

Medical Billing for Pharmacists



Once a fee structure has been designed, (we discussed about ‘Setting up fee structure for Pharmacists’ in our previous article) proper submission of insurance claims can help increase the rate of successful compensation. There are three main strategies for billing: becoming credentialed as a provider, obtaining preauthorization before submission, and submitting the claim without prior authorization. If a pharmacist is credentialed with the insurance carrier, he or she is already authorized to submit claims to the insurance company for those patients using the pharmacist’s program.

If the pharmacist is not a provider for the specific insurance company, the carrier can be contacted for preauthorization. With preauthorization, the insurance carrier preapproves compensation for the pharmacist’s services on a case-by-case basis. Billable services for pharmaceutical care can include, but are not limited to, drug therapy evaluations, patient education, health promotion and disease prevention activities, disease state management services, non-prescription pharmacotherapy consultations, and specialized [pharmacy services](#). Regardless of the specific service offered, the major components needed to complete the process of obtaining compensation are to obtain a provider number, acquire a statement of medical need and proper claim forms, write a cover letter, and prepare to submit claims to third-party payers.

Medical Necessity

A statement of medical need is a document indicating that a service provided by the pharmacist is a necessary part of the patient's treatment. Although this statement may not be required by all third-party payers, providing this statement may increase the likelihood of payment since it communicates that the patient's health care provider thought the service was necessary. This document is filled out by the patient's health care provider to specify the service(s) requested and to give the projected duration for cognitive services; it should be signed by the health care provider. Many pharmacists have developed medical necessity forms that make it easy for health care providers to request pharmacy services by providing checkboxes, fill in the blank, or circle options that specifically name the offered services.

Diagnostic Code

One key component to the statement of medical need is the inclusion of a diagnostic code. These codes include standard ICD-10-CM codes and V codes that describe the patient's health condition. Since it is not within the pharmacist's scope of practice to diagnose, the ICD-10-CM codes must be obtained from the referring provider. In addition, when the code from the physician matches the code provided by the pharmacist, the success rate of receiving reimbursement is higher. It is preferable to obtain the statement of medical need from the health care provider before providing a cognitive service, but the statement can be acquired after the service is performed if the health care provider decides the activity was a necessary part of care.

Claim Form – CMS 1500

The next step in the compensation process is to gather the appropriate claim forms and other necessary codes. Currently, two forms are commonly used for billing of pharmacy services: the CMS-1500 and the Pharmacist Care Claim Form (PCCF). The CMS-1500 form was developed to meet the needs of many health insurers and is the most common form used for outpatient medical services. This is the required form for Medicare billing but is recognized by most third-party payers. This form consists of 33 fields to collect information about the patient, the type

of service performed, the underlying condition necessitating the service, and the provider requesting compensation for the service. A PIN is required in block 33 on each claim submitted to Medicare. This number is the PIN of the physician when billing is incident to physician services. It may be the PIN for the pharmacist if the third-party payer assigns pharmacists their own separate PIN.

Although there are several approaches to obtaining a PIN, perhaps the most direct and successful way is to call the payer, before the claim is submitted, to determine whether that payer will issue PINs for pharmacists. If the identification number field is left blank, the payer most likely will return the claim with instructions on how to complete that field appropriately or how to obtain a PIN. The unique PIN (UPIN) is slightly different and is given to physicians who are allowed to refer patients to other providers. The UPIN of the referring physician goes in 17a on the CMS-1500 form.

Another set of commonly used codes are the CPT codes, which are used for describing medical, surgical, and diagnostic services. Most pharmacy services will be reported with a CPT evaluation and management code. In the outpatient setting, this [coding](#) enables the provider to choose from a variety of codes based on seeing a new or established patient and the level of service provided. The three components used to determine the level of service provided are extent of history obtained, extent of examination performed, and complexity of medical decision making. Although time is not often used as a marker of selection for a CPT code, it may be used as an alternative for the total work involved in providing the service. It is important to note that the documentation for the service must support the code choice(s).

Claim Form – PCCF

The second claim form is the PCCF, which was developed by the National Community Pharmacists Association (formerly the National Association of Retail Druggists). The various sections of the form contain patient information, coding for activities, free text for discussion, certifications, and pharmacy information. The PCCF is primarily based on the National Council for Prescription Drug Programs Professional Pharmacy Services codes. These codes are not specific to a particular service but describe the basic framework for patient care activities. Since most insurers are not familiar with this form, PCCF can be submitted with the CMS-1500.

Cover Letter

When the appropriate forms have been completed, the pharmacist should prepare a cover letter to send to the third-party payer. This letter should include a statement of purpose (request for payment of professional services), the patient's name and identification number, the date and location of service, anticipated outcomes, and the list of documents enclosed with the letter. These documents would include the statement of medical necessity, the CMS-1500 form, the PCCF, and documentation of the service. This letter "sets the stage" for the remaining enclosures; therefore, it should be succinct, clear, and express justification for compensation.

Finally, the claim can be submitted to the third-party payer by hard copy or electronically. Hard-copy submissions are most useful for first time submissions and should include all components listed above. Once a relationship is established between the pharmacist and the company, electronic submissions may be easier, provide faster payment for services, and may require only submission of the CMS-1500.

Payment for Claims

Payment for claims usually will take 4–6 weeks. The pharmacist or the billing department should follow up on claims that have not been paid after 8 weeks. If a claim has been rejected or denied, the responsible personnel should call the billing department of medical benefits for the third-party payer and request an explanation. The reasons for rejection will vary. It simply may be not completing the claim form properly or providing insufficient documentation. Regardless of the explanation, the pharmacist should make any needed changes and resubmit the claim. If the third-party payer does not compensate pharmacists, then decision makers in the company should be contacted to explain the value of the services and be given a valid rationale for changing the policy. The key to receiving compensation is perseverance. Pharmacists may have to resubmit a claim several times before it is paid, but once the payer accepts the claim, compensation in the future is likely to occur in a more timely fashion.

If the claim continues to be rejected after exploring all potential options with the third-party payer, the pharmacist can seek compensation from the patient. If claims are rejected, clarify

the reason for rejection, correct the error or oversight, and resubmit. Errors in claim submission, such as missing information, may be a reason why a claim is denied. Claims may also be rejected because of lack of supporting documentation.

Contacting the insurance company when claims are rejected and making corrections can help decrease the risk of denial when submitting future claims to the insurance company. The process of billing, from gathering forms to resubmitting claims, can be time-consuming. If required you can seek help of medical billing company like [Medical Billers and Coders \(MBC\)](#) who assures maximum reimbursement. To know more about our Pharmacy billing services you can contact us at [888-357-3226](tel:888-357-3226)/info@medicalbillersandcoders.com