WSPA
WASHINGTON STATE **PHARMACY** ASSOCIATION

January 18, 2017

Community Pharmacy Foundation Board
c/o Anne Marie Kondic
Executive Director
amkondic@communitypharmacyfoundation.org

Dear Community Pharmacy Foundation:

With your generous support over the past 5 years, we have been very busy. We believe we have achieved the goals of our Community Pharmacy Foundation grant which stated "the grant will support the project with an ultimate goal of breaking down barriers and creating structural elements necessary for pharmacists to receive reimbursement of pharmacy patient care services, and the development of enduring tools to aid pharmacists across the country in the credentialing and contracting process."

Let's start with a snapshot of the ending… Upon the passage of a state law in May of 2015, health insurance plans licensed in Washington state are required to enroll an adequate number of pharmacists in their medical provider networks. Pharmacists in Washington state will finally be treated on an equal plain as other healthcare providers by health insurance plans. This law went into effect for pharmacists practicing in community settings January 1, 2017. The scope of coverage this law will impact includes patients with coverage in small group, large group, individual and family plans within Washington state. While the law doesn't require self-funded, Medicaid and Medicare plans to enroll pharmacists, we have been working with these groups and there is interest. Some Medicaid managed care plans are already beginning to compensate pharmacists as providers despite no legal requirement to do so. Ultimately, we believe the impact will continue to grow.

There was a long winding road that led us to this solution which was filled with barriers, frustration, partnerships and epiphanies. And, after the fix was completed, there was a windfall of implementation work to identify new areas of need, knowledge gaps, create structure and develop enduring tools to aid our colleagues across the country. We know that CPF grant funds cannot be used for legislative means and, rest assured, they were not. However, as I hope you can see, we couldn't have done this work without the CPF grant support.

Four years prior to the aforementioned legislative efforts, the WSPA began working to get pharmacists into provider networks under existing laws and statutes. With your support of our efforts, we were able to determine the process for enrollment in health plan provider networks and identify knowledge gaps of pharmacists wishing to enroll. In addition to the successful submission of the Washington State Provider Application (WPA), we researched the credentialing requirements for other healthcare

providers and educated partners on the comparable requirements for pharmacists. We also were able to identify ProviderSource, the single site portal for provider credentialing in Washington state, and worked with them to ensure pharmacists would be able to utilize the portal to submit digitally completed Provider Applications to all plans in the state. We partnered with OneHealthPort staff to educate us on the ProviderSource portal, and ensure that the application's fields were appropriate for pharmacists. Your support also assisted many pharmacists in using Provider Source and the WPA to apply to be a network provider. This ultimately fueled our efforts as it resulted in numerous instances of provider network denials by health plans because they "do not credential pharmacists as providers."

Given our previous work with the Office of the Insurance Commissioner (OIC) regarding the "Every Category of Provider" Law (RCW 48.43.045) as part of our initial grant, we took new denials as evidence to the Office of the Insurance Commissioner. RCW 48.43.045 is an anti-discrimination law in Washington that states that providers who provide a covered service within the scope of their practice cannot be categorically excluded from plan provider networks. The denials that pharmacists were receiving was in clear conflict with this law. The CPF grant supported educational efforts with key stakeholders leading to a request for an Attorney General interpretation of whether the law applied to pharmacists. The AG Informal Opinion concluded pharmacists were covered by the "Every Category of Provider" Law. Since an AG Informal Opinion is regarded as a highly probable verdict if a lawsuit was filed, the OIC ramped up their efforts to enforce RCW 48.43.045. We shared this Informal Opinion with the CPF, and numerous other states have used it to better understand their laws.

