#FSHP2018

Understanding Billing Opportunities for Pharmacists

Eric Dietrich, PharmD, BCPS, CPC-A, CEMC
Julie Nickerson-Troy, PharmD, MS, BCACP

Break Through Branch Out

Disclosure

Neither of the speakers (nor immediate family members) have a vested interest in or affiliation with any corporate organization offering financial support or grant monies for this continuing education activity, or any affiliation with an organization whose philosophy could potentially bias the presentation

Break Through #FSHP2018 Branch Out

Objectives

- Discuss current reimbursement opportunities for clinical pharmacy services.
- Describe billing techniques used by pharmacists in the physicians' office and the hospital settings.
- Identify challenges with implementing billing techniques for pharmacists.

Break Through #FSHP2018 Branch Out

Reimbursement Opportunities

Medicare Part A	• Hospitalizations • E&M codes • MTM codes
Medicare Part B	• Incident to and Facility Fee • Transition of Care • Chronic Care Management • Annual Wellness visits • Diabetes Education • MTM
Commercial Private Payer	• Similar to Medicare • Direct Contracting/relationship
Medicare Part C	• Direct contracting/relationship
Medicare Part D	• Direct Contracting/relationship with PDP • MTM

	Billing Codes	Service Location (HB=hospital based, facility PB=Provider based, non-facility)	Reimbursement 2017 Florida
Incident to physician: office visit in a physician-based clinic	99211-99215	PB	99211= $21.36 99212= $43.91 99213=$73.30 99214=$108.24 99215=$146.35
Facility Fee Billing Incident to physician: office visit in a hospital-based clinic	99211-99215 APC code 5012 with HCPCS code G0463	HB	G0463=$99.82
Transitional Care Management TCM (team including provider and pharmacist)	99495 mod. complexity	PB HB	PB 99495=$163.28 HB 99495=$112.16
	99496 high complexity	PB HB	PB 99495=$231.11 HB 99496=$162.49
Chronic Care Management (CCM)	99490 (20 min/month) ACP 5011, CPT 99490	PB HB	PB=$39.37 monthly HB=$30.80 monthly
Complex CCM	99487 (60-89 minutes) 99489 (each add. 30 min)	PB HB	PB=$92.74 monthly / $46.20 HB=$53.33 monthly / $26.66

	Billing Codes	Service Location (HB=hospital based, facility PB=Provider based, non-facility)	Reimbursement 2017 Florida
Medication Therapy Management (MTM)	99605 99606 99607	Community pharmacy, employer, health plan, HB, PB	Variable per payer
CMS Annual Wellness Visits (AWV)	G0438 (initial, once/lifetime) G0439 (subsequent, annual)	PB HB	PB/HB = $173.44 PB/HB = $117.49
Diabetes self-management training	G0108 (individual) G0109 (group)	all	G0108=$51.75 G0109=$13.91
Collection and interpretation of physiologic data	99091	PB HB	$58.79/30 min
CLIA-waived lab tests	Variable per POC test (ie PT/INR 85610-QW)	all	fixed per CPT code (ie PT/INR=$5.43)
Direct contracting			
Value based care contracts			

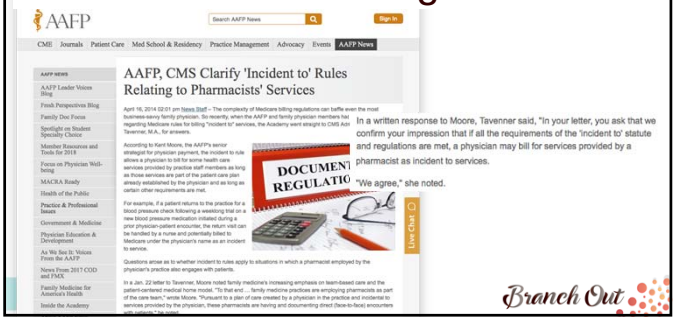
Provider Based Billing

- Incident To
  - "...services that are furnished incident to physician professional services in the physician's office..." and "are billed as ... if you [the physician] personally provided them..."
- Requires direct supervision
  - Physician on the premises and immediately available to assist but is not required to be in the same room

Provider Based Billing

- Incident To
  - Pharmacists are not "providers" and also do not meet the definition of "other qualified healthcare professional" who are specifically noted to be able to provide services in an incident to model
  - In 2014 AAFP reviewed the Medicare criteria for incident to billing and could not find anything that would exclude pharmacists from providing services under this model
  - AAFP directly queried Medicare for clarification

Provider Based Billing


AAFP

AAFP, CMS Clarify 'Incident to' Rules Relating to Pharmacists' Services

In a written response to Moore, Tavenner said, "in your letter, you ask that we confirm your impression that if all the requirements of the 'incident to' statute and regulations are met, a physician may bill for services provided by a pharmacist as incident to services.

