Navigating the Future:

The Rise of Pharmacy Clinical Services Billing

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Disclosures

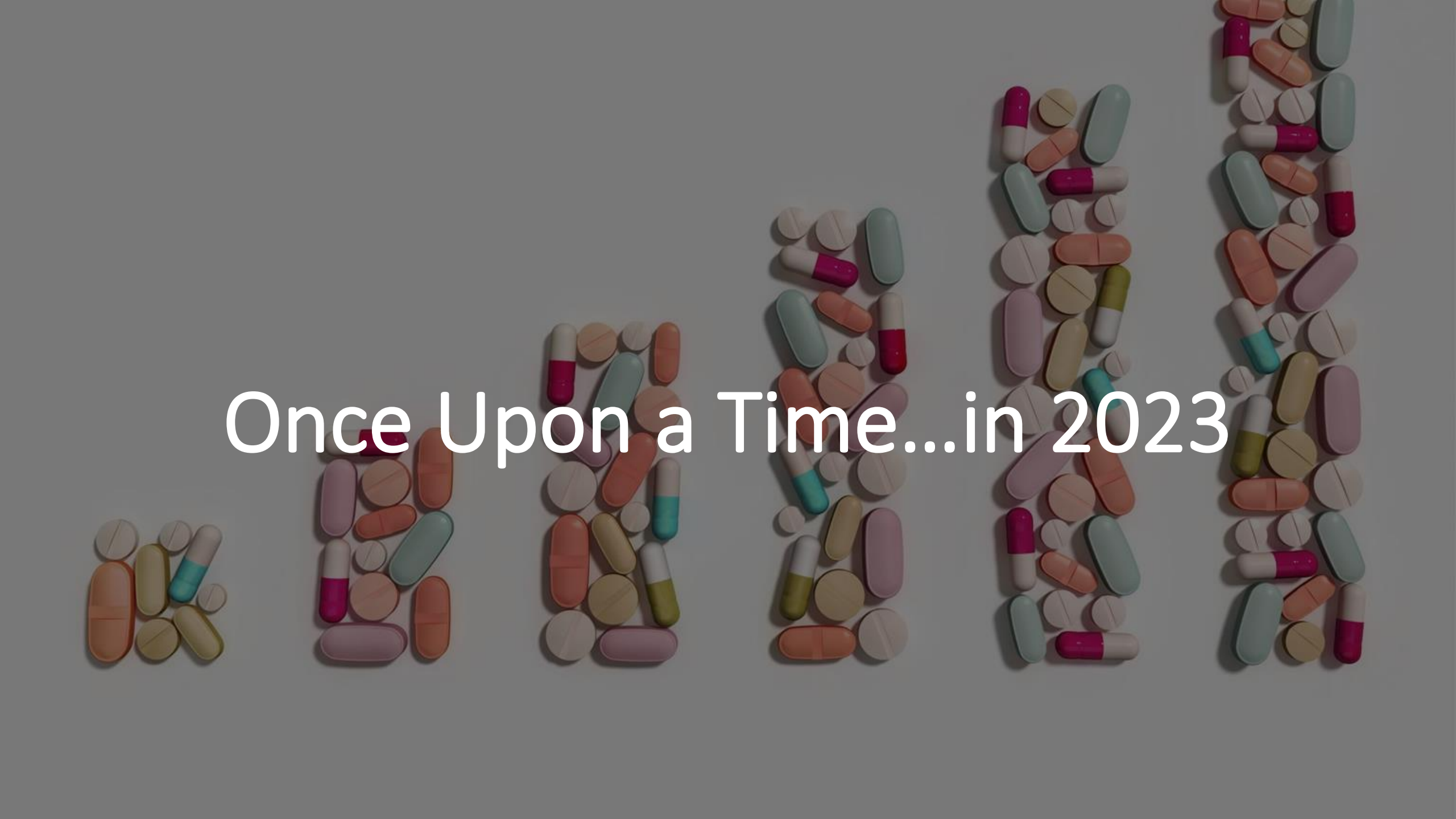
- Brody Maack has no relevant financial relationships to disclosure.

- Off-label use of medications will not be discussed during this presentation.

Learning Objectives

At the completion of this activity, the learner will be able to:

- **Summarize** the impact of HB 1095 on comprehensive medication management billing.
- **Outline** the fundamental elements of medical billing for pharmacists.
- **Examine** billing practices within the Pharmacy Service Enhancement Project (PSEP).
- **Apply** lessons learned from Pharmacy Service Enhancement Project (PSEP) to plan for medical billing in pharmacy practice.