Upon enforcing the "Every Category of Provider" law, the OIC received pushback from the Health Insurance Plans. They had identified a loophole. They claimed that since they have pharmacists in their pharmacy networks so they comply with the rule. Their argument was that health plans contract with pharmacy benefit managers (PBM) who, in turn, contract with pharmacies within their pharmacy networks. Because the PBMs provide a professional fee for pharmacists with a dispensed medication, they complied with the rule. This roadblock ultimately led to us identifying that a legislative fix was needed. Again, the CPF did not financially support our lobbying efforts, but we were successful at passing ESSB 5557 in May 2015, which requires pharmacists' inclusion in health insurance plan provider networks.

Passing this law only opened a door. Unfortunately, in addition to provider enrollment which we were aware of, we were faced with understanding and educating pharmacists and other stakeholders regarding the vast differences between pharmacy billing and medical billing processes as well as the complexities of health information technology gaps. In the past 18 months since passage of ESSB 5557, the Community Pharmacy Foundation Grant has been utilized to support efforts to understand how to address these knowledge gaps and bridge these chasms.

We have learned that there are other classes of providers who were permitted through court cases and law changes to bill as providers, but have had very limited success due to a lack of cohesion in their profession and a lack of understanding. The CPF Grant helped us to prevent this from happening to pharmacists. We have assisted state partners in developing three guidance documents that provided best practice standards for pharmacists billing as medical providers including health insurance plan

processes, provider expectations and an FAQ which addressed key issues and provided definitions pf important terms. These documents have been used to help payers better understand pharmacy training, scope and potential for value. They were shared with the CPF, and have educated pharmacy organizations across the country.

WSPA staff have worked to educate insurance plans, software companies, state partners, consultants, billing and credentialing staff and our profession about the recent changes, potential solutions, the value of pharmacists in patient care and the opportunities for innovation. We have been able to identify key gaps in the difference in billing pharmacy claims and billing medical claims, the different workflows and software systems needed to fill these gaps.

Additionally, we have developed a Billing, Coding and Documentation Guidebook to help pharmacists and pharmacy technicians navigate the medical billing process including documentation. Due to CPT code copywrite by the American Medical Association, royalties are required to be paid to the AMA on every Guidebook which prohibited us from including it in this grant work. We appreciate your previous considerations of how we could work through this obstacle but ultimately had to exclude it from the grant work.

Our findings have been illustrated and summarized in the attached documents.

Attached Documents include:

1. Pharmacy Billing Cycle – An analysis of how a prescription is billed
2. Medical Billing Cycle- An analysis of a medical care visit and billing processes
3. Documentation Processes – A review of documentation processes and standards in current community pharmacy systems compared to those in medical care systems
4. Gap Analysis – A comparison of exiting pharmacy systems and medical care systems, and the gaps in process and software between them
5. Software and Services – A review of the software system gaps, what currently exists in pharmacy systems, and what the solutions are
6. Consolidated Clinical Documentation Architecture Templates – An overview of the standards for clinical documentation, so that pharmacists can build these into their documentation templates
7. Examples – Provides examples of the CCDA templates to standard notes

Finally, with your support WSPA has developed an overview presentation for pharmacy professionals that summarizes our learnings supported by the CPF grant. WSPA will share a link to this voice-over presentation with CPF in January to post on their site for all CPF partners to view. This is a comprehensive overview of definitions, processes and takeaways. We intend on this training being a starting place for pharmacists in other states to better understand medical provider billing.

We cannot thank the Community Pharmacy Foundation enough for their partnership and financial support of this landmark change. Your grant allowed the WSPA to allocate more resources necessary to implement this change for pharmacy professionals in Washington, as well as providing a conduit for

sharing our learnings with other partners. We look forward to future opportunities to partner in evolving the practice of community pharmacy.

