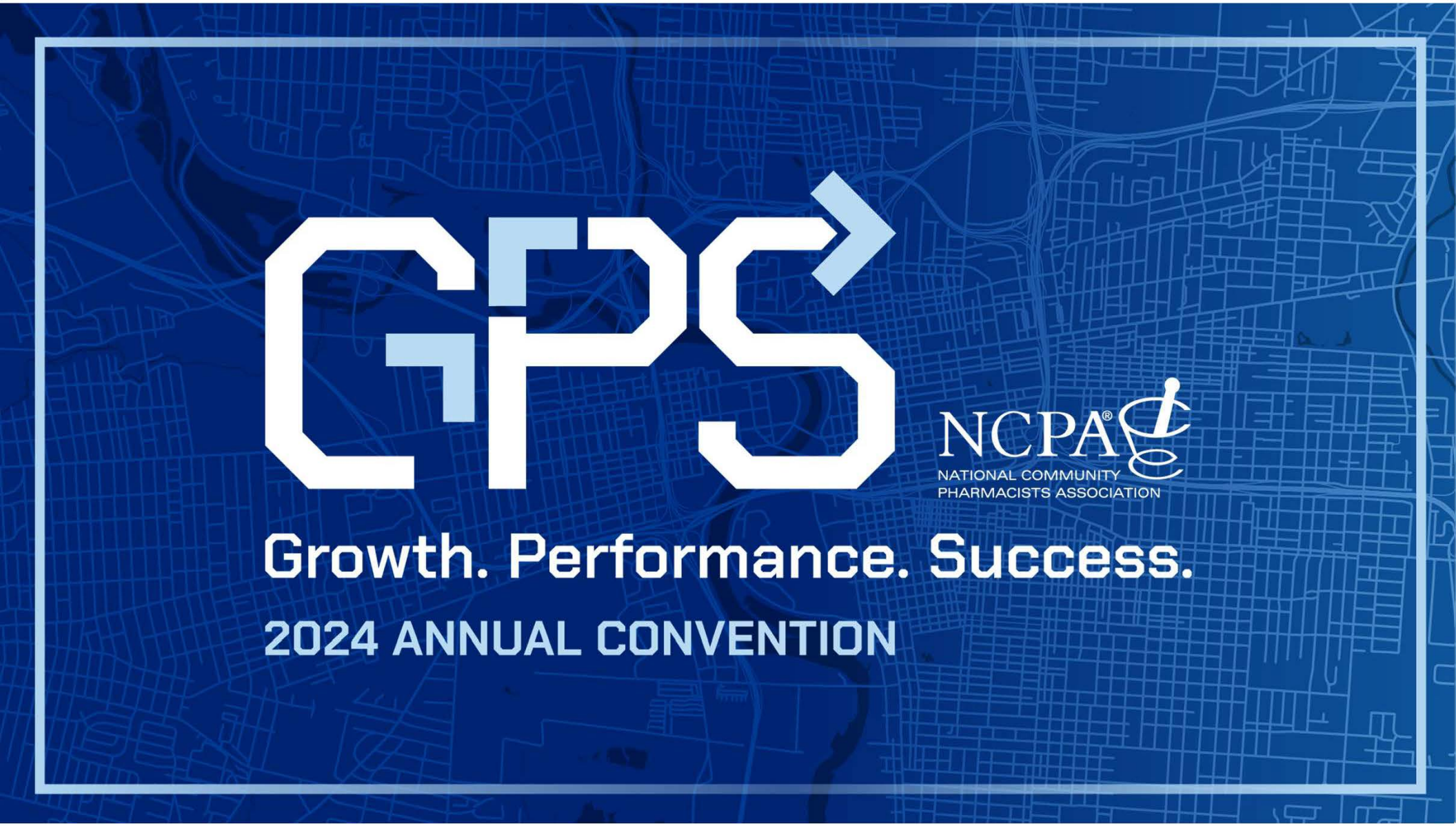
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Decoding the Language of Medical Billing: A Beginners Guide

NCPA 2024 Annual Convention and Expo

Columbus, Ohio

Speaker

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President

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Disclosure Statement

Mary Stoner has a financial interest with Electronic Billing Service and Signetic LLC and the relationship has been mitigated through peer review of this presentation. There are no relevant financial relationships with ACPE defined commercial interests for anyone else in control of the content of the activity.

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Pharmacist and Technician Learning Objectives

1. Compare and contrast prescription benefit and medical benefit billing.
2. Define vocabulary associated with billing the medical benefit.
3. Discuss medical billing opportunities which can be completed independently and those requiring provider collaboration.

