

# Billing Models for Clinical Pharmacy Services

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# Disclosure

- I am a consultant for the SETMuPP research group
- I am a partner of Beacon Health Care Solutions INC.
- I am the co-owner of A to Z Pharmacy Consulting LLC

# Objectives

Upon conclusion of the program, the participant should be able to:

- Describe the current state of clinical pharmacy reimbursement
- Recognize barriers for the reimbursement of pharmacy services
- Differentiate between Part D Medication Therapy Management, Medication Therapy Management, and Evaluation and Management Billing Codes
- Categorize the common attributes within the 10 alternative payment models that are used to support the Patient-Centered-Medical-Home
- Discuss how advancements in telecommunication technology impact how pharmacists provide patient care services

# Pre-Test Question 1

Which of the following statements is true regarding Medicare Part D Medication Therapy Management Service (MTMS) program?

- a) Services must be a face-to-face encounter between a patient and the pharmacist
- b) Service can only be provided by pharmacist or pharmacy intern who is being supervised by a pharmacist
- c) Documentation standards follow the 1995 Evaluation and Management documentation guidelines
- d) Is only available for targeted patient populations

# Pre-Test Question 2

You have office visit with an established uncontrolled diabetic who HbA1c is worsening while on maximally dosed oral diabetic medications. The patient is being re-evaluated for insulin initiation, uncontrolled hypertension, and dyslipidemia. At the end of your clinical note you indicated that you spent 30 minutes counseling and coordinating care. Which of following E & M codes is the most appropriate to billing code to use for this visit?

- a) 99607
- b) 99212
- c) 99213
- d) 99214

# Pre-Test Question 3

You are the director of pharmacy for an outpatient physician based primary care clinic. The clinic system was only able to penetrate 30% of the assigned patient population from Trident Insurance; a commercial health plan. Pharmacist encounters are recognized as eligible engagement encounters. If your clinic system increases their penetration to 50% it will increase your tier and PMPM. Which of following best describes this type of alternative payment model?

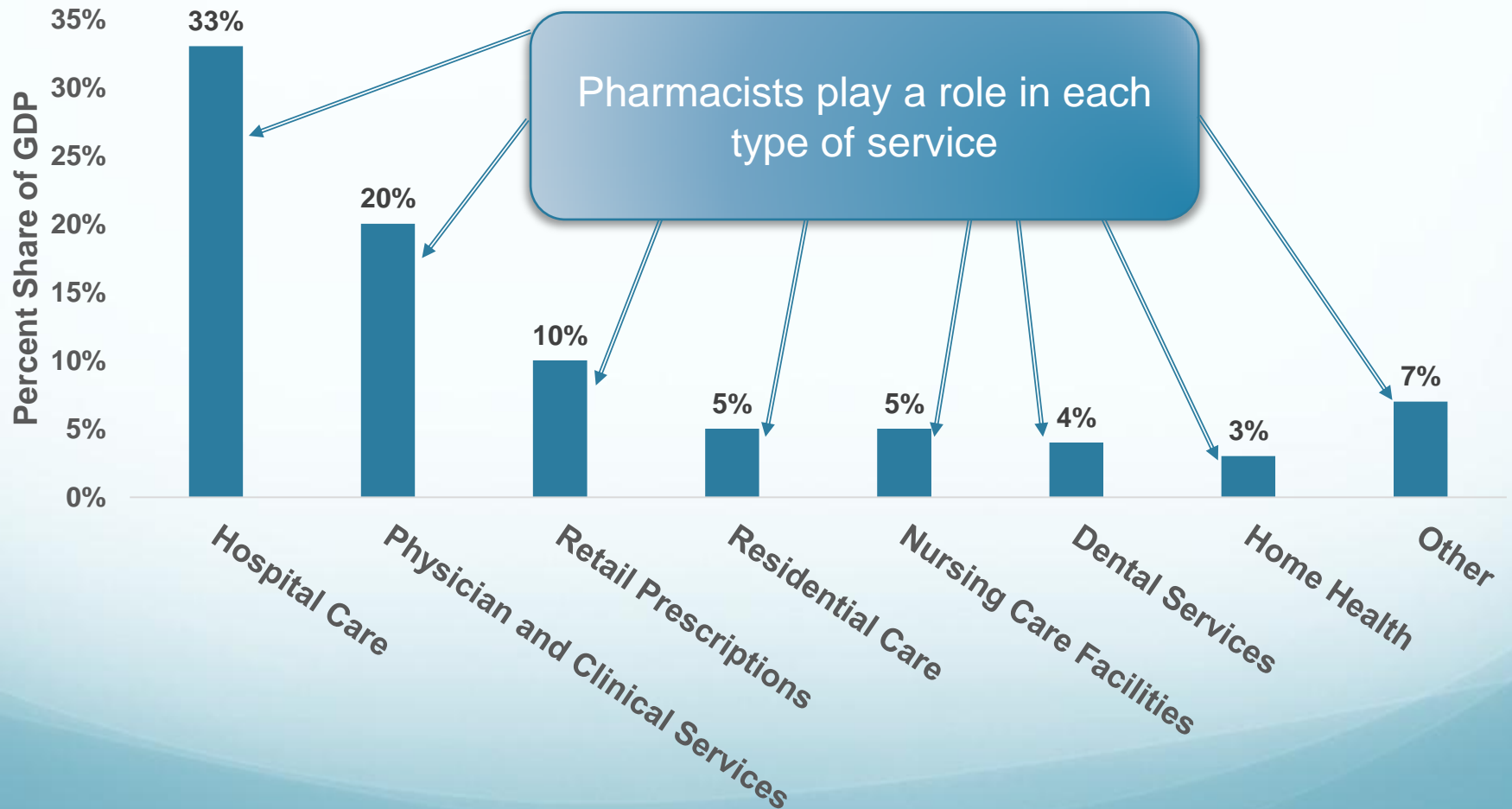
- a) Fee-for-service
- b) Pay for performance
- c) Risk sharing
- d) Care Management

