ThoughtSpot

Strategies for Health Plan Collaboration and Medical Billing Integration
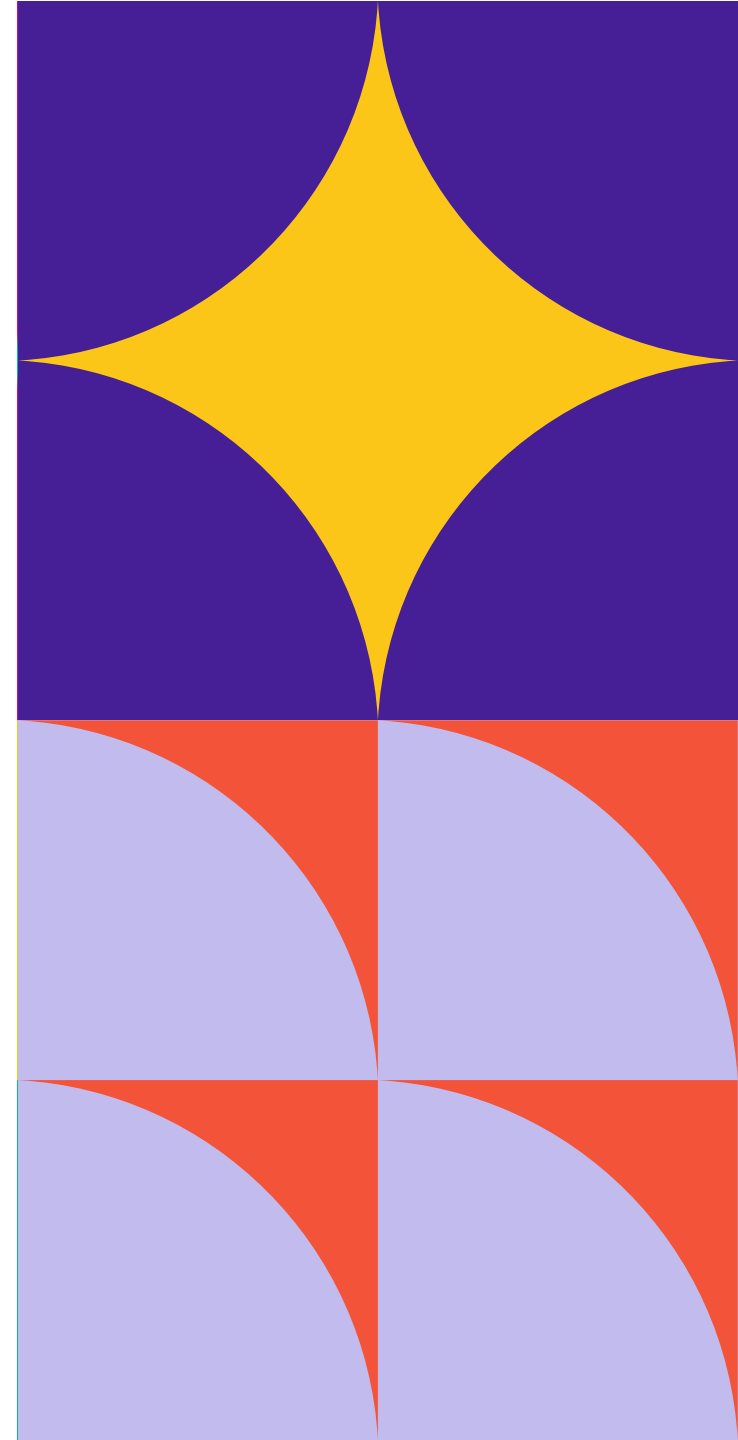
Travis Wolff, PharmD, BCACP

CEO, PharmFurther

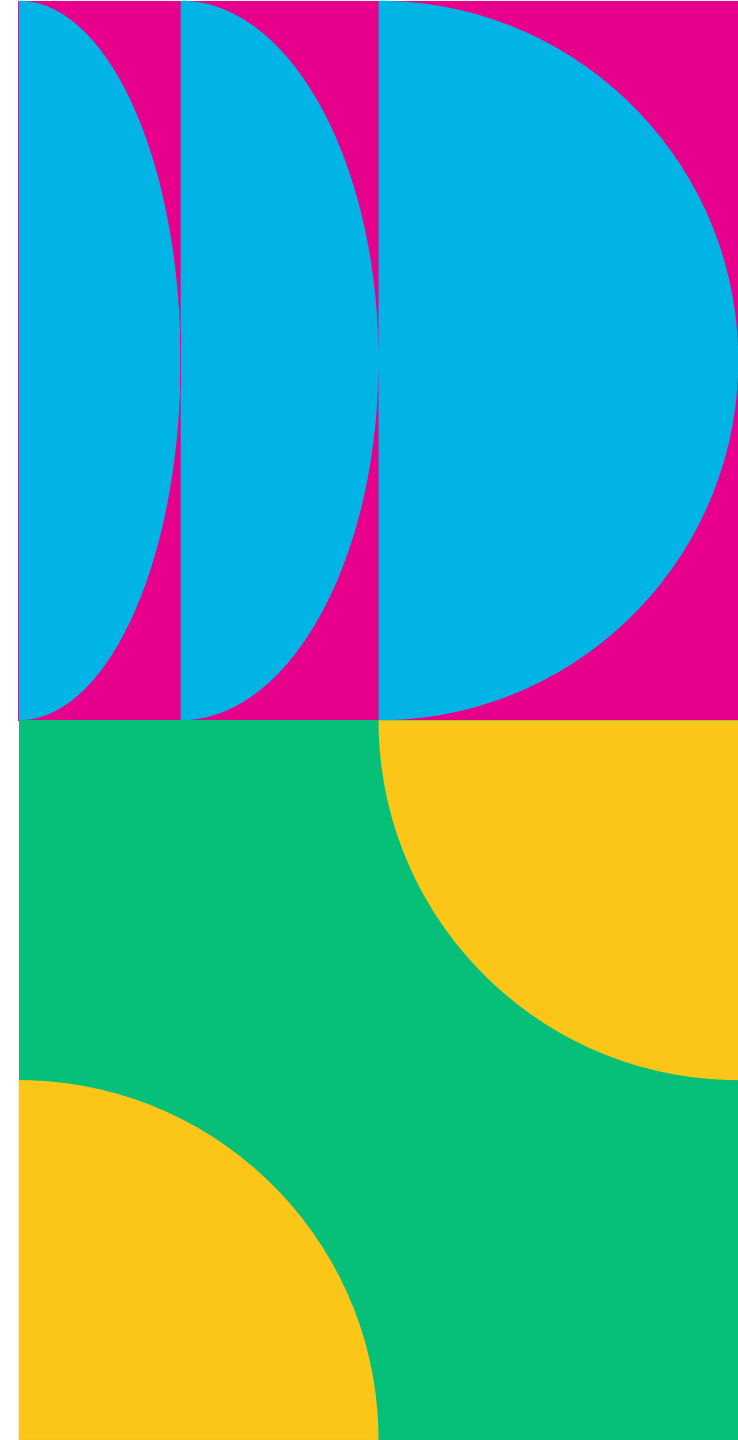**Director, CPESN Medical Billing**

Disclosure Statement

There are no relevant financial relationships with ACPE defined commercial interests for anyone who was in control of the content of the activity.