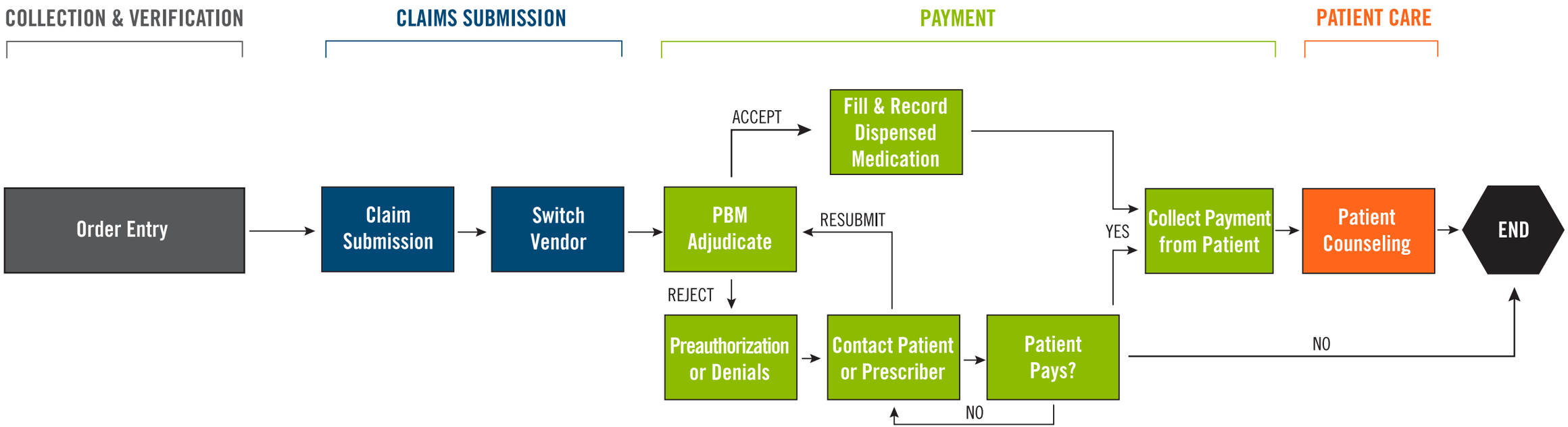
Sincerely,

Jeff Rochon
Chief Executive Officer

Jenny Arnold
Director of Practice Development

COLLABORATIVE HEALTHCARE
OUTCOME IMPROVEMENT CENTER

PHARMACY BILLING CYCLE



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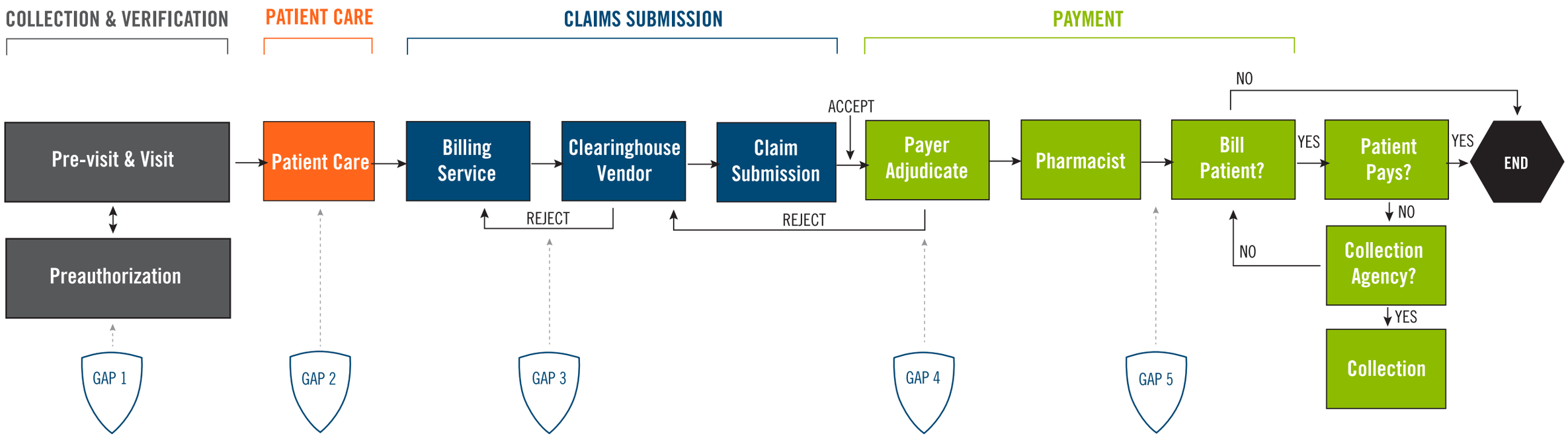
MEDICAL BILLING CYCLE



