Today's Learning Objectives

- Explain 2008 changes to Medicare reimbursement and identify operational changes required to implement them.
- Attain a better grasp of CMS Complexities.
- Understand the payment mechanisms used by CMS for eligible patients and the impact this has on other payors.
- Describe the components of the entire medication use process that could be positively affected by the use of an improved charge description master (CDM).

What we're going to focus on…

- Inpatient changes
  - Medicare’s inpatient prospective payment system or IPPS
- Outpatient changes
  - Medicare’s outpatient prospective payment system or OPPS
- Transparency Issues
Purpose is important

- Maintain a focus on regulation compliance
- Communicate in one voice and send one message
- Integrate charging as a part of the medication use process
- The 6th “right” is the right charge
- Help get ready for EMR and BPOC

Some of the Essentials may be missing

- Get the facts about reimbursement
  *Is there someone who’s following this?*
  *Do you know what’s going on?*
  Not really.

- Use the facts once you have them
  *Can you and do you incorporate changes quickly?*
  No. (e.g. IVIG)
Passionate people get the jobs done

Was this assigned to you, or is it a passion?
If not your passion, find someone else.

How Should I Bill? ... A Bedtime Story for Hospital Pharmacies

See the Appendix slides for details

• Bedtime Scenario 2: The Outpatient
• Bedtime Scenario 1: The Inpatient
• Bedtime Scenario 3: The LTC Resident
• Bedtime Scenario 4: The Observation Patient
Payment Rates:
What Happened and Why?

Most facilities are shocked when payment schemes change, especially when the reality sets in concerning which products and services are being reimbursed and their corresponding rates of reimbursement.

The response from the healthcare providers usually is: How could this have happened?

Digging through the layers of the decision-making process found:

• Their own negligence in failing to pay strict attention to the pharmacy billing system and to the use of appropriate codes and descriptions as well as the charge itself that was partly responsible.
• Facilities neglecting to bill for pharmaceutical products at all because it was "too complicated for too little return" further contributed to the problem. Their patients and their product use were averaged into the calculations, but at a zero dollar price.

New Medicare Reimbursement Regulations

• DRG payment system, based on payment for services categorized into Diagnosis Related Groups, began in 1983 and has remained largely untouched since then.
• Centers for Medicare and Medicaid Services (CMS) has issued extensive changes to the system for the upcoming 2008 fiscal year. However, like several CMS changes, the effective date actually was October 1, 2007.
• The language explaining the rule change is extensive and fills 1047 pages of the August 22 Federal Register published at http://e257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf07-3820.pdf.
The new regulations….

- stipulate redistributions of reimbursement among some medical services and among certain types of hospitals.
- are based primarily on a new severity-adjusted DRG system and transition to a new weighting methodology used by CMS to set relative weights for payment.
- CMS believes that this “severity-adjusted diagnosis-related group system” better recognizes the severity of a patient's illness and subsequent resource use than the original system.
- overall effect is that for a specific illness or condition, the payment for treating a patient who is severely sick will be more than the payment for treating a less-ill patient.

Even the names have changed!

- Known as the Medicare Severity DRG (MS-DRG) system
- new classification scheme has
  - 25 major disease categories
  - 745 diagnosis-related groups (DRGs)
  - three subclasses of complications and comorbidities.
- Although the system has the same number of major disease categories as the original system, DRGs have grown by 207
- new subclass “major complication or comorbidity” has been added.

Comorbidities

- Interpreting the list of comorbidities and understanding the rationale that created them will be a challenge.
- System does not consider all chronic diseases to necessarily be complications or comorbidities.
- “Chronic systolic heart failure, for example, is not a comorbidity that always affects the severity of a patient’s illness, the agency explained; but an acute exacerbation of that chronic disease would be considered a complication or comorbidity.”
What does it all mean?

• It’s unclear to many hospital administrators and healthcare executives how the new regulations will impact hospital operations.
• Organizations like American Hospital Directory (www.ahd.com) are providing services for analyzing impacts on particular operations, transfers to other facilities, outlier payment for costly cases, and other components of reimbursement.

What does all this mean to pharmacy?

• Metrics are crucial!
• Imperative for pharmacy to be able to identify all of the costs associated with all aspects of the medication use process, not just the cost of the medication itself.
• Coupled with the requirement for transparency in pricing, this may be the opportune time to tune up the charge description master to reflect this data.

Quality Measures

• Concept of linking quality measures to payment was to be a stimulus to improving quality in healthcare.
• In fiscal year 2008, hospitals are required to report 27 quality measures in order to receive the full Medicare-payment update.
• Medications play an important role in over half of these, 16 are medication related.
• Metrics are crucial and the pharmacy must not only be involved in patient care to ensure this quality but must leave a thorough documentation trail of how this was accomplished.
• CMS doesn’t just spring sudden changes on facilities. Although six of the measures are new as of October 1, 2007, CMS actually gave facilities almost a year notice to prepare for the enhanced reporting requirements.
• Actual language of these rules is extensive and was published August 2, 2007 at http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-FC.pdf
Medications play a crucial role in 5 of the 6 that include

- HCAHPS survey completed (27-item standardized instrument for measuring patients’ perspectives on hospital care),
- Venous thromboembolism (VTE) prophylaxis ordered for surgery patients,
- VTE prophylaxis administered within 24 hours before or after surgery,
- Appropriate antimicrobial selected for prophylaxis in surgery patients,
- 30-day mortality rate for Medicare patients with acute myocardial infarction, and
- 30-day mortality rate for Medicare patients with heart failure.

