Financial Management: Telling the Patient’s Story Accurately, Completely, and in a Codeable Fashion

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Boulder/Breckenridge, Colorado
Every day is a learning experience. Be willing to learn and adapt to change, then lead your team to do the same!
Learning Objectives:

- Develop strategies for ensuring accuracy and completeness of data submitted for reimbursement and analytics.
- Identify methods for relaying information to health-system executives on the impact of drug therapies, drug expenses, and patient outcomes.
- Examine new metrics that will be essential in defining value and success in the emerging healthcare business model.
- Describe the business model transition from fee-for-service to capitated bundled payments and the impact on revenue cycle management.
Opportunities!!

So much Pharmacy time devoted to managing this

Spend for Drugs + Labor + Overhead

So little Pharmacy time devoted to managing this

Revenue for Drugs + Drug Administration

Pharmacy Budget

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21th Annual ASHP Conference for Pharmacy Leaders
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Everyone has a fiduciary responsibility!!

The P&T Committee
The MD writing orders
The patient taking responsibility
Pharmacy working across all care sites
Social Services Patient Navigator
Revenue Cycle: the Billing Dept
Nursing
Diabetes with complications
Congestive heart failure
Compromised renal function
Consults
Scans & x-rays
Multiple lab tests
Several procedures
Prescription drugs
Specialty drugs

ICD10 codes
CPT codes
HCPCS codes
Modifiers to codes

Big Data Pool
$$$

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Getting it Right!!

- LCDs, NCDs, Prior Auth
- Correct codes
- Payor Status
- Billing units
- IV Drug Admin Fees

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Quick review of charging

- ICD9/ICD10 codes are used by hospitals to designate disease types
- **CPT codes** *(determined by the AMA)*
  - used by physicians to describe procedures they do
  - may include payment for all products used during the procedure
- **HCPCS codes** are for products and may or may not be reimbursed
- **DRGs** apply to inpatients and only to Medicare patients
- **APCs** apply to outpatients and only to Medicare patients
- DRG and APC methodology is often used as a template for other insurance reimbursement
- **Part B** covers drugs administered in an outpatient setting
- **Part D** covers drugs that are considered self-administered *(most oral cancer drugs)*
The Importance of Codes

- Coding is the language that describes what was done and what was used. It’s the operational link between coverage and payment.
- However, any payor at any time can look at what was done and on the merits of that, make a decision that they are not going to pay for it.
- All reimbursable drug and biological HCPCS codes should be assigned Revenue Code 636.
Part B Drugs vs Part D Drugs

- Medicare & other insurers have distinct medical & pharmacy benefits
- Medicare medical benefit ensures that physician services, including physician-administered drugs, and hospital services are covered
- Pharmacy benefit usually covers self-administered drugs (orals and some subcutaneous injectables)
- High copays can cause financial difficulties
- 1 in 4 patients who filled their Rx and incurred >$500 in copays did not return to pick it up or follow up with a new oncology medication within 90 days. Streeter SB, Schwartzberg L, Husain N, Johnsrud M. Patient and plan characteristics affecting abandonment of oral oncolytic prescriptions. *J Oncol Pract.* 2011;7(3 Suppl):46s–51s.
Part B Drugs

*Drugs are tied to physician services and fall under the medical benefit*

- Injectables furnished incident to a physician’s service and not usually self-administered
- Drugs administered via a nebulizer or pump furnished by Medicare
- Immunosuppressive drugs for organ transplant
- Hemophilia blood clotting factors
- Certain oral anticancer treatments (many are Part D)
- A very few oral antiemetics, changes frequently
- Pneumococcal, influenza and hepatitis B vaccines
- Erythropoietin-like drugs for trained home dialysis patients
- Iron dextran, vitamin D injections and erythropoietin-like drugs administered by facilities specializing in the care of ESRD patients
- Osteoporosis drugs
Part D Drugs:
Part of the Pharmacy Benefit

- Benefits only apply to “covered Part D drugs”
- Generally, a Part D drug is a prescription drug that is prescribed and dispensed for self-administration
- Drug must be provided for a medically accepted indication
- If a drug is either Part A or Part B, Part A or Part B will pay for it
  - Methotrexate for cancer would be Part B
  - Methotrexate for rheumatoid arthritis, Part D
- Also includes the following
  - Biological products
  - Insulin
  - Medical supplies associated w/insulin injection (syringes, needles, alcohol swabs, and gauze)
  - Certain vaccines not covered under Part A or B
OPPS 2017: Proposed Changes

Products:
• Increase drug packaging threshold to $110 (was $100 in 2016)
• Revise thresholds for high/low cost status for skin substitute products
• Consider proposals regarding transitional pass-through status

Policy:
• Modify/expand packaging policies
• New Comprehensive Ambulatory Payment Classifications (C-APCs)
• Update Hospital Outpatient Quality Reporting (OQR) Program measures
• Payment for off-campus physician-based departments (implementation of section 603 of the Bipartisan Budget Act (BBA))
Proposed OPPS 2017: 5 drug payment ways

**New drugs not yet assigned unique HCPCS Code**
- No Change from 2016
- 95% of AWP
- Use code C9399, unclassified drugs or biologicals + NDC Code

**New pass-through drugs + radiopharm**
- ASP+6%
- Payment based on WAC + 6% until enough ASP data gathered
- 15 pass-through products have an expired status
- 38 products either keep or gain pass-through status

**Specified covered outpatient drugs (SCODs) costing > $110/day**
- MD Office+6%
- OPPS ASP+6%
- No longer exempting (paying separately)
- 5 -HT3 drugs except for Palonosetron

**Lower-cost packaged products costing <$110/day**
- An ↑ # of drugs have no separate reimbursement, drug costs bundled into the procedure

**IV Drug Admin Fee add on codes paid separately for all 5 drug payment types!!**
Transitional Pass-Through Status: CMS is proposing

- to allow for quarterly expiration of pass-through status for devices, drugs & biologicals ending on the qtr as close to 3 full years as possible after the devices, drugs or biologicals 1st were covered with a pass-through payment
- that pass-through payment status for devices begin on the 1st day on which pass-through payment is made for the device, instead of the date CMS establishes a category
- drugs & biologicals are 1st eligible for pass-through status beginning the next qtr following application approval
- new timeframe would apply to pass-through payment status for devices, drugs & biologicals approved in CY 2017
- to use the “Implantable Devices Charged to Patients” cost to charge ratio (CCR), if it is available, to calculate pass-through payment for devices, instead of the average hospital-wide CCR.
- to calculate the offset amount for pass-through payments at the HCPCS code level rather than the APC level
Drug Payment @ASP+6% (-2% sequestration)
IV Drug Admin Payment
Some non-pass through drugs are paid for as part of a package/bundle

- Those that are packaged/bundled due to cost: Packaging threshold proposed to increase from $100 to $110 per day
- Those that are “Policy packaged” regardless of cost:
  - Diagnostic radiopharmaceuticals
  - Contrast agents Stress agents
  - Anesthesia drugs
  - Drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure
  - Drugs and biologicals that function as supplies when used in a surgical procedure
Just how many kinds of bundles could there be?
Lots!!

