PHARMACY PRACTICE NEWS

Policy

AUGUST 15, 2016

Financial Building Blocks Are Critical!

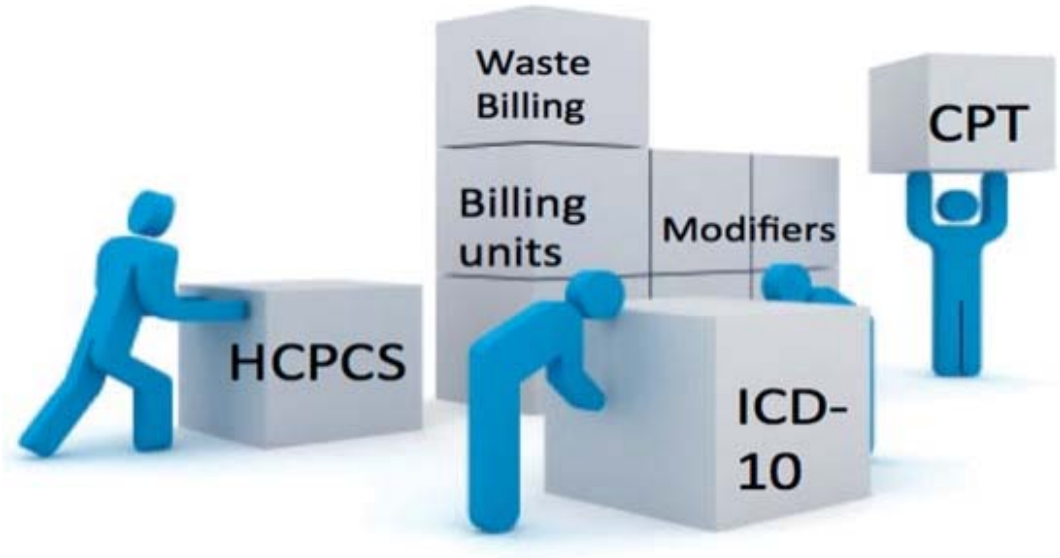
Bonnie Kirschenbaum, MS, FASHP, FCSHP

"Reimbursement Matters" is a tool for maintaining your health system's fiscal health. Please email the author at bonniekirschenbaum@gmail.com (mailto:bonniekirschenbaum@gmail.com) with suggestions on reimbursement issues that you would like to see covered.

Several of my past columns, including those from the June and July issues, have been devoted to providing learning materials and explanations of components of pharmacy reimbursement systems. These articles focused on the crucial theme of *telling the patient's story completely and accurately*—and in a codeable fashion—to ensure that reimbursement is spot-on. Taking this approach is also important because it will help ensure the accuracy of the data being transmitted to the payor, with the Centers for Medicare & Medicaid Services (CMS) used as an example of the quintessential payor (Figure).

CMS issued a new rule on July 1 that reaches beyond these two parameters and emphasizes just how very important accuracy and completeness of data have become. This new CMS rule is required by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 and is designed "to allow organizations approved as qualified entities to confidentially share or sell analyses of Medicare and private sector claims data to providers, employers and other groups who can use the data to support improved care." The rule also states that "qualified entities may provide or sell claims data to providers and suppliers, such as doctors, nurses, and skilled nursing facilities among others."

CMS believes in the use of Medicare and private sector claims data to drive higher quality and lower cost care, and finalized the new rules to enrich its Qualified Entity Program by expanding access to analyses and data that will help providers, employers and others make more informed decisions about care delivery and quality improvement.



Telling the Complete, Accurate Patient Story

CPT, Current Procedural Terminology; **HCPCS,** Healthcare Common Procedure Coding System; ICD-10, International Classification of Diseases, 10th Revision.

Note that the data being shared are claims data! These are the very same data that my columns have been concentrating on, urging attention to detail, completeness and accuracy! Has your pharmacy team taken this seriously and given it the attention due? Or have you closed your eyes to the importance of this component of practice? Can your clinicians recognize which drugs and biologicals have requirements for use, based on local or national coverage determinations (LCDs, NCDs) and prior authorizations? Do they take steps to ensure that the correct documentation supporting the required coding based on the International Classification of Diseases, 10th Revision (ICD-10) is in the electronic health record (EHR)?

Why care about ICD-10? As I noted in a recent column, a complete and accurate ICD-10 depiction of the patient's story can only be told if the clinicians provide complete and accurate documentation in the medical record, both on admission and as treatment unfolds during the encounter, whether in the inpatient or outpatient setting (*Pharmacy Practice News* 2015;42[12]:22-23).

