Expanded Scope of Practice in the Pharmacy Setting: Current Trends and Future State for Pharmacists and Pharmacy Technicians

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Target Audience: Pharmacists and Pharmacy Technicians

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Disclosures

Todd Nova has no actual or potential conflict of interest in relation to this presentation.

Hall Render is a vendor to the health care industry, providing professional legal consultation, advocacy and representation services.

The American Pharmacists Association is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.
Learning Objectives

1. Define the main options available for structuring collaborative pharmacy practice arrangements.

2. Describe the regulatory standards applicable to collaborative pharmacy practice arrangements.

3. Explain the reimbursement implications of key collaborative pharmacy practice models.

4. Discuss key operational considerations that can both facilitate and hinder collaborative pharmacy practice arrangements.
Overview

- Pharmacists and Independent Practice
- Scope of Practice and Collaborative Practice Agreements
- Framework of Pharmacist Billing: Direct v. “Incident-to”
- Concerns with CPAs and Pharmacist Billing
- Impact of Bundled Payment Initiatives
- Federal Regulatory Issues- Anti-Kickback Statute Requirements
1. Collaborative practice pharmacy models are generally feasible as between pharmacists and –

A. Physicians
B. Nurses (RN)
C. Hospice Interdisciplinary Groups (IDGs)
D. Therapists (PT/OT/SLT)
2. Assessment Question

2. Medicare Incident-to billing in the Clinic/Office setting requires the following type of supervision-

A. Personal
B. Direct
C. General
D. Indirect
3. Assessment Question

3. Federal law defines pharmacists as providers (and thus eligible to bill) for independent services for the following programs?

A. Medicare Part B (clinic services)
B. Medicare Part B (outpatient institutional services)
C. Medicare Part C (Medicare Managed Care)
D. None of the above
4. Collaborative practice models implicate the following regulatory standards -

A. Stark Physician Self-Referral Law
B. Antikickback Statute
C. Federal False Claims Act
D. All of the above
Pharmacists and Independent Practice

- Three key elements governing pharmacist involvement in hospital outpatient and physician clinic medication management
  - **Scope of Practice** - expansion of the procedures, actions, and processes that a pharmacist is permitted to perform under their state license
    - Prescriptive authority
    - Test ordering/interpretation
    - Immunization and medication administration
    - Collaborative practice agreements (delegated medical acts)
  - **Designation** - inclusion of pharmacists as providers by Medicare and Medicaid state plans
    - Vaccinations
    - Preventive Care
  - **Payment for Services** - the ability for pharmacists to receive payment for patient care services
Pharmacists and Independent Practice

- **Common example: Anticoagulation/Coumadin Clinic**
  - RNs and Pharmacists ("Non-Prescriber Professionals") performing what are commonly referred to as Evaluation & Management ("E/M") services as well as certain limited scope CLIA-waived testing
  - Patients referred by primary care provider or cardiologist
  - Clinic services subject to Medical Director supervision for ongoing treatment and care pursuant to protocols and orders established and maintained by the Medical Director.

- Medicare claims for payment submitted:
  - On global CMS Form 1500 as incident-to a physician’s service (clinic)
  - On technical component CMS form UB-04 for institutional (hospital/CAH) service

- Distinguish between provider-like services and MTM services.
Pharmacists and Independent Practice

- **Provider Status: Why Does it Matter?**
  - Neither Pharmacists nor RNs (non-advanced practice) can individually enroll in Medicare as providers or suppliers.
  - As a result, they cannot submit Medicare professional claims directly in their own name.

- **Current Status: Federal**
  - For Medicare purposes, pharmacies considered Part B providers solely for the provision of immunizations.
  - Pharmacists not included in the statutory definition of “provider” under Medicare Part B (42 U.S.C.§1395), so they cannot bill directly for patient care services.

