Ambulatory Care PRN Focus Session—Billing Practices in Ambulatory Care Pharmacy: Developing, Implementing, and Sustaining Ideal Models

Activity Number: 0217-0000-15-141-L04-P, 1.50 hours of CPE credit; Activity Type: A Knowledge-Based Activity

Tuesday, October 20, 2015

3:15 p.m. to 4:45 p.m.
Continental Ballroom 4

Note: This session is being recorded for future playback. A complimentary copy of these recordings will be available to all 2015 ACCP Global Conference on Clinical Pharmacy registrants approximately two weeks after the conclusion of the conference.

Moderator: Daniel M. Riche, Pharm.D., BCPS, CDE
Associate Professor of Pharmacy Practice, University of Mississippi School of Pharmacy, Assistant Professor of Medicine, University of Mississippi Medical Center, Jackson, Mississippi

Agenda

3:15 p.m.	Maximizing "Incident-to" Billing Strategies *Sandra Leal, Pharm.D., MPH, CDE* Vice President for Innovation, SinfoniaRx, Tucson, Arizona
3:35 p.m.	Innovative and Integrative Medication-related Services in North America *Karen D. Riley, Pharm.D., BCPS, CGP, BCACP, CDE* Clinical Assistant Professor, University of Florida College of Pharmacy, Gainesville, Florida; Consultant and Medication Therapy Management Specialist, KD Riley Pharmacist Professional Corporation, Ontario, Canada
3:55 p.m.	New Practice Opportunities with Medicare: Annual Wellness Visits & Transitions of Care *Jamie Cavanaugh, Pharm.D., CPP, BCPS* Clinical Pharmacist Practitioner, UNC Hospitals Clinical Specialist, Assistant Professor of Clinical Education, Assistant Professor of Medicine, University of North Carolina, Chapel Hill, North Carolina *Stephanie L. Ballard, Pharm.D., BCPS* Clinical Pharmacist – Family Medicine, Director, Pharmacy Residency Faculty, Family Medicine Residency, UPMC Shadyside, Pittsburgh, Pennsylvania
4:35 p.m.	Question and Answer

Conflict of Interest Disclosures

Stephanie L. Ballard: no conflicts to disclose.
Jamie Cavanaugh: no conflicts to disclose.

Sandra Leal: no conflicts to disclose.
Daniel M. Riche: no conflicts to disclose.
Karen D. Riley: no conflicts to disclose.

Learning Objectives

1. Identify best billing practices for "Incident-to", MTM, Annual Medicare Wellness and Transitions of Care practice models.
2. Describe the implementation of compensation-driven practice models, including the maximization of reimbursements.
3. Discuss strategies to overcome barriers/challenges of incorporating new billing practice models.
4. Explain successful development and implementation strategies of innovative pharmacist-led MTM practices within community and ambulatory care practice settings.
5. Select appropriate MTM compensation strategies to integrate into both community and ambulatory care practice settings.
6. Describe solutions for battling regional challenges when utilizing the MTM practice model.
7. Explain the development of billable Medicare-related ambulatory pharmacy services.
8. Describe the implementation and challenges of compensation strategies using the Annual Wellness model.
9. Describe the implementation and challenges of compensation strategies using the Transitions of Care model.

Self-Assessment Questions

Self-assessment questions are available online at www.accp.com/gc15.

2015 ACCP Global Conference on Clinical Pharmacy

Maximizing "Incident-to" Billing Strategies
Sandra Leal, PharmD, MPH, CDE
October 20, 2015

Conflict of Interests

- None

Learning Objectives

- Describe the development of billable "Incident-to" ambulatory pharmacy services
- Discuss how to implement/maximize compensation strategies using the "Incident-to" model
- Identify the challenges and their solutions with the "Incident-to" model

"Incident-to" Defined

- Defined as those services that are furnished incident to physician professional services in the physician's office (whether located in a separate office suite or within an institution) or in a patient's home.

Source: CMS; https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf

Changes

- Historically pharmacists have only been able to bill at the lowest, 99211 level visit, also known as a "nurse visit."
- In 2014 the CMS changed the definition of "auxiliary staff" to include the following language: "and meets any applicable requirements to provide the services, including licensure, imposed by the State in which the services are being furnished."

Non-Physician Providers (NPP)

- "Incident to" services are also relevant to services supervised by certain non-physician practitioners such as physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, or clinical psychologists.

Source: CMS; https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf

"Incident-to" Pearls

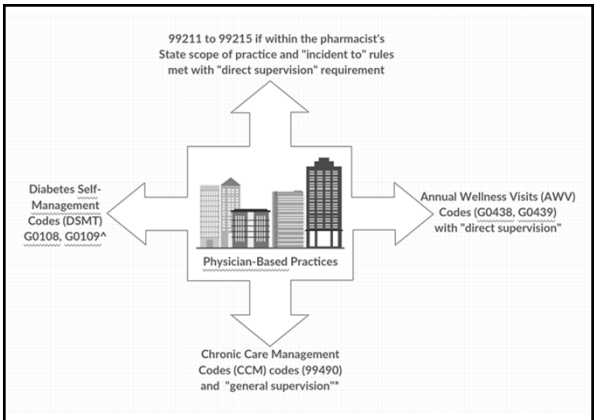
- Cannot be billed when more than 50% of the visit is for counseling or care coordination*
- May not include diagnostic testing*
- "Incident services" supervised by non-physician practitioners are reimbursed at 85 percent of the physician fee schedule^

*Source: American Academy of Family Practice; http://www.aafp.org/fpm/2015/0300/p15.html
^Source: CMS; https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf

To Qualify

- Part of patient's normal course of treatment, during which a physician **personally performed the initial service** and remains **actively involved** in the course of treatment
- Direct supervision
- Patient record should document the requirement for service

^Source: CMS; https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf



^DSMT Program must be accredited by AADE or ADA

Medicare Rules: Degree of Supervision

- General supervision – The physician need not be on-site,
- Direct supervision – The physician must be in the office suite but not necessarily in the same room.