Coming later in 2008, a new twist!

- Medicare no longer will pay the additional costs incurred when conditions occur that “could reasonably have been prevented” through adherence to evidence-based guidelines.
- Change is mandated by the Deficit Reduction Act of 2005 that required CMS to select at least two conditions that are costly or frequent, result in the assignment of patients to a higher-paying DRG when they have that condition as a secondary diagnosis after admission.
- Eight conditions selected by CMS are:
  - Catheter-associated urinary tract infection,
  - Vascular catheter-associated infection,
  - Mediastinitis after coronary artery bypass graft surgery,
  - Decubitus ulcers,
  - Hospital-acquired injury, such as a fracture, from a fall,
  - Object left in patient during surgery,
  - Air embolism, and
  - Blood incompatibility.

Other Open Issues Affecting Pharmacy

- Implementation of cost accounting for Pharmacy product and service costs related to CMS payment denial of costs related to Medical Errors
- Qualification for 340B Pricing
  - Proposed guidelines would allow children’s hospitals in 340B
The Outpatient Medicare System
Keeping up with what’s going on…

• The August 2 issue of the Federal Register has the single-spaced 503-page document in which the Centers for Medicare and Medicaid Services (CMS) explained the changes it wants to make to Medicare’s hospital outpatient prospective payment system. CMS will consider comments received by September 14.
http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-3509.pdf

• CMS Releases Medicare Part D Mailing Guide and Tip Sheets
CMS recently released an updated Medicare Part D mailing schedule for materials that beneficiaries may receive. The guide should help pharmacists answer questions from beneficiaries and assist with outreach activities. The “Guide to CMS, SSA and Plan Mailings for Summer and Fall 2007” is available at http://www.cms.hhs.gov/States/Downloads/mailcpg.pdf

Part B Drugs

• 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
• Oral antiemetics
• 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 patients with ESRD
• Osteoporosis drugs

Medicare Part B Drug Average Sales Price

Overview
2007 ASP Drug Pricing Files
2006 ASP Drug Pricing Files
2005 ASP Drug Pricing Files
Medicare Part B Drugs Regulations
Medicare Part B Drug ASP Transmittals
List
2007 ASP Drug Pricing Files

- The files below contain the payment amounts that will be used to pay for Part B covered drugs for 4thQ 2007. Comparing 4thQ 2007 payment amounts with the previous quarter reveals that for the most part average drug prices in the market remain stable. Overall, payment amounts across all drugs and across the top physician administered drugs on average (weighted by Medicare utilization) are essentially unchanged. Preliminary 2006 data for the top physician administered drugs suggests that overall utilization of these drugs appears to have increased compared with 2005 levels.

- For most of the higher volume drugs (39 out of the top 50), the payment amounts changed 2 percent or less. Overall, the payment amounts for 27 of the top 50 drugs increased, while 1 remained the same. In general among the top drugs with a decrease, there are a number of competitive market factors at work – multiple manufacturers, alternative therapies, new products, recent generic entrants, or market shifts to lower priced products.

2007 ASP Drug Pricing Files

- Studies of Medicare payment rates for oncology drugs by the GAO, OIG % MedPAC found that physicians are generally able to acquire these drugs at prices below the Medicare reimbursement rate. CMS will continue to support groups representing Medicare Part B drug purchasers, especially small and rural purchasers, to help them identify the most favorable drug prices possible. In addition, CMS will continue to work with the OIG to monitor market prices and to ensure ASP data is reported accurately.

- As announced in late 2006, CMS will further ensure that more accurate and, as appropriate, separate payment is made for single source drugs and biologicals under Section 1847A which requires single source drugs or biologicals that were within the same billing and payment code as of October 1, 2003, be treated as multiple source drugs. Payment for these drugs and biologicals is based on the volume weighted average of the pricing information for all of the products within the billing and payment code. See the series of announcements regarding Medicare payment and coding for drugs and biologicals in the "Downloads" section of the ASP "Overview" page at the following address:

IVIG marketplace developments and patients’ access to IV immune globulin services

- CMS and other agencies continue to work with manufacturers, providers, patient groups, and stakeholders to better understand the present situation and to assess potential actions that will help to ensure an adequate supply of IVIG and patients receiving appropriate and high quality care.

- Beginning July 1, 2007, six new HCPCS codes for specific IVIG products were used to implement separate payment for these products (including liquid IVIG, RhoPhylac® and HepaGam BTM).

- For 4th quarter 2007, the Medicare payment amount is increasing about 1.2 percent for lyophilized IVIG (powdered form) and from 0.1 to 1.6 % for 3 liquid IVIG products, the payment amount for a 4th liquid IVIG product is slightly decreased (0.1%).

- In 2007, Medicare will continue to make a temporary separate payment to physicians and hospital outpatient departments for preadministration-related services associated with administration of IVIG. The IVIG pre-administration service payment is in addition to Medicare's payments to the physician or hospital for the IVIG product itself and for administration of the IVIG product via intravenous infusion.
Quarterly ASP Adjustments

- Where applicable, the payment amounts in the quarterly ASP files are 106 percent of the Average Sales Price (ASP) calculated from data submitted by drug manufacturers. The quarter to quarter price changes are generally the result of updated data from the manufacturers of these drugs.

- Medicare Contractor Reporting Template for Medicare Part B Drugs - (Located in the “Downloads” section below)

  As indicated in CR 4140, dated February 15, 2006, Medicare contractors shall use the Medicare Contractor Reporting Template for Part B drugs to report information on all Medicare Part B drugs not paid on a cost or prospective payment basis when payment limits are not listed in the quarterly drug pricing files, or in the OPPS Pricer. Contractors shall also use the template to report pricing information for the NOC drug billing codes. This information must be sent to CMS on a monthly basis to e-mail address: sec303aspdata@cms.hhs.gov.

