

# Basic terminology in obtaining reimbursement for pharmacists' cognitive services

EDITH A. NUTESCU AND ROGER S. KLOTZ

Pharmacy practitioners and pharmacy organizations have envisioned the day when pharmacists will be reimbursed by third-party payers for providing patient care services with or without the provision of a drug or drug-related product. These patient care services have been referred to as cognitive services, pharmaceutical care, disease state management, medication therapy management (MTM), and clinical pharmacy services in order to differentiate them from dispensing services. While pharmacists have been successful in developing and implementing various effective clinical pharmacy practice models, attaining reimbursement for these cognitive services has been generally lacking.

Currently, the profession of pharmacy appears to be gathering momentum in its efforts to seek and obtain reimbursement for cognitive services. However, major barriers, both historic and current, in seeking reimbursement have been the (1) lack of understanding by the third-party payers (e.g., insurance companies, governmental agencies) of the pharmacist's role in patient

**Purpose.** A basic overview and definitions of commonly used billing and reimbursement terminology that pharmacists will need to know to obtain reimbursement for cognitive services are provided.

**Summary.** Currently, the profession of pharmacy has been gathering momentum in its efforts to seek and obtain reimbursement for cognitive services. However, there have been major barriers in seeking reimbursement, including the lack of understanding by third-party payers of the pharmacist's role in patient care and the pharmacist's in-depth knowledge of pharmacotherapy, the lack of appropriate billing codes for pharmacists' services, and the lack of detailed knowledge and understanding by pharmacy practitioners of nondistributive reimbursement mechanisms, processes, and terminology. The types of services provided are usually described by the American Medical Association's Current Procedural Terminology (CPT) codes for the face-to-face provision of patient care services by a pharmacist. As of January 1, 2006, pharmacists

have been able to indicate the appropriate diagnosis code from the *International Classification of Diseases, 9th Revision (ICD-9)* (*ICD-10* will replace the *ICD-9* on October 1, 2007), and CPT code when billing under a major medical plan that recognizes the pharmacist as a patient care service provider. Understanding the billing and reimbursement terminology will aid pharmacist communication with third-party payers, Medicare, and Medicaid. A glossary of the most commonly encountered terms in billing and reimbursement procedures for cognitive services is provided. Also included are lists of Web-based reimbursement resources and references on reimbursement for cognitive services by the pharmacist.

**Conclusion.** An understanding of terminology is important in receiving reimbursement for cognitive services.

**Index terms:** Billing; Codes; Health-benefit programs; Nomenclature; Pharmaceutical services; Pharmacists; Reimbursement

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care and the pharmacist's in-depth knowledge of pharmacotherapy, (2) lack of appropriate billing codes for pharmacists' services, and (3) lack of detailed knowledge and understanding by pharmacy practitioners

of nondistributive reimbursement mechanisms.

Payers have historically seen the pharmacist as a product dispenser. In addition, they often view drug therapy as a commodity business

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because of a very simplistic notion of medication therapy. Because of these misconceptions of pharmacy practice, many private and governmental payers until recently have not recognized pharmacists as providers of patient care, thus limiting pharmacists' ability to bill for cognitive services. However, the efforts of the profession were rewarded when the U.S. Congress passed the Medicare Modernization Act of 2003, which created a prescription drug benefit (Part D) for Medicare recipients, and, for the first time, Congress included an MTM benefit that named pharmacists as the key providers. The legislation requires the payers to reimburse providers of MTM services for specific patient groups. This is the first time that a payer included an MTM benefit into an insurance plan. This becomes a precedent for reimbursement for patient care services provided by the pharmacist that are not product oriented. However, work continues because payers such as Medicare Part B, many state Medicaid plans, and many private payers still do not recognize pharmacists as providers of patient care services.