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Learning Objectives

1. Review strategic approaches for pharmacists to overcome barriers to enrolling as a provider.

2. Discuss best practices for documenting patient encounters for continuity of care inside a busy pharmacy workflow.

3. Outline the basic principles of medical coding to get paid for your services beyond dispensing.

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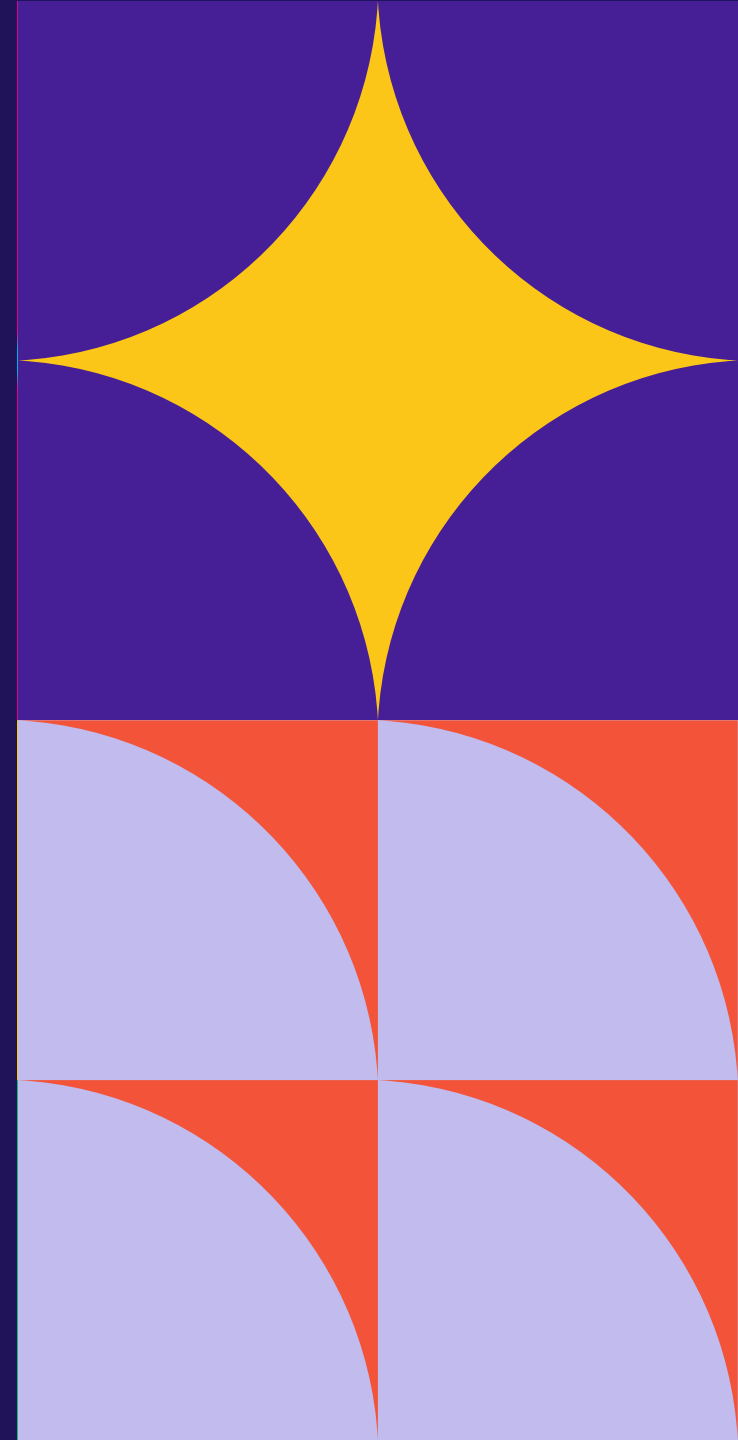
Speaker

Travis Wolff, PharmD, BCACP

CEO, PharmFurther

Director, CPESN Medical Billing

ADCES DSME Billing SME

CDC/NACDD Clinical Pharmacist SME

Overcoming Barriers to Enrollment of the Pharmacist as a Provider

2023 Provider Status End of Year Legislative Update

180 bills were introduced in 43 states pertaining to

- Pharmacist scope of practice

- Payment for pharmacist-provided patient care services, and/or

- The designation of pharmacists as providers

As of December 31, 2023

- 55 bills in 32 states have been signed into law!

o Vaccine Authority

o HIV PrEP/PEP Prescribing Authority

o Opioid Antagonist Prescribing

o Medication Therapy Management

o Point of Care Testing and Treatment

o Contraceptive Prescribing

o Collaborative Practice Authority

o Preventive and Evaluation/Management

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2024 Provider Status End of Year Legislative Update

165 bills were introduced in 41 states pertaining to

- Pharmacist scope of practice

- Payment for pharmacist-provided patient care services, and/or
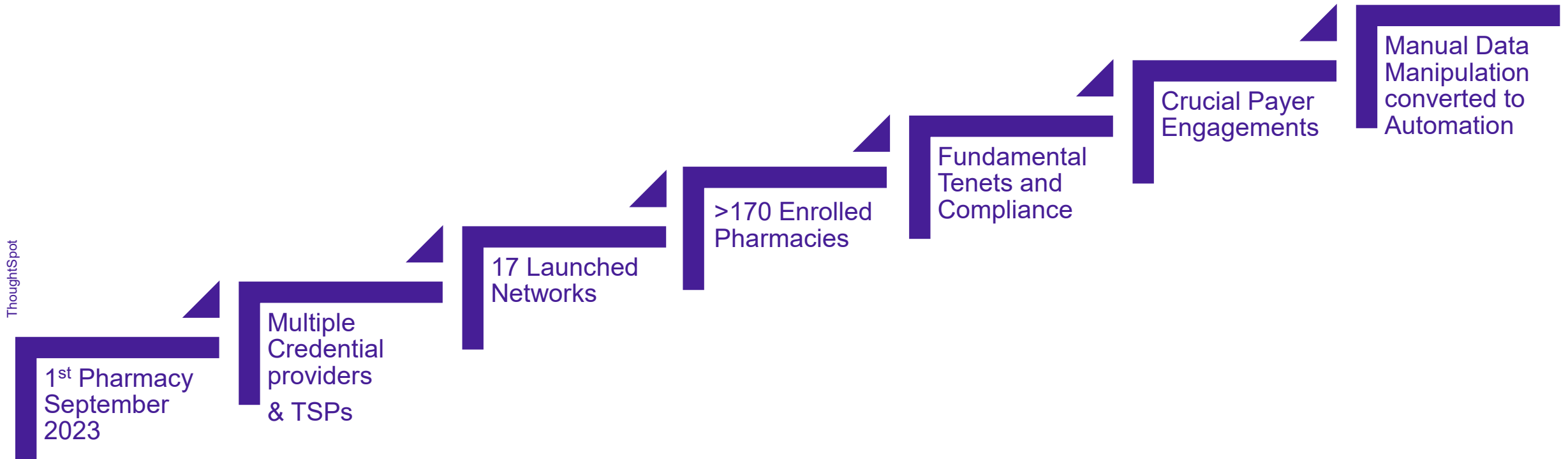
- The designation of pharmacists as providers