- Drugs costing <$110/day
- IV drug admin
- Defined episode of care (e.g. Hip replacement)
- Entire episode of care (e.g. breast cancer)
- CMS Policy-Packaged Drugs,
  Biologicals & Radiopharmaceuticals
Proposed OPPS 2017 Drug Administration Rates

- How many are proposed to increase? 86%
- By how much? 0.4% to 95%
- Are any decreasing? Yes, a few from -18% to -43%

Off to find out if we document completely, use the correct codes and capture Drug Admin revenue for all applicable outpatient drugs (even Patient Assistance Products and those pesky White Bag products)
OPPS 2017 Proposed: Payment for Off-Campus Provider-Based Departments

• What: implement section 603 of 2015 BBA which prohibits items + services furnished by certain off-campus provider-based outpatient departments (PBDs) from being paid under OPPS as of January 1, 2017

• Who: applies to off-campus PBDs not billing Medicare as such as of November 2, 2015 (the “Enactment Date”)

• Rates?: These PBDs paid under the Medicare Physician Fee Schedule (MPFS) at non-facility rates

• Clarifications: generally, off-campus PBDs billing for services paid by OPPS prior to the Enactment Date will continue to be paid for those services under OPPS if the off-campus PBD maintains its excepted status

• Exclusions?: items + services furnished by dedicated emergency departments regardless of location on or off the main hospital campus

• Unknown: 340B Implications

Off to discuss this with legal to see where we stand!

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**OPPS 2017 Proposed: Payment for Off-Campus Provider-Based Departments (PBDs)**

- If paid under **OPPS** prior to Nov 2, 2015, will continue to be paid that way for items or services in the **same clinical family**; items and services in **new clinical families** will be reimbursed under **MPFS**
- If start offering items or services in **different clinical families** as items or services provided by PBD prior to the enactment date, can **No Longer Bill Under OPPS For New Items & Services**

<table>
<thead>
<tr>
<th>Advanced Imaging</th>
<th>Ear, Nose, Throat (ENT)</th>
<th>Nervous System Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airway Endoscopy</td>
<td>General Surgery</td>
<td>Ophthalmology</td>
</tr>
<tr>
<td>Blood Product Exchange</td>
<td>Gastrointestinal (GI)</td>
<td>Pathology</td>
</tr>
<tr>
<td>Cardiac/Pulmonary Rehabilitation</td>
<td>Gynecology</td>
<td>Radiation Oncology</td>
</tr>
<tr>
<td>Clinical Oncology</td>
<td>Minor Imaging</td>
<td>Urology</td>
</tr>
<tr>
<td>Diagnostic tests</td>
<td>Musculoskeletal Surgery</td>
<td>Vascular/Endovascular/Cardiovascular Visits and Related Services</td>
</tr>
</tbody>
</table>
IPPS New Technology Add-on Payments
FY 2017: 4 eligible drugs

Blinatumomab, (BLINCYTO)
- continue new technology add-on payments for FY 2017
- maximum new technology add-on payment remains $27,017.85
- Eligible cases: ICD–10–PCS procedure codes: XW03351 (Introduction of Blinatumomab antineoplastic immunotherapy into peripheral vein, percutaneous approach, new technology group 1) or XW04351 (Introduction of Blinatumomab antineoplastic immunotherapy into central vein, percutaneous approach, new technology group 1).

Defitelio, (Defitelio)
- Eligible cases: identifiable by ICD–10–PCS procedure codes XW03392, XW04392
- Maximum new technology add-on payment is $75,900

Idarucizumab
- Eligible cases: identified by ICD–10–PCS procedure code XW03331
- Maximum new technology add-on payment $1,750

Uridine triacetate (Vistogard)
- maximum new technology add-on payment is $37,500
- Eligible cases: any one of ICD–10–PCS diagnosis codes T45.1X1A,T45.1X1D, T45.1X1S, T45.1X5A,T45.1X5D, and T45.1X55 in combination with ICD–10–PCS procedure code XW0DX82
The Revenue Cycle
So Many Moving Parts!!
Living up to your reimbursement potential
Focus Areas Identified
Always, Always Follow the Money
Do you do this? Can you do it end to end?

MD chooses drug
MD, Nursing & Pharmacy
determine Prior Auth/LCD/NCD
status & confirm documentation
MD writes drug order, then...........

Pharmacy dispensing
drug generates charge

Nursing drug admin
with documentation
generates drug admin
fee

Internal $ transfer
credits pharmacy with
drug & portion of drug
admin fee

Charges sent to MAC, payment received or
denied

Actual dose converted into
CMS billing units
Happens where?
Three Practices to Minimize Drift Between Audits

Healthcare organizations are subjected to strict compliance audits, and the business is dependent on passing those audits. But what happens between audits?

Imagine if you were to cover your speedometer, gas gauge and other warning lights on your car’s dashboard, and you only saw that information when you went in for an oil change. It is not all that different when it comes to managing your infrastructure or environment between audits.
Appropriate Med Ordered PA, NCD or LCD applies

- EHR documentation
- ICD10 supports requirements
- Payment

$0

Who’s responsible? Everyone including Pharmacy Clinicians!
Impact of Billing Errors on Pooled Average Reimbursement Across All Facilities

Prior auth/LCD in place
HCPCS code correct
Billing unit calculation wrong
No waste billed

Find & fix your issues quickly,
they’re impacting everyone!!

New reimbursement
everyone’s paid

Prior auth/LCD in place
HCPCS code correct
Billing unit calculation correct
Appropriate waste billed
Impact of Billing Unit Errors: a Clinical Standpoint

Dose sent to Claim

Prior auth/LCD in place
HCPCS code correct
Billing unit calculation correct
Appropriate waste billed

Dose sent to Claim

Prior auth/LCD in place
HCPCS code correct
Billing unit calculation wrong
No waste billed

A new average dose given? No! Just bad data from wrong Entries!

