Financial Management: Telling the Patient’s Story Accurately, Completely, and in a Codeable Fashion

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Every day is a learning experience.
Be willing to learn and adapt to change, then lead your team to do the same!
Learning Objectives:

- Develop strategies for ensuring accuracy and completeness of data submitted for reimbursement and analytics.
- Identify methods for relaying information to health-system executives on the impact of drug therapies, drug expenses, and patient outcomes.
- Examine new metrics that will be essential in defining value and success in the emerging healthcare business model.
- Describe the business model transition from fee-for-service to capitated bundled payments and the impact on revenue cycle management.
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21th Annual ASHP Conference for Pharmacy Leaders

Opportunities!!

So much Pharmacy time devoted to managing this

Spend for Drugs + Labor + Overhead

So little Pharmacy time devoted to managing this

Revenue for Drugs + Drug Administration

Pharmacy Budget

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Everyone has a fiduciary responsibility!!

The P&T Committee

The MD writing orders

The patient taking responsibility

Pharmacy working across all care sites

Social Services
Patient Navigator

Revenue Cycle: the Billing Dept

Nursing
Diabetes with complications
Congestive heart failure
Compromised renal function
Consults
Scans & x-rays
Multiple lab tests
Several procedures
Prescription drugs
Specialty drugs

ICD10 codes
CPT codes
HCPCS codes
Modifiers to codes

Big Data Pool
$\text{$$$}$
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Getting it Right!!

LCDs, NCDs, Prior Auth
Correct codes
Billing units
IV Drug Admin Fees
Payor Status
Quick review of charging

- ICD9/ICD10 codes are used by hospitals to designate disease types
- **CPT codes** *(determined by the AMA)*
  - used by physicians to describe procedures they do
  - may include payment for all products used during the procedure
- **HCPCS codes** are for products and may or may not be reimbursed
- **DRGs** apply to inpatients and only to Medicare patients
- **APCs** apply to outpatients and only to Medicare patients
- DRG and APC methodology is often used as a template for other insurance reimbursement
- **Part B** covers drugs administered in an outpatient setting
- **Part D** covers drugs that are considered self-administered *(most oral cancer drugs)*
The Importance of Codes

- Coding is the language that describes what was done and what was used. It’s the operational link between coverage and payment.
- However, any payor at any time can look at what was done and on the merits of that, make a decision that they are not going to pay for it.
- All reimbursable drug and biological HCPCS codes should be assigned Revenue Code 636.
Part B Drugs vs Part D Drugs

- Medicare & other insurers have distinct medical + pharmacy benefits
- Medicare medical benefit ensures that physician services, including physician-administered drugs, and hospital services are covered
- Pharmacy benefit usually covers self-administered drugs (orals and some subcutaneous injectables)
- High copays can cause financial difficulties
- 1 in 4 patients who filled their Rx and incurred >$500 in copays did not return to pick it up or follow up with a new oncology medication within 90 days. Streeter SB, Schwartzberg L, Husain N, Johnsrud M. Patient and plan characteristics affecting abandonment of oral oncolytic prescriptions. *J Oncol Pract.* 2011;7(3 Suppl):46s–51s.
Part B Drugs

Drugs are tied to physician services and fall under the medical benefit

- Injectables furnished incident to a physician’s service and not usually self-administered
- Drugs administered via a nebulizer or pump furnished by Medicare
- Immunosuppressive drugs for organ transplant
- Hemophilia blood clotting factors
- Certain oral anticancer treatments (many are Part D)
- A very few oral antiemetics, changes frequently
- Pneumococcal, influenza and hepatitis B vaccines
- Erythropoietin-like drugs for trained home dialysis patients
- Iron dextran, vitamin D injections and erythropoietin-like drugs administered by facilities specializing in the care of ESRD patients
- Osteoporosis drugs
Part D Drugs: 
Part of the Pharmacy Benefit

