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Key Concepts from Collaborative Practice Boot Camp Part 1

- Identify Key Stakeholders
- Perform Needs Assessment
- Establish relationships with colleagues – professionals and staff
- Identify the payor mix (what % medicare, vs medicaid vs private commercial)
- Develop Clinic Proposal
  - Reimbursement

Objectives

- Why is billing for services important
- Review basic billing terminology
- Review incident to billing
- Review facility fee billing
- Explain differences between incident to billing and facility fee billing

Objectives: Non-Facility Billing

- Free standing vs. hospital based clinics
- Review physician billing practices
- Establish relationships with billing department
- Incident to models
  - Medical Director
  - Attending of the Day
- Diabetes Self Management Training
- Billing Lab tests
- Example of Superbill or Chargemaster

Why is Billing Important?

- Your professional time is valuable
- Billing data provides objective information regarding workload
  - Especially useful when combined with patient outcomes
- Helps identify growth of the service over time
- Elevates profession of pharmacy as a unique discipline

Billing for Clinical Services

- Current Procedural Terminology (CPT®)
  - Coding System
  - Publication by AMA
- Descriptive terms and identifying terms for reporting medical services, procedures and lab tests
- Provides a uniform language to describe medical, surgical, and diagnostic services

Billing Forms

- Most payors follow Medicare billing practices
- CMS 1500
  - Billing Medicare Part B
  - Provider 1 is the physician
- CMS 1450 (aka UB-04)
  - Billing Medicare Part A
  - Provider 1 is the hospital

Requirements for "Incident To"

- The services are commonly furnished in a physician's office
- The physician must have initially seen the patient
- There is direct personal supervision by the physician of auxiliary personnel, regardless of whether the individual is an employee, leased employee or independent contractor of the physician
- The physician has an active part in the ongoing care of the patient

http://www.trailblazerhealth.com/Publications/Training%20Manual/incident_to.pdf

"Incident To" Supervision

- Direct supervision in the office setting does not mean that the physician/non-physician must be present in the same room with his aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction while the aide is performing services.

Billing Terminology

- Incident To Model
  - Evaluation and Management (E&M) code
    - Codes the visit
  - ICD-9 codes
    - Codes the diagnoses evaluated in the visit
- Pharmacist Billing Directly
  - Medication Therapy Management Codes
    - 99605, 99606, 99607
  - Payor Contracts

Pharmacist CPT codes

- 99605 - Medication therapy management service; initial assessment or intervention, individual, face to face with the patient, each 15 minutes
- 99606 - Reassessment or intervention, individual, face to face with the patient, each 15 minutes
- 99607 - Each additional 15 minutes (List separately in addition to the code for the primary service
  - Use in conjunction with 99605 and 99606

Part D Billing for MTM Services

- **Models for engaging MTMS**
- **Open access**
  - any pharmacist allowed to provide MTMS for a PDP
  - find patient in your own practice setting
  - determine patients MTMS eligibility
  - provide MTMS
  - submit claim
- **Closed Access**
  - must apply for provider status in PDP's MTM network
  - prior authorization required before MTMS provided
- **Managed Care-like provider networks**

Billing Office

- **Identify individuals who submit claims**
  - Billing Manager
  - Charge Entry clerks
  - Certified Professional Coder (CPC)
- **Most billing departments are unfamiliar with pharmacists in patient care**
  - Link them with billing departments that are familiar with pharmacist billing

Billing Office

- **Billing department works closely with Compliance department**
- **Medical Director role**
- **Establish regular meeting time to discuss billing procedures and follow-up when questions arise**

Diabetes Self-Management Training (DSMT)

- **Program must meet all national standards for diabetes education**
- **Reimbursable only if Recognized by an accrediting agency:**
  - American Diabetes Association (ADA)
  - American Assn of Diabetes Educators (AADE)
  - Indian Health Service (IHS)
- **Must be ordered by physician managing the diabetes**

