Looking Past the Pills to Pay the Bills: Billing in an Ambulatory Care Setting

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Evan Sasson, PharmD, BCPS
Conflict of Interest

- Drs. Elise Kim and Evan Sasson have no conflicts of interest to disclose
Objectives for Pharmacists

• Define Collaborative Drug Therapy (CDTM) and identify the requirements for credentialing in New York State
• Describe facility charges, professional charges, and “incident-to” billing codes
• Explore additional billing opportunities for pharmacists under CDTM agreements
• Apply appropriate billing codes to various clinic visits
Objectives of Pharmacy Technicians

- Describe Collaborative Drug Therapy Management (CDTM)
- Discuss patient care opportunities for ambulatory care pharmacists
- Recognize the ability of ambulatory care pharmacists to bill for their services
The Brooklyn Hospital Center (TBHC)

- Oldest hospital in Brooklyn, NY
- Located in Fort Greene/Downtown area
- 450 acute care beds
- 2 Clinics located on hospital grounds
- 5 Offsite clinics
  - Pharmacotherapy Services in 4 out of 5 clinics
TBHC Clinics

- Annual Wellness Visit
- Anticoagulation
- Asthma
- Cardiology: *Same-day referral*
- Cardiovascular Risk Reduction
- Diabetes
- HIV Primary Care: *Interdisciplinary*
- HIV/Hep C Pharmacotherapy
- Pharmacotherapy
Pharmacotherapy Clinics

- Adherence Counseling
- Asthma/COPD Education/Management
- CVD Risk Reduction
- Diabetes Education/Management
- Hypertension Education/Management
- Medication reconciliation
- Polypharmacy
- Tobacco Cessation Counseling
- Transitions of Care (Post Discharge Medication Reconciliation)
TBHC Ambulatory Care Pharmacy Staff

- 2 Ambulatory Care Specialists
- 4 Faculty: LIU Pharmacy
- 3 PGY-2 Ambulatory Care Pharmacy Residents
- 2 Inpatient/Outpatient Hybrid Positions
Definition of CDTM

“A collaborative practice agreement between one or more physicians and pharmacists wherein qualified pharmacists working within the context of a defined protocol are permitted to assume professional responsibility for performing patient assessments; ordering drug therapy-related laboratory tests; administering drugs, and selecting, initiating, monitoring, continuing, and adjusting drug regimens.”

- American College of Clinical Pharmacy
CDTM Timeline in NY

2011
- CDTM passed with 3-year sunset
- Limited to teaching hospitals, including any diagnostic center, treatment center, or hospital-based outpatient departments (outpatient clinics)

2015
- Moved sunset from 2014 to 2015
- Expanded to all hospitals and nursing homes with on-site pharmacy

2017
- Pharmacists practicing under CDTM, must be credentialed by February 28

2020
- Moved sunset to 2020
- *Make CDTM permanent and expand for Nurse Practitioners as providers*

### CDTM Credentialing in NY

<table>
<thead>
<tr>
<th>PharmD or MS in Clinical Pharmacy</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Must meet both Criteria 1&amp;2</td>
<td>Criterion 1</td>
<td>≥2 years of Licensure</td>
</tr>
<tr>
<td></td>
<td>Criterion 2</td>
<td>≥1 year of Clinical Experience</td>
</tr>
<tr>
<td>≥1 of Criterion 3 or 4</td>
<td>Criterion 3</td>
<td>Board Certified</td>
</tr>
<tr>
<td></td>
<td>Criterion 4</td>
<td>Completion of Residency Program</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BS in Pharmacy</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Must meet both Criteria 1&amp;2</td>
<td>Criterion 1</td>
<td>≥3 years of Licensure</td>
</tr>
<tr>
<td></td>
<td>Criterion 2</td>
<td>≥1 year of Clinical Experience</td>
</tr>
<tr>
<td>≥1 of Criterion 3 or 4</td>
<td>Criterion 3</td>
<td>Board Certified</td>
</tr>
<tr>
<td></td>
<td>Criterion 4</td>
<td>Completion of Residency Program</td>
</tr>
</tbody>
</table>