- Benefits only apply to “covered Part D drugs”
- Generally, a Part D drug is a prescription drug that is prescribed and dispensed for self-administration
- Drug must be provided for a medically accepted indication
- If a drug is either Part A or Part B, Part A or Part B will pay for it
  - Methotrexate for cancer would be Part B
  - Methotrexate for rheumatoid arthritis, Part D
- Also includes the following
  - Biological products
  - Insulin
  - Medical supplies associated w/insulin injection (syringes, needles, alcohol swabs, and gauze)
  - Certain vaccines not covered under Part A or B
OPPS 2017: Proposed Changes

Products:
- Increase drug packaging threshold to $110 (was $100 in 2016)
- Revise thresholds for high/low cost status for skin substitute products
- Consider proposals regarding transitional pass-through status

Policy:
- Modify/expand packaging policies
- New Comprehensive Ambulatory Payment Classifications (C-APCs)
- Update Hospital Outpatient Quality Reporting (OQR) Program measures
- Payment for off-campus physician-based departments (implementation of section 603 of the Bipartisan Budget Act (BBA))
<table>
<thead>
<tr>
<th>Proposed OPPS 2017: 5 drug payment ways</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New drugs not yet assigned unique HCPCS Code</strong></td>
</tr>
<tr>
<td>No Change from 2016</td>
</tr>
<tr>
<td>95% of AWP</td>
</tr>
<tr>
<td>Use code C9399, unclassified drugs or biologicals + NDC Code</td>
</tr>
</tbody>
</table>

| **New pass-through drugs + radiopharm** |
| Payment based on WAC + 6% until enough ASP data gathered |

| **Specified covered outpatient drugs (SCODs) costing > $110/day** |
| MD Office+6% |
| OPPS ASP+6% |

| **Lower-cost packaged products costing <$110/day** |
| ▲ from $100 in 2016 |
| Regardless of cost, products used in packaged services (contrast agents; diagnostic radiopharmaceuticals; anesthesia drugs; drugs, biologicals, & radiopharmaceuticals functioning as supplies in a diagnostic test or procedure; drugs & biologicals functioning as supplies in a surgical procedure) |

- ▲ # of drugs have no separate reimbursement, drug costs bundled into the procedure

- An ▲ # of 5-HT3 drugs have no separate reimbursement, drug costs bundled into the procedure except for Palonosetron

- 38 products either keep or gain pass-through status

- Code changes coming

- Includes blood factor products

- IV Drug Admin Fee add on codes paid separately for all 5 drug payment types!!
Transitional Pass-Through Status: CMS is proposing

- to allow for quarterly expiration of pass-through status for devices, drugs & biologicals ending on the qtr as close to 3 full years as possible after the devices, drugs or biologicals 1st were covered with a pass-through payment
- that pass-through payment status for devices begin on the 1st day on which pass-through payment is made for the device, instead of the date CMS establishes a category
- drugs & biologicals are 1st eligible for pass-through status beginning the next qtr following application approval
- new timeframe would apply to pass-through payment status for devices, drugs & biologicals approved in CY 2017
- to use the “Implantable Devices Charged to Patients” cost to charge ratio (CCR), if it is available, to calculate pass-through payment for devices, instead of the average hospital-wide CCR.
- to calculate the offset amount for pass-through payments at the HCPCS code level rather than the APC level
Drug Payment @ASP+6% (-2% sequestration)
IV Drug Admin Payment
Some non-pass through drugs are paid for as part of a package/bundle

• Those that are packaged/bundled due to cost: Packaging threshold proposed to increase from $100 to $110 per day
• Those that are “Policy packaged” regardless of cost:
  ◆ Diagnostic radiopharmaceuticals
  ◆ Contrast agents Stress agents
  ◆ Anesthesia drugs
  ◆ Drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure
  ◆ Drugs and biologicals that function as supplies when used in a surgical procedure
Just how many kinds of bundles could there be? Lots!!

