

CHAPTER 7

BILLING AND REIMBURSEMENT FOR THE AMBULATORY CARE PHARMACIST

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Chapter 6 discusses the variety of contractual arrangements that managed care companies make with healthcare providers such as networks, capitation fees, and salaried payment. That chapter also introduced the concept of coordinated providers under Accountable Care Organizations (ACOs). Medical insurers contract with physicians and hospitals through networks, capitation and bundled payment models of reimbursement. This section will outline how pharmacists are impacted by these payment arrangements.

Pharmacists are usually paid as hourly or salaried employees of the pharmacy chain or independent pharmacy that employs them. It is almost always the pharmacy, hospital, or clinic, not the pharmacist, who negotiates with third party payers such as private insurers and pharmacy benefit managers. In the retail/community setting, claims are transmitted electronically when the patient fills a prescription and payment for each prescription is calculated at the point of sale. The pharmacist is removed from the contractual process but the bottom line is impacted by each prescription rejection.

In the hospital setting, the charges for all services are added together for the patient's stay. This list is often referred to as the charge master, which is then billed to the insurance company or government payer based on the contractual arrangement between that hospital and payer. This is usually done after the patient is discharged, although a pre-authorization may be requested to verify the patient has coverage and payment is likely. As discussed in **Chapter 6**, the charges may be fee-for-service or may be submitted each day as a daily total (per diem) or one total for the whole hospital stay (per episode).¹

Hospitals and physician practices may be owned by the payer, as with a Health Maintenance Organization (HMO). The healthcare providers in the physician practice, including the ambulatory care pharmacist, are likely paid salary by the payer itself. In this case, a global budget is created for hospital and administrators who are responsible for charging against a budget and for appropriate use of funds.¹ Hospital administrators who are unable to manage budgets appropriately will likely lose their jobs. With the movement towards accountable care and value-based payments, new contractual arrangements linking patient outcomes and

quality measures to payment are changing reimbursement structures.

Ambulatory care pharmacy practice is one of the fastest evolving pharmacy sectors as the profession is continuously changing to include delivery of comprehensive clinical, consultative, and educational patient care services.² Challenges in providing such services still remain; pharmacists lack provider status, as they are not recognized under Title XVIII of the Social Security Act, resulting in reimbursement ineligibility under Medicare Part B.³ One way health care professionals generate income is through billing for their services. Because pharmacists are not recognized as providers by many payers, including Medicare Part B, billing for clinical pharmacy services in the outpatient setting can be complex. Billing is the process of documenting services rendered to patients, and sending a bill for the eligible service to the third party payer for reimbursement. Services are separated into numerical codes, which correlate to the varying complexity of the services. Providers report these numerical codes to third-party payers in order to receive reimbursement for their services.

Reimbursement is a dollar amount which is returned to the organization for properly performing, documenting, and billing for services. Reimbursement amounts for the same services can differ between payers. This means that a health care provider can be paid different amounts for performing the same service, depending on the third party payer. Medicare reevaluates and recalculates reimbursement amounts for outpatient services annually and makes that data publicly available. In general, Medicaid reimburses about half that of Medicare and private payers reimburse 20% more.⁴ Billing also includes cost-sharing, which represents the patient's copay. The next section will focus on both direct and indirect billing methods utilized to receive reimbursement for ambulatory care pharmacy clinical services.

PROVIDER STATUS

Provider status is granted to healthcare providers who provide patient assessments, bill for their services, and receive reimbursement. The diversity of healthcare professionals included in a provider network can vary between private third party payers and the Centers for Medicare and Medicaid Services (CMS). Third party payers define a provider network to ensure quality healthcare is delivered to patients by qualified health care professionals. A summary of third party payer types, and pharmacist billing opportunities for each type can be found in [Table 7-1](#).