As of December 31, 2024

- 45 bills in 31 states have been signed into law!

CPESN Medical Billing Supports:
A State-by-State Approach

- Evaluate opportunities

- Establish Level 1 Relationship

- Facilitate Transparent Credentialing

- Medical Billing Education

- Facilitate Billing Clearing House and Technology Solution Providers (TSP)

  o Track effectiveness and efficiency of claims

  o Identify opportunities and prevent barriers

  o Quality assurance and safety for the profession

  o Design and Deliver Best Practices

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17 Specific States Launched as of August 2024

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1st Pharmacy September 2023

Multiple Credential providers & TSPs

17 Launched Networks

>170 Enrolled Pharmacies

Fundamental Tenets and Compliance

Crucial Payer Engagements

Manual Data Manipulation converted to Automation

CPESN Medical Billing States

- Minnesota
- Texas
- New York
- Arkansas
- Tennessee
- Washington
- Nebraska
- Colorado
- New Mexico
- Virginia
- California
- South Carolina
- Kansas
- Wisconsin
- Maryland
- Kentucky
- Idaho

If your state is not launched yet, you should contact your CPESN Managing Network Facilitator to learn more.

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Raise your hand if you are currently billing medical benefits for anything beyond vaccines

Credentialing

- Essentially a thorough background check to prove qualifications to provide encounter/service

- *"The process by which medical organizations and insurance companies verify the credentials of healthcare providers to ensure they have the required licenses, certifications, and skills to properly care for patients"*

- <u>Usual steps:</u>
  - o Verify clinic (practice location/setting), training, and scope of provider
  - o Provider eligibility for healthcare services within third party rules
  - o Often a pre-application process for simple auto denial reasons
  - o Many require universal CAQH platform, but you should always verify this first

Qualifying with the Payer

- Pharmacists still don't have federal QHCP status (CMS)

- Specific state laws have given pharmacist expanded scope

- Many payers have boundaries of program design

    o Regional teams

    o State specific benefit coverage

- A new path may need to be paved (more on this later!)

- Often the payer does not know there are barriers until you try

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National Committee for Quality Assurance

The National Committee for Quality Assurance (NCQA) is an independent, nonprofit organization that works to improve healthcare quality through the administration of evidence-based standards, measures, programs, and accreditation

- NCQA has established a set of standards that currently serve as a guideline for credentialing healthcare providers
    - o Pharmacists currently do not appear as practitioners included in the credentialing file review
- There is not a standardized process for credentialing pharmacists
    - o Payers may vary in the information required for pharmacist enrollment

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Specific Credentialing Examples

- DSME services billed to CMS

- MediCal in California

- Forward Health in Wisconsin

- BCBS in Texas

- OHCA in Oklahoma

→ BCBS in Arkansas

→ Cigna in Texas

→ United Healthcare in Virginia and more!

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Why should health plans contract pharmacist providers?

- Health plans are expected to demonstrate how they are differentiating their approach with programs to improve outcomes and close gaps in care

- Pharmacists can provide a diverse range of patient care services beyond traditional dispensing services

- Supporting pharmacists as providers allows increased access to care in rural and underserved communities

- Pharmacists, Pharmacy Technicians, and Community Health Workers are integrated in the local community and readily accessible

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Provider Enrollment

Health plans will need to gather a significant amount of information to properly contract with you and provide payment for your services.

These may include, but are not limited to:

Identifying information:
- Individual NPI
- Individual state license number
- Pharmacy/facility NPI
- Pharmacy/facility tax ID
- Pharmacy W-9
- Taxonomy code
- State Medicaid enrollment
- Professional liability insurance
- Curriculum Vitae

Proof or attestation of:
- Completion of board of pharmacy requirements
- Minimum continuing education requirements
- Highest level of education completed
- Completion of cultural competency training
- State certification
- Clinical Laboratory Improvement Amendment (CLIA) waiver (if applicable)
- History of felony conviction/discipline

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Credentialing Services

CAQH Provider Data Website

How Much Does CAQH Credentialing Cost?

- The CAQH application, profile, and Proview database (used for storage and maintenance) are free for healthcare providers and practices.

- Health plans and other healthcare organizations pay fees to use the CAQH Provider Data for credentialing.

