Billing Primer

A Pharmacist's Guide to Outpatient Fee-for-Service Billing

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Executive Summary

Sustainability of pharmacists' patient care services is dependent on having adequate revenue sources. Fee for service (FFS) is currently the most common method of payment for health professionals in the U.S. health care system. Under FFS payment, compensation is based upon the number and types of services provided, often called a volume-based payment model.

The health care system is moving to new payment models that are less volume-based and more value-based to achieve high-quality outcomes of care. Newer payment models use a "fee for value" structure that often includes FFS payments plus additional incentives for meeting quality metrics and cost thresholds.

This primer presents a general overview of outpatient FFS billing for pharmacists; (note that this document does not cover FFS billing for immunizations). A common misconception is that pharmacists do not have any opportunities to be paid for services within the current FFS infrastructure. Widespread financially viable business models for pharmacists' patient care services continue to be a challenge, but opportunities do exist. This primer highlights potential payers for pharmacists' patient care services, commonly used billing codes, requirements for using those codes, and selected links for more information.

By nature, a primer is meant to be an introduction to the topic in a basic format, and therefore, this resource should be utilized as an entree to the broad opportunities and requirements related to FFS. Billing code–specific requirements are subject to change and payer-specific requirements may differ from the general guidance provided in this publication. Pharmacists should rely upon the sources of standardized billing codes and payer-specific contracts for the most up-to-date and relevant information.

Key concepts to consider when utilizing this primer in your practice:

1. All of these billing codes are for **outpatient-provided patient care services.**

2. The **type of organization with which you are working** (e.g., pharmacy, physician practice, hospital clinic) will serve as the foundation for what you are able to bill.

3. If you are employed by an entity that is distinct from where you are providing care or you provide care in more than one type of location (i.e., physician office and pharmacy), you will need **a "lease agreement" between the two entities** to allow billing to occur.

4. The organization you work within needs to **establish policies and procedures** for pharmacist scope of practice, allowable billing with the practice, and collaborative practice agreements where applicable.

5. In order to bill for any service, **there needs to be a contract between the recognized provider or the provider's organization and the third-party payer.** Bills adjudicated without a contract are nearly always rejected.

6. **Once you bill for a Medicare/Medicaid patient, you should bill for all patient care services.** Services should no longer be rendered at "no charge," because doing so is considered fraudulent under Medicare.

7. **Additional factors** that support patient care delivery and ultimately billing for services such as data exchange agreements (including cybersecurity insurance) and pharmacist liability insurance need to be considered.

Contents

Types of Payers

Payment for pharmacists' patient care services can come from different types of payers. The three largest payer sectors in health care are Medicare, Medicaid, and private health plans, including self-insured employers.[1] Medicare spending comprises about 20% of our national health care expenditures, Medicaid comprises approximately 17%, and other government programs (Department of Defense, Veterans Affairs, etc.) contribute 12% to the U.S. health care spend.[1]

Private health plans account for about 34% of national health care expenditures.[1] Within the private sector, employers may contract with private health plans to cover their employees or they may choose to be self-insured by assuming the financial risk of covering their employees' health benefits.[2] Because of the influence of the federal government, many private sector plans look to Medicare when setting their payment policies.[3] A final key payer type is patients who pay out of pocket, accounting for 10% of national health care expenditures.[1]

More Information:
- *National Health Expenditure Fact Sheet*

Different payers require varying billing processes, and pharmacists' patient care services are often covered in the medical benefit rather than the drug benefit.[4] Payers need to be consulted for:

- Determining if and how pharmacists' claims will be recognized.
- Clarifying billing procedures.
- Explaining claims processing information.
- Specifying codes that will be recognized for pharmacists' services.

- Clarifying any other requirements (e.g., prior authorization, specific submission instructions).
- Contracting for pharmacists' services.

Pharmacists working for a health care organization will need to know who is responsible for contracts and they also will likely need to collaborate with the billing and coding department, when available, in outreach to payers. Pharmacists in an independent or chain pharmacy will need to work with their management who will make contact with the payer or join a network that will work on their behalf. Depending on contractual agreements, payment may be sent directly to the pharmacist, a pharmacy, or a provider organization.

The following sections provide a brief overview of different payers and examples of payers that cover pharmacists' services.

Medicare

Medicare is a federal program that provides health insurance for individuals 65 years or older, certain individuals with disabilities, and individuals with end-stage renal disease.[5] The Medicare program is administered by the Centers for Medicare and Medicaid Services (CMS).[5] Pharmacists' services are currently not recognized in the Social Security Act, which details the types of provider services that are covered for direct payment by CMS in the Medicare program.[6] Pharmacy professional associations are actively pursuing "provider status" legislation in Congress that would provide recognition and payment for pharmacists' patient care services in Medicare Part B.[7] Until pharmacists can bill Medicare directly, it is important to understand the

available payment mechanisms for covering pharmacists' patient care services in the Medicare program. This includes opportunities for physicians to bill for pharmacists' services under incident to physician services arrangements in Medicare Part B and for pharmacists to receive payment from Prescription Drug Plans (PDPs) in Medicare Part D.[8-10]

Medicare Part B

Medicare Part B is administered by CMS and covers certain physician services, outpatient care, medical supplies, and preventive services.[11] Specific Medicare Part B services that may involve pharmacists include:

- Incident to physician services in a physician-based practice.[8]
- Incident to physician services in a hospital outpatient clinic.[8]
- Transitional care management (TCM) as part of a team-based bundled payment.[12]
- Chronic care management (CCM) as part of a team-based bundled payment.[13]
- Annual Wellness Visits (AWV).[14]
- Diabetes Self-Management Training (DSMT).[15]

All of these services have specific requirements that include pharmacist collaboration with a physician or qualified nonphysician practitioner (NPP) and *typically are billed using the physician's or NPP's National Provider Identification (NPI) number*.[16] In some cases, the services are delivered under the direct supervision of the physician or NPP, which requires the pharmacist to be physically located in the office-based practice. In other cases, the services can be provided under the general supervision of the physician, and the pharmacist can be located remotely.[8,13] These services will be discussed in detail in later sections. Involvement of pharmacists

in the Medicare Part B services listed above often includes comprehensive medication management, medication reconciliation, disease management, and wellness services.[12-14]

More Information:

- *APhA Pharmacists' Patient Care Services Digest*

CMS contracts with regional Medicare Administrative Contractors (MACs) to process claims, enroll health care providers in the Medicare program, and educate providers about requirements for billing for Medicare Parts A (hospitalizations) and B.[17] Because there can be variation in how different MACs interpret CMS requirements, it is important not only to be familiar with information released by CMS but also to check the website for the MAC in your geographic region for references and information about billing. A listing of the 12 MACs can be found at Who Are the MACs.[18]

Medicare Part D

Medicare Part D provides prescription drug coverage for Medicare beneficiaries who elect to enroll in the program.[19] CMS contracts with PDPs to administer Medicare Part D, including Medication Therapy Management services (MTMS).[20] PDPs may contract with pharmacies or pharmacists to deliver MTMS and/or deliver the service using in-house pharmacists and other health care staff.[20] PDPs may also contract with MTM vendors who in turn may contract with pharmacists to deliver MTMS.[20] Payment rates and service requirements vary among the Part D payers.[20]

The goal of the Medicare Part D MTMS benefit is to optimize therapeutic outcomes through reduction in adverse drug events, provision of patient education, and improved medication adherence.[21] Beneficiaries are targeted for MTMS using eligibility criteria based on the number of chronic conditions, number of medications, and the beneficiary's total Part