Source: American Academy of Family Practice: http://www.aafp.org/fpm/2015/0300/p15.html

Chronic Care Management (CCM)

- General supervision
- 2015 final Medicare physician fee schedule also removed direct employee of the practitioner or practice
- CMS does not stipulate nature of employment or contractual relationship between clinical staff and practitioner or practice billing CCM

Source: Medical Group Management Association (MGMA); http://goo.gl/iOm2UM

Federally Qualified Health Centers (FQHCs)

- A FQHC practitioner is a physician, nurse practitioner (NP), physician assistant (PA), certified nurse midwife (CNM), clinical psychologist (CP), clinical social worker (CSW), or a certified diabetes self-management training/medical nutrition therapy (DSMT/MNT) provider.

Source: CMS; http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf

FQHCs

^FQHCs reimburse G0108 only; they do not cover group visits

State to State Variation

- Scope of Practice
- Medication therapy management versus chronic disease state
- Be broad

Changes

- Prior to the transition to the Medicare Administrative Contractors (MACs), there were 23 Fiscal Intermediaries (FIs) and 17 carriers. Currently, there are 15 MACs which serve as the primary point of contact for:
  - Provider enrollment,
  - Medicare coverage and billing requirements,
  - Training for providers, and
  - Receipt, processing and payment of Medicare fee-for-service claims
- Medicare providers are assigned to the local designated MAC based on their geographic location to the MAC which has jurisdiction for that benefit category and location.

Source: Practicons; http://www.practicons.com/2013/future-plans-for-medicare-administrative-contractors-macs/

Find Your MAC

Source: CMS; http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/

Key Points

- Understand your practice site to determine what codes you can and can not use
- Understand CMS rules
- Always ask for verification

Sandra Leal, PharmD, MPH
Vice President for Innovation | SinfoniaRx
520-302-5325
SLeal@SinfoniaRx.com

2015 ACCP Global Conference on Clinical Pharmacy

Innovative and Integrative Medication-related Services in North America

Karen Riley BScPhm, Pharm D, BCPS, CGP, BCACP, CDE

October 20, 2015

Conflict of Interests

- None to disclose for this presentation

Learning Objectives

- Explain successful development and implementation strategies of innovative pharmacist-led MTM practices within community and ambulatory care practice settings
- Select appropriate MTM compensation strategies to integrate into both community and ambulatory care practice settings
- Describe solutions for battling regional challenges when utilizing the MTM practice model

US Pharmacy Model

- Typically 10 years ahead of most countries with the push from CMS, Ambulatory care development and TJC metrics for measure
- Pharm D entry level to practice for 15 years or greater
- PGY1, 2 and now 3 residency years
- Most Pharm D trained pharmacists in Canada received their advanced degree in the US

Canadian Model CPhA is Leading the Blueprint for Pharmacy

VISION FOR PHARMACY

Optimal drug therapy outcomes for Canadians through patient-centred care

- The Blueprint for Pharmacy is a long-term collaborative initiative for managing and accelerating the changes required in pharmacy practice to meet the health care needs of Canadians
- The Pharmacy profession is working together to achieve a common vision and implement a coordinated plan of action

Canadian Pharmacist Association

VISION FOR PHARMACY

Optimal drug therapy outcomes for Canadians through patient-centred care

In our Vision for Pharmacy

Pharmacists and pharmacy technicians

- practice to the full extent of their knowledge and skills, and are integral to emerging health care models.
- protect the safety, security and integrity of the drug distribution system through the enhanced role of regulated pharmacy technicians and greater automation of dispensing.
- lead the development of and participate in medication safety and quality improvement initiatives.

Pharmacists

- manage drug therapy in collaboration with patients, caregivers and other health care providers.
- identify medication use issues, take responsibility for drug therapy decisions and monitor outcomes.
- initiate, modify and continue drug therapy (e.g., through collaborative agreements, delegated or prescriptive authority), and order tests.
- access and document relevant patient care information in health records, including test results and treatment indications (e.g., in electronic health records).
- empower patients in decision-making about their health, and play a prominent role in health promotion, disease prevention and chronic disease management.
- conduct practice research and contribute to evidence-based health care policy and best practices in patient care.

Pharmacists' services

- are compensated in a manner that relates to expertise and complexity of care.

Canadian Pharmacist Association

State of the nation

- Total licensed pharmacists 38,737
- Total licensed pharmacy technicians 4,349
  - Ontario 2,927
  - British Columbia 915
  - Alberta 457
- Pharmacies 9,843
  - Community pharmacies 9,558
  - Inpatient registered hospital pharmacies 285

Canadian Pharmacist Association

2005 Pharmacists' Expanded Scope of Practice in Canada

X Not implemented

	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL	NWT	YT	NU
Provide emergency prescription refills	X	X	X	X	X	X	X	X	X	X	X	X	X
Renew/extend prescriptions	X	X	X	X	X	X	X	X	X	X	X	X	X
Change drug dosage/formulation	X	X	X	X	X	X	X	X	X	X	X	X	X
Make therapeutic substitution	X	X	X	X	X	X	X	X	X	X	X	X	X
Prescribe for minor ailments/conditions	X	X	X	X	X	X	X	X	X	X	X	X	X
Initiate prescription drug therapy	X	X	X	X	X	X	X	X	X	X	X	X	X
Order and interpret lab tests	X	X	X	X	X	X	X	X	X	X	X	X	X
Administer a drug by injection	X	X	X	X	X	X	X	X	X	X	X	X	X
Regulated Pharmacy Technicians	X	X	X	X	X	X	X	X	X	X	X	X	X

Canadian Pharmacists Association

2010 Pharmacists' Expanded Scope of Practice in Canada

✓ Implemented in jurisdiction P Pending legislation, regulation or policy for implementation X Not implemented

