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Reimbursement for Pharmaceutical Care Services: The California Experience

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Are pharmacists really “Playing Doctor” as a popular NBC show described the Mississippi Medicaid Pharmaceutical Care project? No, but the bottom line of the NBC show was that pharmacists are changing their practice habits to compensate for the decreased rate of return on filling prescriptions. In reality, pharmacists are neither “playing” physician nor merely trying to pad their pockets with a newfound source of income. While it is true that pharmacists are changing their practice habits, they are doing so for the betterment of their patients’ drug therapy outcomes and the healthcare system. The pharmacist serves as the vital link between the patient, physician, and healthcare system. By working with patients and physicians, pharmacists have demonstrated in the literature that they can improve patient drug therapy outcomes, thus preventing unnecessary healthcare expenditures (Fincham, 1998). Pharmacists have long been held in highest esteem by patients, being voted the number one trusted professional for 10 consecutive years. The evidence is clear that pharmacists provide a valuable service to their patients and healthcare programs, thus they should be adequately compensated. It is important for physicians, healthcare plans, and pharmacists to have a clear idea for what pharmacists are being compensated.

For what services should pharmacists be paid? Cognitive reimbursement is a term used to describe payment for non-product-related services. These services involve critical thought processes applied to the appropriateness of medications used by patients. The term and practice has quickly evolved, as it is apparent that no one is going to pay pharmacists to simply think about patient care. Payers and patients are ready to pay for what pharmacists can DO to improve patient outcomes. The concept of Pharmacist Care or Pharmaceutical Care emerged to focus the

pharmacist on all aspects of the delivery of care to patients. Three major categories of reimbursed services are widely recognized: resolution of drug therapy problems, disease state or health management, and extensive patient self-management training and education. Other areas where pharmacists have been successful billing for services are health promotion and disease prevention. Table 1 illustrates the variety of health care areas in which services are provided by pharmacists around the country (Felkey, 1999). The payment for professional prescription filling ensures the safety of a product dispensed and OBRA90 or California mandated counseling. The provision of pharmaceutical care services by a pharmacist is over and above any state or national requirements and warrants appropriate additional remuneration.

The Healthcare Picture

In California, managed care is incorporated into virtually all health insurance plans. The number of fee-for-service enrollees has steadily declined as a cost conscious society prepares for the next millennium. Under managed care, a health plan contracts with specific providers and pays them a capitated payment or a discounted fee-for-service amount. Typically, providers are expected to assume some financial risk for high cost health care under risk sharing arrangements. Providers may also share some savings if the care provided is less costly than anticipated. Maintaining high quality health care is important to employers who, along with the government, are the major purchasers of health care in the U.S. New National Committee on Quality Assurance (NCQA) measures compare various health plans on important aspects of the care provided. Thus maintaining high quality care at the most cost-effective level is an important goal of managed care.

The number of patients paying the entire cost of prescriptions has also decreased as managed care plans grow. Health plans covering prescription benefits increasingly use formularies and other utilization controls to maintain reasonable per member per month (PMPM) prescription costs. Most prescription benefits are managed by pharmacy benefit managers (PBMs) in the form of separate companies or divisions within a health insurance company.

Who are the Payers of Pharmaceutical Care Services?

Value is at the core of determining who will pay for pharmacist care services. For example, if pharmacists take part in an ACE inhibitor preferred product interchange program, an insurer may find this valuable and pay pharmacists for this activity. On the other hand, patients may not find this service of particular value especially if the cost of the medication to the patient does not change. Thus if a pharmacist were to ask a patient to pay for this service, it would likely be unsuccessful. On the other hand, a travel medicine clinic that helps patients prepare for foreign travel on vacation or for business might be of value to patients, but of less interest to the health plan.

Potential sources of reimbursement include patients and their families, insurance companies, medical groups, individual physicians, pharmacy benefit managers, manufacturers, employer groups, hospitals, home health care agencies, assisted living centers, and the government. Patients are an important group because, as consumers, they are a driving force behind what services employers demand of insurers, the services insurers provide to stay competitive, and services the government will provide to the voting constituency. Table 2 lists some current and potential sources of payment for pharmacist services in California *(please help*

us complete this table by faxing us your sources of payment in the survey at the end of this article).