Another barrier has been the lack of appropriate billing codes that pharmacists can use to obtain reimbursement for patient care services. Without the proper codes, claims cannot be submitted for reimbursement for these services. Some pharmacist groups have been successful in obtaining reimbursement for their clinical services by either directly billing the patient or billing under a collaborating physician's provider number. These success stories, however, are limited at best and the attainable reimbursement rates are very low, as typically only low-level services can be billed under the latter model. Recently, the American Medical Association's Current Procedural Terminology (CPT) editorial panel created three codes for the face-to-face provision of patient care services by a licensed pharmacist. This allows

(as of January 1, 2006) the pharmacist to indicate the appropriate diagnosis code (*International Classification of Diseases, 9th Revision [ICD-9]*, and *ICD-10*) and CPT code when billing under a major medical plan that recognizes the pharmacist as a patient care service provider. Despite the availability of the new pharmacy CPT codes, many payers are not yet reimbursing for these codes.

Finally, pharmacists lack a detailed understanding of reimbursement mechanisms, processes, and terminology for nondistributive services. A large number of pharmacists have dealt with the electronic adjudication methods of obtaining reimbursement for filling prescriptions; however, this approach allows billing for products, not services. While some pharmacist groups practicing in home infusion therapy, collaborative practices in private physician offices, and hospital outpatient facilities have some experience with basic billing approaches, the vast majority are still unaware of billing options for their practices.

This article provides a basic overview and definitions of the most commonly used billing and reimbursement terminology that pharmacists will need to be familiar with as the profession begins a new chapter in its quest to obtain reimbursement for cognitive services.

The specific billing procedures used to obtain reimbursement for cognitive services will depend on the pharmacist's provider status, state and regional regulations, the actual physical practice setting, and the organizational structure. The types of services provided are usually described by the CPT and Outpatient Prospective Payment System coding. Billing a third-party payer for the cognitive services provided usually requires the Health Care Financing Administration (HCFA)-Form 1450 or Centers for Medicare and Medicaid Services (CMS)-Form 1500. These forms require that the provider indicates the patient's appropriate

*ICD-9* and *ICD-10* codes, appropriate CPT codes, and revenue codes if applicable as part of the billing statement.

Unfamiliarity with reimbursement terminology can make materials containing billing and reimbursement information difficult to decipher. Understanding the billing and reimbursement terminology will aid pharmacist communication with third-party payers, Medicare, Medicaid, and colleagues from billing departments. Appendix A provides a glossary of the most commonly encountered terms in billing and reimbursement procedures for cognitive services.

### Useful reimbursement resources

Finding resources that are specifically designed to guide pharmacists through the process of billing and obtaining reimbursement for cognitive services can be challenging. Following are some basic reimbursement resources and tools that pharmacists may find useful for conducting research, site development, and setting up a mechanism to be compensated for their cognitive services.

A source of the approved CPT codes is found in a book available from the American Medical Association (AMA) ([www.ama-assn.org](http://www.ama-assn.org)) or Ingenix ([www.ingenixonline.com](http://www.ingenixonline.com)). AMA is the creator of the CPT codes, and it has recently added three pharmacist codes for submitting claims for MTM services. The book is also available in a CD format.

Approved Healthcare Common Procedure Coding System (HCPCS) codes are in a book available from AMA and Ingenix. The HCPCS was created by AMA and is also available in a CD format. This reference is a source of the "S" (service) codes that are used for non-Medicare billing and may in some instances be used by pharmacists for services. An example is S-0195—"Pneumococcal conjugate vaccine, polyvalent, intramuscular, for children from five years

to nine years of age who have not previously received the vaccine.”

A source for ICD-9 diagnosis codes is a book available from AMA and Ingenix. ICD-9 codes are also on the CMS website, [www.cms.hhs.gov/medlearn/icd9code.asp](http://www.cms.hhs.gov/medlearn/icd9code.asp). This CMS website has a training program.

The ICD-10 is replacing the ICD-9 codes because it is more specific to

the patient’s clinical diagnosis. The ICD-10 is scheduled to fully replace the ICD-9 code format on October 1, 2007. The *ICD-10-PCS Coding System and Training Manual* is available at [http://new.cms.hhs.gov/ICD9ProviderDiagnosticCodes/08\\_ICD10.asp#TopOfPage](http://new.cms.hhs.gov/ICD9ProviderDiagnosticCodes/08_ICD10.asp#TopOfPage). There is a training program on the website.

