Tuesday, April 5: Roundtables Session I
5:00 – 6:30 PM
Hilton Orlando
Continuing Education Contact Hours:
Pharmacy and Nursing—1.5

Roundtables Session I is supported by an educational grant from
Bard Medical

Wednesday, April 6: Roundtables Session II
4:00 – 5:30 PM
Hilton Orlando
Continuing Education Contact Hours:
Pharmacy and Nursing—1.5

Roundtables Session II is supported by an educational grant from
RMS Medical Products
Tuesday, April 5: Roundtables Session I
5:00 – 6:30 p.m.
Hilton Orlando – Orange Ballroom EFG
Pharmacist, Pharmacy Technician and Nurse Continuing
Education Contact Hours: 1.5
ACPE Pharmacist Program #: 207-999-11-219-L01-P
ACPE Pharmacy Technician #: 207-999-11-219-L01-T

Engage in dynamic fellowship and educational opportunities, as you network with friends and colleagues during the 2011 NHIA Roundtables program...

**Education Objectives**

1. Examine issues and opportunities impacting the clinical delivery of patient care, including medication and supply preparation, delivery, administration and patient monitoring.
2. Discuss areas of interest to alternate-site infusion managers, including accreditation, quality improvement, staff communication and teamwork.
3. Discuss challenges associated with alternate-site reimbursement, including payer contracting, patient admissions, claim development and submission, and collections activities.
4. Devise strategies to improve sales and marketing efforts, including training of sales personnel, preparing all staff for their role in sales, and implementation of sales action plans.

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<th>Table Topic</th>
<th>Facilitator(s)</th>
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<td>Achieving Successful Accreditation</td>
<td>Frank Marr, PharmD, BS, RPh, General Manager, Walgreens Infusion and Respiratory Services, East Berlin, CT</td>
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<td>Ambulatory Infusion Suite Reimbursement Challenges</td>
<td>Louise Mock, Director of Financial Services, Vital Care, Inc., Meridian, MS</td>
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<td>Applying Industry Guidelines to Home Infusion CVAD (Central Venous Access Device) Care</td>
<td>Debbie Cain, RN, CRNI®, Vice President, Home Parenteral Services, Cox Health, Springfield, MO</td>
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<td>Applying USP &lt;797&gt; Standards to Your Practice</td>
<td>Kim Heagy, RPh, Director of Clinical Services, Vital Care, Inc., Meridian, MS</td>
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<td>Benefits and Pitfalls to Staffing a Hospital Liaison Position</td>
<td>Lauree Criss-Basalyga, Vice President, Sales &amp; Marketing, CarePoint Partners, Pittsburgh, PA; and Matthew Kiraly, RN, BSN, Midwest Regional Sales Manager, CarePoint Partners, Canfield, OH</td>
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<td>Billing Medicare for Enteral Therapy</td>
<td>Kathy Laorenza, Reimbursement Manager, Advantage Reimbursement, LLC a Mediware company, Andover, MA</td>
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<td>Boomers vs. Gen X vs. Gen Y—Communication Strategies to Close the Gap</td>
<td>Barbara J. Petroff, MS, RPh, FASHP, Operations Manager, Critical Care Systems, Wixom, MI</td>
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<td>Donald J. Filibeck, PharmD, MBA, National Director, Pharmacy Services, Critical Care Systems, Dublin, OH; and Kevin L. Ross, RN, BSN, Bartonville, TX</td>
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<td>MJ Graves, Managing Director, MCG Resources, Nashville, TN; and Pete Tanguay, President, Rock-Pond Solutions, Conway, AR</td>
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<td>Clinically Qualifying Your Medicare Part B Patient before Therapy Starts</td>
<td>Bernie McDonald, RN, Nurse Manager, Chartwell Pennsylvania, Pittsburgh, PA</td>
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<td>Considerations When Offering a New Service Line</td>
<td>Beth Hebert, RPh, BS, Pharmacy Site Manager, Southcoast Home Care, Hospice, Palliative and Infusion Services, Fairhaven, MA</td>
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<td>Contracting Strategies</td>
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<td>Corporate Compliance and Its Potential to Impact Your Business</td>
<td>Clay Stribling, Esq, President, HC Comply, Amarillo, TX</td>
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<td>Creating a Successful Pharmacy Student Preceptor Program</td>
<td>Bryce Jackman, RPh, BCNSP, Director of Pharmacy, CarePro Home Health and Infusion Services, Cedar Rapids, IA</td>
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<td>D.E.N.Y. = Downgraded Enteral Nutrition Yikes!</td>
<td>Kerry Stone, MS, RD, CNSC, Regional Nutrition Specialist- West, Walgreens Infusion and Respiratory Services, La Jolla, CA</td>
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<td>Intrarticular Antibiotic Infusions</td>
<td>Felicia Schaps, RN, CRNI®, OCN, CNSC, Clinical Resource Nurse, HomeChoice Partners, Inc. - A DaVita Company, Annandale, VA</td>
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<td>Jen Keiser, General Manager, Homecare Net Solutions-Mediware, Cranston, RI; and Betty Gomez, Vice President of IT Operations Support, ZirMed, Louisville, KY</td>
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<td>LEAN: Continuous Quality Improvement Practices from the Manufacturing Industry</td>
<td>Diana Boschi, RPh, VP, Director of Operations, Empire Home Infusion Services, Malta, NY</td>
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<td>Measuring Infusion Pump Performance</td>
<td>Peter Elias, Director of Equipment Management Services, Medical Specialties Distributors, Stoughton, MA</td>
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<td>Monitoring the Home Nutrition Patient—Key Nutrition Parameters</td>
<td>Karen Hamilton, MS, RD, LD, CNSC, Strategic Manager, TPN Center of Excellence, Coram Specialty Infusion, An Apria Company, Moscow, PA</td>
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<td>Motivating a Sales Force with Compensation Plans*</td>
<td>Louis C. Feuer, MA, MSW, President, Dynamic Seminars and Consulting, Inc., Pembroke Pines, FL</td>
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<td>Overcoming Medicare D Challenges</td>
<td>Sarah Schwebeke, Sr. Contracting Coordinator, Coram Specialty Infusion, An Apria Company, Wauwatosa, WI</td>
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<td>Pharmacy Construction and Remodeling that is U.S. Pharmacopeia (USP) &lt;797&gt; Compliant</td>
<td>Arun Tahiliani, RPh, PhD, Pharmacist, CarePoint Partners, Baton Rouge, LA</td>
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<td>PICC (Peripherally Inserted Central Catheter) Securement</td>
<td>Melissa Leone, RN, BSN, Director of Nursing Operations, Coram Specialty Infusion, An Apria Company, Hamden, CT</td>
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<td>Process Mapping—How Streamlining Your Workflow Can Save Time and Improve Quality</td>
<td>Rad Dillon, RPh, Regional Operations Director, North, HomeChoice Partners, Inc. - A DaVita Company, Columbia, MD</td>
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<td>Recruiting and Retaining Pharmacists from Non-Infusion Practice Settings</td>
<td>Leo Basch, RPh, PharmD, Clinical Pharmacist, Walgreens Infusion and Respiratory Services, Las Vegas, NV; Holly Black, RN, BSN, Regional Nursing Director, West, NW Regions, Walgreens Infusion and Respiratory Services, Ventura, CA; and John E. Sandstrom, PharmD, Manager, Pharmacy Operations, Walgreens Infusion and Respiratory Services, Ventura, CA</td>
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<td>Sales 101—Getting Started in Infusion Sales</td>
<td>Sheryl Raley DeTellis, RN, BSN, MBA, Corporate Director of Sales &amp; Marketing, Florida Hospital Home Infusion, LLP, Altamonte Springs, FL</td>
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<td>Sales Team Building and Training for the Home Infusion Market</td>
<td>Les McKay, Regional Sales Manager, HomeChoice Partners, Inc. - A DaVita Company, Norfolk, VA</td>
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<td>Solving your Beyond Use Dating (BUD) Challenges</td>
<td>Caryn Bing, RPh, MS, FASHP, Clinical Services &amp; Residency Program Manager, Critical Care Systems, Las Vegas, NV</td>
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<td>Subcutaneous Infusion of Immune Globulin (SCIG) vs. Intravenous Infusion of Immune Globulin (IVIG)—Which Approach is Best for Your Patient?</td>
<td>Amy Clarke, RN, Program Manager, Hemophilia/IVIG, Diplomat Specialty Pharmacy, Deerfield, IL</td>
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<td>Surviving Drug Shortages and Recalls</td>
<td>Steve Kennedy, PharmD, Director, Infusion Pharmacy Services, Walgreens Infusion and Respiratory Services, Buffalo Grove, IL</td>
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<td>The Data You Need to Appropriately Assess Territory Performance</td>
<td>Kelly Aldridge, BSW, Regional Vice President of Sales and Marketing, Home Solutions Infusion Therapy, Vineland, NJ</td>
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<td>TRICARE Reimbursement</td>
<td>Cynde Derryberry, Vice President, Reimbursement Advisory Services, MCG Resources, Decatur, IL</td>
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<td>Understanding Payer Networks</td>
<td>Jennifer Notch, Business Office Manager, Fairview Pharmacy Services, Advantage Reimbursement, LLC a Mediware company, Minneapolis, MN</td>
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* This table will only be available at Wednesday's Roundtable II Session