Benefits of CDTM

- Optimized drug therapy management
- ↓ Drug-related problems
- ↑ Access to healthcare
- ↓ Costs

- ↓ Visits for chronic disease states
- Delegation of medication management
  - ↑ Ability to meet pay-for-performance goals

- Better drug-therapy outcomes
- Reduced costs of care
- ↑ Patient satisfaction
- Optimization of drug therapy regimens

- Demonstrate value as an integral part of health care
- Product-oriented → patient-focused

Practice Advisory on Collaborative Drug Therapy Management. AMCP 2012
Healthcare Payers

- **Centers for Medicare and Medicaid Services (CMS)**
  - Medicare: Part A, B, C, D
  - Medicaid

- **Commercial/Private**
  - Employer-based
  - Group
  - Individual

- **Self Pay**
Basic Billing Structure

Facility vs. Professional Charge

Facility Fee

• Reimbursement for level/intensity of clinical services and hospital resources rendered.
  ▪ Includes: operating and overhead costs, supplies, equipment, staff, administration, etc.

• Pharmacists are able to bill incident-to-physician

Professional fee

• Provider’s professional services

• Pharmacists are NOT able to bill
  ▪ Pharmacists are not recognized providers
  ▪ Only in private clinics
“Incident-to” Services For Pharmacists?

January 22\textsuperscript{nd}, 2014: CMS confirms YES!

- “In your letter, you ask that we confirm your impression that if all the requirements of the "incident to" statute and regulations are met, a physician may bill for services provided by a pharmacist as "incident to" services. We agree.”
  - Marilyn Tavenner, M.A., CMS Administrator

- “It just clarifies that CMS recognizes how important it is for pharmacists to be on the front lines with us as physicians in making sure patients have access to the care that they need.”
  - AAFP President Reid B. Blackwelder, MD
“Incident-to” Services

Allows non-physician providers (NPP) provide and report services

1. Occurs in a non-institutional setting (all settings other than hospital or skilled nursing facility)
2. Medicare-credentialed physician must conduct initial evaluation and establish diagnosis
3. NPP may provide follow-up under “direct supervision”
   1. Does not have to be in the same room, but must be present in building and immediately available to provide assistance
“Incident-to” Services

5. Physician must actively participate in and manage patient’s course of treatment

6. Both physician and NPP must be employed by group entity

7. Service must be of a type usually performed in the office setting, and must be part of the normal course of treatment of a diagnosis or illness

*Must document all services provided
## “Incident-to” Billing Codes

<table>
<thead>
<tr>
<th>Assessment 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>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>
</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>
CMS Collapse of E&M Codes

2014 – Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System (ASCPS) Final Rule:

Healthcare Common Procedure Coding System (HCPCS) II

G0463

99211-99215-codes

• Hospital outpatient clinic visits for assessment and management of a patient
• Not reimbursed by patient’s condition (acuity) or types of hospital/nursing services – single flat rate

20 • 4/10/2019

Additional Billing
## Anticoagulation Clinics

<table>
<thead>
<tr>
<th>Code</th>
<th>Service Provided</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>93792</td>
<td>Patient/caregiver training for initiation of home INR monitoring</td>
<td>Charge Amount $135</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicare Allowable $67</td>
</tr>
<tr>
<td>93793</td>
<td>Anticoagulation management for patients taking warfarin</td>
<td>Charge Amount $30</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicare Allowable $14</td>
</tr>
<tr>
<td>85610</td>
<td>Point of care (POC) PT/INR monitoring</td>
<td>$5</td>
</tr>
</tbody>
</table>

- New CPT codes for home and outpatient INR monitoring
- Encompasses ordering, review, and interpretation of INR results, patient education, and dose adjustments
- Clinical laboratory improvement amendments (CLIA) certification for POC INR monitoring
Other Billing Opportunities

- **CMS Transitional of Care (TOC)**
  - 99495, 99496

- **CMS Annual Wellness Visits (AWV)**
  - G0438, G0439

- **CMS Chronic Care Management (CCM)**
  - 99490

- **Diabetes Self Management Training (DSMT)**
  - G0108, G0109

- **Medication Therapy Management (MTM)**
  - 99605, 99606, 99607 – Medicare Part D
Beneficiary’s charge from following inpatient setting:

- Inpatient acute care hospital
- Inpatient psychiatric hospital
- Long term care hospital
- Skilled nursing facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a community mental health center

To:

- His or her home, domiciliary, rest home, or assisted living
Interactive non face-to-face contact (telephone or email) within 2 business days by physician or clinical staff
• ≥2 or attempts in timely manner - document

Pharmacists provide?
YES!

