Oncology Issues

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

Maximizing the Oncology Reimbursement Process

Steven Shore & Renee Matthews

To cite this article: Steven Shore & Renee Matthews (1998) Maximizing the Oncology Reimbursement Process, Oncology Issues, 13:5, 27-30, DOI: 10.1080/10463356.1998.11904779

To link to this article: https://doi.org/10.1080/10463356.1998.11904779

Published online: 18 Oct 2017.

Maximizing the Oncology Reimbursement Process

by Steven Shore, M.B.A., and Renee Matthews, M.B.A.

More than ever, the current health care environment dictates careful attention to claims management. Streamlining the claims management process can have a positive effect on oncology reimbursement and can protect a cancer program or oncology practice in the event of a Medicare audit. Claims that are incomplete or filed incorrectly stand a greater chance of being rejected or denied. Lack of prompt follow-up can result in loss of income and decreased cash flows.

The American Medical Association reports that physicians in private practice lose between 5 to 30 percent of potential income due to mismanagement of insurance claims.[1] Confusion about the various rules and reimbursement methods required by insurance companies, filing limits, and claims processing requirements appears to account for some of the problem. Nearly half (46 percent) of physicians surveyed in 1994 by the Physician Payment Review Commission cited serious problems with medical billing paperwork.[2] Thirty-five percent reported having an inadequate understanding of billing policies and the correct use of billing codes.[3]

Hospital billing departments have similar reimbursement problems and are continually striving to improve efficiency in accounts receivable. The complexity and lack of infrastructure compound the reimbursement issues for the typical hospital. Sound front- and back-end procedures that encompass the entire claims management process from charge capture through the claims appeal are essential.

Successful claims management in either the hospital or private practice setting relies on accurate medical record documentation. Appropriate documentation is required to record facts, findings, and observations about an individual's health history, including past and present illnesses, examinations, tests, and outcomes. Documentation that is correct and complete can also prevent many errors associated with claims processing and may serve as a legal document to validate the care provided.

What are the chances of being audited by Medicare? All reviews are conducted with a focused justification; random reviews usually do not take place. Review of medical records from a cancer program or oncology practice will most likely occur only if evidence of significant irregular reporting patterns is detected when compared to national profiles of similar oncology programs or practices within the same locality or specialty. Although Medicare carriers audit a very small portion of physicians, the odds of a physician practice or hospital undergoing a formal audit increase with each deviation from the norm. Documentation written legibly and in the proper format can save hospitals and practices the thousands of dollars involved in defending themselves in a Medicare audit.

Oncologists must take the lead in ensuring the highest level of documentation possible. The oncologist is responsible for selecting codes that best describe the services performed. Leaving this decision to billing personnel may lead to errors that result in income loss and increased audit exposure. This responsibility is especially important for oncologists in the hospital setting who may have minimal if any contact with billing staff.

AREAS FOR IMPROVEMENT

Reimbursement shortcomings typically fall within four potential areas: missed charges, inappropriate use of codes, unsupported coding, and price/fee structure.

Missed charges. To streamline the reimbursement process and enhance financial cash flow, every oncology practice or hospital billing office should perform a chart audit. Chart audits enable oncologists and billing staff to objectively assess the reimbursement process, identify potential revenue enhancement, and take steps to avoid audit liability.

Chart audits involve a review of CPT and ICD-9 codes. The appropriateness of physician documentation found in the patient chart is compared to the CPT code indicated on the fee slip to determine if over- or under-coding has occurred. The fee slips are then compared to the computer entries made by the billing staff for each patient visit to identify any missed charges or irregularities in data entry.

To avoid missed charges or billing errors, each patient seen on a specified day should be assigned a number. All corresponding paperwork such as fee slips, information sheets, superbills, and insurance forms should exhibit this number and be accounted for at the end of the billing cycle. Patient charts should be subdivided into different sections, such as physician notes, lab work, and chemotherapy flow sheets, to help locate key data and

Steven Shore, M.B.A., is executive director of cancer services at Holy Cross Hospital in Silver Spring, Md. Renee Matthews, M.B.A., is administrator at the Orthopaedic and Sports Medicine Center, P.A., in Annapolis, Md. Jennifer Edwards, M.H.A., manager of physician practice development at ELM Services, Inc., contributed to this article.

organize related treatment information. Depending on the filing limits, a hospital or practice may bill many insurance companies up to a year if missed charges are found in a practice audit.