This table will be recorded. Participant consent will be required.
Introduction to Planning and Preparing for an accreditation survey

- Development of project plan
- Delegation of staff to implement the plan
- Staff education pertaining to survey process
- Review of key focus areas
- Review of physical facility
- Policy & procedure review and update
- Legal document review
- Organizational review to include organizational meeting minutes (governing body and medical standards body if applicable)

Key focus areas

- All required license review (business, professional, etc.)
- Mock staff interviews
- HR record reviews for all documents
  - New employee orientation
  - File distinctions (HR record vs confidential file vs I-9’s)
  - Professional license verifications
- Staff Education documentation
- Meeting minutes for all staff meetings, QI/Performance Management, Safety,
- QI performance program review
- Infection control program review
- Clinical record review
- Cleanroom standards compliance
- DME (infusion pumps, etc.) tracking and management
- Reimbursement audits for compliance
- Pharmacy – Technician operating/checking procedures
- HIPAA compliance
  - HITECH Requirements
- Contracts annual review
- Nursing supervisory visits
Table # 02
Ambulatory Infusion Suite Reimbursement Challenges

Louise C. Mock
Director Financial Services
Vital Care, Inc.
lmock@vitalcareinc.com

- Payers
  - Government
    - Medicare
    - Medicaid
  - Commercial Payers

- Contracts
  - Place of Service
  - Codes
    - Modifiers

- Nursing
Applying Industry Guidelines to Home Infusion CVAD (Central Venous Access Device) Care

Debbie Cain RN, CRNI
Vice President
Home Parenteral Services
Debbie.cain@coxhealth.com

- CDC Guidelines for Prevention of Intravascular Catheter-Related Infections
- Delay in release of 2011 guidelines
- INS (Infusion Nurses Society) Standards of Practice 2011
  - Crosswalk 2006-2011
  - Evidence Based Practice
  - CLABSI Definition
  - Peripheral Infusates Handout
  - Blood Sampling
  - Flushing and Locking
  - Administration Set Change
  - Vascular Access Site Preparation and Device Placement
- Vascular Access Device Stabilization
- Antineoplastic Therapy

References:

CDC Guidelines for Prevention Of Intravascular Catheter-Related Infections 2002

INS Standards of Practice 2011
Personnel Training and Evaluation of Aseptic Manipulation Skills
- Didactic Review
- Written Test
- Media Fill Test
- Gloved-Finger Tip Sampling

Hazardous Drugs
- Storage
- Personnel Protection During Receiving, Distribution, Stocking, Preparation, Disposal
- Environment
- CSTD
- Training

Environmental Quality Control
- Viable and Nonviable Air Sampling
- Pressure Differential Monitoring
- Cleaning and Disinfecting the Compounding Area
- Surface Sampling

Automated Compounding Devices

Beyond-Use Dating
- Risk Level
- Extended BUD
**TABLE # 05**

Benefits and Pitfalls to Staffing a Hospital Liaison Position

Lauree Criss-Basalyga  
Vice President, Sales and Marketing  
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Matthew Kiraly, RN, BSN  
Midwest Regional Sales Manager  
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Cincinnati, OH  
mkiraly@carepointpartners.com

**PLAN:** Due to roundtable sessions occurring as three 30-minute time blocks, 7-8 minutes will be spent discussing each topic:

1. Why staff a hospital liaison position?  
   - Advantages v. Disadvantages

2. What are the responsibilities of a hospital liaison?  
   - Care Coordination v. Marketing

3. Who is the ideal candidate for this position?  
   - Clinical v. Non-Clinical

4. Which type of facilities are best to place a hospital liaison  
   - Quality v. Quantity (University v. Community v. Tertiary Medical Centers)
Billing Medicare for Enteral Therapy

Is your billing staff involved with monitoring and maintaining patient compliance?

