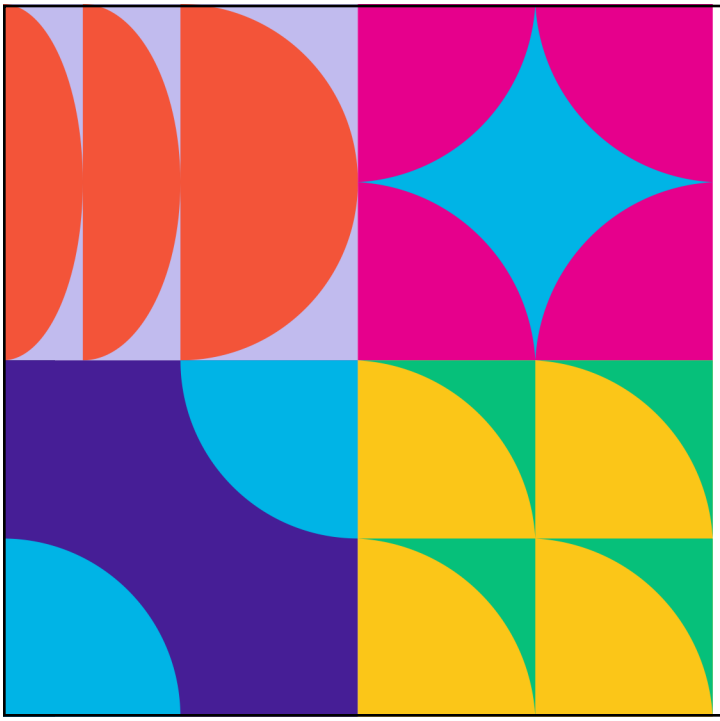

Turning Pharmacy Services Into Revenue With Medical Billing

Shanna K. O'Connor, PharmD, BCACP

Description

Put your billing knowledge to the test with real-world pharmacy scenarios. Determine which services can be translated into reimbursable claims using appropriate documentation and CPT coding. Apply billing and workflow strategies that support sustainable revenue while maintaining high-quality care.

Meet the Faculty

Shanna K. O'Connor,
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Shanna O'Connor

Shanna O'Connor, PharmD, BCACP is Department Head of Pharmacy Practice and Associate Professor at South Dakota State University College of Pharmacy and Allied Health Professions. She received her PharmD from the University of Wyoming and completed residencies with Florida Hospital Celebration Health (Ambulatory Care focus) and UNC Eshelman School of Pharmacy/Kerr drug (Academia and Community). Her career has focused on creation of novel, fiscally sustainable pharmacist-delivered outpatient services. She continues work in advocating for the advancement of the profession and is actively engaged in multiple practice-change projects with partners both in South Dakota and across the nation.

Disclosures

- Shanna O'Connor has no relevant financial relationships with ineligible companies to disclose.
- Shanna O'Connor discloses that AI tools were utilized to summarize content included in this presentation.

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Learning Objectives

Upon completion of this activity, learners should be able to:

- Describe characteristics of services that are aligned with community-based pharmacy practice and could be billed to the medical benefit.
- List key differences between billing the pharmacy and medical benefit.
- Interpret workflow factors that affect reimbursement for clinical services.
- Apply documentation and coding practices in a guided billing scenario to support compliant reimbursement.
- Recommend one workflow improvement to strengthen billing and improve revenue capture.

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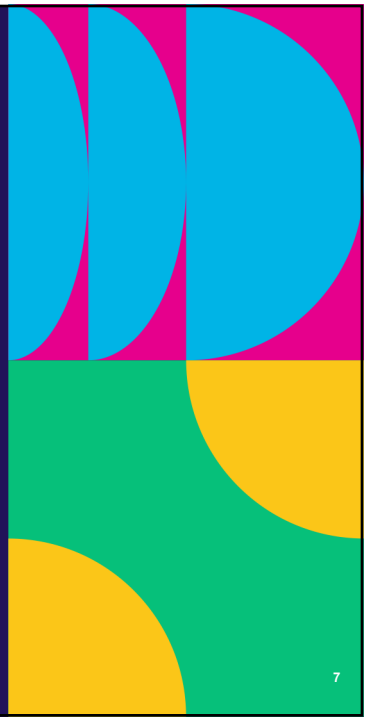
Setting the Stage: Jackrabbit Pharmacy

