

» Oncology Drug Denials Slow Payment in Q4 '07

For years, manufacturers and distributors have wanted to know the percentage of drug claims that are really paid and what the average payment rate is by payer. Today, that data is available through electronic remittance files that were mandated by HIPAA. ERA web-based software is being marketed throughout the country to oncology practices. RemitDATA, located in Memphis, Tennessee, is the leader in oncology reimbursement data analysis. The privately held company has created a massive database of oncology payments from more than 2000 physicians' claims submissions over the last two years. While denials were not generally regarded as a problem in the days of generous drug reimbursement, they are a real issue with the current payment system for injectables.

To provide you with an idea of the prevalence of denials, RemitDATA recently analyzed over \$1 billion in allowed payments for claims adjudicated in Q4 of 2007. Approximately 58% of the data came from Medicare claims and 42% came from commercial payers. For all

HCPCS J-codes (billing codes for injectable drugs), the denial rates were 7.6% for Medicare and a whopping 13.2% for private insurance. Among the drugs that made up the most dollars in reimbursement, those with highest denial rates are evidenced in the chart shown below (Table 1).

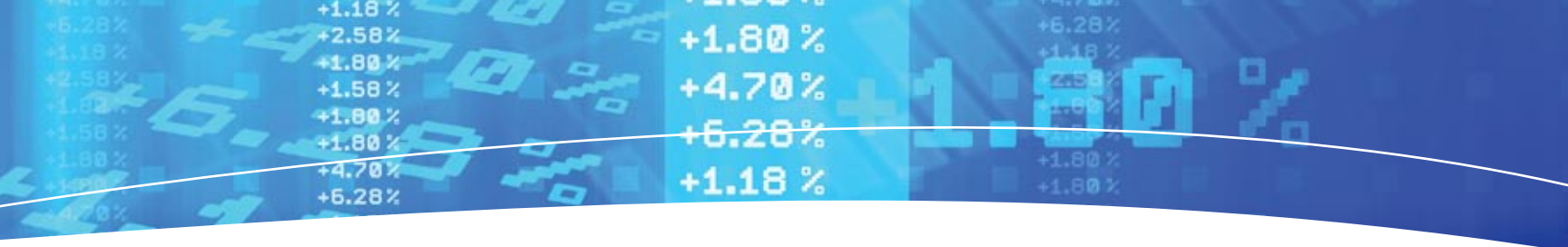
What is causing these claims denials? I believe some of the errors are not denials; they are claims billed erroneously. Lots of them can be resolved on the telephone with payers or by changing the office's billing practices. However, someone in the facility needs to recognize a pattern of billing mistakes and then make the effort to correct them permanently.

The RemitDATA solution helps practices and hospitals recognize patterns and resolve billing issues. Additionally, their oncology-wide claims database can also help manufacturers and other interested parties pinpoint systemic drug rejections that can be corrected by meeting with payers and with educational programs for providers.

Table 1. Denial rates by code.

HCPCS Code	Description	Medicare Denial Rate	Commercial Denial Rate
J9263	Oxaliplatin	10.4%	12.6%
J0885	Epoetin alfa, non-ESRD	10.3%	17.9%
J9035	Bevacizumab injection	9.0%	14.7%
J9310	Rituximab cancer treatment	6.2%	14.1%
J0881	Darbepoetin alfa, non-ESRD	6.1%	18.9%
J9999	Chemotherapy drug, unlisted drug	34.3%	26.6%

Source: RemitDATA, www.remitdata.com



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

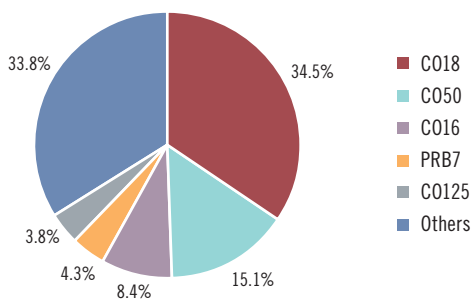
Examples of Systemic Issues for Q4 '07

- **Duplicate Claims (C018, OA18):** This means a claim was submitted twice for the same item or service. While this seems like an easy 'fix', it is the single biggest system-wide problem for all specialties. It occurs because a claim is unpaid so another claim is then submitted. It is an expensive problem for both payers and providers. For oncology, it is particularly egregious because it inflates Accounts Receivable and thereby creates false cash expectations for the practice.
- **Lack of medical necessity (C050):** Medical necessity means that Medicare or another payer did not believe a treatment was reasonable and necessary for a condition. It can happen because of a faulty diagnosis code or actual off-label use that goes against national or local payer policies. In fourth quarter, this occurred most often for darbepoetin alfa and could be due to the complex billing requirements for erythropoiesis stimulating agents (ESAs), which,

in second quarter 2008, are much more complex than they were in 2007 when this data was reported.

- **Claims lack information needed for adjudication (C016, PR16):** This most frequently happens when a drug has no billing code. See the denial rate for J9999—which is quite high. Payers differ on their billing requirements for new drugs that may not have a HCPCS code for months or even years. Thus, rejections are prevalent and providers are justifiably hesitant to use drugs until they have a HCPCS J-code.
- **Payment is included in the payment for another code (C097):** This means that drugs or intravenous solutions have been bundled into payment for another item or service. Increasingly, payers are trying to bundle lower cost drugs (like pain med or diuretics) into office services. Intravenous solutions are not paid for many drug administration services.

Denial Code Frequency—Medicare



Denial Code Frequency—Commercial

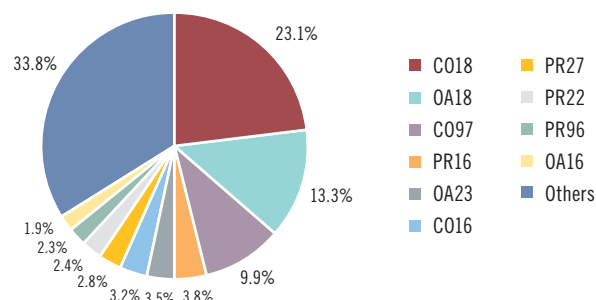


Figure 1. Based on an analysis of claims from 211 community oncologist offices. Source: RemitDATA, www.remitdata.com

While the entire healthcare community is often bothered by the vicissitudes of HIPAA, the ability to use claims exception data to detect problems, patterns, and opportunities in drug payment is a powerful tool. The size of the database is consistently growing as providers recognize

the need to resolve denial issues. Thus, real-time information from paid and unpaid drug claims will provide providers, oncology companies, and payers with an opportunity to diminish administrative costs and pay more expeditiously for cancer care. **BB**