Once Upon a Time…in 2023

HB 1095 → NDCC 26.1-36.11

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Sixty-eighth
Legislative Assembly
of North Dakota

FIRST ENGROSSMENT
with Senate Amendments
ENGROSSED HOUSE BILL NO. 1095

Introduced by

Representative Weisz

A BILL for an Act to create and enact chapter 26.1-36.11 of the North Dakota Century Code, relating to the inclusion of comprehensive medication management services in health benefit plans.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-36.11 of the North Dakota Century Code is created and enacted as follows:

HB 1095 → NDCC 26.1-36.11

- NDCC 26.1-36.11-02:
  - "A health carrier ***shall provide coverage*** for licensed **pharmacists** to provide **comprehensive medication management** to eligible enrollees who elect to participate in a comprehensive medication management program."

HB 1095 → NDCC 26.1-36.11

- **Comprehensive Medication Management**: ***defined***
  - "Medication management pursuant to a standard of care that ensures each enrollee's medications, both prescription and nonprescription, are individually assessed to determine each medication is appropriate for the enrollee, effective for the medical condition, and safe, given the comorbidities and other medications being taken and able to be taken by the enrollee as intended."

HB 1095 → NDCC 26.1-36.11

- **Comprehensive Medication Management**: ***includes***
  1. Performing or obtaining necessary assessments of the enrollee's health status
  2. Formulating a medication treatment plan
  3. Monitoring and evaluating the enrollee's response to therapy, including safety and effectiveness
  4. Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events
  5. Providing verbal or written, or both, counseling, education, and training designed to enhance enrollee understanding and appropriate use of the enrollee's medications
  6. Providing information, support services, and resources designed to enhance enrollee adherence with the enrollee's therapeutic regimens
  7. Coordinating and integrating medication therapy management services within the broader health care management services being provided to the enrollee

HB 1095 → NDCC 26.1-36.11

- **Comprehensive Medication Management**: ***includes***
  8. Initiating or modifying drug therapy under a collaborative agreement with a practitioner in accordance with section 43 - 15 - 31.4
  9. Prescribing medications pursuant to protocols approved by the state board of pharmacy in accordance with subsection 24 of section 43 - 15 - 10
  10. Administering medications in accordance with requirements in section 43 - 15 - 31.5
  11. Ordering, performing, and interpreting laboratory tests authorized by section 43 - 15 - 25.3 and North Dakota administrative code section 61 - 04 - 10 - 06

HB 1095 → NDCC 26.1-36.11

- **Eligible enrollee criteria:**
  - The enrollee is taking five or more chronic medications
  - The enrollee was admitted to a hospital with one of the following diagnoses:
    - (1) Heart failure;
    - (2) Pneumonia;
    - (3) Myocardial infarction;
    - (4) Mood disorder; or
    - (5) Chronic obstructive pulmonary disorder;
  - The enrollee has active diagnosis of comorbid diabetes and:
    - (1) Hypertension; or
    - (2) Hyperlipemia

HB 1095 → NDCC 26.1-36.11

What does this mean for us?

Which of the following are TRUE with regard to HB 1095 "CMM Reimbursement Law"?

A. Comprehensive medication management (CMM) is the same service as medication therapy management as designated by Medicare.
B. HB 1095 effectively expands the scope of practice of pharmacists in North Dakota.
C. HB 1095 will require insurance carriers to provide coverage for CMM provided by pharmacists in North Dakota.
D. Patients must be taking 10 or more medications to be eligible for CMM, per HB 1095.

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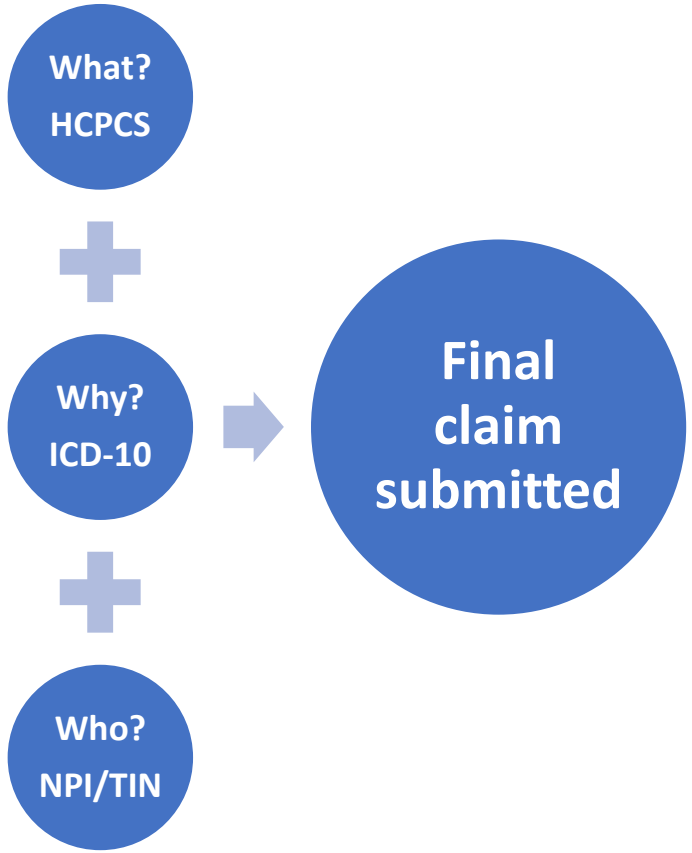
Medical Billing 101

