

## Billing for pharmacists' services provided to ambulatory care patients

In this issue of *AJHP*, Maldonado et al.<sup>1</sup> bring to the fore important information on billing the Centers for Medicare and Medicaid Services (CMS) for patient care services provided by pharmacists. Based on my experience in advising numerous clinicians and administrators on creating financially sustainable clinical pharmacist services, I offer the following comments as additional background for and guidance to readers.

The authors describe multiple methods for outpatient billing, including incident-to billing and facility or technical fee billing. (The terms *facility fee* and *technical fee* are often used interchangeably.) Readers should note that different CMS regulations apply to pharmacist incident-to billing in a physician-based outpatient clinic<sup>2</sup> versus incident-to billing in a hospital-based outpatient clinic.<sup>3,4</sup> In a physician-based clinic, only one bill is submitted for the provider's professional fee, which includes a technical fee for overhead costs. However, in a hospital-based clinic, the professional fee and technical fee are submitted on two bills. Because hospitals have large variability in overhead costs, they are permitted to bill separately for these expenses. Hospital-based clinics are allowed to include the expense of a clinical pharmacist within the facility fee as a component of the clinic's overhead expense.

To determine billing options for pharmacists' patient care services, it is essential to know whether the services were provided in a building that is owned by a physician group or by a hospital. In physician-owned clinics, CMS rules restrict incident-to billing for pharmacists' services to the lowest payment level. However, in a hospital-owned clinic, the clinic may bill across the full range of its facility fees for pharmacists' services, which typically results in recovery of the complete cost of pharmacists' time devoted to patient care.

The *Current Procedural Terminology* code for the facility-fee-level billed depends on the hospital resources used when providing a service and not on the provider status of the practitioner. Thus, pharmacists who are employed or under contract by a hospital and meet all the hospital-based incident-to criteria can bill for facility fees when they see a patient without a physician meeting with the patient at the visit (providing the physician is available to offer direct supervision). Pharmacists

who are employed or under contract by a physician group cannot bill for facility fees individually (even if the service is provided in a hospital-based outpatient clinic), because they are not a hospital resource.

Physicians who care for a patient in a hospital-based outpatient clinic bill for both a professional fee and a facility fee. If a pharmacist in the physician group has provided related services, the physician may bill for a higher facility fee, which has revenue-generating potential and is described by Maldonado et al.

Why are pharmacist-provided ambulatory care clinical services sometimes not sustainable? In my observations, it is less often because of a lack of physician acceptance or poor outcomes and more often attributable to a poor understanding of the billing process for health care services. In the interest of improving medication-related ambulatory care, it is essential for pharmacists and clinic administrators to understand billing opportunities for patient care services provided by pharmacists. I applaud Maldonado et al. for sharing their experience, and I encourage others to report their modes of sustainability as we enter a new era of reimbursement possibilities under health care reform.

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