Is your billing staff identifying when more or less enteral product is shipped?

Are your patients being informed that if they are admitted to the hospital or a Part A stay in a SNF, that they can not bring the formula from home to us?

Are you billing out the amount used based on the order and DIF or are you billing out full cases of both formula and feeding bags if they are required?

If billing out full cases, how do you account for the overage if billing prospectively for the 30/31 day max?

How are you ensuring that claims are being billed on the ship date if using a delivery service or the actual delivery date if being shipped directly to the patient?

Has anyone experienced an issue with the change that down coding of formulas to the LCA (least costly alternative) will no longer be done as of 2/4/11?
<table>
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<th>Section</th>
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</table>
| **1. Personal and Lifestyle Characteristics by Generation** | a. Core Values  
  b. Family  
  c. Education  
  d. Communications Media  
  e. Dealing with money |
| **2. Workplace Characteristics** | a. Work Ethic and Values  
  b. Work is...  
  c. Leadership Style  
  d. Interactive Style  
  e. Communications  
  f. Feedback and Rewards  
  g. Messages that motivate  
  h. Work and Family Life |
| **3. Compensation Strategies** | a. Bonuses (top method)  
  b. Market Level Pay  
  c. Benefits  
  d. Flextime, Vacation and Telecommuting |
Components of the Care Planning Process

- Assessment/Reassessment
- Developing the plan of care
- Obtaining orders
- Education
- Provision of care, treatment and service

Assessment/Reassessment

- Collecting information
- Analyzing data
- Making decisions

Developing the Plan of Care

- Individualized
- Realistic, achievable goals
- Limited to the services provided
- Considerations
  - Clinical problems
  - Psychosocial considerations
  - Cognitive skills
- Patient wishes
- Frequency of reassessment

Obtaining Orders

- Verbal Orders
- Written Orders
- Use of pre-printed forms
- Complete and timely

Education

- Specific to the patients needs and abilities
- Appropriate to the care, treatment and services provided
The chief financial officer’s (CFO) job has become more complex in recent years as mergers and acquisitions, financial structuring, and managing relations with investors and analysts have demanded increasing amounts of time and attention. In the home infusion industry, reimbursement issues often demand an extensive amount of CFO time whether it is understanding the industry, relating to pharmacists and clinicians or understanding the complex inventory and costing issues inherent in the business. All of this can become a serious distraction to one of the primary roles of the chief financial officer, to create and sustain value for their company. This roundtable will focus on the following:

**Understanding how your company creates value**

- Developing a clear strategy that supports the investment “story”
- Establishing firm revenue and cash growth
- Identifying, supporting and tracking outlier “add-backs” to key trends
- Continuous process improvements to drive productivity and to adapt to changing needs
- Maximizing margin through revenue strategies, payor initiatives and inventory management

**How to integrate financial and operational measures**

- Need for timely and accurate data to drive decision-making
- Developing a meaningful daily and weekly flash as well as scorecard
- Moving from a reactive to a pro-active stance in managing the business through vital information reporting
- Need for the input of finance in operational meetings and decisions on a regular basis

**Qualities of a good information system**

- Comprehensive (using all aspects of the system)
- Accuracy (focus on master file and data file clean up; data field rules)
- Consistency (using data field rules to ensure consistency of data)
- Completeness (advantage of “one source” efficiencies of having all of your key data within the same data base)
- Accessibility (users should be able to pull key reports in timely manner)
- Timeliness (industry can no longer afford the one month “look back”) in evaluating the business

**The importance of dialogue and teamwork**

- Finance as a partner to operations
- Sensitivity to the “spotlight” finance will be placing on operations
- Consistent communications regarding and re-focus on the Company’s long-term strategy
- No time for blame --- let’s just find the fix!
Complex patient qualification criteria and documentation requirements make obtaining Medicare reimbursement for home infusion therapies more challenging and error prone than what’s associated with commercial payers. As a result providers typically experience longer days sales outstanding (DSO) and weak cash flow for Medicare Part B claims. Employing this method of clinically reviewing patient documentation prior to admission keeps Medicare DSO at 55.

1. Assign the responsibilities of Medicare Clinical Specialist to several clinical staff members who will be responsible for qualifying all Part B therapies prior to initiating therapy.
2. Educate hospital liaisons/discharge planners to Part B therapy guidelines
3. Utilize Documentation Checklists for each therapy

Challenges Specific to the TPN referral
- Documentation supporting objective proof of the patient’s Medicare approved diagnosis
- MD attestation to permanence and no further surgery or enteral feeding an option
- Creation of a cover letter to submit with the claim which directs the reviewer through the submitted documentation
- Challenges Specific to the inotropic drug infusion (Milrinone/ Dobutamine/ Dopamine)
- Decision tree for Inotropic Drug Infusion
- MD signed data collection tool required with submitted claim

Challenges Specific to Anti Viral/ Antifungal therapy
- For Anti-viral drugs use a primary diagnosis which reflects a viral infection ex. (078.5 which indicates a positive CMV titer)
- Submit the positive viral titers
- If the liposomal form of Amphotericin B is used, show proof of significant renal impairment or intolerance to the non-liposomal form. Justification letter from the MD is recommended

Challenges Specific to Desferal Therapy
- Use Chronic Iron Overload (790.6) as the primary diagnosis
- Submit elevated Ferritin levels
- Justification letter from MD defining the patient’s need for Desferal therapy
Initiating a new pharmacy service line – from inception to conception

Goal of service line
1. Patient need
2. Continuum of care
3. Medical benefit vs. pharmacy benefit
4. Revenue retention vs. Revenue generation

Request for proposal process
1. Clinical analysis
2. Reimbursement projections
3. Rate requests vs rate proposal
4. Defending presentation
5. Business plan writing

Gap analysis
1. Information system needs
2. Pharmacy staffing
3. Clinical assessments
4. Intake and authorizations
5. Call center needs
6. Custom reporting

Operational challenges
1. Point of sale device
2. Co-pay assistance
3. Marketing
4. Controlling growth
1. Develop and maintain a “Contract Rate Comparison” grid in Excel with the current rates for per diems, nursing and drugs. This is a useful reference for Intake and Billing, and also allows you to evaluate contract proposals against your rates with existing contracts (and auto-calculate inflation rates).

