PHARMACY REIMBURSEMENT

A guide for reluctant pharmacists

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Chapter

1

Hospital Inpatient Reimbursement

What are the different types of reimbursement?

There are several types of payer classes for inpatients, including Medicare, Medicaid, Managed Care, Indemnity Insurance and Self-pay.

Medicare A

The hospital bill for an inpatient with Medicare is paid according to the assigned Diagnosis Related Group (DRG). This will be discussed in detail later in the chapter.

Medicaid

The hospital bill for an inpatient with Medicaid is paid at a per-diem rate, usually a lower percentage of a Medicare DRG. Medicaid is state mandated, so different rules and payments apply depending on the state.

Managed Care

Managed Care is a method by which cost containment features are applied to a health plan either by limiting reimbursement to providers and/or reducing utilization. Specifically, capitation is used to pay a set dollar amount determined by a per member per month (PMPM) calculation. Sometimes bills are paid according to a contracted percentage of charges. Numerous plans fall into the managed care category, two of which are described below.

1. Health Maintenance Organization (HMO) – An organization that provides health care in return for pre-set monthly payments. Most HMOs provide care through a network of doctors and hospitals.

2. Indemnity – A traditional insurance medical plan that allows the patient to choose any provider. The enrollee pays a portion of their medical bills through a deductible and co-insurance.

Self- Pay

The hospital bill for an inpatient with self-pay status is paid for by the patient. However, often the patient is unable to meet his or her financial responsibility.

Does the hospital receive separate payments for drugs charged to inpatients?

NO. The only exception to this is blood factor products. Medicare will pay separately for them. All other payers do not.

So, if an expensive drug like Clolar® is administered and charged to an inpatient, the hospital does not get paid for it?

The hospital receives no separate reimbursement. The hospital gets paid in one lump sum according to the DRG or contract with insurance companies. An example of a contract with an insurance company is that the payment for the entire hospital stay = charges – 20%. Contracts differ with each payer.

What is a DRG?

DRG stands for "Diagnostic Related Group". It is used only in the inpatient setting when patients have Medicare or Medicaid. It is part of the Inpatient Prospective Payment System (IPPS). This is the **total payment** the hospital receives for the admission and treatment of Medicare and Medicaid inpatients. Other payers, such as insurance companies, generally follow the same reimbursement, but do not necessarily use the same term.

How is it calculated?

He following information for each patient is entered into a computer program provided by Medicare:

- length of stay
- type of hospital (teaching, community, disproportionate share status, etc.)
- diagnosis codes
- procedure codes
- salary index (based on employees' salaries)

Where can I find a list of DRGs?

http://www.cms.hhs.gov/AcuteInpatientPPS

Click "Acute Inpatient-Files for Download", then "DRG Relative Weights FY 07 Final Data". Below is a representation of the list.

DRG	TYPE	DRG title
1	SURG	CRANIOTOMY AGE >17 W CC
2	SURG	CRANIOTOMY AGE >17 W/O CC
3	SURG *	CRANIOTOMY AGE 0-17
4	SURG	NO LONGER VALID
5	SURG	NO LONGER VALID
6	SURG	CARPAL TUNNEL RELEASE
7	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC
8	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC
9	MED	SPINAL DISORDERS & INJURIES
10	MED	NERVOUS SYSTEM NEOPLASMS W CC
11	MED	NERVOUS SYSTEM NEOPLASMS W/O CC
12	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS
13	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA
14	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION
15	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT
16	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC
17	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC
18	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC
19	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC

If we don't get paid separately for drugs, how can I use DRG information to monitor drug usage?

One approach is to look at the most expensive DRGs reported on claims for your institution. Then, look at the cost of the drugs administered to these patients for any opportunities to contain cost, such as implementation of appropriate use guidelines. It is also important to compare the DRG payment to actual charges. This will give you an appreciation of the financial challenges your hospital faces.

If the hospital doesn't get paid separately for drugs anyway, why do we spend so much time monitoring their cost? Shouldn't we just simply treat patients with the most clinically effective drug therapy regardless of the cost?

