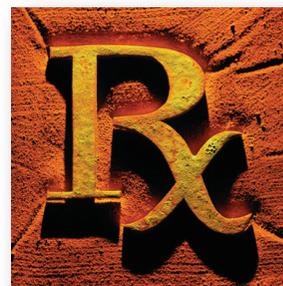


Pharmacists Hope to Bill Under New Medicare 'G' Code

Payment Would Be for Transitional Care After Hospital Discharge

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Will Medicare lock out pharmacists from its new post-hospital transitions payment program? That is not clear yet and might not be for some time, although the Centers for Medicare and Medicaid Services (CMS) says it will establish a new “G” code for such payments in calendar year 2013.

The G code is the latest step by Medicare to tamp down hospital readmissions, many of which are preventable and all of which cost the federal government billions of dollars. In its 2007 report to Congress,¹ the Medicare Payment Advisory Commission (MedPAC), the quasi-government advisory group, found that in 2005, 17.6% of hospitalized patients were readmitted within 30 days of discharge, accounting for more than \$26 billion in spending every year.² MedPAC estimated that 76% of the 30-day readmissions, resulting in \$12 billion in spending, were potentially preventable. In the same report, MedPAC also found that the rate of potentially avoidable rehospitalizations after discharges from skilled nursing facilities was 17.5% in 2004.¹

Medicare officials, as well as members of Congress, have been increasingly concerned about preventable readmissions ever since the release of the MedPAC report, which is why the Patient Protection and Affordable Care Act (PPACA) included a number of programs aimed at reducing readmissions, generally through smoothing the transition of patients from hospital to home. A number of these programs, including the Partnership for Patients and Community-Based Care Transitions Programs, have been discussed in *P&T*.³

Now Medicare is further upgrading its incentives for post-hospital transition care by establishing the Healthcare Common Procedure Coding System (HCPCS) G code. Typically, hospital physicians and doctors in skilled nursing homes bill under Medicare using Current Procedural Terminology (CPT) codes when they discharge a patient. For example, hospital discharge management codes (CPT codes 99238 and 99239) and nursing facility discharge services (CPT codes 99315 and 99316) capture the care-coordination services required to *discharge* a beneficiary from hospital or skilled nursing facility care. The work relative value units for those discharge management services include a number of pre-care, post-care, and intra-care coordination activities. Yet the full gamut of post-care services, such as lifestyle adjustments and medication reconciliation and adherence, lie outside what those discharge codes describe.

Theoretically, the patient’s community primary care physician should be responsible for medication reconciliation and related tasks; however, the CPT office-visit codes that the physician bills for a recently discharged patient cover only “evaluation and management” (E&M) services. These services typically do not include easing a patient’s transition into the home and ensuring that everything has been done to maintain the patient’s ostensibly stabilized post-discharge condition so that he or she does not have to go right back to the hospital or nursing home.

The transition services encapsulated in the new G code include reviewing a patient’s medical record and diagnostic test results, evaluating psychosocial status, and making any necessary adjustments to the plan of care. The CMS envisions that these services would be provided so that the physician or non-physician would not have to see the patient, as is the case when a physician bills under an E&M code. It therefore follows, one would think, that the G code

would be billed by someone other than a physician.

The transition services spelled out in the G code—one could argue that they are the key services in the G code in avoiding readmissions—also include tasks that a *pharmacist* is best able to do, such as assessing a patient’s understanding of the medication regimen, undertaking medication reconciliation, and providing medication therapy management.

Moreover, the kinds of nonphysician providers whom hospitals would like to be eligible to bill under G codes—people employed by the hospital—clearly do *not* have the expertise to perform the medication tasks. These are jobs such as medical assistants, care navigators, social workers, and “health coaches” who, the American Hospital Association says, “are often the team members telephoning patients to assist with follow-up appointments, prescription refills, insurance inquiries, and numerous other social issues.”⁴

John M. Coster, PhD, RPh, Senior Vice President of Government Affairs of the National Community Pharmacists Association (NCPA), says:⁵

NCPA contends that community pharmacies are already performing many of these transitions of care-related activities and should be compensated for them, specifically medication reconciliation. ... CMS currently recognizes community pharmacies as a provider under certain circumstances, as pharmacies currently have the ability to bill under G codes for a limited number of services. *CMS should allow pharmacies [that] participate in the Part B program to bill for transitional care management services that involve medication therapy.*

It thus seems that Medicare might explicitly designate pharmacists as among the “physicians or qualified nonphysician practitioners” eligible to bill under the new G code. The proposed rule issued this past summer does not do that.

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