Payers in Healthcare

- Commercial
- State Government
- Federal Government
- Self-Pay

Billing Definitions



Adapted from reference 1: Kliethermes MK, et al. ASHP 2021:55-88.

Billing Definitions

- **Healthcare Common Procedure Coding System (HCPCS)**
  - Describe **service, product, procedure** provided to the patient
  - Entered by clinician after the service is performed, submitted

Level 1

- Contains **CPT codes** (five digit numbers)
- Owned by AMA, licensed for CMS

Level 2

- Begin with letter, followed by numbers (e.g. G0108)
  - For products/services not included in Level 1
  - Range from A to V
  - **G codes** are for professional services

Kliethermes MK, et al. ASHP 2021:55-88.[1]

Billing Definitions

- **Healthcare Common Procedure Coding System (HCPCS)**
  - Examples:
    - Level 1 CPT Codes

Category 1 (for patient care)	Category 2
Evaluation and Management (E/M) (e.g. 99211-99215)	Tracking codes intended for performance measurement (end with ‘F’)
Medicine (including MTM codes 99605-99607)	**Category 3**
Others included: Anesthesia, Surgery, Radiology, Pathology/laboratory	Temporary codes for emerging technology (end with ‘T’)

Adapted from reference 1: Kliethermes MK, et al. ASHP 2021:55-88.

Billing Definitions

- **Healthcare Common Procedure Coding System (HCPCS)**
  - Examples:
    - Level 2 CPT Codes

A codes: Transportation, medical supplies, miscellaneous and experimental
B codes: Enteral and parenteral therapy
C codes: Temporary hospital outpatient prospective payment system
D codes: Dental procedures
E codes: Durable medical equipment (DME)
G codes: Temporary procedures and 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: Medical services
P codes: Pathology and laboratory
Q codes: Temporary codes
R codes: Diagnostic radiology services
S codes: Private payer codes
T codes: State Medicaid agency codes
V codes: Vision/hearing services

Adapted from reference 1: Kliethermes MK, et al. ASHP 2021:55-88.

