Practice Benchmarking in the Age of Targeted Auditing

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Abstract

The frequency and sophistication of health care reimbursement auditing has progressed rapidly in recent years, leaving many oncologists wondering whether their private practices would survive a full-scale Office of the Inspector General (OIG) investigation. The Medicare Part B claims database provides a rich source of information for physicians seeking to understand how their billing practices measure up to their peers, both locally and nationally. This database was dissected by a team of cancer specialists to uncover important benchmarks related to targeted auditing. All critical Medicare charges, payments, denials, and service ratios in this article were derived from the full 2010

Medicare Part B claims database. Relevant claims were limited by using Medicare provider specialty codes 83 (hematology/oncology) and 90 (medical oncology), with an emphasis on claims filed from the physician office place of service (11). All charges, denials, and payments were summarized at the Current Procedural Terminology code level to drive practice benchmarking standards. A careful analysis of this data set, combined with the published audit priorities of the OIG, produced germane benchmarks from which medical oncologists can monitor, measure and improve on common areas of billing fraud, waste or abuse in their practices. Part II of this series and analysis will focus on information pertinent to radiation oncologists.

Introduction

The current landscape of health care fraud investigation has many oncologists wondering whether their practices would survive a full-scale audit. News stories abound about practices caught in the investigative crosshairs of “fraud strike forces” and other menacingly named organizations. The medical community is witnessing one of the largest expansions in history of audit scope and sophistication, driven primarily by the Medicare Modernization Act and the Obama administration’s commitment to health care accountability and transparency. What has resulted is a complete paradigm shift for private physicians, a new reality demanding increased diligence and austerity with medical billing. This article is the first in a two-part series created to inform medical oncologists, and later radiation oncologists, about the pitfalls in this new audit landscape and the types of billing anomalies that trigger physician investigations. Both parts of the series will also shed light on practice benchmarking, in an attempt to provide guidance for physicians monitoring their practices for potential billing fraud, waste, or abuse.

In the News

Medicare and Medicaid fraud has seen a flurry of news attention recently. In Dallas, TX a physician and six accomplices were arrested after perpetrating the single largest health care scheme in history, defrauding the government out of \$350 million by falsifying Medicare claims for home health care services.¹ Elsewhere, a Wisconsin-based medical oncologist faces over a dozen counts of Medicare fraud and up to 20 years in prison for billing \$1.7 million in undelivered anticancer pharmaceuticals.² In Las Vegas, NV, Medicare settled with a radiation oncologist accused of rendering and billing over \$5.7 million in highly reimbursed, nonessential services.³ In total, the efforts of the Health Care Fraud Prevention and Enforcement Action Team

and Recovery Audit Contractors (RAC) netted a total of \$4.1 billion in 2011 from their systematic identification, targeting, and auditing of suspect providers.⁴

Although these stories were sensational enough for headlines, they are but a small sample of the more than 1,430 criminal health care fraud investigations initiated in 2011.⁴ In reality, the vast majority of federal health care audits do not turn up physicians who willingly and/or knowingly abused Medicare. A large share of the 2011 recovery came from the pockets of physicians who simply failed to pay close attention to changes in the Medicare regulatory environment. Despite the changing nature and inherent complexity of medical billing, the Centers for Medicare & Medicaid Services (CMS) does not show leniency for doctors who have unwittingly overbilled as a result of oversight, poor recordkeeping, or sheer ignorance of the rules. It is paramount that physician providers understand what types of billing abuse activities are being targeted and how they can ensure compliance in their practices. As the government continues to incentivize investigative teams with a percentage of their recoupment, audit frequency and recovery amounts can be expected to rise.

Audit Targeting

The process of being selected for an audit may at times appear arbitrary, but the truth is that the federal government has become extremely sophisticated in its ability to detect deviations from standards in oncology billing. The Office of the Inspector General (OIG) Fraud Task Forces and RACs devote substantial resources to analyzing national Medicare data, composed of hundreds of millions of claims, in order to set baselines from which they can identify suspicious outliers. Although a medical oncologist may believe that billing a few extra infusions rather than push injections is fairly innocuous behavior, he or she does

not realize that auditors are comparing that behavior against thousands of his or her peers. As CMS continues to invest heavily in claims auditing, medical oncologists will need to be closer and closer to national and regional benchmarks if they hope to avoid a targeted audit.