D medication costs.[20] Eligibility can vary significantly among PDPs. Required MTMS include an annual comprehensive medication review and quarterly follow-up and provision of a written summary to the beneficiary that includes a medication list and action plan.[20]

More Information:

- *CMS Fact Sheet Summary of 2017 Medicare Part D MTM Programs*

Medicaid and Other State-Based Programs

Some state-based programs, including Medicaid, cover pharmacists' services that can include MTMS, disease state management services, or preventive services such as smoking cessation. The requirements of state-based MTMS programs can be and often are different from Medicare Part D.[22] State pharmacy associations can provide more information about state-based programs and their requirements.[23]

Selected examples include:

- **Community Pharmacy Enhanced Services Networks:** Many states are forming networks of community-based pharmacies that deliver a core set of patient care services (services vary by the state). State network administrators contract for pharmacists' patient care services, including a Pennsylvania Medicaid managed care organization.[24]

- **Minnesota:** Medicaid beneficiaries with a minimum of one chronic condition and three chronic medications are eligible to receive MTMS from pharmacists who meet the requirements to deliver the services.[25]

- **Ohio:** CareSource, one of the Medicaid managed care organizations in Ohio, contracts with OutcomesMTM to cover MTMS for all Medicaid beneficiaries. OutcomesMTM then contracts with pharmacists to deliver the benefit.[26]

- **Missouri:** MO HealthNet covers MTMS by qualified pharmacists as part of the state's Chronic Care Improvement Program.[27]

- **West Virginia:** Dependents with Public Employees Insurance Agency coverage who are not covered by Medicare can enroll in a diabetes care management program called Face to Face that is delivered by pharmacists who have met the qualifications for the program.[28]

Private Sector

Private sector health plans and self-insured employers may be willing to contract directly with pharmacists or pharmacist employers for patient care services or may allow physicians and other qualified NPPs to bill for pharmacists' services.[10,22] Types of services that may be covered include MTMS, disease management, and health and wellness services, including health screenings.[29]

Federal government policies and reimbursement rates may influence many private sector plans that look to Medicare as the standard for covered services.[3,30] For example, private health plans may recognize and pay for services listed in the Medicare Part B section above, such as incident to physician services.[30] However, this is an individual payer decision and there is substantial variability among the services that are covered by payers. Examples of private sector programs that cover pharmacists' services include:

- **Washington State:** Pharmacists are recognized as providers in most Washington State commercial health plans. These commercial plans are required to include an adequate number of pharmacists as eligible providers in their networks. Services covered are those under the essential benefits requirements and within a pharmacist's scope of practice in the state.[31]

- **The Patient Self-Management Program** administered by the Illinois Pharmacists Association is a multistate, self-insured, employer-funded program that covers pharmacists' services for managing chronic conditions. Pharmacists in ambulatory care settings meet face-to-face with patients to assist them in managing diabetes, hypertension, and hyperlipidemia.[32,33]

- **Wisconsin Pharmacy Quality Collaborative** is a commercial payer/Medicaid program collaboration in Wisconsin that covers MTMS provided by qualified pharmacists for high-risk patients (as defined by the program).[34]

Emerging Value-Based Payment Models

Payment models focused on value rather than volume are emerging in all payment sectors—Medicare, Medicaid, and the private sector. In these models, such as accountable care organizations (ACOs) and patient-centered medical homes (PCMHs), organizations and providers are accountable for coordinating and managing the care of patients across the continuum of care. All or a portion of payment is based on meeting quality metrics and cost thresholds for a defined population of patients.[35]

In the PCMH model, which is focused primarily on physician practices, fee-for-service (FFS) payment is the primary payment source but there are added incentive payments for meeting quality metrics and cost targets.[36] In the ACO model, a legal entity is responsible for the health care costs of an assigned patient population and is positively or negatively incentivized for the ability to meet quality metrics and cost targets for the population.[35] Pharmacist inclusion in ACOs and PCMHs is evolving and can include contracting with ACOs or PCMH practices or being salaried employees of the organization for services such as transitions of care, medication management, and disease management.[35]

FFS codes detailed in this primer may be used within ACO and PCMH models, depending on the payment model.

- **Michigan:** Under a Blue Cross Blue Shield program, Michigan Pharmacists Transforming Care and Quality, clinical pharmacists are integrated into patient-centered medical homes across the state, working with physicians to review patients' medication plans, make necessary changes, and help patients to understand how to use their medications.[35,37]

- **Fairview Health System** has pharmacists working as members of the health care team. Using a whole person approach, these pharmacists provide comprehensive medication management services to targeted high-risk patients (e.g., patients with frequent hospitalizations, individuals with chronic conditions not at goal, patients with multiple medications and/or multiple providers). These pharmacists are responsible for making sure that all of a patient's drug therapies are appropriately indicated, most effective, and safe, and that the patient is adherent. Collaborative practice agreements (CPAs) are in place for medication management for over 15 disease states.[35,38]

- **Geisinger** engages approximately 50 full-time ambulatory clinical pharmacists, both at hospital-based or clinic-based practice sites, in monitoring and managing high-risk patient populations such as those with diabetes, hypertension, and pain management through post-discharge phone calls or visits. Pharmacists then ensure medications have been filled and are taken appropriately, monitor patient labs, provide patient education, assess adverse events and adherence to therapy, and titrate medication therapies when needed in order to prevent future adverse events and readmissions.[35]

More Information:

- *APhA ACO Issue Brief #6: ACO Engagement of Pharmacists*

Importance of Billing Codes

Billing codes are used to document and request payment for services delivered to patients.[39] The codes can also be used to document services even when billing for services is not available. Use of codes for documentation purposes can help quantify the contributions pharmacists make to the health care team and patient outcomes. Reach out to your billing and coding department to discuss how these codes can be used to document services.

It is important to reiterate that submission of billing codes to a payer does not guarantee payment for pharmacists' services. Pharmacists seeking direct payment for services should enter into a contract for services or as an enrolled provider with a payer.

When a payer recognizes the codes and agrees to pay for a pharmacist's services, billing codes can be used to convey FFS payments. Codes must be supported by appropriate documentation that justifies the use of the code.[40] Documentation requirements may vary among payers, contracts, and codes used.[16,41]

Health care providers should charge Medicare or Medicaid the usual and customary fee as charged for the same services provided to patients outside the Medicare or Medicaid program. Doing otherwise could be considered to be fraudulent activity by CMS and comes with significant penalties. Giving away items or services for free or for less than fair market value could trigger penalties

regarding beneficiary inducements and under anti-kickback provisions.[42,43] However, there are limited circumstances where providers, including pharmacists, could waive co-pays, co-insurance, and deductibles (or any part thereof). For more detail and information, see the U.S. Department of Health and Human Services Office of Inspector General regulations and resources on this topic.[42,43]

More Information:

- *HHS Special Advisory Bulletin: Offering Gifts and Other Inducements to Beneficiaries*
- *Federal Register: Medicare and State Health Care Programs: Fraud and Abuse*

Before using specific billing codes to request payment for services, it is first important to understand the construct and categories currently utilized in FFS billing. CMS maintains the Healthcare Common Procedure Coding System (HCPCS) to promote standardization in coding systems for consistency in claims processing. The HCPCS is organized into two primary subsystems:

- **HCPCS Level I—American Medical Association (AMA) Current Procedural Terminology® (CPT®) Codes:** CPT codes are 5-digit codes that describe medical procedures and services.[44] CPT codes are developed and maintained by the AMA's CPT Editorial Panel.[45] According to AMA, "The CPT® coding system offers

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doctors across the country a uniform process for coding medical services that streamlines reporting and increases accuracy and efficiency."[45] In addition to claims processing, CPT codes can be used for functions such as reporting medical procedures and services and developing guidelines for medical care review. CPT codes are used in Medicare, Medicaid, and private sector programs.[45]

■ **HCPCS Level II—G Codes:** HCPCS Level II codes are developed and maintained by CMS to facilitate claims processing for services, supplies, and equipment not covered by current AMA CPT codes. Of the different types of HCPCS Level II codes, G codes are used to identify professional health care procedures and services that would otherwise be coded in CPT but for which there are no CPT codes.[46]

More Information:

• *Healthcare Common Procedure Coding System Level II Coding Procedures*

This primer contains brief descriptions of commonly used billing codes for claims processing of pharmacists' services using examples of services and requirements under the Medicare program. It is not meant to be a comprehensive listing of all codes used in the marketplace and does not provide all the requirements for successful use of each code. Before any of these codes are used, further examination of the complete description of the codes and the requirements of the specific payer are necessary. Additionally, when working with a medical practice, the billing and coding departments will likely be involved in the decision making regarding billing for pharmacists' services.

> **This primer contains brief descriptions of commonly used billing codes for claims processing of pharmacists' services using examples of services and requirements under the Medicare program.**

Understanding How Billing Codes Can Be Applied in Your Practice

Key Factors in Determining Applicability of Billing Codes

There are three key questions that need to be answered to identify the billing codes that could be used to bill for pharmacists' patient care services in a practice:

- Where will the pharmacist deliver the patient care services?
- Does the payer recognize the pharmacist as a provider?
- What services can be contracted?
  - Is a CPA needed or would it be beneficial?

Where will the pharmacist deliver the patient care services?

The location where the patient care services will be delivered is important for two reasons:

- The payer may cover services only in certain practice settings, even if the pharmacist is recognized as a provider (e.g., immunizations).[47,48]
- If the pharmacist is not recognized as a provider, the pharmacist's services may be able to be billed FFS by a physician or qualified NPP. These services require varying levels of supervision by the physician or NPP in order to qualify for payment and are location dependent:
  - For services that require *direct supervision* in a physician office practice, the physician or NPP must be in the same office suite as the health care practitioner (i.e., pharmacist) delivering the service and readily available, if needed.[8]
  - For services that require *direct supervision* in a hospital-based outpatient clinic, the physician or NPP must be in the same building as the health care practitioner (i.e., pharmacist) and immediately available, if needed.[8]

- For services that require *general supervision,* the physician or NPP provides general oversight and direction but does not need to be located in same building or office suite as the health care practitioner (i.e., pharmacist) being supervised.[8] In this example, the pharmacist could be located in a community pharmacy or working as a consultant under the general supervision of a physician in a different location.

Does the payer recognize the pharmacist as a provider?

Yes, the payer recognizes the pharmacist as a provider: When a payer recognizes the pharmacist as a provider of services, the pharmacist can bill directly for the services using the pharmacist's NPI and the specific billing codes for the services the payer recognizes.[49] HIPAA, the Health Insurance Portability and Accountability Act, requires all health care providers—individual or organization—to obtain a unique 10-digit NPI to complete electronic transactions.[49] Both pharmacists and pharmacies must have NPI numbers to bill for clinical services or products.[49] Pharmacists applying for an NPI will choose a primary code and potentially secondary codes from a list of pharmacist-specific codes.[50] Pharmacists and pharmacies may bill using their own NPIs for codes recognized by a payer.

Depending on the contract and the billing code, the pharmacy (rather than the individual pharmacist) may be billing for the services provided by the pharmacist, and a pharmacy NPI will be required. Examples of payers that recognize pharmacists as providers include Part D PDPs (i.e., for MTMS), some state Medicaid and commercial payers, and some private sector payers.

No, the pharmacist is not a recognized provider: When a pharmacist is not recognized as a provider, then the pharmacist's services may be able to be billed under another provider's NPI.[8] Physicians and other NPPs, under certain arrangements and for certain services, can use their NPI to bill for the pharmacist's patient care services.[8] There are very specific requirements that must be met for this billing practice to occur, and the requirements can vary among payers and types of services.[8] CMS, through the Medicare program, is the primary payer that permits physicians or NPPs to use their NPI to bill for select Medicare Part B services provided in an incident to arrangement by pharmacists, and some Medicaid and private sector payers permit this type of billing.[8]

More Information:

- *CMS National Provider Identifier Standard*
- *Health Care Provider Taxonomy Code Set*
- *CMS National Provider Identifier Application/Update Form*

What services can be contracted?

Contracting with a payer: When a payer recognizes a pharmacist as a provider, the payer will also detail what services the pharmacist can contract with a payer to provide. The services can be general—for example, in Washington State, pharmacists can contract with state commercial plans to provide essential health benefit services within the pharmacist's scope of practice—or very specific.[31] In California, the Medicaid program pays pharmacists for naloxone therapy, oral contraception, smoking cessation, travel medicine, and immunizations.[51] It is important to consult the payer to understand which pharmacist-provided services the payer will cover.

Contracting with a physician or NPP: If the pharmacist is not recognized as a provider by a payer, then the pharmacist may be able to enter into a contractual relationship with a physician or NPP provider to deliver services.[8] The types of contractual relationships include pharmacist as a salaried employee of the physician, pharmacist as a leased employee of the physician, or pharmacist or pharmacy contracted with the physician.[8] The services that can be provided are those that the physician or NPP is permitted to delegate to the pharmacist and then FFS bill to the payer using the physician's or NPP's NPI (not the pharmacist's NPI). Examples of the services in the Medicare Part B benefit include incident to physician services, CCM, TCM, AWV, and DSMT when delivered in a physician office practice.[52]

Collaborative Practice Agreements and Billing for Pharmacists' Services

Pharmacists must follow state scope of practice requirements when delivering patient care services.[53] Depending on the state scope of practice, CPAs between physicians and pharmacists may be used to facilitate the delivery of pharmacists' patient care services.[54] Under the agreement, a physician delegates certain functions to the pharmacist such as initiating, modifying, or discontinuing therapy per the terms of the agreement.[54] While CPAs can expand the pharmacist's practice authority and they articulate details on how the services will be conducted, they do not address payment terms.[54]

How Physician Billing for Pharmacists' Services Works

Under certain arrangements, physicians and other qualified NPPs can use their NPI to bill for pharmacists' services.[8] In these arrangements, the pharmacist is collaborating with the physician to carry out aspects of the patient's treatment plan.[8]

Incident to Physician Services

This section describes incident to physician services as defined by CMS for the Medicare Part B program. Other payers may have similar rules as CMS but should be consulted for specifics. CMS defines incident to physician services as those services that are furnished incident to physician professional services in the physician's office (whether located in a separate office suite or within an institution) or in a patient's home.[8] In 2014, CMS clarified that physicians can use incident to billing for pharmacists' services as long as incident to requirements are met and the services delivered are within the pharmacist's state scope of practice.[55,56]

More Information:

- *CMS Response to AAFP MTM Billing Letter*
- *AAFP, CMS Clarify "Incident to" Rules Relating to Pharmacists' Services*

To qualify as incident to, services must be part of the patient's normal course of treatment, during which a physician personally performed an initial service, set up a care plan, and remains actively involved in the patient's course of treatment.[8] The incident to services provided by the pharmacist address specific aspects of the care plan (e.g., medication monitoring, disease management).[56] Generally, incident to claims should not be billed for services rendered on the same day the physician sees the patient.[57] Consult specific payer requirements for further information.

