

FAQ: Pharmacist billing using “incident-to” rules non-facility (physician-based) ambulatory clinic

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Purpose: This document aims to answer frequently asked questions about pharmacists billing using “incident-to” rules in non-facility clinics. 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. Other opportunities for revenue generation (beyond “incidentto”) are not discussed here. All services must be furnished in accordance with applicable State law.

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1. How does billing ambulatory pharmacist patient care services in a non-facility (physician-based) differ from billing in a hospital-based (facility) clinic?

Medicare

For Medicare patients, hospital-based outpatient services (including clinics) are governed by the Hospital Outpatient Prospective Payment System (HOPPS) regulations. Physician offices and physician-based clinics providing services for Medicare patients are not governed by HOPPS, but instead are governed by a number of CMS rulings that can be found at <http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html>. This site includes the Medicare Benefit Policy Manual which describes who can bill under Medicare Part B and the 1995 and 1997 Documentation Guidelines for Evaluation and Management Services which describes the documentation required for billing.

The Medicare Benefit Policy Manual describes which providers may bill under Medicare Part B. Pharmacists are not recognized Medicare Part B providers except when providing immunizations. The Medicare Benefit Policy Manual,

Chapter 15 Section 60¹ describes physician delegation to others working in their offices who provide care to

Medicare patients and a mechanism for billing such services. The title of this Chapter is “Services and Supplies Furnished Incident to a Physician’s/NPP’s Professional Service” and governs the services pharmacists provide in a non-institutional setting. These services are often termed “incident to.” Under these rules, pharmacists can bill for their services in a non-facility clinic. These rules differ in their processes from the HOPPS regulations.

Medicaid

Medicaid rules are state specific and may allow payment for pharmacist-provided patient care services in the ambulatory setting.

Private Payers

Non-facility (physician-based) clinics may negotiate specific contracts with private payers that may include a different mechanism for payment to enable pharmacist reimbursement for patient care services,² including utilizing a direct payment process incorporating the Medication Therapy Management (MTM) CPT codes or another preferred mechanism.² Alternatively, pharmacist provided services may be folded into a capitated payment model and/or associated with pay for performance incentives. Please see the Value Based Payment Models FAQ for more details. **If there are no specific contracts with private payers, billing for pharmacy services defaults to Medicare regulations.**

Medicare patients, by law, may not be treated differently than other patients.

2. What are the requirements for billing for my services using “incident-to”?

In order for pharmacists to bill incident-to the physician, Medicare stipulates that nine requirements must be met. As long as the following requirements are met, you may bill for your services using incident-to billing in the physician-based clinic.^{1,2} Please note for this section, physician includes other practitioners (such as physician assistant to nurse practitioner) authorized by Medicare to receive payment for services incident to his or her own services.

- A. The patient must first be seen by the physician for an evaluation or a Medicare covered service.
- B. The physician must have provided authorization for the service in the medical record. (Usually done by a standard referral process).
- C. The physician must continue to see the patient at a frequency that reflects his/her active participation in the management of the course of treatment. Review of the medical record does not qualify. Although not defined, Medicare fiscal intermediaries may have rules such as a “one of three rule,” or every third visit must be a physician visit. However you choose to interpret this ruling, it should be reasonable and customary.
- D. The service provided by you, the pharmacist, is commonly furnished in a physician or Medicare Part B provider’s office or clinic.
- E. The service must be medically appropriate to be given in the provider’s office or clinic.
- F. Services provided by a pharmacist “incident to” the physician must be within the pharmacist’s scope of practice as dictated by the state’s Pharmacy Practice Act.
- G. Services and supplies must be furnished in accordance with applicable State law. Any other state laws besides the Pharmacy Practice Act that affect your service must be adhered to.
- H. A physician or Medicare Part B-approved practitioner must be on the premises, but not necessarily in the room when incident-to services are performed. The supervising practitioner must be part of the organization.
- I. The pharmacist providing the incident-to service must be an employee, leased or contracted to the physician or Medicare Part B-approved provider. The practice must have some legal control over the person and his or her services, and the person must represent an expense to the practice. Expenses may include salary or non-salary support such as an exam room, office supplies, staff support, etc.

3. Can I be employed by another entity (e.g. school of pharmacy) and use “Incident to” to bill for my services in a non-facility clinic?

As long as all of the requirements are met (see FAQ #2), you can bill for your services.

4. Which type of providers can pharmacist bill “incident to”?

As FAQ 2 (F), above, states that a physician or Medicare Part B approved practitioner must be on the premises to provide direct supervision. The Medicare Benefits Policy Manual describes those who are

Medicare Part B approved practitioners, and that list does include nurse practitioners and physician assistants.

It is important to note that this may vary in interpretation by the regional Medicare Administrative Contractors (MACs) who are contracted by Medicare to administer the Medicare benefit in their region.³ In addition, you must follow your state's pharmacy practice act which may stipulate which providers may act as supervisors.

5. Must the supervising clinician review and sign off on all pharmacist notes?

There is no Medicare requirement that the physician or supervising provider must sign off on all pharmacist notes. The requirement states that the physician or supervising provider establishes the plan of care for the patient that authorizes your service, and the physician or supervising provider must continue to be actively involved in that plan of care. How Medicare Fiscal Intermediaries and your organization interpret that statement may vary, including requiring the supervising provider to sign the pharmacist notes as an indication that they are aware of your activity, following up with a face-to-face visit with the patient at a reasonable frequency indicating active involvement, or some other process that would reasonably be considered to meet the active involvement requirement of the regulations.² In addition, you must follow your state's pharmacy practice act which may outline specific requirements.

