NAVIGATING THE BILLING MAZE: THE BASICS OF MEDICARE PART B BILLING

JULY 13, 2017
9:00 – 10:00 AM

ACPE UAN: 0107-9999-17-079-L04-P 0.1 CEU/1.0 hr

Activity Type: Knowledge-Based

Learning Objectives for Pharmacists: Upon completion of this CPE activity participants should be able to:
1. Describe the Medicare Part B enrollment process, including obtaining a Provider Transaction Access Number (PTAN)
2. Outline specific clinical services offered in the pharmacy setting that are generally covered by Medicare Part B, including diabetes self-management education (DSME)
3. Describe medical billing via X12, how it differs from typical pharmacy billing, and first steps to take to engage in Part B billing

Speaker: Kelley Pope, RNC-NIC, BSN
Kelley Pope is currently the Director of Clinical Practice at Creative Pharmacist, makers of the STRAND Intervention platform. As a registered nurse of 15 years, Kelley has an extensive background in clinical claims reimbursement in the community pharmacy space as well as in accreditation standards for diabetes education. Her primary focus is on claims reimbursement and quality documentation specific to Diabetes Self-Management Education. Kelley is also an industry leader in accreditation for diabetes education, guiding independent pharmacists across the country in receiving their pathway for claims billing. Over the past two years, she has singlehandedly guided more pharmacies in the U.S. through the diabetes accreditation process than any other source. Kelley resides in Evans, GA, where she enjoys raising her 5 children.

Speaker Disclosure: Kelley Pope reports no actual or potential conflicts of interest in relation to this CPE activity. Off-label use of medications will not be discussed during this presentation.
Navigating the Billing Maze: The Basics of Medicare Part B Billing
Kelley Pope, RNC, NIC, BSN
Director, Clinical Practice, Creative Pharmacist
July 19th, 2017

Disclosure

- Kelley Pope is an employee of Creative Pharmacist and will not discuss off label use and/or investigational use in the following presentation.
Learning Objectives

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The Landscape is Changing

• Laws are changing
  • Washington= Provider Status
  • California, Tennessee

• Payers are noticing
  • Risk reduction

• Pharmacists are organizing
  • CPESN’s building throughout the country
The History of the Medical Claim

• First disability claims occurred in 1850
  • Insurance based on steamboat and railroad accidents
  • Claims were sent via paper
• Paper claims were utilized throughout the beginning of the modern history of private insurance until modern use of electronic health records produced
• Electronic claims for clinical services are now expected
• Pharmacists are now offering clinical services
  • Therefore, pharmacists are expected to bill for clinical services like other healthcare professionals

Payers are Noticing

• Pharmacists have new opportunities for direct billing and reimbursement
  • Diabetes Self-Management Education (DSME)
  • Pre-Diabetes Counseling
  • CLIA-waived tests
    • Cholesterol
    • A1c
• Michigan= MTM Reimbursement
You can’t bill without documenting…
And you’d rather not document without billing

Insurance

NCPDP D.0 Format
- Traditional pharmacy pathway for claims billing
- Built for payload of a product

X12 Format
- Traditional pathway for physicians, hospitals, etc
- Built for payload of a service
It’s time to learn medical billing language (it’s simple, really)

ASC X12 Billing

• Title II of HIPAA requires all providers and billers covered by HIPAA to submit claims electronically using the approved format.
• This format is known as ASC X12
• Shorthand for this form is HIPAA 5010

Why is this important?
• This is the pathway that clinical claims are mandated to be billed
X12 Claim Numbers You Need to Know

- Form 270/271
  - Eligibility check for the service. Plain and simple.
- Form 837p
  - ‘P’ stands for ‘professional’
  - This is the actual claim itself
- Form 997
  - Acknowledgement of receipt of the claim by insurance
- Form 835
  - This is the actual payment/denial of the claim by insurance

Form 837p

- Form 837p (the actual claim form) is an electronic version of the HCFA 1500 Universal Claim form
Leverage Technology

• Good news! You don’t have to be able to write in X12
• Today’s clinical practice requires documentation needs and the need for X12 billing
• Clinical documentation and X12 billing platforms exist in the marketplace today

Overwhelmed
Billing Timelines

• The timelines for clinical billing is different from NCPDP D.0 claims (hint: it can be slower)
• Sending an Eligibility Request (Form 270) only gives an estimate
• Medical claims may not be reviewed for 2 weeks

Have you ever paid your copay at the physician’s office only to receive a bill weeks later for an additional fee?

