Understanding the Whirlwind: Today's Reimbursement and Practice Management Roadmap

Mary Ann Kliethermes, BS, PharmD
Vice-Chair, Professor
Chicago College of Pharmacy Midwestern University
February 25, 2017

Are Pharmacists able to bill for their services?

Yes
No
Maybe

Roadmap

The Payers
The Language and Structure Billing
The Rules
The Options for Revenue
Integration of Services

In the Whirlwind

Fee for Service

Alternative Payment

Payers in Health Care

Federal Medicare
State
Commercial or Private
Self Pay

Part A
Medicaid
Employer based

Part B
Insurance exchanges
Group

Part C
Part D
Individual

Follow the Rules

Medical Claim
Who Pays for Healthcare?

[Image of Healthcare Payment Diagram]

California Health Care Foundation


Average Payer Mix in Primary Care and Multispecialty Clinics

[Pie chart showing payer distribution]

Medicare
Medicaid
Commercial
Self-pay
Other


Payment Models

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for Service</td>
<td>Fee for Service</td>
<td>APNs/BAs Fee for Service</td>
<td>Population-Based Payment</td>
</tr>
<tr>
<td>Quality &amp; Value</td>
<td>Quality &amp; Value</td>
<td>Access</td>
<td>Risk</td>
</tr>
<tr>
<td>Pay for Performance</td>
<td>Pay for Performance</td>
<td>Risk-Adjusted Performance</td>
<td>Fixed Payment</td>
</tr>
<tr>
<td>Reimbursement for performance</td>
<td>Reimbursement for performance</td>
<td>Reimbursement for performance</td>
<td>Reimbursement for performance</td>
</tr>
</tbody>
</table>

https://hcp-lan.org - Health Care Payment Learning and Action Network

Commercial Payer challenges and facts

Variety of benefit plan types

Commercial plans are generally risk adverse

Models vary significantly across the county and within states

Are your supervising providers credentialed to provide services for the plans you are targeting

The industry standard is the Medicare billing system

May develop specific contracts defining certain codes for pharmacist's services reimbursement

Commercial Health Insurance Models in Michigan

Conventional indemnity plan

- Allows the participant the choice of any provider without effect on reimbursement. Claims reimbursed as expenses are incurred.

PPO (Preferred provider organization)

- Coverage is provided through a network of selected health care providers. Enrollees may go outside network, but incur larger costs.

HMO (Health maintenance organization)

- Assumes financial risks associated with providing medical services & for health care delivery usually in return for a fixed, prepayd fee.
- Reimbursement only to contracted or employed HMO providers.
- Out of network coverage only in emergency

POS (Point-of-service)

- ‘HMO/PPO’ hybrid
- Resemble HMOs for in-network services.
- Requires a referral from in-network provider to an out of network provider to receive improved coverage for the out of network provider.

Medigap Supplemental Plans

- Pays the Medicare deductibles, copayments, and other expenses

Michigan Consumer Guide to Health Insurance

Medicaid

Medicaid is a state and federal program that provides health coverage if you have a very low income.

States with some form of payment for pharmacist cognitive services: California, Colorado, Iowa, Kansas, Minnesota, Mississippi, Missouri, New Mexico, Ohio, Texas, Washington state, and Wisconsin

Focus on Medicare

Sets the industry standard
Is the largest single payer
Benefits created through legislation
Social Security Act in 1965 – MACRA 2015
CMS is the benefit administrator

Payment
Hospital
Provider
Commercial Payers
PDPs

Where do Pharmacists Fit?

