



Pharmacist Billing for Medicare Patients at Hospital Based Clinics - FAQ

Contact:

Justine Coffey, JD, LLM

Director, ASHP Section of Ambulatory Care Practitioners

sections@ashp.org

Please note: The responses to these questions apply to services furnished on or after January 1, 2011. Additionally, for the purposes of this document, the terms “technical fees” and “facility fees” are used interchangeably and represent “incident to” billing in a hospital-based outpatient clinic.

1. What is a “hospital based clinic”?

A hospital based clinic is a clinic that is financially tied to the hospital and appears on the hospital’s cost report. The clinic is a department of the hospital and has provider-based status in relation to the hospital under 42 CFR 413.65. *CMS Manual System, Pub 100-02 Medicare Benefit Policy, Transmittal 137, December 30, 2010.*

2. What is “facility billing”?

Facility billing is the hospital’s technical charge for services provided in an outpatient department of a hospital and represents “hospital resources utilized.” Pharmacists can bill for services in hospital-based clinics using CPT Evaluation and Management (E&M) Codes 99211-99215 for facility billing. See ASHP publication *Reimbursement for Pharmacist’s Services in a Hospital-based, pharmacist-managed Anticoagulation Clinic* for more information on when to use these codes:

http://www.ashp.org/DocLibrary/News/Pharmacist_managed_Anticoagulation_Clinics.pdf

3. If a doctor sees a patient in a hospital-based clinic and then a pharmacist provides additional counseling or evaluation, can both the doctor and the hospital bill for services?

Generally, only one CPT Evaluation & Management (E&M Code) may be used to characterize a specific patient encounter on a particular date of service. If a recognized provider from the same hospital outpatient department bills a professional fee and a facility fee for their services, other facility fee bills can be submitted as well. Thus, a pharmacist can bill “incident to” a

physician in this practice setting utilizing facility fee only billing (no professional fee for the pharmacist services).

4. What does “incident to” mean?

“Incident to” means the pharmacist is billing under a recognized CMS provider, including a clinical psychologist, licensed clinical social worker, physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife. The criteria for billing “incident to” in a hospital-based clinic include services that are:

1. Furnished by or under arrangements made by the participating hospital;
2. An Integral though incidental part of a physician’s or non physician practitioner’s services;
3. Furnished In the hospital or in a department of the hospital;
4. Furnished under direct supervision of a physician or non physician practitioner.

5. Can a pharmacist take care of patients without direct supervision in a hospital based clinic?

No. Direct supervision is the current standard for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments of hospitals. However, CMS will not enforce supervision requirements for outpatient therapeutic services in Critical Access Hospitals and Small Rural Hospitals for CY 2011.

http://www.cms.gov/HospitalOutpatientPPS/Downloads/CMS_1504FC_OPPTS_2011_FR_Physician_Supervision_Nonenf_Notice.pdf

6. Can a nurse practitioner, physician assistant, or other recognized provider provide direct supervision in a hospital-based clinic?

Yes. Physicians, clinical psychologists, licensed clinical social workers, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives may directly supervise therapeutic **services that they may personally furnish** in accordance with State law and all additional rules governing the provision of their services. *42 CFR 410.27(a)(1)(iv)* and *CMS Manual System, Pub 100-02 Medicare Benefit Policy, Transmittal 137, December 30, 2010.*

<http://www.cms.gov/transmittals/downloads/R137BP.pdf>

7. Does “direct supervision” mean the physician or non-physician practitioner has to be present in the room during the procedure?

No. For services furnished in the hospital, including an on-campus or off-campus outpatient department of the hospital, “direct supervision” means that the physician or non physician

practitioner must be immediately available to furnish assistance and direction throughout the performance of the procedure, but does not have to be present in the room. CMS has not specifically defined the word “immediate” in terms of time or distance. However, an example of a lack of immediate availability would be situations where the supervisory physician is performing another procedure or service that he or she could not interrupt. Also, for services furnished on-campus, the supervisory physician may not be so physically far away on-campus from the location where hospital outpatient services are being furnished that he or she could not intervene right away. See 42 CFR 410.27(a)(1)(iv), and CMS Manual System, Pub 100-02 Medicare Benefit Policy, Transmittal 137, December 30, 2010.

