Advancing Healthcare: Key Steps to Implementing Pharmacist Provider Status

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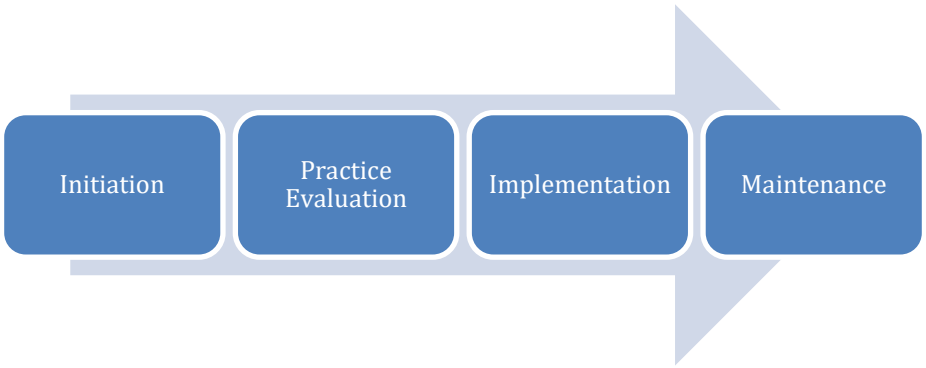
Introduction

Pharmacists across the country are entering a new era of practice with an advancing scope, additional clinical responsibilities, and the ability to directly bill patients and payers for services provided. State governments and Medicaid programs increasingly recognize pharmacists as essential members of the healthcare team, enhancing patient access to care and improving health outcomes. Many states have adopted pharmacy practice laws and regulations that recognize pharmacists as billable providers through commercial payers or Medicaid plans. This "provider status" at the state level enables pharmacists to create financially sustainable models based on direct revenue for patient care but presents uncharted paths for many without experience in healthcare reimbursement. This document is intended to serve as a guide for pharmacists newly recognized as providers who are eligible to be reimbursed for their patient care services and describes the steps necessary for implementing and building a billable practice.

Preparing for provider status can be broken into separate stages: initial planning, current practice evaluation, billing implementation, and maintenance. Each stage will be discussed individually in the following sections.

Stage 1: Initiation and identification of key stakeholders (organization level)
Stage 2: Internal evaluation of existing practice (internal pharmacy practice and team)
Stage 3: Implementation of billing practice and accounting systems (systems needed to send, process, and reconcile claims)
Stage 4: Maintenance of billable services, reviewing performance metrics, and ongoing practice evaluation



Stage 1: Initiation

A. Who are the key contacts/collaborators?

When implementing pharmacist billing for clinical services, you will collaborate with many key individuals or teams. Outside of your organization, your state board of pharmacy can assist with understanding laws, scope of practice, and whether collaborative practice agreements are required. State pharmacy organizations may offer helpful implementation playbooks. Within your organization, start with health system administrative leaders or board of directors for support and championing the process. Compliance, risk, legal, billing, coding, finance, patient relations, and information technology (IT)/electronic health record (EHR) teams often assist with development and operational needs, including EHR build. These key contacts may need education to understand pharmacist provider status. Depending on your organization's onboarding process, you may work with your credentialing and privileging team, human resources, and medical staff services to ensure pharmacists are set up to bill for patient care services.

B. What is Credentialing?

Credentialing is the process by which a healthcare organization obtains, verifies, and assesses an individual's qualifications to provide patient care services.[1] This can be done directly by the healthcare organization or can be delegated to another healthcare entity.[2] Credentialing is often required by regulatory/accrediting bodies, payers (commercial and government), and healthcare organizations. The process starts when the healthcare provider submits an application and supporting documents, such as proof of liability, a curriculum vitae, original copies of certifications, malpractice claim disclosures, and letters of recommendation. These are reviewed and verified to create the credentialing file prior to being reviewed by a credentialing committee that is responsible for making a final determination. Providers are required to be re-credentialed at a cadence established by the healthcare organization.[1]

It will be necessary that each pharmacist has an active National Provider Identifier (NPI) number prior to starting the credentialing process. Additionally, this process varies by state and Medicaid and commercial payers.