Downloads

- October 2007 ASP Pricing File - Updated 09/18/07 [ZIP, 30KB]
- October 2007 ASP NOC Pricing File [ZIP, 7KB]
- October 2007 ASP NDC-HCPCS Crosswalk [ZIP, 225KB]
- July 2007 ASP Pricing File - Updated 09/14/07 [Excel Zipped, 30KB]
- July 2007 ASP NOC Pricing File - Updated 06/21/07 [Excel Zipped 7KB]
- July 2007 ASP NDC-HCPCS Crosswalk [ZIP, 225KB]
- April 2007 ASP Pricing File - Updated 09/14/07 [Excel Zipped, 30KB]
- April 2007 ASP NOC Pricing File [Excel Zipped 7KB]
- April 2007 ASP NDC-HCPCS Crosswalk [ZIP, 225KB]
- January 2007 ASP Pricing File - Updated 09/14/07 [ZIP, 30KB]
- January 2007 ASP NOC Pricing File [Excel Zipped 7KB]
- January 2007 ASP NDC-HCPCS Crosswalk [Excel Zipped 225KB]
- Medicare Contractor Reporting Template for Medicare Part B Drugs [Excel Zipped, 5KB]

ACCC Submits Comments to CMS on HOPPS, 2008 Payment Rates www.accc.org

ACCC’s September 07 recommendations to CMS:

- Recalculate payment rates for separately paid drugs by including charges for all drugs with HCPCS codes and adjust for charge compression, and, in any event, set rates at no less than ASP plus 6%
- Not instruct hospitals to report charges for pharmacy services on an uncoded revenue code line and continue to work with stakeholders to develop a simplified plan to properly reimburse for pharmacy overhead services
- Pay separately for all drugs with HCPCS codes to eliminate the packaging threshold for drugs
- Continue to pay separately for anti-emetics
- Continue to use the current methodology for setting payments for all radiopharmaceuticals
- Continue to make separate payment for contrast agents
- Implement the proposed increases to the drug administration APCs
- Implement the APC Panel’s March 2007 recommendation to make separate payment for concurrent infusions
- Continue to make payment at the current rate for the pre-administration services associated with providing IVIG and consider making an additional payment to protect access to this therapy.
Government’s new pricing methods put squeeze on pharmacies AJHP Sept 1, 2007

- First came average sales price (ASP). Then came average manufacturer price (AMP). Gone for the most part is average wholesale price (AWP), a figure published in privately owned compendia and not defined by federal law or regulation.
- AWPs, as the OIG told Congress on various occasions, are usually not based on actual sales prices and “bear little resemblance to the prices incurred by retail pharmacies.”
- Pharmacies’ actual acquisition costs for generic drugs in 1999, for example, averaged 66% below AWPs, according to one of the OIG’s reports.
- The ASP and AMP for a drug product, however, are defined by federal law and regulation and provided to the Centers for Medicare and Medicaid Services (CMS) by the manufacturing firm. A high-ranking officer of the firm certifies that the prices are calculated accurately.
- AWPs are based on a manufacturer’s sales of a particular pharmaceutical dosage form, strength, and package size to all purchasers in a given quarter. AMPs come from the prices paid to a manufacturer by wholesalers for a pharmaceutical distributed to what is called the “retail pharmacy class of trade.”

AMP and Medicaid prescriptions AJHP 9.1.07

- The Deficit Reduction Act of 2005 installed AMP in place of AWP as the payment basis for Medicaid-covered prescription medications.
- Since 1.1.07 Medicaid’s maximum payment for multiple-source drugs was 250% of the AMP for the cheapest therapeutic equivalent. Previously: 150% of lowest AWP.
- June: OIG reported that “the lowest AMPs may not reflect prices generally available in the marketplace” for certain drugs.
- July: CMS issued regulations to ensure that manufacturers calculate their AMPs in the same way.
- The retail pharmacy class of trade, CMS decided, includes any pharmacy that buys pharmaceuticals from a manufacturer, wholesaler, or other licensed entity and then dispenses the medications to the public, even through the mail.
- CMS also decided that a multiple-source drug for which the agency sets an upper limit for payment, was any drug available as 2 or more therapeutic equivalents. Previously, there had to be at least 3 therapeutic equivalents for CMS to set a FUL.
- State Medicaid programs in January must start abiding by FUL amounts calculated from the new regulations.
- If community pharmacies close or refuse to fill Medicaid prescriptions, those Medicaid-eligible persons then go to the ER.
- ASHP is concerned that Medicaid beneficiaries in general may have problems obtaining medications if community pharmacies cannot sustain themselves financially under the new AMP regulations.
- Poor AMP-based payment rates will make it more difficult for health systems to continue serving Medicaid and uninsured patients.