Billing Definitions

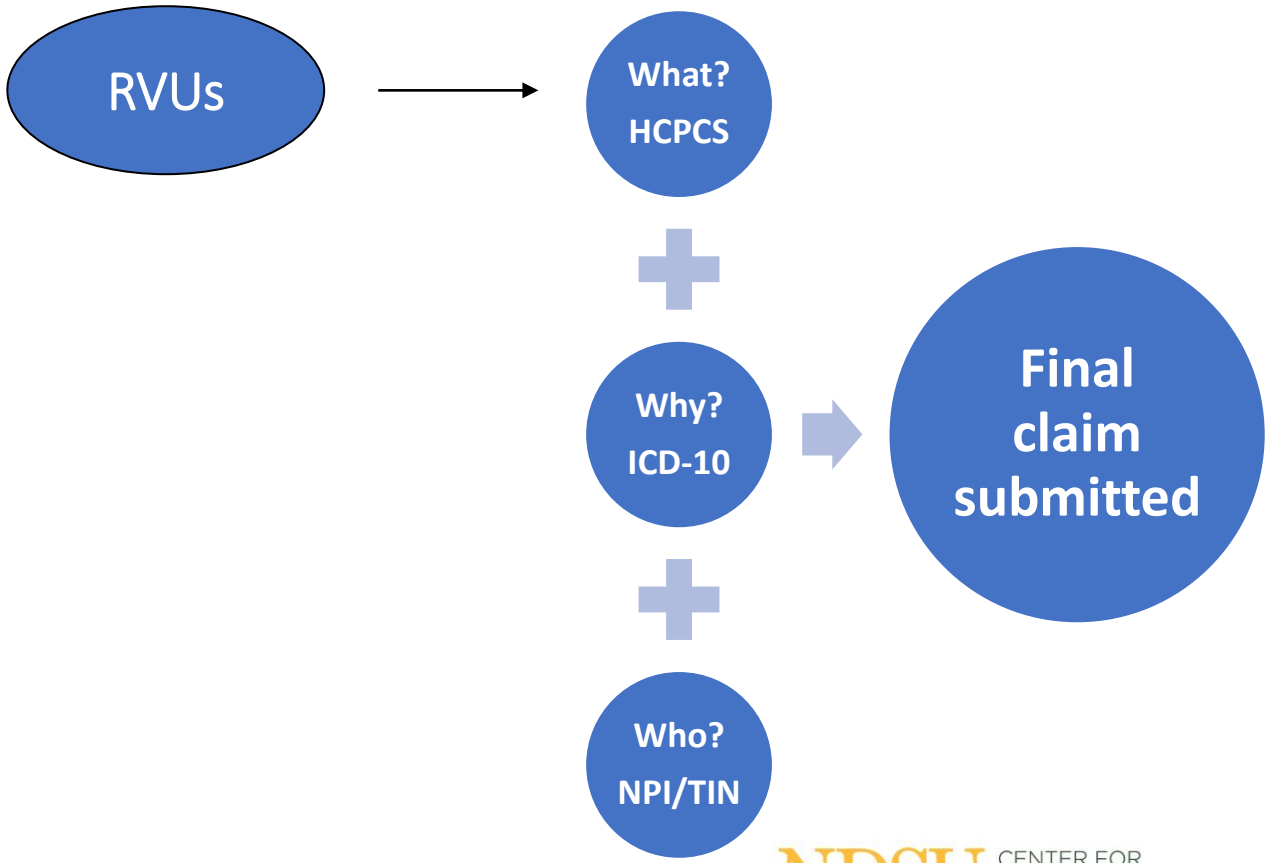
- **International Classification of Diseases, 10th Revision (ICD-10) code[2]**
  - **Diagnosis codes** maintained by WHO, directed by United Nations
  - Example:
    - Z72.0: Tobacco use
    - F17.211: Nicotine dependence, cigarettes, in remission

Billing Definitions

- **National Provider Identifier (NPI) and Tax Identification Number (TIN)[2]**
  - **NPI: Identifies the provider** of billable service
    - 10-digit number
    - Administered by CMS
  - **TIN: Identifies healthcare organization** of billable service
    - Organization must inform CMS of NPI's associated with TIN

Billing Definitions

- **Healthcare Common Procedure Coding System (HCPCS)**



Adapted from reference 1: Kliethermes MK, et al. ASHP 2021:55-88.

Billing Definitions

- **Resource-Based Relative Value Scale[2]**
  - Payment modifier system
    - Modifies payment based on variability of provider resources/skills
    - Practice maintenance costs: e.g. urban vs. rural
    - Level of skill, judgement, stress: e.g. neurosurgery vs. common cold
    - Medical liability costs
  - **Relative Value Units (RVUs)**
    - **Conversion factor** added to CPT codes
    - Based on geographic location
    - Results in *variable* reimbursement throughout country for each code

Billing Definitions

- **Modifiers[2]**
  - Typically required when providing telehealth services
    - ***Added to codes*** used for face-to-face encounters
  - Provide additional information
    - Can describe why multiple codes are billed or modality of service

Billing Definitions

- **Billing Forms[2]**
  - Used for submitting bills to payers
  - Medicare Part A: CMS-1450 form (aka: UB04, 8371 [electronic version])
  - Medicare Part B: CMS-1500 form (aka: 837P [electronic version])

Which of the following are TRUE with regard to medical billing practices?

A. Pharmacists can submit CPT codes without needing to include a diagnosis (ICD) code.
B. A modifier may be required to submit along with a claim in certain situations, such as when a service is provided via telehealth.
C. Pharmacists are eligible to submit any CPT code to MEDICARE without physician supervision.
D. Pharmacists are not eligible to obtain their own National Provider Identifier (NPI) number.