	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL	NWT	YT	NU
Provide emergency prescription refills	✓	✓	✓	P	✓	X	✓	✓	✓	✓	✓	X	X
Renew/extend prescriptions	✓	✓	✓	P	P	X	✓	✓	✓	✓	✓	X	X
Change drug dosage/formulation	✓	✓	✓	X	P	X	✓	✓	X	✓	X	X	X
Make therapeutic substitution	✓	✓	✓	X	X	X	✓	✓	X	X	X	X	X
Prescribe for minor ailments/conditions	X	✓	P	X	X	X	X	P	X	X	X	X	X
Initiate prescription drug therapy	X	✓	P	P	P	X	P	P	X	X	X	X	X
Order and interpret lab tests	X	✓	X	P	P	X	P	P	X	X	X	X	X
Administer a drug by injection	✓	✓	X	P	P	X	P	P	X	X	X	X	X
Regulated Pharmacy Technicians	✓	P	P	P	✓	X	P	P	X	X	X	X	X

Canadian Pharmacist Association

2015 Pharmacists' Expanded Scope of Practice in Canada

✓ Implemented in jurisdiction P Pending legislation, regulation or policy for implementation X Not implemented

	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL	NWT	YT	NU
Provide emergency prescription refills	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	X
Renew/extend prescriptions	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	X
Change drug dosage/formulation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	X	X
Make therapeutic substitution	✓	✓	✓	X	X	✓	✓	✓	✓	✓	X	X	X
Prescribe for minor ailments/conditions	X	✓	✓	✓	X	✓	✓	✓	✓	P	X	X	X
Initiate prescription drug therapy	X	✓	✓	✓	✓	✓	✓	✓	✓	X	X	X	X
Order and interpret lab tests	X	✓	P	✓	P	✓	P	✓	P	X	X	X	X
Administer a drug by injection	✓	✓	P	✓	✓	X	✓	✓	✓	✓	X	X	X
Regulated Pharmacy Technicians	✓	✓	P	P	✓	X	✓	✓	✓	✓	X	X	X

Canadian Pharmacist Association

2005 Provincial Government-Funded Pharmacy Services

	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL
Medication Review/Assessment — Basic/Standard										
Medication Review/Assessment — Specific for Diabetes										
Medication Review/Assessment — Advanced/Comprehensive										
Minor Ailments Assessment/Prescribing										
Smoking Cessation Services										
Immunization										
Prescription Adaptation, Renewals, Trial Rx, Refusal to Fill Rx, Pharmaceutical Opinion, etc.						✓				

Canadian Pharmacist Association

2010 Provincial Government-Funded Pharmacy Services

	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL
Medication Review/Assessment — Basic/Standard			✓		✓					
Medication Review/Assessment — Specific for Diabetes					✓					
Medication Review/Assessment — Advanced/Comprehensive					✓					
Minor Ailments Assessment/Prescribing										
Smoking Cessation Services										
Immunization	✓									
Prescription Adaptation, Renewals, Trial Rx, Refusal to Fill Rx, Pharmaceutical Opinion, etc.	✓		✓			✓				✓

Canadian Pharmacist Association

2015 Provincial Government-Funded Pharmacy Services

	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL
Medication Review/Assessment – Basic/Standard	✓	✓	✓		✓		✓	✓	✓	✓
Medication Review/Assessment – Specific for Diabetes					✓				✓	✓
Medication Review/Assessment – Advanced/Comprehensive		✓			✓			✓		
Minor Ailments Assessment/Prescribing		✓	✓					✓		
Smoking Cessation Services		✓	✓		✓					
Immunization	✓	✓		✓	✓		✓	✓	✓	✓
Prescription Adaptation, Renewals, Trial Rx, Refusal to Fill Rx, Pharmaceutical Opinion, etc.	✓	✓	✓		✓	✓		✓	✓	✓

Canadian Pharmacist Association

Pharmacists in Outpatient Hospital Programs 2011/2012

Program	Percent	Program	Percent
Hematology/onc	81	Asthma/allergy	12
Anticoagulation	56	Pain/palliative care	9
ID/HIV	38	Mental Health	11
Renal	66	General surgery	8
Emergency	57	Neurology	4
Transplantation	56	General medicine	8
Diabetes	34	Gyn/OB	2
Cardiovascular	33	Rehab	3
Geriatrics	18		

http://www.lillyhospitalsurvey.ca/hpc2/content/rep_2012_toc.asp

Objective 1

- Explain successful development and implementation strategies of innovative pharmacist-led MTM practices within community and ambulatory care practice settings

Raising our Visibility

- If you are not at the table, you are on the menu
- Be best known for one thing…
- Be the leading resource for….
- Be worthy to be talked about…
- Branding – re-mark-able – worthy of being or likely to be noticed especially as being extraordinary
- If you want people to be interested - you have to be interesting

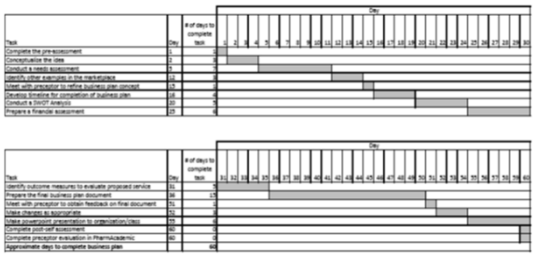
David Arvin Visibility coach. www.visibilitycoach.com ASHP 2015 summer meeting

Development

- Business Plans
  - Needs assessment
  - Service Design
  - Reality Check
  - Key Stakeholder Buy in
  - Business plan
  - Implementation
  - Marketing
  - Service enhancement
  - Outcomes evaluation

How to Develop a Business Plan for Pharmacy Services 2nd edition, 2007 ;Harvard Business Review

GANNT charts



Plan for your success

Put the big rocks in first

Steven Covey

Implementing Ambulatory Services: Considerations

1. Needs assessment
2. Align goals
3. Define scope
4. Standardize approach
5. Propose service
6. Allocate resources
7. Identify key stakeholders
8. Identify quality standards
9. Develop competency standards
10. Develop strategy for compensation
11. Monitor outcomes