ASP & Hospital OP Services AJHP 9.1.07

- MMA 2003 established ASP as the basis for payments to hospitals for the use of certain pharmaceuticals in providing care to outpatients with Part B coverage.
- For 2005–07, the payment rate for those pharmaceuticals was 106% of their ASPs.
- CMS has proposed a payment rate of 105% for 2008.
- ASHP is concerned that ASP plus 6% has not been covering pharmacies’ total costs for acquiring the drugs, handling them, and managing the clinical aspects of medication use.
- As MD offices grapple with the same pay rate, they send some patients to hospitals for drug administration.
- MedPAC reported in January that most oncology, rheumatology, urology, and infectious disease practices interviewed had a blanket policy for sending all Medicare beneficiaries lacking supplemental insurance or having Medicaid eligibility to hospitals if in need of drug treatment: patients unable to pay Medicare Part B’s 20% copay or for whom state-set Medicaid reimbursement inadequately covered Part B copayment.
- ASHP has been “working with members in providing testimony to CMS to advocate for an improvement to the ASP model so hospitals and health systems are reimbursed for the products that are covered under the ASP model for hospital outpatient services.”
- Ernest R. Anderson Jr., pharmacy director at Lahey Clinic in Burlington, Massachusetts, said that in his most recent check of ASP-based payment rates for the clinic’s formulary products, “we were upside down on about a third of the drugs.” For those drug products, the acquisition cost exceeded the payment rate. “We would look at those drugs. It didn’t make sense to carry them,” he said. “We would remove them from our formulary.”
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CMS restricts coverage for erythropoiesis-stimulating agents

- Final national coverage determination from the CMS will permit treatment with erythropoiesis-stimulating agents for anemia related to cancer and other neoplastic conditions.
- Restrict the initiation of therapy to patients with hemoglobin levels less than 10 g/dL.
- Limit the duration of treatment after chemotherapy.
- Limit the starting dose and dose escalation levels.
- The CMS determination is in response to the FDA black box warning placed on epoetin alfa and darbepoeitin alfa after data showed a possible increased risk for death.
- Samuel Silver, MD, director of the University of Michigan Cancer Center Network, said the decision could severely restricting the use of these agents.

How are you going to handle this?

- Leave it to the discretion of the OP or infusion clinic to not use ESAs inappropriately?
- Inform the patient who doesn't fit the model that all costs will be out of pocket?
- Who's going to do this? Pharmacy? Nursing? MD?
- Other???

Did this get done? How long did it take?

New Codes for ESRD-Related EPO

- Dialysis Facilities & Hospitals Billing Medicare FIs for ESRD must use a new billing code.
- New HCPCS code Q4081 indicates 100 units of epoetin alfa.
- This replaces the 1000 unit J code, J0886 in use during 2006.
- Easy to use 2 page article available at:
Did this get done? How long did it take?

**Drug Administration APC’s**
- Reimbursement for OP drug admin increased
- 2006: 6 APCs for drug admin regardless of length of infusion
- 2007: 3 additional new codes for separate payment for additional hours of infusion

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**Chemotherapy Administration**

Services included in the CPT Admin codes:
- Use of local anesthesia
- Starting the IV
- Access to IV, catheter or port
- Routine tubing, syringe, and supplies
- **Preparation of drug**
  - Flushing at completion
  - Hydration fluid

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**Medication Therapy Management**

- Targeted beneficiaries:
  - Multiple diseases
  - Multiple drugs
  - Incur annual costs that exceed a cost threshold of >$4,000 (likely to incur)
Cold Hard Facts

• Clinical services in an inpatient setting are not being reimbursed
• Other healthcare professionals can be the providers of MTMS
• Apply for a provider code ASAP
• Understand the new CPT codes
• Negotiate with private and public sector programs for payment

CPT Codes

• Code 0115T: A first-encounter service performed face-to-face with a patient in a time increment of up to 15 minutes
• Code 0116T: For use with the same patient in a time increment of up to 15 minutes for a subsequent or follow-up encounter
• Code +0117T: Used to bill for additional increments of 15 minutes of time to either of the preceding codes

Why bother to charge and collect on a 2¢ med?

• It’s the wrong attitude to take
• Metrics are crucial
• The charge represents the work done as well as the cost of the med
• Some of the cheapest drugs are the most lethal (KCl, digoxin, heparin)
• Much hospital pricing is artificially low, a loss leader for the drug company
• Plain IVs aren’t like soap in a hotel room
$supplies aren’t free

In the technological age, hospitals should be using a variety of revenue cycle management solutions and coding tools to help streamline the reimbursement process and optimize what revenue still is available.

Supplies aren’t free

IT solutions for charge masters, charge master maintenance, coding and coding compliance, medical necessity verification, reimbursement and information management exist and many are available commercially.

Supplies aren’t free

- Supply cost data should be linked to charge data to ensure charges cover costs with a reasonable mark-up.
- Products covered by annual contracts without escalator clauses should be updated annually with all other increases applied as they occur.
- Excellent communication with your GPO, preferably with electronic downloads, becomes increasingly important to consistent and controlled billing practices.
- Failure to link management of the supply side, whether it is for pharmaceuticals or supplies, and the charge master side leads to missed charges, undercharges and overcharges.
- Challenges of integrating disparate systems, departments and people are not to be underestimated.
- Pharmacy needs to be a major contributor to this segment of the IT and Financial departments. It’s essential for successful healthcare financial management.
The Tangled Web of Pharmacy Pricing
This is not transparency!!

Transparency Objectives:
Consistent, defensible, replicable pricing
• Review charging methodologies for all sites
• Examine the entire medication use process from the perspective of how whatever gets into or onto the patient gets to the chart and gets charged regardless of where the patient is
• Develop a consistent & simple charging methodology to
  – ensure compliant billing
  – reduce patient safety issues
  – realize net revenue opportunities
  – standardize description, CDM aspects, Charging methodology
  – allow for internal benchmarking across the system
• Recommend appropriate, clear role definitions to ensure continual support of the CDM, with internal controls, on-going appropriate coding of Revenue Codes and HCPCS codes and realized net revenue opportunities.