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Medical Billing: Vocabulary

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Vocabulary of Plan Types

HMO*:	Health Maintenance Organization (In Network)
PPO*:	Preferred Provider Organization (In and Out of Network Options)
POS:	Point of Service Plans (HMO/PPO Hybrid)
EPO:	Exclusive Provider Organizations (Restrictive PPO/OON Emergency)
GPPO:	Gatekeeper Preferred Provider Organizations (PPO with referral/PA)
MCO:	Managed Care Organization (Medicaid/Non HMO)
FFS:	Fee for Service
MCR:	Medicare
MCD:	Medicaid
MSA:	Medical Savings Accounts
OON:	Out of Network

*Most Common Commercial Payer Types

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Vocabulary of Enrollment

PTAN:	Provider Transaction Access Number (generally used when referring to your Medicare Provider Number)
NPE:	National Provider Enrollment (East and West for DME enrollments)
A/B MAC:	Medicare Administrative Contractor for Medicare Parts A and B
Participating (PAR):	Always accepts assignment
Non-Participating (NonPAR):	Chooses “assignment” on a claim-by-claim basis
Assignment:	Means you are accepting the allowable as your payment in full
Non-Assignment:	Not accepting the allowable (Payer pays to the patient…sometimes referred to as “Courtesy Claim”)
ICL:	Independent Clinical Laboratory
MDPP/NDPP:	Medicare Diabetes Prevention Program/National Diabetes Prevention Program

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Vocabulary of Enrollment

Provider:	An individual providing clinical services
Supplier:	An organization providing medical products
Ancillary:	An individual or company that provides services that supports clinical services
Credentialing:	The vetting of an individual
Contracting:	The petition and possible offering of a contract
Mass Roster : Biller	Someone who provides mass immunizations and bills on a paper roster form

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Vocabulary of Services

DSME/DSMT:	Diabetes Self Management Education/Training
DMEPOS:	Durable Medical Equipment, Prosthetics, Orthotics and Supplies
POCT:	Point-of-Care Testing
IMM:	Immunizations
PEN:	Parenteral and Enteral Nutrition
MNT:	Medical Nutrition Therapy
MTM:	Medication Therapy Management
E/M:	Evaluation and Management (aka Office Visit Codes)
OTP:	Opioid Treatment Program

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Vocabulary of Claims Data

BIN:	Bank Identification Number
PCN:	Processor Control Number
GRP:	Group Number
DOS:	Date of Service
DOB:	Date of Birth
MBI:	Medicare Beneficiary Identification
Dual Eligible:	Patient is covered by both Medicare and Medicaid
Coinsurance:	A percentage of the allowable that the Patient is responsible for
Copayment:	A set amount the patient is responsible for

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Vocabulary of Claims Process

NCPDP Claims:	Acceptance of the claim using BIN/PCN
EDI:	Electronic Data Interchange
ERA/ERN:	Electronic Remittance Advice/Notice
ELI:	Electronic Eligibility
CEDI:	Common Electronic Data Interchange (Medicare EDI contractor for DME)
DMERC:	Durable Medical Equipment Regional Contractor
PIM:	Program Integrity Manual (Medicare) (aka The law)
LCD:	Local Coverage Determination (Medicare) (The bible)
Articles:	Policy Articles (Medicare) (The Reference)

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Medical Billing: Payers

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PBM Billing vs Medical Billing

PBM

- Real-time Adjudication
- Billing uses NDCs
- Administration Fees (Sometimes)

Medical

- 20-45 day Processing
- Billing uses CPT codes and HCPCS codes
- Administration Fees (Always)
- Different Plan Types per Payer
- Allowables vary
- Deductibles/Coinsurance varies
- Coverage guidelines

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Medical Billing

- Typically yields a much higher reimbursement
- Many payable products/services
- No guarantees of payment; check eligibility and coverage
- Certain situations warrant a Prior Authorization
- A prescription alone may not always be enough
- Requires an understanding of coverage guidelines
- Requires an understanding of documentation guidelines
- Commercial payers work within contracts
- Credentialing/Contracting can be hard

LS0

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Medicare and Medicaid

- Strict Enrollment Guidelines governed by CMS
- Application fee and renewed every 3 or 5 years
- Has written guidelines for coverage
  - Sometimes as specific as what diagnosis qualifies
  - Other times coverage can seem more discretional
- Clearly defined documentation guidelines
- Clearly defined list of items requiring Prior Authorization
- Published Fee Schedules
- Medicare Timely Filing is 365 days from Date of Service

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Revocation/Deactivation

- Revocation is when you are found in non-compliance with enrollment standards, and you are essentially being “kicked out” of the Medicare/Medicaid programs
- Deactivation is when you have a minor unresolved issue with your enrollment that warrants action to reactivate.
- Either of these can cause disruptions in your ability to remain enrolled with Medicaid and long term will affect your ability to contract with Commercial payers, Medicare Advantage and Medicaid MCOs.