Inappropriate use of codes. Too often inappropriate use of codes places oncology providers at risk of not receiving reimbursement for services. Although oncologists should hold primary responsibility for coding, billing personnel should be able to readily identify the procedures and services provided and have a basic knowledge of how to select the correct information from the medical record or flow sheet.

Billing personnel should keep up with the hundreds of revisions made annually to CPT coding. A copy of the CPT code book should be purchased annually to keep up with the new codes, the existing codes that are deleted, and changes to code descriptions. (The 1998 edition of the CPT is available from the American Medical Association by calling 1-800-621-8335.) Billing staff should also follow the current literature on proper coding procedures.

A hospital or practice may also want to evaluate CPT coding behaviors to maximize revenue or to benchmark itself against similar oncology practices or programs. Coding mix should approximate the national distribution as provided by HCFA. Staff should consult HCFA or the many reimbursement hotlines for assistance in determining billing levels.

Unsupported coding. Physicians are compelled to meet strict documentation requirements to justify billing at certain levels. As a general rule, the higher level a physician bills, the higher level of reimbursement the practice or program receives. However, a proportionate level of documentation must be present in the patient's medical record to support the level of service charged. The content of the history of present illness taken, the extent of the physical examination, and the complexity of medical decision making, as well as the actual time spent with a patient, are factors that, when accurately documented in a patient's medical chart, will verify a particular level of billing.

> ...Inappropriate use of codes places oncology providers at risk of not receiving reimbursement for services.

Physicians face a number of constraints that can hamper billing at higher levels. A 1997 survey of physicians published in *Medical Economics* found that physicians spend only 3 percent of their time per week on insurance paperwork.[4] Restrictions imposed by managed care are limiting the amount of time physicians can spend with patients as well as the amount of time they are able to spend accurately documenting their interactions with patients.

These time restrictions can affect the extent of examination and therefore the level of billing. HCFA figures show that 50 percent of new patient visits and initial hospital care are billed at Level 5. Yet for established patients and subsequent hospital care categories, that percentage drops to 4 and 18 percent, respectively. Thirty-four percent of inpatient consultations are billed at Level 5.[5] While it may be unrealistic to expect physicians to bill at Levels 4 and 5 in all cases, physicians can develop strategies for providing documentation that facilitates correct billing. (See "The Insurer's Point of View," page 30.)

Price/fee structure. Before signing up with an insurance carrier, physicians and hospitals need to evaluate their current fee structures. Cancer programs and practices lose thousands of dollars by accepting low fee schedules that barely pay for the costs of service. Billing personnel should be familiar with the specific insurer contracts and all their particular conditions regarding reimbursement.

ACCOUNTS RECEIVABLE MANAGEMENT

The objective of the accounts receivable process is to collect most, if not all, the revenue owed to the hospital or oncology practice in the most timely manner possible. Investment in a practice management system that facilitates timely reports and patient account management is one step many providers have already taken. Here are a few additional tips for optimizing accounts receivable efforts.

■ *Look at aging reports.* The well-managed hospital or oncology practice has roughly forty-five days in accounts receivable, i.e.,

Top Ten ONCOLOGY Coding Tips

1. Strive for complete documentation in the history and physical exam to support appropriate coding. The E&M codes that Medicare audit personnel will most likely select for upcoding include: office visits (99213, 99214, 99215, 99204, 99205); inpatient visits (99222, 99223, 99232, 99233); and consultations (99244, 99245, 99254, 99255).

2. Include a review of records and tests, telephone calls, and written reports when documenting the time variable for office and outpatient services.

3. For face-to-face time with the oncologist, include the nurse's time if he or she obtains the history and performs other duties as required. Remember to document these actions.

4. Bill for chemotherapy administration, even on a day when the oncologist does not make face-to-face contact with the patient, as long as the service is performed by those employees under the direct supervision of and with the involvement of the oncologist. In this situation the oncologist can bill for administration of the drug, not an office visit.

5. Bill for an office visit on the same day as chemotherapy administration as long as they are documented and separately identifiable.

6. Use time as a guideline in CPT code selection. The content of the service provided is really the major criteria for code selection.

7. Medicare will pay for a consultation if one oncologist in a group practice requests a consultation from another oncologist in the same practice, as long as it is well documented and medically necessary.

8. Use established patient codes—not consultation codes—when an oncologist assumes responsibility for a patient's care after an initial consult.

9. Remember that pumps used in the office are not usually reimbursed separately. Most carriers consider the chemotherapy administration by infusion codes to include all supplies and equipment related to the infusion pump.

