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Financial Assistance Toolkit

Financial Information and Learning Network

Helping Providers Meet Patients' Financial Needs

ACCC
Association of Community Cancer Centers

The Center for Provider Education
ACCC

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Helping Providers Help Their Patients

The cost of having a cancer diagnosis presents many challenges for patients, caregivers, and providers. In ACCC's survey, *2012 Cancer Care Trends in Community Cancer Centers*, 95 percent of respondents reported that they were seeing more patients who needed help with co-pays and/or co-insurance. Accordingly, community cancer centers are spending increased time helping patients identify and access resources to help with costs related to medications, missed work hours, transportation, and more.

So what resources are available to help busy clinicians? First, we can join and participate in a variety of discussion forums, such as **ACCC's MyNetwork Financial Assistance Forum.** This forum offers a venue where we can ask and answer questions about how to gain access to free chemotherapy drugs, or how to care for a homeless individual, or how to help a patient with a student visa or one who is undocumented. One important question that comes up again and again: Which staff member should be helping patients identify needed resources and complete all the necessary paperwork for financial assistance—whether it is Social Security disability or free medication from a patient assistance program? Is it the oncology social worker? The patient navigator? Or a dedicated financial specialist?

Whichever staff member performs these vital services, the reality is that most of their time will be uncompensated. Worse, while payers—both public and private—do not reimburse for the increased time our staff is spending on financial assistance services, our hospitals and oncology practices struggle with balancing a good patient experience with reimbursement reductions and an increasing number of underinsured patients. To put it in simple terms, those of us who work at community cancer centers are being asked to do more with fewer resources.

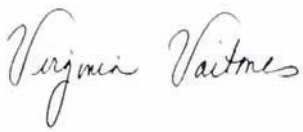
Fortunately, there are organizations we can turn to, including the Association of Community Cancer Centers (ACCC), the leading education and advocacy organization for the multidisciplinary cancer team. With resources like this toolkit—part of ACCC's Financial Information and Learning Network educational project—ACCC is committed to helping us help our patients.

In ACCC's **Financial Assistance Toolkit** you will find everything you need to develop a robust patient financial assistance program, including:

- Worksheets to help assess benefits
- Tools to estimate the costs of chemo care plans
- Sample appeal and collection letters
- Tools to track patient assistance and drug replacement programs
- Policies for pre-authorizations, denials, appeals, and more!

So explore the resources contained within this comprehensive toolkit. Then go online to *www.accc-cancer.org/FILN* and take a look at ACCC's complementary 10-part online course for cancer program staff that offer financial assistance services. Finally, listen to one of ACCC's online video discussions where your peers offer real-world strategies for financial assistance challenges they've encountered at their own programs.

In other words, let ACCC help you help your patients. It's what we do best.



Virginia T. Vaitones, MSW, OSW-C
President-Elect, Association of Community Cancer Centers, March 2012 to March 2013
President, Association of Community Cancer Centers, March 2013 to March 2014

Our Supporters

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ACCC Advisory Committee

We would like to acknowledge and thank the members of the ACCC Advisory Committee, who contributed their valuable time and expertise to this education project.

Thomas M. Beck, MD
St. Luke's Mountain States Tumor Institute
Boise, ID

Faye Flemming, BSN, OCN
Southside Regional Medical Center
Petersburg, VA

Vicky McGrath, MBA, BSN, RN, OCN
Cotton-O'Neil Cancer Center
Topeka, KS

Wendy O'Shaughnessy, MHA
MultiCare Regional Cancer Center
Tacoma, WA

Matt Sherer, MBA, MHA
Tallahassee Memorial Cancer Center
Tallahassee, FL

Judy R. Stone, CMPE
The Stamford Hospital, Carl & Dorothy Bennett Cancer Center
Stamford, CT

Virginia T. Vaitones, MSW, OSW-C
Pen Bay Medical Center
Rockport, ME

Eileen Walker, BSN, MBA
Cancer Care Northwest
Spokane Valley, WA

Benefits Investigation Assessment

Patient Name		
Group Number		
Effective Date		
Insurer		
Insurer Phone #		
Insurer Website		
Deductibles:		
Co-pay Amount (office visits, etc.)		
Co-Insurance		
Out-of-Pocket-Maximum		
Lifetime Maximum		
Authorizations (Y/N):		
	Scans	
		MRI
		CT
		PET
	Chemotherapy	
	Radiation	
		IMRT
		IGRT
Pharmacy Benefits:		
Phone Number for Pharmacy Benefits		
Deductible		
Co-pay		
Yearly Maximum		
Lifetime Maximum		

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Insurance Verification Form

Update ☐ New ☐

Patient Name:_____ ID/SSN #:_____

Patient Insurance ID (if different from above)_____Group Policy #_____

Insurance Company:_____

Primary Insurance?_____ Secondary?_____ Tertiary?_____

Authorization/referral #_____ Name of Contact_____

Date/Time of Auth: _____

Phone/Fax/Address for Auth:_____

Effective Date:_____/_____/_____ PCP:_____ Tel #_____

Prescription Drug Benefit: ☐ Yes ☐ No Deductible_____

Specific Pharmacy Requirement: _____ ☐ Mail order

Co-insurance/Co-pay:_____ Cap for drugs or diagnosis: $_____

Pre-existing?_____ Until when?_____ % worked for eligibility_____

Catastrophic Coverage or Stop-loss_____ When?_____

Medicare? Card Number:_____ Effective:____/____/____

☐ Part A ☐ Part B **Medicare HMO?**_____

Medicare Supplement? ☐ Yes ☐ No Medigap Plan?_____

Does policy cover Deductible? ☐ Yes ☐ No Coinsurance? ☐ Yes ☐ No

Prescription Drugs? ☐ Yes ☐ No

Medicaid? ☐ Yes ☐ No Pending?_____ Spend Down? ☐ Yes ☐ No

Share of Costs?_____ Spend Down Amount $_____

How is cost of drugs affected?_____

Hospice Benefits Enacted? _____

Comments_____

_____

Conclusion: ☐ Patient Has Coverage ☐ Patient Has No Coverage ☐ Research Necessary

Return to TOC

Insurance Verification Policy, page 1 of 2

Policy No:
Approved by:
Effective Date:

I. Policy
To verify that all patients that will be seen at (_____) are covered by insurance prior to the delivery of treatment.

II. Scope
This policy applies to all outpatient sites performing chemotherapy and radiation therapy services.

III. Procedure
Following are detailed procedures to be followed when completing an insurance verification form.

1. The financial specialist is responsible for completing the following sections of the insurance verification form at the time all new patients call for an appointment for medical or radiation oncology. Patient's insurance should be re-verified every six months, or when patients notify the office that their insurance coverage has changed.

- ☑ **Patient Name—**Complete patient's name in full.
- ☑ **Patient Date of Birth—**Enter the patient's birthday.
- ☑ **Date of Appointment—**Enter the date of the patient's appointment.
- ☑ **Date Appointment Scheduled—**Enter the date that the patient called the office for an appointment.
- ☑ **Scheduled by—**Enter the name of the person who scheduled the appointment.
- ☑ **Date—**Enter the date that you called the insurance company to verify patient's insurance.
- ☑ **Insurance Name (Primary)—**Enter the name of the patient's primary insurance company.
- ☑ **Guarantor—**Enter the name of the individual in whose name the insurance is listed.
- ☑ **Relationship—**Enter the relationship of the patient to the guarantor (self, spouse, child).
- ☑ **Policy # —**Enter the policy number, if applicable, for the primary insurance company.
- ☑ **Group # —**Enter the group number, if applicable, for the primary insurance company.
- ☑ **Insurance Name (Secondary)—**Enter the name of the patient's secondary insurance company name.
- ☑ **Guarantor—**Enter the name of the individual in whose name the insurance is listed.
- ☑ **Relationship—**Enter the relationship of the patient to the guarantor (self, spouse, child).
- ☑ **Policy # —**Enter the policy number, if applicable, for the secondary insurance company.
- ☑ **Group # —**Enter the group number, if applicable, for the secondary insurance company.

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Insurance Verification Policy, page 2 of 2

2. Once you have completed the insurance verification form with the sections listed above, contact the primary insurance company and verify coverage for the patient. Complete the following sections:

- ☑ **Phone Number—**Enter the phone number of the insurance company used to verify patient's insurance.
- ☑ **Contact Person—**Enter the name of the person who provided the verification information.
- ☑ **Annual Deductible—**Enter the amount of the annual deductible that the patient is responsible for, check the appropriate box and enter any amount left owed by the patient to the right of the boxes.
- ☑ **Precertification Required—**Check the appropriate box. If precertification is required, please follow the precertification policy.
- ☑ **Referral Required—**Check the appropriate box. If a referral is required, please make sure that the patient is aware that a referral is required. Put a check in the appointment book and/or computer log by the patient's name. When the patient arrives for the appointment, make sure to obtain referral.
- ☑ **Co-payment Required—**Verify that the patient's insurance requires a co-payment, and verify if that co-payment is required for each daily treatment. Enter that amount in the space provided.

3. Once you have verified the primary insurance coverage, contact the secondary insurance company to verify coverage. Complete the following sections:

- ☑ **Phone Number—**Enter the phone number of the insurance company used to verify patient's insurance.
- ☑ **Contact Person—**Enter the name of the person who provided the verification information.
- ☑ **Annual Deductible—**Enter the amount of the annual deductible that the patient is responsible for; check the appropriate box and enter any amount left owed by the patient to the right of the boxes.
- ☑ **Precertification Required—**Check the appropriate box. If precertification is required, please follow the precertification policy.
- ☑ **Referral Required—**Check the appropriate box. If a referral is required, please make sure that the patient is aware that a referral is required. Put a check in the appointment book and/or computer log by the patient's name. When the patient arrives for the appointment, make sure that he or she presents the referral.
- ☑ **Co-payment Required—**Verify that the patient's insurance requires a co-payment, and verify if that co-payment is required for each daily treatment. Enter that amount in the space provided.

4. Once the verification process has been completed, the original copy should be kept in the patient's medical record behind the patient's demographic form.

Under no circumstances should the patient be treated prior to verification of the primary and secondary insurance.

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Request for Outpatient Retail Pharmacy Prior Authorization

Fax to: Clinical Pharmacy Program (800) 583-6289 or

for Medicare HMO Blue and Medicare PPO Blue: (866)463-7700

We plan to respond to your request within two business days of our receipt. To ensure that we can confirm your request (required by NCQA), please be sure to include your fax number.

We cannot process requests unless they contain **all** of the information requested below:		
Patient Information (REQUIRED)		
Name		
BCBSMA ID number		
Is the patient a BCBSMA employee? If yes, please fax request to: **(617) 246-4013**	Yes No	
Date of Birth		
Patient's Diagnosis or ICD-9-CM code		
Physician Information (REQUIRED)		
Name		
Medical Specialty		
BCBSMA Provider number		
Telephone Number		
Fax Number		
Contact Name (if different from physician)		
Please select **one** of the three following sections to complete, depending on the nature of your request for the above-named patient.		
Formulary Exception Request		
Name of non-covered drug you want to prescribe		
Reason for Individual Consideration Request (please check one): ___ Treatment failure with the following covered drugs in class:_____ ___ Documented adverse reaction to the following covered drugs:_____ ___ Other clinical reason (please specify) _____		
Quality Care Dosing Override Request		
Drug name, strength and quantity requested:		
Clinical reason for override (please specify)		
Outpatient Retail Pharmacy Prior Authorization Request		
Drug name:		
Start/End date (must be one year or less):		
Associated Co-morbid diagnosis:		
For Orlistat (Xenical®) only:	Height:	Weight:
For Epogen®/Procrit® only:	GFR:	
	Is patient certified ESRD with Medicare? Yes No	
Prescriber Signature:	Date:	

Return to TOC

Treatment Pre-Authorization Policy

Policy No: **Approved by:**
Effective Date:

I. Policy
All chemotherapy services must be pre-authorized before any services can be performed.

II. Scope
This policy applies to all outpatient sites performing chemotherapy services.

III. Procedure
Following are detailed procedures to be followed when completing an insurance authorization form:

1. Enter the ordering physician's name.
2. Enter the hospital or group name as assigned by the insurance carrier.
3. Enter the patient's insurance carrier name.
4. Enter the insurance carrier fax number.
5. Enter the patient's insurance ID.
6. Enter the patient's date of birth.
7. Enter the patient's name.
8. Enter the patient's Social Security number.
9. Enter the verbiage for the patient's diagnosis.
10. Enter the corresponding ICD-9 code.
11. Complete the CPT codes for lab tests and enter how often they must be done per the physician order.
12. Complete the HCPCS code, drug name, dose, routes, and frequency for all premeds.
13. Complete the HCPCS code, drug names, dosages, routes, and frequency for any and all hydration medications ordered.
14. Enter the HCPCS code, drug name, dosages, routes, and frequency for any and all chemotherapy medications ordered.
15. Enter other information as indicated in the physician orders.
16. Enter HCPCS codes for any and all discharge medications ordered.
17. Enter the treatment start date.
18. Have the ordering physician sign and date the request form.
19. Give the form to the financial specialist.
20. Financial specialist will fax the form to the appropriate insurance carrier.
21. A fax confirmation sheet should be retained for proof request submission.

Allow 24 to 36 hours for a response from the insurance carrier. If you have not received a response within that timeframe, follow-up must be done via phone or fax. Once the authorization has been obtained, the financial specialist will notify the appropriate parties for scheduling purposes.

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Medicare Appeals & Grievances, page 1 of 3

What is an Appeal?
An appeal is the action patients and providers can take if they disagree with a coverage or payment decision made by Medicare or the Medicare plan. Patients and providers have the right to appeal any decision about the patient's Medicare services. An appeal can be made if Medicare or the plan denies:

- A request for a healthcare service, supply, or prescription that the patient or provider thinks the patient should be able to get
- A request for payment for healthcare services or supplies or a prescription drug the patient has already received and was then denied
- A request to change the amount the patient must pay for a prescription drug.

Patients and providers can also appeal if Medicare or the plan stops *providing or paying for all or part of* an item or service the patient or provider thinks the patient still needs. Once the decision is made to file an appeal, the patient and provider should work together to collect any information that may help the case.

Filing an Appeal Under the Original Medicare Program
Get the *Medicare Summary Notice* (MSN) that shows the item or service that is being appealed. Appeals must be filed within 120 days of the date the patient receives the MSN. Appeals can be filed in one of two ways:

1. By following the instructions on the back of the MSN
2. By filling out the *Redetermination Request Form*, and sending it to the Medicare contractor at the address listed on the MSN.

Generally, a decision from the Medicare contractor (either in a letter or a Medicare Summary Notice) will be received within 60 days after they get the request.

Filing an Appeal under a Medicare Health Plan
The steps for filing an appeal can be found in the materials the plan sends the patient each year. Another option is for the patient or provider to call the plan directly.

Filing an Appeal under a Medicare Prescription Drug Plan
Patients and providers have the right to do all of the following—even before they buy a certain drug:

- Get a written explanation (called a "coverage determination") from the Medicare drug plan. A coverage determination is the first decision made by the Medicare drug plan (not the pharmacy) about patient benefits, including whether a certain drug is covered, whether the patient has met the requirements to get a requested drug, how much the patient pays for a drug, and whether to make an exception to a plan rule when the patient or provider requests it.
- Ask for an exception if the patient or provider believes the patient needs a drug that isn't on the plan's formulary.

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Medicare Appeals & Grievances, page 2 of 3

- Ask for an exception if the patient or provider believes that a coverage rule, such as prior authorization, should be waived.
- Ask for an exception if the patient or provider thinks the patient should pay less for a higher tier (more expensive) drug because the patient or provider believes the patient cannot take any of the lower tier (less expensive) drugs for the same condition.

The patient or provider must contact the plan to ask for a coverage determination or an exception. If the network pharmacy cannot fill a prescription, the pharmacist will show the patient or provider a notice that explains how to contact the Medicare drug plan to make the request.

The patient or provider may make a standard request by phone or in writing, if asking for prescription drug benefits not yet received. If asking to get paid back for prescription drugs already bought, the patient or provider must make the standard request in writing.

The patient or provider can call or write the plan for an expedited (fast) request. Requests will be expedited if the patient has not yet received the prescription and the plan determines—or the prescriber tells the plan—that the patient's life or health may be at risk by waiting.

If requesting an exception, the provider must provide a statement explaining the medical reason why the exception should be approved.

What if the Patient Thinks Services are Ending Too Soon?
If patients are getting Medicare services from a hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice, and they think their Medicare-covered services are ending too soon, they have the right to a fast appeal. Providers give patients a written notice before their services end that tells them how to ask for a fast appeal. Patients and providers should work together on this appeal.

Can Someone Help a Patient File an Appeal?
If a patient's provider cannot help, the patient should contact his or her *State Health Insurance Assistance Program (SHIP)* for help filing an appeal.

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Medicare Appeals & Grievances, page 3 of 3

Grievances
A grievance is any complaint or dispute (other than an organization determination) expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare health plan, or its providers, regardless of whether remedial action is requested.

The enrollee must file the grievance either orally or in writing no later than 60 days after the triggering event or incident precipitating the grievance. Listed below are some examples of problems that are typically dealt with through the plan grievance process:

- Problems getting an appointment, or having to wait a long time for an appointment
- Disrespectful or rude behavior by doctors, nurses, or other plan clinic or hospital staff.

Each plan must provide meaningful procedures for timely hearing and resolving both standard and expedited grievances between enrollees and the Medicare health plan or any other entity or individual through which the Medicare health plan provides healthcare services. The Medicare health plan must include in its grievance procedures:

- The ability to accept any information or evidence concerning the grievance orally or in writing not later than 60 days after the event; and
- The requirement to respond within 24 hours to an enrollee's expedited grievance whenever:
  1. A Medicare health plan extends the time frame to make an organization determination or reconsideration; or
  2. A Medicare health plan refuses to grant a request for an expedited organization determination or reconsideration.

Plans must notify all concerned parties upon completion of the investigation as expeditiously as the enrollee's case requires based on the enrollee's health status, but not later than 30 days after the grievance is received.

For more information about the grievance process, see section 20.3 in Chapter 13 of the Medicare Managed Care Manual. A copy of the model notice that plans may use to notify enrollees about their right to an expedited grievance is located in Appendix 5. Click on the **Downloads** section to access Chapter 13.

Grievances about Part D prescription drugs are not processed using these procedures. For information on how to file a grievance about prescription drugs, click on the link to Chapter 18 of the Prescription Drug Benefit Manual under the **Downloads** section.

Quality of care grievances (complaints about the quality of care received in hospital or other provider settings) may be reported through the plan's grievance procedures, the enrollee's Quality Improvement Organization (QIO), or both.

For more information about filing a grievance with the QIO, click on Medicare publication 10112, "Your Medicare Rights and Protection" under the **Downloads** section.

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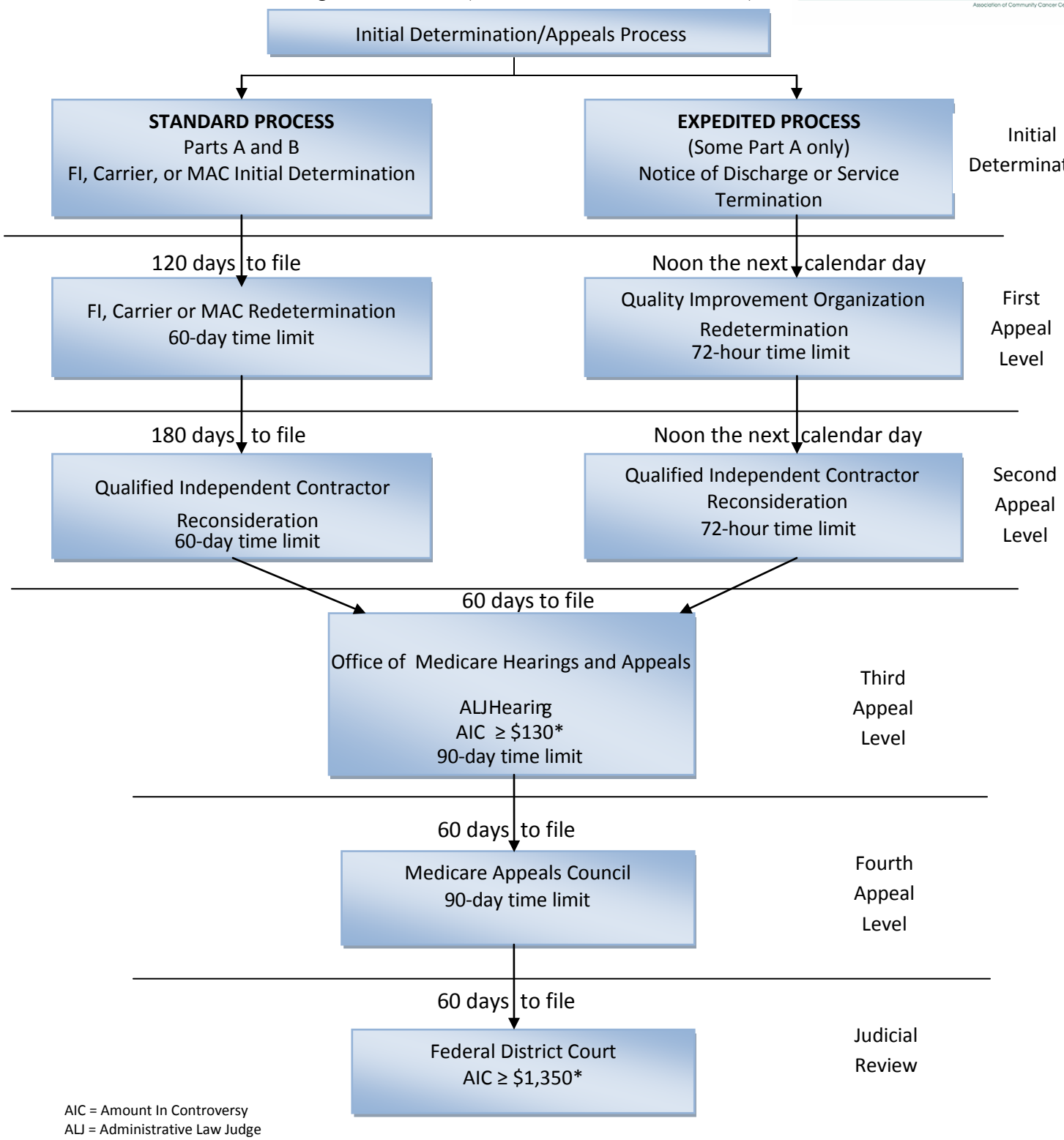
Original Medicare (Parts A & B - Fee-for Service)



AIC = Amount In Controversy
ALJ = Administrative Law Judge
FI = Fiscal Intermediary
MAC = Medicare Administrative Contractor
*The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year (CY) 2012.

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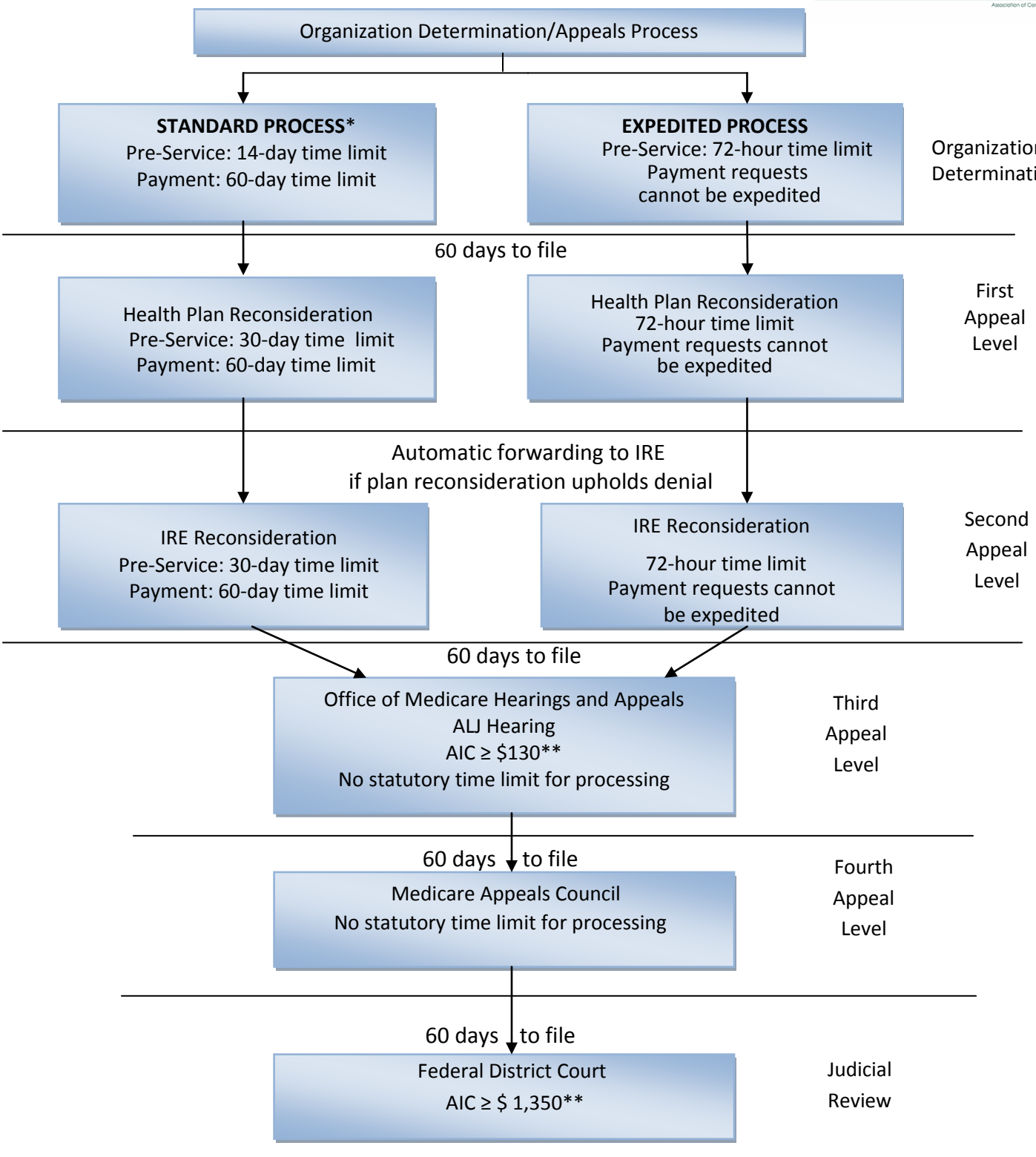
Medicare Managed Care (Part C - Medicare Advantage)



AIC = Amount In Controversy / ALJ = Administrative Law Judge / IRE = Independent Review Entity
*Plans must process 95% of all clean claims from out of network providers within 30 days. All other claims must be processed within 60 days.
**The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year (CY) 2012.

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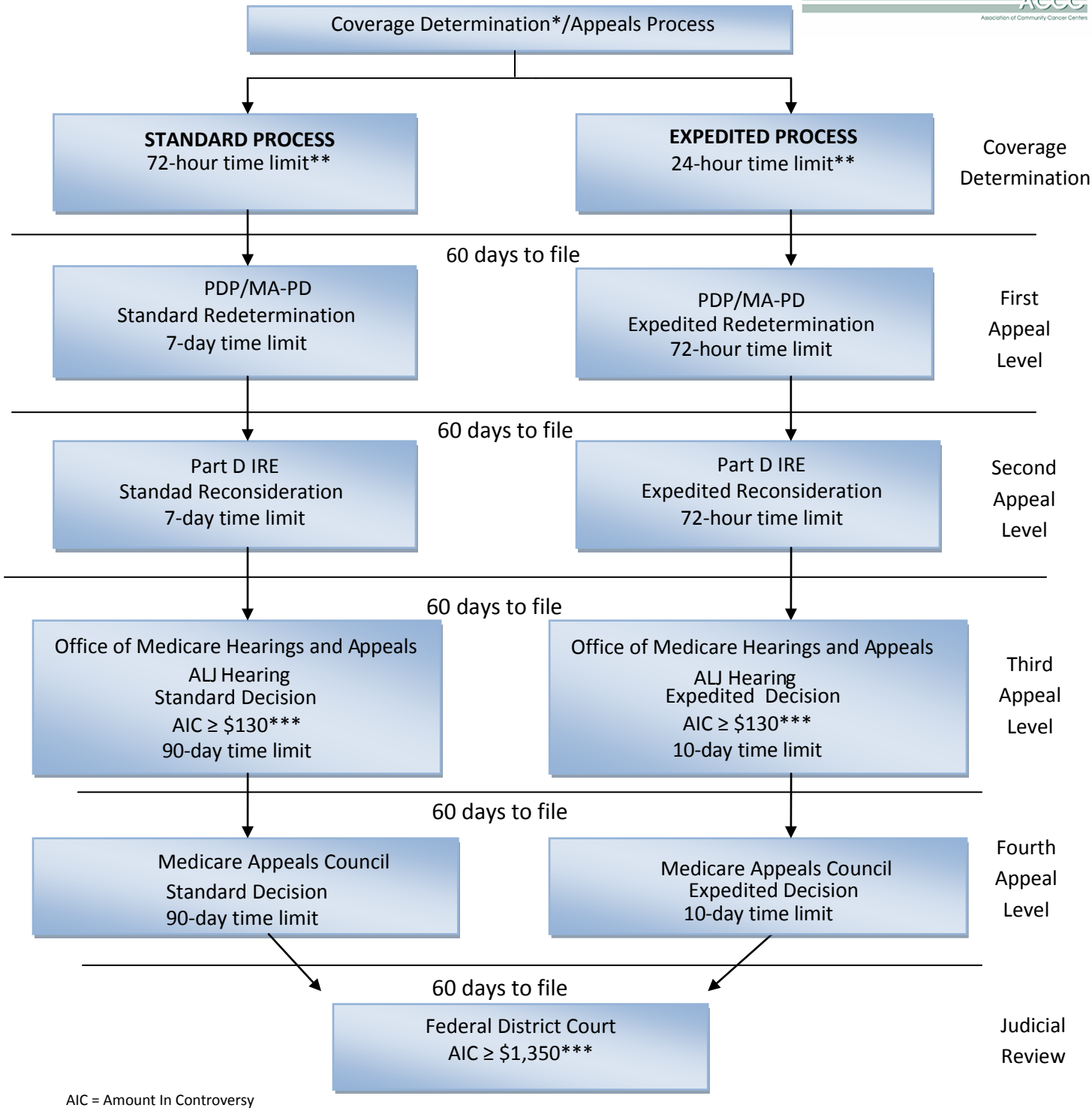
Medicare Prescription Drug (Part D)



AIC = Amount In Controversy
ALJ = Administrative Law Judge
IRE = Independent Review Entity
MA-PD = Medicare Advantage plan that offers Part D benefits
PDP = Prescription Drug Plan
*A request for a coverage determination includes a request for a tiering exception or a formulary exception. A request for a coverage determination may be filed by the enrollee, by the enrollee's appointed representative or by the enrollee's physician or other prescriber.
**The adjudication timeframes generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication timeframe begins when the plan sponsor receives the physician's supporting statement.
***The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year (CY) 2012.

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Medicare FAQs

What is Medicare?
Medicare is health insurance for the following:

- People 65 or older
- People under 65 with certain disabilities
- People of any age with end-stage renal disease (ESRD: permanent kidney failure requiring dialysis or a kidney transplant)

The different parts of Medicare help cover specific services.

Medicare Part A (Hospital Insurance)

- Helps cover inpatient care in hospitals
- Helps cover skilled nursing facility, hospice, and home health care

Medicare Part B (Medical Insurance)

- Helps cover doctors' and other healthcare providers' services, outpatient care, durable medical equipment, and home health care
- Helps cover some preventive services to help patients maintain their health and to keep certain illnesses from getting worse

Medicare Part C (also known as Medicare Advantage)

- Offers health plan options run by Medicare-approved private insurance companies
- Medicare Advantage Plans are a way to get the benefits and services covered under Part A and Part B
- Most Medicare Advantage Plans cover Medicare prescription drug coverage (Part D)
- Some Medicare Advantage Plans may include extra benefits for an extra cost

Medicare Part D (Prescription Drug Coverage)

- Helps cover the cost of prescription drugs
- May help lower prescription drug costs for patients and help protect against higher costs in the future
- Run by Medicare-approved private insurance companies

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[redacted]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO 0938-0008

PATIENT'S REQUEST FOR MEDICAL PAYMENT

IMPORTANT – SEE OTHER SIDE FOR INSTRUCTIONS

PLEASE TYPE OR PRINT INFORMATION — MEDICAL INSURANCE BENEFITS SOCIAL SECURITY ACT

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law. No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

SEND COMPLETED FORM TO:

Your Medicare Carrier
If you need help, call 1-800-MEDICARE
(1-800-633-4227)

1 Name of Beneficiary from Health Insurance Card
(Last) (First) (Middle)

2 Claim Number from Health Insurance Card

Patient's Sex
☐ Male
☐ Female

3 Patient's Mailing Address (City, State, Zip Code)
Check here if this is a new address ☐
(Street or P.O. Box – Include Apartment Number)
(City) (State) (Zip)

3b Telephone Number
(Include Area Code)
(___ ___ ___)
___ ___ ___ – ___ ___ ___ ___

4 Describe the illness or injury for which patient received treatment

4b Condition was related to:
A. Patient's employment
☐ Yes ☐ No
B. Accident
☐ Auto ☐ Other

4c Was patient being treated with chronic dialysis or kidney transplant?
☐ Yes ☐ No

5
a. Are you employed and covered under an employee health plan? ☐ Yes ☐ No
b. Is your spouse employed and are you covered under your spouse's employee health plan? ☐ Yes ☐ No
c. If you have any medical coverage other than Medicare, such as private insurance, employment related insurance, State Agency (Medicaid), or the VA, complete:
Name and Address of other insurance, State Agency (Medicaid), or VA office

Policyholder's Name:

Policy or Medical Assistance No.

Note: If you DO NOT want payment information on this claim released, put an (X) here ☐

6 I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND CENTERS FOR MEDICARE & MEDICAID SERVICES OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO ME.

Signature of Patient (If patient is unable to sign, see Block 6 on reverse)

6b Date signed

IMPORTANT
ATTACH ITEMIZED BILLS FROM YOUR DOCTOR(S) OR SUPPLIER(S) TO THE BACK OF THIS FORM

Form CMS-1490S (SC) (01/05) EF 02/2005

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HOW TO FILL OUT THIS MEDICARE FORM

Medicare will pay you directly when you complete this form and attach an itemized bill from your doctor or supplier. Your bill does not have to be paid before you submit this claim for payment, but you MUST attach an itemized bill in order for Medicare to process this claim. Mail your completed claim form to the Medicare Carrier responsible for processing your claim. If you do not know the address of your carrier, call 1-800-MEDICARE (1-800-633-4227).

FOLLOW THESE INSTRUCTIONS CAREFULLY:

A. Completion of this form.

Block 1. Print your name shown on your Medicare Card (Last Name, First Name, Middle Name).

Block 2. Print your Health Insurance Claim Number including the letter at the end **exactly** as it is shown on your Medicare card. Check the appropriate box for the patient's sex.

Block 3. Furnish your mailing address and include your telephone number in Block 3b.

Block 4. Describe the illness or injury for which you received treatment. Check the appropriate box in Blocks 4b and 4c.

Block 5a. Complete this Block if you are age 65 or older and enrolled in a health insurance plan where you are currently working.

Block 5b. Complete this Block if you are age 65 or older and enrolled in a health insurance plan where your spouse is currently working.

Block 5c. Complete this Block if you have any medical coverage other than Medicare. Be sure to provide the Policy or Medical Assistance Number. You may check the box provided if you do not wish payment information from this claim released to your other insurer.

Block 6. Be sure to sign your name. If you cannot write your name, make an (X) mark. Then have a witness sign his or her name and address in **Block 6** too.

If you are completing this form for another Medicare patient you should write (By) and sign your name and address in **Block 6.** You also should show your relationship to the patient and briefly explain why the patient cannot sign.

Block 6b. Print the date you completed this form.

B. Each itemized bill MUST show all of the following information:

- Date of each service
- Place of each service

Doctor's Office	Independent Laboratory	Outpatient Hospital
Nursing Home	Patient's Home	Inpatient Hospital

- Description of each surgical or medical service or supply furnished.
- Charge for EACH service.
- Doctor's or supplier's name and address. Many times a bill will show the names of several doctors or suppliers. IT IS VERY IMPORTANT THE ONE WHO TREATED YOU BE IDENTIFIED. Simply circle his/her name on the bill.
- It is helpful if the diagnosis is also shown on the physician's bill. If not, be sure you have completed **Block 4** of this form.
- Mark out any services on the bill(s) you are attaching for which you have already filed a Medicare claim.
- If the patient is deceased, please contact your Social Security office for instructions on how to file a claim.
- Attach an Explanation of Medicare Benefits notice from the other insurer if you are also requesting Medicare payment.

DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

COLLECTION AND USE OF MEDICARE INFORMATION

We are authorized by the Centers for Medicare & Medicaid Services to ask you for information needed in the administration of the Medicare program. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act, as amended.

The information we obtain to complete your Medicare claim is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations as necessary to administer the Medicare program. For example, it may be necessary to disclose information to a hospital or doctor about the Medicare benefits you have used.

With one exception, which is discussed below, there are no penalties under Social Security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of the claim. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether worker's compensation will pay for the treatment. Section 1877(a)(3) of the Social Security Act provides criminal penalties for withholding this information.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 16 minutes per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Overview of the Medicaid Program, page 1 of 3

Medicaid and CHIP provide health coverage to nearly 60 million Americans, including children, pregnant women, parents, seniors, and individuals with disabilities. In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives them the flexibility to cover other population groups (optional eligibility groups). States set individual eligibility criteria within federal minimum standards. States can apply to CMS for a waiver of federal law to expand health coverage beyond these groups.

Many states have expanded coverage, particularly for children, above the federal minimums. For many eligibility groups, income is calculated in relation to a percentage of the Federal Poverty Level (FPL). For example, 100% of the FPL for a family of four was $22,350 in 2011. The Federal Poverty Level is updated annually. For other groups, income standards are based on income or other non-financial criteria standards for other programs, such as the Supplemental Security Income (SSI) program.

Affordable Care Act of 2010 Expands Medicaid Eligibility in 2014
The Affordable Care Act of 2010 creates a national Medicaid minimum eligibility level of 133% of the FPL ($29,700 for a family of four in 2011) for nearly all Americans under age 65. This Medicaid eligibility expansion goes into effect on January 1, 2014, but states can choose to expand coverage with Federal support anytime before this date, and some states have already done so.

Other Eligibility Criteria
There are other non-financial eligibility criteria that are used in determining Medicaid eligibility. In order to be eligible for Medicaid, individuals need to satisfy federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship.

Retroactive Eligibility
Medicaid coverage may start retroactively for up to three months prior to the month of application, if the individual would have been eligible during the retroactive period had he or she applied then. Coverage generally stops at the end of the month in which a person no longer meets the requirements for eligibility.

Waivers
States can apply to the Centers for Medicare & Medicaid Services (CMS) for waivers to provide Medicaid to populations beyond what traditionally can be covered under the state plan. Some states have additional "state-only" programs to provide medical assistance for certain low-income people who do not qualify for Medicaid. No federal funds are provided for state-only programs.

Benefits
States establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services within broad federal guidelines. States are required to cover certain "mandatory benefits," and can choose to provide other "optional benefits" through the Medicaid program. Here is a partial list of these benefits.

Mandatory Benefits
- Inpatient hospital services
- Outpatient hospital services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services
- Nursing facility services

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Overview of the Medicaid Program, page 2 of 3

- Home health services
- Physician services
- Rural health clinic services
- Federally-qualified health center services
- Laboratory and X-ray services
- Nurse Midwife services
- Transportation to medical care
- Tobacco cessation counseling for pregnant women.

Optional Benefits

- Prescription drugs
- Clinic services
- Physical therapy
- Occupational therapy
- Speech, hearing, and language disorder services
- Respiratory care services
- Other diagnostic, screening, preventive, and rehabilitative services
- Other practitioner services
- Private duty nursing services
- Personal Care
- Hospice.

Premiums, Co-Payments & Other Cost-Sharing

States have the option to charge premiums and to establish out-of-pocket spending (cost sharing) requirements for Medicaid enrollees. Out-of-pocket costs may include copayments, coinsurance, deductibles, and other similar charges. Maximum out-of-pocket costs are limited, but states can impose higher charges for targeted groups of somewhat higher income people. Certain vulnerable groups, such as children and pregnant women, are exempt from most out-of-pocket costs, and copayments and coinsurance cannot be charged for certain services.

States can charge limited premiums and enrollment fees on the following groups of Medicaid enrollees:

- Pregnant women and infants with family income at or above 150% FPL
- Qualified disabled and working individuals with income above 150% FPL
- Disabled working individuals eligible under the Ticket to Work and Work Incentives Improvement Act of 1999
- Disabled children eligible under the Family Opportunity Act
- Medically needy individuals.

States have the option to impose higher, alternative premiums on other groups of enrollees, if their family incomes exceed 150% of the FPL. Certain groups, such as institutionalized individuals and most children, are excluded from higher cost-sharing.

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Overview of the Medicaid Program, page 3 of 3

Prescription Drugs
Medicaid rules give states the ability to use out-of-pocket charges to promote the most cost-effective use of prescription drugs. To encourage the use of lower-cost drugs, states may establish different copayments for generic versus brand-name drugs or for drugs included on a preferred drug list. For people with incomes above 150% FPL, co-payments for non-preferred drugs may be as high as 20 percent of the cost of the drug. For people with income at or below 150% FPL, copayments are limited to nominal amounts. States must specify which drugs are considered either "preferred" or "non-preferred." States also have the option to establish different copayments for mail order drugs and for drugs sold in a pharmacy.

Glossary
Spousal Impoverishment. Protects the spouse still living in the community from becoming impoverished when the other spouse enters a nursing facility or other medical institution and is expected to remain there for at least 30 days.

Treatment of Trusts. When an individual, their spouse, or anyone acting on the individual's behalf establishes a trust using at least some of the individual's funds, that trust can be considered available to the individual for purposes of determining eligibility for Medicaid.

Transfers of Assets for Less Than Fair Market Value. This practice is prohibited for purposes of establishing Medicaid eligibility. Applies when assets are transferred, sold, or gifted for less than they are worth by individuals in long-term care facilities or receiving home and community-based waiver services, by their spouses, or by someone else acting on their behalf.

Estate Recovery. State Medicaid programs must recover from a Medicaid enrollee's estate the cost of certain benefits paid on behalf of the enrollee, including nursing facility services, home and community-based services, and related hospital and prescription drug services. State Medicaid programs may recover for other Medicaid benefits, except for Medicare cost-sharing benefits paid on behalf of Medicare Savings Program beneficiaries.

Third-Party Liability. TPL refers to third parties who have a legal obligation to pay for part or all of the cost of medical services provided to a Medicaid beneficiary. Examples are other programs such as Medicare, or other health insurance the individual may have that covers at least some of the cost of the medical service. If a third party has such an obligation, Medicaid will only pay for that portion.

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Overview of the Medicare Program

What is Medicare?
Medicare is health insurance. Generally, patients are eligible for Medicare if they are:

- Citizens of the United States
- Aged 65 or older
- People who have worked or whose spouse has worked for at least 10 years in Medicare covered employment
- Younger than age 65 with certain disabilities
- People of any age with end-stage renal disease (ESRD: permanent kidney failure requiring dialysis or a kidney transplant)

Apply for retirement benefits online at: ***www.socialsecurity.gov/retireonline/.*** Apply for disability benefits online at: ***www.socialsecurity.gov/disabilityonline/*.**

The different parts of Medicare help cover specific services.

Medicare Part A (Hospital Insurance)

- Helps cover inpatient care in hospitals
- Helps cover skilled nursing facility, hospice, and home health care

Medicare Part B (Medical Insurance)

- Helps cover doctors' and other healthcare providers' services, outpatient care, durable medical equipment, and home health care
- Helps cover some preventive services to help patients maintain their health and to keep certain illnesses from getting worse

Medicare Part C (also known as Medicare Advantage)

- Offers health plan options run by Medicare-approved private insurance companies
- Medicare Advantage Plans are a way to get the benefits and services covered under Part A and Part B
- Most Medicare Advantage Plans cover Medicare prescription drug coverage (Part D)
- Some Medicare Advantage Plans may include extra benefits for an extra cost

Medicare Part D (Prescription Drug Coverage)

- Helps cover the cost of prescription drugs
- May help lower prescription drug costs for patients and help protect against higher costs in the future
- Run by Medicare-approved private insurance companies

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Overview of the Medicare Coverage Gap, page 1 of 2

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means there's a temporary limit on what the drug plan will cover for drugs. Not everyone will enter the coverage gap. The coverage gap begins after patients and drug plans have spent a certain amount for covered drugs. Also, people with Medicare who get *Extra Help* (see "Ways to Lower Patient Costs in the Coverage Gap" below) paying Part D costs will not enter the coverage gap.

Once patients enter the coverage gap, they receive a 50% manufacturer-paid discount on covered brand-name drugs. Although patients only pay 50% of the price for that brand-name drug, the entire price will count as out-of-pocket spending, which will help patients get out of the coverage gap.

Example: Mrs. Anderson reaches the coverage gap. She goes to her pharmacy to fill a prescription for a covered brand-name drug. The price for the drug is $60 and the dispensing fee is $2. Once the 50% discount is applied, the cost of the drug is $30. The $2 dispensing fee is added to the $30 discounted amount. Mrs. Anderson will pay $32 for the prescription, but the entire $62 will be counted as out-of-pocket spending and will help Mrs. Anderson get out of the coverage gap.

If patients have a Medicare drug plan that already includes coverage in the gap, they may get a discount after the plan's coverage has been applied to the price of the drug. The 50% discount for brand-name drugs will apply to the remaining amount that the patient owes.

Example: Mr. Jones reaches the coverage gap in his Medicare drug plan. He goes to his pharmacy to fill a prescription for a covered generic drug. The price for the drug is $20 and there is a $2 dispensing fee that gets added to the cost. Once the 14% coverage is applied to the $22, he will pay $18.92 for the covered generic drug. The $18.92 amount he pays will be counted as out-of-pocket spending to help him get out of the coverage gap

If patients have a Medicare drug plan that already includes coverage in the gap, they may get a discount after their plan's coverage has been applied to the price of the drug. The 50% discount for brand-name drugs will apply to the remaining amount that they owe.

Example: Patients are in a drug plan that offers a 60% discount on brand-name drugs (after they have spent a certain amount) and they fill a $100 brand-name prescription. The cost of their prescription after their plan's savings is $40. The 50% discount would get applied to the $40 amount and they would pay $20 for the prescription. The $40 will count as out-of-pocket spending and help them get out of the coverage gap.

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Overview of the Medicare Coverage Gap, page 2 of 2

Items That Count Towards the Coverage Gap

- The patient's yearly deductible, coinsurance, and copayments
- The discount patients get on brand-name drugs in the coverage gap
- The amount that patients pay in the coverage gap.

Items That DON'T Count Towards the Coverage Gap

- The drug plan premium
- The amount that patients pay for drugs that are not covered.

If Patients Think They Should Get a Discount

If patients think they've reached the coverage gap and they do not get a discount when they pay for their brand-name prescription, they should review their next Explanation of Benefits (EOB) notice. If the discount does not appear on the EOB, patients should contact their drug plan to make sure that their prescription records are correct and up-to-date. If their drug plan does not agree that patients are owed a discount, they can file an appeal.

Ways to Lower Patient Costs in the Coverage Gap

1. *Consider Switching to Generics or Other Lower-Cost Drugs:* Patients can talk to their provider to find out if there are generic or less-expensive brand-name drugs that would work just as well as the ones they're taking now. Patients might also be able to save money by using mail-order pharmacies.
2. *Pharmaceutical Assistance Programs*: Some pharmaceutical companies offer help for people enrolled in Medicare Part D. Find out whether there's a Patient Assistance Program for the drugs the patients are taking.
3. *State Pharmaceutical Assistance Programs:* Many states and the U.S. Virgin Islands offer help paying drug plan premiums and/or other drug costs.
4. *Apply for Extra Help:*Medicare and Social Security have a program for people with limited income and resources that help patients pay for their prescription drugs. If they qualify, patients could pay between $1 to $6 for each drug. Apply online with Social Security or by calling: 1.800.772.1213. TTY users should call: 1.800.325.0778.
5. *Explore National and Community-Based Charitable Programs:* National and local charitable groups (like the National Patient Advocate Foundation or the National Organization for Rare Disorders) may have programs that can help with your drug costs.

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Special Medicare Rules or Limits on Drug Use

Plans may have special rules or may set limits on how you can get your drugs. These rules encourage you to use drugs that cost the least. Three of the most common controls are:

Prior Authorization
Your Medicare Prescription Drug Plan **may have to approve** some drugs before your doctor writes the prescription. Otherwise, the plan will not pay for it. Your doctor's office will help you do this.

The Medicare Prescription Drug Plan does this to make sure:

- The drug is a standard medical treatment for your condition
- Your doctor has considered other drugs that treat your condition effectively at a lower cost.

Quantity Limits
The plan **may let you have only a certain amount** of the drug each month. This is called a quantity limit. For example, the normal dose for a certain drug is one pill a day, or 30 pills a month. Some people might need two pills per day, or 60 pills per month. The plan may limit the quantity for the month to 30 pills. Then the plan would only pay for 30 pills. If you need more than the plan allows, you and your doctor would need to ask the plan for an exception. You would have to tell the plan why the lower amount doesn't work for you. (For more information, see Exceptions to the Limits)

Step Therapy
These are instructions that say what drugs to use for a condition. They start with the simplest (and usually cheapest) drug to treat the problem or condition. If that drug doesn't work, then you go to the next level and try that one. If that doesn't work, you try the next level.
Some drug plans that use step therapy may ask you to start with an over-the-counter (OTC) medication—a drug you can buy without a prescription. If you have to use an over-the-counter drug first, the plan has to give you the over-the-counter drug for free. The plan cannot charge you for it.

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Co-pay Assistance Checklist, page 1 of 2

PERMISSION: Remember to get written permission to release information including diagnosis, medication/treatment status, household size, financial status, and veteran status from your patient before you contact the co-pay foundation.

☐ I have obtained written permission from the patient.

INSURANCE VERIFICATION: Remember to have insurance cards or other verification of insurance status. Co-pay assistance is intended for patients who have insurance for the medication but struggle to pay the co-pay.

☐ I have verified the patient's insurance status.
☐ I have verified that the patient's identification number and all other information are entered correctly.
☐ I have verified that the patient's name and address match the payer's records.

DIAGNOSIS CODES: Co-pay assistance funds typically use disease or diagnosis as one of the eligibility criteria. Most co-pay programs are looking for the diagnosis code (ICD-9 Code) and name of the primary cancer diagnosis. Other programs are for medications for symptoms (i.e., neutropenia, pain, iron overload) and are looking for the ICD-9 code for the symptom. Having the treatment plan summary with all ICD-9 codes is helpful. Although call center staff for the co-pay assistance programs typically can't tell you what code to use, they will confirm if a code you name is part of the eligibility criteria.

☐ I have used the most appropriate ICD-9-CM diagnosis and CPT procedure codes associated with the patient's diagnosis and care.
☐ I have used the most appropriate CPT and/or HCPCS modifiers where and when appropriate.
☐ I have ensured that the medical record contains appropriate documentation to support the diagnosis and procedure codes submitted on the claim.

BILLING: When billing for drugs, the following information should be provided on the claim form if required by the payer:

☐ I have verified the drug, HCPCS code, and 11-digit NDC number.
☐ I have verified the frequency of administration.
☐ I have verified the route of administration.
☐ I have verified the number of units administered.

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Co-pay Assistance Checklist, page 2 of 2

PRESCRIPTION DRUG COVERAGE: Clarification of type of prescription drug coverage. Some co-pay assistance programs can help patients with Medicare Part D co-pays, while other programs are intended only for patients with commercial insurance.

- ☐ I have contacted the following co-pay assistance program: _____
- ☐ Yes: Patient is eligible for co-pay assistance.
- ☐ No: Patient is not eligible for co-pay assistance.

- ☐ I have contacted the following co-pay assistance program: _____
- ☐ Yes: Patient is eligible for co-pay assistance.
- ☐ No: Patient is not eligible for co-pay assistance.

PROOF OF INCOME: Household tax return(s), SSA 1099, or other proof of income. Co-pay assistance programs typically are based on financial eligibility. Some programs specify the maximum allowable household income (typically 200-500% of federal poverty level), while other programs do not disclose the allowed income. Programs vary on the accepted proof of income. Ask their helpline if in doubt. Examples of proof of income include:

- ☐ I have obtained a copy of the patient's most recent W2 or Federal tax return.
- ☐ I have obtained copies of the patient's checking account statements for the last _____ months.
- ☐ I have obtained copies of the patient's pay stubs for the last _____ months.
- ☐ I have obtained a notarized letter from the patient's family stating that the patient has zero income with an explanation of how the patient is supported.
- ☐ I have provided a signed zero income letter from the provider, including an explanation of how the patient is supported.

MEDICATION LIST: In addition to a list of the patient's medications, some co-pay assistance programs also require that the patient need assistance with a co-pay for a specific drug.

- ☐ I have provided a list of the patient's medications.

PHYSICIAN INFORMATION: Co-pay programs will require the prescribing physician's information including DEA number, NPI number, and license number. Also have the physician's contact information handy.

- ☐ I have verified that the provider's NPI number is included on all information, including the claim.
- ☐ I have verified that the provider's DEA number is included on all information, including the claim.
- ☐ I have verified that the provider's license number is included on all information, including the claim.
- ☐ I have included the provider's contact information.

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Common Questions about Drug Discount Cards, page 1 of 2

Q. What are drug discount cards?

A. Drug discount cards offer discounts on various medical services, including medicine. They are not a form of insurance. Some are free while others may involve a hefty fee. Drug discount cards are offered by state governments, drug companies, and non-profit and for-profit businesses.

Q. How do I pick a drug discount card?

A. Carefully evaluate any and all costs involved, such as handling or shipping fees. The fee may add up to more than the discount. When using a free card, it is still important to consider the cost of your medicine. You should always do comparative shopping. Speak with a representative of the plan about concerns and to check if your medicine is included. If you have several plans or cards, your local pharmacist will usually tell you the least expensive way to get your medicine.

Q. Do some stores have pharmacy discount cards?

A. Yes, many larger chains offer medicine discounts to their customers. Wal-Mart, Sam's Club, and others, for example, offer some generic prescriptions for $4. These programs do not usually include all generics. Again, the pharmacist should be able to help you pick the least expensive way to buy your medicine.