Documenting Patient Care for Continuity and Value Measure
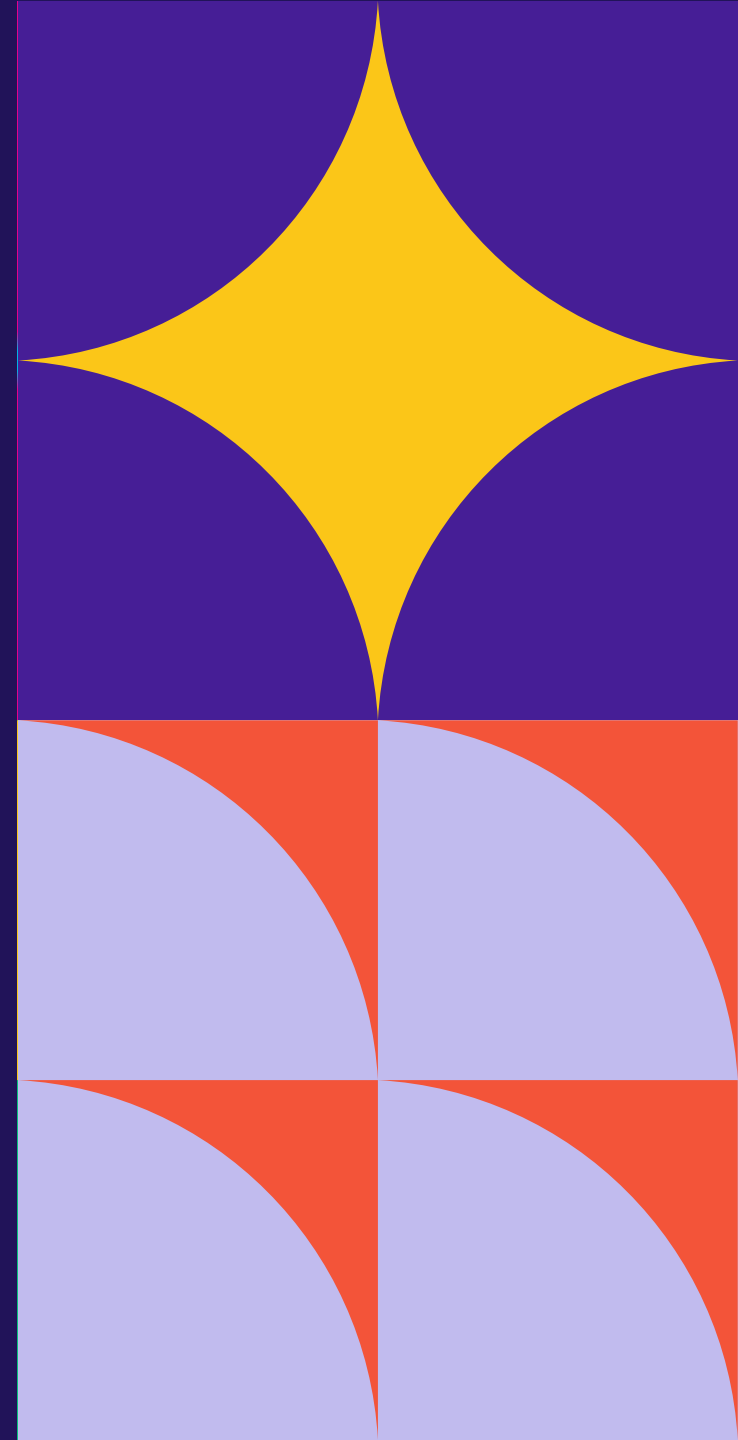
The Importance of Documentation

- "If we want to be providers, we have to look like providers"
- Working within our scope, requires methods of continuity of care
- Billing for your service is more than CPT codes and Diagnosis pointers
- Two main goals
  - o Document the visit and what was done
  - o Attach a claim with codes that the plan can receive

E-care plan is/was a Bridge

- E-care plans still very valuable for VBC
- Easy to integrate into workflow
- Difficult to read information received at the pharmacy level
- Applies to specific patient populations only
- Process learned without the why in many cases

Pharmacists must learn Medical Billing

- D.0 pharmacy management integration
  - Pros: Ease of workflow integration; smaller learning curve
  - Cons: Care documentation where? PBMs also have a smaller learning curve
- Templated system with click boxes and drop downs
  - If the patient fits, can make life easier
  - Can give you confidence (as long as the patient fits)
- Free form EHR documentation and billing tools
  - Any patient fits
  - Can still have templates
  - Harder to learn but more reward at stake

Medical Billing Cycle

Appeal of denials must be submitted within an established time window and may require consent from the patient in addition to additional documentation related to the service.

No real-time adjudication. Need verification process to confirm patient eligibility prior to providing billable services.

Verification of payment requires an internal reconciliation process to review rejections with standard operating procedures for corrections and resubmissions.

Necessary to have chart records with documentation of services rendered available for auditing and future visit reference.

Medical billing is not performed in real-time; however, there are limitations to the timeframe in which claims must be submitted for payment via electronic health records, paper billing, or electronic filing.

Proper payment for services rendered will require a basic understand of medical coding using approved provider codes, CPT codes, and appropriate modifiers.

Denials & Appeals

Patient Eligibility Verification

Claim Payment Reconciliation

Pharmacist Provider Services

Documentation of Services

Claims Submission & Timely Filing

Medical Coding

ASHP: Billing and Reimbursement for Patient Care Clinical Services

Case Study

Pharmacist Provider Services

Patient Eligibility Verification — Log into payer portal and look up patient benefits by name, DOB, and ID number.

Documentation of Services — 68 yo female presents for influenza vaccine; patient was see in consult room for review of current vaccination history and recommended vaccines; she is due for pneumonia, tetanus, and shingles vaccine at this time.

Medical Coding — CPT 99401-preventive health 18 min visit Dx Z23, Z71.85

Claims Submission & Timely Filing — Claim submitted to clearing house using technology solutions provider

Claim Payment Reconciliation — Claim accepted; patient owes $31 due to deductible not met.

Denials & Appeals — None.

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Basic Medical Coding Principles
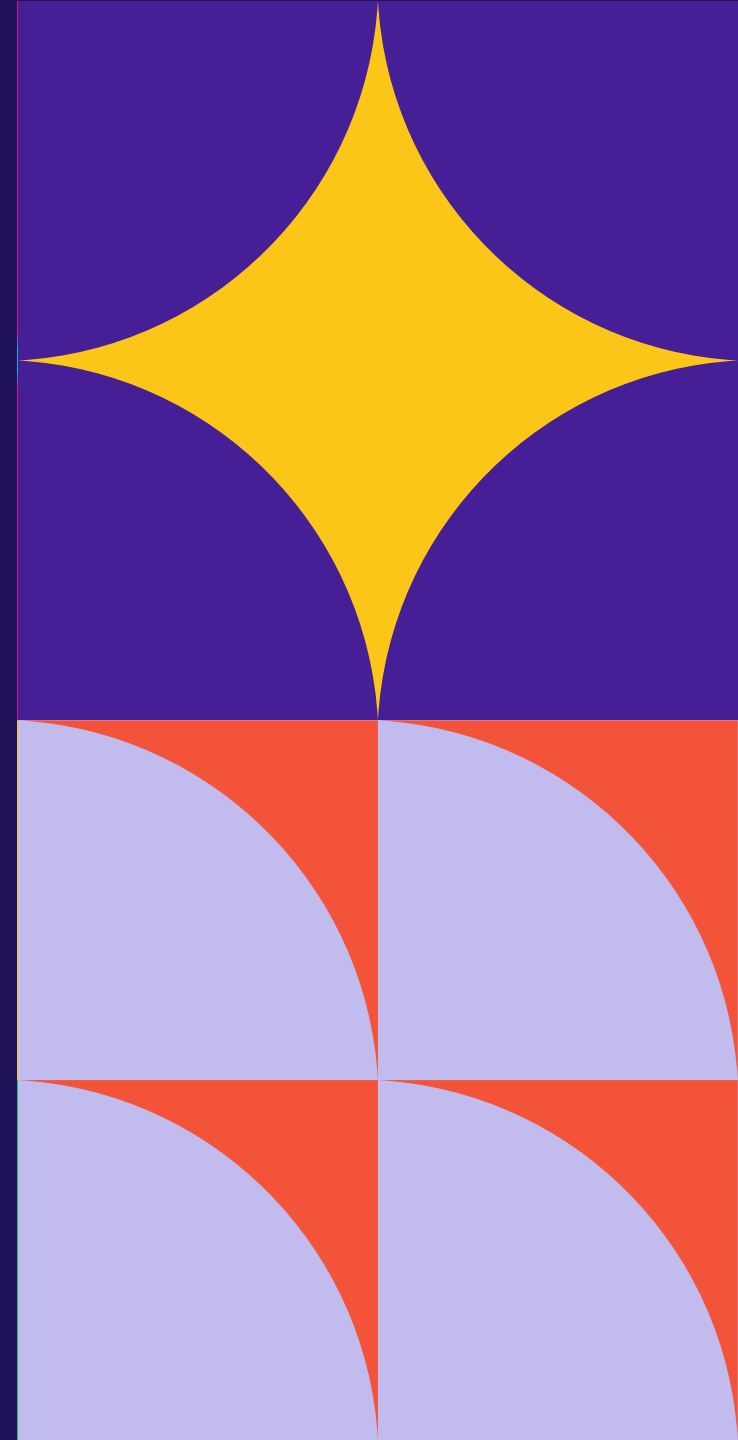
Rx Billing vs Medical Billing