COLLABORATIVE HEALTHCARE
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PHARMACY BILLING DOCUMENTATION PROCESS

COLLECTION & VERIFICATION
1. Collect:
   a. Patient medication, history, demographics, and disease information
   b. Insurance information
   c. Prescription information
2. Complete Drug Utilization Review

CLAIMS SUBMISSION
1. Submit claims
2. Real time claims adjudication
3. Receive notification from PBM:
   a. Insurance coverage eligibility
   b. Co-insurance/co-pays
   c. Deductibles

PAYMENT
Approved Payment
1. Proper filing, checking, and recording of dispensed prescription
2. Collect co-pays
3. Verify PBM payment

Denied Payment
1. Contact PBM to resolve denial of claim; begin prior authorization process
2. Contact patient and prescriber
3. Patient can opt to pay out-of-pocket

PATIENT CARE
1. Counsel patient on medication

MEDICAL BILLING DOCUMENTATION PROCESS

COLLECTION & VERIFICATION
1. Collect
   a. Patient medication, history, and demographics
2. Verify insurance in real-time
   a. Eligibility
   b. Co-insurance/co-pays
   c. Deductibles
   d. Benefit caps
3. Revenue cycle management:
   a. Verify patient address and obtain permission to contact for bill delivery
   b. Provide real-time, out of pocket cost estimation
   c. Collect co-pays
   d. Collect deductibles upfront if possible
   e. Obtain credit card with approval to charge up to a defined amount per co-insurance and deductibles
4. Obtain additional documents, (referral, prior authorization and other approvals, if needed)
5. Obtain balance billing document if contractually allowed

PATIENT CARE
1. History:
   a. Chief complaint
   b. History of Present Illness
   c. Review of Systems
   d. Past, Family, and/or Social History
2. Examination
   a. Physical examination of body areas or organ systems
3. Medication Decision Making
   a. Diagnosis & Treatment options
   b. Amount & Complexity of Data Review
   c. Risk Factors

Utilize Pharmacists' Patient Care Process to improve patient health and outcomes:*
1. Collect medical, medication, and clinical status information
2. Assess information and analyze clinical effectiveness of patient's therapy
3. Plan individualized patient care plan and set clinical outcome goals
4. Implement care plan and coordinate care
5. Follow-up to monitor and evaluate progress, adherence, and outcomes

** See the JCPP Pharmacists' Patient Care Process, May 29, 2014*

CLAIMS SUBMISSION
Post Service
1. Collect and verify:
   a. Patient information and unique identifier
   b. Insurance information (name, address, identifier code)
   c. Diagnosis and procedure codes (ICD 10/CPT©)
   d. Date and place of service
   e. National Provider Identifier (NPI)
2. Claim error resolution
   a. Ensure appropriate documentation in medical record to justify code and severity
3. Check insurers' "payer sheet" or "companion guide"
4. Submit claims

Post Submission
5. Check status daily
6. Resolve denials (common denials: wrong insurance, no prior authorization submitted or additional clinical documentation needed to justify severity)
7. Resubmit claim with correct insurance, prior authorization number or CCD attached

Post Payment
8. Verify deposits & match 835 remittances with contract agreement
9. Reconcile co-insurance & co-payments
10. Reconcile withholdings, offsets, and credit balance forwards due to prior overpayment or adjustment on another claim
11. Bill patient for payments, deductible (if not collected upfront) and co-insurance, if applicable

