

## » Medicare Policies Change ESA Use and Payment

It has been almost one year since the Centers for Medicare and Medicaid Services (CMS) changed their national coverage policy (NCD) for erythropoiesis stimulating agents (ESAs)—epoetin alfa (EPO) and darbepoetin—in cancer. The ESA coverage policy went into effect for practices July 30, 2007. The policy limited use of the ESAs to patients with hemoglobins of less than 10 gm/dL or hematocrits of less than 30%. Moreover, effective January 1, 2008, Medicare also changed the billing parameters for ESAs with implementation by all Medicare contractors by April 7, 2008. To ascertain the impact that these changes have had on community oncologists, RemitDATA®, a reimbursement company with a database of over \$1B in paid claims, provided us with oncology payment data from the last year through the most recent quarter (Table 1.)

To get an idea of the prevalence of denials and other payment problems, we looked at paid remittance (claims) from over 1500 cancer physicians. Bear in mind that paid claims data do not reflect accounts receivable (as it does not reflect what payers have never reimbursed or claims that are patient responsibility). Data analyzed included chemo-related ESA claims (patients who had some chemotherapy administration in their claims data) and ESAs in general. Approximately 58% of the data came from Medicare claims and 42% came from commercial payers. Three aspects of claims data were examined—drug utilization, claims denials, and days from service until actual payment (DSO).

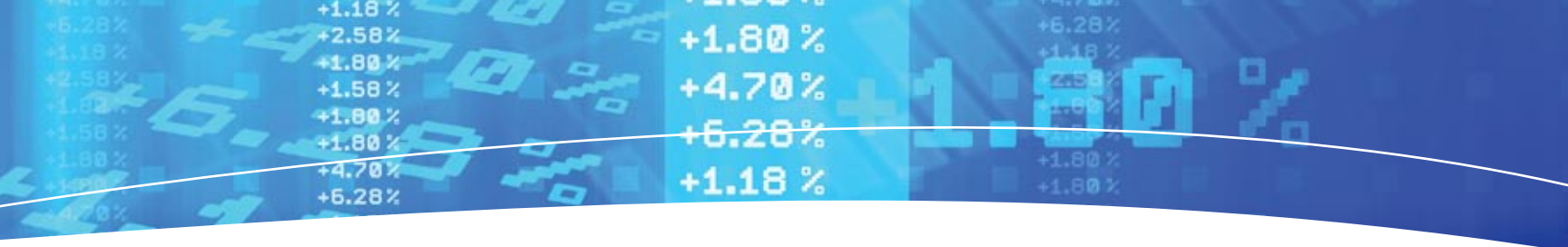
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**Table 1. Utilization data for Medicare and private insurance patients in terms of paid services for the past six quarters are as follows:**

Year	Quarter	Medicare PAID Claims % of Chemo Pts on ESA	Non-Medicare PAID Claims % of Chemo Pts on ESA
2007	1	76%	62%
2007	2	72%	55%
2007	3	61%	42%
2007	4	55%	34%
2008	1	52%	32%
2008	2	51%	27%

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By Bobbi Buell, MBA, Managing Partner, Sausalito Healthcare Partners

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Medicare's policy changed. Yet, the *FDA-approved labeled indication* for ESAs and ASCO (American Society of Clinical Oncology) /ASH (American Society of Hematology) ESA clinical

guidelines are not as restrictive as Medicare policies. Moreover, four major insurers assured ASCO last year that they would not adopt the CMS policy. But, surprisingly, [cont. on pg 46 >>](#)

