to the amount the payer will reimburse, and then develops an action plan to help the patient cover any "gaps" between what the hospital charges and what insurance will pay for the medication. This plan may include the use of financial assistance resources or even pharmaceutical cost-relief programs for patients. The financial counselor summarizes the action plan to the ITF Committee by determining:

- The reimbursement amount for the medication based on the patient's insurance.
- The patient's out-of-pocket costs (charge amount – reimbursement amount = patient responsibility).
- If the medication should be added to the formulary using payer mix (private vs. public) to calculate overall reimbursement.

Coming to a Decision

Generally, if the "gap" between cost and reimbursement is less than $1,000, the treatment is accepted and the medication is added to the formulary. If the "gap'" is greater than $1,000, then a payment plan is developed for the patient. If we are not able to develop a payment plan with the patient, the medication may not be approved. The ITF Committee does take other factors into consideration during decision-making, including; frequency of use, patient need, lack of alternatives, or possibly offsetting contributions from other ancillary services. Once a new service or medication is approved:

- The gatekeeper notifies the requesting physician
- Pharmacy acquires the medication
- Registration will post and schedule the patient.

The ITF Committee reviews the final reimbursement numbers once the service is completed. Per policy, any new treatment or medication not approved during this fast track process cannot be re-submitted by the physician for a period of at least six months, unless the patient has gained access to a program that changes his or her financial situation. Usually, the committee can make a decision on new non-formulary treatment requests within five business days. If a decision is needed sooner, the infusion supervisor communicates with the ITF Committee, which will work with the physician to help avoid any significant treatment delay.

Financial Outcomes

The ITF Committee also reviews the listing of Medicare accounts written off due to lack of medical necessity. Data is trended based on: service line, department, physician, and specific service provided. Using this review process, the ITF Committee identified major issues related to screening for medical necessity before administration of the drug epoetin alfa and two needed processes:

1. Physician education regarding standardized order sets, which ensures capture of all the diagnostic information required for the NCD/LCD
2. Pre-screening of the orders prior to providing the service.

Case Study 1. Epoetin alfa (Procrit® and Epogen®) is currently FDA-approved for the management of anemia due to chronic kidney disease and ongoing cancer chemotherapy. Cancer patients who qualify for epoetin alfa fall under a Risk Evaluation and Mitigation Strategy (REMS) protocol, and are required to follow a specific outpatient monitoring protocol. Patients with chronic kidney disease (CKD), defined as CKD stages III-V, qualify for epoetin alfa under medical necessity. These patients are screened for baseline hemoglobin (Hgb) and hematocrit (Hct) values to match standards within the drug prescribing guidelines. All patients must have a baseline Hgb/Hct of less than 10/30 g/dL to start treatment.

Once treatment begins, if the Hgb/Hct rises by greater than 1 g/dL in any two-week period, the prescribing physician must be contacted and advised to hold treatment or decrease the dose by 25 percent. For the renal population, treatment can continue until a patient's Hgb is at therapeutic levels, as defined as 11.5 g/dL. Oncology patients must follow the rules in the REMS guidelines. These patients cannot receive treatment if their Hgb/Hct is above 10/30 g/dL. At that point, treatment must be withheld, and dose adjusted to keep Hgb/Hct values between 9.5 and 10 g/dL.

In this case study, the majority of patients on epoetin alfa were

CKD patients. The NCD/LCD requires two diagnoses specifying the stage of the CKD and the type of anemia. Nephrologists were educated on the diagnosis coverage requirements and an order form was created to ensure capture of the required documentation. As a result, write-offs for these patients were virtually eliminated.

Case Study 2. The ITF Committee identified a write-off trend due to lack of medical necessity for HCPCS J9045: carboplatin injection for patients with uterine cancer. (Six patient accounts with a total of $28,620 in write-offs.)