Medicare audits can be triggered by a number of factors, but the majority of investigations are initiated through programs like Medicare Comprehensive Error Rate Testing and the aforementioned data analytics of the RACs. Knowing what these auditors look for does not simply provide the means for escaping detection, but rather the opportunity to take preemptive and corrective action against common areas of billing abuse. Fortunately, oncologists need not rely on guesswork to predict where auditors will be focusing their efforts. Each year the OIG publishes a work plan detailing an extensive list of program vulnerabilities and billing abuses that will be targeted by the various auditing organizations under their purview. The OIG continues to increase its focus on reviewing and monitoring claims where it sees the potential for fraud, waste, and abuse. The 2012 work plan includes 349 planned reviews, a handful of which are important for oncologists billing under Medicare Part B.⁵ Some of the important reviews include

- Unusually high payments made to an individual oncologist during a specified period of time.
- Hospital-owned outpatient clinics billing with the incorrect place-of-service.
- Abuse of incident-to services by oncologists and their midlevel providers.
- Incorrect billing for evaluation and management codes related to established patient visits.
- Claims submitted with services rendered or referred by excluded providers.
- Unjustified use of off-label anticancer pharmaceuticals.
- Drug waste billing for multiuse vial pharmaceuticals.
- Billing for infusion practices that are not justified by medical necessity.

Practice Benchmarking to Mitigate Audit Risk

Many of the OIG reviews listed above are driven by analyses of the national Medicare database. Reviews begin with the identification of normal billing behavior, driven by criteria such as total charges, billed service volumes, and established medically unlikely edits. Auditors then plot all providers against those thresholds and identify exceptions to the norm of billing behavior. To prevent abuse, most of these thresholds for “normal billing behavior” are not available to the public.

Medicare does, however, provide access to the entirety of its Part B claims database, allowing the public to view the data set and interpret what normal behavior might look like. The difficulty for the physician community is that the Medicare database takes a great deal of time and technical prowess to navigate and manipulate. Most practices do not have the resources to devote to aggregating and stratifying millions of records, or to continuously monitoring Medicare benchmarks. But for those few practices and consulting groups with the resources to do so,

the dissection of the Medicare claims database can produce strikingly germane benchmarks for avoiding an audit or investigation. The following are three such examples.

Evaluation and Management Services

At \$1.2 billion in submitted charges, Evaluation and Management (E/M) constituted more than 25% of non-drug-related medical oncology charges to Medicare in 2010. Year after year, E/M continues to be one of the most abused coding sections in Medicare. The temptation with E/M is two-fold, first being the inclination to bill for every touch point with the patient, regardless of medical need, and second to aim for the highest complexity possible, hoping that medical documentation will support the choice. In both of these cases, Medicare has started to enhance claims scrutiny.

In the first scenario, the most oft-abused CPT code for capturing patient encounters is 99211, the basic established patient visit. Like many misunderstood topics, 99211 is best explained by stating what it is not. The basic established visit is not a code to bill when the patient calls to report a symptom, asks for advice in the hallway, or has their blood drawn by the nurse. Figure 1 demonstrates that the low level of reimbursement for 99211 is driven in part by the extremely high rate of Medicare rejection, at just over 20% of submitted claims. Practices that repeatedly attempt to pass through medically insignificant encounters may find themselves on the wrong end of an audit.

In the second scenario, Medicare has noticed that some medical oncologists have established a pattern of billing all E/M encounters at a high complexity level to maximize reimbursement. Billing patterns such as these are simple to detect and signal a lack of support for coding a complex encounter. The E/M bubbles in Figure 1 demonstrate a clustering of codes in the 99213 and 99214 levels, with much less paid for the highly complex and less significant visits. If Medicare submitted claim volume can be trusted as a proxy for “average” billing patterns, a medical oncologist should aim to have 9% of established patient visit claims submitted between 99211 and 99212, 36% to 99213, 47% to 99214, and 9% to 99215 (Figure 1).

The final E/M issue to keep on the radar is the use of Modifier 25. This modifier was created to reimburse E/M activity when the patient requires exceptional evaluation and care beyond the base procedure, or as CMS defines it, a “significant, separately identifiable E/M service.”⁶ What began as an exception has quickly become the rule, with more than 35% of established patient visits being billed as “above and beyond” with Modifier 25. In 2010, medical oncologists charged almost \$400 million with the modifier, on 2.6 million visits. As a result of these volumes, and the potential for abuse, the OIG has made it clear that it will investigate the routine use of Modifier 25 without documentation of separate and identifiable services.

