



Tackling Chemotherapy Reimbursement

ONE INSTITUTION'S PROACTIVE MULTIDISCIPLINARY APPROACH YIELDS POSITIVE RESULTS

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The U.S. healthcare system operates a complex reimbursement system, including both public and private third-party payers. A multitude of factors, such as high treatment costs, off-label drug use, and mandatory pre-authorizations, have culminated to make chemotherapy reimbursement particularly challenging for community cancer centers. As the cost of intravenous and oral chemotherapy escalates, so does the need to guarantee that our community cancer centers are being reimbursed for their services. Here's how St. Luke's Mountain States Tumor Institute (MSTI) improved reimbursement, patient satisfaction, *and* its bottom line.

Staging an Intervention

In recent years, MSTI staff became alarmed by the increasing complexity of the reimbursement process coupled with the financial impact of denied claims. Cancer program staff brought these and other reimbursement issues to the attention of hospital administration, but without concrete examples, the scope of the problem was unknown. The situation changed drastically in 2005.

In August 2005, a patient with metastatic lung cancer started treatment with bevacizumab, a novel monoclonal antibody. At that time, bevacizumab only had FDA approval for metastatic colorectal cancer. The oncologist's decision to use bevacizumab was based on a recent abstract presented at ASCO. After the patient received several cycles of treatment, at a cost of more than \$40,000, the patient died. Several weeks later, the payer denied the claim because bevacizumab had been prescribed for off-label use.

News of the \$40,000 denial quickly rippled through the organization. Upon further examination, MSTI found that its oncologists were also prescribing bevacizumab for breast, lung, and kidney cancers. Although the use of bevacizumab was being investigated in clinical trials, the drug did not have formal FDA approval for those indications. While the \$40,000 loss—and the potential for additional denials based on off-label drug use—concerned administration, the oncologists at MSTI were, in a sense, isolated from the finan-



Nearly 3,000 new patients are seen each year at MSTI, and between 600 and 800 patients are receiving antineoplastic drug therapy at any given time.



MSTI is an integral part of St. Luke's Health System, a four-hospital, private, non-profit system centered in Boise, Idaho. Comprised of five outpatient oncology clinics spread throughout 200 miles in Southern Idaho, MSTI serves the entire state of Idaho, and parts of Utah, Nevada, and Oregon.

cial consequences of their treatment decisions because they are employees of St. Luke's, the large non-profit organization that oversees MSTI. In freestanding cancer centers or an oncology practice, oncologists are often financial stakeholders, with a greater interest in areas where they may be losing or making money.

Two facts became readily apparent to cancer center staff. First, MSTI had opportunities for improving the chemotherapy reimbursement process. Second, no one was exactly sure whose responsibility it was to establish an organized process for improving reimbursement and how it should be carried out. Eventually, the burden came to rest on pharmacy when administration asked its pharmacists to verify patient diagnoses against the treatment being prescribed by oncology.

Traditionally, pharmacists have been viewed as having "ownership" of all aspects of drug therapy. Some community cancer centers even consider billing as a critical role of the oncology pharmacist.¹ Billing is a wide, comprehensive term. And while pharmacists are often responsible for pharmacoeconomics and controlling cost, their formal training teaches little about billing and reimbursement. Bottom line: pharmacy needed help.

The Patient Financial Advocate

The idea of creating the position of a patient financial advocate at MSTI stemmed from a 2003 article in *Oncology Issues* entitled, "Adding Dedicated Financial Specialists to Your Team: Why Reimbursement Specialists Make Sense for Community Cancer Centers."² The authors outlined potential areas of responsibility in a cancer center that a patient financial advocate might coordinate, including:²

- Handling authorizations for chemotherapy and supportive treatments in the infusion area, as well as authorizations for radiation therapy, and other procedures
- Communicating insurance issues to physicians
- Referring patients with financial needs to social workers
- Working one-on-one with patients to act as liaisons to the billing department
- Counseling patients on their financial responsibilities
- Creating written agreements to resolve outstanding debt.

The authors suggest that job qualifications for a patient financial advocate include 1) formal education in social work or social science; 2) work experience in medical cod-

ing and billing; and 3) knowledge of medical terminology.

Based on our recent \$40,000 financial loss, administration was able to justify the new staff position fairly easily. Assuming an annual salary of approximately \$35,000, financial coordinators easily pay their own salary by saving the institution from significant financial losses.

