

Identifying Profitable Areas of Expansion: Obtaining Reimbursement

Daniel E. Buffington, Pharm.D., M.B.A.

*Clinical Assistant Professor of Medicine, University of South Florida
College of Medicine, Tampa*

Having developed a private-practice model for providing pharmaceutical care and clinical consulting services, Dr. Daniel Buffington has learned a great deal about getting reimbursed for nondispensing services. The practice is in a 1,500-square-foot medical office adjacent to the university and is staffed by five full-time employees, including one pharmacist, as well as a part-time physician. Services, which are offered to local patients, hospitals, managed care organizations, and physicians, include drug information, clinical research, and disease-state management. The model is based on the traditional model used by medical practices.

When billing for services, it is important to clearly separate services from products. The types of services you might provide include

- Medication counseling
- Drug regimen review
- Drug interaction screening
- Pharmacokinetic consultations
- Nutritional support
- Pain management consultations
- Patient education counseling and materials

In setting up your service, be sure to have background documentation supporting the need for the service, as well as treatment plans or algorithms as guides to help ensure the provision of consistent care. Standard reporting formats should be used so that you document your services thoroughly and consistently. A plan for marketing your services is essential, as are referral networks for identifying patients. Components of the network may be

- Physicians
- Pharmacists
- Other health care professionals
- Patients
- Organized health care facilities

Although five to ten years ago there was little likelihood that a pharmacist would be reimbursed for nondispensing services, the percentage has risen to about 20% or 30%. In many cases, Dr. Buffington asserted, pharmacists are not getting paid because they are not seeking payment. A false assumption, he says, is that patients are not willing to pay out of pocket. In his practice, if an insurance company rejects a claim, patients are willing to pay the fee 85% of the time. "That is phenomenally high; we attribute it to the time we spend with patients and the fact that they perceive the value of the service," he said.

Important Tools of Medical Billing

Understanding basic forms and coding systems for medical billing is critical for success. Key among them:

- **Current Procedural Terminology (CPT) codes.** These were created by and are published in a manual put out by the American Medical Association. CPT codes are used not only by physicians but also by physical therapists, chiropractors, and other allied health providers to describe their services—including medical procedures, diagnostic tests, and surgeries. Certain codes in the manual are applicable to pharmacy services.
- **Resource Based Relative Value System (RBRVS).** Implemented in 1991, the RBRVS represents the thinking that *procedural* medicine and *cognitive* medicine are different and should have separate, distinct billing codes. Based on this system, a new section was added to the CPT manual for “evaluation and management” codes that relate to generic cognitive services and their delivery to both outpatients and inpatients.
- **International Classification of Diseases-9 (ICD-9) codes.** These are diagnostic codes required by all third-party payers before they can process a claim. ICD-9 codes are shorthand for certain diseases, tests, and procedures. They are published by PMI Corporation.

Evaluation and Management Codes

The codes in the CPT manual that run from 99201 to 99499 are for evaluation and management. The codes reflect five levels of service, ranging from initial visit with a new patient to a complex office visit with a return patient who has several medical problems and diagnoses. “These codes are generic; they don’t state the specific disease process, they state the degree to which you do certain things,” Dr. Buffington said. Evaluation and management codes relate specifically to history-taking, examinations, and medical decisions. Time spent with the patient is not the key variable in determining the appropriate code; rather, it is complexity of the history, exam, or decision-making. An example of high-complexity medical decision-making might relate to a patient with end-stage renal disease who was just discharged from the hospital after having his left leg amputated. He has two new prescriptions and is being transitioned back into the dialysis unit.

The CPT manual provides criteria to help practitioners determine the applicable level of care. Roughly 30 codes in the entire CPT manual are applicable to the services pharmacists provide, Dr. Buffington noted, ranging from 99201 to 99239.

Documentation and Forms

Documentation of your services is critical. As far as third-party payers are concerned, “if it wasn’t documented, it wasn’t done.” Even if you share a charting and documentation system with other types of practitioners in your facility, you need your own system as well so that you can be as thorough as possible.

