GPS

NCPA
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

Growth. Performance. Success.

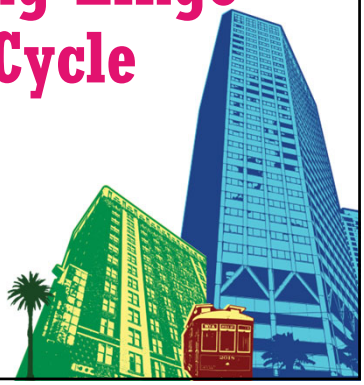
NCPA 2025 ANNUAL CONVENTION

1

Which Code is it Anyway?

Understanding Medical Billing Lingo and Implementing Revenue Cycle Strategies That Work

NCPA 2025 Annual Convention and Expo



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Speaker

Jennifer Griffin, PharmD, MS

Clinical Pharmacist, Harps Food Stores, Inc.

- Doctor of Pharmacy degree from Harding University College of Pharmacy in Searcy, Arkansas
- Bachelor of Science in Healthcare Administration and a Master of Science in Health Promotion from the University of Central Arkansas in Conway, Arkansas
- Specializes in medical billing, point-of-care testing and treatment workflow, and marketing clinical services.
- Serves on the CPESN USA Network Development Committee as a NextGen participant

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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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Pharmacist and Technician Learning Objectives

1. Define key medical billing terminology.
2. Discuss the revenue cycle management process.
3. Outline medical billing workflow best practices to achieve timely reimbursement.

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About Our Pharmacies

Harps Food Stores, Inc.

- Employee-owned small regional chain based out of Springdale, Arkansas
- 39 pharmacies operating across Arkansas, Missouri, and Oklahoma
- Implemented a medical billing workflow in all locations
- 10+ years of successful medical billing experience

HARPS™ PHARMACY

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Focusing on Workflow

At our pharmacies, one of our core focuses is ***workflow***.

Every enhanced service that we offer is streamlined into the pharmacy workflow.

- It started with immunizations and has grown immensely!

Without effective workflow strategies in place, even the most capable teams can be overwhelmed.

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Focusing on Workflow

- Delegate non-clinical tasks
  - Make sure technicians are doing data entry, resolving insurance issues, counting medications, etc.
- Medication synchronization
  - Transitions a majority of prescription volume from urgent to planned for.
  - I know that when MedSync drops into my queue, I have a few days to finish those up.

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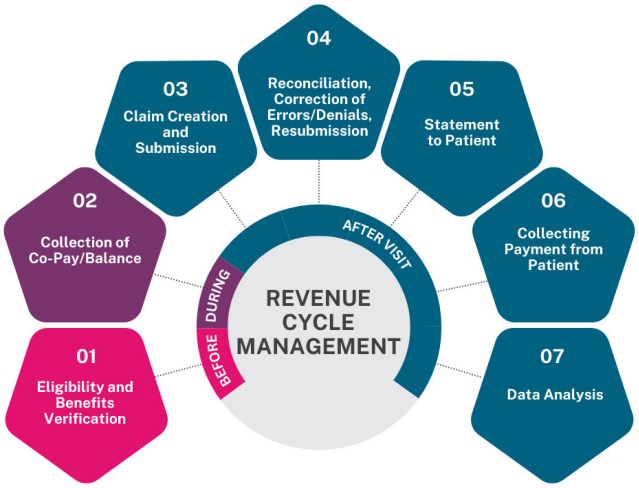
Revenue Cycle Management Overview



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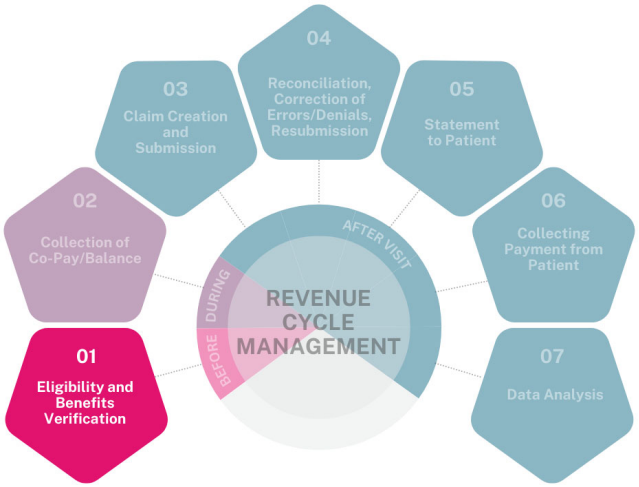
Eligibility and Benefits Verification



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Eligibility and Benefits Verification

- Highly encourage appointments
  - Walk-in patients may have a longer wait, but it's still faster than urgent care!
- The technician collects the patient's medical insurance card
  - Is coverage active on the date of service?
  - What is the patient's copay, deductible, or coinsurance?

