Billing as a Pharmacist Provider: What you Need to Know about Codes

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Disclosure Statement

- None of the planners for this activity have relevant financial relationships with ineligible companies to disclose.

Learning Objectives

At the completion of this activity, the participant will be able to:

1. Recognize which codes pharmacists use for pharmacist provider status with Ohio Medicaid patients; and

2. Discuss requirements needed for each billing code can use for Ohio Medicaid patients

Healthcare Payment

Pharmacy

Medical

Outpatient Payment Distribution

Fee-for-Service

- Set payment for particular service
- Code submitted to explain service provided

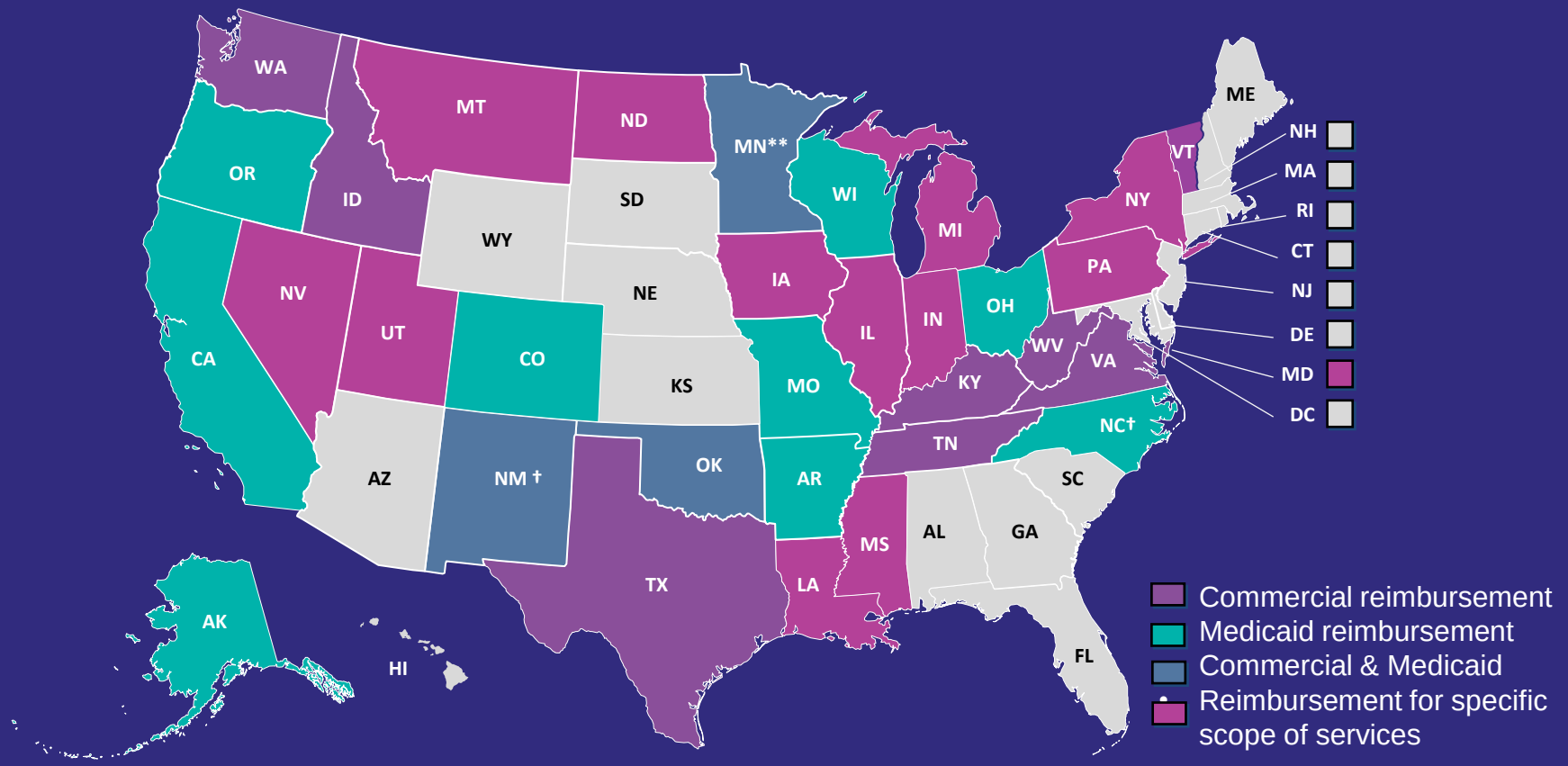
Value-based Payment

- Increasing incidence
- Value over volume
- Examples
  - Population health
  - Episode of care
  - Capitation (PMPM)
  - Risk sharing
  - Pay-for-performance

Current Procedural Terminology (CPT)

- Codes released annually by Centers for Medicare and Medicaid Services (CMS)
  - >20,000 codes exist
  - Relative value unit (RVU) and rates for each code
  - Payors base rates off Medicare
  - Typically physicians receive 100% fee schedule; 'mid-level providers' receive 85%
- Underlying requirements
  - ICD10 codes submitted to payor for primary diagnosis
  - Medical necessity
  - Documentation must justify code selection

Payment for Pharmacist Services in the States*



*Examples of states where pharmacists are receiving reimbursement for a broad or narrow scope of their patient care services. Not intended to be a comprehensive representation.
**Reimbursement is for medication therapy management (MTM), however MTM is broadly defined to encompass services within pharmacist state scope of practice
†Pharmacist reimbursement for a broad scope of services is largely tied to the requirement of being an advanced practice pharmacist