The MACRA-mandated rule goes on to state that there are "strict privacy and security requirements for all entities receiving patient identifiable and beneficiary de-identified analyses or data, as well as expanded annual reporting requirements." The rule notes, for example, that "if entities receive patient identifiable data or analyses, they must use protections that are at least as stringent as what is required of covered entities and their business associates for protected health information (PHI) under the HIPAA Privacy and Security Rules."

Organizations that meet certain qualifications can access patient-protected Medicare data to produce public reports. Qualified entities must combine the Medicare data with other claims data (e.g., private payor data) to produce quality reports that are representative of how providers and suppliers are performing across multiple payors, for example, Medicare, Medicaid or various commercial payors. For further information on the qualified entity program, go to the Qualified Entity Certification Program website at https://goo.gl/?8Csyvt. Complete language of the rule, published July 7, 2016, is available at www.federalregister.gov.

Learning the LCD Process

Although LCDs are under the purview of the geographically determined Medicare Administrative Contractors (MACs), they are based on Medicare reimbursement rules and are structured using ICD-10 coding. A search for all LCDs and NCDs can be conducted on your MAC's website. An excellent and thorough example of an LCD that can be used as a learning tool for your pharmacy team is the revised LCD for thrombolytic agents recently published by Novitas. This can be accessed at https://goo.gl/?SuGI9K.

CMS Issues OPPS Corrections

The July 2016 column excerpted several changes in the Hospital Outpatient Prospective Payment System (OPPS) that affect reimbursement of drugs and biologicals. CMS has since issued corrected information to your revenue cycle team that includes the following: The Change Request (CR) changed the Ambulatory Payment Classification number for the Healthcare Common Procedure Coding System (HCPCS) code Q5102 from 1761 to 1847. Also, business requirement 9658.3 in the CR had incorrect termination date for C9743, C9458 and C9459. The correct termination date should be June 30, 2016, instead of June 30, 2015. The transmittal number and CR release date and link to the transmittal were also changed. All other information remains the same. For more information on the OPPS updates, read MLN Matters Number: MM9658, which you can access on the CMS website at https://goo.gl/?QJMlyP. Look for the following key information when reviewing the updates:

Corrected: July 2016 Update of the Hospital Outpatient Prospective Payment System (OPPS) MLN Matters Number: MM9658 Revised. Related CR #: CR 9658 Related CR Release Date: June 28, 2016. Effective Date: July 1, 2016. Related CR Transmittal #: R3552CP. Implementation Date: July 5, 2016.

Biosimilars: A New Resource For Your e-Library

The Academy of Managed Care Pharmacy has launched an online “Biosimilars Resource Center” (BRC), which is designed to be an unbiased, policy-neutral repository of educational resources and information on biosimilars for pharmacists, physicians, nurses and other health care providers. The site was developed in partnership with leading national pharmacy organizations and can be accessed at www.biosimilarsresourcecenter.org.

The BRC website will provide a comprehensive range of materials, including frequently asked questions, white papers, web-based educational seminars, continuing education programs and journal articles. It will be continually updated as the latest information, laws and regulations become available.

External Pump Payment Clarification

Medicare has clarified its policy for prolonged drug and biological infusions that are started incident to a physician’s service using an external infusion pump. Detailed in MLN Matters Number: SE1609, the clarification states that although

Medicare will pay for drugs/biologicals that aren't usually self-administered and are furnished as "incident to" physicians' services, the physician or hospital must incur a cost for the drug/biological. Generally, the administration will start/end while the patient is being managed in the physician's office or the hospital outpatient department. Medicare's payment for administration will also include payment for equipment used. However, equipment (e.g., external infusion pump) used to begin administration of the drug/biological that the patient takes home to complete the infusion is not separately billable as durable medical equipment.

Note that there are important exceptions: Begin the drug infusion in the care setting using an external pump, send the patient home for a portion of the infusion duration and have the patient return at the end of the infusion. The drug or biological continues to be covered and is billable incident to a physician's service.

It is also important to report proper Current Procedural Terminology (CPT)/HCPCS codes for the drug/biological and its administration, and to report procedure code 96379 for the use of the external pump. Enter the word "PUMP" in block 19 on the CMS-1500 claim form or electronic equivalent to indicate use of an external pump for the administration of prolonged drug infusion services. CPT code 96379 should be billed on a single line for each date of service.

For more information, access the MLN Matters article at https://goo.gl/?xFxWer.