

**FAQ: Alternatives to “incident-to” billing for revenue generation in non-facility  
(physician-based) ambulatory clinics for pharmacists  
Date of Publication: March 2019**

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**Purpose:** This document aims to answer frequently asked questions about opportunities for pharmacists billing for services beyond using “incident-to” rules in non-facility clinics. “Incident-to” frequently asked questions are addressed in another document.

Non-facility clinics are physician owned outpatient practices or hospital affiliated practices with a different tax identification number than the hospital. In comparison, hospital-based outpatient services are hospital-owned facilities and services are billed using a facility fee. Facility fee billing is not discussed here.

## **1. Beyond CPT “incident-to” codes, what are other opportunities for revenue generation in non-facility (physician-based) ambulatory clinics?**

Opportunities for revenue generation include Diabetes Self- Management Training/Education (DSMT/E), insulin pump training, Medicare Annual Wellness Visits, Chronic Care Management (CCM), Transitional Care Management (TCM), and immunizations. Each of these is described below.

### *Diabetes Self- Management Training/Education (DSMT/E)*<sup>1</sup>

For complete information, refer to CMS Medicare Benefit Policy Manual Chapter 15, Section 300. G codes (e.g. G0108 and G0109) can be used for DSMT/E if you have an accredited Diabetes Self-Management Education program (accredited or recognized by American Diabetes Association or American Association of Diabetes Educators). The certified diabetic educator credential (CDE) is not required, except if an RD or nutrition professional is the sole instructor in the DSMT program. These can be run and managed by one discipline, but RD, RN, or RPh must be the program instructor and a team approach is encouraged. Pharmacists who develop/manage these programs do not have to be CDEs. Billing must use the NPI of the practice or pharmacy, not the individual NPI of the pharmacist. The code G0108 is used for each 30 minutes of an individual DSMT/E session (reimbursement rate around \$51). Medicare covers this if no group session is available within 2 months (plus other criteria). The code G0109 is used for each 30 minutes of a group (2 to 20 persons) DSMT/E session (reimbursement rate around \$15/patient). Payment to non-physician practitioners for DSMT program services (G0108 or G0109) are paid at the full fee schedule (not at 85% of fee schedule).

Note: Diabetes Self-Management Training (DSMT) = Diabetes Self-Management Education (DSME) Medicare term is DSMT, thus DSMT refers to DSME that is reimbursable.

### *Insulin pump training*<sup>2,3</sup>

Billing for insulin pump training can be done as part of DSMT/E and billed under G0108 and G0109. In order to bill for this training, the facility must have an ADA or AADE recognized or accredited DSMT/E program. Instead of the above option, insulin pump training and education is often included in the price to the payer. The pump training is paid by the pump company to the individual pump trainer, or to the clinic. Aside from billing directly for insulin pump training, the counseling services provided as part of this education can count as a component of E&M services (99212-99215). Education-specific CPT codes, 98960-98962, are not paid by Medicare, but may be paid by private payers (these codes do not require a DSMT program to be recognized by ADA or AADE, but the program must have a standardized curriculum).

A certified pump trainer can be reimbursed a fixed amount from the pump company that covers up to 2 months of training and management. If any additional education or management is required by the patient after the 2 months of initial training, the pharmacist educator may bill the patient’s individual insurance provider under diabetes education and self-management codes (Healthcare Common Procedure Coding System codes G0108 and G0109) provided the pharmacist practices in an ADA- or

AADE-recognized or accredited program. Most patients will have cost sharing through their payer that the pharmacist must collect in the form of a deductible.

#### Medicare Annual Wellness Visits (AWV) <sup>4</sup>

Annual Wellness Visits were established under the Affordable Care Act, effective January 1, 2011. These services are covered by Medicare for beneficiaries who are no longer in the first 12 months of their first Part B coverage period. Prior to an AWV, an Initial Preventative Physical Examination (IPPE), “Welcome to Medicare Preventative Visit,” is completed by a physician or qualified non-physician practitioner. A pharmacist may not provide or bill for the IPPE service. This initial preventative visit is paid for completely by Medicare. Following the IPPE, other licensed, non-physician practitioners working under the direct supervision of a physician may perform subsequent Medicare Wellness. Pharmacists may provide and bill for these services. The HCPCS codes for these Medicare wellness visits are G0438 and G0439.