Assumptions and Resources



Jackrabbit Pharmacy: Poised for success but not quite there

- Scenario: Independent pharmacy with established contract for non-dispensing services
  - Non-dispensing services being offered already (e.g., test-and-treat, chronic disease management)
    - Autonomous practice for pharmacists (versus collaborative practice)
  - Credentialing of pharmacists is done with payors
  - Staff are comfortable using terms related to medical billing
    - Credentialing and Contracting
    - Book of Business
    - CPT, ICD-10, Level of service
  - **The challenge**: Medical billing is not optimized

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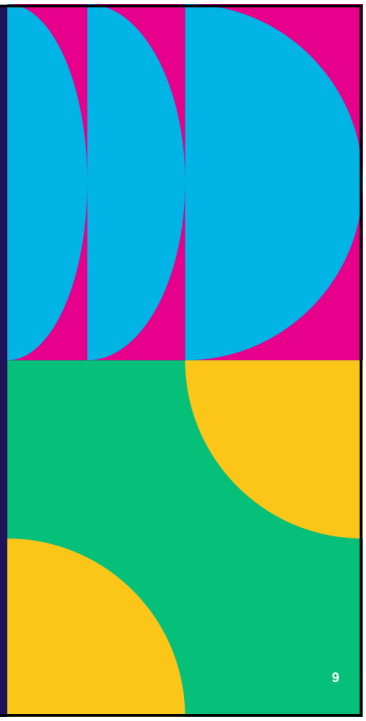
What this session will (and won't) focus on

Refresher Term Sheet



What services can be billed to the medical benefit?

- Aligned with community-based practice
  - Space and equipment considerations
    - Privacy area for patient interactions
    - Necessary equipment for patient evaluation (e.g., scale, stethoscope, analyzers for samples)
  - Workflow considerations
    - Walk-in versus scheduled services
    - Integration with dispensing workflows
    - Post-visit workflows for billing follow-up
  - Scope of practice (match to permissiveness of regulation)
  - Clinical ability of providers
  - Match to patient population needs
- Compliance with requirements (medical necessity and coverage alignment)

Electronic Code of Federal Regulations. www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-411/subpart-A/section-411.15

Example Pharmacy-Based Services

- **Prevention:**
  - Immunizations
  - HIV pre- and post-exposure prophylaxis (PrEP and PEP)
  - Travel medicine
  - Contraception/emergency contraception
- **Chronic and acute treatment:**
  - Test-and-treat-based protocols
  - Urinary tract infections
  - Chronic disease management
    - Medication management
    - Medication administration (e.g., long-acting injectable antipsychotics)
    - Medications for opioid use disorder (MOUD)

Compliance

Medical Necessity

- Services or supplies that are "**reasonable and necessary** for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."
- And meet specific criteria (examples):
  - Diagnosis and/or treatment of illness or injury
  - Preventive physical examinations, with the goal of health promotion and disease prevention, and additional preventive services

Coverage Alignment

- Medicare example: National Coverage Determinations or Local Coverage Determinations
- Medicaid generally follows CMS framework but with greater variability by state for coverage rules and documentation requirements
- Coverage elements outlined in individual contract/agreement with private payer

Electronic Code of Federal Regulations. www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-411/subpart-A/section-411.15

‘Billable Service’

- Documentation
  - Medical necessity documentation:
    - The clinical and administrative evidence a provider must maintain to justify that a rendered service met established coverage criteria under federal, state, and payer-specific rules
    - Without adequate documentation: claims are subject to denial, audit, or fraud referral (regardless of if service was clinically appropriate)
  - Proof the service occurred - documentation must show:
    - The service was performed
    - It required the level of care delivered

Electronic Code of Federal Regulations. www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-411/subpart-A/section-411.15

