

Reimbursement for Pharmacist's Services in a Hospital-based, Pharmacist-managed Anticoagulation Clinic

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Key Findings

- ✓ Under Medicare Part B, pharmacist MTM Current Procedural Terminology (CPT) codes 99605, 99606, and 99607 are not required for services provided incident to a physician when provided in hospital-based clinics
- ✓ Pharmacists can provide and be reimbursed for services in a hospital-based anticoagulation clinic
- ✓ Pharmacists can bill for the full range of CPT evaluation and management (E&M) codes including codes above 99211 for these services

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Introduction

The value for pharmacist-managed anticoagulation clinics has been clearly established in the pharmacy literature.^{1,9} Improved patient outcomes, including reduced hospital admissions for preventable embolism, bleeding, or treatment of thrombosis are well documented. Although pharmacists, as medication therapy experts, are uniquely qualified to provide this service, reimbursement for pharmacists' services has been challenging.

While this analysis discusses anticoagulation clinics, the relevant regulations could also be applied to other medica-

tion therapy management patient care services in hospital-based clinics.

Challenges

The interpretation of the reimbursement rules and regulations applicable to hospital-based pharmacist-managed clinics has created confusion for pharmacists as well as those responsible for billing and paying for these services. Pharmacist-specific medication therapy management service (MTM) CPT billing codes may be confused with billing "incident-to" evaluation & management (E&M) billing codes recognized by the Center for Medicare and Medicaid Services (CMS).



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The American Medical Association’s CPT codes are the standard used by healthcare providers for reporting professional services, laboratory tests and medical procedures in healthcare claims. Each CPT code consists of a narrative description of the patient intervention and an identifying code. Pharmacist specific MTM CPT codes are used for services for patients beyond routine dispensing of prescription medication and related patient information documents. The codes are used to bill any health plan that covers MTM services, including the Medicare Part D prescription drug benefit and some state Medicaid programs⁹. The codes currently used are 99605, 99606, and 99607. MTM codes are not recognized nor are they reimbursable under Medicare Part B.

Pharmacists, in collaboration with physicians, may report medically necessary E&M services associated with managing anticoagulation therapy using CPT codes 99211-99215^{10, 11}. “Incident-to” CPT evaluation & management (E&M) codes are used for services incident to physician’s services. This range of E&M codes reflects different levels of service. The complexity, amount of work and documentation reflected in an E&M code varies, for example, by type of service, place of service, and patient’s status within the practice (e.g., new or established). As with any other medically necessary service, however, there are explicit criteria that must be met and documented to obtain reimbursement for these services¹². Generally, only one E&M code may be used to characterize a specific patient encounter on a particular date of service.

Regulations

Pharmacists can provide anticoagulation therapy management services using the CPT codes for incident-to services that re-

flect the appropriate complexity of care provided. These services must be separately identifiable and medically necessary.

According to 42 CFR Parts 410, 416 et al., discussing INR testing with associated services,

“If a hospital provides a distinct, separately identifiable service in addition to the test, the hospital is responsible for billing the HCPCS code that most closely describes the service provided. Billing a visit code in addition to another service merely because the patient interacted with hospital staff or spent time in a room for that service is inappropriate. A hospital may bill a visit code, based on the hospital’s own coding guidelines which must reasonably relate the intensity of hospital resources to the different levels of HCPCS codes. Services furnished must be medically necessary and documented.”

CMS has further clarified the issue with three frequently asked questions (FAQ) posted on their website, FAQ numbers 9655, 9656, and 9657.

Advocacy

ASHP members have voiced concerns regarding reimbursement for hospital-based pharmacist-managed anticoagulation services provided incident-to physician services. ASHP, through our Section of Home, Ambulatory and Chronic Care Practitioners and Government Affairs, has worked with CMS to clarify interpretation of regulations and appropriate documentation for reimbursement. Based upon the three most clearly defined significant issues, the following analysis was developed:

<p>Issue Being Addressed:</p>	<p>Are pharmacists required to use the MTM CPT codes (99605-99607) when they are providing patient care in hospital provider based on-site clinics incident to a physician?</p>
<p>ASHP Analysis and Interpretation</p>	<p>ASHP’s analysis finds that CMS does not require the use of the MTM codes by a pharmacist because:</p> <ol style="list-style-type: none"> 1) If a medication therapy management service is provided incident to a physician the hospital should use “incident to” CPT codes 99211-99215.³ CMS’s opinion on negating separate payment for medication therapy management applies to situations where there is not a separately payable, medically necessary, incident-to visit. 2) Under the hospital outpatient prospective payment system (OPPS), CMS does not recognize MTM as a distinct reimbursable pharmacist specific service when part of services provided to patients by hospitals.
<p>Background and CMS FAQ and/or Federal Register Information</p>	<p>1) As indicated on page 68061 of the November 24, 2006 Federal Register notice, Vol. 71, No. 226 and CMS FAQ 9596, “We indicated that we had no need to distinguish medication therapy management services provided by a pharmacist in a hospital from medication therapy management services provided by other</p>