| Pharmacy Benefit	Medical Benefit
Billing a product using NDC number	Billed using CPT codes plus Dx code
Real time adjudication/response process	Billing is not real-time
Pharmacies bill insurers through a PBM	Many ways, but sent to payer for processing

Medical Coding vs Billing

Coding

- Translating what was done for the patient into a universal code to create a claim

- Codes allow for HIPAA and a universal language from provider to provider (and payer)

- Reading a visit note and documenting using codes

- consider translating a phone in prescription into a latin based Rx

    o Take one tablet by mouth every morning.

    o T1T PO QAM

Billing

- Follow up to claims transmitted

- Appealing denied claims

- Processing EOBs for appropriate third-party payment as well as patient responsibility

- Creating patient statements for patient responsibility (owed)

- Collecting statements via Accounts Receivable processes

Coding

- CPT
- HCPCS
- ICD-10
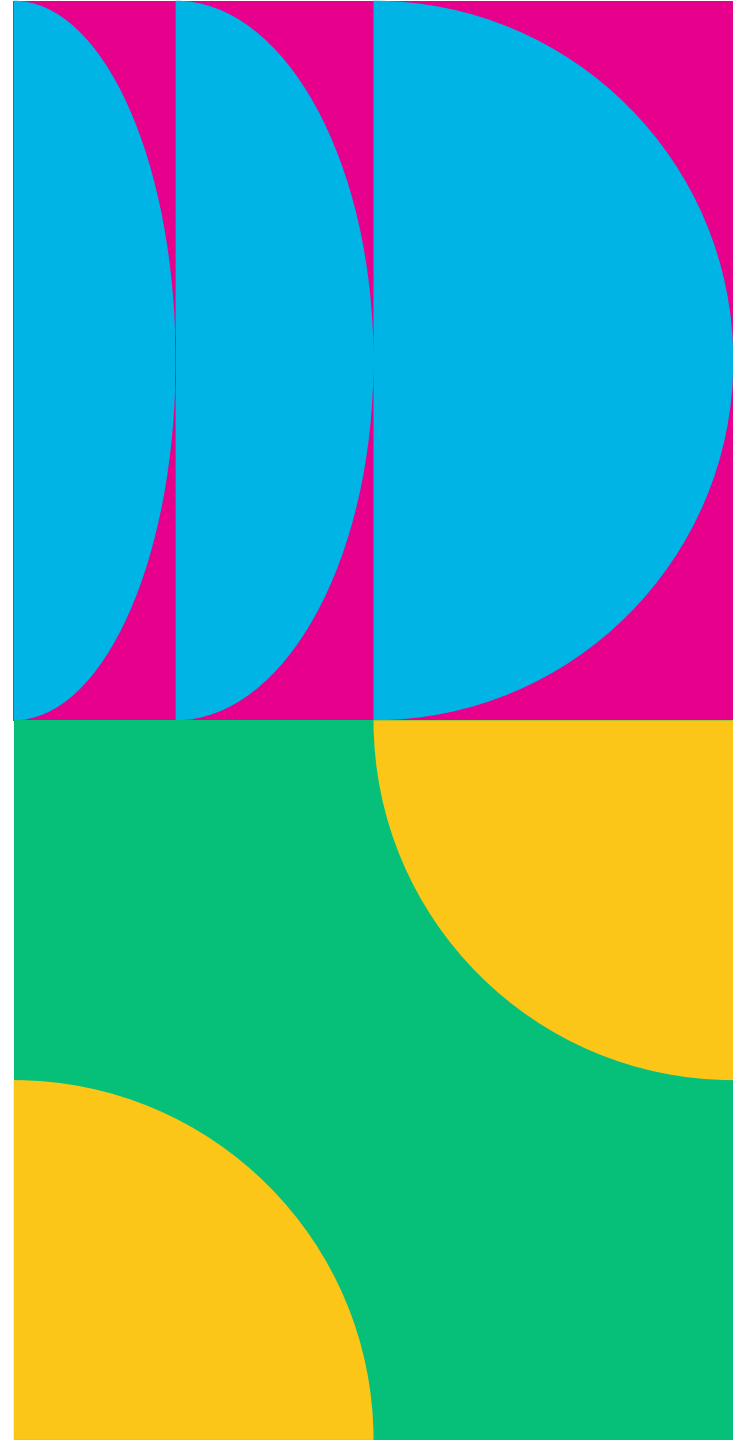
CPT- Current Procedure Terminology

- What we did for the patient

- CPT Category I

  - Used as primary documentation for billing encounter

  - Five-digit numeric codes divided into six major ranges

- CPT Category II

  - corresponds to performance measurement

  - five-digit, alphanumeric codes are typically added to the end of a Category I CPT code with a hyphen

  - optional, and may not be used in the place of Category I codes

- CPT Category III

  - corresponds to emerging medical technology

- CPT Modifiers

  - two-digit numeric or alphanumeric codes that are added to the end of the Category I CPT code

  - provide important additional information to the procedure code

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HCPCS-Healthcare Common Procedure Coding System

Commonly pronounced "hick-picks" code

- Correspond to services, procedures, and equipment not covered by CPT codes

- Correspond to services, procedures, and equipment not covered by CPT codes. This includes durable medical equipment, prosthetics, ambulance rides, and certain drugs and medicines