For the Medicare Part B program, incident to physician services are defined as those services that are an integral, although incidental, part of the physician's professional services and part of the patient's normal course of treatment.[8,58] Under an incident to arrangement, the physician or qualified NPP provides an appropriate level of supervision for delegated services to auxiliary personnel that can include a pharmacist.[8,58]

Most incident to services must be provided under **direct supervision,** meaning that although the physician or qualified NPP does not have to be physically present in the patient's treatment room while incident to services are provided, he or she must be present in the office suite (physician office) or in the building (hospital outpatient clinic) and immediately available to render assistance, if necessary.[8,58] Under **general supervision,** the physician provides overall direction and control, but the physician's presence is not required.[8,58]

Auxiliary personnel means any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician or of the legal entity that employs or contracts with the physician.[58] Similarly, the supervising physician may be an employee, leased employee, or independent contractor of the entity billing and receiving payment for the services.[58]

CMS recognizes nurse practitioners, physician assistants, clinical nurse specialists, and certified nurse midwives as qualified NPPs for incident to physician services for billing purposes.[8] CMS pays for services supervised by NPPs at 85% of the physician rate.[8]

To qualify as an incident to arrangement, the individual providing the care to the patient must be an expense to the physician or qualified NPP supervising the care.[8] Auxiliary personnel, including pharmacists, who are working under the supervision of a physician or NPP can function under one of the following arrangements:

- The pharmacist may be contracted by the physician practice to provide services.
- The pharmacist may be leased to the physician practice (e.g., the physician practice pays the pharmacist's primary employer for the pharmacist's time).
- The physician practice may hire the pharmacist as a salaried employee.[8,58]

It is critical to understand that the pharmacist's services are not billed directly by the pharmacist under the pharmacist's NPI but rather the pharmacist is performing the service on the physician's or qualified NPP's behalf and therefore the physician's or qualified NPP's NPI number is used for billing. In incident to physician services billing arrangements, the physician bills (using his or her NPI) for the ancillary service(s) provided by the pharmacist.[8] It is incorrect to say that the pharmacist bills for his or her clinical service through an incident to process.

The essential requirements for the incident to service must be documented in the patient record.[8] It is important to note that not all pharmacists' services can be billed incident to and that requirements can vary based on settings (e.g., federally qualified health centers have different requirements).[8] Different codes are used depending on whether the pharmacist performs the service for a physician-based practice or a hospital-based outpatient clinic.[8]

More Information:

- *CMS Medicare Learning Network "Incident to" Services*
- *Medicare Benefit Policy Manual*
- *A Tale of Two Charges Understanding the CMS Supervision Requirements for "Incident To" Billing*

In incident to physician services billing arrangements, the physician bills (using his or her NPI) for the ancillary service(s) provided by the pharmacist.[8] It is incorrect to say that the pharmacist bills for his or her clinical service through an incident to process.

Finding Potential Billing Codes for My Outpatient Practice Location

Figure 1 depicts three common outpatient practice settings and how the billing codes detailed in this guide could be used for payment for pharmacists' services (note that the figure depicts the use of these codes based on the current state of pharmacy practice). The chart delineates those codes that could be used when the pharmacist is recognized as a provider and those that can be billed by a physician or NPP for the pharmacist's services using the physician's or NPP's NPI.

Using Figure 1, locate the outpatient practice setting of interest. The applicable billing codes for that setting are listed for two scenarios—if the pharmacist is recognized as a provider and if the pharmacist is not recognized as a provider. Find more detailed information about each of the codes by clicking on the link or referring to the appropriate page number in this primer. Each description contains general information about the code as well as applicable information for pharmacists.
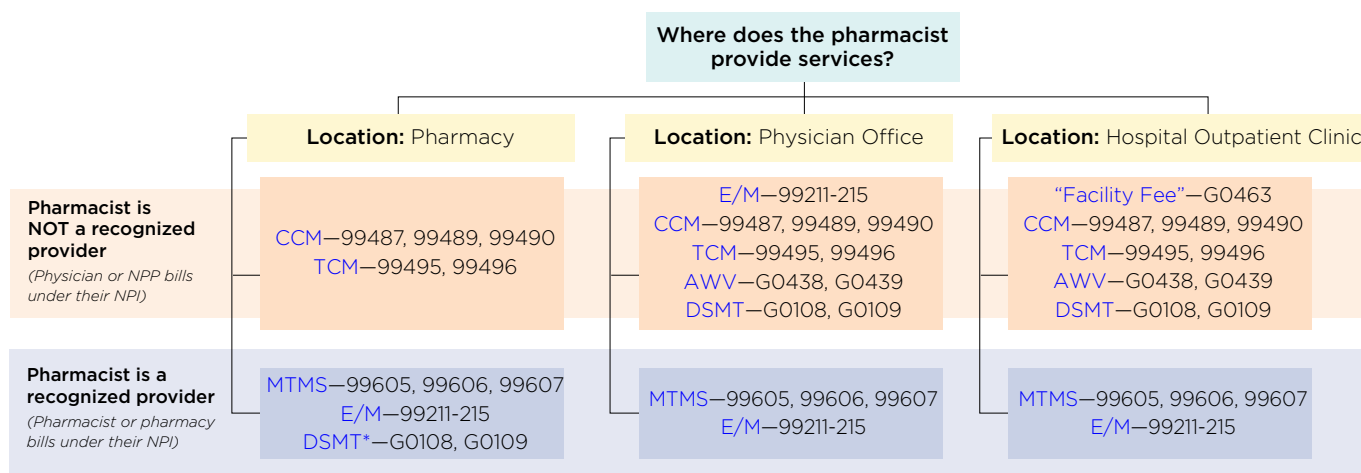
It is important to note that codes are payer specific and not all payers will recognize the codes described in the next section—Description of Billing Codes. Payers may also recognize other codes than the ones listed. Consult the payer to determine what codes are recognized and to understand the payer's requirements for use of the billing codes. Payers may also require the use of electronic clinical documentation codes (SNOMED CT) within electronic documentation systems to facilitate reporting of outcomes measures.[59]

More Information:

- *AMCP Standardized Framework for Cross-Walking MTMS to SNOMED CT Codes*
- *Pharmacy Health Information Technology Collaborative*

The following pages include commonly used billing codes for pharmacists' patient care services and brief descriptions with links to additional information.

Figure 1. Commonly Used Codes for Outpatient Billing of Pharmacists' Services

	Where does the pharmacist provide services?		
	Location: Pharmacy	**Location:** Physician Office	**Location:** Hospital Outpatient Clinic
Pharmacist is NOT a recognized provider *(Physician or NPP bills under their NPI)*	CCM—99487, 99489, 99490 TCM—99495, 99496	E/M—99211-215 CCM—99487, 99489, 99490 TCM—99495, 99496 AWV—G0438, G0439 DSMT—G0108, G0109	"Facility Fee"—G0463 CCM—99487, 99489, 99490 TCM—99495, 99496 AWV—G0438, G0439 DSMT—G0108, G0109
Pharmacist is a recognized provider *(Pharmacist or pharmacy bills under their NPI)*	MTMS—99605, 99606, 99607 E/M—99211-215 DSMT*—G0108, G0109	MTMS—99605, 99606, 99607 E/M—99211-215	MTMS—99605, 99606, 99607 E/M—99211-215

* DSMT can be billed by a pharmacy (not a pharmacist). The pharmacy must furnish other services covered by Medicare Part B and be accredited by a CMS-approved accreditation organization.