APhA

For Every Pharmacist. For All of Pharmacy.

Billing Disclaimer

- Codes and payment released annually by CMS
  - States and private insurance base payment off CMS rate
  - States and private insurance can determine eligibility criteria
- Rules/regulations for code requirements should always be reviewed by the individual provider using the code
- Payment listed is publicly for Medicare and Medicaid rates
- Documentation must accurately reflect the service provided

MTMS Codes

- Pharmacist-specific codes created following implementation of Medicare Part D
- Some private/commercial payors may have fee schedule established

HCPCS Code	Non-Facility Price
99605	Current Physician Fee Schedule does not price this HCPCS code.
99606	Current Physician Fee Schedule does not price this HCPCS code.
99607	Current Physician Fee Schedule does not price this HCPCS code.

Available at: https://www.cms.gov/medicare/physician-fee-schedule/search?Y=0&T=4&HT=2&CT=1&H1=99211&H2=99215&C=56&M=5

Evaluation and Management (E/M)

- Cognitive services by healthcare professional(s) in diagnosing and treating illness or injury
- Most common set of codes utilized in outpatient medicine
- Establish/new patient visit (9920x) reimburse higher
- Codes may be determined by medical decision making (MDM) or time-based

HCPCS Code	Requirements
99211	Outpatient office visit, <10 min
99202/99212	Outpatient office visit, 10-19 min
99203/99213	Outpatient office visit, 20-29 min
99204/99214	Outpatient office visit, 30-39 min
99205/99215	Outpatient office visit, 40-54 min

Available at: https://www.cms.gov/medicare/physician-fee-schedule/search?Y=0&T=4&HT=2&CT=1&H1=99211&H2=99215&C=56&M=5

Medical Decision Making (MDM)