Additional Considerations

• You may need an accounts receivable and/or claims review department
  • Estimations may not be exact
  • Technicians are in a prime position to assume this role
  • Technologies may offer this ability
• Having the ability to bill doesn’t mean you’re eligible for payments
  • Your pharmacy may need to become ‘credentialed’, or accepted, into the insurance
• You may need additional certifications to bill for certain services
  • Diabetes Self-Management Education (DSME)
Additional Considerations

• You may need to make updates to your relationship with Medicare
  • PTAN
  • Medicare: How are you registered?
• You may need to create a relationship with private insurance companies
  • Sometimes called ‘contracting’ or ‘credentialing’

Documenting Clinical Claims

• Documentation must ‘fit the bill’
  • Specifics of documentation are based on:
    • Standards of practice
    • Specific insurance requirements
  • Some services you provide are ‘time-based,’ while others are ‘service-based’
    • Time-based: DSME Services, Office Visit (E/M codes)
    • Service-based: A1c test, Cholesterol test
• Documentation should fit in your workflow
  • Utilize the med sync appointment to leverage your clinical workflow
Value-Based Care is Here

Our first goal is for 30% of all Medicare provider payments to be in alternative payment models that are tied to how well providers care for their patients, instead of how much care they provide – and to do it by 2016. Our goal would then be to get to 50% by 2018.”

“Our second goal is for virtually all Medicare fee-for-service payments to be tied to quality and value; at least 85% in 2016 and 90% in 2018.”

-Sylvia Mathews Burwell, HHS Secretary


Value-Based Care is Here

- North Carolina pharmacies in the CCNC solution are now being paid for value-based care
- CCNC patient admission rates are consistently 40-50% lower than non-CCNC Medicaid patients
- Transitional care management patients are 20% less likely to return to the hospital
- CCNC has delivered the state of North Carolina a 4-year savings of nearly $1 Billion

Source: www.ccnccares.com
Patient Care Services

- Patient care services must be *individualized*.
  - Only 50% of chronic care medications are taken properly

- Patient care services must be *dosed according to need*.
  - Should every patient receive all services, including patient monitoring?
  - i.e. 28 y.o. well-controlled HTN patient vs 64 y.o. uncontrolled HTN patient

- Patient care services must be *documented appropriately*.
  - “If you didn’t document it, you didn’t do it.”

Why Value-Based Care Matters

- Pharmacists improve outcomes through medication management and optimization, education, accountability, and more

- Insurers are taking notice and are rapidly expanding pharmacists’ abilities to bill for clinical claims

- Pharmacists as providers is coming (in fact, it’s already here)
  - Washington
  - Tennessee
  - Senate Bill 109
How Can You Prepare?

• Learn
  • Connect with your state pharmacy association to discover clinical services you can offer in your state
  • Discover steps you’ll need to take to offer these services
    • CLIA-waiver
    • DSME Accreditation
    • CPESN

• Prepare
  • Develop your documentation system
  • Engage with common insurances in your area
    • What type of insurance offerings do they provide?
      • i.e. PPO, HMO, etc?

How Can You Prepare?

• Engage
  • Connect with others in your state who may be offering similar services
  • Engage with your patients
    • Actively market your services
• Patient care services will depend on the patient, payer, and pharmacist!
• Is the patient eligible for patient care services through their insurance provider or payer?
• Do you (or your pharmacy) have the requirements for a particular patient care service?

Utilize Your Current Med Sync Model

Leverage the patient appointment to provide (and bill) for clinical services
Med Sync and The Appointment-Based Model

• Medication Adherence Program (MAP)
  • Aligning medications to similar fill dates
  • Review of medications
  • Patient encouraged to pick up prescriptions on a particular date (no specific time)

• Appointment-Based Model (ABM)
  • Leverages the alignment of medications to make a definitive impact on the outcome of chronic care patients
  • Involves engagement with patient in the counseling booth
  • Patient arrives at a specific date and time

Appointment-Based Model

“The basic tenets of an ABM are: (1) holistic care of the patient; (2) regularly scheduled visits to the pharmacy by the patient; (3) communication with the patient in advance of the scheduled visit to proactively assess needs related to medications and health conditions; and (4) pharmacist-patient engagement on a regular basis to address these needs.”

- Rebecca Chater, RPh, MPH, FAPhA

Example: John M.

- 57 y.o. retired firefighter
- Diabetes, HTN
- 2 recent hospitalizations due to a mild heart attack

Active Learning

- Which X12 Form is used for determining patient insurance eligibility?
  a) 837
  b) 835
  c) 270
  d) 99210
  e) 8675309
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Background on the Appointment-Based Model

• 86% of healthcare is driven by chronic care patients
  • Only 50% of chronic care medications are taken properly

• Studies show a MAP improves adherence
  • NCPA study: Patients enrolled in the program had 2.5 times greater odds of adherence as controls during the evaluation period.
  • Patients enrolled in ABMS are 21% less likely to discontinue drug therapy than patients not enrolled.

• Studies show a MAP improves fill rates
  • NASPA Study: Average person filled 2 more refills per year per medication

“While exploring the mountain peaks, sometimes you get burned”

Questions?
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