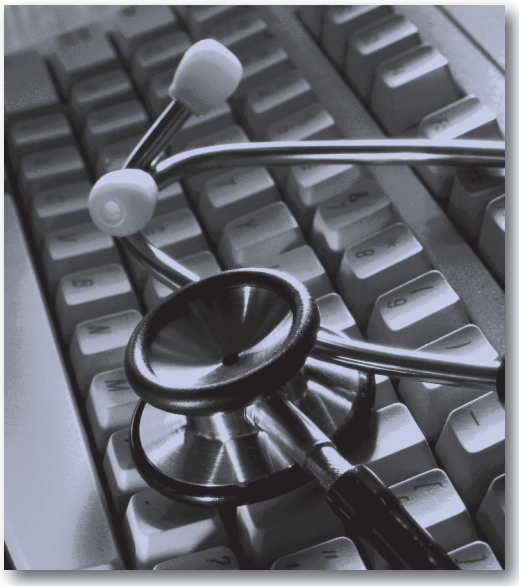
CHAPTER 7
Regulatory and Financial Considerations of Billing for Telehealth Pharmacy Practice



THE LANGUAGE OF HEALTHCARE BILLING

To communicate with those who are responsible for managing, submitting, and paying medical claims, it is beneficial to understand the process, common terms, and general rules utilized. Healthcare fee-for-service billing uses a payment process that employs code sets that describe what service, product, or procedure was provided (Healthcare Common Procedure Coding System [HCPCS] codes); why it was provided (10th revision of the International Statistical Classification of Diseases and Related Health Problems [ICD-10] codes); and who provided it (National Provider Identifier [NPI] number; **Figure 7.1**). A tax identification number (TIN) may be used in place of the NPI number if the claim is being submitted by an organization rather than an individual provider such as a hospital, health system, or medical group. The HCPC code is further adjusted by a factor called relative value units (RVUs) that considers variability in provider cost, value, and liability of the work performed when providing the service being billed.

Healthcare Common Procedure Coding System (HCPCS) Codes

HCPCS codes, often referred to as "hick picks," describe what was provided to the patient by the billing provider and may reflect a service, product, or procedure (**Table 7.1**). There are two levels of HCPCS codes: Level 1, which contains the Current Procedural Terminology (CPT) codes, which have five numeric digits (e.g., 99211), and Level 2 codes, which unlike Level 1 codes, begin with a letter followed by four numeric digits (e.g., G0108). The HCPC Level 1 CPT codes are owned and maintained by the American Medical Association (AMA) and licensed for use by CMS. An AMA standing committee creates, defines, reviews, updates, and distributes the CPT codes. There are three categories of CPT codes, for which only category 1 is used for patient care services. Within category 1 there are six subsections. The subsections of evaluation and management (E&M) and medicine, which contain the MTM codes, are the CPT codes usually used by eligible providers for reimbursement of pharmacist patient care services. Although Medicare does not recognize MTM codes under Medicare Part B, commercial plans may use the MTM codes in Medicare Part C and D if they so choose.

Because not all products and services are included in the AMA CPT codes, CMS created HCPC Level 2 codes. The categories of HCPC Level 2 codes range from A through V. The G codes are used for professional services and provide opportunities for pharmacist reimbursement for services, including several for direct reimbursement of diabetes-related services.

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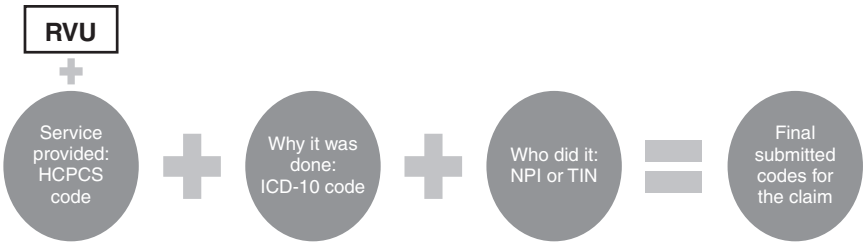