ASHP 2014 Ambulatory Care Conference, Dallas

Needs Assessment

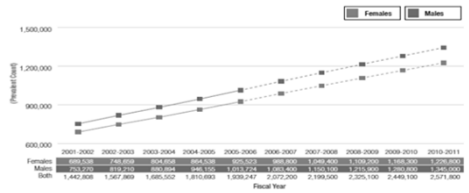
- Drug related errors
  - In the US, the Institute of Medicine report indicated that medication related problems account for more than 2 million serious adverse events and up to 7,000 annual deaths[1]
  - In Canada, drug-related hospitalizations cost about $2.6 billion per year[2]. In one study, 20% of patients discharged home from an acute care facility experienced an adverse effect and 60% of these were drug related[3]

1. Institute of Medicine (IOM). To err is human; building a safer health system. Washington, DC; National Academy Press 2001
2. Hohl, C.M., et al. *Ann Emerg Med.* 2011. 58(3):270-279.
3. Forster, A.J., et al. *Ann Intern Med.* 2003. 4138(3): 161-167.

Mine the Chronic Illness Data

PROJECTION FOR CANADA

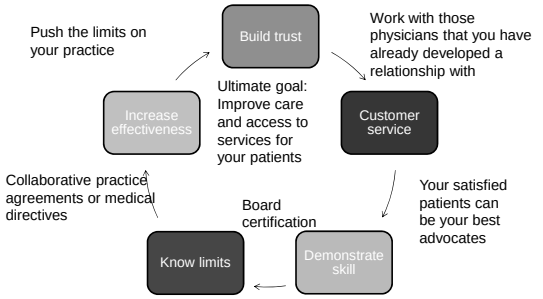
Figure 3:
Observed and projected prevalence of diagnosed diabetes among people aged 1 year and older, by sex observed: 2001-2002 to 2005-2006 and projected: 2006-2007 to 2010-2011[6]



Transitions of Care Resources

- Hospital to Home- Facilitating Safe Medications at Transitions Toolkit
- Document developed by ISMP Canada with Ontario Ministry of Health and Long Term Care
- ISMP High Alert Medications in Community

Scope & Relationships



Key Stakeholders

Tell a Story…..

- Paint a picture
- Move and captivate people
- Touch people's emotions

Elevator Speech

- 15 seconds to 2 minutes
- Brief chance encounters
- Highlight pharmacy value
- What's in it for them

Donald M. Berwick, MD, MPP, President & CEO, Institute for Healthcare Improvement.
Sharon Enright and Sara White. ASHP Leadership Academy 2010-11.

Outcomes that Ambulatory Care Pharmacists Can Impact

Health programs examples

- CMS Star ratings
- PCMH certification programs
- Health Insurance Exchange
- HEDIS
- CMS hospital readmission reduction
- CMS Medicare Shared Savings program

Performance Measures

- COPD, HF, pneumonia, stroke 30 days readmission rates
- Chronic diseases
- Diabetes (AIC, BP, LDL)
- Immunizations
- Tobacco cessations
- Falls Risk

Competency Standards and Certifications

- It appears that there is not enough hospital pharmacy residency trained pharmacists to meet the hiring needs of hospitals in Canada – 20% mark reached in 2011
- Some Canadian pharmacists look to the US for certification
  - CGP – 380 Canadians
  - BCPS – 115 Canadians
  - BCACP – 11 Canadians
- ADAPT – CPhA sponsored program that aids in preparation for pharmacists in hospitals for the ambulatory care practice environment
- Entry level to practice Pharm D 1st grads UofT 2015

Strategies

- Opportunities/needs/timing – use your past & present connections to develop your future
- Be a part of:
  - Committees- Seniors Information Network
  - Board of director opportunities
  - Community involvement – health fairs, diabetes
- Utilize resources that already exist and tailor to your needs
- Find people with a passion to work with

Professional Service Workflow

Inside a Pharmacy

- Staffing – do you have the right professional staff and support staff?
- Workflow & tools
- Physical space
- Time management -& appointment scheduling
- Do you have the technology that you need?

Outside a Pharmacy

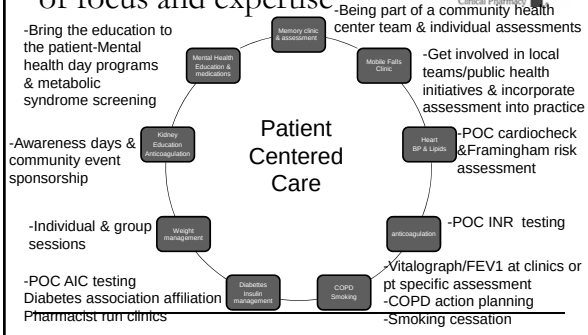
- Opportunity to develop your own company
- Portable computer and printer
- Educational resources

Marketing

- Start slow and start with the “low-hanging fruit”
- Start with patients you know
- Promote your skills
- Use social media, billboard signs, radio, You-tube
- Use your progress as part of your marketing process
  - Eg. Promote new services every time you change your marketing approach

Marketing for Pharmacists 2nd edition APhA

Keep expanding your areas of focus and expertise



Objective 2

- Select appropriate MTM compensation strategies to integrate into both community and ambulatory care practice settings

Compensation & Generating Income

Within Payment Model

- MedsCheck (MTM)
  - + professional opinions
  - + Immunization (vaccine markup)
  - Smoking cessation
- Home visit
  - + falls assessment
  - + memory assessment
  - + immunizations
- Third party payers

Outside of Payment Model

- Weight loss program
  - + MedsCheck
  - + Immunization
  - + diabetes & lipid management & POC
- Company wellness plans
  - + MedsCheck
  - + Immunization
  - + point of care testing

Generating Income Using Clinic Models or TOC

Clinics

- Specific topics for each month using topics already highlighted in the media – eg Heart & Stroke, Diabetes, Fall prevention month
- Assessments – falls, mental health, prediabetes, diabetes, COPD, memory, cardiovascular risk
- Set up MTM appointments during the clinic for patients who need follow up
- Point of care testing – AIC, lipids, TSH, H. pylori, influenza, FEV1
- Annual Wellness visits – follow CMS model

Transitions of Care (TOC)

- Use community remuneration to facilitate pharmacy related transitions of care

Objective 3

- Describe solutions for battling regional challenges when utilizing the MTM practice model

We are at the tip of the iceberg!