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Eligibility and Benefits Verification

Deductible: the amount you pay for covered health care services before your insurance plan starts to pay.

Copayment: a fixed amount you pay for a covered health care service.

Coinsurance: the percentage of costs of a covered health care service you pay after you've paid your deductible.

https://www.healthcare.gov/glossary/. Accessed 09/09/2025

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Eligibility and Benefits Verification Example

A patient comes into your pharmacy because they think they have the flu. They hand you their insurance card and you look them up to verify their insurance is active and how much to charge them.

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Example #1

PATIENT, TEST
123 FAKE STREET
ANYWHERE, CA 99999

Edit | Print | Feedback

Member Status	Date of Birth	Gender	Current Plan Effective Date	Relationship to Subscriber
Active Coverage	01/01/2000	Female	Jan 1, 2024 - Dec 31, 9999	Self

Member ID Card | Additional Benefit Notes

Member ID:	**ABC123456789**
Group Number:	**ZZ0001**
Group Name:	BRONZE EXP PLAN STANDARDIZED

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Example #1

Benefit Information Expand

▾ Physician Visit - Office: Sick- BY

Information / Details	Co-Insurance	Co-Payment	Benefit Deductible	Limitations	Authorization
In Network **Benefit Start Date:** Jan 1, 2025	0% / Service Year(s)	$50 / Day(s)	Refer to: Health Benefit Plan Coverage	–	–
In Network **Benefit Start Date:** Jan 1, 2025 • SPECIALIST	0% / Service Year(s)	$100 / Day(s)	Refer to: Health Benefit Plan Coverage	–	–

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Eligibility and Benefits Verification Example

A patient comes into your pharmacy because they think they have strep. They hand you their insurance card and you look them up to verify their insurance is active and how much to charge them.

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Example #2

Benefit percentage Active Coverage

Plan pays	You pay
80%	20%

Benefits usage

Accumulator begin date: 01/01/2025

Individual deductible	**Family deductible**
$1,000.00 Total met — $1,000.00 Max	$2,000.00 Total met — $3,000.00 Max
Individual out-of-pocket	**Family out-of-pocket**
0 Total met — CALL FOR DETAILS Max	0 Total met — CALL FOR DETAILS Max
Individual annual maximum	**Individual lifetime maximum**
0 Total met — N/A Max	0 Total met — N/A Max

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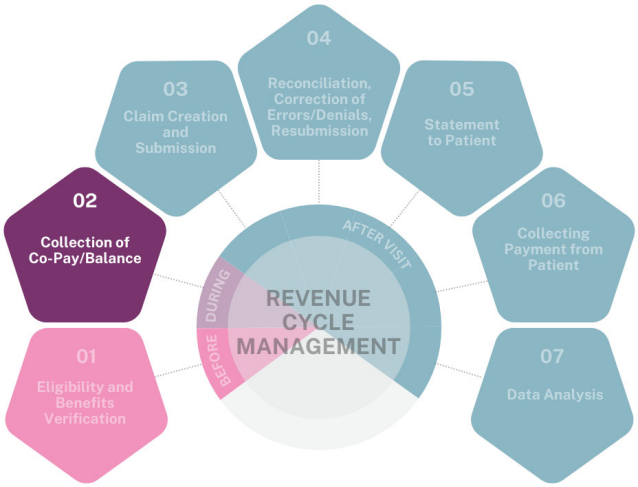
Collection of Copay/Balance



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Collection of Copay/Balance

- When to collect payment—
  - Collect at the time of service or bill the patient later
  - Be consistent and communicate clearly with patients

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Collection of Copay/Balance

- If you collect at the time of service:
  - Immediate revenue and reduced risk of non-payment
  - May need to send a bill or refund later
- If you bill the patient later:
  - Bill the exact amount owed after the claim is processed
  - Delayed revenue and higher risk of non-payment

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Collection of Copay/Balance

- Your services are just as valuable as any other healthcare provider.
  - Patients are used to paying copays and deductibles.
- Just as patients push back regarding their prescription cost, they may do the same with their medical cost.