All providers who want to submit claims for providing patient care services must have a National Provider Identifier (NPI) number, including pharmacists. This is the first time that pharmacists as individual practitioners will be given a provider number to allow them to submit claims as individuals. Providers and provider organizations must have their NPI number by May 23, 2007. From October 2, 2006, to May 22, 2007, CMS systems will accept an existing legacy Medicare billing number or an NPI number on claims. From May 23, 2007, and forward, CMS systems will only accept NPI numbers. More information on this process is available at <http://nppes.cms.hhs.gov>.

Additional web-based and printed reimbursement resources are listed in Appendix B and Appendix C, respectively. With the rapid pace of changing information on reimbursement details and regulations, pharmacists are encouraged to periodically review published and real-time web-based information and resources.

### Significance of understanding basic reimbursement terminology

Pharmacist implementation of successful models for obtaining cognitive services reimbursement is critical to the future of pharmacy. Successful implementation of a program to obtain reimbursement for cognitive services is also critical to the care of our patients and the quality of their lives. Pharmacist practitioners have shown that patients will pay out of pocket, but self-pay reimbursement limits the number of patients who can access these services. This limits the clinical

care and cost-reduction benefits to a relatively small group of patients or their families who can afford to pay for the services and care provided. Implementing a full cognitive services reimbursement program by a few pharmacy practitioners will create a model that can be implemented by others. A successful cognitive services reimbursement program allows for the pharmacist to provide quality patient care to a broad spectrum of patients and ultimately reduce the cost of care.

Reimbursement models generally are focused on obtaining reimbursement from private or governmental payers. As the number of uninsured patients continues to grow and health care savings accounts are expanded, patients and their families will be the decision-makers as to what services and by whom these services will be provided to get the maximum benefit from their health care dollars. As a result, the patient payer must be considered in the reimbursement model. Medication therapy reimbursement models must be properly planned and implemented to support a cognitive services practice.

A major step in the development and implementation of a cognitive services reimbursement program is the understanding of the industry’s terminology, which has developed over a number of decades. Such understanding allows the proper completion of claim forms as specified by each patient’s payer.

### Conclusion

An understanding of terminology is important in receiving reimbursement for cognitive services.

### Appendix A—Terminology important in receiving reimbursement for cognitive services

#### Ambulatory Payment Classification (APC)

**Groups:** The basic unit of payment in the Medicare Prospective Payment System (PPS) for outpatient visits or procedures is the APC. Under the APC system, outpatient services and procedures are classified for purchases of payment (similar to diagnosis-related groups

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(DRGs]). (Example APC codes: APC 0600 = low-level clinic visit, APC 0611 = midlevel emergency room visit.)

**Appeal:** A request made to a payer to reconsider a decision, such as a claim denial. Most appeals must be submitted in writing within a specified period.

**Assignment of benefits:** An instruction provided by an insured patient to a health plan that directs payment to be sent directly to the provider of an item or service. In this scenario, the provider is responsible for billing the health plan for the item or service.

**Balance billing:** The practice of a provider billing a patient for all charges not paid for by the insurance plan, even if those charges are above the plan's usual, customary, and reasonable charge or are considered medically unnecessary. Managed care plans and service plans generally prohibit providers from balance billing except for allowed copayments, coinsurance, and deductibles.

**Benefit cap:** The total dollar amount that a payer will reimburse for covered medical services.

**Capitation:** A reimbursement method that pays the provider a set fee each month or quarter on the basis of the number of patients enrolled in the insurance plan. This is usually measured in terms of per member per month. Since the capitated payment will not vary according to the number of patients seen, under the payment method the health care provider (not the insurer) assumes all, or most, of the financial risk for providing care.

**Carve Out:** The assignment through contractual arrangements of specialized services to an outside organization.

**Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration [HCFA]):** The U.S. government agency that administers the Medicare and Medicaid programs.

**Certification:** Certification is the official authorization for use of services.

**Claim:** A form submitted to a payer (by a health care provider or patient) to request payment for items or services provided.