Billing as DSMT

- **The "incident to" requirements… do not apply to DSMT services**
- **DSMT is a stand-alone provision**
- **10 hours of initial training**
- **2 hours per year thereafter**
- **Programs exist in multiple settings, can bill from**
  - Hospital
  - Dietician or Medical Director NPI
  - Community Pharmacy

http://www.trailblazerhealth.com/Publications/Training%20Manual/incident_to.pdf

Laboratory Tests

- **CLIA Waived Lab Certificate**
  - https://www.cms.gov/CLIA/downloads/HowObtainCertificateofWaiver.pdf
- **Point-of-Care Equipment (CholesTech LDX, GDX, DCA 2000, ImmunoDip, CoaguChek, Etc)**
- **Labs must have corresponding ICD code**
  - Non-matched lab will be denied

Date of Service: _____

Family Medicine Center

Pharmacotherapy Clinic

Patient Name: _____ MRN: _____

Insurance: _____ DOB: _____

CPT Codes:

ESTABLISHED PATIENTS

- ☐ 99211 – Brief
  - ☐ Add modifier 25 if E-code provided on same day
- ☐ 99212 – Limited
- ☐ 99213 – Detailed
- ☐ 99214 – Moderate
- ☐ 99215 – Comprehensive
- ☐ G0108 _____ units (1 unit = 30 minutes) Diabetes out-patient, self-management training, individual, per 30 minutes.
- ☐ G0109 _____ units (1 unit = 30 minutes) Diabetes out-patient, self-management training, group, per 30 minutes
- ☐ 99199 – Reduced fee
- ☐ 99354 – Extended visit , first hour
- ☐ 9903470 – Missed appt

OTHER

- ☐ 96372 – Therapeutic or diagnostic injection
- ☐ J1817 – SQ Insulin administration _____ (each 5 units of insulin dose given equals 1 unit billed)
- ☐ 93784 – Ambulatory blood pressure monitoring ($267) (recording, scanning analysis, interpretation, and report)
- ☐ 90471 – Immunization Admin (1st injection/first week)
- ☐ 90724 – Flu vaccine, ☐ G9008 – Admin of flu vaccine

MEDICATION THERAPY MANAGEMENT SERVICES (MTM)

- ☐ 99605 _____ units (initial visit, first 15 min)
- ☐ 99606 _____ units (follow-up visit, first 15 min)
- ☐ 99607 _____ units (each additional 15 mins)

Diagnosis (ICD-9 codes):

- ☐ V58.61 – Long-term (current) use of anticoagulants
- ☐ 250.00 – Diabetes, type I, controlled of complication or unspecified type
- ☐ 250.01 – Diabetes, type I, controlled
- ☐ 250.02 – Diabetes, type II, uncontrolled
- ☐ 250.03 – Diabetes, type I, uncontrolled
- ☐ 250.60 – Diabetes, type II, controlled w/ unspecified compl.
- ☐ 250.61 – Diabetes, type II, controlled w/ specified compl.
- ☐ 250.62 – Diabetes, type II, uncontrolled w/ unspecified compl.
- ☐ 250.63 – Diabetes, type I, uncontrolled w/ unspecified compl.
- ☐ 250.4_ – Diabetic Nephropathy
- ☐ 250.5_ – Diabetic Retinopathy
- ☐ 250.6_ – Peripheral Neuropathy
- ☐ 272.00 – Hypercholesterolemia (pure)
- ☐ 272.4 – Hyperlipidemia
- ☐ 271.9 – Glucose intolerance
- ☐ 790.29 – Abnormal glucose, other (rks Pre-diabetes)
- ☐ 401.10 – Hypertension, benign
- ☐ 401.00 – Hypertension, malignant

LAB

- ☐ 85610QW – PT/INR (Dx V58.61)
- ☐ 80061QW – Lipid panel (Dx 250.00)
- ☐ 84460QW – ALT (code V58.69) Drug _____
- ☐ 84450QW – AST (code V58.69) Drug _____
- ☐ 83036QW – HbA1c (Dx 250.00)
- ☐ 82947QW – Glucose (Dx 250.00)
- ☐ 82010QW – blood ketones quant. (Dx: 250.00)
- ☐ 82570QW – urine creatinine (Dx: 250.00)
- ☐ 82044QW – urine albumin (Dx: 250.00)
- ☐ 81003QW – urinalysis (Dx: 250.00)
- ☐ 81002QW – Urinanalysis – using reagent strip (Dx: 250.00)
- ☐ 85018QW – Hemoglobin (Dx: V58.61)
- ☐ 82947QW – Glucose (Hemocue) (Dx: 250.00)