Remember that their copay is their copay, and they will have to pay it wherever they go.

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Collection of Copay/Balance

- Medical billing is not in real-time
- When a patient is meeting a deductible, we can only make our best guess of what they may owe until insurance fully processes the claim.

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Collection of Copay/Balance

- Use payer fee schedules
  - Helps guide what to collect for deductibles or coinsurance
  - We recommend creating a pricing guide for
    - Cash pay patients
    - Each payer (based on their specific fee schedule)
- Fee schedule: a predetermined list of charges or fees established by a healthcare provider, facility or insurance company for specific medical services, procedures or treatments.

https://www.mayoclinic.org/billing-insurance/glossary Accessed 09/10/2025.

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Sample Fee Schedule

Point of Care Test HCPCS/CPT	Description	Rate
87400	Influenza a/b antigen test	$14.70
87426	COVID-19 antigen test	$31.52
87430	Strep antigen test	$16.89
Evaluation and Management		
99202	New patient 15-29 min	$57.17
99203	New patient 30-44 min	$89.30
99211	Established patient <10 min	$18.16
99212	Established patient 10-19 min	$44.92
99213	Established patient 20-29	$73.15

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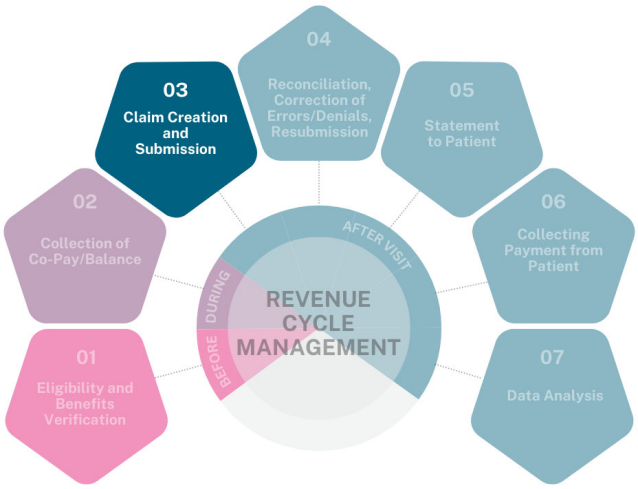
Claim Creation and Submission



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Claim Creation and Submission

Healthcare Common Procedure Coding System (HCPCS): divided into two levels

- Level I: comprised of Current Procedural Terminology (CPT)
- Level II: a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes

Current procedural terminology (CPT) codes: a set of character codes used by medical professionals for billing and authorization of services

ICD codes: an international disease classification system used in diagnosis and treatment.

https://www.mayoclinic.org/billing-insurance/glossary. Accessed 9/10/2025

https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system Accessed 10/8/2025

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Claim Creation and Submission

- You have options when it comes to how you create and submit claims
  - Submit through a third-party vendor
  - Submit directly through your pharmacy management system
    - It may not feel intuitive at first but it's doable!
- Use "billing blanks" to simplify claim creation.
  - A cheat sheet of what codes to bill for the service

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Claim Creation and Submission

NAME **DOB** **Date**

CPT Code 99202
New Patient 15 - 29 Minutes

Code Billing
BIN 016904
PCN SB520

Pharmacist _____

ADDITIONAL INFORMATION

Product Service ID Qualifier (436-E1)	**07-** Common Procedure Terminology CPT4
Product Service ID (407-D7)	**99202**
Diagnosis code qualifier (492-WE)	**02-** ICD-10 Clinical Modifications CPT4
Diagnosis Code (424-D0)	**See Protocol**
Procedure Modifier Code (459-ER)	**QW -** Medicare/Medicaid ONLY

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Claim Creation and Submission

NAME	DOB	Date

CPT Code 87400
Influenza A Test

Code Billing	
BIN	016904
PCN	SB520

Pharmacist _____

ADDITIONAL INFORMATION

Product Service ID Qualifier (436-E1)	**07-** Common Procedure Terminology CPT4
Product Service ID (407-D7)	**87400**
Diagnosis code qualifier (492-WE)	**02-** ICD-10 Clinical Modifications CPT4
Diagnosis Code (424-D0)	**See Protocol**
Procedure Modifier Code (459-ER)	**QW** - Medicare/Medicaid ONLY