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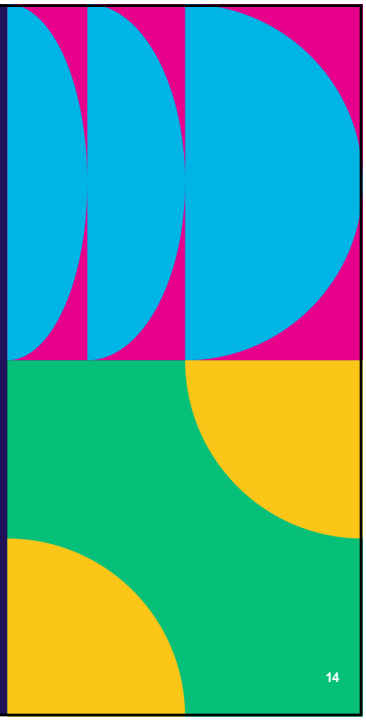
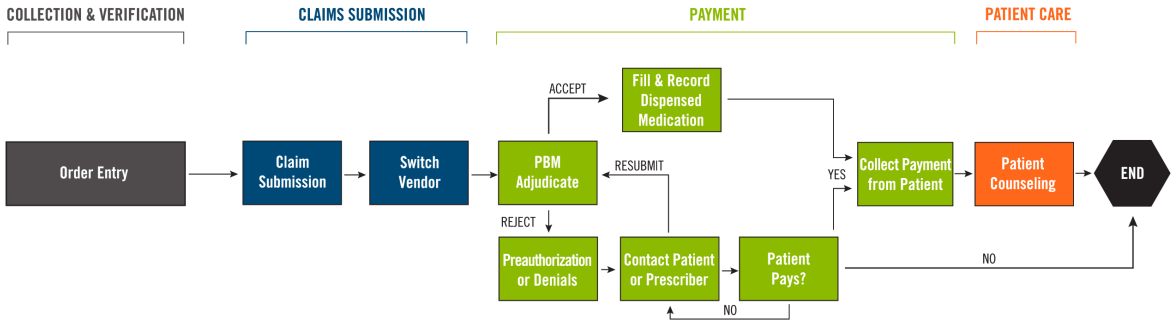
Logistics: Pharmacy and Medical Benefit Billing

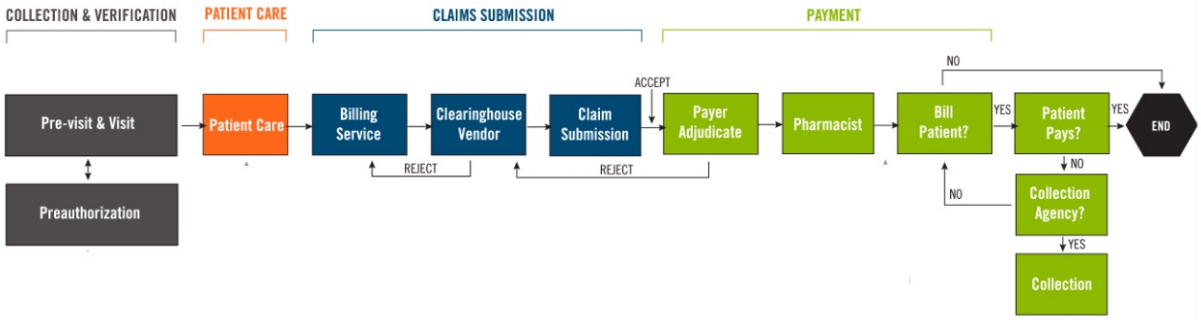


Payment, Pharmacy Billing Cycle



Arnold J. Washington State Medical Billing Experience. Presentation made to JCPP Jan 15, 2025. Slides available at: https://jcpp.net/wp-content/uploads/2024/11/2025-JCPP-Washington-Presentation.pptx.

Payment, Medical Billing Cycle



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Billing Cycle Similarities and Differences

Similarities

Eligibility

- Patient needs to have insurance
- Drug needs to be on formulary

Process

- Collection of copay at point of service
- Audit can evaluate compliance after the fact
- Claim submitted as set of specific codes in designated fields in software

Differences

Eligibility

- 'In network' (and contracted)
- Determining eligibility for service vs. drug

Process

- Determination of copay/coinsurance amount challenges
- Audit for medical billing evaluating documentation
- Completely different software elements

Software Differences

Medical Billing Software

- Codifies notes in HL7 standard with SNOMED codes
- Generates claims in 837 standard
- Revenue Cycle Management
- Checking enrollment and claims

Pharmacy Billing Software

- NCPDP Standard "language"
- Notes field not standardized
- Medical Claims require intermediary
- Limited ability to share data
- Some have eCare Plan development and sharing

Arnold J. Washington State Medical Billing Experience. Presentation made to JCPP Jan 15, 2025. Slides available at: https://jcpp.net/wp-content/uploads/2024/11/2025-JCPP-Washington-Presentation.pptx.