"We agree," she noted.

Provider Based Billing

- Incident To
  - In Florida, statutory authority for clinical services mainly comes from 64B16-27.830 Florida Administrative Code
  - Discusses Prescriber Care Plans (analogous to a Collaborative Practice Agreement)
  - If pharmacist services are provided under a CPA they meet State Scope of Practice requirement to perform incident to services

Provider Based Billing

- Incident To
  - Level 3 (99213) and Level 4 (99214) most likely to be utilized by pharmacists for their services
  - General billing requirements for established patients:
    - Level 3: very brief history; 2 disease states being managed; medications being managed
      - Ex) stand-alone INR visit
    - Level 4: more extensive history; 3 disease states being managed; medications being managed
      - Ex) Diabetes visit with management of HTN and lipids

Provider Based Billing

- Incident To
  - Barriers
    - Buy-in at the institution level, billing/compliance department, and MAC
    - Unclear if rules consistently apply across commercial payers
    - State Scope of Practice issues
    - Understanding of billing requirements for different levels of service
  - Pros
    - Reimbursement sufficient to offset salary in most settings
    - The services we are already providing are equivalent to a Level 3 or Level 4 so very little to change in our workflow

Provider Based Billing

- Transitional Care Management (TCM)
  - Transition of care defined as any transfer of care between one provider and/or setting to another provider and/or setting
  - One of the more common transitions is hospital discharge
  - In 2013 Medicare developed TCM codes to incentivize outpatient clinics to more quickly intervene with patients recently discharged in the hopes of improving readmission rates
  - Requirements
    - Established patient at the clinic
    - Contact with patient within 2 business days of discharge
    - In-clinic visit within 7 or 14 calendar days (depending on TCM code)

Provider Based Billing

- TCM
  - TCM models differ
    - Joint in-clinic visits – pharmacist involvement addresses medication-related issues and reduces the time required by the physician[1]
      - Pharmacist-only visits (via incident to-type model) likely not possible due to billing requirements of TCM codes
    - Post-discharge calls – address medication related issues, coordinate follow-up visits, connect with other care services
    - Mix of the two
  - Pharmacists can leverage the additional reimbursement for TCM codes vs. standard visit codes to offset the time spent on services

[1]Cavanaugh JJ, et al. J Gen Intern Med 2014;29:798-804

Provider Based Billing

- TCM
  - Extra reimbursement created via utilization of TCM codes as opposed to standard office visit codes
    - Pharmacists completing post-discharge follow-up phone calls and helping to get patients into clinic in the appropriate time frame create opportunities to utilize TCM codes
    - Additional (and substantial) clinical value provided by pharmacist involvement which improves quality and continuity of care

TCM Code / Reimb*	Office Visit Code / Reimb*	Net Difference
99495 / $164.57	99214 / $108.24	$56.32
99496 / $233.36	99215 / $146.35	$87.01

*non-facility pricing for Medicare

Provider Based Billing

- TCM
  - Barriers
    - Prompt patient identification (investigate potential for automated reports)
    - Less than 100% "capture rate" (clinical value still provided)
    - Clinical impact can be reduced by limited (or lack of) hospital information
    - High volumes necessary for significant levels of FTE offset
    - Phone call can be performed by any non-clerical staff, not just pharmacy
    - Can't bill in same month as CCM
  - Pros
    - Viable model for billing and reimbursement for pharmacy services
    - Phone call requires only general supervision
    - With appropriate volume and efficiency can offset relevant FTE amounts

Provider Based Billing

- CCM
  - Originally developed by Medicare in 2015
  - Expanded in 2018 to include codes for Complex Chronic Care Management and additional time spent
  - Meant to reimburse practices for patient care services that occur outside of face-to-face clinic visits with a provider
  - Patient has to have at least 2 chronic conditions to qualify
    - Conditions should last at least 12 months, and
    - Place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline

Provider Based Billing

- CCM
  - Patient has to have Comprehensive Care Plan developed by physician; revised or monitored at each subsequent encounter
    - Can use G0506 to bill for development of the Comprehensive Care Plan
    - If patient has been seen in the last year not required to come to clinic for a visit with the sole purpose of developing Comprehensive Care Plan to initiate CCM services
  - Physician required to play larger role in Complex CCM by making moderate to high complexity medical decisions
    - Physicians able to direct clinical staff who provide services for the patient to count towards threshold time

