Understanding health care billing basics

Abstract

Objective: To provide pharmacists a basic understanding of health care billing and current opportunities for generating revenue for their patient care services.

Data: Primary data source is CMS, as Medicare billing processes are viewed by the industry as the U.S. standard for health care billing.

Summary: The current U.S. health care billing process for patient care services is a complex and difficult system for many to fully grasp, especially pharmacists who are relatively new to generating revenue for patient care services. Health care billing is challenging for varied reasons, including multiple payers; nuances of the locations where services may be provided (i.e., institutional vs. noninstitutional); variation in state laws and regulations; and the legislative process, with regulations that change or are updated frequently, often yearly. Adding to the complexity is that health care billing has its own language of terms and abbreviations that, if not understood, impede billing discussions and interpretation of rules and regulations. Although health care billing models are moving away from fee-for-service to value-based payment models, it is important to understand the basics of the current model. The transition is not likely to completely overhaul the current system but over time to build on much of the current infrastructure as a starting point for the new billing models. This article provides the basics of health care billing and explains the particular details and processes pharmacists need to know to generate revenue for their services.

Conclusion: Although pharmacists have yet to universally establish themselves as health care providers able to bill payers in federal and state programs, they have the opportunity to work as auxiliary personnel under an eligible provider who may bill for a pharmacist’s services. Thus, pharmacists are capable of generating revenue. The process remains complex and requires a clear understanding of the rules and regulations.

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Mary Ann Kliethermes, BS, PharmD, vice chair and professor, Chicago College of Pharmacy, Midwestern University, Downers Grove, IL

Correspondence: Mary Ann Kliethermes, BS, PharmD, 555 31 St., Downers Grove, IL 60515; mkliet@midwestern.edu

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Learning objectives
At the conclusion of this knowledge-based activity, pharmacists will be able to:
- List the four types of payers that reimburse for health care services.
- State two strategies for potential revenue for pharmacist services from commercial payers.
- Name the CMS documents that are the definitive source for the rules and regulations for health care reimbursement under Medicare Parts B, C, and D.
- List the healthcare common procedural coding system (HCPCS) codes that may be used by eligible billing providers to generate revenue for pharmacist services.
- List the “incident-to” rules for both institutional outpatient services and physician office services.
Preassessment questions
Before participating in this activity, test your knowledge by answering the following questions. These questions will also be part of the CPE assessment.

1. Current procedure terminology (CPT) codes are
   a. Level 2 healthcare common procedure coding system (HCPCS) codes
   b. Codes that include the incident to evaluation and management (E&M) codes that providers may use to support pharmacist services
   c. Used by Medicare Part A for billing purposes
   d. Developed and maintained by CMS

2. Ambulatory payment classifications (APC) codes are used in which setting?
   a. Hospitals or health systems for services in their ambulatory clinics
   b. Physician offices for diabetes education services
   c. Assisted living and group homes for clinical provider services
   d. In-home services provided by Medicare Part B providers

3. The industry standard for health care billing is based on which of the following payer or organization methods?
   a. American Medical Association
   b. State-specific rules and regulations
   c. CMS
   d. America’s Health Insurance Plans

Introduction
As pharmacists continue to shift from primarily dispensing duties to greater participation in direct care of patients, understanding existing and future billing mechanisms is imperative. For sustainability of these vital services, there exists a need for pharmacists to understand opportunities to generate revenue. In the fast-changing health care environment, where reimbursement for patient care services is moving rapidly from fee-for-service (FFS) to value-based payments, reimbursement methods have become even more complex. It is important that providers and pharmacists avoid wrong turns, as errors will result in denied claims and potentially significant fines. Pleading ignorance is not an acceptable excuse. A key to the journey of understanding health care reimbursement is understanding the basics of health care billing.

Reimbursement for services by pharmacists providing or expanding into direct patient care is more problematic than for other providers because of the lack of provider status and associated laws, rules, and regulations. For pharmacists to submit bills to both government health care payers or commercial health care payers, pharmacists and their services need to be recognized in some manner for coverage. Currently, because of payment policies, in most situations pharmacists may not bill or be directly reimbursed for patient care services. At the federal level and in some state and commercial programs, however, pharmacists may generate revenue ancillary to those providers who are eligible to submit claims. Many payers designate that payment for patient care services is dependent on the services authorized in state practice acts. Therefore, payable services are also determined on the basis of scope of practice outlined in a provider’s state practice act.

Payers in health care
To understand pharmacist revenue generation potential for patient care services, first it is important to recognize the payers and the payer mix in the patient population where services will be provided. Health care payers can be divided into four major groups: commercial, federal government, state government, and self-pay. Although self-pay is possible, it is not common and is difficult to sustain; therefore, we will not discuss it in this article.

In the ambulatory setting, the typical payer mix for primary care and multispecialty clinics is 50% commercial, 30% Medicare, 7% state Medicaid, and the remaining composed of smaller health care payers, such as worker’s compensation, self-pay, etc. A specific geographical location may alter the typical payer mix. If the population served is a low-income urban community, Medicaid may have a greater presence. For services provided in an upscale location with a younger population, commercial payers may dominate the payer mix. In most clinics, Medicare is the single largest payer and one reason Medicare processes dominate health care billing.