You are transitioning a service from
‘not billed’ to ‘billed under the medical benefit.’

What must change in workflow?

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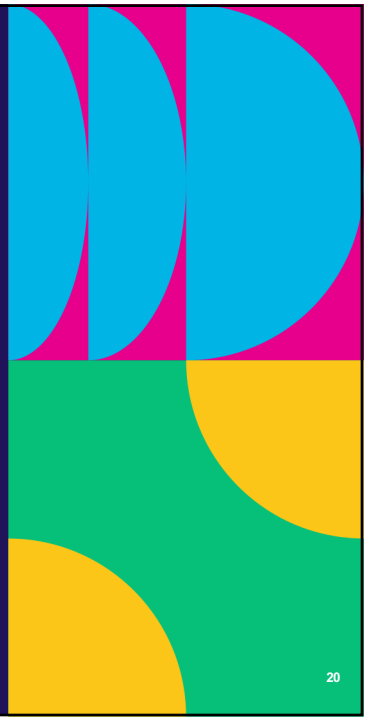
Which two factors change the most
in this scenario?

A. Real-time adjudication expectations
B. Documentation expectations
C. Timing of payment
D. Staff roles involved
E. Software used



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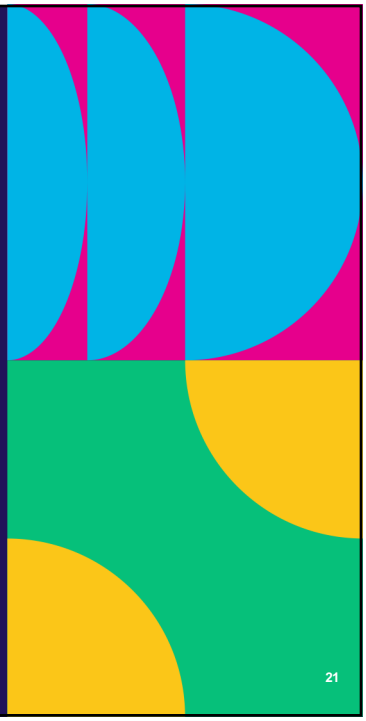
Jackrabbit Pharmacy: Medical Billing Workflow



Workflow factors can affect reimbursement for non-dispensing services

- **Workflow for service itself**
  - Physical space considerations
  - Maintaining dispensing workflow while non-dispensing service occurring
  - Variability in approach based on scheduled/walk-in service
  - Documentation streamlining (efficiency for time balanced with comprehensive for audit)
  - Patient follow-up (depending on service)
  - Communication of service with others on healthcare team
- **Claims**
  - Filing occurs after service delivery, so entirely different process
  - Payment review/tracking
  - Rejections and challenges

Jackrabbit Pharmacy: Identify threats to reimbursement

Monday, 3:30pm: Pharmacy is short-staffed (1 pharmacist, 1 technician)

- Queue is 5 scripts behind
- 3 vaccine appointments scheduled 3:45-4:30
- Patient walks in requesting help with:
  - Sore throat + headache + fever + malaise (test-and-treat service)
  - Medication refill

Complicating factors

- No clear triage workflow
  - Pharmacist typically runs full walk-in visit and majority of immunization visits
  - Dispensing priorities and non-dispensing tasks have unclear prioritization
- Documentation done after visit is completed
- EHR template is long and inconsistently used

Reimbursement Threats/Corrections

Threats

- Dispensing vs. service conflict
  - Mismatch in level of skill being used potentially
  - Inefficient use of pharmacist time, technician 'stuck'
  - Documentation time competing with dispensing needs
- Walk-in vs. scheduled variability
  - Challenges for staffing
  - Queue management

Potential Corrections

- Technician-driven intake + triage algorithm
- Float staff coverage model for non-dispensing services
- Walk-in conversion to 'same-day scheduled'
- 'Dispensing pause' for service delivery
- Structured documentation template aligned with billing requirements

Workflow changes to consider: What could go wrong/right?