# National Health Expenditures 2017<sup>1-2</sup>

- U.S health care spending increased 3.9%
- 3.5 trillion dollars annually
- \$10,739 per person
- Health care spending accounted for 17.9% of the overall gross domestic product
- Roughly \$333.4 billion was spent on retail prescription drugs

# National Health Expenditures 2017<sup>1-2</sup>

Percentage of Spending by Type of Service





# Fast Fact on Economic Value of Pharmacist

- Report to the Office of Inspector General in 1990<sup>3</sup>
  - “There is strong evidence that clinical pharmacy services add value to patient care and reduce health care utilization costs.”
    - **Projected annual savings of 220 million in averted health care cost for pharmacist-conducted drug regimen reviews**
- Public Health Service Report on Advanced Pharmacy Practice to the US Surgeon General<sup>4</sup>
  - Pharmacist-provided medication management services have demonstrated a significant return on investment (ROI)
    - **ROI as high as 12:1 and an average of 3:1 to 5:1**

# Federal Support for Pharmacy Services

- Health Resource and Service Administration 2010<sup>5-6</sup>
  - Lauds Patient Safety and Clinical Pharmacy Services Collaborative (PSPC)
    - 50% reduction in severe medication related adverse events
    - Pharmacist Play a role in identifying errors and improving patient health outcomes
    - Pharmacist “Can-and-do improve care”
- United States Public Health Service USPHS Report to US Surgeon General 2011<sup>7</sup>
  - “One of the most evidence-based decisions to improve the health system is to maximize the expertise and scope of the pharmacist and minimize expansion barriers of an already existing and successful health care delivery model.”