Face-to-face visit within 14 days*
(99495)
($124.56)

Face-to-face visit within 7 days*
(99496)
($180.86)

*Face-to-face only with a provider
Annual Wellness Visit

Personalized plan to help prevent disease and disability based on current health and risk factors

First 12 months of Medicare Part B enrollment

- Initial Preventative Physical Examination (IPPE)

After 12 months

- Initial Annual Wellness Visit (G0438) ($197.13)
- Every 365 days (G0439) ($134.19)

AWV – Requirements

- Health risk assessment (HRA)
  - Demographic data, self-assessment of health status, behavioral risks, activities of daily living, etc.
- Medical and family history
- List of providers and suppliers; Establish advance directives
- Detect any cognitive impairment
- Review risk factors for depression
- Review functional ability and level of safety
  - Perform ADL’s, fall risk, hearing impairment, home safety
- Obtain vitals (height, weight, BMI, BP)
- Establish appropriate screening schedule for next 5-10 years
Medicare Annual Wellness Visit Questionnaire

For an upcoming appointment with Elise Kim, PharmD on 3/13/2019

Which is your dominant hand?

- Right
- Left
- Either/ambidextrous

How well can you dress yourself?

- Independently
- Need some help
- Completely depend on someone else

How well can you complete grooming tasks?

- Independently
- Need some help
- Completely depend on someone else

How well can you feed yourself?

- Independently
- Need some help
- Completely depend on someone else

How well can you bathe yourself?

- Independently
- Need some help
- Completely depend on someone else

How well can you use the bathroom by yourself?

- Independently
- Need some help
- Completely depend on someone else

How well can you get in/out of bed?

- Independently
- Need some help
- Completely depend on someone else

How well can you walk in your home?

- Independently
- Need some help
- Completely depend on someone else
Medicare Annual Wellness Visit Questionnaire

For an upcoming appointment with Elise Kim, PharmD on 3/13/2019

Is the tub or shower floor slippery and do you need support?

- yes
- no

Do you need some support when you get in and out of the tub or up from the toilet?

- yes
- no

Are there papers, books, towels, shoes, magazines, boxes, blankets, or other objects on the floor?

- yes
- no

BACK  CONTINUE  CANCEL
<table>
<thead>
<tr>
<th>Service</th>
<th>Date of Service</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Screening</td>
<td>10/19/2018</td>
<td>10/19/2019</td>
</tr>
<tr>
<td>Bone Mass Measurements</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td>7/26/2017</td>
<td>7/26/2022</td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>4/1/2017 per MD note</td>
<td>4/1/2027</td>
</tr>
<tr>
<td>Tobacco</td>
<td>10/19/2018</td>
<td>10/19/2019</td>
</tr>
<tr>
<td>Depression</td>
<td>10/19/2018</td>
<td>10/19/2019</td>
</tr>
<tr>
<td>Diabetes Self-Management Training</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>9/2018 per patient</td>
<td>9/1/2019</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>HIV</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>IBT for CVD reduction</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>IBT for obesity</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical Nutrition Therapy</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td>DRE 5/2018</td>
<td>5/1/2019</td>
</tr>
<tr>
<td>STIs and HIBC</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Mammography</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Pap Test &amp; Pelvic Examination</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Ultrasound for AAA</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>HBV Vaccination</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>PCV13</td>
<td>7/29/2015</td>
<td>-</td>
</tr>
<tr>
<td>PSCV23</td>
<td>6/26/2017</td>
<td>-</td>
</tr>
<tr>
<td>Influenza</td>
<td>9/20/2018</td>
<td>Fall 2019</td>
</tr>
</tbody>
</table>
Chronic Care Management (CCM)