On review, here's what was happening. A physician provided orders with a non-specific ICD diagnosis code of 179: Malignant Neoplasm of Uterus, Part Unspecified. For medical necessity coverage, the LCD requires the specific anatomical site of the uterus involved: ICD diagnosis code 182* - Malignant Neoplasm of Body of Uterus. After the review, the infusion supervisor discussed the specific LCD requirements with the ordering physician. Now infusion center staff pre-screens carboplatin orders for diagnosis specificity and obtains clarification when needed. This pre-screening process has eliminated these write-offs.

Case Study 3. After the ITF Committee addressed and remedied the infrequent high-dollar write-offs, the committee began to address the low-dollar/high-frequency write-offs, such as laboratory tests. After one such review, the ITF Committee identified opportunities for physician education related to medical necessity for magnesium CPT 83735, which is impacted by therapeutic infusion. The ITF Committee was also able to provide physician education related to NCD coverage for:

- CPT 82378 – CEA (Arcinoembryonic Antigen)
- CPT 86304 – CA125 (Tumor Antigen by Immunoassay CA 125)
- CPT 86300 – CA15-3 (Tumor Antigen, Immunoassay, CA15-3) and CA19-9 (Tumor Antigen by Immunoassay CA19-9).

Medical Necessity Write-Offs, NCDs & LCDs

On a quarterly basis, the hospital received a report with account-specific data for Medicare medical necessity write-offs. The director of Coding, Compliance & Reimbursement began reviewing these reports to identify trends for service lines, as well as opportunities for physician and coding education. From this initial analysis the hospital determined that the departments providing the services needed to be aware of their write-offs. Accordingly these reports became a monthly review and standing agenda item for the reporting departments.

The review revealed two key findings. First, the hospital as a whole needed to tap into subject matter experts to better understand the services experiencing write-offs. Second, physicians needed education on the completeness of their documentation and the interpretation of the NCDs/LCDs.

The ITF Committee became the vehicle to discuss write-offs and identify where education and process changes were needed to ensure complete documentation prior to providing services. A monthly case-by-case review allowed the ITF Committee to proactively identify strategies to decrease write-offs from patients who frequented services and to obtain complete documentation for future visits.

As a standing agenda item, any new or revised NCDs/LCDs are brought to the ITF Committee for review and discussion. The committee then identifies key individuals to provide the necessary staff and physician education. In addition, the ITF Committee researches any new infusion services prior to providing the service to ensure that:

- NCD/LCD requirements are understood and met
- Physician education is provided
- Order sets are standardized or created
- Staff education for pre-screening is provided.

Key Successes

The ITF Committee has benefitted our patients, family members, and staff, including our private practice physicians. The stress of the illness alone is significant, but when compounded with managing the financial side of treatment, patients are often overwhelmed. At a time when satisfaction is highly valued by both patients *and* payers, our outpatient infusion center provided a great service to its patients by reducing the negative incidents when patients are burdened with bills, insurance forms, and even collections.

Often the person to hear from patients about financial and billing challenges associated with treatment is the ordering physician. No hospital wants its physicians to be burdened with complaints about hospital billing. This situation only occurs after the patient has received treatment and may occur several months following treatment. We found that the ITF Committee engaged our physicians and brought them into the solution. Their feedback has been positive and contributes to patient volume growth.

For the hospital, the benefit has been a substantial decrease in financial write-offs. Further, decisions to approve treatment with the understanding that a write-off was likely were being made in a controlled, managed, and proactive manner. Note: the hospital awarded the ITF Committee with an *Innovation Award for Finance*.

Process improvements and strategies discussed in this article are derived from a single facility. Variables, such as facility volumes and payer mix, will undoubtedly affect performance. We recommend that administrators review their own write-off reports to identify opportunities specific to their program. The solutions provided within this article are suggestions; each facility should determine their own process for reducing service write-offs. With healthcare reform, innovative, proactive processes to reduce the cost of care are now a priority and a responsibility. Although this initiative did not eliminate write-offs completely, nor should that be expected, the processes described significantly reduced the quantity of write-offs. As with quality efforts, we are constantly chasing zero. OI

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References

1. Desai SS. Inhouse authorization center to improve reimbursement for outpatient chemotherapy infusions. *Am J Health Syst Pharm*. 2011;68(9):828-834.