# Federal Support for Pharmacy Services

- U.S Department of Health and Human Services effective 2014<sup>8</sup>
  - New regulations that would allow hospitals to expand their definition of “medical staff” to allow non-physician practitioners, including pharmacists, to have privileges like other medical staff members
- Center for Medicaid and CHIP Services 2017<sup>9</sup>
  - Encouraged states to pass laws and regulations to allow pharmacists to dispense drugs prescribed independently, under collaborative practices agreements (CPA), standing orders, or other predetermined protocols
  - 48 states and Washington DC have some form in place already

# Current State of Reimbursement for Cognitive Services

- We have made significant progress at local levels
- Reimbursement for pharmaceutical care is sparse
- Often limited in scope
- Financially not incentivized
- Lacks uniform parity across populations
- The barriers identified in DHHS report to OIG in 1990 are the same barriers we have today

# Reimbursement Barriers

- Professional barriers<sup>3</sup>
  - Unfamiliar with State and Federal billing regulations, opportunities, processes, and terminology
  - Poor understanding of Managed Care and Health Care Policy
  - Credentialing vs privileging?
  - Limited procedure codes available that are specific to pharmacy services
  - Provider Status ≠ Prescriptive Authority

# Reimbursement Barriers

- Economic Barriers<sup>3</sup>
  - Product-based reimbursement structure
    - Reimbursement linked to sale of a product
    - Dispensing fees do not adequately reflect the value of the pharmacist clinical expertise
    - Volume based rebate structure
  - Underutilization of supportive personnel
    - Unsustainable pharmacist-to-pharmacist and pharmacist-to-technician staffing ratios
    - Limited ability to delegate to technician and other ancillary staff

# Reimbursement Barriers

- Federal and State Legislative Barriers<sup>3</sup>
  - Only 18 states reimburse pharmacists for cognitive services under Medicaid
  - Lack of federal recognition that pharmacists are qualified non-physician health care practitioners
  - Medicare does not recognize pharmacists as suppliers of medical services outside of mass immunization suppliers and CLIA waived laboratory services under Part B Medicare
  - State insurance codes and regulations often do not include pharmacists as reimbursable health service providers

# Reimbursement Barriers

- Inter-professional Barriers<sup>3</sup>
  - Physicians and other health care providers are unaware of pharmacists' clinical training and advanced training opportunities (residencies)
  - 'Scope Creep'
  - Pharmacists are a highly educated and expensive resource
  - Billing specialists/departments have very little experience with pharmacist billing for cognitive services
  - Insurers are either oblivious, or resistant, to reimbursing pharmacists through medical benefits



# Reimbursement Barriers

- Informational Barriers<sup>3</sup>
  - Limited access to pertinent patient information
  - Telecommunication technologies differ by site of care
  - No efficient system in place for bidirectional provider communication, verbal or electronic
  - Medication therapy management software disrupts pharmacists workflow and is viewed as a work around process

# Barriers to Sustainability

- What the practice of pharmacy needs:
  - Provider/Supplier status
  - Reimbursement under major medical benefit
  - Provider non-discrimination laws

# Local Provider Status

- Board of Pharmacy
  - Determines scope of practice through definition
- State Department of Health
  - Determines if pharmacists are qualified billing, or rendering, health service providers
  - Credentialing pathway and statewide protocols for pharmacists
- Consumer Business Bureau
  - Enforces the essential health benefit and (should) have in place provider non-discrimination laws or statutes

# Provider Status: State Level

- Domain one<sup>10</sup>
  - Provider designation
    - Is there language that identifies pharmacists as providers in state code?
      - Where to look?
        - Pharmacy practice act
        - Business and professional code
        - Public health code
        - Insurance code
        - State Medicaid code

# Provider Status: State Level

- Domain two<sup>10</sup>
  - Scope of practice
    - SHOULD align with education and training that pharmacists receive
      - Typical provisions include but not limited
        - Definitions of Pharmaceutical Care
        - Definitions for the practice of clinical pharmacy
        - Statewide prescribing protocols
        - Medication therapy management
        - Medication administration
        - Immunizations
        - Lab orders and interpretation

# Provider Status-State Level

- Domain three<sup>10</sup>
  - Reimbursement for cognitive services
    - Payment **should not** be attached to the product being dispensed
    - Payment **should** be a covered health service
    - Payment for the service **should not** solely be put on the consumer/member
      - Copays vs consultation fees
    - Payment **should not** be limited by place of service (POS) with some exceptions
      - Inpatient prospective payment system (IPPS)