Provider Based Billing

- CCM
  - Optimal utilization is proactive patient management as opposed to reactive
  - Numerous activities "covered" and can be performed by all clinical staff under general supervision (not complete list)

Prior authorizations	Medication Refills	Ordering Laboratory tests
Referrals	Patient counseling	Medication management
Coordination of Care	Development / adjust of care plans	
Chart review to screen for needed preventive health services		

Provider Based Billing

- CCM
  - Barriers
    - Patient's have to opt-in and incur a copay with each billed encounter
      - Why paying for services now that traditionally received without charge?
    - "New" so institutions may be hesitant implement
    - May require up-front personal costs to have the time to provide services
    - Accurately tracking time spent on existing services can be difficult
    - Can't bill in same month as TCM
  - Pros
    - Good reimbursement; 100% "capture rate" for services provided
    - Ideally used for chronic medication management which is our specialty
    - Can augment in-clinic services; improves patient access to care

Provider Based Billing

- Annual Wellness Visit (AWV)
  - Goal is to provide Personalized Prevention Plan Services (PPPS)
  - Have to be $\geq$ 12 months beyond initial Medicare Part B enrollment
  - Have to be $\geq$ 12 months from Initial Preventive Physical Examination (IPPE) or last AWV
  - Initial AWV (G0438) and Subsequent AWV (G0439)
    - Only one Initial AWV per beneficiary per life; Subsequent AWV can be completed one per year

Provider Based Billing

- AWV
  - Each AWV has specific elements that must be completed each visit
    - Clearly outlined by Medicare (MLN – ABCs of Annual Wellness Visits)
  - A core component is the Health Risk Assessment
  - Also emphasizes coordination of care across different providers, preventive care, and functional assessments
  - Pharmacists shown to provide at least similar levels of quality as physicians[1] or even improvements in specific areas[1]
  - Patients accepting of pharmacists as providers of AWVs[2]

1. Sewell MJ, et al. J Manag Care Spec Pharm. 2016;22:1412-1416 | 2. Sherill CH, et al. J Manag Care Spec Pharm. 2017;23:1125-1129

Provider Based Billing

- AWV
  - Barriers
    - Time to complete visits: average 73 minutes in one analysis[1]
    - Can be reliant on patient referral unless marketed to patients
    - Extensive list of elements that must be completed; all elements may not be fully utilizing the training and skillset of pharmacists
    - Patients can only be seen once per year
    - Must in a clinic with high number of Medicare patients
  - Pros
    - Pharmacists can perform under Direct Supervision
    - Reimbursement is reasonable; breakeven depends on overhead costs and efficiency of visits

1. Warshany K, et al. Am J Health Syst Pharm. 2014;71:44-9

Provider Based Billing

- 99091 – Collection and interpretation of physiologic data, 30 minutes
  - PB/HB = $58.79 for 30 minutes of time spent receiving and interpreting patient generated health data (PGHD) electronically stored and transmitted to the physician office
    - Glucose and blood pressure prime examples
  - "Physician or other qualified healthcare professional, qualified by education, training, licensure/regulation"
  - Patients have to opt-in; incur a copay
  - Cannot bill in the same month as CCM or TCM
  - Still not 100% clear if pharmacists able to furnish

Hospital Based Billing

- Governed by
  - Inpatient Prospective Payment System IPPS
  - Outpatient Prospective Payment System OPPS
- Billed on CMS1450 (UB04)
- Florida Hospital Celebration
  - Facility Fee
  - CLIA waived lab tests
  - MTM codes
  - TCM
  - Direct contracting (Employer groups, insurance, PGX)

HB-Facility Fee Billing

- Technical fee, not professional fee
- Represents hospital resources utilized
- Recognized by private insurers and CMS since 2000
  - CPT E&M Codes 99211-99215
  - G0463 with APC 5012
    - Medicare collapsed CPT levels into one G-code in January 2014

https://www.gpo.gov/fdsys/pkg/FR-2015-11-13/pdf/2015-27943.pdf

HB-Facility Fee Billing

HCPCS	APC	Description	Billed Amount	Payment
99211		Level 1 hospital clinic visit	$130.00	
99212 99213		Level 2 hospital clinic visit	$261.00	
99214		Level 3 hospital clinic visit	$391.00	
99215		Level 4 hospital clinic visit	$521.00	
G0463*	5012	Hospital outpatient clinic visit		$99.82