How aggregated BIG Data portrays the acceptable dose

Find & fix your issues quickly, they’re impacting everyone!!
Putting $ into Perspective

Rituximab billing error
HCPCS code: J9310
Billing unit 100mg
July 2016 ASP $791.40

Case Description
Billing unit 10 fold error
Each 1000mg dose billed as 1 billing unit
instead of 10 billing units
Got $791.40 but lost $7122.60 for each pt
Assume 1000 patients/yr
Lost revenue = $7,122,600

Chronic Care Management
Opportunity Available $
$60/month/eligible patient
for 20 minutes
documented service

Would need to manage
9892 patients for 20
minutes each month for 1
year to earn
$7,122,600
Prior Approval vs. NCDs and LCDs

<table>
<thead>
<tr>
<th></th>
<th>Prior Approval (Payor)</th>
<th>NCDs and LCDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applies to:</td>
<td>3rd party carriers (possibly Medicaid)</td>
<td>Medicare (possibly Medicaid)</td>
</tr>
<tr>
<td>Need Patient’s payor status?</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Drug tagged in CPOE/PDM?</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Link to actual rule needed?</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Rule Requirements:</td>
<td>Ask permission first before drug administration</td>
<td>Understand &amp; follow requirements, document completely and thoroughly. Code correctly and as required</td>
</tr>
<tr>
<td>Payment:</td>
<td>Only if permission is given first</td>
<td>Determined after the fact and may be denied if not all rules followed</td>
</tr>
</tbody>
</table>
What’s Covered and What’s Not

• The fact that a drug, device, procedure, or service has a Healthcare Common Procedure Coding System (HCPCS) code and a payment rate under OPPS does not imply coverage by Medicare
• Indicates only how the product, procedure, or service may be paid if covered by the program
• FI’s/MACs determine if all program requirements for coverage are met, e.g. that it’s reasonable and necessary to treat the beneficiary’s condition and whether it’s excluded from payment
Off Label Indications

• Dilemma often arises when the literature supports and a patient is treated for an off-label indication
• Fact that it is off-label may be sufficient grounds for FI to deny payment
• Patient and billing assistance programs offered by several pharmaceutical companies may be helpful in providing support when attempting to have denials overturned
• Officially Accepted Compendia can be used to support the off-label decision. Be aware of what they are!
• http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/compendia.html
LCDs, NCDs & Prior Authorizations

- Essential that all concerned
  - understand which drugs have these requirements
  - have set a procedure for how to handle them
  - ensure the required documentation is in the medical record BEFORE the drug order is written and ESSENTIAL before the drug is actually prepared and administered
  - Can't be remedied after the fact
- If this step not taken or documentation missing, no payment made
- Get LCDs and NCDs from your MAC's website and the prior authorization list from your payors. Pay attention to the ICD-10 codes that apply
- Work out a plan with infusion centers as to responsibility for who's doing what, who's documenting what, how's this info going to be transmitted to pharmacy
- Equally important is ensuring that it remains a permanent part of the record in real time sequence for auditing purposes
NCD/LCD References

- Each MAC publishes their own LCDs
What’s your facility doing to move forward?

New Therapeutic Modalities

Meets

Healthcare Payment Reform
New Health Economy: An Epochal Shift *Expectations Mandate Efficiency & Cost Controls*

From your Pharmacy’s perspective this means

- Recognize that payors have a huge say in how drugs are used
- Payors pit drug mfgs against each other for deep discounts in exchange for preferred or exclusive formulary spots
- Work in tandem with payors, not independently against them!
- Wide ranges of utilization management strategies to ensure appropriate use of high cost agents
  - prior authorization criteria (on and off-label)
  - dose-optimization strategies
  - quantity limits
  - formulary tiering,
  - channel management
  - utilization review
Innovative Strategies

• Formulary intraoperability: Sync yours with those of payors
• Acquisition and Distribution need to change!
  ❖ Establish a specialty pharmacy relationship
  ❖ Revamp “drugs from home/brown bag policies”
  ❖ Ramp up white bag policies
  ❖ Patient assistance programs
• Who’s doing this? Where is it documented? Do you use this info?
  ❖ Precertification, rigorous attention to Prior authorization, LCD/NCD
  ❖ ABN notice for off-label use
• IT Support
  ❖ Provide payor status info to pharmacy
  ❖ Adaptation of the EMR to document each step
  ❖ Claims data is used as the basis for future directions, a short window of opportunity to “right your data”
Suggestions from ICLIO, an institute of ACCC @ accc-iclio.org

- High dollar medication approval process
- Enroll every patient into a support program, regardless of on or off-label use
- Robust Off-Label Policy & Procedure: predetermination
- Patients are made aware of financial risk, required to sign an ABN or NONC
- Pharmacy follows every claim to ensure payment
- Effective and traceable form of communication is essential
Key Takeaways

• Key Takeaway #1
  ❖ Move out of your silo, Recognize implications of your decisions & actions and remember, it’s not about you, it’s about the patient!!

• Key Takeaway #2
  ❖ The 3 Elements to Leadership are vision, understanding the situation and having the courage to act while remembering that It’s not a popularity contest!!

• Key Takeaway #3
  ❖ Pharmacy is part of the healthcare ecosystem, every part of which has to step up their efforts to contribute to affordability. What are you going to start doing? Stop doing? Keep Doing?

• Key Takeaway #4
  ❖ Under OPPS, CMS is making packaging-related changes in CY 2017 for conditionally packaged ancillary services, drugs that function as supplies in surgical procedures, and conditionally packaged outpatient laboratory tests but not drug administration services
Self-Assessment Questions

1. What is the CY 2017 packaging threshold for drugs, biologicals, and radiopharmaceuticals?

2. What is the payment rate for non-pass through, separately payable drugs and biologicals above the packaging threshold?

3. T or F: Biosimilar biological products will be eligible for pass-through status under the OPPS, and payment will be at the reference product’s ASP + 6% under both the OPPS and PFS.

4. T or F: In CY 2017, CMS will package drugs that function as supplies in surgical procedures

5. Under which payment systems will eligible provider-based off-campus facilities be paid? Ineligible facilities?
Answers to Self-Assessment Questions

1. $110 per day
2. ASP + 6%
3. The statement is true.
4. That statement is true.
5. Grandfathered as of November 2, 2015: OPPS
   Non-grandfathered provider-based off-campus facilities: ASC PPS or PFS, no longer will be eligible to bill under the OPPS.
Self Assessment Question

Are you prepared to add biosimilars to your formulary?

☑ Yes
☒ No
Self Assessment Question

Help me! I need more info on payment reform & reimbursement

☑️ True
☒ False
Appendix of Additional Background Materials

- 340B
- OPPS 2017 Charts & Tables
- Billing Details & Definitions
- ICD-10
- Self-administered drugs
- Billing for drug waste
- A new drug is approved, what should I do?

- Program eligibility and registration
- Eligibility of drugs for purchase under 340B
- Patient eligibility to receive 340B drugs
- Requirements for covered entities
- Arrangements for contract pharmacies
- Manufacturer responsibilities
- Rebate options for AIDS drug assistance programs
- Program integrity

Unknown: unclear if this mega-guidance will replace existing, limited guidance documents or how it will be treated in terms of HRSA audits.