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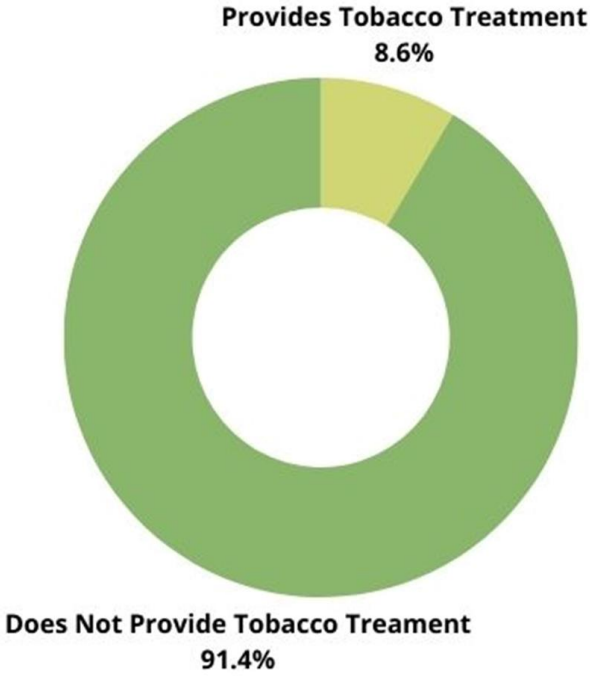
From Concept….to Reality

Once Upon a Time…in 2022

- Tobacco cessation delivered by pharmacists in ND was NOT commonplace



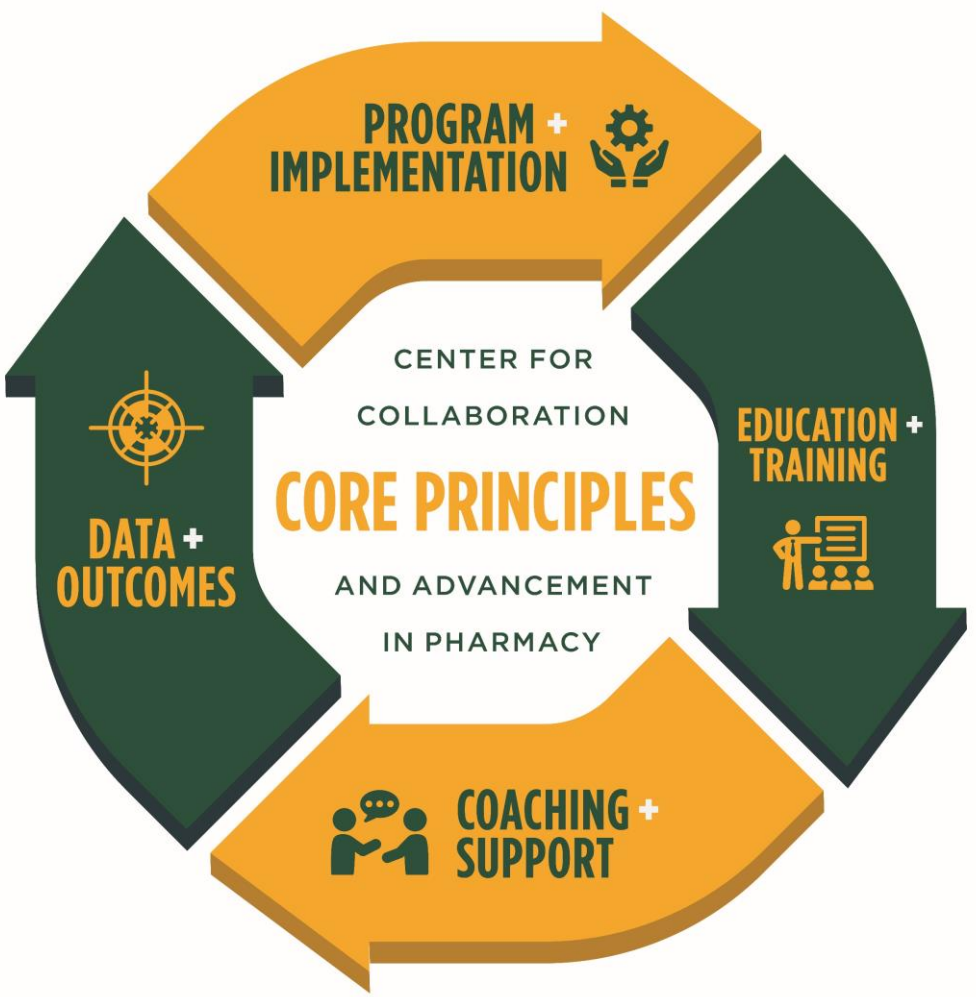
Pharmacist services provided (n = 235)

Only 4 Pharmacists billing for tobacco cessation (n = 21)

Data from: ND Pharmacy Service Enhancement Project Survey, poster presented at ASHP Midyear, December 2022.