Methods of Payment and Setting Fees

Several mechanisms have been used to determine what to charge and how to pay for pharmacists' services. Some payment methods used to pay pharmacists and other healthcare providers include fee-for-service, per capita (capitated) payments, fees based on cost savings realized, and resource based relative-value scales (RBRVS). Methods for payment of pharmacists are evolving. As more is known about the costs and benefits of pharmaceutical care, the methods of payment will evolve as well. As in the early days of paying physicians a fee-for-service, this method is now the most common payment method in California for payment of pharmaceutical care services. Tempting as it may seem as a method for payment, fees based on cost savings realized may be severely reduced after initial year savings are squeezed out of the system. It is likely that a combination of fee-for-service and capitated methods will emerge once pharmaceutical care is widely practiced.

Pharmacists use a variety of methods to determine how much to charge for a particular service. Under the fee-for-service method, a flat rate is set for a particular service or fees are charged based on an hourly rate. For example, some pharmacists charge $60/hour and then break the fee down into 10 minute increments depending on the length of the visit. Others may charge a flat rate depending on the type of service and level of complexity. For instance, a pharmacist might charge one fee (e.g. $100) for an initial asthma work-up and then a lower (e.g. $25) fee for each follow-up visit. Mixing these two methods may continue to be a common practice. The flat rate service fee works for standardized services such as disease state management and an hourly

fee might work better for drug therapy problem resolution and services where time requirements are more variable. An important factor in setting rates is the cost of providing the service. The cost of the pharmacist's time, space utilization, and other costs should be considered when setting fees. Additionally, competition between pharmacists and from other providers will play an important role in what pharmacists charge. The key to setting fees is to set them before marketing a service, in-service staff on the fee structure, and then let the patient know how much the care is going to cost before providing the service.

Non-distributive pharmacy services are not currently provided under a typical managed care capitated structure. As pharmacists continue to demonstrate the ability to effect positive patient outcomes, capitated methods to pay for pharmaceutical care may soon become reality. A patient-based capitated approach is used by some pharmacists to charge the patient or family a yearly fee that covers them regardless of number of times seen. However, the inability to adjust fees midyear if a patient's care becomes more labor intensive than originally estimated is a downside to the patient -based capitated program.

Finally, the most complicated system, but possibly the most accurate, is the resource-based relative value scale (RBRVS). This pricing system is used by Medicare and some third party payers to pay for services by accounting for differences in the complexity of a patient visit. In this complex system, relative value units are assigned to a service based on current procedural terminology (CPT) and other codes. At this moment, not enough is known about the time requirements and benefits or the range of possible services provided by pharmacists to accurately determine a RBRVS for pharmacists providing care in the community pharmacy.

Some services provided by pharmacists will not be covered or paid by insurers. Thus, the pharmacist must decide if patients will be billed for unreimbursed amounts. Additionally, full payment could be collected from the patient and then the patient submits the claim to the insurer. Whichever method is chosen, the pharmacist should have a plan to charge patients for care the day the service begins and make it clear to the patient how the process will work prior to delivering services.

Steps in Billing (see Figure 1)

Data Gathering-Once the pharmacy environment is ready for pharmaceutical care and a documentation method is in place, the pharmacist is ready to work with the patient and the patient's physician. The information gathered during a patient interview or a patient-completed history form includes not only a medication history, but also a complete medical history. The first step in the rather simple process of billing is to collect information from the patient regarding insurance plans. This information can be obtained along with the complete medical history. Both pharmacy benefits and medical benefits information should be obtained from the patient. If the patient does have insurance, a statement that allows the pharmacist to accept assignment of benefits on the patient's behalf for the services to be provided should be signed. The pharmacist could also include a statement obligating the patient to accept responsibility for any portion of the bill that the insurance company does not reimburse. If the service provided is a disease management related service, and if the patient does not have medical insurance with a fee-for-service plan, the patient should be informed that they are responsible for the total amount of care provided. If the patient has a managed care plan, the primary physician group may be responsible for all medical care services provided to the patient, including those disease

management services provided by pharmacists. In this case, the pharmacist should talk to the medical group about the value of the services provided. If the pharmacist has identified a drug specific problem, such as non-compliance, the pharmacy benefit management company might provide payment.