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Medicaid

- Must be Enrolled with Medicare
- Application fee may be waived with proof of Medicare application fee paid
- Has written guidelines for coverage
- Clearly defined documentation guidelines
- Clearly defined list of items requiring Prior Authorization
- Published Fee Schedules
- Medicaid often covers items in addition to Part B products
  - Incontinent Products
  - Breast Pumps
  - Vaccines for Children and Adults (sometimes through Rx plan and others through Medical plan)
  - State mandated clinical services provided by Pharmacist's
- Medicaid Timely Filing is generally 365 days
  - Some can range from 90-180 days (examples NY (90), TX (95), GA (180))

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Medicare Advantage

- Enrollment is now replaced with “Credentialing/Contracting”
- No fee to credential/contract
- Must be enrolled with FFS Medicare
- Must follow Medicare Part B guidelines
  - But you must watch them close to make sure they process claims correctly
- HMO plans require that you be “In Network” or obtain an “Out of Network” Prior Authorization to consider payment through their plans
- PPO plans allow any willing provider to bill their plans
  - Vaccines and POCT are paid at 100%

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Medicaid MCOs

- Enrollment is now replaced with “Contracting”
- No fee to credential/contract
- Must be enrolled with FFS Medicaid
- Must follow Medicaid guidelines
- Generally, will only process claims for network providers
  - Occasionally non-contracted Providers can attempt to obtain a Prior Authorization (very rare)

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Other Payers (Commercial)

- Requires Credentialing/Contracting to be “In Network”
- Generally no fee to credential/contract
- Must be enrolled with FFS Medicare
- HMO plans require In Network or an OON Prior Authorization
- PPO plans allow “any willing provider”
  - Benefit structure is based on the providers network status
- Normally covers Medicare coverage criteria
- Contracts normally based on a (%) of the Medicare Fee Schedule
- Contracts generally reduce timely filing guidelines

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Medical Billing: Opportunities

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Vaccines (855B Any Enrollment)

- Medicare Enrollment 855B: Mass Immunizer or Pharmacy*
- Flu
- Pneumonia
- COVID
- Administration Fees
- "In-Home" Administration

*Preferred Enrollment Type

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2024-25 Medicare Part B Influenza & Administration

LS0

- Fluad Trivalent (PF).....$83.490
- Afluria, Fluzone, Fluvarix, FluLaval Trivalent (PF).....$22.350
- Afluria, Fluzone Pediatric Trivalent.....$10.929
- Afluria, Fluzone Trivalent.....$21.858
- FluMist Trivalent.....$28.871
- Flucelvax PF, Flucelvax.....$36.849
- Fluzone HD Trivalent PF.....$83.492
- Flublok Trivalent PF.....$83.492
- Administration Fee..... $29.83 - $41.40*

*Geographically Adjusted

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2024-25 Medicare Part B Pneumococcal & Administration

- PCV15.....$253.56
- PCV20.....$298.036
- PCV21.....$327.893
- PCVS23.....$133.472
- Administration Fee..... $29.83 - $41.40*

*Geographically Adjusted

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LS0

**Billable in SNF Part B

2024-25 Medicare Part B COVID-19 & Administration**

- Novavax.....$161.538
- Pfizer (Yellow Cap).....$65.550
- Pfizer (Blue Cap).....$87.780
- Comirnaty.....$155.895
- Moderna.....$147.060
- Spikevax.....$161.652
- Administration Fees.....$39.78 - $55.20 *

*Geographically Adjusted

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"In-Home" Administration

"In-Home" administration additional payment: $35.31 - $49.00*

- HCPCS code M0201
- For patients unable to travel or at high risk of exposure by coming to the location
- Limited based on the number of patients in one location
  - 1-9 same place you can bill the M0201 for up to 5 of the patients
  - 10 or more in the same place you can bill the M0201 for only 1 of the patients
  - Individual living space you can bill one for each vaccine administered
- Available for remote locations (home, assisted living, SNF Part B (COVID only), temporary lodging, group home, etc.)
- Make sure you are using the correct place of service code on your claims