MEDICAL NUTRITION THERAPY

- ☐ 97802 – Initial MNT _____ (1 unit = 15 min.)
- ☐ 97803 – MNT reassess _____ (1 unit = 15 min.)
- ☐ 97804 – MNT, group _____ (1 unit = 30 min.)
- ☐ G0270 – MNT, re-referral _____ (1 unit = 15 min.)
- ☐ G0271 – MNT, re-referral grp __ (1 unit = 15 min)

- ☐ 414.00 – Ischemic heart disease
- ☐ 413.10 – Angina w/ documented, not iatrogenic
- ☐ 427.31 – Atrial fibrillation
- ☐ 427.90 – Cardiac dysrhythmia, unspecified
- ☐ 428.0 – Congestive heart failure
- ☐ 435.99 – Transient ischemic attacks
- ☐ 440.0 – Atherosclerosis
- ☐ 440.80 – Atherosclerosis
- ☐ 444.22 – Arterial thrombosis/embolism- lower extremity
- ☐ 453.40 – Deep vein thrombosis, unspecified
- ☐ 459.81 – Venous insufficiency, unspecified

- ☐ 493.90 – Asthma
- ☐ 250.00 – Non-insulinal diabetes
- ☐ 996.02 – Heart valve prosthesis
- ☐ V03.82– Pneumococcal vaccine
- ☐ V04.81 – Influenza virus vaccine
- ☐ 277.7 – Metabolic syndrome
- ☐ Other: _____

Signature:

Attending Physician: ☐Frank Lawler, MD; ☐Dewey School, MD; ☐Rhonda Sparks, MD; ☐James Barnett, MD; ☐Steve Crawford, MD; ☐John Zubialde, MD; ☐Kathy Kelly, MD; ☐James Bend, MD_____

RTC: _____

Rev 2/09

Documentation Requirements

- **99211 – Level 1 Established patient**
  - SOAP note
  - Time spent with the patient
  - At least one objective parameter (wt, FSBS, INR, etc)
- **99212-99215 - Levels 2-5 require more documentation and physician face time**
  - North Carolina and New Mexico

Objectives—Facility Billing

1. What are the pharmacist billing options for cognitive services?
2. How does facility billing work?
3. Who can provide services under the facility Outpatient Prospective Payment System (OPPS) and at what level?
4. Do the pharmacists need to use the Medication Therapy Management (MTM) CPT codes?
5. What is meant by incident to?
6. What are the specific requirements of Medicare to provide incident to services?
7. What are the implications for pharmacists providing collaborative care?

Perspective on Cognitive Billing for Pharmacists

- Striving for provider status under Medicare Part B
- Still challenged by lack of understanding of a pharmacist's role in patient care by
  - Medicare
  - Other third-party payers
  - Hospital administration
  - Hospital billing, compliance, and legal staff

Recent Advances in Clinical Services

- October 2003—Medication Therapy Management Services (MTMS) under Medicare Part D
- February 2005—MTM CPT temporary codes approved (0115T, 0116T, 0117T)
- February 2007—MTM CPT permanent codes approved (99605, 99606, 99607) with status E
- March 2010—Health care reform bill passed and signed which expands MTMS

Reimbursement Options

- Direct Billing of Payer
  - Pharmacists may bill Medicare directly for
    - Immunizations
    - Durable Medical Equipment (DME)
    - Diabetes Education
    - MTMS
- Indirect Billing of Payer
  - "Back door billing"
  - "Incident to" physician services
    - Private physician office—professional fee level 1
    - Hospital-based clinic—facility fee

Billing Options for Clinical Services in Hospital-Based Clinics

- **Facility charge incident to physician care since practicing in hospital based clinics**
  - Individual visits
  - Same day as physician visit
- **Pharmacy Medication Therapy Management (MTM) CPT billing codes (99605, 99606, 99607)**
- **Fee for service**
- **Diabetes billing codes, smoking cessation?**

Facility Billing

- **Same day visits**
  - Professional bill from the physician or mid-level provider
  - Facility fee for the clinic staff services incident to the phy**sician**
- **Separate day visits**
  - Facility fee for the clinic staff services incident to the referring physician

Facility Billing

- **Facility Fee Structure**
  - **Hospital Outpatient Prospective Payment System (HOPPS)**
  - **Uses Ambulatory Payment Classification (APC) codes (600, 601, 602)**
  - **APC codes correspond to Current Procedural Terminology (CPT) Codes or Evaluation and Management (E&M) Codes**
    - 99211 and 99212 map to APC 600 (~$44)
    - 99213 maps to APC 601 (~$52)
    - 99214 and 99215 map to APC 602 (~$82)
- **Reimbursement**
  - **Professional fee—to the provider**
  - **Facility fee—to the hospital or provider-based department—covered only by Medicare**

Who can provide services under the facility OPPS?