Auxiliary Personnel
Pharmacist

Medicare Part A
- IPPS (Inpatient Prospective Payment System)
- MS-DRGs (Medical Severity Diagnosis Related Groups)
- Revenue Codes

Medicare Part B
- PFS (Physician fee schedule)
- MACRA Quality Payment Program
- HOPPS (Hospital Outpatient Prospective Payment System)
- Eligible providers

Medicare Part C
- all Part A and Part B services, may provide Part D
- Rules on relationships with providers
- CMS Call Letter
- Payment fixed per-member-per month

Medicare Part D
- CMS Call Letter
- CY 2017 Medication Therapy Management Program Guidance Memo
- Payment a direct subsidy payment per enrollee

CMS: Center for Medicare and Medicaid Services
(HCHA – Health Care Financing Administration – old name)

Medicare Part A
- Universal benefit
- Covers
- Hospitals, Health Systems
- Long term care
- Hospice and Home Health

Medicare Part B
- Must Opt out
- Must have contributed to Social Security
- Covers outpatient services

Medicare Part C
- May opt in
- Medicare Advantage
- Administered by commercial payers

Medicare Part D
- May opt in
- Administered by commercial payers (PDPs)

State
Medical scope of practice
Insurance
Regulations
Medicare Administrative Contractors (MACs)

- CMS uses MACs:
  - To process Medicare claims
  - Enroll health care providers in the Medicare program
  - Educate providers on Medicare billing requirements
  - Handle claims appeals
  - Answer beneficiary and provider questions
  - Section 1861 of the Social Security Act defines items and services for which Medicare “may” pay


Paying for Value Not Volume

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

Source: CMS; https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact‐sheets/2015‐Fact‐sheets‐items/2015‐01‐26‐3.html

Understanding the Language of Healthcare Billing

Basic structure of health care services payment

Language of Medicare Reimbursement

- HCPCS (Healthcare Common Procedure Coding System)
  - Level 1 – CPT (Current Procedural Terminology codes)
    - 5 numeric digits ex. 99605
  - Level 2 – Codes for product supplies and services not covered under CPT (ambulance and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician’s office)
    - Single alphabetical letter followed by 4 numeric digits
**CPT: Current Procedural Terminology codes**

Nomenclature to report medical services & procedures for payment

Maintained and owned by the AMA

Category 1 (3 categories)

- Evaluation and management (E&M): 99201–99499
- Example: 99211 incident to code
- Surgery: 10000–69990
- Pathology and laboratory: 80000–89967
- Medicine: 90281–99099; 99151–99199; 99500–99607
- Example: 99605–99607 medication therapy management services

**Level 2 HCPC codes**

- A-codes: Transportation, Medical Supplies, Misc. & Experimental
- B-codes: Enteral & Parenteral
- C-codes: Temporary Hospital Outpatient Prospective Payment System
- D-codes: Dental Procedures
- E-codes: Durable Medical Equip. (DME)
- G-codes: Temporary Procedures & Professional Services
- H-codes: Rehabilitative Services
- J-codes: Drugs Administered Other Than Oral Method, Chemotherapy Drugs
- K-codes: Temporary Codes for DME Regional Carriers
- L-codes: Orthotic/Prosthetic Procedures
- M-codes: Pathology and Laboratory
- N-codes: Pathological and Laboratory
- P-codes: Temporary Hospital Outpatient Prospective Payment System
- Q-codes: Durable Medical Equip. (DME)
- R-codes: Temporary Codes
- S-codes: Diagnostic Radiology Services
- T-codes: Private Payer Codes
- U-codes: State Medicaid Agency Codes
- V-codes: Vision/Hearing Services

**ICD-10 Codes: International Classification of Diseases, 10th Revision**

- For classifying diagnoses and reason for visits in all health care settings.
- Codes may be 3, 4, 5, 6 or 7 alpha/numeric characters
- Code or codes from A00.0 through T88.9, Z00-Z99.8
- 69,000 codes

**NPI number: National Provider Identifier**

- A unique 10-digit identification number issued to health care providers

**Why are RVUs important**

- Work RVU x GPCI + Practice expense RVU x GPCI + Professional liability RVU x GPCI = Total RVU

- Total RVU X conversion factor = $S for a CPT code

RVU: Relative Value Unit

GPCI's: Geographic Practice Cost Indices

**Resource-based Relative Value Scale (RBRVS)**

A system for describing, quantifying, and reimbursing physician services relative to one another.