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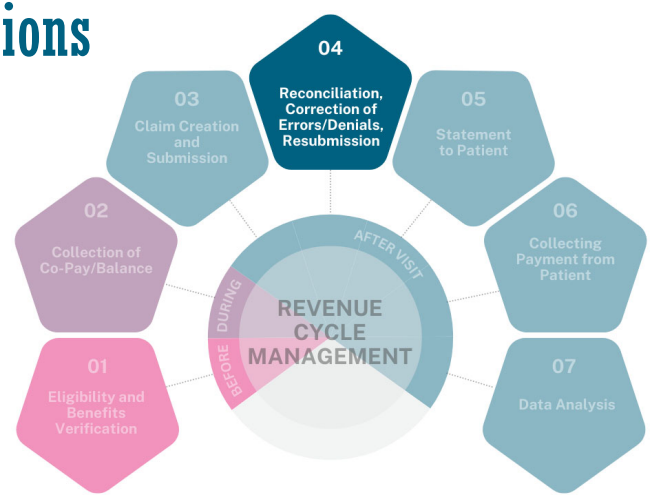
Reconciliation, Correction of Errors/Denials, & Resubmissions



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Reconciliation, Correction of Errors/Denials, & Resubmissions

- The MOST important step
  - You can submit claims all day but what matters is making sure they get paid.
  - Your pharmacy provided the service – you should be paid for it.
- Rejected claims = your money sitting out there
  - Often these claims require just a simple fix.
- Review payer rejected claims once weekly
  - Timely correction improves cash flow.

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Reconciliation, Correction of Errors/Denials, & Resubmissions

- The goal is to avoid payer-rejected claims
  - Compare it to pharmacy claims adjudicating – something was submitted incorrectly
- The common issues are quick fixes!
  - Misspelled or hyphenated names
  - Incorrect member ID numbers
  - Other simple data entry errors

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Reconciliation, Correction of Errors/Denials, & Resubmissions

- Some rejections require outreach.
  - Occasionally, you will need to contact your third-party vendor or payer regarding a claim.
  - Having a reliable point of contact is essential because odd rejections will inevitably occur.

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Example Rejections

REJECT MESSAGE(S)

- The Member on file has secondary or tertiary coverage and must have Other Subscriber Information. The claim is billed as Primary incorrectly.

REJECT MESSAGE(S)

- Either the Member First Name, _____ , Last Name, _____ , Member ID, _____ , or date of birth, _____ , does not match member information on file. Please correct for future claim submissions.

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Let's Fix Some Claims!

Claim Information Submitted:

- Name: TEST PATIENT
- Member ID: 123456789
- DOB: 01/01/2000
- Group: ZZ0001

REJECT MESSAGE(S)

- Either the Member First Name, _____ , Last Name, _____ , Member ID, _____ , or date of birth, _____ , does not match member information on file. Please correct for future claim submissions.

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PATIENT, TEST
123 FAKE STREET
ANYWHERE, CA 99999

Edit | Print | Feedback

Member Status	Date of Birth	Gender	Current Plan Effective Date	Relationship to Subscriber
Active Coverage	01/01/2000	Female	Jan 1, 2024 - Dec 31, 9999	Self

Member ID Card | Additional Benefit Notes

Member ID:	ABC123456789
Group Number:	ZZ0001
Group Name:	BRONZE EXP PLAN STANDARDIZED

Claim Information Submitted:

- **Name: TEST PATIENT**
- **Member ID: 123456789**
- **Group: ZZ0001**
- **DOB: 01/01/2000**