- IV drug admin
- Drugs costing <$110/day
- CMS Policy-Packaged Drugs
- Biologicals & Radiopharmaceuticals

Defined episode of care (e.g. Hip replacement)

Entire episode of care (e.g. breast cancer)
Proposed OPPS 2017 Drug Administration Rates

- How many are proposed to increase? 86%
- By how much? 0.4% to 95%
- Are any decreasing? Yes, a few from -18% to -43%

Off to find out if we document completely, use the correct codes and capture Drug Admin revenue for all applicable outpatient drugs (even Patient Assistance Products and those pesky White Bag products)
OPPS 2017 Proposed: Payment for Off-Campus Provider-Based Departments

- **What:** implement section 603 of 2015 BBA which prohibits items + services furnished by certain off-campus provider-based outpatient departments (PBDs) from being paid under OPPS as of January 1, 2017
- **Who:** applies to off-campus PBDs not billing Medicare as such as of November 2, 2015 (the “Enactment Date”)
- **Rates?:** These PBDs paid under the Medicare Physician Fee Schedule (MPFS) at non-facility rates
- **Clarifications:** generally, off-campus PBDs billing for services paid by OPPS prior to the Enactment Date will continue to be paid for those services under OPPS if the off-campus PBD maintains its excepted status
- **Exclusions?:** items + services furnished by dedicated emergency departments regardless of location on or off the main hospital campus
- **Unknown:** 340B Implications

Off to discuss this with legal to see where we stand!
OPPS 2017 Proposed: Payment for Off-Campus Provider-Based Departments (PBDs)

- If paid under OPPS prior to Nov 2, 2015, will continue to be paid that way for items or services in the same clinical family; items and services in new clinical families will be reimbursed under MPFS.
- If start offering items or services in different clinical families as items or services provided by PBD prior to the enactment date, can No Longer Bill Under OPPS For New Items & Services

<table>
<thead>
<tr>
<th>Advanced Imaging</th>
<th>Ear, Nose, Throat (ENT)</th>
<th>Nervous System Procedures</th>
</tr>
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<tbody>
<tr>
<td>Airway Endoscopy</td>
<td>General Surgery</td>
<td>Ophthalmology</td>
</tr>
<tr>
<td>Blood Product Exchange</td>
<td>Gastrointestinal (GI)</td>
<td>Pathology</td>
</tr>
<tr>
<td>Cardiac/Pulmonary Rehabilitation</td>
<td>Gynecology</td>
<td>Radiation Oncology</td>
</tr>
<tr>
<td>Clinical Oncology</td>
<td>Minor Imaging</td>
<td>Urology</td>
</tr>
<tr>
<td>Diagnostic tests</td>
<td>Musculoskeletal Surgery</td>
<td>Vascular/Endovascular/Cardiovascular</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Visits and Related Services</td>
</tr>
</tbody>
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IPPS New Technology Add-on Payments
FY 2017: 4 eligible drugs

Blinatumomab, (BLINCYTO)
- continue new technology add-on payments for FY 2017
- maximum new technology add-on payment remains $27,017.85
- Eligible cases: ICD–10–PCS procedure codes: XW03351 (Introduction of Blinatumomab antineoplastic immunotherapy into peripheral vein, percutaneous approach, new technology group 1) or XW04351 (Introduction of Blinatumomab antineoplastic immunotherapy into central vein, percutaneous approach, new technology group 1).

Defitelio, (Defitelio)
- Eligible cases: identifiable by ICD–10–PCS procedure codes XW03392, XW04392
- Maximum new technology add-on payment is $75,900

Idarucizumab
- Eligible cases: identified by ICD–10–PCS procedure code XW03331
- Maximum new technology add-on payment $1,750

Uridine triacetate (Vistogard)
- maximum new technology add-on payment is $37,500
- Eligible cases: any one of ICD–10–PCS diagnosis codes T45.1X1A, T45.1X1D, T45.1X1S, T45.1X5A, T45.1X5D, and T45.1X5S in combination with ICD–10–PCS procedure code XW0DX82
The Revenue Cycle
So Many Moving Parts!!
Living up to your reimbursement potential
Focus Areas Identified

- Accurate CDM
- CDM–PDM match
- IV drug admin billing
- Waste billing
- Zero-priced drug billing
- Bundled items billed
- LCD/NCD requirements met
- Document Prior auth in EHR
- Payor info shared
- Codeable documentation

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Always, Always Follow the Money
Do you do this? Can you do it end to end?
MD chooses drug
MD, Nursing & Pharmacy
determine Prior Auth/LCD/NCD
status & confirm documentation
MD writes drug order, then ..........
Three Practices to Minimize Drift Between Audits

Healthcare organizations are subjected to strict compliance audits, and the business is dependent on passing those audits. But what happens between audits?