Known: all covered entities will be affected at some level. For some this means substantial programming and process changes to ensure compliance.
### Significant Impacts: Determining Patient Eligibility

<table>
<thead>
<tr>
<th>Current Guidance: 3 steps</th>
<th>Proposed Mega-Guidance 6 steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services must be provided at a facility that’s registered for the 340B program and listed on the public 340B database</td>
<td>Covered entity has access to the individual’s patient records, which show that covered entity is responsible for care</td>
</tr>
<tr>
<td>Covered entity must have an established relationship with the individual, maintaining records of the individual’s healthcare</td>
<td>Services must come from a provider who is either employed by a covered entity or is an independent contractor for the covered entity, which may bill for services on behalf of the provider</td>
</tr>
<tr>
<td>Individual must receive healthcare services from providers either are employed by covered entity or maintain contractual/other arrangements (eg consult referral) such that covered entity responsible for care provided</td>
<td>Drug individual receives must be ordered or prescribed by the covered entity provider as a result of the service already described</td>
</tr>
</tbody>
</table>
### Significant Impacts: Determining Patient Eligibility

<table>
<thead>
<tr>
<th>Current Guidance: 3 steps</th>
<th>Proposed Mega-Guidance 6 steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare services individual receives from covered entity are consistent with services for which entity received grant funding or federally qualified health center look-alike status. Disproportionate share hospitals exempt from requirement</td>
<td>The individual’s healthcare is consistent with the scope of the federal grant, project, designation, or contract.</td>
</tr>
<tr>
<td>Note: individual not considered a patient of covered entity if only healthcare service individual receives from covered entity is dispensing of a drug or drugs for self-administration or administration at home</td>
<td>The drug is ordered or prescribed based on a healthcare service classified as outpatient.</td>
</tr>
</tbody>
</table>
Significant Impacts: More Requirements

- Discharge prescriptions from an inpatient stay no longer will qualify; only drugs billed as part of an outpatient visit will be eligible, (may require more complex eligibility processes in contract pharmacy settings)
- Referring providers must meet stricter requirements that will limit eligibility
- Medicaid managed care organizations (MCOs)
  - Covered entities will have an obligation to prevent duplicates
  - Contract pharmacies must exclude Medicaid MCOs in the same fashion that they currently carve out Medicaid fee-for-service providers from their 340B purchases
- Bundled Medicaid drugs will not be 340B eligible
- Contract pharmacies will be required to undergo quarterly reviews by the covered entity with which they are contracted
Key Issues in Play
Not all are covered by the MegaRule

- Orphan Drugs
  - Addressed in a previous HRSA guidance
  - Ruled against in a court decision
- CMS covered outpatient Drug Rule
- Final Average Manufacturer Price (AMP) Rule released impacting Medicaid Billing and Reimbursement
- Medicaid Rebate Rule
- Limited distribution drugs, specialty drugs
- Material breach requiring corrective action and repayment
- The furor over drug pricing
  - Congressional hearings regarding drug pricing
  - Medicare reimbursement and 340B
  - POS codes
340B Requires

- Eligible Facility
- Eligible Physician
- Eligible Patient
- Eligible Drug

Got all 4?
There’s no such thing as Presumptive Eligibility!!
Proposed OPPS 2017
Charts & Tables
Resources

❖ OPPS Proposed 2017 Rule

❖ PFS Proposed 2017 Rule

❖ ASP files
  • http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html
## Proposed Drugs With Expiring Pass-Through Status:

15 Drugs that no longer have Pass-Through Status in 2016, 2017 SI Not Yet Published!

<table>
<thead>
<tr>
<th>CY 2016 HCPCS Code</th>
<th>CY 2016 Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9497</td>
<td>Loxapine, inhalation powder, 10 mg</td>
</tr>
<tr>
<td>J1322</td>
<td>Injection, elosulfase alfa, 1 mg</td>
</tr>
<tr>
<td>J1439</td>
<td>Injection, ferric carboxymaltose, 1 mg</td>
</tr>
<tr>
<td>J1447</td>
<td>Injection, TBO-Filgrastim, 1 microgram</td>
</tr>
<tr>
<td>J3145</td>
<td>Injection, testosterone undecanoate, 1 mg</td>
</tr>
<tr>
<td>J3380</td>
<td>Injection, vedolizumab, 1 mg</td>
</tr>
<tr>
<td>J7181</td>
<td>Factor XIII (antihemophilic factor, recombinant), Tretten, per i.u.</td>
</tr>
<tr>
<td>J7200</td>
<td>Factor ix (antihemophilic factor, recombinant), Rixubus, per i.u.</td>
</tr>
<tr>
<td>J7201</td>
<td>Factor ix (antihemophilic factor, recombinant), Alprolix, per i.u.</td>
</tr>
<tr>
<td>J7205</td>
<td>Injection, factor viii, fc fusion protein, (recombinant), per i.u.</td>
</tr>
<tr>
<td>J7508</td>
<td>Tacrolimus, Extended Release, Oral, 0.1 mg</td>
</tr>
<tr>
<td>J9301</td>
<td>Injection, obinutuzumab, 10 mg</td>
</tr>
<tr>
<td>J9038</td>
<td>Injection, ramucirumab, 5 mg</td>
</tr>
<tr>
<td>J9371</td>
<td>Injection, Vincristine Sulfate Liposome, 1 mg</td>
</tr>
<tr>
<td>Q4121</td>
<td>Theraskin, per square centimeter</td>
</tr>
</tbody>
</table>
## Proposed Drugs With Pass-Through Status:

**38 DRUGS WILL HAVE PASS-THROUGH STATUS IN 2017**

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>A9586</td>
<td>Florbetapir f18, diagnostic, per study dose, up to 10 millicuries</td>
<td>G</td>
<td>1664</td>
</tr>
<tr>
<td>C9137</td>
<td>Injection, Factor VIII (antihemophilic factor, recombinant) PEGylated, 1 I.U.</td>
<td>G</td>
<td>1844</td>
</tr>
<tr>
<td>C9138</td>
<td>Injection, Factor VIII (antihemophilic factor, recombinant) (Nuwiq), 1 I.U.</td>
<td>G</td>
<td>1846</td>
</tr>
<tr>
<td>C9349</td>
<td>PuraPly, and PuraPly Antimicrobial, any type, per square centimeter</td>
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<tr>
<td>C9447</td>
<td>Injection, phenylephrine and ketorolac, 4 ml vial</td>
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<tr>
<td>C9460</td>
<td>Injection, cangrelor, 1 mg</td>
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<td>C9461</td>
<td>Choline C 11, diagnostic, per study dose</td>
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<td>C9470</td>
<td>Injection, aripiprazole lauroxil, 1 mg</td>
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<tr>
<td>C9471</td>
<td>Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg</td>
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<td>C9472</td>
<td>Injection, talimogene laherparepvec, 1 million plaque forming units (PFU)</td>
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<tr>
<td>C9473</td>
<td>Injection, mepolizumab, 1 mg</td>
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<td>C9474</td>
<td>Injection, irinotecan liposome, 1mg</td>
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<tr>
<td>J0695</td>
<td>Injection, ceftolozane 50 mg and tazobactam 25 mg</td>
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<tr>
<td>J0875</td>
<td>Injection, dalbavancin, 5 mg</td>
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<td>1659</td>
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</table>
# Proposed Drugs With Pass-Through Status:

**38 DRUGS WILL HAVE PASS-THROUGH STATUS IN 2017**

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
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<tbody>
<tr>
<td>J1833</td>
<td>Injection, isavuconazonium sulfate, 1 mg</td>
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<tr>
<td>J2407</td>
<td>Injection, oritavancin, 10 mg</td>
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<td>J2502</td>
<td>Injection, pasireotide long acting, 1 mg</td>
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<td>J2547</td>
<td>Injection, peramivir, 1 mg</td>
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<td>J2860</td>
<td>Injection, siltuximab, 10 mg</td>
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<td>J3090</td>
<td>Injection, tedizolid phosphate, 1 mg</td>
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<td>J7313</td>
<td>Injection, fluocinolone acetonide intravitreal implant, 0.01 mg</td>
<td>G</td>
<td>9450</td>
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<td>J7503</td>
<td></td>
<td>G</td>
<td>1845</td>
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<tr>
<td>J8655</td>
<td>Netupitant (300mg) and palonosetron (0.5 mg)</td>
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<tr>
<td>J9032</td>
<td>Injection, belinostat, 10 mg</td>
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<td>J9039</td>
<td>Injection, blinatumomab, 1 mcg</td>
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<td>J9271</td>
<td>Injection, pembrolizumab, 1 mg</td>
<td>G</td>
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<td>J9299</td>
<td>Injection, nivolumab, 1 mg</td>
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<tr>
<td>Q5101</td>
<td>Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram</td>
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<tr>
<td>Q9950</td>
<td>Injection, sulfur hexafluoride lipid microsphere, per ml</td>
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<td>Q9982</td>
<td>Flutemetamol F18, diagnostic, per study dose, up to 5 millicuries</td>
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<td>Q9983</td>
<td>Florbetaben F18, diagnostic, per study dose, up to 8.1 millicuries</td>
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</table>
Policy-Packaged Drugs, Biologicals, and Radiopharmaceuticals

- Certain non-pass-through drugs, biologicals, and radiopharmaceuticals are “policy-packaged”
  - All diagnostic radiopharmaceuticals
  - All contrast agents
  - Anesthesia drugs
  - Implantable biologicals that are surgically inserted or implanted into the body through a surgical incision or natural orifice
  - Drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure
  - Drugs and biologicals that function as supplies or implantable devices in a surgical procedure

- Others are packaged because their per day costs do not exceed a cost threshold $100 in 2016, $110 in 2017

- Payment for all packaged drugs, biologicals, and radiopharmaceuticals is included in the services & procedures with which they are reported
## Non-Pass-Through Separately Payable Drugs

<table>
<thead>
<tr>
<th>Drugs and Biologicals</th>
<th>Radiopharmaceuticals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs and biologicals that are separately payable will be paid at ASP+6%, under the statutory default, a payment policy adopted in 2013</td>
<td>CMS will pay all non-pass-through separately payable therapeutic radiopharmaceuticals at ASP+6%</td>
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<tr>
<td>Radiopharmaceutical manufacturers are not required to submit ASP</td>
<td>If ASP data are not available, CMS will base payment on mean unit cost from its claims data</td>
</tr>
<tr>
<td>• Some manufacturers voluntarily submit data</td>
<td></td>
</tr>
<tr>
<td>• CMS will use if for a “patient ready” dose</td>
<td></td>
</tr>
</tbody>
</table>

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# OPPS 2017 Proposed Payment Drug Administration

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th>2017 SI</th>
<th>APC</th>
<th>Payment Rate</th>
<th>2016 SI</th>
<th>APC</th>
<th>Payment Rate</th>
<th>Change (%)</th>
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<tbody>
<tr>
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<td>B</td>
<td>B</td>
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<td>APC</td>
<td>Payment Rate</td>
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<td>Payment Rate</td>
<td>Change (%)</td>
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<td>S 5695</td>
<td>280.27</td>
<td>.4%</td>
<td></td>
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</tr>
</tbody>
</table>
Comprehensive APCs

- Comprehensive APC (C-APC) = classification for the provision of a primary service and all adjunctive services provided to support the delivery of the primary service.

- CMS finalized its proposal to continue implementing the C-APC payment methodology made effective in CY 2015 where CMS makes a single, all inclusive prospective payment based on the cost of all individually reported codes packaged into the C-APC.

- CMS proposes 25 new C-APCs to be paid under the existing C-APC payment policy beginning in CY 2017.
Packaged payment for drugs that function as supplies in surgical procedures

• CMS: a basic tenet of prospective payment is packaging of all integral, ancillary, supportive, dependent, or adjunctive services into primary services.

• package payment for 4 drugs that function as supplies in a surgical procedure
  - HCPCS code J0583 Injection, bivalirudin, 1 mg
  - HCPCS code J7315 Mitomycin, ophthalmic, 0.2 mg
  - HCPCS code J0130 Injection abciximab, 10 mg in 2016
  - HCPCS code C9447 Injection, phenylephrine and ketorolac, 4 ml vial, (currently has pass-through status for CY 2016, packaging delayed to CY 2018, after pass-through status has expired)
Blood & blood products CY2017

- Continue to establish payment rates for blood and blood products using CMS blood-specific CCR methodology, implemented 2005
- Because costs of blood & blood products are reflected in the overall costs of C-APCs, no separate payments for blood & blood products when they appear on the same claims as services assigned to C-APCs.23
- New P Codes for Pathogen-Reduced Blood Products
  - HCPCS Workgroup creating 3 new codes for pathogen-reduced blood products (1 platelet, 2 plasma products)
  - CMS creating interim payment amounts based on crosswalks to existing blood product codes while new product claims data accumulates
Payment for Blood Clotting Factors CY2017

- blood clotting factors paid at ASP+6% plus a furnishing fee using an updated amount
- CY 2017 updated furnishing fee was $0.209 per unit

Who’s responsible for ensuring that the furnishing fee gets billed and collected?
### Medicare Payment for IV drugs

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Drug &gt; $110/day in 2017</th>
<th>Drug &lt; $110/day in 2017</th>
<th>Specialty Drug or Patient Assistance Drug or Nominal Price Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do I get paid for Patient clinic visit?</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Do I get paid for the drug?</td>
<td>Yes with a HCPCS code</td>
<td>Not separately, included in the bundle $</td>
<td>no</td>
</tr>
<tr>
<td>Do I bill for the drug?</td>
<td>yes</td>
<td>yes</td>
<td>Yes @ $0 charge</td>
</tr>
<tr>
<td>Do I get paid for IV drug administration?</td>
<td>Yes with the correct CPT code &amp; documentation</td>
<td>Yes with the correct CPT code &amp; documentation</td>
<td>Yes with the correct CPT code &amp; documentation</td>
</tr>
</tbody>
</table>

OPPS 2017 rules will continue to pay separately for drug administration even when the drug itself is bundled or packaged!!
Billing Drug Administration Codes

- Drug administration billed without a corresponding drug results in a denial of the administration code. e.g. White bagging or brown bagging
- Bill the HCPCS code for the drug administered with the correct quantity of billing units and a zero charge
- Check with your MAC and append the modifier recommended to all of the administration codes billed for the same date of service
- no HCPCS code? Use Not Otherwise Classified (NOC) “J” code - J3490 or J3590 (non-chemotherapy) or J9999 (chemotherapy), the NDC # and a zero charge
- Append the MAC recommended modifier to all of the administration codes billed for the same date of service
- Drug administered can’t be in the Self-Administered Drug Exclusions list
- Only chemotherapy drugs, immunotherapy, biologics and monoclonal antibodies are billed with chemotherapy administration codes
How do I do this?