2023 Medical Decision-Making Guide				
MDM	**Straightforward Complexity** DX: Minimal Data: None or 1 Risk: Minimal	**Low Complexity** DX: Low Data: Limited Risk: Low	**Moderate Complexity** DX: Moderate Data: Moderate Risk: Moderate	**High Complexity** DX: High Data: Extensive Risk: High
MEDICAL DECISION MAKING - 2/3 components required				
	Straightforward	**Low**	**Moderate**	**High**
Complexity of Problems Addressed at the Encounter	**Minimal** • 1 self-limited or minor problem	**Low** • 2 or more self-limited/minor problems • 1 stable chronic illness • **1 stable, acute illness** • 1 acute, uncomplicated illness/injury • **1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care**	**Moderate** • 1 or more chronic illness with exacerbation, progression or side effect from treatment • 2 or more stable chronic illnesses • 1 undiagnosed new problem w/ uncertain prog 1 acute illness w/ systemic symptoms • 1 acute complicated injury	**High** • 1 or more chronic illnesses w/ severe exacerbation, progression or side effect of treatment • 1 acute or chronic illness/injury that poses a threat to life or bodily function
Data *Each unique test, order or documents contributes to the combination of 2 or 3 in this category	**Minimal or none**	**Limited** *(must meet 1 of 2 categories)* **Category 1: Tests and documents** Any combo of 2 from: • Review of prior external notes, each unique source *; • Review of the results of each unique test *; • Ordering of each unique test * OR **Category 2:** • Assessment requiring independent historian	**Moderate** *(must meet 1 of 3 categories)* **Category 1: Tests, documents or independent historian** Any combo of 3 from: • Review of prior external notes, each unique source *; • Review of the results of each unique test *; • Ordering of each unique test * • Assessment requiring an independent historian OR **Category 2: Independent interpretation of tests** • Independent interpretation of test performed by another provider OR **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external provider	**Extensive** *(must meet 2 of 3 categories)* **Category 1: Tests, documents or independent historian** Any combo of 3 from: • Review of prior external notes, each unique source *; • Review of the results of each unique test *; • Ordering of each unique test * • Assessment requiring an independent historian OR **Category 2: Independent interpretation of tests** • Independent interpretation of test performed by another physician /other qualified health care professional OR **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external provider
Risk	**Minimal risk of morbidity from additional diagnostic testing or treatment**	**Low risk of morbidity from additional diagnostic testing or treatment**	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription Drug Management • Decision regarding minor surgery w/ identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significant limited by social determinants of health	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery w/ identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization **or escalation of hospital level of care** • Decision not to resuscitate or to de-escalate care because of poor prognosis • **Parenteral controlled substances**

CODINGAID www.managedresourcesinc.com

https://www.ubmd.com/content/dam/ubmd/ubmd/Compliance/2023%20E-M%20Changes%20-%20Presentation.pdf

Time-Based Billing

- AMA changes in January ‘21 allowing E/M to be either MDM or time-based
- Billing for total time when >50% care coordination or patient counseling
  - Time can include with patient, documentation, review of labs, history, etc.
  - Can not include time on administrative tasks

Telehealth

- Time based codes established for telephone visits
- Video visits can use E/M codes with a modifier

HCPCS Code	Non-Facility Price
G2012	Brief check in by qualified health provider
99441	Phone E/M, 5-10 min
99442	Phone E/M, 11-20 min
99443	Phone E/M, 21-30 min

Available at: https://www.cms.gov/medicare/physician-fee-schedule/search?Y=0&T=4&HT=2&CT=1&H1=99211&H2=99215&C=56&M=5

