

Billing Guidance for Pharmacists' Professional and Patient Care Services

Version 2.0

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This paper provides the pharmacy sector of the healthcare industry with guidance on the billing of pharmacists' clinical services.

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I. PURPOSE

The purpose of this white paper is to provide guidance to pharmacists and payers on the billing for pharmacists' provided patient care services.

II. BACKGROUND

The practice of pharmacy is evolving along with changes in healthcare delivery. With this change, the supply and demand factors for health care services are transforming. Patient demands on the healthcare system are expected to increase significantly and outpace current provider supply over the next few years. Interdisciplinary, team-based approaches have been acknowledged as a key strategy to meet the future Primary Care Provider shortage.

Pharmacists are increasingly providing patient care services in a variety of settings spanning inpatient, outpatient/ambulatory clinics, and community pharmacies. Community pharmacists are continuing to provide services distinct from the traditional prescription dispensing function, offering patient care services such as:

- immunizations,
- point-of-care (POC) testing;
- medication therapy management (MTM);
- chronic care management;
- transitions of care management;
- patient education and
- counseling.

State-by-state regulations stipulate the provision of the scope and types of services that can be delivered by pharmacists.

Traditionally pharmacist-provided patient care services have most commonly been billed to payers or health plans under "Fee for Service (FFS)" methodology. However, professional service billing and reimbursement has been limited. Pharmacists providing professional/clinical services in an FFS ambulatory care setting began billing Medicare Part B, State Medicaid Programs and other payers often using American Medical Association (AMA) Current Procedural Terminology (CPT®) codes as "incident to" physician billing processes.

Based on the Medicare Modernization Act of 2003 (MMA), the Medicare Part D program required prescription drug plans (PDP) and Medicare Advantage Plans (MAPDs) create and implement an MTM program. Subsequently CPT® codes specific to Medication Therapy Management were developed.

Since the initiation of the Medicare Part D programs, Medicaid and other third-party payers outside of Part D programs have adopted MTM services utilizing provider contracts. Additionally team and value-based care and billing models have been adopted.

In order to support the team and value-based billing of patient-care services, specific documentation of the diagnosis, service, complexity of service, etc. is required. Some criteria are defined in the CPT® or other Healthcare Procedure Code System (HCPCS) codes; others are defined in specific program requirements.

III. BILLING FOR PHARMACIST PATIENT CARE SERVICES

The mechanisms by which pharmacists can receive reimbursement for patient care services have advanced in recent years; however, the billing process for services remains inconsistent across systems and settings of care. For example, in the community pharmacy setting, pharmacists have established direct billing mechanisms for services provided under third-party contracts, which may require the use of CPT® codes, including pharmacist-specific MTM codes.

Any integrated practice management system solution which includes billing and reporting of pharmacists' clinical services, must take into account the pharmacist's workflow. The systems and processes that exist in dispensing pharmacies today are designed and developed to operate using the NCPDP Telecommunication, SCRIPT and/or Specialized Standards. The Telecommunication Standard supports the fields for the billing of professional services and is allowed under HIPAA regulation for pharmacy service billing. In alternative practice settings other billing methodologies may be used.

A. BILLING METHODOLOGIES

There are several methods for billing pharmacist patient care services. The use of a particular method is dependent, at least in part, on the type of benefit providing coverage for the service, provider-payer contracts, care settings and professional service agreements.

1. CONTRACT BASED REIMBURSEMENT

Pharmacists or pharmacies may receive reimbursement based on contracts with payers or through professional service agreements with or between providers. Reimbursement rates and billing methodology are negotiated between the pharmacy or pharmacist and the health plan/payer/provider. There is currently little standardization in these agreements. Payment may be fee-for-service or may be covered under a global rate, capitation or similar arrangements.

2. DIRECT PATIENT PAYMENT

Pharmacists may charge patients directly for their services on a cash transaction basis. The cost structure is established by the pharmacy or pharmacist. Patients pay for the service out of pocket and may receive documentation to obtain potential reimbursement from their health plan or through a flexible benefit program.

3. "INCIDENT TO" BILLING

Pharmacist services may be delivered across various settings of patient care such as a physician office or clinic, under the supervision of and in collaboration with a physician or recognized practitioner. A common approach to billing in these settings is "incident to" billing where the practitioner or clinic bills for the services of the pharmacist "incident to" the practitioner or clinic service. The billing entity receives payment and reimburses the pharmacist.