Commercial payers
Although 50% of a typical clinic revenue source, commercial payers actually comprise multiple payers with numerous and differing benefit plans. Adding to the complexity is that payer models differ across the nation and even within a particular state. Because of variability in reimbursable services between models, states, and benefit plans, it is difficult to give specific guidance other than encourage providers to investigate the plans that predominate in the population of patients they intend to serve. Options for eligible providers are to develop specific contracts to cover the services provided with agreed-upon service billing codes, or to use a more general process of becoming a credentialed provider to submit service billing codes as an in-network provider. Under the general system, the commercial payers often use the Medicare billing system because it is considered the industry standard.

It is important to note that commercial payers are risk adverse in the management of their plans and beneficiaries, whereas government payers’ purpose is to manage high-risk patients such as seniors and those who are medically disabled. Therefore, benefit coverage is varied across the types of payers. The common types of commercial payer models are listed in Table 1.

State and federal government payers
Medicaid. Medicaid is a combined state and federal program that provides health coverage for patients with very low or no income. The federal government matches state funding on the basis of a specified percentage of program expenditures, called the federal medical assistance percentage (FMAP). FMAPs range from 50% to 75%, average 57%, and are adjusted every 3 years. Each state can establish its own benefit plan and provider payment rates within federal requirements. States may use FFS or a managed care model...
in engaging and paying providers. Thus, variability exists in provider eligibility and scope of services reimbursed.

Fourteen state Medicaid programs offer some level of direct reimbursement to pharmacists for patient care services (Table 2). Pharmacists residing in those states should consult state regulations for the particular rules on billing and reimbursement. A specific group of Medicaid beneficiaries are termed “dual eligible.” This group of patients receives benefits from Medicare and Medicaid in which the primary payer is Medicare and state Medicaid is a secondary payer that assumes payment of the Medicare copay.

**Medicare.** Medicare is the benefit provided to a U.S. citizen or legal resident (or spouse) who has paid at least 10 years of taxes into Medicare through employment. Benefits are available when they turn 65 years of age or older or have become medically disabled. Medicare benefits are established through legislative action by the U.S. Congress, beginning with the Social Security Act in 1965, and are updated periodically with subsequent laws, including the most recent Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

There are four Medicare benefit plans. Medicare Part A covers hospital and long-term care services. Beneficiaries contribute to Medicare Part A through social security tax while employed. Subsequently, once they are eligible for benefits, beneficiaries are provided Medicare Part A at no additional charge. Medicare Part B covers outpatient services. Eligible beneficiaries are automatically enrolled and must opt out of the benefit if they do not wish to participate or pay the monthly required premium to remain enrolled in Part B. For Medicare Part A and Part B, the plan covers 80% of the billable services, with the patient responsible for the remaining 20%. Some patients may have coinsurance that covers the 20% copay. This may be in the form of private retirement benefits, Medigap plans, and state Medicaid coverage such as dual-eligible.

Medicare Part C is the federal government’s managed care benefit arm that covers major medical services. The term often used for Medicare Part C is Medicare Advantage. CMS outsources management of these plans to commercial payers, who submit bids to CMS to be an approved plan under Medicare Part C. Each plan must offer all the benefits under Parts A and B but are free to add additional benefits; therefore, a number of plans also include prescription benefits. Unlike Medicare Part B, in which a fee is paid to the provider for each service, CMS pays the commercial Medicare Part C plan a set amount per member per month. To ensure quality in the plans, CMS created Star Ratings, a quality measurement program that is based on a 1 to 5 scale. Plans with Star Ratings in the 4 to 5 range receive both financial and program incentives, whereas those plans with poor ratings in the 1 to 2 range risk reductions in payment as well as termination from the program.

The most recent added Medicare benefit is Medicare Part D, which covers prescription medications and is a familiar benefit to pharmacists. CMS is the federal agency whose role is to administer these benefits and to set the rules and regulations for how they are enacted. It is important to understand who receives payment from CMS for each of these benefits, as the recipient dictates for pharmacists the entity they may need to work with to generate revenue for their services (Table 3). It is equally important to understand which documents provide the rules and regulations for each of the benefits. These documents are the definitive source for providers in understanding and interpreting the required processes for payment and revenue under Medicare Parts A through D.
Medicare Part A’s system of payment for the operating costs of acute care hospital inpatients is the inpatient prospective payment system (IPPS). For a number of years, hospitals have worked under a global payment system in which a set amount for each hospital stay is paid per diagnosis or the medical severity–diagnosis-related groups (MS-DRGs) codes. Attached to the DRG codes are revenue codes for non-diagnosis costs such as room and board. This requires hospitals to carefully manage their patients so as not to exceed the set payment for a condition or set of conditions. Part A also has payments tied to quality measurement. The most noted one is the hospital readmission reduction program, which financially penalizes hospitals if they have a higher than expected 30-day readmission rate for certain conditions (beneficiary is readmitted to the hospital for the same DRG within 30 days for which they were discharged).