(continued)	<p>hospital staff, as the Outpatient Prospective Payment System (OPPS) only makes payments for services provided incident to physicians' services. Hospitals providing medication therapy management services incident to physicians' services may choose a variety of staffing configurations to provide those services, taking into account other relevant factors such as State and local laws and hospital policies." On page 68062, CMS states that "A hospital may bill a visit code, based on the hospital's own coding guidelines which must reasonably relate the intensity of hospital resources to the different levels of HCPCS codes. Services furnished must be medically necessary and documented." Hospitals are permitted to bill these pharmacist services using visit codes (CPT codes 99211-15) for these services.</p> <p>2) CMS has stated in the Federal Register that, "Medication therapy management services are not new services in the OPPS, as they have been provided to patients by hospitals in the past as components of a wide variety of services provided by hospitals, including clinic and emergency room visits, procedures, and diagnostic tests. As such, in the CY 2007 proposed rule, we noted that we believe their associated hospital resource costs were already incorporated into the OPPS payments for these other services that are based on historical hospital claims data."</p> <p>Further, as stated in CMS FAQ 9655, updated April 6, 2009, "Although we do not make separate payment for medication therapy management services, the costs for this service are included in the costs of other services, such as clinic and emergency department visits, procedures, and diagnostic tests, furnished by the hospital to the beneficiary on the same day. Therefore, the costs for medication therapy management are reflected in OPPS payment rates, thereby providing payments to hospitals for these services."</p> <p>Note: ASHP believes a key factor in understanding the different situations described by CMS is understanding that there are a "variety of services provided by hospitals" which is different from providing services "incident to a physician" in a "physician based clinic"</p> <p>Federal Register, Volume 71, Number 226, pages 68061-68062 http://edocket.access.gpo.gov/2006/pdf/06-9079.pdf</p> <p>CMS FAQs 9655, 9656, and 9657 posted on CMS website https://questions.cms.hhs.gov/cgi-bin/cms_hhs.cfg/php/enduser/std_alp.php?p_sid=CJbaKauj</p>
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Issue Being Addressed:	Are pharmacist's services, providing patient care in anticoagulation clinics that are hospital based, covered by CMS?
ASHP Analysis and Interpretation	<p>1) ASHP's analysis finds that as long as the service is incident to a physician, is medically necessary and documented appropriately, follows hospital guidelines and state law, pharmacists can provide patient care incident to a physician in a hospital-based clinic.</p> <p>2) Pharmacists that are providing care to patients incident-to a physician must ensure the care provided meets the necessary level of intensity of care and is a medically necessary, separately identifiable event.</p>
Background and CMS FAQ and/or Federal Register Information	<p>CMS FAQ 9656, updated April 6, 2009, notes, "Under the OPPS, we have no need to distinguish medication therapy management services provided by a pharmacist in a hospital from medication therapy management services provided by other hospital staff, as the OPPS only makes payments for services provided incident to physicians' services.</p> <p>Hospitals providing medication therapy management services incident to physicians' services may choose a variety of staffing configuration to provide those services, taking into account other relevant factors such as State and local laws and hospital policies."</p> <p>According to the FAQ 9657, updated April 6, 2009, "Medication therapy management services are provided as components of a wide variety of services provided by hospitals, including clinic and emergency department visits, procedures, and diagnostic tests.</p>

(continued)	<p>Billing a visit code in addition to another service merely because the patient interacted with hospital staff or spent time in a room for that service is inappropriate. A hospital may bill a visit code based on the hospital's own coding guidelines, which must reasonably relate the intensity of hospital resources to the different levels of HCPCS codes. Services furnished must be medically necessary and documented. Providers should work with their local contractors regarding the medical necessity for these visits.</p> <p>For example, CPT code 85610 (Prothrombin time) is a code that describes performance of the prothrombin time test. If the only service provided is a venipuncture and lab test to determine the prothrombin time, then this is all that should be billed. If a hospital provides a distinct, separately identifiable service in addition to the test, the hospital is responsible for billing the code that most closely describes the service provided.”</p> <p>It should be emphasized to all practitioners that hospitals are permitted to bill these pharmacist services using visit codes (CPT codes 99211-15) for these services.”</p> <p>CMS FAQ 9656 posted on CMS website https://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=CJbaKauj</p>
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Issue Being Addressed:	Can pharmacists providing patient care in anticoagulation clinics that are hospital based bill at levels above a 99211?
ASHP Analysis and Interpretation	ASHP’s analysis finds that pharmacists are not restricted to level 99211, but may bill above 99211 following state law and hospital policy with appropriate documentation of medical necessity. However, based on CMS’ FAQs, we advise that planning with your fiscal intermediary be considered before routinely billing above 99211.
Background and CMS FAQ and/or Federal Register Information	<p>As stated on page 68062 of Federal Register / Vol. 71, No. 226 / Friday, November 24, 2006 / Rules and Regulations, “A hospital may bill a visit code, based on the hospital’s own coding guidelines, which must reasonably relate the intensity of hospital resources to the different levels of HCPCS codes. Services furnished must be medically necessary and documented.”</p> <p>Federal Register, Volume 71, Number 226, page 68062 http://edocket.access.gpo.gov/2006/pdf/06-9079.pdf</p>

Conclusion

ASHP will continue to work with CMS to address members’ needs and to provide information through our Section of Home, Ambulatory and Chronic Care Practitioners activities, Government Affairs Division, our website and educational programming. For more information, please contact Deborah Perfetto, Pharm.D., Director of Section of Home, Ambulatory and Chronic Care Practitioners at dperfetto@ashp.org.

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