Drugs and Biologicals

Drugs and biologicals make up approximately 80% of all medical oncology charges submitted to Medicare each year. In 2010, submitted charges soared to \$13.3 billion for cancer-

Figure 1. Medicare payment totals by Current Procedural Terminology code.

related pharmaceuticals. It is no surprise, then, that drugs are a major target for audit recovery efforts in 2012. (Table 1).

A review of Medicare claims rejections for drugs and biologicals, represented in Table 1, reveals that nearly \$640 million in medical oncology drug charges were denied in 2010. The top 10 denied drugs include several popular colorectal and non-small-cell lung cancer medications like bevacizumab (Avastin), as well as a handful of RBC boosters. Rounding out the top 10, with a denial percentage of 17%, is the often misused CPT code J9999 (not otherwise classified chemotherapy drug). It is important for medical oncologists to be aware that J9999 is not a catch-all for every chemotherapy drug without a CPT assignment. Experimental drugs are not covered by J9999, and Medicare pays close attention to all “unclassified” claims to ensure sufficient documentation and demonstrable medical necessity.

The OIG work plan outlines three major reviews being conducted on oncological drug practices, one of which is particularly relevant for breast cancer specialists. A common exploitation in drug billing involves what Medicare calls “drug waste.” Current Medicare provisions allow for the billing of unused drugs to alleviate the burden of disposing of expensive medicines with brief shelf-lives. This allowance only extends to single-use vials, or anticancer pharmaceuticals with less than 12 hours of usage after opening. Multiuse vial medications, including the popular breast cancer medicine trastuzumab (Herceptin), are not eligible for drug waste billing.⁷ Any trastuzumab that is not administered to a patient cannot be billed to Medicare. A review of the Medicare Part B data reveals that more than \$420 million in trastuzumab charges were filed in 2010, with \$500,000 billed under the JW modifier, indicating drug waste. Medicare has made it clear that their audit teams will be focused on improper billing for multiuse vials such as trastuzumab in coming months.

In addition to drug waste, the OIG work plan details plans for a review of Medicare payments for off-label anticancer pharmaceuticals. CMS recognizes that its reimbursement guidelines will not always keep pace with medical discovery, and therefore provides oncologists with the latitude to treat patients with off-label drugs when the body of published evidence supports their use. The 2012 OIG review will examine off-label payments to ensure that patients were first prescribed an FDA-approved anticancer drug, and that it proved ineffective in

Table 1. Top 10 Drug Denials

Drug	Denied Charges	% Denied
Darbepoetin alfa	\$79M	8
Bevacizumab injection	\$73M	5
Rituximab injection	\$48M	4
Epoetin alfa	\$46M	7
Pegfilgrastim injection	\$37M	3
Pemetrexed injection	\$27M	5
Oxaliplatin	\$22M	4
Docetaxel injection	\$18M	4
Zoledronic acid	\$18M	4
Chemotherapy drug	\$17M	17
All drugs and biologicals	\$638M	5

Abbreviation: M, million.

improving the patient’s condition, before resorting to the use of an off-label regimen. In the event that the patient’s condition improved before off-label drugs were prescribed, the OIG will quantify what the Medicare savings would have been using the FDA-approved regimen.⁸

Infusion Practices

One of the new additions to the OIG work plan in 2012 deals with Medicare’s outpatient payments for cancer drugs and their administration. The administration of chemotherapy drugs has historically been vulnerable to overbilling because reimbursement is tied to the length of time the drug is administered. Poor timekeeping and manipulation of timing thresholds has created a predictable level of coding abuse, and Medicare intends to crack down on the practice.

For both chemotherapy and nonchemotherapy drugs, a conflict of interest has emerged related to the amount of time spent administering an infusion. Practices are incentivized to exceed the 90 minutes allowed for an initial infusion (96413) so that they can bill the additional hour (96415) starting in the 91st minute. At an average Medicare reimbursement of \$30 for the additional hour, it is no surprise that medical oncology staff attempt to stretch the length of the treatment. The same phenomenon is frequently observed with initial nonchemotherapy infusions (96365) and subsequent hour services. (96366). For physicians looking for guidance, the average ratio of subsequent hours to initial infusions is 0.54 for chemotherapy, and 0.57 for nonchemotherapy drugs.