2. Review existing contracts for “gray areas” that could cause problems in an audit. Can you defend your billing decisions based on your current contract language? (If your contract is silent on an issue, the answer is: not easily.)

3. Elicit feedback from your Reimbursement Management team on the reimbursement structure (can we set up our system to bill this way?) as well as language that clarifies the appropriate way to bill in compliance with the contract.

4. If a payer will not accept the NHIA Model Contract in its entirety, share a priority checklist with your contract negotiator. Language can be included in the body of the contract or added as “payment notes” to national contracts.

Infusion Contract Negotiations – Priority Checklist

- Per Diem definition - Preferred: bill all days up to 72 hours. If payer insists on paying only for days a drug is infused/injected, ask for language supporting catheter care billing on non-drug days.
- Drug definition - Add to the NHIA definition a specific reference that hydration fluids, flushes, carriers, additives and lipids are payable at your drug reimbursement rate. Example: All legend drugs assigned an NDC code are billable at the appropriate drug rate, including drugs used as diluents (the agent that dilutes the substance), flushes (the agent used to maintain the patency of the venous access device) or solutions (the agent or vehicle that delivers the active drug ingredient, or is the active drug ingredient in the case of hydration).
- AWP Source definition (if using AWP) – and language protecting against change in AWP methodology.
- Wastage/Reimbursement for change in orders, hospitalization, etc. – define payment terms for both drugs and per diems (up to 7 days). If payer will only reimburse drugs in this scenario, define per diem “wastage” rate for TPN reimbursement.
- Individual consideration and/or NOC language – for drugs/therapies not defined in a specific per diem.
- Basis for drug billing - define billing by vial or Rx; if the latter, need language to reimburse for single dose vials as well as “Keep Vein Open” situations
- Multiple per diems – guidelines for billing multiple per diems (e.g. one code per day, one unduplicated code per day) and coding/pricing. Preferable to say all multiple per diems are billable.
- BID Nursing visits – language to clarify that BID visits are each billable as 99601 (and appropriate additional 99602 units)
- Clean claim payment language (interest!)
- Inflation schedule – annual increases if not a “percent of charges” contract.
- Billing codes – these should be listed next to each rate or rate description

The compliance process can assist infusion providers by identifying high-risk behavior before it becomes legal liability.

Recent trends show larger risk to infusion providers from:

- ZPIC audits
- RAC audits
- PBM audits
- OIG investigations

By implementing compliance programs, an infusion provider will:

- Appoint Or Hire A Compliance Officer Or A Compliance Committee
- Implement A Comprehensive Employee Training Program
- Implement A Comprehensive Employee Training Program
- Establish a Confidential Disclosure Program
- Establish Internal Audits to Monitor Compliance
- Enforce Policies And Procedures
- Respond To Detected Offenses

In addition, ongoing compliance monitoring will assist in identifying new high-risk areas.

Auditing leads to Implementation leads to Training

Effective auditing involves processes as well as claims.

Effective compliance requires that an infusion provider supply the compliance officer with two key resources - time and money.
Prepare a Syllabus for the period of time the student will be at the location. Our Syllabus is broken down week by week with assigned activities to be completed by the end of each week.

College of pharmacy should provide all documentation related to blood borne pathogen training, vaccinations. We have the students complete our HIPAA training on day 1.

**Week 1**

- **(Day 1)** Write a one-page paper of what your impression of home care/home infusion is with regards to what a Home Infusion Pharmacist does. Also, comment on what your goals are for this rotation and what you want to get out of this rotation.
- Review patient charts and familiarize yourself with patients (you will follow 8–9 patients during this rotation). Following a patient means:
  - Review chart, patient history (current and past), med list, etc.
  - Evaluate drug therapy provided by CarePro (Right drug? Right formula?)
  - Review any lab work
  - Discuss labs, findings, or any recommendations with the pharmacists
  - Minimum of weekly follow-up calls to your patients
  - Relay any pertinent information to other health care professionals
  - You will “Work up” one of your patients and present this work up the last week to the pharmacists.
- Go on nursing visits (scheduled each week of rotation)
  - Taking Blood pressures and Vitals is okay, check with the RN and do vitals first (RN may double check readings).
- **Disease State Modules**
  - Routes of Administration, Multiple Sclerosis, Hepatitis C (mandatory) TPN & TPN Worksheets, Enteral Nutrition, Pain Management & Narcotic dose equivalency worksheets, Fluids & Electrolytes (optional)
- Choose a journal club topic (present during week 2)
  - Should be a topic applicable to the world of Home Infusion
- Complete a drug review sheet daily, and discuss each Friday.
- Assist with patient labs if needed
- Assist other pharmacists with patient calls
- Free Medical Clinic Thursday 08:30-2pm (every Thursday)
- Review Iowa Law manual with regards to:
  - How does CarePro differ from other retail pharmacies with regards to providing CII prescriptions, and handling CII partial fills? (We take care of Hospice patients, LTCF patients, and patients on parenteral CIs).
  - Does a home infusion pharmacy need a special pharmacy license?
  - What is the RPh to technician ratio that must be maintained in Iowa?
- Drug information questions as needed (impromptu basis)
- Select a topic for final presentation to Pharmacists and Nursing staff (may be assigned by Preceptor)
- Follow technicians to observe IV compounding, and clean room maintenance
- Discuss business issues with Director of Pharmacy or Director of Operations if desired
- Meet with Dietitian to discuss the role of the dietitian in managing enteral patients
- Weekly discussions with Preceptor to discuss DI sheets, answers to DI requests, discuss patient populations specific to home infusion.
TABLE # 15
D.E.N.Y. = Downgraded Enteral Nutrition Yikes!

Kerry Stone MS, RD, CNSC
Regional Nutrition Specialist
Walgreens Home Infusion Carlsbad, CA 92011
Kerry.Stone@Walgreens.com

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D.E.N.Y. = Downgraded Enteral Nutrition Yikes!