# Provider Status: National Level (Medicare)<sup>11</sup>

- Medicare enrolls both physician and non-physician practitioners using CMS-855I forms
- Medicare reimburses Physicians 100% of Medicare part B physician fee schedule
- Medicare definition of “Physician” includes:
  - Doctors of Medicine or Osteopathic Medicine
  - Doctors of Dental Medicine or Surgery
  - Doctors of Podiatric Medicine
  - Doctors of Optometry
  - Chiropractors

# Medicare Eligible Providers

- Medicare reimburses non-physician practitioners 15% less for direct billing
- Non-physician practitioners includes:
  - Anesthesiology assistant
  - Audiologist
  - Certified Nurse Midwife
  - Certified registered nurse anesthetist
  - Clinical nurse specialist
  - Clinical social worker
  - Mass immunizer roster biller (includes pharmacists)
  - Nurse practitioner
  - Occupational therapist
  - Physical therapist
  - Physician Assistance
  - Clinical Psychologists
  - Registered dietitians or nutritional professionals
  - Speech and language pathologists



# Incident to Physician Services

Public Health, 42 CFR, §414.34 (6)(b). Payment for services and supplies incident to a physician's service.<sup>12</sup>

- *Services of nonphysicians that are incident to a physician's service.*
- Incident to a physician's service are paid as if the physician had personally furnished the service
- Incident to a eligible non-physician practitioners are paid at 85% of Part B FFS
- Traditionally CPT code 99211 used to describe these outpatient visits.
  - **This is not the case!**
- Must meet strict criteria set forth by Medicare

# CMS Clarifies Incident-To Billing

- American Academy of Family Physicians<sup>13</sup>
  - CMS agreed with the AAFP that if all of the requirements of the incident to statute and regulations were met, a physician could bill for services provided by a pharmacist as incident to services.

AAFP, CMS Clarify 'Incident to' Rules  
Relating to Pharmacists' Services

# Provider Anti-Discrimination

- Public Health, 42 CFR (4)(C)(A) 438.12 –PIHPS, PAHP, PCCM (IE Medicaid)<sup>14</sup>
  - **An MCO, PIHP, or PAHP may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.**
- 42 U.S. Code § 300gg–5 - Non-discrimination in health care providers<sup>15</sup>
  - **A group health plan and a health insurance issuer offering group or individual health insurance...**

# Check In Time

1. Federal and State legislative bodies recognize and support the expansion of pharmacists scope of practice to provide health services
2. “There is strong evidence that clinical pharmacy services add value to patient care and reduce health care utilization costs.”  
OEI-01089-89160, 1990
3. Though we have made significant progress; the barriers for reimbursement and recognition as health service providers, identified in the OIG report in 1990, are the same barriers we face today
4. The three domains of pharmacist provider status include: 1) health care provider designation; 2) Aligning state scope of practice laws to the training pharmacist receive today; 3) Reimbursement for cognitive service

# Language of Health Care Reimbursement

# Common Terminology<sup>16</sup>

- HCPCS
  - Current Procedural Terminology (CPT codes)
  - G Codes
- ICD – 10
- NPI
- Incident-to
- Forms
  - CMS 1500, CMS 1450

# HCPSCS

- Healthcare Common Procedure Coding System
  - ‘Hick Picks’
- HIPAA established HCPSCs as a requirement
- Category 1: CPT Codes
  - Numeric (Ex: 99211)
- Category 2:
  - Alphanumeric (Ex: G0438)

# CPT Codes

- Current Procedural Terminology
  - Used in billing to describe the type of service
  - Describes the patient encounter in terms of complexity
  - Laboratory tests
- Each code is very specific and may have restrictions on who can use the code
- Strict documentation requirements for each code



# ICD-10-CM Codes

Used to describe conditions which were discussed or managed during the patient visit

- Disease
  - E (Endocrine) 11 (T2 DM) .(Control, complication)
- Finding
  - R (R39.9) LUTS
- Complication
  - T
- External Causes of Morbidity
- Factors Influencing Health
  - Z (therapeutic drug monitoring)