That's the whole point. Our goal as pharmacists is to ensure appropriate drug therapy. This is a dual responsibility encompassing both cost and effectiveness. No patient should receive inferior treatment because of cost. At the same time, we should be good stewards of pharmaceutical expenditures and always be cognizant of effects on the bottom line. (Remember: Your salary is tied to the hospital's revenue!)

Chapter

2

OUTPATIENT REIMBURSEMENT

What are the different types of reimbursement ?

There are several types of reimbursement for outpatients, including Medicare Part B for hospital clinics and physician clinics/offices. Medicaid, Managed Care, Indemnity Insurance and self-pay are other types of reimbursement.

Medicare Part B

Medicare Part B coverage and payments differ according to the setting in which a patient is treated. However, there are some common methodologies each share. They include (1) the use of the average sales price + 6% methodology for payment and (2) the 20% co-payment the patient is responsible for paying, with the exception of some vaccines. The ASP is calculated by Medicare using data furnished by pharmaceutical manufacturers, and is updated quarterly.

Hospital Outpatient Clinics

The bill for an outpatient with Medicare is paid by a rate-per-service basis that varies according to the assigned Ambulatory Payment Classifications (APCs). This payment method is used only in the hospital outpatient clinic setting when patients have Medicare or Medicaid, and is part of the Outpatient Prospective Payment System (OPPS). This is the payment the hospital clinic receives for each visit by Medicare and Medicaid outpatients.

What is an APC?

APC stands for "Ambulatory Payment Classification". Other payers, such as insurance companies generally follow the same reimbursement, but do not necessarily use the same term.

An APC is essentially an outpatient DRG. Services in each APC are similar clinically and in terms of the services they require. A payment rate is established for each APC. Unlike DRGs,

hospitals may be paid for more than one APC per patient encounter. An APC can represent a service, procedure, or item, including some drugs.

Where can I find a list of APCs?

http://www.cms.hhs.gov/HospitalOutpatientPPS, Addendum A

Below is a representation of that list.

APC	Group Title
0001	Level I Photochemotherapy
0002	Level I Fine Needle Biopsy/Aspiration
0003	Bone Marrow Biopsy/Aspiration
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow
0006	Level I Incision & Drainage
0007	Level II Incision & Drainage
0748	Bleomycin sulfate injection
0750	Dolasetron mesylate
0751	Mechlorethamine hcl inj
0752	Dactinomycin actinomycin d
0753	Spectinomycn di-hcl inj
0759	Naltrexone, depot form
0760	Anadulafungin injection
0763	Dolasetron mesylate oral

What are pass-through drugs?

Pass-through Drugs

Certain drugs are granted “transitional pass-through” status for two, but no more than three years. These drugs are paid for separately, and are assigned a status indicator of “G”. (Status Indicators will be covered later in the chapter.) These drugs have their own APC code, and are paid for separately..

The pass-through drugs for calendar year 2007 are:

1. idursulfase injection
2. ranibizumab injection
3. Abatacept injection
4. Anadulafungin injection
5. Decitabine injection
6. Ibandronate injection
7. Micafungin injection
8. Ziconotide injection
9. Pegaptanib sodium injection
10. Togecycline injection
11. Hyaluraonodase recombinant
12. Fluocinolone acetonide implt.
13. Aprepitant oral
14. Clofarabine injection
15. Paclitaxel protein bound
16. Natalizumab injection

Does the hospital receive separate payments for drugs charged to hospital outpatients?

Yes and no. Some are bundled in the APC payment for the patient’s visit while others are paid for separately.

How do I know if a drug is paid for separately or not? Look at the SI (Status Indicator) listed in http://www.cms.hhs.gov/HospitalOutpatientPPS, Addendum B as described below.

<u>Indicators of OPPS Payment Status</u>

A

Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example:

- EPO for ESRD Patients
- Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital

B

Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).

C

Inpatient Procedures

Not paid under OPPS. Admit patient. Bill as inpatient.

D

Discontinued Codes

Not paid under OPPS or any other Medicare payment system..

E

Not paid under OPPS or any other Medicare payment system. .

F

Corneal Tissue Acquisition; Certain CRNA Services and Hepatitis B Vaccines

Not paid under OPPS. Paid at reasonable cost.