**Claims review:** The method by which an enrollee's health care service claims are reviewed before reimbursement is made. The purpose of this monitoring system is to validate the medical appropriateness of the provided service and to be sure the cost of service is not excessive.

**Clinical Laboratory Improvement Amendments (CLIA):** Federal regulations that govern laboratory practice and quality standards. The regulations were expanded in 1992 to include all laboratories performing tests on humans for purposes of diagnosis, prevention, or treatment of disease. Physicians' offices and pharmacies are included.

**CLIA-waived tests:** Tests with minimal complexity that are used when the risks of erroneous results are insignificant if manufacturers' directions are followed. If operating under

a CLIA waiver, this is the category of tests to which a pharmacy or a pharmacy service is limited to without having a physician laboratory director.

**CMS-1500 form (formerly the HCFA-1500 form):** A standardized Medicare claim form required by Medicare for submission of claims to a Medicare carrier and most payers when a provider submits claims for reimbursement. Health care providers, including physicians' offices, nursing agencies, home infusion providers, and durable medical equipment (DME) and respiratory therapy providers, use this claim form for submitting paper claims.

**Coding:** In the context of reimbursement, coding is a nomenclature system used by insurers and providers to identify diagnoses and describe patient care services and products. Codes also serve to track use of and establish reimbursement rates for facility and professional services. Procedural and diagnosis coding is based on the information contained in the patient's medical record and cannot be coded on the basis of reimbursement levels.

**Cognitive services:** Services provided by the pharmacist for the purposes of promoting optimal health and drug therapies and that are not necessarily drug-product related.

**Coinsurance:** A cost-sharing arrangement between an insured and the insurer in which the insured will be required to pay a percentage of the cost for the health care services received.

**Collaborative care:** Drug therapy management and other arrangements that allow pharmacists to assist physicians in the selection, initiation, and modification of a patient's drug therapy and in monitoring the use and response to drug therapy in selected patients or groups of patients.

**Compensation:** Payment for a service that reflects reimbursement for the cost of the service and the value added by the provider.

**Copayment:** A cost-sharing arrangement between an insured and the insurer in which the insured will be required to pay a specified dollar amount for a particular item or service.

**Coverage:** Coverage refers to the terms and conditions under which a payer will or will not provide benefits for a specific treatment. Coverage policies are usually developed for new technologies or procedures. Frequently, private payers rely on coverage policies developed by Medicare.

**Credentialing:** The formal process of becoming a recognized medical provider for a medical plan; it is required by many health plans before payment for services will be authorized.

**Current Procedural Terminology (CPT):** A system of terminology and coding (five-digit codes) developed by the American Medical Association that is used for describing, coding, and reporting specified medical services and procedures. CPT codes describe the patient encounter in terms of complexity. Spe-

cific CPT codes describe outpatient visits, inpatient services, and multidisciplinary team conferences. Each CPT code may include documentation requirements to support the specific code used, especially if CMS is involved. CPT codes also include laboratory tests and procedures. (Example CPT codes: 99211 = low-level office visit for established patient, 90471 = immunizations.)

**Deductible:** A cost-sharing arrangement between an insured patient and the insurer in which the patient will be required to pay a fixed dollar amount of covered expenses each year before the payer will reimburse for covered health care expenses. Generally, an insured patient must meet a deductible each calendar year.

**Denial:** Refusal by an insurer to reimburse services that have been rendered; there can be various reasons for denial.

**Diagnosis:** The provider's determination of a patient's condition, sign, or symptom using the *International Classification of Diseases, 9th Revision (ICD-9)* (in October 2007 the *ICD-10* coding system will go into effect).

**Direct costs:** Nonprorated costs associated with service delivery; they include an employee's time and consumable supplies required to provide service for one patient.

**DRG:** A statistical system of classifying any inpatient stay into groups for purposes of payment. This is the form of reimbursement that CMS uses to pay hospitals for Medicare recipients. Also used by a few states for all payers and by some private health plans for contracting purposes. A standard flat rate per procedure is derived from this scale, which is paid by Medicare for their beneficiaries.

**Eligibility:** The process of determining whether a patient qualifies for benefits on the basis of factors such as enrollment date, preexisting conditions, valid referrals, and so forth.