The physician fee schedule (PFS) is used by providers as the guide for reimbursement under Medicare Part B. However, since MACRA’s implementation in 2017, providers must also meet the requirements for reimbursement under the MACRA-Quality Payment Program. Hospitals or health systems that own and operate outpatient services use the outpatient prospective payment system (OPPS) for health care services reimbursement. Because pharmacists are not considered an eligible provider under Medicare Part B, they fall under the regulations that describe services from auxiliary personnel.

Most of the Medicare reimbursement guide documents are updated yearly. CMS releases proposed changes to the respective Part B documents with a call for comments in the spring. After a thorough review of all comments, CMS releases a final updated document in November containing the final rules, responses to all comments, and rationale for CMS decisions. It is important to note that beneficiaries typically pay 20% of the Medicare-approved amount in copays for most outpatient services.

To assist in administering the Medicare Part A and Part B benefits, CMS contracts with private organizations called Medicare administrative contractors (MACs). The role of MACs is listed in Table 4. CMS divides the country into 13 regions, each with its own contracted MAC. MACs are important because they may add interpretation to Medicare billing codes. Therefore, it is wise to check with your region’s MAC for the final and definitive rules and guidelines before you recommend any Medicare billing code to a provider. You may find a MAC for your region at this CMS link: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/#zpic.

Medicare Part C and D payment rules and policies are updated and changed by CMS through annual call letters. For Part D medication management therapy (MTM) programs, there is also the MTM Program Guidance and Submission Instruction Memo. CMS annually releases regulations pertaining to Part C or Part D for the upcoming calendar year via a call letter to provide final program rules, including methodologies used to pay MA and Part D sponsors. Draft versions of the regulations are released to solicit public comments before final versions are issued. The final call letters are issued in late spring.

To stay abreast of this activity besides receiving daily news e-mail notices from pharmacy associations, you may sign up for daily news notifications or directly access the CMS website at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/#zpic.
The language of health care billing

Medicare billing processes are considered the standard for health care billing in the United States. Understanding Medicare billing terminology and codes will greatly assist you in understanding all health care billing, including commercial and state Medicaid billing. The basic structure and process of health care billing is depicted in Figure 1. The claim submitted should include what service was provided (healthcare common procedural coding system [HCPCS] code), why it was done or the diagnosis (International Classification of Disease, 10th Revision [ICD-10] code), and who did it (national provider identifier [NPI] number); or, if billing as a large group or organization, a tax identification number (TIN) may also be used. Depending on the payer, the HCPCS code may be adjusted by a system called the resource-based relative value scale (RBRVS), which uses relative value units (RVUs) to adjust for differences among providers.

HCPCS codes

The first element that needs to be coded in health care billing is the service provided. This is defined by HCPCS, often referred to as “hicpic” codes. There are two levels within the HCPCS system. Level 1 consists of the current procedure terminology (CPT) codes. These codes are identified by five numeric digits (e.g., 99605). Level 2 codes describe services not contained within CPT and certain health care products and supplies. These HCPCS Level 2 codes are identified by a single alphabetic letter followed by four numeric digits (e.g., G0465).

Level 1 HCPCS codes, more commonly referred to as CPT codes, are owned and maintained by the American Medical Association (AMA). They were first published in 1966 to help record clerks more easily understand how to document physician services and were not originally intended for billing. Twenty years later, in 1983, Medicare merged CPT codes with Medicare HCPCS codes for the purpose of Medicare billing. A standing committee within AMA creates, reviews, updates, and distributes these codes as warranted.

There are three categories of CPT codes, but only Category 1 is routinely used for health care billing (Table 5). Category 1 has six levels of codes. The codes available

<table>
<thead>
<tr>
<th>Service provided: HCPCS code</th>
<th>Why it was done: ICD-10 code</th>
<th>Who did it: NPI or TIN</th>
<th>Final submitted codes for the claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>RVU</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Figure 1.** Basic structure and process for health care service billing.

**Table 5.** Current procedure terminology (CPT) codes

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Example 1</th>
<th>Example 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and management (E&amp;M)</td>
<td>99201–99499</td>
<td>99211</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>00100–01999</td>
<td>91100–91150</td>
</tr>
<tr>
<td>Surgery</td>
<td>10000–69990</td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td>70000–79999</td>
<td></td>
</tr>
<tr>
<td>Pathology and laboratory</td>
<td>80000–89398</td>
<td></td>
</tr>
<tr>
<td>Medicine</td>
<td>90281–99099</td>
<td>99151–99199</td>
</tr>
<tr>
<td>Category 2: Supplementary tracking codes used for performance measurement, consisting of 4-digit numeric codes with an “F” at the end.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category 3: Emerging technology temporary codes that have a “T” after the code, designating that they are temporary.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 6.** HCPCS Level 2 codes

| A codes: Transportation, medical supplies, misc. & experimental |
| B codes: Enteral & parenteral therapy |
| C codes: Temporary hospital outpatient prospective payment system |
| D codes: Dental procedures |
| E codes: Durable medical equipment (DME) |
| G codes: Temporary procedures & professional services |
| H codes: Rehabilitative services |
| J codes: Drugs administered other than oral method, chemotherapy drugs |
| K codes: Temporary codes for DME regional carriers |
| L codes: Orthotic/prosthetic procedures |
| M codes: Medical services |
| P codes: Pathology and laboratory |
| Q codes: Temporary codes |
| R codes: Diagnostic radiology services |
| S codes: Private payer codes |
| T codes: State Medicaid agency codes |
| V codes: Vision/hearing services |

