



Impact of a Pharmacy-led Infusion Financial Advocacy Team on Reimbursement Denials

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BACKGROUND

- Preauthorization (PA) processing for infusion centers within Samaritan Health Services (SHS) are not standardized, have led to substantial denials in reimbursement.
- The American Society of Clinical Oncology (ASCO) statement: **“Financial toxicity” of infusion medications a major concern**, especially for biological products.¹
- Boesken et al. redesigned their infusion center’s pharmacy-led authorization workflow. Write-offs for denial of PAs reduced from \$1.8 million in lost revenue in 2016 to \$739,039 in 2018.²
- In the two years following implementing a new preauthorization team, Desai et al. reported \$1.4 million in chemotherapy drug recovered.³

OBJECTIVES

- Identify best practices in infusion services financial advocacy to pre-screen patients for insurance coverage and financial assistance.
- Establish a pharmacy-led, infusion services financial advocacy team dedicated for management of preauthorization, reimbursement denials, and medication assistance.
- Report impact of an infusion services financial advocacy team as preauthorization denial charges as well as financial assistance obtained for infusion center patients.

METHODS

- Interviewed current financial advocacy SHS personnel, identified primary issues with current workflow including scheduling patients for infusions prior to receiving confirmation of preauthorization.
- New team hired and workflow implemented based on above findings on January 1st, 2021.
- Obtained financial reports through SHS Regional Billing Office and Pharmacy Administration. Patients split into two groups based on date of their denials:
 - PRE: Denials occurring between Oct 1st - Dec 31st, 2020
 - POST: Denials occurring between Jan 1st – Mar 31st, 2021
- Reviewed electronic medical records (EMR) to determine total charges of medications denied for each visit in the study period, associated diagnosis, and medications administered.

RESULTS

- Primary outcome of number patients who experienced denials at GSRMC increased after new workflow implementation.
 - PRE: 5 patients, POST: 12 patients
- Most patients with denials had a solid tumor diagnosis (N=11), while also accounting for the smallest average charges from first denial.
- Medicare advantage plans had the most denials and the least charges.
 - Medicare accounted for the largest average charges from first denial based on one patient whose one medication charge was an extreme outlier (one ocrelizumab charge at \$43,250).
- The mean charge per patient from the first denial decreased, despite overall denials increasing due to more expensive medications denied in the PRE phase.

Figure 1. Distribution of diagnoses

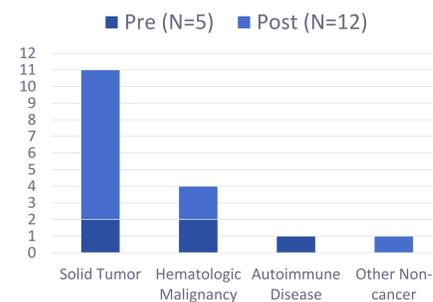


Figure 2. Average charges from first denial by diagnosis (one outlier excluded)

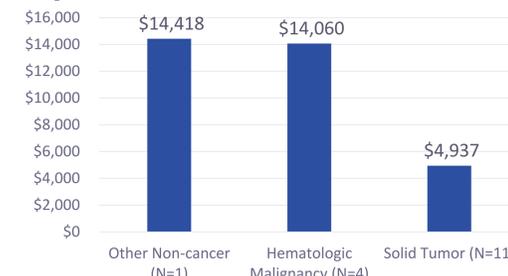


Figure 3. Average charges from first denial by insurance (one outlier excluded)

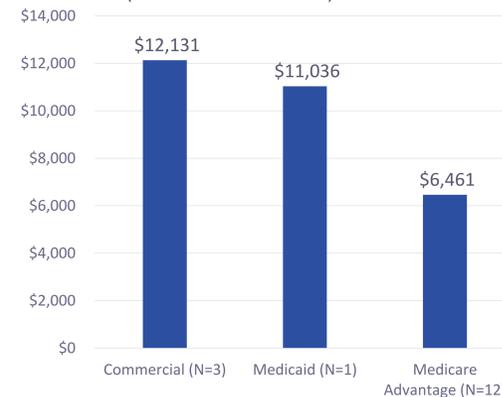
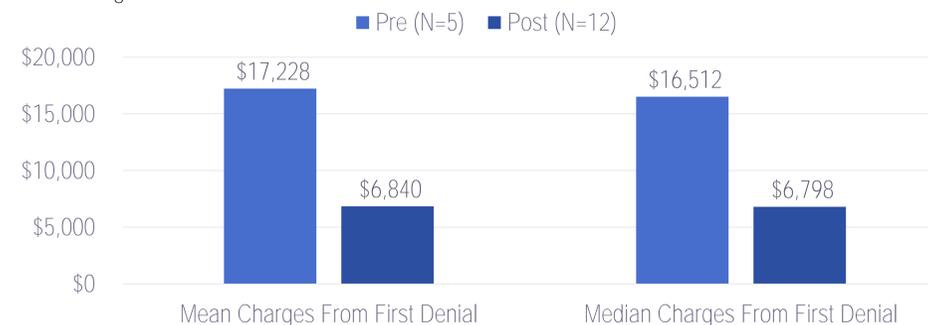


Figure 4. Average charges from first denial by medication



Figure 5. Charges Pre vs Post Intervention



CONCLUSIONS

- Total number of patients that experienced denials increased after implementation of new team and workflow. Apparent decrease in denied charges likely incidental.
- Our data helps identify growth areas for this newly established team
 - Number of personnel
 - Halting treatment scheduling without preauthorization.
- Oncology made up the majority of PA denials.
 - Solid tumor patients had the most denials, while also having the least denied charges.
- Limitations of this study include, but are not limited to: small sample sizes, short time period measured pre/post intervention, differences in study population pre/post.
 - Extenuating circumstances with the new advocacy team likely masked the overall potential of this group and did not allow us to analyze copayment assistance.

FUTURE IMPLICATIONS

- Success of this new team will likely lead to expansion of their workflow to other infusion centers within SHS
- It may be informative for future studies to follow individual denials from time of denial, through the appeal process, to final status
- Analyzing workflow for specific subsets of patients may show inefficiencies for those with more frequent denials in the study period, e.g. solid tumors. Implementing hard stops to workflow of outlier medications such as ocrelizumab could enhance cost savings in the future.

REFERENCES & ACKNOWLEDGEMENTS

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Special thanks to Ronda Fast, Katlynn Frasier, Kozie Knutson, and Kara Wells