**Evaluation and management services and codes:** CPT codes for new (99201–99205) or established (99211–99215) patients, office or outpatient visits, and consultations; CPT codes for these services are frequently used by pharmacists practicing in an office-based or hospital outpatient facility environment.

**Explanation of benefits:** Statement sent by payers to health care beneficiaries that details the charges for the services received, the amount the insurance company will pay for those services, and the amount the beneficiary will be responsible for paying.

**Fee for service:** Fee for service is the traditional kind of health care policy. Insurance companies pay fees for the services provided to the insured people covered by the policy. This type of health insurance offers the most choices of doctors and hospitals. Any doctor may be seen, and the patient may change doctors at any time.

**Fee schedule:** A listing of the maximum fee that a health plan will pay for a certain service based on CPT billing codes. (Also referred to as fee maximums or as a fee allowance schedule.)

**Formulary:** An approved list of prescription medications covered by a payer. Depending on the individual plan, an insured may have an open formulary, which would allow access to nonformulary medications at a higher cost, or a closed formulary, which would require that the insured access only those medications included on the health plan's formulary.

**Gatekeeper:** In managed care, it refers to the provider designated to direct an individual patient's care. In practical terms, it is the provider who refers patients to specialists and subspecialists for care.

**Gatekeeping:** The authorization or nonauthorization of health care services, usually performed by a third-party payer.

**Grievance:** Request made to a payer to reconsider coverage of a health care service that is not currently a covered benefit.

**HCFA common procedure coding system:** A three-level coding system consisting of CPT codes (level I), national or alphanumeric codes (level II), and local codes (level III) used by payers and providers for billing purposes. CPT and national level II codes are recognized and used by a majority of health care insurers.

**HCFA-1450 form (UB-92 form):** A uniform billing form required for submitting and processing claims for institutional (hospital-based) providers. All services are billed in a standardized, consistent format on each invoice. It merges billing information with diagnostic codes, including almost all the elements from the uniform hospital discharge data set.

**Health maintenance organization (HMO):** An organization that provides comprehensive health care services for subscribing members in a particular geographic area. People enrolled in an HMO pay dues in return for the right to health care services at a lower-than-average cost.

**ICD-9:** The coding system maintained by the National Center for Health Statistics and CMS. This coding system differentiates diagnostic conditions and is used by hospitals, governments, health insurance plans, and health care providers around the world. *ICD-9* codes are updated annually. Providers should purchase a new book each year. Providers can begin using the *ICD-10* codes as of May 2006 and must use only the new codes starting May 2007. As of May 2007, the *ICD-9* coding format will be eliminated.

**ICD-10:** The update of *ICD-9*. Both hard copy and electronic versions of *ICD-10* are available.

**Indirect costs:** Prorated costs of doing business; they include nonrecurring capital expenditures for equipment, waste removal, overhead, quality-control procedures, and personnel training.

**Inpatient:** A patient admitted to a hospital and receiving services under the direction of a physician for at least 24 hours.

**Insurance, primary:** The medical insurance plan that must be billed first when a patient is covered by more than one insurance plan.

**Insurance, secondary:** The medical insurance plan to be billed for charges that remain after payment from the primary insurance carrier.

**Insurance, supplemental:** Medical insurance meant to provide additional coverage beyond that provided by Medicare. Medicare must be billed first; supplemental insurance may pay additional portion of charge.

**Integrated health care network:** A network of health care financing and delivery that organizations created to provide a continuum of care, ensuring that patients get the right care, at the right time, by the right provider.

**Long-term-care (LTC):** LTC policies cover health services for persons who are chronically ill, disabled, or mentally retarded. Patients must require assistance with a specified number of daily activities, such as eating, bathing, and dressing. LTC hospitals are currently excluded from the PPS and must meet average patient length-of-stay requirements.

**Managed care:** A system that combines the functions of health insurance and the actual delivery of care, where costs and use of services are controlled by such methods as gatekeeping, case management, and use of care. All HMOs, all preferred provider organizations (PPOs), and many fee-for-service plans have managed care. Participating providers (physicians, dentists, pharmacists) generally agree to accept discounted payment and to abide by the plan's cost and quality-control measures.