1) Medicare – Fee Schedule and changes in the least costly alternative determination
2) DMEPOS – A change in providers for many consumers. How will the industry respond to this new model?
3) State Medicaid / Medi-Cal denials
4) Health Insurance Plans:
   • Payment tiers or single per diems
   • Reasons behind formula denials
   • Consumers left to figure it for themselves and their potential pit falls
   • WIC - What it takes to become enrolled
   • Alternatives
     Manufacturer programs
     Web based procurement
5) Home made enteral formulas
   • What type of information is available to the patient?
   • What are the complications associated with home made enteral formulas?

References:

3) The Oley Foundation Life Line Newsletter. 2007
Hickman Catheters can be used to administer antibiotics intra-articularly for treatment of sepsis of total knee replacement or septic total joint arthroplasty.

Care should be taken to avoid injection of contaminants or microbes since it is a direct route to a joint.

Betadine ointment is placed over the end caps to prevent infection. Two Hickman catheters are often placed in case one is lost to mishap. Both are sutured in place. Tubing should not be allowed to dangle and should be secured to the leg.

Antibiotic incompatibility can be a problem resulting in crystal precipitation into the joint, so antibiotics given should be compatible with the antibiotics used intraoperatively in the irrigation. For example: cephalosporins and vancomycin precipitate when mixed and produce an inflammatory response, therefore, patients receiving IV cephalosporins should not receive intraarticular vancomycin and vice versa.

The largest volume that should be used intra-articularly during each injection is 10ml except in rare cases of antifungal agents, which must be infused with larger volumes.

The catheters are NOT flushed with saline after injection of the antibiotic.

Do not mix a concentration of greater than 1gm in 10 ml sterile NS to avoid precipitation.

For potentially toxic medications (such as Vancomycin) the serum trough level should be checked daily until stable, then once weekly.

The antibiotic dose should be adjusted to keep the trough at low-normal levels. The reason for this is that the intra-articular and surrounding tissues are receiving hundreds of times higher concentration than is recorded by the lab in the peripheral blood.

Generally the hickman catheters are removed in the OR following six weeks of intraarticular antibiotic therapy. This is done under local anesthetic.

Reference: Leo A. Whiteside, MD, Missouri Bone and Joint Center, St. Louis, MO
### Overview

In 2012, all of the electronic claim formats that you use are changing! And in 2013, the transition continues, as the U.S. moves from the ICD-9 to the ICD-10 coding system. This roundtable will help you ensure that you are aware of what you should be doing to prepare.

### Topics

1. **Changes to the X12 formats**, which will transition from version X12 4010 to X12 5010. Most common:
   - 837 Professional and 837 Institutional electronic claims
   - 835 electronic remittance
   - 270/271 eligibility verification
2. **Changes to the NCPDP formats**, which will transition from version NCPDP 5.1 to NCPDP D.0:
   - NCPDP E1 eligibility verification
   - NCPDP B1/B2/B3 electronic claim
3. **Timeline:**
   - 1/1/11 – payers and providers begin “external” testing; CMS accepts both 4010 and 5010
   - 12/31/11 – external testing must be complete
   - 1/1/12 – all electronic claims must use 5010; 4010 no longer accepted
4. **What you should be doing to prepare**
   - Read communications from your vendor and your clearinghouse (software changes, transition timing)
   - Plan your testing with your business scenarios
   - Upgrade well before 12/31/11
5. **Transition from ICD-9 to ICD-10:**
   - Effective October 1, 2013, you must use ICD-10 rather than ICD-9 diagnosis codes on all HIPAA transactions. The electronic claim formats above support ICD-10 codes.
   - Many vendors will use General Equivalence Mappings (GEM)s developed by the CDC to help you translate your data from ICD-9 to ICD-10. Some intervention from your clinical staff may be required, as some ICD-9 codes have no direct ICD-10 translation.
6. **Timeline:**
   - 10/1/13 – claims must use ICD-10 codes for medical diagnoses and inpatient procedures
7. **What you should be doing to prepare**

### References

- CMS’s steps to prepare: [http://www.cms.gov/ICD10/05a_ProviderResources.asp](http://www.cms.gov/ICD10/05a_ProviderResources.asp)
- Summary of changes to the X12 formats: [http://www.ncvhs.hhs.gov/070730p4.pdf](http://www.ncvhs.hhs.gov/070730p4.pdf)
LEAN: Continuous Quality Improvement from the Manufacturing Industry

1) What is Lean
2) What are the Lean principles and rules
3) Measurements and Scoreboards
4) Team huddles and meetings
5) Examples of ways you can apply the Lean principles to your daily operations
## TABLE # 19
### Measuring Infusion Pump Performance

**Peter Elias**  
Director, Equipment Management Services  
MSD, Stoughton, MA  
pelias@msdistributors.com

<table>
<thead>
<tr>
<th>Accuracy Comparison of Multi-Therapy Electronic &amp; Infusion Pumps</th>
<th>CADD PRIZM 6101</th>
<th>GemStar</th>
<th>CURLIN</th>
<th>BodyGuard (323)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accuracy reported</td>
<td>±6%</td>
<td>± 5%</td>
<td>±5%</td>
<td>±5%</td>
</tr>
<tr>
<td>Accuracy reported by room temperature</td>
<td>36-104 °F</td>
<td>41-104 °F</td>
<td>55-90 °F</td>
<td>59-113 °F</td>
</tr>
<tr>
<td>Accuracy reported by infusion rate</td>
<td>NO</td>
<td>±10% 0.1-5 ml/hr</td>
<td>NO</td>
<td>±5% at low flow rates</td>
</tr>
<tr>
<td>Accuracy reported by humidity</td>
<td>10-90%</td>
<td>NO</td>
<td>NO</td>
<td>20-90%</td>
</tr>
<tr>
<td>Accuracy reported by back-pressure</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>Priming volume deducted from bag volume</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
</tr>
</tbody>
</table>

**Factors Affecting Flow Accuracy for Disposable Pumps**

**Disposable Pumps:** Claimed flow accuracy typically within ± 15%; for some pumps can degrade to ± 20% within stated conditions. Outside of these conditions, and accuracy can degrade to ± 40%.