Q. How much do drug discount cards cost?

A. While some cards are free, others have annual fees that range from $12 to as high as $100. Some companies that advertise free medicine have a "processing fee" for each prescription.

Q. How much will I save if I use one of these cards?

A. The discounts offered vary widely depending on the program, the drugstore, and the prescription medicine being purchased.

Q. Will the discount card always give me the lowest price?

A. You may pay more for some brand-name medicines, even with a discount, than you would pay for the generic version or you may find the medicine for a lower cost at a different pharmacy.

Source: *www.needymeds.org*

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Common Questions about Drug Discount Cards, page 2 of 2

Q. Will all my medicines be discounted?

A. Not necessarily. This is a consideration if you are paying a fee. Contact the program to see what medicines are available before making a payment.

Q. What precautions should I take when choosing a drug discount card?

A. Ask the following questions about the discount card:
1. Is there a contact or customer service number that I can call in case of problems?
2. What is the refund policy on fees?
3. If I am being asked to send money, am I certain my medicine is available at a discount?
4. Is the medicine I need available at no or low-cost through a patient assistance program? (Usually, this option would be better.)
5. Are my drugs provided through a mail-order or a walk-in pharmacy? If it's a walk-in pharmacy, is there one close to me? If it is a mail-order pharmacy, are there additional handling and shipping costs?

Source: *www.needymeds.org*

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Financial Assessment Form for Insured Patients, page 1 of 2

Name: _____ MR#/Account#_____

Date: _____PT. phone_____Diagnosis_____

MD: _____DOS_____TREATMENT START DATE _____

PATIENT NEEDS HELP WITH:

- ☐ Health insurance
- ☐ No/Inadequate prescription coverage
- ☐ Transportation
- ☐ Assistance at home
- ☐ Social Service referral
- ☐ Referral to PFS (Patient Financial Services)
- ☐ Applied for assistance via PFS or other program
- ☐ Housing/Utility/Food/Daily expenses

PATIENT IS:

- ☐ Unable to continue working/loss of income
- ☐ Unemployed
- ☐ Collecting disability through work
- ☐ Need to apply for disability
- ☐ Patient receiving Social Security benefits
- ☐ Patient with GAP in Coverage
- ☐ Patient receiving unemployment benefits

INSURANCE VERIFICATION

Primary Insurance Provider

- ☐ Ins. Provider:_____
- ☐ Deductible YTD:$_____PD YTD$_____
- ☐ OOP Max YTD:$_____PD YTD$_____
- ☐ Co-Insurance:$_____Co-Ins met YTD$_____
- ☐ Policy #_____
- ☐ Co-pay:$_____
- ☐ Effective date of Ins. plan:_____
- ☐ Co-Ins balance YTD$_____

COMMENTS:_____
_____

Secondary Insurance Provider

- ☐ Ins. Provider_____
- ☐ Deductible:$_____PD YTD$_____
- ☐ Co-Insurance:$_____
- ☐ Policy #:_____
- ☐ Co-Pay:$_____
- ☐ OOP $_____MET$_____BAL.$_____

UNINSURED PATIENT

Has patient been interviewed by PFS or other program?
Results:_____
Is patient eligible for uninsured discount 25% with additional 15% with prompt pay, total 40%_____

☐ **EXPLAINED SPLIT BILL/SPG**

PATIENT RESPONSIBILITY $_____

NOTES:

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Financial Assessment Form for Insured Patients, page 2 of 2

Estimate payment plan established with Billing and SPG

Billing_____

SPG_____

Marital status:	Married	Single	Divorced	Widowed	
Taxes filed during last eligible year yes no			Most recent pay stubs (last 2)		
Number of people in household			Number of dependents:		
Patient Gross Income:			Household Income		
Employment	Working	Retired	Disability leave	Unpaid leave	Unemployed

2012 MassHealth Income Standards and Federal Poverty Guidelines

Family Size	MassHealth Income Standards		100% FPL		120% FPL		133% FPL		135% FPL	
	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly
1	$522	$6,264	$931	$11,172	$1,117	$13,404	$1,239	$14,868	$1,257	$15.084
2	$650	$7,800	$1.261	$15,132	$1,513	$18,156	$1,677	$20,124	$1,703	$20,436
3	$775	$9,300	$1,591	$19,092			$2,116	$25,392		
4	$891	$10,692	$1,921	$23,052			$2,555	$30,660		
5	$1,016	$12,192	$2,251	$27,012			$2994	$35,928		
6	$1,141	$13,692	$2,581	$30,972			$3,433	$41,196		
7	$1,266	$15,192	$2,911	$34,932			$3,873	$46,464		
8	$1,383	$16,596	$3,241	$38,892			$4,311	$51,732		
For each additional person add	+$133	+$1,596	$330	$3,960			$439	$5,268		
	150% FPL		200% FPL		250% FPL		300% FPL		400% FPL	
	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly
1	$1,397	$16,764	$1,862	$22,344	$2,328	$27,936	$2,793	$33,516	$3,724	$44,688
2	$1.892	$22,704	$2,522	$30.264	$3,153	$34,836	$3,783	$45,396	$5,044	$60,528
3	$2,387	$28,644	$3,182	$38,184	$3,978	$47,736	$4,773	$57,276	$6,364	$76,368
4	$2,882	$34,584	$3,842	$46,104	$4,803	$57,636	$5,763	$69,156	$7,684	$92,208
5	$3,377	$40,524	$4,508	$54,024	$5,628	$67,536	$6,753	$81,036	$9,004	$108,048
6	$3,872	$46,464	$5,162	$61,944	$6,453	$77,436	$7,743	$92,916	$10,324	$123,888
7	$4,367	$52,404	$5,822	$69,864	$7,278	$87,336	$8,733	$104,796	$11,644	$139,728
8	$4,862	$58,344	$6,482	$77,784	$8,103	$97,236	$9,723	$116,676	$12,964	$155,569
For each additional Person add	$495	$5,940	$660	$7,920	$825	$9,900	$990	$11,880	$1,320	$15,840

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PAP Program & Resources for Patients & Providers, page 1 of 10

BenefitsCheckUp®

www.benefitscheckup.org

Sponsored by the National Council on Aging (NCOA), this website offers online and confidential assistance for seniors and caregivers by searching more than 1,100 federal, state, and private prescription drug programs and determining those for which the senior may be eligible. Medicare patients with limited income and resources may be able to get help paying for their Medicare prescription drug costs. The patient's income must be less than $16,335 if single and $22,065 if married. Patients in Alaska or Hawaii may qualify even if income is higher than these limits.

Complete an online survey to see if a patient is eligible. At the same time, providers can start the application process for the Medicare Savings Programs (a valuable benefit of at least $96.40 per month) and also find out if patients might be eligible for other benefit programs.

Co-Pay Relief

www.copays.org

The Patient Advocate Foundation's Co-Pay Relief Program (CPR) currently provides direct financial support to insured patients, including Medicare Part D beneficiaries, who must financially and medically qualify to access pharmaceutical co-payment assistance. The program offers personal service to all patients through the use of call counselors; personally guiding patients through the enrollment process.

Currently, CPR is offering assistance to insured patients who are financially and medically qualified and are being treated for breast cancer, lung cancer, lymphoma and cutaneous T-cell lymphoma, prostate cancer, kidney cancer, colon cancer, pancreatic cancer, head and neck cancer, malignant brain tumors, sarcoma, multiple myeloma, myelodysplastic syndrome (and other pre-leukemia diseases), and pain.

CPR offers a secured website for providers to enroll electronically on behalf of their patients. To obtain information on how to register and submit an application on your patient's behalf go to: *www.copays.org/providers.php*. You will receive an email to confirm your registration and create your password. You will need to provide your provider tax Identification Number, National Provider Identifier, and a valid email address to complete the registration process The application process should take approximately five minutes to complete. To register now go to: *https://sx2035.unicentric.com/cprportal/PreRegisterProviderPharmacy.aspx*. If you have already registered with CPR, log in at: *https://sx2035.unicentric.com/ cprportal/Login.aspx* to start the application process.

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Note: CPR provides assistance to patients on a first come, first served basis and processes applicants in the order in which their completed applications are received. A thorough review of the completed application packet, in its entirety, is necessary before a final determination of acceptance for assistance can be made.

Questions? Contact CPR at: 866.512.3861 (757.952.0118) to obtain more information.

Needy Meds

www.needymeds.org

Patient assistance programs (PAPs) are usually sponsored by pharmaceutical companies and provide free or discounted medicines to low-to-moderate income, uninsured, an underinsured people who meet the guidelines. Eligibility and application requirements vary from program to program. Here are four easy steps to find PAPs on this website:

1. Search by name of the drug. PAPs are found by searching for the name of the medicine.
2. Click on the Brand Name Drugs link at: *www.needymeds.org/drug_list.taf*.Click on the first letter of the drug's name in the alphabet bar. An alphabetical listing of all the drugs offered through a PAP are listed. If it is not there, then click on the Generic Name Drugs link at: *www.needymeds.org/generic_list.taf* and follow the same procedure.
3. Click on the name of the medicine. This will open a program page with contact information, medication dosages, application if available, eligibility criteria, and other details of the PAP.
4. Call the program. Please do not call NeedyMeds with specific program questions. Some programs will make exceptions to their eligibility criteria. The drugs offered and the program requirements change, so it may pay to call back from time to time.

If your medicine is not on either list or is not available through a PAP at this time go to: *www.needymeds.org/indices/cantfindmeds.htm.* Providers and patients can also access other services, such as:

- ***Applications Assistance:*** *http://www.needymeds.org/local_ programs.taf.* Many local programs and individuals assist providers and patients to use patient assistance programs. For a small fee, they can help with such things as finding a program, completing the forms, and working with physicians who must sign the forms. Click on your state to bring up a list of local programs. Click on the name of the program for more information.
- ***Disease-based Assistance:*** *http://www.needymeds.org/copay_branch.taf*. This database of programs can help with the costs associated with specific diseases or medical conditions. Disease-based assistance programs can cover many types of expenses, including drugs, insurance co-pays, office visits, transportation, nutrition, medical supplies, and child or respite care. Providers and patients can search these programs by disease or condition, area of services, or by program name.

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- ***Assistance with Government Programs:*** *www.needymeds.org/indices/government_ programs.htm.* There are state and federal programs that assist low-income residents. Click on your state to bring up a list of local programs. Click on the name of the program for more information. NeedyMeds.org has also compiled a list of Medicaid sites:

  http://www.needymeds.org/indices/medicaid.htm. Other helpful links include the federal poverty guidelines: *http://www. needymeds.org/indices/povertyguidelines.htm,* and a list of discount drug programs: *http://www.needymeds.org/indices/discountcards.htm.*

At this time, NeedyMeds.org does not have a phone helpline. All NeedyMeds information is available on its website. Providers or patients who need help using the website can email: *info@needymeds.com.*

Partnership for Prescription Assistance

http://www.pparx.org

The Partnership for Prescription Assistance (PPA) helps qualifying patients without prescription drug coverage get the medicines they need for free or nearly free. PPA offers a single point of access to more than 475 public and private programs, including nearly 200 pharmaceutical patient assistance programs. To learn more, download the brochure at: *http://www.pparx.org/sites/default/files/ PPA_brochure.pdf.*

Here's how PPA works:

- ***Step 1: Tell us what medicines your patient takes.*** Go to: *www.pparx.org/en/gethelp/select-meds* to search for and pick out the medicines. Type the name of the medicine into the box and click the search button. Once the search is complete you can add one or more prescription drugs from your search to the My Medicines list, which appears on the right side of the page. Repeat this process until you have entered and selected all of the medicines.
- ***Step 2: Tell us about your patient.*** Provide basic information about the patient and the type of drug coverage (if any) he or she currently has. Answer short questions, such as the patient's residency, age, and household income, to see which patient assistance programs they may qualify for. You must answer *all* questions on this page for your patient to be considered. If you need assistance, please call 1.888.477.2669 Monday through Friday, from 9:00 am to 5:00 pm EST.
- ***Step 3: Get your results.*** See which prescription assistance programs your patient may be eligible for and select the ones you would like to apply to.
- ***Step 4: Complete the application process.*** Print, complete, and mail your applications to each program you are applying to.

  PPA offers other resources, including:
- A list of co-pay programs at: *www.pparx.org/en/prescription_assistance_ programs/co-payment_programs.*

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- A list of discount drug card programs at: *https://www.pparx.org/en/prescription_assistance_ programs/discount_cards.*
- Information about Medicare drug coverage at: *https://www.pparx.org/en/prescription_assistance_programs/medicare_drug_coverage*

Patient Access Network Foundation

http://www.panfoundation.org/
PAN is an independent non-profit organization that provides assistance to underinsured patients for their out-of-pocket expenses for life-saving medications. Providers and their patients can apply for assistance by calling 1.866.316.7263 or start the application online at: *http://www.panfoundation.org/fundingapplication/index.php?9.*

In order for patients to qualify for co-payment assistance with the Patient Access Network Foundation, they must meet the following eligibility criteria:

- Patient is insured and insurance covers the medication for which the patient seeks assistance.
- The medication must treat the disease directly.
- Patient's income must be below a designated percentage of the Federal Poverty Level, depending on individual fund requirements.
- Patient is prescribed a high-cost drug for the disease, depending on individual fund requirements.
- Patient must reside and receive treatment in the U.S.

Patients applying for financial assistance for their copayments need to have access to the following information:

Step 1. Select the disease for which you are seeking assistance, the patient's insurance type, and the medication(s). If the patient is commercially insured and has selected a medication for which the manufacturer program has a co-pay card program, you will be made aware under the alternative programs box. Please research these other programs as manufacturer programs may be more generous than what PAN has to offer.

Step 2. You will need to select the use type. As a provider, click the "I am applying for someone else" box. If the patient is applying, he or she will click the box "I am applying for myself." If you are from a specialty pharmacy, you will need to undergo training with the PAN Foundation. Contact Korab Zuka at: *kzuka@panfoundation.org* or 202.347.9273 for more information.

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Step 3. You will need to access to the following information for the patient:
***Demographic information*:**

- First and last name
- Social Security number or Alien Number
- Date of birth
- Gender and marital status
- Employment status
- Phone number
- Street address and email address
- Language the patient speaks and understands
- Residency status.

***Income Information*:**

- Number of people in the household
- Income received from wages, tips, or salaries
- Income from IRA distributions, pensions, or annuities
- Social Security benefits, including the amount of the benefits received
- Any other income (child support, alimony, rental income, etc.).

Insurance and Co-payment Information:

- Primary insurance carrier
- Policy ID number
- Group number
- Telephone number
- Secondary insurance carrier and contact information
- What is the patient's co-pay or co-insurance for his or her medications?
- Does the patient receive assistance from any other co-pay or coinsurance assistance organizations?
- How did the provider or patient first hear about Patient Access
- Network?

Step 4. You will need to access to the following information for the provider:

- First name
- Last name
- Phone number
- Fax number
- Email
- Address.

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Step 5. Review the application to make sure the information entered is correct and then submit the application online at: *http://www.panfoundation.org/fundingapplication/patientEnrollment.php*. Applications and supporting documents can also be mailed to: PAN Foundation, P.O. Box 221858, Charlotte, NC 28222-1858 or faxed toll-free to: 1.866.316.7261.

Patient Advocate Foundation

www.patientadvocate.org

The Patient Advocate Foundation offers patients assistance with specific issues they are facing with their insurer, employer, and/or creditor regarding insurance, job retention, and/or debt crisis matters relative to their diagnosis of life threatening or debilitating diseases. Their professional case managers and attorneys specialize in mediation, negotiation, and arbitration, and they advocate on behalf of patients experiencing the following issues:

Access To Care

- Preauthorization
- Coding and billing
- Insurance appeals process
- Expedited appeals process
- Access to pharmaceutical agents
- Access to medical devices
- Access to surgical procedures
- Expedited applications for Social Security Disability, Medicare, Medicaid, SCHIPS, and other social programs.

Job Retention

- Family Medical Leave Act (FMLA) qualifications
- Disability accommodations
- Communication with the Equal Employment Opportunity Commission (EEOC) and State Fair Employment Practices Agencies (FEPA)
- Denial of income
- Denial of health benefits.

Debt Crisis

- Housing
- Utilities
- Food
- Transportation to medical treatment
- Child care.

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PAF can also help patients with co-pay assistance. Co-pay assistance programs are administered by diagnosis, and patients must qualify financially and medically. Some states offer additional co-pay assistance programs that assist with medications and various living expenses. The case managers at the Patient Advocate Foundation will explain the available programs, provide the patient with the resources, and help initiate the application process.

For co-pay assistance, go to: *www.copays.org*. Questions? Contact the Patient Advocate Foundation at: *help@patient advocate.org* or call: 800.532.5274.

RxAssist

http://www.rxassist.org

The RxAssist database contains eligibility information and applications for more than 150 pharmaceutical company patient assistance programs. The database can help providers find out whether a drug is available, which pharmaceutical company program offers the drug, and how to apply for the medication. RxAssist also has information available on co-pay assistance programs. In order to use the database, visitors must register either as a provider or patient.

Download the provider brochure at: *http://www.rxassist.org/providers/documents/RxAssist-Brochure-Provider-Color.pdf*.
Download the patient brochure at: *http://www.rxassist.org/providers/documents/RxAssist-Brochure-Patient-Color.pdf.*

Resources Available

- Searchable database to find brand and generic medications from: pharmaceutical company programs, retail pharmacy programs, and drug discount coupons
- Application forms for pharmaceutical company programs
- Pricing for generic drugs at national retail pharmacies
- Information on local and national assistance and benefits programs
- Patient materials on medication management and safety.

Using RxAssist

- **Step 1**. Go to *www.rxassist.org.*

- **Step 2**. Search for medications. Click the "Learn More" button, enter the medication name and click "Submit." All existing programs appear. If no program(s) exist for the medication, click the "Resources" tab at the top of the page for other types of help that might be available.

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- **Step 3**. Download patient assistance program applications. Online applications are available for most programs. Applications may be printed blank or filled out on your computer.

- **Step 4**. Search for national or local programs. Click "Additional Help" to find healthcare and other resources.

- **Step 5**. Search for patient materials. Click "Patient Education" for a variety of easy-to-understand information.

RxAssist Learning Center
RxAssist created the Learning Center to give providers and patients a website with news, information, and resources for the safety net community.

- Join RxConnects, a listserv discussing issues related to medication access.
- Join RxUpdates and receive regular notification of changes in pharmaceutical company and other medication assistance programs.
- Keep current with healthcare reform with our monthly "Spotlight" feature.
- Register for our webinar presentations where you can learn more about important healthcare issues.
- Visit our library for guides, fact sheets, articles, and publications to help you in your day-to-day work.

Questions? Call 401.729.3284 or email *info@rxassist.org*.

RxHope™

https://www.rxhope.com
Here's how this web-based patient assistance program works. The provider enters the site and clicks on the Patient Assistance Application link. Providers then choose from the available products, fill in the application, and depending on the manufacturer, either print and fax the application for signature verification or mail the printed application to the appropriate address. Some products do not require a fax or mail; they may be completed electronically. All information is sent to the pharmaceutical manufacturer for final approval and shipping.

Healthcare providers and their staff can set up accounts online to order free medications for their patients through our automated patient assistance online system. If you would like to create a free account for ONE HEALTHCARE PROVIDER, please read the instructions below. If you would like to set up account for MULTIPLE HEALTHCARE PROVIDERS, please call RxHope at 1.877.267.0517 and a customer service representative will assist you.

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In order to set up your free account and place orders online for both individual and multiple provider accounts, the following criteria is required:

1. You must be a healthcare provider or their staff.
2. A valid state license number for the healthcare provider.
3. An email address. (This will become your login.)
4. The medication for which the patient is applying.
5. The Patient's first and last name.

Once you have the above information available, go to: *https://www.rxhope.com/Prescriber/Register.aspx* and follow the instructions. You will be setting up your free account and creating an order for your patient all at the same time.

RxHope provides this service to physicians and patients free of charge. RxHope is available to assist providers and patients Monday through Friday, from 8:00 am to 7:00 pm EST by calling 1.877.267.0517. You can also contact RxHope by emailing: *Customer Service@RxHope.com*.

Rx Outreach®

http://www.rxoutreach.com

Patients can use Rx Outreach regardless of their age or if they use another discount medicine program or patient assistance program. To use Rx Outreach, the patient's income needs to be less than a certain amount of money each year. This amount differs depending on the number of financially dependant people living in the house:

- ***1-person household***: Less than $32,670/year. (Alaska: less than $40,800/year; Hawaii: less than $37,620/year).
- ***2-person household***: Less than $44,130/year. (Alaska: less than $55,140/year; Hawaii: less than $63,960/year).
- ***3-person household***: Less than $55,590/year. (Alaska: less than $69,840/year; Hawaii: less than $63,960/year).
- ***4-person household***: Less than $67,050/year. (Alaska: less than $83,820/year; Hawaii: less than $77,130/year).
- ***More than 4-person households:*** For each additional person in the house, add $11,460/year. For example, if it is a six-person household, the patient's income must be less than $89,970 ($67,050 + $11,460 + $11,460= $89,970).

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Providers and patients can enroll in the program by following these four steps:

1. Assess patient qualification using the criteria above.
2. Download the application and see if the patient's drug is on the Rx Outreach Drug List: *http://www.rxoutreach.org/wp-content/uploads/2010/10/10-1172RxOtrchFrm788single.pdf*. The list shows the pricing for all drugs offered.
3. Obtain a prescription from the provider. If the medicine is on Tier 1 or Tier 2, patients can get a 180-day supply with one refill. If the medicine is on the Tier 3 list, patients can get a 90-day supply with three refills.
4. Mail the completed application, the prescription(s), and payment to: Rx Outreach, P.O. Box 66536, St. Louis, MO 63166-6536.

For more information, go to: *www. rxoutreach.org* or call 1.800.769.3880, Monday through Friday, from 7:00 am to 5:30 pm CST.

Together Rx Access® Card

http://www.togetherrxaccess.com

To qualify for a Together Rx Access® Card, individuals must:

1. Not be eligible for Medicare.
2. Have no prescription drug coverage of any kind.
3. Have a household income that is equal to or less than: $45,000 for a single person; $60,000 for a family of two; $75,000 for a family of three; $90,000 for a family of four; $105,000 for a family of five. (Families of six or more and residents of Alaska and Hawaii should contact the Together Rx Access Program at: 1.800.444.4106.)

Applying for the Together Rx Access® Card is free and takes just a few minutes. Patients may apply:

- Online using the checklist at: *www.togetherrxaccess.com/p/prescription-savings/abouttogether-rx-access/enroll.aspx.*
- By downloading, printing, and filling out the application at: *www.togetherrxaccess.com/App_Controls/Enrollment/pdf/TRx_Access_Enroll_English.pdf*. The completed application should be mailed to: Together Rx Access, LLC, P.O. Box 9426, Wilmington, DE 19809-9944.
- Over the phone by calling: 1.800.444.4106.

Patients who enroll online or by phone can use their member ID number at participating pharmacies within two hours of enrollment. To use the card, patients show it to their pharmacists when purchasing brand-name prescription medicines. Savings on generic drugs are also available and vary by pharmacy. Participating pharmacies can be found online at: *www.togetherrxaccess.com/p/prescription-savings/about-together-rx-access/pharmacies.aspx*

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Patient Assistance Checklist for Uninsured Patients

- ☐ I have received the chemotherapy order written by the physician?
- ☐ I have met with the patient to assess his or her ability to pay for treatment?
- ☐ Based on this meeting, is the patient able to pay out-of-pocket for drug(s)?
  - ☐ YES ☐ NO
  - If no, list drug(s) below and continue on with checklist.
  - _____
  - _____
- ☐ Is a replacement drug program available?
  - ☐ YES ☐ NO
  - If yes, identify drug and program:
  - _____
- ☐ Does the patient qualify for this program?
  - ☐ YES ☐ NO
  - If no, state reason(s) why:
  - _____
- ☐ I have completed all the necessary forms and paperwork for the drug replacement program.
  - ☐ YES ☐ NO
  - If no, state reasons why:
  - _____
- ☐ Does the patient need drug(s) that are not available through a drug replacement program?
  - ☐ YES ☐ NO
  - If yes, identify which drugs:
  - _____
- ☐ Is Foundation assistance available for any of these drug(s)?
  - ☐ YES ☐ NO
  - If yes, identify Foundations:
  - _____
- ☐ I have completed all the necessary forms and paperwork for these drug replacement program(s).
  - ☐ YES ☐ NO
  - If no, state reasons why:
  - _____

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The Americans with Disabilities Act & People with Cancer, page 1 of 5

What is the Americans With Disabilities Act?
The Americans With Disabilities Act of 1990 (ADA) gives civil rights protections to people with disabilities. It can help people with disabilities gain equal opportunity in:

- Employment
- Public accommodations
- Transportation
- State and local government services
- Telecommunications.

What is a Disability Under the ADA?
The Americans With Disabilities Act may apply to you if:

- You have a physical or mental problem that substantially limits one or more of your "major life activities"
- You have a record of having had such a problem in the past
- Other people think you have such a problem, even if you do not actually have it.

On January 1, 2009, the ADA Amendments Act of 2008 went into effect. This Act made some major changes to the way the definition of disability has been interpreted under ADA in the past. Some of the "major life activities" covered by ADA include but are not limited to caring for yourself, doing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

The 2008 amendment also includes major body functions, including but not limited to functions of the immune system, *normal cell growth*, digestive, bowel, bladder, central nervous system, brain, respiratory, circulatory, endocrine, and reproductive systems. These changes can help people with cancer, because in the past they often had a hard time meeting the definition of disability.

Q&A'S ABOUT EMPLOYMENT DISCRIMINATION
This section deals only with employment discrimination, a potential problem for people who have had cancer. The section of the ADA that applies to jobs is called Title I. After the discussion of jobs, there is information about the ADA in settings and situations other than the workplace. The sections of the ADA that apply to these different settings and situations are Titles II through V.

Does the ADA Apply to My Employer?
The law applies to employer with 15 or more employees. Job discrimination against people with disabilities by these employers is not legal if practiced by:

- Private employers
- State and local governments
- Employment agencies
- Labor organizations
- Labor management committees.

Employees of the US government are not covered under the ADA. But they have the same protections under a different law, which is enforced by the Office of Federal Operations of the EEOC. To file a

Source: American Cancer Society

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complaint, a federal employee must first contact an equal employment opportunity counselor at the agency in which they believe the discrimination took place. You can read more about these protections at: *www.eeoc.gov/facts/fs-fed.html*.

Whom Does the ADA Cover?
In order to be protected by the ADA at work, the ADA must apply to your employer. And, you must be qualified and able to perform the "essential functions" of the job. See the section called "What are the essential functions of a job under ADA?"

Although the ADA defines the term *disability*, it does not include a list of conditions that are always considered disabilities. Instead, each case must be looked at on its own merits. According to the United States Equal Employment Opportunities Commission (EEOC), cancer is not always considered a disability. The ADA can help protect you when cancer prevents or makes it very hard for you to do everyday tasks, such as household chores, bathing, and brushing your teeth. But this kind of disability must be permanent or long-term.

The ADA also protects you if you had cancer in the past, but are doing well now. An employer may not discriminate against you because you used to be sick. The ADA also prevents an employer from discriminating against you if he or she thinks you are sick, even if you aren't.

Which Employment Practices Does the ADA Cover?
If you have a disability and are qualified for a job, the ADA does not allow the employers noted above to discriminate in employment practices, such as:

- Recruiting and advertising for job openings
- Job application and hiring
- Training
- Job assignments
- Tenure
- Promotions
- Pay
- Benefits
- Leave
- Firing
- Lay off
- All other employment-related activities, terms, conditions, and privileges.

An employer cannot take action against you because you ask for your rights under the ADA. The Act also protects you if you are discriminated against because of your family, business, social, or other type of relationship or association with a person who has a disability. For instance, this means an employer cannot discriminate against you because your spouse or child has cancer. Still, the ADA does not completely protect your job just because you have a disability and are qualified for the job. The employer can still fire or lay off (terminate) an employee with a disability for legitimate business reasons. For instance, a disabled worker would not be protected during downsizing.

Source: American Cancer Society

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The Americans with Disabilities Act & People with Cancer, page 3 of 5

What are the Essential Functions of a Job Under the ADA?

If you have a disability, you must be qualified to perform the *essential functions* of a job in order to be protected from job discrimination by the ADA. Essential functions are the fundamental duties required by the job itself. An employer cannot refuse to hire you because your disability prevents you from performing duties that are not essential to the job. But you must satisfy the employer's job requirements such as education, employment experience, skills, or licenses. Employers are not required to lower their job standards to accommodate someone with a disability. Nor do they have to provide personal-use items such as glasses or hearing aids.

You also must be able to perform the essential functions of the job either on your own or with reasonable accommodation (see definition of accommodation in the next section).

What is Reasonable Accommodation Under the ADA?

Reasonable accommodation is how an employer makes adjustments to a job that allow an employee with a disability to perform the essential functions of that job. But reasonable accommodation can start even before hiring; for example, it may be a change in procedure that allows a qualified disabled person to apply for a job. For those already working, reasonable accommodation can be a change that allows disabled people to enjoy benefits and privileges of employment the same as those enjoyed by employees without disabilities. Examples of reasonable accommodations may include:

- Providing equipment or devices, or adapting them so the person with a disability can use them
- Restructuring a job
- Changing work schedules
- Reassigning the employee to a vacant position
- Adjusting or modifying tests, training materials, or policies
- Providing e-readers and/or interpreters
- Making the workplace easy to get into and use by people with disabilities.

An employer must accommodate a qualified applicant or employee with a disability unless the employer can show that making the accommodation would not be reasonable. That means that the accommodation would be very difficult or expensive (an "undue hardship" or unreasonable). These factors include the type and cost of the accommodation in relation to the size, resources, nature, and structure of the employer's operation. In general, a larger employer would be expected to make accommodations requiring greater effort or expense than would be required of a smaller employer.

The facts of your case will help determine whether an accommodation will make it possible for you to do the job and, if so, what kind of accommodation is needed. Employers do not have to know about every kind of disability to know whether or how to make a reasonable accommodation. They are required to accommodate only those disabilities they know about and that do not cause too much hardship for the employer. The requirement is usually triggered by a request from a person with a disability, who often can suggest a workable accommodation.

Accommodations must be made on a case-by-case basis because the type and extent of a disability and the requirements of the job will vary in each case. If you do not ask for an accommodation, the employer is not required to provide one. If you ask for an accommodation, but cannot suggest one

Source: American Cancer Society

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that will work for you, you and the employer should work together to identify one. There are also many public and private resources that can provide help without cost.

What are Employers Allowed to Ask Job Applicants with Disabilities Under the ADA?
When you apply for a job, employers can't ask you if you are disabled. They also cannot ask about the type or how severe a disability you have. *Employers may not ask you if you have or have ever had cancer*. But they can ask you about your ability to perform certain job tasks. An employer can ask you to describe or show them how, with or without reasonable accommodation, you will perform the duties of the job.

If all new employees in similar jobs are required to have a medical exam, you may be offered a job conditionally, pending the results of a medical exam. The medical exam must be related to the job and in line with the employer's business needs. But an employer cannot reject you because of information the medical exam reveals about your disability unless the reasons for rejection are related to the job and necessary to conduct the employer's business. The results of all medical exams must be kept confidential. Medical files must be kept separate from work or personnel files.

Should I Tell My Employer I Have a Disability?
If you think you will need accommodation in order to apply for a job or to perform essential job functions, you should tell the employer that you have a disability. Employers are only required to provide reasonable accommodation if they know about the disability. Generally, the employee is the person who must tell the employer that an accommodation is needed. *But you are not required to offer information about having cancer or another disability when you apply for a job*.

Does My Employer Have to Provide Any Accommodation I Request?
No. There is some flexibility built into the reasonable accommodation requirement under the ADA. For example:

- Employers can choose among effective accommodation options and do not always have to provide the accommodation that the employee requests.
- Employers do not have to provide accommodations that pose an undue hardship for them.
- Employers do not have to provide personal-use items that are needed for daily activities both on and off the job.
- Employers do not have to make an accommodation for a person who is not otherwise qualified for the job.
- Employers do not have to remove essential functions, create new jobs, or lower production standards to accommodate a disabled employee.

Under the ADA, Does the Employer Have to Hire a Qualified Applicant with a Disability Over Other Qualified Applicants?
No. The ADA does not require an employer to hire a person with a disability over other applicants because the person has a disability. The ADA only prohibits discrimination on the basis of disability. It makes it unlawful to refuse to hire a qualified applicant with a disability just because he or she is disabled. It's also unlawful to refuse to hire the qualified person because a reasonable accommodation is required to make it possible for this person to perform essential job functions.

Source: American Cancer Society

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Do I Have to Pay for It If I Need Reasonable Accommodation Under the ADA?
Generally, no. The ADA requires the employer to provide the accommodation unless doing so would cause an undue hardship on the employer's business. If the cost of providing the needed accommodation would be too much, you must be given the choice of

- Providing the accommodation yourself, or
- Paying for the portion of the accommodation that causes the undue hardship.

An employer cannot make up the cost of providing a reasonable accommodation by lowering your salary or paying you less than other employees in similar jobs.

If the Health Insurance Offered by My Employer Does Not Cover All Medical Expenses Related to My Disability, Does the Company Have to Get Extra Coverage for Me Under the ADA?
No. The ADA only requires an employer to provide employees with disabilities equal access to whatever health insurance coverage is offered to other employees. The same is true for employees with cancer or for employees who have family members with cancer or a history of cancer.

What Agency Enforces ADA Job Protections?
The Equal Employment Opportunities Commission (EEOC), along with state and local civil rights enforcement agencies, enforces the part of the ADA that covers employment protection.

What Should I Do If I Think I'm Being Discriminated Against in a Work Situation Because of My Disability?
If you think you have been discriminated against at work because of a disability, you can file a complaint with an EEOC field office located in certain cities throughout the United States. If your employer is a state or local government, you should contact the US Department of Justice.

A discrimination charge generally must be filed with the EEOC within 180 days of the action that you believe to be discriminatory. If a state or local law covers discrimination on the basis of disability, the charge must be filed with the proper state or local fair employment practice agency within 300 days of the discriminatory action. EEOC field offices can refer you to the agencies that enforce those laws. But to protect your rights, it is best to contact the EEOC right away if you suspect discrimination, at 1.800.669.4000. If you work for the US government, you have only 45 days to contact your agency EEOC officer, and the process is somewhat different from that for private employers.

If the EEOC decides that you have been discriminated against, you are entitled to a remedy that will place you in the position you would have been in if the discrimination had never occurred. You may be entitled to hiring, promotion, reinstatement, back pay, or reasonable accommodation, including reassignment. You also may be entitled to payment of your legal fees. Keep in mind that these decisions may take a long time depending on the nature of the claim and how it is resolved.

If the EEOC does not believe discrimination has occurred, or when attempts to resolve the problem have failed and the EEOC decides not to sue on your behalf, you can request a "right to sue" letter from the EEOC 180 days after filing your complaint. After you get this notice of right to sue, you have 90 days to file the suit. If you sue, you may want to hire a private attorney to represent you.

Source: American Cancer Society

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ERISA & Insurance-Based Long-term Disability, page 1 of 2

Overview
Long-term disability refers to different types of disability benefits that are insurance-based and are received for longer than a period of one year. These benefit payments are not made by the Social Security Administration, but by the insurance company covering the retirement, health, or benefit plan offered by the patient's employer.

What is ERISA?
ERISA stands for the Employee Retirement Income Security Act of 1974. This legislation established specific standards to protect employees when filing claims with group health plans or plans providing disability benefits. These standards are intended to protect claimants against unnecessary delays by the insurance company in making a determination of their claim. It also guarantees the claimant access to information regarding how a determination is made. Furthermore, it guarantees claimants and beneficiaries a full review of any denied claim. In summary, ERISA is intended to make the process of applying for and receiving disability from a private insurer similar to that of the Social Security Administration.

This does not mean that filing for insurance-based disability is easier than filing with the SSA. Claims with private insurance companies may be extremely difficult. ERISA has established the process for claimant application, timeframes, and procedures for determinations by insurance companies, an internal appeals process, and (if the internal appeals process has been exhausted), the right of the claimant to file suit against the insurance company in state or federal court. However, disability coverage has been a growth industry for insurance companies because they have found legal loopholes and practices that enable them to circumvent many of the ERISA guidelines established to protect patients.

Bad Faith Insurance Practice
An act of "bad faith" on the part of an insurance company is not an honest mistake or oversight. Bad faith implies that there has been an intentional practice set in place by an insurance company to purposefully commit fraud or deny legitimate disability claims. A charge of "bad faith" against an insurance company is very difficult to establish. Nonetheless, there have been a number of bad faith cases that have resulted in substantial awards to beneficiaries (see Boicourt v. Amex Assurance Co., David Clayton v. United Service Automobile Association, Vann v. The Travelers Insurance Company, etc.).

Some examples of bad faith insurance practice are:

- A baseless denial of coverage
- Failure to communicate policy information to a claimant
- Denial of a claim without proper investigation
- Untimely or unnecessary delay of determination or payment
- Failure to pay the full value of a claim
- Refusal to enter negotiations or legal procedures with regard to the claim

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ERISA & Insurance-Based Long-term Disability, page 2 of 2

Eligibility
Eligibility for long-term disability is typically similar to those eligibility requirements set by the Social Security Administration. However, because long-term disability is based upon the policies set by private insurers and your employer, it is important to note that the eligibility requirements are specific to the coverage of the patient's policy. This means that a legitimate disability or condition may not be covered due to the restrictions of the insurance policy. It is important to know the specific conditions and disabilities covered by the policy to determine the patient's eligibility for long-term disability.

Patients can get a free evaluation of their case by an advocate online at: *www.socialsecuritydisability.ws/erisa_disability_help_form.html.*

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FAQs:Family & Medical Leave Act , page 1 of 6

What is the Family and Medical Leave Act (FMLA)?
The Family and Medical Leave Act (FMLA) of 1993 was designed to help employees balance their work and family responsibilities by allowing them to take reasonable unpaid leave for certain family and medical reasons. The FMLA provides certain employees with up to 12 weeks of unpaid, job-protected leave per year. It also requires that the employee's group health benefits be maintained during the leave.

To Whom Does the FMLA Apply?
FMLA applies to all public and private employers with 50 or more employees. These employers must provide an eligible employee with up to 12 weeks of unpaid leave each year for any of the following reasons:

- For the birth and care of the newborn child of an employee
- For placement with the employee of a child for adoption or foster care
- To care for an immediate family member (spouse, child, or parent—but not a parent
- 'in-law") with a serious health condition
- When the employee is unable to work because of a serious health condition

Special rules apply to school employees. There are some limits on reduced schedules and taking FMLA leave near the end of a term.

Special FMLA Rules for Military Families
In 2008 the FMLA was expanded to include "military family leave entitlements." FMLA can be used by military families for these purposes:

- The spouse, son, daughter, parent, or next of kin of a member of the Armed Forces can now take up to 26 work weeks of leave to care for the service member with a serious injury or illness.
- There may also be urgent family situations (called "qualifying exigencies") that arise due to active military duty, which may qualify family members to take up to 12 weeks of FMLA.
- Spouses working for the same employer are limited to a combined total of 26 work weeks in a single 12-month period if the leave is to care for a covered service member. You can get more detailed information from the Department of Labor (see "Additional resources") or read their fact sheet on the Web at: *www.dol.gov/esa/whd/regs/compliance/whdfs28a.pdf.*

Who Can take FMLA Leave?
Employees are eligible for FMLA leave if *all* of the following apply:

- They have worked for their employer at least 12 months
- They have worked at least 1,250 hours over the past 12 months, or about 25 hours per week
- They work at a location where the company employs 50 or more employees within 75 miles.

Source: American Cancer Society

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FAQs: Family & Medical Leave Act , page 2 of 6

Military reservists returning from active duty are entitled to the rights and benefits they would have had if they had been continuously employed. For example, George returned to his regular job on June 1 after a 1-year tour of active duty. On July 6, he learned that his child has cancer and will need intensive treatment. He can request FMLA to care for his sick child right away, even though his hourly job requirement was not fulfilled.

What if I Left My Job and Then Returned to It? What Counts Toward the1,250 Hours that I Need to Qualify for FMLA?
First of all, the 12 months of service do not have to be continuous or consecutive; all time you have worked for the employer is counted. But, you still must have worked 1,250 hours in the past 12 months to qualify (unless you are a military reservist returning from active duty, as mentioned before). The 1,250 hours include only those hours actually worked for the employer or spent in active military duty. Paid leave time, previous FMLA leave, and other absences from work do not count toward the 1,250 hours.

Your individual record of hours worked is used to decide whether 1,250 hours had been worked in the 12 months before you start FMLA leave. The following may help you figure out whether the 1,250-hour requirement has been met:

- Roughly 25 hours worked in each of the 52 weeks of the past year, or
- More than 104 hours worked in each of the 12 months of the past year, or
- About 40 hours worked per week for more than 31 weeks (over 7 months) of the past year.

If you are a military reservist returning to your job after active military duty, you will be treated as if you had been continuously employed during your active duty period. See the section “Who can take FMLA leave?”

What Counts as a Serious Health Condition?
There is more than one way to define a serious health condition. It can mean any illness, injury, impairment, or physical or mental condition that involves any period of illness or treatment connected with patient care. This means at least one overnight stay in a hospital, hospice, or residential healthcare facility, *and* any period of illness or treatment which involves incapacity afterward—which means the person cannot work, go to school, or perform regular activities.

But a serious health condition does not always mean a hospital stay. It may also be a condition that has ongoing treatment, which includes any length of incapacity due to *any* of the following:

- A health condition (including treatment and recovery from it) that lasts more than 3 days in a row, and any treatment after that. It includes any length of incapacity related to that same condition, and must also involve:
  - Being treated 2 or more times by or under the supervision of a healthcare provider, or
  - Being treated once by a healthcare provider with an ongoing regimen of treatment.

Source: American Cancer Society

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FAQs: Family & Medical Leave Act , page 3 of 6

- A permanent or long-term condition for which treatment may not be effective (for instance, a severe stroke, terminal cancer). Only supervision by a healthcare provider is required, not active treatment.
- Any absences for surgery or multiple treatments for a condition which would likely result in a period of incapacity if not treated (for example, chemotherapy or radiation treatments for cancer).

How Far Ahead of Time Must I Request FMLA Leave?
If possible, an employee must give an employer at least 30 days notice before FMLA leave is to start. This only applies to planned medical treatments and elective surgery. Knowing that far ahead is rarely possible when you have cancer. In the case of unexpected need due to serious illness, you must let your employer know as soon as possible, at least within 1 to 2 business days of when you first learn you will need leave.

May I Use FMLA to Take Off Several Short Periods?
The FMLA leave can be taken all at once or it can be taken in shorter blocks of time, such as 2 days a week, or 1 week a month, as long as it is taken for a single reason. FMLA can also be used to reduce the amount of time you work each day, for instance, so that you work a part-time schedule for a while. You may need a doctor's note to verify that your medical condition is serious and that you are unable to work for these times, or that your family member's serious illness requires you to take this time for his or her care.

Does Time I Took Off for Illness or Pregnancy Count Against My FMLA Time if I Need to Take Off Again for a New Illness in the Same 12 Months?
Time taken off work because of any illness, pregnancy, or complications of pregnancy can be counted against the 12 weeks of family and medical leave in a 12-month period. The employer must let the employee know that the pregnancy leave was counted as FMLA.

Does Workers' Compensation Leave Count Against My FMLA Leave?
It can. FMLA leave and workers' compensation leave can run together. This means that time off for a serious work-related injury or illness can be counted as FMLA leave. The employer must notify the employee when the leave time starts that the workers' compensation leave will be counted as FMLA leave.

Who Defines the 12-month Period During Which I Can Take Off Up to 12 Weeks Under the FMLA?
In selecting your 12-month period, the employer may choose to use:
- The calendar year, January through December
- Any fixed 12-month "leave year" such as their fiscal year, or a year required by state law
- A year that starts on your anniversary date (counted from the date you were hired)
- The 12-month period counted forward from the date your first FMLA leave begins
- A "rolling" 12-month period measured backward from the date you used FMLA leave.

Source: American Cancer Society

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FAQs: Family & Medical Leave Act , page 4 of 6

Can I Use My Sick or Vacation Time for FMLA So That I Can be Paid?
The FMLA only requires unpaid leave. But it permits an employee to choose to use accrued paid leave, such as vacation or sick leave, for some or all of the FMLA leave period. The law also permits the employer to require the employee use paid leave in this way. The employer must decide if an employee's use of paid leave counts as FMLA leave, based on information from the employee. When paid leave is used instead of unpaid FMLA leave, it may be counted against the 12 weeks of FMLA leave if the employee is notified that this is the case when the leave begins.

Who Counts as Immediate Family?
An employee's spouse, son, or daughter under the age of 18, and parents are immediate family members for FMLA purposes. The term "parent" does not include a parent in-law. The terms "son" or "daughter" do not include those age 18 or over unless they are unable to take care of themselves because of mental or physical disability that limits one or more of the major life activities as those terms are defined in regulations issued by the Equal Employment Opportunity Commission (EEOC) under the Americans With Disabilities Act (ADA). For military families in certain situations, the son, daughter, parent, or next of kin of an adult armed forces member can take FMLA to provide care for up to 26 work weeks. If you are taking FMLA leave to take care of someone else, your employer may require that you prove your relationship with that person. You may also have to provide proof that he or she has a serious illness.

Must I Give My Employer My Medical Records and What is Medical Certification?
No, you do not have to provide medical records to use FMLA. But for any leave taken due to a serious health condition, the employer may request that you provide *medical certification* which confirms that a serious health condition exists. This is usually a note or form signed and dated by a doctor that states all of the following:

- That you (or your family member) have a serious illness
- When the illness started
- Whether absences are expected to be continuous or in short blocks of time
- When you may be expected to return to work
- Whether further treatment will be needed after the absence.

If your employer asks you for an update on your medical certification or for a second opinion, you may need to provide it in order to keep your FMLA rights (see below).

Can My Employer Ask about My Leave While I am Absent?
Yes, your employer can ask about your leave during the time you are out, but they can only ask you. Your employer may ask you questions to confirm whether the leave you are taking qualifies for FMLA. The employer may also require that you give them reports on your status and ask whether you intend to return to work after leave.

Source: American Cancer Society

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If the employer wants a second opinion about your condition, you may have to get another medical certification (a letter or form signed by a doctor that states that a serious illness is involved). The employer would have to pay for this.

The employer may also have a doctor representing them contact your doctor or healthcare provider, but they need your permission to do so. They can contact your doctor only to clarify what is said in your medical certification or to be sure that it was actually written by him or her. They may *not* try to get more information about your health condition or that of a family member.

Can My Employer Make Me Come Back to Work Before I Run Out of FMLA Time?
Under some conditions, your employer may deny your continuing on FMLA leave if you do not provide the required medical certification (written information signed by your doctor). But the employer may not make you return to work early by offering you a light duty assignment.

Will I Lose My Job if I Take FMLA Leave?
Most of the time, employees will not lose their jobs if they use FMLA leave. When you return to work, employers must give you the same job or an equivalent one. Employers are not allowed to interfere with, restrain, or deny any right provided under this law. Employers cannot use taking FMLA leave as a negative factor in employment decisions, such as hiring, promotions, or disciplinary actions. Also, FMLA leave cannot be counted under "no fault" attendance policies.

The employer does not have to allow certain highly paid, salaried ("key") employees to return to the same job after FMLA leave. But the employer still must allow the FMLA leave and maintain the employee's benefits. The key employee can ask to be restored to his or her former job after the leave is over. It's important to know that the employer may refuse to let the employee go back to his or her previous job if doing so causes "substantial and grievous" financial injury to the company.

Employers are also not required to continue FMLA benefits or give jobs back to employees who would have been laid off or otherwise would have lost their jobs if they had continued to work during the FMLA leave period as, for example, due to a general layoff.

Employees who state that they do not intend to return to work lose their rights to FMLA leave and the job. Employees who are unable to return to work and have used up their 12 weeks of FMLA leave in the 12-month period no longer have FMLA protections of leave or of getting their jobs back.

Source: American Cancer Society

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FAQs: Family & Medical Leave Act , page 6 of 6

In some cases, if an employer has told an employee that they need a medical statement that he or she is fit for duty and can return to work, and the employee does not get that statement, the employer may not allow the employee to come back to the job. Or the employer may delay the employee's return until they get the statement.

Can My Employer Refuse to Grant Me FMLA Leave?
If you are an eligible employee who has met FMLA's notice and certification requirements (written information from your doctor), and you have not already used up your FMLA leave for the 12-month period, you may not be denied FMLA leave. But any employee who lies or uses fraud to get FMLA leave from an employer loses his or her FMLA rights to get back their job or to keep their health benefits.

Do I Have to Pay for My Healthcare Insurance While I am on FMLA Leave?
Your employer is required to keep your group health insurance coverage while you are on FMLA leave if health insurance was provided before the leave was taken. It must be kept on the same terms as if you had continued to work. If you paid all or part of the healthcare premiums, arrangements will need to be made for you to continue to pay your share while on leave.

In some cases, the employer may make you repay the premiums it paid to keep your health coverage if you do not return to work after FMLA leave. Your employer cannot do this if your reason for not going back to work was your or your family member's serious health condition. You may need to check with the Wage and Hour Division of the Department of Labor if your employer asks that you pay back the premiums.

Are Federal Government Employees Covered by the FMLA?
Most employees of the United States government are covered by the FMLA or similar rules. Federal employee leave policies are administered by the US Office of Personnel Management (OPM). You may need to contact your agency's personnel or human resources office to find out exactly what applies to you.

I Work for a Company that Employs Fewer Than 50 People. Is There Any Kind of Leave My Employer Must Offer?
Some states have their own laws or requirements for employers, and there may be other laws that apply to your situation. You can contact the Department of Labor to find someone who knows more about your state.

Where Can I Find Out More About the FMLA?
To learn more about FMLA provisions and rules, read the FMLA Fact Sheet posted on the US Department of Labor Web site at: *www.dol.gov/whd/regs/compliance/whdfs28.pdf*, or call the Wage and Hour Division's referral and information line at the Department of Labor at 1.866.4.USWAGE (1.866.487.9243). They can give you other helpful information and tell you how to reach the Department of Labor division office nearest you.

Source: American Cancer Society

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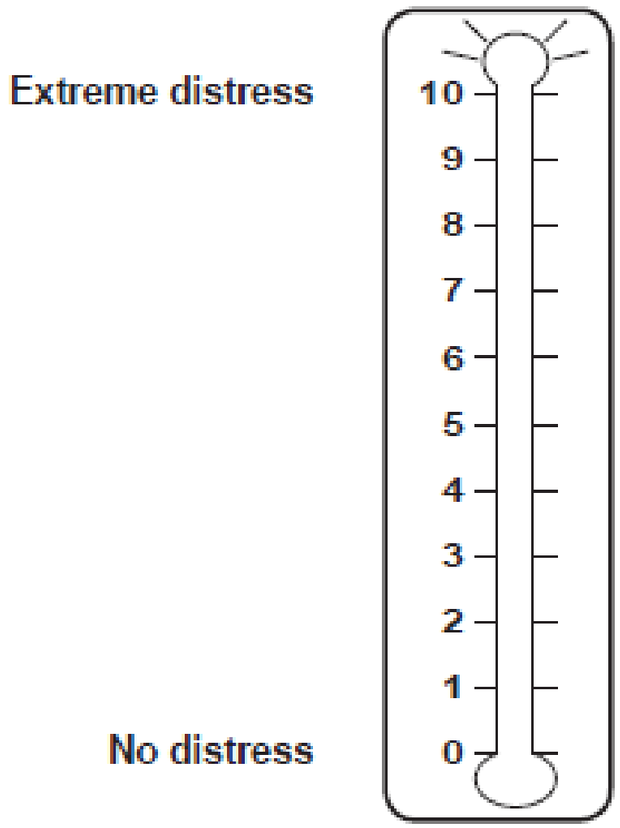
SCREENING TOOLS FOR MEASURING DISTRESS

Instructions: First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.



Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Child Care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/School
❑	❑	Treatment decisions
		Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues
		Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities
❑	❑	**Spiritual/religious concerns**

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling Swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Tingling in hands/feet

Other Problems: _____

Printed Name or PIC / Signature _____ Date / Time _____

DIS-A

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Qualifying for Social Security Disability, page 1 of 2

In order to be eligible for Social Security Disability, individuals must fit several qualification criteria put forth by the Social Security Administration (SSA). First, individuals must be able to prove to the SSA that they are "permanently disabled," or suffering from a condition that has lasted, or is expected to last, more than 12 calendar months. Because of this time guideline, it is important that individuals keep their medical records and other paperwork organized and up to date to prevent any confusion or question about the extent of a disability. The SSA will attempt to make a judgment as to whether or not a person's disabling condition prevents the individual from achieving any type of "substantial gainful activity." The condition must prevent the individual from performing the duties of his or her previous employment *and* make it impossible to find a new line of work due to age, education, or impairment.

SSDI

One of two federal programs that provide assistance to disabled individuals, Social Security Disability Insurance (SSDI) is funded by the Social Security tax fund, so individuals who qualify as disabled under the above criteria must also have sufficient work credits in order to qualify for payments. Basically, an individual must have paid Social Security taxes on his or her wages long enough to qualify for benefits. Generally, individuals must have a consistent work history and have worked a minimum of five of the ten years previous to the onset of disability. The work credit requirement can be somewhat less for younger applicants, as parents' work credits can be applied to applicants under the age of 22. For more go to: *www.socialsecurity-disability.org/ssdi/qualify-for-ssdi*.

SSI

Need-based Supplemental Security Income (SSI) has no work requirements. To qualify for SSI, individuals must be over 65 years old, be legally blind, or be disabled, and have total family assets amounting to less than $3,000. Assets, as determined by the SSA, include income (wages, pensions, other benefits programs, etc.) and resources (stock holdings, real estate, cash savings, etc.). Individuals who meet these requirements may be eligible for SSI payments regardless of previous work history. For more go to: *www.socialsecurity-disability.org/ssi/qualify-for-ssi*.

Reasons for Denial

Due mostly to the ever increasing volume of Social Security disability claims, denial rates for applications at the initial stage are about 60%. In the reconsideration stage, or first level of appeal, that number jumps to more than 80%. The most common reasons for denial: the inability of an individual to prove the severity of a disability due to insufficient medical records or other documentation or insufficient work history to meet the work credit requirements of the SSA. Many individuals are unfamiliar with the Social Security appeals process, and are unaware of the proper procedures to pursue their claim in the case of a denial. In order to avoid such problems, individuals should continuously seek treatment from medical professionals and keep all records organized and complete. In addition, the experience of a Social Security attorney or advocate can be invaluable.

