

10 Facts about Pharmacist Billing in Physician Based Clinic



The role of the pharmacists has come a long way from over the counter sales (OTC) to now providing direct-care services such as immunizations, point-of-care (the delivery of health care services to patients at the time of care), wellness and prevention screenings, medication therapy management, chronic condition management and patient education, and sometimes even counselling. These new skills have taken them beyond the traditional dispensing of prescription function, and are now more often than not part of a team based system.

These new setting within which pharmacists now practice include inpatient facilities such as hospitals, nursing homes, and rehabilitation centres; outpatient, urgent care, and ambulatory clinics; patient centred medical homes (PCMHs), and Accountable Care Organizations (ACOs). The new delivery care model, the ACOs, are the most prominent among which pharmacists now work along with a group of doctors and hospitals who together offer coordinated care to their Medicare patients.

The changing healthcare reforms now permit pharmacists to bill patients directly on a cash-transaction basis, provide services under a third-party insurance-contracted service, and/or use [pharmacist-specific current procedural terminology \(CPT\) codes](#).

1. Of all the services offered by pharmacists, Medication Therapy Management (MTM) services have shown improved outcomes and helped reduce costs.
2. These services are provided through collaborative practice agreements (CPAs). Although not all, but in most states, pharmacists can modify prescriptions under a collaborative agreement. Under this agreement pharmacists can address drug-related adverse effects (DAEs) and improve therapeutic outcomes for patients.
3. For the delivery of MTM services, 3 pharmacist-specific CPT codes (99605, 99606, and 99607) have been established and are used by Medicaid, private health insurers, or Medicare. MTM for Medicare Part D beneficiaries is among the most prominent types of direct patient care services that are reimbursed by payers today.

4. **Pharmacy medicare part B and part D** : For Medicare beneficiaries seen in a physician office by a pharmacist, MTM CPT Codes are not recognized, since physician offices fall under Medicare Part B. Medicare recognizes MTM services only under Part D. Under Medicare Part D, MTM services are paid through administrative fees to a Prescription Drug Benefit Plan. If your physician office or clinic has a dispensing licensed pharmacy, there is the opportunity to contract with Prescription Drug Benefit Plans to provide MTM and use the MTM codes through that venue. The physician-based clinic may have specific private payer contracts or state Medicaid opportunities that will allow the utilization of the MTM CPT codes in this setting. If there are no such opportunities in your setting, the default is to Medicare billing

CMS billing:

1. When **billing under CMS**, if the same physician's office submits two separate bills to CMS on the same day, CMS will pay the lesser of the two bills usually the pharmacist's bill at the 99211 code level, thereby a loss of revenue. But if a patient is in another specialty clinic and then sees the pharmacist in a primary care clinic on the same day, two separate bills from both places can be generated on the same day.
2. However, some Medicare and Medicaid (CMS) compensation policies are very limiting for pharmacists' to practice in new areas, particularly within integrated care teams. For example, pharmacists are not included in the statutory definition of providers under Medicare Part B, and therefore, cannot directly bill for patient care services. And given that many state and private health plans align their payment policies with Medicare policies pharmacists as a result cannot bill directly for patient care services
3. Medicare Part B pays for the evaluation and management of medical conditions and also medical decision making based on disease states of the patient. However, medication management under Medicare Part B is not paid for by CMS. Nevertheless, documentation must address the medical condition and therapy plan that gives authorization for pharmacist services by the physician.
4. To request for reimbursement under the Transitional Care Management, pharmacists must meet the "incident-to" requirements by CMS by using the HCPCS codes 99496 and 99495, within 7 and 14 days of discharge respectively, only if in collaboration with a licenced Medicare healthcare provider.
5. Another area under which pharmacists' can be reimbursed 100 percent as per the Medicare fee schedule, is when there is the "incident to" concept where a pharmacist bills services under a physician's National Provider identifier number (issued by CMS), unlike the 85 percent reimbursement when the service is billed under the pharmacist's number.
6. For "incident-to" billing, there are five billing levels (99211-99215) each increasing in degrees of simple to complex encounters - with 99211 being a simple patient encounter to 99215 being a complex encounter. But even though the 99211 level has no requirements for documentation elements and where pharmacists are restricted to billing, it is still considered an evaluation and management code (E&M), and therefore a patient's medical conditions need to be evaluated and managed, else cannot be billed under this level.

Nevertheless, there is light at the end of the tunnel, and it has been forecasted that, in 2018, Alternative Payment Models (APMs) and fee-for-service (FFS) quality initiatives may tend to hit 50 percent and 90 percent, respectively, of [reimbursements for pharmacists](#) alone.

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