# Evaluation and Management Services

- General definition:
  - Face-to-face professional services
  - Physician or other qualified healthcare professional
  - Follows AMA CPT coding manual, 1995 E/M documentation guidelines, or 1997 E/M documentation guidelines
- Purpose:
  - Documentation for payment for the provision of health care services for new or established patients

- AMA CPT Coding Manual Quick Reference 99201-99205

- New Patient

<b>Office or Other Outpatient Services</b>					
<b>Patient:</b> New					
<b>Required Components:</b> 3/3					
Code	99201	99202	99203	99204	99205
<b>Required Key Components</b>					
<b>History and Exam (#1 and #2)</b>					
Problem-Focused	X				
Expanded Problem-Focused		X			
Detailed			X		
Comprehensive				X	X
<b>Medical Decision Making (Complexity) (#3)</b>					
Straightforward	X	X			
Low			X		
Moderate				X	
High					X
<b>Contributory Factors</b>					
<b>Presenting Problem (Severity) (#1)</b>					
Self-limited or Minor	X				
Low to Moderate		X			
Moderate			X		
Moderate to High				X	X
<b>Counseling (#2)</b> See E/M Guidelines					
<b>Coordination of Care (#3)</b> See E/M Guidelines					
<b>Typical Face-to-Face Time (#4)</b>					
Minutes	10	20	30	45	60

- AMA CPT Coding Manual Quick Reference 99211-99215
- Established Patient (Most common)

Office or Other Outpatient Services					
Patient: Established					
Required Components: 2/3					
Code	99211	99212	99213	99214	99215
<b>Required Key Components</b>					
<b>History and Exam (#1 and #2)</b>					
Problem-Focused	N/A	X			
Expanded Problem-Focused			X		
Detailed				X	
Comprehensive					X
<b>Medical Decision Making (Complexity) (#3)</b>					
Straightforward	N/A	X			
Low			X		
Moderate				X	
High					X
<b>Contributory Factors</b>					
<b>Presenting Problem (Severity) (#1)</b>					
Minimal	X				
Self-Limited or Minor		X			
Low to Moderate			X		
Moderate to High				X	X
<b>Counseling (#2) See E/M Guidelines</b>					
<b>Coordination of Care (#3) See E/M Guidelines</b>					
<b>Typical Face-to-Face Time (#4)</b>					
Minutes	5	10	15	25	40

# History

<b>TYPE OF HISTORY</b>	<b>CC</b>	<b>HPI</b>	<b>ROS</b>	<b>PFSH</b>
<b>Problem Focused</b>	Required	Brief	N/A	N/A
<b>Expanded Problem Focused</b>	Required	Brief	Problem Pertinent	N/A
<b>Detailed</b>	Required	Extended	Extended	Pertinent
<b>Comprehensive</b>	Required	Extended	Complete	Complete

# Physical Examination

(Pharmacy area of deficiency)

TYPE OF EXAMINATION	DESCRIPTION
<b>Problem Focused</b>	Include performance and documentation of one to five elements identified by a bullet in one or more organ system(s) or body area(s).
<b>Expanded Problem Focused</b>	Include performance and documentation of at least six elements identified by a bullet in one or more organ system(s) or body area(s).
<b>Detailed</b>	Include at least six organ systems or body areas. For each system/area selected, performance and documentation of at least two elements identified by a bullet is expected. Alternatively, may include performance and documentation of at least twelve elements identified by a bullet in two or more organ systems or body areas.
<b>Comprehensive</b>	Include at least nine organ systems or body areas. For each system/area selected, all elements of the examination identified by a bullet should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of at least two elements identified by bullet is expected.*

# Medical Decision Making<sup>17</sup>

- Based on number of diagnoses and **treatment options**
- Amount and/or complexity of information reviewed, summarized, or ordered
- Risk of complication and/or morbidity or mortality to the patient
- Time spent counseling or coordinating care
  - **Must be more than 50% of the encounter**

# Medical Decision Making

Final Result for Complexity					
A	Number of dx or txt options	$\leq 1$ Minimal	2 Limited	3 Multiple	$\geq 4$ Extensive
B	Highest Risk	Minimal	Low	Moderate	High
C	Amount and complexity of data	$\leq 1$ Minimal	2 Limited	3 Multiple	$\geq 4$ Extensive
Type of decision making		Straight-Forward	Low-Complex	Mod-Complex	High-Complex