- **Current Status: Private Payors/States**
  - Private payors may reimburse pharmacists for patient care services (must in some states).
  - However, because pharmacists generally omitted from Medicare Part B (not “providers” or “suppliers”), most private and state health plans do not compensate for broad spectrum pharmacist patient care services.
Pharmacists and Independent Practice

- Medicare Statutory Authority
    - (a) The benefits provided to an individual by the insurance program established by this part shall consist of—(1) entitlement to have payment made... for medical and other health services...
Pharmacists and Independent Practice

- Medicare Statutory Authority
  - 42 U.S.C. § 1395x. Definitions
    - (s) The term “medical and other health services” includes (among others):
      - Physicians’ services
      - Services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician’s professional service, of kinds which are commonly furnished in physicians’ offices and are commonly either rendered without charge or included in the physicians’ bills
      - Hospital services (including drugs and biologicals which are not usually self-administered by the patient) incident to physicians’ services rendered to outpatients and partial hospitalization services incident to such services
      - Hospital diagnostic services
      - Outpatient physical therapy, speech-language pathology and occupational therapy services
      - Rural health clinic services and Federally qualified health center services
      - PA or NP services under appropriate physician supervision
      - Certified nurse-midwife services
      - Qualified psychologist services
      - Clinical social worker services
Pharmacists and Independent Practice

- Medicare Statutory Authority
  - 42 U.S.C. § 1395x. Definitions
    - (d) The term “supplier” means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this subchapter.
    - (u) The term “provider of services” means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, [or] hospice program...
Pharmacists and Independent Practice

- **Federal Developments**
  - **H.R. 4190**
    - Would have given pharmacists supplier status at the federal level by adding the following to 42 U.S.C. § 1395x(s) ("Medical and other health services"):
      - "(GG) pharmacist services furnished by a pharmacist, as licensed by State law, individually or on behalf of a pharmacy provider— (i) which the pharmacist is legally authorized to perform in the State in which the individual performs such services; (ii) as would otherwise be covered under this part if furnished by a physician, or as an incident to a physician’s service; and (iii) in a setting located in a health professional shortage area (as defined in section 332(a)(1)(A) of the Public Health Service Act), medically underserved area, or medically underserved population..."

- **H.R. 592 and S. 314**
  - Reintroduction of H.R. 4190 (2015)

- **H.R. 592 and S. 109**
  - Reintroduced again in 2017
  - There is bipartisan support for this legislation
Pharmacists and Independent Practice

- **State Developments**
  - Laws recognizing independent practice status vary
  - ~39 states have laws in place recognizing pharmacists as providers *for certain services* in Medicaid State Plan or state code:
    - Recent additions: North Dakota, Vermont, Washington
      - WAC 182-502-0002: The Washington state health care authority recognizes pharmacists as providers, coverage of in-scope services required
    - States with legislation in progress: Illinois, Massachusetts
  - ~48 states and D.C. permit pharmacists to enter into collaborative practice agreements with a physician or another prescriber for drug therapy management
    - Includes CO, GA, NV, NH, NC, ND, OR, WI, WA
    - Note – specific elements must be addressed prior to implementation
    - Billing and payment remains an issue
  - **Various other states** have limited classes of other clinical services:
    - Ex: NC (Hemophilia management services - Medicaid); OR (Clozapine monitoring – Medicaid)
    - Ex: Vaccination authority (~27 as delegated medical act; ~16 independently)
Pharmacists and Independent Practice

- State Developments (Cont.)
  - Laws reflect differences in addressing independent practice status

  - Wisconsin - addresses provider status through the services that may be delegated by a physician to a pharmacist
    - Wis. Stat. 450.033: “A pharmacist may perform any patient care service delegated to the pharmacist by a physician.”

  - Vermont - addresses provider status via definitions of “healthcare provider” and “clinical pharmacy”
    - Vt. Stat. Ann. tit. 26 §2022 (14)(B): “Practice of clinical pharmacy” the health science discipline in which, in conjunction with the patient’s other practitioners, a pharmacist provides patient care to optimize medication therapy and to promote disease prevention and the patient's health and wellness

  - Virginia - “practice of pharmacy” includes “the management of patient care under the terms of a collaborative agreement.”
    - Collaborative agreements may “include the implementation, modification, continuation, or discontinuation of drug therapy pursuant to written or electronic protocols, provided implementation of drug therapy occurs following diagnosis by the prescriber; the ordering of laboratory tests; or other patient care management measures related to monitoring or improving the outcomes of drug or device therapy.” VA Code Ann. § 54.1-3300
Pharmacists and Independent Practice