4. BILLING USING PROCEDURE CODES

Procedure codes are found in the HCPCS and the Level I American Medical Association CPT® codes. Specific CPT® codes were developed in 2005 for the payment of an MTM service provided by a pharmacist. Information on use of these codes can be found at <http://www.pstac.org/services/mtms-codes.html>. These CPT® codes are not used under Medicare Part B, but may be used by Medicaid, private health insurers, or Medicare Part D plan administrators in determining reimbursement for MTM services. Pharmacist may also use other HCPCS/CPT® codes such as Evaluation and Management or immunization codes. The payer contract may specify the allowed HCPCS/CPT®, diagnosis (ICD-10) or other codes for reimbursement.

Current payment coding and billing methods are available to practices where pharmacists either are or serve as part of a patient care team. Resources are available for payment and coding methods from various organizations such as [American Pharmacists Association \(APhA\)](#) and

[American College of Clinical Pharmacy \(ACCP\)](#).

B. BILLING FORMATS

Multiple formats exist for billing pharmacist patient care services and are dependent on the billing mechanisms. CPT® codes are traditionally used to identify the service being billed. However, based on trading partner agreement, the billing format can be either X12N 837 or NCPDP Telecommunication Standard. For administrative simplification of the pharmacy billing process, the use of the current NCPDP Telecommunication Standard provides a cost effective alternative for many pharmacies. It is recommended that pharmacies contact the payer to determine which billing format should be used. If X12N 837 is required for billing pharmacist patient care services and the pharmacy system cannot support it, there are services that can assist with translation.

The table below outlines examples of billing methods that could be negotiated within trading partner agreements.

Provider Type	Billing Method Submitter Type	Covered Benefit	Billing Format	Code Set
Pharmacy Provider	Real-Time	Pharmacy (Product + Service)	NCPDP Telecommunication Standard Claim Billing (e.g., See Section 16- Vaccine Services – Pharmacy Benefit Billing & Processing in the Telecommunication Version D and Above Questions, Answers and Editorial Updates)	- Product ID - Other Amount Submitted - Incentive Amount - DUR Code Sets
Pharmacy Provider	Real-Time	Pharmacy (Service Only with Product Identification)	NCPDP Telecommunication Standard Claim Billing (B1, B2, B3)	- Product ID - DUR Code Sets
Pharmacy Provider	Real-Time	Pharmacy (Service Only)	NCPDP Telecommunication Standard Claim Billing (S1, S2, S3)	- Product ID (HCPCS, CPT®) - DUR Code Sets
Pharmacy Provider	Real-Time	Medical (Product + Service)	NCPDP Telecommunication Standard Claim Billing (B1, B2, B3)	- Product ID (HCPCS, CPT®) - DUR Code Sets
Pharmacy Provider	Real-Time	Medical (Service Only)	NCPDP Telecommunication Standard Service Billing (S1, S2, S3)	- Product ID (HCPCS, CPT®) - DUR Code Sets
Pharmacy Provider	Batch	Medical /DME	ASC X12N 837	HCPCS, CPT®
Pharmacy Provider	Paper,	Medical	Proprietary Invoice	Trading Partner

	Electronic Form			Agreement
Pharmacy Provider	Electronic Form	Pharmacy (Product + Service)	Universal Claim Form	- Product ID - Other Amount Submitted - Incentive Amount - DUR Code Sets
Pharmacy Provider	Electronic Form	Medical/DME	Centers for Medicare & Medicaid Services (CMS) 1500	HCPCS, CPT®
Pharmacy Provider	Web-based Proprietary	Medical (Service Only)	Proprietary Invoice	Proprietary
Medical Provider	Batch	Medical	ASC X12N 837	HCPCS, CPT®
Medical Provider	Electronic Form	Medical	Centers for Medicare & Medicaid Services (CMS) 1500	HCPCS, CPT®

Medicare Part D Prescription Drug Plans allow coverage of pharmacist patient care services under the MTM Program. The NCPDP Telecommunication Standard beginning with version D.0 includes transactions specifically designed for the submission of professional service claims.

The submission of a claim for pharmacist patient care services may vary based upon the practice setting of the pharmacist providing the services and/or the benefit package through which the services are covered. The Telecommunication Standard is always the billing format of choice for pharmacy providers. In other environments and when the service is covered under a medical plan benefit the ASC X12N 837P Health Care Claim is the preferred method.

