FAQ: Facility Fee Billing

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Purpose

When looking to establish a billable service within a clinic space, it may be overwhelming to figure out where to start. Below are several questions geared toward helping pharmacists identify what billing opportunities may be available along with important considerations. This document focuses specifically on facility fee billing, which is the hospital's technical charge for services provided in an outpatient department of a hospital.

For other billing information, please review other documents in the ASHP Resource Center:

1. Pharmacist Billing Using Incident-to Rules in Ambulatory Clinic
2. Alternatives to Incident-to Billing in Ambulatory Clinics
3. Medicare Annual Wellness Visits FAQ
4. Transitional Care Management Codes FAQ
5. Chronic Care Management FAQ
6. Billing Quick Reference Sheet

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When considering starting a billable service, practice location is important as it can drive billing opportunities. This document specifically focuses on **facility billing**.

1. Facility billing is limited to hospital-based clinics. Hospital-based clinics are financially tied to the hospital. Hospital-based clinics will appear on the organization's Medicare cost-report. Another way to glean this information is through billing. Hospital-based billing will have bills submitted under the hospital tax identification number (TIN) not under the National Provider Identifier (NPI) of a provider.[1] Members of your organization's finance department or clinic leadership may be able to guide you in determining whether a particular site is hospital-based vs physician-based.
    a. Even within hospital-based clinics there are further designations that can impact reimbursement. It is important to know if hospital-based clinics are considered on-site or off-site.
        i. How do you know if your clinic is off-site?
            1. It is designated as an "off-campus" provider-based site AND
            2. It is located at least 250 yards from the hospital's campus AND
            3. It was acquired or built after November 1, 2015 (some exemptions apply)
        ii. Determining the on-site or off-site classification of your hospital-based clinic is important as the reimbursement for off-site clinics changed as a result of the 2019 OPPS Final Rule.[2] This rule began implementation of site-neutral payments, decreasing the reimbursement of off-site hospital outpatient departments so that it is equal to the Physician Fee Schedule (PFS) payment.

2. Facility billing is the hospital's technical charge for services provided in an outpatient department of a hospital. Unlike physician-based billing, facility costs are not built into the hospital reimbursement structure (ex: facilities/maintenance, lighting/electricity). The facility fee is essentially reimbursement for the use of hospital space and resources.
    a. Several years ago, the Hospital Outpatient Prospective Payment System (OPPS) collapsed all of these billing codes into a new code (G0463) which signifies a "Hospital Outpatient Clinic Visit for Assessment & Management of a Patient".[3]
        i. Hospital-based billing typically occurs using a CMS-1450 form, also known as a Universal Billing (UB)-04. The 837I is the electronically submitted version of this form. For a facility charge to be billed, it would typically be billed on this form under the supervising provider's NPI.[4]
            1. HCPCS codes submitted on the CMS1450 are matched to specific Ambulatory Payment Classifications or APCs. The APCs are used by CMS to determine the reimbursement provided to the hospital.

What resources may be useful in planning facility billing?

Annually, the Outpatient Prospective Payment System (OPPS) establishes rules or changes to rules related to billing in the hospital outpatient setting. These rules are typically published in November on the Federal Register website for the upcoming Coverage Year (CY).

1. The Medicare Benefit Policy Manual outlines more specifics related to provision of care for Medicare patients and Medicare claims. The Medicare Benefit Policy Manual is maintained by CMS. Some sections that may be useful are:
    a. Chapter 6, section 20 – Outpatient Hospital Services details coverage of outpatient therapeutic services incident-to physicians including qualifying service criteria and hospital locations, definitions of a hospital outpatient and outpatient encounter, and supervision requirements
    b. Chapter 15, section 60 – Services and Supplies details incident-to rules for defined auxiliary staff including qualifying service criteria and financial relationship between auxiliary personnel and the eligible provider
2. The Medicare Learning Network (MLN) translates rules and regulations from CMS into language that is easier to understand, and in some instances, it simplifies requirements to be compliant with federal regulations. Anyone can register to receive updates from MLN. One particular document that may be useful in facility billing planning is the Hospital Outpatient Prospective Payment Fact Sheet.
3. You may need to estimate potential revenue for your service to justify a business case.
    The facility fee payment rates are determined annually and can be found online at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates
    a. Select most recent date for Addendum B
    b. Under related links select 'Addendum B'
    c. Read and accept the agreement
    d. Open spreadsheet with Excel
    e. Search 'G0463'

Once I have my references, who do I bring them to for discussion at my health system?

1. Who should I speak with at my practice site (pre-implementation) to receive proper internal approvals? Depending on the set-up of the clinic, it may be beneficial to discuss with the following individuals:
    a. Medical Director & Director of Pharmacy/Pharmacy Manager: Can assure pharmacy services properly compliment medical services for the practice (from a clinical standpoint). The Medical Director may also help to identify target populations for pharmacist visits and help with the development of any clinic protocols that are needed.
    b. Office Manager/Clinic Manager, Providers, Clinical staff (Medical assistants or nurses): May help to identify how pharmacy services fit into the flow of the practice from an operational standpoint. It is important to ensure the clinic is supportive of the pharmacist's plan and buys into the value of the pharmacist.

   c. Billing/Coding Specialist: To discuss plans for G0463 coding based on meetings with clinical and operational team members and share references for more formal review of coding potential.