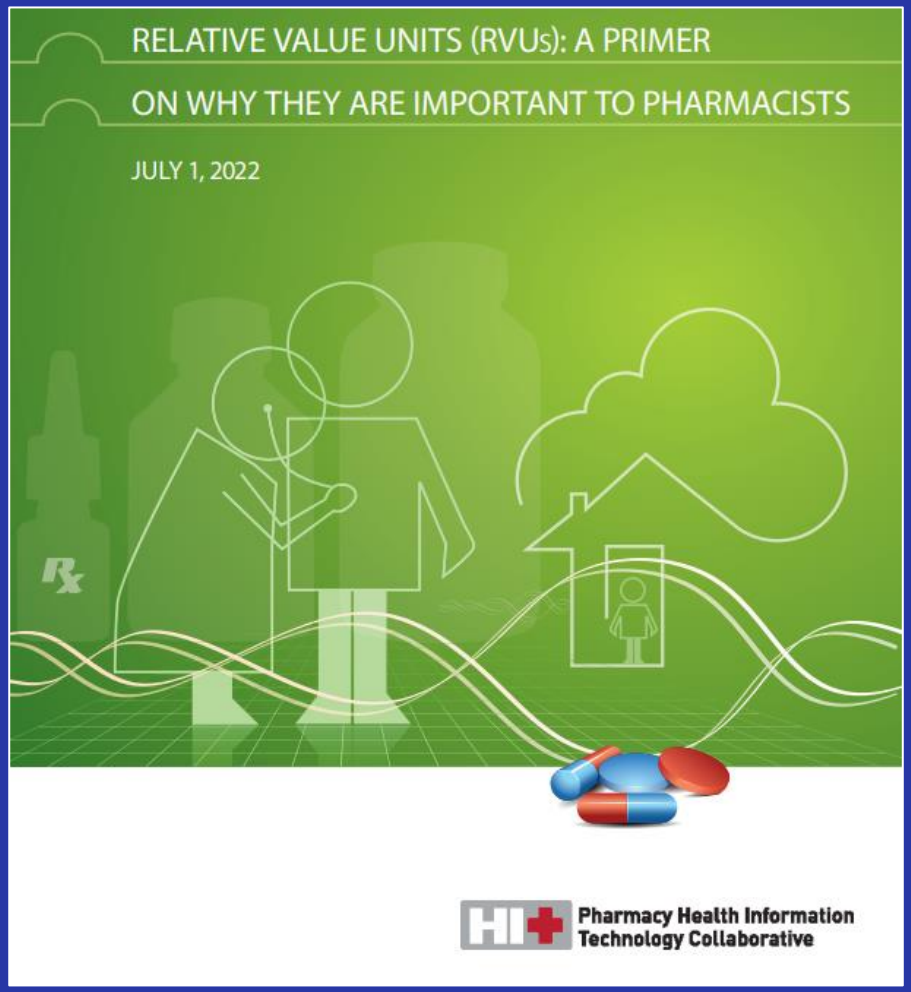
Other Codes for Pharmacy Consideration

- Transitional Care Management (TCM)
- Chronic Care Management (CCM)
- Remote Patient Monitoring (RPM)
- Remote Therapeutic Monitoring (RTM)
- Diabetes Self-Management Education
- Diabetes Prevention Program
- POCT testing
- Device teaching
- Smoking cessation
- Anticoagulation Management
- Annual Wellness Visit
- Medication Administration
- Vaccine Administration

New codes added every year!

Available at: https://www.cms.gov/medicare/physician-fee-schedule/search?Y=0&T=4&HT=2&CT=1&H1=99211&H2=99215&C=56&M=5

What is an RVU?



http://www.pharmacyhit.org/pdfs/FINAL%20PHIT%20WG1%20RVU.pdf

EXAMPLE CASES FOR BILLING

Case #1

You have a patient that you know smkkes and you want to enroll them for smoking cessation. You schedule a face-to-face visit to discuss their smoking history.


STOP

Case #1

You have a patient that you know smokes tobacco. You want to enroll them in your tobacco use disorder program. You schedule a face-to-face visit to discuss their tobacco history.

Case #1

Before the appointment, you have a pharmacy technician call to remind the patient about the appointment.

What (if any) billing code can you use for this encounter?

ANSWER

This is not a billable encounter when completed by a pharmacy technician or intern.

If a pharmacist makes the call, this is not enough of a service to justify a billing code.

Case #1a

The patient arrives at 9:32, but you are busy checking prescriptions, so you eventually sit down for the visit at 9:51. You talk to the patient until 10:08.

Together you decide the patient will try nicotine patches tomorrow.

What (if any) billing code can you use for this encounter?

Case #1b

The patient arrives at 9:32, but you are busy checking prescriptions, so you eventually sit down for the visit at 9:51. You talk to the patient until 10:08,

Patient decides they are not ready to quit smoking and leaves.

What (if any) billing code can you use for this encounter?