G

Pass-Through Drugs and Biologicals

Paid under OPPS; Separate APC payment includes pass-through amount.

H

(1) Pass-Through Device Categories

Separate cost-based pass-through payment; Not subject to coinsurance.

(2) Radiopharmaceutical Agents

Separate cost-based non-pass-through payment.

K

(1) Non-Pass-Through Drugs, Biologicals, and

Paid under OPPS; Separate APC payment.

(2) Brachytherapy Sources

Paid under OPPS; Separate APC payment.

(3) Blood and Blood Products

Paid under OPPS; Separate APC payment.

L

Influenza Vaccine; Pneumococcal Pneumonia Vaccine

Not paid under OPPS. Paid at reasonable cost; Not subject to deductible or coinsurance.

M

Items and Services Not Billable to the Fiscal Intermediary

Not paid under OPPS.

N

Items and Services Packaged into APC Rates

Paid under OPPS; Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.

P

Partial Hospitalization

Paid under OPPS; Per diem APC payment.

Q

Packaged Services Subject to Separate Payment Under OPPS Payment Criteria.

Paid under OPPS; Addendum B displays APC assignments when services are separately payable.

(1) Separate APC payment based on OPPS payment criteria.

(2) If criteria are not met, payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.

S

Significant Procedure, Not Discounted when Multiple

Paid under OPPS; Separate APC payment.

T

Significant Procedure, Multiple Reduction Applies

Paid under OPPS; Separate APC payment.

V

Clinic or Emergency Department Visit

Paid under OPPS; Separate APC payment.

Y

Non-Implantable Durable Medical Equipment

Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.

X

Ancillary Services

Paid under OPPS; Separate APC payment.

How are drugs without pass-through status paid?

This information can also be found in the aforementioned Addendum B.

Drugs that have not been granted pass-through status are paid for in one of two ways:

1. Packaged

Reimbursement for drugs that cost less than $55.00/administration is packaged into the payment within the payment for the associated service or separate payment (individual APCs). Patients are normally asked to pay a 20% co-pay.

2. Non-packaged

Drugs with an administration cost of greater than $55.00 are paid for separately and are assigned APCs.

How do I know how much a drug is reimbursed?

http://www.cms.hhs.gov/HospitalOutpatientPPS, Addendum B

Below is a representation of the list.

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment	*Indicates Change
J0470	Dimecaprol injection	CH	N						
J0475	Baclofen 10 MG injection		K	9032		198.27		39.65	*
J0476	Baclofen intrathecal trial		K	1631		69.54		13.91	*
J0480	Basiliximab		K	1683		1377.97		275.59	*
J9062	Cisplatin 50 MG injection		B						
J9264	Paclitaxel protein bound		G	1712		8.73		1.75	
J7320	Hylan G-F 20 injection	CH	D						
J3520	Edetate disodium per 150 mg		E						

Physician Owned Outpatient Clinics and Offices

In this setting, physicians are paid according to a fee schedule, and Medicare Part B drugs are not paid on a cost or prospective payment Like OPPS drugs, they are paid for based on the Average Sales Price (ASP) + 6%. The ASP is calculated by Medicare using data furnished by pharmaceutical manufacturers, and is updated quarterly. It should be noted that while hospital outpatient clinics and physician owned clinics and offices use the ASP methodology, they do not always cover the same drugs.

Where can I find a list of ASPs ?

http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2007aspfiles.asp#TopOfPage, Then click "2007 ASP Drug Pricing Files"

Below is a representation of the list.

Payment Allowance Limits for Medicare Part B Drugs

Effective January 1, 2007 through March 31, 2007

HCPCS Code	Short Description	HCPCS Code Dosage	Payment Limit
J0470	Dimecaprol injection	100 MG	$25.511
J0475	Baclofen 10 MG injection	10 MG	$198.270
J0476	Baclofen intrathecal trial	50 MCG	$69.536
J0480	Basiliximab	20 MG	$1,377.965
J9062	Cisplatin 50 MG injection	50 MG	$12.257
J9264	Paclitaxel protein bound	1 MG	$8.666

Note 1: Payment allowance limits subject to the ASP methodology are based on 3Q06 ASP data.