- **Temperature:** significant effect on disposable pump performance due to changes in a drug's viscosity
  - Devices calibrated to skin temp = flow restrictors must be taped to skin
    - Peripheral skin temperature vs. more central sites
  - Devices calibrated to room temp (e.g., fast-flow-rate devices 50-250 mL/hr) = longer flow regulators not taped to skin, are sensitive to changes in ambient temperature.
    - Expect an ↑ or ↓ in flow rate by 2-3% for every 1ºC of temperature change

- **Viscosity** has an inverse effect on flow rate; flow rate will decrease with ↑ in the dynamic viscosity of the fluid. Concentration of a drug in solution can significantly affect viscosity, as can temperature fluctuations.

- **Atmospheric Pressure:** A study found a 35-64% reduction in flow rates under low ambient pressure (600 mmHg) for four disposable pumps (included spring, elastomeric, and negative-pressure pumps). Same study found varieties of pressure at the catheter tip affected flow rate.

- **Back Pressure:** Manufacturers calibrate pumps to operate a specific back pressure- deviate from that, and accuracy is affected. For one elastomeric brand, approx. 0.5% change in accuracy for every 2.54 cm of pump displacement (movement up or down) away from the infusion site.

- **Partial Filling:** causes internal pressure to increase, resulting in faster emptying

- **Storage:** when stored in fridge or freezer and not brought to room temp before use, significantly slowed the infusion rate (10-34%). Previously frozen elastomerics demonstrate reduced infusion rates up to 21%.

**Using Elastomeric Pumps for Chemotherapy:**

Hardy et al³: disposable elastomeric pump was least accurate of 6 pumps tested to deliver 5FU, with accuracy ranging from -5% to 13%.

**KEY TO INFUSION PUMP ACCURACY:** Managing patient and caregiver expectations.

**REFERENCES:**

PN Home Nutrition Support: Review of key considerations and clinical pearls for the safe and effective management of patients requiring nutrition support in the home.

I. Transitioning Nutrition Support Patients from Hospital to Home
   A. Insurance considerations for PN coverage at home
   B. Educational needs—Patient & Caregiver
   C. Choosing a home infusion provider

II. Practical Translation of the Nutrition Prescription in the Home
   A. Hospital orders vs. Homecare orders
   B. PN Cycling
   C. Glucose Infusion Rate

III. Transition of Patients between Nutrition Support Therapies
   A. HNST vigilance & monitoring
   B. RD: Expert diet education (including ORS) for therapy transition
   C. MD & RPh: Medication optimization

IV. Patient Independence and Therapy Compliance
   A. Patient independence and therapy compliance (independence vs. accountability)
   B. Support groups: Therapy specific; disease specific
   C. Ongoing patient and caregiver education
   D. Monitoring
   E. When to make a referral to the IRC?

References
Paying for performance has been a part of the infusion industry almost from its inception. When deciding what to pay a sales person let’s talk about what you may need to consider in order to build your revenues from new and existing accounts.

1. Do we need to pay a commission or will a simple salary work best?
2. What are the issues in paying sales people who do not work for full-time for our company?
3. How can salary or commission be used to generate business from new accounts?
4. Who should be included in a commission plan?
5. When should we pay commissions?
6. Can the money sales people spend on marketing effect their salaries?
7. Contribute a variety of payment and salary plan options for the group to discuss.

* This table will only be available at Wednesday's Roundtable II Session
Medicare Part D provides optional coverage of outpatient drugs, including infusion drugs, to beneficiaries who enroll in prescription drug plans offered by private entities. Part D does not cover drugs for which payment is available under Parts A or B.

Beneficiary Concerns

- Limited Benefits
  - Plan Formularies
  - Gaps in Coverage

- Understanding Out of Pocket Expenses
  - Premiums, Deductibles, & Copays
  - Alternative Sources - Discounts & Coupons, Annual Reductions, and Free Medication
    - Partnership in Drugs toll free number, (888) 477-2669
  - Low Income Subsidy (LIS) – Dual Eligible

- Enrollment Period – Initial and Annual

Provider Concerns

- Turnaround Time – To deliver or not?
- Reimbursement - Inconsistent Payments
- Part B vs. Part D
- Effectively Communicating Cost - Handling Unexpected Expenses
- Contract Hurdles
  - Out of Network/Non-Matching Pharmacy
  - Claim Rejections
  - Responding to Audits

Additional Resources

- [http://www.amcp.org/amcp.ark?p=AA5B4A21](http://www.amcp.org/amcp.ark?p=AA5B4A21)
USP 797 compliant facilities:

Be very familiar with what you have and what USP 797 requires. At the very least, you need:

a. A line of demarcation, beyond which traffic is highly restricted and into which street shoes may not be worn. This leads into the ante room
b. An ante room, which has an appropriate sink and gowning facilities
c. A clean room (Buffer area) which contains a LAFW, has positive pressure created by HEPA filtered air. This room should also have seamless floors, minimal sharp corners, washable walls and ceilings. The pressure may be measured by a pressure meter, or in the case of open design facility by an air flow meter.
d. Direct Compounding area (LAFW)
e. In addition, if you are doing a significant volume of hazardous compounding, you need a separate clean room with negative pressure and Biological safety cabinets, which may need to be vented to the outside.

Additional considerations:

Significant costs are generally incurred with generating sufficient filtered air to create a positive pressure in the clean room (dedicated A/C units).

If finances are not a consideration, or if you are starting fresh, consider modular clean rooms. They are highly effective and mobile, if mobility is desirable.

You may also consider using Compounding Air Isolators (CAIs) for non hazardous compounding and Compounding Air Containment Isolators (CACIs) for hazardous compounding. Generally more cumbersome to use, but they are relatively easy to install and are mobile, if mobility is desirable.

Consider pass through windows for ease of transferring materials from the clean room.

Remember that while the facility needs to be impeccable, many contamination problems arise out of inadequate training rather than the facility itself.
Catheter Securement Strategies for Home Infusion

1. Discuss the most common catheter complications in home infusion:
   a. Occlusion
   b. Infection
      i. Discussion of average home infusion catheter infection rates vs. average hospital catheter infection rates.
   c. Dislodgement

2. Discuss the definition of catheter stabilization. Is a device necessary?
   a. Rationales for catheter securement
      i. Prevent dislodgement
      ii. Prevent pistoning (discuss implications)
      iii. Reduce costs associated with catheter replacement (compare to hospital)
      iv. Reduce needlestick opportunities

3. Importance of catheter securement in home infusion
   a. More or less important than in the hospital?
   b. Does importance differ with catheter or patient type?
      i. Discuss implications of pediatrics, confused patients, etc.