- Physician work (time, technical skill & effort, judgment & stress)
- Practice expense (rent, wages)
- Professional liability insurance

Relative value unit (RVU) is assigned to each billing code

RVUs are determined by AMA Committee from physician survey

Based on Conversion factor that estimates the sustainable growth rate (SGR) and Geographic Practice Cost Index

Repealed by MACRA but still used by Commercial Payers

**Basic structure of health care services payment**

- CPT code
- ICD 10
- NPI number

Coding for billing
Billing Forms

PFS
- 837P
- CMS-1500

[link to PFS forms]

HOPPS
- 837I
- CMS-1450

[link to HOPPS forms]

Specific Billing Requirements

APC (Ambulatory Payment Classifications) Codes for HOPPS

Pays for most clinic and emergency department visits
- Outpatient payment groups based on HCPCS codes
  - Similar clinical services
  - Similar resource consumption

APC for Outpatient E/M service
- Describe use of space and supplies
- Describe involvement of hospital employees
- Example: APC code 5012 (was 0634) with HCPCS code G0463

Incident to Services Requirements

<table>
<thead>
<tr>
<th>Physician Office Services</th>
<th>Hospital Outpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>The service must be medically necessary, authorized &amp; documented.</td>
<td>Same</td>
</tr>
<tr>
<td>The authorized provider must provide subsequent services at a frequency that reflects active participation in managing the patient and plan of care.</td>
<td>Same</td>
</tr>
<tr>
<td>A financial relationship must exist between the auxiliary personnel and the eligible provider</td>
<td>An employee relationship must exist with the hospital as an employee, leased employee, or independent contractor</td>
</tr>
<tr>
<td>Services provided are within the scope of practice for the auxiliary personnel as dictated by the State practice act</td>
<td>Same</td>
</tr>
</tbody>
</table>

E/M: Evaluation and Management

[link to E/M guidelines]
Medicare E/M Code Documentation Requirements

Four levels of complexity or risk with medical decision-making

- Problem focused
- Expanded problem focused
- Detailed
- Comprehensive

<table>
<thead>
<tr>
<th>Assessments of care</th>
<th>Problem focused</th>
<th>Expanded problem focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of decision-making</td>
<td>Straightforward</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Established patient E/M codes</td>
<td>99211</td>
<td>99212</td>
<td>99213</td>
<td>99214</td>
</tr>
<tr>
<td>Usual length of visit (minutes)</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>25</td>
</tr>
</tbody>
</table>

CMS General Rules

“Medically necessary” as “services or supplies that are proper and needed for the diagnosis or treatment of a medical condition and are provided for the diagnosis, direct care, and treatment of the medical condition, meet the standards of good medical practice in the local area, and are not mainly for the convenience of the patient or the provider”

“Usual/Customary/Reasonable” is the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

Any enrolled provider accepting Medicare and Medicaid may not discriminate against Medicare/Medicaid patients, including providing a different service level between Medicare and commercial patients using the same billing code.

https://www.healthcare.gov/glossary/

Revenue Generation Options for Pharmacists

Billing Codes

- Payable to the Institution
  - Facility Fee APC code 5012

- Payable to the Eligible Provider
  - E/M established patient codes
  - Transition Care Management Codes (TCM)
  - Chronic Care Management Codes (CCM)
  - Complex Chronic Care Management Codes
  - Annual Wellness Visits

- Payable to Pharmacists
  - MTM codes
  - Diabetes self-management training (DSMT)
Assessments of Care

<table>
<thead>
<tr>
<th>Problems focused</th>
<th>Expanded problem focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decision-making</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Straightforward</td>
<td></td>
<td>Low</td>
<td>Moderate</td>
</tr>
<tr>
<td>Established pt E/M codes</td>
<td>99211</td>
<td>99212</td>
<td>99213</td>
</tr>
<tr>
<td>CC</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>HPI elements</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>ROS elements</td>
<td>N/A</td>
<td>N/A</td>
<td>Minimum of 10 elements</td>
</tr>
<tr>
<td>PFSH elements</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>PE elements</td>
<td>N/A</td>
<td>≥4 elements (1995)</td>
<td>&gt; 4 or 3 from chronic conditions (1997)</td>
</tr>
</tbody>
</table>

Challenges for Pharmacists

Pharmacists are not providers and do not qualify as auxiliary personnel?