Medicare

Title XVIII of the social security act recognizes health care providers eligible to receive

reimbursement from Medicare Part B. Such providers are listed in **Figure 7-1**. As mentioned previously, pharmacists are not recognized as providers under Title XVIII; therefore, lack ability to receive reimbursement for their services in the outpatient setting.³



Figure 7-1. Non-physician providers eligible for reimbursement from Medicare Part B

Additionally, Medicare Part D, which provides prescription benefits, gives variable options for patients to choose a prescription drug benefit plan to best suit their needs. Regardless of which plan is chosen, it is required that all plans offer medication therapy management (MTM) services to their beneficiaries. MTM services can be provided by pharmacists or other qualified providers and is reimbursable by Medicare Part D when the service is provided in the community pharmacy setting.²

State Programs

Individual states have the ability to enact legislation to allow pharmacists to bill for services and receive reimbursement. A state legislature can trump the federal social security act and allow pharmacists to have provider status in that state. In May 2015, Washington became the first state to sign legislation requiring pharmacists be included in health insurance provider networks.⁵ At the time of this writing, 38 states designate pharmacists as providers in at least one statute or Medicare provision.⁶

Private Third-Party Payers

Generally, most private third-party payers follow CMS rules and regulations; however, pharmacists have worked directly with commercial third-party payers to create contracts for

payment of their services. There is no obligation for a commercial payer to recognize pharmacists as providers and it is up to their discretion whether they include or exclude pharmacists from their provider network.

Self-insured employers are another third-party payer in which pharmacists may directly bill. Self-insured employers are businesses where the employer pays out-of-pocket for their employee’s healthcare expenses, handling all paperwork and payment for health claims. Self-insured employers have the ability to recognize pharmacists as providers; however, like private third-party payers there is no obligation to include or exclude pharmacists within their provider network.

Self-Pay Patients

Cash paying patients always reserve the right to pay cash for services. Pharmacists may bill dependent on the market demand of patients willing to pay pharmacists cash for their services.

Payer Types	Can a pharmacist bill directly?
Medicaid / State Programs	Only if an individual state passes legislature.
Medicare	Part B – No. Pharmacists are not recognized as providers.
	Part D - Yes, Medication therapy management is a required element can be provided by pharmacists or other qualified providers.
Commercial Third Party Payers	Only if the commercial payer includes pharmacists in their network
Self-Insured Employers	Only if the Self-Insured Employer includes the pharmacists in their network
Cash Paying Patients	Yes, if the patient is willing to pay

Table 7-1. Payer types²⁴

BILLING FOR CLINICAL PHARMACY SERVICES IN AN AMBULATORY SETTING

If a healthcare professional is not included in the provider network of a third-party payer, they will receive no reimbursement for their services from that payer; however, there are ways in which they can generate revenue by indirectly billing for services. Each health care professional carries their own unique National Provider Identifier (NPI) number. An NPI number identifies specific healthcare professionals or healthcare entities (e.g. hospitals, nursing homes, etc.) on HIPAA standard transactions such as bills.⁷ Although pharmacists are not eligible to bill Medicare Part B under their own NPI number, they can collaborate with a physician or other recognized provider to bill indirectly under the collaborating provider's NPI number. To bill under another healthcare professional's NPI number using any of the billing methods outlined below, a collaborative practice agreement is often written and signed by all parties. A collaborative practice agreement is a signed document granting authority to a pharmacist (or other healthcare professional) to bill for services under a supervising practitioner's NPI number.³ A collaborative practice agreement includes specific practice protocols which the pharmacist must follow.

"Incident To" Billing Methods for Pharmacists

Indirect or "incident to" billing is the framework under which a non-physician practitioner may bill under a supervising physician's NPI number, given certain criteria are met. CMS defines "incident to" as those services that are furnished "incident to" physician professional services in the physician's office, separate office suite, in an institution, or a patient's home.⁸ In the outpatient setting, health care professionals utilize Current Procedural Terminology (CPT) codes to identify services rendered and International Classification of Diseases-10 (ICD-10) codes to detail the indication for those services. The indirect billing method is utilized by ambulatory care pharmacists and other mid-level practitioners who work in conjunction with a physician to see patients and bill for services. There are several conditions which CMS requires in order for a non-physician provider (NPP) to be eligible to bill for services "incident to" ([Table 7-2](#)).⁸