No sacred cows and no taboos
This is not transparency!
If the final patient charge is affected by:
- how the drug is ordered
- whether or not the product is profiled
- where the product is administered (inpatient unit vs procedural area)
- how the drug is entered into the pharmacy system
- which size and configuration of packaging is chosen by pharmacy (injectable meds are the worst)
- the route of administration
- the drug delivery method chosen
- the manufacturer, if the product is multisource or generic
- how the drug is documented as given (or not)

What you’ll probably find…
- Areas of opportunity and areas of exposure
- Many discrepancies between how meds are handled in regular inpatient beds vs. procedural areas
- Regular inpatient beds on regular Nursing units
  – appear to have reasonable procedures and compliance when it’s examined.
- Procedural areas (inpatient and outpatient)
  – lots of workarounds
  – compliance appears to be an issue
  – Don’t get as much focus as inpatient beds despite the fact that here’s where there’s still revenue opportunities

What else is missing…
- A clearly defined, written policy on maintaining the drug dictionary in the pharmacy system
- A naming convention
- A clearly defined written policy on maintaining the pharmacy section of the chargemaster
Identifying System and Process
‘Workarounds’

If any purchasing or design decisions have been made without first taking into account the needs or wishes of all of the departments affected by the new technology, then personnel in the departments will find ways to circumvent the system.

Workarounds

• Workarounds mirror every shortcut or bad decision that has been made during the planning and training and implementation phases.
• You can identify the decision that was made that eventually led to the workaround.
• Acceptance of workarounds is the normalization of deviance or the attitude that “that’s the way it is.” Neither of these has a place in a culture of patient safety.

Culture is the medium for growth

An organization’s culture is what allows it to grow & flourish just like organisms grow & flourish when placed into sterile medium.
Culture Club by Vicki Z. Lauter

- Health care leaders need to employ patience and persistence if they’re going to create a beneficial, shared culture in a growing system.
- As health care systems continue to expand, many are struggling to create a shared culture among their diverse facilities, one that reflects core values and permeates all levels of the organization.
- **Consistency:** To ensure that its culture is represented in all of its offices or operations, an organization must apply and measure the same processes, policies and rules throughout the system. If there is a significant variance, then the culture will not be seen as important or a contributing factor to the organization’s success. Everyone within a system contributes to its culture, whether through support, neglect or subversion.

The much maligned and often scoffed at Charge Description Master (CDM)

- Is the tool that will provide the link between the valuable services & products that pharmacy provides and the payers who will reimburse for those services.
- In a world of electronic transactions, that link is vital. It means the difference between financial viability and reimbursement woes.
- It is the bedrock on which multiple other changes will be built.

The CDM serves many purposes

- Is the charging tool for both products and services
- Should include RVU’s
- Should be able to provide statistics automatically rather than having to calculate these manually
  - Workload
  - Pharmacy cost of treating a DRG
Using the service category concept

- Easily allows “sensitive” products to be culled out for nominal priced charges
- Can be updated easily by blocks of numbers rather than line item by line
- Is defensible
  - Handling costs for injections or biologics far outstrip those for tablets & capsules

PRODUCT AND SERVICE CATEGORIES

- Oral Solids, Tablets, Capsules
- Oral Liquids
- Injectable Products
- Chemotherapy Products
- Biological Products
- Controlled Substances (All routes) Schedule II, III, IV, V and steroids
- EENT Products
- Inhalations, IPPB, Otics, Ophthalmics
- Topical Products
- Creams, Ointments, Powders, Sprays, Vaginal Products, Rectal Products
- Anesthesia & Radiology Products
- Diagnostic Products (Including Reagents, tests, etc.)
- Enteral Nutritional Products
- Procedural Fees & Non-Dispensing Activities:

Defined CHARGING UNITS

Oral Solids:
- The standard unit is one unit dose capsule or tablet. Charge (1) for each tablet or capsule dispensed.
- Exceptions include unit-of-use packaging with two (2) tablets, (e.g., Aspirin, Tylenol, etc.) or
- Nitroglycerin unit-of-use package of 25 tablets. In this case, charge (1) for each unit-of-use package dispensed.

Oral Liquids:
- The standard unit is one unit dose cup or ped-pod or equivalent unit dose volume (e.g., charge for each dose of a liquid even though 60mL may have been dispensed). Charge (1) for each dose of liquid dispensed.
- Exceptions include unit-of-use packaging such as antacids in 5 oz bottles. In this case, charge (1) for each unit-of-use package dispensed.
Defined PROCEDURAL FEES

Chemotherapy Prep Fee:
• Charge (1) chemotherapy prep fee for each chemotherapy prepared and/or admixed. If a second drug is added, do not charge a second unit. The dollar value assigned to this is inclusive of the supplies required for preparing chemotherapy.

Prefill CADD Delivery System:
• Charge (1) for each CADD reservoir that is filled with solution and drug product. If a second drug is added, do not charge a second unit.

