

Pharmacist Reimbursement for Anticoagulation Services

Michael Smith, Pharm.D., BCPS, CACP
Clinical Coordinator
William Backus Hospital

Faculty Disclosures

- Michael Smith, PharmD, BCPS, CACP has no actual or potential conflict of interest associated with this presentation
- In the past, he was on the Speakers Bureau of Glaxo Smith Kline but is no longer since 2013.
- Please note, the taped version has incorrect information.

Learning Objectives

- Identify the reimbursement issues with a pharmacist-run anticoagulation service or clinic
- Describe the process for billing for anticoagulation services
- Identify challenges and obstacles for reimbursement issues for anticoagulation services
- Discuss solutions to the challenges of reimbursement for pharmacist-run anticoagulation services

Sources of Payment

- Who- Payer
 - Medicare, Medicaid, Private insurance
- What- Service
 - INR testing, Evaluation and Management (E/M) services
- Where-Location
 - Physician's office, Hospital based outpatient clinic

Reimbursement

- Pharmacist are not providers according to Medicare, therefore, they cannot bill directly
- Anticoagulation management is NOT considered Medication-Therapy-Management (MTM) by Medicare

Reimbursement

- Physician's Office
- "incident to" physician services
 - Allows for physicians to bill for services provided by non physicians
 - Physician receives the payment

Reimbursement

Physician's Office

- Providers (NPs, PAs) may bill any level of service that is appropriate to the care that was rendered
- Pharmacists services may only be billed as a low-level office visit (code 99211)

Reimbursement

Hospital Based Clinic

- Hospital Outpatient Prospective Payment System (HOPPs)
 - "Facility Fee" or "Technical Fee"
- Hospital bills for services provided by any healthcare practitioner*

*Within their scope of practice by state license and institution policy.

Reimbursement

Hospital Based Clinic

- Billing level is set by the institution
- Must be:
 - Three levels
 - Approved by administration
 - Based on time and/or complexity
 - Must be reasonable

Reimbursement

For both "incident to" and HOPPs:

- Billable service must be reasonable and medically necessary
- Ordered by a physician
- Include an Evaluation and Management (E/M) component.
- Under direct supervision of a physician

Reimbursement

- Evaluation and Management
 - Assessing the patient for adverse effects, drug interactions, compliance, general health, and their current INR value
 - Managing those issues, adjusting the dosage regimen if needed and providing education
- This is the expertise you are providing
- This is what justifies your bill and must be appropriately documented

Reimbursement

- Documentation must include:
 - Indication for warfarin therapy
 - Target INR level and range
 - Date of visit
 - Current INR value
 - Current dose and any recommended changes
 - Statement of a "face to face" encounter
 - Name and credentials of person providing the service
 - Education provided to the patient

Reimbursement

- Other recommended documentation
 - Vital signs
 - Patient's weight
 - Date of next visit

Reimbursement

Direct Supervision by a Physician

- 2010 Rule: Physician assistants and nurse practitioners may provide supervision if the service is within their scope of practice
- Must be immediately available to provide assistance and direction if needed

Reimbursement- Direct Supervision

- In hospital/on hospital campus
 - Supervisor must be in the hospital or in the on-campus Provider-Based-Department (PBD)
- Off campus- Supervisor in the PBD
 - PBD does not necessarily mean the actual department or suite. The facility's Medicare application will define the PBD

Reimbursement - How To

Physician Office "incident to" Billing

- Billed by the physician, physician receives the payment
- Pharmacist must be employed by the physician
- CPT code 99211 (low level) on CMS Professional Billing Form 1500

Reimbursement- How To

HOPPs "Facility Fee"

- Hospital bills for the use of its facility
- A Physician (medical director, referring MD, PCP) is referenced on the bill
- Hospital policy determines the criteria for billing at different levels, but must reasonably relate to the intensity of the resources needed

Reimbursement

CPT codes are converted to the corresponding Ambulatory Payment Classification and billed on form UB92

CPT Code	APC Code	Description
99211	600	Low level outpatient visit
99212		
99213	601	Mid level outpatient visit
99214	602	High level outpatient visit
99215		

Note, these codes are for "established" patients. Codes 99201-99205 are for "new" patients. "New" is defined as new to your healthcare system, not just your clinic. They also convert to the same ACP codes of 600-602

Reimbursement

Medicaid

- Must contact your state
- Likely to be billed by a similar process as Medicare and reimbursed at a fixed rate for outpatient services

Reimbursement

Private Insurers

- Each payer may have a different process
- Must contact them to discuss proper billing procedure and necessary codes
- May need prior authorizations
- Patient is likely to incur a co-pay for each visit

Reimbursement

What about the laboratory fee?

- "Clinical Laboratory Fee Schedule"
- CPT 85610: "Prothrombin Time"
 - Use "QW" modifier if using a CLIA-waived testing device (most POC devices)
- ICD9 V58.61 "long term use of anticoagulants"

Reimbursement

- Common pitfalls
 - Trying to bill for medication therapy management (MTM)
 - Trying to bill for non- "face to face" encounters, not including a statement that 'proves' the patient was there
 - Expecting to be paid what you bill
 - Must be consistent with your billing levels

Reimbursement

References

- <http://www.cms.hhs.gov/hospitaloutpatientPPS/>
- http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=4160&p_created=1109953141
- http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3542&int_NumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&choOrder=date
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