MSTI's Chemotherapy Pause

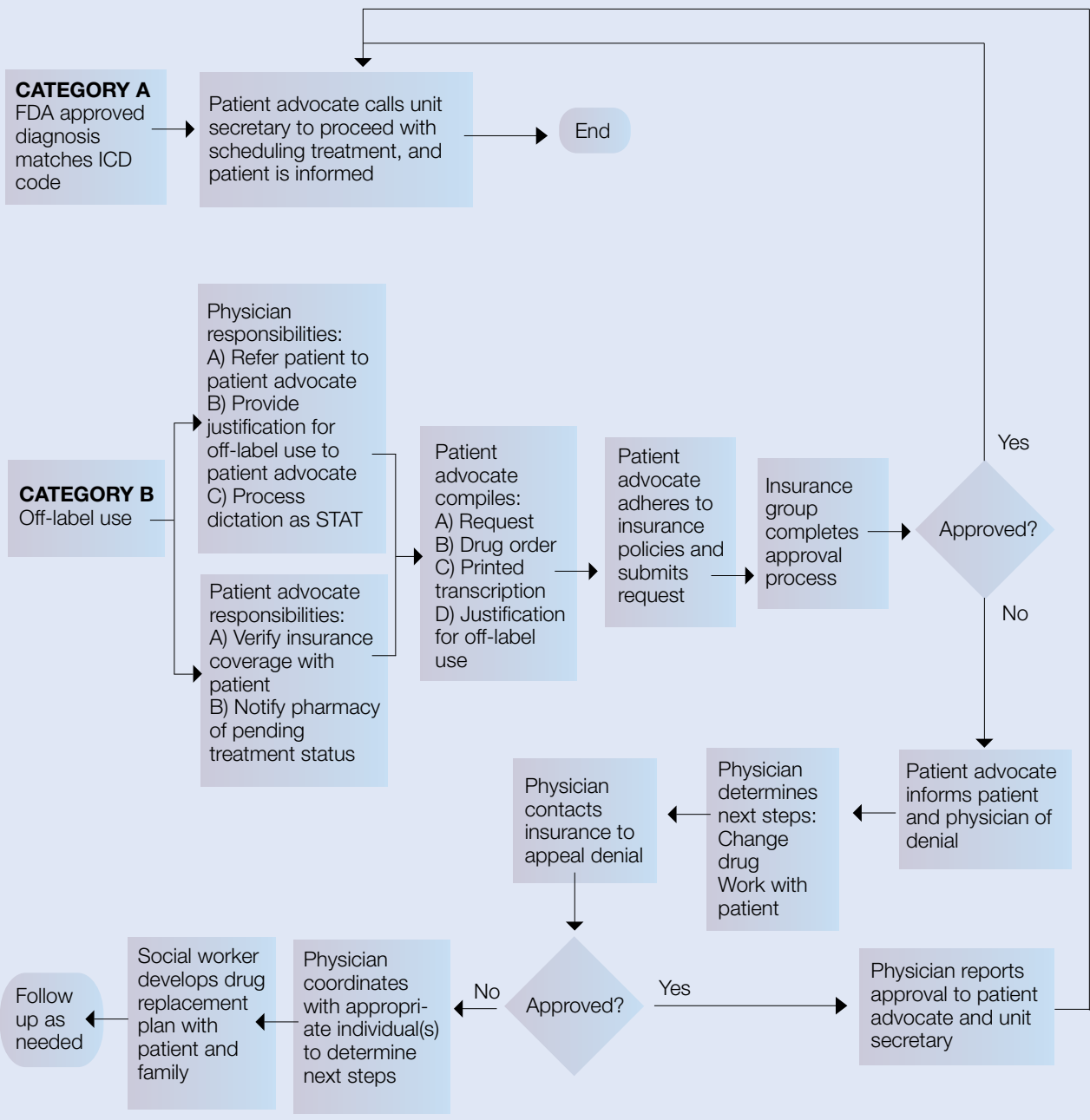
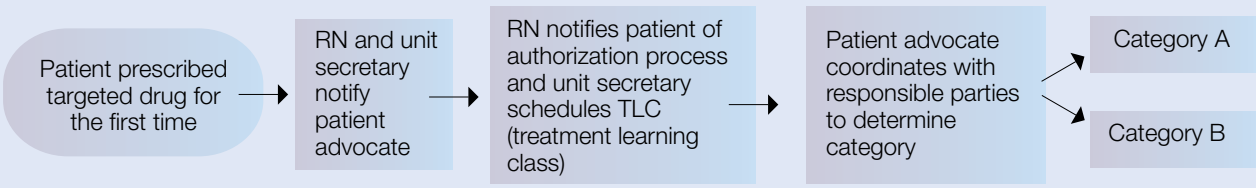
We established a multidisciplinary committee to address problems related to chemotherapy reimbursement. Stakeholders from administration, pharmacy, nursing, medical oncology, social work, and financial services were solicited for support. This committee immediately recognized that it would be impossible to verify reimbursement for every single drug before the patient began treatment. Instead—based on cost and likelihood of off-label use—we created two lists of "targeted" drugs that were causing financial strain at our institution. Some of the frequently prescribed high-cost drugs at our institution included bevacizumab, cetuximab, rituximab, and trastuzumab.