PAYMENT
1. Review and determine contract limitations and restrictions on amounts and services patients can be billed
2. Patient follow up
3. Provide printed copies of Billing Policy to patients when setting up deferred payment plan
4. Corrective actions for non-payments
5. Collection

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COLLABORATIVE HEALTHCARE
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GAP ANALYSIS

GAP 1

GAP: Patient management

CHALLENGE: Determine insurance eligibility, schedule appointments, and collect patient information prior to or during visit

SOLUTION: Practice Management and/or Revenue Cycle

GAP 2

GAP: Clinical documentation

CHALLENGE: Use industry standards and structured documentation templates to record, receive, and transmit patient information electronically

SOLUTION: Electronic Health Record (EHR) system designated as an ONC Certified HIT*

*See the National Coordinator for Health Information Technology (ONC) Health IT Certification Program

GAP 3

GAP: Coding & claims submission

CHALLENGE: Use industry standards to code and submit claims

SOLUTION: Clearinghouse; Billing Service

GAP 4

GAP: Different adjudicator

CHALLENGE: Understand medical necessity standards and contract requirements for each payer

SOLUTION: Clearinghouse

GAP 5

GAP: Payment collection

CHALLENGE: Track claims, review denials, and collect payments from payers and patients

SOLUTION: Revenue Cycle and/or Practice Management

SOLUTIONS

SOLUTION: Practice Management and/or Revenue Cycle Management*

- **HIPAA & regulatory compliance**
- Scheduling
- Patient registration
- Insurance eligibility verification
- Claims processing and tracking
- Charge capture and posting
- Reimbursement management
- Patient billing, payment, and collection
- Reports and benchmarks

*Many software providers integrate features of both Practice Management and Revenue Cycle Management into one system

SOLUTION: Electronic Health Record (EHR) System*

- **HIPAA & regulatory compliance**
- Maintain medical record
- Internal clinical notes and documents
- External notes and documents
- Laboratory and imaging documents
- E-prescribing
- Staff workflow
- Meaningful Use Certificate
- Patient portal

*ONC Certified HIT. See the National Coordinator for Health Information Technology (ONC) Health IT Certification Program

*See Consolidated Clinical Document Architecture (C-CDA) Templates

*May be stand-alone or bundled:
- Billing services and /or Clearinghouse
- Revenue Cycle Management and/or Practice Management System

SOLUTION: Billing Services

- **HIPAA & regulatory compliance**
- Coding compliance

OR

SOLUTION: Clearinghouse

- **HIPAA & regulatory compliance**
- Claims compliance
- Secure transmission to payers

SOLUTION: Clearinghouse

- **HIPAA & regulatory compliance**
- Claims compliance
- Secure transmission to payers