A similar problem persists with relation to the injection versus infusion decision. For chemotherapy administration and therapeutic, prophylactic, and diagnostic injections and infusions, an intravenous or intra-arterial push is defined as (1) an injection in which the health care professional is continuously present to administer the substance/drug and observe the patient; or (2) an infusion of 15 minutes or less.⁹ Reimbursement rates offer disincentive to render a shorter course of treatment by delineating between the injection and the more lucrative infusion at the 15-minute mark (Table 2). At 16 minutes of administration, the medical oncology staff is allowed to bill for

Table 2. Medical Oncology Benchmarks

Benchmark	Per New Patient
Initial chemotherapy administration	5.2
Total chemotherapy administration	9.3
Initial nonchemotherapy administration	6.7
Total nonchemotherapy administration	16.4
Total hydration	1.6
Port irrigation	0.7

the full hour of chemotherapy infusion, a difference in Medicare reimbursement of approximately \$28. Although taking more time to administer drugs is not an indication of fraud, medical oncology practices must be careful not to set protocols that manipulate administration times to maximize revenue. The national average ratios indicate that initial chemotherapy push injections (96409) to initial chemotherapy infusions (96413) should be approximately 0.15. At injection:infusion ratios significantly lower or higher than 0.15, physicians may encounter resistance from Medicare's audit function.

Going Forward

Established patient visits, drug waste, and infusion patterns are simply three examples of how national benchmarking can help guide physicians to safer billing practices in this age of health care auditing. The disruption of a full OIG audit can be debilitating to a medical oncology practice, even at its best. So what is a practice to do?

The best way to avoid an audit is to stay educated on changes in billing regulations and keep close oversight over the processes in oncology that are most vulnerable to abuse. The OIG work plan is updated on a regular basis, keeping the physician community informed about where auditors are focusing, and therefore, where the practice needs to be focused with regard to compliance and improvement. To ensure compliance on all of

OIG's target areas, practices must also have a strong sense of where their practice patterns measure up against national and regional standards. An important caveat is that Medicare thresholds and benchmarks should not be confused with quality indicators, as governmental cost-out priorities in billing may not always align with optimal patient care and outcomes. Oncologists must use their best judgment in aligning their practice patterns with Medicare benchmarks while continuing to define quality patient outcomes both nationally, within professional societies, and locally in their own practices.

The critical Medicare ratios and benchmarks presented in this article represent only a small fraction of what practices can track and monitor using Medicare data. As the auditing paradigm continues to shift, it is important that practices utilize and derive value from the datasets that drive physician investigations.

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References

1. Zimmerman A, Radnoffsky L: Doctor accused of big Medicare scam. Wall Street Journal, February 29, 2012, p A3
2. Commins J: Washington oncologist indicted in \$1.7M Medicare fraud scheme. Health Leaders Media, July 15, 2011, <http://www.healthleadersmedia.com/page-2/HEP-268600/WA-Oncologist-Indicted-in-17M-Medicare-Fraud-Scheme>
3. US Department of Justice, Office of Public Affairs: Las Vegas physician to pay U.S. \$5.7 million to resolve false claims act allegations related to radiation oncology services and other procedures. June 30, 2011, www.justice.gov/opa/pr/2011/June/11-civ-866.html
4. US Department of Health and Human Services: Health care fraud prevention and enforcement efforts result in record-breaking recoveries totaling nearly \$4.1 billion. February 14, 2012, <http://www.hhs.gov/news/press/2012pres/02/20120214a.html>
5. US Department of Health and Human Services: Office of the Inspector General Work Plan, Fiscal Year 2012, 2012. <http://oig.hhs.gov/reports-and-publications/archives/workplan/2012/Work-Plan-2012.pdf>
6. Centers for Medicare & Medicaid Services. Internet-Only Manual (IOM) Pub.100-04, Chapter 12, Section 30.5, Rev. 968. Issued: May 26, 2006, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>
7. Centers for Medicare & Medicaid Services. Internet-Only Manual (IOM) Pub. 100-04, Chapter 17, Section 40, updated per Change Request (CR) 6711, Transmittal 1962, dated April 30, 2010, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf>
8. US Department of Health and Human Services: Office of Inspector General Work Plan, Fiscal Year 2012. U.S. Department of Health & Human Services, 2012, <http://oig.hhs.gov/reports-and-publications/archives/workplan/2012/Work-Plan-2012.pdf>
9. Centers for Medicare & Medicaid Services. Internet-Only Manual (IOM) Pub.100-04, Chapter 12, Section 30.5, Rev. 968. Issued: May 26, 2006, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>