• Create a CDM # for each complimentary product
   Infliximab 10mg/ml    CDM# 12345
   Infliximab, no charge    CDM # 12346

• Pharmacy creates a corresponding PDM entry for these complimentary products & links it to the CDM#

• When the complimentary product is used, pharmacy must use the order entry for the complimentary product, not for the purchased product

• Bill for the appropriate drug administration fee(s)
What should I do with this info?

• Note APC renumbering and ensure correct use
• Ensure IV drug admin codes being used for
  ❖ ALL drugs given IV regardless of packaging status
  ❖ White bagged, patient assistance or study drugs
• Calculate missed revenue
• Ensure that the right codes are being used with the right products
  ❖ “Chemo” includes traditional chemo, immunotherapy, biologics, biosimilars (all considered complicated)
Billing Details & Definitions
April 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS) Provider Types

6. Billing for Drugs, Biologicals, and Radiopharmaceuticals

Hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS codes are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

Hospitals are reminded that under the OPPS, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a “new” drug as regulated by the FDA under the New Drug Application (NDA) process. In these situations, hospitals are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399 (Unclassified drug or biological) is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the hospital should report an appropriate unlisted code such as J9999 or J3490.
My Survival Rules

• Get the best pricing possible, Use patient assistance programs when applicable
• Use 340B if you qualify (don’t cheat)
• Capture all charges in all areas including radiology, cath lab, etc even if not reimbursed
• Have a pristine and timely CDM
• Have a $ tsar on staff
• Bill for and collect co-pays
• Know what your bad debt is and have it offset in your budget
• Bill for all related services, supplies and admin fees even if they’re not reimbursed
• Be a part of the team that negotiates terms with the 3rd party payers
• Know what the pharmacy $ costs are for each service the facility is offering and make sure that the C suite knows them too
• You may not be deciding what services the facility will be offering, but it’s your job to convey what the pharmacy $ costs are
• If the facility’s offering the service, then the $ have to go into your budget
Some things to think about....

- Does your facility have a multidisciplinary revenue oriented team or committee?
- Is Pharmacy a regular member?
- Who else is there?
  - Financial (audit, accounts receivable, accounting)
  - Clinical (medicine, pharmacy, radiology, laboratory, resp therapy, nursing)
  - Legal (risk management)
  - Social services
- What’s on the agenda?
  - Payment denials?
  - Patient assistance programs?
  - Policy on off label use?
  - Copayment collections?

From: Alternatives when the system fails .
ASHP Virtual Symposium on MMA Reimbursement Issues
Anything missing?

- A focus on regulation compliance
- Integrated charging as part of the medication use process
- A clearly defined written policy on pharmacy PDM & CDM maintenance
- A naming convention
- Delays in fixing discrepancies
  - Wrong Rev codes
  - Duplicate products with multiple listings and prices
  - PDM changes reflected in the CDM and vice versa
Getting it Right: Correct Codes & Timely Changes

Coding is the language used to transmit information to payers. Using correct HCPCS codes is essential!

- Miscellaneous codes: use ONLY until a HCPCS assignment which may be before the drug gets FDA approval. Cleanse your CDM of miscellaneous codes.
- Revenue Cycle team or CDM handler: must make timely changes, updates don’t languish
- Beware Brand specific HCPCS codes and make these change rapidly when they occur. e.g. when Granix™ entered the market, not only did it get its own code, but the one for Neupogen™ changed as well.
- Goal: a perfect match between the drug description, the billing units and the HCPCS code in the CDM and the PDM (drug dictionary)
- Rebilling’s permitted within a specific timeframe. Rebill errors ASAP if billing unit calculation or HCPCS codes wrong
### Brand Name Specific HCPCS Codes

Most HCPCS codes are listed generically, but a few are unique to the brand name. Develop unique CDM listings for Brand Name products.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0800</td>
<td>Corticotropin injection</td>
<td>40 UNITS</td>
</tr>
<tr>
<td>J0834</td>
<td>Cosyntropin cortrosyn inj</td>
<td>0.25 MG</td>
</tr>
<tr>
<td>J1459</td>
<td>Inj IVIG privigen 500 mg</td>
<td>500 MG</td>
</tr>
<tr>
<td>J1460</td>
<td>Gamma globulin 1 CC inj</td>
<td>1 CC</td>
</tr>
<tr>
<td>J1556</td>
<td>Inj, Imm Glob Bivigam, 500mg</td>
<td>500 MG</td>
</tr>
<tr>
<td>J1557</td>
<td>Gammaplex injection</td>
<td>500 MG</td>
</tr>
<tr>
<td>J1559</td>
<td>Hizentra injection</td>
<td>100 MG</td>
</tr>
<tr>
<td>J1560</td>
<td>Gamma globulin &gt; 10 CC inj</td>
<td>10 CC</td>
</tr>
<tr>
<td>J1561</td>
<td>Gamunex-C/Gammaked</td>
<td>500 MG</td>
</tr>
<tr>
<td>J1566</td>
<td>Immune globulin, powder</td>
<td>500 MG</td>
</tr>
<tr>
<td>J1568</td>
<td>Octagam injection</td>
<td>500 MG</td>
</tr>
<tr>
<td>J1569</td>
<td>Gammagard liquid injection</td>
<td>500 MG</td>
</tr>
<tr>
<td>J1442</td>
<td>Inj, Filgrastim G-CSF 1mcg</td>
<td>1 MCG</td>
</tr>
<tr>
<td>J1446</td>
<td>Inj., tbo-Filgrastim, 5 mcg</td>
<td>5 MCG</td>
</tr>
</tbody>
</table>
Getting it Right: Billing units

- Medicare & most other payers require converting the drug dose given into billing units which are submitted for billing
- Paid only for the amount used for that patient, not the entire vial
- Medicare allows billing for waste, most other payers don’t
- **Ensuring that this conversion is working correctly through all the steps between the drug being entered into the pharmacy computer system all the way through to the bill being released is essential.**
- Lots of places this can go awry and leave you billing for only a fraction of what you should be.
- Amazingly even though this has been in place for over 10 years, billing unit errors are one of the major flaws reported by Medicare
Although biosimilars have been in use in Europe & other countries for over a decade, the 1<sup>st</sup> true US biosimilar was released for sale in early September 2015

- **Trade Name:** Zarxio
- **Biosimilar name:** filgrastim-sndz
- **Manufacturer:** Novartis a division of Sandoz
- **HCPCS Code:** Q5101
- **Short Description:** Inj filgrastim g-csf biosim
- **Long Description:** Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram (which defines the billing unit or HCPCS code dosage as 1mcg)
- **Injection:** NDC 61314-304-01 300 mcg/0.5 mL in a single-use prefilled syringe
- **Injection:** NDC 61314-312-01 480 mcg/0.8 mL in a single-use prefilled syringe
The patient receives 300mcg in a single use prefilled syringe. What do I bill for?