Disability vs. Retirement

SSDI, SSI, and Social Security Retirement are three benefits programs managed by the SSA. Many people currently receiving SSDI or SSI are unsure of what will happen to their disability payments once they reach retirement age.In the case of Social Security Disability Insurance, a disability program funded by the Social Security tax, some or all of your monthly payment may be converted to a retirement benefit upon reaching retirement age, but the total amount of benefits should remain the same. Individuals should notify the SSA immediately if their payment goes up, as they will be responsible for the repayment of any excess money awarded to them in error.

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Qualifying for Social Security Disability, page 2 of 2

In the case of Supplemental Security Income, you may still be able to keep some or all of your monthly payment, depending on the amount of your retirement benefit. If your retirement benefit increases your monthly income, some or all of your need-based SSI payment may be abated.

Online Disability Case Evaluation
If you feel that your patient qualifies for SSDI or SSI based on the above criteria for eligibility, go online to: *www.socialsecurity-disability.org/form/free-disability-evaluation* and help your patient fill out an online disability case evaluation.

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Sample Hardship Letter

Date
Provider
Address
Fax number

Re: Your name
Your address
Your social security number
Account number, reference number, date of procedure, etc.

Dear Sir or Madam:

I am writing to notify you of my inability to pay the above-referenced bill for (describe). I have received the enclosed bill (enclose a copy of the documentation that the billing company sent you), but I am unable to pay the bill as outlined. I am not attempting to dispute the charges, nor am I writing to indicate an unwillingness to pay; I'm simply writing to request alternate arrangements for this bill.

My income of (your income amount) is enough to cover my monthly expenses of (expenses) and offset my day-to-day cost of living, but as you can see, my income does not exceed my expenses by the amount of my bill. Therefore, I'm requesting to make payment arrangements that would allow me to pay this bill in full over a period of time consistent with my income and expenses.

I propose the following payment arrangement: (estimate how much you can afford to send in monthly payments, followed by how long it would take you to pay off the bill's balance at that rate). I understand that you are under no obligation to accept this payment arrangement; I'm respectfully requesting that you grant this arrangement or offer me a similar payment plan so that I can satisfy this debt within my current financial limitations.

Thank you for your consideration. If you require any additional information, or supporting documentation for my financial status, please contact me at: (provide your daytime phone number, evening phone number, e-mail address and mailing address).

Sincerely,

Patient's Signature Line

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Tips for Patients Applying to Patient Assistance Programs

- ☑ If you have any questions, call the program directly. Eligibility requirements, drugs, dosages, even programs, change regularly so it's best to go directly to the program for information. If you do not qualify for the PAP but cannot afford your medicine, tell the representative. Some companies may make hardship exceptions and are willing to review situations on a case-by-case basis. Sometimes you can write an appeal letter to the program explaining your financial hardship.

- ☑ Review the Federal Poverty Guidelines and Percentages over the Poverty Guidelines when looking at the eligibility guidelines of a program.

- ☑ Fill out as much information on the application as possible, including the doctor's address and phone number. Highlight the directions for the doctor and where he or she needs to sign. Give the doctor's office an addressed-and stamped-envelope to send in the application or highlight the fax number so it is easy to find.

- ☑ Plan ahead so your medicine supply doesn't run out. When sending in an application, pay attention to the refill process and the amount of allowable refills. Each program is different; some require a call from the doctor's office while another may allow the patient to call directly for a refill; others may require a new application, which takes time.

- ☑ Be neat and complete. The directions on the application should be completed exactly as directed. Print neatly. If something is unreadable or there is a blank, then the application may be denied, which can delay the process of receiving the medicine. Put "N/A" or "not applicable" in blanks that are not filled out to indicate the material was read through and not skipped over. Include supplementary forms if requested. Make sure all accompanying photocopies are clean and readable.

Source: *www.needymeds.org*

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5 Ways to Control Oncology Drug Costs

1. **Speed up Turnover Inventory**

   Don't leave expensive drugs sitting on your shelf. Instead deliver them to your patients in a timely manner so you don't tie up working capital. Inventory management software can help speed up and streamline this process.

2. **Standardize Your Care**

   While most providers consider guidelines from the National Comprehensive Cancer Network (NCCN) as standard of care, the guidelines are very broad. If your program can implements its own guidelines to standardize care, you might increase practice efficiency and decrease costs.

3. **Become a Clinical Trial Site**

   Diversifying your services can offer patients access to the latest therapies and provide revenue. Keep in mind, however, average reimbursement for industry clinical trials tends to be much higher than the fixed reimbursement rate paid by the National Cancer Institute.

4. **Consider a Hospital-Physician Partnership**

   If an oncology practice partnered to perform infusion in a 340B-qualifying hospital-owned clinic, it can be a win for both sides. A professional services agreement between the practice and the hospital could let the practice remain independent, reduce overhead and other costs, and simplify billing.

5. **Join a Pilot Program**

   Today, a number of payers are sponsoring pilot programs aimed at improving quality of patient care and disease management. Often, these pilot programs offer some type of reimbursement for program participation.

Source: Chesanow, N. 5 ways to control oncology drug costs. Medscape Business of Medicine. Available online at: *www.medscape.com/viewarticle/736849*.

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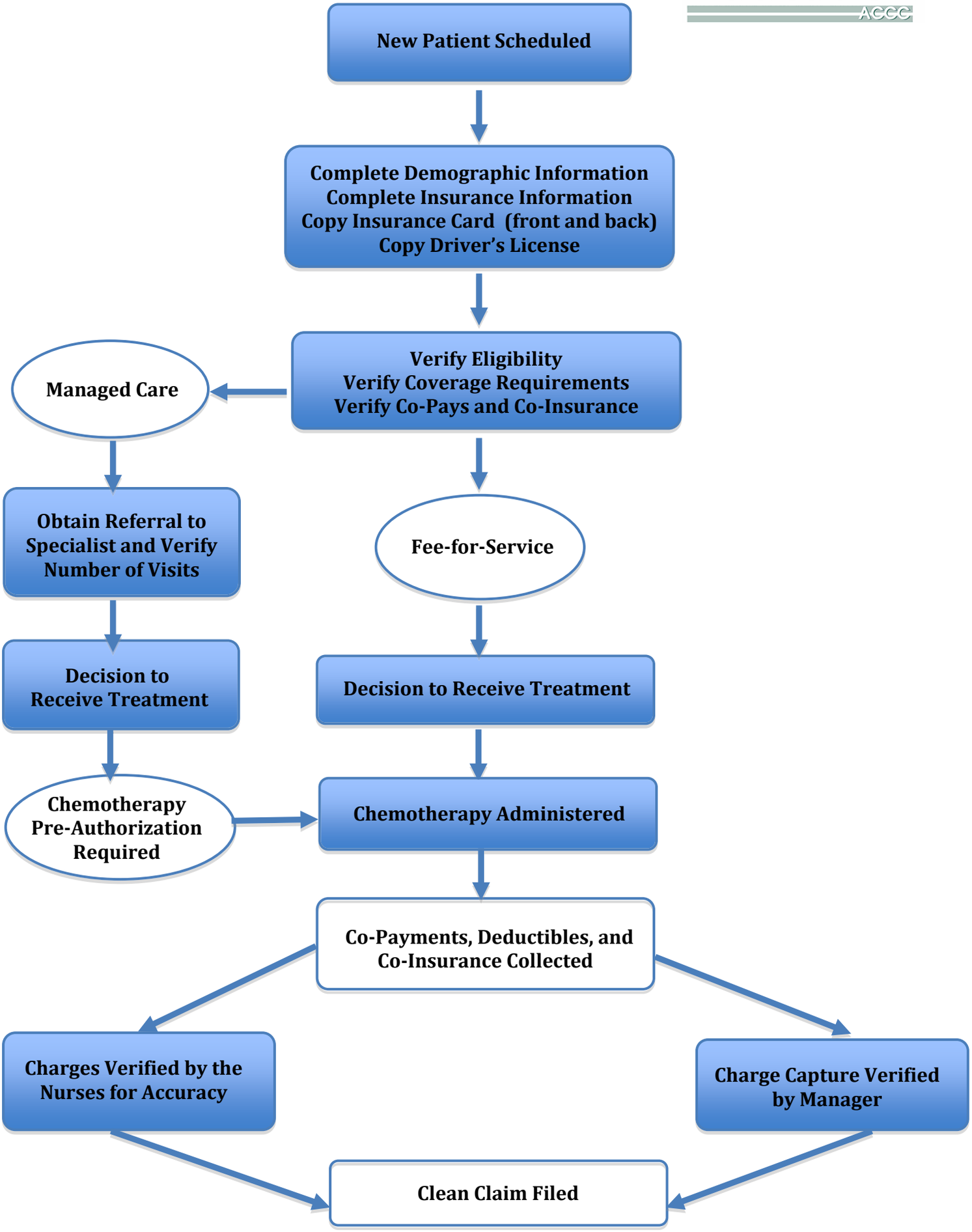
Charge Capture Flowchart



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Charge Capture Policy

Policy No: **Approved by:**
Effective Date:

I. Policy

To verify that all charge forms are appropriately entered for all outpatient oncology services.

II. Scope

This policy applies to all outpatient services delivered.

III. Procedure

Detailed procedures to be followed initiating and billing for outpatient oncology services:

1. Print a Medical Oncology Encounter Form for each patient the evening prior to the patient's scheduled visit or before the patient is seen.
2. Enter all required demographic information, either through a computerized system or by hand.
3. Leave the ICD-9-CM diagnosis information blank and complete on the day of the patient visit.
4. Attach the Encounter Form, with demographic information, on the outside top cover of the patient chart.
5. After the physician has completed the visit, he/she will return the patient chart with the completed Encounter Form to the appropriate cancer program staff.
6. Batch all of the forms for the day and attach a Medical Oncology Daily Encounter Form Summary.
7. Verify that the demographic data are complete for each patient and that each scheduled patient has an Encounter Form or cancellation/no-show status and sign the summary sheet.
8. Review the batch for accuracy and clinical logic. Correct as appropriate, and sign the summary sheet. Return the batch to the appropriate cancer program staff.
9. Enter charges as recorded for each patient within one day of service using the following rules:
   - ☑ All services recorded will be charged.
   - ☑ Visit charges for the facility (which are separate from the professional E&M charges) are charged based on specific payer guidelines.
   - ☑ Each patient can have only one consultation.
10. Once all charges have been entered for a particular day, print a transaction register from the charge data entry system. Compare the transaction register to the Encounter Forms entered to verify that all charges have been entered prior to closing out the charge batch.
11. After data entry is complete, file the batched Encounter Forms, the Summary Sheet, and the transaction register in the center billing files for reference as needed.

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Common Coding & Billing Errors, page 1 of 3

MEDICAL ONCOLOGY

Common Charge Capture Errors

1. Therapeutic infusion (96367) vs. therapeutic push (96375). A push is 15 minutes or less; an infusion is 16 minutes or longer.
2. Concurrent infusion (96368). This code can only be billed once when a therapeutic infusion is running concurrently with a chemo infusion, such as leucovorin. If it runs over 2 hours, only 1 can be billed.
3. Hydration (96360 or 96361). Can be billed only if an order by the physician is written for hydration; it cannot be billed to keep a line open. Must be a separate and distinct infusion (not running with any other infusion) for 31 minutes or more.
4. Proper charging for single-dose vial drug waste. Review CMS guidelines for proper billing of single-dose vials and check with LCD for specific coding. Some require a JW modifier and some do not.
5. Additional hours (96366: therapeutic or 96415: chemo) vs. sequential drug (96367: therapeutic or 96417: chemo). Additional hours are billed for the same drug being infused beginning with the 91st minute. Sequential drug is billed when a different drug is being infused.
6. Do not round off infusion times. Always document exact start and stop time because at the 91st minute you can bill an additional hour.
7. Incorrect billing units: Always follow CMS billable units to ensure the proper amount is being charged.
8. All infusions, pushes, and injections must be given and documented at a separate time. If an injection or push is given during a chemo or therapeutic infusion, both cannot be charged.

Documentation Errors

1. Omission of stop time for IV pushes.
2. Single-dose drug vial documentation. The date, time, amount, and reason must be documented in the medical record with each drug waste.
3. Proper documentation for chemo orders. We recommend following the ASCO/ONS Standards for Safe Chemotherapy Administration, which can be found on the ASCO website. Here are a few key requirements:
   - Maintain and use standardized, regimen-level, preprinted, or electronic forms for chemotherapy prescription writing (oral and parenteral).
   - Verbal orders are not allowed, except when holding or stopping chemotherapy. All new chemotherapy orders or changes to orders must be made in writing by the provider.

Return to TOC

Common Coding & Billing Errors, page 2 of 3

- Complete orders must include:
  - ☑ Patient's full name and a second patient identifier (e.g., medical record number, DOB)
  - ☑ Date
  - ☑ Diagnosis
  - ☑ Regimen name and cycle number
  - ☑ Protocol name and number (if applicable)
  - ☑ Appropriate criteria to treat (e.g., based on relevant laboratory results and toxicities)
  - ☑ Allergies
  - ☑ Reference to the methodology of the dose calculation or standard practice equations (e.g., calculation of creatinine clearance)
  - ☑ Height, weight, and any other variables used to calculate the dose
  - ☑ Dosage. Doses do not include trailing zeros
  - ☑ Route and rate (if applicable) of administration
  - ☑ Schedule
  - ☑ Duration
  - ☑ Cumulative lifetime dose (if applicable)
  - ☑ Supportive care treatments appropriate for the regimen, including pre-medications, hydration, growth factors, and hypersensitivity medications
  - ☑ Sequence of drug administration (if applicable).

RADIATION ONCOLOGY

Charge Capture

The most common missed charges are:

- Dose Calculations: 77300
- Treatment Devices: 77332, 77333, 77334, 77338
- Weekly Physics Check: 77336
- Special Treatment Procedure: 77470

Documentation

1. In Radiation Oncology, each activity and step in the process for patient treatment must have 3 items:
   - ☑ A physician's order for each and every step in the process
   - ☑ Physician's oversight
   - ☑ Physician's documented approval and written report(s). The documentation must cover ALL procedures, both technical and professional. Nothing is understood or standing with regards to orders in radiation oncology. Every billed item must have corresponding documentation in the chart, backed up by physician orders for performance with physician signatures indicating acceptance of the procedure. The key to documentation is clearly explaining MEDICAL NECESSITY for each procedure.
2. Most common codes without proper documentation:
   - Special Treatment Procedure: 77470
   - IMRT: 77301
   - Special Physics Consult: 77370

Return to TOC

Common Coding & Billing Errors, page 3 of 3

MOST COMMON PROCESS RECOMMENDATIONS

- ☑ Hardwire your pre-certification and prior-authorization processes—preferably with a financial counselor dedicated to and accountable to the cancer center. Implement a chemotherapy and/or radiation oncology "pause," in that treatment does not commence until pre-certification is complete.
- ☑ Verify insurance at the beginning of each month.
- ☑ Set up payment plans in advance of treatment.
- ☑ Do not write off line-item denials without further drill-down.
- ☑ If billing is in a centralized hospital department, set up a communication method that includes the cancer center staff in any denials and/or write offs before they occur.
- ☑ Coding diagnosis should be performed by a certified coder from source documents (path report, physician dictation, physician order).
- ☑ Nurses should not be responsible for chemo charge capture; this task should be performed by a billing specialist or coder.
- ☑ A complete review of all radiation oncology charges should be performed at the end of treatment.

Return to TOC

Checklist for Claims Submission

- ☑ Verify that the patient's identification number and all other information are entered correctly.
- ☑ Ensure that the patient's name and address match the payer's records.
- ☑ Verify that the provider's NPI number is included on the claim.
- ☑ Use the most appropriate ICD-9-CM diagnosis and CPT procedure codes associated with each individual patient's diagnosis and care.
- ☑ Ensure the medical record contains appropriate documentation to support the diagnosis and procedure codes submitted on the claim.
- ☑ When billing for drugs, ensure the following information is provided on the claim form if required by the payer:
  - Name of the drug, HCPCS code, and 11-digit NDC number
  - Frequency of administration
  - Route of administration
  - Number of units administered.
- ☑ Use the correct CPT and/or HCPCS codes and modifiers where and when appropriate.
- ☑ Indicate the setting where the service was provided (e.g., physician office or hospital outpatient).
- ☑ File the claim in a timely fashion.
- ☑ Provide complete and accurate information upon request.

Return to TOC

Checklist for Revenue Cycle Review or Audit

Processes to Review

- ☐ Patient registration (obtaining and verifying current insurance and patient information)
- ☐ Pre-certification (verifying patient insurance coverage for the anticipated type of care)
- ☐ Physician orders (verifying that orders are complete and are communicated to the appropriate staff and organizations)
- ☐ Patient scheduling (verifying that registration, pre-certification, and prior authorization have been completed, and that all required orders are complete)
- ☐ Prior authorization (requires specific treatment plan or orders)
- ☐ Financial specialist (verify process for pre-treatment counseling)
- ☐ Check-in (checking for changes in insurance and patient information)
- ☐ Pre-Infusion (verifying processes to receive any required labs to determine that lab results indicate "ok to treat" and to notify pharmacy to mix drugs)
- ☐ Pharmacy (verify appropriate signed physician order, charge entry for dispensed, and wasted drugs)
- ☐ Infusion charge capture (verify drug, dose, route, and duration)
- ☐ Charge entry (verify proper code selection for infusion procedures)
- ☐ Charge transfer (verify accuracy of charge entry data transferred to claims production)
- ☐ Claims production (verify processes for claims that are identified by internal "scrubber"as potentially unpaid)
- ☐ Claims feedback (verify processes for notification of unpaid claims)
- ☐ Financial specialist (verify process for resolving unpaid claims)

Items to Audit

- ☐ Physician orders
- ☐ Physician-assigned diagnosis
- ☐ Nursing documentation
- ☐ Claims
- ☐ EOBs and Remittance Advices

Return to TOC

Claims Billing Policy

Policy No: **Approved by:**
Effective Date:

I. Policy
To ensure that all patients receiving services are billed through the billing system and the appropriate payments are posted.

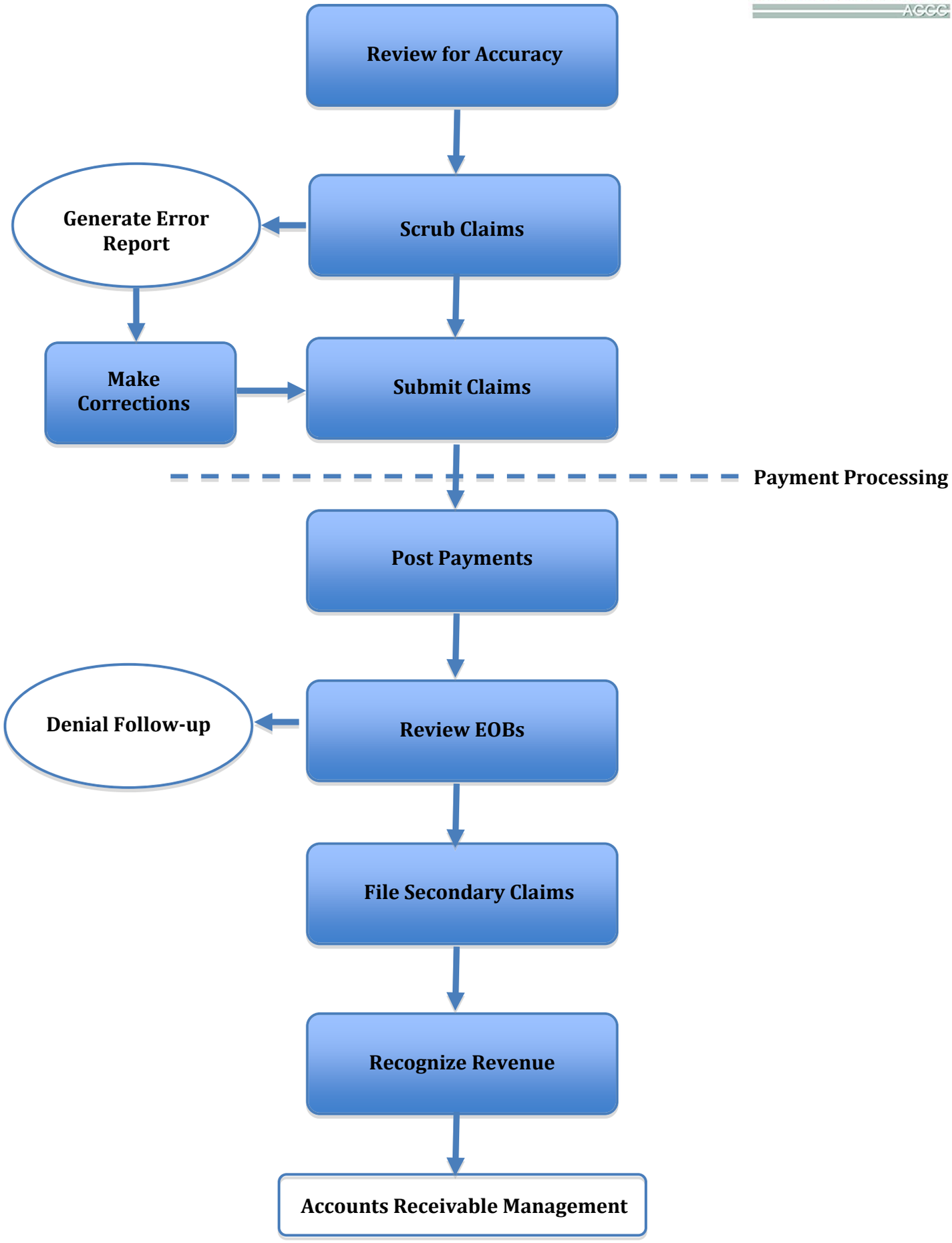
II. Scope
This policy applies to all sites performing services.

III. Procedure
Following are detailed procedures to be followed when performing the billing function:

1. Once the charges have been entered and a charge audit has been performed, the insurance claims and/or patient statements are ready to be generated.
2. Submit claims electronically—no less than once per week submitted. Patient statements are normally set up to print once per month. Each statement should be reviewed prior to mailing to verify that the appropriate charge and/or payment information has been posted accurately.
3. Claims will go through a sequence of edit checks (billing scrubbers and local medical review policy edits). An error report is generated that provides details as to why the claim has not passed the processing function. The error report is used to make the necessary changes to the claim. It is imperative that the billing department works closely with the cancer center, as the information from the cancer center is crucial to the billing process.
4. Once the claim passes all edits, the claim is then submitted to the insurance company for payment.
5. Once the payer reviews the claim, payment is made via an explanation of benefits (EOB) directly to the hospital for the services rendered. Post the appropriate payments to the patient accounts. Post all checks, print a copy of the transactions entered into the system, and review that list against the adding machine tape and EOBs to validate that all payments have been entered accordingly. The EOBs, a copy of all checks, and the adding machine tape will be filed in a day file for that day's payments.
6. A review of the EOB happens at the time of payment posting. If the claim is denied, the EOB is passed along to the denial and follow-up representative. If the insurance carrier pays the claim, and there is a balance left, the patient will receive a statement when the appropriate patient statements are printed.
7. If the primary insurance company has paid the claim appropriately, and the patient has a secondary insurance company, the claim is processed to the secondary insurance. A copy of the EOB from the primary insurance is attached to the claim for verification to the secondary insurance carrier.

Return to TOC

Claims Production & Payment Processing



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Sample Collection Phone Call Scripts

If the financial counselor/navigator role is hard-wired into the oncology practice or cancer center, phone calls for collections should be a rare occurrence. Best practice is for the financial counselor/navigator to proactively meet with patients prior to the start of treatment and routinely throughout their treatment process if and/or when a financial or insurance change occurs. Prospectively setting up payment plans is recommended.

If the patient is still under treatment, the financial counselor/navigator should meet with the patient before or after their appointment in a private setting to discuss collections or large balances, instead of making phone calls.

Here are some sample collection call scripts if calls become necessary.

Sample Collection Call Script #1

Hi, this is XX, the financial counselor at XX Cancer Center, is Mr. XX available? I am calling in regards to an unpaid balance in the amount of $XX for your chemo/radiation, at XX Cancer Center. I have noted that you have gotten behind on your co-pays/routine payments and I wanted to inquire if any changes have occurred in your insurance status or work situation. Are you able to make a payment today over the phone or would you like to come in and meet with me to discuss the changes in your financial situation? Thank you for your time and I look forward to seeing you on XX day.

Sample Collection Call Script #2

Hi, this is XX, the financial counselor at XX Cancer Center, is Mr. XX available? This is the second call in regards to an unpaid balance in the amount of $XX for your chemo/radiation, at XX Cancer Center. Because of the age of the account, an action is required on your part to resolve the balance or set up a payment plan. Are you able to make a payment today over the phone or would you like to come in and meet with me to discuss the changes in your financial situation? Thank you for your time and I look forward to seeing you on XX day.

Sample Collection Call Script #3

Hi, this is XX, the financial counselor at XX Cancer Center, is Mr. XX available? This is the third call in regards to an unpaid balance in the amount of $XX for your chemo/radiation, at XX Cancer Center. We have made several attempts to discuss payment of your overdue account balance, we will need you to make a payment today over the phone or schedule an appointment to discuss a payment plan. Our policy requires we turn your account over to an outside collection agency if payment is not received within 30 days. Thank you.

Return to TOC

Sample Collection Letter #1

Date:

John Doe
Address
City, State, Zip Code

Dear Mr. Doe,

This letter is to remind you of your outstanding balance in the amount of $ _____. Please remit this balance within ten (10) days or contact our office at _____ to advise us when we can expect to receive your payment or if you would like to make other financial arrangements with us.

As a courtesy to our patients, we do accept MASTER CARD and VISA. If you choose to pay your balance with this option, simply complete the form at the bottom, sign, and return this letter to our office.

If you have already mailed your payment, please accept our thanks and apologies for any inconvenience this letter may have caused.

Sincerely,

Patient Account Coordinator

❑ **MASTER CARD** ❑ **VISA**

Card # _____ Expiration Date _____

Cardholder's Signature _____ Date _____

Cardholder's Name _____Amount $ _____

Return to TOC

Sample Collection Letter #2

Date:

John Doe
Street Address
City, State, Zip Code

Dear Mr. Doe,

On (date reminder letter sent), I informed you of your outstanding balance. To date, I have not received payment for this balance nor have you contacted me to discuss your account.

Please contact our office as soon as possible so we do not have to continue further collection efforts. I hope you will act promptly by forwarding to us your payment in full immediately or by contacting me to discuss other financial arrangements.

My phone number is _____.

I look forward to resolving this matter soon.

Sincerely,

Patient Account Coordinator

Return to TOC

Sample Collection Letter #3

PATIENT NAME _____ ACCOUNT # _____

In consideration of an extension of credit granted to (name)_____, as a patient of (physician) _____, agrees to pay the sum of $_____ per month to be applied toward the outstanding balance of $ _____.

This amount is due on the _____ of each month, beginning (date) _____ and will continue until final payment is made on (date) _____.

I understand if I fail to make these scheduled payments, my account will be turned over to an outside collection agency.

SIGNATURE _____ DATE _____

PRINT NAME _____

WITNESS_____DATE_____

RELATIONSHIP TO PATIENT _____

Return to TOC

Denied Claims & Appeals Checklist

REVIEW THE DENIAL

☑ Review the explanation of benefits (EOB) sent by the patient's payer.
- Claims often are denied as a result of simple errors, such as missing identification numbers, patient names, or signatures; claim errors may also consist of reporting incorrect codes or modifiers.

☑ Resubmit the corrected claim form immediately after addressing any errors.

RESUBMIT THE CLAIM FORM

☑ If the reason for denial was not a result of claim submission errors, then submit a letter of medical necessity, as well as supportive materials and literature that highlight the following:
- Patient's medical history.
- Other therapies that have been tried or were contraindicated.
- Medical reasons this patient was prescribed therapy with the drug.
- Medical risks to patient due to foregoing or delaying therapy with the drug.

APPEAL THE DENIAL

☑ If the patient's payer denies the claim again, then consider filing a grievance and reviewing the appeals process; filing a grievance or an appeal must be done as soon as possible as to avoid any timeframe limitations.

☑ Monitor payer response to appealing the denied claim and determine if continued action is necessary.

☑ Patients or their representatives may decide to become involved in the appeals process.

Source: Leukine Reimbursement Guide

Return to TOC

Insurance Denial & Follow-up Policy

Policy No: **Approved by:**
Effective Date:

I. Policy
To ensure that all insurance denials are reviewed and processed in a timely manner.

II. Scope
This policy applies to all outpatient sites performing chemotherapy services.

III. Procedure
Following are detailed procedures to be followed when reviewing insurance denials:

1. The billing clerk will meet with the designated patient account representative on a weekly basis to gather the week's denials for the cancer institute.

2. The billing clerk will review the denials with the patient account representative for any appropriate questions.

3. The billing clerk will individually review each insurance company denial and take the necessary action as requested by the carrier:
   - ☑ Provide appropriate diagnosis for procedure and/or drug.
   - ☑ Provide any additional medical record information as requested by insurance company.
   - ☑ Verify if the service is actually non-covered and notify patient accounts representative.
   - ☑ Verify the appropriate diagnosis and or procedure code as requested.

4. The billing clerk, with the assistance of the patient account representative, will document on the patient's account any action that was taken to process the denial.

5. The billing clerk will keep a log of the types and number of denials in order to track any inconsistencies that may be occurring in registration, charge entry, or claims submission.

6. Report findings to the appropriate director and patient account representative on a monthly basis.

Return to TOC

Tips for Filing Claims

For Electronic Claims DO…

☑ Verify, file, and keep all transmission reports.
☑ Track clearinghouse claims to ensure successful transmission.
☑ Ensure your computer software is consistent with the clean claims rules.
☑ Verify that your software correctly prints the CMS-1500 claim form.
☑ Call your software vendor, if needed, to address the above two items.

For Paper Claims DO…

☑ Use only original claim forms (printed in red drop-out ink).
☑ Avoid folding claims, if possible.
☑ Resist using terms such as "refiled claim," "second request," or "corrected claim."
☑ Avoid handwritten claims.
☑ Use all UPPERCASE letters.
☑ Stay inside the lines of each block.
☑ Ensure claims are printed darkly.

For Paper Claims DON'T…

- Send unnecessary attachments.
- Use staples or paperclips.
- Attach "post-it" notes.
- Mark up the claim with highlighters.
- Use circles or additional markings.
- Attach labels or stickers.
- Add notes or instructional assistance.

Source: Texas Medical Association

Return to TOC

Tracking Form for Denied Claims

Patient's Name	Medical Record or Account #	Payer	Provider	Location Where Treated (if multiple sites)	Date of Service	CPT Code	Support Documentation Sent With Claim	Reason for Denial	Date to Follow-Up	Staff Assigned to Follow-up

By utilizing this tool in excel format, sort the spreadsheet by patient, provider, payer, etc. so trends can be analyzed.
Establish Reason Codes for trending such as: 1. Registration, 2. Charge Entry Error, 3. Duplicates, 4. Medical Necessity, 5. Diagnosis, 6. Proper Documentation, 7. Bundled Services, 8. Non-covered Services

Return to TOC

Sample Appeal Letter #1

LETTER ON BEHALF OF A PATIENT TO APPEAL DENIAL FOR CARE

[Name]
[Insurance Company Name]
[Address]
[City, State ZIP]

Re: [Patient's Name]
[Type of Coverage]
[Group number/Policy number]

Dear [Name of contact at insurance company]:

Please accept this letter as [patient's name] appeal to [insurance company] decision to deny coverage for [state the specific procedure/drug(s) denied]. It is my understanding based on your letter of denial dated [date] that this procedure has been denied because: [Quote the precise reason for the denial stated in denial letter].

As you know, [patient] was diagnosed with [disease] on [date]. Currently Dr. [name] believes that [patient] will significantly benefit from [procedure/drug name(s)]. Please see the enclosed letter from Dr. [name] that discusses [patient's] medical history in more detail.

[Patient] believes that you did not have all the necessary information at the time of your initial review. [Patient] has also included with this letter, a letter from Dr. [name] from [name of treating facility] who is a specialist in [specialty]. [His/Her] letter discusses the procedure in more detail. Also included are pertinent medical records, and journal articles explaining the procedure and the results.

Based on this information, [Patient] is asking that you reconsider your previous decision and allow coverage for the procedure Dr. [name] outlines in his letter. The treatment is scheduled to begin on (or was started on) [date]. Should you require additional information, please do not hesitate to contact [Patient] at [phone number]. [Patient] will look forward to hearing from you in the near future.

Sincerely,
[Your Name]

Return to TOC

Sample Appeal Letter #2, page 1of 2

LETTER ON BEHALF OF A PATIENT TO APPEAL DENIAL FOR CARE

[Name]
[Insurance Company Name]
[Address]
[City, State ZIP]

Re: [Patient's Name]
[Type of Coverage]
[Group number/Policy number]

Dear [Appeals Analyst]:

I am writing, on behalf of [Patient], to appeal the [Health Plan] decision to deny [service, procedure, or treatment sought] for [Patient].

It is our understanding that [Health Plan] is denying coverage on the basis that "[cite Health Plan's language in the denial letter]." [Attach denial letter.] We believe that [service, procedure, or treatment sought] is medically necessary to treat [Patient]'s medical condition and that [service, procedure, or treatment sought] is a covered plan benefit.

[Health Plan] covers medically necessary services that are not expressly excluded, which are described in the Evidence of Coverage and which are authorized by the member's PCP and in some cases approved by an Authorized Reviewer. [Attach relevant section from Evidence of Coverage.] The entire treatment team has recommended that [service, procedure, or treatment sought] is medically necessary. [Attach supporting medical letter from physician.]

Contrary to your letter, [service, procedure, or treatment sought] is a covered service. [Service, procedure, or treatment sought] is stated as a covered benefit in your Member Handbook, is implicitly covered in the Evidence of Coverage, and is not expressly excluded as a covered service in the Evidence of Coverage. [Quote from Member Handbook and Evidence of Coverage to establish that the service, procedure, or treatment is a covered benefit and not expressly excluded.] [Cite your state's mandated benefit laws requiring that the health plan provide this coverage.]

[Describe member's health condition, and why the service, procedure, or treatment would benefit the member and the consequences if the patient does not receive this treatment.]

[If the treatment is out-of-network, establish that there are no comparable services offered within the network.]

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Sample Appeal Letter #2, page 2 of 2

[Finally, if you feel the Health Plan won't cover the service because of the precedent, ask them to consider covering it as an extra-contractual benefit, and to pay for the service, procedure, or treatment out of the Health Plan's catastrophic payment pool.]

[If the member requires immediate treatment for the condition, request an expedited hearing. Request that they respond within 72 hours of mailing of the letter.] [Attach a letter from your treating physician describing the patient's condition.]

Thank you for your immediate attention to this matter.

Sincerely,
[Your name]

cc: [Possible individuals to whom you should consider sending copies of your letter]
[Health Plan Medical Director]
[Medical Group Medical Director]
[Your primary care or treating physician]
[Your state representative if you anticipate further denials]

Return to TOC

Sample Appeal Letter #3

LETTER FOR PATIENT TO USE
TO APPEAL DENIAL FOR CARE OUT OF NETWORK

[Date]

[Name]
[Insurance Company Name]
[Address]
[City, State ZIP]

Re: [Patient's Name]
[Type of Coverage]
[Group number/Policy number]

Dear [Name of contact person at insurance company]:

Please accept this letter as my appeal to [insurance company]'s decision to deny coverage for [state the specific procedure/drug(s) denied]. It is my understanding based on your letter of denial dated [date] that this procedure has been denied because: [Quote the precise reason for the denial stated in denial letter]

I have been a member of your [state name of PPO, HMO, etc.] since [date]. During that time I have participated within the network of physicians listed by the plan. However, my primary care physician, Dr. [name] believes that the best care for me at this time would be [state procedure]. At this time there is not a physician within the network who has extensive knowledge of this procedure. Dr. [name of primary care physician], a plan provider, has recommended that I have the procedure done outside the network by Dr. [name of specialist] at [name of treating facility].

I have enclosed a letter from Dr. [name of primary care physician] explaining why he recommends [procedure]. I have also enclosed a letter from Dr. [name of specialist] explaining the procedure in detail, his qualifications and experience, and articles that discuss the procedure.

Based on this information, I am asking that you reconsider your previous decision and allow me to go out of network to Dr. [name] for [name of procedure]. The procedure is scheduled to begin on [date]. Should you require additional information, please do not hesitate to contact me at [phone number]. I look forward to hearing from you in the near future.

Sincerely,
[Your Name]

Return to TOC

Job Description: Financial and Billing Coordinator

TITLE: **FINANCIAL AND BILLING COORDINATOR**

JOB NO:

DEPT NO:

SUPERVISOR: **CANCER CENTER ADMINISTRATOR**

FUNCTION:

Responsible for ensuring all charge entry, coding, and reimbursement activities, including securing, maintaining, and distributing the most current coding information and implementing changes.

ESSENTIAL JOB FUNCTIONS:

1. Ensures cancer center staff is updated on most recent billing and coding requirements.

STANDARD: Routinely reviews local, state, and federal requirements for medical and radiation oncology billing and educates staff to most accurate procedures.

2. Pre-registers all new patients.

STANDARD: Obtains all appropriate information necessary to perceptively screen patients, obtains all relevant medical data, and provides directions and other information to patients.

3. Oversees pre-certification of patients.

STANDARD: Oversees chart coordinators in the pre-certification of patients. Oversees the contacting of insurance companies, referring physicians, etc., and obtaining certification to provider services to the patient.

4. Reviews all accumulated charges prior to entry into the information system.

STANDARD: Ensures that correct coding is accumulated throughout the process of a patient visit prior to ordering information into the information system. Makes appropriate changes and educates personnel on the appropriate utilization of codes.

5. Keys information into information system and produces billing material.

STANDARD: Ensures that all information must be entered accurately.

6. Reviews and verifies insurance claims.

Return to TOC

Job Description: Financial and Billing Coordinator

STANDARD: Ensures that claims are accurate prior to submission.

7. Follows up with insurance companies and ensures claims are paid.

STANDARD: Contacts insurance companies to ensure prompt payment.

8. Resubmits insurance claims that have received no response, denials, etc., with appropriate information.

STANDARD: Ensures that payments are received for services rendered by appropriately following up with the insurance companies.

9. Performs financial counseling for patients and family members.

STANDARD: Utilizing physician prescription and treatment plan in conjunction with insurance verification, determines insurance and patient responsibility. Reviews all information with patient and sets up payment plan for payment completion by end of course of treatment if possible.

10. Determines co-payments to be paid by patient and informs receptionist for collection.

STANDARD: As part of financial counseling, sets up payment schedule to include required co-payments. Informs receptionist and ensures collection.

11. Posts all payments received for patients being followed.

STANDARD: Makes line item posts payments to the system. Follows and rectifies any inappropriate payments.

EDUCATION & EXPERIENCE:

High school diploma or equivalent.

QUALIFICATIONS:

- 2 years prior billing experience for physician practice required.
- Oncology billing experience preferred.
- Knowledge of medical terminology.
- Knowledge of insurance industry.
- Knowledge of grammar, spelling, and punctuation to type correspondence.
- Skill in using computer programs and applications.

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Job Description: Patient Access Coordinator, page 1 of 3

TITLE: **PATIENT ACCESS COORDINATOR**

DEPARTMENT:

REPORTS TO:

SALARY RANGE:

JOB#:

JOB SUMMARY:

The Patient Access Group of the Medical Oncology and Hematology Department is responsible for on-boarding all new patients into the department. Under direction of the supervisor, the Patient Access Coordinator performs specific functions requiring specialized education or training, such as oncology coding (ICD-9, CPT, HCPCS), knowledge of NCCN guidelines for drug therapy indications payable by insurers or Medicare and Medicaid, and patient advocacy and drug replacement programs that enhance or replace charity care provided by the institution.

Performs team's processes with respect to patients with an inability to pay, i.e., serves as liaison between Medical Oncology and Hematology Department and Finance, submitting applications for Medicaid, FAP, grants, etc., and determines eligibility for any Federal, State, or internal healthcare assistance programs. Provides assistance to all patients of the Medical Oncology and Hematology Department from pre-registration to collection of funds. He or she evaluates patient insurance benefits and counsels patients on financial matters, including benefits, financial support, drug assistance, co-pay assistance, and other assistance programs. Handles inquiries from customers regarding any aspect of services received or status of account, and applies outstanding customer service skills on a daily basis. Has functional knowledge of patient access and billing operations in the specialized field of medical oncology and hematology.

MAJOR ACCOUNTABILITIES AND CRITICAL RESPONSIBILITIES:

1. Demonstrates knowledge of the revenue cycle.

2. Performs follow-up of claims. Maintains files and contacts appropriate parties to determine correct status and follow-up of unpaid accounts. Processes and follows-up on all assigned patient accounts until paid in full, managing accounts receivable for professional service billing.

3. Updates receivable system with any new, corrected, or pertinent information in relation to resolution of receivable accounts, and ensures that proper information for follow-up is shown in medical record.

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Job Description: Patient Access Coordinator, page 2 of 3

4. Understands and accurately applies requirements for pre-certification of chemotherapy drug regimens; pre-certifies treatments as indicated by government and private insurers.

5. Insures eligibility and benefits are properly verified prior to initial visit and thereafter as directed.

6. Makes daily deposits. Balances credit card machines and other deposit reconciliations as required.

7. Pre-registers patients. Demonstrates ability to have meaningful discussion of benefits with patient when pre-registering, and when present in the department.

8. Does financial counseling. Evaluates care plans and communicates with patient to establish payment expectations based on individual insurance benefit plans.

9. Demonstrates skill with EHR or EMR system as required.

10. Assists physicians in determining approved regimens for treatment. Familiar with NCCN guidelines and ensures that regimens are approved according to same.

11. Demonstrates knowledge of coding for ICD-9, CPT, and HCPCS.

12. Applies department processes for non-profit, community, pharmaceutical, Federal, State, and health system financial assistance programs. Demonstrates knowledge of Federal and State requirements for assistance to patients with an inability to pay.

13. Demonstrates knowledge of drug replacement programs, grant programs, co-pay foundation programs, and other cancer-related patient support options. Processes and monitors applications for same, and captures highest level of value to patient and institution. Maintains cumulative value record of same.

14. Provides timely and accurate information regarding patient data and status to other health system departments, physicians, physician office staff, and other public agencies while ensuring patient confidentiality is not breached.

15. Exhibits excellent customer service skills and serves as an advocate for the patient in obtaining and understanding all assistance programs.

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Job Description: Patient Access Coordinator, page 3 of 3

ADDITIONAL RESPONSIBILITIES:

- Performs other related duties as assigned or requested in order to maintain a high level of service.
- Completes required continuous training and education, including department specific requirements.
- Demonstrates professional work behavior by following Service Standards and Success factors.
- Complies with departmental organizational policies and procedures and adheres to external agency requirements.
- If bilingual, capabilities such that accurate and effective communications exists.

QUALIFICATIONS AND REQUIREMENTS:

- High School diploma or equivalent required, some college or business school training preferred.
- Five (5) or more years prior equivalent experience in a business setting is preferred.
- A high degree of computer literacy in a PC environment is required with strong organizational, interpersonal and communication skills.

PATIENT POPULATION SERVED:

Adult and Geriatric

MANUAL SKILLS:

- Significant portions of daily assignments involve application of manual skills requiring motor coordination
- Combination with finger dexterity.

PHYSICAL EFFORT:

- Duties involve little or no exertion of physical effort.

PHYSICAL ENVIRONMENT:

- Generally pleasant working conditions. Nature of duties performed presents little or no potential for job-related accidental injury.

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Job Description: Patient Advocate, page 1 of 2

Title: **Patient Advocate**

Job No.

Reports to: **Billing Manager**

Non-Exempt

SCOPE:
Under minimal supervision, the Patient Advocate is responsible for insurance and eligibility verifications and assessment of financial requirements of recommended treatment. Treatment including, but not limited to, chemotherapy, surgery, radiation therapy, office visits, counseling, nutrition, and other cancer-related therapy. The Patient Advocate counsels the patient on insurance benefits and co-payments and obtains pre-authorization when applicable. This position is in constant communication with patients, physicians, nursing staff, and third-party payers.

ESSENTIAL DUTIES AND RESPONSIBILITIES:
- Performs insurance verification with all third-party payers. Obtains initial and subsequent pre-authorization for recommended services on all new patients and internal referrals.
- Ensures all demographic, insurance, and patient eligibility information is obtained, current, and entered into the electronic medical record (EMR) in an accurate and timely manner.
- Re-verifies benefits and obtains authorization and/or referral after treatment plan has been discussed prior to the initiation of treatment. Ensures appropriate signatures are obtained on all necessary forms including, but not limited, AOB, insurance verification, and treatment pathway.
- Communicates to the treatment team any anticipated issues with coverage that may impact the sequencing and timeliness of care.
- Utilizes the Summary of Patient Reimbursement and Liability form and obtains appropriate approvals as required.
- Performs financial counseling process on all patients prior to treatment, which includes outlining and explaining financial obligations and billing process and establishing payment arrangements with the patients as necessary for the planned treatment and or procedures.
- Documents financial counseling process and discussions in the EMR and forwards necessary documentation to the central business office.
- Assists patients in obtaining financial assistance (i.e., Medicaid, drug replacement) outside assistance (i.e., transportation, other community services as indicated) and assists patient to fill out forms as necessary relative to financial liability and estimated treatment costs.
- Demonstrates an understanding of the need for patient confidentiality to protect the patient and the clinic corporation. Follows all necessary HIPAA regulations to protect patient information.
- Follows policies and procedures to contribute to the efficiency of the front office. Assists with other front office functions as requested.

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Job Description: Patient Advocate, page 2 of 2

MINIMUM QUALIFICATIONS:

Formal Education and Certification

- High school diploma or equivalent.
- Associate's degree in health sciences and/ or medical records certificate program preferred.
- Minimum five years medical business office experience with insurance procedures and patient interaction necessary.

Knowledge and Experience

- Working knowledge of healthcare insurance, particularly Medicare and Medicaid.
- Strong knowledge of diagnostic (ICD-9), procedural (CPT) coding, and cancer terminology
- Basic Microsoft office computer skills including word processing and Outlook.
- Familiarity with basic functions of an EMR.

Personal Attributes

- Strong written, oral, and interpersonal communication skills.
- Organizational and problem-solving skills also necessary.
- Highly self-motivated, self-directed, and attentive to detail.
- Able prioritize and execute tasks in a high-pressure environment.
- Strong customer service orientation.
- Experience working in a team-oriented, collaborative environment.

PHYSICAL DEMANDS AND WORKING CONDITIONS:

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

- Sitting for long periods of time.
- Stooping, bending, and stretching for files and supplies.
- Occasionally lifting files or paper weighing up to 30 pounds.
- Requires manual dexterity sufficient to operate a keyboard, calculator, telephone, copier, and other office equipment.
- Vision must be correctable to 20/20 and hearing must be in the normal range for telephone contacts.
- Must be able to view and type on computer screens for prolonged periods of time.

WORK ENVIRONMENT:

The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. Work is performed in an office environment. Involves frequent interaction with staff, patients, and the public.

Employee Signature **Date**

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Job Description: Patient Financial Advocate, page 1 of 3

Payroll Title: **Patient Financial Advocate**

Unit and Area:

Position Number:

Revision Date:

Dept Title:

I. JOB SUMMARY

The Patient Financial Advocate is responsible for assisting patients and/or families to access financial resources. The Advocate assists Social Services with guidance to those patients who may qualify for assistance through state, county, and federal programs. The Advocate is also available to patients and families to answer questions regarding their insurance, to give estimates of co-pay amounts, and to aid patients in obtaining prior authorizations for services.

II. DUTIES AND RESPONSIBILITIES

A. Professional

1. Assist appropriate patients and families to explore options for financial assistance for medical services with referral to Social Services when appropriate.
2. Follow up with appropriate patients and families for financial assistance needs.
3. Obtain necessary insurance information for patients. Answer questions or direct patients to appropriate staff members for questions regarding insurance, billing, payment, and/or collection arrangements.
4. Meet with patients to discuss estimated costs of therapies.
5. Work closely with patients and Patient Financial Services (PFS) to resolve account balance issues and establish payment plans.
6. Obtain needed prior insurance authorization for diagnostic tests (i.e., PET Scans and Medical Imaging).
7. Develop appropriate templates of charges by care regimen to assist patients.
8. Refer patients to Social Services for “free drug replacement” from pharmaceutical companies.
9. Assist Social Services with HLA testing authorization for BMT patients.
10. Complete Disability and Medical Necessity forms to assist patients.
11. Perform other duties and responsibilities as assigned.

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Job Description: Patient Financial Advocate, page 2 of 3

B. Professional Communication

1. Maintain confidentiality in matters relating to patient and family.
2. Interact with patients and families with a variety of developmental and socio-cultural backgrounds.
3. Provide information to patients and families to reduce anxiety and convey an attitude of acceptance, sensitivity, and caring.
4. Maintain professional relationships and convey relevant information to other members of the healthcare team within facility and any applicable referral agencies.
5. Initiate communication with peers about priorities.
6. Relay information appropriately over telephone, pagers, and other communication devices.

C. Teamwork

1. Accept assignments based on workload, priorities, and the qualifications and competencies of self and of other staff members.
2. Work closely with other staff, coworkers, peers, and other members of the healthcare team to ensure a positive and effective work environment.
3. Report to appropriate personnel regarding assignments and projects.
4. Initiate problem-solving and conflict resolution skills to foster effective work relationships with peers.
5. Report to work on time and as scheduled.

D. Professional Development

1. Attend staff meetings, in-services, and continuing education.
2. Contribute to annual reviews of peer performance as requested by the unit or area supervisor, manager, or director.
3. Assist in the development of indicators, thresholds, study methods, and data collection as assigned.
4. Respond to problems and opportunities to improve care and customer service.
5. Support involvement in the hospital's Performance Improvement (PI) initiatives.
6. Participate in and maintain competencies required for the position and specific unit or area(s) of assignment.

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Job Description: Patient Financial Advocate, page 3 of 3

III. JOB REQUIREMENTS

A. Bachelor's degree in social work or related field.
B. If individual has BSW, he or she will continue to obtain current licensure to practice in state, or the ability to obtain a license within six months.
C. Excellent communication skills to include oral and written comprehension and expression.
D. Ability and willingness to exhibit behaviors consistent with standards for performance improvement and organizational values (e.g., efficiency and financial responsibility; safety; partnership and service; teamwork; compassion; integrity; and trust and respect).
F. Ability and willingness to exhibit behaviors consistent with principles for service excellence.
G. A minimum of two year's experience in health-related agency or completion of field placement in healthcare setting.
H. Awareness of philosophy of care as it relates to Patient Financial Services.
I. Demonstrate knowledge of current resources and programs to assist the patient's need for financial resources, i.e., Social Security Disability programs.
J. Demonstrate ability to act with sensitivity as a patient advocate.
K. Demonstrate interview skills and clearly define the problems and concerns to patients and family systems as related to medically-related financial needs.

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Job Description: Patient Financial Counselor, page 1 of 2

Job Title:	**Patient Financial Counselor**
Department:	**Medical Oncology**
Reports To:	**Director, Oncology Services**
Work Schedule:	**Part time:** Three days a week 8:00 am-5:00 pm; must be flexible to allow for vacation coverage; no weekends, no overtime, no travel

JOB SUMMARY:
To initiate and coordinate pre-certification and prior authorization for patients with their insurance carrier, to provide financial counseling to patients, and to work closely with the business office to ensure timely claim and account follow up.

PRIMARY JOB DUTIES:
- Coordinate with the patient, physician, insurance company, and hospital on the complete pre-certification process, including second opinions and tertiary referrals.
- Make and answer telephone calls from patients and insurance companies regarding the pre-certification process.
- Process additional information requests and coordinate with the insurance biller on requests for letters of medical necessity from and to insurance companies.
- Receive and process insurance information and forms from patients and insurance companies.
- Review provider and chemotherapy schedules, checking patients' accounts for outstanding insurance claims over 60 days and communicating with the biller to request additional claim follow up.
- Review patient chemotherapy protocols and determine insurance benefits and patient responsibility.
- Establish payment arrangements with the patient and document appropriately in the practice management system.
- Discuss payment arrangements with patients for outstanding patient balances.
- Process oral medication prescriptions for potential office dispensing.
- Work with pharmaceutical companies and other resources to obtain grants and financial aid for patients in need.
- Perform other duties as assigned.

QUALIFICATIONS:
To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

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Job Description: Patient Financial Counselor, page 2 of 2

EDUCATION AND/OR EXPERIENCE:
High school diploma or general education degree (GED); or six months to one year related experience and/or training, including customer service; or equivalent combination of education and experience; medical terminology, medical insurance experience preferred

CERTIFICATES, LICENSES, REGISTRATIONS:
None required.

LANGUAGE SKILLS:
Ability to read and interpret basic business correspondence, safety instructions, operating instructions, and policy manuals. Ability to write routine business correspondence. Ability to speak effectively and communicate with physicians, patients, and other staff members.

MATHEMATICAL SKILLS:
Ability to add, subtract, multiply, and divide in all units of measure, using whole numbers, common fractions, and decimals.

REASONING ABILITY:
Ability to apply common sense understanding to carry out detailed but uninvolved written or oral instructions. Ability to deal with problems involving a few concrete variables in standardized situations.

PHYSICAL DEMANDS:
The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. While performing the duties of this job, the employee is regularly required to sit, must have finger dexterity, and talk and hear. The employee must occasionally stand and walk and lift and/or move up to 10 pounds. Specific vision abilities required by this job include close vision, distance vision, color vision, peripheral vision, and ability to adjust focus.

OTHER SKILLS AND ABILITIES:
Basic keyboard skills and computer knowledge; Good communication skills; Good telephone skills, including use of multi-line phone; Professional demeanor and attitude; Ability to work effectively with others. Medical terminology helpful.

WORK ENVIRONMENT:
This job is performed indoors in a controlled environment where the noise level is usually moderate. The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job.