Please reference the [Medicare Annual Wellness Visits FAQ](#) for more detail on this service

#### Transitional Care Management <sup>5</sup>

Transitional Care Management (TCM) codes 99496 and 99495 went into effect on January 1, 2013 as part of the Affordable Care Act. The Transitional Care Management services can be used to bill for physician and “qualified non-physician providers” care management following discharge from an inpatient hospital setting, observation setting, or skilled nursing facility. Pharmacists can serve as the “qualified non-physician providers” to provide some of these services. However, the claim for these services must be submitted under a Medicare recognized provider, so a pharmacist in this role must collaborate with a licensed Medicare provider. Pharmacists may provide the non face-to-face care and coordination components of these visits. In addition, they may be involved in the face-to-face visit and assist the Medicare recognized provider by assessing and supporting treatment regimen adherence and medication management. To contribute to TCM services, the pharmacist must meet the “incident-to” requirements described in CMS Benefit Policy Manual Chapter 15 Section 60 with the exception of direct supervision. General supervision is permitted for TCM services. The TCM claim should be submitted on the day of the face-to-face visit. Only 1 TCM claim may be paid by CMS within a 30 day time period.

Please reference the [Transitional Care Management FAQ](#) for more detail on this service

#### Chronic Care Management (CCM) <sup>6</sup>

CCM codes, 99490, 99487 and 99489, may be billed for Medicare beneficiaries with two or more chronic conditions. Licensed clinical staff may perform in person or telephonic management for enrolled participants billed under the qualified healthcare provider. Please reference the [Chronic Care Management FAQ](#) for more detail on this service.

### Immunizations<sup>7</sup>

The vaccines that may be provided by a pharmacist, and the ages for which you are allowed to vaccinate, vary by state law.

To administer Part B covered vaccines, you must be enrolled in a Medicare program with a provider number. This Medicare provider number will be the pharmacy's, not an individual pharmacist's. A specific immunization provider number will be obtained from a Medicare Part B Fiscal Intermediary for the pharmacy. If you are located in a physician office, immunizations administered at this site can be billed with the physician's Medicare Part B number. This Medicare provider number can be obtained using form CMS-855.

In addition to Part B covered vaccines, pharmacists are also able to administer Part D vaccines. Beginning January 1, 2008, the negotiated price for a Part D vaccine is comprised of the vaccine ingredient cost, a dispensing fee (if applicable), sales tax (if applicable), and a vaccine administration fee. Medicare Part D covered vaccines should NOT have a separate copay for the vaccine and its administration. If a Part D plan charges coinsurance, it should be applied relative to the entire price of both components. Listed below are commonly administered vaccines and further information regarding their administration and diagnosis codes.

Additionally, pharmacists in the clinic setting may administer both Part B and Part D vaccines. Part B vaccines are generally billed under the supervising physician (or other qualifying provider). Part D vaccines can be billed, but often require an online intermediary platform for proper billing. Outside of Medicare, commercial payers and Medicaid may be billed under the supervising provider with pharmacists functioning as additional clinical staff.

Importantly, Medicare will not pay for a vaccine administration when billed with a 99211 on the same date of service. When a higher complexity level CPT code is performed the vaccine administration should be reported with modifier -25.

## **2. Can a pharmacist use the MTM CPT codes when working in a physician-based clinic?**

For Medicare beneficiaries seen in a physician office by a pharmacist, MTM CPT codes are not recognized, since physician offices fall under Medicare Part B. Medicare recognizes MTM services only under Part D. Under Medicare Part D, MTM services are paid through administrative fees to a Prescription Drug Benefit Plan. If your physician office or clinic has a dispensing licensed pharmacy, there is an opportunity to contract with Prescription Drug Benefit Plans to provide MTM and use the MTM codes through that venue. The physician-based clinic may have specific private payer contracts or state Medicaid opportunities that will allow the utilization of the MTM CPT codes in this setting. If there are no such opportunities in your setting, the default is to Medicare billing rules.<sup>8</sup> **References**

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### Acknowledgements

**Elena Kline, PharmD, BCGP, BCACP, Certified Health Coach**

Core Faculty, Troy Beaumont Family Medicine  
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We kindly thank the contributors from previous versions of this document, including Mary Ann Kliethermes, Ashley Marie Parrott, Gloria Sachdev, Renu F. Singh, and Amy Stump.