# Types of Billing Forms

- CMS 1500 form
  - Non-hospital outpatient visits & Procedures (immunizations, lab tests, blood draws, etc...)
- UB-92 Claim Form (CMS 1450)
  - Hospital outpatient visits
  - Commonly used for Coumadin clinics

# Check In

- What we did?
  - CPT
- Why we did it?
  - ICD-10
- Who did it?
  - NPI
- How we report it?
  - CMS 1500
    - Reality – EHR

# Medication Therapy Management

# Varies by Payer, State, & Site

- Medicare A
  - Hospital and hospital based clinics
- Medicare B
  - Outpatient provider based clinics
- Medicare D
  - Prescription Drugs
- Medicaid
  - Varies by State Authority
- Exchange, Commercial, etc.
  - Consumer Business Bureau and Essential Health Benefit

# Example of Pharmacist Fee Schedule

Procedure Codes:	
<b>99605</b> Medication therapy management services provided by a pharmacist, individual, face-to-face with patient, initial 15 minutes, with assessment, and intervention if provided; initial 15 minutes, new patient	\$35.01
<b>99606</b> Initial 15 minutes, established patient	\$30.01
<b>99607</b> Each additional 15 minutes	\$13.33
<b>99201-99215</b> Evaluation & Management services, pursuant to a clinical pharmacy/collaborative practice agreement for post-diagnostic disease state management services	Varies by Contract

# MTMS Billing: Medical Benefit<sup>16</sup>

- General definition:
  - **Face-to-face patient assessment and intervention**
  - **Pharmacist only**
  - **Upon request/referral or pharmacist discretion**
  - Optimize response to medications or to manage treatment related interactions or complications
- Documented elements
  - Review of pertinent patient history
  - Medication profile
  - **Recommendations** for improving health outcomes and treatment compliance

# Medicare Part D MTM<sup>18</sup>

All Medicare Part D plans must have an MTM program that:

- Ensures optimum therapeutic outcomes **for targeted beneficiaries** through improved medication use
- Reduces the risk of adverse events
- Is developed in cooperation with licensed and practicing pharmacists and physicians
- **May be furnished by pharmacists or other qualified providers**
- **Limited to targeted populations**
- **Can be face-to-face or telephonic**

# Part D MTM

## Core Services:

- Comprehensive Medication Review
- Quarterly targeted medication review (TMRs)
- Interventions for patients and prescribers

## Documentation Includes 3 components:

- Medication Action Plan (MAP)
- Personal Medication Record (PMR)
- MTM Firms
  - *OutcomesMTM, Mirexa, CSS, Nexus, ActualMeds, etc.*

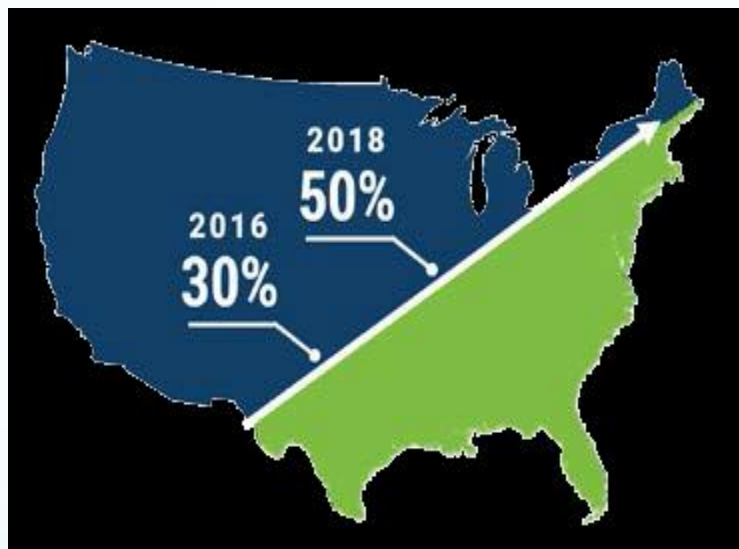


# Medicare Part D MTM

- Eligible providers of CMRs
  - Pharmacists
  - Physicians
  - Nurse practitioners
  - Physician assistants
  - Registered Nurses
- Eligible MTM providers
  - Pharmacy technicians
  - Case Workers
  - Pharmacy interns
  - Other