- Provided by CMS to Medicare patients if:
  - ≥2 chronic conditions expected to last ≥12 months
  - These conditions significantly ↑ risk of death, acute exacerbation/decompensation, or functional decline
  - Comprehensive care plan established, implemented, revised, or monitored
CCM Services

- Services include 5 core activities
  1. Structured recording in patient health information
  2. Maintaining a comprehensive care plan for each patient
     - Patient centered: problems list, goals, medications, prognosis, etc.
  3. Providing 24/7 access to care
     - Face to face as well as telephone, messaging, internet, etc.
  4. Comprehensive care management
     - Systems based approach
  5. Transitional care management
     - Coordinated efforts across all settings of care
## CCM Codes

<table>
<thead>
<tr>
<th>Duration of Services</th>
<th>CCM</th>
<th>Complex CCM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>At least 20 minutes</td>
<td>More than 60 minutes</td>
</tr>
<tr>
<td>CPT Code(s)</td>
<td>99490</td>
<td>99487</td>
</tr>
<tr>
<td>Services Provided</td>
<td>5 core CCM services</td>
<td>5 Core CCM services that include:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Moderate or high complexity clinical decision making</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Establishment or substantial revision of care plan</td>
</tr>
<tr>
<td>Average payment per unit service</td>
<td>$36.09</td>
<td>$58.84</td>
</tr>
<tr>
<td>Eligible for 30-minute add-on</td>
<td>No</td>
<td>Yes – 99489 ($29.64)</td>
</tr>
</tbody>
</table>

- Billed on a monthly basis
- 99489 for each additional 30 minutes of complex CCM services delivered in a month

**Goal:** Educate and empower Medicare beneficiaries with diabetes to better manage and control their conditions, and reduce complications and hospitalizations → reduce financial and human cost

**Requirements:**
- DSMT accreditation from AADE or ADA ($1100)
- Bill incident to a recognized provider
First 12 months: up to 10 hours
Subsequent years: 2 hours/year

**G0108**: individual, per 30 minutes
- $62.82
- Only 1 hour during first 12 months unless no group session available within 2 months of date

**G0109**: group session (2 or more patients), per 30 minutes
- $17.29/beneficiary
MTM Codes

**Goal:** Improve outcomes through patient education regarding overall disease state and medications used to manage them

- Pharmacists must obtain an NPI number to bill

<table>
<thead>
<tr>
<th>Initial encounter (15 mins): 99605</th>
<th>Follow-up (15 mins): 99606</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each additional 15-min increments: 99607</td>
<td></td>
</tr>
</tbody>
</table>

Sources for MTM payments

- Medicare Part D sponsors (these are usually health insurance companies)
- Third–party MTM vendors (e.g., Mirixa®, OutcomesMTM®)
- Employer–based health plans
- Healthcare organizations looking to reduce errors and readmissions
- Accountable care organizations
- Patient–centered medical homes
- State–sponsored MTM programs (in certain states)
- Patients, if they elect to pay directly for these services
Look-up tool:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/

How to use booklet:

Codes developed by the AMA to describe any medical service or procedure a healthcare provider may provide to a patient

- Method of communication for services provided between health care professionals and insurance payer
- Insurance payers track health data and measure performance and efficiency

→ Dollar amount assigned by each payer
Relevant CPT Codes

**Influenza Immunization**
- G8482 Influenza immunization administered or previously received
- G8483 Influenza immunization was not administered for documented reasons

**Pneumococcal Vaccination Status for Older Adults**
- G0009, 4040F Pneumococcal vaccine administered or previously received

**Medication Reconciliation Post Discharge**
- 1111F Med rec within 30 days of discharge from inpatient facility
# Relevant CPT Codes