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

Medicare

The NPI of the Medicare recognized provider (i.e. physician or Medicare Part B-approved practitioner) must be used on the paper or electronic CMS 1500 claim form when billing using 'incident-to' rules.² Generally the NPI of the referring provider is used, however, if this provider is not "on the premises" the day the patient is seen, an alternative provider NPI (one who is present) must be used. Since pharmacists are not Medicare recognized providers, we are restricted to a 99211 evaluation and management code level if billing Medicare with our own NPI number (not using "incident-to").

Non-Medicare

Your practice site and/or non-Medicare payer may require the pharmacist to use his/her NPI number. This may be for internal tracking purposes or it may be required under the contract or state Medicaid rules.²

7. Can a pharmacist see and bill the patient for an evaluation and management service on the same day as a physician visit?

A pharmacist would not want to see and bill the patient for an evaluation and management service on the same day as a physician visit in the same office or clinic. If the same clinic or physician office submits

two separate bills for evaluation and management services to CMS on the same day, CMS will pay the lesser of the two bills which would likely be the pharmacist bill (most pharmacists are restricted to the 99211 code level based on the regional Medicare Fiscal Intermediaries determinations). As such, the result would be a significant loss of revenue. However, if a patient is seen in another clinic and then sees you in your care clinic on the same day (e.g. endocrinology visit and then your visit in internal medicine), two bills may be generated as these are two different clinics.

This concept does not apply to Medicare Annual Wellness Visits which can be provided on the same day as a physician visit and the practice may bill for both services using a modifier 25.

8. What is the billing process in a physician's office and who are the key people that manage this process?²

Most physician offices or clinics employ or contract with professional billers and coders. An individual who holds the title of Compliance Officer usually leads this department or a contracted entity. With regard to physician office-based services billing procedures, the Compliance Officer is responsible for assuring that the billing process is consistent with and does not deviate from the rules and regulations of federal and state law, Medicare and Medicaid, and the contractual rules and obligations for any private payers. Additionally, there are professional coders who are trained to correctly code and bill for services rendered by the physician office or clinic.

All payers, in particular the state Medicaid and federal Medicare, may audit any participating practice. If billing practices do not meet the laws, rules and regulations, the provider may be responsible for refunding all payments for which the bill did not meet the established rules. For government payers, there may be additional penalties, including criminal judgments.

9. What are the documentation requirements to bill in the physician office setting?²

Documentation required for billing is defined under the 1995 and 1997 Documentation Guidelines for Evaluation and Management Services. Medicare Part B pays for the evaluation and management of medical conditions and medical decision making based on disease states (ICD-10 codes). They do not pay for medication therapy management under Medicare Part B. Documentation must address the medical condition and therapy plan that resulted in authorization for pharmacist services by the physician. For "incident-to" billing, there are five billing levels (99211-99215). An increasing level of complexity defines each of these levels, with 99211 being a simple patient encounter to 99215 being a complex encounter. Each level above 99211 has certain requirements for documentation elements in the history, physical exam and a hierarchy for the intensity of medical decision-making.⁴

The 99211 level, where most pharmacists are restricted to billing, has no requirements for documentation elements.

However, even when billing the 99211 level the patient's medical conditions need to be evaluated and managed. Documentation must show evidence of patient evaluation for their condition within the scope of the provider, and then subsequent management of the condition. For example, a pharmacist seeing a patient and noting that the blood pressure was 120/80 in the medical record with no evaluation or management is not an acceptable 99211 bill. Evaluating whether that blood pressure is at the patient's goal, evaluating for complications to the medication regimen for hypertension and providing continued education on hypertension and therapy would qualify as an evaluation and management. The Medicare Fiscal Intermediary may have additional documentation rules as in this example for "incident to" billing:

Documentation Requirements:

- The progress note must substantiate the service performed and be signed by the person performing it.
- When the physician is involved with a particular service, his or her contribution to the care must be documented. This will assist in substantiating his or her continued involvement in the patient's care.
- The extent of physician involvement should reflect the patient's condition, increasing with instability and uncertainty of the situation.
- All documentation should support the level of care provided.

Level of Service: E/M Overview⁴

Level	History	Physical Exam (1997 Multi System Exam Elements)	Med Decision Making	Counseling & Coordination of Care
99211 (Level 1) Minimal	Minimal	Minimal	None	5 minutes
99212 (Level 2) Problem Focused	CC, HPI	1-5 Elements	Straightforward	10 minutes
99213 (Level 3) Expanded Problem Focused	CC, HPI, ROS	6 or more elements	Low Complexity	15 minutes
99214 (Level 4) Detailed	CC, HPI, ROS, PFSH	12 elements	Moderate Complexity	25 minutes
99215 (Level 5) Comprehensive	CC, HPI, ROS, PFSH	All elements	High Complexity	40 minutes

Must address 2 of 3 areas. In order to select the billing level based on time, >50% must be spent faceto-face with the patient and be documented. E/M= evaluation and management; CC = chief complaint; HPI = history of present illness; ROS = review of systems; PFSH = past medical, family or social hx

Level of Service: Medical Decision Making Overview⁴

Level	Diagnosis/Management Options	Amount/Complexity of Data	Risk of Complication, Morbidity or Mortality
99212 (Straightforward)	Minimal (0-1)	Minimal or None (0-1)	Minimal
99213 (Low Complexity)	Limited (2)	Limited (2)	Low
99214 (Moderate Complexity)	Multiple (3)	Moderate (3)	Moderate
99215 (High Complexity)	Extensive (4)	Extensive (4)	High

Choose Level met in 2 of 3 areas.

10. How much will I be reimbursed for my services?

Reimbursement is based on the level of service and CPT code submitted. You can look up the current reimbursement for each CPT code using the CMS Physician Fee Schedule Look-up Tool available <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/>.⁵

References

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