Establish with Physician	Physician or Medicare Part B-approved provider must perform an evaluation or service for the same problem that is being evaluated by the pharmacist's service Physician must establish a plan of care which includes future incidental services.
Active Involvement	Physician or Medicare Part B-approved provider must be actively involved in the patient's course of treatment and provide subsequent services at a frequency that reflects their active involvement
Common Services	Services rendered must be of a type that are commonly furnished in the physician's office or clinic.
Services Order	The physician or Medicare Part B-approved provider must have provided authorization for the service and authorization must be documented in the medical record.
Employee Relationship	The pharmacist providing the service must be an employee, leased, or contracted to the physician or Medicare Part B-approved provider.
Scope Of Practice	All services rendered must be within the scope of practice for that specific healthcare professional and medically appropriate to be given in the provider's office.
Direct Supervision	A physician or Medicare Part B-approved provider must be on the premises, but not necessarily in the same room, when services are being performed. Direct Physician Supervision also requires the physician must be clinically appropriate to supervise any situation or emergency that may arise.

Table 7-2. “Incident to” rules²

“Incident to” Billing in an Institutional Ambulatory Setting

Hospital based “incident to” billing refers to physician outpatient clinics that are financially

tied to a hospital. To determine if a physician clinic is financially tied to a hospital, check to see if they have similar tax identification numbers or ask the billing department for that clinic or hospital. When a patient is seen by a Medicare Part B recognized provider, they may bill two fees: a professional fee for the services they perform and a facility fee for the hospital to cover facility expenses. Because pharmacists are not recognized providers under Medicare Part B, pharmacists can only bill via a facility fee and cannot bill a professional fee. The disadvantage of facility fee billing is the extra financial burden on the patient. For example, if a patient sees the physician and pharmacist in the same day, they will receive two bills: a bill for the professional fee for the physician and their facility bill, and a separate facility fee bill that includes the services provided by the pharmacist.²

“Incident to” Billing in a Non-Institutional Ambulatory Setting

Physician clinic based “incident to” billing refers to a physician outpatient clinic that is not financially tied to a hospital. The physician, or physician group, owns the entity in its entirety and the clinic practices under their own business tax identification number. Unlike hospital based “incident to” physician billing which can bill a facility fee, physician based clinics cannot bill a facility fee and only have the option to bill professional fees. Again, because pharmacists are not recognized providers under Medicare Part B, they must indirectly bill “incident to” physician for their professional fees. The same CMS “incident to” rules apply (**Table 7-2**). When billing “incident to” in physician based clinics, pharmacists may be reimbursed at 100% of the physician rate, or 85% of the physician rate if a non-physician provider (NPP) is serving as the supervising provider.⁹

Billing Levels

Billing for services in both hospital and physician based clinics are executed via five CPT codes 99211-99215. CPT code 99211, or level 1 billing, is the lowest level of billing and yields the lowest reimbursement. CPT code 99215, or level 5 billing, is the highest level of billing and yields the highest reimbursement amount. When billing at the lowest level, 99211, there are no documentation requirements; however, when documenting a patient visit to support a higher level of billing, there are three main areas required: number of body systems reviewed, number of disease states assessed, and the level of complexity of decision making.¹⁰ The level of billing is then determined by the complexity of the visit based on the components included in the note documentation (**Table 7-3**). For most regional carriers of CMS, pharmacists are limited to the lowest billing level, 99211, when billing “incident to” because they are not recognized Medicare Part B providers.² For non-Medicare “incident to” billing, state Medicaid programs and commercial third party payers may allow pharmacists to bill at

higher levels as long as documentation supports the higher level of billing.²

<p>Patient History</p>	<p>Patient history is comprised of several components such as family history, social history, history of present illness, chief complaint, and review of systems. Review of systems analyzes each organ system (genitourinary, respiratory, etc) pertinent to the patient’s chief complaint. The more systems reviewed, the more complex the visit and the higher the billing level able to be billed.</p>
<p>Physical Exam</p>	<p>The physical exam is a required component of the visit. Physical exam can range from a multi-system physical exam, to a single-organ exam. CPT code 99211 may be billed without a physical exam. The more elements involved in the physical exam, the higher the billing level able to be billed.</p>
<p>Medical Decision Making</p>	<p>Medical decision making complexity is based on the three main components of the number of diagnostic options, amount of complexity, and the risk of decision making. A points system is utilized to categorize the level of medical decision making and the appropriate corresponding billing level.</p>

