FAQ: Pharmacist Billing Using Evaluation and Management Codes and the "Incident-To" Rules for Non-Facility (Physician-Based) Ambulatory Clinics

Date of Publication: October 2024

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Purpose

This document aims to answer frequently asked questions about billing using evaluation and management codes with "incident-to" rules for pharmacist services in non-facility clinics. Non-facility clinics are physician owned outpatient practices or hospital affiliated practices that are considered a separate entity from the hospital by use of a different tax identification number than the hospital. Other opportunities for revenue generation are not discussed here. All services must be furnished in accordance with applicable State law.

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

Frequently Asked Questions

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

Physician offices and physician-based clinics providing services for Medicare patients are governed under the Medicare Benefit Policy Manual for Medicare Part B[1] (100-02 | CMS) and the Physician Fee Schedule which is updated annually. Hospital based (facility) clinics are governed by the Medicare Benefit Policy Manual for Medicare Part B and the Hospital Outpatient Perspective Payment System (HOPPS) resulting in variation of certain rules.

2. What are the opportunities for payment for pharmacist patient care services with respect to "incident to" among healthcare payers?

Medicare

Chapter 15 Section 60 "Covered Medical and Other Health Services" describes physician delegation to others working in their offices who provide care to Medicare patients and a mechanism for billing such services. These services are termed "incident to." Under these rules, Medicare eligible providers may bill for pharmacist patient care services using "incident to" allowed CPT or HCPC codes. Physicians (MD, DO) Nurse Practitioners (NPs), Certified Nurse-Midwives (CNMs), Clinical Nurse Specialists (CNSs), and Physician Assistants (PAs) are nonphysician

practitioners who are authorized to delegate and bill for services provided by clinical or auxiliary personnel. [3]

Medicaid

Medicaid rules are state specific. States may have direct payment to pharmacists, services folded into a value-based capitated model, or they may have allowances for "incident to" payment for pharmacist-provided patient care services.

Private Payers

There may be several mechanisms for pharmacist patient care service reimbursement with private payers[2]. Physician-based (non-facility) clinics may negotiate specific contracts with private payers including a direct payment process using allowable billing codes, services may be folded into a value-based capitated payment model, or they may use a Medicare like "incident to" process.

When Medicaid or a private payer does not document a specific process to bill for pharmacist patient care services, billing defaults to Medicare regulations. Medicare patients, by law, may not be treated differently than other patients.

3. What are the requirements for billing my services using "incident-to"?

For a Medicare eligible provider to bill "incident to" for pharmacist provided patient care services, Medicare stipulates that each of the following requirements must be met.[1, 2, 4] Medicare Administrative Contractors (MACs) may add further details to the requirements and should be reviewed.[5]

A. The physician or nonphysician practitioner must initiate treatment.
The referring provider(s) must be the first provider to see the patient and establish their plan of care. The pharmacist may never be the initial visit for that patient.

B. The "incident to" service must be an integral, although incidental, part of the patient's professional services in the course of diagnosis or treatment of an injury or illness.
The delegating physician or nonphysician practitioner should indicate the medical necessity for the "incident to" service. This may be done using the referral process or medical record documentation.

C. *The physician or nonphysician practitioner must continue to see the patient at a frequency that reflects his/her active participation in the management of the course of treatment. Although not defined in the regulations, a Medicare fiscal intermediary may set rules e.g. "one of three rule," or every third visit must be a physician visit. CMS overarching principle of reasonable and customary should guide interpretation of this rule. Review of the medical record does not meet this requirement.*

D. The service must be medically appropriate and commonly furnished in a physician's office or clinic.
The physician or nonphysician practitioner would typically provide that service If the clinical or ancillary staff were not available. There is documentation that it is medically necessary and delegation to ancillary clinical staff is authorized.

E. Services provided are within the state scope of practice for the auxiliary clinical personnel.
Services by a pharmacist "incident to" the physician or nonphysician practitioner must be within the pharmacist's scope of practice as dictated by the state's Pharmacy Practice Act.

F. Services are rendered without charge (included in the physician or nonphysician practitioner bill)
There is not an extra charge other than the physicians or nonphysician practitioner "incident to" submitted bill.

G. A physician or nonphysician practitioner must provide direct supervision, defined as present in the office suite and immediately able to render assistance, if necessary. The supervising provider does not need to be in the same room when incident-to services are performed.

H. The ancillary or clinical staff providing the 'incident to" services must be a direct financial expense to the physician or practice (such as a "W-2" or leased employee, or independent contractor).

4. 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?

