Billing for pharmacists' cognitive services in physicians' offices: Multiple methods of reimbursement

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Abstract

Objectives: To evaluate the charges and reimbursement for pharmacist services using multiple methods of billing and determine the number of patients that must be managed by a pharmacist to cover the cost of salary and fringe benefits.

Setting: Large teaching ambulatory clinic in North Carolina.

Main outcome measures: Annual charges and reimbursement, patient no-show rate, clinic capacity, number of patients seen monthly and annually, and number of patients that must be seen to pay for a pharmacist's salary and benefits.

Results: A total of 6,930 patient encounters were documented during the study period. Four different clinics were managed by the pharmacists, including anticoagulation, pharmacotherapy, osteoporosis, and wellness clinics. "Incident to" level 1 billing was used for the anticoagulation and pharmacotherapy clinics, whereas level 4 codes were used for the osteoporosis clinic. The wellness clinic utilized a negotiated fee-for-service model. Mean annual charges were $65,022, and the mean reimbursement rate was 47%. The mean charge and collection per encounter were $41 and $19, respectively. Eleven encounters per day were necessary to generate enough charges to pay for the cost of the pharmacist. Considering actual reimbursement rates, the number of patient encounters necessary increased to 24 per day. "What if" sensitivity analysis indicated that billing at the level of service provided instead of level 1 decreased the number of patients needed to be seen daily. Billing a level 4 visit necessitated that five patients would need to be seen daily to generate adequate charges. Taking into account the 47% reimbursement rate, 10 level 4 encounters per day were necessary to generate appropriate reimbursement to pay for the pharmacist.

Conclusion: Unique opportunities for pharmacists to provide direct patient care in the ambulatory setting continue to develop. Use of a combination of billing methods resulted in sustainable reimbursement. The ability to bill at the level of service provided instead of a level 1 visit would decrease the number of patients needed to pay for a pharmacist.

Keywords: Billing codes, reimbursement (pharmacist), pharmacy services, clinical pharmacist practitioners.

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Medication therapy management (MTM) services positively affect patient care. Positive outcomes described in the literature include improved quality indicators for patients with chronic diseases and decreased health care costs.[1–5] Despite the benefits of MTM services for individual patients and the health care system, these services are not consistently reimbursed.[6]

Historically, pharmacists have billed for product delivery but not for cognitive services. During the past decade, the profession has focused on obtaining provider status for pharmacists and developing sustainable reimbursement models for direct patient care services. Core components of MTM have been defined by national organizations,[7] and most states allow pharmacists to deliver immunizations. The Health Resources and Services Administration has developed the award-winning Patient Safety and Clinical Pharmacy Services Collaborative to integrate clinical pharmacy services into the care of high-risk patients.[8] Current Procedural Terminology (CPT) codes for MTM services have been developed; however, these codes are not recognized by all payers.[9,10] The Asheville Project developed a care model that improved outcomes for patients with chronic illnesses such as diabetes, asthma, hypertension, dyslipidemia, and depression.[1–3]

Health care reform and the growth of the patient-centered medical home (PCMH) model and accountable care organizations increase the need for pharmacists in ambulatory care settings. The role of the pharmacist in PCMH has been previously described.[11,12] The 2007 joint principles focused on the foundational elements of PCMH, including the following: (1) every patient has a personal physician, (2) care is provided in a physician-directed medical practice that includes a health care team, (3) whole person care is provided, (4) care is integrated and coordinated, (5) enhanced access to care and services is provided, and (6) reimbursement models recognize the value of PCMH.[13] According to the joint principles, payers should pay for services related to coordination of care, for face-to-face services, and for care provided outside of an office visit; practices for improving the quality of care should be rewarded; and practices to share in health care savings from decreased hospitalizations should be allowed.[13] Currently, the most common methods for billing for pharmacist services in physician offices involve facility fees in hospital-based clinics and the "incident to" model in private practice. Use of MTM codes has not been widely adopted in ambulatory care because of lack of reimbursement by third-party payers. An analysis of pharmacist charges for services in ambulatory clinics noted that the mean charge per visit using the "incident to" model was $37 for a level 1 visit. Moreover, the authors demonstrated that conversion from established "incident to" billing to use of pharmacist MTM codes would be cost prohibitive.[14] This article describes the charges and reimbursement rates associated with billing for pharmacist services in a family health center.

At a Glance

Synopsis: Based on a retrospective analysis of financial data during a 4-year period (2006–10) in an ambulatory care practice with well-established clinical pharmacy services in western North Carolina, the authors evaluated the charges and reimbursement rates associated with billing for pharmacist services. They considered multiple billing methods to determine the number of patients that must be seen by a pharmacist to cover the cost of a pharmacist's salary and fringe benefits. A sensitivity or "what if" analysis examined the impact of visit charges on patient volume that is needed to pay for the cost of the pharmacist. The authors found that the ability to bill at the level of service provided instead of a level 1 visit would decrease the number of patients needed to pay for a pharmacist.

Analysis: *Cognitive services in an ambulatory care pharmacy are billed using a variety of methods, but because pharmacists do not have provider status, insurance companies do not routinely allow Current Procedural Terminology (CPT) codes higher than a level 1 visit. This study used a "what if" sensitivity analysis to evaluate how CPT code charges affect the number of patients that must be seen daily to pay for the cost of the pharmacist's salary and fringe benefits. The "what if" analysis demonstrated that if pharmacists were able to bill a CPT code at higher levels, the number of patients needed to be seen daily to pay the pharmacist would decline. Although ambulatory care pharmacists routinely provide the level of care that would warrant billing a higher level of service, lack of provider status limits the profession from appropriate reimbursement for services rendered.*

Objectives

The objectives of this study were to (1) evaluate charges and reimbursement for pharmacist services in an outpatient family health center recognized as a PCMH and (2) determine the number of patients that must be managed by a pharmacist to cover the cost of salary and fringe benefits. A sensitivity or "what if" analysis was performed to examine the impact of visit charges on patient volume that is needed to pay for the cost of the pharmacist.

This study was a retrospective analysis of financial data during a 4-year period (2006–10) in an ambulatory care practice with well-established clinical pharmacy services. Data were collected from monthly and annual internal financial reports and an electronic medical record and included annual charges and collections, clinic capacity, number of patients seen (monthly and annually), and patient no-show rates. Data were included from three established clinics, including anticoagulation, pharmacotherapy, and osteoporosis clinics. In addition, projections for charges were determined for a new wellness clinic that began after the study period (Table 1).

Setting

Mountain Area Health Education Center (MAHEC) Family Health Center provides medical care for approximately