-Use your challenges, barriers and roadblocks to create new paths as you are on a journey

-Build it and they will come!

-Don't give up! The solution to the problem is yet to be found

Every pharmacist is a leader… But the most important person you will every lead is yourself!

- Unique and special
  - Capable of great things
  - Life long self mastery journey
  - Whole career/life a blank canvas
- Untapped leadership potential
  - Don't squander the opportunity
  - Lead a super star workgroup
- Mentor/coach approach
  - Your own experience

White SJ. ASHP Leadership course 2010-2011

White Sara, Leading Yourself. Pharmacy Leadership Academy 2012

Ontario Reimbursement & Scope of Practice Disconnect

Payment Model		Scope of Practice	
Medscheck Annual	$60	Provide emergency refills	$0
Medscheck Diabetes	$75	Renew/extend prescriptions	$0
Medscheck Follow up	$25	Change drug/dose formulation	$0
Medscheck at Home	$150	Initiate drug therapy for smoking cessation	$0
Professional opinion	$15	Administer a drug by injection	$7.50

ALBERTA: Scope of Practice

- Summer 2006: Alberta government announced new regulations that expand the scope of practice for pharmacists, including the authority to prescribe Schedule 1 (Rx only) drugs.
- All pharmacists on the Alberta College of Pharmacists' clinical register may adapt prescriptions and prescribe in an emergency
- However, only pharmacists who demonstrate that they have met the requirements as outlined in Regulations may initiate prescriptions or prescribe to manage ongoing therapy ("**Additional Prescribing Authorization**")
- 2014: New Pharmacy Agreement formalizes the Alberta Pharmacists' Association as the representative authority for pharmacists in negotiations with government.

❑ New Compensation Plan for Pharmacy Services introduced

Canadian Pharmacist Association

Alberta Reimbursement Model

Service or Intervention	Compensates pharmacists for:	Compensation Rate:
Assessment and Adaptation of a Prescription	Assessing the appropriateness of prescriptions, based on an individual patient's unique needs, and include: • altering the dosage or regimen of a prescribed drug (excludes the formulation) • substituting another drug that is expected to have a similar therapeutic effect (excludes generic substitution).	**$20** fee per patient per day for each adaptation assessment.
Patient Assessment for Rx Renewal	Completing an assessment of a patient resulting in the renewal of a patient's prescription.	**$20** fee per patient per day for each renewal assessment.
Patient Assessment in a Medication Related Emergency	Assessing a patient and providing authorization for medication therapy in the absence of an existing Rx in an emergency situation.	**$20** fee per patient per day for each emergency assessment.
Assessment for Refusal to Fill a Rx	Assessing a patient which results in a refusal to fill a prescription based on one of the following: potential overuse / abuse, or a falsified or altered Rx.	**$20** fee per patient per day for each assessment.

Canadian Pharmacist Association

Alberta Reimbursement Model

Service or Intervention	Compensates pharmacists for:	Compensation Rate:
Patient Assessment for Initiating Medication Therapy	For pharmacists with **additional prescribing authorization (APA)** for assessing patients when initiating medication therapy or changing medication therapy.	**$25** fee per patient per day for each assessment.
Comprehensive Annual Care Plans (CACP)	A CACP includes the completion of a patient assessment, a Best Possible Medication History (BPMH), resolution of any drug therapy or drug-related problems as well as a follow-up and monitoring plan. Must meet the criteria of a patient with "Complex Needs".	**$100** fee for assessment and medication review (**$125** if pharmacist has APA). **$20** follow-up fee (**$25** if pharmacist has APA).
Standard Medication Management Assessment (SMMA)	A SMMA is similar to the CACP and is meant for patients who do not meet the criteria used in a CACP. It includes completion of a patient assessment, a Best Possible Medication History (BPMH), resolution of any drug therapy or drug-related problems as well as a follow-up and monitoring plan. Must meet the criteria of a patient with one chronic condition from a list of conditions and being taking 4 or more different medications.	**$60** fee for assessment and medication review, once per year (**$75** if pharmacist has APA). **$20** follow-up fee (**$25** if pharmacist has APA).

Canadian Pharmacist Association

Battles & Solutions

- Regional organizational barriers
  - The same processes are required throughout the geographic area so find someone to work with
  - Money & resources are limited so use them wisely
- Transitions of care issues
  - Sell the advantage of your services
  - Organizations need frequent reminders about your services
  - Keep in mind that the current services may have to fail before the appropriate parties will buy into your model
- Things work slowly in health care – find the connections that you need for the inside scoop
- Presentations, presentations, presentations

References & Resources

- ACCP
  - Ambulatory Care Pharmacists survival guide 3rd edition 2013
  - Clinical Pharmacy Services: successful practices in community hospitals, 2005
  - How to Develop a Business Plan for Pharmacy Services 2nd edition, 2007
  - How to prove the value of your Clinical Pharmacy Services when Resources are limited, 2003
  - How to Bill for Clinical Pharmacy Services, 2001
- ASHP
  - Building a Successful Ambulatory Care Practice, 2012
  - Managing Anticoagulation Patients in hospital, 2007
- APhA
  - Marketing for Pharmacists 2nd ed, 2007
  - How to start a MTM practice: Guidebook for Pharmacists

We need to make a difference

- The profession of pharmacy needs to be proactive
  - Providers who demonstrate and promote their value are more likely to thrive in the future healthcare environment.
  - We have an extremely competitive health care market
    - Competing with each other and with other healthcare professionals to meet patients' needs using government funded health care dollars
    - Pressured to increase productivity and fill increasing numbers of prescriptions.
  - Choice to allow things to continue on the present course, or change it.
  - We can be passive or take control over our careers

Good Luck with your Journey

Never stop dreaming, for dreams are nourishment for the soul. . .