# FINANCIALLY SUPPORTING AN ENHANCED CARE TEAM IN YOUR CLINIC

# NATIONALLY, THINGS ARE CHANGING



Goals of the U.S.  
Department of Health and  
Human Services (HHS):<sup>19</sup>

- 30% of U.S. health care payments in APMs or population based payments by year 2016, and
- 50% by year 2018

# Ten Models of Payment

Model	Notes
FFS CPT code expansion (fee for services)	Payment for non-traditionally reimbursed codes
FFS payment enhancement	Increased FFS rate level based on quality outcomes or tiers of clinic systems/providers
FFS + lump sum payments (most common)	Periodic lump sums are paid for wrap around services (NCQA PCMH Cert.)
FFS + PMPM (per-member-per-month)	Engagement driven and often include pharmacy services
FFS + P4P (pay for performance)	Based on predetermined outcome or process measures (HEDIS, STARS)
FFS with risk or shared saving (PMPY)	Informed by ROI analysis and can include medical and pharmacy savings

# Ten Models of Payment

Model	Notes
FFS + PMPM + P4P	Monthly care coordination and retrospective outcome based payments (6-12 months)
FFS + Lump Sum + P4P	No requirements for lump sum with quality metrics for P4P
FFS + Lump Sum + P4P + PMPY	No requirements for lump sum with quality metrics for shared savings that are risk adjusted for case mix
Comprehensive	Risk adjusted PMPM that covers all services and payments

# Ten Methods of Payment<sup>20</sup>

Fee for Service

Capitation/Care  
Management

Quality  
Payments

Total Cost of  
Care/Risk  
Contracting

# Methods of Payment

Fee for  
Service

- Traditional source of income based on service performed
  - Negotiated with individual payers
- The ten payment models purposed
  - FFS plays a role in 8/10 of the models
- CPT and FFS is not going away any time soon
  - Provide a baseline minimum payment
  - Used for data acquisition purposes
    - Outcomes
    - Gaps in care
    - Risk adjustment
    - Engagement visit

# Methods of Payment

- Per member per month (PMPM) payment for attributed members
  - Can be for specific services (e.g.. Care Management)
  - Global payment for primary care

## Benefits

- Supports non-encounterable interaction
- Allows flexibility in the model (depending on criteria in contract)
- Decreases administrative hassle and allows ability to align
- Supports team based care model

## Drawbacks

- Relies on team based care model
- Need payer penetration to make viable



# Methods of Payment

- Bonuses for meeting incentive metrics:
  - Incentive Measures
  - Medicare Stars Measures
  - HEDIS Measures
  - NCQA PCMH

## Benefits

- Allows additional revenue for demonstrating process and outcome metrics
- With focus and priority, are achievable

## Drawbacks

- Less predictable
- Measures and payments vary across payers

# Methods of Payment

Total Cost of  
Care/Risk  
Contracting

- Shares financial risk of care delivery
- Calculates projected cost for a population
- Negotiates upside and downside shared risk for achieving the target budget

## Benefits

- Allows maximal flexibility as long as outcomes are achieved
- Supports development of deeper population management capability

## Drawbacks

- Requires infrastructure and financial support to taking risk
- Need relationship with hospital and specialty partners to maximize effectiveness

# APM Example

PCMH Potential Revenue Streams	
Total Qualifying Encounters	15,000
Total FFS Revenue	\$1,500,000
PMPM Case Rate	\$250/month
Penetration 2016	30%
Adjusted PMPM Revenue	\$375,000
P4P Metrics Met	6 of 15
Weighted P4P Revenue	\$875,000/\$2,200,000
County Level Capitation Rate (wrap rate)	\$284
Eligible PPS Encounters	8,000
Wrap Revenue	\$1,472,000
<b>Total Revenue (FFS+PMPM+P4P+Wrap)</b>	<b>\$4,222,000</b>