AWV = Annual Wellness Visit (page 23); CCM = Chronic Care Management (page 21); DSMT = Diabetes Self-Management Training (page 26); E/M = Evaluation and Management (page 16); Facility Fee (page 18); MTMS = Medication Therapy Management Services (page 25); TCM = Transitional Care Management (page 19).

Description of Billing Codes

Physician Office Visit—Evaluation and Management (CPT Codes 99211–99215)

Five evaluation and management (E/M) CPT codes (99211–99215) can be used for established patients (established with the physician, even if new to the pharmacist) based on the level of complexity of service delivered (Table 1).[60] CPT codes 99211–99215 are used across the health care system in Medicare and some Medicaid and private sector programs.[60] Private health plans generally follow CMS rules for billing these CPT codes for E/M services, but it is important to verify whether the plan has additional requirements.[41] CPT codes for E/M services are used for "a face-to-face encounter with a patient that includes both evaluation (requiring documentation of a clinically relevant and necessary exchange of information) **and** management (providing patient care that influences, for example, medical decision making or patient education)."[60]

The three components considered in billing E/M services using CPT codes 99211–99215 are:[40]

- Evaluation of history, physical exam, and medical decision making.
- The nature of the presenting problem, counseling, and care coordination.
- Time.

The level of complexity for a new patient is determined by evaluation of the patient in all three categories of history, physical exam, and medical decision making.[40] For an established patient, the level of complexity is determined by evaluation of two of the three categories.[40] Documentation to support the billing code selected is essential.[40] Time spent face to face with the patient must be documented, and it only becomes a primary determining

Patient history can fall into one of four types (problem focused, expanded problem focused, detailed, and comprehensive) depending on the following documented elements: chief complaint, history of present illness, review of systems, and past social and family history. There are specific activities that comprise each element.[40]

Examination includes four types: problem focused, expanded problem focused, detailed, and comprehensive.[40] Classification of the level of examination is dependent on the number of affected body areas or organ systems reviewed.[40]

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option (such as drug therapy), which CMS notes is determined by considering these factors:[40]

- The number of possible diagnoses and/or the number of management options that must be considered.
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.
- The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

factor when more than 50% of the time spent with the patient is on counseling and care coordination.[40] Consult a billing guide or billing and coding expert for more specifics on appropriate documentation.

Table 1. CPT Codes for Office or Other Outpatient Visit for Evaluation and Management of Established Patient

CPT Code	Description
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	Office or outpatient visit for the evaluation and management of an established patient. Usually the presenting problems are self-limited or minor. Typically, 10 minutes are spent face to face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent performing or supervising these services.
99214	Evaluation and management of an established patient. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face to face with the patient or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face to face with the patient or family.

CPT = Current Procedural Terminology®.
Source: Reference 60.

More Information:

- *CMS Medicare Learning Network Evaluation and Management Services*
- *AAFP Level-II vs. Level-III Visits: Cracking the Codes*
- *Documentation History in Evaluation and Management Services*

As stated earlier, it is important to note that the three categories of history, physical exam, and medical decision making are the primary determinants for which of the five CPT codes are used for E/M services.[40] The time allotments mentioned with each code are only estimates and only become a factor when more than 50% of the time spent with the patient is on counseling and care coordination.[40]

Interpretations vary regarding the level of E/M CPT code that can be billed for auxiliary personnel (such as pharmacists) services under an incident to arrangement. It is important to check with billing and coding representatives within the local organization and with the payer to clarify how these codes can be used.

Application of CPT codes for E/M:

- CPT codes 99211–99215 could be billed directly by the pharmacist if recognized as a provider by the payer (e.g., Washington State) for E/M services.[61]

- If the pharmacist is not recognized by the payer as a provider, CPT codes 99211–99215 could be billed by a physician or NPP for the pharmacist's services as long as the pharmacist is working with the physician in an incident to arrangement under direct supervision in a physician's office.[62] Documentation should include the identity and credentials of the supervising physician and the staff who provided the service. Notes should indicate the degree of the physician's involvement and document the link between the services of the two providers.[16] Time-based billing for counseling and care coordination is not permitted by Medicare for incident to services.[63,64]

Interpretations vary regarding the level of E/M CPT code that can be billed for auxiliary personnel (such as pharmacists) services under an incident to arrangement. It is important to check with billing and coding representatives within the local organization and with the payer to clarify how these codes can be used.

More Information:

- *Medicare Coverage Database*
- *Medicare Benefit Policy Manual*
- *AMA CPT Code Lookup (free log-in required)*

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Hospital Outpatient Clinic Visit—Evaluation and Assessment (HCPCS Level II G Code G0463)

Billing code G0463 is used for hospital outpatient clinic visits for assessment and management of a patient.[65]

The G0463 code, used in the Medicare program, may also be referred to as a facility fee.[65] There is no difference between new and established visits in the use of this code.[65] Only one G0463 code can be billed per patient each day by any health care practitioner.[65] The hospital bills the facility fee for pharmacist services that are provided incident to the physician services.[16]

Application of HCPCS Level II G Code G0463:

The incident to requirements in physician-based practices generally also apply to incident to physician services in outpatient hospital-based practices, including the direct supervision requirement, although the physician may be in the same building (versus the same office suite), immediately available, and able to perform the work that the pharmacist is doing. Physicians must issue an order for services to be delivered in an incident to arrangement in an outpatient hospital-based practice.[8]

More Information:

- *CMS Medicare Learning Network 2014 Update of the Hospital Outpatient Prospective Payment System*

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Transitional Care Management (CPT Codes 99495 and 99496)

In 2014, CMS began providing coverage for TCM services.[12] TCM is billed as a bundled payment that covers the transitional services of a care team during the first 30 days after a patient is discharged from the hospital.[66] The 30-day TCM period begins on the date the beneficiary is discharged from the inpatient hospital setting and continues for the next 29 days.[12] Assessing and supporting treatment regimen adherence and medication management are required components of TCM and an ideal opportunity for pharmacist integration as clinical staff on the care team.[12]

A TCM code can only be used once for a patient in a 30-day time period.[12] If multiple providers (e.g., primary care provider and cardiologist) are involved in the patient's care, the first provider to bill for the TCM code will be the one who is paid for providing TCM.[12] It is critical to follow the specified time frames in both delivering and billing for TCM in order to be paid. TCM codes are primarily used in the Medicare program but may soon be used in other sectors.