Paolo Coelho
The Pilgrimage

Questions?

Thank you for your attention

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New Practice Opportunities with Medicare: Transitions of Care

Jamie Cavanaugh, PharmD, CPP, BCPS
October 2015

Conflict of Interests

- No financial relationships pertinent to this activity.

Learning Objectives

- **Explain the development of billable Medicare-related ambulatory pharmacy services**
- Describe the implementation and challenges of compensation strategies using the Annual Wellness model
- **Describe the implementation and challenges of compensation strategies using the Transitions of Care model**

Development of
Transitional Care Management Codes

Goal: Reduce 30 day re-hospitalization

- Reimburse for care management and care coordination

Federal Register.2012;77(222):68979 -68993.
Image: http://www.aethon.com/wp-content/uploads/2014/07/HRA-thumb7.jpg

Application of
Transitional Care Management Codes

- Effective January 1, 2013
- 99495, 99496
- Requirements are complex

Federal Register.2012;77(222):68979 -68993.
Medicare Learning Network. *Transitional Care Management Services*. 2013;ICN908628.

Qualifying Transitions of Care
Transitional Care Management Codes

From: Inpatient Setting

- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long Term Care Hospital
- Skilled Nursing Facility
- Inpatient Rehabilitation Facility
- Hospital Outpatient Observation or Partial Hospitalization
- Partial Hospitalization at a Community Mental Health Center

To: Community Setting

- Home
- Domiciliary
- Rest Home
- Assisted Living

Federal Register.2012;77(222):68979 -68993.
Medicare Learning Network. *Transitional Care Management Services*. 2013;ICN908628.

Requirements of
Transitional Care Management Codes

1. Interactive communication (non-face-to-face)
2. Face-to-face visit

Federal Register.2012;77(222):68979 -68993.
Medicare Learning Network. *Transitional Care Management Services*. 2013;ICN908628.

Interactive Communication
Timing

- Within 2 business days of discharge
  - Patient or caregiver
  - Telephone, electronic, etc.
  - 2 attempts within 2 business days, if unsuccessful must continue to attempt until successful within the 30 day time frame of service

Federal Register.2012;77(222):68979 -68993.
Medicare Learning Network. *Transitional Care Management Services*. 2013;ICN908628.

Interactive Communication
Provider

- Licensed clinical staff
  - "Incident to" billing definition of clinical staff
  - Must meet state licensure and scope of practice
  - No exhaustive list, but does includes pharmacists
- General supervision rule
  - "Incident to" rules apply, except the appropriate practitioner does not have to be physically in the same location at the time service

CMS. (2015). Payment for Chronic Care Management Services Under CY 2015 Medicare PFS [Transcript]. Retrieved from: www.cms.gov

Non-face-to-face Services
Clinical Staff

- Must be furnished unless determined not medically indicated
- Services may include
  - Obtaining & reviewing records
  - Reviewing follow-up needs
  - Interaction with other health care professionals
  - Provider education to patient or caregiver
  - Referrals for community resources
  - Assistance in scheduling follow-up

Medicare Learning Network. *Transitional Care Management Services*. 2013;ICN908628.

Face-to-Face
Requirements

CPT Code 99495

- Moderate medical decision making
- Within 14 calendar days of discharge

CPT Code 99496

- High medical decision making
- Within 7 calendar days of discharge

Type of Decision Making	Number of Possible Diagnoses and/or Management Options	Amount and/or Complexity of Data to Be Reviewed	Risk of Significant Complications, Morbidity, and/or Mortality
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

* 2 of 3 elements must be met or exceeded

Federal Register.2012;77(222):68979 -68993.
Medicare Learning Network. *Transitional Care Management Services*. 2013;ICN908628.

Face-to-Face Providers
Transitional Care Management Codes

- Physicians
- Qualified non-physician practitioners
  - Certified nurse-midwives
  - Clinical nurse specialists
  - Nurse practitioners
  - Physician assistants

Federal Register.2012;77(222):68979 -68993.
Medicare Learning Network. *Transitional Care Management Services*. 2013;ICN908628.

Face-to-Face Services
Provided by Licensed Clinical Staff

- May furnish:
  - Communication with agencies and community services
  - Provide education to patient and caretakers to support self-management, independent living, and activities of daily living
  - Assess and support treatment regimen adherence and medication management
  - Identify community and health resources
  - Assist patient and family in accessing needed care and services

Medicare Learning Network. *Transitional Care Management Services*. 2013;ICN908628.

Submitting the Claim
Transitional Care Management Codes

- Date of service 30 days from discharge date
- Only one provider can bill
- Not reimbursed if patient is readmitted within 30 day time period
- Claim should not be reported if the patient dies prior to the 30th day

Federal Register.2012;77(222):68979 -68993.
Medicare Learning Network. *Transitional Care Management Services*. 2013;ICN908628.