Defined Non-Dispensing Activities

Allow for documentation of non-dispensing pharmacy activities.
The standard unit is one function or task.
Document (1) for each task completed.
Use the patient profile for documentation purposes.

a. Therapeutic Intervention: (RVU 10)
Document (1) each time pharmacy intervenes in therapy, whether this is requested or voluntary.
For example: Calling or leaving a note about:
  – a non-formulary drug
  – therapeutic duplication
  – lack of indication
  – dosage or therapeutic recommendation
  – potential allergy or interaction
  – other

b. Detailed Profile Review: (RVU 20)
Document (1) each time the pharmacist examines the patient’s medical record to assess the appropriateness of medication orders, monitor and evaluate treatment and progress, or update individual patient profiles for rounds.
This includes participation in interdisciplinary rounds, ID rounds, beta-blocker review, reconciliation of medications, or other reviews of the patient’s medication list and chart.

c. Pharmacy Dosing Consult-Initial or Complex (RVU 60)
This includes initial anticoagulation consults, initial kinetic consults, nutrition consults, pain consult, complex ED consult, DVT consult, and others.
d. Pharmacy Dosing Consult-Simple or Follow-up (RVU 30)
Document (1) for any follow-up dosing or simple consults. This includes follow-up anticoagulation visits, follow-up kinetics monitoring, daily TPN monitoring, simple pharmacy-to-dose consults, simple ED consults, and others.
How to price?

• Drug cost + “mark-up” = patient charge
• Mark-up could also be considered a handling fee
• Abandon the % mark-up concept
• Use a fee concept reflective both of handling costs and net revenue for the dosage form

Not recommended:

• Based on AWP
• Has little relationship to cost of product
• Has been abandoned by both CMS who now use ASP and Medicare who now use AMP
• AWP = Average wholesale price
• ASP = Average sales price (determined by CMS, updated and published quarterly)
• AMP = Average manufacturer price (determined by CMS, updated and published quarterly)

ASP: Average selling price of manufacturer’s sales of all US purchases for each NDC for one calendar quarter, divided by total number of units sold in that quarter

Excludes nominal pricing and Medicaid “best price.”
Includes volume and prompt pay discounts, free goods, chargebacks, rebates

CMS abandoned AWP and moved to ASP October 2005
Why AWP doesn’t work

- Meaningless # not reflective of actual cost
- Abandoned by CMS in October 2005
- Is NDC dependent
  - NDC is a code for the drug, manufacturer and package size
- Pharmacy system files were built years ago using an NDC # that may no longer reflect what actually is being purchased

1st DataBank’s Drug Data File Changes
- Changes relate to publishing Blue Book Average Wholesale Price (AWP) and the proposed settlement of class action litigation concerning Blue Book AWP.
- If approved, 1st DataBank will
  - Adjust its reporting of Blue Book AWP for certain prescription drugs by reducing the mark-up factor utilized in connection with the calculation of Blue Book AWP data field to 1.20 for all NDCs having a mark-up factor to WAC or Direct Price in excess of 1.20 (adjustment estimated to occur during the 2nd quarter 2008),
  - Discontinue publishing Blue Book AWP data field for all drugs no later than 2 years after the final court order effective date
  - Establish a centralized data repository to facilitate access to discoverable material concerning its drug price reporting practices,
  - Work with major participants in the healthcare industry in court approved discussions intended to facilitate the establishment of a sustainable benchmark for drug reimbursement.
- First DataBank will continue to publish other available drug pricing information including WAC, Direct Price, suggested wholesale price, Federal Financing Participation Upper Limits (FFPUL)

What should the mark-up be?
Currently: Based on a % of the “cost” with ranges of % depending on the cost

Options:
- Based on a % of the acquisition cost with % mark-up determined by dosage form
- Based on a fixed fee for each dosage form regardless of the acquisition cost
- Rationale: Regardless of cost, each product within a dosage form or service class requires the same handling procedures.
Mark-up is Paying for the Medication Use Process

- Establishing a formulary
- Purchasing the product (using GPO pricing)
- Storing the product
- Receiving and reviewing the MD order
- Entering the MD order into Pharmacy System
- Dispensing the product (from Pharmacy or from Pyxis which has been stocked by pharmacy)
- Administering the product
- Charting the administration
- Charging for the product
- Collecting for the charge

What’s available from the GPO Pharmacy Purchasing Catalog

- Electronic List of all contracted products with firm pricing for the duration of the contract
- Defined escalator clauses
- Pricing on an “each” basis as opposed to a package or a case
- An NDC for each product as well as both the trade and generic names

Should the NDC of the actual product being dispensed be a part of this project?

- Yes
  - is the tie to the actual acquisition price for both the contract price and the wholesaler selling price
  - required for Robotic dispensing
  - required for Medicaid billing
  - required for BPOC
Must Win Battles: Lessons from Successful and Failed Journeys

- rather than spreading resources too thin, focus on three to five key challenges - must-win battles (MWBs) that are crucial to achieving goals
- a well-chosen MWB, must make a real difference, be market focused, create excitement, be specific and tangible, and be winnable
- the Transparency in pharmacy pricing is a MWB

http://knowledge.wharton.upenn.edu/article/1538.cfm

Must-Win Battles: How to Win Them, Again and Again published by Wharton School Publishing

My Survival Rules

- Get the best pricing possible
- Use 340B if you qualify (don't cheat)
- Use patient assistance programs when applicable
- Capture all charges in all areas including radiology, cath lab, etc even if they're not reimbursed
- Have a pristine and timely CDM
- Have a $ tsar on staff
- Bill for and collect co-pays
- Know what your bad debt is and have it offset in your budget
- Bill for all related services, supplies and admin fees even if they're not reimbursed
- Be a part of the team that negotiates terms with the 3rd party payers
- Know what the pharmacy $ costs are for each service the facility is offering and make sure that the C suite knows them too
- You may not be deciding what services the facility will be offering, but it's your job to convey what the pharmacy $ costs are
- If the facility's offering the service, then the $ have to go into your budget

Are you confident that Nursing and the Billing Department are doing their parts to ensure your financial stability?
If the answer is “no”, then step up and do something about it.