**Table 2. Q1/Q2 2008 Medicare Paid Claims—Top 5 Denial Reasons**

HCPCS	Description	Average Denial Rate/Reason	Total Paid
<b>J0885</b>	<b>Epoetin alfa, non-esrd</b>	<b>12.1%</b>	<b>\$6,538,591</b>
Top 5 reasons for Denial (Q1)	C018 C050 C04 COB18 C029	Duplicate Claim 23.0% Medical Necessity 18.1% Modifier Problems 15.3% Duplicate Claim 9.4% Filing Deadline Expired 4.6%	
<b>J0885</b>	<b>Epoetin alfa, non-esrd</b>	<b>46.2%</b>	<b>\$2,974,124</b>
Top 5 reasons for Denial (Q2)	C016 C04 C050 C018 C011	Missing Information 56.7% Modifier Problem 17.3% Medical Necessity 11.7% Duplicate Claim 6.0% Inconsistent Diagnosis 2.1%	
<b>J0881</b>	<b>Darbepoetin alfa, non-esrd</b>	<b>5.8%</b>	<b>\$76,014,022</b>
Top 5 reasons for Denial (Q1)	C018 C050 C0109 C0109 COB18	Duplicate Claim 38.3% Medical Necessity 20.2% Wrong Payer Billed 5.6% Wrong Payer Billed 4.2% Duplicate Claim 3.7%	
<b>J0881</b>	<b>Darbepoetin alfa, non-esrd</b>	<b>40.4%</b>	<b>\$24,102,311</b>
Top 5 reasons for Denial (Q2)	C016 C050 C04 C018 C011	Missing Information 47.5% Medical Necessity 16.6% Modifier Problem 15.9% Duplicate Claim 7.6% Inconsistent Diagnosis 4.5%	

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many community cancer practices appear to have adopted Medicare policies for non-Medicare patients when the policy changed. Additionally, commercial procedures for authorization and payment review have, according to some practices, become more complex for ESAs.

To see how Medicare billing policies impacted practices, dates of service for Medicare claims denials for EPO and darbepoetin were compared from Q1 to Q2 (through June 7) (Table 2.)

We dig into the ESA topic from a different vantage point—by looking at paid remittance claims from 1,500 physicians over the last six quarters. By analyzing this data, we can see three distinct financial problems for practices relating to ESA usage: lower volume, high denial rate, and poor cash flow.

While the Q2 (until June 7) increase in Medicare denials for both ESAs are startling, it is not surprising. Despite the fact that cancer practices and Medicare Administrative Contractors had almost three months to prepare for claims submission changes, the billing requirements are complex. Every claim for a non-dialysis-related ESA, whether for cancer or for other indications, must contain “the most recent” hemoglobin or hematocrit result in a very specific place and an HCPCS<sup>1</sup> code modifier. Additionally, providers and Medicare contractors had differing implementation dates for the new billing requirements, which probably caused confusion on both sides in the very beginning of the quarter. Yet, this data certainly evidences systems and coding problems for community practices:

- About 50% of the errors for both drugs are missing information (CO16)—this is probably either a hemoglobin or hematocrit result.
- Missing or incorrect modifiers (CO4)—this means that community practices do not really understand the requirement.

<sup>1</sup>HCPCS are Medicare-generated billing codes.

- Finally, medical necessity denials (CO50) increased in terms of actual numbers—this can mean that lab results are not matching the national coverage requirement.

Another related issue for the practices in this database is the days outstanding from service until payment of ESA claims. Right now, the payment time from service does not differ very much for Medicare and commercial payers, which has never before been true as Medicare is required to pay ‘clean’ claims within 14 days. For darbepoetin, in Q2 until June 7, the days ranged from 126 to 131 and, for EPO, days ranged from 41 to 50. Practices report experiencing more delays with darbepoetin due to private payers’ requiring tougher authorizations and post-payment reviews, plus darbepoetin dollar volume is considerably higher in the RemitDATA database.

The ESA issues we have outlined—declining volume, high numbers/percentages of denials, and poor cash flow—do not bode well for the cash position of many oncology practices in the short term. Cancer practices should use a remittance automation product like RemitDATA to analyze the causes of their ESA denials. Practices may be able to fix problems easily with a call to their billing system vendor or claims clearinghouse or to their Medicare contractor. But, practices will have to move quickly to meet their immediate cash needs. Otherwise, due to the widespread use and the financial importance of ESAs, there could be serious problems for community practices that do not resolve their billing issues now. **BB**

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The Centers for Medicare and Medicaid Services (CMS) recently recognized the NCCN Drugs & Biologics Compendium™ as a source in determining coverage decisions for anti-cancer chemotherapy drugs, and other drugs and biologics used in cancer care. (CMS, 6/5/08)