<http://www.cms.gov/transmittals/downloads/R137BP.pdf>

8. If my patient has normal laboratory values can I still bill the “facility billing” fees?

Yes, if a documented service has been provided in addition to the lab test. As stated on page 68062 of Federal Register / Vol. 71, No. 226 / Friday, November 24, 2006 / Rules and Regulations, “A hospital may bill a visit code, based on the hospital’s own coding guidelines, which must reasonably relate the intensity of hospital resources to the different levels of HCPCS codes. Services furnished must be medically necessary and documented.” Federal Register, Volume 71, Number 226, page 68062, <http://edocket.access.gpo.gov/2006/pdf/06-9079.pdf>. Please also see ASHP’s document *Reimbursement for Pharmacist’s Services in a Hospital-Based, Pharmacist-Managed, Anticoagulation Clinic* for further information.

http://www.ashp.org/DocLibrary/News/Pharmacist_managed_Anticoagulation_Clinics.pdf

9. Can a pharmacist use any of the “established patient” CPT codes?

Sometimes. When a recognized CMS provider (not a pharmacist) marks on a charge document the professional fee associated with 99211-99215, often the hospital will automatically associate the equivalent facility fee with 99211-99215 (in more astute hospital settings the professional fee and technical fees can be marked independently). Thus, there are two separate bills that are generated for each patient visit. The professional fee is reported on CMS form 1500 and the technical fee is reported on CMS form 1450. The pharmacist must be certain that when he/she marks 99211-99215, that the billing staff clearly understands that this is a designation for billing “incident to” services and thus should only bill the technical/facility fee on the CMS form 1450. Pharmacists should not charge a professional fee, billed on a CMS 1500, as they are not a recognized provider. To make the distinction more clear, often a hospital will develop an internal CPT code or add a modifier to the CPT code. For example, for CPT Code 99213, the hospital may add modifier 17, so that it is noted on the internal charge document as 9921317. 9921317 is not a real billable CPT code, but is an example of what a hospital might add to a charge document to track patient visits that are only billed a technical/facility fee. When the hospital billing staff sees a 9921317 on a charge document, they understand to bill just the 99213 technical fee on the CMS 1450 and not submit a CMS 1500 for that visit.

10. Is facility billing and the use of CPT codes the same thing as Ambulatory Payment Classifications (APC)?

The services provided in the outpatient setting are identified on the hospital's CMS 1450, aka UB 04 claim form using CPT codes. These codes are then matched to specific APCs, which are used by the Centers for Medicare and Medicaid Services to determine the annual Medicare prospective payment to the hospital. Essentially, CPT's are used to bill out for services and the associated reimbursement is noted as an APC. *See 42 CFR 410.27(a)(1)(iv), and CMS Manual System, Pub 100-02 Medicare Benefit Policy, Transmittal 137, December 30, 2010.*

<http://www.cms.gov/transmittals/downloads/R137BP.pdf>

11. Can a pharmacist use the Medication Therapy Management (MTM) CPT codes when working in a hospital based clinic?

MTM codes are not recognized nor are they reimbursable under Medicare Part B, which covers hospital-based outpatient services. Thus, they should not be used in this practice setting for any clinical pharmacy services. "Incident to" billing should be used in this practice setting. MTM CPT codes may be used to bill any health plan that covers MTM services, including the Medicare Part D Prescription drug benefit and some state Medicaid programs, but this does not guarantee recognition of these codes, nor reimbursement. *ASHP Policy Analysis: Pharmacist provider Status in 11 State health programs. Daigle, L., Chen, D., September 2008.*

<http://www.ashp.org/DocLibrary/Advocacy/ProviderStatusPrograms.aspx>.

12. Whose NPI number should be assigned to the patient's billing information when a pharmacist sees a patient in a hospital-based clinic?