Note 2: The absence or presence of a HCPCS code and the payment allowance limits in this table does not indicate Medicare coverage of the drug. Similarly, the inclusion of a payment allowance limit within a specific column does not indicate Medicare coverage of the drug in that specific category. These determinations shall be made by the local Medicare contractor.

What constitutes a drug being labeled as not otherwise classified (NOC)?

NOC Drugs are those that are not paid on a cost or prospective payment basis but are not listed in the quarterly ASP drug pricing files.

Where can I find a NOC drug list?

http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2007aspfiles.asp#TopOfPage, Then click "January 2007 ASP NOC Pricing File"

Below is a representation of the list.

Payment Allowance Limits for Medicare Part B Not Otherwise Classified (NOC) Drugs

Effective January 1, 2007 through March 31, 2007

Drug Generic Name	Dosage	Payment Limit
Aztreonam	500 MG	$11.963
Bumetanide	0.25 MG	$0.223
Propofol	10 MG	$0.171
Protonix	40 MG	$3.995
Valproate Sodium	100 MG	$1.169
Vasopressin	20 UNITS	$2.027

Medicaid

The bill for a visit from an outpatient with Medicaid is paid according to the rules of the individual state that apply to the different levels of Medicaid coverage. Outpatient drugs administered to Medicaid patients in a physician's office are usually not covered when billed from that location. However, they may be covered if a prescription for the same drug is filled by an outpatient pharmacy.

Managed Care

Managed Care plans pay for outpatient visits and administered drugs depending on the contracted plan. For instance, a contract may include that a certain managed care plan will pay "charges – X%".

Self- Pay

The hospital bill for an outpatient with self-pay status is paid for by the patient. Often the patient is unable to pay.

Chapter

3

HCPCS CODES

What are HCPCS codes?

HCPCS stands for "Healthcare Common Procedure Coding System". The system is divided into Levels I and II codes.

What are Level I codes?

Level I is comprised of CPT (Current Procedural Terminology) codes maintained by the American Medical Association. They are primarily used to identify medical services and procedures provided by physicians that are billed to both public and private insurance companies.

What are Level II codes?

Level II codes identify products, supplies, and services not included in the CPT codes. Drugs are included in this level. HCPCS Level II codes are used only for Medicare covered patients in a hospital outpatient setting, not in a physician owned clinic or office. Please note that the existence of a code does not guarantee coverage.

Where can I find a list of HCPCS Level II codes?

http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS?list.asp#TopOfPage

From there, three lists are available for download:

1. 2007 Alpha-Numeric HCPCS file

Below is a representation of that list::

HCPC	Long Description	Short Description
J0470	INJECTION, DIMERCAPROL, PER 100 MG	Dimecaprol injection
J0475	INJECTION, BACLOFEN, 10 MG	Baclofen 10 MG injection
J0476	INJECTION, BACLOFEN, 50 MCG FOR INTRATHECAL TRIAL	Baclofen intrathecal trial
J0480	INJECTION, BASILIXIMAB, 20 MG	Basiliximab
J9062	CISPLATIN, 50 MG	Cisplatin 50 MG injection
J9264	INJECTION, PACLITAXEL PROTEIN-BOUND PARTICLES, 1 MG	Paclitaxel protein bound
J7320	HYLAN G-F 20, 16 MG, FOR INTRA-ARTICULAR INJECTION	Hylan G-F 20 injection
J3520	EDETATE DISODIUM, PER 150 MG	Edetate disodium per 150 mg

2. 2007 Alpha-Numeric Index

Below is a representation of that list:

2007 HCPCS Alpha-Numeric Index

Abarelix, J0128
Abatacept, J0129
Abciximab, J0130Acetazolamide sodium, J1120
Acetylcysteine, inhalation solution, J7608
Acetylcysteine, injection, J0132
Acyclovir, J0133
Adalimumab, J0135

3. 2007 Table of Drugs

Below is a representation of that list:

A

Abarelix 10 mg J0128
Abatacept 10 mg J0129
Abciximab 10 mg IV J0130
ACTH, see Corticotropin
Acthar, see Corticotropin
Actimmune, see Interferon gamma 1-B Acetazolamide sodium up to 500 mg IM, IV J1120