## Tobacco Use

<table>
<thead>
<tr>
<th>Minimal Counseling (&lt;3 minutes)</th>
<th>Counseling may be conducted and documented with the use of E/M codes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT, CDT or G Code</td>
<td>99201-99205 (new patients) 99211-99215 (established patients)</td>
</tr>
<tr>
<td></td>
<td>Increased level of service may be applied.</td>
</tr>
<tr>
<td>Payer guidelines apply</td>
<td>Payer guidelines apply</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intermediate Counseling (3-10 minutes)</th>
<th>Individual session</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT, CDT or G Code (Estimated reimbursement range)</td>
<td>99406 ($10)</td>
</tr>
<tr>
<td>Individual counseling session^ † D1320 (dentists only)</td>
<td>99406 (Symptomatic)</td>
</tr>
<tr>
<td>Individual session [Asymptomatic] G0436 ($16.33)</td>
<td>99406† ($15.37-$17.95)</td>
</tr>
<tr>
<td>Individual session [Symptomatic] 99406‡ ($12-$29)</td>
<td>Payer guidelines apply</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intensive Counseling (11+ minutes)</th>
<th>Individual or group session</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT, CDT or G Code (Estimated reimbursement range)</td>
<td>99407 (use HQ modifier to indicate group session) ($19)</td>
</tr>
<tr>
<td>Individual counseling session^ † D1320 (dentists only)</td>
<td>Individual session [Asymptomatic] G0437 ($29.78)</td>
</tr>
<tr>
<td>Individual session [Symptomatic] 99407‡ ($29.96)</td>
<td>Group session 99407 Payer guidelines apply</td>
</tr>
</tbody>
</table>
| Individual session 99407 ($15-$32) | }
Relevant CPT Codes

Diabetes

- Diabetes: Hemoglobin A1c (HbA1c)
  - 3044F HbA1c <7%
  - 3045F HbA1c 7-9%
  - 3046F HbA1c >9%

- Diabetes: Medical Attention for Nephropathy
  - 3060F (+) microalbuminuria
  - 3061F (-) microalbuminuria
  - 3062F (+) macroalbuminuria
  - 3066F (-) macroalbuminuria
  - G8506 Patient receiving ACE-I or ARB therapy
Relevant CPT Codes

**Hypertension**

- **Systolic**
  - 3074F, G8752 <130 mmHg
  - 3075F, G8752 130 to 139 mmHg
  - 3077F, G8753 ≥140 mmHg

- **Diastolic**
  - 3078F, G8754 <80 mmHg
  - 3079F, G8754 80 to 89 mmHg
  - 3080F, G8755 ≥90 mmHg

**65 years +**

- 1159F, 1160F annual medication reconciliation
Patient Cases
### Patient Information

<table>
<thead>
<tr>
<th>HPI</th>
<th>PD is a 59 year-old female presents to Anticoagulation clinic for warfarin therapeutic drug monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMH</td>
<td>Afib, DM2, HTN, and CHF</td>
</tr>
<tr>
<td>SH</td>
<td>(-) EtOH, (-) tobacco: quit 15 years ago</td>
</tr>
<tr>
<td>FH</td>
<td>DM2 and Afib</td>
</tr>
<tr>
<td>Vitals</td>
<td>129/78 mmHg HR 78</td>
</tr>
</tbody>
</table>

### Warfarin Information

<table>
<thead>
<tr>
<th>Current dose</th>
<th>Warfarin 5 mg po QHS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>POC INR history (goal 2-3)</th>
<th>Date</th>
<th>INR</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1/8</td>
<td>2.1</td>
<td>5 mg</td>
</tr>
<tr>
<td></td>
<td>2/8</td>
<td>2.1</td>
<td>5 mg</td>
</tr>
<tr>
<td></td>
<td>3/14</td>
<td>2.4</td>
<td>5 mg</td>
</tr>
</tbody>
</table>
## Patient Case: PD

### POC INR today = 2.6

<table>
<thead>
<tr>
<th>Service and CPT</th>
<th>Billing Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticoagulant monitoring for a patient taking warfarin</td>
<td>93793</td>
</tr>
<tr>
<td>POC prothrombin time tested in clinic</td>
<td>85610</td>
</tr>
</tbody>
</table>
### Patient Information

| HPI | PK is a 49-year-old AA woman referred to pharmacotherapy clinic by her PCP for medications management 2 weeks after being discharged from the hospital |
| PMH | HTN, DM2 |
| SH  | (-) EtOH, (+) tobacco: for 35 years |
| FH  | Non contributory |
| Vitals | 158/105 mmHg  HR 78 (last week: 149/92 mmHg, HR 85) |
| Pertinent labs | HbA1C: 7.4%, Scr: 1.1 mg/dl, Microalb/creat ratio: 465 mg/dl |
| Home Medications | Metformin 500 mg po BID  
Lisinopril 10 mg po daily  
Atorvastatin 20 mg po daily |
## Service and CPT