10. Bill for the appropriate "J" code. If an oncologist administers 100cc, do not submit a claim for administration of two 50cc's.

outstanding invoices dating back forty-five days. However, the typical oncology practice or hospital billing office has a little less than sixty days in accounts receivable. Having greater than sixty days in accounts receivable is a sign that a hospital or practice needs to examine its billing procedures. Problems may be related to a lack of supporting documentation submitted for use of specific drugs and/or to the practice of keeping on the books accounts that likely will never be collected. It should be noted that a large, "older" accounts receivable can reduce the value of a practice.

As every oncology practice or hospital knows, as a result of managed care, net collections as a percentage of gross charges have been going down slightly year by year. The typical billing office collects 70 percent of gross charges; hospitals collect between 50 and 60 percent.

Providers should not hesitate to send delinquent claims to a collection agency after all other collection efforts have been exhausted. The dollars collected may potentially offset lost income. However, failure of these efforts may result in a patient account being closed. Billing managers should inform practice or program leaders prior to the closing of any aberrant patient accounts.

■ *Refer to the explanation of benefits (EOB) to support your appeals.* Incorrect fee remuneration, service downcodes, and denial of service payment can be appealed. Approximately one-half of all appeals are won by the physician.[6] However, practices and hospitals lose thousands of dollars each year due to incomplete requests for review and appeal. Thorough follow-up is critical. A letter of appeal to the insurance carrier should state clearly why payment should be received or

adjusted. Make sure to attach documents to support each claim. At times a phone call or faxed information is sufficient. Also, do not hesitate to involve the patient regarding an appeal if you truly believe the payer made an error in judgment.

■ *Correct denied claims.* If a payment was denied, do not send the original claim form with "corrected" or "second request for payment" written at the top of the form. Correct the problem and submit a new claim. There is no reason to highlight an oversight or correction; in fact, it could lead to another rejected claim or slower payment.

■ *Investigate financial resources for uninsured or underinsured patients.* Offer payment plans or credit card payment access for patients. Eliminate unnecessary paperwork whenever possible.

■ *Be persistent when requesting payment from insurance companies.* Regularly review your list of unpaid claims, note all insurance companies with whom you have had contact, and detail any information in writing.

Most importantly, establish formal, regularly held meetings between medical staff and billing supervisors. These meetings will enhance communication and provide an opportunity to provide overall direction to the practice.

The Insurer's Point of View

by Katherine Dunphy

When a physician office bills Medicare using E&M codes, physicians and staff must ensure that the basic requirements of good documentation are followed. In my experience as director of Medicare Part B beneficiary and professional relations in New York, N.Y., it is not uncommon to see physicians submit to Medicare only brief statements such as "Sepsis, shock, admit to the CCU," with the expectation of Level 4 reimbursement. This degree of documentation does not provide sufficient information for the medical staff to determine the level of service rendered.

While it is true that physicians are pressured by time constraints, physicians must make a concerted effort to improve the extent of their documentation in order to receive the reimbursement they deserve. On the whole, physicians *are* assessing the required examination, history, and medical decision making during patient visits. However, physicians must ensure that, however routine, such reviews are properly documented to justify appropriate reimbursement.

Physicians and their staff can take steps to ensure that there is enough documentation to support each service or procedure charged to Medicare. For example, specialty-specific templates can be created to prompt physicians to record the level of assessment that occurs but might not otherwise be documented. These prompts can be tailored to each specialty's needs, and organized per level of billing for common procedures and services.

Medicare wants physicians to be reimbursed for the work they perform. However, physicians must face the reality that documentation of what has most likely been a standard part of their medical practice is a necessity in today's reimbursement environment.

Katherine Dunphy is director of Medicare Part B beneficiary and professional relations for Empire Medicare Services in New York, N.Y.

REFERENCES

[1]*Mastering the Reimbursement Process.* Published by the American Medical Association, 1996.

[2]National Opinion Research Center. Survey of physicians about the Medicare Program and Fee Schedule. Commissioned by the Physician Payment Review Commission. Washington, D.C., May 1994.

[3]Ibid.

[4]Chesanow N. How doctors spend their working hours. *Medical Economics.* 74(23):116-130 November 24, 1997.

[5]Health Care Financing Administration. Bureau of Data Management & Strategy, Office of Health Care Information Systems, May 13, 1998.

[6]Torras H. *Health Care Fraud and Abuse.* Augusta, Ga.: Health Care Consultants of America, Inc., 1997.