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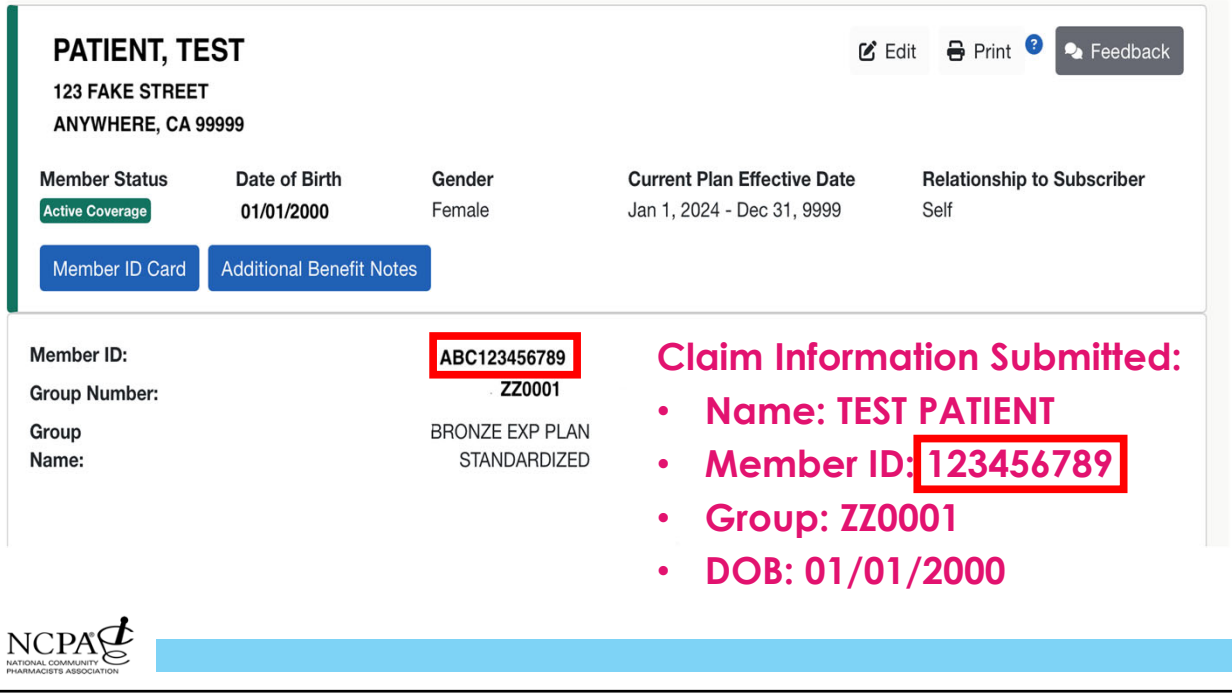

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Let's Fix Some Claims!

Claim Information Submitted:

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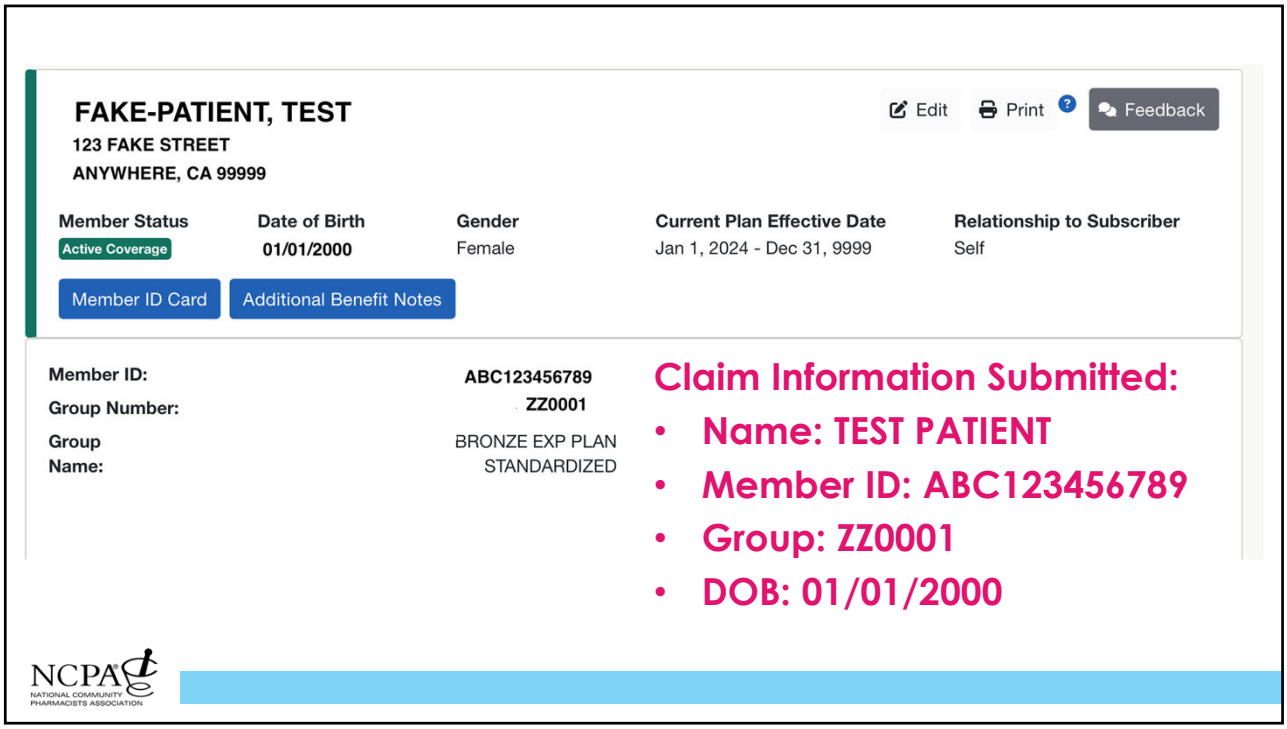
FAKE-PATIENT, TEST
123 FAKE STREET
ANYWHERE, CA 99999
Edit
Print
Feedback
Member Status
Active Coverage
Date of Birth
01/01/2000
Gender
Female
Current Plan Effective Date
Jan 1, 2024 - Dec 31, 9999
Relationship to Subscriber
Self
Member ID Card
Additional Benefit Notes
Member ID:
ABC123456789
Group Number:
ZZ0001
Group Name:
BRONZE EXP PLAN STANDARDIZED
Claim Information Submitted:
• Name: TEST PATIENT
• Member ID: ABC123456789
• Group: ZZ0001
• DOB: 01/01/2000