Documentation-Documentation of patient care activities is vital to reimbursement. If you didn't document it, you didn't do it! The type of documentation required for pharmaceutical care does not go on the back of a prescription, which makes it episodic and strictly drug related, nor can it simply be entered into many distribution-only systems. Separate patient charts or a documentation computer system must be used to adequately track patient care. By documenting patient care activities, a continuous record is created that allows each pharmacist to have an accurate and updated picture of the healthcare of every patient. In addition, during a third party payer audit, evidence of the care provided should easily be retrievable. To enhance the ability to gather and share information with other health care providers, the patient should sign a statement (usually at the end of the patient history form) allowing the release of medical information necessary for providing pharmaceutical care services and processing payment from a third party payer. A drug therapy problem or healthcare need may arise from the data gathering stage or a previously identified one. The resolution and follow-up of this patient care need or problem forms the basis of the billable event.

Medical Necessity-A medical necessity form serves several purposes and should be obtained before scheduled care is to be provided. The first purpose is to inform the patient's physician of the care the patient needs. The second purpose is to inform the medical insurance company that the care provided is considered by the physician to be a necessary part of the patient's medical

care. Since the same diagnosis (ICD-9) codes that the physician uses for billing are used, the medical necessity form provides a place for the ICD-9 code and diagnosis to be entered by the physician or office staff. Pharmacists must use the ICD-9 code assigned to that patient by the physician. It should not be left blank on the billing form or indirectly determined from the diagnosis. If the physician signs and approves of the medical necessity, it may be prudent to call the medical insurance company for prior authorization. However, since pharmaceutical care is still a new concept to insurers, gaining prior authorization may be difficult. The goals at this point are to determine what type of coverage the patient has, if the insurer covers referred specialists, the patient's deductible and if its been met, and the process for submitting a claim (if you have not previously submitted a claim for this insurer). Assuming prior authorization is obtained, the patient is ready to be seen. Obtaining the medical necessity and prior authorization take time and are most appropriate for scheduled visits.

Billing Submission-At the completion of patient care, activities are documented and follow-up care is scheduled if necessary. Contacting the payer to request prior authorization for a service may increase success in billing. It is important to include in the dialogue with the payer that "the primary care physician has asked me [as a referred specialist] to instruct the patient on self-monitoring of their disease". Currently there is no universally used on-line adjudication system for processing pharmaceutical care claims. Thus promptly submitting forms for reimbursement after the patient encounter is important for the economic viability of the service. If a disease management service has been provided, the medical necessity form should be sent along with the HCFA-1500 billing form to the medical insurer. The HCFA-1500 can be completed either manually or by using one of the commercially available computer programs (Poirier, 1999;

Rudolph, 1997). It should be clear on this form that a pharmacist is providing the service because physician CPT codes are used. Just like a dietician or podiatrist, the pharmacist is a referred specialist performing a service requested by the primary care physician. If the care provided is the resolution of a specific drug problem, for example compliance with a medication, some sources recommend using the National Community Pharmacists Association (NCPA) Pharmacist Care Claim form (Poirier, 1999; Rudolph, 1997). This form collects specific data about the problem, action, result, time and specific drug(s) involved. Whatever the form used and payer contacted, allow about one month for processing of claims before calling the third party payer about unresolved claims. Patience and perseverance will be rewarded.

Keys to Success

Billing for pharmaceutical care services requires different procedures, a patient focused environment, and the right mindset. In traditional reimbursement, pharmacists are paid for dispensing a product. This service is usually paid by the pharmacy benefits portion of the patient's insurance coverage or by the patient directly. In pharmaceutical care, the pharmacist is often billing the medical benefits provider rather than the pharmacy benefits provider for a service rather than a drug.

The provision of pharmaceutical care services requires all the pieces of the puzzle to be effective (Johnson, 1997): an appropriate patient care area, efficient workflow, effective use of ancillary personnel, written policy and procedures, training, documentation, a marketing and reimbursement strategy, and outcomes management. Figure 2 describes some practical "do's and don'ts" of reimbursement. An important trap to avoid is the saying, "I'm not going to do it until I get paid for it" because payers have another saying, "we're not going to pay you until you're

doing it". Providing pharmaceutical care is a result of the natural evolution of our profession and getting paid for that service is merely the next step.

Figure 2

Reimbursement Practice Points

DOs

- Start with a reasonable marketing plan and stick to it
- Establish fees before you start a service
- Provide a service that patients need and you enjoy doing
- Make sure you can perform the service and do it well
- Be very familiar with the procedures payers require for reimbursement
- Verify medical coverage for your procedure and get authorization if possible
- Be persistent and resubmit rejected claims!