4. Should home care utilize the same stabilization devices as the acute care environment?
   a. Is there value in having a catheter stabilization device included in a dressing change kit?

5. What types of products do you like/use?
   a. Discussion of styles and brands
   b. Discuss reasons for preferences (including these possibilities)
      i. Ease of use – learning curve
      ii. Effectiveness
      iii. Cost (Determine whether anyone is able to secure reimbursement)
**Why process map?**
- Reduce waste
- Reduce overall process time
- Reduce errors
- Reduce paperwork
- Evaluate compliance with existing standard operating procedures
- Flowcharts easier to understand than text
- Simplify writing / revising of policies and procedures

**Likely targets of process mapping:**
- The Critical Path
- Processes that are:
  - Error or Waste Prone
  - Time-Consuming or Delay-Producing
  - High Resource Use
  - Frustrating / Complaint-Generating

**Steps:**
- Macro Flowchart (3 - 5 steps, no decisions)
- Select a step to analyze further
- Create Functional Activity Flowchart (FAF)
- Create Gantt chart if needed
- Ask the Eight Questions (CRAB CAKE)
  - Rationale - why are we doing it?
  - Customer - who benefits from this step?
  - Added Value - what benefit accrues from this step?
  - Best Person - is step done by best person?
  - Compliance - does it diverge from official SOP or other standards?
  - Assets - is the person performing it trained / equipped to perform it?
  - Koincide - could it be done in parallel with another step?
  - Earlier - could it be done earlier?
- Create proposed changes
- Implement and monitor

**Tips**
- Identify all decision points
- Ask workers who actually perform the process
- One-on-ones often helpful

Preferred Candidate Profile from Non-Infusion Practice Settings

- Professional Demeanor
  - Leadership
  - Emotional intelligence (ability to work efficiently in teams)
  - Confidence in decision making
- Communication Skills: Ability to Communicate Professionally at Multiple Levels
  - Prescribers
  - Clinical team members
  - Patients and caregivers
- Heart of a Teacher
  - Team member development
  - Nurse or caregiver education/instruction
  - Patient instruction
- Heart of a Student: Desire to expand clinical skills and knowledge
  - Infectious diseases
  - Pain management
  - Nutrition
  - Oncology
  - Bleeding disorders
  - Immune disorders

Non-Infusion Pharmacy Practice Settings

- Hospital
- Retail
- Specialty
- Long Term Care
- Pharma/Biotech

Retaining Pharmacists

- Educational opportunities/training
  - Organized on-boarding manuals with specific time-bound roadmaps
    - HR/administrative check-list
    - Introduction to Infusion Pharmacy Practice
    - Field trips
    - Clinical training
    - Reimbursement training
    - Routes of administration training
    - Policies and procedures
  - Professional associations
  - Opportunities to attend medical conferences/symposia
- Career advancement opportunities
  - Marketing
  - Management
- Competitive salary/benefits
Who To Hire?

Selection Criteria

1. Goals “If you aim at ____________, you are _____________ _____ _____ _____!”

2. Budget

3. Two Types of Sales Person
   a. __________________________
   b. __________________________

4. Character

5. Competency

6. Chemistry
   Culture - Culture is the chemistry that leads to success!

Where to Focus

1. Evaluate company strengths & weaknesses
2. Evaluate service area and provider list
3. Rapid results accounts
   a. Hospitals
   b. Physician Offices
      • __________________________
      • __________________________
      • __________________________
      • __________________________
   c. Alternative Sources
      • __________________________
      • __________________________
      • __________________________
      • __________________________
The success of any company or organization largely depends on effective teamwork. Teams, not the motivational title we toss around in business, but true blue teams share three characteristics:

1. They struggle for **shared aspirations** – a common goal
2. They have **measurable performance** – Referrals and Referral Sources
3. They have **joint accountability** – sharing successes and failures alike

Effective teamwork accomplishes more, as teams work together faster and will be more productive. Effective teamwork is essential for an organization to realize its high-performance potential. Good team relationships are the catalyst to a productive group with great morale and motivation. Team building activities initiate the process of establishing and developing a greater degree of cooperation and trust between team members.

Interactive exercises, team assessments, and group discussions enable groups to cultivate this greater sense of teamwork. Team building activities are aimed at improving communication and collaboration skills within and between groups of people working together.

High-performing teams can accomplish something much bigger and work more effectively than a group of the same individuals working on their own. With high-performance teams you have a strong synergy of individual contributions.

The 5 elements that lead to team dysfunction¹ and keep your team and organization from reaching its full potential:

4. Absence of Trust
5. Fear of Conflict
6. Lack of Commitment
7. Avoidance of Accountability
8. Inattention to Results

**Group Activities**

- **Lowering the helium stick**: a group is required to use their index fingers to lower the stick to the ground. It is rather tricky as the stick tends to rise rather than go down. It requires team work and strategic planning in order to achieve the goal.
- **Blindfold hunt**: This can be executed as an indoor or outdoor activity. In this activity various objects are scattered around and one participant is blindfolded and his/her partner must guide him/her to the objects, verbally.
- **Story narration**: Each member of a group is given a picture, which is not revealed to the others. As each member’s turn comes they have to unfold the picture and contribute to the creation of a story based on all the pictures held by the members of the group.

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¹ *The Five Dysfunctions of a Team*, by Patrick Lencioni.
Outline for discussion

- Assigning Expiration Dates based on available data
- Site of Care and Logistical Considerations in assigning BUD
- BUD Considerations for Administration Methods and Infusion Device Selection
- External Factors Affecting Stability
- Implications of data extrapolation—What if there is no data?
- Q and A, Discussion

Selected references:


TABLE # 30
Subcutaneous Infusion of Immune Globulin (SCIG) vs. Intravenous Infusion of Immune Globulin (IVIG)—Which Approach is Best for Your Patient?