SOLUTION: Revenue Cycle Management and/or Practice Management*

- **HIPAA & regulatory compliance**
- Scheduling
- Patient registration
- Insurance eligibility verification
- Claims processing and tracking
- Charge capture and posting
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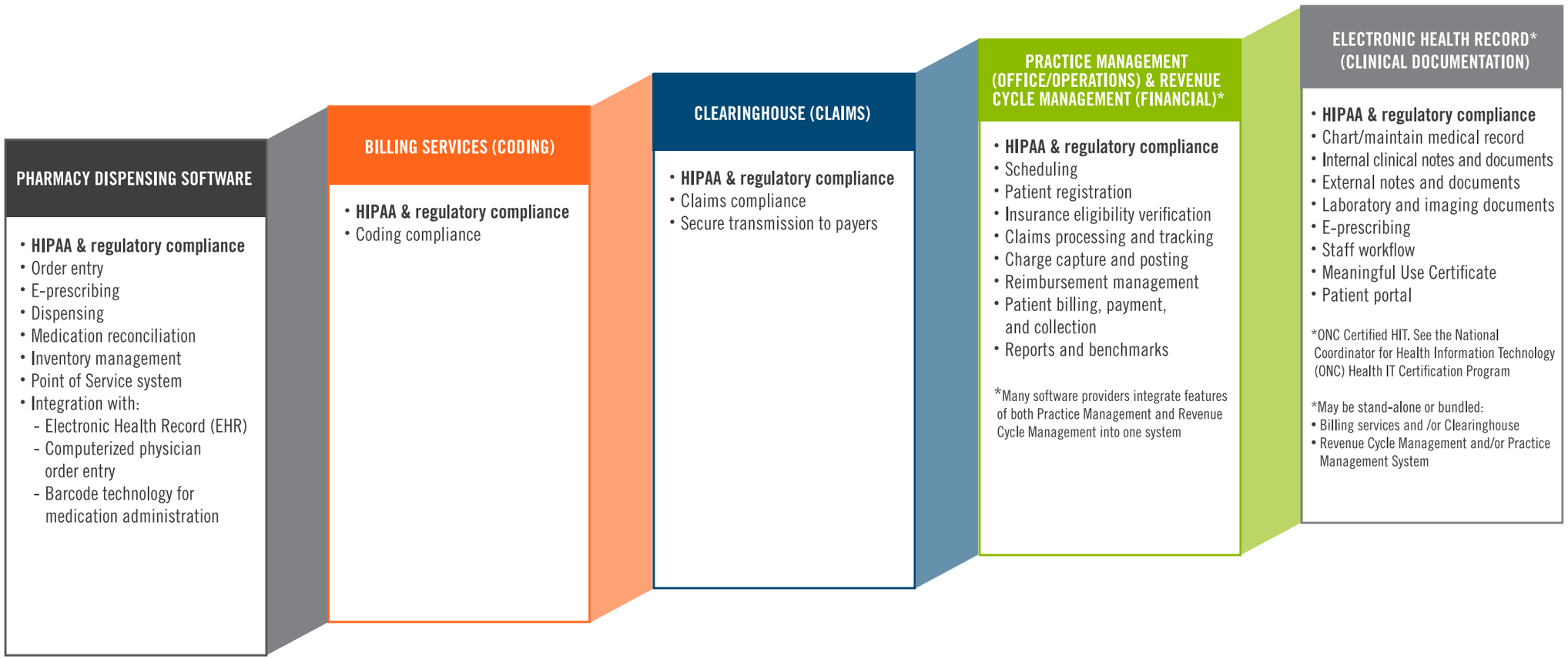
SOFTWARE AND SERVICES FOR MEDICAL BILLING



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COLLABORATIVE HEALTHCARE
OUTCOME IMPROVEMENT CENTER

CONSOLIDATED CLINICAL DOCUMENT ARCHITECTURE (C-CDA) TEMPLATES[1]

The C-CDA documents are the standardized templates used for sharing patients' clinical data among providers and with patients for their Patient Health Record (PHR). Of the nine templates in the C-CDA, only seven are applicable to pharmacy professionals. While pharmacy professionals may not use the Diagnostic Imaging Report and Operative Notes templates, they should be aware that they exist as part of the C-CDA. Pharmacy professionals should select a certified Electronic Health Record (EHR) system[2] that can receive and send C-CDA documents.