- Limitations and barriers pharmacists provider status implementation:
  - Inconsistent utilization of pharmacists in various clinical settings
  - Lack of payor awareness regarding benefits of pharmacist involvement (e.g., readmissions, E.D. diversion)
  - Lack of defined qualifications of pharmacist providers
  - Lack of uniformity among states and public health plans
  - Lack of payment for services, provider status notwithstanding
Scope of Practice & Collaborative Practice Agreements

- Pharmacist scope of practice mainly defined by state laws:
  - These laws vary greatly with regard to:
    - The extent of the authorized services
    - Limits on practice sites and health conditions
    - Restrictions on authority to order lab tests
    - Mechanism for implementation (pharmacist or physician/APC-centric)

- Some states have additional requirements for pharmacists to participate in collaborative practice arrangements
  - **California**: clinical residency requirement
  - **Maryland**: residency, certificate training, board-approved exam, clinical experience, and training related to the relevant disease states
  - **Virginia**: patient’s informed consent to be treated via CPA
  - **Wisconsin**: very broad
Collaborative Practice Agreements (CPA)

- Formal agreements between a licensed pharmacist and a licensed provider that allow the pharmacist to participate in specific patient care functions
  - **Provider**: diagnoses condition, supervises care, and refers the patient to a pharmacist
  - **Pharmacist**: performs specific patient care functions based on the provider’s referral and often established protocols. Can include:
    - Assess patients
    - Order, interpret, and monitor laboratory tests
    - Initiate, adjust, or discontinue drug therapy
    - Provide care coordination for wellness and disease prevention
    - Conduct essential patient education
    - Provider written or verbal communication to referring prescriber with recommendations
  - Separate or incident-to payment for the performance of these activities may or may not be available.
The Framework of Pharmacist Billing

- Pharmacist scope of practice and provider status intersects with the ability to seek payment for patient care services - State and Federal law considerations
  - Direct Billing
  - “Incident-to” Billing

- Medicare professional claims for Non-Prescriber Professional services in the freestanding clinic setting may only be billed in accordance with the “incident-to” physician services regulations at 42 CFR § 410.26.
  - “Incident-to” services are defined as those services that are furnished incident to a physician or NPP’s professional services in non-institutional settings, including a physician’s office or a patient’s home (excluding hospitals and skilled nursing facilities).
Direct Billing

- **Direct billing by pharmacists**
  - Pharmacists seek payment directly from the third-party payor (government or private)
  - Generally private payors, some Medicaid state agencies
    - Medicaid Managed Care becoming more common
    - Direct payments incorporating MTM or other codes for billing
    - Folding payment into a capitated or bundled payment model
Direct Billing (Cont.)

- **Direct billing requirements**
  - Pharmacists must enroll in health plan provider networks
    - May have credentialing requirements
    - May have processes specific to each plan
  - Pharmacists must bill the plan for covered patient care services
  - Pharmacists must comply with the plan’s billing requirements
“Incident-to” Billing

- **Medicare Benefit Policy Manual, Chapter 15**
  - “[S]ervices performed by permitted nonphysician practitioners incident to a physician’s professional services include not only services ordinarily rendered by a physician’s office staff person (e.g., ...blood pressures and temperatures...), but also services ordinarily performed by the physician such as minor surgery... and other activities that involve evaluation or treatment of a patient’s condition.” *Medicare Benefit Policy Manual, Pub 100-02, Chapter 15 § 60.2.*

- **Compliance**: Provider must delegate the services to the pharmacist consistent with state law
“Incident-to” Billing (Cont.)

- “Incident-to” Items and Services
  - Statutory basis for coverage in definition of “medical and other health services”
  - Medicare Regulations:
    - Clinic/Office – 42 C.F.R. § 410.26
    - Institutional – 42 C.F.R. § 410.27
  - Medicaid:
    - State-specific
"Incident-to" Clinic/Office Billing

- When following criteria are met, supervising physician or NPP may bill independently and submit claim to Medicare on CMS Form 1500 for payment based on MPFS for services by auxiliary personnel, (42 C.F.R. § 410.26).
  - Services and supplies are furnished in a noninstitutional setting to noninstitutional patients;
  - Services and supplies are an integral, though incidental, part of the service of a physician or NPP provided “in the course of diagnosis or treatment of an injury or illness;”
  - Services and supplies are either commonly furnished without charge or included in the bill of a physician or NPP;
  - Services and supplies are of a type commonly furnished in the office setting;
  - In general, services and supplies furnished under the direct supervision of the physician or NPP;
  - Services and supplies furnished by the physician, NPP or auxiliary personnel; and
  - Services and supplies are furnished in accordance with applicable State law.
“Incident-to” Clinic/Office Billing (Cont.)