The supervising physician/practitioner's NPI number should be assigned. If the ordering/referring physician is not able to provide direct supervision, the supervising physician/non physician practitioner's NPI should be used to bill for services on the CMS 1450 form.

13. If a pharmacist is not employed by the hospital, can they still bill for services provided to a hospital outpatient?

Yes. Medicare Part B does not pay for any service that is furnished to a hospital outpatient by an entity other than the hospital unless the hospital has arrangements with that entity to furnish that particular service to its patients. So a pharmacist would have to have an "arrangement" with the hospital to provide services. *Medicare Benefit Policy Manual, Chapter 6, Hospital Services Covered Under Part B, Rev. 137, 12/30/10.*

<http://www.cms.gov/manuals/Downloads/bp102c06.pdf>

14. What constitutes an “arrangement” for billing purposes under Medicare Part B?

The hospital may have a pharmacist furnish certain services to its patients through arrangements under which receipt of payment by the hospital for the services discharges the liability of the beneficiary or any other person to pay for the service. In permitting providers to furnish services under arrangements, it is not intended that the hospital merely serve as a billing mechanism for the pharmacist. Accordingly, for services provided under arrangements to be covered, the hospital must exercise professional responsibility over the arranged-for services. Once such arrangement might be for the hospital to contract for services from the organization supplying the clinical pharmacy services. Medicare General Information, Eligibility, and Entitlement Manual, Pub.100-01, chapter 5, section 10.3.
<http://www.cms.gov/manuals/downloads/ge101c05.pdf>.

15. Is a Collaborative Drug Therapy Management (CDTM) agreement needed for each patient cared for by a pharmacist in a hospital based clinic?

CDTM laws are specific to each state. Review your state laws for protocol and scope of practice before initiating your practice model.

16. Can pharmacists provide reimbursable patient care for episodes not related to any laboratory services in conjunction with a patient visit?

Yes. The services must be medically necessary and documented. Please see FAQ number 8 above for further information.

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Special Acknowledgement:

Developed by the Section of Ambulatory Care Practitioners' Clinical Business Development Section
Advisory Group

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Gloria Sachdev, PharmD, BS Pharm, RPh
Clinical Assistant Professor, Primary Care
College of Pharmacy
Purdue University;
Adjunct Assistant Professor
School of Medicine
Indiana University;
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Indianapolis, IN

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Mary Ann Kliethermes, BS, Pharm.D.
Associate Professor
Vice Chair - Ambulatory Care
Department of Pharmacy Practice
Chicago College of Pharmacy
Midwestern University
Downers Grove, IL

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Sciences
Albany, NY

Kathy Donley, B.S., MBA, R.Ph.
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Akron General Medical Center
Department of Pharmacy
Akron, OH

Santhi Masilamani, Pharm.D., CDE
Pharmacy Clinical Manager
Harris County Hospital District
Houston, TX

Jeffrey Rapp, Pharm.D.
Clinical Coordinator
Dept. of Pharmacy
St. Mary's Good Samaritan, Inc.
Centralia, IL

Steven M. Riddle, BS.Pharm., BCPS, FASHP
Vice President of Clinical Affairs
Pharmacy OneSource, Inc.
Bellevue, WA

Erika E Smith
Ambulatory Supervisor
Froedtert Hospital
Milwaukee, WI

Jeffrey Steffey, R.Ph., M.B.A., FMPA
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Mercy Hospital Grayling
Grayling, MI

Mark D. Triboletti, Pharm.D.
Clinical Pharmacy Specialist
Department of Veterans Affairs
Whitestown, IN

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Clinical Pharmacotherapy
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Akron, OH

ASHP Staff:

David Chen, R.Ph., MBA
Director, Pharmacy Practice Sections and
Section of Pharmacy Practice Managers
American Society of Health-System Pharmacists
Bethesda, MD

Justine Coffey, J.D., LL.M.
Director, Section of Ambulatory Care
Practitioners
American Society of Health-System Pharmacists
Bethesda, MD