Federal Register Vol. 74, No. 223 page 60551

"We do not specify the type of hospital staff (for example, nurses or pharmacists) who may provide services in hospitals because the OPPS only makes payment for services provided incident to physicians' services. Hospitals providing services incident to physicians' services may choose a variety of staffing configurations to provide those services…"

Example—E&M Form

Evaluation and Management Levels for Hospital
Rev. Date 10/07/2009

New Patient: Never seen at UHC, or not seen in the last 3 years at UHC. **Established Patient**: Seen within last 3 years at UHC.

Services

Abdominal binder application
Ace wrap application
Admit notification, paperwork and transport to unit
Advance Directives Assistance and Education
Adverse Reaction to Drug Immediate
Adverse Reaction to Drug Mild/Moderate
Anorectal manometry
Antibiotic Injection
Assist blood draw (ARUP only)
Arterial blood draw (non-ARUP)
Assist patient due to limited mobility
Assist with compiling patient forms
Includes medical history form, new patient form
Audiogram
Biofeedback
Bladder Irrigation
Bladderscan (PVR by scan)
Blood draw (only ARUP only)
Blood draw (non-ARUP)
Blood Pressure Check (BP)
Cast Removal
Cauterization Granulation Tissue
Central line care w/ or w/o dressing change
Collar application (Cervical)
Collect blood from implant ven access device
Collect blood cntrl or periph cath venous
Color vision examination
Conscious sedation
Cystostomy tube change
Doclot by lytic implant ven access device
Mask Fitting (complex) (Sleep Studies)
Medical Emergency Transport
Medication Reconnciliation
Mini- mental status exam
Nebulizer treatment
New GYN History
New OB History
Oral/nasal medications administered
Orthostatic Blood Pressure Complex
Orthostatic Blood Pressure Simple
Ortho tilting
Ostomy care
Oxygen admin./monitoring
Pain Mapping
Pap Smear exam assistance (G0101) ***
Peak Flow (not vital capacity)
Percutaneous tube care
Pelvic / breast exam asst. (G0101) ***
Pessary (insertion/removal (not new pessary)
PICC line care w/ dressing change
PICC line removal
PICC reposition
Pin Care
Pin Removal (non-buried, pull only)
Portable pump maintenance & refill
Port Cath w/ or w/o dressing change
Port Cath removal
Post Void Residual (PVR)
Prolonged monitoring, >30 mins.
Prostate cancer screening (G0102) ***
Urinary catheter, indwelling (simple)
Urinary catheter, foley (complicated)
Urinary catheter, Foley removal
Vaginal irrigation w/ medication
Vaginal irrigation w/ saline
Vaginal Douche (pre chart)
Vital Capacity
Vital Signs (mobile unit)
Voiding trials studies
Vulvar Cleansing (only)
Vul. Child Check
Wound care / Dressing change
Wound care management, non-selective
Wound care management, selective
Wound culture
Volume Passing w/o dressing

Education

Patient education >60 mins.
Patient education 15-30 mins.
Patient education 31-45 mins.
Patient education 46-60 mins.
Diet
(Use patient education for HIV or anticoagulation education)

Specimen Collection & Processing

Blood glucose test (device)
Candida testing
Glucose fingerstick
Hemoccult read in clinic (stool guiac, occult blood)
Hemmocult supplies & education (for outside lab)
KOH wet prep
Mono-spot
PKU Test (Phenylketonuria) (for outside lab)
Ph check
Rapid Strep Test
Skin test, unlisted antigen
Sputum collection to be sent to outside lab
Stool collection to be sent to outside lab
TB Test
Throat culture to be sent to outside lab
Urinalysis, partial (urine cipstick)
Urine collection / culture to be sent to outside lab
Urine pregnancy test
Rectal culture to be sent to outside lab
Vaginal culture to be sent to outside lab
Wound culture to be sent to outside lab

Notes:

Check guidelines for decision procedure.