Figure 7.1. Healthcare billing structure

Table 7.1. HCPC Code Categories

Level 1 HCPC CPT Codes	

Category 1
• Evaluation and management (E&M): 99201–99499
  ◦ Example 99211–99215 (established patient codes)
• Anesthesia: 00100–01999; 99100–99150
• Surgery: 10000–69990
• Radiology: 70000–79999
• Pathology and laboratory: 80000–89398
• Medicine: 90281–99099; 99151–99199; 99500–99607
  ◦ Example 99605–99607 MTM codes
	Category 2
	• Supplementary tracking codes that are intended to be used for performance measurement. They are 4-digit numeric codes with an F at the end.
	Category 3
	• Emerging technology temporary codes have a T after the code, designating they are temporary.

Level 2 HCPC Codes	
A Codes: Transportation, medical supplies, miscellaneous, and experimental **B Codes:** Enteral and parenteral therapy **C Codes:** Temporary HOPPS (Hospital Outpatient Prospective Payment System) **D Codes:** Dental procedures **E Codes:** Durable medical equipment (DME) **G Codes:** Temporary procedures and professional services **H Codes:** Rehabilitative services **J Codes:** Drugs administered other than oral method, chemotherapy drugs	**K Codes:** Temporary codes for DME regional carriers **L Codes:** Orthotic/prosthetic procedures **M Codes:** Medical services **P Codes:** Pathology and laboratory **Q Codes:** Temporary codes **R Codes:** Diagnostic radiology services **S Codes:** Private payer codes **T Codes:** State Medicaid agency codes **V Codes:** Vision/hearing services

International Classification of Diseases, 10th Revision (ICD-10) Codes

The "why" a service is provided, or the diagnosis, is identified using a medical classification system termed ICD-10 codes, which are maintained by the World Health Organization under the direction and authority of the United Nations. The 11th Revision, or ICD-11, was released in 2018, with implementation expected to begin January 1, 2022. Besides expanding on new medical conditions and other diagnostic needs, ICD-11 will have improved digital utility linking with other classification and electronic terminologies that offer the promise of facilitating interoperability.

National Provider Identifier (NPI) / Tax Identification Number (TIN)

The provider of a billable service is designated by the NPI number, a 10-digit identification number that all U.S. healthcare providers (pharmacists included) and healthcare organizations can obtain. Administered by CMS, the NPI was created as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for use in electronic transactions of HIPAA information. Healthcare organizations have the option to bill under their TIN. In this situation, the organization must alert CMS to the NPI numbers associated with the submitted billing occurring under their TIN.

Resource-Based Relative Value Scale

The Resource-Based Relative Value Scale (RBRVS) is a payment modifier system created to level the payment due to variation in provider resources and skills associated with CPT billing codes. The practice variations that RBRVS addresses are associated with costs of maintaining a practice (e.g., urban versus rural); level of physician technical skill, required judgment, and stress (e.g., an established patient visit for a neurosurgeon managing a brain tumor vs. a family practitioner managing a common cold); and differences in medical liability costs. Relative value units (RVUs) are added to CPT codes based on a mathematically calculated conversion factor, which is adjusted based on geographic location using the geographic practice cost indexes (GPCI; also referred to as "gypsies"). Because of the geographic adjustments, the reimbursement of any single code will vary across the country. An AMA committee meets several times a year to make RVU value recommendations that CMS reviews and adopts.

Use of Modifiers

Billing modifiers are usually required when delivering telehealth services, most often when using codes that would be utilized during face-to-face encounters. Billing modifiers provide additional information about the service and may be used to help describe why multiple codes are being billed (i.e., using modifier 25 when conducting an Annual Wellness Visit [AWV] the same day a physician sees the patient for a problem-focused visit) or some other nuance to the service provided, such as modality. Similarly, it must be understood whether regulations require each code and/or service to utilize both audio/video technologies or whether other modalities are allowed.