Link to CMS Guidance: https://www.cms.gov/medicare/coverage/preventive-services/home-vaccine-administration-additional-payment

*Geographically Adjusted

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Point-of-Care Testing (855B ICL)

https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm

- Strep (Cepheid).....$35.09
- RSV + Flu A/B (Cepheid).....$142.63
- Flu A/B (Cepheid).....$95.80
- COVID (Cepheid).....$51.31
- COVID + Flu A/B + RSV (Cepheid)....$142.63
- Hemoglobin A1C (Alere).....$9.71
- Lipid Panel (Abbott).....$13.39
- Cholesterol (PTS).....$8.19

Warning:
Cash models ONLY work if you are NOT enrolled with Medicare Part B. Medicare requires billing and requires accepting assignment!

DSMT (855B Pharmacy)

Diabetes Self-Management Education/Training

❖ Requires DSME Accredited Program through ADCES

- Medicare Part B covers
  - 10 hours the first year
  - 2 hours each subsequent year

- Individual per 30 minutes.....$59.28
- Group (2-20) per 30 minutes.....$15.65

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MNT (855B Pharmacy)

Medical Nutrition Therapy

❖ Requires a Registered Dietician on Staff

- Medicare Part B covers
  - 3 hours the first year
  - 2 hours each subsequent year

- Individual per 15 minutes (initial assessment).....$36.28
- Individual per 15 minutes (re-assessment).....$31.62
- Group (2 or more) per 30 minutes.....$16.64

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Part B Drugs (855S DME)

- Immunosuppressive (for organ transplant patients)
- Oral Anti-Cancer and Anti-Emetic
- Respiratory Solutions
- Insulin (being infused with a durable pump)
- Other Infusion Drugs (IVIG)
- Dispensing Fees (Immunosuppressive, Oral Anti-Cancer, Anti-Emetic)
  - 1st Drug per 30 days (first time post transplant for Immunosuppressive drugs).....$50
  - 1st Drug per 30 days.....$24
  - Subsequent Drug per 30days.....$16
- Dispensing Fees (Respiratory).....$57*/$33 per 30 days or $66 per 90 days

*Initial Dispensing

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DMEPOS (855S DME)

Durable **M**edical **E**quipment

- Walking Devices
- In-Home Equipment
- Traction Equipment
- Mobility Equipment
- Respiratory Equipment
- Infusion Equipment
- Bathroom Safety*
- Breast Pumps*
- Blood Pressure Monitors

Prosthetics and **O**rthotics

- Diabetic Footwear
- Artificial Limbs
- Eyewear
- Bracing

Supplies

- Ostomy
- Urological
- Surgical Dressings
- Diabetic Supplies
- Parenteral Nutrition
- Enteral Nutrition
- Incontinence*

*Not Covered by Medicare

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DMEPOS New Categories

- Three new categories are being added as of October 26, 2024:
  - Cognitive behavioral therapy devices
  - Rehabilitative therapy devices
  - Urinary suction pumps
  - External electrical stimulation devices (not otherwise classified)

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HIV PrEP Drugs (Starting 09/30/24)

- Previously covered under Medicare Part D, now under Medicare Part B
  - 855S DME/POS Supplier or 855B Pharmacy
- **Preventive** service covered at 100% (no deductibles or coinsurance)
- Antiretroviral drugs for **treatment** of HIV continue coverage under Part D
- Cabotegravir 1mg .....$TBD
- Emtricitabine 200mg and Tenofovir Disoproxil Fumarate 300mg.....$1.062
- Emtricitabine 200mg and Tenofovir Alafenamide 25mg $75.621
- 30 Day Dispensing Fee (injectable and oral) $24
- 60 Day Dispensing Fee (injectable and oral) $40
- 90 Day Dispensing Fee (oral only) $56

PrEP FAQ: https://www.cms.gov/files/document/faq-prep-hiv-06242024.pdf

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OTP (855B Opioid Treatment Program)

- Certified by SAMHSA
- Allowed by: ***Other professionals permitted to give this type of therapy or counseling by state law and scope of practice***
- Weekly payments
- Medicare Advantage must contract with OTP providers
- Currently only 1,517 OTP providers in the United States
- Covers:
  - Counseling, therapy, toxicology testing, assessments, medications, intensive outpatient program services.
- Will require a physician to serve as the Medical Director