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Average Time Spent on Financial Advocate Tasks

The Center for Provider Education ACCC Association of Community Cancer Centers

Procedure	Time Spent (minutes)	Financial Advocate A	Financial Advocate B	Financial Advocate C
Add-on appointment		20 minues		
Append QCL		15 minutes		
Approval of treatment		15 minutes		
Authorization expiration		30 minutes		
Authorizations for procedure(s)		30 minutes		
Authorization for radiation oncology TX		30 minutes		
Authorization for drugs		15 minutes		
Authorization for test(s)		30 minutes		
Authorization for treatment		30 minutes		
Billing issue		30 minutes		
Call to patient		15 minutes		
Check insurance information		15 minutes		
Chemotherapy pause		30 minutes		
Complete necessary application(s)		30 minutes		
Contact Patient Financial Services		30 minutes		
County Assistance applications		45 minutes		
Disability applications		30 minutes		
FMLA applications		30 minutes		
Financial advocate interview with patient		30 minutes		
Insurance inquiry		15 minutes		
Insurance investigation		30 minutes		
Miscellaneous activities		15 minutes		
New start(s)		30 minutes		
Non-covered services		30 minutes		
Other (Identify activity)		15 mini		
Pre-authorization		30 minutes		
Psychiatric referral		5 minutes		
Referrals (all others)		30 minutes		
Social Work referral		5 minutes		
Regimen change		30 minutes		
Reminder to Patient		15 min		
Self-pay		45 minutes		
Triage request		30 minutes		
Verification of benefits		15 minutes		

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Chemotherapy Care Plan

Insurance plan:		
Diagnosis:		
TREATMENT PLAN:		
Initial consult:		
Estimated Chemo Start Date:		
# MD visits with chemo:		
# of cycles:		
# days in cycle:		
Total # of chemo infusions:		
SCHEDULE	**Weekly**	
	Q O Week	
	Q 3 Week	
	OTHER	
Pre-meds	**J Codes**	**Push or Infusion**
#1		
#2		
#3		
#4		
Chemo list (J codes)	**J Codes**	**Duration**
#1		
#2		
#3		
#4		
#5		
VAD	**Yes**	**No**
Supportive care drugs	**J Codes**	**Route**
#1		
#2		
#3		

Approved by:	**Pre-certification #**	**# Cycles**	**Date**

Comments:

		Date
MD Signature		
RN Signature		
FC Signature		

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Estimate of Patient Responsibility of Treatment Costs

ESTIMATE SUMMARY

Date of Service:
Account Medical Record:
Patient Name:
Provider:
Insurance:
Policy Number:
CO-PAY: Specialist visit:
CO-INSURANCE % PLAN TERMS:

Date of Service	Procedure & Revenue Code	Charge Amount	Contract Allowance	Co-Pay	Co-insurance (Percentage)	Co-insurance (Dollars)	Plan Deductible	Deductible Paid to Date	Deductible Remaining	PATIENT ESTIMATED RESPONSIBILITY
1/1/2012			$ 500.00	$ 10.00	50%	$ 250.00	$ 1,000.00	$ 50.00	$ 950.00	$ 510.00
2/1/2012			$ 300.00	$ -	50%	$ 150.00	$ 1,000.00	$ 560.00	$ 440.00	$ 300.00
3/1/2012			$ 2,000.00	$ 10.00	50%	$ 1,000.00	$ 1,000.00	$ 860.00	$ 140.00	$ 1,080.00
4/1/2012										
5/1/2012										
TOTAL PATIENT ESTIMATED RESPONSIBILITY										$ 1,890.00

Office co-payments are due at time of service. Payment plans are available.

Estimated Payment Plan agreement, please sign below.

PATIENT (GUARANTOR)
SIGNATURE_____DATE_____

Disclaimer: The purpose of the ESTIMATE is to allow the patient (guarantor) and provider to better understand the patient's financial obligation for a particular healthcare service rendered by the provider. The ESTIMATE does not guarantee insurance payment to the provider and is based on benefit coverage and eligibility for services outlined above at the time the ESTIMATE is generated. The ESTIMATE does not affect Insurance actual claim adjudication and payment accuracy. It is merely an estimate of potential patient responsibility

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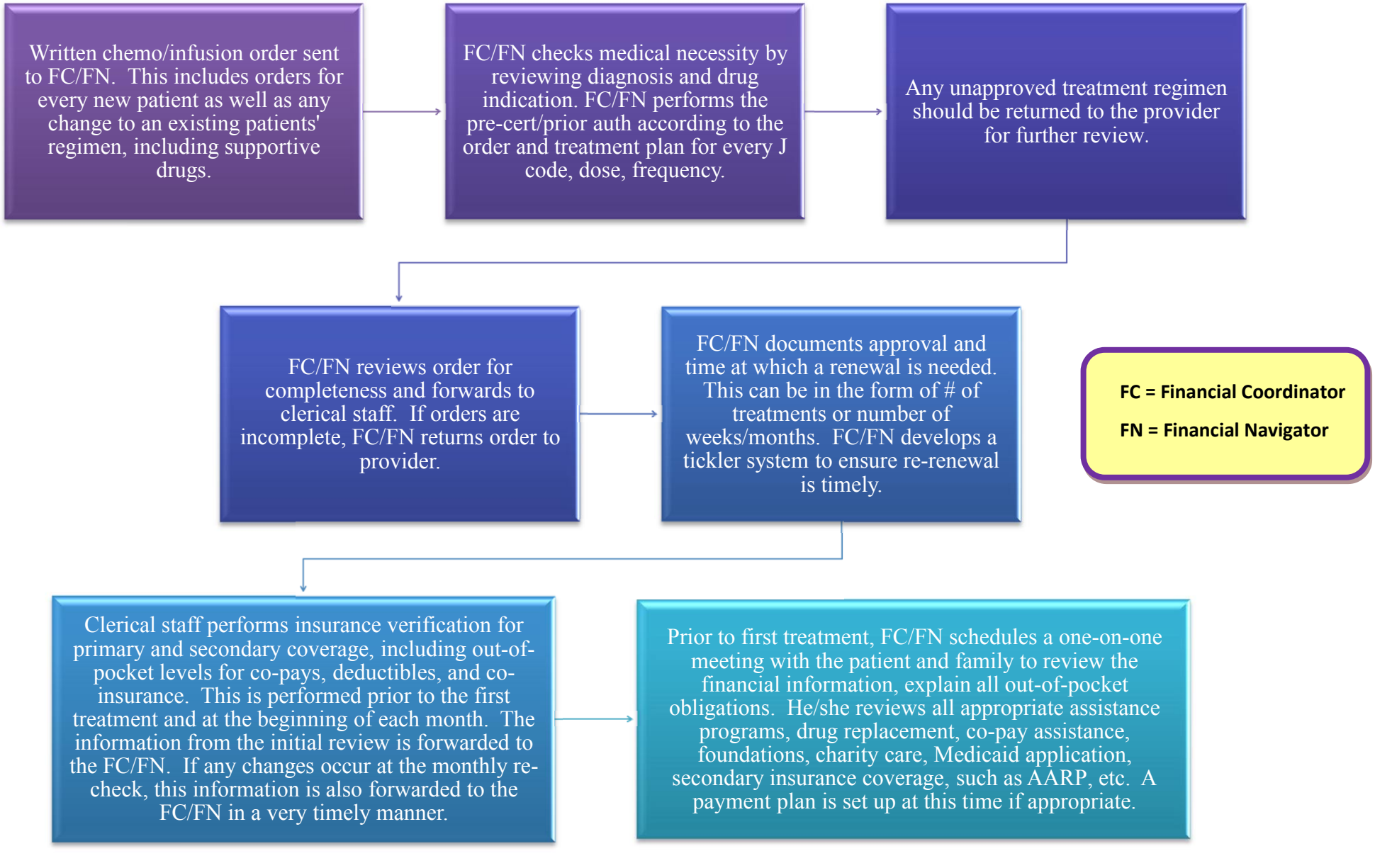
Financial Assistance Navigation Flowchart



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Financial Counselor/Nurse Navigator Care Plan

Affix Patient Label Here

Insurance Plan:

Diagnosis:

TREATMENT PLAN

Initial MD visit date:
F/C tech. charge

Chemo start date:

MD visit with chemo:

How many cycles ___ x days in a cycle_____ = total chemo infusions_____

Schedule: WKLY Q OTHER WEEK Q 3RD WEEK OTHER_____

Amount of time needed to infuse chemo: #1_____
#2_____
#3_____
#4_____

Any Pre Meds: Y or N

Number IV push: (pre-medication)_____ times total infusions = _____
anything that takes less then 20 min

Number IV infusion (pre-medication)_____x total infusions = _____
anything that takes more then 20 min

Supportive IV infusion:

Y or N

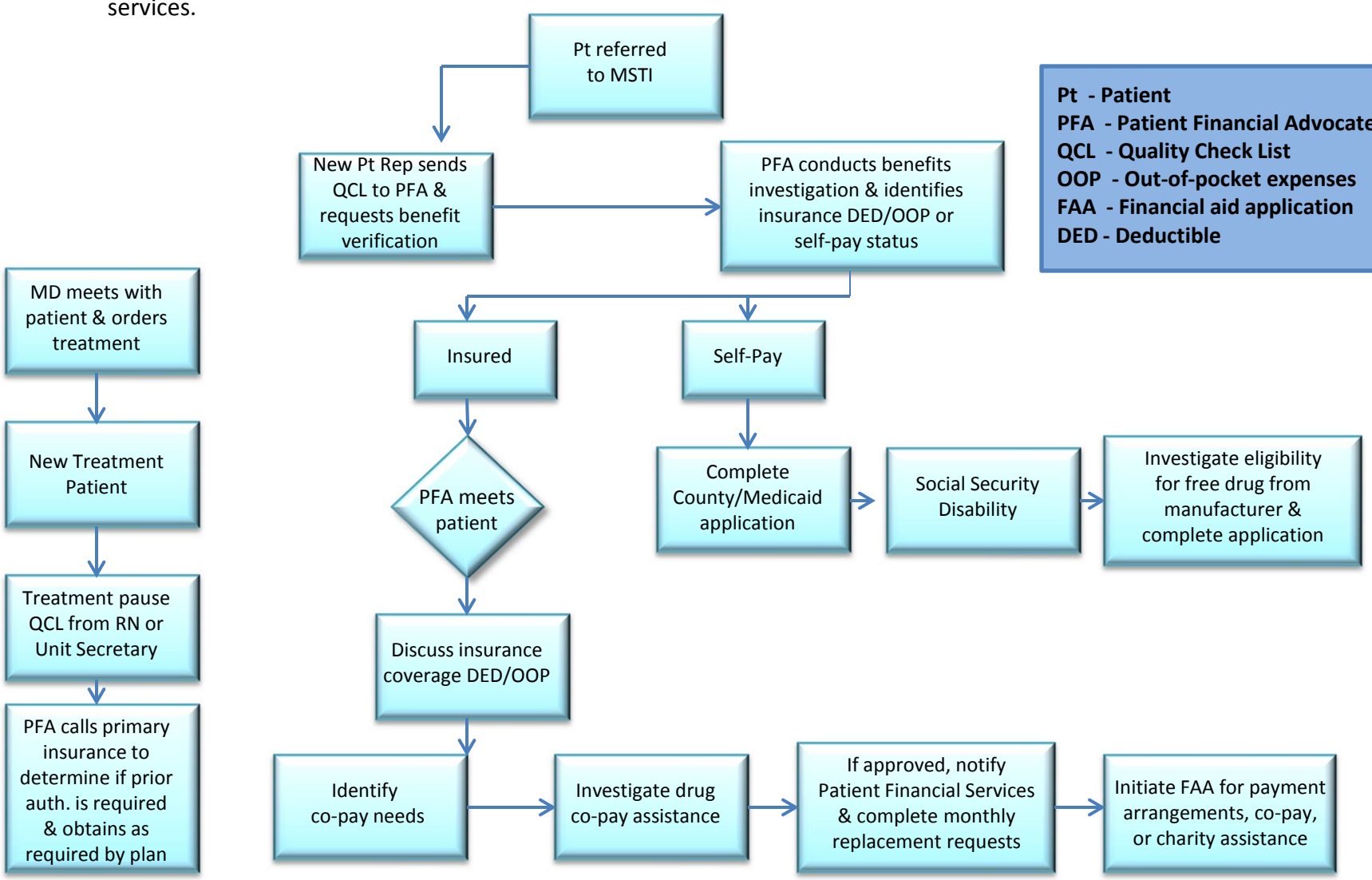
Y or N if yes how many should include MD visit _____

J-codes

Return to TOC

New Patient Treatment Flowchart

Mountain States Tumor Institute, Boise, Idaho, flow-charted how new patients move through their system. See how the patient financial advocates work in conjunction with physicians to ensure reimbursement for services.



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Oral Chemotherapy Tracking Tool

	Patient Name A	Patient B	Patient C
Patient identification number			
Drug 1			
Dose			
Source of financial assistance			
Notes (status of assistance)			
Cost per month			
Average number of cycles for drug			
Cost-savings			
Drug 2			
Dose			
Source of financial assistance			
Notes (status of assistance)			
Cost per month			
Average number of cycles for drug			
Cost-savings			
Drug 3			
Dose			
Source of financial assistance			
Notes (status of assistance)			
Cost per month			
Average number of cycles for drug			
Cost-savings			
Drug 4			
Dose			
Source of financial assistance			
Notes (status of assistance)			
Cost per month			
Average number of cycles for drug			
Cost-savings			
TOTAL COST SAVINGS			

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Outpatient Pharmacy Claims Tracking Tool

Month	Patient A	Patient B	Patient C
Patient identification number			
Insurance company			
Medication and strength (dose)			
Prescription number			
Dispense date			
Quantity			
NDC			
Prescribing physician			
Cost			
Co-pay amount			
Co-pay covered by secondary insurance			
Co-pay covered by self-pay			
Co-pay covered by Foundation assistance (identify Foundation)			
Patient qualified for financial assistance (drug replacement)			
Charity write off of co-pay			
Charity write off of total cost of drug			
Profit margin			
Month dispensed			

Return to TOC

PAP Flow Chart

Step 1	Step 2	Step 3		
Provider writes chemotherapy order for patient.	Chemotherapy order is sent to finance staff.	Staff identifies the patient's financial status and follows the appropriate flow chart below.		
No insurance	Identify if patient qualifies for any programs (SSDI, Medicaid, etc.). Identify if replacement drugs are available.	Fill out forms for all programs. Complete forms for companies that have a replacement program if patient qualifies.	Identify if foundation funding is available for anything not able to get replaced.	Fill out forms for Foundation funding that is available.
Medicaid Program	Verify benefits.	Verify drugs are indicated for dx and authorize if necessary.	Identify if replacement drugs are available if necessary. Will need to appeal to receive drugs.	Identify patient's responsibility.
Medicare Only	Verify benefits.	Verify drugs are indicated for dx.	Identify if replacement drugs are available if necessary. Will need to appeal to receive drugs.	Identify patient's responsibility.
Medicare & Supplemental	Verify benefits.	Verify drugs are indicated for dx.	Identify if replacement drugs are available if necessary. Will need to appeal to receive drugs.	Identify patient's responsibility and if there is none start treatment.
Medicare & Secondary	Verify benefits.	Verify drugs are indicated for dx and authorize secondary insurance if necessary.	Identify if replacement drugs are available if necessary. Will need to appeal to receive drugs.	Identify patient's responsibility.
Medicare Advantage	Verify benefits.	Verify drugs are indicated for dx and authorize if necessary.	Identify if replacement drugs are available if necessary. Will need to appeal to receive drugs.	Identify patient's responsibility.
Other Government Programs	Verify benefits.	Verify drugs are indicated for dx and authorize if necessary.	Identify if replacement drugs are available if necessary. Will need to appeal to receive drugs.	Identify patient's responsibility.
Managed Care	Verify benefits.	Verify drugs are indicated for dx and authorize if necessary.	Identify if replacement drugs are available if necessary. Will need to appeal to receive drugs.	Identify patient's responsibility.
Commercial	Verify benefits.	Verify drugs are indicated for dx and authorize if necessary.	Identify if replacement drugs are available if necessary. Will need to appeal to receive drugs.	Identify patient's responsibility.

The PAP Flow Chart was provided courtesy of Wendalyn Andrews, Practice Manager, Hematology and Oncology, The University of Arizona Cancer Center – North Campus.

Identify if patient qualifies for charity care within the clinic or institution and complete paperwork.	Create payment plan for any balance if available or collect balance.				
Collect out-of-pocket costs.					
Identify if foundation assistance is available.	Fill out forms for foundation funding that is available.	Identify if patient qualifies for charity care within the clinic or institution and complete paperwork.	Create payment plan for any balance if available or collect balance.		
If patient has responsibility, identify if foundation assistance is available.	Fill out forms for foundation funding that is available.	If patient qualifies, send in EOB and/or anything else to help verify amount for foundation to pay.	If any balance, create payment plan or collect balance.		
Identify if foundation assistance is available.	Fill out forms for foundation funding that is available.	If patient qualifies, send in EOB and/or anything else to help verify amount for foundation to pay.	If any balance, create payment plan or collect balance.		
Identify if foundation assistance is available.	Fill out forms for foundation funding that is available.	If patient qualifies, send in EOB and/or anything else to help verify amount for foundation to pay.	If any balance, create payment plan or collect balance.		
Identify if foundation assistance is available.	Fill out forms for foundation funding that is available.	If patient qualifies, send in EOB and/or anything else to help verify amount for foundation to pay.	If any balance, create payment plan or collect balance.		
Identify if manufacturer assistance is available and fill out forms if applicable.	If no manufacturer assistance, then identify if foundation assistance is available.	Fill out forms for foundation funding that is available.	If patient qualifies for manuafacturer or foundation assistance, send in EOB and/or anything else to help verify amount owed.	Process payment using co-pay card or whatever form of payment the program has.	If any balance create payment plan or collect balance from patient.
Identify if manufacturer assistance is available and fill out forms if applicable.	If no manufacturer assistance, then identify if foundation assistance is available.	Fill out forms for foundation funding that is available.	If patient qualifies for manuafacturer or foundation assistance, send in EOB and/or anything else to help verify amount owed.	Process payment using co-pay card or whatever form of payment the program has.	If any balance, create payment plan or collect balance from patient.

SUMMARY OF COVERED CHARGES PER COMMERCIAL CONTRACT: MEDICAL ONCOLOGY

Service Description	Rev Code	HCPCS	Charge Master	INS A	INS B	INS C	INS D	INS E
ADM OF FLU VACCINE	771	G0008	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ADM. OF PPV VACCINE	771	G0009	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONCOLOGY CLINIC INITIAL VISIT	280	99204	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONCOLOGY-CLINIC VISIT MINIMAL	280	99211	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONCOLOGY RETURN VISIT-BRIEF	280	99212	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONCOLOGY RETURN VISIT-ROUTINE	280	99213	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONCOLOGY VISIT MINIMAL NEW	280	99201	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONCOLOGY VISIT BRIEF NEW	280	99202	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONCOLOGY VISIT ROUTINE NEW	280	99203	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONCOLOGY VST COMPREHNSIVE NEW	280	99205	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONCOLOGY VISIT EXTENDED	280	99214	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONCOLOGY VISIT COMPREHENSIVE	280	99215	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONC TRANSFUSION 1ST HR OR LESS	391	36430	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONC TRANSFUSION EA ADDL HR	391	36430	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NON-CHEMO IM SUBCUTANEOUS	260	96372	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONCOLOGY CHEMO INJ IV PUSH	331	96409	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CHEMO INFUSION 1ST HR OR LESS	335	96413	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CHEM INFUSION EVRY ADDL 1HR	335	96415	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONCOLOGY INFUSION PUMP REFILL	335	96521	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONCOLOGY - TRANSFUSION KIT	271		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NON-CHEMO INJECTION IV PUSH	260	96374	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NON CHEMO INF IV 1ST HR OR LES	260	96365	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NON CHEM INF IV EACH ADD HOUR	260	96366	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONC. VAD KIT	270		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CHEMO ADMINISTRATION INTRATHEC	331	96450	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
INITIATION OF PROLONGED INFUSI	335	96416	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PUMP KIT	270		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BONE BX KIT	270		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PLEBOTOMY TMT	940	99195	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MASSAGE THERAPY 1/2 HOUR	990		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MASSAGE THERAPY 1 HOUR	990		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
AROMATHERAPY 1 HOUR	990		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
THERAPEUTIC MASSAGE	990	97124	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MANUAL THERAPY TECHNIQUES	990	97140	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MASSAGE THERAPY (STAFF)	990		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MASSAGE THERAPY (COMM)	990		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MULTIDISCIPLINARY TEAM VISIT	510		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONC-VENIPUNCTURE SIMPLE	300	36415	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DECLOTTING BY THROMBOLLYTIC AG	369	36593	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BONE MARROW BX - CLINIC	369	38221	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BONE MARROW ASPIRATION - CLINC	369	38220	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
THORACENTESIS	369	32421	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LUMBAR PUNCTURE	369	62270	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BIOPSY OF SKIN	510	11100	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FECAL OCCULT BLOOD	300	82270	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CLN I & D SIMPLE CYST	510	10060	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CLN-ARTHROCENTESIS SM JOINT	510	20600	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NON-CHEMO IV PUSH. EA ADD PUSH	260	96375	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
N-CHEM IV DRG INF SEQ TO INIT	260	96367	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IV INF HYDRATION 31 MIN TO 1HR	260	96360	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IV INF HYDRATION EA ADD HOUR	260	96361	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CHEMO ADM IM/SQ NON HORM ANTIN	331	96401	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CHEMO ADMIN IM/SQ HORM ANTINEO	331	96402	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CHEMO ADM IV PUSH EA ADD DRUG	331	96411	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CHEMO ADM IV INF EA AD SEQ INF	335	96417	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IRRIGATION OF IMPLANTED VAD	940	96523	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IMMUNIZATION ADM. 1 VACCINE	771	90471	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IMMUNIZATION ADM EA AD VACCINE	771	90472	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NCHEMO IV DRG INF CON TO INIT	260	96368	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BLOOD COLLECTION FROM IMPL VAD	369	36591	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CLN-BX SKIN LES EA ADD	510	11101	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NCHEMO IVP EA ADD SEQ SAME DRG	260	96376	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FINE NEEDLE ASPIRATION	369	10021	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PLASMAPHERESIS	369	36514	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00

Note: Reimbursement is subject to change due to bundling and medical necessity or updated rates.

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SUMMARY OF COVERED CHARGES PER COMMERCIAL CONTRACT:

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Service Description	Rev Code	HCPCS	Charge Master	INS A	INS B	INS C	INS D	INS E
ACETAMINOPHEN 325MG UDTAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ALLOPURINOL 100 MG UDTAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MG HYDROX/AL HYDROX/SIMETH 30	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ALEMTUZUMAB 30MG/ML VIAL	636	J9010	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ASPIRIN 80 MG UDTAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ATROPINE SULFATE 0.4 MG/1 ML 1	636	J0461	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
AZACITIDINE 100MG VIAL	636	J9025	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BLEOMYCIN SULFATE 15 UNITS	636	J9040	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BENDAMUSTINE 100MG/20ML INJ	636	J9033	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BORTEZOMIB 3.5MG	636	J9041	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BISMUTH SUBSALICYLATE 30ML UD	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BEVACIZUMAB 25MG/ML 4ML VIAL	636	J9035	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BEVACIZUMAB 25MG/ML 16ML VIAL	636	J9035	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CA GLUCONATE 10% 0.465 MEQ/1 M	636	J0610	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CARRIER BAG 0.001 ML	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CEFEPIME 1 GRAM VIAL	636	J0692	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CEFTRIAXONE 1000 MG/10 ML VIAL	636	J0696	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CHEMO SYRINGE 0.001ML	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CARBOPLATIN 50MG	636	J9045	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CORMED 0.001ML DEVICE	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CISPLATIN PER 10MG	636	J9060	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CETUXIMAB 2MG/ML 50ML VIAL	636	J9055	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CYCLOPHOSPHAMIDE LYOPH 100MG	636	J9070	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CYANOCOBALAMIN 1000 MCG/1 ML 1	636	J3420	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DEXTROSE 5%-NACL 0.45% 1000 ML	636	J7042	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DEXTROSE 5%-NACL 0.45% 500 ML	636	J7042	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DEXTROSE 5%-NACL 0.9% 1000 ML	636	J7042	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DEXTROSE 5%-NACL 0.9% 500 ML B	636	J7042	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DEXTROSE 5% 100 ML BAG	636	J7060	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DEXTROSE 5% 250 ML BAG	636	J7060	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DEXTROSE 5% 500 ML BAG	636	J7060	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DACARBAZINE 100MG	636	J9130	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DOCETAXEL 20MG	636	J9171	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DIMETHYL SULFOXIDE 50ML IRR	636	J1212	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DENILEUKIN DIFTITOX. 300MCG	636	J9160	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DIPHENHYDRAMINE 25 MG UDCAP	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DIPHENHYDRAMINE 50 MG/1 ML 1ML	636	J1200	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DIPHENHYDRAMINE SYRUP 5 ML/12.	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DARBEPOETIN ALFA 100MCG/0.5ML	636	J0881	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DARBEPOETIN ALFA 200MCG/0.4ML	636	J0881	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DARBEPOETIN ALFA 60MCG/0.3ML	636	J0881	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DIPTHERIA & TETANUS 0.5ML	636	90718	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DEXAMETHASONE 10 MG/1 ML 1MLVI	636	J1100	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DEXAMETHASONE 10 MG/1 ML 10MLV	636	J1100	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DEXAMETHASONE 4 MG UDTAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DEXAMETHASONE 4 MG/1 ML 1MLVIA	636	J1100	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DOXORUBICIN 10 MG	636	J9000	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DOXORUBICIN LIPOSOMAL 10MG	636	J9001	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DEXRAZOXANE (TOTECT)500MG/50ML	636	J1190	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ENOXAPARIN 100MG/1ML SYRINGE	636	J1650	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ENOXAPARIN 60MG/0.6ML SYRINGE	636	J1650	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ENOXAPARIN 80MG/0.8ML SYRINGE	636	J1650	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
EPHEDRINE 50 MG/1 ML 1MLVIAL	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
EPOETIN (NON ESRD) PER 1000U	636	J0885	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
EPOETIN (NON ESRD) PER 1000U	636	J0885	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
EPOETIN (NON ESRD) PER 1000U	636	J0885	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
EPOETIN (NON ESRD) PER 1000U	636	J0885	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
EPOETIN (NON ESRD) PER 1000U	636	J0885	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
EPIRUBICIN 2MG INJ.	636	J9178	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ETOPOSIDE 10MG	636	J9181	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
EVACUATED BOTTLE 0.001 ML BOT	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FUROSEMIDE 40 MG/4 ML 4MLVIAL	636	J1940	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FLUDARABINE 50MG	636	J9185	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FILGRASTIM INJ 300MCG	636	J1440	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FILGRASTIM 480MCG/1.6ML INJ	636	J1441	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00

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SUMMARY OF COVERED CHARGES PER COMMERCIAL CONTRACT:

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Service Description	Rev Code	HCPCS	Charge Master	INS A	INS B	INS C	INS D	INS E
FLUOROURACIL 500MG	636	J9190	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FLU VACCINE 0.5ML SYRINGE	636	90656	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FULVESTRANT 250MG/5ML SYR	636	J9395	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FENTANYL TRANSDERMAL PATCH 100	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FENTANYL 12MCG PATCH	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FERROUS SULFATE 325 MG UDTAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FOSAPREPITANT 115MG/5ML INJ	636	J1453	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
GEMCITABINE 1000MG/25ML VIAL	636	J9201	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
GEMCITABINE 200MG	636	J9201	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
GRANISETRON INJ. 100MCG	636	J1626	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FLU H1N1 0.2ML BOT	636		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FLU H1N1 5ML VIAL	636		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FLU H1N1 - PF 0.5ML SYRINGE	636		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
HYDROCODONE W/ACETA UDTAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
HYDROMORPHONE 2 MG UDTAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
HYDROMORPHONE 2 MG/1 ML SYR	636	J1170	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
HEPARIN 5000 U/1 ML 1MLVIAL	636	J1644	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
HEP B VACCINE PED/ADOL. IM	636	90744	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
HEPATITIS A VACC. ADULT DOSE	636	90632	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
HYOSCYAMINE EXT REL 0.375MG	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IFOSFAMIDE PER 1GM	636	J9208	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
GAMMAGARD 10% 10GM/100ML LIQ	636	J1569	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
GAMMAGARD 10% 5GM/50ML LIQ	636	J1569	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IRON SUCROSE COMPLEX 100MG/5ML	636	J1756	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IRON DEXTRAN 50 MG/1 ML 2MLAMP	636	J1750	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IRINOTECAN 20MG	636	J9206	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IRINOTECAN 20MG	636	J9206	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IXABEPILONE 15MG/7.5ML VIAL	636	J9207	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IXABEPILONE 45MG/22.5ML VIAL	636	J9207	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
POTASSIUM CHLORIDE 10 MEQ UDTA	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
POTASSIUM CHLORIDE 20 MEQ/10 M	636	J3480	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
POTASSIUM CHLORIDE 20 MEQ/15 M	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
POTASSIUM CHLORIDE 40 MEQ/20 M	636	J3480	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LEUCOVORIN 20MG/ML 17.5ML VIAL	636	J0640	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LEUCOVORIN 10MG/ML 5ML VIAL	636	J0640	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LIDOCAINE 1% 30 ML VIAL	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LIDOCAINE 1% MPF 30ML VIAL	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LIDOCAINE 1% 5 ML AMP	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LIDOCAINE 2.5%-PRILOCAINE 2.5%	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LOPERAMIDE 2 MG UDCAP	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LEUPROLIDE 22.5MG/1.5ML INJ	636	J9217	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LEUPROLIDE ACETATE 30MG INJ	636	J9217	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LEUPROLIDE (DEPOT SUSP). 7.5MG	636	J9217	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LORAZEPAM 2 MG/1 ML 1MLVIAL	636	J2060	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LORAZEPAM 0.5 MG UDTAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LEVOTHROXINE 0.112MG UDTAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LEVOFLOXACIN 750MG/150ML D5W	636	J1956	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MAG SULFATE 1GM/100ML IVBAG	636	J3475	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MG SULFATE 1 GM/2 ML 2MLVIAL	636	J3475	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MAG SULFATE 2GM/50ML IVBAG	636	J3475	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MANNITOL 25% 12.5 GM/50 ML 50M	636	J2150	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MEPERIDINE 50 MG TUBEX	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MEPERIDINE 75 MG TUBEX	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
METHYLPREDNISOLONE NA SUCCINAT	636	J2930	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
METHYLPREDNISOLONE UP TO 125MG	636	J2930	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MORPHINE SULFATE 10 MG TUBEX	636	J2270	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MORPHINE SULFATE 4 MG TUBEX	636	J2270	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MESNA 200MG	636	J9209	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MESNA 400MG UDTAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
METOCLOPRAMIDE. UP TO 10MG INJ	636	J2765	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MITOMYCIN 5MG	636	J9280	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
METHOTREXATE LPF 50MG/2ML VIAL	636	J9250	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
METHOTREXATE SODIUM 5MG	636	J9250	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SODIUM BICARBONATE 8.4% 50 ML	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SODIUM CHLORIDE 0.9% 100 ML IV	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00

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Service Description	Rev Code	HCPCS	Charge Master	INS A	INS B	INS C	INS D	INS E
SODIUM CHLORIDE 0.9% 100ML BAG	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SODIUM CHLORIDE 0.9% 10 ML VIA	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SODIUM CHORIDE 0.9% 150ML BAG	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SODIUM CHLORIDE 0.9% 1000 ML I	636	J7030	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SODIUM CHLORIDE 0.9% 250 ML IV	636	J7050	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NACL 0.9% 250ML IVBAG	636	J7050	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SODIUM CHLORIDE 0.45% 1000 ML	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SODIUM CHLORIDE 0.45% 500 ML I	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SODIUM CHLORIDE 0.9% 500 ML IV	636	J7040	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NACL 0.9% 500ML IVBAG	636	J7040	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SODIUM CHLORIDE 0.9% 1 ML ML	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NTG 0.4MG (1-150) 25 TAB BOT	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
OXYCODONE-ACETA 1 TAB UDTAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
OCTREOTIDE LAR DEPOT 30MG SYR	636	J2353	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONDANSETRON INJ PER 1MG	636	J2405	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONDANSETRON INJ PER 1MG	636	J2405	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
OXALIPLATIN 100MG/20ML INJ	636	J9263	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
OXALIPLATIN 50MG/10ML INJ	636	J9263	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
OXYCODONE IR 5MG TAB BULK	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PREDNISONE 20 MG UDTAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PACLITAXEL 30MG	636	J9265	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PACLITAXEL PROTEIN BOUND 100MG	636	J9264	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PEGFILGRASTIM 6MG/0.6ML SYR	636	J2505	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PHYTONADIONE 10 MG/1 ML 1MLAMP	636	J3430	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PHYTONADIONE 5 MG TAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PALONOSETRON INJ 0.05MG/ML 5ML	636	J2469	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PAMIDRONATE PER 30MG INJ	636	J2430	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PEMETREXED 100MG/4ML VIAL	636	J9305	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PEMETREXED 25MG/ML 20ML VIAL	636	J9305	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PENTAMIDINE INH SOL. PER 300MG	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PNEUMOVAX 23 SDV	636	90732	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
TUBERCULIN SKIN TEST 5 TU/0.1	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PROCHLORPERAZINE 10MG UTAB	259	Q0164	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PROCHLORPERAZINE 10 MG/2 ML 2M	636	J0780	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PROCHLORPERAZINE 5 MG ORAL	259	Q0164	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
RANITIDINE 50 MG/2 ML 2MLVIAL	636	J2780	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
RITUXIMAB 100MG	636	J9310	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SYRINGE 0.001 ML SYR	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ALTEPLASE 2MG CATHFLO INJ	636	J2997	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
TOPOTECAN 4MG	636	J9351	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
TRASTUZUMAB 10MG	636	J9355	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
VINBLASTINE 1MG	636	J9360	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
VINCRISTINE 1MG	636	J9370	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
VINORELBINE PER 10MG	636	J9390	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ZOLEDRONIC ACID 4MG VIAL	636	J3487	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CIDOFOVIR 75MG/ML 5MLAMP	636	J0740	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DECITABINE 50MG/10ML INJ	636	J0894	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DARBEPOETIN ALFA 500MCG/ML SYR	636	J0881	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
EPINEPHRINE 1:1000 1 ML AMP	636	J0171	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FAMOTIDINE 20MG UDTAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FUROSEMIDE 20 MG UDTAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
GOSERELIN IMPLANT PER 3.6 MG	636	J9202	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
HEP LOCK FLUSH 100U/ML 10ML	636	J1642	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
HYALURONIDASE 150 U/1 ML 1MLVI	636	J3470	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
HYDROCORTISONE 100 MG/2 ML VIA	636	J1720	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IBUPROFEN 200MG TABLET	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LACTATED RINGERS 1000ML IVBAG	636	J7120	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LORATADINE 10MG UDTAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
METHYLPREDNISOLONE NA SUCCINAT	636	J2920	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MORPHINE SULFATE 10 MG/5 ML 5M	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONDANSETRON 4 MG UDTAB	636		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
RANITIDINE 50MG/50ML IVBAG	636	J2780	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BACTERIO NACL 0.9% 30 ML VIAL	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
STERILE WATER 10ML VIAL	270		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BACTERIOSTATIC WATER FOR INJ 3	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00

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Service Description	Rev Code	HCPCS	Charge Master	INS A	INS B	INS C	INS D	INS E
VANCOMYCIN 1000 MG/20 ML VIAL	636	J3370	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SODIUM CHLORIDE 0.9% 50 ML IVB	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
STERILE H2O IRRIGATION 1000ML	270		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IMIGLUCERASE INJ 200 UNITS	636	J1786	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LACTATED RINGERS 250ML NON-PVC	636	J7120	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CYTARABINE 100MG/5ML VIAL	636	J9100	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CYTARABINE 2000MG/20ML	636	J9100	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CYTARABINE LIPOSOME10MG/ML 5ML	636	J9098	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FULVESTRANT 125MG/2.5ML SYR	636	J9395	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FOLIC ACID 1 MG UDTAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IDARUBICIN 5MG/5ML VIAL	636	J9211	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
INSULIN REGULAR HUMAN 100 U/1	259	J1815	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ENOXAPARIN 40MG/0/4ML SYRINGE	636	J1650	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LEUPROLIDE 11.25MG DEPOT	636	J1950	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MITOXANTRONE INJ PER 5MG	636	J9293	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PENTOSTATIN. PER 10MG INJ	636	J9268	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SANDOSTATIN LAR DEPOT 20MG VL	636	J2353	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
TEMSIROLIMUS 25MG/2.5ML VIAL	636	J9330	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PANITUMUMAB 20MG/ML 5ML VIAL	636	J9303	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PANITUMUMAB 20MG/ML 20MLVIAL	636	J9303	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IMMUNE GLOB RHO D LIQ 5000IU	636	J2792	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ACETAMINOPHEN 500MG CAPLET	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FENTANYL 25MG PATCH	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PRIVIGEN 10% LIQ 10GM/100ML	636	J1459	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DALTEPARIN 2500IU/0.2ML SYR	636	J1645	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DALTEPARIN 5000IU/0.2MLSYR	636	J1645	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PRIVIGEN 10% LIQ 20GM/200ML	636	J1459	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PRIVIGEN 10% LIQ 5GM/50ML	636	J1459	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ZOLEDRONIC ACID (RECLAST) 5MG	636	J3488	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DALTEPARIN 15000INT.UNIT/0.6ML	636	J1645	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
VIAFLEX BAG 150ML	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
VIAFLEX BAG 500ML	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ALBUTEROL 2.5MG/3ML SOL	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FAMOTIDINE 20MG/2ML VIAL	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DIP-TET-ACELL (PERT) 0.5ML IM	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
GAMUNEX 10% 10GM/100ML	636	J1561	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PNEUMOCOCCAL 7-VALENT CONJ VAC	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MENINGOCOCCAL VACCINE SC	636	90733	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
HEMOPHILUS B CONJ/TET 0.5ML	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ACETAMINOPHEN 160MG/5ML BOT	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
VALSARTAN 40MG TAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PATIENTS OWN MED 1 EA	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
OCTREOTIDE 0.05MG/ML AMP	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NELARABINE 250MG/50ML VIAL	636	J9261	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
INTERFERON ALFA-2B 50MINT.UNIT	636	J9214	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
HYDROXYZINE 50MG/ML INJ	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
INTERFERON ALFA-2B 10INTUNI/ML	636	J9214	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
INTERFERON ALFA-2B 18MIU/3ML	636	J9214	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DALTEPARIN 12500INT.UNIT/0.5ML	636	J1645	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DALTEPARIN 10000INT.UNIT/1ML	636	J1645	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DALTEPARIN 7500 INT.UNIT/0.3ML	636	J1645	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
C1 EST INHIB HUMAN 500UNIT/5ML	636	J0598	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONDANSETRON 4MG ODT TAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NAPROXEN 250MG TAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NAPROXEN 375MG TAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LEVOFLOXACIN 250MG TAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LEVOFLOXACIN INJ 250MG	636	J1956	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LEVOFLOXACIN 500MG/100ML BAG	636	J1956	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FERRIC NA GLUC CMPLX/SUC62.5MG	636	J2916	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
TRASTUZUMAB 21MG/ML	636	J9355	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DESMOPRESSIN ACETATE 4MCG/ML	636	J2597	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PNEUMOCOCCAL PEDI-13 VALENT VA	636	90670	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
HYALURONIDASE OVINE 200UNIT/ML	636	J3471	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CALCIUM CARBONATE 500MG TAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CLOTRIMAZOLE 10MG TROCHE	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00

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OXYCODONE LIQUID 5MG/5ML	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CLADRIBINE 10MG/10ML VIAL	636	J9065	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
TOBRAMYCIN 80MG/2ML VIAL	636	J3260	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CABAZITAXEL 60MG VIAL	636	J9043	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ALGLUCOSIDASE ALFA 50MG VIAL	636		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LEVOLEUCOVORIN 50MG VIAL	636	J0641	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ALBUTEROL INHALER HFA 8GM	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IPRATROPIUM/ALBUTEROL 3ML INH	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
HYDROMORPHONE 1MG/ML SYR	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DENOSUMAB 120MG/1.7ML VIAL	636	J0897	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NYSTATIN 500 000 UNIT/5ML BOT	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ASPIRIN 325MG TABLET	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IBUPROFEN 400MG TABLET	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ACETAMINOPHEN 650MG/20.3ML BOT	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LIDOCAINE 1% 5ML MPF VIAL	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LIDOCAINE 1% 20ML VIAL	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PANTOPRAZOLE 40MG/10ML VIAL	636	C9113	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
GOSERELIN ACETATE 10.8MG SYR	636	J9202	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DOXORUBICIN LIPOSOMAL50MG/25ML	636	J9001	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DALTEPARIN 18000INT.UNIT/0.72M	636	J1645	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ARSENIC TRIOXIDE 10MG/10ML AMP	636	J9017	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ALPRAZOLAM 0.25MG TAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ALPRAZOLAM 0.5MG TAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LEVALBUTEROL 1.25MG/0.5ML	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LEVALBUTEROL 0.63MG/3ML	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DEGARELIX 80MG/4ML INJ	636	J9155	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ERIBULIN 1MG/2ML VIAL	636	J9179	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DIPHENHYDRAMINE ELI 12.5MG/5ML	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ALBUMIN 5% 250ML BOT	636	P9045	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MAGNESIUM OXIDE 400MG TAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SCV-07 (INVESTIGATIONAL DRUG)	256		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DACARBAZINE 200MG/20ML VIAL	636	J9130	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ALGLUCOSIDASE 50MG/10ML VIAL	636	J0221	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
GAMUNEX-C 10% LIQ 10GM/100ML	636	J1561	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
GAMMAGARD 10% LIQ 10GM/100ML	636	J1569	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
GAMMAGARD 10% LIQ 5GM/50ML	636	J1569	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MANNITOL 20% 100GM/500MLPREMIX	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ENOXAPARIN 120MG/0.8ML SYR	636	J1650	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ENOXAPARIN 150MG/ML SYR	636	J1650	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ENOXAPARIN 30MG/0.3ML SYRINGE	636	J1650	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
TRASTUZUMAB 10MG INJECTION	636	J9355	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SODIUM POLYSTYRENE 15GM/60ML	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DOCETAXEL 20MG/ML VIAL	636	J9171	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
FOSAPREPITANT 150MG/5ML VIAL	636	J1453	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DEXTROSE 5% 1000ML BAG	636	J7070	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DOCETAXEL 80MG/4ML VIAL	636	J9171	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SULFAMETHOX/TRIMETH DS TAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DARBEPOETIN ALFA 300MCG/0.6ML	636	J0881	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CALCIUM FOLINATE300MG/30ML INJ	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ONDANSETRON 4MG TABLET	636	Q0162	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MMR VACCINE 0.5ML VIAL	636	90707	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
OCTREOTIDE LAR 10MG INJ	636	J2353	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ALBUTEROL INH SOLN 2.5MG/3ML	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
OXYCODONE IR 5MG TAB	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IPILIMUMAB 50MG/10ML VIAL	636	J9228	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
GAMMAGARD 10% LIQ 20GM/200ML	636	J1569	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
METHYLNALTREXONE 12MG/0.6ML	250		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PIPERACILLIN/TAZOBACTAM 3.375G	636	J2543	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PIPERACILLIN/TAZOBACTAM 2.25GM	636	J2543	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PIPERACILLIN/TAZOBACTAM 4.5GM	636	J2543	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DEXRAZOXANE 250MG INJ	636	J1190	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
MORPHINE SULFATE 2MG INJ	259		$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00

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SUMMARY OF COVERED CHARGES PER COMMERCIAL CONTRACT: RADIATION THERAPY, page 1 of 2

Service Description	Rev Code	CPT/HIPPS	Charge Master	INS A	INS B	INS C	INS D	INS E
SIMULATION SIMPLE	333	77280	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SIMULATION INTERMEDIATE	333	77285	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SIMULATION COMPLEX	333	77290	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SIMULATION 3 DIMENSIONAL	333	77295	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
CT GUIDE PLACE RAD TX FLDS	350	77014	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BASIC DOSIMETRY CALC CENT AXIS	333	77300	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IMRT PLANNING	333	77301	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
TELETX ISODOSE PLAN SIMPLE	333	77305	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
TELETX ISODOSE PLAN INTERMEDIA	333	77310	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
TELETX ISODOSE PLAN COMPLEX	333	77315	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SPEC TELETX PORT PLAN HEMI/TOT	333	77321	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BRACHYTX ISODOSE PLAN SMPL 1-4	333	77326	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SPECIAL DOSIMETRY TLD OR MICRO	333	77331	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
TREATMENT DEVICES SIMPLE	333	77332	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
TREATMENT DEVICES INTERMEDIATE	333	77333	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
TREATMENT DEVICES COMPLEX	333	77334	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
PHYSICS CONSULT WEEKLY	333	77336	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SPECIAL PHYSICS CONSULT	333	77370	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
RAD TX 6-10 MeV 1 AREA SIMPLE	333	77403	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
RAD TX 11-19 MeV 1 AREA SIMPLE	333	77404	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
RAD TX 20+ MeV 1 AREA SIMPLE	333	77406	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
RAD TX 6-10 MeV 2 AREAS INTERM	333	77408	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
RAD TX 11-19 MeV 2 AREA INTERM	333	77409	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
RAD TX 20+ MeV 2 AREAS INTERME	333	77411	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
RAD TX 6-10 MeV 3 AREAS COMPLX	333	77413	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
RAD TX 11-19 MeV 3 AREAS COMPL	333	77414	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
RAD TX 20+ MeV 3 AREAS COMPLEX	333	77416	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
THERAPEUT RADIOLOGY PORT FILMS	333	77417	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IMRT DELIVERY SINGLE OR MULT	333	77418	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
STEREOSCOPIC XRAY GUIDE RAD TX	333	77421	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SPECIAL TREATMENT PROCEDURE	333	77470	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
INTRAFRACTION TRACK MOTION	333	0197T	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LARYNGOSCOPY INDIRECT DIAGNOST	369	31505	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LARYNGOSCOPY FLEX DIAGNOSTIC	369	31575	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NON CHEMO SC/IM INJECTION	260	96372	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NON CHEMO IV PUSH/INJECTION	260	96374	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NON CHEMO IV INFUSION 1ST HR	260	96365	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NONCHEMO IV INFUSION EA ADD HR	260	96366	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NEW PT VISIT LVL 1 PROB FOCUS	510	99201	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NEW PT VISIT LVL2 EXP PROB FOC	510	99202	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NEW PT VISIT LVL3 DET LOW COMP	510	99203	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NEW PT VST LVL4 COMP MOD COMPL	510	99204	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
NEW PT VST LVL5 COMP HIGH CMPL	510	99205	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
EST PT VISIT LEVEL 1 MINIMAL	510	99211	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
EST PT VISIT LVL 2 PROB FOCUS	510	99212	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
EST PT VISIT LVL3 EXP PROB FOC	510	99213	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
EST PT VISIT LVL4 DET MOD COMP	510	99214	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
EST PT VST LVL5 COMP HIGH COMP	510	99215	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
DESIGN MLC DEVICE FOR IMRT	333	77338	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LINEAR ACLRTR NR TX 1 SESSION	333	G0173	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
LNR ACCLRTR NR TX MAX 5 SESSIO	333	G0251	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SBRT MANAGEMENT	333	77435	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IV INF HYDRATION 31 MIN TO 1HR	260	96360	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
IV INF HYDRATION EA ADD HOUR	260	96361	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00

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SUMMARY OF COVERED CHARGES PER COMMERCIAL CONTRACT: RADIATION THERAPY, page 2 of 2

Service Description	Rev Code	CPT/HIPPS	Charge Master	INS A	INS B	INS C	INS D	INS E
IRRIGATION OF IMPLANTED VAD	940	96523	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BLOOD COLLECTION FROM IMPL VAD	369	36591	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
US PROSTATE VOL STUDY FOR BT	402	76873	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BT ISODOSE PLAN COMPLEX	333	77328	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
US INTERSTITIAL RE APPLIC	402	76965	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
INTERSTITIAL RS APPL COMPLEX	333	77778	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SUPERV HNDL LOAD RAD SOURCE	333	77790	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BRACHYTHERAPY NEEDLE	272	C1715	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BX SRC STRANDED I-125 PER:SRC	278	C2638	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BX SRC NONSTRANDED I-125 PR:SR	278	C2639	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BX SRC STRANDED P-103 PER:SRC	278	C2640	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BX SRC NONSTRANDED P-103 PR:SR	278	C2641	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BX NONSTRANDED HDR IR-192 PRSR	278	C1717	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
HDR BRACHYTX 1 CHANNEL	333	77785	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
HDR BRACHYTX 2-12 CHANNEL	333	77786	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
HDR BRACHYTX OVER 12 CHANNELS	333	77787	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
THORACENTESIS	369	32421	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
BRACHYTHERAPY UNLSTD PROCD	333	77799	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
SRS LINEAR BASED CRANIAL	333	77372	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
ROBOTIC SBRT LNRSR 1ST FRACTN	333	77373	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00
RBOTIC SBRT LNRSR 2-5 FRACTNS	333	77373	$ 100.00	$ 80.00	$ 75.00	$ 92.00	$ 60.00	$ 25.00

Note: Reimbursement is subject to change due to bundling and medical necessity or updated rates.

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Tracking Form for Delayed or Discontinued Medical Care

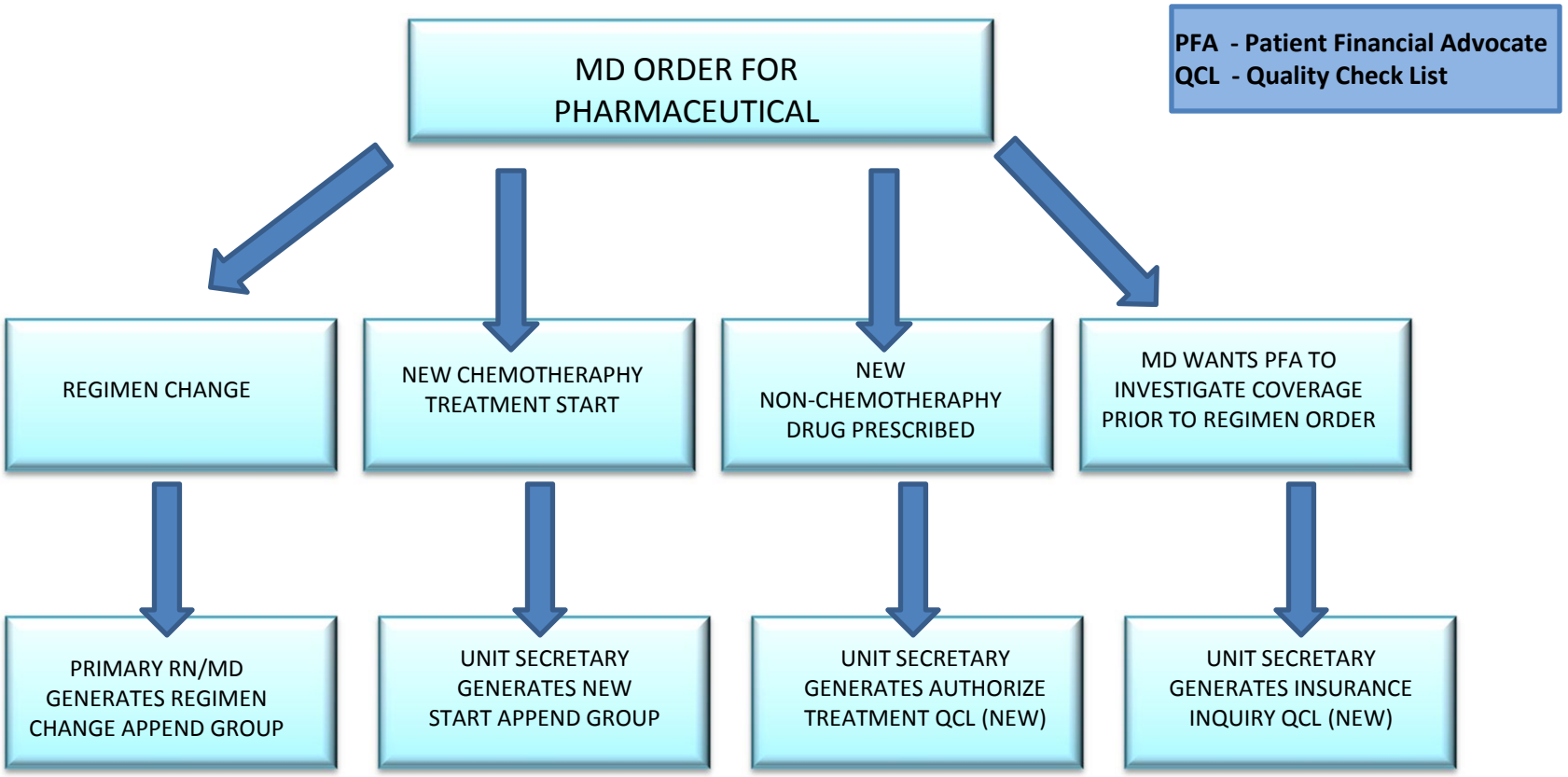
Delay of care due to personal financial hardships/Track by:												
Age												
Payer												
Disease												
Stage												
Other												
Discontinuation of care due to personal financial hardships/Track by:												
Age												
Payer												
Disease												
Stage												
Other												

Tracking Tool: Patient Volume & Financial Assistance

Patient Stats/Assisted with:										
Medicaid Application										
Assisted by Grants/Foundations										
Successful Payment Plan/Payments										
Co-pay Assistance										
Drug Replacement										
Other:										
Patient Stats/$ Tracking										
Medicaid Application										
Assisted by Grants/Foundations										
Successful Payment Plan/Payments										
Co-pay Assistance										
Drug Replacement										
Other:										

Treatment Authorization Process

Mountain States Tumor Institute, Boise, Idaho, flow-charted what happens when a physician submits a pharmaceutical order. One option: the physician wants the patient financial advocate to investigate coverage prior to treatment.



WE REQUIRE 5 BUSINESS DAYS TO OBTAIN PRIOR AUTHORIZATION BEFORE TREATMENT STARTS.