- **Superbill:** This is a single-page form, in a grid format, that identifies all the services provided by that practice. The superbill, which expedites billing and quality assurance, is commonly used in physician practices and has been a successful tool in Dr. Buffington’s practice. After the practitioner fills it out, he or she turns it over to the staffer who handles billing, often referred to as the “medical reimbursement specialist.”
- **HCFA 1500 form:** This is the standard medical reimbursement claim form

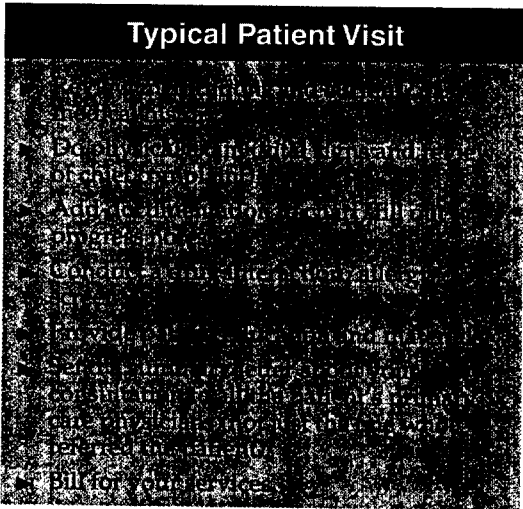
Evaluation and Management Codes

CPT Codes 99201-99499

| History | | | | |
|-----------------|-----------------|----------------------------|-------------------|--------------|
| Type | Chief Complaint | History of Present Illness | Review of Systems | Past History |
| Focus | | | | |
| Expanded | | | | |
| Detailed | | | | |
| Comprehensive | | | | |
| Complete | | | | |
| High complexity | | | | |

What To Include in Patient Charts

- Vital signs
- General appearance
- History of present illness
- Review of systems
- Billing and reimbursement information
- Medical history
- Signed consent forms for treatment and surgery
- Progress notes



used by third-party payers. It lists only a limited amount of information:

- Level of service provided
- Date of service
- Location of service
- General information on the patient
- ICD-9 code
- Provider information, including provider number

Although the HCFA 1500 form can be submitted by mail or electronically, Dr. Buffington recommends sending it by mail so you can attach a one- or two-page summary and justification of your services that answers key questions the payer is likely to ask if the claim is rejected. An “expected initial response” is for the payer to call and say, “We don’t pay pharmacists for this type of service.” Be persistent in resubmitting and justifying the claim because an initial rejection does not always mean that you won’t succeed.

- Third-party billing services: You can take advantage of the billing expertise of others, such as independent companies or your institution’s billing department, which will likely charge you about 7 to 15% of the amount they collect. The cost can be worth it because these specialists are well educated about reimbursement and are aggressive about going after claims. Also, they can provide you with valuable technical support for billing tasks.

Conclusion

The vast majority of billing for pharmaceutical care is fee-for-service rather than capitated. To be able to bill you need to follow these steps:

- Offer a consistent organized service.
- Document your care and results in complete, accurate medical records.
- Generate a superbill to summarize your services.
- Fill out a HCFA 1500 form reflecting the care delivered to the patient.
- Submit the claim.

“If you follow the traditional medical billing model, you’re following the path of least resistance,” Dr. Buffington said. To get started in providing pharmaceutical care services and seeking reimbursement for them, he recommends starting with one service, one patient, and the skills you’re most comfortable with. Try getting reimbursed by one payer, and experiment with approaches until you find the one that works. Bear in mind that patients and payers are far more willing to reimburse than pharmacists realize.

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American Society of Health System Pharmacists, Center on Pharmacy Practice Management. “Executive Summary: Building Your Non-Acute Pharmacy Service Areas”. Proceedings from the ASHP Second Annual Leadership Conference on Pharmacy Practice Management, October 1997. Pages 8-10.