DON'Ts

- Don't send your patient care documentation forms in with your reimbursement forms
- Don't omit any boxes that need to be filled in on the HCFA-1500 form
- Don't bill the pharmacy benefits division of the third party payer for disease management services

Key terms used in this article or in billing

- *CPT* (Common Procedural Terminology)
- *ICD-9* (International Classification of Diseases, 9th Revision)
- *UPIN* (Universal Provider Identification Number)
- *RBRVS* (Resource-based Relative Value Scale)
- *HCFA* (Health Care Financing Administration)

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Table 1. Topic Areas of Pharmacist Services Where Reimbursement is Obtained Across the United States

Addiction	Fertility	Pharmacy Groups
Administration	HIV/AIDS	Professional Education
Allergy & Flu	Home Infusion	Robotics
Alternative Medicine	Home Visit/Delivery	Self Care
Anti-Coagulation	Hormone Replacement	Smoking Cessation
Asthma	Hyperlipidemia	Software
Cancer	Hypertension	Travel Clinic
Cholesterol	Immunization	Weight Loss
Compliance	In-House Pharmacy	Wellness
Compounding	Long Term Care	Women's Health
Counseling	Nuclear Medicine	Workman's Compensation
Diabetes	Nutrition	Workflow Simulation
Disease Management	Pain Management	World Wide Web
Drug Monitoring	Patient Education	
Drug Information	Pharmaceutical Care	

Felkey, 1999

Figure 1 Pharmaceutical Care Billing Procedure-for Fee-for-Service or Self-Pay Patients

