Coding for Pharmacy Services

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While insurance payers generally permit a mid-level provider to bill for services performed in his or her name and National Provider Identifier (NPI), pharmacists are not typically included. According to the Centers for Medicare & Medicaid Services (CMS) in the Medicare Claims Processing Manual:[1]

Advise physicians to use CPT codes (level 1 of HCPCS) to code physician services, including evaluation and management services. Medicare will pay for E/M services for specific non-physician practitioners [i.e., nurse practitioner (NP), clinical nurse specialist (CNS) and certified nurse midwife (CNM]) whose Medicare benefit permits them to bill these services. A physician assistant (PA) may also provide a physician service, however, the physician collaboration and general supervision rules as well as all billing rules apply to all the above non-physician practitioners. The service provided must be medically necessary and the service must be within the scope of practice for a non-physician practitioner in the State in which he or she practices.

The Medicare Payment Advisory Commission (MedPAC) addressed the involvement of clinical pharmacists in managing drug treatment in a June 2002 report, both in view of cost reductions and improvement in the quality of care.[2] This report adds that while individuals 65 and older represent only 13 percent of the total healthcare population, they consume 35 percent of all prescription medications in the United States. Pharmacist participation in a multidisciplinary patient care team may improve clinical outcomes.[3]

Pharmacists may also play a valuable role in reinforcing drug dosing schedules and educating patients about their medications. As a result, patient compliance with complicated drug regimens and follow-up visits may improve—potentially leading to better treatment outcomes.

Drug management has the potential to improve the quality of care for Medicare patients by:

- Reducing the incidence of adverse drug effects
- Improving patient outcomes
- Improving patient compliance with drug therapy.

Conversely, adverse drug events can increase patient morbidity or mortality, increase the length of hospital stays, or lead to increased emergency room visits.

Medication Therapy Management

Drug management is an evolving approach to care in which the drug therapy decisions are coordinated collaboratively by physicians, pharmacists, and other healthcare professionals together with the patient.

Medication therapy management services (MTMS) are patient-specific clinical evaluations, recommendations, and interventions directed toward clinically complex patients. MTMS go above and beyond the standard activities of product preparation and dispensing.[4] MTMS codes are not used to describe the provision of product-specific information or any other routine dispensing activity. Medication therapy management services describe:

- Face-to-face patient assessment
- Intervention as appropriate
- Performed by a licensed pharmacist.

MTMS are provided to optimize the response to medications or to manage treatment-related medication interactions or complications. As part of MTMS, pharmacists will:

- Review pertinent patient history
- Complete a medication profile (prescription and non-prescription)
- Provide specific recommendations for improving health outcomes and treatment compliance.

The above elements must be documented and may include education and training, monitoring medication compliance, modifying therapy, formulating a treatment and/or follow-up plan, management of medication problems or complications, providing recommendations for disease prevention, and/or evaluating the patient's knowledge of medication(s) and willingness to comply with medication requirements. The procedure codes for these services are:

- **99605:** Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient.
- **99606:** Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, established patient.

- **+99607:** Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; each additional 15 minutes.

The Medicare Modernization Act (MMA) has defined targeted beneficiaries as individuals who have multiple chronic diseases (such as diabetes, asthma, hypertension, and/or congestive heart failure), are taking multiple covered drugs, and will incur high annual medication costs. MTMS are initiated at the request of the patient and describe services that are out of the ordinary. Remember: these codes are *not* reported to describe a counter discussion regarding dispensed medications.[5]

The good news is that there are specific procedure codes to report MTMS, but the bad news is that these services may not be reimbursed separately by insurers. For example, Medicare does not provide reimbursement in the hospital outpatient department for MTMS under the Outpatient Prospective Payment System (OPPS). According to CMS:[6]

Under the OPPS, we have no need to distinguish medical 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.

With regard to physician office or freestanding centers, the Medicare Physician Fee Schedule (MPFS) assigns MTMS services status indicator "X," indicating these codes represent an item or service that is not within the statutory definition of "physicians' services" for MPFS payment purposes.

Although Medicare does not pay separately for MTMS services, other non-governmental payers may include these codes on their payment schedules. However, there may be certain restrictions, such as allowing payment for each of these codes only once in a 365-day period.

Drug Supply Codes

According to CMS, pharmacies may bill the Durable Medical Equipment Regional Contractor (DMERC) for certain classes of drugs, including oral antiemetic and oral anticancer drugs. In addition to the codes for the drugs themselves, there are also HCPCS Level II codes for the dispensing of oral medications:

- **Q0511:** Pharmacy supply fee for oral anticancer, oral antiemetic, or immunosuppressive drug(s); first prescription in a 30-day period.
- **Q0512:** Pharmacy supply fee for oral anticancer, oral antiemetic, or immunosuppressive drug(s); subsequent prescription in a 30-day period.

Beginning January 1, 2006, and continuing through the present, Medicare pays a supply fee of $24 for the first prescription of an oral antiemetic or oral anticancer drug in a 30-day period and $16 for each subsequent prescription.[7] There are different allowances for the dispensing of immunosuppressive drugs after a transplant and dispensing inhalation drugs delivered via durable medical equipment.

The supply fee codes must be billed on the same claim form as the HCPCS Level II code for the oral drug, and each supplier will be limited to 12 supply fees (represented by code **Q0511**) per beneficiary per calendar year. In addition, Medicare will downcode **Q0511** to **Q0512** if more than one claim for **Q0511** is received from the supplier for a beneficiary during the 30-day period (with the exception of allowing for a refill within seven days of the end of the 30-day period).

Additional information on these pharmacy supply codes is provided in Chapter 17 of the Medicare Claims Processing Manual, including the requirement that suppliers that bill the DMERC for drug supply must have a pharmacy license to dispense drugs.[8]

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