IV. BENEFITS OF NCPDP STANDARDS FOR PROFESSIONAL PHARMACY SERVICES

The benefits of using NCPDP Standards to process transactions for these professional activities include the following:

- Offers pharmacy providers the ability to demonstrate the value of these services in real-time.
- Ensures a consistent implementation of all pharmacy transactions, both product and professional services, using fields, values, and code sets which were developed by the pharmacy industry according to current provider, payer and patient needs.
- Provides payers/processors the ability to review and adjudicate claims in real-time for pharmacy professional services that occur across various practice settings.

NCPDP Telecommunication Standard includes transactions sets for billing of pharmacy services as well as dispensed products. Thus, any pharmacy setting that can transmit a pharmacy claim to a payer would also be able to transmit a service claim (e.g., MTM, diabetes education). Some areas of pharmacy practice do not currently utilize the Telecommunication Standard and would submit pharmacy service claims using the ASC X12N 837 standard for payment. The use of two standards for the submission of pharmacy service claims allows payers and pharmacy settings to utilize the billing and transmission standard which best fits their

individual needs.

V. APPENDIX

PHARMACIST PATIENT CARE PROCESS

Recognizing the need for a consistent process in the delivery of patient care across the profession, the Joint Commission of Pharmacy Practitioners (JCPP) released the Pharmacists' Patient Care Process in May 2014. The process is applicable to any practice setting where pharmacists provide patient care and for any patient care service they provide.

In order to provide context for the billing of patient care services, an overview of the Pharmacist Patient Care Process is summarized below. (<https://icpp.net/patient-care-process>).

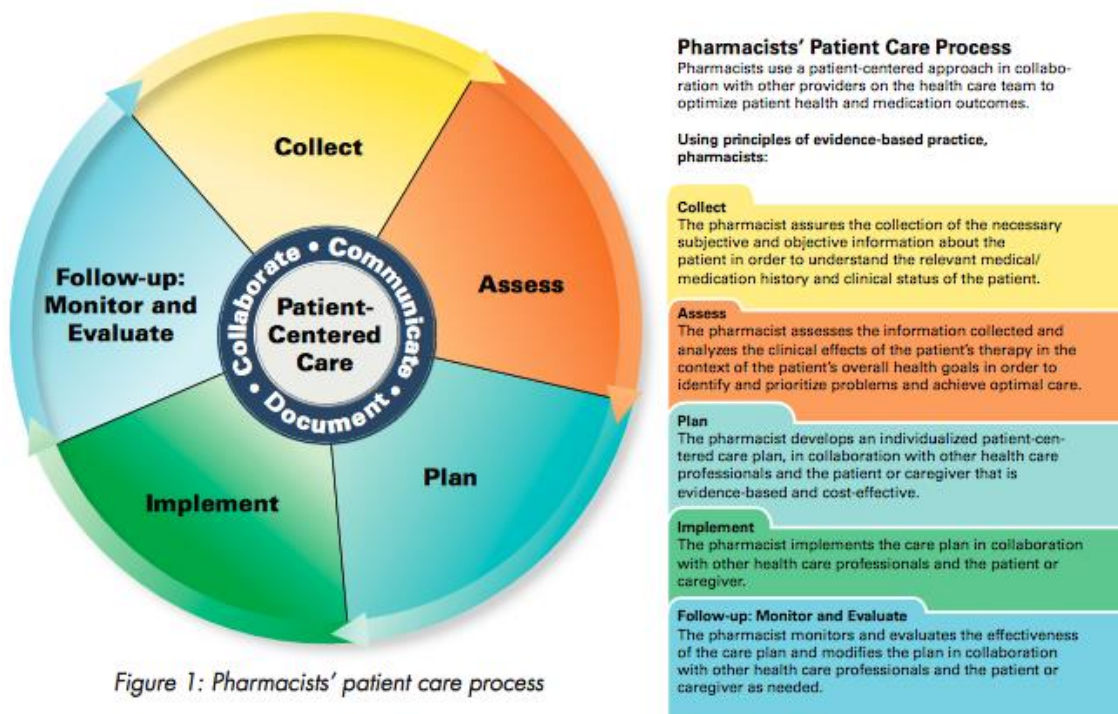


Figure 1: Pharmacists' patient care process

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