**Medicaid:** A jointly funded federal and state health insurance program for low-income individuals who meet established eligibility criteria (programs vary from state to state).

**Medical necessity:** Medical information justifying that the service rendered or the item provided is reasonable and appropriate for the diagnosis or treatment of a medical condition or illness.

**Medicare:** A federal health insurance program for the elderly (ages 65 years and older), certain disabled individuals, and people with end-stage renal disease. Medicare is administered by CMS.

**Medicare carrier:** A private insurance organization under contract with the federal government to administer the receipt and processing of Part B claims for the Medicare program.

**Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000 (BIPA):** BIPA is a federal law that includes many changes to the structure of and payment systems for Medicare and Medicaid. These changes amend several sections of the Social Security Act, the Balanced Budget Act of 1997, and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

**Medicare Part A:** Also called hospital insurance. Part of the federal health program that helps

to pay for (not limited to) inpatient hospital care, inpatient care in a skilled nursing facility following a covered hospital stay, home health care, and hospice care. Most people do not have to pay for Medicare Part A since they or their spouse paid Medicare taxes while they were working.

**Medicare Part B:** Also called medical insurance. Part of the federal health program that helps to pay for doctor's services, outpatient hospital care, clinical laboratory and diagnostic services, surgical supplies and DME, ambulance services, and other medical services that are not covered by Part A. The covered service or supplies must be medically necessary. After 65 years of age, individuals may choose to enroll in the program and pay monthly premiums and an annual deductible for services covered by Medicare Part B.

**Medicare Part D:** Part of the federal health program that helps to pay for prescription medications and that will implement medication therapy management (MTM) programs.

**Medicare Prescription Drug, Improvement, and Modernization Act of 2003:** An act signed into law on December 8, 2003, designed to improve benefits to seniors and disabled people. It includes a prescription drug benefit.

**Medigap:** Health plans offered by private insurance companies to individuals with Medicare. Plans cover costs not typically covered by Medicare (designed to "fill the gaps" of Medicare coverage). Costs covered may include coinsurance amounts, deductibles, and prescription drugs.

**Member:** A term used to describe a person who is enrolled in an insurance plan; the term is used most frequently in managed care.

**MTM:** MTM is provided by a pharmacist and is a face-to-face assessment or intervention to improve a patient's response to medications and avoid potential drug-related complications. This service is distinct from providing product-specific information when dispensing a medication to a patient. A consensus conference of 11 national pharmacy organizations in July 2004 defined MTM as "a distinct service or group of services that optimize therapeutic outcomes for individual patients. MTM services are independent of, but can occur in conjunction with, the provision of a medication product." MTM has a "broad range of professional activities and responsibilities within the licensed pharmacist's . . . scope of practice . . . according to the individual needs of the patient."

**National drug code (NDC):** A numerical coding system for drug identification. NDC numbers are assigned by the Food and Drug Administration and are typically used to bill payers for the drugs provided to health care beneficiaries.

**National Provider Identifier (NPI):** An identifier for use in standard electronic health care transactions. The NPI will be the single provider identifier, and it must be used by