Abbreviations used: RVU, relative value unit; HCPCS, healthcare common procedural coding system; ICD-10, International Classification of Disease, 10th Revision; NPI, national provider identifier; TIN, tax identification number.
HEALTH CARE BILLING BASICS

Table 7. E&M CPT code billing rules

<table>
<thead>
<tr>
<th>Assessments of care</th>
<th>NA</th>
<th>Problem focused</th>
<th>Expanded problem focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decision making</td>
<td>NA</td>
<td>Straightforward</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Established patient E&amp;M codes</td>
<td>99211</td>
<td>99212</td>
<td>99213</td>
<td>99214</td>
<td>99215</td>
</tr>
<tr>
<td>Chief complaint</td>
<td>NA</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Review of systems elements</td>
<td>NA</td>
<td>N/A</td>
<td>Problem pertinent</td>
<td>2–9 elements</td>
<td>Minimum of 10 elements</td>
</tr>
<tr>
<td>Past family and social history elements</td>
<td>NA</td>
<td>NA</td>
<td>Pertinent or 1 item from any of the areas</td>
<td>1 element from 2 or 3 of the 3 categories</td>
<td></td>
</tr>
<tr>
<td>Physical exam elements</td>
<td>NA</td>
<td>1–5 elements in ≥1 organ systems</td>
<td>&gt;6 elements in ≥1 organ systems</td>
<td>2 elements in 6 organ systems or 12 in ≥2 organ systems</td>
<td>Elements from 8 organ systems (1995)</td>
</tr>
<tr>
<td>Usual length of visit (min)</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>25</td>
<td>40</td>
</tr>
</tbody>
</table>

Abbreviations used: E&M, evaluation and management; CPT, current procedure terminology; NA, no assessment.

to eligible Medicare providers to bill pharmacist-based auxiliary services are under the evaluation and management code set, often referred to as E&M codes. The MTM codes, which are not recognized by Medicare but are from several other payers, are found under the last Category 1 level in the CPT Medicine codes.

The HCPCS Level 2 codes are listed in Table 6 and have categories of codes starting with the letters A through V. Pharmacists may recognize some of these codes: for example, E codes, which are used to bill Medicare for durable medical equipment; and J codes, which are used to bill administered medications under Medicare Part B. Under HCPCS Level 2, the G codes are used primarily for patient care services and for services where pharmacists may help generate revenue.

Resource-based relative value scale

HCPCS codes may be adjusted by a payment modifier system called RBRVS. The RBRVS was created to address concerns among providers about significant variation in practice expenses (e.g., urban vs. rural), physician technical skill, required judgment and stress (e.g., a typical routine family medicine visit vs. a post–organ transplant visit), and professional liability.

In 1989, the Omnibus Budget Reconciliation Act (OBRA) created the RBRVS system to be used in the Medicare Part B payment model. The RBRVS system consists of RVUs created for each billing code based on a complex conversion factor developed at Harvard University. The system is maintained by an AMA committee that meets several times a year to set the RVUs.

ICD-10 codes, NPI, and TIN

The “why” a service was provided is the diagnosis code, which currently is identified by the International Classification of Disease, 10th Revision (ICD 10). This medical classification system is maintained by the World Health Organization under the direction and authority of the United Nations. The 11th edition is expected to be released in 2018 and will integrate into the ICD-11 codes the systematized nomenclature of medicine clinical terms (SNOMED CT codes), a standardized vocabulary for clinical terminology that will facilitate electronic documentation and exchange of patient clinical information. The national provider identifier (NPI) is a 10-digit identification number available for issue to all health care providers (pharmacists included) and health care organizations in the United States.

The NPI was established as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is administered by CMS as the identifier of all providers who use electronic transaction of HIPAA information. Organizations that wish to bill as such and not as individual providers may use the organization’s tax identification number (TIN) and alert CMS to the NPI numbers that are associated with that TIN.

Billing forms

Two universal standard billing paper forms are the accepted method for submitting bills to Medicare and the majority of other payers for services. Hospital-based billing and Medicare Part A use the CMS-1450 form, also called the Uniform Billing (UB)-04. An old term for this form, the UB-92, may appear occasionally. For outpatient services and Medicare Part B, the CMS-1500 form—originally the Health Care Financing 1500 form and often still referred to as HCFA 1500—is the standard form. For electronic submission, the standard formats (same as the paper format) are termed 837P for outpatient billing and 837I for institutional provider billing.

Specifications and directions for programming the required billing elements may be found on the CMS website.
Specific Medicare billing requirements and revenue generation options

The options available for pharmacists to provide patient care services and generate revenue depend on the particular practice site where the service will be provided (i.e., a health system/hospital outpatient clinic, an independent physician or physician group office, a community pharmacy, a federally qualified health center). Many rules transcend the site of practice, but certain rules are practice-site specific; therefore, it is important to recognize those differences.