Table 7-3. Billing components²

MEDICATION THERAPY MANAGEMENT

Medication Therapy Management (MTM) is a medical service provided to optimize drug therapy and improve therapeutic outcomes. Medication therapy management services are patient-centered services, rather than product-centered services.¹¹ In 2003, The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) created Medicare Part D but also required insurers to cover MTM services for their beneficiaries.¹² The MMA identifies three MTM parts: education to improve patient’s medication understanding, programs to increase medication adherence, and detection and prevention of adverse drug reactions.¹³ MMA does not require that MTM services be provided by a pharmacist, but as drug experts, pharmacists can play a vital role in improving patient’s health care quality and reducing exacerbations.¹³ MTM services can be billed via CPT codes which are chosen based on the visit length of time (**Table 7- 4**). These CPT codes are not recognized by Medicare Part B, because MTM is not a covered service under Part B, only Part D; therefore, these CPT codes cannot be utilized in the physician clinic setting as Medicare Part B is the entity that covers

services provided in the physician office (hospital-based or physician-based). These CPT codes; however, can be utilized via contracts with prescription drug benefits plans under Part D in a licensed dispensing pharmacy setting. MTM services can still be provided by a pharmacist or other practitioner in the institutional or non-institutional outpatient settings; however, billing codes utilized are those that are covered by Medicare Part B and pharmacist billing methods are similar to other pharmacy services in these settings, as outlined previously.

CPT Code 99605	Billed for a new patient visit for the initial 15 minutes of face-to-face MTM.
CPT Code 99606	Billed for an established patient for the initial 15 minutes of face-to-face MTM.
CPT Code 99607	Billed for each additional 15 minutes of MTM. This code can only be used after billing either 99605, or 99606.

Table 7-4. MTM CPT Codes²⁵

TRANSITIONAL CARE MANAGEMENT

Transitional care management (TCM) refers to services offered during a period where a patient is transitioning from an inpatient to an outpatient setting. This transition represents a vulnerable time for the patient who is now required to manage changes in diagnosis, medications, and/or lifestyle habits.¹⁴ These rapid and sometimes drastic changes can increase the patient’s risk of exacerbation and hospital readmission if not properly managed.¹⁴ The Centers for Medicare and Medicaid puts a strong emphasis on quality of healthcare, and in October 2012 introduced the Hospital Readmissions Reduction Program. Through this program hospital reimbursement rates are reduced if patients are readmitted to the hospital within 30 days.¹⁵ In addition, effective January 1, 2013, Medicare created a new method for reimbursement of transition-related activities. These CPT codes for TCM services may be used to bill physician and qualified non-physician providers care management following patient discharge. Qualified non-physician providers who may provide TCM services include: certified nurse-midwives, clinical nurse specialists, nurse practitioners, and physician assistants.¹⁴ TCM appointments aim to reduce hospital

readmissions by minimizing patient risk of new or changed medication regimens and ensuring proper education of lifestyle habits and self-management of chronic disease. The TCM CPT codes provide higher rates of reimbursement and combine face-to-face and non-face-to-face TCM components into one billing code (**Table 7-5**). The required components for TCM billing are outlined in **Table 7-6**. Additional components, not required, may include: caregiver education, managing medications, obtaining and reviewing discharge information, reviewing pending diagnostic tests and treatments, communicating with other health care providers, establishing referrals, arranging community resources, and assisting with follow up with other providers or services.¹⁶⁻¹⁸

Visit Type	Timing (Calendar days)	CPT Code	Complexity	Claim Deadline
TCM	Within 7 days of discharge	99496	High	30 days from discharge
TCM	Within 14 days of discharge	99495	Moderate	30 days from discharge