** Active wound care management definitions:
Debridement and cleaning of wounds performed by clinician.
Dressing: Able to choose what tissue is removed (using scissors, tweezers, scalpel, wet rag for hydrogels, hydrocolloid, transport films and instruments.

Debridement Definitions:
Nonselective debridement: No ability to choose what tissue is debrided. Methods used may be mechanical (wet to dry dressings, wet rag, hydrogels, hydrocolloid, transparent films and instruments.

Selective debridement: Ability to choose what tissue is debrided by enzymes, wet dry dressing & sharps, sharp debridement (the surgeon, nurse practitioner, physician assistant, or other multiple wounds, with the best pain and wound control.
Sharp debridement

*** If minors in and met, bill Pap as level 2. Pelvis as level 3 and Prostate as level 2

Acuity Levels

Level 1: Cheeks, VS, Pain, history, chief complaint, etc.
Level 2: Level 2 is GREEN
Level 3 is SKY BLUE
Level 4 is YELLOW
Level 5 is RED
MCI EMS Fields - Order to equipment
Medication Order or Medical Supply Set (pulsed)

Prepared by: Revenue Integrity

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Rev. Date 10/07/2009

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Vaginal irrigation w/ saline
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Vital Signs (mobile unit)
Voiding trials studies
Vulvar Cleansing (only)
Vul. Child Check
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Wound care management, non-selective
Wound care management, selective
Wound culture
Volume Passing w/o dressing

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Patient education >60 mins.
Patient education 15-30 mins.
Patient education 31-45 mins.
Patient education 46-60 mins.
Diet
(Use patient education for HIV or anticoagulation education)

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Blood glucose test (device)
Candida testing
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Hemmocult supplies & education (for outside lab)
KOH wet prep
Mono-spot
PKU Test (Phenylketonuria) (for outside lab)
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Rapid Strep Test
Skin test, unlisted antigen
Sputum collection to be sent to outside lab
Stool collection to be sent to outside lab
TB Test
Throat culture to be sent to outside lab
Urinalysis, partial (urine cipstick)
Urine collection / culture to be sent to outside lab
Urine pregnancy test
Rectal culture to be sent to outside lab
Vaginal culture to be sent to outside lab
Wound culture to be sent to outside lab

Compression dressing (no supply)
Coordination of care (external to UHC)
Crisis intervention
Crutch Fitting
Discharge instructions (see education)
DME application (durable medical equipment)
Drain Removal
ECG / EKG
Ear Microscopy (incidental) *
Electronic analysis of pump
EMG
Enema Administration (single)
Fecal disimpaction (manual or multiple enemas)
Fetal monitoring < 1 hour
Fetal monitoring 1-4 hours
Fetal monitoring > 4 hours
Fetal Heart Tones
Filler Testing
Flu Shot only
Glucose 72-hour
Height Check Only
Heclock flush (maintenance only)
Heclock (IV start - KVO only)
Holter Monitor
Home BP unit / glucometer equipment check
Immunization
Implant port dressing change
Inject, intra-arterial
Inject, intra-venous
Injection (IM/SQ)
Injection, Allergy
Irrigate the ear
Irrigate the ear w/spoon or forceps
Irrigation of Eye (continuous)
IV medication admin (infusion)
IV for hydration
Mask Fitting (simple) (Sleep Studies)

Pulse Oximetry *
Pulse Oximetry with exercise*
Refill /maintain implanted pump / port
Routine foot care
Routine OB visit
Routine post-partum visit
Scope clean only
Skin Care
Snellan exam (eye chart)
Spirometry testing (equip required)
Spirometry, Incentive
Splint application any type, pre-formed
Supply only
Sugar Meter download data only
Suture / Staple removal Site_____
Tissue expansion
Topical medication administration
Trach tube change replace and clean
Tracheostomy care w/dressing change
Unnaboot Application
Urinary catheter, indwelling (simple)
Urinary catheter, foley (complicated)
Urinary catheter, straight (simple)
Urinary catheter, Foley removal
Vaginal Irrigation w/ medication
Vaginal Irrigation w/ saline
Visual Acuity Testing (eye chart)
Vital Capacity
Vital Signs (multiple sets)
Voiding trials- studies
Weight check only
Wet Chilo Check
Wound care / Dressing change
Wound care management, non-selective
Wound care management, selective
Wound check basic
Wound Packing and dressing

Notes:
* Check guidelines for incidental procedures.