Case #1 Summary

- Total time patient is on site:
  932-1008 (36 min)
- Total time pharmacist is with patient:
  951-1008 (17 min)

1a – no therapy recommended

1b – patient will start nicotine patches

Code	Brief description
99202	New pt; 15-29 min
99203	New pt; 30-44 min
99211	Est pt; 5-10 min
99212	Est pt; 10-19 min
99213	Est pt; 20-29 min
99441	Tele 5-10 min
99442	Tele 11-20 min
G2012	Brief check in

Case #1 Rationale

- New patient can only be billed one time
- Visit preparation, documentation, non-face-to-face follow up time can be included in encounter
  - *>50% of time must be spent on care coordination or patient counseling*

Code	Brief description
99202	New pt; 15-29 min
99203	New pt; 30-44 min
99211	Est pt; 5-10 min
99212	Est pt; 10-19 min
99213	Est pt; 20-29 min
99441	Tele 5-10 min
99442	Tele 11-20 min
G2012	Brief check in

Case #2

- You have a patient referred to you by a provider for management of hypertension. You schedule the patient for a face-to-face visit.

Case #2a

- The patient comes to the visit for their appointment. You meet with the patient from 11:12 until 11:58 to gather the patient history. At the end of the visit, you initiate lisinopril 5mg daily.

Case #2b

- The patient comes to the visit for their appointment. You begin meeting with the patient at 11:12. At 11:23, your technician grabs you for a phone call and prescription authorization. You come back in and resume your visit with the patient from 11:32 until 11:58 to gather the patient history. At the end of the visit, you initiate lisinopril 5mg daily.

Case #2 Summary

2a) Total time with patient:
1112-1158 (46 min)

2b) Total time with patient:
1112-1123; 1132-1158
(37 min)

Code	Brief description
99202	New pt; 15-29 min
99203	New pt; 30-44 min
99211	Est pt; 5-10 min
99212	Est pt; 10-19 min
99213	Est pt; 20-29 min
99441	Tele 5-10 min
99442	Tele 11-20 min
G2012	Brief check in

Case #2 Rationale

- Needs to be time with patient
  - Unless time away is spent on visit preparation, documentation, non-face-to-face for that specific patient encounter
- Current rules restrict pharmacist billing codes

Code	Brief description
99202	New pt; 15-29 min
99203	New pt; 30-44 min
99211	Est pt; 5-10 min
99212	Est pt; 10-19 min
99213	Est pt; 20-29 min
99441	Tele 5-10 min
99442	Tele 11-20 min
G2012	Brief check in

Case #2 continued

2 weeks after visit, you call the patient to remind them to have labs drawn to check sCr and K+ after starting the ACE-I.

Can you bill for this?

ANSWER – calling to remind to pick up refill, lab draw is likely <u>not</u> enough to justify billing

Case #2 continued

3 weeks after visit, you call to tell patient their labs came back normal. You also talk check to see if the patient is experiencing any side effects and if they have any home BP readings since your last visit. You develop an exercise goal for the patient.

Can you bill for this?

ANSWER – YES

Code	Brief description
99202	New pt; 15-29 min
99203	New pt; 30-44 min
99211	Est pt; 5-10 min
99212	Est pt; 10-19 min
99213	Est pt; 20-29 min
99441	Tele 5-10 min
99442	Tele 11-20 min
G2012	Brief check in

Case #3

- You have a patient referred to you by a provider for management of diabetes and asthma. You schedule the patient for a face-to-face visit.

Case #3

The patient comes for an in-person visit from 2:12 – 2:49. You complete a comprehensive medication review on the patient, administer annual influenza vaccine, perform a POCT A1c test, and initiate insulin.