TCM has one required face-to-face visit with a physician or authorized NPP and additional non–face-to-face interactions during the 30-day period.[12] The non–face-to-face interactions for TCM services can be provided after hours under general supervision (e.g., without the physical presence of the physician or NPP).[12] If pharmacists are included as part of the TCM team, their services could be covered as part of the bundled payment.
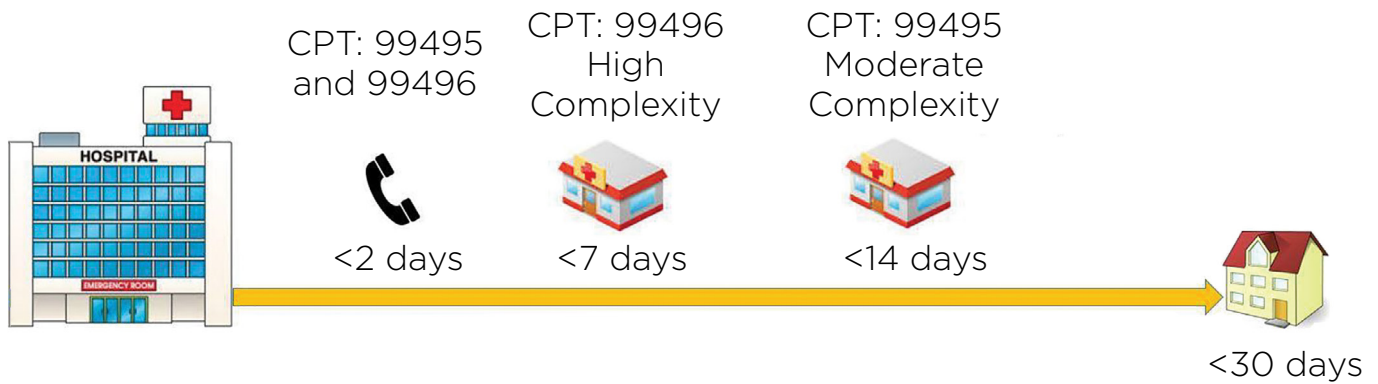
CMS notes that requirements for TCM services include:[12]

- The services are required during the beneficiary's transition to the community setting following particular kinds of discharges.

- The health professional accepts care of the beneficiary post-discharge from the facility setting without a gap.

- The health professional takes responsibility for the beneficiary's care.

- The beneficiary has medical and/or psychosocial problems that require moderate- or high-complexity medical decision making.

The two billing codes used for TCM are 99495 and 99496 for patients whose medical and/or psychosocial problems require moderate-complexity (99495) or high-complexity (99496) decision making during transitions in care from an inpatient hospital setting, partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting.[12] For both codes, interactive contact with the patient, usually by phone, must occur within 2 days of discharge.[12] High-complexity patients must have a face-to-face visit with a physician or authorized NPP within 7 calendar days of discharge, and moderate-complexity patients must have a face-to-face visit within 14 calendar days of discharge (Figure 2).[12]

The physician or NPP can also separately bill additional visits with a patient related to new problems that arise during the 30 days.[66] There are specific requirements for certain non–face-to-face services that must be provided as part of the team-based TCM services over the 30 days unless it is determined that they are not medically necessary.[12] Patients are required to pay a co-pay for TCM services.[12]

Figure 2. Billing Codes for Transitional Care Management

CPT: 99495 and 99496 — <2 days

CPT: 99496 High Complexity — <7 days

CPT: 99495 Moderate Complexity — <14 days

<30 days

Requirements for non–face-to-face services provided by physicians or qualified NPPs (unless not medically necessary) include:[12]

- Reviewing discharge information (e.g., discharge summary or continuity of care documents).
- Reviewing the need for or following up on pending diagnostic tests and treatments.
- Interacting with other health professionals who will assume or reassume care of the beneficiary's system-specific problems.
- Providing education to the beneficiary, family, guardian, and/or caregiver.
- Establishing or reestablishing referrals and arranging for needed community resources.
- Assisting in scheduling required follow-up with community providers and services.

Requirements for non–face-to-face services provided by clinical staff (unless not medically necessary) include:[12]

- Communicating with agencies and community services the beneficiary uses.
- Providing education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living.
- Assessing and supporting treatment regimen adherence and medication management.
- Identifying available community and health resources.
- Assisting the beneficiary and/or family in accessing needed care and services.

Application of CPT codes for TCM: Note that CPT codes for TCM are used for a bundled payment to a team of health care practitioners billed by a physician or qualified NPP. Pharmacists can contribute to TCM services as "licensed clinical staff under the supervision of physicians or NPPs."[12] Of note, the required TCM services of medication reconciliation and management may occur separate from the face-to-face visit, but must be furnished no later than the date of the face-to-face visit.[12] Examples of TCM services in which pharmacists can participate include assessing continuity of care documents, supporting medication reconciliation and medication management, and providing education to the patient or caregiver. Contractual arrangements for pharmacists working under general supervision apply to TCM services.

See the CMS guidance document for additional information regarding TCM requirements.

More Information:

- *CMS Medicare Learning Network Transitional Care Management Services*
- *New Codes for Transitional Care Management and Chronic Care Coordination Services*
- *CMS Frequently Asked Questions About Billing the Medicare Physician Fee Schedule for Transitional Care Management Services*
- *CMS Medicare Benefit Policy: Expansion of Medicare Telehealth Services for CY 2014*

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Chronic Care Management (CPT Codes 99490, 99487, and 99489)

In 2015, CMS began covering CCM services for non–face-to-face care coordination for Medicare beneficiaries with multiple chronic conditions.[67] In 2017, CMS added coverage for *complex CCM services.* CPT code 99490 is used for CCM services, and requires at least 20 minutes of clinical staff time each calendar month.[67] CPT code 99487 is used for complex CCM services and requires at least 60 minutes of clinical staff time per calendar month with an option of adding CPT code 99489 for additional 30 minute increments.[67] CCM and complex CCM are directed by a physician or qualified NPP, with the following requirements:[67]

- Patients have multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient.
- Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.
- Comprehensive care plan is established, implemented, revised, or monitored.

Complex CCM also requires moderate- or high-complexity medical decision making by the billing physician or other billing practitioner.[67]

CMS permits clinical staff to provide the CCM service incident to the services of the billing physician (or other appropriate practitioner) under the general supervision (rather than direct supervision) of the physician or qualified NPP.[67] That means that licensed clinical staff outside the practice may provide the services as long as the appropriate incident to rules are followed, and the physician does not have to be physically present but must be available by phone, if needed.[8]

The three core requirements to bill for CCM include:

- Securing the eligible beneficiary's consent to CCM.[67]
- Having five specified capabilities needed to perform CCM.[67]
  - Use a certified electronic health record (EHR) for specified purposes.
  - Maintain an electronic care plan.
  - Ensure beneficiary 24-hour-a-day, 7-day-a-week access to care.
  - Facilitate transitions of care.
  - Coordinate care.
- Providing a minimum of 20 minutes (CCM) or 60 minutes (complex CCM) of non–face-to-face care management services per month.[67]
  - The time allotments are for face-to-face or non–face-to-face time with the patient and associated care coordination and do not include time spent in documentation. Time must be recorded.[68]

Patients must agree to participate in CCM via verbal or written consent, and for new patients or patients not seen in the previous year, CCM services must be initiated during an AWV, Initial Preventive Physical Examination (IPPE), or comprehensive E/M visit.[67] CCM services cannot be billed for beneficiaries residing in long-term care facilities or skilled nursing facilities.[67]

The care plan must be documented using a structured format in a certified EHR.[67] The care plan must also be shared electronically (can include fax).[67]