Weekly Tracking for Financial Advocate Activities

The Center for Provider Education ACCC

Activities (listed alphabetically)	Date	No. Performed	Date	No. Performed	Date	No. Performed	Date	No. Performed	Date	No. Performed	Grand Total
Add-on appointment											
Append QCL											
Approval of treatment											
Authorization expiration(s)											
Authorizations for procedure(s)											
Authorization for radiation oncology TX											
Authorization for drugs											
Authorization for test(s)											
Authorization for treatment											
Billing issue											
Call to patient											
Check insurance information											
Chemotherapy pause											
Complete necessary application(s)											
Contact Patient Financial Services											
County Assistance applications											
Disability applications											
FMLA applications											
Financial advocate interview with patient											
Insurance investigation											
Miscellaneous activities											
New start(s)											
Non-covered services											
Other (identify activity)											
Pre-authorization											
Psychiatric referral											
Referrals (all others)											
Social Work referral											
Regimen change											
Reminders to patients											
Self-pay											
Triage request											
Verification of benefits											
Grand Total of Activities:											

Acronym Glossary, page 1 of 3

ACCC	Association of Community Cancer Centers
ACS	American Cancer Society
AHFS	American Hospital Formulary Service
AHRQ	Agency for Healthcare Research and Quality
AMA	American Medical Association
APC	Ambulatory Payment Classification
ARRA	American Recovery and Reinvestment Act of 2009
ASCO	American Society of Clinical Oncology
ASP	Average Sales Price
ASTRO	American Society for Radiation Oncology
AWP	Average Wholesale Price
CAC	Carrier Advisory Committee
C-Code	Tracking codes to assist Medicare in establishing future APC rates
CCOP	Community Clinical Oncology Program
CED	Coverage with Evidence Development
CER	Comparative Effectiveness Research
CMD	Chief Medical Director or Carrier Medical Director
CMO	Chief Medical Officer
CMS	Centers for Medicare & Medicaid Services (formerly known as HCFA)
CPEP	Clinical Practice Expert Panel
CPT	Current Procedural Terminology codes
DMERC	Durable Medical Equipment Regional Carrier – the insurance company that contracts with Medicare to handle certain items/services such as take-home drugs, wheelchairs…
DMERC	Durable Medical Equipment Regional Carrier
EHR	Electronic health record
EMR	Electronic medical record
EMTALA	Emergency Medical Treatment and Active Labor Act
ESA	Erythropoiesis Stimulating Agent

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Acronym Glossary, page 2 of 3

FFS	Fee-for-service
FI	Fiscal intermediary -- the insurance company that contracts with Medicare to handle Medicare claims for a hospital's services, whether inpatient or outpatient
GAO	Government Accountability Office (formerly General Accounting Office)
GDP	Gross Domestic Product
HCPCS	Health Care Common Procedure Coding System
HHS	[Department] of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HITECH	Health Information for Economic and Clinical Health Act, part of ARRA
HMO	Health maintenance organization (a type of insurance plan)
HOPD	Hospital Outpatient Department
ICD-10-CM	International Classification of Diseases, 10th Edition-Clinical Modification, by October 1, 2013
ICD-9-CM	International Classification of Diseases, 9th Edition-Clinical Modification
IOM	Institute of Medicine
IRB	Institutional Review Board
J-Code	HCPCS codes for drugs
LCD	Local Coverage Determination
MAC	Medicare Administrative Contractor -- the insurance company that contracts with Medicare to handle all Part A and Part B Medicare claims (hospital, physician, etc.) whether inpatient or outpatient.
MedCAC	Medicare Evidence Development Coverage Advisory Committee
MedPAC	Medicare Payment Advisory Commission
MEI	Medicare Economic Index
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MMA	Medicare Prescription Drug, Improvement and Modernization Act of 2003
MSA	Medicare Medical Savings Account (a type of insurance plan)
NCD	National Coverage Determination
NCI	National Cancer Institute
OIG	Office of the Inspector General (Department of Health and Human Services)

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Acronym Glossary, page 3 of 3

OPEN	Oncology Pharmacy Education Network, a membership division of ACCC
OPPS	Outpatient Prospective Payment System
P4P	Pay-for-Performance
PFFS	Private-fee-for-service (a type of insurance plan)
PFS	Physician Fee Schedule
PPO	Preferred provider organization (a type of insurance plan)
PQRI	Physician Quality Reporting Initiative
PSO	Provider-sponsored organization (a type of insurance plan)
QOPI	Quality Oncology Practice Initiative
RAC	Recovery Audit Contractor (Medicare)
REMS	Risk Evaluation and Mitigation Strategies
RFB	Religious Fraternal Benefit (a type of insurance plan)
RUC	[AMA's Specialty Society] Relative [Value] Update Committee
SGR	Sustainable Growth Rate
WAC	Wholesale Acquisition Cost
WAMP	Widely Available Market Price

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Active Listening 101

Active listening is a communication technique that requires the listener to feed back what is heard to the speaker by re-stating or paraphrasing what was heard in the listener's own words. Active listening improves personal relationships, reduces misunderstanding and conflicts, strengthens cooperation, and fosters understanding. The skill is proactive, accountable, and professional.

Active listening is comprised of three primary elements: comprehension, retention, and response.

- ***Comprehension***—develop a shared meaning between parties through tone of voice, use of vocabulary and context, and speech pattern.
- ***Retention***—take notes if necessary.
- ***Response***—respond both verbally and non-verbally.

Active Listening Tactics

- Listen and hear rather than waiting to speak.
- Watch body language.
- Find common ground.
- Paraphrase the speaker's words back to him or her as a question. ("*I see/hear/feel like you are afraid of*…").
- Suspend your own frame of reference and judgments.
- Validate what the speaker is saying and feeling ("*You seem to feel angry, is that because*…?").

Barriers to Active Listening

- Distractions
- Trigger words
- Vocabulary
- Limited attention span
- Emotions
- Noise and visual distraction
- Cultural differences
- Interrupting or influencing.

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Active Listening Tips

- Limit interruptions. Set your voice mail to pick up immediately. Establish a no-interruptions policy with colleagues when you are with patients and families. Use a chalkboard or other system on your door to reflect that you are currently with someone and when you will be available for other patients.
- Remember that your patient and his or her family are *guests* in your office. Treat them like you would a visitor in your home. Ask if they are comfortable with their chairs and with the temperature of the room. Like guests, patients and families tend to pick up our demeanor and activity level and follow the energy of their hosts. If you speak calmly and warmly, your visitors will ease into the discussion.
- Body language encourages engagement. Positioning yourself directly across from patients and families may feel intimidating especially if they are defensive or embarrassed about their financial circumstances. Sitting at a 35 to 45 degree angle with your knees towards the patients and family members indicates a non-confrontational attentiveness. If you are visiting with several family members, a rolling chair can help you shift to face the person speaking. Keep your arms relaxed and open.
- Verbally acknowledge that talking about financial matters can be difficult. Assure patients and families of your desire to help them take care of their treatment and financial needs.
- Have at least 2 to 3 minutes of discussion with patients and families before you begin to take notes. If you use a computer for note-taking, angle the keyboard and/or screen so your body is not turned away from your guests. Maintain eye contact as you type. It is helpful to allow patients and families to see your notes before the end of your visit. Transparency builds trust.
- Be prepared for a variety of emotional reactions. Some people are stoic and may seem distant. Be warm, but focus on the business at hand. Other people are more emotive and may cry or become visibly anxious. When this happens, stop the conversation. Verbally acknowledge that the situation is difficult. Ask if they need a minute and allow them to sit in silence until they are ready. Have tissues available.
- It's natural to match our breathing rate to the people around us. If someone is very anxious, try getting physically closer to them and pick up your breath rate for 30 to 60 seconds. When you slow back to a normal breathing pattern, they will often follow you.
- Clarify or summarize every 5 to 7 minutes. "*We started talking about co-pays, but you seem to have concerns about your living expenses. Do you need some resources for utility assistance first, and perhaps we'll talk about co-pays at our next visit*?" This 5 to 7 minute interval of time allows you to check in periodically to ensure that you have an accurate picture of patients' priorities without being so repetitive that they feel you are demeaning them.

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Communication Skills 101

Effective communication is a two-way process involving listening and speaking. It is a learned skill that requires practice. Listening and speaking are equally important to the process. To listen effectively, you must resist formulating your response while the other person is still speaking. The better option: allow a thoughtful pause while you both digest what has been said.

Tips for Effective Speaking

- Pay attention—not just to your words, but also to your non-verbal message(s).
- Putting a desk between you and the patient and family can foster a perception of distance. If possible, position yourself at a 35 to 45 degree angle towards the patient and keep your arms relaxed and open towards their body.
- Try not to look tense or stressed, instead adopt a relaxed and calm demeanor. Look up frequently to maintain eye contact.
- *DO* smile, sit, or stand comfortably.
- *DON'T* cross your arms across your chest.
- Have at least 2 to 3 minutes of discussion with the patient and family before you begin to take notes. Never "doodle." Shuffle papers as little as possible. Patients must feel that your focus is on them and what they are saying.
- Allow patients and families to see your notes before the end of your visit. Remember: transparency builds trust.

Beginning the Conversation

- Limit interruptions.
- Verbally acknowledge that this situation can be difficult and assure the patient and family of your desire to help them.
- Be prepared for a variety of emotional reactions.

Build Rapport

- There are three basic ways people receive and deliver communication: visual, auditory, or emotive. "*I see what you mean*," or "*I hear what you are saying*," or "*I know how you feel*" are clues to how your patient thinks and understands. Use his or her "language."
- Make eye contact and mirror slightly the posture of the person(s) you are speaking with.

Demonstrate your Interest, Empathy, and Desire to Help

- Speak calmly and warmly. Treat patients and families as your "guests."
- Use the appropriate language. "*I understand*…" If you don't understand what the patient or family is saying, ask leading questions. For example: "*Help me be sure I understand. When you say you need help with your bills, do you mean that you don't understand the bills or that you need help to pay the bills?*")
- Do not monopolize the conversation.
- Do not interrupt the patient.

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Communicating with Compassion, page 1 of 3

There are four key elements to making communication more meaningful:

1. ***Attention***: Being aware of the signs, signals, and clues that indicate when something is important to someone.
2. ***Acknowledgment.*** Letting someone know that you recognize and appreciate them as a unique individual.
3. ***Affection.*** The human touch of warmth, comfort, humor, and kindness.
4. ***Acceptance***. Allowing the situation(s) to be the way it is.

These elements can improve your communication skills, which, in turn, can help you provide financial assistance to cancer patients and their families.

Aspects of Attention

- ☑ Ensuring that you listen, see, and empathize.
- ☑ Asking permission to help or to assist.
- ☑ Giving choices (e.g., "*What is the most important issue that you need help you with*?")
- ☑ Accepting the response—whether positive or negative.
- ☑ Observing the patient's body language and gestures, such as the tone of voice or facial expressions.
- ☑ Responding to signals; following the other person's lead.
- ☑ Recognizing what is *and* what isn't appreciated.
- ☑ Focusing on what is "right" with a patient, rather than what is "wrong."

Barriers to Paying Attention

1. Following your own agenda instead of the patient's lead by:
   - Not asking permission.
   - Not offering choices, or a sense of control.
   - Intruding, interrupting, or controlling a conversation.
   - Getting caught up in your own feelings, opinions, and needs.
   - Focusing only on your tasks and what you are doing for the patient and avoiding being "present" with them.

2. Making assumptions by:
   - Assuming the person wants your help.
   - Never asking questions to check that you understand the patient or that the patient understands you.
   - Ignoring signals or being insensitive.
   - Never noticing and acknowledging how someone is feeling.

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Communicating with Compassion, page 2 of 3

Aspects of Acknowledgment

☑ Showing appreciation and respect.
☑ Taking a genuine interest in the patient.
☑ Asking good questions.
☑ Helping patients to feel needed, wanted, and valued.
☑ Recognizing abilities, qualities, and strengths.
☑ Offering validation and affirmation.

Barriers to Acknowledgment

1. Giving advice, such as:
   - "*What you really need to do is*…"
   - "*If I were you, I would use the other co-payment program*."

2. Invalidating, discounting, denying, or minimizing someone's feelings, perspective, or experience by saying:
   - "*Don't cry. The situation is not as bad as you think*."
   - "*The situation could be worse*."

3. Showing superiority or "out-doing" the other person by using words, such as:
   - *"Your surgery won't be as bad as the surgery I had last year."*
   - *"I heard about another patient who was much worse off than you."*

Aspects of Affection

☑ Finding common ground.
☑ Sharing.
☑ Exhibiting warmth, comfort, and kindness.
☑ Being thoughtful and considerate.
☑ Smiling, when appropriate.
☑ Applying the appropriate use of touch.

Barriers to Affection

1. Separating yourself from the other person by:
   - Showing no warmth, feelings, or empathy.
   - Being distant and aloof.
   - Staring, or making no eye contact.
   - Talking about the person as if they were an object, or as if they were not in the room.
   - Talking down to someone, being condescending.

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Communicating with Compassion, page 3 of 3

2. Feeling sorry for the other person and using words, such as:
   - "*It must be awful to be you right now*."
   - "*I feel so sorry for you*."

Aspects of Acceptance

☑ Helping patients and families feel safe and comfortable with you.
☑ Being non-judgmental.
☑ Demonstrating humility; being willing to say: "*I don't know*."
☑ Being open.
☑ Giving permission to speak freely.
☑ Giving patients and families permission to express their feelings.

Barriers to Acceptance

1. Avoidance and pretense by:
   - Pretending that the situation is different from the way it really is.
   - Pretending to know the answer when you don't.
   - Avoiding difficult issues or questions that patients and families may have.
   - Avoiding the obvious or the inevitable.

2. Attempts to "rescue" the patient or "fix" the situation by:
   - Trying to "save" the patient from his or her problems.
   - Trying to fix, change, or make the situation or problems better, instead of helping patients deal with their present problem(s).

3. Negativity as personified by:
   - Getting irritated, complaining, or blaming the patient or family.
   - Being critical, judgmental, sarcastic, or bitter.
   - Being indifferent.
   - Getting defensive, taking it personally, being inflexible.
   - Laying guilt: "*If you had only worked more hours, you would have qualified for disability*."

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How to Check for Understanding

A diagnosis of cancer is never easy. In addition to complex information about cancer treatment, patients and families must now understand and deal with the *cost* of treatment. It is even harder when patients have trouble paying for their medications and treatment. For some patients, the financial difficulties begin when they are first diagnosed with cancer. For others, financial pressures build up over the course of treatment. Before you can help these patients and families, you must first ensure that they understand the information you are sharing. Here are some statements or questions you can use to check how well a patient or family member understands the information you are providing.

- **Please stop me if you do not understand something. I will be happy to go over the information again.**
- **Let me know if I am going too fast or too slow.**
- **Does this information make sense?**
- **Have I answered your question(s)?**
- **Do you have other questions at this time?**
- **Are you still with me?**
- **Am I overwhelming you with this information?**
- **Should I go into more detail?**
- **Tell me if I am unclear or if I use words that you do not understand.**
- **Please stop me if I begin to explain something that you already understand.**
- **Is the information I am providing helpful to you?**

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How to Deal with Anger

Anger is a common emotion expressed by cancer patients and their families. A person with cancer may be angry about the way the diagnosis has affected his or her life and relationships with others. Anger can be expressed in a positive way or in an unhealthy way. As someone who will be in direct contact with both patients and their families, it is important for you to know how to handle anger in an appropriate and professional manner. Here are some strategies to consider.

- **Don't take it personally**. Your first reaction when confronted by an angry patient or family is to get angry back. Remember that the person may not be angry with you but with issues related to the diagnosis, including loss of control, financial stressors, family pressures, treatment side effects, and more. Allow the person to vent without interrupting for about 60 to 90 seconds. If this is the first meeting with the patient or their family, use your name to reinforce that you are a person like them—not an institution. When speaking, use a soft tone to help move the person toward a calmer place. Try to get the person to sit down as this strategy can also diffuse some of the anger. The calmer you can remain, the more effective you will be in getting the person to a less angry place.

- **Acknowledge the anger**. Another common response may be to physically or psychologically withdraw from the situation, which might only anger the person more. It is important to demonstrate that you understand why the patient is angry. Use active listening to understand the issues behind the anger. Personalize the conversation by using the person's name. It is critical to acknowledge feelings so the person feels that he or she is being heard and that someone is listening.

- **Take the anger seriously**. Never dismiss the person's anger as not important, even if their response seems out of proportion. Ask questions to better understand where the anger is coming from. To help you identify the underlying causes of their anger, use phrases such as, "*Tell me more about how this situation came about*?"

- **Work toward resolving the issue(s), if possible.** One you determine the source of the person's anger, ask yourself if this is an issue that you can realistically resolve. Remember: positive action can help ease and reduce anger. For example, if the person is angry because he or she had to walk so far from the patient parking area, make appropriate suggestions and offer workable solutions. Nothing can be more difficult for a patient in active treatment than to add to their fatigue. If your cancer center has valet parking, suggest this option. If the patient's family is driving, suggest dropping the patient off first at a closer location before parking the car. Suggest using a wheelchair once the patient enters the building to conserve precious energy. Offering multiple alternatives gives back control to the patient and their family.

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It's All in How You Phrase It, page 1 of 4

You may have the best of intentions when providing financial assistance to patients and families, but everyone has said the wrong thing at the wrong time. That's why the phrasing of your communications is so important. It can mean the difference between helping resolve an issue or adding to an already difficult situation.

Are you careful about the way you phrase your statements? Test your abilities by reading each of the statements below and replacing each statement with a suitable alternative phrase. Check your answers using the answer key provided.

1. What I'm suggesting to you is… _____
2. This is what I would do.

   _____
3. I think you should… _____
4. I understand. _____
5. I think you are doing the right thing.

   _____
6. You really need to complete that paperwork.

   _____
7. Why do you want to do that? _____
8. All I am saying is… _____
9. I'm here to tell you that… _____
10. I certainly can't blame you for feeling that way.

    _____
11. I don't know of anyone else in your situation.

    _____

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It's All in How You Phrase It, page 2 of 4

12. I think it might be helpful if… _____

13. I would certainly consider… _____

14. In situations like this, I usually… _____

15. My recommendation would be to… _____

16. They don't know anything.

_____

17. Why aren't you getting help with that?

_____

18. Too bad you didn't qualify for that program.

_____

19. You will just have to find a way to make the co-pays.

_____

20. I wish you'd work with me more so I can get you assistance.

_____

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It's All in How You Phrase It
ANSWER KEY, page 3 of 4

You may have the best of intentions when providing financial assistance to patients and families, but everyone has said the wrong thing at the wrong time. That's why the phrasing of your communications is so important. It can mean the difference between helping resolve an issue or adding to an already difficult situation.

Are you careful about the way you phrase your statements? Test your abilities by reading each of the statements below and replacing each statement with a suitable alternative phrase. Check your answers using the answer key provided.

1. What I'm suggesting to you is… **Have you considered…**

2. This is what I would do.
   Given the options, what seems like the best choice for you (for your situation) is…

3. I think you should… **Choose the option that will be best for you and your situation.**

4. I understand.
   a. It seems as though you have a lot going on.
   b. It sounds like you are finding ways to manage this for yourself.

5. I think you are doing the right thing.
   The right decision is the one you're most comfortable with after hearing all of the options.

6. You really need to complete that paperwork.
   a. It would really help me so that I can help you if the necessary paperwork was completed.
   b. The sooner the paperwork is completed, the sooner we can resolve this situation, which will lessen the stress on you.

7. Why do you want to do that? **That is one option. Have you also considered…**

8. All I am saying is… **Let me explain this in another way.**

9. I'm here to tell you that…
   My role is to work with you and help you to understand all of your options.

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It's All in How You Phrase It
ANSWER KEY, page 4 of 4

10. I certainly can't blame you for feeling that way.
    You have every right to feel the way that you do.

11. I don't know of anyone else in your situation.
    There are many people who've been diagnosed with cancer who are dealing with these issues, and there are many options that I can present that may help you.

12. I think it might be helpful if… **What would be most helpful for you at this time?**

13. I would certainly consider… **Have you considered…**

14. In situations like this, I usually… **In situations like this, it might be helpful if…**

15. My recommendation would be to…
    Given your specific situation, there are several options available. I'd like to review them and see which may be best for you.

16. They don't know anything.
    Sometimes it may seem as if no one has or knows the right answer.

17. Why aren't you getting help with that?
    a. **Tell me more about why you haven't followed through getting help?**
    b. **It can be hard sometimes to accept help of any kind.**

18. Too bad you didn't qualify for that program.
    a. **Each program has different criteria, but there are many programs available.**
    b. **Although you didn't qualify for that program, there are other programs for which you may qualify.**

19. You will just have to find a way to make the co-pays.
    Let me explore some other options for you.

20. I wish you'd work with me more so I can get you assistance.
    I want to help you find some solutions, and I need you to work with me.

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Physician Office Versus HOPD

	Physician Office	HOPD
Claim form	CMS 1500	CMS 1450 (aka UB-04)
Line item detail on claim (DOS, HCPCS/CPT code, description, units being billed, charges for the line)	For all billable services	For all or some billable services (some may be bundled to a single line when the included items are not payable, such as miscellaneous pharmacy supplies)
Revenue codes on claim	None on claim	Required for each line item on claim
Diagnosis codes on claim	3 on the claim, must be "tagged" to each billed line item	Up to 18 on the claim, order may be important in some cases, no "tagging" to line items
CMS payment system for services	Physician Fee Schedule	Hospital Outpatient Prospective Payment System (grouping HCPCS/CPT codes into APC group payment amounts)
CMS payment for various codes	Per Physician Fee Schedule	Per HOPPS system
CMS payment for drugs	Prevailing Average Sales Price + 6%	Prevailing Average Sales Price + 6%
Non-payment of claims	On the Remittance Advice or the Explanation of Benefits. Many payers use CMS codes for non-payment explanation.	On the Remittance Advice or the Explanation of Benefits. Many payers use CMS codes for non-payment explanation.

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Terminology Guide

Facility versus Non-Facility

These terms refer to the licensure status of the entity providing services. "Facility" indicates an entity that is licensed, owned, and operated as an institution, such as a hospital. "Non-facility" indicates a site of service that is licensed, owned, and operated as a physician's office.

Co-pay versus Co-insurance

In general, the term "co-pay" refers to the fixed dollar amount that a patient pays out-of-pocket for certain services, such as physician visits or the patient's share of a prescription drug plan (e.g., $5 co-pay for a generic drug prescription refill). "Co-insurance" refers to the variable amount that a patient pays. For example, Medicare expects enrollees to pay 20% of the total amount that Medicare allows for chemotherapy drugs and infusion.

Pre-certification versus Prior Authorization

These terms are often used interchangeably, and some payers have their own definitions. In general, however, a "pre-certification" indicates that the insurance plan covers the category of services (e.g., outpatient chemotherapy infusions are covered), while "prior authorization" indicates that the insurance plan has specifically approved for this patient a particular service, drug, or number of encounters.

Replacement Drugs

When a provider receives replacement drugs for patients who qualify, those drugs can be received before or after the patient has been treated. For those drugs received in advance, the drug is used for the patient and the drug is billed to the carrier with a $0 charge. This method allows the payer to realize and pay the administration codes that are billable with the drug(s). For those drugs that are received after the treatment, the patient received the drugs while the provider received no payment. These drugs should still be billed to the payer. In many cases, the provider's system categorizes and reports those drugs as unpaid. The drugs often are written off as charity care or bad debt. When the drugs are later replaced, the provider must correct the charity and/or bad debt recording in order to avoid inadvertently falsifying those figures. This action is particularly important for non-profit providers.

A policy and procedure should be established to identify each occasion that a drug was replaced (generally by pharmacy) and to delineate the specific actions necessary to generate the correction (e.g., pharmacy enters an internal charge and/or credit code that is transmitted to the billing office or system, and the billing office or system generates a correction notice to finance). A tracking system should be established by the parties that are involved, usually a pharmacy staff person in conjunction with the financial coordinator.

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Understanding Codes

HCPCS: Healthcare Common Procedure Coding System

- CPT: Current Procedural Terminology codes, a subset of HCPCS for almost everything except drugs
- One code for just about anything one can do to or for a patient
- J-codes: drugs
- C-codes (hospitals only) and Q-codes: temporary codes until permanent ones are assigned

APCs: Ambulatory Payment Classifications

- The items or group of items to which payment amounts are assigned under Medicare's Hospital Outpatient Prospective Payment System (OPPS)

Modifiers

- Generally 2-characters to be appended to HCPCS/CPT codes as further detail
- Some Modifiers

  -25: Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service

  -27: Multiple outpatient hospital encounters on the same date

  -59: Distinct procedural service

  -76: Repeat procedure by the same physician

  -77: Repeat procedure by another physician

  -QV: Item or service provided as routine care in an approved clinical trial

ICD-9: International Classification of Diseases Version 9

- 4- or 5-digit diagnosis codes (three digits and one/two decimal places) plus procedure codes
  - Neoplasms: 140.xx-239.xx; V58.0 Radiation, V58.1 Chemotherapy
- ICD-10 has been looming for years and promises to dramatically change the assignment and use of diagnosis coding

Revenue codes: hospitals only

- 3 digit codes that define the hospital department to which any revenue applies (e.g. 636: separately payable drugs, 250: other pharmacy…)

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What are Drug Tiers?, page 1 of 2

How much a drug costs depends on what “tier” the drug is on. The plan puts each drug it covers on a tier, or level. Then the plan decides how much you will pay if you use a drug on that tier. Sometimes, this is called your cost-sharing amount.

The cost can be either:

- A fixed amount that you would pay for each level, called a **co-pay**
- A percent of the cost of the drug, called **coinsurance**

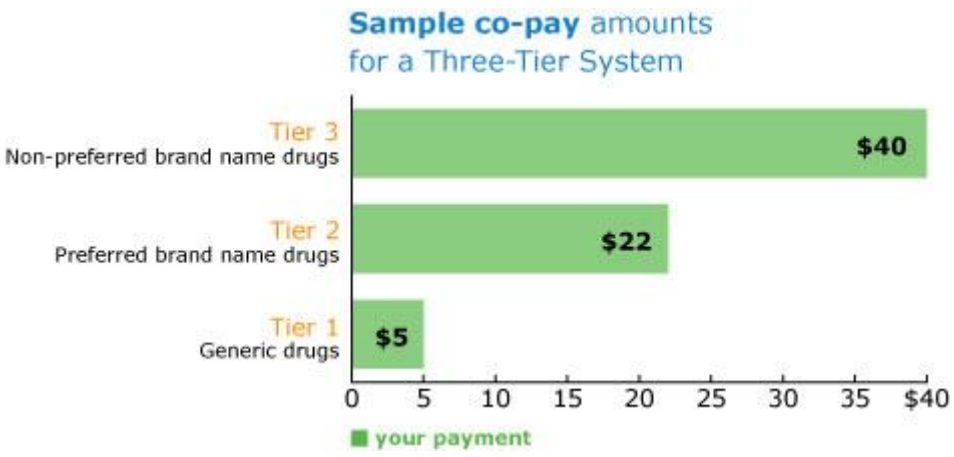
In general, your plan's tiered co-pay and coinsurance amounts will only apply until you hit the coverage gap, or "donut hole." In 2013, you will hit the coverage gap when your co-pays or coinsurance, plus the amount the plan has paid for your drugs, equals $2,970. Then you will begin paying a discounted percentage of your drug costs.

During the coverage gap, you will pay 79% of the cost for **generic** drugs and 47.5% of the cost for **brand**-name drugs. You will also pay a small fee to pharmacy. All plans will have these discounts. You do not need to do anything to get these discounts. The pharmacy will give them to you automatically.

After your **total drug costs** hit $6,733.75, you will pay 5% or less of the drug cost, and the plan will pay the remaining 95%.

Co-pay
The plan sets a fixed price for all the drugs on each tier. Each plan can tell you how many tiers it has and what the co-pay amount is for each level. The typical Medicare formulary has three or four tiers, but some have more – check with your plan to see how many tiers it has. The drug list will say which tier each drug is on.

Example 1



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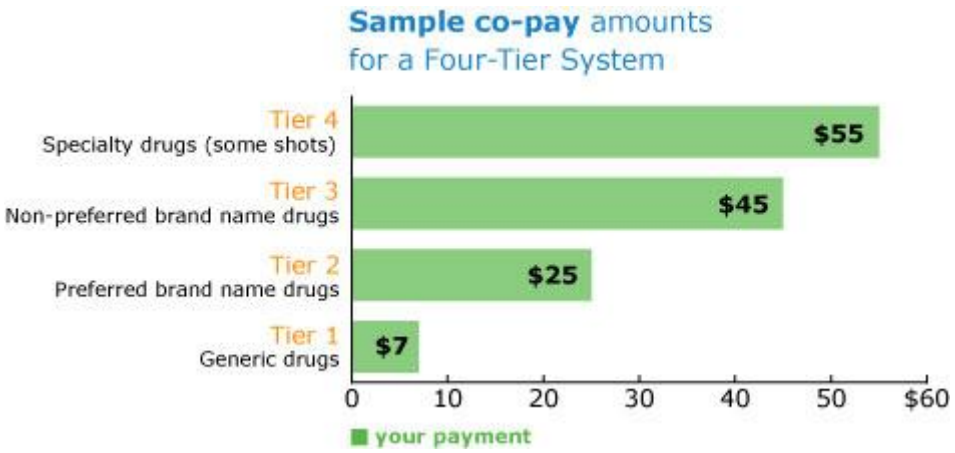
What are Drug Tiers?, page 2 of 2

Example 2

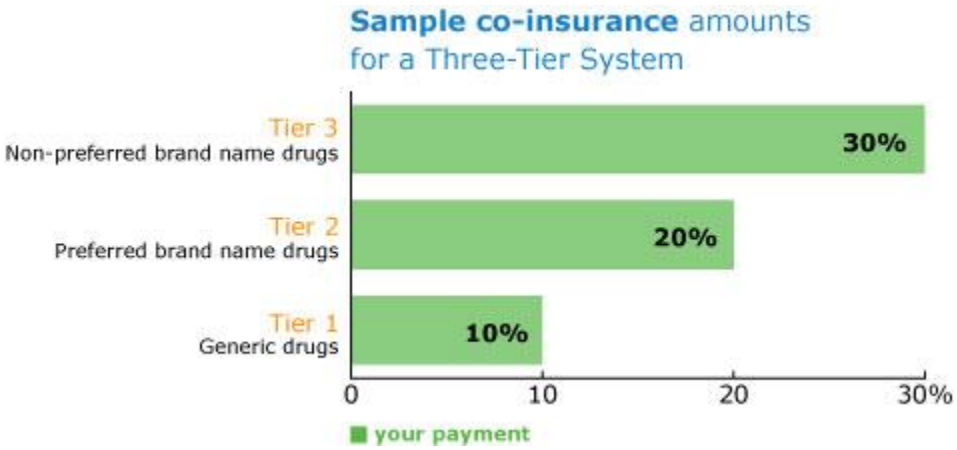


"Preferred drugs" are brand name or generic drugs that the plan believes treat a medical condition as well as other similar drugs. If your drug is "preferred," you will have a lower co-pay or price than if you take a similar, non-preferred drug. You can still use drugs in the "non-preferred" level, but you will have to pay more for them. (You can ask your plan to make an exception and let you pay less for the drugs.)

Coinsurance
Coinsurance means that you pay a percentage of your drug's cost. The plan decides what percentage you will pay. You would pay a different percentage for each tier.

The plans give their members a discounted price. You would pay a percentage of that discounted price.

Example 3



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What is a Drug List or Formulary?

Most Medicare Prescription Drug Plans will have a formulary, which is the list of drugs the plan covers. Each plan will publish its formulary on its website. The Medicare.gov Prescription Drug Plan Finder shows you:

- If the plan covers your drugs.
- The tier or level each drug is on, which tells you how much the drug will cost. A lower tier will have a lower cost. Instead of showing a tier for each drug, some formularies will tell you whether a drug is "approved" or "preferred."
- If there are any special rules or limits on how you can buy the drug.

Which drugs will be covered, and on the drug list?
Medicare has developed basic guidelines about plan formularies. They must cover drugs that are used to treat common conditions. They also must have at least two drugs from each type or class of drugs. Medicare has reviewed and approved each plan's drug list.

Formularies will include generic and brand name drugs.

> **"Brand name" drugs -** When the U.S. Food and Drug Administration approves a drug for the first time, there is only one manufacturer who makes and sells that drug under their patent. New drugs get to be known by the brand name. These are referred to as "brand name drugs" until their patent expires.
>
> **"Generic" drugs -** A generic drug can be produced after the brand name drug's patent has expired. It is also called a "generic equivalent." Before a generic drug can be sold, the U.S. Food and Drug Administration must approve its use. If you follow the directions on the drug's label, the generic and the brand name drug should have the same effects, safety and risks.

How do I get information about my plan's drug list?
Each Medicare Prescription Drug Plan is required to post its formulary on its website and update it each month. You can also find information about drug lists at *www.medicare.gov/find-a-plan.*

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CODING

The 7 Deadly Sins of Infusion Center Documentation

by Cindy Parman, CPC, CPC-H, RCC

Medical record documentation takes the form of paper records, electronic medical records (EMRs), and blended or hybrid records that incorporate elements of both paper and electronic records. While it seems obvious that the medical record must include all necessary data, some infusion services require careful attention to ensure complete documentation.

In addition to detailed written physician orders, documentation of medical necessity, complete diagnosis information, and patient-specific treatment planning, freestanding and hospital-based infusion centers may want to review the following documentation issues.

1. Documenting Venipuncture

Many patients who receive drug administration services require regular laboratory testing to ensure that treatment is working or to assess the patient's physical reaction to the drug regimen. The venipuncture procedure code is **36415**: Collection of venous blood by venipuncture.

Nursing staff typically document blood samples obtained via implanted port (code **36591**) or PICC line (code **36592**), but staff who obtain a blood sample via venipuncture, such as phlebotomists or medical assistants, also need to document this service in the individual patient medical record. The medical record should include the site accessed, the condition of the access site, presence of erythema or inflammation, and patient complaints of pain or discomfort.

2. Recording Wasted Drugs

Medicare encourages providers to schedule patients in such a way that drugs are used in the most clinically efficient manner. However, if the provider must discard the remainder of a single use vial after administering a dose of the drug to a Medicare patient, the Medicare contractor will pay for the amount of drug discarded along with the amount administered, up to the amount of the drug indicated on the vial or package label. Some Medicare contractors require the following modifier to be reported on the claim form—**JW:** Drug amount discarded or not administered to any patient.

It is essential that the individual patient medical record include documentation of both the amount of drug administered and the wasted drug amount billed to the patient. Although drug waste is tracked by the pharmacy, the individual chart must contain documentation to support all services, drugs, and supplies charged to the patient.

3. "Rounding" Drug Administration Time

Official coding guidance from the American Medical Association (AMA) states that the actual time over which the infusion is administered determines the number, type, and sequencing of administration codes for which infusion time is a factor.

While busy infusion centers often find it difficult to accurately capture the exact start and stop time for each medication delivered, evidence illustrates that "rounding" drug administration times may result in lost revenue. In this situation, infusion centers have a tendency to "round down," which may eliminate the use of an "each additional hour" drug administration code.

For example, if the patient receives 5FU administered intravenously for 92 minutes, infusion centers should report two administration codes—**96413** (initial hour of IV chemotherapy) and **96415** (each additional hour of IV chemotherapy). However, if the time is "rounded" to 90 minutes, the only code that can be charged is **96413**, a revenue loss of approximately $37 in the outpatient hospital setting. This number may seem like a small reimbursement loss, but if "rounding down" of administration times occurs frequently, lost revenue increases exponentially. (Remember, the "each additional" hour code can only be added if there is *more than* 30 minutes beyond the first hour. In other words, at least 91 minutes of infusion time must elapse before the "each additional" hour code can be reported.)

4. Documenting in Five-Minute Increments

As indicated above, when reporting codes for which infusion time is a factor, the actual time over which the infusion is administered is reported. Very few drug administration services begin exactly on the hour; most often the administration begins at 9:36 am, 10:02 am, 4:11 pm, or a similar time.

Although the pumps used in the infusion center to administer the drugs can be programmed for a specific time period, bag overfill and individual patient considerations generally mean that the infusion did not last exactly 30 minutes, 45 minutes, or other specified 5-minute time increments. The reimbursement concern in this situation is that the infusion center may either consistently lose revenue because the actual administration time has not been accurately reported, or may inappro-

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priately receive additional reimbursement by inflating the administration time to ensure that all infusions are reported in five-minute increments.

For example, an intravenous chemotherapy infusion begins at 9:58 am and ends at 10:14 am, a total of 16 minutes. However, the administration time is recorded in the patient chart as 10:00 start time and 10:15 end time, a total of 15 minutes. Based on the time recorded, this service would be billed as an IV push. (An intravenous or intra-arterial push is defined as either an injection during which the healthcare professional who administers the drug is continuously present to administer the injection and observe the patient, or an infusion of 15 minutes or less.) However, the actual administration time supports an IV infusion code—a potential loss of approximately $93 in the hospital outpatient setting. In other words, report an infusion of 15 minutes or less using the code for IV push. Report an infusion of 16 minutes or more using the code for an IV infusion.

5. Recording all Mini-Bag Infusions as Requiring 16 Minutes

As mentioned above, an intravenous or intra-arterial push is defined as either an injection during which the healthcare professional who administers the drug is continuously present to administer the injection and observe the patient, or an infusion of 15 minutes or less.

This means that if a nurse is present for a drug administered by push technique that requires 20 minutes of face-to-face time, the service is coded as an IV push administration. In addition, if the nurse hangs a mini-bag of medication that requires 13 minutes of administration time, this service is also reported with an IV push code.

To borrow a current phrase, it is what it is. Infusion centers should document the exact time of the infusion and report the appropriate code for the service provided. This practice may mean that some mini-bag administrations are coded as infusions and others are reported with the code for an intravenous push. Make certain to avoid bad charting habits, such as automatically recording each mini-bag infusion with 16 minutes of infusion time in order to bill a higher-paying administration code.

6. Assigning Drug Administration Codes by Protocol

In an effort to improve efficiency and ensure that all relevant codes are captured and charged, some providers develop a list of administration codes to be reported "per protocol." Unfortunately, this practice may also result in lost revenue. For example, codes reported for a standard FOLFOX protocol include:

- **96413:** Chemotherapy administration, IV, up to 1 hour
- **96411**: Chemotherapy administration, each additional IV push
- **96416**: Chemotherapy administration, prolonged infusion requiring pump
- **96368**: Therapeutic drug administration, IV, concurrent infusion
- **96375**: Therapeutic drug administration, each additional IV push.

However, if the pre-medications in the mini-bag required more than 15 minutes to administer and the Oxaliplatin required more than 90 minutes to deliver, the resulting administration codes would be:

- **96413:** Chemotherapy administration, IV, up to 1 hour
- **96415**: Chemotherapy administration, IV, each additional hour
- **96411**: Chemotherapy administration, IV push
- **96416**: Chemotherapy administration, prolonged infusion requiring pump
- **96368**: Therapeutic drug administration, IV, concurrent
- **96367**: Therapeutic drug administration, IV sequential drug.

While many patients may require 15 minutes or less for the infusion of the pre-medications and may receive the chemotherapy administration in 90 minutes or less, additional time required for either service increases the drug administration reimbursement for the FOLFOX regimen.

7. "Cloned" Notes

Templated medical record documentation has increased with the advent of electronic medical records. Medicare and other payers have stated that "cloned" medical record documentation does not support medical necessity for an individual patient. While CMS has not taken a formal position on templates, the agency has conveyed that templates are meant to prompt medical record documentation, not include pre-printed paragraphs of general information.

In addition, documents that include pre-populated information may not accurately describe the care provided to an individual patient or reflect the procedures performed on a given date of service. Medicare contractors generally publish newsletters or other documents to remind providers that information in the medical record must support the medical necessity of the services rendered and the appropriateness of the service provided.

For example, PBSI Medicare Services states that the detection of cloned medical records may lead to an investigation of potentially fraudulent practices.

A Word to the Wise

Medical record documentation supports the number of drug administration services, the method of administration, and the length of drug delivery. In an era of increased Medicare audits and scrutiny by other insurers, infusion centers must maintain complete and accurate medical record documentation. Incomplete charting, such as rounded administration times, omitting documentation for venipuncture or wasted medications, coding by drug protocol, or the use of cloned documentation templates may decrease reimbursement and/or elevate the possibility of refunds in a payer audit.

Cindy Parman, CPC, CPC-H, RCC, is a principal at Coding Strategies, Inc., in Powder Springs, Ga.

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Emerging Role of PHARMACISTS IN PRIVATE ONCOLOGY PRACTICES

by Brian A. Larson, RPh

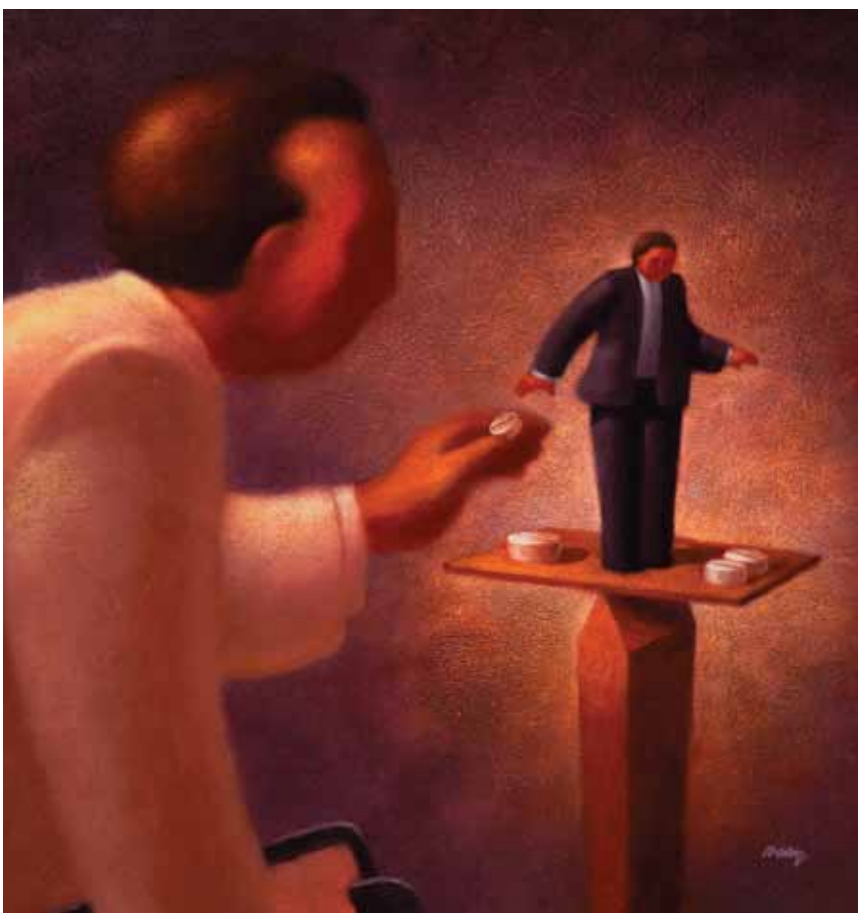
Rising drug costs, declining reimbursement, and continuing growth of new cancer therapies create unique challenges for today's private oncology practices. Oncologists searching for ways to manage these complexities are realizing they must leverage resources that offer support from both a clinical and business perspective. One solution: oncology-trained pharmacists. These professionals are emerging as a viable solution for helping to improve patient care *and* to optimize cash flow in the practice setting. Here's a look at how an oncology pharmacist may benefit your practice.

Clinical Contributions

While the list of challenges facing oncology practices is long, none is more important than improving the care delivered to patients. Extensive knowledge about diagnosis and treatment of cancer and the development of new technologies and new cancer-fighting agents have vastly improved care in our country; these advances have also increased the need for improved education of clinical staff and collaboration between all members of the health-care team. For oncology practices, a pharmacist's clinical knowledge of various types of drugs—including chemotherapy agents—provides tangible benefits with regard to staff training and drug education.

Oncology therapies have become increasingly complex, with many nuances to each protocol that include sequencing, length of infusions, physical compatibility with other medications, and chemical stability. Pharmacists are on the front line when it comes to understanding new and existing agents, and can offer important information to physicians and hands-on training to clinical staff about drugs and how they interact with other medications.

Collaboration between the pharmacist and all practice personnel—physicians, nurse practitioners, infusion nurses, practice administrators, and financial staff—extends beyond training to include serving as a valuable resource. Many different types of questions arise daily. These can range from simple drug information questions to more unique, complex concerns that fall beyond the scope of an oncologist's daily routine. Pharmacists' drug information training and experience gives them the knowledge and skills necessary to quickly research and report back the appropriate information.



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Frequently, questions arise around how to handle adverse drug reactions, including how to adjust the dose and whether it's safe to resume treatment with the same drug following a reaction. When a patient develops a reaction after beginning four or five different medications, pharmacists can often help pinpoint which medication is most likely to have caused the reaction. Pharmacists can also answer questions on dosing for morbidly obese patients, pain control, nausea, and skin reactions, as well as possible medication interactions with other medications, herbal remedies, or food.

As pharmacists become more involved in oncology practices, oncologists are looking to pharmacists to serve as an important checkpoint in a patient's treatment prescriptions. How? Pharmacists check the appropriateness of the order, verifying that the dose, frequency, route of admin-

Return to TOC

istration, and duration are consistent with the patient's condition, manufacturer's recommendations, and applicable standards of practice.

Operational Value

Let's face it. Oncology therapeutics are expensive, complex, and have an enormous business component. Managing the pharmacy operations within a practice—regardless of its size—is extremely important to ensuring its financial viability and the safety of its patients. Pharmacists, with their specialized training, can have a significant impact on improving performance in the areas of inventory management, drug-waste tracking, compliance issues, and admixture training.

Managing inventory. My years working within the oncology practice setting suggest a typical oncologist spends about $2 million on drugs per year. Because drugs are a practice's biggest cost, oncologists and practice administrators are placing more emphasis on effective inventory management. Clearly, to provide the best care, practices need to have drugs available to meet the needs of their patients, but having large amounts of expensive drugs on hand, especially those not frequently used, can lead to waste and tie up cash that could be used for other practice objectives.

Effective inventory management is complex and begins with efficient purchasing. Oncologists often have many drug choices to prescribe patients with certain types of cancer, and pharmacists can help make informed decisions about drugs. Although clinical considerations always come first, pharmacists can conduct a comparative analysis of regimen costs and the consequences of choosing certain drugs over others. This analysis can potentially help the practice cut back on the number of drugs it uses, reduce costs, and improve efficiency.

Tracking drug waste. For many practices, monitoring and more effective managing of drug waste created by partial vials and/or expired drugs can be a real boost to the bottom line. For example, auto-ship programs, designed for efficiency and guaranteed supply, can create an opportunity for waste, if not closely monitored. With the goal of reducing the time drugs spend on the shelf and getting reimbursed more quickly for drugs used, a pharmacist can work with nurses to determine optimal inventory levels to meet demand by looking at upcoming appointments and ordering accordingly. Practices can increase the number of inventory turns per year by watching for patterns of slow moving drugs. In some cases, active monitoring of drug inventories can provide opportunities for aggressive management of those drugs at risk of expiring. Pharmacists can develop effective procedures for checking in the order and comparing the invoice with products, including ensuring the right drug, strength, size, quantity, and the correct "in date."

Ensuring drug compliance. Pharmacists offer expertise during medication audits and with Material Safety Data Sheet (MSDS) compliance. For example, an assessment of an oncology practice's ESA-prescribing patterns can determine whether the practice is following the Medicare guidelines put in place in 2007. If discrepancies are found, a pharmacist can help develop a pre-authorization process and re-educate staff on appropriate use. Likewise pharmacists have the knowledge, resources, and access to information to help a practice be OSHA compliant with MSDS information.

Admixture training. In many instances, the size of the practice determines who in the practice actually prepares intravenous admixtures. With the average size of oncology practices in the United States about 2.4 oncologists, my observations from years spent in oncology practices shows this responsibility often falls to oncology nurses. Practices with two or three physicians might also use admixture technicians to take orders, create IVs, and deliver them to the infusion room. Using admixture technicians can have financial benefits for a practice by freeing up highly compensated oncology nurses from spending time in the mixing room, allowing more efficient scheduling in the infusion room and keeping nurses focused on what they do best—providing care to patients.

Whether a practice is using oncology nurses or admixture technicians to prepare the solutions, the complexity of therapeutic agents, as well as rapid introduction of new agents and new regulations, makes thorough instruction critical. In many practices, training on how to mix and administer drugs is "handed down" from the most experienced nurse to new nurses or technicians. Oncology pharmacists can teach nurses how to use the dose calculators provided by the drug manufacturers, provide a check of math on all calculations, and educate staff about what possible side effects to watch for with new drugs. This supervision can create process improvements and enforce procedures that can reduce potentially costly or dangerous errors.

Why Add a Pharmacist?

As the economy slows, employers and businesses often cut back on staff and other expenditures in an effort to reduce the cost of doing business. Here's a brief look at how adding a pharmacist to your staff or hiring a consultant pharmacist can benefit your practice by improving patient care and cash flow. Specifically, pharmacists:

- Understand new and existing agents, and can train clinical staff about these drugs, and how they interact with other medications
- Can improve patient safety by verifying dose, frequency, route of administration, and duration
- Can improve performance in the areas of inventory management, admixture training, drug waste tracking, and compliance issues
- Free up oncology nurses from spending time in the mixing room, allowing more efficient scheduling in the infusion room and keeping nurses focused on providing patient care
- Can teach nurses how to use the dose calculators provided by the drug manufacturers, provide a check of math on all calculations, and educate staff about what possible side effects to watch for with new drugs.

FOR PRACTICES TO REMAIN VIABLE, ONCOLOGISTS AND PRACTICE ADMINISTRATORS SHOULD ASSESS THEIR CURRENT SITUATION TO DETERMINE THE BEST COURSE OF ACTION IN MANAGING THEIR PHARMACEUTICAL NEEDS.

Financial Value

The current method in which physicians are reimbursed for goods and services has put increased pressure on practices to capture every billable dollar. In fact, a recent national poll of 315 oncology practice decision-makers cited declining reimbursement as the most significant challenge to practice viability in the next two years. Thirty-nine percent of oncologists, and 52 percent of practice administrators and executive directors reported their practices have seen a significant decrease in reimbursement over the past two years. The national poll was conducted by KJT Group and sponsored by US Oncology in 2008.

Effective drug pricing is one area where practices can enhance financial performance. With complicated, constantly changing reimbursement guidelines, and third-party payers widely varying in coverage of different formularies, continual analysis of drug costs and values is essential. This time-consuming, yet valuable task naturally falls within the responsibilities of a pharmacist, who can then make recommendations to physicians on fair pricing for drugs in order to capture all potential revenue.

In October 2007, a session at ACCC's 24th Annual National Oncology Economics Conference, "A Pharmacist's Role in Private Practice Management and How to Justify the Position" by Steven D'Amato, RPh, BCOP, suggested that "a reliable charge capture program would discover that the average oncology clinic [outpatient] has a loss of 0.25 percent—0.5 percent of gross charges." That formula translates to a one-physician practice billing $5 million per year losing as much as $50,000 in charges.

The reasons for billing losses are many. One of the most common (and also most easily prevented) is medications that are never billed. Sometimes clinical staff incorrectly marks or neglects to mark something on the superbill; other times billing staff misses a charge, uses the wrong code, or simply under bills. Another common mistake: not accounting for single dose vials and lost superbills—especially between multiple sites of service. Pharmacists can provide key leadership in a practice's charge capture program.

Verifying that diagnoses and/or symptoms have been properly documented to support indications for use of specific drugs can greatly enhance the charge capture process by preventing denial of claims, and ensures the information is readily available should the practice need to provide rationale to payers. In addition to knowledge of the clinical uses for drugs, pharmacists:

- Have knowledge of the correct billing codes and units
- Provide accurate start-of-the-month and end-of-the-month inventories
- Analyze purchase history reports
- Review billing data by J-code unit
- Assist in tracking down missing billings.

From my personal experience and reviewing charge capture data from practices across the country, when I, or another pharmacist, was involved in an in-depth review of billings and assisted in tracking down the missing billings, the recovery rate was as high as 75 percent. This compares to a 25 to 35 percent recovery rate when the pharmacist was only involved in the review portion of the process.

Consultant Pharmacists—an Alternative Option

Whether a practice has one oncologist or 20, it faces many of the same challenges, especially when it comes to drug complexity, costs, and reimbursement. While larger practices have the resources to add an in-house pharmacist to their staff, smaller practices can still benefit from access to a pharmacist. An arrangement with a pharmacist on a part-time, consultant basis can deliver clinical, operational, and financial benefits—at a fraction of the expense.

While direct patient interaction and counseling is not optimally delivered in such a consultant arrangement, pharmacy expertise, staff education and training, drug information, admixture support, and financial auditing and analysis are easily accessed remotely with supplemental onsite visits. A typical arrangement can consist of an oncology-trained consultant pharmacist working with a practice to:

- Provide clinical support
- Train nurses and admixture technicians
- Aid in long-term planning and establishing processes and procedures that support better inventory management, charge capture, and regimen analysis.

Today's technology allows consultant pharmacists to easily provide support, guidance, and answers via telephone, email, and Internet.

The Road Ahead

If there's one certainty, the healthcare industry is going to continue to change. Downward pressures on reimbursement with upward pressures on costs will continue to be the trend. Private practice oncology is no exception. For practices to remain viable, oncologists and practice administrators should assess their current situation to determine the best course of action in managing their pharmaceutical needs. These professionals must then make it a priority to stay on top of the trends and issues that can affect their ability to provide high-quality care while remaining financially sound. Being open to new and different ways of operating their practices, such as using consultant pharmacists, can prove beneficial.

Brian A. Larson, RPh, is pharmacy manager, Oncology Pharmaceutical Services, at US Oncology. He has more than 30 years experience as a pharmacist.

Hardwiring prospective processes for sending an accurate, clean claim

— Elaine Kloos RN, CNA-BC, MBA

Many processes exist that are crucial to the financial success and viability of a cancer center or oncology private practice. The processes most important to financial success are those that check for insurance coverage, those that ensure complete capture of all billable items, those that convert entered charges to clean and compliant claims for billing purposes, and those that ensure collection of appropriate payments. Each of these processes is more complex for oncology than for virtually any other service line. For infusion services, this complexity stems from the use of multiple drugs in innumerable combinations for a wide variety of diagnoses requiring complicated documentation and coding. A review of this revenue cycle for oncology services should consist of the following:

1. A hard-wired process should exist for insurance verification, pre-authorizations and pre-certifications. This process should take place prior to the patient receiving chemotherapy. The patient should have a private meeting with a financial counselor reviewing the details of their covered benefits, including review of co-pays, co-insurance and deductibles. The financial counselor should also assist the patient with access to financial assistance programs via the provider or associated institutions, third party foundations and/or pharmaceutical company programs. For best practice, the financial counselor is physically in the cancer center or oncology office and should report to the practice administrator or cancer center administrator. Regular updates to check any changes to the patients' coverage and status of life-time benefits should occur. A policy should be in place and followed for off-label/off-compendium treatments to ensure the patient is aware of any out of pocket expenses for non-covered treatment regimens.