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Opioid Stats

- Opioid Related Deaths
  - 111,029 deaths in 2022
  - 107,543 deaths in 2023 (3% decrease)
- Pharmacy care group shows higher rates of retention (Jan 2023 study)
  - Pharmacy based: Out of a group of 25 patients 89% continued treatment
  - Usual Care Groups: Out of 5 patients only 17% continued treatment

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OTP Reimbursements

New Patient (add-on code).....$225*
Periodic Assessment (add-on code).....$130*
Intensive Outpatient Program (IOP).....$900*

Weekly treatments:

Medication-assisted treatment, Methadone.....$300*
Medication-assisted treatment, Buprenorphine oral $325*
Medication-assisted treatment, Buprenorphine injectable.....$2,000*
Medication-assisted treatment, Naltrexone.....$1,650*

Take-home Supply:

Take-home supply of Methadone (add-on code).....$40.71
Take-home supply of Buprenorphine (add-on code).....$71.76
Take-home supply of nasal Naloxone per 30 days.....$56*
Take-home supply of nasal Naloxone 2-pack of 8mg per 0.1 ml nasal spray.....$127*

*Geographically Adjusted

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Medicare Diabetes Prevention Program (CMS 20134)

- 1 in 3 people have prediabetes
- 337,224,257 people in the United States as of 10/06/2024
  - 1 birth every 9 seconds
  - 1 death every 11 seconds
  - 1 migrant every 28 seconds
  - Net gain of 1 person every 18 seconds
- Currently there are only 865 MDPP providers in the United States

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MDPP Reimbursements

*Behavioral Counseling (in-person group).....$25 for 60 minutes

*Behavioral Counseling (distance learning group).....$25 for 60 minutes

*Up to 22 visits billed (combined), in a 12-month period

- Months 1-6: one in-person/distance learning visit every week (up to 16)
- Months 7-12: one in-person/distance learning visit every month (up to 6)

5% weight loss from baseline.....$145 one time payment

9% weight loss from baseline..... $25 one time “add-on” payment

Maintenance of 5% weight loss from baseline in months 7-12 .....$8 “add on”

- Months 7-12, once participant achieves 5% WL, supplier may submit Maintenance of 5% WL claim with attendance claim (G9888 + G9886/G9887). Medicare will pay for Maintenance 5% WL up to 6 times in months 7-12.

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Evaluation/Management (855B Clinic/Group)

- Pharmacist provides services “Incident To” a clinician visit
  - Wellness Visits
  - Chronic Care Management
  - Tobacco Sensation Counseling
  - Alcohol Abuse Counseling
  - Obesity Counseling
  - Vaccine Consultation
- Billed by the clinic practice unless specifically allowed by Medicaid or Commercial plans based on your state scope of practice laws.
- If you are enrolling as a clinic/group practice a clinician must be PHYSICIALLY present to provide DIRECT supervision.
- Owning a Clinic Group Practice is governed by the CPM (Corporate Practice of Medicine) laws

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Test and Treat*

* Only allowed in certain states!

- Evaluation/Management codes are not covered by Medicare
  - However, POCT is covered by Medicare if ordered by a Medicare recognized practitioner
  - Do not bill your individual NPI to Medicare as Pharmacists are not a recognized practitioner in the federal program
- Only allowed in certain states
  - Review your state scope of practice laws
  - MN, WI, TN, WA, KS, AR, KY, TX, NM are just some of the states where this is allowed
- Only allowed by certain payers
  - Check with Medicaid, Medicaid MCOs, and Commercial payers

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Summary

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5 Basic Steps E-E-C-A-D

To provide service or not requires 5 basic steps:

1. Enrollment: Am I properly enrolled with this payer to bill this service?
2. Eligibility: Is the patient eligible for benefits from a payer that I can bill on this date of service? LS0
3. Coverage: Does the patient's condition justify the service per the payer's policy (Will the service be covered?)? LS1
4. Allowable: How much will the payer allow for reimbursement?
5. Documentation: What documentation is necessary to support the claim?

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Medical Billing

- Pharmacist expansion of services plays a critical part of the overall health of our nation
- Expanding into these services can be a profitable venture, but can turn quickly to failure if you are unprepared or have poor execution
- Education is key to the success of your programs
- Medical billing is vastly different than pharmacy billing and this must be acknowledge, grasped, prepared for, implemented, and executed
- Implement software specifically build for medical billing
- Dig in and rise up!

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Questions?

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