Case #3

Total time with patient:
212-249 (37 min)

Code	Brief description
99202	New pt; 15-29 min
99203	New pt; 30-44 min
99211	Est pt; 5-10 min
99212	Est pt; 10-19 min
99213	Est pt; 20-29 min
99441	Tele 5-10 min
99442	Tele 11-20 min
G2012	Brief check in

Case #3 Rationale

- Time-based code with a new patient
- Can also bill the influenza vaccine
- Current rules do not allow billing for the POCT tests

- **You should not also bill the CMR through OutcomesMTM!!! The CMR is part of the encounter you are billing for with the E/M code**

Code	Brief description
99202	New pt; 15-29 min
99203	New pt; 30-44 min
99211	Est pt; 5-10 min
99212	Est pt; 10-19 min
99213	Est pt; 20-29 min
99441	Tele 5-10 min
99442	Tele 11-20 min
G2012	Brief check in

WHERE TO START

Identifying Gaps in Care

- Most payors now have components of VBC in contracts with health-systems/providers
  - Capitation (e.g., PMPM)
  - Pay-for-performance
  - Bundled payments
  - Shared savings
- Being tied into provider performance
- Both practices and payors are using dashboards for tracking
  - Helpful to identify gaps in care

Dashboard Example

	Panel Size*	Annual wRVU**		Third Next Available Appointment (TNAA)***	A1c <9%	HTN control	Pneumovax rate for age >65 yo
Goal		**5100**		**7 days**	**64%**	**62%**	**77%**
Provider A	2700	7922		13 days	62%	68%	54%
Provider B	3500	11281		32 days	48%	60%	72%
Provider C	1200	2971		3 days	74%	78%	42%
Provider D	2000	4954		7 days	72%	74%	72%

Available at: http://www.pharmacyhit.org/pdfs/FINAL%20PHIT%20WG1%20RVU.pdf

Pharmacy Medical Billing and Clinical Documentation Vendors

OHIO PHARMACISTS ASSOCIATION

	Billing			Workflow Optimization							Administrative					Contact Information
Name of Company	Patient Eligibility Verification	Medical Billing Capability	Claim Reconciliation	Documentation Capability	Customizable Documentation Template Capability	Cloud-based HIPPA Compliant Storage	Provider To Provider Communication (Phone, Fax, Email)	Supports Health Information Exchange (HIE) with other systems	Secure Online Patient Portal	Secure Video Visit Capability	Assist with payor credentialing/enrollment	Scheduling Capability	Reminder Phone Calls for Scheduling	Interface With Dispensing Software	Reporting And Analytic Capability	
DocStation	Pending	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	support@docstation.com
Mobile Mediclaim	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	sales@mobilemediclaim.com
Prescribe Wellness	No	Yes	No	Yes	Yes	Yes	Fax only	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	prescribewellness.com/contact
RXNT	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	No		Yes	Yes	No	Yes	jmayes@rxnt.com
CSS Health	No	Yes	No	Yes	Yes	Yes	Yes		No	Yes		Yes	No	Yes	Yes	apnsupport@csshealth.com
EnlivenHealth (Formally FDS Amplicare)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Nikki.Miller@omnicell.com
Electronic Billing Services, Inc.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Pending	Yes	Yes	Yes	Yes	Yes	Yes	enrollments@ebsservice.com

Last updated – July 2022

For additional information regarding this document, please reach out to: opa@ohiopharmacists.org subject line: *pharmacy vendor document*

Question 1

Which of the following outcomes is typically associated with the pharmacy side of the benefit?

a. ED utilization
b. Medication adherence
c. Vaccination rates
d. Hypertension control

Question 2

The medical side of the benefit typically uses which of the following codes for outpatient visits?

a. Outcomes MTM (or similar online vendor)
b. Pharmacist-specific CPT codes (e.g., 99605-99607)
c. Evaluation and Management (E/M) codes (i.e., 99211-99215)
d. DIR fees

Question 3

Combining the time spent reviewing a patient chart, seeing a patient, and documenting are all components of:

a. Medical decision making
b. Time-based billing
c. Telehealth
d. Value-based care

Question 4

Pharmacists could use which of the following to help them start to services.

a. Provider dashboards
b. RVU resources
c. CPT manual

Billing Questions?

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