Ms. Kloos is a senior consultant for Oncology Management Consulting Group, headquartered in Pipersville, Penn.

2. Because of frequent regulatory changes, the superbill/charge master should be reviewed on a regular basis to ensure that all appropriate codes are present and accurate. An in-depth review should take place on a quarterly basis to coincide with corrections and updates released by various sources such as CMS.

3. A methodical and meticulous review of the processes for charge capture, charge entry and bill production should be undertaken on a regular basis, especially if staff turnover is high. A detailed encounter form should correlate with the superbill/charge master to assure that all billable codes are on the encounter form and available for use. Staff should be trained on how to select the correct charge and a check and balance system should be in place to ensure no charges are omitted. The individual responsible for charge entry should also be trained to double check for missed charges (e.g. some regimens regularly include pre/post treatment therapeutic hydrations). Meticulous attention should be paid to reconcile each patient appointment with the encounter form daily. Lastly, a system to ensure that the charges actually make it to the bill completely and according to payer requirements should be in place and reviewed for accuracy.

4. A verification process should be in place to ensure that the documentation in the clinical charts for all services rendered were appropriately coded and charged. This includes accurately documenting start time and end time for all pre-meds, hydration (not concurrent) and chemotherapy. Diagnosis coding must come from "source" documents provided by a physician. This includes accurately following the ESA guidelines and documenting chemo induced anemia as well as documenting appropriately for the use of anti-emetics. A defined process should exist to handle and charge for drug waste for single use vials (or other appropriate situations such as an expired drug).

Finally, a system should be in place that verifies that documentation and bills meet current Medicare rules. An in-depth audit with an ample sample size of medical records should be conducted to get a clear picture of comparing the medical record documentation to the 1500/UB and EOB. Line item detail should be reviewed to ascertain appropriate payment.

5. Best practices across the country are placing a strong emphasis on front-end processes ensuring that all financial details are obtained and discussed with the patient in a prospective manner. Taking advantage of third party programs that financially assist the patient typically covers the expense of a financial counselor. Given the declining reimbursements for oncology practices and centers, all staff and physicians must maintain a focus on the revenue cycle in order to survive. Reducing rework and eliminating redundant processes greatly enhances the operation and can lead to enhanced throughput. Hardwiring prospective processes for sending an accurate, clean claim greatly improves cash flow and eliminates the need for retrospectively correcting errors.

Here a Form, There a Form

by Cindy Parman, CPC, CPC-H, RCC

Claims, appeals, requests for additional documentation, insurance enrollment and credentialing forms—all require physician or staff time to complete. Charging the patient may appear to be the way to recoup for this lost time, but a number of laws, regulations, contract requirements, and other issues affect billing for this service.

Who Pays?

Do not assume that the patient can always be charged for form completion. The American Medical Association (AMA) provides a formal opinion on this issue as part of its Code of Medical Ethics:[1]

> ***Opinion 6.07 – Insurance Forms Completion Charges:*** *The attending physician should complete without charge the appropriate "simplified" insurance claim form as part of the service to the patient to enable the patient to receive his or her benefits. A charge for more complex or multiple forms may be made in conformity with local custom.*

With respect to "local custom," you may need to have healthcare regulatory counsel review applicable state laws. If a form or document must be completed by a physician, practice, facility, or cancer program as a state requirement, it may not be possible to charge the patient for this mandatory service. However, if the form is required by the state, there may be separate reimbursement. For example, the California Division of Workers' Compensation reimburses for the completion of certain forms:[2]

> ***Final Treating Physician's Report of Disability Status (DWC Form RU-90)*** *where the physician renders an opinion concluding that the employee is released to return to the pre-injury occupation or concluding that the employee's injury is likely to permanently preclude the employee from returning to the pre-injury occupation. Use code 99080.*

In contrast, the Indiana State Medical Association states:[3]

> ***Indiana law is silent on this specific issue. Indiana's general law on fees, 844 IAC 5-2-9, states:*** *"Fees charged by a practitioner for his/her professional services shall be reasonable and shall reasonably compensate the practitioner only for services actually rendered." The rule also includes a series of factors to consider when determining reasonableness. Physicians should check their contracts with commercial insurance companies to see if the terms of the contract prohibit such administrative fees. Medicaid does not allow such fees.*

You also need to check your participation agreements and payer contracts to ensure that this charge can be billed to the patient. Each contract or agreement will define "patient liability," or the dollar amount an insured individual is legally obligated to pay for services rendered by a provider. For example, when the code for special reports (99080) was billed to Regence Blue Shield, the resulting EOB statement indicated that the code was a provider "write off" that could not be charged to the patient.[4]

Patient Notification

After you review all relevant state and insurance payer regulations and requirements for form completion charges, and you determine that you may charge the patient directly for this service, your next step is to draft a policy and patient notification statement.

Establishing a billing policy ensures that charges are uniformly applied to the entire practice or facility patient population. The Tennessee Medical Association states that the practice or facility should: "Apply the policy equally to all eligible patients unless financial hardship will be considered on a case-by-case basis."[5] Ideally during the initial patient visit—and before you charge the patient for the completion of forms—you must provide the patient with a written schedule of the charges for form completion. You can do this by directing patients to a notice on your website, by posting the information in the waiting room, and/or by providing a written document to the patient and family.

Again, it is best to draft any language for this notice with the assistance of regulatory counsel, but considerations include:

Introduction. This statement informs the patient that payment is required for the completion of certain forms; that this service requires extra work, time, and financial resources in excess of what is required to complete and maintain the medical record; and provides information on how long completion of the form will take. This policy section may also include a statement that payment is required prior to form completion.

Forms completed with no charge. While not required, this section notifies the patient that some items do not require separate payment, such as:

- Application for public assistance forms
- Family Medical Leave Act (FMLA) forms
- Workers' Compensation forms
- Department of Social Services (DSS) forms
- Social Security Administration (SSA) forms.

Specific forms to be completed at no charge will be determined by each facility, practice, or cancer program.

Forms that will be completed at a stated charge. This section should include the fees for form completion (per page, per form, per hour, etc.) and a list of forms that will be completed by the provider. Remember that the amount charged for form completion

may also by impacted by state law. For example:

- Loan payment forms
- Credit insurance forms
- Unemployment insurance forms
- Life insurance applications
- Passport applications
- Adoption forms
- Sports physicals
- Disability, Workers' Compensation and FMLA forms.

Instructions. This section provides patients with guidelines on how to complete their portion of the form; to provide a stamped, addressed envelope; and a timeline for form completion and submission. In a survey performed by the Medical Group Management Association, some practice administrators indicated that their physicians completed the first form without charge and then required a nominal fee for each subsequent form.[6]

There's a Code for That...

Although providers tend to think of form completion as a service that is not reimbursed by insurance payers, there is a specific procedure code to report this service:

- ***99080:*** Special reports, such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form.

According to *CPT Assistant*, Winter 1994, this code is not to be reported for brief standard reports, but is intended to be charged for detailed forms that are not part of the basic healthcare service, such as those related to accidents, injuries, and other special reports. For insurers that reimburse for this service, a copy of the "special report" may be required prior to reimbursement. Of note, code 99080 is *not* reported in addition to the evaluation and management service codes for work-related or medical disability evaluations performed by the treating physician (refer to codes 99455 and 99456).

Regardless of whether the special report will be reimbursed by the insurer or the patient, code 99080 allows providers to track these costs and charges.

Cindy Parman, CPC, CPC-H, RCC, is a principal at Coding Strategies, Inc. in Powder Springs, Ga.

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How a Dedicated Coder Can Help Improve Your Bottom Line

by Cindy C. Parman, CPC, CPC-H, RCC

In an ideal world: sophisticated software allows staff to capture charges as they complete work. The charge capture system communicates with the billing system, and the codes are automatically transferred to the insurance claim. Technology provides a fool-proof system that eliminates the need for human intervention.

In the real world: CPT® coding guidelines, HCPCS Level II codes, payer policy, bundling issues, medical necessity, and constantly changing government regulations create a complex situation. As the level of complexity in medical coding increases, so does the risk of lost revenue and increased liability.

Whether oncology care is being provided in an office setting, at a freestanding cancer center, or at a hospital-based cancer program, adding a dedicated coder to your staff can benefit your program. Options include hiring an experienced coder or training an existing staff member; both will require a financial investment. Coders with nationally recognized coding certifications have generally completed a standard course of study, passed a nationally recognized coding examination (generally 150 questions or more), and are required to maintain CEUs on an annual basis. There are a number of 'certifications' available, but not all of them are nationally recognized. Nationally certified coders typically require a higher salary.

Here are 12 activities that a dedicated medical coder can complete:

1. Ensure the correct assignment of evaluation and management (E&M) codes, and provide immediate feedback on documentation issues. Approximately one third of the Medicare dollars spent annually reimburses patient visit services. As a result, E&M visits are an audit target and have been a focus of the Office of the Inspector General (OIG) Work Plan for several years. An average practice may lose $50,000 a year due to under-coding, often because staff or physicians are fearful that claims coded too high will be rejected, or trigger a payer audit.

2. Capture all services, detect potential for unbilled services, and track emerging reimbursement issues. Payer policy is dynamic. Oncology practices must stay up to date on covered services, new codes for emerging technologies, and changes in reimbursement allowances. Even small changes in procedural or diagnostic codes can result in increased payment. The use of current codes also results in the presentation of a more accurate provider profile to local payers.

PHOTOGRAPH/BIG STOCK

3. Maintain the accuracy of diagnosis codes. Correct diagnosis code assignment documents the medical necessity for complex services. In addition, oncologists frequently treat more than the malignancy, and diagnosis codes are necessary to report all patient conditions. For example, if an oncologist treats anemia, hair loss, skin erythema, nausea, pain, or other medical issues, these diagnosis codes would be reported in addition to the primary diagnosis representing the malignancy.

Diagnosis codes are added, deleted, and/or updated on Oct. 1 each year. With the elimination of the "grace period" to implement these changes, a dedicated medical coder can update diagnosis codes on charge tickets or in computer systems.

4. Ensure that correct procedure codes are submitted. CPT® and HCPCS Level II procedure codes are updated throughout the year, and a dedicated medical coder will remain current on these coding changes. The American Medical Association (AMA) updates Category III CPT procedure codes twice a year (during the annual update of the CPT Manual, and July 1). The Centers for Medicare & Medicaid Services (CMS) may perform quarterly updates of HCPCS Level II procedure codes that affect oncology practices.

5. Guarantee correct modifier application. Omission or incorrect use of procedure code modifiers can result in lost revenue. While modifier -59 requires close monitoring to ensure that it is not overused, other modifiers such as -76 (repeat service) and -58 (staged procedure) may require manual application in certain situations. A dedicated medical coder can ensure that claims requiring modifiers are submitted correctly the

first time, eliminating the need to re-file or appeal denials.

6. Ensure that charge tickets and dictation templates are updated and review all forms used for documentation. When superbills or charge capture documents are not updated annually (at a minimum), practices run the risk of assigning outdated or incomplete codes for diagnoses and procedures. Documentation of all services provided to an individual patient is crucial to reimbursement, and a dedicated coder can review any forms or templates for compliance with regulatory guidelines.

7. Decrease denials and ensure that timely filing deadlines are met. According to Medicare statistics for calendar year 2004, the specialty of radiation oncology experienced a denial rate of 7.2 percent of the services billed. It is possible that practices leave money on the table because billing staff do not have the time or the necessary resources to appeal denials, or maybe no single individual is responsible for following up on appeals.

8. Monitor managed care/contractual reimbursement. The medical coder can ensure that copayments, deductibles, and other patient responsibilities are communicated to front desk staff. To maintain an oncology practice's financial health, these repetitive, small dollar charges must not be neglected. In addition, a dedicated coder can track reimbursement by insurance payer and provide information that assists with future contract negotiations.

9. Monitor Medicare regulatory changes, such as quarterly changes to bundling guidelines, transferred patients from skilled nursing facilities, and medical necessity updates. In certain situations, procedures will not be covered by insurance and preauthorization may be required for complex treatment plans. For Medicare, an Advance Beneficiary Notice (ABN) is required to obtain payment from the patient for these non-covered services, and certain other insurers require a waiver of liability to be signed by the patient.

10. Remain current on non-physician practitioner, teaching physician, and locum tenens regulations.

11. Perform compliance monitoring (e.g., internal audits).

12. Provide physician and staff education.

Physicians and facilities are responsible for knowing the coding guidelines—or employing someone who does. In addition to staying current with coding changes, oncology practices and hospital-based programs need to establish processes to monitor compliance with payer guidelines. The good news is that through appropriate coding oncology practices and hospital-based programs may improve their bottom line.

Cindy C. Parman, CPC, CPC-H, RCC, is a principal at Coding Strategies, Inc.

Improving Patient Adherence with Oral Chemotherapy

by Steve D'Amato, RPh, BCOP

In Brief

Non-adherence can have profound clinical consequences in the treatment of chronic diseases—especially cancer. Medication non-adherence in patients with cancer is a growing concern today due to the increasing availability of new oral agents. Many factors contribute to patient non-adherence to treatment regimens. Understanding the potential barriers and factors that affect patient adherence will help providers develop strategies to promote patient adherence to oral treatment regimens. Optimal patient outcomes require adherence, education, communication, ongoing monitoring, and follow-up.

The use of orally administered antineoplastic agents continues to rise and is likely to increase in the coming years with the development and approval of new oral formulations to fight cancer. As research identifies new "targets," the subsequent development of new agents to affect those targets (Table 1) is changing the approach to treating various malignancies. Patients diagnosed with cancer today have five-year survival rates, and these rates continue to increase over time. In some cases, cancer is becoming a chronic disease, where traditional chemotherapy is combined with newer therapies over prolonged periods of time. At the same time, oral agents introduce challenges for providers and patients.

Benefits and Risks of Oral Chemotherapy

Oral antineoplastic agents offer patients many potential advantages. For example, a patient who is on oral chemotherapy may be able to return to work sooner than one who is receiving more "traditional" cancer treatment. Oral agents are also more convenient for most cancer patients. They do not require IV access, thereby avoiding complications with infusion, clotting, and infections. Self-administration also means fewer trips to the hospital or practice. Finally, there is some evidence that these oral agents may have less severe adverse effects compared with intravenous therapies.[1]

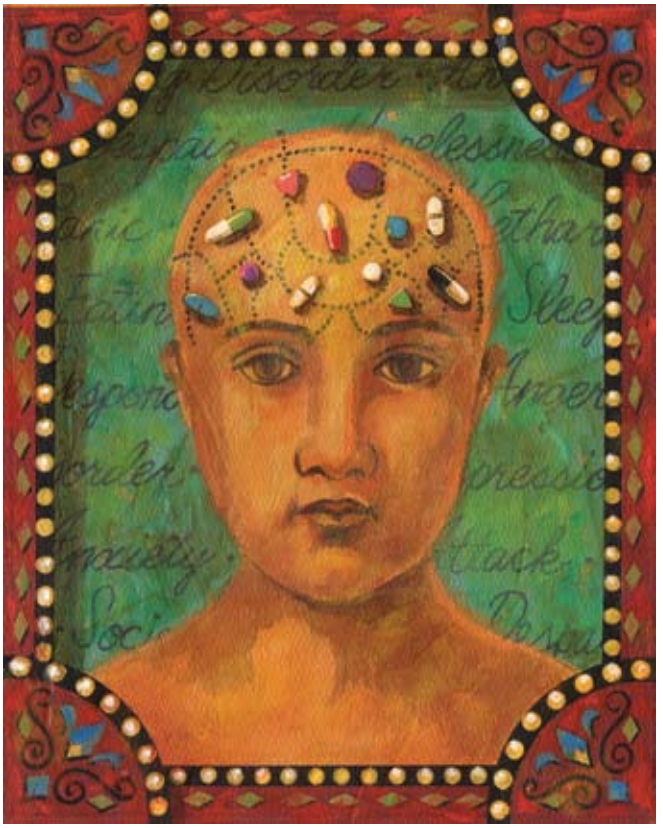
While patients prefer the convenience of oral medications, the self-administration of oral chemotherapeutic agents presents its own challenges. For example, self-administration may increase the risk of medication errors and possibly compromise the effectiveness of the anticancer therapy. Some oral agents may have drug/drug interactions. To prevent unwanted toxicity and therapeutic misadventures, providers and patients need to understand the mechanisms of action and potential drug/drug interactions associated with these newer agents. Clinicians can then take the necessary steps to prevent problems and maximize the efficacy of oral chemotherapeutic agents.[1] Other potential problems associated with oral chemotherapy may include:

- Patient non-adherence
- Nausea and vomiting
- Lack of patient education
- Toxicity profiles of newer agents
- Dysphagia (difficulty in swallowing)
- Odynophagia (painful swallowing)
- Cost.

Many of these potential problems need to be identified and discussed with the patient *prior* to starting any

Table 1. Newer Oral Antineoplastic Agents

Agent	Indication
Capecitabine (Xeloda®)	Breast and colon cancer
Dasatinib (Sprycel®)	Chronic myeloid leukemia/acute lymphocytic leukemia
Erlotinib (Tarceva®)	Non-small cell lung cancer and pancreatic cancer
Gefitinib (Iressa®)	Non-small cell lung cancer
Imatinib (Gleevec®)	Chronic myeloid leukemia/gastro-intestinal stromal tumor
Lapatinib (Tykerb®)	Breast cancer
Lenalidomide (Revlimid®)	Multiple myeloma/myelodysplastic syndrome
Nilotinib (Tasigna®)	Chronic myeloid leukemia
Sorafenib (Nexavar®)	Renal cell carcinoma/hepatocellular carcinoma
Sunitinib (Sutent®)	Renal cell carcinoma/gastro-intestinal stromal tumor
Thalidomide (Thalomid®)	Multiple myeloma
Vorinostat (Zolinza®)	Cutaneous T-cell lymphoma



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oral chemotherapeutic regimen. Drug interactions are of particular importance. An excellent article on this topic was published in the *American Journal of Health-System Pharmacy*.[2]

The increasing use of complementary and alternative medicine—along with nutritional supplements and herbal products—further complicates medication management for many patients taking oral chemotherapeutic agents.

Another area where there is a paucity of data concerns the safe handling of these oral agents. For example, oral chemotherapeutic agents could lead to inadvertent exposure of family members to hazardous substances and environmental contamination. The safe practice standards that have been applied to intravenous chemotherapy must also be applied to oral chemotherapy.[3]

Adherence is Critical

In the past, almost all chemotherapy was delivered intravenously. Assuming a patient received all scheduled cycles of chemotherapy within the defined treatment period, providers could monitor and be assured of adherence with intravenous therapy. Today the treatment landscape has changed. When patients receive self-administered oral antineoplastic medications as part of their treatment regimen, they may not receive the same intensive teaching and monitoring as patients receiving intravenous therapy only. Thus, patients may not receive the same amount of education and monitoring as patients receiving intravenous therapy.[4]

Oral chemotherapy is effective *only if* patients adhere to their administration schedule. But it can be challenging for providers to monitor true adherence because the patient is not taking the drug at the hospital or practice. Clinicians are further limited by the lack of a gold-standard measurement for assessing patient adherence.

With relatively few studies on patient adherence to oral chemotherapy, however, it is difficult to measure the prevalence of this problem. In developed countries, adherence rates average around 50 percent in patients with chronic illnesses. For oncology, published studies reflect a highly variable adherence rate:[5]

- 17 to 27 percent for hematologic malignancies
- 53 to 98 percent for breast cancer
- 97 percent for ovarian cancer.

In one study of 2,378 breast cancer patients who started adjuvant tamoxifen therapy between 1990 and 1996, adherence during the first year of treatment was 87 percent, but declined to only 50 percent after 4 years.[5] These findings showed that nearly one fourth of tamoxifen-treated patients

A Matter of Semantics

Adherence and compliance are terms that are used to describe the extent to which patients take medications as prescribed. Compliance is defined as the consistency and accuracy with which a patient follows the regimen prescribed by a physician or other health professional. This term has largely been replaced by the term adherence as the term compliance implies a patient has a subordinate relationship to the provider. Additionally, the World Health Organization (WHO) also determined that the term "compliance" is too closely associated with blame. Therefore, most providers use the term adherence to define the extent to which a patient's behavior (e.g. taking medications, following a diet) corresponds with agreed upon recommendations.

Related terms include "concordance" and "persistence rate." Concordance is defined as the agreement in the types of data that occur in natural pairs. In healthcare, this term reflects the agreement between a patient and provider that involves the patient in decision making. Persistence rate refers to the number or percentage of patients still receiving therapy at the end of a defined period of time.[1,2]

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were put at risk for suboptimal clinical response due to poor adherence. Other studies have shown similar results.[5,6,7]

As cancer is generally perceived as a life-threatening and serious disease, one would expect a higher rate of adherence, and yet some patients do adjust their doses without informing their healthcare provider. For example, some cancer patients may exhibit over-adherence to self-administered medication, increasing the dose because of perceived ineffectiveness or because they believe more is better. Often unrecognized by clinicians, this practice can lead to a substantial increase in toxicity. Conversely, a cancer patient may decrease the dose because of actual or perceived toxicity. Patients taking very expensive oral agents may also reduce their dose to delay the need to refill the costly drug.

Barriers and Predictors to Non-adherence

Adherence to treatment depends on many co-existing factors. Major predictors of poor adherence to oral medications have been well characterized[8] (see Table 2). Common barriers to adherence are often under the patient's control. Reasons cited by patients for not taking medications include forgetfulness, decision to omit doses, lack of information, emotional factors, and other priorities. Healthcare systems can create barriers to adherence by limiting access to care, using restricted formularies, and having high costs for drugs, co-payments, or both. Complex administration schedules, prohibitive cost, adverse effects, and poor access to medications all affect adherence rates.

Another barrier: patients may have a limited understanding of the rationale for therapy. Patient education is extremely important so that the individual understands the purpose of the intervention along with the expected results and potential side effects that may be encountered. Providers must recognize and respect the patient's cultural and religious beliefs and be aware of language deficits and poor literacy. Poor communication with the healthcare team and patient dissatisfaction with care also contribute to poor adherence.

Other factors that can play a role in non-adherence include:[9]

- Failure to fill an initial prescription
- Failure to refill a prescription appropriately
- Omitting doses
- Unsanctioned therapeutic holidays
- Taking too many doses, also known as over-adherence
- Prematurely discontinuing medication
- Taking a dose with prohibited foods, liquids, or other medications.

In the end, patient adherence to a long-term intervention depends on the patient's view of the benefits, risks, and cost of the intervention.

Improving Adherence to Oral Chemotherapy

Adherence is a complex and multifaceted issue that can alter the outcomes of therapy.[5,10] Over-adherence and non-adherence are dangerous and can lead the practitioner to change the dose or prescribe a different agent because of apparent non-responsiveness or unexpected adverse effects. They can also result in unnecessary diagnostic testing, changes in dose or therapeutic regimen, and hospitalizations. These outcomes all bring about increased costs to the healthcare system. Table 3 provides a brief list of potential consequences related to non-adherence to oral chemotherapy.

Table 2. Factors Associated with Non-adherence to Oral Medications

- Presence of cognitive impairment
- Presence of psychological problems, especially depression
- Treatment of asymptomatic disease
- Inadequate follow-up or discharge planning
- Adverse effects of medication
- Patient's lack of belief in the benefits of treatment
- Patient's lack of insight into the illness
- Missed appointments
- Poor provider-patient relationship
- Presence of barriers to medications or care
- Complexity of treatment
- Cost of medication, co-payment, or both

Table 3. Potential Consequences of Non-adherence with Oral Medications

- Increase in physician visits
- Increased hospitalization rates
- Longer hospital stays
- Decreased patient satisfaction
- Poor patient-provider relationships
- Compromised disease outcomes, such as decreased time to relapse and decreased survival

Since numerous factors contribute to patient medication adherence, it is unlikely that one single approach will be optimally effective. Instead, providers should use a multidisciplinary approach to promote medication adherence in their cancer patients. For example, collaboration among pharmacists, pharmacy technicians, oncology nurses, behavioral specialists, and physicians has been shown to improve patient adherence to oral chemotherapy.[5,11] Complex treatment regimens can adversely affect patient adherence. Pharmacists, in particular, can play a key role by working with prescribers on ways to simplify treatment regimens and reviewing patient medication profiles to identify potential drug interactions.

Educating cancer care providers about the issues and barriers to adherence is imperative. Educated providers can then communicate this important information to their cancer patients. Involving cancer patients in all aspects of the decision-making process has been shown to increase patient motivation and adherence. Providers can ensure that patients feel like they are part of the cancer care team by:

- Reassuring patients that oral anti-cancer therapies are very effective cancer treatments
- Educating patients that responses can take time to evolve
- Assuring patients that the healthcare team is there to support them
- Conducting regular, follow-up calls
- Providing frequent reassurance that patients can always call someone for clarification or advice

Case Study

A 50-year-old woman with metastatic breast cancer is prescribed capecitabine 1250 mg/m^2 by her medical oncologist. The physician instructs her to take four 500 mg tablets in the morning and four 500 mg tablets in the evening for 14 days, take 7 days off, return to the clinic in 3 weeks for a follow-up appointment, and to call if she has any problems.

Three weeks later the patient returns to the clinic with painful erythema and swelling of the hands along with diarrhea which caused her to miss several days of work. She also complained of nausea. She said she began taking antacids with her medication to help the nausea but it did not improve. She stated that she stopped taking her capecitabine with four days left to go because she felt so miserable. When asked why she did not call the clinic, the patient stated "I did not want to bother anyone and I thought everyone gets sick with chemotherapy."

This not uncommon illustration could have been prevented by education and early contact.

Education. Patient and family education is probably the most important factor in achieving a successful outcome. The benefits (value of the treatment) and the expected side effects of the medication should be explained in detail to the patient prior to initiation of treatment. Written, drug specific information should also be provided to the patient. A careful patient history and list of current medications is required to identify any potential adherence issues and possible drug interactions (e.g. phenytoin, warfarin, aluminum containing antacids). In this case, the patient started taking antacids with capecitabine. This contributed to the toxicity she encountered as antacids increase plasma levels of capecitabine.

Early contact. Capecitabine requires close monitoring during initiation of therapy, and providers should maintain repeated contact with the patient during the first cycle of treatment. This contact serves to establish trust and a connection with the patient to assess patient understanding of the treatment regimen and to identify any patient issues. A clinic contact should be provided to the patient, and the patient should be encouraged to call for any issue. In addition, a follow-up appointment in 7 days, instead of 3 weeks should be scheduled to assess the patient during the first week of therapy and to reinforce patient education and provide support. In this case, nausea could have been identified earlier, the appropriate intervention initiated, thus preventing the unwanted toxicity seen here (diarrhea, hand and foot syndrome).

- Taking reports of adverse events seriously and attempting to minimize their severity.

Equally important is for providers to actively listen to their cancer patients. This practice helps providers understand the patient's wishes and develop a customized approach to a specific treatment regimen as necessary. Regularly scheduled meetings to evaluate patient responses to therapy may also help identify issues with adherence and the resulting effect on outcomes.

Comprehensive patient and family education has been shown to enhance adherence to oral chemotherapy. This education should address the dose, frequency, timing of dosing, what to do if a dose is omitted, side effects and symptom management, and what to do if an adverse effect is encountered. Written aids and explanations of the importance of adherence, along with the possible ramifications of non-adherence should be fully discussed. Providers should not overload patients with detailed drug information if they are receiving information about their diagnosis, prognosis, or proposed treatment options. Scheduling a different time to discuss specific drug therapy may be required. Other aids such as pillboxes, calendars, diaries, alarms, and other tools may also be helpful.

Follow-up is critical to optimal patient adherence. Providers should monitor adherence and persistence on a regular basis. Refills on prescriptions should be restricted as appropriate. Patients who have missed or cancelled appointments should be contacted. These patients are often the ones who need the most help to improve their adherence to a treatment regimen. Efforts should be made to schedule follow-up visits that are convenient and efficient for the patient.

In the end, establishing trust and communication, providing support and education, instituting effective treatment plans, and providing effective follow-up with patients all contribute to improved patient adherence rates and (hopefully) improved outcomes.[8,12]

Steve D'Amato, RPh, BCOP, is a clinical pharmacy specialist with the Maine Center for Cancer Medicine and Blood Disorders in Scarborough, Maine.

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Improving Revenue Capture

In 2000 the implementation of ambulatory payment classifications (APCs) resulted in devastating financial losses to many hospital-based outpatient oncology departments around the country. Flash forward a few years. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) alleviated some of these losses, but drug costs continue to escalate and a new reimbursement methodology—average sales prices (ASP)—looms on the horizon. To continue to provide quality care to their patients with cancer, today's hospitals *must* focus attention on revenue cycle management.

The Big Problems

HealthEast Cancer Care is a three acute-care hospital system that serves the east metro area of the Twin Cities of Minneapolis and St. Paul, Minn. A busy, thriving program, HealthEast Cancer Care treats nearly 1,800 new analytic cases per year.

When APCs were introduced, the process of adjusting the hospital's charging systems was managed "behind the scenes" by patient accounting and finance personnel, with very little communication, input, or even the knowledge of clinical leaders and staff. The hospital system did not actively scrutinize the new charging system until its three infusion therapy departments began to experience diminishing revenues. This disturbing trend continued for several consecutive months from August to October 2002.

To solve the problem, HealthEast Cancer Care brought together the leaders of the various departments involved in the revenue cycle. The hospital's infusion therapy departments manage their patient populations by admitting each patient to a series account that allows for recurring visits over the course of treatment. This system, which is common in hospital-based outpatient programs, is an adaptation of the inpatient charging system. It is very difficult to customize the system for changing needs. Leaders from Patient Accounting, Health Information Services, Compliance, and Information Technology (IT) were overwhelmed by the many process and system changes needed if the hospital were to achieve proper charge capture, document medical necessity to assure payment, and educate the nursing staff to assure a consistent and accurate charging practice. The group believed that the cost of revamping the systems might not be worth the effort.

In November 2002, HealthEast Cancer Care participated in a Center for Provider Education Cancer Program

How HealthEast Cancer Care revamped revenue cycle management

by Connie Selle, CPht, RPht

Improvement Project (CPIP) seminar offered by the Association of Community Cancer Centers. Approximately 25 leaders from the hospital's Corporate, Finance, Patient Accounting, and cancer service line attended the one-day program. The presenter provided ideas from an *Oncology Reimbursement Toolbox* that outlined a series of steps to use in analyzing and correcting the revenue cycle in order to achieve maximum charge capture. Our staff took the program's message to heart, and immediately created an action plan adopting the presenter's recommendations. Staff that attended that seminar understood that they could not pursue this initiative in a silo, independent of operations. If the hospital was to increase revenue charge capture, it would need significant collaboration with many department leaders across the organization.

Getting Started

HealthEast Cancer Care identified representatives from all the departments that shared responsibility for the revenue cycle. These individuals became part of a newly formed revenue cycle team. The team involved all stakeholders, including Patient Accounting, Compliance, Contracting, IT, Coding and Billing, Health Information Services (medical records), as well as the clinical staff who understand the clinical procedures and who generate the charges.

The team's first step was to flowchart the revenue cycle. This exercise helped the group identify rules, opportunities, optimal management features, and potential minefields within each segment of the revenue cycle. During the flowcharting process, the team identified the following questions that would need to be answered before revenue charge capture could be improved:

- What happens when a patient calls for an appointment?
- What happens when a patient walks in for services?
- What information is necessary throughout the processes?
- Once the physician's orders are received, what occurs when the information enters the clinical setting?
- How is medical necessity determined?
- How do we charge for services rendered?
- How and when do we submit claims to payers?
- How do we know we are being paid appropriately on these claims?

Analyzing the revenue cycle components, the team found problems in three major areas: payer problems, inter-departmental problems, and billing department software problems.

Payer problems. Looking at Medicare patients (close to 50 percent of the cancer center's payer mix), the revenue cycle team found that the chargemaster was inaccurate and did not keep up-to-date with regulatory requirements. Reportable and reimbursable items were not being captured on the chargemaster. Chargemaster review and coding updates occurred annually during the consulting review process, and the current process did not allow for regulatory updates within the year.

The revenue cycle team also found problems with its managed care patients. Managed care payers were inspecting charges, refusing to pay certain claims, and down coding for specific outpatient services. The team found that the hospital's managed care plans had little to no interaction with the oncology service line. A number of these plans were unaware of new technology that needed to be incorporated into contracts. The hospital's managed care contracts would need to be reviewed and updated to allow for adequate reimbursement of oncology outpatient services.

Inter-departmental problems. The revenue cycle team found that most of these issues related to a lack of established communication between the billing department and the cancer service line. For example, select line items such as new technology and pharmaceuticals were being denied payment. While the billing department was receiving the denied claims, the oncology department remained unaware of the denials. Because the cancer service-line leaders were not receiving denial or underpayment data, they could not initiate performance improvement.

The revenue cycle team also discovered that the billing department was handling edits and denials with limited clinical expertise and may have been stripping off questionable charges. This lack of clinical expertise meant that billing staff was spending less time on outpatient denials. Frequently, the hospital was forced to write-off outpatient denials or underpayments.

Billing department software problems. The revenue cycle team identified problems with the billing department's software edits. The hospital used claims scrubbers to generate pre-billing edits. A potential for line-item write-offs exists if the claims scrubber flags a certain charge edit. In many systems, the programmed edits differ from the Outpatient Code Editor. Often, claim-scrubbing software adopts the physician standard, which is incorrect in the outpatient prospective payment system (OPPS) environment and up to two reporting quarters behind the physician Correct Coding Initiative (CCI) standard issued by CMS. To resolve problems with software edits, the patient accounting department needed to check with the vendor of the claims edit software to determine whether the edits were based on hospital or physician standards.

Finally, the revenue cycle team identified problems with the diagnosis coding. Simply put, clinical staff did not have the expertise to ensure correct coding. To

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Lessons **Learned**

1. ***Dedicated oncology reimbursement specialists work.*** The cancer service-line leader at HealthEast Cancer Care made the case for a dedicated oncology reimbursement specialist position. She prepared a concise explanation of why the position was needed, stressing the benefit of having a dedicated staff member oversee the outpatient cancer care reimbursement process.

At HealthEast, a dedicated revenue cycle manager was added as soon as the system recognized several consecutive months of diminishing revenues. The revenue cycle action plan was developed in tandem by the revenue cycle manager and the cancer care program director. The revenue cycle manager position has a dual reporting relationship to both the cancer care program director and the pharmacy director.

A dedicated full-time employee can help coordinate the revenue cycle, analyze the infusion services treatment mix, and track revenue capture across the service line. (See July/August 2004 *Oncology Issues* for more on how dedicated financial coordinators can strengthen your cancer service line.)

Once the reimbursement specialist was in place, this individual coordinated the revenue cycle team's efforts. The reimbursement specialist had to first understand the current processes, then take these apart and redesign the cycle from the point of service to the point of the patient's exit from the service.

To produce accurate charges and reduce denials or underpayments and non-payments, back-end processes need as much attention as front-end processes. While the revenue cycle team refined the front-end processes, the oncology reimbursement specialist analyzed back-end processes by reviewing error rates.

2. ***Revenue charge capture is a team effort.*** A fragmented revenue cycle can result in poor communication, which hinders improvement. The revenue cycle team developed a Revenue Capture Accountability Grid (see Table 1) for the cancer program. This tool ensured that all responsibilities are covered across the revenue cycle. From nursing staff to cashiers, the staff at HealthEast Cancer Care worked as a team to increase revenue charge capture. The cancer service-line director and the reimbursement specialist in tandem put the grid to work and hold staff accountable.

Getting front-line clinical nurse managers involved on the front-end spreads buy-in and commitment farther and faster. Clinical managers and directors must know how their billing is done, who is doing it, how registration works, and what the local medical review policy (LMRP) issues are. It's part of doing business.

The revenue cycle management team worked closely with the clinical staff to educate them about new processes and expectations for performance. The team found that the clinical staff wanted to do the job well. Once mentored, their performance met or exceeded the targets.

In another display of teamwork, the hospital brought together the medical director, the oncology reimbursement specialist, and representatives from oncology administration, managed care, finance, and pharmacy staff and asked them to assume a more proactive role in assessing new drug technology. The hospital put a system in place to monitor new technologies that are likely to be introduced; assess the reimbursement landscape; and proactively work with insurers and industry to maximize reimbursement.

3. ***Stop duplicate billing.*** Medicare defines duplicate claims as ones that are submitted to one or more Medicare contractors from the same provider for one of the following: the same item or service, the same beneficiary, and/or for the same date of service. Medicare *does not* pay for duplicate claims, and the submission of duplicate claims is a major reason for many Medicare claim denials.

Medicare pays the first claim that is approved and denies subsequent claims for the same service as duplicate claims. Duplicate claims also may delay payment. Billing staff or the third-party billing services must understand and stay current on Medicare claim-filing rules.

The daily charge report that is distributed to each site leader has been an important tool in reducing duplicate billing. HealthEast Cancer Care's goal is to submit a "clean claim" the first time.

4. ***Leverage clinical expertise in the appeals process.*** The revenue cycle team found that outpatient denials and underpayments were not monitored in an efficient manner. Cross-department collaboration was critical if these appeals were to get the attention they deserved. Staff and department leaders were asked to determine break-even points for claims appeals—a typical threshold is $500—and focus on preventing future denials, as well as appealing current denials that are higher than the agreed upon threshold.

The first step in this process is to generate a monthly report of outpatient medical necessity denials. This report should be routed to department managers to analyze the denied claims and determine if appeal is possible. If a denial is appealed, these department managers must compile clinical information to assist with the appeal process. The Billing department uses this clinical information to create the formal appeal packet that is sent to the payer.

improve their diagnosis coding skills, staff would need to be trained about relevant ICD-9-CM codes.

The Big Fix

Once the revenue cycle team identified the barriers to successful charge capture, it was time to develop an action plan.

The oncology service line was charged with developing a program plan—a tool that would become the master revenue cycle management program. The plan would include a statement of understanding, objectives and goals (both long- and short-term), and schedules. Hospital administrators would need to give the plan their approval and total support.

Looking at the "big picture," the revenue cycle team carried out its action plan in phases. The action plan consisted of six key components:

1. Conduct a baseline net revenue audit of the oncology services provided.
2. Develop a paper-based Patient Encounter Form.
3. Conduct a daily retrospective charge review.
4. Maximize the revenue benefit from Evaluation and Management (E&M) codes
5. Implement a system to establish medical necessity.
6. Develop educational guides and conduct training for clinical charge staff.

HealthEast realized immediate improvement in charge capture by adding a dedicated revenue cycle manager to the cancer service line.

4 Tips for Creating Clean Claims

- Define the requirements for complete charge entry and develop the necessary tools to facilitate the process.
- Identify where errors occur in the work process.
- Determine whether systems and databases are mapped and integrated accurately among departments.
- Determine whether the existing system needs to be enhanced or replaced, or whether staff needs additional training.

The revenue cycle team started by conducting a baseline net revenue audit of the oncology services provided.

At the time, HealthEast Cancer Center did not have a process in place to ensure that it was being paid the anticipated reimbursement. To correct this problem, the team initiated a net revenue audit of patient charges. The revenue cycle team took a random sampling of three categories of service: chemotherapy, medical infusions, and blood product infusions. The sampling was performed for both Medicare and Medicaid patients and other third-party payers. The revenue cycle team compared the patient's medical record documentation with the UB-92. Numerous problems were causing claim denials and, even more important, underpayment. On average, the team's audit revealed that the hospital was losing almost $900 per patient/per billing cycle date. This shortfall was primarily due to five factors:

- Improper charge capture
- Improper use of modifiers
- No utilization of E&M codes
- Lack of medical necessity documentation
- Lack of consistent charging practices between cancer care sites.

As the analysis progressed, the revenue cycle team determined that a charge form was needed to capture key information. The group created the "Patient Encounter Form" to reflect the activities of the entire patient encounter. The form included commonly provided procedures, commonly used ICD-9-CM diagnosis codes that apply to these services, and a space to add any other activity not captured. This form helped link procedure coding with diagnosis coding relative to medical necessity in a format that had not previously existed.

The team then developed a daily charge report to monitor the previous day's charging activity. The IT department generates this report which is routed to each clinical site leader and also to the revenue cycle manager. This report resulted in total charges being reviewed in a timely manner. Modifications and cor-

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Table 1: Revenue Capture Accountability Grid

ACTIVITY	STAFF RESONSIBILITIES
Registration	
Patient demographic and insurance information verified at each visit	Nursing staff
Referrals obtained prior to each visit	Nursing staff
Co-pays collected at registration	Cashier
Patients with financial issues identified at registration and referred to financial counselors	Nursing staff, reimbursement specialist, program director
Care Documentation	
Physician orders checked for signatures	Nursing staff
Patient orders, charts checked against medical necessity requirements coverage documentation requirements	Nursing staff
Clinical staff made aware of managed care contract details relating to coverage documentation requirement	Reimbursement specialist, program director
Contact person in billing for clinical staff	Reimbursement specialist
Charge Entry and Coding	
E&M codes used by nurses in all relevant situations	Nursing staff, reimbursement specialist
Charge slips reviewed for errors	Nursing staff, reimbursement specialist
Billing accounts compared against patient chart and treatment schedule	Nursing staff, reimbursement specialist to identify errors and omissions
Contact person(s) in coding for clinical staff, in oncology for coding staff	Reimbursement specialist
Billing	
Bills reviewed for missing charges before sent to payer	Billing staff, nursing staff, reimbursement specialist
Clinical documentation compared against medical necessity requirements for services provided	Nursing staff, coding staff
Contact person(s) in oncology for billers, in billing for oncology staff	Reimbursement specialist

rections could now be made *before* the charge reached the claims department. Although the clinical staff initially expressed strong resistance to monitoring the report on a daily basis, they now consider the added task to be the most valuable tool for ensuring charge accuracy.

The revenue cycle team also found that hospital-based resource consumption needed to be reconciled with codes that reflected staff effort. The work group designed an oncology-specific E&M (evaluation and management) scorecard with hospital-based visit level criteria to help staff determine appropriate level and care documentation requirements. The compliance staff reviewed the scorecard for hospital-wide consistency. The scorecard would also ensure that hospital-specific guidelines complied with Medicare regulations. Unit staff was asked to review and field test these guidelines, then, offer suggestions. Finally, staff were trained on how to use the scorecard and educated about the impor-

ACTIVITY	STAFF RESONSIBILITIES
Denial and Under-Payment Management	
Oncology department regularly informed of recent denials and underpayments by billing	Reimbursement specialist, nurse manager, program director
All denials over a certain amount analyzed for possible appeal	Reimbursement specialist, nurse managers, program director
Remittances from commercial payers analyzed for underpayments	Contracting, billing staff, reimbursement specialist
Oncology involved in appealing medical necessity denials	Reimbursement specialist, nurse managers, program director
Payment plans periodically reviewed to ensure patients following designated payment schedule	Financial counselors, reimbursement specialist
Administrative Oversight	
Regular meetings between all members of revenue cycle team to discuss process improvement opportunities and delegate tasks	Program director, reimbursement specialist
Regular meetings between oncology and contracting departments to discuss contract negotiations, ease of implementation of potential contract terms	Program director, billing staff, coders, contracting, pharmacy, reimbursement specialist
Denials data analyzed to identify causes and target process improvement opportunities	Reimbursement specialist, program director
Process in place for identifying and responding to new drugs and technology posing reimbursement problems	Reimbursement specialist, program director, nursing staff
Contact person(s) in contracting for clinical staff, in oncology for contracting	Reimbursement specialist
Regulatory Oversight	
Medicare and managed care communications reviewed regularly for reimbursement changes and additions	Reimbursement specialist, program director
CDM update with most recent reimbursement information	Reimbursement specialist, program director
Encounter forms updated with most recent reimbursement information	Reimbursement specialist, program director, nursing staff
Costs of drugs and supplies regularly reviewed, charges adjusted when appropriate	Pharmacy staff, reimbursement specialist, program director
Changes in reimbursement communicated to relevant staff (clinical staff, coders, billers)	Reimbursement specialist
CDM contact person(s) for clinical staff, in oncology for CDM.	Reimbursement specialist

tance of coding the correct visit levels. Today the hospital is realizing significant revenue from the correct usage of E&M services.

The ability to apply relevant medical necessity on recurring visits over the course of treatment is crucial to payer billing requirements. The revenue cycle team implemented "visit notification," to notify the Clinipac® system (an electronic admitting, coding, and charging system) of a patient visit that allowed management of medical necessity on a daily basis. The visit notification function generates an independent coding abstract that allowed the health information management department to place diagnosis coding for a single date of service. Prior to visit notification implementation, the diagnosis code was placed on the medical record at the time of initial annual registration of the monthly series patient.

The revenue cycle team worked closely with hospital staff on all these changes. Charging and coding guides or

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After putting the revenue cycle management action plan into effect, the fiscal year 2004 error rate in charge capture plummeted to less than 10 percent.

"crib sheets" were developed for nursing staff. Staff was given E&M education training for coding and billing clinical services. The revenue cycle team educated staff about the importance of correct chart documentation to appropriately bill for services. The team stressed the importance of nursing staff learning to apply reimbursement strategies in the practice setting.

Challenges and Barriers

Of course, change is never easy. The revenue cycle team faced several key challenges and barriers as it implemented revenue cycle management at the service-line level.

Because no single department "owned" the entire revenue cycle process, mobilizing support and creating a "sphere of influence" with patient accounting, contracting, and compliance leaders presented a challenge. Staff needed to change from a "business as usual" attitude to one that embraced collaboration and teamwork. Flowcharting the responsibilities of each department helped break down the communication barriers that had existed.

While the initial net revenue audit captured people's attention, it also triggered a discussion about what constituted a "significant" financial loss. The finance department, which worked with total system revenues, described the financial losses of the outpatient infusion service as not that significant in the overall picture. On the other hand, the cancer service-line leader believed that she was being "held to the fire" for service-line profitability.

Finally, software and hardware coordination between departments was a primary challenge. Discovering that the inpatient charging system could be adapted and had the capability of visit notification allowed the IT department to streamline the process. A single additional computer workstation was installed to facilitate the charge entry and admitting process and to communicate to nursing staff.

The Final Analysis

An effective revenue cycle program plan will help oncology team members anticipate departmental changes and develop new processes that may be needed to provide quality cancer care. The revenue cycle program should be coordinated with any existing master oncology business plans. The revenue cycle program should also allow for progress assessments and changes to meet the program goals. Once the action plan has been carried out, the work is not over. In the ever-changing healthcare arena, keeping a vigilant eye on the management of the revenue cycle is critical.

HealthEast Cancer Care found that relying on a single outside general consulting service for Medicare billing compliance had limited the financial success of its oncology service. Contracting with an outside consultant specializing in cancer care and hospital-based billing requirements provided a return on investment for the hospital.

Making the changes suggested by the consultant and the revenue cycle team took time. The review and redesign of work flow and processes took two to three months. The staff education phase took 15 days to complete. HealthEast Cancer Care staggered the actual implementation timeline because the changes were so significant. By focusing upon one procedure at a time, the hospital did the job right.

Within the first month of the project implementation, the hospital saw results. A difference in revenue capture was reflected in the quarterly outpatient product-line profitability report. Fiscal year 2003 demonstrated an 88 percent error rate in charge capture. After putting the revenue cycle management action plan into effect, the fiscal year 2004 error rate in charge capture plummeted to less than 10 percent. Today, HealthEast Cancer Care is confident that it is accurately capturing 95 percent of all available charges.

These revenue cycle changes dramatically improved the relationship between the cancer service line, registration, and the business office, but the work is never done. If error rates climb, the cancer reimbursement specialist and the cancer service line leader meet with the revenue cycle team to review data, develop an action plan, educate staff, redesign the processes, and ensure implementation.

Corporate commitment to this initiative is strong. Revenue cycle management is a strategic initiative for the healthcare system and a priority for all staff. This project has been successful because leadership committed to becoming intimately acquainted with the revenue cycle and offered full support.

HealthEast Cancer Care achieved a sense of project ownership for nursing and clinical staff including learning and "speaking the language" of reimbursement. The hospital continues to enjoy a strong network of communication among the revenue cycle team. The revenue cycle management team is constantly vigilant. The team meets monthly to continue to work through the issues, sustain the gain, and identify other areas of opportunity.

Connie Selle CPht, RPht, is revenue cycle manager at HealthEast Cancer Care and Pharmaceutical Services in Maplewood, Minn.

A Model Oncology Patient Assistance Program

The Problem
Sarasota Memorial Health Care System, a community not-for-profit hospital located in Southwest, Fla., faced a growing challenge of how to effectively case manage its uninsured and underinsured cancer patients.

The Solution
During discussions on how to reduce the negative financial impact on the health system's outpatient infusion department, a suggestion was made to start an oncology patient assistance program.

Uninsured and Underinsured: A Growing Concern

Sarasota Memorial Health Care System is the safety net provider in its region. In recent years, however, its outpatient infusion center has seen a drastic increase of patients who cannot afford their chemotherapy treatment. Before too long, the hospital's outpatient infusion center began to experience fiscal difficulties. After the Pharmacy Department voiced concerns over ever-increasing drug costs, the hospital recognized that it would have to make changes to how it was providing care to its uninsured and underinsured patients.

At the same time, in my former role as oncology case manager, I began to see an increasing trend of repeat admissions and lack of follow-up after cancer diagnosis. A few cancer patients experienced the feeling of getting "lost" in our healthcare system. These patients were often anxious, frightened, and desperately in need of social services.

The Solution: An Oncology Patient Assistance Program

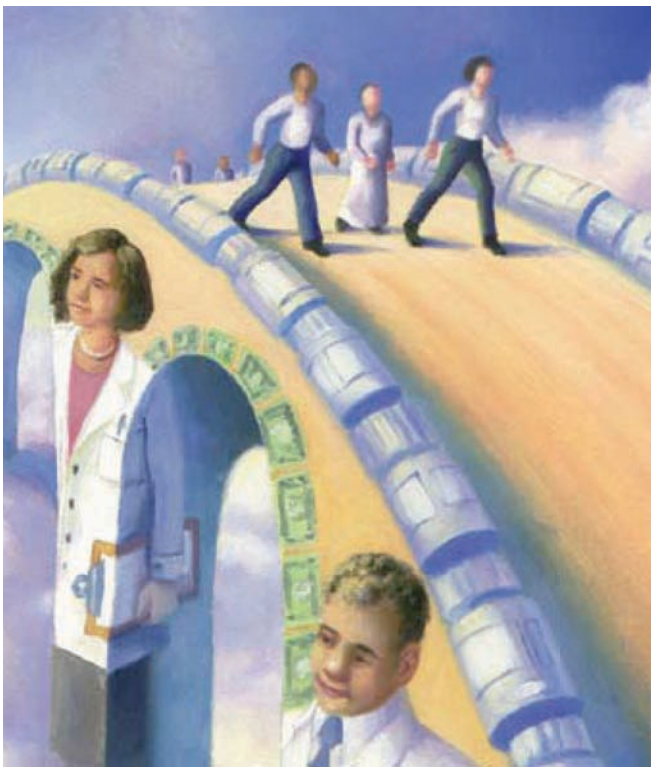
Calling on my years of experience managing an outpatient clinic, I suggested that patient assistance programs might possibly mitigate some of the fiscal challenges the hospital faced. A few hours of research verified that most of the major drug manufacturers have established patient assistance programs. Accessing these programs would benefit the hospital's cancer patients *and* help the outpatient infusion center recoup some of its financial losses. Even more important, these programs would help our uninsured and underinsured patients pay for their chemotherapy and allow the hospital to continue acting as the safety net provider for these underserved patients.

The first step was developing a comprehensive, well-thought-out plan for introducing and managing this new program. Equally important—identifying a champion to encourage and promote the program. In our case, two leaders stepped up to the plate: the director of Oncology Patient Services and the director of Pharmacy. Both individuals recognized the value of an oncology patient assistance program and actively supported and promoted the program.

In the fall of 2003, I started meeting with the hospital's uninsured and underinsured cancer patients, applying on their behalf for drug replacement and assistance from the major pharmaceutical companies. The program started small—in an accordion file that I kept next to my desk. Slowly but steadily, the file and the number of patients I was helping grew. At the start I worked on this program only part-time, but the cancer program quickly realized that its patient volumes required a full-time commitment to truly ensure the program's success.

Once the decision was made to allow me to work full time on the oncology patient assistance program, our cancer program developed a pre-clinic appointment system. All new cancer patients—regardless of payer source—meet with me and our oncology social worker prior to treatment.

At this pre-clinic appointment, we provide an orientation to our unit, perform an admission assessment,



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and obtain any necessary lab tests. We also sit down with patients and family members to review an individualized education packet with information about that patient's diagnosis and plan of care, which was put together prior to their appointment. During this visit, I also evaluate for eligibility and interest in patient assistance programs. Patients and their families spend the last part of their pre-clinic visit with the oncology social worker. Any referrals that need to be made are done at this time to the appropriate agencies.

The addition of this pre-clinic visit has had a measurable positive effect on our cancer patients and their families. Anecdotally, patients have shared that "they feel they are part of their treatment team and better prepared for their experience." From the hospital's perspective, the pre-clinic visit allows staff to be proactive and completely focused on meeting the needs of our patients. Moreover, the pre-clinic visits have improved patient outcomes and reduced hospital admissions—a win-win situation for patients and staff.

Learning as We Grew

As with any new program, we faced our share of challenges. Each pharmaceutical company patient assistance program is different, including the application processes and the eligibility requirements. Even established relationships must be continually monitored, as pharmaceutical companies often make changes to their application process and eligibility requirements.

Once our applications for drugs started being approved, our pharmacy was taking delivery of drugs that had not been ordered through the pharmacy's ordering system. We quickly realized that we needed to develop a proper storage and release method for these drugs. We also needed a full-time pharmacist to oversee the drug replacement program. Eventually, our patient assistance program was bringing in enough volume to justify a part-time pharmacy technician. (For more on the pharmacist's perspective, turn to page 24.)

One of the first tools created by our pharmacist was a spreadsheet that tracks a patient's use of the drug, when the initial patient assistance application is made, and when and how much of the drug was financially recouped for each patient.

At this time, we realized we would need to add another important member to our oncology patient assistance team—a staff member from the finance department. In fact, a financial liaison is necessary to comply with most pharmaceutical company patient assistance programs. At our institution, our financial staff member is responsible for taking the information from the spreadsheet discussed above and placing it in the correct financial accounts so that all patients are credited appropriately.

The Application Process

Enrolling a patient in our oncology patient assistance program is not a simple task.