Version A: Efficiency-first

Technician completes structured intake

Pharmacist documents after the visit (end-of-day batch)

Template optimized for speed (checkbox-heavy)

Version B: Compliance-first

Pharmacist documents in real time during visit

Full template used every time

Minimal delegation

Version C: Hybrid

Technician intake + partial documentation

Pharmacist completes key elements during visit

Finalization after visit using structured prompts

What strengths and risks does each workflow introduce?

Version A: Efficiency-first

Technician completes structured intake

Pharmacist documents after the visit (end-of-day batch)

Template optimized for speed (checkbox-heavy)

→ **Strengths:** Fast, preserves dispensing workflow

→ **Risks:** Recall bias may equate to less support for higher level services

Version B: Compliance-first

Pharmacist documents in real time during visit

Full template used every time

Minimal delegation

→ **Strengths:** Strong audit defensibility

→ **Risks:** Disrupts dispensing workflow (system-level revenue loss)

Version C: Hybrid

Technician intake + partial documentation

Pharmacist completes key elements during visit

Finalization after visit using structured prompts

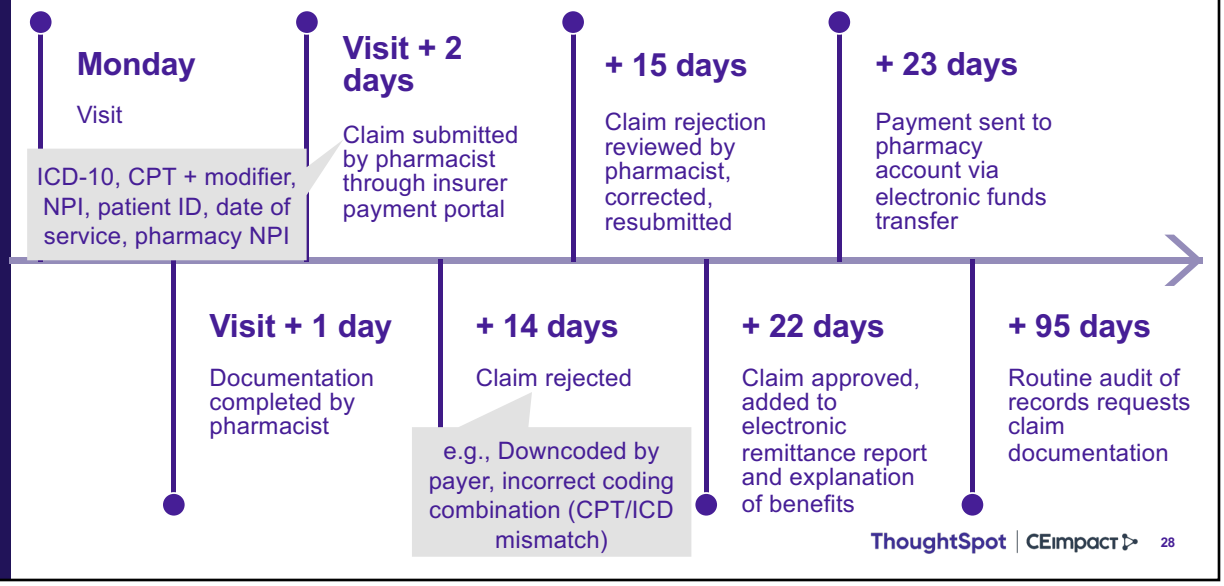
→ **Strengths:** Balanced

→ **Risks:** Inconsistency = variability in documentation quality

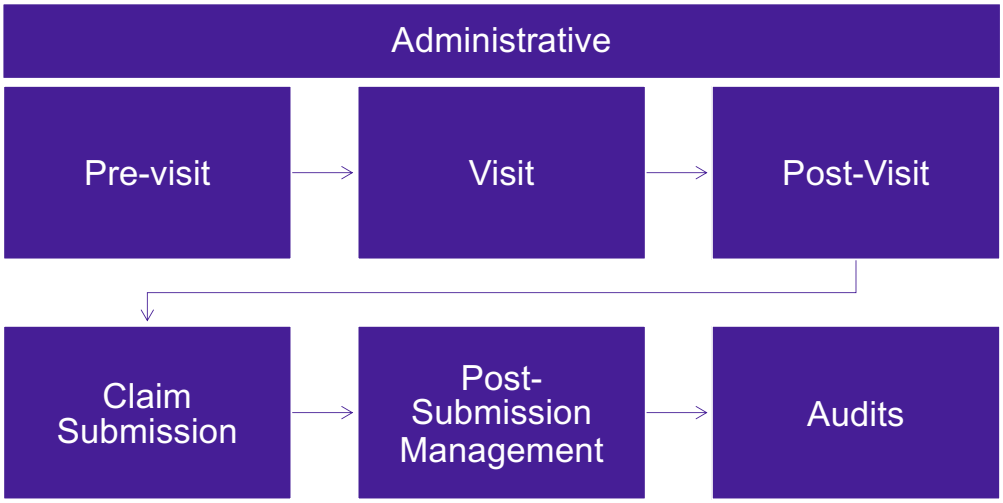
Documentation as Defensive Infrastructure

- Documentation timing/efficiency
  - Interrupted visit → incomplete/delayed documentation → missing elements for CPT level → risk for miscoding of visit
  - No structured intake → inconsistent medical necessity capture
  - No defined follow-up → missed billable touchpoints (e.g., chronic care management)

Jackrabbit Pharmacy Claim Evolution



Points in Time to Consider for Medical Billing 'Workflow'



Consider Jackrabbit (or your) Pharmacy: Review medical billing workflow points

- Many billing errors happen before the visit even occurs

- **Pre-Visit**
  - Is the patient eligible to be seen under existing contracts for this service?
  - What is the process for eligibility screening?
  - Are all eligible patients captured?
  - How does scheduling work?
  - How are walk-ins handled?
- Risks to evaluate:
  - Service provided but not covered?
    → Guaranteed non-payment
  - Service covered but not provided?
    → No payment to collect