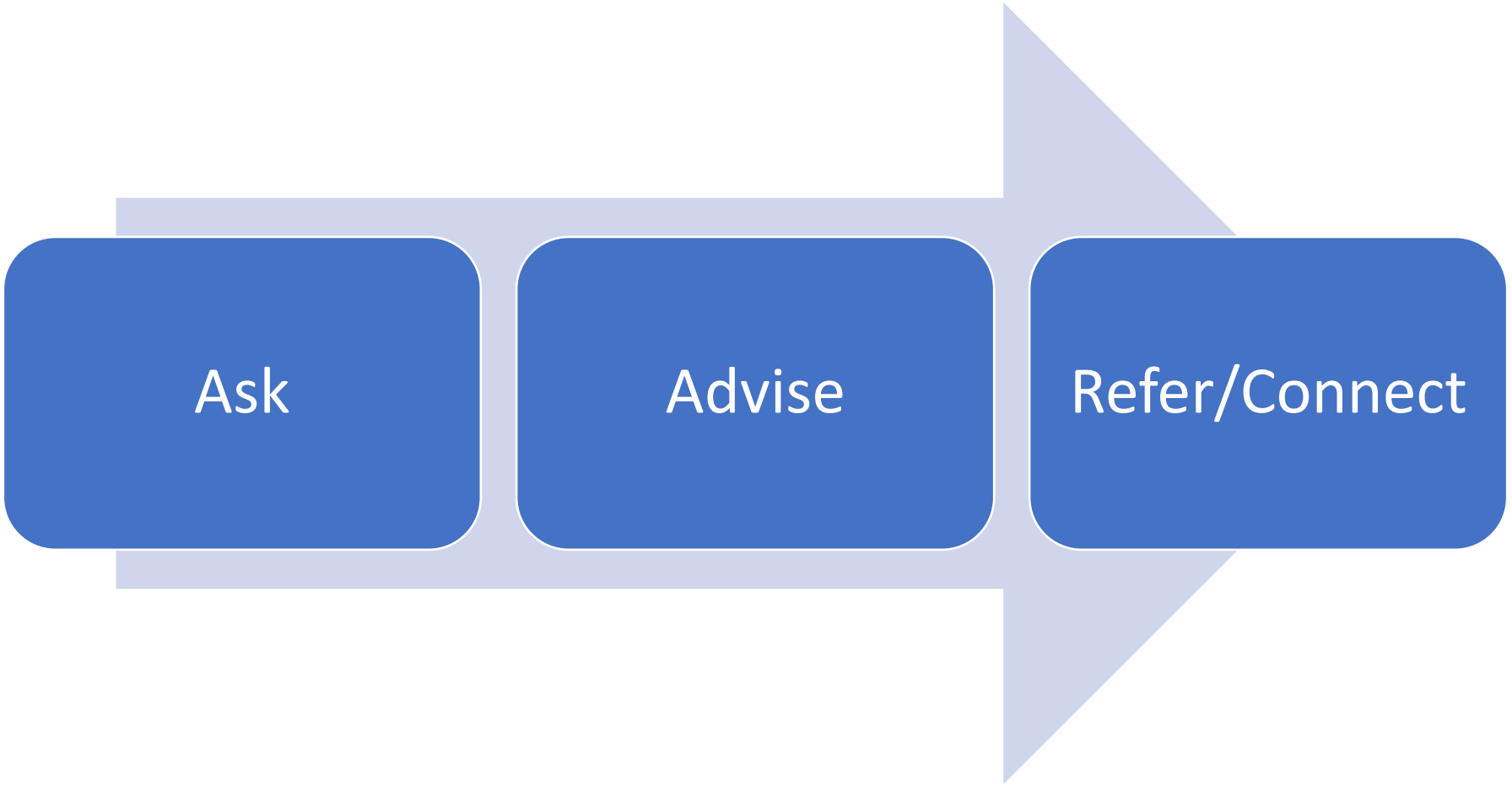
ND Pharmacy Service Enhancement Project

- How to overcome barriers?
  - Utilize principles of **implementation science** to identify **contextual factors**
  - Design a program that leverages NDSU Center for Collaboration and Advancement in Pharmacy's ***Four Core Principles***:



https://www.ndsu.edu/centers/cap/about_cap/four_core_principles/

Tobacco Cessation Best Practices



PSEP Project

- Project ***Setting***:
  - 6 pilot sites
    - 2 rural community pharmacies
    - 4 urban community pharmacies

PSEP Project *Design*

- Baseline education
- Monthly academic detailing/coaching
- Monthly peer-learning meetings
- Ongoing resource provision, support for billing/documentation
- Identification of barriers/contextual factors through ethnography

PSEP Project *Evaluation*

Quantitative

- Fidelity of Ask-Advise-Refer/Connect provision
- Tobacco cessation medication prescribing
- Billing codes submitted
- Pharmacy staff comfort/confidence/motivation

Qualitative

- Ethnographic semi-structured interviews
- Observations (during each site visit) of pilot sites and key informants

PSEP Project

What are we seeing so far?