Give someone on your staff permission to be excited about working with this. You need fiscal health champions as well as clinical champions.

- Does your facility have a multidisciplinary revenue oriented team or committee?
- Is Pharmacy a regular member?
- Who else is there?
  - Financial (audit, accounts receivable, accounting)
  - Clinical (medicine, pharmacy, radiology, laboratory, resp therapy, nursing)
  - Legal (risk management)
  - Social services
- What's on the agenda?
  - Payment denials?
  - Patient assistance programs?
  - Policy on off label use?
  - Copayment collections?

From: Alternatives when the system fails
ASHP Virtual Symposium on MMA Reimbursement Issues
More Reimbursement Help:

Reimbursement Matters columns are available at www.pharmacypracticenews.com

Click on Columnists on the left side of the page, then on “Reimbursement Matters” to access these reprints

Appendix

• The following slides are for your reference as you work on these issues.
• My contact information:
  • bkirschen@aol.com

What are Fiscal Intermediaries?

• US is divided into several geographical regions, each assigned to a Fiscal Intermediary (FI)
• FI receives billings from the hospital and OP clinics and submits them to CMS for payment
• Knowing who your fiscal intermediary is and what peculiarities may affect your region is important
• Each FI has a toll free number
  – See www.cms.hhs.gov/medlearn/tollnums.asp
• CMS releases updates & software to FIs quarterly
• Provider education articles available shortly after a CR is issued. See: cms.hhs.gov/medlearn/matters
Quick review of charging

- ICD9 codes are used by hospitals to designate disease types
- CPT codes
  - are used by physicians to describe procedures they do
  - are determined by the AMA
  - may include payment for all the products used during the procedure
- HCPCS codes are for products and may or may not be reimbursed
- DRGs apply to inpatients and apply only to Medicare patients
- APCs apply to outpatients and apply only to Medicare patients
- DRG and APC methodology is often used as a template for other insurance reimbursement

American Medical Association (AMA)

Diversity of Organizations


Editorial Panel

Resource Utilization Committee (RUC)

Code Descriptions Hierarchy

PSTAC

What is CPT?

  - Active Organizational / Healthcare Industry Process
  - Community of Practitioners and Payors
  - Coding System
  - Publication
- Descriptive terms and identifying terms for reporting medical services, procedures and lab tests
- Provides a uniform language to describe medical, surgical, and diagnostic services
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 determine if all program requirements for coverage are met, e.g., that it is reasonable and necessary to treat the beneficiary’s condition and whether it’s excluded from payment.

The Importance of Codes

- Codes are needed for reimbursement, but the fact that a product has a code does not guarantee payment.
- Coding is the language with which to describe 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.

- A dilemma often arises when the literature supports and a patient is treated for an off-label indication.
- The fact that it is off-label may be sufficient grounds for the FI to deny payment.
- Patient and billing assistance programs offered by several of the pharmaceutical companies may be helpful in providing support in attempting to have these denials overturned.
Another peculiarity of coding is that often the billing units assigned are not the same as the vial sizes. To ensure correct reimbursement, the Charge Description Master (CDM) must be adjusted accordingly or a crosswalk created.

A new drug is approved.... what should I do?

• Some of the brightest minds in the pharmacy department are devoted to feverishly preparing P&T submissions extolling the virtues and known pitfalls of the product and crafting prescribing guidelines to ensure wise use in the institutional setting
• Unfortunately, few of the brightest minds are concerned about the practical aspects of actually acquiring the product and incorporating it into the logistics of the pharmacy operations
CMS Billing Procedure on Uncoded New Drugs

- Hospitals now receive 95% of AWP on newly approved drugs and biologicals used in an outpatient setting that have not yet been assigned a product-specific HCPCS code.
- Previously, there was no payment until a specific billing code had been approved.
- Use Unclassified Drug or Biological HCPCS code C9399
- For full details see: www.cms.hhs.gov/manuals/pm_trans/R188CP.pdf

What to do with a new drug

- Contact your GPO to determine pricing, contract status and other negotiated terms
- Contact the manufacturer for information on patient assistance programs, reimbursement programs or assistance that outline the steps for documentation required for reimbursement
- Assign a Charge Description Master (CDM) # and a price (billing departments should accept changes at least weekly)
- Link the CDM # to the CMS billing code for new drugs

What to do with a new drug

- Stay aware of assignment of a designated code to replace this. (Unfortunately no easy-to-use recap available, just quarterly CMS website updates)
- Submissions using the wrong code are rejected
- If used in an Outpatient setting, ensure that the code assigned matches the billing units being reimbursed
- Consider using a crosswalk to automatically correct for this
What to do with a new drug

- Activate the drug in the Pharmacy Computer Drug Master File and link it to the CDM # (Don’t forget to change miscellaneous codes for actual and designated ones as soon as they are assigned)
- Contact the Pharmacy Computer Vendor if new drug data is not provided on a timely basis
- Avoid miscellaneous CDM numbers and “in-house–created” drug entries. They are the kiss of death to reimbursement.