Category A includes targeted drugs that had an FDA-approved indication for which the doctor was prescribing. Category B includes targeted drugs prescribed for off-label uses. If a drug is on either list, our patient financial advocate must determine whether treatment for the patient's diagnosis will be approved and/or if pre-authorization is needed *before* treatment begins. To streamline this workflow process, we include on these two lists the approved indication(s) and off-label or investigational uses for each targeted drug. We also include MSTI's available research protocols specific to each targeted drug.

Our next move was to implement a "Chemotherapy Pause." (The term was coined as an analogy to a "Surgical Pause," when a surgical team "pauses" in the operating room for a moment to ensure the plan is agreed upon.) MSTI's chemotherapy pause has four components:

1. A consideration of all possible treatment options.
2. Patient attendance of our treatment learning class. During this class, patients are educated about exactly what they can expect during their chemotherapy regimen.
3. A guarantee that the treatment will be reimbursed by the third-party payer.
4. An evaluation of the financial impact the treatment regimen will have on the patient and their family.

Figure 1: Chemotherapy Pause

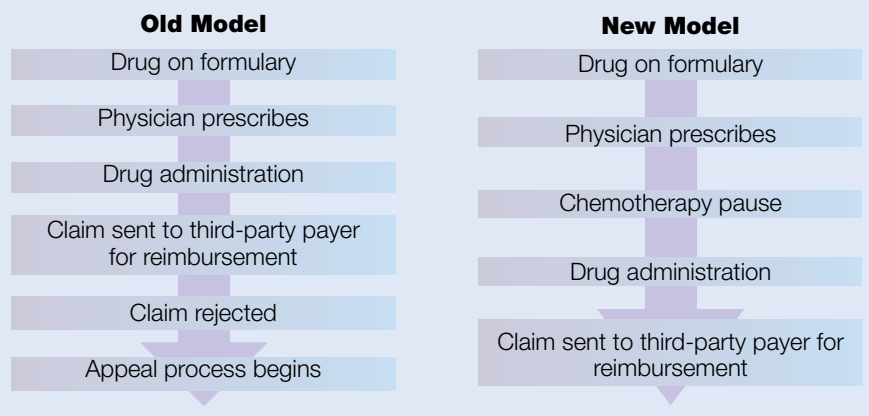


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Thomas M. Beck, MD, medical director of St. Luke's Mountain States Tumor Institute, confers with a member of his staff.

Figure 2. A Comparison between the Old and the New Reimbursement Model



The New System at Work

MSTI's chemotherapy pause begins when a patient is prescribed a targeted drug for the first time (see Figure 1). The oncology nurse is responsible for notifying the patient financial advocate that a targeted drug is being prescribed and informing the patient that a drug authorization process is required before treatment starts.

The next step is for the patient financial advocate to determine the category of the drug. For Category A drugs, the patient financial advocate verifies the patient's diagnosis and insurance coverage and the patient proceeds with treatment. For Category B drugs, the physician must complete a form, which includes FDA-approved indications and any literature citations or research available for off-label use. Additionally, the patient financial advocate sends a dictation of the patient visit where the chemotherapy was prescribed to the appropriate insurer to justify the chemotherapy treatment plan. Oral chemotherapy drugs all fall into Category B, and our patient financial advocate and/or social worker must work with the oncologist to complete all the necessary paperwork for obtaining these drugs.

Next, the patient financial advocate sends the reimbursement request, chemotherapy order, physician dicta-

tion of the patient visit, and literature in support of the off-label use to the appropriate payer. If the request is approved, the patient is scheduled for treatment. If the request is denied, the patient is referred to a social worker who initiates a patient assistance application from the appropriate pharmaceutical company. At the same time, the physician and/or the patient may appeal the denial from the insurance company.