- Like CPT codes, each HCPCS code should correspond with a diagnostic code that justifies the medical procedure

ICD-International Classification of Diseases

- Why we did what we did for the patient

- Diagnostic codes that create a uniform vocabulary for describing the causes of injury, illness and death

- Used to represent a doctor's diagnosis and the patient's condition In the billing process

- Used to determine medical necessity

- ICD-10-CM

  - ICD was created by the World Health Organization in the 1940s, and about every 10-15 years it is reviewed and revised

  - Read as the 10 revision of the ICD code

  - -CM at the end stands for "clinical modification"

- Clinical Modification gives more flexibility and specificity to describe the encounter

  - ICD-10 has 14,000 codes

  - ICD-10-CM has over 68,000 codes

Category I CPT Codes

Divided into six large sections based on which field of health care they directly pertain to:

- Evaluation and Management: 99201 – 99499

- Anesthesiology: 00100 – 01999; 99100 – 99140

- Surgery: 10021 – 69990

- Radiology: 70010 – 79999

- Pathology and Laboratory: 80047 – 89398

- Medicine: 90281 – 99199; 99500 – 99607

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Category I CPT Codes

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- **Pathology and Laboratory: 80047 – 89398**

- **Medicine: 90281 – 99199; 99500 – 99607**

HCPCS

- Healthcare Common Procedure Coding System (HCPCS), commonly pronounced "hicks-picks."

- This code set is based upon CPT. In fact, the first level of HCPCS is identical to CPT

- HCPCS was developed by the Centers for Medicare and Medicaid (CMS) for the same reasons that the AMA developed CPT: for reporting medical procedures and services.

- Coders today use HCPCS codes to represent medical procedures to Medicare, Medicaid, and several other third-party payers.

- As with CPT modifiers, coders should always order functional HCPCS modifiers first, and informational modifiers second.

ICD-10 "Tree"

- A seven-character, alphanumeric code
- Each code begins with a letter; that letter is followed by two numbers
  - These first three characters are the "category"
    - Describes the general type of disease or injury
- The category is followed by a decimal point and the subcategory
- This is followed by up to two subclassifications
  - Further explain the cause, manifestation, location, severity, and type of injury or disease
- The last character is the extension
  - Signifies the type of encounter that it is (initial, subsequent)

ICD-10 Tree

The first digit of an ICD-10-CM code is always an alpha, the second digit is always numeric, and digits three through seven may be alpha or numeric.

A01 – {Disease}

- A01.0 {Disease] of the lungs
  - o A01.01 … simple
  - o A01.02… complex
    - A01.020 … affecting the trachea
    - A01.021 … affecting the cardiopulmonary system
      - ➢ A01.021A … initial encounter
      - ➢ A01.021D … subsequent encounter
      - ➢ A01.021S … sequela (A condition that is the result of a previous injury or condition)
      - ➢ Reference example Medical Billing and Coding Certification Book Copyright 2023 Red Ventures Company

How to Look Up ICD-10 Codes

Volume I

- Tabular Index
- Technical definitions with specificity

Volume II

- Alphabetic Index
- General descriptions to get you close

You may start with Volume II to understand the category of ICD-10 for the encounter performed, but then ALWAYS use that to cross reference to the Volume I Tabular to verify what you are documenting.

ICD-10 code ranges

TOPIC	RANGE
Certain infections and parasitic diseases	A00-B99
Neoplasms	C00-D49
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	D50-D89
Endocrine, nutritional and metabolic diseases	E00-E89
Mental, Behavioral and neurodevelopmental disorders	F01-F99
Diseases of the nervous system	G00-G99
Diseases of the eye and adnexa	H00-H59
Diseases of the ear and mastoid process	H60-H95
Diseases of the circulatory system	I00-I99
Diseases of the respiratory system	J00-J99
Diseases of the digestive system	K00-K95
Diseases of the skin and subcutaneous tissue	L00-L99
Diseases of the musculoskeletal system and connective tissue	M00-M99
Diseases of the genitourinary system	N00-N99

|	
Pregnancy, childbirth, and puerperium	O00- O9A
Certain conditions originating in the perinatal period	P00-P96
Congenital malformations, deformations and chromosomal abnormalities	Q00-Q99
Symptoms, signs, and abnormal clinical laboratory findings, not elsewhere classified	R00-R99
Injury, poisoning, and certain other consequences of external causes	S00-T88
External causes of morbidity	V00-Y99
Factors influencing health status and contact with health services	Z00-Z99

Importance of Modifiers

Professional Component

- Refers to the services performed by a fully licensed medical professional

- Important for the reimbursement process, and is usually noted with the inclusion of modifier -26 after a procedure cod

- Professional services include the evaluation of a test, but not the administration of the test

Technical Component

- Refers to the portion of a medical procedure that concerns only the technical aspect of the procedure, but not the interpretative, or professional aspect

- Might include the administration of a rapid Strep test, but would not include the assessment of that test for disease
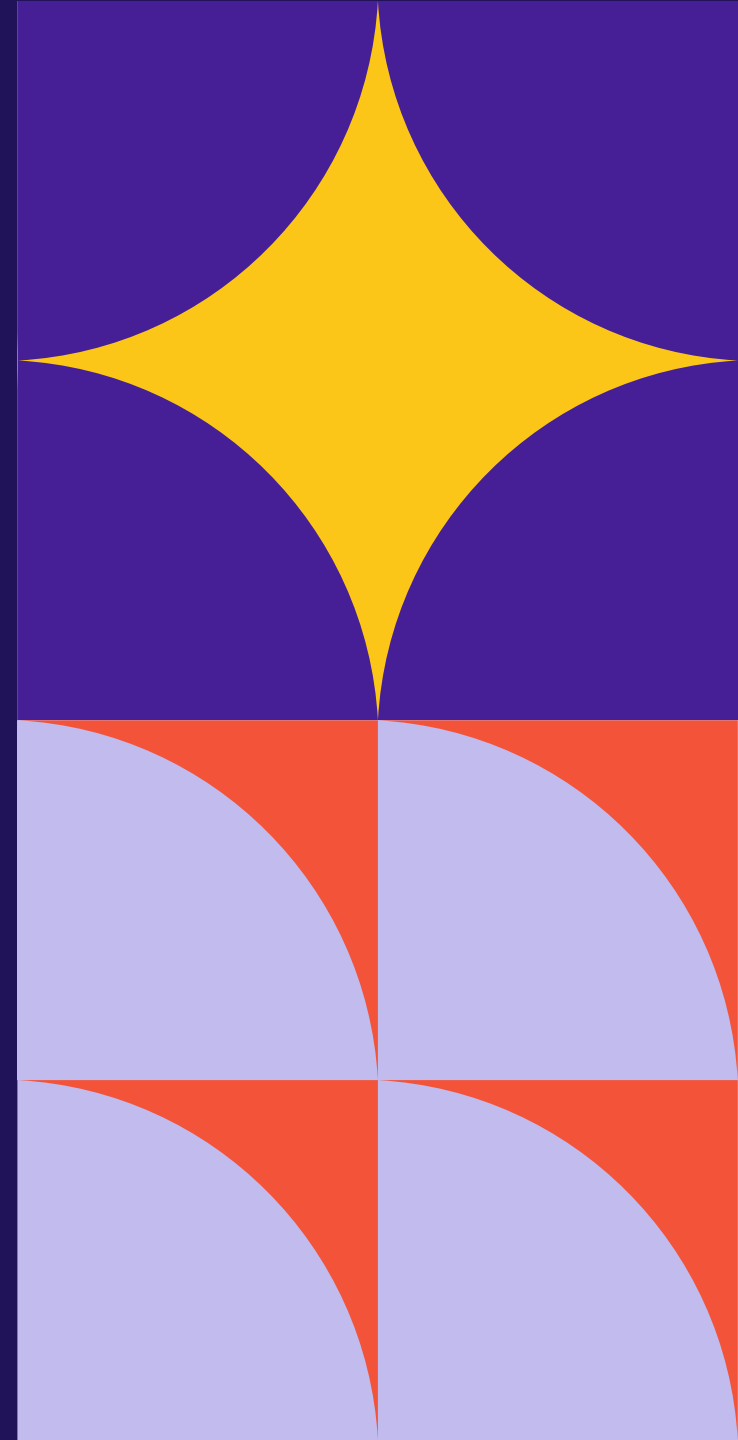
Check your knowledge:

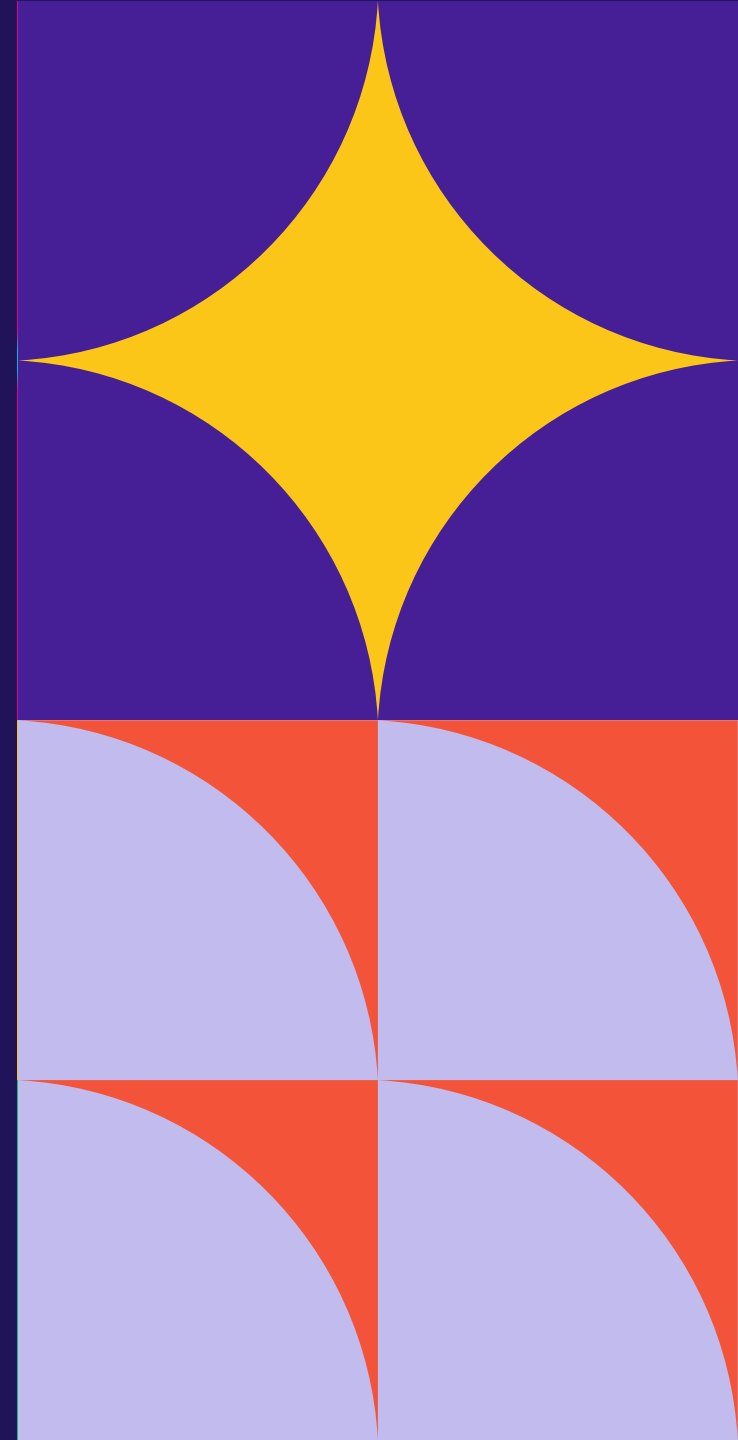**What code describes the service/encounter delivered to the patient?**
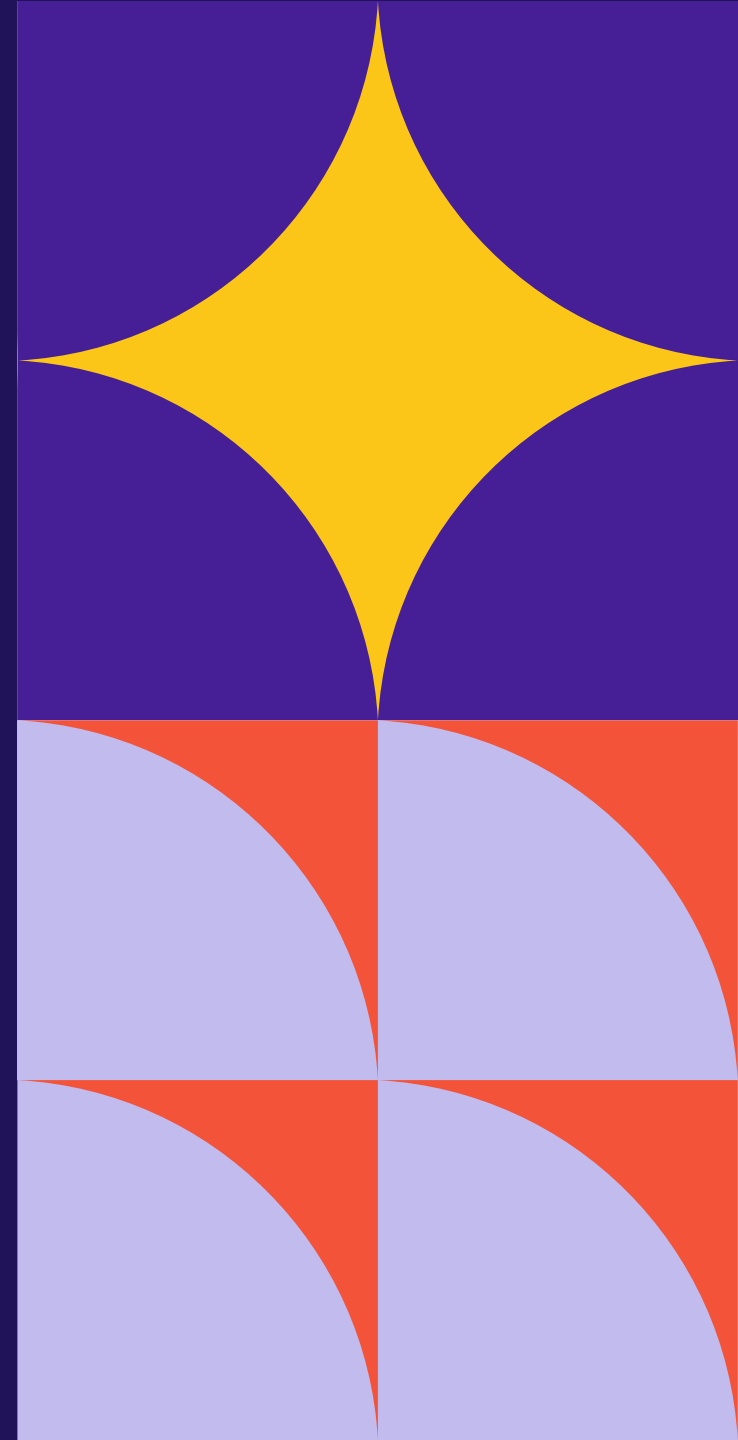
Check your knowledge:

What code describes the service/encounter delivered to the patient?

CPT code or if Medicare HCPCS code
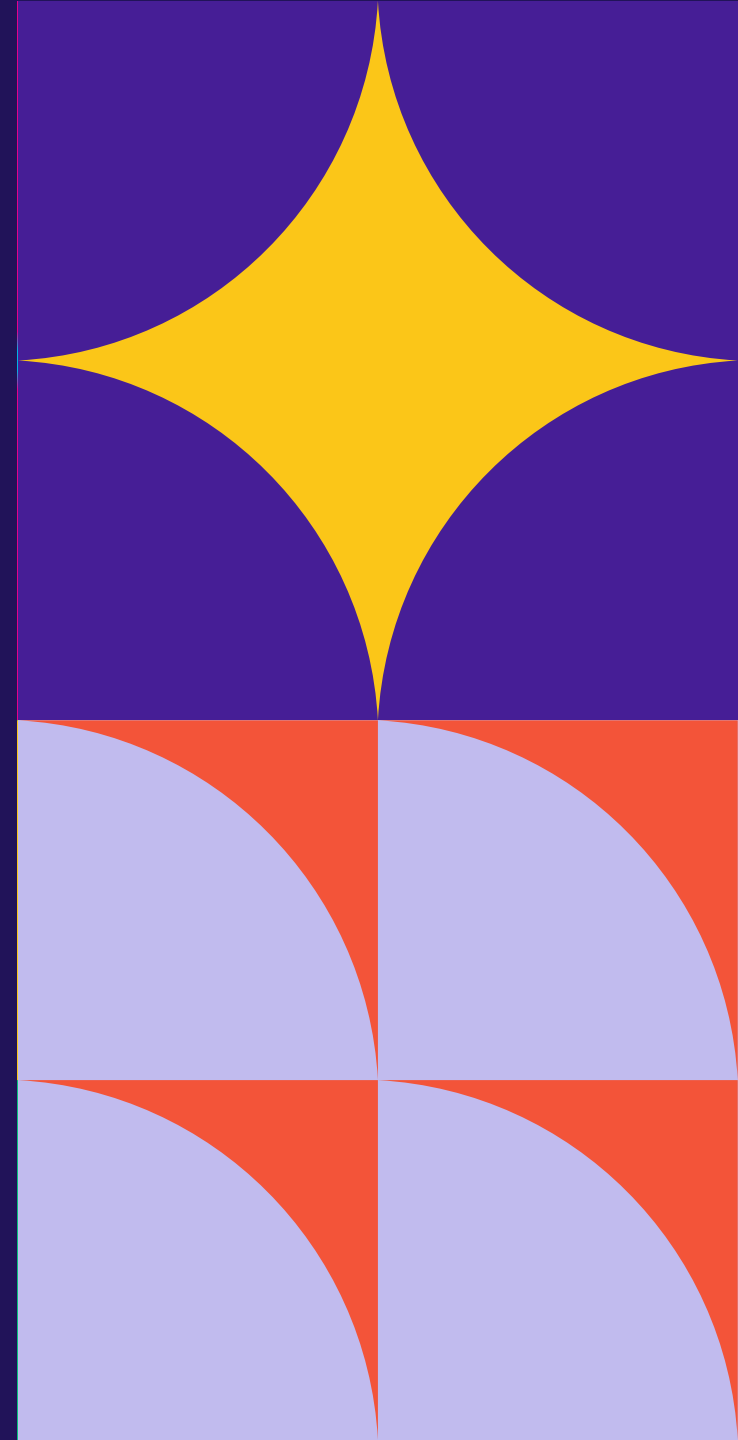
Check your knowledge:

What code describes the reason or why the patient qualified for the service/encounter delivered?

Check your knowledge:

What code describes the reason or why the patient qualified for the service/encounter delivered?

Diagnosis Code

Paving New Roads

- Need an agreed upon destination

- A demand to travel it
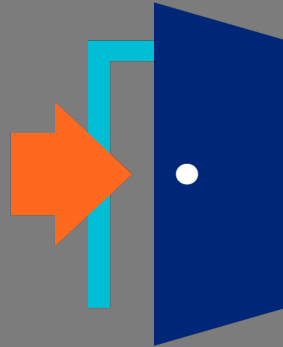
- Increasing scope as destination is readily achieved

Google image search: "dirt road to four lane highway progression.
Accessed 12 April 2025.

Where are your destinations?

Closing Gaps in Care

HbA1c levels

Blood Pressure

Med Adherence

Statin use

Access to Care

Point-of-Care testing

Prescribing Protocols

Access to patients

Social Drivers of Health

Identification of patient needs

Direct connections to resources

Education & Counseling

Vaccine awareness

Smoking Cessation

MTM

Questions?

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