** Active wound care management definitions:
(Debridement and cleaning of wounds performed by clinical staff.)
Selective: Able to choose what tissue is removed during debridement. Methods used may be hydrogels, hydrocolloid, transport films and instruments.
Square centimeter:_____
Non-selective debridement: Not able to choose what tissue is debridement. Methods used may mechanical debride by enzymes, wet-dry dressing & abrasion, soak and scrub. For multiple wounds, add the total size of all wounds.
Square centimeter:_____

*** If criteria is not met, bill Pap as level 2, Pelvic as level 3 and Prostate as level 2

Acuity Levels
Level 1: Check-in, VS, Pain, history, chief complaint, etc.
Level 2: Level 2 is GREEN
Level 3 is SKY BLUE
Level 4 is PLUM
Level 5 is RED
BOLDED ITEMS -
Orthostatic BP check simple
Pain mapping
Adverse reaction to drug mild/moderate
Patient Education >60 min
Excluded from E&M acuity level billing per guidelines

Prepared by: Revenue Integrity

Documentation for Facility Billing

- Facility dependent
- Document ICD-9 or 10 codes
- Documentation must support the level of billing
- Must show that the patient was assessed
  - For example, warfarin monitoring & assessing patient for bleeding and thrombosis
- Try to standardize—i.e. template if possible

May pharmacist bill any level of facility charge?

Federal Register Vol. 74, No. 223 page 60551

"A hospital may bill a visit code based on the hospital's own coding guidelines which must reasonably relate the intensity of hospital resources to different levels of HCPCS codes. Services…must be medically necessary and documented."

Billing Logistics

- Pharmacist sees the patients with or without the physician and completes E&M billing form & assigning appropriate ICD-9 or 10 codes for diagnosis
- Clinical documentation goes into the medical record to support the level of billing
- Billing form gets entered into the billing system
- Billing system converts this into the appropriate bill to payer (a CMS 1450 or UB-04 form to Medicare or other payers or direct bill to patient)
- UB-04 sent to Medicare Fiscal Intermediary (FI) or other payer
- Reimbursement or rejection letter received back
- Utilize appeals process if necessary

Do the pharmacists need to use the MTM CPT codes?

ASHP's analysis* finds that CMS does not require the use of the MTM codes by a pharmacist because

1) If a medication therapy management service is provided incident to a physician, the hospital should use "incident to" CPT codes 99211-99215.3 CMS's opinion on negating separate payment for medication therapy management applies to situations where there is not a separately payable, medically necessary, incident-to visit.

2) Under the hospital outpatient prospective payment system (OPPS), CMS does not recognize MTM as a distinct reimbursable pharmacist specific service when part of services provided to patients by hospitals.

*American Society of Health-System Pharmacists. Reimbursement for Pharmacist's Services in a Hospital-based, Pharmacist-managed Anticoagulation Clinic. Available on the web at http://www.ashp.org/DocLibrary/News/Reimbursed_Managed_Anticoagulation_Clinics.pdf (accessed January 19, 2009).

Do the pharmacists need to use the MTM CPT codes?

ASHP's analysis* finds that CMS does not require the use of the MTM codes by a pharmacist because:

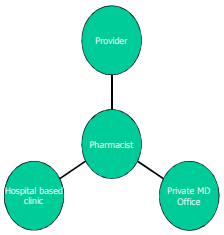
As stated in CMS FAQ 9655, updated April 6, 2009, "Although we do not make separate payment for medication therapy management services, the costs for this service are included in the costs of other services, such as clinic and emergency department visits, procedures, and diagnostic tests, furnished by the hospital to the beneficiary on the same day. Therefore, the costs for medication therapy management are reflected in OPPS payment rates, thereby providing payments to hospitals for these services."