Table 7-5. Billing Codes for Transitional Care Management (TCM) Billing¹⁶⁻¹⁸

Interactive Contact	Interactive contact must be made with the patient via e-mail, telephone call or face-to-face appointment within 2 days of the date of care transition.
Non-Face-To-Face Services	The practitioner must provide non-face-to-face services to the beneficiary. These services may be conducted by licensed clinical staff under the physician or NPP’s direction. If the physician or NPP determines that non-face-to-face services are not indicated, then they are not a required element.
Face-To-Face Visit	A moderately complex patient must have a face-to-face visit within 14 days of the date of transition of care. A highly complex patient must have a face-to-face visit within 7 days of

	<p>the date of transition of care.</p> <p>Medication reconciliation and management must be furnished before or on the date of the face-to-face visit.</p>
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Table 7-6. Required components for transitional care management billing¹⁹

While pharmacists are not included in the list of qualified non-physician providers able to bill for TCM services, these codes present an opportunity for pharmacist’s services to be reimbursed as a part of a multidisciplinary team. The billing claim itself must be submitted under a Medicare recognized provider and can only be billed once per beneficiary during the TCM period (30 days post-discharge); however, the high reimbursement rates reflect the need for involvement of multiple providers. As medication experts, the required medication reconciliation component offers pharmacists a unique niche to become a more incorporated part of the TCM team.

ANNUAL WELLNESS VISITS

Annual Wellness Visits (AWV) aim to provide a personalized prevention plan to reduce patient risk of morbidity or mortality. The components of a Medicare AWV include: a health risk assessment, establishing current providers, family history, past medical history, risk factors for depression or other mood disorders, and functional ability.¹⁹ AWVs also include a general checkup of height, weight, body mass index, blood pressure and any other measurements deemed necessary based on the medical diagnoses the patient has received.¹⁹ The health risk assessment component of an AWV addresses demographic data, self-assessment of health status, psychosocial risks, behavioral risks, activities of daily living (dressing, bathing, and walking etc.), and instrumental activities of daily living (shopping, housekeeping, and managing finances etc.) at a minimum.¹⁹ Unlike TCM services, Medicare Part B will reimburse for AWVs performed by a pharmacist. Additional providers recognized by Medicare to provide AWV include: physicians, qualified non-physician practitioners (physician assistant, nurse practitioner, or certified clinical nurse specialist), or medical professionals (health educators, registered dieticians, nutrition professionals, or other licensed practitioner) under the direct supervision of a physician. Pharmacists fall under the category of other licensed practitioner; therefore, require direct supervision (as defined in “incident to” rules) by a physician.¹⁹

Billing for Medicare AWVs can be multifaceted, because there are time frames and requirements to consider when billing. Optimally, AWV would be conducted on an annual basis for each patient. The initial AWV is billed with one code (G0438) and subsequent AWVs are billed with a separate code (G0439). An Initial Preventive Physician Examination (IPPE) is a “Welcome to Medicare” physical and can only be performed by a physician or NPP. Medicare will cover the initial AWV if it is 1) at least 12 months following an IPPE or 2) for beneficiaries who are no longer within 12 months of their Medicare coverage effective date. Subsequent AWVs cannot be billed within 12 months of the initial AWV. Medicare will pay for one initial AWV per lifetime and one subsequent AWV per year thereafter.¹⁹

CPT Code	Type of Visit
G0402	Initial Preventive Physician Examination (IPPE) or “Welcome to Medicare” physical
G0438	Initial Annual Wellness Visit
G0439	Subsequent Annual Wellness Visit

Table 7-7. Medicare annual wellness visit billing codes

CHRONIC CARE MANAGEMENT

Chronic conditions such as diabetes and heart failure are devastating life-long diseases, and primary care services help to contribute to better health and quality of life for patients living with chronic disease. Effective January 2015, Medicare began paying for Chronic Care Management (CCM), recognizing the value primary care brings to health care.²⁰ CCM aims to utilize non-face-to-face interactions to decrease the risk of hospital readmission and prevent exacerbations by educating patients on their conditions, their medications, and providing access to care. Eligible CCM patients must have two or more chronic conditions which place the patient at significant risk of death, acute hospitalization, or functional decline.²¹ CCM chronic conditions include, but are not limited to, diabetes, heart failure, Alzheimer’s disease, asthma, cancer, COPD, depression, and osteoporosis.²¹ CCM has several required elements such as recording patient demographics, a written, patient-centered, care plan to be documented and given to the patient, providing 24/7 access to care, and managed

