

FAQs: Billing for Supervised Medication Deprescribing Services Under Care Management Codes on the Medicare Physician Fee Schedule (PFS)

Medication deprescribing—the planned, supervised process of dose reduction or discontinuation of a medication when its continued use may no longer be providing net clinical benefit—is an increasingly recognized component of high-quality, patient-centered care. Despite growing clinical consensus that deprescribing constitutes active medical management, practitioners have reported uncertainty about whether existing physician care management service codes encompass this work and can be used to bill for aspects of deprescribing furnished in-between office visits.

This document illustrates some of the ways in which ongoing, medically necessary clinical management related to tapering or discontinuing medication, may be included in various care management service code families for payment under the Medicare Physician Fee Schedule (PFS). While it would not be possible to describe every physician service that potentially includes medication management, we provide some notable examples to assist practitioners. We note that medication management is covered under both Medicare Part B and Part D, so deprescribing work that is already paid for as part of medication management under Part D, cannot also be billed to the PFS. Practitioners must ensure that they meet all criteria for billing the various PFS services, which encompass more than just medication-related work, and avoid duplicative billing.

1. What is medication deprescribing?

Medication deprescribing is the planned, supervised process of dose reduction or discontinuation of a medication when its continued use may no longer be providing net clinical benefit. It can involve any type of medication requiring a carefully monitored, supervised dose reduction or discontinuation process including hypertensives, corticosteroids, and psychotropic medications (e.g., antidepressants). Medication deprescribing may include:

- Developing, reviewing, and revising a care plan for deprescribing, including the tapering schedule, target doses, and contingency plans for symptom recurrence or discontinuation reactions.
- Monitoring and assessing patient-reported symptoms between visits (e.g., via patient portal messages, structured symptom questionnaires, phone or other electronic check-ins), including symptoms of withdrawal/discontinuation syndrome and signs of relapse or re-emergence of the underlying condition.
- Communicating with the patient (or caregiver) about taper progress, symptom management strategies, next dosing steps, and when to seek urgent care.
- Coordinating care among members of the treatment team (e.g., between prescribing practitioner, clinical pharmacist, therapist) regarding the deprescribing plan.
- Adjusting the taper schedule based on patient response, including dose holds, slower taper increments, or temporary dose increases to manage discontinuation symptoms.

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- Medication management activities, including reviewing the patient’s full medication list to identify interactions or complications relevant to the taper, and communicating dose changes to the pharmacy.
- 2. Does medication deprescribing qualify as a billable care management activity under the Chronic Care Management (CCM) and Principal Care Management (PCM) codes?**

Medication deprescribing can be counted as billable time under the CCM codes (CPT codes 99437, 99439, 99487, 99489, 99490, 99491) or PCM codes (CPT codes 99424, 99425, 99426, 99427), if all other requirements to bill these services are met. The CCM and PCM service elements include medication reconciliation, management and oversight of self-management as part of comprehensive care management (see the CY 2020 PFS final rule Tables 23 and 24 at 84 FR 62695 through 62696). Similarly, the PCM code descriptors include care management for a single high-risk disease that may require frequent adjustments in the medication regimen (among other criteria). Related clinical activities commonly performed as part of deprescribing, such as medication review, care plan development and revision, symptom monitoring, patient communication, and care team coordination may be counted, as reflected in CCM and PCM service elements.

3. Can a clinical pharmacist’s time be counted for deprescribing activities?

Yes, pharmacists can provide services incident to the professional services of a physician or non-physician practitioner just as other clinical staff may do (see the CY 2021 PFS final rule at 85 FR 84592 through 94593). These “incident to” services can count as billable time for reporting various care management services to the PFS under the appropriate level of supervision and other applicable “incident to” rules, and consistent with the care management service definitions. Pharmacists must be working within their scope of practice and in accordance with applicable state law, and the services cannot also be covered under Medicare Part D or paid under other Part B services. CMS encourages team-based care models that leverage the expertise of clinical pharmacists in medication management and deprescribing.

4. Are there specific clinical guidelines CMS expects clinicians to follow for deprescribing activities?

Aspects of certain PFS service codes may require evidence-based care (such as use of a validated rating scale), but most PFS care management services do not require adherence to any single clinical guideline for payment. Please refer to the full billing instructions for a given code set. We expect clinicians to exercise evidence-based clinical judgment for deprescribing activities. Widely recognized resources for deprescribing include guidelines from professional societies, peer-reviewed deprescribing protocols, and FDA-approved drug labeling regarding recommended tapering schedules. The deprescribing plan should be individualized to the patient’s clinical circumstances.

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5. Can the Behavioral Health Integration (BHI) codes (General BHI and the Psychiatric Collaborative Care Management (CoCM) codes) be used to report deprescribing activities?

Behavioral Health Integration (BHI) services are care management services for behavioral health conditions that are integrated with primary care and provided over a calendar month(s). They include General BHI Care Management (CPT code 99484) and Psychiatric Collaborative Care Management (CPT codes 99492, 99493, 99494). These code families may encompass deprescribing activities, such as supervised tapering and discontinuation of selective serotonin reuptake inhibitors (SSRIs) and other psychiatric medications where patients require longitudinal monitoring for discontinuation syndrome, relapse risk, and dose adjustments. For example, the General BHI code descriptor includes facilitating and coordinating treatment such as pharmacotherapy, and follow-up monitoring including the use of applicable validated rating scales. The Psychiatric CoCM codes describe a very specific, evidence-based model of care that includes the administration of validated rating scales with development of an individualized treatment plan, tracking patient follow up and progress, and consultation of the prescribing primary care practitioner with a specially qualified psychiatric consultant (among other service elements). Practitioners could use these code families if all billing criteria are met.

6. How do I choose among care management service codes, when more than one may be relevant?

Practitioners should select the code set that most accurately reflects the services furnished (including the service period), the care team structure, and for which they meet all billing criteria. For example, the transitional care management service codes (CPT codes 99495-99496) include assessment and support for treatment regimen adherence and medication management, but are specific to post-discharge care and require a high-level in-person visit within a specified timeframe post-discharge. Also, medication reconciliation and management must be performed on or before the visit date. If a practitioner does not meet all of the criteria for TCM (for example, the patient is not post-discharge or does not receive the in-person visit) but is being weaned off a medication in relation to a serious illness, PCM or other care management services may still be appropriate for billing.

7. Where can clinicians find additional information about billing requirements for PFS care management services, and other billable services that may include medication deprescribing activities?

The CPT Codebook is a foundational resource, explicitly delineating service elements related to medication management for many different physician services. Practitioners can also work with their MAC to address additional questions regarding criteria for billing deprescribing activities under various care management and other PFS services. The PFS Care Management webpage provides additional resources and billing guidance: <https://www.cms.gov/medicare/payment/fee-schedules/physician/care-management>.

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