If the payer denies the off-label request a second time, the oncologist meets with the patient to discuss further treatment options. At this time, the patient and his or her family must carefully weigh out-of-pocket expenses versus the benefits of treatment. At the same time, the patient financial advocate and/or social worker continues working with the patient to evaluate drug replacement options.

While this new system has put increased responsibilities on MSTI staff and cancer patients, we are not dealing with billing on the back end—through the appeals process and after

a patient is treated and dollars are lost. The chemotherapy pause changed our paradigm. Today, we capture patients when they enter our system and guarantee reimbursement prior to anti-cancer treatment (see Figure 2).

The Outcome

Measuring the financial efficacy of the new system and the chemotherapy pause has been challenging. In terms of drug reimbursement dollars, we collected data at one of our outpatient clinics (see Figure 3). During an eight-month period, one patient financial advocate processed 41 reimbursement requests, totaling more than \$200,000 in drug costs. This dollar figure represents the potential for loss had the claims for reimbursement been denied.

We have also looked at non-financial outcomes after the implementation of the new system, including patient satisfaction surveys. Over the last few years, patients scored our institution in the 90 percentile for all provided services, except billing (see Figure 4). After the addition of the patient financial advocates and the chemotherapy pause, our patient satisfaction scores for billing have started to increase.

MSTI's most noteworthy success has been to significantly increase provider awareness. Prior to the implemen-

Figure 3. Select Drug Authorization Outcomes between September 2005 and April 2006

Drug	Approved	Denied	Total Drug Cost
Bevacizumab	21	5	\$150,384
Cetuximab	6	1	\$33,264
Oxaliplatin	1	0	\$7,452
Paclitaxel, protein bound	1	0	\$3,914
Rituximab	6	0	\$11,382
TOTALS	35	6	\$206,846

tation of the chemotherapy pause, many of our oncologists were not taking into consideration the significant costs associated with treatment. The widespread success of the chemotherapy pause and the patient financial advocates has resulted in our oncologists taking more responsibility for evaluating the costs of the treatment they are prescribing.


Based on these outcomes, administration has approved additional patient financial advocates to help with the growing demand for these types of services. Our future goal is to have a patient financial advocate meet with every new cancer patient before treatment starts to outline treatment plans and predict financial obstacles—regardless of the cost of the drug regimen.

Ongoing Challenges

Thanks to the ever-changing rules of third-party payers, we continue to encounter reimbursement obstacles. One third-party payer, for example, is requiring its patients to “brown bag” certain drugs. Specifically, patients must purchase all subcutaneous and intramuscular injections (for example, goserelin, leuprolide, and octreotide) from a retail pharmacy and bring them to our chemotherapy infusion center for administration. These patients have seen one time co-pays greater than \$700. MSTI’s patient financial advocates and social workers are priceless resources for helping our patients with this obstacle.

Another obstacle to adequate chemotherapy reimbursement is the lack of a system for separating outpatient oncology service charges and bills from the rest of the hospital’s service lines. Currently, we are all still under one “roof.” A

separate billing department would make it possible to track authorizations, evaluate unnecessary losses, and have dedicated personnel specializing in oncology accounts.

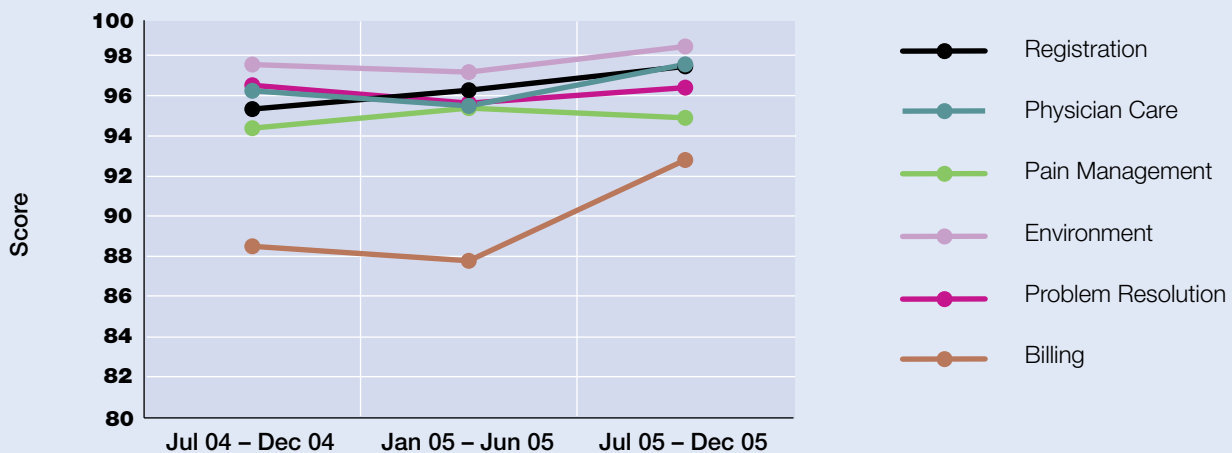
Community cancer centers face a chemotherapy reimbursement landscape that is complex and constantly changing. To navigate these changes, programs will need to develop new internal processes. Dedicated financial advocates and a system for ensuring appropriate reimbursement prior to drug administration are crucial if cancer programs are to remain solvent. Many community cancer treatment centers will likely need to use financial advocates and social workers whose primary responsibility is assistance with cost recovery. Developing a system similar to MSTI’s “Chemotherapy Pause” will improve your ability to cope with the constantly changing formularies and reimbursement rules, while maintaining the highest standards of patient care. 