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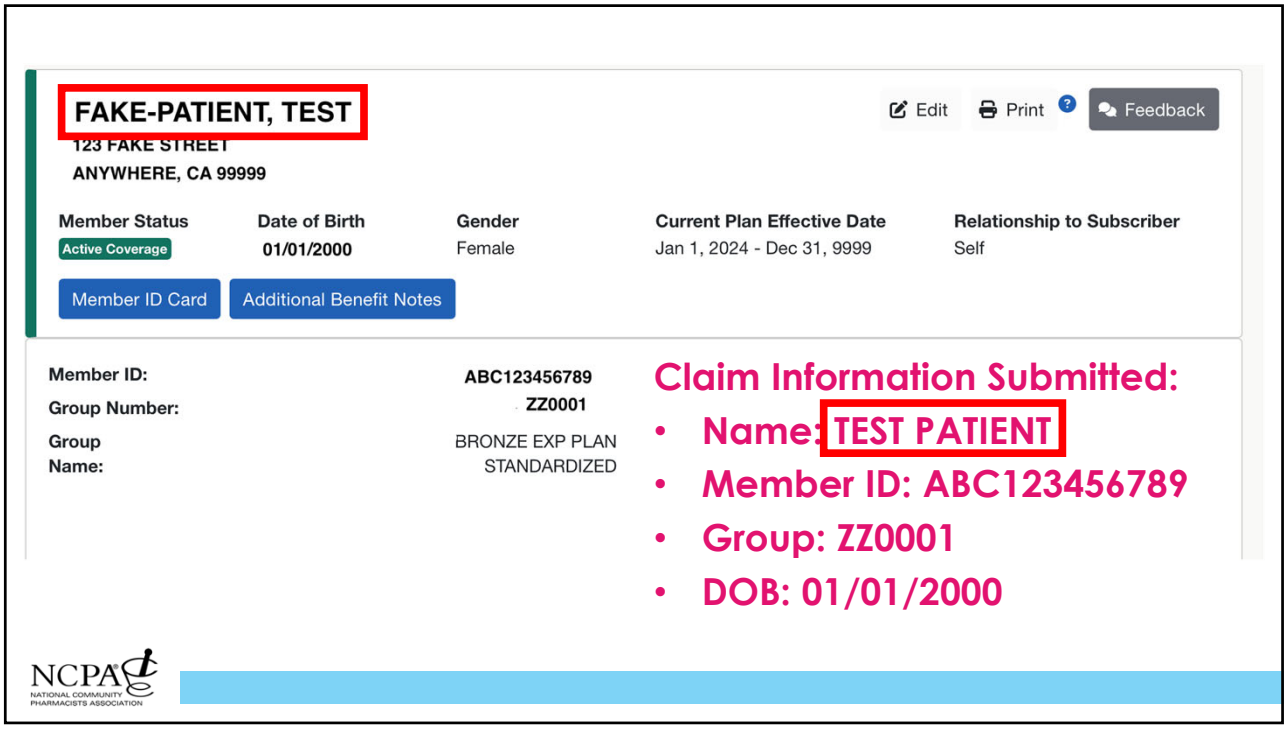
FAKE-PATIENT, TEST
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Edit
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Current Plan Effective Date
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Member ID Card
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Group Number:
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Group Name:
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Claim Information Submitted:
• Name: TEST PATIENT
• Member ID: ABC123456789
• Group: ZZ0001
• DOB: 01/01/2000