Two examples, a health system outpatient clinic and an independent physician or physician group office, follow. Consult appropriate billing and payment references for more detailed information on billing requirements in various settings.

Hospital and health system outpatient settings

In 1997, as hospitals began moving into the ambulatory space and creating health systems, the Balanced Budget Act provided CMS the authority to create a prospective payment system for hospital outpatient services, the OPPS rules. For hospitals and health systems to qualify for OPPS, the space where outpatient services are provided must be financially tied to the hospital, meaning the outpatient space is identified under the hospital’s TIN. Unlike the payment system for Medicare Part B, the OPPS does not include hospital facility costs (e.g., electricity, office personnel, janitorial services) in the hospital reimbursement structure. Therefore, under OPPS, when an eligible Medicare provider sees a patient in a hospital-owned outpatient space, a professional fee plus a “facility fee” are generated and paid.

Another difference is that HCPCS codes are grouped together into ambulatory payment classifications (APCs). Eligible providers under OPPS may delegate incidental services to auxiliary personnel, which includes pharmacists. When this occurs, the hospital may submit a facility fee for the services provided; however, because auxiliary personnel are not recognized Medicare providers, a professional fee is not billed.

In 2015, CMS changed the method for payment of the facility fee by collapsing all “incident-to” services into one HCPCS code, G-0463, which is billed under the APC category 5012. For example, if you are providing diabetes-related patient care services under the supervision of a billing family practitioner in a hospital clinic under the hospital TIN, your visit would be billed using the HCPCS code G-0463 and APC code 5012. For 2016, the payment for the G-0463 code under APC 5012 is $106.56, with a $21.32 copay for the patient.

In most situations, this incident-to generated revenue is higher for pharmacists’ patient care services in an institutional setting than for services in a noninstitutional setting, such as a physician’s office. This creates confusion among pharmacists as well as patients. Pharmacists may be providing similar services, but because of how CMS considers or determines cost of services in different provider settings (institutional versus noninstitutional), reimbursement rates differ by provider setting. In addition, the OPPS billing codes apply to meeting patients’ deductibles; thus patients may be financially responsible for a greater portion or the entire bill if they have not met their deductible.

Clinic or physician group office setting

Clinic or physician office revenue options from Medicare billing are currently undergoing significant changes as a
result of the passage of MACRA. Providers in the ambulatory setting are transitioning from fee-for-service to full value-based payments.

This transition requires pharmacists to both understand fee-for-service rules under PFS and value-based payment under MACRA, which began in January 2017. MACRA legislation converts the previous Medicare requirements of incorporating technology known as “meaningful use,” the physician quality reporting system and the value-based modifier, into the merit-based incentive program system (MIPS) and APMs beginning in 2017. The goal of MACRA over time is to convert all payment into APMs.

The majority of options for pharmacist revenue generation under PFS are through the E&M CPT codes billed by the supervising providers. To use these codes, the service provided must clearly document that patient evaluation and medical management occurred. When supervising providers use these codes to bill for the work of auxiliary personnel such as pharmacists, it is termed “incident-to.” For pharmacist services, the supervising provider would use the established patient E&M billing codes (99211–99215). The range reflects increasing levels and intensity of service based on the range

### Table 9. Revenue-generating potential for pharmacists

<table>
<thead>
<tr>
<th>Practice setting</th>
<th>Billing options</th>
<th>CPT billing codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician office</td>
<td>Medication therapy management (MTM)**</td>
<td>99605, 99606, 99607</td>
</tr>
<tr>
<td></td>
<td>Incident-to</td>
<td>99211–99215</td>
</tr>
<tr>
<td></td>
<td>Incident-to: Transitional care management (TCM)</td>
<td>99496 (within 7 d D/C)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99495 (within 14 d D/C)</td>
</tr>
<tr>
<td></td>
<td>CMS annual wellness visit (AWV)</td>
<td>G0438 (initial, once/lifetime)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>G0439 (subsequent. annual visit)</td>
</tr>
<tr>
<td></td>
<td>Incident-to physician: Chronic care management</td>
<td>99490 (20 min per mo)</td>
</tr>
<tr>
<td></td>
<td>Incident-to physician: Complex chronic care management</td>
<td>99487 (60 min per mo)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99489 (each additional 30 min)</td>
</tr>
<tr>
<td></td>
<td>Diabetes self-management training</td>
<td>G0108 (individual)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>G0109 (group)</td>
</tr>
<tr>
<td></td>
<td>Diabetes education</td>
<td>98960 (individual)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>98961 (2–4 patients)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>98962 (5–8 patients)</td>
</tr>
<tr>
<td>Hospital health system</td>
<td>Incident-to physician: Office visit in a hospital-based clinic (Hospital outpatient)</td>
<td>APC code 5012 with HCPCS code G0463</td>
</tr>
<tr>
<td></td>
<td>Incident-to: Transitional care management (TCM)</td>
<td>99496 (within 7 d D/C)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99495 (within 14 d D/C)</td>
</tr>
<tr>
<td></td>
<td>CMS annual wellness visit (AWV)</td>
<td>G0438 (initial, once/lifetime)</td>
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<tr>
<td></td>
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<td>G0439 (subsequent. annual visit)</td>
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<tr>
<td></td>
<td>Incident-to physician: Chronic care management</td>
<td>99490 (20 min per mo)</td>
</tr>
<tr>
<td></td>
<td>Incident-to physician: Complex chronic care management</td>
<td>99487 (60 min per mo)</td>
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<td></td>
<td></td>
<td>99489 (each additional 30 min)</td>
</tr>
<tr>
<td></td>
<td>Diabetes self-management training</td>
<td>G0108 (individual)</td>
</tr>
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<td></td>
<td></td>
<td>G0109 (group)</td>
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<tr>
<td></td>
<td>Diabetes education</td>
<td>98960 (individual)</td>
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<tr>
<td></td>
<td></td>
<td>98961 (2–4 patients)</td>
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<td></td>
<td></td>
<td>98962 (5–8 patients)</td>
</tr>
<tr>
<td>Community pharmacy</td>
<td>MTM**</td>
<td>99605, 99606, 99607</td>
</tr>
<tr>
<td></td>
<td>Incident-to: TCM</td>
<td>99496 (within 7 d D/C)</td>
</tr>
<tr>
<td></td>
<td>Incident-to physician: Chronic care management</td>
<td>99490 (20 min per mo)</td>
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<td>Incident-to physician: Complex chronic care management</td>
<td>99487 (60 min per mo)</td>
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<td>Diabetes self-management training **</td>
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<td>98962 (5–8 patients)</td>
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</tbody>
</table>