care services.²¹ CMS requires the billing practitioner to conduct a comprehensive evaluation & management visit, AWV, or IPPE visit prior to billing for CCM services.²¹ Additionally, healthcare providers are required to inform patients of their CCM eligibility and obtain a written consent form before furnishing services.²¹ The practitioner must also explain to the patient how to revoke CCM services and that only one practitioner may bill for CCM services per month.²¹ A CCM visit provides payment for at least 20 minutes of a health care professionals' time per month of non-face-to-face care.

Billing for CCM is conducted on a per month basis and codes may only be submitted once per month per patient. This prevents multiple physician offices from conducting CCM visits on the same patient in the same month. CCM billing is not eligible to be billed in the same period as TCM services, hospice supervision services, or certain end-stage renal disease services.¹⁷ Pharmacists may provide CCM services and bill "incident to" the billing physician or non-physician practitioner and/or contribute to 20 minute/month time allotment, as long as they comply with all "incident to" physician billing requirements. CMS provided an exception under Medicare's "incident to" rules to allow clinical staff (including pharmacists) to provide services under general supervision of a physician or non-physician provider. Therefore, not requiring the physician to be on the premises providing direct supervision. CCM visits are billed using CPT code 99490. Although patient copayments or coinsurance applies to CCM visits; CCM provides a valuable service which may prevent patient costs for more expensive face-to-face visits in the future.

Transitional care management, annual wellness visits, and chronic care management appointments are three unique services that are only eligible for reimbursement by Medicare Part B, unlike "incident to" services, which may be reimbursed by Medicaid, commercial third party payers, and self-insured employers.

DIABETES SELF-MANAGEMENT TRAINING

Diabetes Self-Management Training (DSMT) is a service provided to patients with a new diabetes diagnosis or patients struggling to control their diabetes. Pharmacists must be a member of a recognized DSMT program by the American Association of Diabetes Educators, the American Diabetes Association, or Indian Health Services division of diabetes treatment and prevention in order to provide DSMT services.²² Because pharmacists are not a recognized Medicare provider, pharmacists may not bill for DSMT services; however, because pharmacies are a recognized Medicare entity, a pharmacist can bill under the pharmacy if it is a certified DSMT facility.

DSMT services may also be billed in either a physician based or hospital based clinic. In order for a pharmacist to bill for DSMT services the pharmacist must have a written physician's order for DSMT services for the patients involved. During the first initial year, up to 10 hours of DSMT services can be billed per patient in 30 minute increments in either individual or group training.²¹ After the first year, up to 2 hours of DSMT services can be billed per patient in 30 minute increments in either individual or group training.²² Subsequent years begin 12 months after the first DSMT visit. Individual visits are billed under CPT billing code G0108, group visits of 2-20 people are billed under CPT billing code G0109.²² Individual visits provide a higher reimbursement rate per person than group visits.²²

CLINICAL LABORATORY IMPROVEMENT ASSESSMENTS – WAIVED LABORATORY

The Clinical Laboratory Improvement Amendments (CLIA) is the way CMS regulates laboratory testing performed on humans.²³ CLIA ensures laboratories are performing tests correctly and providing accurate test results. CLIA covers blood tests such as electrolyte and cholesterol levels, in addition to home drug tests, pregnancy tests, and any other tests requiring bodily fluids. In order for a pharmacy to do point-of-care testing such as diabetes or cholesterol screening, they must apply for a CLIA certificate of waiver. The entity must use application form CMS-116 and pay a \$150.00 application fee. If approved, the entity will receive a CMS Part B Provider Identification Number (PIN). Pharmacists submit claims to CMS by using the entities PIN on the CMS 1500 form and the proper CPT codes. Pharmacists are allowed to bill because the claim is for the laboratory services only, and not for cognitive services. There are numerous CPT billing codes for the variety of CLIA-waived laboratory assessments available. The pharmacy can bill CMS for the tests performed by their pharmacist, and the pharmacy will receive reimbursement.

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