- Trade Name: Zaxio
- Biosimilar name: filgrastim-sndz
- HCPCS Code: Q5101
- Short Description: Inj filgrastim g-csf biosim
- Long Description: Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram (which defines the billing unit or HCPCS code dosage as 1mcg)
- Injection: NDC 61314-304-01 300 mcg/0.5 mL in a single-use prefilled syringe
- Injection: NDC 61314-312-01 480 mcg/0.8 mL in a single-use prefilled syringe
CMS Billing for Uncoded New Drugs

- Hospitals receive 95% of AWP on newly approved drugs and biologicals used in an outpatient setting that have not yet been assigned a product-specific HCPCS code.
- Use Unclassified Drug or Biological HCPCS code C9399 plus the NDC # (essential to get correct payment!!!!!)
- [www.cms.hhs.gov/manuals/pm_trans/R188CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R188CP.pdf)
- Using miscellaneous codes = $0 once a code is assigned. Be careful, stay on top of this!!
ASP Methodology

• uses several sources of data as a basis for payment, including
  ❖ ASP
  ❖ wholesale acquisition cost (WAC)
  ❖ average wholesale price (AWP).
• 2016 OPPS rules: the term “ASP methodology” and “ASP-based” are inclusive of all data sources and methodologies described therein.
• Additional information on the CMS Web site at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html
Average Selling Price (ASP)

- ASP Average selling price of manufacturer’s sales of all US purchases for each NDC for one calendar quarter, divided by total number of units sold in that quarter
- Excludes nominal pricing and Medicaid “best price.”
- Includes volume & prompt pay discounts, free goods, chargebacks, rebates
- For 2014, ASP calculations do not include 340B pricing
- Is updated quarterly, get on the distribution list!!
- [http://www.CMS.gov/McrPartBDrugAvgSalesPrice/01a172013ASPFiles.asp](http://www.CMS.gov/McrPartBDrugAvgSalesPrice/01a172013ASPFiles.asp)
- CMS abandoned AWP and moved to ASP October 2005
- H.R. 800 would exclude prompt-pay discounts from manufacturers to wholesalers from the calculation of a drug's average sale price
ASP Quirks

- The Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007 requires CMS to apply an alternative volume weighting computation to its calculation of ASP-based payment amounts.
- Prior to April 1, 2008, manufacturers' ASP data for smaller and larger package sizes are treated the same in CMS's calculation of the payment amounts;
  - ASP for 1 vial is treated the same as the ASP for a box of 10 vials
- 4.1.2008: ASPs for larger package sizes have greater impact on payment amounts and ASPs for smaller package sizes have less;
  - i.e., the ASP for a box of 10 vials is given 10 times the weight of a single vial.
Keep your eye on ASP

- Is based on the price the manufacturer sells the product at to the distributor or specialty pharmacy
- Is not based on the price you pay
- Does not take into account or include any mark-ups you pay to purchase the product
- 2017: does not include 340B sales price
- Lobby for ASP restructuring? Probably more important than the % mark-up!
CMS Posts ASP Drug Pricing Files Quarterly, Get them and use them!!

- A good review of applicable HCPCS codes and allowable billing units (go.cms.gov/16LuwS1)
- Visit 3 files are published quarterly
  - Payment Allowance Limits for Medicare Part B Drugs
  - ASP NDC - HCPCS Crosswalk for Medicare Part B Drugs
  - ASP NOC NDC - HCPCS Crosswalk for Medicare Part B Drugs
**Payment Allowance Limits for Medicare Part B Drugs**

*Effective through Sept 30, 2016 (qtrly changes possible)*

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>Billing Unit</th>
<th>Payment Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1110</td>
<td>Inj dihydroergotamine mesylt</td>
<td>1 MG</td>
<td>58.614</td>
</tr>
<tr>
<td>J1450</td>
<td>Fluconazole</td>
<td>200 MG</td>
<td>4.030</td>
</tr>
<tr>
<td>J1570</td>
<td>Ganciclovir sodium injection</td>
<td>500 MG</td>
<td>58.121</td>
</tr>
<tr>
<td>J2675</td>
<td>Inj progesterone per 50 MG</td>
<td>50 MG</td>
<td>1.039</td>
</tr>
<tr>
<td>J7520</td>
<td>Sirolimus, oral</td>
<td>1 MG</td>
<td>7.870</td>
</tr>
<tr>
<td>J9178</td>
<td>Inj, epirubicin hcl, 2 mg</td>
<td>2 MG</td>
<td>1.287</td>
</tr>
<tr>
<td>J9200</td>
<td>Floxuridine injection</td>
<td>500 MG</td>
<td>16.276</td>
</tr>
<tr>
<td>Q0166</td>
<td>Granisetron hcl 1 mg oral</td>
<td>1 MG</td>
<td>0.942</td>
</tr>
</tbody>
</table>
What’s all the fuss with NDC #’s?

• National Drug Code #s that identify
  ❖ The manufacturer (1st set of digits)
  ❖ The drug (2nd set of digits)
  ❖ The package size (3rd set of digits)

• NDC reporting is essential for Medicaid and 340B billing
  ❖ Why? Because the manufacturer doesn’t want to pay Medicaid rebates or offer 340B pricing if his drug wasn’t the one being used!!!
  ❖ CMS wants outpatient departments and clinics & physician offices to do a better job of reporting NDCs

• New HRSA 340b GPO exclusion language makes hospitals much more NDC centric: imperative that NDCs are accurate
ICD-10
ICD-10 Assessment and Maintenance Toolkit for Providers
This in-depth toolkit shows how you can manage your revenue cycle by:
• Assessing ICD-10 progress using key performance indicators (KPIs) to identify potential productivity or cash flow issues
• Addressing opportunities for improvement
• Maintaining progress and keeping up-to-date on ICD-10

Get ICD-10 Answers in One Place

The ICD-10-CM/PCS Frequently Asked Questions web page has answers to your questions about:

- Claims processing and billing
- Coding
- General Equivalence Mappings (GEMs)
- Home Health
- National Coverage Determinations (NCDs)
- Local Coverage Determinations (LCDs)

Roadto10.org is your one-stop source for all things ICD-10

ICD-10 Documentation and Coding Concepts for Ancillary Services

An AHIMA-certified coder presents training focused on unique ICD-10 clinical documentation needs and hot topics for each ancillary service. These webinars will follow the same outline and objectives catering to each service line with specific examples.