# Advancement in Telecommunication<sup>21</sup>

## **Billing Guidance for Pharmacists' Professional and Patient Care Services**

*Version 2.0*

June 2018



# Electronic Data Interchange Standards in Healthcare IT

- American National Standards Institute (ANSI)
  - Electronic Data Interchange for Insurance (X12N 837)
  - Institutional Claims (X096)
  - Dental Claims (X097)
  - Professional Claims (X098)
  - Health Care Service Data (HCSDRG)
- NCPDP Telecommunication Standards
  - Prescription information
    - Health Care Insurance
    - Pharmacy Benefit Managers
    - Pharmacies
    - Providers
  - **Professional Pharmacy Services**

# NCPDP Professional Services

- Created Standards to process transaction of professional activities in real-time
- Allows pharmacy providers to demonstrate
  - Value of their professional activities
  - Consistent implementation of both product and professional services
  - Allow payers and processors the ability to review and adjudicate professional claims across many practice settings

# NCPDP Professional Services

- Transaction sets for billing of pharmacy service allow the pharmacy to transmit a claim in nearly any setting to a payer
  - Professional Service codes (PPS)
  - Reason for service codes
  - Result of Service Codes
  - MTM Action Codes
  - Drug Utilization review Codes (DUR)

# NCPDP-Example<sup>22</sup>

## Drug Utilization Review & Pharmacy Professional Service Codes

<b>Value</b>	<b>Definition</b>	
CS	Patient Complaint/Symptom	
MR	Medication Review-Code indicating comprehensive review and evaluation of patient's entire medication regimen	
AS	Code indicating evaluation of patient for purpose of developing therapeutic plan	
PT	Perform Laboratory-Pharmacist performed clinical laboratory test on patient	
M0	Prescriber consulted	
Level of Effort Codes		
<b>Code</b>	<b>Meaning</b>	<b>Definition</b>
13	Level 3	Counseling and coordination of care required less than 15 minute of pharmacist's time (moderate complexity)



# Point of Care Clinical Services<sup>23</sup>

- Using dummy NDC codes to adjudicate pharmacy care activities at the pharmacy
  - Growing in popularity with some PBMs and insurance plans
- Example
  - Patient Training on Glucose Monitors NDC Number: **99999-9999-36** Reimbursement: \$1 per minute, up to 30 minutes  
Submit number of minutes as the quantity
  - Formulary Interchange NDC Number: **99999-9999-32**  
Reimbursement: \$4 This code should be used when a prescription for a medication not on the Health Plan is switched to a formulary medication. Claims should not be submitted if the prescriber authorizes a medical exception or obtains a prior authorization. Submit quantity of 1.

# Post-Test Question 1

Which of the following statements is true regarding Medicare Part D Medication Therapy Management Service (MTMS) program?

- a) Services must be a face-to-face encounter between a patient and the pharmacist
- b) Service can only be provided by pharmacist or pharmacy intern who is being supervised by a pharmacist
- c) Documentation standards follow the 1995 Evaluation and Management documentation guidelines
- d) Is only available for targeted patient populations**

# Post-Test Question 2

You have office visit with an established uncontrolled diabetic who HbA1c is worsening while on maximally dosed oral diabetic medications. The patient is being re-evaluated for insulin initiation, uncontrolled hypertension, and dyslipidemia. At the end of your clinical note you indicated that you spent 30 minutes counseling and coordinating care. Which of following E & M codes is the most appropriate to billing code to use for this visit?

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- b) 99212
- c) 99213
- d) 99214**

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You are the director of pharmacy for an outpatient physician based primary care clinic. The clinic system was only able to penetrate 30% of the assigned patient population from Trident Insurance; a commercial health plan. Pharmacist encounters are recognized as eligible engagement encounters. If your clinic system increases their penetration to 50% it will increase your tier and PMPM. Which of following best describes this type of alternative payment model?

- a) Fee-for-service
- b) Pay for performance
- c) Risk sharing
- d) Care Management**

# Questions

# References

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