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Reconciliation, Correction of Errors/Denials, & Resubmissions

- **Explanation of benefits (EOB):** a statement provided to an insured person noting how a claim was paid or why it wasn't covered.

https://www.mayoclinic.org/billing-insurance/glossary. Accessed 9/10/2025

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Reconciliation, Correction of Errors/Denials, & Resubmissions

Patient Name: TEST PATIENT Patient Account #: ID #: ABC123456789 835 #:
Provider #: NPI #: Claim #:

SERV	DATE(S) OF SERVICE FROM THRU	PROCE-DURE CODE	NUMBER DAYS/ SERVICES	SUBMITTED CHARGES	NON-ALLOWED CHARGES	REMARK CODE	DISCOUNT	DISCOUNT CODES	OTHER INSURANCE PAID	DEDUCTIBLE /COPAY	COINSURANCE	VALUE POOL CONTRIBUTION	PROVIDER PAYMENT
00001	07/07/2025	87430	0001	28.00	0.00		13.00	K	0.00	0/0	0.00	0.00	15.00
00002	07/07/2025	99211	0001	56.00	0.00		16.20	K	0.00	0/0	4.80	0.00	35.00
PATIENT RESP.		4.80											
CLAIM TOTALS				84.00	0.00		29.20		0.00	0.00	4.80	0.00	50.00

		TOTAL SUBMITTED CHARGES	TOTAL NON-ALLOWED CHARGES		TOTAL DISCOUNT		TOTAL OTHER INSURANCE PAID	TOTAL DEDUCTIBLE /COPAY	TOTAL COINSURANCE	TOTAL VALUE POOL CONTRIBUTION	TOTAL PROVIDER PAYMENT
CLAIM GRAND TOTAL	1	84.00	0.00		29.20		0.00	0.00	4.80	0.00	50.00
NET PAYMENT											

DISCOUNT CODES
K NETWORK DISCOUNT

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Claims Tracking

	A	E	F	G	H	I	J	K	L
1	Service Dates	Patient Name (Patient Control Number) (ID)	Patient Amt	Total Charged Amt	Adjustments	Total Paid Amt	DOB	Address	Pharmacy of Service

- Tracking claims, insurance payments, and patient payments can be as simple as a spreadsheet you create yourself.
- Include necessary headings such as:
  - Patient information (DOS, patient name, DOB, address, type of service provided, etc.)
  - Insurance payment information (patient pay amount, total charged, insurance adjustments, insurance payment, etc.)
  - Statement information (statement sent on mm/dd/yyyy, date paid)

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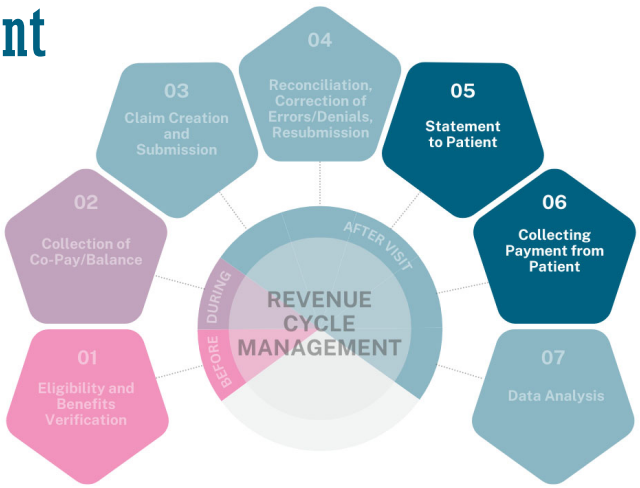
Statement to Patient & Collecting Payment from Patient



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Statement to Patient & Collecting Payment from Patient

- Decide on a process that works best for your community because you know your patients best.
- What we do:
  - Send monthly statements to patients with an outstanding balance.
  - Patients can pay in person, over the phone, or by mailing a check.
- Other options:
  - Call patients directly about their balance.
  - Set up a notification in their pharmacy profile to prompt payment next time they pick up a prescription.