**Pharmacists may bill directly provided they have a contract with a prescription drug plan for Part D MTM services; and for diabetes self-management and education as an accredited site with American Association of Diabetes Educators or the American Diabetes Association.
of assessments of care and the complexity or risk of medical decision making done during the patient visit.

Two sets of rules guide the documentation required for these codes, and providers may choose to use either one. They are the 1995 Documentation Guidelines for Evaluation and Management Services and the 1997 Documentation Guidelines for Evaluation and Management Services.11 The differences between the two documentation guidelines are the required documentation elements within the history of present illness and the physical exam. As noted in Table 7, the assessment may be described as problem focused, expanded problem focused, detailed, or comprehensive; and the complexity of medical decision making may be described as straightforward, low complexity, moderate complexity, and high complexity. Listed underneath the assessments is the required E&M documentation to bill a particular level. Depending on the type and complexity of the services provided, the most common incident-to codes billed by the supervising provider for pharmacist services are 99211–99214.

**Incident-to rules**

When services are delegated to auxiliary personnel, the service must always follow the incident-to rules listed in Table 8.12 The incident-to billing criteria are used for both OPPS and PFS. They are the same except for two of the requirements. The first criterion states there must be direct medical supervision of the services provided by auxiliary personnel. To accommodate for hospital structure, direct supervision in OPPS differs from the requirement for PFS, which states the supervising provider must be in the same office suite. In the hospital setting, direct supervision is defined as present on the same campus, and if the hospital space is off campus, the direct supervisor must be in the same department. The purpose of the direct supervision rule is for beneficiary safety, requiring a supervising provider to be immediately available to furnish assistance if medically needed.

The second criteria is that auxiliary personnel may provide services only to established patients; therefore, a new patient must first have seen and Medicare must have received an outpatient visit bill from an eligible provider. The purpose for this rule is to ensure that the eligible provider is the person establishing the beneficiaries’ plan of care.

Additional criteria state that the services delegated must be services the supervising provider is capable of providing and billing for, must usually be provided in the outpatient setting, and must be documented as medically necessary by the supervising provider. For ongoing services provided by auxiliary personnel, the eligible provider must continue to be involved in the plan of care. This is defined as evidence that the supervising provider is continuing to direct the plan of care via patient visits and documentation.

The second difference between OPPS and the physician setting under PFS is the type of financial relationship the physician has with the auxiliary personnel being supervised. Under OPPS, the auxiliary personnel must have an employee relationship with the hospital in the form of full employee, leased employee, or independent contractor. In the physician/clinic setting under PFS, the requirement is that the eligible billing provider has a financial relationship with the auxiliary personnel; this is interpreted as an expense to the billing provider. In most situations, this condition is met through an employee-type situation similar to what is defined in OPPS. It does not, however, preclude different kinds of financial relationships or structures that may meet the criteria.

When considering an alternative financial relationship, it is advisable to adhere to the principle of usual, customary, and reasonable when designing the agreement. The final criterion is that auxiliary personnel may only perform delegated services within their state scope of practice. Therefore, a review of your state’s pharmacy practice act is a critical step.

Two relatively new E&M code classifications under both PFS and OPPS have an additional exception for incident-to rules of supervision: transitional care management (TCM) and chronic care management (CCM). The incident-to rule for supervision of auxiliary personnel when the eligible provider is billing these services is general supervision. General supervision is defined as a direct oversight relationship between the supervising practitioner and the clinical staff who provide the ancillary services. Therefore, there is no requirement for the pharmacist to be in the same physical space as the supervising provider; however, there must be evidence of supervision through sharing a plan of care and sufficient supervisory communication. These codes give community pharmacists the opportunity to contract with a billing-eligible provider to provide certain patient care services that are required elements for billing these codes.