Consider Jackrabbit (or your) Pharmacy: Review medical billing workflow points[2]

- **Visit**
  - Intake (who collects what information)?
  - Service delivery and coordination with dispensing workflow?
  - Is real-time or delayed documentation most ideal?

- Risks to evaluate
  - Service provided but inefficient?
    → Other workflows may suffer
  - Efficient service but gaps in documentation?
    → Risks for incorrect coding

Consider Jackrabbit (or your) Pharmacy: Review medical billing workflow points[3]

- **Post-Visit**
  - When/how is documentation finalized/checked?
  - Who selects CPT/ICD-10 codes?
  - How do these tasks fit with other staffing duties?
  - How does communication between individuals occur?

- Risks to evaluate:
  - Coding misaligned with documentation?
    → Potential audit failure
  - Missing charge capture entirely?
    → No payment

Consider Jackrabbit (or your) Pharmacy: Review medical billing workflow points[4]

- **Claim Submission**
  - Who completes charge entry into billing system?
  - Who 'scrubs' claims? Who submits to payers?

- Risks to evaluate
  - Missed elements in coding?
    → Rejection
  - Chronic undercoding?
    → Incorrect payment amount/audit exposure

Consider Jackrabbit (or your) Pharmacy: Review medical billing workflow points[5]

- **Post-Submission Management**
  - Who tracks claim status?
  - Who is responsible for reviewing and interpreting payer responses?
  - Who identifies rejections, corrects, and resubmits?
  - Who is in charge of denial management (appeals)?
  - Who reconciles payment?

- Risks to evaluate
  - No tracking system?
    → Lost claims (no payment)
  - Failure to appeal when appropriate?
    → Lower/no payment
  - Not reconciling expected and actual payment?
    → Over/under payment (audit risk, missed payment)

Consider Jackrabbit (or your) Pharmacy: Review medical billing workflow points[6]

- **Audits**
  - Who conducts internal quality audits?
  - Who responds to external audits?

- Risks to evaluate
  - No internal quality assurance (QA)?
    → Repeat errors
  - Poor/delayed response to external audit?
    → Contract at risk

Consider Jackrabbit (or your) Pharmacy: Review medical billing workflow points[7]

- **Strategy/Administration**
  - Are the right services being offered?
  - Should a service be stopped?
  - Are other contracts available?
  - Are billing processes optimized?