	Continuity of Care Document (CCD)	Consultation Notes	Discharge Summary	History and Physical Notes	Procedure Notes	Progress Notes	Unstructured Documentation
	Clinical, demographic, and administrative patient information	*Results from a provider's request for opinion or advice from another provider*	*Patient information for continuation of care after discharge*	*Medical report of patient's current and past conditions*	*Broad, encompassing patient's non-operative procedures*	*Patient's clinical status during an outpatient visit or hospitalization*	*Non-CDA documents that do not fit in other templates (e.g., pdf)*
REQUIRED	• Allergies • Medications • Problem List • Procedures • Results	• Assessment • History of Present Illness • Physical Examination • Plan of Care • Reason for Visit OR • Reason for Referral	• Allergies • History of Present Illness • Physical Examination • Plan of Care • Reason for Visit OR • Reason for Referral	• Allergies • Assessment • Chief Complaint • Family History • General Status • History of Past Illness • Medications • Physical Examination • Plan of Care • Reason for Visit • Results • Review of Systems • Social History • Vital Signs	• Assessment • Complications • Plan of Care • Post-procedure Diagnosis • Procedure Description • Procedure Indications	• Assessment • Plan of Care	
OPTIONAL	• Advance Directives • Encounters • Family History • Functional Status • Immunizations • Medical Equipment • Payers • Plan of Care • Social History • Vital Signs	• Allergies • Chief Complaint • Family History • General Status • History of Past Illness • Immunizations • Medications • Problem List • Procedures • Results • Review of Systems • Social History • Vital Signs	• Chief Complaint • Discharge Diet • Family History • Functional Status • History of Past Illness • Immunizations • Medications • Problem List • Procedures • Results • Review of Systems • Social History • Vital Signs	• History of Past Illness • Immunizations • Instructions • Problem List • Procedures	• Allergies • Anesthesia • Chief Complaint • Family History • History of Past Illness • History of Present Illness • Medical (General) History • Medications • Medications Administered • Physical Exam • Planned Procedure • Procedure Disposition • Procedure Estimated Blood Loss • Procedure Findings • Procedure Implants • Procedure Specimens Taken • Procedures • Reason for Visit • Review of Systems • Social History	• Allergies • Chief Complaint • Interventions • Instructions • Medications • Objective • Physical Examination • Problem List • Results • Review of Systems • Subjective • Vital Signs	

1. HL7 Implementation Guides for CDA Release 2: IHE Health Story Consolidation, DSTU Release 1.1 - US Realm, pp 80-83, July 2012

2. ONC Certified HIT. See the National Coordinator for Health Information Technology (ONC) Health IT Certification Program

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EXAMPLES

Service	Transitions of Care[3]	Pharmacist Care Notes[3]
Description	Documenting care provided before a patient transitions between practice settings: • Medications administered/dispensed • Medications ordered at transfer • Medication reconciliation • Laboratory tests results and orders • Patient instructions and counseling • Clinical status	Documenting counseling services including, but not limited to: • Medication use • Possible side effects • Dietary considerations • Clinical indications
CCDA Template	Continuity of Care Document (CCD)	Progress Note
CCDA Sections REQUIRED:	• **Allergies**: active and relevant history • **Medications**: current medications and pertinent history • **Problem List**: Pertinent current and historical clinical problems related to transition of care • **Procedures**: History of procedures (inpatient settings only) • **Results**: Document test results and observations	• **Assessment**: Clinician's impressions and diagnoses • **Plan of Care**: Patient care including orders, referrals, interventions, encounters, and procedures
CCDA Sections INCLUDE:	• ***Encounter***: lists encounters or interactions • ***Functional Status***: patient's level of awareness, capabilities, and resources • ***Immunization***: current and pertinent history • ***Medical Equipment***: medical and durable equipment • ***Plan of Care***: medication action plan and pharmacist related care.	• ***Allergies***: Active and relevant history • ***Medications***: Active and pertinent history and current medications • ***Objective***: Tests, measures and observations. • ***Physical Examination***: examination observations • ***Problem List***: List of relevant clinical problems • ***Results***: Test results and observations • ***Review of Systems***: Patient's symptoms • ***Subjective:*** Current conditions, response to progress of treatment, and change in treatment • ***Vital Signs:*** Vital signs collected as part of a treatment plan

3. Recommendations for Use of the HL7 Consolidated CDA Templates for Pharmacy, Version 1.0, NCPDP, March 2014

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