Benefits of Utilizing
Transitional Care Management Codes

- Favorable reimbursement rates
  - Support additional services

CPT Code	Non-Facility Price	Work RVU*	Comparator Evaluation and Management Code
99496	$232.41	3.05	99215 $146.24 Work RVU 2.11
99495	$165.54	2.11	99214 $108.34 Work RVU 1.50

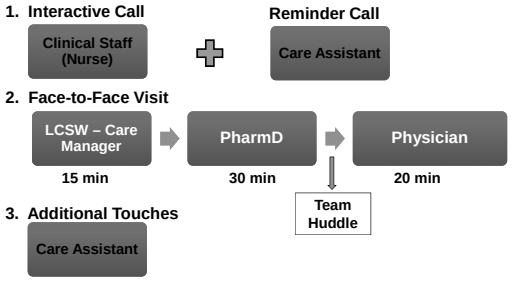
* RVU=Relative Value Unit

http://www.cms.gov/apps/physician-fee-schedule

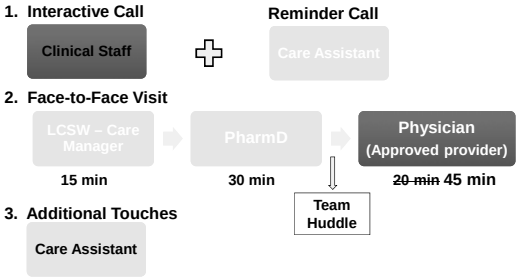
Pharmacy's Role
Transitional Care Management Codes

- Non-face-to-face requirements
  - Facilitate use of TCM codes
- Medication reconciliation
  - During interactive contact
  - Face-to-face
- Other suggested elements that may be furnished by licensed clinical staff

Practice Example
University of North Carolina Internal Medicine Clinic



Required Elements
Practice Example



Justification – RVU & Outcomes
Practice Example

CPT Code	Non-Facility Price	Work RVU*	Comparator Evaluation and Management Code
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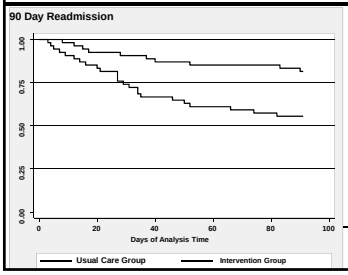

Readmission
30 days: 9% vs. 26%, p=0.023
90 days:19% vs. 44%, p=0.004

JGIM.2014;29(5):798-804

Real Life Logistics
Transitional Care Management Codes

- Identification of patients discharged
- Date of service
  - Work with claims department and IT to create solutions
- Regular review of payment
  - Denied? Resubmit using appropriate evaluation & management codes

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New Practice Opportunities with Medicare: Annual Wellness Visits

Stephanie L. Ballard, PharmD, BCPS
October 2015

I have no relevant financial relationships or commercial interests to disclose in conjunction with this presentation.

Learning Objectives

- **Explain the development of billable Medicare-related ambulatory pharmacy services**
- **Describe the implementation and challenges of compensation strategies using the Annual Wellness model**
- Describe the implementation and challenges of compensation strategies using the Transitions of Care model

20 MINUTES TO FOCUS ON APPLICATION

- Development
  - Overview
  - Visit requirements
  - Reimbursement
- Implementation
  - Admin considerations
  - Barriers
  - Pearls

TinyURL Links

Example: ABCs of the Annual Wellness Visit
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf

Becomes: http://**tinyurl.com/AWV-ABCs**

JANUARY 2011: THE AFFORDABLE CARE ACT ADDS THE ANNUAL WELLNESS VISIT (AWV) FOR MEDICARE BENEFICIARIES:

- Preventative health maintenance visit
- No out-of-pocket cost
- Reimbursed for $110-180*
- May be delegated to pharmacists

WHAT IS THE AWV?

An **extended**, **face-to-face** visit to **gather patient history**, **conduct assessments** and **address prevention care** that may be missed during serial acute visits.

Keep in mind…

- No out of pocket cost for patients, but subsequent screenings or referrals will be subject to copays.
- Routine annual physicals are not covered by Medicare.

TIME IS MONEY.

AWVs require 30 minutes at a minimum (Range: 30-73* mins)[1-3]

Time burden = opportunity

1) Am J Health-Syst Pharm 2014;71(1):44-9
2) J Am Pharm Assoc 2014; 54(4):427-34
3) J Am Pharm Assoc 2015; 55(4):449-54

AWVS ARE OPPORTUNITIES

The Medicare population has recognized medication regimen review needs.

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VISIT REQUIREMENTS

MEDICARE REQUIRES VISIT ACTIVITIES IN THREE DOMAINS:

A. Demographics and history
B. Examination and health risk assessments
C. Screening schedule and health risk counseling

A. Demographics and history

Age, gender, race/ethnicity	Social history	Individual and family medical history	List of providers

B. Examination and health risk assessments

BP, height, weight, BMI	Depression risk	Cognitive impairment	Functional ability/safety

C. Screenings and health risk counseling

Wellness counseling	List of risk factors	Age appropriate screenings	Final list of conditions and screenings

= patient handout requirement

IMPLEMENTATION TOOLS

ADAPTED FROM JAPHA 2014; 54(4):427-34

Required Element	Tools
History, list of providers	**Health Risk Assessment form (HRA)**
Depression Screening	**2Q/PHQ-9**, Edinburgh, Geriatric Depression Scale
Functional ability screening	HRA form, **Timed Up and Go test**, observation, Katz ADL, Lawton IADLs, Hearing handicap inventory for the elderly
Cognitive function	HRA form, **MiniCog**, GPCOG, or AD8
Lifestyle	HRA form, interview
Immunizations	**ACIP recommendations**
Age-appropriate screenings	**USPSTF calculator**, built-in reminders in health record

HRA RESOURCES

1. CDC recommendations and example: http://tinyurl.com/AWVHRA-CDCrec
2. Family Practice Management example: http://tinyurl.com/AWVHRA-FPM
3. How's Your Health.org (free online): http://www.medicarehealthassess.org/
4. How's Your Health.org paper chart: http://tinyurl.com/AWVHRA-ACP
5. MaineHealth toolkit: http://tinyurl.com/AWVHRA-MaineHealth

ASSESSMENT RESOURCES

1. PHQ-9: http://www.phqscreeners.com/
2. Timed Up and Go (TUG or UpNGo): http://tinyurl.com/AWV-TUnGtest
3. Hearing Handicap Inventory for the Elderly (HHIE) http://tinyurl.com/AWV-HHIE
4. Activities of Daily Living (ADLs/iADLs): http://tinyurl.com/AWV-ADLs
5. U.S. Preventive Services Task Force Screenings (USPSTF) Calculator: http://epss.ahrq.gov/
6. Advisory Committee for Immunization Practices (ACIP) : http://tinyurl.com/ACIPrecs