- Risks to evaluate
  - No review?
    → Continuation of low value service
    → Misalignment between contracts and offered services
    → Missed opportunities for new/expanded services

Consider Jackrabbit (or your) Pharmacy: Review medical billing workflow points[8]

- **Strategy/Administration**

Error	Financial impact
No eligibility check	$0
Downcoded visit	-30-50% revenue + audit risk
Missed follow-up	Lost longitudinal revenue
Audit failure	Recoupment risk
Gaps in strategic administration	Medical billing not optimized

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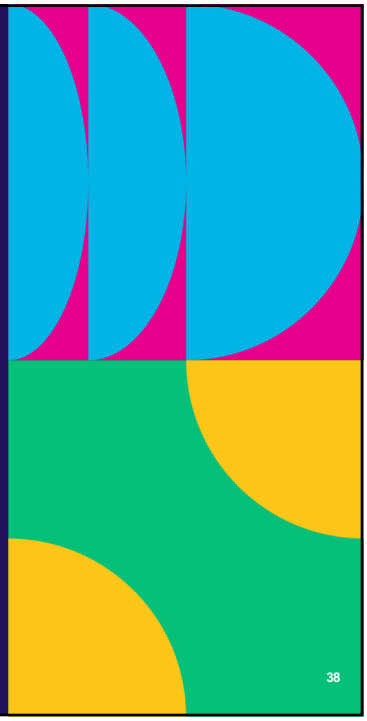
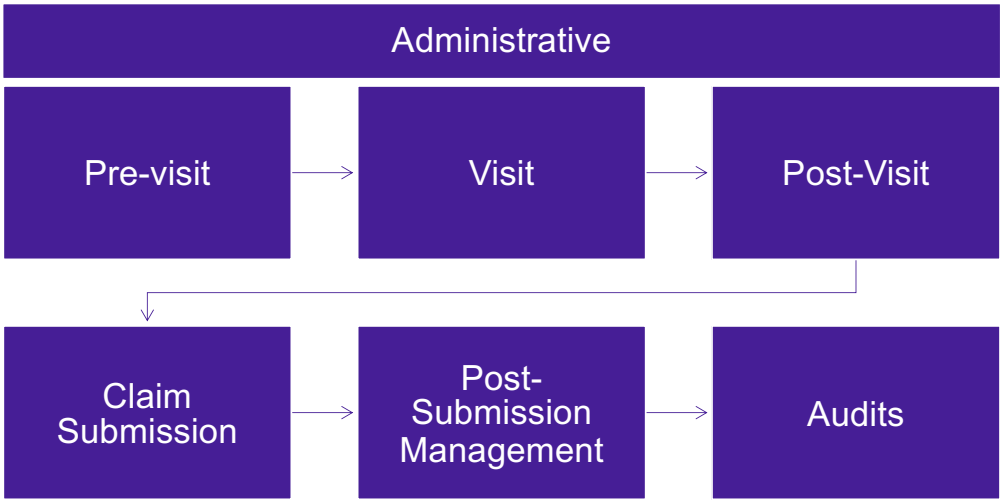
Practical Changes To Improve Medical Billing Workflow



Choose one workflow area and identify a way to improve



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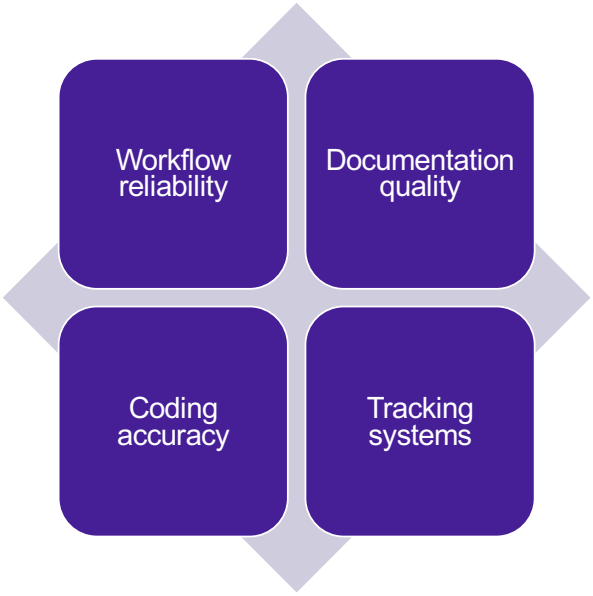
Next Steps

Medical Billing Success



Questions?