*American Society of Health-System Pharmacists. Reimbursement for Pharmacist's Services in a Hospital-based, Pharmacist-managed Anticoagulation Clinic. Available on the web at http://www.ashp.org/DocLibrary/News/Reimbursed_Managed_Anticoagulation_Clinics.pdf (accessed January 19, 2009).

What is meant by incident to?

- The Outpatient Prospective Payment System (OPPS) only makes payments for services provided incident to physicians' services.
- Incident to requires direct supervision for all hospital outpatient therapeutic services whether on or off campus.

Billing perspective before 2010



Facility Billing—MD not needed en-suite

Incident to billing—MD en-suite

Who may supervise?

Supervising physician <u>or non-physician practitioner</u>

Federal Register Vol. 74, No. 223 page 60584

'the supervisory physician or nonphysician practitioner must have, within his or her State scope of practice and hospital-granted privileges, the ability to perform the service or procedure. We believe that our interpretation of the requirement means that the supervisor must be a person who is "clinically appropriate" to supervise the service or procedure.'

Who may not supervise? Ouch!

Federal Register Vol. 74, No. 223 page 60581-2

'We are not expanding the regulations further to allow supervision by pharmacists, registered nurses, or other medical professionals. These professionals are not recognized in the Social Security Act as providing services that would be physicians' services if performed by a physician and they may not enroll in Medicare as independent practitioners and receive payment directly for their professional services.'

What is direct supervision in a hospital based clinic?

Federal Register Vol. 74, No. 223 page 60579

For services furnished on a hospital's main campus, we proposed that direct supervision means that the supervisory physician or non-physician practitioner must be present on the same campus, in the hospital or the on-campus provider-based department (PDB) of the hospital as defined in §413.65, and immediately available to furnish assistance and direction throughout the performance of the procedure.

What is direct supervision in a hospital based clinic?

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"we assume the physician supervision requirement is met on hospital premises because staff physicians would always be nearby within the hospital."

What is direct supervision in a hospital based clinic?

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"For off-campus provider-based departments of hospitals, the physician or non-physician practitioner must be present in the off-campus PBD, as defined in §413.65, and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician or non-physician practitioner must be in the room when the procedure is performed."

http://www.cms.hhs.gov/transmittals/downloads/R116bp.pdf

Definitions—on or off campus

Main campus versus off-campus

'For purposes of the provider-based regulations, "campus" means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by CMS, to be part of the provider's campus.'

http://www.cms.hhs.gov/transmittals/Downloads/a03030.pdf

Definitions—Provider-Based Department (PBD)

Provider-Based Department

- **Departments may be defined to Medicare in an "attestation" that is voluntary.**
- **Caution against defining too broadly—still must meet "immediately available" to furnish assistance.**

Definitions—what is a "procedure"?

Procedure

Federal Register Vol. 74, No. 223 page 60585

'The use of the term "procedure" is intended to encompass all services and procedures and includes all components of a service or procedure furnished by a hospital to an outpatient…and covered and paid by Medicare, regardless of whether separate payment is made for those component services. …the term "service" may be substituted for the word "procedure"…'

Does the pharmacist have to see the patient the same day as the provider?

Federal Register Vol. 74, No. 223 page 60576

"Each occasion of a service by a non-physician does not need to also be the occasion of the actual rendition of a personal professional service by the physician responsible for the care of the patient."

"the physician must personally see the patient periodically and sufficiently often enough to assess the course of treatment and the patient's progress and, where necessary, to change the treatment regimen.''

What are the specific requirements of Medicare to provide incident to services?

- **Yearly order from physician to provide services—plan of care**
- **Labs should be ordered under the referring provider**
- **Avoid standing orders**

Plan of Care--Example

Plan of care for Thrombosis Service Anticoagulation Management:

Plan of Care Applies to: Patients referred to the University of Utah Health Care Thrombosis Service for Anticoagulation Management to include referrals from the following:

- University Healthcare Inpatient Thrombosis Service
- University of Utah Thrombosis Center
- Redwood Anticoagulation Clinic
- Huntsman Cancer Center Anticoagulation Management Service (AMS)
- Madsen Family Medicine or Clinic 2 Clinical Pharmacist

Definition(s): Thrombosis Specialist: A non-physician health care practitioner (e.g. pharmacist or nurse) trained in anticoagulation management.