To assess for eligibility and interest in the program, I must first review each drug application and all of its requirements with the patient. Interested patients must then provide necessary documentation. I make it clear to patients that the process cannot go forward without this paperwork.

Once I have received the proper documentation from the patient and determined that the patient is eligible, I obtain patient consent and forward the application to the appropriate physician for his or her signature.

After the application is submitted to the appropriate pharmaceutical company, I need to monitor it closely and follow up to see if the application has been reviewed and if the application has been accepted or denied. Fortunately, our denial rate is low because of our thorough pre-screening process and because we ensure that all the necessary documentation is submitted with the application.

Once an application is approved by the pharmaceutical company, the drug shipment must be tracked to ensure that the correct amounts are received and credited to the appropriate patient. At our institution, a pharmacy technician or pharmacy inventory control specialist is responsible for identifying the drug shipment as a patient assistance drug program shipment, determining if the drug has been shipped intact, and then dating and initialing the invoice with copies provided to both the pharmacist and the oncology care coordinator. The information is then entered into the patient assistance program drug spreadsheet and held in separate inventory until the pharmacist approves the release of the medication.

Medication is usually shipped in monthly increments and the oncology care coordinator is responsible for applying for continued shipments of the drug or beginning new applications if the patient's drug therapy changes.

We also work with cancer patients to identify other sources of coverage and help them apply to any eligible programs. These programs include federal and state programs, such as Social Security, Medicare, and Medicaid, and nonprofit programs, including the American Cancer Society, the Susan G. Komen Breast Cancer Foundation, the Patient Advocate Foundation, the Leukemia and Lymphoma Society, and the Cancer Fund of America. Once patients become eligible for any other coverage, they are taken off the oncology patient assistance program immediately and their financial class is changed by our financial liaison.

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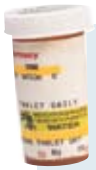

The Pharmacist's Role

by Lisa Hymel, PharmD

Developing and maintaining a successful oncology patient assistance program requires a multidisciplinary approach. Pharmacists bring to the table a unique skill set, including regimen assessment and monitoring; patient and staff education; and expert drug management. Here's a brief look at how our team works within an oncology patient assistance program.

Regimen Assessment and Monitoring

At Sarasota Memorial Health Care System, notification of a pre-clinic appointment for a new chemotherapy patient sets many wheels into motion.

The pharmacy's first responsibility is to review the chemotherapy orders. The process is not simple. In addition to checking for appropriate indications, dose, and rate of infusion, we must also look at the drug regimen in terms of what it will *cost* the patient and the institution. In today's restrictive reimbursement climate, this last question has become increasingly important. At the same time, as a pharmacist, it is becoming more difficult to recommend a lower cost therapy given the more innovative, well-studied chemotherapies that are rapidly becoming the standards of care.

At Sarasota Memorial Health Care System, as in most other comprehensive cancer centers, we believe that *all* cancer patients should have access to the latest treatments, regardless of whether or not they can pay. Our model oncology patient assistance program allows us to treat our patients equally—without incurring heavy financial losses to the healthcare system.

Patient and Staff Education

The chemotherapy education sheets our patients receive at their pre-clinic visits were developed by our pharmacy department.

We also provide face-to-face patient education on the second day or cycle of chemotherapy—sooner if the patient needs immediate education. During these visits, the pharmacist and patient go through a patient care checklist to assess for any chemotherapy-related symptoms. Following this assessment, we provide detailed information about the treatment regimen and/or drugs and make any necessary interventions or changes in therapy.

In addition to patient education, the pharmacy department provides support and education to cancer center staff. The oncology care coordinator, for example, comes to us with any prescription-related concerns, such as a prescription not being filled. Our pharmacy department then works with the oncology care coordinator and our social workers to resolve these issues.

Free Drug Management

As part of a double-check system, the pharmacy department is also responsible for reviewing all applications that come out of the oncology patient assistance program. Once applications are approved, the pharmacist or pharmacy technician faxes the application to the appropriate company. The pharmacist and the pharmacy technician then track the drug until it is received from the drug company. After signing for the drug, the pharmacy technician inputs the drug quantity and the date received into the master drug spreadsheet for the oncology patient assistance program and ensures that the drug is credited to the appropriate patient. When we verify drug receipt from the manufacturer, we can then reverse the drug charges that were made to the patient's account.

One challenge: many of the pharmaceutical programs are prospective replacement programs only. If a patient starts therapy prior to being enrolled in the oncology patient assistance program, for example, some companies do not replace the drug our pharmacy has already dispensed. We have to then charge the patient for the drug that has already been dispensed. If the patient cannot pay, the account may have to be closed with no reversals. In these situations, our pharmacy takes the loss. In the end, however, it is still better than having to take the financial loss for the entire treatment regimen.

Some pharmaceutical patient assistance programs offer retrospective replacement, in which case the pharmacy does not have to incur this bad debt.

The situation can become even more complex for our Medicaid patients. For example, some pharmaceutical companies withhold approval of patient assistance applications if they know that the patient has also applied for Medicaid. (Oftentimes, this information is required on the pharmaceutical company's application.) There have also been times when patients go on Medicaid in the middle of their treatment. In these situations, we reverse the amount of the drug we have already received off of the patient's account, close out all pending patient assistance applications, and bill the remainder of the treatment regimen to Medicaid.

These complex scenarios underscore the importance of having a finance staff member on the oncology patient assistance team.

At least twice a month, the pharmacist reviews the master drug spreadsheet for the oncology patient assistance program.

Another challenge has been to ensure that the drug is actually delivered to the pharmacy department—and not to the office of the physician who signed the application. Given the choice, manufacturers seem to want to deliver to the physician's office versus our hospital-based outpatient infusion center. We rely on our efficient tracking system and the support of the receiving department to successfully manage the drug inventory of the oncology patient assistance program.

As a member of the oncology patient assistance program, I find that nearly every work day offers something new and different to do. Some days, I feel like I am attempting to put together a financial "puzzle" where the pieces don't quite seem to fit. Other times the pieces seem to fall perfectly into place. No matter what the day is like, I know that our program has made a positive difference in the lives of many of our cancer patients.

Lisa Hymel, PharmD, is a clinical pharmacist in the Outpatient Oncology Department at Sarasota Memorial Health Care System in Sarasota, Fla.

10 QUICK TIPS
FOR STARTING AN ONCOLOGY PATIENT ASSISTANCE PROGRAM

Step 1: Gather Your Facts.
Research your patient volume. Know what treatment regimens your cancer center is losing money on and why. Find out if the manufacturers of these drugs have a patient assistance program.

Step 2: Develop a Plan.
If your hospital or practice is going to invest staff time in the program, you need to show exactly how this program will work. Identify staff responsibilities and develop a budget, including a forecast of how much money the program can recoup in drug replacement costs.

Step 3: Identify a Champion.
As with any new program, you need staff and physician buy-in to be truly successful. Oncology will need to work closely with Pharmacy to get this program up and running.

Step 4: Meet with Patients.
Develop a system for meeting with your uninsured and underinsured patients. Establish a process for educating patients about the program.

Step 5: Put Together a Team.
Decide who will oversee the patient assistance program. Know which staff will be a part of the team: case managers, oncology nurses, social workers, pharmacists and/or pharmacy technicians are a good start.

Step 6: Identify a Way for Managing Drug Inventory.
Develop a spreadsheet for all patients receiving drugs through the oncology patient assistance program. This information is necessary to comply with pharmaceutical company guidelines and to credit patients correctly.

Step 7: Familiarize Yourself with the Different Pharmaceutical Patient Assistance Programs.
Build relationships with your industry counterparts. Monitor any changes to their drug replacement applications or eligibility criteria.

Step 8: Streamline the Application Process.
Know what information you need, including any patient documentation. Develop a timeline for submitting, monitoring, and following up on all applications.

Step 9: Measure the Program's Success.
Communicate to management the dollar amount of replacement drugs that the program has recouped. Gather data about patients that your program has helped. Measure how the program is improving patient outcomes and the cancer center's bottom line.

Step 10: Identify Opportunities for Growth.
In addition to pharmaceutical patient assistance programs, consider helping with appeals and denials. As the number of uninsured and underinsured patients increases, invest resources to grow the oncology patient assistance program.

A Wise Investment

Our oncology patient assistance program has been up and running since the fall of 2003, and I have never had a negative experience with a pharmaceutical patient assistance program representative. Instead, it is clear that the goal of these companies is to make sure that eligible patients have access to their life-saving drug.

Pharmaceutical patient assistance programs are either prospective (where product is supplied from the time the application is approved) or retrospective (where the entire treatment is covered). While prospective programs provide drugs for current or upcoming regimens so that the cancer center does not have to supply the drug and wait for it to be replaced, these programs do not replace drugs that have already been provided to the patient. If patient applications are not submitted before the first treatment is given or if an application is held up waiting for signatures or paperwork from the patient, the cancer center can still incur drug costs. To minimize these costs, we review program requirements with patients at their pre-clinic appointment so that applications can be completed as soon as possible.

While the time we spend on our oncology patient assistance program is not reimbursed by any payers, the money recouped from drug replacement more than covers the salaries of a full-time RN (the oncology care coordinator), a full-time pharmacist, and a part-time pharmaceutical technician and financial staffer. Since we started the program, Sarasota Memorial Health Care System has realized approximately $500,000 each year in oncology drug replacement costs—money that our outpatient infusion center and pharmacy used to have to write off as bad debt from non-payer patients. And this dollar number keeps growing. So far this year, our program has already recouped about $400,000 in replacement anticancer drugs. Due to an increasing patient load, we are on target to far exceed our annual projections.

But most importantly, the oncology patient assistance program has stabilized the financial performance of our outpatient infusion center so we continue to offer our patients quality care in their communities.

As far as the future, we see many growth opportunities for our oncology patient assistance program. For example, we have been involved with some cases where Medicare has denied off-label use of a certain anticancer drug. Our patient assistance program stepped in to coordinate an appeal process. In this specific instance, we obtained the drug through the pharmaceutical company's compassionate care program. Off-label and other reimbursement efforts require a coordinated effort from our oncology patient assistance team.

Marie Borsellino, RN, OCN®, is oncology care coordinator at Sarasota Memorial Health Care System in Sarasota, Fla.

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Welcome to the Vortex—

Negotiating and Building Relationships with Your Payers

by Dawn Holcombe, MBA, FACMPE, ACHE

Life used to be easy. Medicare fee schedules were published and codes changed modestly. After brief discussions on fee schedule changes, private payer contracts were renewed annually. Today, the relationship between provider and payer has become much more complicated. Medicare rates and policies are a source of constant frustration and change, requiring oncology practices to get involved in policy discussions with Congressional members and to interact daily with Medicare carriers. Private payer contracts are also in flux.

Fee schedules for both professional fees and drug reimbursement need to be tightly negotiated. Questions about quality of care and pay for performance alternatives abound. Rate changes for some specialties may dramatically affect other specialty services. When it comes to oncology policy, external entities are holding as much sway, if not more, than the contracted oncology physicians. Questions are even being raised about the delivery models for oncology care that have emerged over the last 10 years. In short, today's oncology community is taking nothing for granted.

Get Engaged!

In a recent study, 51 percent of oncologists surveyed reported that in the next five years they anticipated making some strategic changes to their practice, including mergers, sales, acquisitions, or closing their practice.[1] However, an alarming 43 percent of oncologists reported that they did not anticipate *any* changes.[1]

Many oncology practices and community cancer centers are focused inwardly on minimizing operating costs, managing drug inventory as efficiently as possible, and implementing technology tools, such as e-prescribing and electronic medical records (EMRs). What they do not realize is that external, non-physician-owned entities are playing an increasing role in their immediate future. Every day, these external entities are courting payers, seeking to manage oncology on behalf of small, medium, and large payers. Before entering into payer discussions and negotiations, oncology practices and community cancer centers must first know *who* these entities are and *what* they offer payers.

Companies seeking to take the lead in oncology management, such as ICORE, CareCore Oncology, and P4 Healthcare, and specialty pharmacy organizations are in discussions with key regional and national payers. These companies are seeking blanket contracts for states and regions with insurers like Anthem, Wellpoint, UnitedHealthcare, and others. Even companies that were working to bring oncology practices and community cancer centers along in the negotiating process may choose to abandon that strategy and find it more productive to work from the top down with payers.

So what can oncology practices and community cancer centers do? First, be proactive—plan for change and identify and explore major payer initiatives in your region. If you fail to notice change and adapt your strategic planning accordingly,[2] you will likely be blindsided by payer decisions when it is too late to effect any change. For example, here's what happened recently in Florida. In early 2009, Blue Cross and Blue Shield of Florida engaged ICORE to manage oncology costs and treatment choices through the use of drug formulary restrictions, prior authorizations, and pre-certifications. These changes were considered onerous by the practicing oncologists in that state. At the time this article went to press, the final outcomes of the resulting standoff between the affected oncology providers and their patients versus the payer and the third-party manager were not yet resolved. Although the new contract was to be effective July 1, 2009, physicians had until September to choose to sign their contract renewals. The contract negotiations between Blue Cross Blue Shield of Florida and ICORE had been ongoing for about a year, however, the first physicians in the state knew of these discussions was when they received the announcement letter.

Additionally, Magellan Health Services, which owns ICORE, purchased First Health (a Medicaid insurer) in July 2009 from Coventry, a large national insurer. Part of the purchase agreement provided that Coventry was to roll out Magellan's ICORE oncology management services in five of its key markets before the end of 2009. Starting Dec. 1, 2009, ICORE oncology management will also take place in Missouri.

Understand the Payer Perspective

Oncology practices that seek to approach payers should understand that they are competing for the payers' attention with these external companies whose marketing message is "We can save you millions of dollars on your oncology spend." Payers have a markedly different mindset than most oncology practices and community cancer centers. Payers see oncology as a cost center. Each site of service and each regimen is a cost that can and should be compared with alternative options. Payers expect practices and centers to be run as efficient businesses, with evidence-supported decisions and cost-effective streamlined operations.

Further, payers are beginning to question the choices being made in the treatment of cancer. Many payers are feeling pressured by employers to justify their management of the premium dollar. Other payers are asking if cancer care can be delivered in alternative settings such as pharmacy- or payer-owned infusion centers. Today, payers are using multiple tools and strategies to help manage cancer care treatment and costs, including adopting Medicare reimbursement policies and rates, using specialty injectable

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programs, blanket prior authorizations, and more.

Adoption of Medicare policies and rates. Increasingly payers are recognizing that ASP+6 percent (the Medicare reimbursement rate for drugs provided in a practice or freestanding cancer center) is not sustainable, and they are turning instead to rates of ASP+12 percent or +19 percent. However, only a small number of payers are also adjusting professional reimbursement rates.[1]

Specialty injectable programs. Specialty pharmacies and pharmacy benefit managers (PBMs) are actively suggesting to payers that their programs for compliance, disease management, and patient support and education offer a safe and less costly alternative to the "buy and bill" model used today. While anecdotally, many payers speak to their preference for eliminating the "buy and bill" model, liability issues and additional costs and drug waste have caused some payers to reconsider. Still, this topic is a hot issue that will be addressed on an individual level by almost every payer. And oncology practices and community cancer centers need to know if *their* payers are exploring such programs.

Blanket prior authorizations. Often these programs are implemented when payers suspect inappropriate use or choices of care, or it could be just as simple as payers putting in a program to prove to their customers (employers) that they are appropriately managing the oncology spend. Payers use blanket prior authorizations as a screening tool—both to gather information on the care being delivered and to restrict approved care to follow specific payer-driven parameters. These authorizations also become a pathway to payer-driven guidelines and preferred-treatment regimens.

Care management entities. Faced with the complexities of oncology care and the multitude of oncology drug choices, payers are listening to external care management entities that promise to manage drug costs and choices and to narrow variation of care through approval processes. Often, practicing oncologists will not be aware of payer discussions with such entities until the announcement of a policy change. At times, these care management entities operate in a manner that is masked to the practice or community cancer center, gathering data on clinical practice patterns and drug costs to be used later in payer policy changes. For example, Magellan's ICORE program operated for years as a specialty pharmacy, offering private guidance to payers on oncology drug choices, pricing, and utilization, and now has turned its focus to more visible oncology management goals, starting with the initial contracts with Blue Cross Blue Shield of Florida and Coventry.

Partnering with external parties for oncology guidance, direction, and/or drug management. For the most part, these programs are being explored on a large regional or national basis. To date, these programs have been developed on an individual basis with participating practices and community cancer centers, and the oncology community at large has not been invited to participate. Oncology-based entities with these type of pilot programs include US Oncology, CancerCare Northwest, University of Pittsburgh Medical Center (UPMC), and CCE (Cancer Centers of Excellence). Other partnerships are more commercial, such as centralized negotiating entities like P4 Healthcare. Still others come from outside the world of practicing oncology and focus on building oncology management strategies, like CareCore Oncology and ICORE. None of

…prior to entering into negotiation with payers, build your own value portfolio…that outlines your program's business case.

these partnerships and entities uses the same set of guidelines and drug management policies, and all are seeking to differentiate their results from the central care population by cost savings.

Viewing oncology as a drug management issue, more than a disease specialty. Oncology is such a complex field that, to date, there has been little unanimity about how to manage the disease and its costs, even among large national payers. For oncology practices and community cancer centers, this scenario presents costs and operational challenges because they must deal with multiple individual payer approaches and payer contract issues. It presents similar challenges to payers since the provider base is so diverse. Any single payer could be contracting in its regional markets with numerous small practices of five or fewer physicians, multiple hospital-based cancer centers, one or more nationally networked practice(s), and one or more academic institution(s).

PBMs and companies such as CareCore Oncology, ICORE, and P4 Healthcare promise payers savings on drugs as a primary outcome of their process, and risk losing sight of other disease management issues for the complex specialty of oncology.

What about Specialty Pharmacy?

Speaking at a recent payer-focused meeting, a key leader in a major specialty pharmacy chain stated that "it was time to let doctors doctor, and to let pharmacists manage drugs." This comment reflects a sentiment often expressed by specialty pharmacy and by some payers—that it is time to move management and even oversight of oncology drugs used in clinical practice into the specialty pharmacy arena; that oncologists are better suited to identifying cancers, than managing drugs.

As an industry, specialty pharmacy developed out of the need for patient support, education, and assistance in the procurement and oversight of hemophilia drugs, and soon branched into other specialties and diseases. At a recent national specialty pharmacy conference a majority of sessions addressed oncology and oncology drug management. The specialty pharmacy industry looks at the growing pipeline of oncology-oriented drugs and sees a lucrative business opportunity. Additionally, moving oncology drugs from the medical benefit into the pharmacy benefit gives payers more flexibility in building consumer insurance benefit designs, and gathering key information, such as the NDC code, so that payers may request volume rebates from pharmaceutical manufacturers through their PBMs.

Some companies have increased their visibility under the specialty pharmacy and oncology management umbrellas, as part of their marketing initiatives with private payers. At the recent Academy of Managed Care Pharmacy held in Orlando on April 15 – 17, 2009, speaker Bill Sullivan of Specialty Pharmacy Solutions offered examples of specialty pharmacies that he determined were offering "innovative services" in the management of specialty pharmacy drugs. Number four on his Top Ten Innovators in Specialty Pharmacy list was a name familiar to many in the oncology world—P4 Healthcare. The company was lauded for its oncology programs, which "integrate P4-administered and payer-endorsed pathways into the oncologist marketplace with proactive communication, education, and significant financial incentives for positive patient adherence."[3] When payers start to consider companies as "specialty pharmacy" and "oncology managers," it also affects the perspectives of the oncology community.

What Does This Mean for *You*?

The traditional "4 P's" of marketing—product, price, place, and promotion—no longer work in healthcare. Innovative oncology practices and community cancer centers are now focused on stabilizing their business processes, with emphasis on the following new rules—"4 C's"—for marketing and competitive negotiations:

- ***Continuum***—Developing upstream and downstream connections and collaborations. For example, refining relationships with referral streams, helping primary care to manage cancer screenings and prevention activities, and better collaboration with hospitals to capture costs and implications of hospitalizations and symptom management.
- ***Care***—Defining and measuring patient satisfaction, establishing and monitoring outcomes measures, developing formal treatment plans, and improving follow-through, quality, and choices.
- ***Cost***—Looking at cost a number of different ways—per day, per treatment, per patient, per disease, etc. Understanding that the costs of cancer care extend far beyond the costs a single office or practice can track in their patient charts.
- ***Comparativeness***—Building registries to understand populations and care using real-world data and incorporating internal and external information on relative comparisons.

Strategies to Help Prepare for Payer Negotiations

Oncology practices and community cancer centers should review their marketing portfolios and competitive position in the context of these 4 C's. And prior to entering into negotiation with payers, build your own value portfolio (or "brag book") that outlines your program's

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Strategies to Help Address Completed Contracts or Proposals

Sometimes, before an oncology practice or a community cancer center has a chance to approach a payer regarding a new collaborative relationship or to enter into contract negotiations, they are presented with completed new contracts and program proposals. Often, these new contracts are the result of the payer contracting with an external entity for oncology management services or some type of drug management. If your oncology practice or community cancer center is in this position, here are 11 key steps to take:

1. ***Don't be afraid to ask for help.*** Often an experienced external expert can catch trends or changes that you may not anticipate, or identify seemingly "innocuous" clauses that may be significant down the road.
2. ***Review the new proposal carefully.*** Understand what is being asked of your program, your physicians, and your patients. Identify areas that may have been ignored or not addressed by the proposal.
3. ***Know your numbers.*** Run the proposed fee schedules and rates against your total patient volume—not just the top reimbursement codes. Often a few codes may look attractive, but after looking at the whole picture, you may discover that the new contract or proposal may not cover your operating costs.
4. ***Identify overhead burdens or additional costs.*** Sometimes your program may incur additional costs or overhead to be compliant with the new contract or proposal. Find out if those "new" costs are covered in the proposal. If not, ask why.
5. ***Look carefully at reimbursement bases.*** Payer contracts can and should offer rates for professional services that appropriately reflect your operational costs. Knowing your own costs will help you negotiate appropriate professional rates, allowing you to then negotiate rates for drugs that approximate breakeven on acquisition and handling costs—a win/win for you *and* the payer. With today's reimbursement climate, it no longer makes sense to accept contractual terms that push high margins on drugs. In fact, high margins on certain drugs tend to mean that payer wants you to use that drug instead of another drug. Look carefully to see if that choice is one you would make for your patients from a medical standpoint.
6. ***Assess the impact of the new proposal on your patients.*** If you have legitimate concerns about certain regimens or drugs that you feel are being "pushed" by a payer, it is fair to ask why and discuss your concerns with the payer.
7. ***Consider if you can afford to accept the contract.*** Fear of losing market share will not help your program if it accepts contracts for large numbers of patients on which it loses money on each patient. You cannot make up losses with higher volume at loss rates. If other programs choose to accept such a contract, it may be that they do not understand the loss issue, and will not be around long enough for you to worry about their short-term increase in market share.
8. ***Examine any third party involvement in the contract.*** Know the role(s) the third party is expected to play.
9. ***Know your responsibilities with regards to patient data.*** If your program is expected to provide data to the payer or a third party, know what data you are providing, where the data will go and how it will be used, and/or if the data is being sold, aggregated or not, at any point along the line to other entities. Ensure that your program receives copies of all reports that include your data (appropriately blinded) so that you can actively engage in analysis and discussion about the data with the payer. Ask if you will have access to additional data on the full costs of your patients upstream and downstream related to this contract or proposal. Your payer is looking at this information, and you have the right to expect to see the same information and to be involved in any analytics and discussion. Finally, try to identify if there is a way that the submitted data can be turned around and used against you in future years with this payer.
10. ***Understand that it's your decision.*** You always have the right (and obligation as your patients' advocate) to point out concerns and issues with any proposed payer contract. These issues may be universal enough (and *not* focused on specific rates) that they are voiced by other providers in a geographic region. Your state oncology professional association may agree to voice concerns about liability, new waste, overhead burdens, and general increases and barriers to care relevant to any particular contract. It has been common in payer/provider negotiations for the providers to be the first to acquiesce for the good of their patients. Now that margins are excessively tight and oncology practices and community cancer centers are actually incurring costs to provide care to some patients, providers can no longer afford to compromise to the point of loss in negotiations. The most responsible action for your patients is to ensure that your physicians will continue to be there for them.
11. ***Understand Your Liability.*** Ultimately, the oncology practice or community cancer center is liable for the treatment provided. If incentives or programs within the contract ask you to make choices or obtain key drugs from sources that could affect your liability, do not hesitate to point this information out to the payer. In fact, go one step further and ask for a waiver of liability where the payer is making a medical decision regarding treatment for their member(s). Odds are you will not receive one, but you will have made the point regarding your concerns. From that point, you can take a stand to agree or disagree with the policy or program.

Traditional approaches to payer contracting and negotiations will not serve oncology practices and community cancer centers in 2010.

business case. Critical areas that need to be addressed include:

Know Your Market and Strategy. Take the time to do some strategic planning. Understand your actual and potential positioning.[2] A strategic retreat could be pivotal in obtaining buy-in and setting course for the cancer program. (For more on this topic, see "Strategic Planning for Practices" in the September/October 2008 *Oncology Issues*.)

Quality of care. This information should be defined in clear, measurable terms. For example, "In the last year, our program ranked in the 91st percentile of patient satisfaction ratings," versus the more generic, "Our program provides patient-focused care that our patients love."

Formal treatment programs and processes. These programs and processes should be identified and standardized. Examples could include pain management, oral drug compliance, symptom management for full completion of therapy, and fatigue measurement and management.

Operational policies. These policies will be an important step to help avoid management from external entities. In other words, payers may accept your internal treatment approval documents as an alternative to an externally managed document or process. For example, a payer might negotiate tight management of off-label choices as an alternative to an external process. Keep in mind, your formal processes, programs, or policies must be diligently double checked, monitored, and regularly reported on before payers will consider them to be a true working program.

Formal quality review processes. If your cancer program can show you have established tangible standards of care and a review process to ensure that these standards are met and continually improved upon, you will have far greater negotiating power with payers.

Data, data, data. The more you know about your internal costs of care, and the costs of care (upstream and downstream) that payers incur for your services, the better. Ask your software vendors (or drug distributors) what data they track globally (even de-identified) and ask for access to those reports. You may receive very interesting information that could help your program benchmark for trends and utilization.

Size matters—unfortunately. You may be the best oncology practice or community cancer center in the region, but if your market share is not substantial for any given payer, chances are you will be left out of any key oncology negotiations. Increasingly, practices or smaller community cancer centers are aligning with other groups, institutions, or networks to solidify their presence within their own markets. Keep in mind, however, that a large group or network that only has a small presence in any particular payer's regional or local market is likely to offer little additional value from a negotiating perspective. That said, this type of alignment may still offer benefits and value in terms of economies of scale and operational issues that are worth considering.

New collaborations with complementary delivery schema. This component of your business case should include up- and down-stream data and address the other aspects of care that touch your patients before, during, and after the care you provide. Identify opportunities for better integration, reduction of redundancy of diagnostics, better communication, collection of communal information, and a way to link technology or records.

It's Only the Beginning

Traditional approaches to payer contracting and negotiations will not serve oncology practices and community cancer centers in 2010. Rather, succeeding at payer relationships and negotiations will require a higher degree of sophistication. Start by understanding that oncology providers are not the only entities bringing the topic of oncology to the table, and that failure to develop an active, ongoing relationship with key payers, may end with you being left behind and at a significant disadvantage. Key payers may propose large national oncology management contracts from the top down—whether or not they have been actively engaged in negotiations with your practice or program.

Today's payer relationships and negotiations are complicated, and more likely to require the involvement of an external consultant to navigate the rocky waters. A neutral, third-party consultant can help assure that providers and payers are on the same page when entering into negotiations. This professional can help each side understand the other's position and issues prior to sitting down together to build a new relationship or work on a new program or policy. An outside consultant who understands the issues on both sides can also help diffuse deep emotional history and bring both parties forward to a new collaborative relationship.

However your oncology practice or community cancer center chooses to negotiate with its payers, remember the 4 C's—*cost*, *continuum*, *comparativeness*, and *care*. And, as always, the size of your program, the data it collects, the quality of its care, and its overhead and costs will play a significant role in any payer negotiations.

Dawn Holcombe, MBA, FACMPE, ACHE, is president, DGH Consulting, and Executive Director, Connecticut Oncology Association, South Windsor, Conn.

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The Oncology Social Worker's Role in the Reimbursement Process

by Vaughn Knapp, MSW

Today's oncology social workers play a critical role in reimbursement, assisting with pre-authorizations, coverage denials, and patient assistance programs. The oncology social workers at St. Luke's Mountain States Tumor Institute see their "chemotherapy pause" as the best way to meet the needs of cancer patients *and* ensure the cancer program's financial viability.

Why Social Workers?

A key component of healthcare social work is to help patients navigate a very complex system. Cancer patients are usually fatigued, in pain, and/or coping with high levels of anxiety. At a time when they should focus solely on getting better, many patients are worried about how they will pay for their cancer treatment. In fact, our experience has been that many patients and their family members present with nearly as much stress about their financial situation during six months or a year of treatment, as they do about the cancer diagnosis itself.

During this tumultuous time, the oncology social worker helps patients and family members cope with the complex interplay of stressors, developing a unique bond with patients and families. As the literature has shown, the bond and rapport between oncology social workers, patients, and families often results in increased patient satisfaction. If treatment goes well, the oncology social worker assists patients and families in adjusting to their "new normal." If treatment does not result in a cure, oncology social workers help patients and family transition to palliative care.

The Oncology Social Worker's Role in the "Chemotherapy Pause"

Money is *always* a sensitive subject, and patients dealing with a cancer diagnosis and treatment require delicate handling. The bond the oncology social worker has forged with the family can make the sensitive process of applying for medication assistance more successful and increase the likelihood for patient follow through. We help patients and families understand that the cancer center's goal in applying for medication assistance is to prevent the burden of medical costs—for the cancer center *and* the patients and families.

Insurance companies are often unconvinced of the efficacy of newer, more expensive chemotherapy drugs, establishing prescreening processes to deny payment for these drugs. In our program, while the financial advocate focuses on the preauthorization and pre-approval process, the oncology social worker works in tandem with this team member to help patients and families cope with the stress of waiting for their medication. In the worst case scenario—when medication is unavailable—oncology social workers help patients and families with anger and grief issues.

In several cases, I have had to complete the patient assistance application process with a surviving spouse. I was able to draw upon my trained skills in dealing with bereavement and grief to make this difficult process easier on the surviving family members. In addition to educating surviving families about grief and coping mechanisms, I provide tangible help paying for the cost of medications.

Patient Assistance Programs: The Good, the Bad, and the Ugly

With the current reimbursement climate, community cancer centers should look at dedicating staff to work directly with patient assistance programs. Pharmaceutical patient assistance programs, in particular, have helped thousands of Americans who could not afford their anti-cancer medication. And it is not only uninsured patients who benefit; some patient assistance programs help insured patients by providing medications that have been denied payment by insurers.

Patient assistance programs offer clear benefits to community cancer centers, including:

- The ability to offer the same level of care for all patients—regardless of the individual's ability to pay for the treatment.
- The freedom to prescribe the highest standard of patient care suggested by the treating physician.
- The ability to treat patients without incurring an overwhelming financial burden.

The patient assistance process varies tremendously from manufacturer to manufacturer and from drug to drug. Access to patient assistance programs also runs the gamut from easy to extremely difficult. ACCC's online list of reimbursement assistance hotlines is a good resource: *www.accc-cancer.org*.

GlaxoSmithKline, for example, has a phone approval process that can put medication in the patient's hand an hour later. AstraZeneca's and Genentech's SPOC (single point of contact) programs are taking the lead to cover the Medicare Part D "donut hole" deficit by providing

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pre-approval assistance and expanding income eligibility.

Of course patient assistance programs also fall on the other end of the spectrum. Roche, for example, has a stringent program that requires that attorneys and accountants verify (in writing) income for patients who clearly live on the margin of the working poor.

Some patient assistance programs are generous with whom they help, others restrict their outreach to less than 200 percent of the federal poverty limit, approximately $1,600 a month for a single person. Think about the hard choices cancer patients are forced to make trying to afford $200 in pain medication on that income. Could *you* afford 10 percent of your monthly income for medication every month?

When our patients hit a difficult program, they are prone to just give up. Remember, these individuals are dealing with pain and fatigue—in addition to all of the other stressors of treatment—that make it difficult to complete onerous applications. Patients may or may not tell us when they are stymied by the application process. Many of our patients are private in nature. They grew up during the Depression or in a social milieu where giving out financial information was just not socially acceptable. Unfortunately, any reluctance on their part to provide the necessary financial information can halt or even derail the patient assistance process. At this point, a skilled and empathetic oncology social worker can make all the difference.

Applying for Assistance

Each patient assistance program is unique. Tracking all of these programs requires a dedicated staff member to ensure that patients apply for the correct programs in the correct time frames.

Careful monitoring of application submissions and patient follow-up with financial documentation is required to make sure the replacement drug will be provided. And if the oncology social worker coordinating patient assistance applications is not a dedicated specialist in this area, your cancer center may face financial losses far greater than the amount spent to fund the oncology social worker's salary. The financial advocate and the oncology social worker must work seamlessly together to ensure drug reimbursement and to recover medications. This time-consuming process includes several challenges:

Different applications, different criteria. Each manufacturer uses a specific application form and requires different documentation of financial need. This situation is very confusing to many cancer patients. They don't understand why they must submit (and resubmit) different information to several different companies.

Even worse, patient assistance programs often change criteria and forms. One cancer patient completed and submitted a form only *one* day after such a change; the manufacturer would not accept the old application.

Unfortunately, this challenge is not easily addressed. Online services and automatic form-generating programs are insufficient because they don't necessarily modify their forms as quickly as the manufacturers do. Even a one-day time lapse can mean a loss of thousands of dollars, particularly with the newer oral chemotherapy agents. These programs have several other drawbacks. First, they offer no assistance getting patients to provide the necessary documentation. Second, these programs cannot address the variability of all the different patient assistance programs. Some manufacturers require that patient data be phoned in for the initial application, or a new application be generated each time.

Communication glitches. Some programs notify the clinic (by fax or mail) that a patient has been accepted into a program; others do not. If the patient assistance program is a "direct ship" program where the medication is sent directly to the patient, the cancer center can be left out of the loop. In some cases, we have believed that patients were taking medication for a month or more before we learned that they were not.

Drug replacement. Some patient assistance programs replace stocks of medication already given to patients. Other programs only replace the drug that was given after the application was submitted. Some manufacturers require providers send in copies of the treatment record after the patient has received the dose. Still other programs backfill only a limited number of treatments or a limited number of vials of medication.

Payer denials and appeals. Some patient assistance programs offer help with the denial and appeal process, providing copies of clinical research studies and putting together appeal letters that fulfill payer requirements for reversing a denial and paying for a drug. Unfortunately, such assistance can sometimes bring about a false sense of security that the drug will be replaced, resulting in a costly mistake for provider and patient.

The Future is Today

There are some indications that pharmaceutical companies are attempting to streamline their patient assistance programs. In 2006, several manufacturers at ACCC's two annual meetings committed to making the patient assistance forms more uniform and easier to access. While coming to consensus and modifying the initial application process is a first step in improving the patient assistance process, it is our opinion that a bigger overhaul is required in order to break down all the systemic barriers to patients accessing medication.

As cancer care providers, we need to advocate to pharmaceutical manufacturers and legislators to continue to improve patient assistance programs. We must also educate them as to how proper utilization of patient assistance programs provides a safety net for patients, families, *and* providers.

When, and if, such improvements are made, cancer patients will still need local help navigating our complex healthcare system. In addition, community cancer centers will still need experienced staff to oversee these patient assistance and drug replacement programs to ensure that the program is adequately reimbursed for the care it provides to patients.

As we all know, the landscape of chemotherapy reimbursement is complex and constantly changing. New internal processes will be required to cope with these changes. Community cancer centers will need to establish and continue to fund patient financial advocate and oncology social work positions whose primary responsibility is assistance with cost recovery. Not only is the future solvency of the cancer program at risk, so too is patient access to the most appropriate and best quality care.

Vaughn Knapp, MSW, is an oncology social worker at St. Luke's Mountain States Tumor Institute in Boise, Idaho.

Return to TOC

Quirks in the Reimbursement

It's hard to get paid if you don't know the rules

by Bonnie Kirschenbaum, MS, FASHP, FCSHP

Healthcare reimbursement is complex. Each year, community cancer centers face new, revised, and rescinded rules and regulations—changes that must be learned and then put into practice.

And 2010 is no different. Then just as cancer program staff and charge capture teams finally figure out what needs to be done to submit claims and get paid for services rendered, new wrinkles appear in the budget fabric.

What can community cancer centers do to better understand and perhaps even streamline this process? You can start by taking some refresher courses.

Drug Reimbursement 101

The Medicare program as administered by the Centers for Medicare & Medicaid Services (CMS) has three parts: A, B, and D. Part A covers hospital inpatient and skilled nursing facility, home health care, and hospice care. Hospital outpatient services are administered through Part B and the Hospital Outpatient Prospective Payment System (OPPS). Reimbursement for covered medications, including some oral cancer chemotherapies, administered pursuant to a physician's care falls under Part B, as does reimbursement for physician services, medical supplies (e.g., durable medical equipment), and end-stage renal disease services (see Table 1). Medicare Part D (Medicare Prescription Drug Coverage) is a prescription drug option run by private insurance companies approved by and under contract with Medicare. Medicare Part D covers outpatient prescription drugs and may include some oral anticancer drugs and some injectable products that are considered self-adminstered.

The setting of care affects reimbursement. Care provided in the physician office is reimbursed under the Medicare Physician Fee Schedule (MPFS), while hospital-based care is reimbursed under the OPPS. Finally, care provided in the hospital inpatient setting is reimbursed under the Inpatient Prospective Payment System (IPPS). Various coding options exist for each practice site, and prior authorization is required in some cases.

Reimbursable specialty drugs and biological products falling under Part B are reimbursed by CMS through the OPPS in one of four ways (see Table 2). In 2010 the basis for reimbursement for new drugs for which a Healthcare Common Procedure Coding System (HCPCS) code has not yet been assigned is 95 percent of average wholesale price (AWP). Pass-through payments may be available for new drugs and biologicals, and the basis for these payments is average sales price (ASP)+6 percent or the wholesale acquisition cost (WAC)+6 percent until enough ASP data are available.

CMS makes routine quarterly updates and community cancer centers must monitor and act on these changes. For example, starting April 1, 2010, Medicare's OPPS recognized the following drug products as having "pass-through" status:

- Ecallantide injection
- Fludarabine phosphate oral tablets
- Ofatumumab injection
- Pralatrexate injection
- Telavancin injection
- Ustekinumab injection.

Note that the billing unit for each product differs from the vial size or tablet strength. (For more information, go to: *www.cms.hhs.gov/MLNMattersArticles/downloads/MM6857.pdf.*)

In 2010, when the daily costs of specified covered outpatient drugs exceed the threshold of $65, drugs administered in the hospital outpatient setting are reimbursed at ASP+4 percent. When these drugs are administered in the physician office setting, they are reimbursed at ASP+6 percent. If daily drug costs fall below the $65 threshold, the costs usually are packaged (i.e., bundled) into the payment for an ambulatory payment classification (APC). The costs for "packaged products" are not reimbursed separately with the exception of one antiemetic agent, palonosetron, which is reimbursed separately, regardless of daily cost.

Each quarter, CMS publishes an updated ASP drug pricing file. The file is available online at: *www.cms.gov* and provides links to the actual listing of reimbursable Part B drugs and the amounts that will be reimbursed, as well as a reminder of the billing units for each drug code. Not surprisingly, reimbursement amounts for some drugs go up, while other payments go down. The rationale CMS provides is that a number of competitive market factors at work—such as multiple manufacturers, alternative therapies, new products, recent generic entrants—coupled with market shifts result in lower priced products.

Ambulatory surgery centers (ASCs) are subject to the same payment rates for any drug that is separately payable

Table 1. 2010 Part B Drugs

- 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
- Oral antiemetics (separate payment limited to palonosetron in 2010)
- 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

Table 2. 2010 Reimbursement of OPPS Drugs and Biologicals

New Drugs Not Yet Assigned Unique HCPCS Codes
- Reimbursed at 95 percent of AWP; same as in 2009
- Use code C9399, unclassified drugs or biologicals

New Pass-through Drugs
- Reimbursed at ASP+6 percent *or* payment based on WAC+6 percent until enough ASP data gathered
- In 2010, four pass-through drugs have an "expired" status
- In 2010, 21 drugs either kept or gained pass-through status

Specified Covered Outpatient Drugs (SCODs) costing >$65/day
- Reimbursed at ASP+4 percent
- In 2010, 5-HT3 drugs are no longer exempt (paid separately), except for Palonosetron
- Includes blood factor products

Lower-cost Packaged Products costing <$65/day
- In 2010, these drug costs remain bundled into their procedures (i.e., no separate reimbursement); same as in 2009

in the hospital outpatient area. However, to qualify for payment in this setting, the drug must be administered immediately before, during, or after a procedure that is approved in this setting and must be billed on the same claim and date as the procedure itself.

The Medicare Part D benefit covers only drugs that are classified as Part D drugs. Generally, Part D drugs include outpatient prescription drugs (i.e., drugs prescribed and dispensed for self-administration by the patient). They also include biological products, insulin, medical supplies associated with the injection of insulin (e.g., syringes, needles, alcohol swabs, sterile gauze), and certain vaccines not covered under Part A or Part B. Pneumococcal and influenza vaccines are covered by Part B. Hepatitis B vaccine is covered under Part B for individuals at high or intermediate risk; for all other individuals, it could be covered under Part D. All other currently available vaccines and future vaccines would be covered under Part D, but coverage could be subject to plan prior authorization requirements demonstrating medical necessity.

Reimbursement for Oral Chemotherapy 101

Unlike injectable chemotherapy, which is covered under Medicare Part B, oral chemotherapy usually is covered by Part D. So, unless your facility has contracted with CMS or a PBM to become a Part D provider, oral chemotherapy will not be reimbursed in the outpatient setting. Examples of these agents include Tarceva, Nexavar, and Revlimid. These drugs are indicated for lung and pancreatic cancers, kidney and liver cancers, and multiple myeloma and myelodysplastic syndrome, respectively. And the number of oral chemotherapeutic agents is expected to grow significantly. The problem: if your community cancer center provides services to patients on these regimens—including answering their questions and helping them manage their protocols—your operating expenses are likely to increase.

Some third-party payers, in response to pressure from employers to reduce healthcare costs, have added a new

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Working with Your

CFO

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In addition to talking with pharmaceutical company representatives, the pharmacy director also needs to sit down with the hospital's CFO to discuss each new drug likely to hit the market during the coming year. Advocate for making the pharmacy director a part of the hospital's financial team. If that scenario is not possible, the pharmacy director should at least be on a comfortable conversational basis with this team. Set a routine time to talk about the financial implications of pharmaceutical budget decisions that the hospital may be considering or faced with, including the new drugs expected to reach the market and the possibility of coverage. This discussion includes determining whether the pharmaceutical company will have appropriate charitable coverage for the new drugs. If the answer is no for a particular drug and that drug is likely to be highly used, the financial team needs to be proactive and plan for that scenario. In turn, the pharmacy should set expectations for its GPO regarding the importance of reimbursement for new drugs in the contract negotiating process.

Getting the attention of your CFO or the billing department is not always easy. Your community cancer center can start by reviewing the following high-priority issues. Decide which are working smoothly at your program and which need urgent attention. Then schedule a discussion with the financial group affected by them, bring this list, and begin a dialogue.

The Charge Description Master

There are two components to the CDM, one for inpatients and one for outpatient departments and clinics. When a good working relationship exists between Pharmacy and Billing, CDM corrections and additions should be made at least weekly and processed in a timely fashion. The billing department should be aware of the significant reimbursement changes initiated by CMS, and should be ready and willing to help make the CDM change process run smoothly.

If after review, the problems are huge, break them down into smaller increments. Identify which drugs need fixing and work on the significant dollar ones first. Fix at least one drug a day

The Drug Master File(s)

Most pharmacy information systems use a commercially available drug master file, like the one from First DataBank. The file encompasses every drug approved by the FDA, as well as over-the-counter medications, herbals, nutraceuticals, and dietary supplements. Corresponding NDC numbers are also in the file.

One of the first steps to installing a pharmacy computer system entails paring down and customizing this drug master file to meet the needs of your community cancer center. But without regular maintenance, the system's reliability can begin to break down. Often one product or brand was selected as being representative of all products within that generic. This may or may not have been a match to those products actually being purchased at the time. If the database is not frequently reconciled with the purchasing program, the NDC number supplied by scanning the product's bar code may not match information in the database.

If multiple databases are used, it is essential that all systems be in sync. A perfect fit is vital to ensure accurate dispensing, administration, and subsequent billing. If

Table 1. A Three-Year Comparison of Drug Administration Reimbursement Rates

CPT Code	Description	2008	2009	2010
96413	Chemotherapy IV infusion, first hour	$149	$191	$215
96415	Chemotherapy IV infusion, each additional hour	$51	$37	$37
96409	Chemotherapy IV push, first and/or initial drug	$105	$127	$127

bar coding is in place, drug shortages and wholesaler substitutions will definitely influence how effective and efficient the scanning process will be. So a process for recognizing and incorporating shortage and replacement products into the database needs to be developed. Tolerance for these wholesaler practices should be minimal and this statement needs to be conveyed both to the wholesalers and to the GPO representing the community cancer center. On the "To Do" list:

- Eliminate products from the drug master file that are no longer used in the facility
- Select products that have been added to the formulary, replacing "in-house" built codes that may not be accessing safety check information
- Ensure a match between the dosage forms selected from the commercial database and the ones used in the facility
- Ensure a match between the brand purchased and the brand selected from the commercial database for generically available products
- Implement a discipline to be followed when contracts change or when products become unavailable and substitutes are used
- Remember that too much flexibility results in complexity in each subsequent step.

CMS Corrections, Clarifications, Code Changes, and Updates

Unfortunately CMS routinely needs to issue corrections to decisions that are published in error. This practice means that the Pharmacy and/or Billing Department must have the ability to go back in time to identify the patients that are affected by these corrections and then appropriately rebill.

In addition to publishing quarterly updates in payment rates, CMS also routinely changes HCPCS codes. This practice means that the Pharmacy and/or Billing Department must be aware of the changes and implement them quickly to mitigate the number of rebills. Identify how your community cancer center can stay on top of these changes and how quickly you can process a change.

APC Changes

Your community cancer center must pay close attention to the proposed reconfiguration of drug administration APCs. Although drugs themselves may or may not be reimbursed, actual administration of a drug remains payable with a wide array of codes available to cover a wide variety of situations. The drug administration APC groupings decreased to five in 2009, with the payment rates for a number of these increasing while others decreased. (Table 1 shows a three-year comparison of reimbursement for select administration codes.) Paying close attention to detail, ensuring that the correct codes are being used for administration of all drugs including those that are packaged into a procedure code, and monitoring documentation of administration are all important steps. Coordination between the pharmacy and the clinic setting is imperative if full payment is to be realized. Documentation, including hang time, rate changes, and end of infusion or "down time," is essential.

The therapeutic, prophylactic, and diagnostic injection and infusion CPT codes are 96365-96379, while the chemotherapy and other highly complex drug or highly complex biologic agent administration CPT codes are 96401-96450. Services included in the CPT codes for drug administration are:

- Use of local anesthesia
- Starting the IV
- Access to IV, catheter, or port
- Routine tubing, syringe, and supplies
- Preparation of drug
- Flushing at completion
- Hydration fluid.

Unlisted " aste

Numerous drugs are distributed in package sizes that do not necessarily equal the doses prescribed for particular patients. If the drug is not stable and cannot be saved for a patient's next encounter, then a provision for legitimately billable drug waste should be made. This practice entails documenting both what was administered and what was discarded and billing appropriately for both. Check with your FI or MAC to determine what is required to meet their specifications; it may be the use of the JW modifier.

Faulty Drug Charge Capture

There are multiple reasons for faulty drug charge capture:

- The drug may not be entered into the outpatient billing system or may be entered incorrectly
- All of the products used as adjuncts to therapy may not be entered into your billing system
- Standing orders may not spell out every product and how it was administered
- Floor stock not in automated dispensing cabinets linked to the billing system may never be captured
- Work-arounds by nursing staff may allow products to be used without being tied to a specific patient.

Your community cancer center will need to identify and eliminate these system flaws in order to be accurately reimbursed for all of the drugs administered to patients.

RAC-related Concerns

The Medicare Modernization Act of 2003 mandated that CMS establish a Recovery Audit Contractor (RAC) program that finds and recovers Medicare overpayments. As part of this program, RACs may review any provider and they receive a bonus every time they recoup Medicare payments. After undergoing a demonstration project in California, Florida, and New York, the Tax Relief and Health Care Act of 2006 made the RAC program permanent, and the program was expanded to all 50 states in 2010.

CMS "safeguards" include not using random selection except to establish an error rate and not targeting a claim solely because of high-dollar potential. In other words, there must be reason to suspect overpayment. Self-audit is essential for community cancer centers as the 2010 RAC audits will be based on looking at services for previous years, most commonly 2008 and 2009.

fourth tier of drugs. Patients participating in these plans pay 20 to 30 percent of the cost of certain high-cost drug therapies used to treat certain illnesses (e.g., cancer, rheumatoid arthritis, multiple sclerosis) instead of the flat copayments required for most drugs. This approach shifts part of the cost of the most expensive drugs to patients. Some of these drug therapies cost as much as $15,000 per month, and the out-of-pocket cost of copayments for patients is substantial, although many plans have a cap. These caps could limit how much third-party payers will pay per patient/per year or how much the patient must contribute per year.

Charge Capture 101

Coding is the language with which providers describe what was done and what was used. It's the operational link between coverage and payment. Codes that apply to products, including drugs, are maintained and released annually by the CMS-HCPCS Work Group. For more information, log onto: *http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp#TopOfPage*. (Table 3 lists the different code types.) Keep in mind that any payer (Medicare or third-party) at any time can look at what was done and make a decision that they are not going to pay for the services.

The fact that a drug, device, procedure, or service has a HCPCS code and a payment rate under the OPPS does not imply coverage by Medicare. It indicates only how the product, procedure, or service may be paid *if* covered by the program. For Medicare reimbursement purposes, the country is divided into several geographical regions, each assigned to a Fiscal Intermediary (FI) or Medicare Administrative Contractor (MAC) (see Figure 1). The FI or MAC receives billing claims from hospitals, outpatient clinics, and physician practices and submits them to CMS for payment.

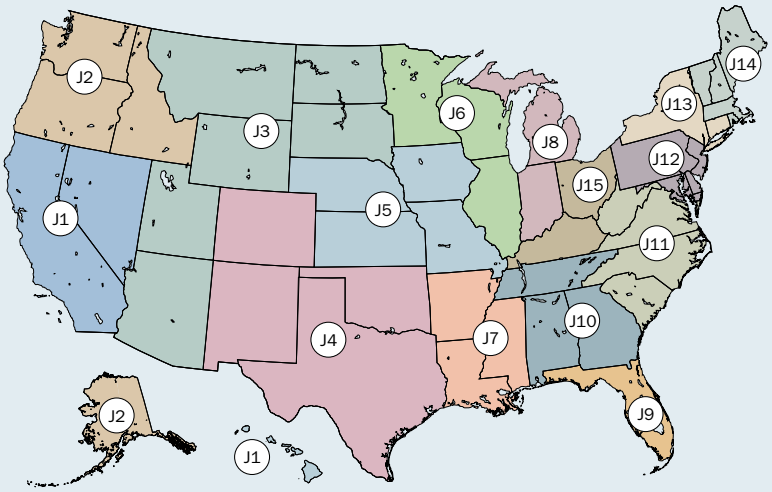
FIs or MACs determine if all program requirements for coverage are met, e.g., that it is reasonable and necessary to treat the beneficiary's condition and whether it's excluded from payment. Local and national coverage decisions are a part of their responsibilities as well (see Tables 4 and 5). CMS releases updates and software to FIs and MACs quarterly, and provider education articles are available shortly after a coverage decision is issued. Knowing your FI or MAC and what peculiarities may affect your region is important. Each FI or MAC has a toll-free number, and you can access this information online at: *www.cms.hhs.gov/medlearn/tollnums.asp*.

Community cancer centers should always aim for error-free charge capture. If not, potential consequences can include an inaccurate portrayal of the cost of treatment, with a substantial fraction of OPPS drug cost appearing on claims lines with a pharmacy revenue center but no (i.e., blank) HCPCS code or inaccurate billing units.

Drug Compendia 101

CMS recently issued a new rule that ensures that patient care involving the off-label use of medications will be guided by objective, evidence-based drug information and not just what is published in the drug's package insert as an approved use. Still, dilemmas often arise when a cancer patient is treated with a drug using an off-label indication. The fact that the indication is off-label may be sufficient grounds for the FI or MAC to deny payment. Unless compelling reasons exist that are supported by published lit-

igure 1. edicare Administrative Contractors



Legend A/B MAC urisdictions and Contractors

J1 Palmetto Government Benefits Administrator, LLC (Palmetto GBA)
J2 National Heritage Insurance Corporation (NHIC)
J3 Noridian Administrative Services, LLC (NAS)
J4 Trailblazer Health Enterprises (Trailblazer)
J5 Wisconsin Physicians Services Health Insurance Corporation (WPS)
J6 Noridian Administrative Services, LLC (NAS)
J7
J8 National Government Services (NGS)
J9 First Coast Service Options, Inc. (FCSO)
J10 Cahaba Government Benefit Administrators, LLC (Cahaba GBA)
J11 Palmetto Government Benefits Administrator, LLC (Palmetto GBA)
J12 Highmark Medicare Services, Inc. (HMS)
J13 National Government Services (NGS)
J14 National Heritage Insurance Corporation (NHIC)
J15 Highmark Medicare Services, Inc. (HMS)

Protest filed. Until CMS makes a final decision, current fiscal intermediaries and carriers will continue to provide Medicare claims processing services.

Return to TOC

Table 3. Healthcare Billing Codes

- **ICD-9 Codes**: Used by hospitals to designate disease types
- **CPT Codes**: Used by physicians to describe procedures they do. These codes are determined by the American Medical Association and may include payment for all products used during the procedure.
- **HCPCS Codes**: Used for products and may or may not be reimbursed.
- **DRG* Codes**: Apply in the inpatient setting and only to Medicare and Medicaid patients.
- **APC* Codes**: Apply in the outpatient setting and only to Medicare and Medicaid patients.

* DRG and APC methodology is often used as a template for other insurance reimbursement (i.e., third-party payers).

