February 20, 2020

The Honorable Seema Verma, Administrator
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Targeted Probe and Educate Audit Process

Dear Administrator Verma:

On behalf of the Board of Directors of the Community Oncology Alliance ("COA"), we are submitting this letter regarding recent problems community oncology practices are experiencing with the Targeted Probe and Educate ("TPE") audit process, as we will describe below.

As you know, COA is an organization that is dedicated to advocating for the complex care and access needs of patients with cancer and the community oncology practices that serve them. COA is the only nonprofit organization in the United States dedicated solely to independent community oncology practices, which serve the majority of Americans receiving treatment for cancer. COA's mission is to ensure that patients with cancer receive quality, affordable, and accessible cancer care in their own communities where they live and work. For 17 years, COA has built a national grassroots network of community oncology practices to advocate for public policies to support patients with cancer.

It has come to our attention that there is widespread implementation of TPE audits that are investigating evaluation and management ("E&M") visits on the same day as drug administration, particularly Part B chemotherapy and immunotherapy drugs. These audits were triggered by the use of modifier 25 as specified in Section 30.5, Chapter 12 of the Medicare Claims Processing Manual. These audits are currently impacting cancer practices in Medicare Administrative Contractor ("MAC") regions JH and JL, managed by Novitas Solutions ("Novitas"). We have had approximately 25 practices that have reported medical record requests and we are hearing that states outside of regions JH and JL are now beginning to receive letters regarding the same TPE audits. While our organization strongly supports appropriate checks and balances in providing cancer care to seniors and others covered under Medicare, these audits are having a very serious negative impact on community oncology practices in these MAC regions, as detailed below.

While the purpose of the audit is to focus on one line item – the coding of office visits – the entire claim is being held up for payment while that single line item is being audited. The result of this is that a practice’s cash flow may be severely impacted for up to 75 days as the practice continues to provide cancer care to their patients. Having drug claims for purchased and administered Medicare Part B drugs outstanding is an incredible financial hardship for these practices as payment for these drugs must be paid within 30 days to their wholesalers. Small and rural practices are particularly impacted by this hold placed on the payment of all claims. This totally unreasonable payment hold by Novitas can not only affect a practice’s financial credit, but their
long-term survival as a source of quality, high-value, and accessible cancer care for the communities they serve. As is documented extensively, community oncology practices are already strained by the sequester payment cut, 340B hospitals shutting off referrals, pharmacy benefit managers (“PBMs”) and the insurer complex low-balling reimbursement and abusing patients, and a variety of other pressures. This payment hold by Novitas will be the nail in the coffin for small and rural community oncology practices.

As we are sure you realize, billing for E&M visits on the same day as drug infusions is a long-standing Medicare issue. COA firmly believes that E&M is a necessary component to ensure the proper care, safety, and monitoring of patients with cancer. During the E&M and drug infusion visits, oncologists are coordinating care, managing side effects (including psychosocial factors), making decisions about the proper course of treatment, altering the course of therapy, and having detailed discussions with patients and their caregivers. We certainly appreciate your focus on the E&M process and codes, especially in reducing the paperwork and reporting involved in documenting the medical visit.

It is critical to understand that in cancer care, providing the office visit (E&M billed services) on the same day as chemotherapy is administered to patients is extremely beneficial to patients. Same day administration of chemotherapy following the E&M office visit allows for better care coordination and does not require that the patient return on the next day to receive treatment. That is disjointed cancer care, not coordinated cancer care, and can be a great strain on seniors who require transportation to get to their appointments. Additionally, no cancer patients, especially seniors, should have to be burdened further by coming back the next day for treatment simply because of a bureaucratic coding process. This is worse than paperwork over patients – it’s process over patients! We can go on and on about how this also will adversely impact caregivers with additional expenses, lost productivity, etc., accompanying a cancer patient to an office visit and then administration of chemotherapy, but we will stop here. We are sure you understand the mental, financial, and logistical strains.

Practices are reporting that these Novitas audits are being conducted on both a pre-payment and post-payment basis. Once again, to underscore, entire claims are being held to investigate just one line item. Making these audits “post-payment audits” would solve the issue regarding claims payment for the drug and other services portion of the entire claim and would not expose practices to undue financial risk. The pre-payment process is punitive to practices providing seniors with cancer care, especially care involving Part B drugs.

COA strongly requests that Novitas (and all MAC carriers) simply pend the E&M office visit line item for pre-payment claims and not the entire claim. We also strongly request that this be made a “post-payment audit” process to avoid the issue of holding claims for the other services and Part B drugs provided. We also note that the Medicare Billing Manual guidelines must be clarified to avoid unnecessary, burdensome audits.

COA believes that audit processes, such as these TPE audits, should strive to do the least harm to those providers working hard to provide critical cancer care to Medicare seniors. No MAC should have the ability to hold payment for what can be millions of dollars when a single claim is the focus of an audit. We know you are working hard to reduce burdens to providers. This situation is an unreasonable burden!

Thank you for your attention to this very important matter. Please contact us with any questions.

Sincerely,

Michael Diaz, MD
President

Ted Okon
Executive Director

CC: Demetrios Kouzoukas, Principal Deputy Administrator for Medicare and Director