- “Auxiliary personnel” means “...any individual... acting under the supervision of a physician (or other practitioner)... and meets any applicable requirements to provide incident to services, including licensure, imposed by the State in which the services are being furnished.” 42 C.F.R. § 410.26.
“Incident-to” Institutional

- Medicare Part B pays for therapeutic hospital services and supplies furnished with a physician or NPP’s service in the institutional setting if the services are (42 C.F.R. § 410.27):
  - An integral, although incidental, part of the physician’s or NPP’s professional services;
  - Furnished in the hospital to hospital patients;
  - Furnished under the direct supervision of the physician or NPP;
  - Furnished in accordance with state law; and
  - Furnished by or under arrangements made by the hospital.
“Incident-to” Billing

Can anti-coagulation monitoring be provided “incident to” a physician’s services in an office?

Yes, if the requirements are met, i.e., the services are part of a course of treatment during which the physician personally performs the initial service and is actively involved in the course of treatment, is physically present in the immediate office when services are rendered by the employee, and the service represents an expense to the physician or other legal entity that bills for the service.
“Incident-to” Billing

- In 2014, the American Academy of Family Physicians asked CMS to comment on whether physicians may bill incident-to for pharmacist services. CMS responded:

“In your letter, you ask that we confirm your impression that if all the requirements of the incident to statute and regulation are met, a physician may bill for services provided by a pharmacist as ‘incident to’ services. We agree.”

-Letter from CMS Administrator to American Academy of Family Physicians (March 25, 2014).
“Incident-to” Billing (Cont.)

- Incident-to billing: Key Clarifications
  - Each occasion of service by NPPs need not also be the actual rendition of a personal professional service by a physician.
  - OK for physician to perform an initial service only provided there are “subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment.” Medicare Benefit Policy Manual, Pub 100-02, Chapter 15, § 60.1(B).
  - Not available if the order for services originates from a physician outside of the billing group practice (or hospital).
    - Would require billing physician or NPP (or group practice prescriber) to personally perform the initial service and order and supervise ongoing treatment. Then, supervising physician or NPP can bill CPT 99211 for certain ongoing therapeutic management services rendered by RN or pharmacist.
    - Supervising (not originating) physician should bill.
“Incident-to” Billing (Cont.)

- Incident-to billing: Key Clarifications (Cont.)
  - **Supervision:**
    - Physician or a provider must be on the premises (office suite) and immediately available, but not necessarily in the same room (“direct supervision”). *See 42 C.F.R. § 410.32(b)(3).*
    - *Note: Institutional direct supervision only requires “immediately available”*
  - **Relationship:**
    - Pharmacist must be an employee, or contractor of the physician or their group practice
      - Must represent an expense of the billing entity (W-2, leased employee, or independent contractor)
      - Could be an issue if billed through entity X but the NPP is separately employed by entity Y, and not contracted to provide services to entity X.
“Incident-to” Billing (Cont.)

- Other Considerations
  - Medicaid state guidance – rules and scope of coverage vary
  - Private payor contract language (typically Medicare rules apply)
  - Direct supervision requirements (hospital vs. physician office)
Concerns related to “Incident-to” Billing

- **Scope of Practice (physician and pharmacist)**
  - The supervisory physician or NPP must have, within his or her State scope of practice and hospital-granted privileges (if in a hospital), the knowledge, skills, ability, and privileges to perform the service or procedure.