“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.”

Marilyn Tavenner, Chief Administrator CMS


Challenges for Pharmacists

Pharmacists as auxiliary providers cannot bill higher than 99211

2016 Physician Fee Schedule – clarification noted in the background section regarding billing incident to physician by auxiliary personnel. It is clearly stated that the supervising provider should bill and get paid for incident to services provided by auxiliary personnel just as if the supervising provider were personally providing the service. Thus, pharmacists meeting all the incident to criteria and documentation criteria can have their services billed for using CPT 99211-99215 and paid at 100% the physician rate (or 85% of the NPP rate, if a NPP is supervising).

- Final Rule Posted in official Federal Register 11-16-15
  - Pages 71065-71068 and 71372

Challenges to Provider Reimbursement Codes

- Must meet incident to rules
- Cannot use established patient or CCM codes to provide MTM (Part D definition) services nor double dip
- Need to utilize several if not all the codes for financial sustainability
- Services provided must be within the state pharmacist scope of practice.

Other Provider Billing Options for Medicare Only

<table>
<thead>
<tr>
<th>Billing Options</th>
<th>CPT billing codes</th>
<th>Medicare Reimbursement (MI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Annual Wellness Visit</td>
<td>G0488 (initial, once in lifetime)</td>
<td>fixed per region, G0488 = $112.84</td>
</tr>
<tr>
<td></td>
<td>G0439 (subsequent, annual)</td>
<td></td>
</tr>
<tr>
<td>Transitional Care Management</td>
<td>99490 (within 7d D/C)</td>
<td>fixed per region, 99490 = $224.40</td>
</tr>
<tr>
<td></td>
<td>99495 (within 14d D/C)</td>
<td>99495 = $158.58</td>
</tr>
<tr>
<td>Chronic Care Management (CCM)</td>
<td>99490</td>
<td>PB: $41.14 monthly</td>
</tr>
<tr>
<td></td>
<td>99487 (60 min, monthly)</td>
<td>99487: $31.49 monthly</td>
</tr>
<tr>
<td></td>
<td>99489 (each additional 30 min to 99487)</td>
<td>99489: $47</td>
</tr>
</tbody>
</table>

Codes Pharmacist May Bill

- Medicare Part D
- MTM Codes
- DSMT

MTM CPT Codes

- 99605 (previously 0115T): New patient, face-to-face visit: Initial 15 minutes
- 99606 (previously 0116T): Established patient, face-to-face visit: Initial 15 minutes
- 99607 (previously 0117T): Face-to-face visit
  - For each additional 15 minutes
  - Used only in addition to 99605 or 99606
  - List separately

Diabetes Self-Management Training

The DSMT Program must have:

- Accreditation from AADE or ADA
- A partnership with a provider that can bill Medicare

The beneficiary must have:

- A diabetes diagnosis
- A written referral for DSMT


DSMT Codes

<table>
<thead>
<tr>
<th>Codes Medicare Reimbursement (MI)</th>
<th>Description</th>
<th>Allowable Units</th>
</tr>
</thead>
</table>
| G0108 - E52.56                    | Individual DSMT  
  - Medicare allows for 1 hour  
  - Billable in 30 minute increments (1 unit) | 2 units = 1 hour |
| G0109 - E41.28                    | Group DSMT  
  - 2 or more participants  
  - Medicare allows 9 hours  
  - Billable in 30 minute increments (1 unit) | 18 units = 2 hours |
| G0108/G0109                       | Medicare allows for any combination of 2 hours  
  - Billable in 30 minute increments (1 unit) | 4 units = 4 hour |

*CPT Codes that may be accepted by private insurers: 99600, 98961, 98962
Source: AADE, [https://www.diabeteseducator.org/docs/default-source/legacy-docs/resources/pdf/general/Diabetes_Services_Order_Form_Background_Final.pdf](https://www.diabeteseducator.org/docs/default-source/legacy-docs/resources/pdf/general/Diabetes_Services_Order_Form_Background_Final.pdf)

Other Billing Options

- Private Payers
  - Contractual relationships
    - Commercial payers
    - Self-Insured Organizations
  - Health Care Organizations
- State Based Programs
  - 10 states
- Cash
- CLIA-Waived Lab
It is all changing!