Pilot Site Panel:

Amy Crowell, Family HealthCare

Anna Aberle, Medicine Shoppe

Nathan Schlecht, Forman Drug

PSEP Project: Pilot Site Panel

- *What has **gone well** implementing tobacco treatment services?*

PSEP Project: Pilot Site Panel

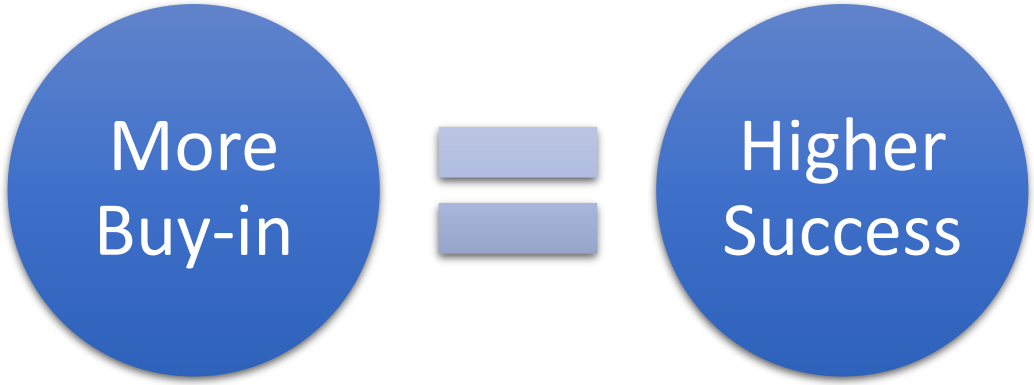
- *What has **been challenging** implementing tobacco treatment services?*

PSEP Project: Pilot Site Panel

- *What **solutions** have you found help to overcome barriers with tobacco treatment implementation?*

PSEP Project: *What are we seeing so far?*

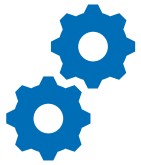
- Pharmacy Technicians can be involved in the AAR workflow
- Site champions with support staff buy-in leads to greater workflow change



PSEP Project: *What are we seeing so far?*

- Other Common facilitators:

Workplace infrastructure



Workflow integration with dedicated staff

Organizational support from proactive leaders

Community engagement

Passionate site champions

Adaptability

PSEP Project: *What are we seeing so far?*

- ND Quits Barriers:
  - Lack of patient commitment
  - Inconsistent communication between ND Quits and patient
  - Waning ND Quits outreach
  - Insufficient NRT provided to patients by ND Quits
- ND Quits Facilitators:
  - Successful quit attempts
  - ND Quits is supportive regardless of insurance coverage

PSEP Project: *What are we seeing so far?*

- Other Common barriers:

Financial constraints & reimbursement issues

Staffing limitations

Increased workload

Organizational culture & competing priorities

Operational challenges & sustainability concerns

Patient-related factors

PSEP Project: *What are we seeing so far?*

- Possible **Solutions**:
  - Discomfort with asking patients about tobacco use
    - Ongoing coaching and training
    - Resources provided with scripting
    - 80% patients want to quit tobacco, and expect to be asked about it!

PSEP Project: *What are we seeing so far?*

- Possible **Solutions**:
  - Time constraints
    - Optimize workflow efficiencies: when to ask about tobacco?
    - Standardize workflow
    - AAR takes less than 3 minutes to deliver! (Even less than that in a team-based environment)