2. Once my internal team is an agreement with moving forward, who should I schedule meetings with corporately to ensure proper approvals (to progress to implementation)?
   a. Legal: To ensure the services you are providing are within the scope of pharmacy practice for your state. Collaborative practice agreements may or may not be necessary.
   b. Compliance: To ensure the oversight and documentation of the services provided are compliant with regulations and done in an ethical manner. This department will also review and provide feedback on any policies/procedures and/or templates developed in relation to services provided.
   c. Revenue Cycle: It is important the revenue cycle team is aware of the "new" services being performed by the pharmacist and submitted for billing. This team can keep an eye out to ensure reimbursement is received for the services provided and can alert the practice of any reimbursement denials/issues as they arise.
   d. Billing/Coding: As you are nearing implementation, setting up a training class with your billing/coding specialist will ensure you are meeting all required documentation standards.
      i. In smaller hospitals or health-systems, the pharmacist may have responsibility for submitting their own charges or completing billing forms to submit charges. If this is the case, partnering with billing/coding and compliance departments for development of internal documentation and submission processes is crucial.
   e. IT support: Prior to seeing patients, work with your IT team to ensure pharmacist has access to necessary components to adequately perform services and document services. This should also include the development of a schedule and a visit template. It is important to also engage IT to see where there may be support for capture of metrics to help demonstrate the value of the service being provided.
      i. Metrics to be captured and evaluated will likely vary based on the priorities of the clinic or organization. Understanding the approach to reimbursement (fee for service vs a value-based care model) will be helpful in defining which metrics will be meaningful to the clinic or organization.
   f. Clinic Manager: It is prudent to loop back with your clinic manager to establish the clinic workflows for pharmacist visits. Who will be checking in the patients? Who will be rooming the patients? Where will the visits take place? Working these details out in advance will ensure a smooth clinic flow.

3. Now that the proper approvals are in place, are there any other departments to connect with (post-implementation)?
   a. Payor Contracting: Once services are up and running and the G0463 code is being billed, it can be beneficial to meet with corporate contracting to determine if the rate of reimbursement is enough to cover a proper proportion of the pharmacist's salary. If the reimbursement is less than expected, the contracting team may be able to negotiate better rates with certain payors or develop alternative contracts for pharmacy services specifically.
   b. Financial Analyst: After a few months of operation, a financial analyst will be able to review charges and reimbursement. This will proactively identify any issues with

contracting or billing. Additionally, this data will be essential for supporting the pharmacist role in the clinic from a financial standpoint.

c. Clinic providers and staff: Routine touchpoints with clinic providers and staff can help ensure ongoing success of the service. Often staff and provider meetings are good opportunities to discuss what is going well, what needs improved upon, and to provide some general patient stories or metrics demonstrating the value of the program to help gain buy-in.
d. Clinic and/or pharmacy leadership: Provide routine updates to the clinic and/or pharmacy leadership, focusing on metrics to demonstrate the value of the service. Including one or two impactful patient stories can also help paint a complete picture of the effectiveness of the service. These pieces will be critical to fostering sustainability and growth of the service.

What are other considerations when establishing a service using facility fee?

1. Documentation requirements:
    a. Historically, hospitals had the ability to charge a facility fee at different levels based on intensity of services as defined by the organization. In 2015, CMS collapsed all facility levels into the G0463 code. There are not established criteria for documentation of a G0463. Organizations may set their own documentation requirements to support billing a facility fee. It is also important to check with your MAC for any potential requirements related to G0463 billing.
        i. Often, pharmacists will choose to build a documentation template to meet the requirements of billing a 99211 incident-to. There are more defined criteria around billing of this code along with local guidance from MACs. Since many commercial payers do not cover facility fee billing, these patients may be billed with an established patient CPT E&M code, so documentation that meets E&M coding criteria is crucial.
            1. It may be beneficial to engage your revenue cycle (billing/coding) and compliance teams to review documentation templates to ensure expectations for your organization are being met as well.

2. Incident-to criteria
    a. "Incident-to" refers to billing that is submitted under a CMS recognized Part B provider. Pharmacists are not Medicare-eligible providers and generally submit bills under a supervising eligible provider. The criteria for billing a service "incident-to" differ between a physician-based clinic and a hospital-based clinic. For any service being billed "incident-to" **regardless of site**, the service must be:[5,6]
        i. An integral, though incidental, part of eligible provider's services
        ii. Commonly rendered without charge or included in an eligible provider's bill
        iii. A type that is commonly furnished in an eligible provider's office or clinic
        iv. Medically necessary and authorized (ordered) by an eligible provider with documentation

v. Provided to established patients (patients have seen an eligible provider where a plan of care has been established)
vi. The authorized or ordering provider maintains an active role in the treatment of the patient and the plan of care
vii. Within scope of practice for the auxiliary personnel

There are additional specific criteria for both physician-based (professional fee) and hospital-based clinic "incident-to" billing. For hospital-based clinic "incident-to" billing, the service must also:[4]

viii. Be provided by an individual with an employee relationship to the hospital (ex: hospital employee, leased employee, or independent contractor)
ix. Be provided under general supervision.
    1. General supervision means that the service is under the direction and control of the provider, but the provider does not need to be present while the service is performed.

3. Remote Services Consideration
    a. The COVID-19 pandemic and subsequent public health emergency has led to waivers that allow for more flexibilities related to providing services remotely.
        i. For services that normally meet the definition to bill facility fee, there may be the opportunity to provide these services remotely. To consider a facility fee for remote services, the professional providing the service must be located within the hospital that has the patient registered as a hospital outpatient in the patient's home. CMS states that when the services are provided in this manner, a telehealth service is not being provided.[7,8]

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