Table 4. Example of a National Coverage Determination (NCD)

NCD for Abarelix for the Treatment of Prostate Cancer (110.19)

The evidence is adequate to conclude that abarelix is reasonable and necessary as a palliative treatment in patients with advanced symptomatic prostate cancer: (1) in whom GnRH agonist therapy is not appropriate; (2) who decline surgical castration; and (3) who present with one of the following:

- Risk of neurological compromise due to metastases
- Ureteral or bladder outlet obstruction due to local encroachment or metastatic disease
- Severe bone pain from skeletal metastases persisting on narcotic analgesia.

Find this NCD and others online at: *http://www.cms.hhs.gov/mcd/search.asp?clickon=search.*

Table 5. Example of a Local Coverage Determination (LCD)

LCD for Infliximab (Remicade™) L28890
Issued by: First Coast Service Options, Jurisdiction 9, MAC-Part A

Documentation and indications: For patients who are unable to tolerate methotrexate or in the rare instance that methotrexate is contraindicated for a patient, treatment with infliximab alone will be covered only if documentation is maintained in the patient's record that clearly indicates the reason that the patient cannot take methotrexate.

Find this LCD and others online at: *http://www.cms.hhs.gov/mcd/search.asp?clickon=search.*

erature in refereed journals, CMS and many other payers remain adamant about not supporting off-label drug use. Because off-label therapy can be used in the treatment of cancer, it is imperative that your community cancer center decides how to handle this issue. Whatever your decision, it will require the support of the administrative team to work with the physician staff to uphold the decision made regarding off-label drug use.

Several pharmaceutical companies offer patient and billing assistance programs that may provide support when attempting to have denials for off-label use overturned. Keep in mind, however, that only those compendia officially recognized by CMS can be used to support the off-label decision. Currently, CMS recognizes four drug compendia:

1. The *American Hospital Formulary Service Drug Information* (*AHFS-DI*)
2. *The National Comprehensive Cancer Network Drugs & Biologics Compendium*™
3. Thomson Micromedex's *DrugDex*® compendium
4. Gold Standard/Elsevier's *Clinical Pharmacology.*

The agency's process for determining changes to the list of compendia used to determine medically accepted off-label uses of drugs and biologicals in chemotherapy regimens places a high priority on whether a publication's evidence evaluation process is transparent and free from conflicts of interest. January 15 of each year opens the window for the annual review of new compendia and a subsequent decision for inclusion.

Billing Units 101

Several years ago CMS moved to using the concept of billing units rather than vial sizes when structuring its reimbursement tables. Medicaid uses billing units as well, although to further confuse the issue, they are not necessarily the same as those used by Medicare. Although these changes have been amply discussed in the pharmacy literature, implementation of the billing unit concept continues to plague pharmacy directors and those involved with managing all the pieces of the pharmacy computer and automated dispensing systems. The billing unit tables are not static and require vigilance to ensure that the correct billing units are matched to the correct billing codes (HCPCS codes) in the pharmacy charge description master. Failure to do so will result in significant over- or under-charging and the resulting complications of an audit. NDC (National Drug Code) changes provide an additional complication.

The goal is to be able to convert dispensable quantities—either from automated dispensing cabinets or the pharmacy IV room—into a HCPCS billable quantity. Some community cancer centers have built and maintain conver-

To be truly successful, cancer program pharmacies must merge together the clinical and practical aspects.

sion tables by 1) going through the pharmacy system, if it supports this function; 2) using a lookup table with conversion logic in the translator outbound to the financial system; or 3) building a multiplier table on the back end of the financial system. This multiplier table takes the number of units sent from the transaction and multiplies it by the appropriate factor without affecting the price. These "crosswalks" build the bridge between a drug's description in the Drug Master File (which is used to enter an order into the Pharmacy computer system) and its description in the CMS system (which is driving reimbursement). These crosswalks provide an automatic conversion from one to the other in order to guarantee the accuracy of the number of units being billed, rather than leaving it to the discretion of the order entry person.

Drug Approval 101

The arrival of a new drug in the marketplace culminates many years of painstaking work coupled with anxiety on the part of the research team and subsequently the pharmaceutical company submitting the application to the Food and Drug Administration (FDA). With FDA approval comes a fanfare of publicity and a huge surge in information about the product, as well as advertising to the medical profession and often to the general public.

At this point, the team responsible for gathering drug information and preparing formulary submissions to a cancer center's Pharmacy and Therapeutics (P&T) Committee begins it work. This preparation may include crafting a set of prescribing guidelines to ensure that the product is used wisely at the community cancer center. While some of the brightest minds in the pharmacy department are devoted to these issues, not all of these individuals are concerned

Action Items for Community Cancer Centers

- ***Pay strict attention to pharmacy and clinic billing systems.*** Your systems should allow for easy coding and reimbursement updates from CMS and private payers. Check and re-check your computer systems and software. If updates are difficult and time-consuming, it may be time for an upgrade.
- ***Use appropriate codes and descriptions, as well as appropriate and complete documentation.*** Remember, payment will not be made unless there is correct documentation and correct use of the drug.
- ***Bill for* all *drugs.*** Do not neglect to bill for drugs because it's "too complicated for too little return." Remember, inaccurate and inadequate reimbursement for providing drug and biological therapies leads to reduced beneficiary access.
- ***Renegotiate your purchase price for drugs.*** Use the same rationale CMS uses in its ASP calculations—that competitive market factors and market shifts result in lower priced products.
- ***Determine whether it is to your advantage to become a Part D supplier.*** Unless your community cancer center is a Part D provider, oral chemotherapy will not be reimbursed in the outpatient setting. And with the number of oral agents only expected to increase in the future, *now* is the time to look at this issue.
- ***Know when new drug compendia are approved.*** Each year, CMS reviews new compendia and makes a subsequent decision to formally recognize the compendia. Your patients' financial welfare may depend on you knowing the current approved compendia.
- ***Bill for units correctly.*** Understand that there is ongoing maintenance with the CDM (charge description master), HCPCS codes, and NDC (National Drug Code) changes. Then develop a strategy for handling these issues with your charge capture team.

about the practical aspects of actually acquiring the product and incorporating it into the logistics of the pharmacy operations. To be truly successful, cancer program pharmacies must merge together the clinical and practical aspects. There is no payment, for example, unless there is correct documentation and correct use of the drug in the first place. This type of activity is no different from setting practice guidelines for a product and then following up to make sure the drug is used only when the guidelines are met.

CMS and many private payers are rigid about paying only for FDA-approved indications or those listed in the accepted compendia and then only when the ordering physician has formulated and documented evidence of appropriate use. Think of these challenges as an exciting game where clinical pharmacy skills are invaluable in looking for status indicators, which are the clues to reimbursement. In other words, each CPT code has a corresponding status indicator, which helps determine certain payment decisions. FIs or MACs who ultimately dissect this information can be a great resource. Get to know your FI or MAC and tap them for information. See page 46 for practical steps on how to handle the payment aspects of a new drug entry.

340B Drug Pricing Program 101

The 340B Drug Pricing Program offers drug discounts to help eligible hospitals and other federally qualified healthcare facilities provide outpatient care for the nation's uninsured and underinsured patients. However, eligible healthcare facilities must implement, manage, and meet the stringent compliance requirements of this federal program. Facilities that participate in the program are required to adhere to strict compliance measures to ensure the drug discounts are only claimed for drugs dispensed to eligible patients.

If participation in the 340B Drug Pricing Program has been suggested as a way to maximize medication savings, community cancer centers should first examine the regulations, staffing, and compliance challenges before moving forward. The program has multiple implications for pharmacy purchasing, wholesale acquisition, and GPO contracts compliance.

Patient Assistance Programs 101

Obtaining free drugs for patients is not an easy or fast process, but it is possible. Although a recent survey of health clinics found that some do not participate in patient assistance programs that supply free medications to poor patients because the programs' requirements are too complex and time-consuming, this source of financial help should not be ignored.

A coalition of drug companies and healthcare providers has launched a new effort to make it easier to find information on private and public programs offering free medications. The new outreach campaign includes three national call centers and a new website to help consolidate details on about 275 assistance programs. The American Society of Health-System Pharmacists (ASHP) website offers excellent insight into using these programs at *http://www.ashp.org/pap*.

Specialty Pharmacies, REMS, and RDDS 101

Today, community cancer centers need to understand the role of specialty pharmacies and other restricted drug distribution systems (RDDS). RDDS established by pharmaceutical manufacturers, specialty pharmacies, or other specialty suppliers may be a component of REMSs (risk evaluation and mitigation strategies), which are required by the FDA to manage known or potential serious risks from certain drugs. Products with REMS requirements or high-cost specialty drugs in high-option tier insurance plans may be available only through RDDS. If so, community cancer centers must anticipate the use of these drugs and create mechanisms to facilitate their use.

Pharmacists at community cancer centers have concerns about using specialty suppliers, including

- Access to pharmaceuticals
- Operational challenges
- Product integrity
- Financial implications
- Continuity of care issues
- Patient safety concerns.

When a patient brings a specialty drug obtained at home into a community cancer center for administration—a practice known as "brown bagging"—concerns are raised about product integrity and institutional liability. Having a product shipped directly to the provider, a practice known as "white bagging," also sets off a cascade of potential complications, including storage and disposal issues. (For more on brown bagging and white bagging, see "Challenging New Delivery Models for Injectable Drugs" in the "Issues" column of the May/June 2010 *Oncology Issues*.)

The choice between a pharmacy-centric approach, which prohibits brown bagging or white bagging but is costly, and a patient-centric approach, which permits the practice under certain conditions and is less costly, often hinges on the community cancer center's finances, tolerance for liability, and ability to skillfully manage the processes involved. Unfortunately, the recent shift from a traditional supply chain model to a specialty pharmacy supply chain model for high-cost pharmaceuticals has the potential to increase pharmaceutical costs for community cancer centers. A dialogue is needed between health-system pharmacists and GPOs to address the GPO's role in mitigating the financial implications of this

changing paradigm and assisting in clarifying the safety issues.

Partnering with Industry

In today's reimbursement environment, the pharmaceutical industry would be wise to recognize the importance of coverage and payment. Developing a corporate commitment to understanding the intricacies of the reimbursement process and working toward appropriate coverage should be an integral part of every pharmaceutical company's strategy for bringing a new drug to market. In practical terms, pharmaceutical companies must begin working with CMS *and* private payers long before the drug is launched with the goal of obtaining coverage at the time of FDA approval of the new pharmaceutical entity.

Few pharmaceutical companies are doing this today. Pharmacy departments at community cancer centers can help. Sitting down and thrashing out reimbursement issues with the pharmaceutical company *before* a drug comes to market should be just as important to the pharmacy as discussing the clinical merits of the new product. Traditionally, the only request that many pharmacy departments have made of pharmaceutical companies is to provide complimentary drugs as part of their patient assistance programs. That approach is no longer acceptable because pharmacies lose a tremendous amount of money on charitable programs. Rarely, if ever, do these programs include the new and more expensive drugs that are driving up pharmacy costs. And the number of patients for whom hardship assistance is provided is small compared to the reimbursement available through third-party coverage, including CMS.

Reimbursement Matters

Most community cancer centers are shocked when payment methodologies change, especially when the reality sets in concerning which products and services are being reimbursed and their corresponding rates of reimbursement. The response from healthcare providers usually is: *How could this have happened*? Remember, change is inevitable—particularly with regards to the rules and regulations passed by CMS. And because private payers tend to follow Medicare's reimbursement lead, it is more important than ever to understand reimbursement changes and trends. Community cancer centers that do not keep current risk possible financial ruin, audits, and/or investigations.

What to Do with a New Drug—Tips for Community Cancer Centers

- ✔ Contact your GPO to determine pricing, contract status, and other negotiated terms.
- ✔ Contact the manufacturer for information on patient assistance programs and reimbursement programs or assistance with the documentation required for reimbursement.
- ✔ Assign a charge description master (CDM) number and a price. Billing departments should accept changes at least weekly.
- ✔ Link the CDM number to the CMS billing code for new drugs.
- ✔ Stay aware of new code assignments by reading the quarterly CMS website updates.
- ✔ Understand that submissions using the wrong code are rejected.
- ✔ If the drug is used in an outpatient setting, ensure that the code assigned matches the billing units being reimbursed. Consider using a crosswalk to help in this effort.
- ✔ Activate the drug in the pharmacy computer drug master file and link it to the CDM number. Do not forget to change miscellaneous codes for actual and designated codes as soon as they are 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.

Bonnie Birschen Baum MS FASHP FCSHP is a healthcare consultant with senior management experience in both the pharmaceutical industry and the pharmacy section of large corporate healthcare organizations and teaching hospitals.

Additional Resources

In addition to numerous updates available on the CMS website (*www.cms.gov*), the American Society of Health-System Pharmacists (*www.ashp.org*) and the American Pharmacists Association (*www.aphanet.org*) offer a wealth of information. ASHP's clinical specialists' listserve also provides an opportunity to ask questions of your colleagues.

Through its lobbying efforts on Capitol Hill, the Association of Community Cancer Centers (ACCC) has had success regarding reimbursement for high-cost drugs in the hospital outpatient setting by emphasizing that patients must have access to effective chemotherapy. In fact, ACCC created the Oncology Pharmacy Education Network (OPEN) to specifically focus on pharmacists and business managers in oncology. For more information about OPEN, go to: *http://www.accc-cancer.org/openwe*

Some Case Studies for Billing Payers Correctly

– Elaine Kloos, RN, NE-BC, MBA and Teri Guidi, MBA, FAAMA

To be appropriately reimbursed, we must bill payers correctly. But to do that and to get all of the information onto a claim according to the rules, all of the systems that collect and record the necessary information must work perfectly. Just one "broken" step can have devastating results. To illustrate – and we hope to motivate – the reader to remain vigilant, we offer the following true situations from our client files.

Accurate drug administration times

Nursing documentation of services provided is critical. If staff rounds off the times for drug administration, it is very possible to either over-charge or to under-charge for this work.

Case 1: Nursing documentation at one practice always indicated "even" start and stop times – 9:00, 10:05, 11:30 etc. Upon observation, we noted that a nurse charted start time at 9:00 and stop time at 10:30. However, she actually started the treatment at 8:57 and stopped at 10:33. Thus, instead of billing just one hour of infusion (96413) for 1-1/2 hours, the center was entitled to bill two infusion codes (96413 and 96415) for the 96 minutes. If this occurs just three times each day throughout the year, the center would miss $22,500 at CMS payment rates.

Precise drug unit recording

Similarly, rounding drug units can result in significant missed revenue. This is often caused by software programs that do not calculate the billable drug units correctly.

Case 2: One hospital infusion center's system calculated billable units correctly for JXXX, but then the system rounded the decimal places to the nearest whole number instead of to the next whole number (e.g. rounding 1.4 to 1 unit instead of rounding appropriately to 2 units). This drug was administered roughly twice each day, so for each missed billable drug unit the "lost" Medicare revenue was $56, or $28,000 over the course of a year.

Case 3: In a busy infusion suite, particularly where nurses "share" patients during one encounter, it is quite easy for someone to overlook documentation of a quick push. CMS pays $100 for one chemotherapy push (96409) – we reviewed charts for a busy infusion center and found that an average of 15 pushes were missed every week, short changing the practice by $84,240 over the course of a year.

Form accuracy

Something as simple as a form can cause a misunderstanding that leaves things un-charged.

Case 4: In one very small practice that treated patients only two days per week, the nursing flow sheet was labeled "IV Administration" and the nurse took that literally. She only documented intravenous procedures and left all injections uncharted and thus unbilled. Their losses for the year totaled $11,440.

Case 5: Or consider the office where the regimen-specific chemo order forms included diagnosis codes for the physicians to circle. When a new indication for a drug was approved, the forms were not updated with the new code, leaving the physicians only diagnosis code choices that would not be "medically necessary." In just the first two months, over $28,500 in potential reimbursements went unpaid, classified as "not covered" by the payers.

Interdepartmental accountability

Clear delineation of each department's responsibilities is important to avoid gaps in the process. Nowhere is this more evident than in cases where one department does not understand what another department does.

Case 6: When we reviewed the processes at a center in California, we learned that pharmacy dispensed "shelf stock" to the infusion suite and booked the expense to the infusion account. Among those items were growth factors. For other drugs, pharmacy entered the charges for billing directly. Unfortunately, the nurses who used the shelf stock for pre-medications did not know that they needed to enter charges for those items. In just three months, this resulted in more than $188,000 in lost reimbursements for the "shelf stock."

Up-to-date systems and processes

Finally, it is vital to ensure that all of your systems and processes are always up to date. Codes are especially prone to change.

Case 7: A few years ago a seemingly small typographical correction to a new drug's HCPCS code was made, changing the billable units by a simple decimal place (5 mg to .5 mg). Dozens of centers we visited that year had missed the difference. Thus, each time they administered JXXXX, they were under-billing the units by ten fold because the unit conversion was not updated. So instead of billing 200 units for each administration, only 20 were billed. For every 100 patients receiving this particular drug, that totals over $170,000 in missed payments.

More recently, when a new product finally received a J-code, the billing units were specified at 1mg. The product is available in single use vials of 300mg which is also the typical dose. Prior to the J-code, most practices billed using the non-specific HCPCs code, indicating the quantity as one "unit" (i.e. one vial). Failure to update to the new code and units caused an infusion center to under-bill 299 units each time the drug was administered. Although volume was small – only one patient per month – the lost revenue for the six months before we identified the problem added up to $86,000.

Clearly just a small breakdown in the processes can make an enormous difference. The message? When it comes to reimbursement, you should sweat the details. H

Elaine Kloos is a Senior Consultant for Oncology Management Consulting Group in Pipersville, Penn.

Teri U. Guidi, MBA, FAAMA, is president & CEO of, Oncology Management Consulting Group in Pipersville, Pennsylvania. She is a member of HONI's Editorial Advisory Board and serves as one of the HOPE panelists.

Index of Advertisers

Tackling Chemotherapy Reimbursement

One institution's proactive multidisciplinary approach yields positive results

by Jessie Modlin, PharmD, and David B. Wilson, RPh, BCOP

The U.S. healthcare system operates a complex reimbursement system, including both public and private third-party payers. A multitude of factors, such as high treatment costs, off-label drug use, and mandatory pre-authorizations, have culminated to make chemotherapy reimbursement particularly challenging for community cancer centers. As the cost of intravenous and oral chemotherapy escalates, so does the need to guarantee that our community cancer centers are being reimbursed for their services. Here's how St. Luke's Mountain States Tumor Institute (MSTI) improved reimbursement, patient satisfaction, *and* its bottom line.

Staging an Intervention

In recent years, MSTI staff became alarmed by the increasing complexity of the reimbursement process coupled with the financial impact of denied claims. Cancer program staff brought these and other reimbursement issues to the attention of hospital administration, but without concrete examples, the scope of the problem was unknown. The situation changed drastically in 2005.

In August 2005, a patient with metastatic lung cancer started treatment with bevacizumab, a novel monoclonal antibody. At that time, bevacizumab only had FDA approval for metastatic colorectal cancer. The oncologist's decision to use bevacizumab was based on a recent abstract presented at ASCO. After the patient received several cycles of treatment, at a cost of more than $40,000, the patient died. Several weeks later, the payer denied the claim because bevacizumab had been prescribed for off-label use.

News of the $40,000 denial quickly rippled through the organization. Upon further examination, MSTI found that its oncologists were also prescribing bevacizumab for breast, lung, and kidney cancers. Although the use of bevacizumab was being investigated in clinical trials, the drug did not have formal FDA approval for those indications. While the $40,000 loss—and the potential for additional denials based on off-label drug use—concerned administration, the oncologists at MSTI were, in a sense, isolated from the finan-

Nearly 3,000 new patients are seen each year at MSTI, and between 600 and 800 patients are receiving antineoplastic drug therapy at any given time.

MSTI is an integral part of St. Luke's Health System, a four-hospital, private, non-profit system centered in Boise, Idaho. Comprised of five outpatient oncology clinics spread throughout 200 miles in Southern Idaho, MSTI serves the entire state of Idaho, and parts of Utah, Nevada, and Oregon.

cial consequences of their treatment decisions because they are employees of St. Luke's, the large non-profit organization that oversees MSTI. In freestanding cancer centers or an oncology practice, oncologists are often financial stakeholders, with a greater interest in areas where they may be losing or making money.

Two facts became readily apparent to cancer center staff. First, MSTI had opportunities for improving the chemotherapy reimbursement process. Second, no one was exactly sure whose responsibility it was to establish an organized process for improving reimbursement and how it should be carried out. Eventually, the burden came to rest on pharmacy when administration asked its pharmacists to verify patient diagnoses against the treatment being prescribed by oncology.

Traditionally, pharmacists have been viewed as having "ownership" of all aspects of drug therapy. Some community cancer centers even consider billing as a critical role of the oncology pharmacist.[1] Billing is a wide, comprehensive term. And while pharmacists are often responsible for pharmacoeconomics and controlling cost, their formal training teaches little about billing and reimbursement. Bottom line: pharmacy needed help.

The Patient Financial Advocate

The idea of creating the position of a patient financial advocate at MSTI stemmed from a 2003 article in *Oncology Issues* entitled, "Adding Dedicated Financial Specialists to Your Team: Why Reimbursement Specialists Make Sense for Community Cancer Centers."[2] The authors outlined potential areas of responsibility in a cancer center that a patient financial advocate might coordinate, including:[2]

- Handling authorizations for chemotherapy and supportive treatments in the infusion area, as well as authorizations for radiation therapy, and other procedures
- Communicating insurance issues to physicians
- Referring patients with financial needs to social workers
- Working one-on-one with patients to act as liaisons to the billing department
- Counseling patients on their financial responsibilities
- Creating written agreements to resolve outstanding debt.

The authors suggest that job qualifications for a patient financial advocate include 1) formal education in social work or social science; 2) work experience in medical coding and billing; and 3) knowledge of medical terminology.

Based on our recent $40,000 financial loss, administration was able to justify the new staff position fairly easily. Assuming an annual salary of approximately $35,000, financial coordinators easily pay their own salary by saving the institution from significant financial losses.

MSTI's Chemotherapy Pause

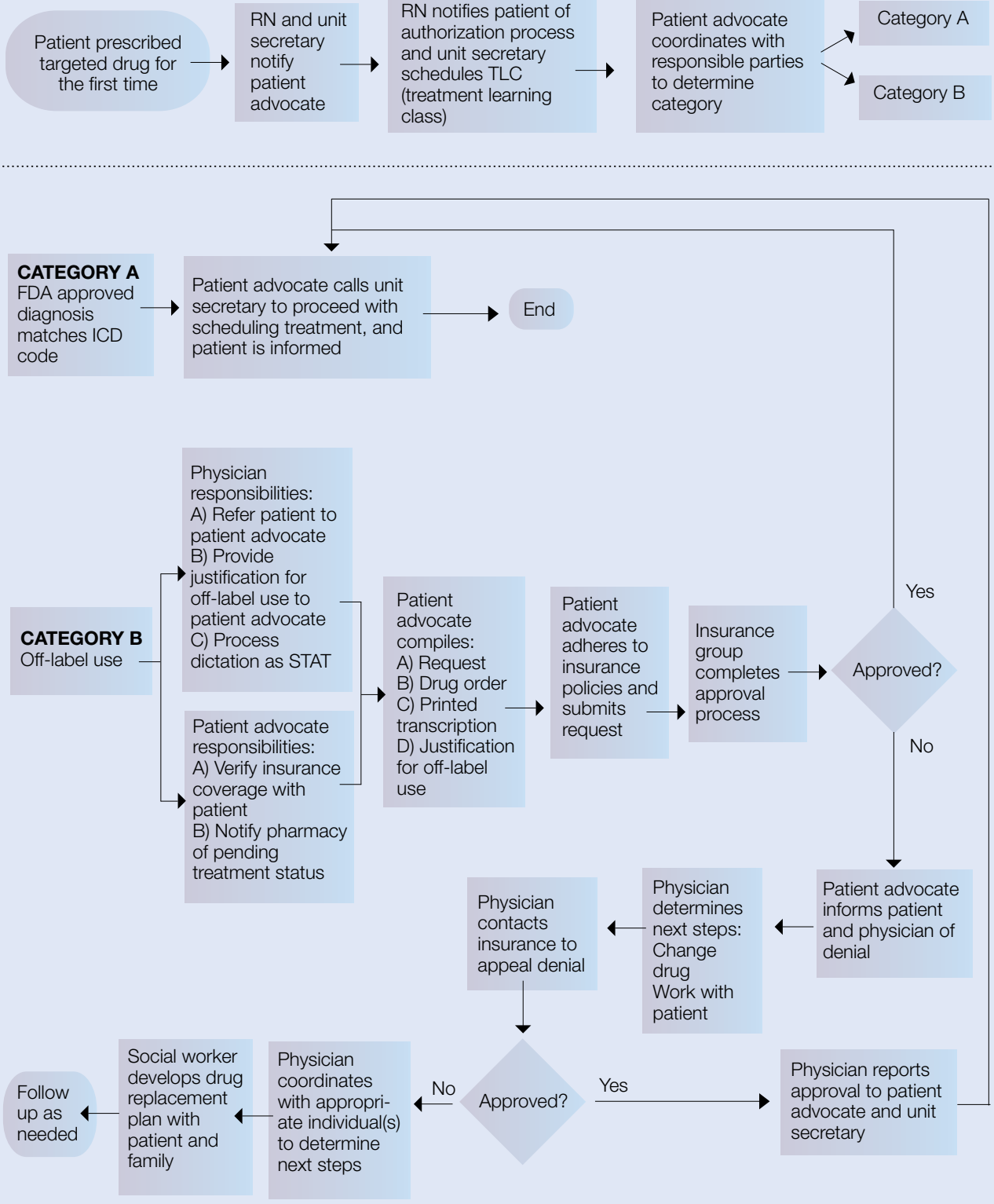
We established a multidisciplinary committee to address problems related to chemotherapy reimbursement. Stakeholders from administration, pharmacy, nursing, medical oncology, social work, and financial services were solicited for support. This committee immediately recognized that it would be impossible to verify reimbursement for every single drug before the patient began treatment. Instead—based on cost and likelihood of off-label use—we created two lists of "targeted" drugs that were causing financial strain at our institution. Some of the frequently prescribed high-cost drugs at our institution included bevacizumab, cetuximab, rituximab, and trastuzumab.

Category A includes targeted drugs that had an FDA-approved indication for which the doctor was prescribing. Category B includes targeted drugs prescribed for off-label uses. If a drug is on either list, our patient financial advocate must determine whether treatment for the patient's diagnosis will be approved and/or if pre-authorization is needed *before* treatment begins. To streamline this workflow process, we include on these two lists the approved indication(s) and off-label or investigational uses for each targeted drug. We also include MSTI's available research protocols specific to each targeted drug.

Our next move was to implement a "Chemotherapy Pause." (The term was coined as an analogy to a "Surgical Pause," when a surgical team "pauses" in the operating room for a moment to ensure the plan is agreed upon.) MSTI's chemotherapy pause has four components:

1. A consideration of all possible treatment options.
2. Patient attendance of our treatment learning class. During this class, patients are educated about exactly what they can expect during their chemotherapy regimen.
3. A guarantee that the treatment will be reimbursed by the third-party payer.
4. An evaluation of the financial impact the treatment regimen will have on the patient and their family.

Figure 1: Chemotherapy Pause



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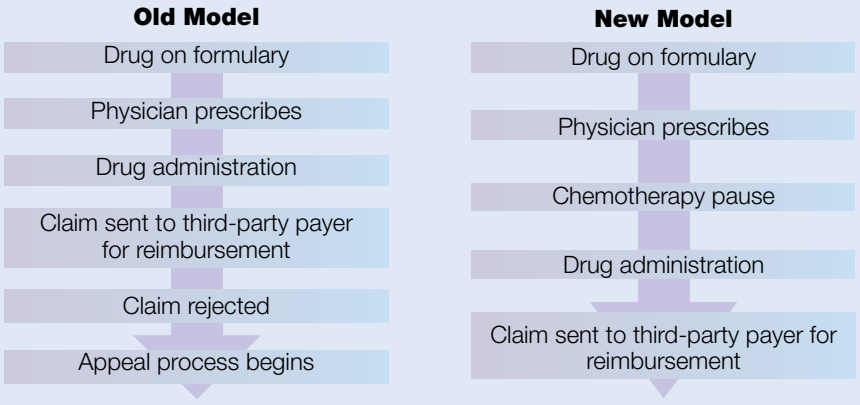
Thomas M. Beck, MD, medical director of St. Luke's Mountain States Tumor Institute, confers with a member of his staff.

Figure 2. A Comparison between the Old and the New Reimbursement Model



The New System at Work

MSTI's chemotherapy pause begins when a patient is prescribed a targeted drug for the first time (see Figure 1). The oncology nurse is responsible for notifying the patient financial advocate that a targeted drug is being prescribed and informing the patient that a drug authorization process is required before treatment starts.

The next step is for the patient financial advocate to determine the category of the drug. For Category A drugs, the patient financial advocate verifies the patient's diagnosis and insurance coverage and the patient proceeds with treatment. For Category B drugs, the physician must complete a form, which includes FDA-approved indications and any literature citations or research available for off-label use. Additionally, the patient financial advocate sends a dictation of the patient visit where the chemotherapy was prescribed to the appropriate insurer to justify the chemotherapy treatment plan. Oral chemotherapy drugs all fall into Category B, and our patient financial advocate and/or social worker must work with the oncologist to complete all the necessary paperwork for obtaining these drugs.

Next, the patient financial advocate sends the reimbursement request, chemotherapy order, physician dictation of the patient visit, and literature in support of the off-label use to the appropriate payer. If the request is approved, the patient is scheduled for treatment. If the request is denied, the patient is referred to a social worker who initiates a patient assistance application from the appropriate pharmaceutical company. At the same time, the physician and/or the patient may appeal the denial from the insurance company.

If the payer denies the off-label request a second time, the oncologist meets with the patient to discuss further treatment options. At this time, the patient and his or her family must carefully weigh out-of-pocket expenses versus the benefits of treatment. At the same time, the patient financial advocate and/or social worker continues working with the patient to evaluate drug replacement options.

While this new system has put increased responsibilities on MSTI staff and cancer patients, we are not dealing with billing on the back end—through the appeals process and after a patient is treated and dollars are lost. The chemotherapy pause changed our paradigm. Today, we capture patients when they enter our system and guarantee reimbursement prior to anti-cancer treatment (see Figure 2).

The Outcome

Measuring the financial efficacy of the new system and the chemotherapy pause has been challenging. In terms of drug reimbursement dollars, we collected data at one of our outpatient clinics (see Figure 3). During an eight-month period, one patient financial advocate processed 41 reimbursement requests, totaling more than $200,000 in drug costs. This dollar figure represents the potential for loss had the claims for reimbursement been denied.

We have also looked at non-financial outcomes after the implementation of the new system, including patient satisfaction surveys. Over the last few years, patients scored our institution in the 90 percentile for all provided services, except billing (see Figure 4). After the addition of the patient financial advocates and the chemotherapy pause, our patient satisfaction scores for billing have started to increase.

MSTI's most noteworthy success has been to significantly increase provider awareness. Prior to the implemen-

Figure 3. Select Drug Authorization Outcomes between September 2005 and April 2006

Drug	Approved	Denied	Total Drug Cost
Bevacizumab	21	5	$150,384
Cetuximab	6	1	$33,264
Oxaliplatin	1	0	$7,452
Paclitaxel, protein bound	1	0	$3,914
Rituximab	6	0	$11,382
TOTALS	**35**	**6**	**$206,846**

tation of the chemotherapy pause, many of our oncologists were not taking into consideration the significant costs associated with treatment. The widespread success of the chemotherapy pause and the patient financial advocates has resulted in our oncologists taking more responsibility for evaluating the costs of the treatment they are prescribing.

Based on these outcomes, administration has approved additional patient financial advocates to help with the growing demand for these types of services. Our future goal is to have a patient financial advocate meet with every new cancer patient before treatment starts to outline treatment plans and predict financial obstacles—regardless of the cost of the drug regimen.

Ongoing Challenges

Thanks to the ever-changing rules of third-party payers, we continue to encounter reimbursement obstacles. One third-party payer, for example, is requiring its patients to "brown bag" certain drugs. Specifically, patients must purchase all subcutaneous and intramuscular injections (for example, goserelin, leuprolide, and octreotide) from a retail pharmacy and bring them to our chemotherapy infusion center for administration. These patients have seen one time co-pays greater than $700. MSTI's patient financial advocates and social workers are priceless resources for helping our patients with this obstacle.

Another obstacle to adequate chemotherapy reimbursement is the lack of a system for separating outpatient oncology service charges and bills from the rest of the hospital's service lines. Currently, we are all still under one "roof." A separate billing department would make it possible to track authorizations, evaluate unnecessary losses, and have dedicated personnel specializing in oncology accounts.

Community cancer centers face a chemotherapy reimbursement landscape that is complex and constantly changing. To navigate these changes, programs will need to develop new internal processes. Dedicated financial advocates and a system for ensuring appropriate reimbursement *prior* to drug administration are crucial if cancer programs are to remain solvent. Many community cancer treatment centers will likely need to use financial advocates and social workers whose primary responsibility is assistance with cost recovery. Developing a system similar to MSTI's "Chemotherapy Pause" will improve your ability to cope with the constantly changing formularies and reimbursement rules, while maintaining the highest standards of patient care.

Jessie Modlin, PharmD, and David B. Wilson, RPh, BCOP, are oncology pharmacists at St. Luke's Mountain States Tumor Institute in Boise, Idaho.

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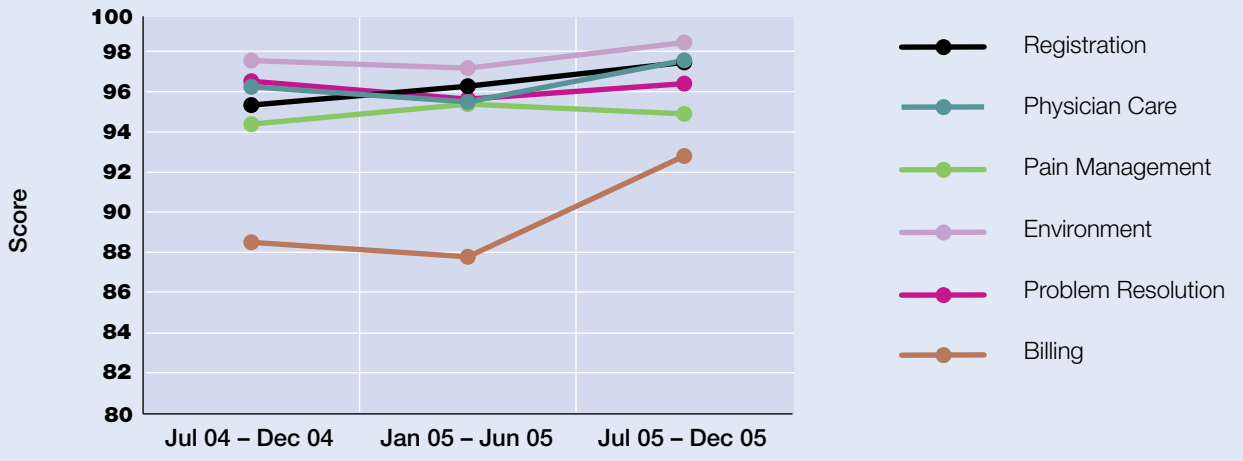
Figure 4. St Luke's MSTI Patient Satisfaction Scores



10 Basic Notions of Health Economics[1]

1. Human wants are unlimited but resources are finite.
2. Economics is as much about benefits as it is about costs.
3. The costs of healthcare programs and treatments are not restricted to the hospital, or even to the healthcare sector.
4. Choices in healthcare (in health planning or in a treatment mode) inescapably involve value judgments.
5. Many of the simple rules of market operation do not apply in the case of healthcare.
6. Consideration of costs is not necessarily unethical.
7. Most choices in healthcare relate to changes in the level or extent of a given activity; the relevant evaluation concerns these marginal choices, not the total activity.
8. The provision of healthcare is but one way of improving the health of the population.
9. As a community we prefer to postpone costs and bring forward the benefits.
10. Equity in healthcare may be desirable, but reducing inequalities usually comes at a price.

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Deconstructing Chemotherapy Reimbursement

Cancer treatment has changed dramatically over the past several years with exciting novel drug therapies entering the oncology arena. These new treatments are more expensive than older drugs by 10-fold, sometimes even 100-fold. They do not replace older therapies, but rather are being added to the standard treatment regimens.

In general, these new treatments are less toxic and patients are treated with them for a longer period of time. An example of a new treatment is adjuvant therapy for breast cancer patients. For many years, the gold standard of treatment was a regimen known as A/C (doxorubicin/cyclophosphamide), with a total cost in the hundreds of dollars. Paclitaxel was then added to the treatment regimen, raising the cost to thousands of dollars. Today an entire year of trastuzumab is commonly added, bringing the total cost of treatment to hundreds of thousands of dollars.

During the past few years, third-party payers experienced increased difficulty absorbing the increasing cost of treating cancer—largely due to the rapidly rising cost of cancer drugs. In response, third-party payers have made the process of chemotherapy reimbursement more complex than ever for providers.

Chemotherapy reimbursement from third-party payers is complicated by several factors. One of the most difficult factors is drug preauthorization. Each third-party payer has its own unique list of drugs that require preauthorization, making the reimbursement process inconsistent and confusing for both patients and providers.

Another factor complicating chemotherapy reimbursement is off-label use. Oncologists are treating cancer more aggressively, yet pharmaceutical manufacturers are reluctant to invest money in applying for new indications for which the drug is already in use. According to a recent study, 68 percent of oncologists reported that they placed "high importance" on prescribing off-label. Interestingly enough, the same article stated that 30 percent of respondents reported decreased prescribing of off-label indications because of reimbursement challenges.[3] This study highlights the disparity between what physicians would prefer to do for patient care, and what they actually do because of reimbursement issues.

Oral anti-cancer agents have brought their own reimbursement challenges. For example, a one-month supply of sorafenib, a new multikinase inhibitor for renal cell carcinoma, costs approximately $4,330 and is only supplied by specialty pharmacy providers. In order for cancer patients to obtain this drug, the prescribing oncologist must complete lengthy enrollment forms. In most community cancer centers, oncologists are too busy to carry out this task, so it is usually delegated to nursing or medical assistants who are already overloaded with work and other responsibilities. Applications for many oral chemotherapy agents are similar to the applications for pharmaceutical patient assistance programs—every drug requires extensive paperwork and knowledge of the patient's financial status.

Telephones, Computers, and Virtual Patients

by Cindy Parman, CPC, CPC-H, RCC

Once upon a time there was a phone in my parents' house. There was only one phone; it was on the wall in the kitchen. It was a black, rotary dial phone, and we were on a "party line." Fast forward to the present day: the best way to keep in touch with patients may be a reminder text to their cell phone, which is where they keep their calendar and list of contacts, access email, and play games.

As a result, the nature of patient encounters may also be changing, requiring the addition of new codes to charge tickets and a complete understanding of billing for these non-face-to-face services. According to information published by the American Medical Association (AMA), research indicates that 20 percent or more of clinical services provided in certain specialties is performed over the telephone. So community cancer centers will need to consider reimbursement challenges presented by these electronic and virtual services. Note that while these services can be charged by a physician practice or freestanding cancer center, the codes are not reported in the hospital outpatient department and do not have a technical component.

Telephone Services

The CPT® Manual includes a series of codes for telephone services, which are defined as non-face-to-face evaluation and management (E/M) services provided via the telephone. There are separate codes for physicians and for qualified nonphysician healthcare professionals listed in separate sections of the Manual. While the AMA does not define who is considered a "qualified nonphysician healthcare professional," the individual who takes the call and performs the E/M service must have the authority to do so in his or her scope of practice. Some payers provide specific guidance in this area. For example, PriorityHealth limits qualified nonphysician healthcare professionals to: certified nurse practitioners; physician assistants; licensed masters-level social workers (LMSWs); psychologists (both LLPs—limited licensed psychologist—and PhDs); certified diabetes educators; registered dietitians; master of science (MS)-level trained nutritionists; clinical pharmacists; and respiratory therapists.

These time-based codes include:

- **99441**: Telephone evaluation and management (E/M) service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
- **99442**: Same definition as code 99441 except 11-20 minutes of medical discussion
- **99443**: Same definition as code 99441 except 21-30 minutes of medical discussion.

These physician codes are mirrored by three codes with the same definition that can be reported by a qualified nonphysician healthcare professional:

- **98966**: Same definition as code 99441 with 5-10 minutes of medical discussion
- **98967**: Same definition as code 99441 except 11-20 minutes of medical discussion
- **98968**: Same definition as code 99441 except 21-30 minutes of medical discussion.

Community cancer centers that report a telephone E/M code must meet seven criteria:

1. The patient must be an established patient. In addition, these codes were designed for the management of chronic medical conditions, not acute care episodes.
2. The service must constitute an "episode of care" and the call must be initiated or requested by the patient to discuss a medical condition(s). Telephone calls from the provider's office to communicate the results of laboratory tests or imaging services, remind patients of appointments, etc., are not considered telephone E/M services for purposes of code assignment.
3. The telephone call cannot be a result of a face-to-face patient encounter within the previous 7 days. If so, the telephone call is considered to be part of the post-service to the prior office visit.
4. The telephone call cannot result in a patient visit during the next 24 hours (or the soonest available appointment). If the telephone discussion ends with the decision to see the patient in the office as soon as possible, then this discussion is considered part of the pre-service work for the office visit.
5. The visit time in medical discussion must be documented and met for the selection of the code.
6. Only one telephone E/M service can be reported during a 7-day period and telephone visits are not reported if they relate to a procedure and occur during the postoperative period of the procedure.
7. Last, these codes for telephone E/M cannot be reported in addition to the codes for anticoagulant management, nursing home management, or care plan oversight services.

Documentation for telephone E/M encounters includes history obtained and symptoms reviewed, verbal

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patient assessment performed, medical decision making, treatment recommendations, and communication of information to the patient.

Online Evaluation and Management

An online electronic medical evaluation is a non-face-to-face evaluation and management (E/M) service provided via a secure Internet connection. Again, the CPT Manual lists separate codes for physicians and for qualified nonphysician healthcare professionals. These codes include:

- **99444**: Online evaluation and management service provided by a physician to an established patient, guardian, or healthcare provider not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network.

This physician code is mirrored by a code with the same definition that can be reported by qualified nonphysician healthcare professionals:

- **98969**: Online evaluation and management service provided by a qualified nonphysician healthcare professional to an established patient, guardian, or healthcare provider not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network.

Similar to reporting telephone patient encounters, required criteria must be met to report an online patient encounter:

1. The patient must be an established patient. In addition, these codes were designed for the management of chronic medical conditions, not acute care episodes.
2. The service must constitute an "episode of care" and the online inquiry must be initiated by the patient to discuss a medical condition(s). Email communications from the provider's office to the patient to provide routine information, appointment reminders, or test results would not meet the requirement for these codes.
3. Reportable services include the physician's or nonphysician healthcare professional's personal timely response to the patient's inquiry and must involve permanent storage of the encounter (hardcopy or electronic) as part of the patient medical record.
4. The online evaluation cannot be a result of a face-to-face patient encounter within the previous 7 days. If so, the online encounter is considered to be part of the postservice work of the prior office visit.
5. Only one online E/M service can be reported during a 7-day period and online encounters are not reported if they relate to a procedure and occur during the postoperative period of the procedure.
6. Last, these codes for online E/M cannot be reported in addition to the codes for anticoagulant management, nursing home management, or care plan oversight services.

Documentation for online E/M encounters includes a summary of all communication with the patient and encompasses writing prescriptions, laboratory orders, and related telephone calls. The encounter should also include documentation of history reviewed or obtained, changes in medication, initiation of treatment programs, and recommendations for patient care.

Insurance Reimbursement

Reimbursement for electronic or telephone healthcare services does not always keep pace with patient need for these services. For example, Mountain State Blue Cross Blue Shield states that telephone calls are not covered "because there is no direct patient care or contact." However, this particular payer states that a participating provider can bill the member for the denied service.

PriorityHealth does provide reimbursement for both telephone and online (e-visits) encounters for members of fully funded HMO, POS, and PPO plans, subject to specific guidelines. For example, this payer requires that email communication: "…must use encrypted or authenticated email for online medical evaluation visits. Standard email is not acceptable, since it is not secure, has no 'terms of use' or legal disclaimers in place to protect the provider, and can easily expose patient PHI including email addresses to unintended third parties."

Medicare does not pay for telephone or online patient encounters (although there are RVUs listed for these codes in the Medicare Physician

Fee Schedule) and has listed these codes with the status indicator of "N," which indicates a noncovered service. As a result, Medicare beneficiaries cannot be charged for telephone or online patient encounters.

Looking Ahead

In response to changing expectations on the part of patients and payers, physician practices must use available technology to provide services in a non-face-to-face manner. Most often the time spent on the phone with patients cannot be reimbursed because it is considered part of a face-to-face visit that occurs before or after the call, the call is short, or the payer does not cover telephone services. Online patient visits may also not be reimbursed because the electronic communication system does not meet the necessary guidelines, the medical topic does not meet criteria, or the payer, again, does not provide payment. Oncology practices should continue to monitor payer guidelines and bulletins in the event coverage becomes available for these technology-based patient encounters, and ensure that all guidelines are met to bill those payers who provide reimbursement.

PHOTOGRAPH/ISTOCKPHOTO

Cindy Parman, CPC, CPC-H, RCC, is a principal at Coding Strategies, Inc., in Powder Springs, Ga.

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The Value of Dedicated Financial Coordinators

by Teri U. Guidi, MBA, FAAMA, and Elaine Kloos, RN, NE-BC, MBA

As payers continue to tighten their requirements to reimburse providers for care, it is not surprising that community cancer centers—in physician practices and in hospitals—are increasingly looking for ways to ensure optimal financial performance. In addition, the evolution of "accountable care" is shining the spotlight on the need to manage the quality of care as well as the costs. Accountable Care Organizations (ACOs) will be expecting to pay for care in a new manner that will certainly heighten the pressure on providers to receive all reimbursements appropriately due in a timely fashion.

Today, a key best practice to ensure receipt of reimbursements is to employ a financial coordinator. Due to the very complex nature of oncology services (including the detailed coding and billing for those services), it is vital for cancer centers to have a dedicated financial coordinator for oncology.

These individuals serve on the front line for the cancer center, working to maximize the likelihood of submitting a "clean" and payable claim for services. Financial coordinators also advocate for patients and assist them with accessing as many outside services as possible to help minimize the financial burden of cancer care.

KEY RESPONSIBILITIES AND FUNCTIONS

Financial coordinators provide services for both medical and radiation oncology and, depending on patient volume, cancer programs may consider employing more than one financial coordinator in the cancer center. Key responsibilities of this staff member include:

Insurance verification. Before the patient's first visit is scheduled, his or her current insurance enrollment must be verified. Some providers have access to electronic systems for this verification, but few include all insurers' information and some may be outdated. The initial information is generally captured by clerical staff. This function should be performed each month without fail and both primary and secondary insurances should be verified.

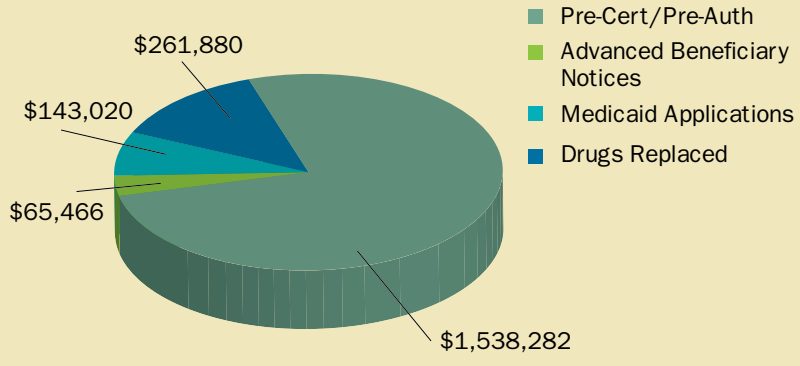
Pre-certification and pre-authorization. When the provider determines the treatment plan, this information must be available to the financial coordinator as soon as possible—either in paper format or electronically. Once the financial coordinator receives this notification, he or she can begin the pre-certification or pre-authorization process. Before a patient begins treatment, the financial coordinator should double check the patient's insurance enrollment and identify the patient's specific insurance plan. The financial coordinator then obtains from the payer coverage benefit details related to the patient's treatment.

An organized financial coordinator will maintain a file or database for all major payers' plans, updating information periodically, to speed the pre-certification and pre-authorization process. Included would be:

- Any policies or rules regarding medical necessity for specific drugs (matching a patient's diagnosis to the approved list of conditions for each drug)
- Number of treatments permitted before renewing the pre-authorization.

The financial coordinator should keep a file on each patient to ensure that pre-authorizations do

Figure 1. Quantifying the Financial Coordinator's Value: An Example of Annual Cost-savings for One Community Cancer Center



Holy Cross Hospital, Michael and Dianne Bienes Cancer Center, Fla.

not run out or expire and maintain a tickler system in order to re-certify when appropriate.

In regards to radiation therapy, more payers are requiring pre-certification for IMRT, SRS, SBRT, HDR, and any other special procedures. BID (i.e., twice a day) treatments, whether external beam or HDR, should also be discussed with the payer prior to the start of treatment to ensure that the appropriate modifier is used in preparing the claim for service.

Patient interaction. The next important step is meeting with the patient. Prior to that meeting, the financial coordinator approximates the cost of the patient's prescribed treatment regimen. At the face-to-face meeting, the coordinator then discusses any out-of-pocket costs for which the patient is responsible. Unfortunately, out-of-pocket costs for patients continue to rise exponentially as employers are passing on more of the healthcare costs to their employees.

Out-of-pocket expenses include: co-insurance, deductibles, and co-pays. The financial coordinator must approach this sensitive subject very much as a patient advocate, helping the patient understand that many venues can be accessed to assist patients if they are struggling with the cost of their cancer care.

At this meeting, the financial coordinator will also explain that patient co-pays are due at the time of check-in. If patients need to work out alternative payment plans, this information should be noted in their registration, so the check-in staff realizes the situation. In other words, all co-pays should be paid at check-in so the check-in staff can smoothly perform all duties and not be involved in discussing various financial details with patients.

For patients who cannot meet the financial obligation, the financial coordinator can discuss additional steps, including:

- ***Payment plans***. If the patient can cover the out-of-pocket expenses but cannot necessarily pay them promptly, a payment plan can be set up. This plan should be a written agreement

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that is signed by the patient.

- ***Secondary coverage***. For patients covered by Medicare only, discussion and cost estimates for secondary coverage is warranted. This process can include an application to the Medicaid program if the patient meets the financial criteria. If the patient can afford a secondary insurance, such as AARP, the cost is typically much less than the 20 percent out-of-pocket that Medicare does not cover.
- ***Applications for assistance***. Many types of patient assistance programs are available.
- ***Hospital assistance programs and/or charity care***. The financial coordinator should assist the patient with the paperwork and ensure it is forwarded to the appropriate hospital staff.
- ***Co-pay assistance programs***. Most of these programs require that patients complete extensive paperwork. Patients must understand their accountability in this process and receive assistance as appropriate so the ball does not get dropped. Some of the more common co-pay assistance programs can be found on pages S54-S58.

TEAM AND STAFF INTERACTION

The financial coordinator must be an integral member of the cancer center team, frequently interacting with clinical, clerical, and billing staff.

The financial coordinator and the clinical staff need to develop processes and communicate regularly about new patients' treatment plans, changes to treatment plans, and scheduling. The financial coordinator should be notified of any changes in a patient's treatment regimen in order to re-check for authorizations. For example, whenever a patient's treatment regimen is changed and a new drug or supportive care drug added, the financial coordinator should re-check authorizations.

The financial coordinator and billing staff need to communicate when a patient's treatment is denied for any reason. Over time, denials should decrease dramatically as a result of the financial coordinator's work on the front end.

In the event of a denial, the financial coordinator needs to communicate with the appropriate physician(s). If the payer declines to cover care, the financial coordinator should notify cancer center management to take appropriate action (for example, conferring with physicians regarding the treatment plan). If the treatment plan is not adjusted, the financial coordinator should discuss the costs with the patient and have the patient sign an ABN (advance beneficiary notice) prior to proceeding. If pharmaceutical replacement programs are accessed, the financial coordinator needs to work closely with the pharmacy staff.

QUANTIFYING THE VALUE

Because the financial coordinator position does not generate direct revenue, getting approval to staff this position may be difficult. Regularly measuring the financial coordinator's true value is an important step in justifying the financial coordinator position. The most convincing argument comes from drug replacement programs. These programs give the provider free drugs to replace those given to qualifying patients. Although the scale of these programs and their options have diminished in recent years, drug replacement programs still offer very direct and readily measured value.

Additional benefits accruing from the financial coordinator's efforts are best defined in terms of charges that would otherwise have been at risk for non-payment due to non-coverage, lack of insurance, and more. And finally, financial coordinators benefit cancer centers in terms of time saved from reduced handling of denials and appeals.

Figure 1 (page S4) is an example of infusion services data that could be realized annually from a community cancer center employing a financial coordinator:

- Average number of infusion chairs in the sample: 18
- Average number of financial coordinators in the sample: 1.5
- Average financial coordinator salary in the sample: $50,000
- Average charges checked for pre-certification/pre-authorization: $1,538,282
- Average charges covered by ABNs obtained by the financial coordinators: $65,466
- Average charges for patients who were assisted in applying for Medicaid: $143,020
- Average value (purchase cost) of drugs replaced by drug replacement programs: $261,880

In this example, financial coordinator services brought the cancer center a drug value of $261,880 and "protected" more than $1.7 million in charges otherwise at risk of being challenged or unpaid.

Teri Guidi, MBA, FAAMA, is president and CEO, and Elaine Kloos, RN, NE-BC, MBA, is senior consultant at the Oncology Management Consulting Group, in Pipersville, Pa.

What Cancer Survivors Need to Know About Health Insurance

Published by the National Coalition for Cancer Survivor ship, this booklet discusses several aspects of health insurance that are important to cancer survivors. First, it describes the many different types of health insurance that are available and what cancer survivors should look for when considering a health insurance policy. Then, it looks at the rights cancer survivors have under state and federal law that can help them buy and keep health insurance coverage. The booklet also lists places cancer survivors can turn to for information on how to solve their health insurance problems. It is available online at: *www.canceradvocacy.org/assets/documents/health-insurance-publication.pdf*.

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Association of Community Cancer Centers
11600 Nebel Street, Suite 201
Rockville, MD 20852-2557
www.accc-cancer.org

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