Imagine if you were to cover your speedometer, gas gauge and other warning lights on your car’s dashboard, and you only saw that information when you went in for an oil change. It is not all that different when it comes to managing your infrastructure or environment between audits.
- EHR documentation
- ICD10 supports requirements
- Payment

- No awareness, no follow-up
- No documentation to support use requirements
- No payment due to lack of medical necessity

Who’s responsible? Everyone including Pharmacy Clinicians!
Impact of Billing Errors on Pooled Average Reimbursement Across All Facilities

Prior auth/LCD in place
HCPCS code correct
Billing unit calculation wrong
No waste billed

New reimbursement
everyone’s paid

Find & fix your issues quickly,
they’re impacting everyone!!

Prior auth/LCD in place
HCPCS code correct
Billing unit calculation correct
Appropriate waste billed
Impact of Billing Unit Errors: a Clinical Standpoint

**Dose sent to Claim**
- Prior auth/LCD in place
- HCPCS code correct
- Billing unit calculation correct
- Appropriate waste billed

**Dose sent to Claim**
- Prior auth/LCD in place
- HCPCS code correct
- Billing unit calculation incorrect
- No waste billed

**Find & fix your issues quickly, they’re impacting everyone!!**

**A new average dose given? No! Just bad data from wrong Entries!**
- How aggregated BIG Data portrays the acceptable dose

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Putting $ into Perspective

Rituximab billing error
HCPCS code: J9310
Billing unit 100mg
July 2016 ASP $791.40

Case Description
Billing unit 10 fold error
Each 1000mg dose billed as 1 billing unit instead of 10 billing units
Got $791.40 but lost $7122.60 for each pt
Assume 1000 patients/yr
Lost revenue = $7,122,600

Chronic Care Management Opportunity Available$
$60/month/eligible patient for 20 minutes documented service
Would need to manage 9892 patients for 20 minutes each month for 1 year to earn
$7,122,600
# Prior Approval vs. NCDs and LCDs

<table>
<thead>
<tr>
<th></th>
<th>Prior Approval (Payor)</th>
<th>NCDs and LCDs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Applies to:</strong></td>
<td>3rd party carriers (possibly Medicaid)</td>
<td>Medicare (possibly Medicaid)</td>
</tr>
<tr>
<td><strong>Need Patient’s payor status?</strong></td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td><strong>Drug tagged in CPOE/PDM?</strong></td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td><strong>Link to actual rule needed?</strong></td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td><strong>Rule Requirements:</strong></td>
<td>Ask permission first before drug administration</td>
<td>Understand &amp; follow requirements, document completely and thoroughly. Code correctly and as required</td>
</tr>
<tr>
<td><strong>Payment:</strong></td>
<td>Only if permission is given first</td>
<td>Determined after the fact and may be denied if not all rules followed</td>
</tr>
</tbody>
</table>
What’s Covered and What’s Not

• The fact that a drug, device, procedure, or service has a Healthcare Common Procedure Coding System (HCPCS) code and a payment rate under OPPS does not imply coverage by Medicare
• Indicates only how the product, procedure, or service may be paid if covered by the program
• FI’s/MACs determine if all program requirements for coverage are met, e.g. that it’s reasonable and necessary to treat the beneficiary’s condition and whether it’s excluded from payment
Off Label Indications

• Dilemma often arises when the literature supports and a patient is treated for an off-label indication
• Fact that it is off-label may be sufficient grounds for FI to deny payment
• Patient and billing assistance programs offered by several pharmaceutical companies may be helpful in providing support when attempting to have denials overturned
• Officially Accepted Compendia can be used to support the off-label decision. Be aware of what they are!
• http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/compendia.html
LCDs, NCDs & Prior Authorizations

