Health Plan Policy Directives:
Enabling the Billing of Pharmacist-Provided Medical Services under 5557

The intent of this document is to identify policy conditions/requirements that health plans will have in place to enable the billing and appropriate reimbursement of medical services provided by pharmacists. The Office of the Insurance Commissioner intends to treat pharmacists like any other provider in implementing SB 5557 in accordance with relevant state and federal law. It is not likely that any new regulations will be needed from the Office of the Insurance Commissioner to implement SB 5557.

For services covered under the patient's medical benefit (i.e. medical services), the health plan's policies and procedures will be consistently applied across all clinical professionals providing those services. For the purposes of Contracting, Credentialing, Utilization Management, and Coding/Billing/ Reimbursement, health plan policy directives (and related WACs) that apply to all other providers that bill and are reimbursed for medical services will apply to pharmacists as well.

For services covered under the patient's pharmacy-drug benefit, billing and reimbursement policies and procedures will not be impacted.

The policy directives 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.

Contracting

The contract between a health care professional and a health care plan is the fundamental document that frames, defines, and governs their relationship. Contractual provisions affect payment, internal department processes, and confidential records as well as clinical decision-making. Pharmacists entering into contracts with health plans under this rule will be subject to RCW 48.44.020 and RCW 48.46.243.

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. Appropriate level of billing and member cost share/coinsurance payment will be determined based on standard processes as already established with other providers.

Credentialing

Pharmacists will be credentialed either by

- A health plan contracted organization, such as a facility or medical clinic, that performs health plan approved credentialing activities and has been approved for delegated credentialing, or

- By completing an individual credentialing approval process with each health plan

As part of the credentialing process, every pharmacist must:

1. Demonstrate that they meet Washington State Pharmacy Licensure Requirements (RCW 18.64; WAC 246-861 and WAC 246-863)

Licensure Requirements	
Licensure Application	• State Licensure Application Form
Education	• Pharmacy Degree from an Accreditation Council for Pharmacy Education (ACPE) accredited pharmacy program
Examination	• North American Pharmacy Licensure Examination • Multi-state Jurisprudence Examination
Training	• 1,500 hours of experiential training • 7 hours of HIV training
Renewal	• 15 hours of continuing education annually

2. Attest that all licensing requirements associated with services to be performed, including processes to obtain appropriate prescriptive authorization from healthcare provider(s) with independent prescriptive authority and/or appropriate CDTA(s), when applicable, have been/will be met.

   Provide any/all CDTA identifier(s) that are on file with the PQAC.

3. Demonstrate that they have liability coverage at a minimum level established by the health plan, either independently or as part of a delegated or non-delegated group.

It is recognized that a pharmacist's education and training required for licensure meets the competency requirements for health plan covered services that fall within a pharmacist's scope of practice. Similar to other provider types, as service requirements become more advanced health plans may, at their individual discretion, require pharmacists to have advanced training and/or certification in addition to licensure in order to be considered for and subsequently be extended contracts within that Plan's network. When considering advanced training and certification requirements, health plans will take into account existing industry standard guidelines or recommendations. This requirement may not be used in a manner designed to exclude categories of providers unreasonably (WAC 284-43-205(2)). Health Plans are not required to guarantee that any specific licensed pharmacist will be included in their network.

Delegated credentialing organizations must meet the credentialing requirements set by the health plan. However, provider organization and provider-health plan organizations may put in place, as part of their privileging process, additional certification and/or training requirements for their employed and/or contracted providers.

Utilization Management

A. Medical services provided by credentialed, contracted pharmacists may be covered when:

1. Those services fall within their scope of practice as defined by RCW 18.64.011 (23) and regulated by WAC 246-863-110 and are not related to dispensing of drugs often covered under the pharmacy benefit.

   AND

2. In the patient record of the billing provider, the diagnosis(ses) is documented and the need for the clinical services provided is supported.

   AND

3. Another provider is not also billing for the same services (or related training, such as insulin pump training) on the same day. Limitations on billing for the same day of service apply to pharmacists in the same manner as other providers.

   AND

4. For Section B ONLY: Prior authorization and/or referral is obtained. Note: The requirement to obtain a prior authorization and/or referral applies to the service and not to the provider delivering the service, i.e. a pre-authorization would be required whether a pharmacist or any other provider performed the service.

   AND

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

B. Health plans will identify specific services that REQUIRE prior authorization and/or referral in accordance with WAC 284-43-410. Those services will require prior authorization or a referral regardless of the type of provider who will deliver that service.

Coding/Billing/Reimbursement

All medical services billed to health plans must be associated with a diagnosis code that pertains to the service being billed. That diagnosis code must either be a valid:

- Z-series diagnosis code selected by the pharmacist, or
- ICD10 diagnosis code from the range A00-Y99 that is assigned by a physician or other qualified health care professional.

Claims for payment of these medical services must include the appropriately coded diagnosis.

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 revision (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.

These established industry coding and billing guidelines include the requirement for services provided to be supported by a permanent documentation of records that is subject to audit at any time. Those guidelines also outline the detail and extent of required documentation.

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.