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REIMBURSEMENT

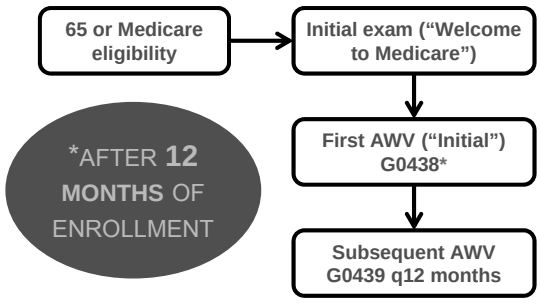
REIMBURSEMENT BASICS

Visit Type	Code	State of PA	San Fran
First AWV	**G0438**	**$168.44**	**$209.56**
Subsequent AWVs	**G0439**	**$113.53**	**$143.59**

Use the Medicare payment finder to find local reimbursement rates:

tinyurl.com/MedicarePhysicianFeeSchedule

PATIENTS ARE ELIGIBLE FOR AN AWV ONCE PER YEAR*



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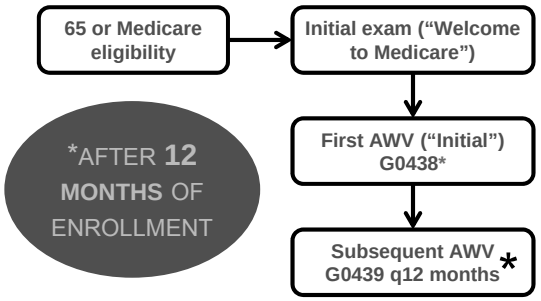

SUSTAINABILITY

Assuming $120,000/year salary and benefits[1]

- 1,070 AWVs per year or 2.9 AWVs per half day 8x/week
- Large practices – 12-18% utilization
  - ❑7-8 visits per half day where 2 are AWVs
  - ❑Moderate practices 54% utilization
- Utilization - National: 14.5%, PA 12%, CA 13%

1. Park I. JAPhA 2014; 54(4):435-40
2. Medicare Preventive Service Utilization rates by state **http://tinyurl.com/AWV-CMS2014utilization**

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ADMINISTRATIVE CONCERNS

ADMINISTRATIVE CONCERNS

- Supervision
- Recruitment
- Ordering privileges AND comfort

Who bills Medicare for a pharmacist-run AWV?

The supervising physician.

SUPERVISION REQUIRED.

- **AWVs may be delegated to... "A medical professional** (including a health educator, registered dietitian, or nutrition professional or other licensed practitioner) or a team of such medical professionals, **working under the direct supervision** (as defined in CFR 410.32(b)(3)(ii)) **of a physician**..."[1]
- CFR 410.32(b)(3)(ii): "**in the office suite and immediately available** to furnish assistance and direction throughout the performance of the procedure"[2]

1) MLN Matters News Flash:MM7079 **http://tinyurl.com/AWV-MM7079**
2) Federal Register Vol 75 No 226 (Detailed interpretation) **http://tinyurl.com/AWV-FRSupervision**

SUPERVISION

- Physician residency training programs: supervision limitations
- Is the supervisor the PCP?
- What can I do under my state laws? Institutional policies?
  - New therapies? Enact standing orders?

RECRUITMENT/SCHEDULING

- How many people should I recruit initially?
  - Starting: 100-150 mailings/month[1,2] with uptake reported under 5%[1]
- How will the patients know that this is a prevention visit, not for acute complaints?
  - Clear materials, trained front staff
- How will 12-month reschedules occur?

1) Am J Health-Syst Pharm 2014;71(1):44-9
2) J Am Pharm Assoc 2014; 54(4):427-34

NON-MEDICATION ORDERS ARE COMMON

Referrals: nutrition, gastroenterology, audiology, physical/occupational therapy

Radiology: ultrasound for abdominal aortic aneurism, mammography, DXA

Labs: medication monitoring, cholesterol screening, diabetes screening

Vaccinations: Pneumococcal, zoster, Tdap

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ACCESS **AND** COMFORT

PREPARING FOR NON-MEDICATION ORDERING

- **Identify preferences for whom to consult**
- Work with health record support for appropriate access
- Arrange for formal training on ordering procedures
- Highly prescriptive protocols with physician buy-in for controversial items (e.g. mammography)

BARRIERS – THE SHADYSIDE FAMILY HEALTH CENTER EXPERIENCE

Supervision
- ❑Changed from preceptor of the day to medical director

Lab/test follow-up
- ❑Ensure results go to primary care provider

Same-day complaints
- ❑V25 modifier + separate service… how to submit?

Contracting

No-Shows

PEARLS

Use existing e-record documentation
Integrate learners
Overlap/double-book patients
Target health plan incentives for early visits
Pre-empt barriers with communication

"THE PHYSICIAN IS BILLING."

Published Reports of Pharmacist-Run Annual Wellness Visits

UNC-Chapel Hill Internal Medicine Clinic
Internal Medicine Residency, North Carolina
Warshany K, Sherrill CH, Cavanaugh J et al. Medicare annual wellness visits conducted by a pharmacist in an internal medicine clinic. AJHP 2014;71(1):44-9

Chickahominy Family Practice
Private Family Practice, Virginia
Thomas MH. Development and implementation of a pharmacist-delivered Medicare annual wellness visit in a family practice office. JAPhA 2014; 54(4):427-34

Mountain Area Health Education Family Health Center
Family Medicine Residency, North Carolina
1. Park I, Sutherland SE, Ray L et al. Financial implications of pharmacist-led Medicare annual wellness vists. JAPhA 2014; 54(4):435-40
2. Wilson CG, Park I, Sutherland SE et al. Assessing pharmacist-led annual wellness visits: Interventions made and patient and physician satisfaction. JAPhA 2015; 55(4):449-54