



Dear Ann:

We are writing to request an in-person or virtual meeting with CMS staff to discuss pharmacist services. As COVID-19 continues to spread across the country, pharmacists have stepped up to fill critical roles – they are managing medication regimens for COVID-19 patients, mitigating drug shortages, and providing vital complex management of chronic conditions. The pandemic has highlighted the importance of pharmacists, but it has also laid bare some of the continuing barriers to fully integrating and engaging pharmacists in healthcare teams. Collectively, our organizations have submitted numerous comments detailing these barriers and we believe that a face-to-face discussion might help finally address and resolve these concerns to the benefit of our patients and the nation’s healthcare system. While we greatly appreciate CMS’ recent statements regarding pharmacists’ engagement in patient care services in the Physician Fee Schedule (PFS) proposed rule for CY 2021, additional clarification is necessary to ensure patient access and the development and continuity of effective care delivery models. Specifically, we would like to address the lack of clarity around billing for pharmacists providing higher level evaluation and management (E/M) services (E/M codes above 99211 (99212-99215) that are provided incident to a physician or non-physician practitioner (NPP) and to discuss additional areas for pharmacist engagement.

Regarding incident-to billing, to ensure patients have access to critical services, whether provided in-person or via telehealth, CMS must ensure that physicians or non-physician practitioners (NPPs) can bill for pharmacists’ services using billing codes reflective of the complexity, duration, and intensity of the services. However, at present, confusion remains regarding which codes can be billed for services provided by auxiliary personnel incident to a physician or NPP. It is not feasible that a pharmacist providing a 45-minute office visit to manage multiple chronic conditions and multiple medications for a complex Medicare beneficiary under an incident to arrangement with a physician would be limited to having the service billed as a Level 1 visit (99211), that only has an anticipated time commitment of 5 minutes. We have had limited discussion with CMS representatives in other meetings about this issue, and now would like to have a specific meeting to discuss this topic. We can provide case studies that highlight the types of complex services pharmacists are providing incident to physician services.

In 2016, the Physician Fee Schedule (PFS) Final Rule stated that eligible providers could bill for auxiliary personnel provided incident-to services “...as if they personally furnished the service.”¹ However, CMS’s plan in the 2020 PFS Final Rule² to adopt the AMA CPT E/M Office or Other Outpatient and Prolonged Services Code and Guideline Changes in 2021³ created new confusion around incident-to services. The guideline notes that “[t]he E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional...if the physician’s or other qualified health care professional’s time is spent in the supervision of

¹ CMS. Medicare program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to part B for CY2016. (Final rule). Federal Register. 80: 220. (November 16, 2015) p. 71066 <https://www.federalregister.gov/d/2015-28005/p-1578>. Accessed June 22, 2020.

² CMS. Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies. (Final rule). Federal Register. Federal Register. 84. (November 15, 2019) <https://www.federalregister.gov/documents/2019/11/15/2019-24086/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other>. Accessed July 29, 2020.

³ AMA. CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes. 2019, available at: <https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf>

clinical staff who perform the face-to-face services of the encounter, use 99211.”⁴ The guideline further notes that “[f]or E/M services that require prolonged clinical staff time and may include face-to-face services by the physician or other qualified health care professional, use 99415, 99416. Do not report 99354, 99355 with 99415, 99416, 99XXX.”⁵ Additionally, the guideline’s definition of the term “medical decision making,” differs from the current CMS definition, which could potentially limit the ability of auxiliary staff to participate in patient care.⁶ Read together, these statements suggest that incident-to billing is limited only to codes 99211, 99415 and 99416, which is a total departure from CMS’ policy as outlined in the FY 2016 PFS.

These contradictory statements have generated uncertainty among provider compliance officers and Medicare Administrative Contractors (MACs). Some MACs have indicated that medication management services provided by pharmacists cannot be billed higher than 99211, even when a physician is involved, despite the complexity, decision making and time necessary to provide certain services. Limiting providers to billing the lowest E/M codes will limit the provision of high-quality, accessible care and shift additional burden to already overtaxed physicians. Studies have shown that without the ability to utilize incident-to services provided by pharmacists and other clinical staff, the average physician would need to see patients for 18 hours each day, every day of the year just to meet the minimum recommended preventative services and chronic care requirements.⁷ Physicians are suffering burn out with current caseloads – removing vital clinician support will only exacerbate the problem. Thus, it is imperative that CMS work with us to resolve these billing concerns.

We believe pharmacists are key to increasing patient access and improving health outcomes. We look forward to discussing the value and contributions pharmacists provide and working collaboratively with CMS to ensure our healthcare system fully and effectively capitalizes on those contributions.

Please contact Jillanne Schulte Wall at jschulte@ashp.org and Michael Baxter at mbaxter@aphanet.org to arrange a face-to-face meeting with our organizations to discuss these important issues which need to be urgently addressed before the 2021 PFS proposed rule is finalized.

We look forward to meeting with you soon.

Sincerely,



Tom Kraus, J.D.
ASHP Vice President, Government Relations



Ilisa BG Bernstein, Pharm.D., J.D.
APhA Senior Vice President, Pharmacy Practice and
Government Affairs

⁴AMA CPT Editorial Panel (2019) at 1-2.

⁵AMA CPT Codebook, p. 14.

⁶ Id. At 6; CMS definition in MLN matters.

⁷ See Kimberley Yarnall et al., “Primary Care: Is There Enough Time for Prevention?” AM. J. PUB. HEALTH (April 2003), available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447803/> (Finding that a primary care physician with a typical panel of 2,500 patients would need 7.4 hours every day to provide all recommended preventive services to patients); T. Ostbye et al., “Is there time for management of patients with chronic diseases in primary care?” ANN. FAM. MED. (May-June 2005), available at: <https://pubmed.ncbi.nlm.nih.gov/15928223/> (Finding that a physician would need 10.6 hours each day, every day to provide all chronic care services for a typical patient panel).