



Pharmacist Billing for Ambulatory Pharmacy Patient Care Services in a Physician-Based Clinic and Other Non-Hospital-Based Environments – FAQ

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

For Medicare patients, hospital-based outpatient services (including clinics) are governed by the Hospital Outpatient Prospective Payment System (HOPPS) regulations. However, 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 physician-based clinic. These rules differ in their processes from the HOPPS regulations.

Non-institutional physician-based offices and 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, 3, 4} Alternatively, pharmacist-based services may be folded into a capitated payment model and or associated with pay for performance incentives. 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. In certain states, Medicaid rules and laws may allow payment for pharmacist-provided patient care services in the ambulatory setting.

2. If I am employed by another entity (e.g. school of pharmacy), but also practice in a physician-based clinic, how do I bill for my services?

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}

- 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. (Expense may include salary, non-salary support such as an exam room, office supplies, staff support etc.)

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

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 Fiscal Intermediaries who are contracted by Medicare to administer the Medicare benefit in their region.^{5,6}

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

There is no 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 she is 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

5. 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 the 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.⁷

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

For Medicare patients, pharmacists are not recognized as Medicare Part B providers and can only bill “incident-to” the physician supervising in the practice or clinic. Consequently, pharmacists are restricted to billing at the 99211 code level. Therefore, the NPI of the Medicare provider (i.e. physician or Medicare Part B-approved practitioner) must be used on the paper or electronic CMS 1500 claim form.²

For non-Medicare patients, the clinic 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 on the same day as a physician visit?

A pharmacist would not want to see and bill the patient on the same day as a physician visit in the same office or clinic as that would not be fiscally prudent to the organization. If the same clinic or physician office submits two separate bills to CMS on the same day, CMS will pay the lesser of the two bills which will always be the pharmacist bill at the 99211 code level. The result would be a significant loss of revenue. However, if a patient is seen in an endocrinology clinic and then sees you in a primary care clinic on the same day, two bills may be generated as these are two different clinics.

8. If I practice in a community pharmacy, how do I bill for my cognitive services?⁸

There are a number of ways a community pharmacy may bill for cognitive services which may vary by state and the Medicare Part D Prescription Drug Plans (PDP) available to you at your location. Several states pay community pharmacists to provide various levels of cognitive services to State Medicaid beneficiaries.

Certain Medicare Part D PDP plans contract with community pharmacists to provide MTM services required under Medicare Part D. Community pharmacists and pharmacies (as well as any other entity) may secure contracts with private payers. This has been most successful with local self-insured employers or self-insured business groups. Finally, community pharmacists (as well as any other entity) may submit bills to any provider, but they would need to determine which providers are eligible under a patient’s particular health insurance plan to submit bills, the rules of participation (they may need to sign a participation agreement) and then standard procedures would need to be followed in submitting the bill. The process is explained well in the following publication: Poirier S,

Buffington DE, Memoli GA. Billing Third Party Payers for Pharmaceutical Care Services. *J Am Pharm Assoc.* 199;33:50-64. Unfortunately payment return on billing is probably around 30%.

9. Beyond CPT “incident to” codes and MTM codes, which other codes or methods can pharmacists use to bill for clinical services in a physician-based clinic or in a community pharmacy?

*Refer to reference 9 for up-to-date Physician Fee Schedules

Diabetes Self- Management Training/Education (DSMT/E)¹

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 by American Diabetes Association or American Association of Diabetes Educators). These can be run and managed by one discipline (e.g. an RPh, RN, or RD), though 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.¹⁰ 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 or more 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).

Insulin pump training^{11, 12}

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 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-recognized 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)^{1,13,14,15}

For complete information, refer to CMS Medicare Benefit Policy Manual Chapter 15, Section 280.5. Annual Wellness Visits were established under the Affordable Care Act, effective January 1, 2011. These services are provided by Medicare for beneficiaries who are no longer in the first 12 months of their first Part B coverage period. Prior to an AWW, 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 this 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. The 2013 Medicare reimbursement rates are: G0438=\$169 and G0439=\$112.⁹

Visit Type	Timing	HCPCS Code
Welcome to Medicare (IPPE) Visit*	Within 12 months of Medicare enrollment	G0402
First Annual Medicare Wellness Visit (MWV)	First MWV (>12 months from IPPE visit)	G0438
Annual Medicare Wellness Visit	Subsequent MWVs	G0439

* Can only be performed by a physician or other qualified non-physician practitioner

CLIA-Waived lab^{1,16,17}

CLIA-waived labs is a term used to describe laboratory procedures that can be completed in ambulatory care practice settings (i.e. community pharmacies, hospital-based outpatient clinics, etc.). A CLIA Certificate of Waiver can be obtained using form CMS-116. Receiving this Certificate of Waiver gives the pharmacy, or sight of testing, a CMS Part B Identification Number (PIN) (cost of obtaining this PIN is \$150). Billing for these services is a charge submitted for the laboratory services only, not for any cognitive services. This claim is submitted using the CMS 1500 form. To maintain a CLIA-waived labs certification, the practice must maintain a manufacturer quality assurance log that is available for inspection. In order to complete a laboratory test in a CLIA-waived facility, there must be a statement of medical necessity and ICD-9 code from the physician for the laboratory test being performed.

Immunizations^{18, 19, 20,}

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.

Commonly Administered Vaccines

	Vaccine Code & Description	Administration Code	Diagnosis Code
Influenza*	90657 – Split virus, 6-35 months dosage, for intramuscular or jet injection use	G0008	V04.81
	90658 - Split virus, 3 years and above dosage, for intramuscular or jet injection use		
Pneumococcal*	90732 – Pneumococcal polysaccharide vaccine, 23-valent, adult dosage, for subcutaneous or intramuscular use	G0009	V03.82
Hepatitis	90743 – Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use	G0010	V05.3
	90744 – Hepatitis B vaccine, pediatric/ adolescent dosage (3 dose schedule), for intramuscular use		
	90746 – Hepatitis B vaccine, adult dosage, for intramuscular use		

*Medicare Part B covered vaccines

Transitional Care Management^{21, 22, 23}

Transitional Care Management is a new Medicare program that went into effect on January 1, 2013 as part of the Affordable Care Act. The Transitional Care Management services can be used to bill 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 in medical decision making through services such as medication reconciliation. To request reimbursement for these services, the pharmacist must meet the “incident-to” requirements described in CMS Benefit Policy Manual Chapter 15 Section 60.

Visit Type	Timing (Calendar Days)	HCPCS Code	Complexity	Claim Date
Transitional Care Management	Within 7 days of discharge	99496	High	30 days from discharge
Transitional Care Management	Within 14 days of discharge	99495	Moderate	30 days from discharge

10. What is the billing process in a physician’s office and who are the key people that manage this process?^{2, 24}

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 and 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.

11. Which information or documentation must be included in order 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-9 codes). They do not pay for medication 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 pharmacists are restricted to billing, has no requirements for documentation elements.

However, it is still an evaluation and management code (E&M), and therefore a 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:

1. The progress note must substantiate the service performed and be signed by the person performing it.
2. 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.
3. The extent of physician involvement should reflect the patient's condition, increasing with instability and uncertainty of the situation.
4. All documentation should support the level of care provided

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