- **Collaborative practice standards**
  - In many states, pharmacists need to ensure collaborative agreements contemplate service scope and that supervising practitioner is appropriately involved in supervision of the services in accordance with the collaborative agreement requirements

- **Coverage Standards**

- **Correct coding/billing**

- **Other regulatory regimes:**
  - CLIA
  - OSHA
  - DEA
Concerns related to Diagnostic Test Billing

- Test billing is fact specific:
  - Medicare
    - Though many diagnostic tests can be performed and billed as incident-to under general (rather than direct) supervision, NPPs are not “physicians” for purposes so they may not perform the supervision required for Medicare diagnostic tests (May include: i) PT/INR; ii) Hgb/Hct; iii) Guaiac).
    - NPPs may perform themselves and then bill for some diagnostic tests
    - “General supervision” means “the procedure is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure.” 42 C.F.R. § 410.32.
  - Medicaid
    - Test coverage is state-specific
Concerns in Contractual Arrangements with Pharmacists

- **Overcharging or Upcoding** - using a billing code to receive a higher reimbursement rate than the level of service justified
  - Time-based or complexity-based

- **Unbundling** - using two or more billing codes where one global code could be used instead

- **Double-Billing** - having two providers claiming payment for the same services rendered to the same patient on the same date; or trying to bill both a private and public payor for the same services rendered to the same patient on the same date
Concerns in Contractual Arrangements with Pharmacists (Cont.)

- Billing when a test or procedure is unsupported by documentation or authorization
  - Unsigned records
  - No documented medical necessity
  - Unsupported by diagnosis codes
Concerns Related to Independent Practice Authority

- Scope of Practice
- Licensure
- Fraud, Waste and Abuse
  - Medically unnecessary tests or services
  - Services actually provided
  - Beneficiary inducements
  - Stark Law
  - Anti-Kickback Statute
  - Coding compliance (JW modifiers, E&M coding standards, LCD and NCDs)
  - Specific FI/MAC guidance re required elements to bill 99211 E&M code
Concerns Related to General Pharmacy Law Issues

- Drug diversion
- Beneficiary inducements (reward programs; coupons)
- Excluded individuals and individuals who do not have the required credentials providing services
- Coordination of benefits
- Medicare Part D reimbursement rules and Part D sponsor agreements
- HIPAA and HITECH, and related IT matters
- Pharmaceutical environmental issues (disposal; hazardous waste)
Concerns Related to General Pharmacy Law Issues

- Unsupported tests/services
- Use of another provider’s tax ID
- Duplicate billing
- False Claims Act (potential criminal penalties)
- Antikickback Statute (see below) risks
Bundled Payment Initiatives

- CMS Bundled Payments for Care Improvement (BPCI) Initiative
  - Organizations to enter into payment arrangements that include financial and performance accountability for episodes of care
  - 4 Models (Participants as of April 2016):
    - Model 1 (1): Episode of care focused on the acute care inpatient hospitalization. Awardees provide a standard discount to Medicare from the usual Part A hospital inpatient payments
    - Separate TC and PC, but gainsharing permitted
    - Model 2 (649): Starting at inpatient admission, episodic care payments for a 30-, 60- or 90-day period
    - Model 3 (862): Starting at post-acute admission, episodic care payments for a 30-, 60- or 90-day period
    - Model 4 (10): Prospective bundled payment arrangement
  - Lump sum payment made to a provider for the entire episode of care includes PC and TC
Bundled Payment Considerations

- Billing and coding compliance
  - Duplicate payments/claims
  - Coding compliance (JW modifiers, E&M coding standards, LCD and NCDs)

- Development of operational capabilities
  - Identification of patients eligible for bundles
  - Data analytics and information sharing
  - Patient Tracking
Federal Anti-Kickback Statute (AKS) Overview

- 42 U.S.C. § 1320a-7b(b)

- Prohibits a person or entity from knowingly and willfully offering, paying, soliciting or receiving remuneration, directly or indirectly, overtly or covertly, in cash or in kind, to induce or reward the:
  - Referral of an individual for the furnishing of any item or service that may be reimbursed under a federal health care program, or
  - The purchase, lease, ordering or arranging for or recommending the purchasing, leasing or ordering of any item, facility or service that may be reimbursed under a federal health care program.

- Remuneration includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.
AKS Overview (Cont.)