• Essential that all concerned
  ❖ understand which drugs have these requirements
  ❖ have set a procedure for how to handle them
  ❖ ensure the required documentation is in the medical record BEFORE the drug order is written and ESSENTIAL before the drug is actually prepared and administered
  ❖ Can't be remedied after the fact
• If this step not taken or documentation missing, no payment made
• Get LCDs and NCDs from your MAC’s website and the prior authorization list from your payors. Pay attention to the ICD-10 codes that apply
• Work out a plan with infusion centers as to responsibility for who's doing what, who's documenting what, how’s this info going to be transmitted to pharmacy
• Equally important is ensuring that it remains a permanent part of the record in real time sequence for auditing purposes
NCD/LCD References

- Each MAC publishes their own LCDs
  - Novitas JL Medical Policy Center
  - Novitas JH Medical Policy Center
What’s your facility doing to move forward?

New Therapeutic Modalities

Meets

Healthcare Payment Reform

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New Health Economy: An Epochal Shift *Expectations*
*Mandate Efficiency & Cost Controls*

From your Pharmacy’s perspective this means

- Recognize that payors have a huge say in how drugs are used
- Payors pit drug mfgrs against each other for deep discounts in exchange for preferred or exclusive formulary spots
- Work in tandem with payors, not independently against them!
- Wide ranges of utilization management strategies to ensure appropriate use of high cost agents
  - prior authorization criteria (on and off-label)
  - dose-optimization strategies
  - quantity limits
  - formulary tiering,
  - channel management
  - utilization review
Innovative Strategies

- Formulary intraoperability: Sync yours with those of payors
- Acquisition and Distribution need to change!
  - Establish a specialty pharmacy relationship
  - Revamp “drugs from home/brown bag policies”
  - Ramp up white bag policies
  - Patient assistance programs
- Who’s doing this? Where is it documented? Do you use this info?
  - Precertification, rigorous attention to Prior authorization, LCD/NCD
  - ABN notice for off-label use
- IT Support
  - Provide payor status info to pharmacy
  - Adaptation of the EMR to document each step
  - Claims data is used as the basis for future directions, a short window of opportunity to “right your data”
Suggestions from ICLIO, an institute of ACCC @ accc-iclio.org

- High dollar medication approval process
- Enroll every patient into a support program, regardless of on or off-label use
- Robust Off-Label Policy & Procedure: predetermination
- Patients are made aware of financial risk, required to sign an ABN or NONC
- Pharmacy follows every claim to ensure payment
- Effective and traceable form of communication is essential
Key Takeaways

• Key Takeaway #1
  ❖ Move out of your silo, Recognize implications of your decisions & actions and remember, it’s not about you, it’s about the patient!!

• Key Takeaway #2
  ❖ The 3 Elements to Leadership are vision, understanding the situation and having the courage to act while remembering that It’s not a popularity contest!!

• Key Takeaway #3
  ❖ Pharmacy is part of the healthcare ecosystem, every part of which has to step up their efforts to contribute to affordability. What are you going to start doing? Stop doing? Keep Doing?

• Key Takeaway #4
  ❖ Under OPPS, CMS is making packaging-related changes in CY 2017 for conditionally packaged ancillary services, drugs that function as supplies in surgical procedures, and conditionally packaged outpatient laboratory tests but not drug administration services
Self-Assessment Questions

1. What is the CY 2017 packaging threshold for drugs, biologicals, and radiopharmaceuticals?
2. What is the payment rate for non-pass through, separately payable drugs and biologicals above the packaging threshold?
3. T or F: Biosimilar biological products will be eligible for pass-through status under the OPPS, and payment will be at the reference product’s ASP + 6% under both the OPPS and PFS.
4. T or F: In CY 2017, CMS will package drugs that function as supplies in surgical procedures
5. Under which payment systems will eligible provider-based off-campus facilities be paid? Ineligible facilities?
Answers to Self-Assessment Questions

1. $110 per day
2. ASP + 6%
3. The statement is true.
4. That statement is true.
5. Grandfathered as of November 2, 2015: OPPS
   Non-grandfathered provider-based off-campus facilities: ASC PPS or PFS, no longer will be eligible to bill under the OPPS.
Self Assessment Question

Are you prepared to add biosimilars to your formulary?

☑ Yes
☒ No
Self Assessment Question

Help me! I need more info on payment reform & reimbursement

✅ True
❌ False