HB-Facility Fee Billing

- Challenges
  - Provider/admin/facility initial buy-in
  - Patient registration/consent process
  - Insurance referrals/authorizations process
  - Only one submission per day; Medicare 3 day payment window
  - Required to follow incident to rules with general supervision
- Pros
  - Reimbursement sufficient to offset pharmacist time
  - Can be utilized for many pharmacy service types (med rec, disease management, dosing adjustment, drug monitoring, TC)

HB-CLIA Waived Lab Billing

- Requires a CLIA Certificate of Waiver
- Apply to CMS or work with laboratory to be added to their certificate
- Use for point of care services
  - PT/INR
  - Lipid panels
  - Liver function tests
  - Glucose/A1C

HB-Facility Fee and Lab Billing

- 2003 Billing for Anticoagulation Management Service (AMS); utilizes CPA
- 2010 OPPS allowed for billing different levels: FHCH implemented higher level billing in 2013
- 2014 Billing for Medication Management Services
- 2017 Billing for Surgical Preparedness Services

HB-MTM Billing

- Sanchez, et.al. in Pharmacy Purchasing & Products 2014 describing Asante Rogue Regional Medical Center billing E&M codes
- Resident research project
- Revenue Integrity Department
- Piloted on glycemic management and TPN services

Sanchez, RPh, PharmD, BCPS, D., Feyerharm, RPh, J., Kick, PharmD, J., & Nisson, RPh, PharmD, S. Charging for inpatient medication therapy management. Pharmacy Purchasing & Products. 2014; 11(7):30.

HB-MTM Billing

- MTM services provided by a pharmacist, individual, face to face with patient, with assessment and intervention if provided.

CPT Code	Criteria	Billed Amount
99605	Initial 15 minutes, new patient	$130
99606	Initial 15 minutes, established patient	$130
99607	Each additional 15 minutes	$130

Pharmacist Services Technical Advisory Coalition. (2010). Pstac.org. Retrieved 5 April 2018, from http://www.pstac.org/services/mtms-codes.html

HB-MTM Billing

- Challenges
  - Provider/admin/facility initial buy-in
  - Adjustment to workflow may be necessary (FTF interaction and documentation)
  - Medicare DRG payment does not reimburse for this charge
  - Tracking payments
- Pros
  - Billing for services that are already being provided
  - Minor adjustment to workflow
  - Medicare has billing data when setting future payment rates

HB-MTM Billing

- FHCH Experience
  - Number of MTM units billed:
  - Amount billed to insurance: $
  - Average $ billed per patient consult

Codes billed per Consult	Frequency	Total Amount billed
1 CPT Code		$
2 CPT Codes		$
3 CPT Codes		$

HB- TCM Billing

- TCM codes are billing for a 30 day management period to Medicare part B by a provider
- Required components
  - Interactive contact within 2 business days
  - Certain non FTF services
    - Provider: Review DC info, follow up, arrange referrals, etc.
    - Clinical staff: assess adherence and med management
  - A FTF visit furnished by the provider
    - Med rec and management must be furnished at or before the FTF visit

HB-TCM Billing

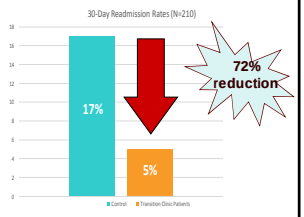
HCPCS	Complexity	Appt Timing	Payment
99495	Moderate	within 14 days of DC	$112.16 hospital
99496	High	within 7 days of DC	$162.49 hospital

HB-TCM Billing

- Challenges
  - Provider/admin/facility initial buy-in
  - Adjustment to workflow may be necessary (documentation)
  - Patient no-show rates of 50%
  - Connectedness
  - Billing tracking (drop day 30; revert to E/M if readmitted)
- Pros
  - Cost savings generated by reduced hospitalizations
  - Revenue generated directly from billing visits
  - Revenue generated indirectly from referrals

HB-TCM Billing

- FHCH experience
  - Reduced hospitalizations (72%), estimated savings of $93,600
  - Revenue generated from billing
  - Referrals to other departments of the hospital
  - Reduction in medication discrepancies (ave. 4 per patient)



HB- Direct Contracting

- Pharmacogenomic testing
- Employer contracts
- Insurance contracts

Understanding Billing Opportunities for Pharmacists

Eric Dietrich, PharmD, BCPS, CPS-A, CEMC
Julie Nickerson-Troy, PharmD, MS, BCACP