ICD-10 Documentation and Coding Concepts
CMS Webcast
www.roadto10.org/ancillary-webcasts/#p
Self Administered Drugs
CMS Clarifies When To Treat Outpatient Drugs as Supplies

- June 8 policy document: CMS explains when to treat self-administered outpatient drugs as supplies related to a medical procedure
- The cost of these drugs is packaged within procedural codes and cannot be billed to the patient
- The document also announces new billing codes and updates CMS's list of pass-through drugs
Medicare JH Medical Policy (JH) Local Coverage Article for Self-Administered Drug Exclusion List (A51866) (Effective 01/01/2014)

- Medicare provides only limited benefits for outpatient prescription drugs. The program covers drugs that are furnished “incident to” a physician’s service provided that the drugs are not usually administered by the patients who take them. Each Medicare Administrative Contractor (MAC) as well as fiscal intermediary and carrier must make its own determinations for determining which drugs will be excluded from coverage. The detailed process for this determination is available in the Medicare Benefit Policy Manual Internet-Only Manual (IOM) Publication 100-02, Chapter 15, Section 50.2.

- DEFINITIONS
  - Self-administered—administered by the patient to him or herself. This does NOT include administration by spouses, nursing aides, allied health professionals, or physicians. Therefore, oral medications are considered self-administered drugs. However, payment for an oral drug is made as a rare exception when the drug is an oral anti-cancer drug or an oral antiemetic that is given with chemotherapy treatments (See IOM 100-02, Chapter 15, Section 50.5.3 and 50.5.4).
• DEFINITIONS
  - Usually self-administered—the term “usually” means more than 50% of the time for all Medicare beneficiaries who use the drug. Therefore, if a drug is self-administered by more than 50% of Medicare beneficiaries, the drug is excluded from coverage and the contractor may not make any Medicare payment for it. In other words, this determination is made by evaluating beneficiaries as a collective whole rather than basing it on an individual drug or individual beneficiary.
  - Acute condition—any condition that the expected course of treatment is < 2 weeks
  - Chronic condition—any condition that requires treatment for > 2 weeks
Other considerations

Route of Administration
- Drugs delivered IV are presumed to be NOT usually self-administered
- Drugs injected IM are presumed to be NOT usually self-administered, although depth and nature of the drug may be considered.
- Drugs administered SC are considered to be usually self-administered

Status of the Condition
- Acute: any condition that the expected course of treatment < 2 weeks
- Chronic condition: any condition that requires treatment for > 2 weeks

Frequency of Administration
- Infrequent injection: e.g., drug given monthly or < once per month
- Frequent injections: e.g., drug given one or more times per week or > once per month
OIG Policy Statement Regarding Hospitals That Discount or Waive Amounts Owed by Medicare Beneficiaries for Self-Administered Drugs Dispensed in Outpatient Settings

• Purpose: to assure hospitals that they will not be subject to OIG administrative sanctions for discounting or waiving amounts Medicare beneficiaries may owe for self-administered drugs (SADs) they receive in outpatient settings when those drugs are not covered by Medicare Part B, subject to the conditions specified.
• designed to address the question whether various guidance documents issued by CMS require hospitals to bill and collect (or make good faith efforts to collect) their usual and customary charges for SADs that are not covered by Medicare Part B (Noncovered SADs) to comply with OIG’s fraud and abuse authorities.
• http://oig.hhs.gov/compliance/alerts/guidance/policy-10302015.pdf
I’ve heard you can bill for drug waste ...

how does this work?
Answer these 4 questions

• Is the drug being used for a Medicare patient being treated in an outpatient area?
• Are you using a single dose vial/pkg of the drug?
• Does the product have a HCPCS code?
• Does the dose fall into the pass-through or separately payable category and not the <$110/day bundle or any other packaged or bundled payment category?
• If yes, proceed to waste billing
• If no, then there’s nothing to do
Steps to Take

• Build all injectable drugs regardless of packaging at the HCPCS billing unit level
• Review the MAC requirements for your geography
• Determine which drugs are going to be waste candidates
• Create a CDM # for each one
  ❖ Drug A CDM #123456
  ❖ Drug A waste CDM# 123457
• Convert dose administered into billing units, round up to next whole billing unit
• Document the dose administered in the medical record
• Determine the number of billing units wasted
  ❖ The # in the vial (use the NDC ASP CMS Qtrly update) minus the number of billing units used for the dose
• Document the amount wasted & the reason why in the medical record
• Bill the dose administered using billing units
• Bill the amount wasted using billing units & identifying this with the JW modifier
Reducing Reimbursement Loss
or Compliance Errors

Billing for waste is not mandatory but if trying to recoup those $, then.....

• Know the rules your contractor requires you to follow

• You must use a modifier (JW) to differentiate waste from dose administered

• Decide which products your outpatient department is going to apply this to. e.g. may decide to only apply this to a handful of expensive agents in the infusion clinic or specialty outpatient clinics.

• Develop a P&P and orient your staff, revenue cycle

• Make use of IT but do frequent compliance checks

• Ensure that required documentation is actually happening and in the manner specified by the MAC
A new drug is approved.... what should I do?
• Some of the brightest minds in the pharmacy department are devoted to feverishly preparing P&T submissions extolling the virtues and known pitfalls of the product and crafting prescribing guidelines to ensure wise use in the institutional setting

• Unfortunately, few of the brightest minds are concerned about the practical aspects of actually acquiring the product and incorporating it into the logistics of the pharmacy operations
What to do with a new drug

- Contact your GPO to determine pricing, contract status and other negotiated terms
- Contact the manufacturer for information on
  - patient assistance programs
  - reimbursement programs or assistance that outline the steps for documentation required for reimbursement
- Assign a Charge Description Master (CDM) # and a price
- Link the CDM # to the CMS billing code for new drugs
- Be aware of the billing units assigned to the product and create the necessary crosswalk
What to do with a new drug

- Stay aware of assignment of a designated code to replace this
  (Unfortunately no easy-to-use recap available, just quarterly CMS
  website updates and MLN Matters bulletins)
- Submissions using the wrong code are rejected
- Outpatient settings: ensure code assigned matches billing units being
  reimbursed, consider crosswalks to auto correct (commercial or in-
  house)
- Activate the drug in the Pharmacy Computer Drug Master File and link
  it to the CDM # (Don’t forget to change miscellaneous codes for actual
  and designated ones as soon as they’re assigned)
- Contact the Pharmacy Computer Vendor if new drug data is not
  provided on a timely basis
- Avoid miscellaneous CDM numbers and “in-house–created” drug
  entries. They’re a reimbursement *kiss of death*