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Example Billing Statement

Harps Pharmacy #144
1120 East German Ln
Conway, Arkansas 72032
501-329-3733

HARPS PHARMACY

BILLING STATEMENT

TEST PATIENT
123 FAKE STREET
ANYWHERE, CA 99999

Statement Date	Account Number	Payment Due	Amount Due
10/01/2025	123456789	11/01/2025	$20.00

Date	Description	Total Charges	Adjustments	Insurance Payments	Patient Pay
08/01/2025	FLU TEST	$150	$50	$80	$20.00
				Patient Payments	– $0
				Amount Due	$20.00

For your convenience, payments can be made by mail, phone, or in person at the Harps Pharmacy listed at the top of this statement. We accept cash, credit/debit cards, and checks. If you have any questions regarding this statement, please contact Harps Pharmacy.

Thank you for choosing Harps Pharmacy for your healthcare needs!

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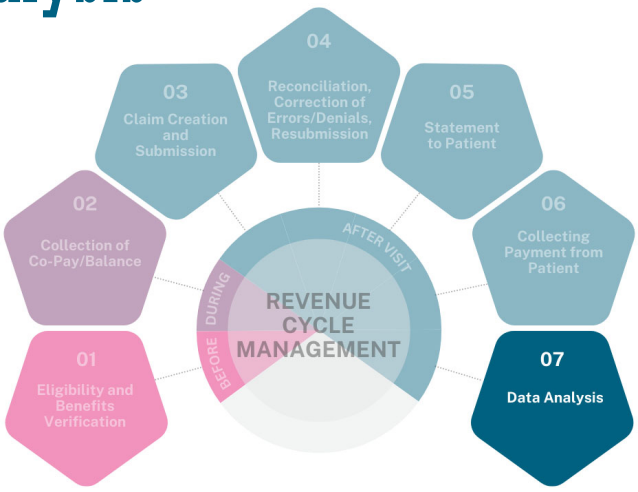
Data Analysis



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Data Analysis

- Take the time to regularly review claims
  - Are you billing the correct amount?
  - Are you underbilling instead of overbilling?
  - Are you being paid the correct amount?
  - Are there patterns in payer-rejected claims?
  - Are technicians entering claim data correctly?

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Data Analysis: Overbilling vs. Underbilling

- Overbilling is not a bad thing
  - The insurance will only pay up to the allowable amount.
  - Allowable amount: this refers to the maximum amount that an insurance company is willing to pay for covered medical services or procedures.
  - If you underbill, you will be underpaid.

https://www.mayoclinic.org/billing-insurance/glossary. Accessed 9/10/2025

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Data Analysis: Overbilling vs. Underbilling

- Scenario #1
  - Total Billed: $150.00
  - Insurance Paid: $100.00
- Scenario #2
  - Total Billed: $80.00
  - Insurance Paid: $80.00

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Data Analysis: Overbilling vs. Underbilling

- **Overbilling** Example
  - Total Billed: $150.00
  - Insurance Paid: $100.00
- **Underbilling** Example
  - Total Billed: $80.00
  - Insurance Paid: $80.00

Missed out on $20 in additional revenue due to underbilling.

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Pro Tips and Lessons Learned

- Delegate medical billing tasks to a technician and empower them by providing dedicated time each week to these tasks.
- Run test claims before going live (if possible).
- Have strong payer contacts.
- Review payments, denials, and payer rejections weekly.
- Avoid underbilling.

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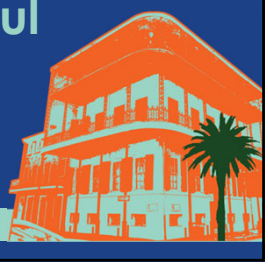
You Have Support!

- Use CPESN resources
- Connect with other pharmacists
  - Don't reinvent the wheel - reach out to those doing what you want to be doing.

You are needed— We can't be successful without YOU!



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Activity

Take 1 minute to identify/write down what your next step is moving forward with medical billing when you return home to your pharmacy.

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Contact Information

Jennifer Griffin, PharmD, MS
Clinical Pharmacist
Harps Food Stores, Inc.
jennifermgriffin12@gmail.com

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Resources

Ransom, T. (n.d.). Medical billing in revenue cycle management (RCM) process. Medical Billing in Revenue Cycle Management (RCM) Process. https://www.imagineteam.com/blog/medical-billing-revenue-cycle-management-process

https://www.mayoclinic.org/billing-insurance/glossary

https://www.cms.gov/medicare/physician-fee-schedule/search

https://www.healthcare.gov/glossary/

https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system Accessed 10/8/2025

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