Sustainability Plan

Selected Codes for Pharmacist-Provided Services

The following preventative services and CPT codes were selected for applicability to the Pharmacist-Physician Collaboration Toolkit and are not inclusive of all billable services pharmacists may provide.

Medicare Preventative Services

Medicare Quick Reference Charts can be found here as well as here.

a. **Tobacco Cessation**

i. **Medicare** information can be found here.

ii. **Description**-Recognizing the health related problems caused by smoking and tobacco use, Medicare (and other payers) covers counseling to help patients understand the benefits of tobacco cessation and take steps to do so.

1. **Requirements**: Patients must be a tobacco user at the time of billing (with or without the presence of tobacco related health complication), must be competent at the time of counseling
2. **Coverage**: Medicare covers 2 quit attempts (8 sessions per calendar year), Medicare also covers an E&M visit on the same day if medically necessary.
4. **Tenncare Coverage**: Tenncare now covers smoking cessation products for all beneficiaries. Further information can be found here.
5. **Cost**: $0 coinsurance for counseling visits; however, if the quit plan involves medication, depending on the Part D medication coverage (if any) or other medication coverage, there may be payment required for nicotine replacement products, Chantix®, bupropion or other products.
5. **Other Info**: 1-800-QUITNOW -Free Coaching for Smoking Cessation for any patient. For more information, click here.

iii. **Coding and Billing**

1. **99406:** 3-10 minutes for asymptomatic patient, intermediate visit
2. **99407:** 10 minutes for asymptomatic patient, intensive visit

iv. **Considerations for Pharmacists-**For Medicare patients, services may be performed and billed by pharmacists following "incident to" guidelines. Other payors may directly reimburse pharmacists; consult contracts or contact carriers for further information.

b. **Cardiovascular Risk Counseling**

i. **Medicare** information can be found here.

ii. **Description**-Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes.

1. **Requirements:** Patients must competent and alert when counseling is delivered, must receive counseling from a PCP or other qualified provider in a primary care setting
2. **Coverage**: Medicare covers one session annually, *eligible for telehealth*
2. **Cost**: $0 copay, no coinsurance and deductible does not apply
3. **Components**: Counseling should include encouraging the use of aspirin for the primary prevention of CVD when the benefits outweigh the risks for men age 45-79 years and women 55-79 years, high blood pressure screening and behavioral counseling to promote a healthy diet for adults with hyperlipidemia,

hypertension, advancing age and other known risk factors for cardiovascular and diet related chronic disease

iii. **Coding and Billing**

1. **G0446:** Face-to-face behavioral counseling for cardiovascular risk reduction, 15 minutes

iv. **Considerations for Pharmacists-**Some commercial health carriers may reimburse G codes; consult contracts or contact carriers for further information.

v. **Resource**-The MLN Matters recommends aspirin use and dietary counseling using the Five As approach adopted by the USPSTF to help affect behavioral health changes.

c. **Diabetes Self-Management Education/Training**

ii. **Medicare** information can be found here.

iii. **Description**-Medicare refers to Diabetes Education as DSMT or Diabetes Self-Management Training. It is a preventive service that helps patients manage their diabetes and prevent additional complications. DSMT providers cooperate to offer patients with Type 1 or Type 2 diabetes services that include educating and empowering patients to better manage and control their conditions, reduce hospitalizations and complications, and reduce costs.

1. **Requirements:** Patients must be diagnosed with diabetes at the time of care, must have a provider referral for DSMT
2. **Coverage:** Medicare Part B may cover up to 10 hours of initial DSMT (1 hour of individual training and 9 hours of group training *[2-20 people]*). Medicare beneficiaries may qualify for 2 hours of follow up training each year if it takes place in a calendar year after the year the initial training was provided. *Initial DSMT is a once in a lifetime Medicare benefit.*
3. **Cost:** Patients are responsible for the 20% co-insurance and the Part B deductible applies. Many Medicare supplements cover this 20%.
4. **Accreditation:** *Accreditation must occur prior to any payment to DSMT organizations or providers*. CMS approves accreditation by 2 organizations.
    a. The American Diabetes Association (ADA)
    b. The Association of Diabetes Care and Education Specialists (ADCES)

iii. **Coding and Billing**

1. **Codes**
    a. **G0108:** Diabetes outpatient self-management training services, individual, per 30 minutes
    b. **G0109:** Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes
    c. **GQ:** modifier for asynchronous telecommunications system
    d. **02:** Place of Service Code for telehealth
2. **DSMT Entities**
    a. Clinics
    b. DMEPOS
    c. FQHC
    d. Health Dept
    e. Home Health Agency
    f. Hospital (Outpatient only)
    g. **Pharmacy** (must be a part B provider)
    h. Skilled Nursing Facility

3. **DSMT Providers**
    a. Clinical Nurse Specialists
    b. Clinical Social Worker
    c. Nurse Practitioner
    d. Physician
    e. Physician Assistant
    f. Psychologist, Clinical
    g. Registered Dietitian/Nutrition Professional
4. **Excluded from Billing for DSMT**
    a. CDECS (stand alone)
    b. End-stage Renal Facility (Dialysis Center)
    c. Hospice Service
    d. Hospital Inpatient Service
    e. Nurse (billing alone)
    f. Nursing Home
    g. Pharmacist (**billing alone**)
    h. Rural Health Clinics

iv. **Considerations for Pharmacists**-Pharmacists may bill Medicare services under DSMT entities in clinics or community pharmacies. Some commercial health carriers may reimburse G codes; consult contracts or contact carriers for further information.

v. **Resource-**https://www.orpca.org/initiatives/dtp/patient-engagement-tool-library/patient-self-management-and-education/198-telligen-cms-medicare-diabetes-self-management-training-tip-sheet/file

d. **Transitional Care Management**

i. **Medicare** information can be found here.

ii. **Description**-These services are provided when a beneficiary is discharged from a higher level of care to their home or lower level of care to help make sure the transition is effective, the patient receives appropriate care, gaps in care are closed and the patient is more closely monitored.

