

Pharmacist and Other Provider Expectations:

Operationalizing the Billing of Pharmacist-Provided Medical Services under 5557

The intent of this document is to list and briefly describe expectations and/or requirements that will need to be met by pharmacists, other providers, and other stakeholders in order to operationalize, within their organizations, the reimbursement of pharmacist-provided services that are covered under a patient's medical benefit (i.e. medical services), e.g. provider contracts will need to be signed, billing systems will need to be in place, etc.

Services covered under a patient's pharmacy-drug benefit are not impacted.

For the purposes of Contracting, Credentialing, Utilization Management, and Coding/Billing/Reimbursement the practices and conditions that are followed and the automated systems infrastructure that is used by all other providers that bill and receive reimbursement for medical services will apply to pharmacists as well.

The expectations outlined below are intended to clarify or identify additions and limitations that are specific to medical services delivered by pharmacists and billed to health plans.

Applicability

The 5557 legislation only requires Washington State licensed insured large group, small group, individual, and family plans (48.43.005 (26)) to reimburse for pharmacist provided medical services. These reimbursement requirements may not apply to Federal plans such as Medicare, Tricare, Taft-Hartley AND other State plans, e.g. PEBB/Uniform Medical plans, Washington State Medicaid and related plans, commercial self-insured plans, etc. They also may not apply to health plan sponsored programs, such as the Medication Therapy Management (MTM) program sponsored by Medicare, that are targeted at managing the care of specific populations. MTM programs may have patient eligibility requirements and only be offered through specific network of providers, defined by the health plan.

Though the 5557 legislation does not require all health plans to reimburse for pharmacist-provided medical services, it does not preclude them from doing so at their discretion.

The appropriate health plan(s) should be contacted prior to delivering services to determine whether pharmacist provided medical services are subject to reimbursement.

Contracting

For medical services, i.e. services that are not related to dispensing of medications (Pharmacy-Drug Benefit Services), pharmacists will be held to the exact same standards of copy, deductible, and reimbursement policy in effect and under the spirit of the Washington State Every Category of Provider Law for every service within their scope of practice. Contracted pharmacists, non-contracted pharmacists, pharmacists operating under direct supervision, and the

like will all be subject to the exact same rules as are in place by carriers for credentialing standards, billing standards, and site requirements for all providers in that carrier's network. No special dispensation or consideration will be given for any professional specialty regardless of their readiness to operate within the health carrier environment necessary to adjudicate medical plan benefit structures either regulated or not by the WA OIC.

For each of their benefit plans, the health plan (in alignment with CMS and/or national mandates, e.g. ACA) will determine if a type of provider is to be designated as a primary care provider or a specialty care provider. For the limited number of health plan products where a patient co-pay differential exists, that determination will establish whether the patient will have a primary care co-pay or a specialty care co-pay when visiting a provider of that type. Similar to other providers, pharmacists should check with each health plan to determine whether they will be designated as primary care or specialty care specific to that patient's benefit plan.

Organizations/Pharmacists interested in being contracted with a health plan need to contact the health plan directly for the process steps. These process steps, which are the same that apply to all providers, can typically be found by doing an Internet search with the words '*health-plan-name* credentialing'. (Contracting and credentialing are typically an integrated process.) Multiple months should be allowed for completing this process.

Credentialing

Existing delegated credentialing agreements may be updated to include requirements associated with the credentialing of pharmacist. Similar to other provider types within that organization, pharmacists who provide direct patient care will need to be individually credentialed by the contracted organization. Health systems and clinics may need to implement additional education/training program for their credentialing staff in order to credential pharmacists.

Pharmacies with a credentialing program in place that meets health plan delegation requirements will be eligible to apply for delegated credentialing.

Pharmacists that work in organizations without a delegated credentialing agreement with the health plan will need to be credentialed directly by the health plan in order to bill for services. Pharmacists need to contact each health plan to inquire about their process. The process, which is the same that applies to all providers, can typically be found by doing an Internet search with the words '*health-plan-name* credentialing'. (Contracting and credentialing are typically an integrated process.) Multiple months should be allowed for completing this process.

Utilization Management

Medical services provided by pharmacists must fall within their scope of practice as defined by RCW 18.64.011 (23) and be regulated by WAC 246-863-110 and not be related to dispensing of medications often covered under the Pharmacy-Drug Benefit.

Medical services provided by pharmacists should be coordinated with other care team members to ensure continuity of care and optimal cost-effectiveness of care. Use of electronic medical records and other forms of communication to enhance care are encouraged to ensure patient safety and effective care.

Similar to other providers, coverage for medical services, including whether contracted/non-contracted pharmacists can deliver those services, will be subject to terms and limitations in each patient's benefit plan.

When a pharmacist, based upon a referral from another provider, provides medical services that referring provider should be in the network of the health plan that will be billed for the service. Similar to other providers that receive referrals, information about the care and treatment should be sent to the patient's primary care provider or referring provider, if one exists and is known, as a professional courtesy.

Pharmacists should check with the patient's health plan to determine what medical services will be covered and require a prior authorization and/or referral. In many cases, some or all of the pre-service requirements can be found on the health plan's web sites. Best Practice Recommendations for information related to pre-service requirements can be found at <https://www.onehealthport.com/content/best-practices-recommendations-overview>, in the Prospective Review Section.

In the patient record of the provider organization that is billing the health plan, the diagnosis(es) must be documented and the need for the provided clinical services must be supported.

Coding/Billing/Reimbursement

The determination of patient eligibility and the billing/collection of patient cost share, e.g. deductible, copay, and coinsurance, will be the responsibility of the organization/pharmacist providing the service.

Pharmacists billing for medical services must obtain a National Provider Identified (NPI). An NPI is a required field on claim forms.

An ICD10 coded diagnosis(es) will be required on claims submitted to health plans for medical services provided by pharmacists. That diagnosis code must either be a valid Z-series diagnosis code selected by the pharmacist or a valid ICD10 diagnosis code from the range A00-Y99 that is assigned by a physician or other qualified health care profession.

Patient record documentation will be maintained to support the medical services that are coded and billed. The detail and extent of supporting documentation will be consistent with industry standard coding guidelines. Where current record keeping practices in pharmacies may not meet those standards, practice enhancements should be expected.

Medical services provided and billed need to be coded per established industry coding and billing guidelines such as those published by the American Medical Association's Current Procedural Terminology (CPT) codebook, International Classification of Diseases 10th revisions (ICD10 CM), the Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) Level II codes, and the National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services.

Similar to other providers, automated medical billing infrastructure will be utilized for claims submission of pharmacist provided services. Institutional providers will use CMS-1450 (UB-04) claim form & X12 837I transaction format. Professional providers will use CMS-1500 claims form & X12 837P transaction format. Some health plans may accept the paper version of the claim forms, but use of the paper form rather than an electronic claim will create additional work and slow down the overall process.

Reimbursement processes for medical services will be consistent with those in place for all other providers. Health plans will offer no instruction in how coding should be done or which codes should be used. Health plan systems will accept and adjudicate all valid codes in accordance with the patient's benefits. Services will be reimbursed per the terms of the health plan contract, subject to current WACs.

Health plans may also require reporting of quality metrics that support optimal outcomes and effective delivery of care in the same manner as other providers.

Similar to other providers, a pharmacy or pharmacy group delivering covered medical services to a health plan's member must bill that health plan under their own Tax ID or must bill 'incident to' an MD/DO using that provider's Tax ID. In either case, another organization can be used as a billing service.

Services covered under the patient's pharmacy-drug benefit will continue to be billed and reimbursed per the terms of the health plan contract, subject to current WACs.