CPT codes for CCM can only be billed one time for a patient per month and cannot be billed in the same month as codes for TCM because transitions of care is covered in the description of CCM.[69] Because complex CCM requires moderate- to high-complexity medical decision making, the physician or NPP must be involved with the patient during the month in which codes for complex CCM are billed.[67] The physician or qualified NPP may also bill using E/M CPT codes for specific problems that are managed during the same time that CCM services are provided.[69] Given their relatively recent introduction, CPT codes for CCM are primarily used in the Medicare program but may soon be used in other sectors. It is also important to note that beneficiaries are charged a co-pay (20% cost share) for every CCM visit, whether it's face-to-face or non–face-to-face.[67]

Application of CPT codes for CCM: Note that CPT codes for CCM are used for a bundled payment to a team of health care practitioners billed by a physician or qualified NPP. Pharmacists are considered "clinical staff" under CMS guidelines for CCM and can provide CCM services under general supervision of a physician or NPP.[67]

More Information:

- *CMS Medicare Learning Network Chronic Care Management Services*
- *CMS Frequently Asked Questions About Physician Billing for Chronic Care Management Services*
- *Chronic Care Management: An Overview for Pharmacists*

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Annual Wellness Visit (HCPCS Level II G Codes G0438 and G0439)

Medicare covers an initial AWV and subsequent AWVs focused on Personalized Prevention Plan Services (PPPS) for Medicare beneficiaries.[14] Beneficiaries should receive an IPPE in the first 12 months they are covered by Medicare Part B. Following the first 12 months of the Part B coverage period, Medicare covers AWVs for beneficiaries if they have not received an IPPE or an AWV within the past 12 months.[14,70,71]

The initial AWV is a once in a lifetime visit billed under code G0438.[14,70,71] Subsequent AWVs are conducted annually thereafter and are billed under code G0439.[14,70,71] AWVs apply only to Medicare FFS; requirements differ for federally qualified health centers. Both types of AWVs must include a PPPS.[14,72] Pharmacists are permitted to conduct AWVs under the direct supervision of a physician.[70]

According to CMS, Medicare Part B covers an AWV if it is furnished by a physician (doctor of medicine or osteopathic medicine), physician assistant, nurse practitioner, certified clinical nurse specialist, or medical professional (including a health educator, registered dietitian, nutrition professional, or other licensed practitioner) or a team of such medical professionals who are working under the direct supervision of a physician.[70] Per this statement, pharmacists may provide the initial or subsequent AWVs as "other licensed practitioners." However, pharmacists cannot provide the IPPE.[70]

The components of an initial AWV include:[14]

- Acquire Beneficiary History
  - Conduct a health risk assessment.
  - Establish a list of current providers and suppliers.
  - Establish the beneficiary's medical and family history.
  - Review of the beneficiary's potential risk factors for depression, including current or past experiences with depression or other mood disorders.
  - Review of the beneficiary's functional ability and level of safety.
- Assessment
  - Conduct assessment of height, weight, body mass index, blood pressure, and other routine measurements.
  - Detect any cognitive impairment that the beneficiary might have.
- Counsel Beneficiary
  - Establish written screening schedule for beneficiary.
  - Establish a list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or underway.
  - Furnish personalized health advice to the beneficiary and appropriate referral to health education or preventive counseling services or programs.
  - Furnish, at the discretion of the beneficiary, advance care planning services.

Updates are made to each of the components during subsequent AWVs.[14]

Application of HCPCS codes for AWVs:

Pharmacist-delivered AWVs are billed under the NPI of the physician or authorized NPP who delegates and directly supervises the pharmacist.[14] AWVs are a Medicare benefit available through the Medicare Part B and Medicare Advantage programs. Beneficiaries do not pay a co-pay for AWVs unless additional services are rendered and billed.[14,71]

More Information:

- *CMS Medicare Learning Network The ABCs of the Annual Wellness Visit*
- *Frequently Asked Questions From the March 2012 Medicare Preventive Services National Provider Call: The Initial Preventive Physical Exam and the Annual Wellness Visit*
- *Medicare Preventive Services Interactive Educational Tool*
- *Review of Opioid Use during the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)*

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Medication Therapy Management Services (CPT Codes 99605–99607)

AMA CPT codes have been created for the documentation and billing of Medication Therapy Management Services (MTMS) by pharmacists.[60] The AMA CPT coding manual states, "MTMS describe face-to-face patient assessment and intervention as appropriate, by a pharmacist. MTMS is provided to optimize the response to medications or to manage treatment-related medication interactions or complications."[60] CPT codes for MTMS are time-based codes.[60,73]

MTMS includes the following documented elements: review of the pertinent patient history, medication profile (prescription and nonprescription), and recommendations for improving health outcomes and treatment compliance.[60,73] These codes are not to be used to describe the provision of product-specific information at the point of dispensing or any other routine dispensing-related activities.[73]

Application of CPT codes for MTMS: It is important to note that the CPT codes for MTMS are not specific to use within Medicare Part D.[29] These CPT codes are recognized by some Part D MTM plans (not CMS directly), several state Medicaid programs, and could be used in the private sector to submit claims for MTMS (if the payer recognizes the codes).[29] Because they are specific to pharmacists, the CPT codes for MTMS can also be used to internally document and attribute pharmacists' services, including in team-based care models. CMS currently does not recognize the CPT codes for MTMS for payment of Medicare Part B services, and payment valuation (known as relative value units, or RVUs) has not been established by AMA or CMS for these codes.[62] Because the code description refers to face-to-face delivery of MTMS, it would be up to an individual payer to determine if MTMS provided via telehealth delivery could be billed using the CPT codes for MTMS and whether any code modifiers would be needed in addition to the CPT codes for MTMS.

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Table 2. CPT Codes for Medication Therapy Management Services

CPT Code	Description
99605	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, initial 15 minutes, with assessment, and intervention if provided; initial 15 minutes, new patient.
99606	Initial 15 minutes, established patient.
99607	Each additional 15 minutes. (List separately in addition to code for the primary service. Use 99607 in conjunction with 99605 or 99606.)

CPT = Current Procedural Terminology®.
Source: References 63 and 76.

Diabetes Self-Management Training (HCPCS Level II Codes G0108 and G0109)

DSMT is a service where health care providers educate patients to successfully self-manage diabetes.[74] The program includes instruction in self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin-dependent; and motivation for patients to use self-management skills.[74] Medicare covers DSMT services when these services are furnished by an accredited provider (practitioner or organization) that meets certain quality standards.[74] DSMT services may be furnished by a physician, individual, or entity that furnishes other services for which direct Medicare Part B payment may be made and is accredited by an accreditation organization approved by CMS.[75] The American Association of Diabetes Educators (AADE) and American Diabetes Association (ADA) offer CMS-approved DSMT accreditation programs.[76,77]

Medicare has additional requirements based upon whether training is being provided for the first time or if the patient has received DSMT in the past.[75,78] Requirements for initial and follow-up visits include: [75,78]

- Initial DSMT.
    - Furnished within a continuous 12-month period.
    - May not exceed a total of 10 hours.
        - 9 of the 10 hours should be furnished in a group setting consisting of 2 to 20 individuals (not all must be Medicare beneficiaries).
        - 1 of the 10 hours may be an individual session to assess the beneficiary's training needs.
    - The training must be furnished in increments of no less than 30 minutes.

- Follow-up DSMT.
    - Begins at least 1 calendar year following the beneficiary's initial training.
    - May not exceed 2 hours of individual or group training per year for a beneficiary.
    - Must be furnished in increments of no less than 30 minutes.
    - The physician must document the specific medical condition that the follow-up training must address in both the referral for training and the beneficiary's medical record.