<table>
<thead>
<tr>
<th>Service and CPT</th>
<th>Billing Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility</td>
<td>99212</td>
</tr>
<tr>
<td>Screened and identified as tobacco user. Smoking and tobacco cessation counseling &gt;10 minutes</td>
<td>G9902, G9906, 4004F, and 99407</td>
</tr>
<tr>
<td>Medication reconciliation 30 days following hospital admission</td>
<td>1111F</td>
</tr>
<tr>
<td>HbA1c between 7 to 9%</td>
<td>3045F</td>
</tr>
<tr>
<td>(+) Macroalbuminuria</td>
<td>3062F</td>
</tr>
<tr>
<td>Patient on ACE-I or ARB therapy</td>
<td>G8506</td>
</tr>
<tr>
<td>Systolic BP ≥140 mmHg</td>
<td>3077F, G8753</td>
</tr>
<tr>
<td>Diastolic BP ≥90 mmHg</td>
<td>3080F, G8755</td>
</tr>
</tbody>
</table>
# Patient Case: DH

<table>
<thead>
<tr>
<th>Patient information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HPI</strong></td>
<td>DH is a 71 year old female who presents to Annual Wellness Visit clinic for her initial AWV</td>
</tr>
<tr>
<td><strong>PMH</strong></td>
<td>HTN, HLD, asthma</td>
</tr>
<tr>
<td><strong>SH</strong></td>
<td>(-) Tobacco; (-) EtOH; (-) Illicit drugs</td>
</tr>
<tr>
<td><strong>FH</strong></td>
<td>Non contributory</td>
</tr>
<tr>
<td><strong>Vitals</strong></td>
<td>BP 127/76 mmHg, P 78 bpm</td>
</tr>
</tbody>
</table>
# Patient Case: DH

<table>
<thead>
<tr>
<th>Service &amp; CPT</th>
<th>Billing Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Annual Wellness Visit</td>
<td>G0438</td>
</tr>
<tr>
<td>Colonoscopy (4 years ago – negative)</td>
<td>G0121, 3017F</td>
</tr>
<tr>
<td>Influenza (November 2018)</td>
<td>G8482</td>
</tr>
<tr>
<td>PCV 13 and PPSV 23 (up-to-date)</td>
<td>G0009, 4040F</td>
</tr>
<tr>
<td>Tobacco (non-user)</td>
<td>G9903, 1036F</td>
</tr>
<tr>
<td>Mammography (up-to-date)</td>
<td>G0204, G9899</td>
</tr>
<tr>
<td>Advance Care Planning (updated during clinic visit)</td>
<td>1123F</td>
</tr>
<tr>
<td>Functional Status Assessment ✓</td>
<td>1170F</td>
</tr>
<tr>
<td>Medication Reviewed by Pharmacist ✓</td>
<td>1159F, 1160F</td>
</tr>
<tr>
<td>Hypertension (SBP &lt;130 mmHg) (DBP &lt;80 mmHg)</td>
<td>3074F, G8752</td>
</tr>
<tr>
<td></td>
<td>3080F, G8755</td>
</tr>
</tbody>
</table>
Beware MediCaid Fraud!

• You can NOT bill patients for services and offer the same services *pro bono* or at a reduced rate for other patients

• Self-pay fees may be charged on a sliding scale or flat rate, but if a service is offered for free, it must be free for all
Conclusion

- Pharmacists must be credentialed in NYS to participate in CDTM
- CDTM allows pharmacists to optimize drug therapy management
- CMS identifies pharmacists as auxiliary personnel to bill “incident-to”
- Include all applicable codes when billing for a visit
Looking Past the Pills to Pay the Bills:
Billing in an Ambulatory Care Setting

Elise Kim, PharmD, BCACP, BC-ADM

Evan Sasson, PharmD, BCPS