1. **Requirements:** Patients transitioning from an inpatient hospital setting like acute, psychiatric, long-term care, skilled nursing, rehab hospital, or observation status to the patient's own home, rest home, community mental health center, or assisted living facility. *The practitioner must obtain consent before furnishing or billing for TCM (consent may be verbal or written but MUST be written in the medical record).*
2. **Coverage:** TCM services may be offered *within the 30 day period starting on the date when the beneficiary is discharged from inpatient care and continuing for the next 29 calendar days* including the following 3 components:
    a. **Interactive Contact**-within 2 days of discharge date, the provider initiates direct and interactive communication with the patient (telephonic, in person or electronic). This contact may include scheduling a follow up appointment but must also address the types of services the patient had during admission, what discharge diagnosis was and what follow up services are needed
    b. **Face to face visit-**required face to face time must be furnished under minimum direct supervision (supervision of auxillary staff by billing

practitioner), may be provided beginning on the day of discharge through day 30

c. **Non face to face services-**may be furnished under general supervision (the billing practioner provides overall direction and control, but their direct physical presence is not required during the provision of services), may be provided beginning on the day of discharge through day 30

vi. **Coding and Billing**

1. **99495:** Communication within 2 days of discharge, moderate complexity medical decision making during the service period, face-to-face visit within 14 calendar days of discharge
2. **99496:** Communication within 2 days of discharge, high complexity medical decision making during the service period, face-to-face visit within 7 calendar days of discharge
3. **G2025-**FQHC for moderate or high complexity decision making

vii. **Considerations for Pharmacists-**As part of the collaborative team, pharmacists may participate in manage and coordinating transitional care services under the supervising physician, who will likely bill directly for transitional care management services.

ix. **Resources-**

1. Reimbursement Tips: FQHC Requirements for Medicare Transitional Care Management (TCM)
2. Implementing Transitional Care Management in Primary Care Presentation

e. **Chronic Care Management**

i. **Medicare** information can be found here**.**

ii. **Description**-CCM aims to better coordinate the care that patients with two or more chronic conditions receive in order to prevent more costly and complicated medical problems.

1. **Requirements**: Patients are eligible for CCM if they have 2 or more chronic conditions, have seen their provider within the last 12 months, and consent verbally or in written form to the program. Patients are excluded from CCM if they have End Stage Renal Disease, are currently enrolled in Hospice Care, are receiving Home Health Care or are receiving CCM from another provider.
2. **Coverage**: 20 minutes or more of clinical staff time coordinating care for Medicare beneficiaries.
3. **Cost**: CCM is covered by Medicare at 80%, leaving 20% coinsurance for the patient's responsibility. The average reimbursement for CCM is around $40 total (in fee-for-service clinics) leaving around $8 for the patient responsibility if not covered by supplement, Medicaid, or other payer.
4. **Note**: In rural health clinics the initiating visit must be conducted under indirect supervision whereas fee-for-service clinics may outsource all parts of CCM.

v. **Coding and Billing**

1. **99490**: Chronic Care Management (20 min) provided by clinical staff directed by physician or other qualified health care professional per calendar month
2. **99491**: Chronic Care Management (30 min) provided personally by physician or other qualified health professional
3. **99487**: Complex Chronic Care Management Services (60 min) of clinical staff time directed by physician or other qualified health professional

4. **99489**: Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional

vii. **Considerations for Pharmacists-**CCM services may be billed by qualified health care professionals, including pharmacists. Through current Medicare regulations, pharmacist billing is indirect.

f. **Remote Patient Monitoring**

i. **Medicare** information can be found here.

ii. **Description-**Remote Patient Monitoring involves providing the beneficiary with an FDA cleared device for monitoring a health parameter by collecting health data from the patient's location and electronically transmitting that information securely to providers in a different location (data can include vital signs, weight, blood pressure, blood sugar, pacemaker information, etc.). When deviations from expected results are obtained, interventions can be made.

1. **Requirements:** Patients must have 1 or more chronic conditions (monitored by device provided). *The practitioner must obtain consent before furnishing or billing for RPM (consent may be verbal or written but MUST be written in the medical record).*
2. **Coverage:** 20 minutes or more of clinical staff time coordinating RPM services
3. **Cost:** RPM is covered by Medicare at 80%, leaving 20% coinsurance for the patient's responsibility. This is often covered by the Medicare supplements, Medicaid, or other payers; however, if that is not an option that will remain as the patient responsibility.

iii. **Coding and Billing**

1. **99453:** One-time device set up and patient education on use of device
2. **99454:** Monthly device provision and monitoring of patient data
3. **99457:** Device monitoring and patient communication, initial 20 minutes
4. **99458:** Device monitoring and patient communication, additional 20 minutes of service

vii. **Considerations for Pharmacists-**RPM services may be billed by qualified health care professionals, including pharmacists. Through current Medicare regulations, pharmacist billing is indirect.

viii. **Resource-Remote Patient Monitoring (RPM) Toolkit**