Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

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To cite this article: James L. Wade III & Leon Dragon (1994) Medicare's Challenge to Oncologists, Oncology Issues, 9:3, 19-20, DOI: 10.1080/10463356.1994.11904472

To link to this article: https://doi.org/10.1080/10463356.1994.11904472

Published online: 18 Oct 2017.

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Medicare's Challenge to Oncologists

by James L. Wade III, M.D., and Leon Dragon, M.D.

The honeymoon is over. Not long after the marriage between medical oncologists and the Resource-Based Relative Value Scales (RBRVS) system, medical oncologists are learning to live with the intrusive realities of this new relationship. Since the RBRVS codes were introduced almost two years ago, Medicare has quietly watched and measured our performance. Oncologists' coding behavior is now neatly allocated by regions, population served, and frequency and type of services provided to Medicare beneficiaries. The clear challenge to oncologists is to properly identify the codes associated with different levels of service and to document patient interactions in detail in the medical record.

When the evaluation and management codes were first introduced, Medicare's plan was to measure how we used these new units of work. During 1992 and through 1993, Medicare kept close track of the number, location, and pattern of visit and chemotherapy administration codes. Beginning in late 1992, Medicare began to screen physicians by requesting the medical record documenting a particular code's use. This request was meant to achieve two goals: 1) educate Medicare about how physicians interpreted the new codes and 2) help Medicare educate physicians about what determines the level of service. Implicit in this is

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TABLE 1. RAMS ANALYSIS

Specialty: Primary Care
Procedure Code: 9921

Physician*	Jan.-June 1992 No. services	No. patients	Services/ patients	Peer group services/patient -2 Std. day	Norm	+2 Std. day
Dr. 1	159	611	2.61	0.43	1.53	2.63
Dr. 2	184	27	6.81	0.43	1.53	2.63
Dr. 3	586	265	2.18	0.43	1.53	2.63

Number of providers falling beyond two standard deviations: 25 (Provided by Medicare Part B, State of Illinois)
Number of providers aberrant after review by the medical director: 14

Code** lowest to highest level	Dr. #1 No. services	%	Accum %	Dr. #2 No. services	%	Accum %	Dr. #3 No. services	%	Accum %
99211	0	0.0	0.0	0	0.0	0.0	0	0.0	0.0
99212	1	.6	0.6	0	0.0	0.0	0	0.0	0.0
99213	0	0.0	0.6	0	0.0	0.0	2	0.3	0.3
99214	158	99.4	100.0	184	100.0	100.0	556	85.7	86.0
99215	0	0.0	100.0	0	0.0	100.0	91	14.0	100.0
Total	159	100.0		184	100.0		649	100.0	

* Data from HCFA, Medicare, State of Illinois
** Specific code descriptions are found on pages 19-23 of the 1993 CPT Manual

the need for the medical record to document information needed for audit purposes rather than for individual record keeping.

These initial forays were done under the aegis of the Comparative Performance Review (CPR) program. The CPR was intended as a way to inform practicing physicians about how their coding practice varied from their peers based on norms that were generated from the data acquired earlier that year. This program was for educational purposes only. No coding changes were made, and it was not punitive. The program ended October 1, 1993. Currently, Medicare is using two strategies to evaluate and judge physician coding practices: the Focused Medical Review (FMR) and the Comparative Medical Review (CMR) programs.

FOCUSED MEDICAL REVIEW

The FMR program is an analysis of all utilization data by all providers. It is statistically driven to identify aberrant utilization patterns where a particular code is at variance with the National Claims History Data Base (NCHD). Identified codes are those where a statistical comparison by state finds that the code is used more than two standard deviations above the national average. Codes may also stand out if there are too many services per 1,000 beneficiaries, too high a cost per 1,000 beneficiaries, or if a significant monetary savings could be realized if the code was used at the national average level.

The aberrancy can occur for a number of reasons. One of the most common reasons is incorrect identification of the provider specialty. Medicare still lists some oncologists as primary internists or family practitioners. This incorrect label will make their behavior stand out quite a bit from their primary care peers. A second cause of aberrancy may be a local factor, such as a misinterpretation of a code or an improper designation of the site of service. For example, the coding of chemotherapy or office procedures when actually given in another location could trigger the identification of a code as aberrant. A third possible cause of aberrancy may be local practice patterns that differ from the norm. If, for instance, a group of oncologists had developed a particular interest in prolonged infusion chemotherapy, then the code 96414 may have been used enough to be identified as aberrant for that given regional Medicare population, although the treatment given was entirely appropriate. Finally, there will be those codes identified where the coding behavior does not reflect how our peers are actually practicing, either by mistake or by design, and Medicare will spot this behavior.

...**a**ssume the worst and document as if you know you will be audited.

COMPARATIVE MEDICAL REVIEW

The Focused Medical Review will locate areas of interest for further study. Medicare can take the results and either design corrective action through education (i.e., through state oncology societies) or begin to use the aberrancies identified in the FMR and look at specific practices. This process is called the Comparative Medical Review (CMR). The CMR is based on a computer program called RAMS (Retrospective Analysis of Medical Services), which consists of more than 50 programs that are designed to profile a provider's practice to identify aberrant utilization patterns. RAMS details for each provider how each code is used in comparison with his or her regional and statewide peers by specialty. The code used by the provider will be compared with other codes, the number of patients seen, and the number of services per beneficiary.

With RAMS, specific coding patterns can be identified. Table 1 shows three physicians who are compared with the norm. They were analyzed by frequency of evaluation and management codes used, the number of patients seen, and the number of services per patient. All three physicians display aberrant behavior because of the high number of level 4 and 5 services provided in comparison with their peers. They would also have been identified as displaying aberrant behavior if they had coded for level 3, but had seen their patients more often each month.

The take-home message is:

- Code appropriately for the work you do.
- Avoid erroneous downcoding as well as upcoding.
- Document in your note to support the level of service. (Refer to the CPT handbook for details.)
- See patients when you think they need to be seen.

The American Medical Association is working on clearer guidelines for what is needed to support a level of service in the medical record. Until those guidelines are available, assume the worst and document as if you know you will be audited. That way, if you do get a request from Medicare for records, you will be ready.

Finally, work with your state oncology society if you are audited. A local carrier's decision that higher levels of your service are too frequent (even if service was appropriate) will also affect your colleagues. Fellow society members can provide constructive suggestions about how others in your state are faring. ■