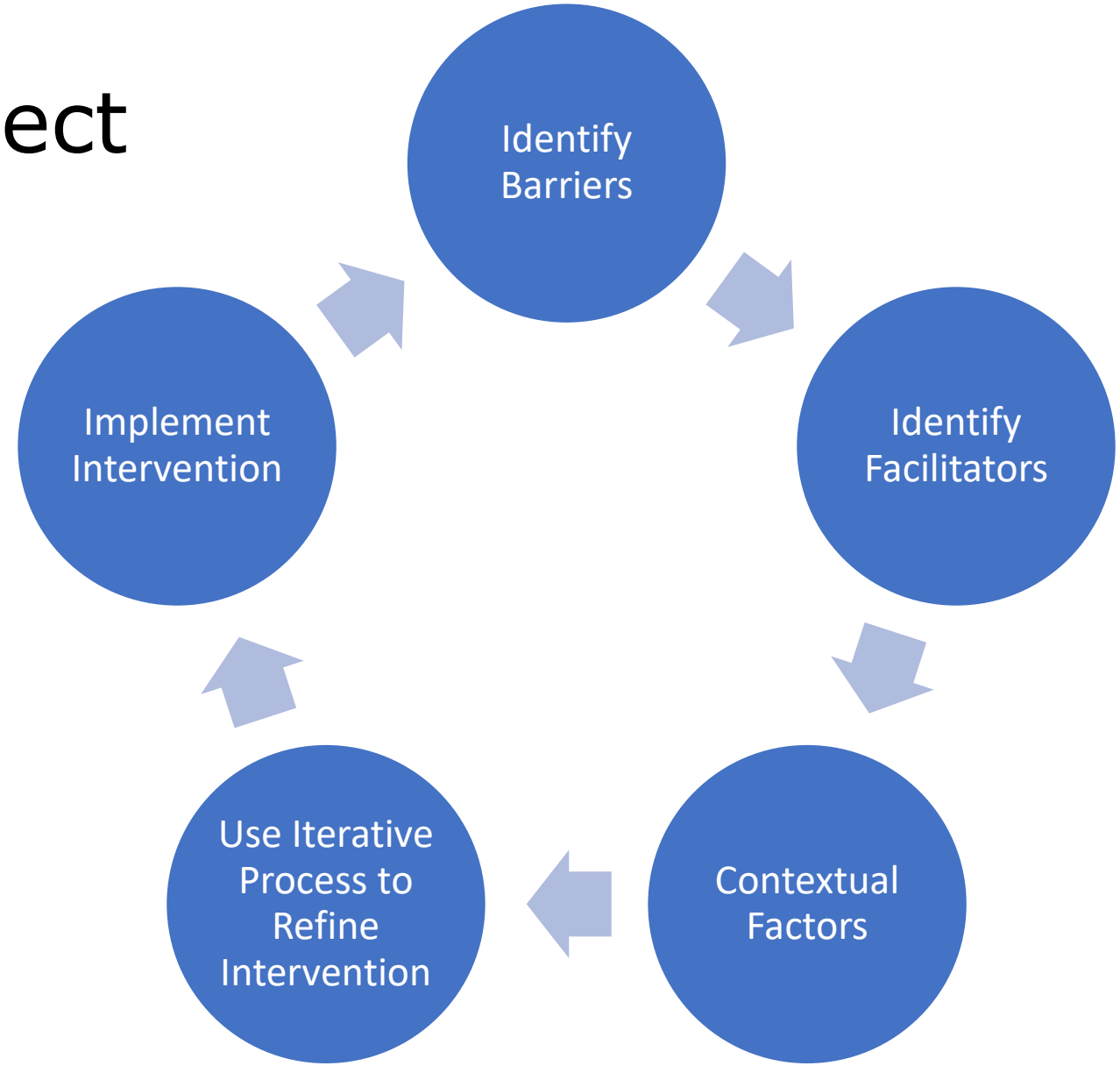
PSEP Project: *What are we seeing so far?*

- Possible **Solutions**:
  - Staff buy-in
    - Identify a site champion
    - Provide incentives to staff for AAR process
    - The more AAR is done, the more comfortable staff are

PSEP Project: *What are we seeing so far?*

- Possible **Solutions**:
  - Workflow changes
    - Leveraging telehealth can help with:
      - Efficiency
      - Reduce patient no shows
    - Peer learning meetings allow sites to share resources and ideas
    - Academic detailing

PSEP Project



Reflection Question

- What changes will you need to make in order to be prepared to implement medical billing at your practice site?

PSEP Project Team Acknowledgments

- Ellen Rubinstein, PhD
- Kelly Buettner-Schmidt, PhD, RN, FAAN (nursing)
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- Lisa Nagel, PharmD
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PSEP Project Team Acknowledgments

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  - Emma DuPont, BS
  - Amanda Bergman, BS
  - Hailey Wanner, BS (PharmD/MPH Candidate)

PSEP Project Team Acknowledgments

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    - Brooke Suttles
    - Julia Jones
    - Taylor Giesen

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References

1. Kliethermes MK, Reiter J, Maack B. Exploring Revenue Opportunities with Telehealth for Pharmacists. In: DeRemer CE, ed. Strategies for establishing telehealth pharmacy practice models in ambulatory care settings. American Society of Health-System Pharmacists (ASHP); 2021:55-88.
2. Kliethermes MA, Brown TR, American Society of Health-System Pharmacists, eds. Building a Successful Ambulatory Care Practice: Advancing Patient Care. Second edition. American Society of Health-System Pharmacists; 2019. DOI: https://doi.org/10.37573/9781585285112, Online ISBN: 9781585285112, Print ISBN: 9781585285105

Questions???

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