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- Repeals the Sustainable Growth Rate (SGR) Formula
- Changes the way that Medicare rewards clinicians for value over volume
- Streamlines multiple quality programs under the new Merit Based Incentive Payments System (MIPS)
- Provides bonus payments for participation in eligible Alternative Payment Models (APMs)

MIPS Value Based Payment

Quality Measures

- **168 Measures**

Example of measures:
- Use of high-risk medications in the elderly
- Medication management for people with asthma
- Documentation of current medications in medical record
- Adherence to antipsychotic medications
Improvement Component

Most participants: Attest that you completed up to 4 improvement activities for a minimum of 90 days.

Groups with fewer than 10 participants or if you are in a rural or health professional shortage area: Attest that you completed up to 2 activities for a minimum of 90 days.

Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model: You will automatically earn full credit.

APMs not in advanced AMP automatically earn credit

Examples of Improvement Activities

Population Management
- Participation in CMMI models such as the Million Hearts
- Participation in research that identifies interventions, tools or processes that can improve care of a targeted patient population.
- Manage medications to maximize efficiency, effectiveness and safety by:
  - Reconcile and coordinate medications and provide medication management
  - Integrate a pharmacist into the care team
  - Conduct periodic, structured medication reviews

Coordination of Care
- Implementation of practices/processes to develop regularly updated individual care plans for at-risk patients

Behavioral and Mental Health
- Depression screening and follow-up plan
- Tobacco use

Advancing Care Information Component

Complete the required measures for a minimum of 90 days:
- Security Risk Analyst
- e-Prescribing
- Provide Patient Access
- Send Summary of Care
- Request/Accept Summary of Care

Choose to submit up to 9 measures for a minimum of 90 days for additional credit.

Alternative payment models (APMs)

In 2017, under the Quality Payment Program, clinicians may earn a 5 percent incentive payment through participation in the following Advanced APMs:

- Comprehensive EHR Care Model (EHR adoption)
- Comprehensive EHR Care Model (non-EHR adoption)
- Medicare Shared Savings Program ACOs—Track 2
- Medicare Shared Savings Program ACOs—Track 3
- Next Generation ACO Model
- Oncology Care Model OCM (cancer risk management)

Integration Into Teams

Pharmacists’ Patient Care Process

[Diagram showing the patient care process]

Health Care Team: Complex Adaptive System

- Diverse individuals who learn together defined by interdependent connections that vary in intensity and may be inconsistent.

Mindfulness

- How members think
- How members work
- How members respond

Meaningful interactions

- Information exchange
- Problem-solving & dissolving
- Eliminate variation in training and status
- Learning & action occur together without hierarchy or excessive time

Strategies for Optimal Workflow

- Collect required patient information once.
- Minimize how often a patient is moved.
- Use evidence-based practices to reduce any disagreements in patient management.
- Eliminate unneeded or excessive activities.
- Eliminate any duplicative communication.
- Provided concise, consistent and clear information to the patient.

Evidence Based Workflow Design

- Team practicing at highest skill level
  - Pre-visit planning
  - Pre-visit laboratory testing
  - Sharing or splitting the documentation
  - Specific patient care delegated to team members
  - Flexible scheduling for ebbs & flows of patient demand

Improvised communication

- Internally amongst providers
- Between patients and clinic providers & staff
- Between external providers and clinic

Quality improvement projects around clinician concerns

References for work-flow and Teamwork Improvement


Are Pharmacists able to bill for their services?

- Yes
- No
- Maybe

Thank You

mkliet@midwestern.edu