Fraud and abuse in billing are a major concern for Medicare. Therefore, providers must abide by important general rules from CMS when working in an environment where revenue is being generated through Medicare billing. The first principle is that of usual, customary, and reasonable costs as defined by CMS: charges within a geographic area should be the same or similar to those of other providers delivering the same medical service.

The second principle is that of medical necessity: services or supplies provided should meet accepted standards of medical or health care practice. When a physician refers a patient for pharmacist services, even when the pharmacist is considered auxiliary personnel, there must be a documented medically necessary reason for the referral. The third principle is that any enrolled provider accepting Medicare and Medicaid reimbursement may not discriminate against Medicare and Medicaid patients, including providing a different service or supply, or supplies provided should meet accepted standards of medical or health care practice. When a physician refers a patient for pharmacist services, even when the pharmacist is considered auxiliary personnel, there must be a documented medically necessary reason for the referral. The third principle is that any enrolled provider accepting Medicare and Medicaid reimbursement may not discriminate against Medicare and Medicaid patients, including providing a different service level for Medicare, Medicaid, and commercial patients using the same billing code. Unless an organization has a specific contract with payers, organizations will follow Medicare rules to avoid any situation that may put them at risk for discrimination against Medicare and Medicaid patients.

**Conclusion**

Although pharmacists have yet to universally establish themselves as health care providers who are able to bill payers in federal and state programs, they have the opportunity to work as auxiliary personnel under an eligible provider
who may bill for a pharmacist’s services. Thus, pharmacists are capable of generating revenue. The process remains complex and requires a clear understanding of the rules and regulations. It also requires diligence in staying up to date, as rules and regulations may be altered or updated as frequently as yearly.

CMS has greatly improved guidance in its rules and regulations with the Medicare Learning Network. When pursuing billing of any medical service under Medicare, it is always prudent to consult the rules and regulations of the respective benefit, whether federal, state, or commercial. Health care billing is complex and has numerous nuances based on setting, state differences, and provider differences. These factors make it difficult to rely solely on interpretation by others.

The scope of this article is not intended to describe all the possible billing codes that pharmacists may use to generate revenue, either by working with a billing provider or directly with a payer. A summary is provided in Table 9.

References

2. Correspondence with Krystalyn Weaver, National Alliance of State Pharmacy Associations, June 2, 2017.


Editor’s note: The information in this article is provided as a courtesy for informational purposes only and is not intended to be, and should not be interpreted as, reimbursement or billing advice.
HEALTH CARE BILLING BASICS

CPE assessment
This assessment must be taken online; please see “CPE information” in the sidebar on previous page for further instructions. The online system will present these questions in random order to help reinforce the learning opportunity. There is only one correct answer to each question.

1. Current procedure terminology (CPT) codes are
   a. Level 2 healthcare common procedure coding system (HCPCS) codes
   b. Codes that include the incident to evaluation and management (E&M) codes that providers may use to support pharmacist services
   c. Used by Medicare Part A for billing purposes
   d. Developed and maintained by CMS

2. Ambulatory payment classifications (APC) codes are used in which setting?
   a. Hospitals or health systems for services in their ambulatory clinics
   b. Physician offices for diabetes education services
   c. Assisted living and group homes for clinical provider services
   d. In-home services provided by Medicare Part B providers

3. The industry standard for health care billing is based on which of the following payer or organization methods?
   a. American Medical Association
   b. State-specific rules and regulations
   c. CMS
   d. America’s Health Insurance Plans

4. Documentation of care for E&M codes for pharmacists is based on which of the following?
   a. Pharmacist patient care process: collect, assess, plan, implement, monitor, and evaluate
   b. Level of risk in medical decision making, from straightforward to complex
   c. Number of boxes checked in the electronic health record
   d. Time spent by the physician reviewing the pharmacist note

5. To secure direct reimbursement for pharmacist patient care services from health care payers, pharmacists need three state and federal rules to align: laws granting pharmacist provider status, state insurance rules and regulations to mandate paying pharmacists for their services, and which of the following?
   a. Pharmacists need to be in the payer’s network.
   b. Pharmacists need to be credentialed by the payer.
   c. Pharmacists’ state practice act must include the services covered by the payer in the pharmacist’s scope of practice.
   d. Pharmacists need to establish a collaborative practice agreement with a provider or providers.

6. Which of the following statements is true regarding a typical payer mix for patient care services in the ambulatory setting?
   a. Medicare is the single largest payer.
   b. Commercial payers are typically 75% of the payer mix.
   c. State Medicaid is the single largest payer.
   d. Medicare comprises 10% of a typical payer mix.