Universal Billing Forms

Billing forms developed by CMS are utilized as the universal forms for submitting bills to Medicare and most other payers of healthcare services. For services reimbursed under Medicare Part A, the paper CMS-1450 form, also called the Universal Billing or UB04 form, is used; the electronic version is called 837I. For services paid under Medicare Part B, the paper CMS-1500 form is the standard form and the 837P form is used for electronic submissions. Instructions for completing the forms may be found on the CMS website.

GENERAL BILLING RULES

To prevent fraud and abuse, CMS has established rules to govern Medicare billing. CMS states that billing charges should be usual, customary, and reasonable; meaning that charges should be the same or similar to other like providers delivering the same medical service within a geographic area. Thus, the charges for your service should be equivalent to what is a typical cost or charge for pharmacists in your area providing the same service. This rule needs to be considered when subcontracting with a provider who will bill your services as incident-to theirs. A second rule is that services

should be medically necessary, defined as healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms meet accepted standards of medicine. When services are referred to a pharmacist, the medical necessity for such a referral in treating the patient's condition should be documented by the referring provider. A third rule is that providers accepting Medicare and Medicaid payment may not discriminate against Medicare and Medicaid patients; for example, they cannot provide a different level of service for Medicare or Medicaid patients versus their service for commercial patients for the same billing code. To avoid risk of Medicare fraud or abuse, unless there exists a specific contract with payers, providers and payers universally follow Medicare rules for submitting bills to request payment for services provided.

TELEHEALTH PHARMACY PRACTICE SPECIFICS

An understanding of billing codes and mechanisms for pharmacists is a necessary foundation for exploring how to appropriately provide and bill for telehealth pharmacy practice services. Similarly, deciphering the CMS guidelines for billing and reimbursement can often be the most challenging task in establishing a sustainable telehealth pharmacy practice service. While CMS is not the only payer of telehealth pharmacy practice services, as mentioned, it often sets the precedent for how other payers will set up their services. It is important to note that in order to get proper reimbursement for telehealth pharmacy practice services, you must understand not only the federal and state regulations, but also the documentation requirements, codes allowed under telehealth, and what services can actually be performed under these codes. The combination of this information becomes the who, what, where, and how of telehealth pharmacy practice delivery and billing.

- *Who*: The who of telehealth regulations refers to which provider or healthcare professional types can bill these services. Medicare originally designated only nine provider types as being allowed to bill telehealth encounters that included Medicare B recognized providers, such as physicians, nurse practitioners, and physician assistants. Since the COVID-19 public health emergency (PHE), all qualified healthcare professionals may bill for services within their scope of practice via telehealth. As a reminder, pharmacists are not a qualified healthcare professional per Medicare rules and regulations. Thus, they cannot directly bill Medicare, but their services may be billed incident-to a physician or Medicare-eligible provider when certain requirements are met.
- *What*: The what of telehealth describes the specific list of services and codes that can be provided via telehealth. Refer to link (updated Aug 2021): https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.
- *Where:* The where of telehealth refers to not only where the patient is located but also to the provider. Prior to COVID-19, patients had to be located a specific distance away from the clinic and/or in a healthcare provider shortage area. Likewise, the regulations specified providers must render services from their billing locations. Federal regulations have now waived the location requirements to allow both patients and providers to engage in telehealth visits from their homes. This continues to evolve and may vary between payers and state regulations. Generally, the patient and provider must be physically present in the state in which the provider is licensed. State and commercial payer requirements may vary.
- *How*: The how of telehealth relates to the specific modality of delivery. Whether the visit is audio/video, audio only, asynchronous messaging (such as via a portal), or remote patient monitoring differs in which providers or ancillary team members can perform and bill for each modality. The how may also refer to the platform used and the requirements for each modality.