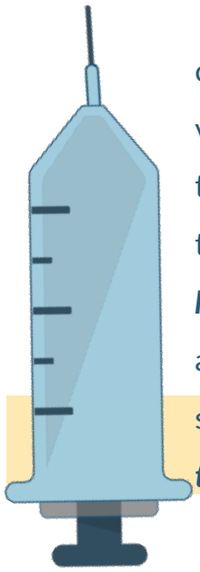
NATIONAL INFUSION CENTER ASSOCIATION

INCORPORATING INJECTABLES IN INFUSION OFFICES

Authors: NICA & Ken Idicula



The biopharmaceutical drug pipeline is growing rich with provider-administered specialty medications. In the case of biological products, administration is typically parenteral via intravenous infusion, intravenous push, or subcutaneous injection. Injectable formulations are either administered by a healthcare provider in an office setting or self-administered by a patient. ***Patients prescribed a drug with a formulation requiring administration by a healthcare provider need a site of care in which to receive these medications.*** An infusion operation that hasn't diversified to incorporate provider-administered injectables can't provide a site of care option for these products. ***To optimize this delivery method and create new opportunities for your patients, consider the addition of injectable therapies to your infusion business.***

SO WHY INJECT?

Infusion centers typically see patient volumes from neurology, gastroenteroloy, rheumatology, dermatology, and infectious disease practices. Growing the infusion center service line requires identifying community needs and local specialty physicians who require not just services but injection services for their patients. Injections can be viewed as a gateway to IV market share. In some instances, injections may be prescribed prior to, or in accordance with, an infusion-based regimen. This, in turn, may result in the addition of an entirely new patient population that the infusion center can service. This growth leads to operational efficiencies. This can be illustrated in the following scenario: A growing center assumes a variety of operational costs, one of those costs primarily being labor. As the center obtains more patients, costs associated with clinician labor will be distributed amongst multiple patients compared to a few. The added revenue will also reduce the overhead cost burden. Therefore, specialty physician injection referrals can boost financial performance and improvements in community health. ***This focus on other referral pathways can increase volume and support efforts to transition patients to the most appropriate, efficient, cost-effective site of care.***

REIMBURSMENT

The maximum allowable amount for reimbursement for healthcare provider-administered drugs is equal to Wholesale Acquisition Cost (WAC) plus 5% (WAC +5%) of the benchmark NDC or, if no WAC data is available, CMS reimbursement is currently Average Sales Price (ASP) plus 6% (ASP+6%). The maximum allowable cost corresponds to the dose in the narrative description of the HCPCS or CPT code. When the procedure code specifies no dose in the narrative, the reimbursement rate is based on what corresponds to a typical dose for the particular code.

Billing for the administration of a complex injection in the office often requires the use of CPT 96372 (Therapeutic, prophylactic, or diagnostic injection, specify substance, or drug; subcutaneous or intramuscular) or the use of CPT 96401 (Chemo administration, subcutaneous or intramuscular). NICA recommends checking with your carrier to see if they will accept this code.

One thing that every practice should note is that moving reimbursement each month requires extra-close monitoring of the Average Sales Price. The organization should track it individually by patient and by carrier. Typical risks include the changes in carrier or loss of insurance by patient, co-pay changes, timing on deductible (if late in the year it's generally low and – early in the year it's generally high), loss or change in co-pay cards, change in rebates, and changes in reimbursement.

HOW DOES THIS LOOK FOR MY PRACTICE?

Injections can add supplemental revenue to any infusion center. In the case study illustrated below, one patient on Injectable A can generate a margin of $260.73 and 10 new patients roughly equates to $33k in margin per year for an AIC. Injectable B illustrates a similar story with a margin equating to roughly $143 per patient, and just over $18k for 10 new patients per year.

Injectable	March '19 ASP	ASP+6%	Admin	Margin	TX/YR	Margin/Year	10 New Patients
A	$2,976.00	$3,156.00	$80.73	$260.73	13	$3,389.49	$33,894.90
B	$1,048.50	$1,111.50	$80.73	$143.73	13	$1,868.49	$18,684.90

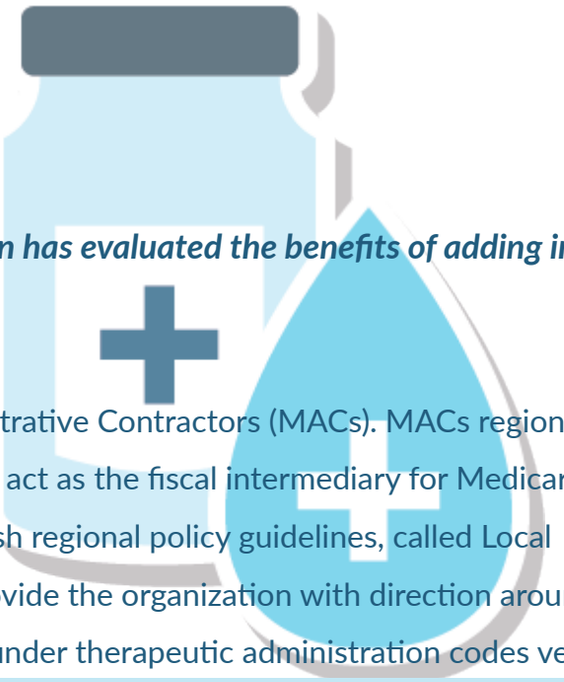
This reimbursement is not inclusive of volume-based rebate incentives that the drug manufacturer could potentially offer. For example, if a practice were to purchase 102 vials of Injectable A at the listed Q1 WAC provided below, the associated rebate would be in excess of $12,000. Similarly, if the practice were to purcahse 102 vials of Injectable B, the associated rebate would exceed $6,000.

Injectable A	% off WAC	WAC Q1
101+	6%	$2,000
76-100	4%	
50-75	2%	

Injectable B	% off WAC	WAC Q1
101+	6%	$1,000
76-100	4%	
50-75	2%	

*Note: These are hypothetical examples using arbitrary numbers. Each organization may or may not be eligible for volume-based discounts based on site of care, utilizations, and other factors. Refer to the drug manufacturer for guidelines.

BEST/WORST PRACTICES



What are the next steps now that the organization has evaluated the benefits of adding injections to its current line of business?

NICA advises that you get to know your Medicare Administrative Contractors (MACs). MACs regionally manage policy and payment related to reimbursement and act as the fiscal intermediary for Medicare. They also manage provider claims for payment and establish regional policy guidelines, called Local Coverage Determinations (LCDs). MACs will be able to provide the organization with direction around unit billing and whether the injection should be classified under therapeutic administration codes versus chemotherapy administration codes. Additionally, the facility may choose to allocate a specific chair dedicated solely for injections. This chair can be housed in a repurposed unused exam room. Your facility should be prepared for handling an adverse reaction to the injection by having a reaction protocol in place and the necessary equipment on hand to manage the potential adverse reactions, based on the risks of the particular medication. When evaluating staffing requirements, strongly consider utilizing lower-level staff such as a medical assistant or licensed vocational nurse if possible and dependent upon state requirements/restrictions. Determining the staff assigned to administer each medication should be made based on the safety and risks of the medication. Many injectables require prior authorization. Always check a payer's requirements before administering a medication.

WANT MORE INFORMATION ON INCORPORATING INJECTABLES?

Check out our website for other tools for infusion centers such as The Federal Regulatory Landscape and the NICA Minimum Standards for Office Infusion.