- most Health Insurance Portability and Accountability Act covered entities (health plans, health care providers). Pharmacies and pharmacists are now eligible for NPIs.
- Office of Inspector General (OIG):** The Department of Health and Human Services' OIG provides oversight of fraud and abuse issues and is the enforcement arm for the Medicare and Medicaid programs.
- Out-of-pocket maximum:** Total dollar amount an insured will be required to pay for covered medical services during a specified period, such as one year. The out-of-pocket maximum may also be called the stop-loss limit or catastrophic expense limit.
- Outpatient:** A patient who receives health care services without being admitted to a hospital.
- Payer:** The party who actually makes payment for services under the insurance coverage policy. In a majority of cases, the payer is the same as the insurer. But, as in the case of very large self-insured employers, the payer is a separate entity under contract to handle the administration of the insurance policy.
- Payment:** The amount of reimbursement provided to the hospital and the physician for services related to the procedure.
- Per diem:** A negotiated, per-day fee for services. Usually seen in inpatient hospital and nursing facility settings.
- Pharmacists' CPT codes:** Three fairly recent category III (temporary) codes assigned to pharmacists that can be used as of January 1, 2006. Codes 0115T (initial face-to-face assessment), 0116T (subsequent face-to-face assessment), and 0117T (any appointment lasting beyond 15 minutes) describe pharmacist-provided MTM services under Medicare Part D. It is extremely important that pharmacists start using the new CPT codes as soon as possible to ensure that they are moved from temporary code status to permanent status.
- Pharmacist Services Technical Advisory Coalition (PSTAC):** PSTAC was founded in 2002 to improve the coding infrastructure necessary to support billing for pharmacists' professional services. The coalition has been successful in integrating pharmacists and their professional services into the traditional medical services billing model. PSTAC provides the national leadership necessary to position and secure pharmacy's place in the electronic data interchange health encounter and claims processing and payment environment concerning all health care providers' professional services.
- Policyholder:** Purchaser of an insurance policy; in group health insurance, this is usually the employer who purchases policy coverage for its employees.
- PPO:** A fee-for-service, coordinated care plan with incentives to use network providers under contract or arrangement to deliver benefit packages approved by CMS. A PPO acts as an intermediary between the beneficiary and the insurance company, employer, or union welfare fund.
- PPS:** A reimbursement structure under Medicare that pays hospitals a fixed per-case rate based on the DRG assignment.
- Prescription drug plan:** Provider of medication coverage under Medicare Part D.
- Prior authorization:** A review of the need for health care items or services before services are rendered or products are provided. This refers to a decision made by the payer to cover or not cover the charges before the services are provided.
- Prospective payment:** A prospective payment is a payment that is determined before care is actually given. It gives the provider organization a financial incentive to use fewer resources, as it gets to keep the difference between what is prepaid and what is actually used.
- Provider:** One who delivers health care services within the scope of a professional license.
- Provider identification number (PIN):** Assigned to providers by the medical credentialing department of the health insurance plan; it is used in block 33 of the CMS-1500 form and is frequently required before payment may be made.
- Provider sponsored organization (PSO):** A PSO is a public or private entity established and operated by a health care provider, or a network of affiliated health care providers, that shares substantial financial risk with respect to the provision of those services and has at least a majority financial interest in the entity. PSOs must meet federal standards for quality and solvency, comply with Medicare contractor requirements, and deliver a substantial portion of coordinated care through the affiliated network of providers.
- Provider status:** Official recognition by the billing department of the medical plan as a medical provider; it is required for payment by many plans. A PIN may or may not be assigned.
- Reimbursement:** The payment by the patient (first party) or insurer (third party) to the health care provider for services rendered.
- Resource-Based Relative Value Scale:** A system instituted by CMS for determining physicians' fees. Each treatment or encounter by a physician is assigned a relative value based on the time, skill, and training required for treating the condition.
- Resource Utilization Group:** A classification system designed to differentiate patients by their levels of resource use.
- Revenue codes:** Revenue codes are used by hospitals to bill for each cost center for which there is a separate charge. All payer types require the use of revenue codes to delineate total costs.
- Skilled nursing facility (SNF):** A SNF is a facility that provides skilled nursing care and related services to inpatients requiring medical or nursing care or provides rehabilitation services for injured, disabled, or sick persons.
- SOAP note:** A type of documentation of clinical findings with a specific problem-oriented format that uses the terms subjective, objective, assessment, and plan to describe the patient encounter and plan of care.
- Social Security Act (SSA):** The SSA is the federal law that sets forth the Medicare (Title XVIII) and Medicaid (Title XIX) programs.
- Superbills:** Superbills are used routinely in practice to help organize billing. They usually contain the most commonly used CPT and ICD-9 and ICD-10 codes in each specific office.
- Tax Equity and Fiscal Responsibility Act (TEFRA):** TEFRA governs Medicare payment to non-PPS hospitals, including rehabilitation facilities and long-term-care hospitals. Under TEFRA, payments for inpatient operating costs are based on the provider's inpatient costs compared to a payment ceiling and are determined, in part, by the base year of 1982 for facilities in existence at that time. The payments for hospitals that began operating after 1982 are based on the second-cost reporting period. Hospitals that do not exceed their base-year costs in subsequent years are rewarded with an incentive payment.
- Third-party administrator (TPA):** An organization outside the insuring organization that handles the administrative duties and, at times, use review. TPAs are used by organizations that actually fund the health benefits but delegate the administration of the plan to someone else.
- Third-party payer:** Any payer for health care services other than the insured person. It can be an insurance company, an HMO, a PPO, or the federal government.
- Transitional pass-through payment:** A mechanism that allows for additional payment for new technology under the Medicare Outpatient Prospective Payment System. These payments are for medical products that were not included in the 1996 CMS cost study from which APCs were derived, and they are in addition to the related APC payment. For medical devices, transitional pass-through payment is based on hospital charges adjusted by a hospital-specific cost-to-charge ratio developed by CMS for this purpose. Separate payment will eventually be phased out as CMS incorporates costs for new technology into the overall APC payment.
- Unbundling:** The act of separating a medical procedure into its many components, resulting in payment for each component rather than a lower global price for the entire procedure.
- Unique physician and practitioner identification number (UPIN):** A unique number assigned to each Medicare physician and practitioner to identify the referring or ordering physician on Medicare claims. A UPIN is different from a PIN, which is assigned to Medicare providers and reported on the claims form to identify who provided the service to the beneficiary. A physician may have both a PIN and a UPIN assigned by CMS. The PIN and UPIN are not interchangeable. The PIN will replace the UPIN in 2007.
- Upcoding:** The intentional or accidental act of changing a procedure code, such as a CPT code digit, to reflect a higher intensity of care, thus generating higher payment.