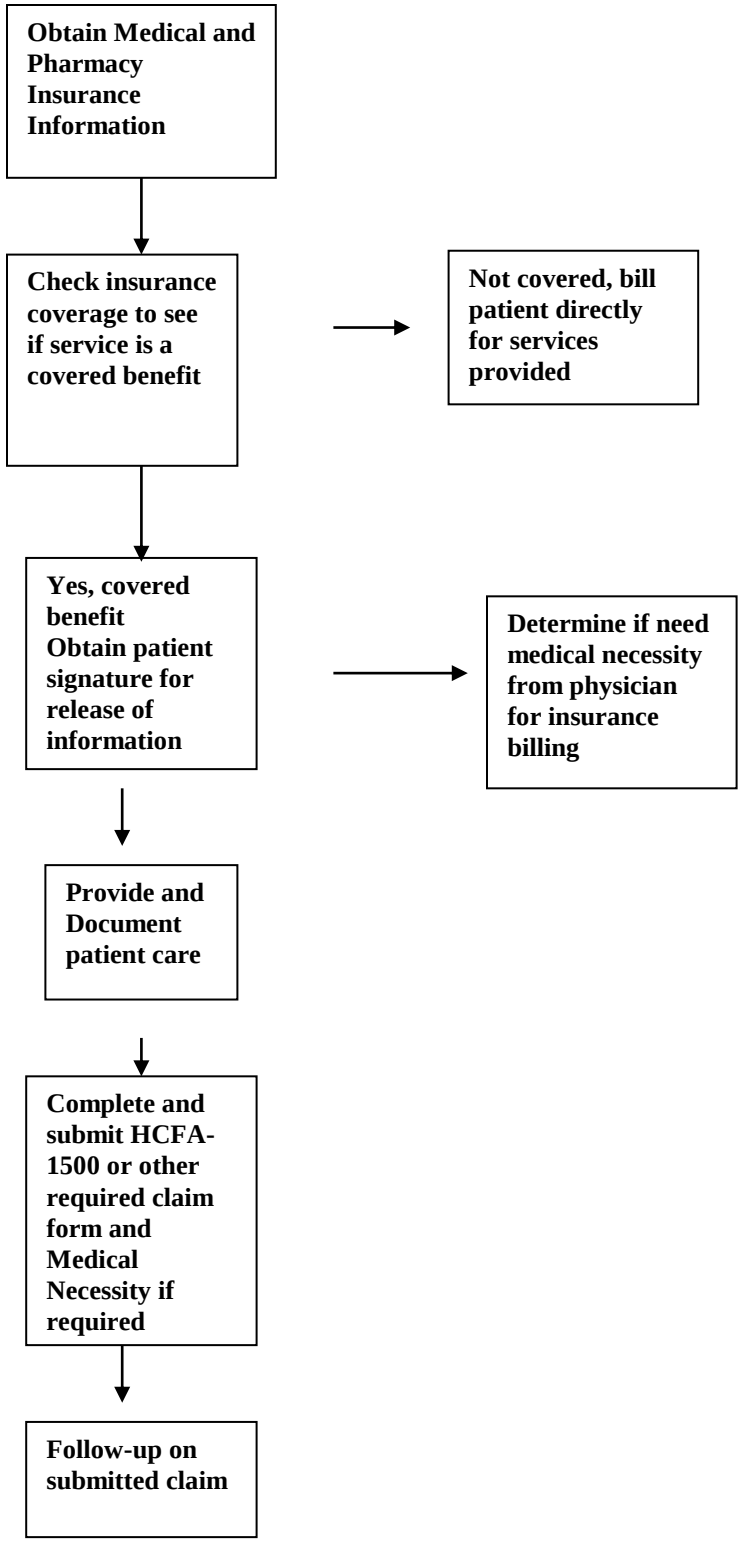

Table 2
Pharmaceutical Care Reimbursement Projects in California for Community Pharmacists

Disease	Payer	Comments
Asthma	Blue Cross of California	high risk patients identified by payer and pharmacists paid $25 per visit up to 4 visits/year Pharmacist must be identified as a provider by taking approved coursework
Diabetes and Asthma	research project supports	MediCal patients identified for a pilot project* Pharmacists paid for providing disease state management for high risk fee-for-service MediCal patients in 7 counties Pharmacist must be identified as a provider by meeting certain requirements
Immunizations	patient self pay, Medicare	multiple pharmacists provide immunization services
Anticoagulation	physician group	pay percentage of pharmacist salary for specific clinic visits
Anticoagulation, dyslipidemia, GERD, PUD, hypertension, asthma, and diabetes	research project supports first year, thereafter physician group supports	Medical group demonstration project** Pharmacist paid to manage identified high risk patients over 1 year for a group of primary care physicians.
Positive Outcomes Program	County of Monterey County of Kern OMNI Healthcare Sutter Preferred VEBA	adjudicated through PCN Pharmacist paid a $10 fee for approved submission of a prescription or drug therapy problem
Diabetes	CalOPTIMA	adjudicated through PCN Pharmacist paid $5 fee for providing Diabetes Retinal Eye Exam Reminder

Diabetes	**patient self pay, various health care plans on a patient specific need basis**	**various pharmacists provide care and are paid for services by patients and health plans**

* proposed project-Contact Carlo Michelotti, CPhA for more information

**proposed project-Contact Kathy Johnson, USC for more information

Survey of Pharmacist Care Reimbursement in California

Please take a moment to complete this survey. We find there is a general lack of comprehensive information about what services are being paid for and by whom in California. All information will be kept confidential. Only compiled information, not individual responses will be published. We will publish the summary results in a future issue of the Journal. You may fax your results to Kathy Johnson, Pharm.D., Ph.D. (323) 442-1462 or via email: kjohnson@hsc.usc.edu Thank you!

1. What services are reimbursed and for what diseases?

2. What patients are eligible for the services?

3. How much is charged? How much is paid? What is the method of payment (eg flat fee, capitated rate, etc)

4. How do you submit your claim for processing (eg paper claim using the HCFA-1500, NCPA Pharmacist Care Claim Form, Specific billing form provided by company (fax us an example), etc)

5. Who pays for the services (what company and/or health plan)? To whom is the claim submitted?

6. Are there special requirements a pharmacist must meet in order to be a provider? What are the requirements?

7. Pharmacist Name, address, phone, fax (in case we must clarify your responses) (this information will be kept confidential)

Thank you for your input.
FAX your information to: Kathy Johnson 323-442-1462

Mississippi Medicaid Project:

The state of Mississippi has reacted to its extremely high fee for service emergency room costs by implementing a special pharmacist initiative. The Health Care Financing Administration (HCFA) has granted a 2 ½ year waiver to compensate pharmacists for specific disease management services. Four disease states have been selected for pharmacist management. They include: anticoagulation, asthma, dyslipidemia and diabetes. Pharmacists must pass a disease specific credentialing exam, administered by the National Association of Boards of Pharmacy (NABP), and take hands on training from approved providers in order to receive payment for their services. Pharmacists must also obtain physician referral, via a medical necessity form for each patient they feel is a candidate for their services. A limited number of visits (10) are allowed per patient per year. The fee paid per visit is $20. An analysis of the impact of the project are due at the end of the demonstration period.