There are two billing codes used for DSMT, one for sessions with an individual and one for group sessions:[75]

- G0108 is used for each 30 minutes of an individual DSMT session.
- G0109 is used for each 30 minutes of a group (two or more persons) DSMT session.

DSMT must meet three conditions to be covered by Medicare:

- Ordered by a physician or qualified NPP who is treating the beneficiary's diabetes.[74,75]
    - The order must include the number of hours of training, the topics to be covered, and the type of training—individual or group.
- Must be included in a comprehensive care plan.[75]
- Must be "reasonable and necessary" (from Medicare's perspective) for treating and monitoring.[75]

Application of HCPCS codes for DSMT: A pharmacy that participates in Medicare Part B (e.g., Durable Medical Equipment supplier or roster billing of Part B vaccines) and has DSMT accreditation from a CMS-approved organization can be eligible to deliver and receive payment for DSMT services.[78] The pharmacist who provides DSMT services does not need to have additional credentials (i.e., Certified Diabetes Educator or Board Certified–Advanced Diabetes Management) in order to deliver care. Pharmacists working in physician office practices that have DSMT-accredited programs may also participate in the delivery of DSMT, but the service would be billed under the accredited physician practice (since pharmacists are not recognized Part B providers).[79] Incident to billing requirements do not apply to DSMT services because DSMT is considered by CMS to be a stand-alone benefit.[80] Private sector payers and state Medicaid programs may also cover DSMT services. Consult specific health plans for their requirements.

More Information:

- *CMS Medicare Learning Network Diabetes Self-Management Training Services*
- *Billing Medicare for Diabetes Self-Management Training*
- *Diabetes Self-Management Education/ Training Reimbursement Toolkit*
- *AADE Applying for Accreditation*
- *ADA Education Recognition Requirements*

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Summary

FFS opportunities exist for pharmacists who want to shift their practices to focus on patient care services. This billing primer has covered some of the common CPT and HCPCS G codes that currently can be used for documenting and requesting payment for pharmacists' services. As evidenced by the requirements for use of the codes, collaboration with other health care providers is paramount as pharmacists create bridges to compensation for patient care services. As more payment relationships are formed and as pharmacists gain provider status, other CPT and HCPCS G codes may be appropriate to consider depending on the practice and existing contracts with payers. Now and in the future, it is essential that the specific payer requirements for each code be followed during the documentation and billing process.

Now and in the future, it is essential that the specific payer requirements for each code be followed during the documentation and billing process.

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Appendix. Quick Reference Overview: Fee-for-Service Billing Codes

This quick reference is not all-inclusive. For additional information, contact CMS or your local billing department. Medicare payment amounts for those CPT codes that Medicare covers can be accessed as part of the CMS Physician Fee Schedule.[1]

Billing Option	CPT/HCPCS Billing Codes	General Overview
Incident to Physician: Office Visit[2,3,4*] *Direct Supervision*	99211 99212 99213 99214 99215 *(Physician-based)*	• Providing evaluation (requiring documentation of a clinically relevant and necessary exchange of information) and management (providing patient care that influences, for example, medical decision making or patient education) services face-to-face to a patient in the physician's office.[3] • Billing codes are based on complexity of the patient and severity of disease states, and as patient complexity and severity increase, a higher CPT code can be billed as long as the documentation supports the code reported for payment.[3] • As higher CPT codes are billed, more time is spent with patient and more documentation is required.[3]
	G0463 *(Hospital-based)*	• Since January 1, 2014, CMS recognizes HCPCS code G0463 (hospital outpatient clinic visit for assessment and management of a patient) for payment under the OPPS for outpatient hospital clinic visits, and CPT codes 99201–99205 and 99211–99215 are no longer recognized for payment under the OPPS.[4] • No difference between new and established patient visits.[4]
Incident to Physician: Transitional Care Management[5] *General Supervision* *Bundled Payment*	99496, within 7 days of discharge	• Established patient whose medical and/or psychosocial problems require moderate- or high-complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences upon the date of discharge and continues for the next 29 days.[5 †] • High-complexity patients must be contacted within 2 business days of discharge and receive face-to-face visit within 7 calendar days of discharge.[5]
	99495, within 14 days of discharge	• See above description.[†] • Moderate-complexity patients must be contacted within 2 business days of discharge and receive face-to-face visit within 14 calendar days of discharge.[5]

Billing Option	CPT/HCPCS Billing Codes	General Overview
Chronic Care Management[6,7] *General Supervision*	99490, 20+ minutes per month	• At least 20 minutes of clinical staff time directed by a physician or other qualified NPP, per calendar month, with the following required elements: • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient. • Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. • Comprehensive care plan established, implemented, revised, or monitored. • Patient needs to be residing at home or in a domiciliary, rest home, or assisted living facility. • Physician or other qualified NPP must document and share with the patient and/or caregiver a plan of care that addresses the physical, mental, cognitive, social, functional, and environmental assessment.[6] ‡
Complex Chronic Care Management[6,7] *General Supervision*	99487, 60+ minutes/month	• See above description.‡ • Similar to CCM requirements, but substantial revision of comprehensive care plan must occur, patient requires moderate- or high-complexity medical decision making, and 60 minutes of non–face-to-face clinical staff time directed by a physician or other qualified NPP, per calendar month.[6]
	99489, each additional 30 minutes	• See above description.‡ • Each additional 30 minutes of clinical staff time for complex CCM directed by a physician or other qualified NPP, per calendar month.[6] • Can only be used with 99487.[6,7]
CMS Annual Wellness Visit[8,9] *Direct Supervision*	G0438, initial, once in lifetime G0439, subsequent, annually	• Initial visit occurs once, following the first 12 months that a patient has Medicare Part B.[8,9] • Subsequent visit occurs annually, for patients who have not had an AWV or IPPE within the past 12 months. [8,9]
Medication Therapy Management Services[10-12]	99605, first encounter services (15 minutes) 99606, follow-up encounter with established patient (15 minutes) 99607, used with 99605 or 99606 for additional 15-minute increments	• Face-to-face patient assessment and intervention as appropriate, by a pharmacist.[10,12] • MTMS include the following documented elements: • Review of the pertinent patient history. • Medication profile (prescription and nonprescription). • Recommendations for improving health outcomes and treatment compliance.[10,11] • Currently CMS does not provide payment directly to pharmacists for MTMS CPT codes.[12]

Billing Option	CPT/HCPCS Billing Codes	General Overview
Diabetes Self-Management Training[13-15]	G0108, individual visit G0109, group visit	• Evidence-based intervention that facilitates the knowledge and skills of people with diabetes to optimize their ability to self-manage the disease.[13] • Must be ordered by physician or NPP in charge of patient's diabetes care, included in comprehensive care plan, and be reasonable and necessary.[14] • DSMT program must be accredited by a CMS-recognized DSMT accrediting body.[13-15] • Restrictions apply related to the number of individual and group visits that a patient can receive.[13-15]

Physician or qualified NPP bills under his or her NPI for pharmacists' services.

AWV = Annual Wellness Visit; CCM = Chronic Care Management; CMS = Centers for Medicare and Medicaid Services; CPT = Current Procedural Terminology®; DSMT = Diabetes Self-Management Training; HCPCS = Healthcare Common Procedure Coding System; IPPE = Initial Preventive Physical Examination; MTMS = Medication Therapy Management Services; NPI = National Provider Identification; NPP = Nonphysician Practitioner; OPPS = Outpatient Prospective Payment System; TCM = Transitional Care Management.

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