If you are employed by another entity, all required "incident to" rules must be met for a bill to be submitted by the practice site for your services. Your employer and the medical office or clinic must establish a reasonable and customary contract (payment for services reflect the cost of a pharmacist in your community) such that you are a direct financial expense to the physician or practice.

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

Medicare does not require a physician or supervising provider to sign off on pharmacist notes. The requirement is the physician or supervising provider establishes the plan of care for the patient which should establish a need and authorization for your service; and the physician or supervising provider must continue to be actively involved in the 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 at a reasonable frequency indicating active involvement.[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 supervising Medicare recognized eligible provider physically present on the day of service (i.e. physician or Medicare Part B-approved practitioner) must be used when billing under 'incident-to" rules.[2] If not the referring provider, the supervising provider present that day must be employed by the organization. Note this may be confusing to patients when they do not recognize the supervising provider as their medical care giver on their explanation of benefits.

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, a requirement of a payer 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?

Medicare Manual Chapter 12 section 30 states a MAC may not pay two E/M office visits billed by a physician (or physician of the same specialty from the same group practice) for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems in the office, off campus-outpatient hospital, or on campus-outpatient hospital setting which could not be provided during the same encounter.[1] Thus a pharmacist would not want a billable encounter with a patient for an evaluation and management service on the same day as a physician visit. CMS will only pay the lesser of the two bills, or the bill related to the pharmacist's services. (Medicare pharmacist's services are restricted to the 99211 code). However, if a patient is seen by a provider for an entirely different medical problem or procedure and sees the pharmacist in their clinic on the same day e.g. an endocrinology visit for thyroid disease and then a pharmacist visit for diabetes in the endocrine office; two bills may be generated as these are unrelated problems. In such situations the modifier code 25 should be used.

> *Code 25 modifier definitions: A significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service.*

Medicare Annual Wellness Visits can be provided on the same day as a physician visit and the modifier 25 should be used to bill both services. There is an exception for Rural Health Clinics where Medicare rules state this may not occur.

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 contracted entity. The Compliance Officer is responsible for assuring 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. Professional coders are trained to correctly code and bill for services rendered by practitioners within the physician's office or clinic.

All payers have audit processes for any participating practice. If billing practices do not meet the laws, rules and regulations, the provider may be responsible for refunding all payments where the bill did not meet the established rules. For government payers, there may be additional penalties, including criminal felony judgments.

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

In 2021 CMS adopted the AMA's Evaluation and Management (E/M) Services Guidelines and no longer follow the 1995, 1997 CMS E/M documentation requirements. In 2023 the AMA extensively updated the document with more in-depth guidance on determining the level of medication decision making, complexity and risk.[6] The document also includes E/M coding guidance for different practice sites that utilize the E/M code category such as emergency rooms, hospital observation units and nursing facilities. (Of note the CCM family falls under E/M codes but are not addressed in this document). The AMA 2023 updates no longer provide a direct crosswalk between the established patient codes (99211-99215) and suggested medication decision making, risk and complexity. Guidance is provided via an extensive narrative and a table that provides three categories of elements. CMS refers to the AMA document in their guidance.[7]

For CPT 99211, the AMA document provides the following guidance:

- It should be used for face-to-face services performed by clinical staff.
- The concept of medical decision making does not apply.
- Its use is for a minimal problem that may not require the presence of the physician or other qualified health care professional.

There are no requirements listed for documentation of services at the 99211 level, or the level of services restricted by Medicare for clinical staff including pharmacists. However, MACs may have requirements for 99211 billing. For example, one of the MACs (Noridian) requires the following for 99211 billing:[8]

- Typically, five minutes are spent performing or supervising these services.
- Medical records must be adequately documented to reflect the reason for the patient's visit and any treatment rendered.
- There must be recorded elements of history obtained, examination performed, and/or clinical decision making, as well as physician supervision.
- There is supervision by a physician.
- All incident to provisions must be met.

As most payors have adopted the AMA guidance, pharmacists able to bill higher level established patient codes (99212-99215) in their states, a review of the AMA document is highly encouraged for guidance in choosing the correct code level for billing their services.

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

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/ .[9]

11. Is there a list in Medicare of CPT codes that are allowed to be delegated for "incident to" services?

CMS does not provide a list of codes where they allow "incident to" billing for clinical staff services. In Medicare regulations certain codes specifically state delegation to clinical staff may be done, other codes clearly state the service must be provided by an eligible health care practitioner, and other codes do not address who may provide the service and are termed silent. For codes that are silent, it is best to review any MAC guidance and follow the interpretation by your organization's compliance officer.

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Published on behalf of the ASHP Section of Ambulatory Care Practitioners
Section Advisory Group on Compensation & Practice Sustainability

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