7. When pharmacists are providing services to Medicare Part B patients in a physician office setting under an incident-to arrangement, the supervising provider should use which of the following billing codes?
   a. Codes used for medication therapy management services (99605–99607)
   b. E&M codes for a new patient (99201–205)
   c. E&M codes for an established patient (99211–99215)
   d. Office visit in a hospital-based clinic (APC 5012 with G0463)

8. You have recently contracted with a family practice group to provide comprehensive medication management services for their medication high-risk patients. They have asked you to work with their billing officer to set up a method to generate revenue for your services. The practice is primarily using Medicare Part B fee-for-service billing. Before the meeting, you would like to review the billing regulations. Which of the following CMS documents should you review?
   a. Inpatient prospective payment system (IPPS)
   b. Physician fee schedule
   c. MACRA-Quality Payment Program
   d. Outpatient prospective payment system (OPPS)

9. Medicare administrative contractors (MACs) are regional contracted private organizations that CMS uses to help administer Medicare Part A and Part B. Before deciding on a supervising provider billing mechanism to generate revenue for your services, you should consult your region’s MAC for which of the following reasons?
   a. The MAC will process all of your claims.
   b. You must enroll in the MAC first with your national provider identifier (NPI) number.
   c. As the Medicare auditors, to know what they need in documentation.
   d. MACs may have added local coverage determination for Medicare billing codes.

10. Supervising providers can bill for auxiliary providers, including pharmacists, in an incident-to arrangement for services provided in what part of Medicare?
    a. Medicare Part B
    b. Medicare Part D
    c. Medicare Part C
    d. Medicare Part A
11. To submit a Medicare claim for health care services, which of the following is the list of correct components?
   a. HCPCS code, International Classification of Disease, 10th edition (ICD-10) code, NPI, or tax identification number (TIN)
   b. CPT code, quality measure, NPI
   c. HCPCS code, ICD-10 code, state license number
   d. G code, ICD-10 code, TIN

12. The CPT codes and relative value units are updated and maintained by
   a. CMS
   b. Commercial payers
   c. American Medical Association
   d. Office of Management and Budget

13. Which of the following is a true statement about the resource-based relative value Scale (RBRVS)?
   a. As of 2017, it is required to be added to all HCPCS codes for Medicare billing.
   b. It is an adjustment factor that compensates for variation in medical practice expenses.
   c. It is a popular tool used by providers.
   d. It is used routinely in value-based payment models.

14. Which of the following best describes 837P and 837I?
   a. Billing codes to be used for pharmacists’ services
   b. Billing codes to be used for auxiliary services
   c. Exception codes added to claims
   d. Electronic versions of Medicare standard billing forms CMS 1500 and CMS 1450

For the next three questions, use the following case: your pharmacy department in a community hospital/health system is expanding pharmacist patient care services into its ambulatory clinic. You will be providing medication management services for patients with heart failure and hypertension in the cardiology clinic. You are employed by the hospital, and the clinic is across the street from the hospital.

15. Which of the following are the optimal billing codes to use in this setting?
   a. Established patient incident-to E&M codes 99211–99215
   b. Medication therapy management codes 99605–99607
   c. APC code 5012 with HCIPC Level 2 code G0463
   d. Complex chronic care management codes 99487 and 99489

16. You are told by administration that you will be using the “facility fee” billing method under OPPS for incident-to services supervised by the physician. Which of the following best describes facility fee billing?
   a. It is desirable for patients, as it has no copay and bypasses any patient deductibles.
   b. Since hospital operational costs are not included in the professional fee structure, it is a system to pay for these costs.

17. The supervising eligible provider will be the on-call cardiologist from the team for the days you are in clinic. For incident to rules, where must the cardiologist be “immediately available” while you are in clinic?
   a. The cardiologist must be on the hospital/health system campus.
   b. The cardiologist must be in the office suite where you are conducting your clinic.
   c. The cardiologist may be anywhere in the community available by page.
   d. The cardiologist may be anywhere but must have established and shared the plan of care.

18. You run an anticoagulation clinic and often see patients with a new clot, either a deep vein thrombosis or pulmonary embolism, within 2 days of discharge. You are often the first provider to see these patients after the acute event. Is your supervising eligible provider able to bill these visits using incident to?
   a. Yes, because you have a collaborative practice agreement to manage these patients.
   b. Yes, because the hospital physician saw the patient in the hospital to set the plan of care.
   c. No, the supervising billing provider must first see the patient in the outpatient setting and set the plan of care.
   d. No, because anticoagulation services are located in a specialty clinic within the organization and not where the ordering primary care physicians are located.

19. You are seeing a patient with diabetes who was referred to you in a family practice office. The purpose of the visit is to adjust their insulin dose based on reported blood glucose levels. You collect the blood glucose readings and ask about signs and symptoms of low and high blood glucose levels. You perform vital signs and check the patient’s feet. Which of the following established E&M codes is the most appropriate billing code to use for this visit by the supervising provider?
   a. 99211
   b. 99212
   c. 99213
   d. 99214

20. Which of the following Medicare services with billing codes under PFS may a supervising provider permit services to be provided under general supervision, thus allowing community pharmacists to provide this service in the pharmacy and not in the clinic?
   a. Annual wellness visit
   b. Complex chronic care management
   c. Diabetes self-management training
   d. Established patient visits