Therapeutic Goal:

- To achieve and maintain the patient's coagulation test results in the range set by the patient's primary provider, referring provider, and/or the American College of Chest Physicians (ACCP) current guidelines.
- The initial dosage and expected duration of therapy will be determined by the referring provider or the inpatient anticoagulation service and will be consistent with institutional protocols, documented in the referral form.
- If the proposed dosage or duration of anticoagulation therapy does not agree with the current ACCP recommendations or institutional protocols, the case will be reviewed and approved by the medical director of the Thrombosis Service.

The thrombosis specialist will:

- Manage all aspects of the patient's anticoagulation therapy in collaboration with the referring or primary care provider (PCP) and the Thrombosis Service medical director(s).
- Initiate, adjust, or renew orders for the patient's anticoagulation therapy as appropriate, per established guidelines, to include the following:
  - Medications:
    - Warfarin
    - Unfractionated heparin (UFH)
    - Low molecular weight heparins
    - Fondaparinux
    - Dabigatran
    - Other antithrombotic agents
    - Antiplatelet agents
    - Vitamin K
  - Labs:
    - PT/INR, PTT
    - Anti-Xa levels
    - CBC
    - Urinalysis (UA)
    - Stool
    - Stool guaiac
    - HCG
- Evaluate each patient's risk for thromboembolism and appropriate use of antithrombotic medications.
- Monitor the patient's coagulation test results to determine the efficacy of treatment, and determine if therapeutic goals have been achieved. All coagulation test results will be evaluated.
  - Identify and assess the patient for variables that affect therapy and evaluate each individual result with respect to treatment goals.
  - Adjust the anticoagulant dose as needed when the therapeutic goals of treatment are not being met.
  - Notify the referring or primary care provider and/or the Thrombosis Service medical director(s) for all coagulation test results significantly out of range as per protocol.
  - Educate the patient/caregiver on therapeutic results, any dose changes, and any anticoagulation issues as determined per thrombosis specialist.
  - Order appropriate date/time for the next coagulation test.
    - During initiation and if the patient's coagulation test results are unstable (not at steady state), the patient will be followed at a minimum of once to twice weekly or as needed to ensure patient safety.
    - The monitoring interval will be increased at one-week intervals, as coagulation becomes more stable.
    - Tests within the therapeutic range may require less frequent monitoring.
    - Tests greatly out of range may require physician consultation and/or more frequent monitoring.
- Assess all drug-related problems and communicate findings (except for minor problems) to the referring or primary care provider such that the patient receives appropriate medical attention.
  - If the PCP or the referring provider cannot be reached in a reasonable amount of time, the medical director of the Thrombosis Service will be contacted.
  - The patient will be sent to the nearest appropriate care facility.
  - All adverse drug reactions (ADRs) or drug errors will be reported per the UHC protocol.
- Manage any clinically significant drug interactions and contact the physician as needed.
- Document all patient visits or contacts in the patient's medical record.
- Discontinue the patient's anticoagulation therapy when the patient's physician discontinues anticoagulant therapy or until the patient is discharged from the Thrombosis Service by other means.
- Review with the referring or primary care provider any unexpected questions or complications which arise during the patient's interaction with the Thrombosis Service.
- Direct outpatients with emergent medical issues to call 911 or go to the nearest emergency room.

This plan of care must be renewed no less than annually after consultation with the referring or primary care provider.

Provider Signature:_____**Date:**_____

Plan for Cognitive Pharmacy Billing

1. Assure each pharmacist has appropriate supervision as defined by Medicare
2. No billing where physician supervision cannot be established
3. Create a plan of care type referral that is updated yearly
4. Update current referrals to include plan of care
5. Do away with standing orders if possible
6. Standardize documentation as much as possible.
7. Educate staff and providers of these changes

How do we sustain practice in outpatient clinics?

- **Medicare patients can be charged a facility fee**
- **May bill MTM codes to those payers reimbursing**
- **May bill fee for service to other patients**
- **Cost avoidance—law suits, readmissions, ED visits, etc.**
- **Improved outcomes such as provider efficiency, disease state outcomes, improved exceptional patient experience, etc.**

Summary

- Reimbursement is critical to sustaining a clinical service
- Relationships with billing personnel is key and should be ongoing
- Role of the clinical pharmacist is important as health care reform moves forward

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QUESTIONS