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Figure 4. St Luke’s MSTI Patient Satisfaction Scores



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Basic Notions of Health Economics¹

1. Human wants are unlimited but resources are finite.
2. Economics is as much about benefits as it is about costs.
3. The costs of healthcare programs and treatments are not restricted to the hospital, or even to the healthcare sector.
4. Choices in healthcare (in health planning or in a treatment mode) inescapably involve value judgments.
5. Many of the simple rules of market operation do not apply in the case of healthcare.
6. Consideration of costs is not necessarily unethical.
7. Most choices in healthcare relate to changes in the level or extent of a given activity; the relevant evaluation concerns these marginal choices, not the total activity.
8. The provision of healthcare is but one way of improving the health of the population.
9. As a community we prefer to postpone costs and bring forward the benefits.
10. Equity in healthcare may be desirable, but reducing inequalities usually comes at a price.

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Deconstructing Chemotherapy Reimbursement

Cancer treatment has changed dramatically over the past several years with exciting novel drug therapies entering the oncology arena. These new treatments are more expensive than older drugs by 10-fold, sometimes even 100-fold. They do not replace older therapies, but rather are being added to the standard treatment regimens.

In general, these new treatments are less toxic and patients are treated with them for a longer period of time. An example of a new treatment is adjuvant therapy for breast cancer patients. For many years, the gold standard of treatment was a regimen known as A/C (doxorubicin/cyclophosphamide), with a total cost in the hundreds of dollars. Paclitaxel was then added to the treatment regimen, raising the cost to thousands of dollars. Today an entire year of trastuzumab is commonly added, bringing the total cost of treatment to hundreds of thousands of dollars.

During the past few years, third-party payers experienced increased difficulty absorbing the

increasing cost of treating cancer—largely due to the rapidly rising cost of cancer drugs. In response, third-party payers have made the process of chemotherapy reimbursement more complex than ever for providers.

Chemotherapy reimbursement from third-party payers is complicated by several factors. One of the most difficult factors is drug preauthorization. Each third-party payer has its own unique list of drugs that require preauthorization, making the reimbursement process inconsistent and confusing for both patients and providers.

Another factor complicating chemotherapy reimbursement is off-label use. Oncologists are treating cancer more aggressively, yet pharmaceutical manufacturers are reluctant to invest money in applying for new indications for which the drug is already in use. According to a recent study, 68 percent of oncologists reported that they placed “high importance” on prescribing off-label. Interestingly enough, the same article stated that 30 percent of respondents reported decreased

prescribing of off-label indications because of reimbursement challenges.³ This study highlights the disparity between what physicians would prefer to do for patient care, and what they actually do because of reimbursement issues.

Oral anti-cancer agents have brought their own reimbursement challenges. For example, a one-month supply of sorafenib, a new multikinase inhibitor for renal cell carcinoma, costs approximately \$4,330 and is only supplied by specialty pharmacy providers. In order for cancer patients to obtain this drug, the prescribing oncologist must complete lengthy enrollment forms. In most community cancer centers, oncologists are too busy to carry out this task, so it is usually delegated to nursing or medical assistants who are already overloaded with work and other responsibilities. Applications for many oral chemotherapy agents are similar to the applications for pharmaceutical patient assistance programs—every drug requires extensive paperwork and knowledge of the patient’s financial status. ☐