- Intent-based criminal statute
  - Statutory exceptions and regulatory safe harbor protection requires strict compliance with terms
  - Failure to comply with an exception or safe harbor does not mean an arrangement is per se illegal (facts and circumstances analysis)
- Covers arrangements where “one purpose” of the remuneration was to induce referrals
- Violation is a felony punishable by a maximum fine of $25,000, imprisonment up to five years, or both.
- OIG may impose civil monetary penalties and exclude parties from federal health care programs
Physician-Owned Pharmacy

- **Investments in group practices safe harbor** (42 CFR 1001.952(p))

- Protects return on investments made to practitioners investing in their own solo or group practices if:
  - Equity interests in the practice/group are held by licensed health care professionals who practice in the practice/group
  - Equity interests are in the practice/group itself, and not a subdivision of the practice/group
  - If a group practice: (a) must meet definition of “group practice” definition under Stark, and (b) be a unified business with centralized decision-making, pooling of expenses and revenues, and a compensation/profit distribution system that is not based on satellite offices operating substantially as if they were separate enterprises or profit centers
  - Revenues from ancillary services, if any, must be derived from “in-office ancillary services” (as defined under Stark)
Physician-Owned Pharmacy

- **Investments in group practices safe harbor** (42 CFR 1001.952(p))
  - Protects return on investments in solo or group practices (that meet group practice definition under Stark)
  - *Only protects equity interests in the group/practice itself and not subdivisions of the practice/group*
  - Compliance with IOAS as evidence of intent

- **Small Entities Investment Interests Safe Harbor** (42 CFR 1001.952(a))
  - Unavailable for arrangements that comply with the IOAS exception to Stark
  - Compliance with IOAS exception as evidence of intent under AKS
Physician-Owned Pharmacy

- **Personal Services and Management Contracts Safe Harbor** *(42 CFR 1001.952(d)) – discussed above*
  - e.g., physician supervision services & other physician remuneration relationships between practice physicians and the pharmacy

- **Space rental safe harbor** *(42 CFR 1001.952(b))*
  - If referring physician or group practice owns/leases space rented to pharmacy
  - In general, must meet the rental of office space Stark exception requirements in addition to the following requirements:
    - Lease must cover all of the premises leased during the term;
    - Aggregate rental charge is set in advance; and
    - If part-time lease, must specify the exact schedule of such intervals, their precise length, and the exact rent for such intervals
Physician-Owned Pharmacy

- Joint ownership by multiple physicians (not in the same group practice) or by multiple group practices, or a combination of both
- Stark: Will not comply with IOAS exception
- AKS: May comply with small entity investment interests safe harbor
  - Likely problematic requirements (of the 8 safe harbor requirements):
    - No more than 40% of value of investment interests held by investors in a position to make or influence referrals or otherwise generate business for the pharmacy
    - No more than 40% of the pharmacy’s gross revenue may come from referrals or business otherwise generated by investors
    - Terms on which investment offered to passive investors (i.e., not responsible for daily management) in a position to otherwise generate business for the pharmacy should be no different from terms offered to other passive investors
- State laws may prohibit this type of arrangement for non-Medicare/Medicaid arrangements
AKS in Pharmacy Management/Services

- AKS prohibits a person or entity from knowingly and willfully offering, paying, soliciting or receiving remuneration, directly or indirectly, overtly or covertly, in cash or in kind, to induce or reward the:
  - **Referral** of an individual for the furnishing of any item or service that may be reimbursed under a federal health care program, or
    - Referral includes **marketing** services, etc.
  - The purchase, lease, **ordering or arranging for or recommending the purchasing, leasing or ordering** of any item, facility or service that may be reimbursed under a federal health care program.
Conclusion

- State and federal laws and regulations are moving towards expanding pharmacists’ roles in patient care as a provider.

- With the growing emphasis on the grappling with the opioid crisis, managing medications for chronic conditions, and vaccination, there will be a greater need for health care providers.

- Pharmacists, pharmacy technicians, and others can take advantage of this development through collaborative practice arrangements and other opportunities permitted under the law.
1. Assessment Question

1. Collaborative practice pharmacy models are generally feasible as between pharmacists and –

A. Physicians

B. Nurses (RN)

C. Hospice Interdisciplinary Groups (IDGs)

D. Therapists (PT/OT/SLT)
2. Assessment Question

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QUESTIONS?

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