Bedtime Scenario 1: The Inpatient

- This patient has been admitted to an inpatient bed and is sleeping at the facility
- The inpatient CDM applies as does inpatient pricing
- If a Medicare beneficiary, Part A covers 80% of the cost of the admission, and the patient is responsible for 20%
- Patient may have additional insurance for the co-pay
- The Inpatient Prospective Payment System (IPPS), with its Diagnosis-Related Group (DRG) methodology regulates the payment of inpatient costs
- But the entire IPPS system is undergoing substantial review by CMS to more accurately reflect the costs of providing the services

Bill Properly for Take-Home Part B Drugs

- Effective July 1, 2006, CMS clarified billing for take-home oral anticancer drugs, oral antiemetics, immunosuppressants and the associated supplying fees when these Part B drugs aren’t part of a procedure performed in the hospital.
- Hospitals are being instructed to bill their durable medical equipment regional carrier for these multi-day prescriptions.
- There is no change to billing a one-day supply of these products used in conjunction with a procedure.
There may, of course, be no "right" answer to any of these questions

**Q:** Inpatients who usually receive their Part B medications as outpatients.
- Part B Medications are reimbursed only when administered in the outpatient setting or in a physician’s office.
- A dilemma arises if the patient’s admitted and the physician orders a Part B medication, e.g. Neulasta, Aranesp or Lupron Depot.
  Convenient for the patient to get the medication while hospitalized rather than make a separate visit to the facility after discharge, but the cost of the product is prohibitive and there’s no reimbursement for product administered in the hospital.
  Do you allow these products to be used only in the outpatient infusion center? Do you ask the patient to stop at the infusion center immediately following discharge? If so, is there the potential for refusal of payment, as the patient cannot be in two places on the same day?

**A:** Unfortunately, not all questions have satisfactory answers.

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**First the Fog, Now a Patch of Thorns**

- Whether a Part D drug is covered or not is determined by the formulary of the PDP in which the Medicare beneficiary has enrolled.
- Not all formularies are the same and knowing which formulary covers which patient is only the first step in resolving some thorny payment questions.
- The dilemma is especially difficult for four groups of patients:
  - discharged but are still on the hospital premises
  - inpatients who usually receive Part B medications as outpatients
  - Part D patients stabilized on medications not on the hospital formulary
  - observation or “23-hr admit” patients.

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**There may, of course, be no "right" answer to any of these questions**

**Q:** Meds from home. The patient participates in Part D and takes prescription medications covered by the PDP formulary. The hospital formulary does not include these medications. The discrepancies are discovered during a medication reconciliation at admission. What should you do?

**A:**
- **Suggested solutions**
  - Change the patient’s medications to therapeutic equivalents on the hospital formulary, then switch them back to the originals on discharge.
  - Allow the patient to use “meds from home” while in the hospital.
- But if this option is chosen, who is responsible for identifying the medications? How is billing going to be handled—or should there be any billing at all?
- P&T policy should state why, when and how a patient’s own personal supply of medications may be utilized and must be written to comply with the JCAHO Medication Management standards regarding this issue.
- Medications generally shouldn’t be kept at the bedside but stored in the nursing units or automated dispensing units, then dispensed and charted by nursing.
Bedtime Scenario 2: The Outpatient

- These patients sleep at home and come to the hospital to use outpatient facilities
- Meds used during their visit may be covered under OPPS, Medicare Part B, or may be paid for out-of-pocket
- Medicare covers 80% of the cost of Part B drugs based on ASP with a 20% co-pay by the patient
- Unfortunately, many facilities opt not to bill for this co-pay
- If the pharmacy drug spend for these patients is $1 million, $200,000 is a huge sum to be ignoring. Think of how many therapeutic interventions would be needed to recoup this amount.
- If the patient has Part D and your facility is a Part D provider, you could be filling outpatient prescriptions that the patient uses at home
- Outpatient medications can't be dispensed at inpatient prices, and the patient can be billed only for the co-pay allowed by the plan. The plan itself must be billed for the remainder.

Bedtime Scenario 3: The Nursing Home Resident

- This person sleeps in a nursing home bed, which may be operated by the hospital or may be a freestanding entity
- Nursing home residents are not considered inpatients, so the inpatient CDM, billing system or pricing can't be used for them
- If the resident has Part D coverage, the plan terms must be used for prescription coverage. This applies to hospitals of all sizes in all geographic areas including critical access hospitals
- The answer to billing complexities lies in integrating the pharmacy computer system with the hospital billing system to allow individual electronic bill to be sent to the appropriate Medicare Part D plans.
- Billing needs to see all details of the transaction for reporting purposes (pharmacy outpatient prescription charge, patient co-pay, third-party payment and the write-off amount, if any)
- The resident should be billed only for the co-pay for each medication

Bedtime Scenario 4: The Observation Patient

- Clinical Observation Units: a viable solution to constraints in the ER, lack of inpatient beds and the CMS shift towards a greater reliance on outpatient services, mimicked by the private payers
- Are reimbursed under the OPPS
- CMS reimburses for observation services for a minimum of 8 hours to a maximum of 24 hours, patients may stay for up to 48 hours, payment stops at 24 hours
- Observation services are bundled with the initial ER visit except for 3 APC's: asthma, chest pain and congestive heart failure which are separately billable at a predetermined fee
- Patients can be admitted from an observation unit, they cannot be discharged to an observation unit
There may, of course, be no "right" answer to any of these questions.

Q: Observation or “23-hr admit” patients and those temporarily on the premises.

The patient is not admitted to the facility, but is simply under observation. The patient has Part D coverage and is on a combination of oral meds as well as ophthalmic, oto, nasal and inhalation medications that need to be continued during the observation period. What should you do?

A: You could dispense new supplies to the patient, but these are not billable. Use the patient’s supply that already has been paid for by Part D. e.g. if an observation or outpatient needs a dose of Advair 500/50 during a stay of 2 to 3 hours, it’s not prudent to send a $125+ inhaler for the patient if he has his own and routinely self-administers it.