Amy Clarke, RN
Program Manager, Specialty Infusion
Diplomat Specialty Pharmacy, Flint, MI
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Talking Points/Bullets:

- Brief Immune Globulin Overview
- Goal of therapy for: Immunodeficiency vs. Autoimmune & Neuro
- Factors affecting product selection
- Approved Indications for use
- Off label use... reimbursement concerns
- Product differences
- IVIG Pros and Cons
- SCIG Pros and Cons
- Assessment of patient appropriateness for therapy type
- Clinical & Educational Support
- Collecting supportive data re: efficacy of therapy
- Taking advantage of pharma pipeline and educational tools

Resources:

Immune Deficiency Foundation
http://www.primaryimmune.org/

Jeffrey Modell Foundation
http://www.info4pi.org/

FDA Approved Immune Globulin list
http://www.fda.gov/BiologicsBloodVaccines/BloodBloodProducts/ApprovedProducts/LicensedProductsBLAs/FractionatedPlasmaProducts/ucm127589.htm

Search IgG product name to download Prescribing Information.
TABLE # 31
Surviving Drug Shortages and Recalls

Steve Kennedy, Pharm.D.
National Director of Pharmacy Services
Walgreens Infusion and Respiratory Services
Steve.Kennedy@Walgreens.com

State of the Union:
- "This is getting ridiculous. We are doing our best but drug shortages are killing us." Purchasing Manager
- "This is the worst I have seen it in 25 years of practice." Pharmacy Manager
- "It wouldn't be a Friday without a Recall." Company joke

Drug Shortages are one of ASHP’s top initiatives: There was a Supply Chain Summit November 5th made up of 55 representatives from manufacturers, wholesalers, providers, and the federal government. They agreed it is a system issue that needs long term fix. The group will continue to work in group to further explore, prioritize, and develop a detailed action plan.

Shortages:

a. Resources:
   - U.S Food and Drug Administration Digest Bulletin
   - ASHP Drug Shortage Resources http://www.ashp.org/shortages
   - ASPEN
   - Group Purchasing Organization Website

b. Reasons: Manufacturing problems, raw material issues, discontinued by suppliers, recalls, and unknowns.

c. Allocation process: Always have an active Back-Order. Reach out to all your manufacturer contacts.

d. Actions:
   a. Pre-Plan and have a policy – See ASHP site for example
   b. Operational Assessment: Stock on hand, time to impact, alternate sources/products,
   c. Therapeutic Assessment: Patients affected and therapeutic alternatives
   d. Legal Assessment: Non-contracted suppliers, gray market, International market
   e. Evaluate the information and pull the team together
   f. Establish plan. Consider IT impact, need for temporary changes to policy, and reimbursement.
   g. Communicate the plan to all healthcare members as early as possible

Recalls:
Recalls may be conducted on a firm's own initiative (voluntary), by FDA request, or by FDA order under statutory authority.

a. Notification mechanisms: FDA & ASHP Bulletins, Manufacturers, Distributors, News Media

b. Actions:
   1. Pre-Plan and have a procedure: Components: notification process, action plan based on levels, documentation
   2. Operational Assessment: Pharmacy or Consumer level
   3. Therapeutic Assessment: # of Patients affected, potential harm, and therapeutic alternatives
   4. Time lines
   5. Evaluate the information and pull the team together to establish a plan.
The Data You Need to Appropriately Assess Territory Performance

- Overview of Topic

- Discuss types of employees you manage.

- How do you currently gauge acceptable performance for your employees? Successful performance?

- Review the types of tools your currently use to assess your team's performance.

- Do you assess performance on any or all of the following per employee or team?
  - Therapy type
  - Payer
  - Account
  - Geography
  - Revenue

- What tool(s) is most effective for you? For your team?

- What tools would you like, but don’t currently use?

- How do you communicate your expectations to your team?

- How do you handle underperformers?
Contracts and TRICARE

- Authorized Provider
  - Must have a state license & be accredited by a national organization
  - Medicare-certified providers are considered TRICARE-authorized providers
- Network - Provider agrees to file claims and accepts the TRICARE allowable charge as payment in full
- Non-Network providers - two types:
  - Participating: Agrees to accept the TRICARE allowable charge as payment in full
  - Non-Participating: May charge the beneficiary 15% more than the TRICARE allowable charge
- Note that Tricare for Life is not associated with any contract that you may have with TRICARE North, South or West

TRICARE CLAIMS

- Drugs - NDC/Units Quantity Field
  - Whenever a Miscellaneous "J" code is used your entry of the NDC Quantity is the quantity used for pricing – pricing is based on AWP (meaning the HCPC quantity and the NDC quantity are the same).
  - J code HCPCS Quantities must always be stated in “whole” numbers. NDC quantities can be stated in up to three places to the right of the decimal. When pricing, the NDC Quantity is “rounded” to the nearest "whole" number.
- Drugs - NDC Measurement (Package/Unit Indicator) field
  - The unit of measurement (UOM) for each NDC must be submitted
  - UOM should always be submitted as “Units” (UN, ML, or GR for EDI HIPAA 837 and "U" for paper CMS-1500 claims)
- Supplies/Pump/TPN/Enteral
  - Never use “S” Codes for any supply or drug. S Codes are currently on the government “no pay” list.
  - Bill using A, E, B Codes
- Nursing
  - Nursing is billable using 99601 and 99602
- Ambulatory Infusion Suites (AIS)
  - POS should be 11
  - SS Modifier is required on all claim lines

TRICARE Reimbursement

- TRICARE and TFL process Home Infusion Therapy drugs at AWP-5% (if administered in the AIS the rate is ASP +6%)
  - If your contract states CMAC – 10%, then your drug reimbursement would be AWP -15% (10% + 5%)
  - A, E & B Codes reimburse at Medicare fee schedule. PDAC allows you to search all states
    https://www.dmepdac.com/dmecsapp/do/feesearch. If no fee schedule, then claims will pay at State Prevailing Rate -
  - Nursing reimbursement will vary based on location – pricing can be found at
### TABLE # 34
Understanding Payer Networks

**Jennifer L. Notch**  
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- **Medicare**  
  - Part B  
  - Part C  
    - Commercial  
  - Part D  
    - PBM’s  
- **Medicaid**  
  - Committee’s  
- **Commercial Insurance**  
  - Provider Relation Rep’s  
  - Quarterly Meetings  
- **Networking Tools and Resources**  
  - List Serv’s  
  - LinkedIn  
  - Community Groups
I. Definitions
   a. Social Media
   b. Industrial Media (Traditional)
   c. Hybrid

II. Social Media
   a. Communications
   b. Collaboration
   c. Multimedia
   d. Review and opinions
   e. Entertainment

III. Current Uses and Future Uses

IV. Identify how NHIA can utilize the media to benefit its members