**Usual, customary, and reasonable charge:** A method of determining benefits by comparing providers' charges with those of their peers in the same community and specialty.

**Utilization review:** A retrospective review of a patient's course of treatment that evaluates the appropriateness of care on the basis of medical necessity.

**V-Codes:** Codes used to further characterize the selected ICD-9 or ICD-10 code (e.g., patient with atrial fibrillation receiving anticoagulation management—ICD-9 427.31 for atrial fibrillation plus V code 58.61 for chronic anticoagulation management).

### Appendix B—Suggested web-based reimbursement resources

Information on the Outpatient Prospective Payment System: [www.cms.gov/HospitalOutpatientPPS](http://www.cms.gov/HospitalOutpatientPPS)

Information on the Clinical Laboratory Improvement Amendments (CLIA) and CLIA waivers: [www.fda.gov/cdrh/clia](http://www.fda.gov/cdrh/clia) and [www.phppo.cdc.gov/clia](http://www.phppo.cdc.gov/clia)

Explanation of reimbursement terms on the American Physical Therapy Association website: [www.apta.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=16055](http://www.apta.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=16055)

Helpful terminology related to reimbursement on the National Recreation and Park Association website: [www.nrpa.org/content/default.aspx?documentId=953](http://www.nrpa.org/content/default.aspx?documentId=953)

Glossary of reimbursement terms on the Reimbursement Principles, Inc., website: [www.reimbursementprinciples.com/terms.html](http://www.reimbursementprinciples.com/terms.html)

Copies of the Health Care Financing Administration-1450 (UB-92) and Centers for Medicaid and Medicare Services (CMS) 1500 forms may be obtained from the CMS website: [www.cms.hhs.gov/CMSForms](http://www.cms.hhs.gov/CMSForms)

ASHP's Pharmaceutical Reimbursement Resource Center: [www.ashp.org/reimburse](http://www.ashp.org/reimburse)

Pharmacist Services Technical Advisory Coalition: [www.pstac.org/index.html](http://www.pstac.org/index.html)

The Medication Therapy Management Services codes can be found on the American Medical Association website: [www.ama-assn.org/ama/pub/category/3885.html](http://www.ama-assn.org/ama/pub/category/3885.html)

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### Appendix C—Suggested references on reimbursement for cognitive services

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