C. What is Privileging?

Privileging is the process by which a healthcare organization authorizes an individual provider to perform a specific scope of patient care services. To receive privileges, a healthcare provider submits an application for an initial review by a privileging committee. The committee reviews the application to verify the provider's credentials and ensure satisfactory performance. Clinical privileges are often granted based on evidence of an individual's current competence, as well as relevant experience and credentials. Providers must undergo reappraisal of privileges at intervals determined by the healthcare organization.[1]

D. **What is Contracting?**
Contracting with payers to ensure payment for pharmacist services is crucial. Work with your legal and contracting departments to understand when and how pharmacists can be added to payer contracts. Managed care and the credentialing and privileging teams may also be involved.

Stage 2: Current Practice Evaluation: Analysis of existing model and gap identification

A. **What should be evaluated within the existing clinical practice model?**
Pharmacists establishing a new clinical practice or patient care services after achieving provider status should carefully consider gaps that may exist between their current and desired practice models. Changes or updates to existing workflows and systems may be necessary to support billing requirements. Patient referrals, clinical workflows, documentation, practice logistics, EHR configuration, and communication pathways should be examined to ensure the desired model is supported and complies with existing provider standards and pharmacist scope of practice.

B. **What should be considered for referrals to your service?**
Pharmacists should determine the appropriate pathway for patients to be referred for their services (e.g., EHR, other). Some states may have different requirements. Decide how referrals will be documented and information that should be included within the referral template. Consider if there is an opportunity for referral management with support staff. Determine if scheduling can be linked to the referral. Additionally, consider what is needed for payer authorization.

C. **What determines the scope of practice?**
Even when payers recognize and reimburse pharmacists for clinical services, the authorization to provide those services will be dependent on state pharmacy practice acts, board of pharmacy regulations, and institutional privileging. Some states allow pharmacists broad autonomy in their pharmacy scope of practice while others allow for collaborative authority, i.e., collaborative practice agreements, or may have rules that are more restrictive. State medical, nursing, or other healthcare professional practice acts may need to be reviewed as well for any enabling or restrictive language involving pharmacists on interprofessional care teams.

D. **How will provider status and billing change practice logistics?**
Pharmacists who implement billing for their patient care services may need to adapt their clinical practice to support the new model. Revenue generation may change requirements for visit volume, the site of practice, and resources needed for the new model. Consider current patient expectations for scheduling and pharmacist availability. Additionally, pharmacists working with residents and students must consider how learners interact with patients and how this will impact billable services.

E. **What is a typical length for a patient visit?**
Professional fees may be submitted based on visit complexity or time increments. Pharmacists should be aware of standard codes attributed to levels of service and adopt

visit templates that include documentation required for billable visits and anticipated volume for a sustainable service. Visit standards for other provider such as 20-minute, 30-minute or 40-minute visits should be considered when determining visit length. Organizations may have daily or monthly visit volume targets that can be adopted for pharmacists billing for clinical services.

F. Can pharmacists bill for work performed by residents or students?
Generally, pharmacists can only bill for services that they directly provide to patients. Unless directly supervised, residents (not credentialed) and students are not billable. This may impact the practice model and how learners are incorporated into direct patient care. Consult your compliance departments for additional guidance.

G. How might patient experience and expectations be impacted?
Patients may experience shorter appointment times and be responsible for associated visit copays. Non-reimbursable clinical care may no longer be provided.

H. How does billing for patient care services change documentation requirements?
Pharmacist visit documentation must meet existing standards to support billable services.
Utilize resources to develop documentation and templates such as ASHP Guidelines on Documenting Pharmaceutical Care. Ensure consistency with your organization's established billing guidance.

I. What components do I need to include in my documentation?
Documentation components usually include the chief complaint, associated problems and diagnosis codes, medical decision making, time spent on counseling and coordination of care, and any relevant supervision. The Pharmacist Billing/Coding Quick Reference Sheet For Services Provided in Physician-Based Clinics provides a summary of documentation components based on level of service and type of billing. For telehealth, specific documentation around delivery, patient and provider location, and compliance requirements may be necessary.

J. Who should I engage with in my organization to determine documentation practices?
Work with the pharmacy department, other clinical providers, compliance, billing and coding, and IT to ensure pharmacist documentation meets all requirements. Consistency in documentation across practice areas is important, but best practices may vary in different clinical areas. Consult your organization’s compliance and IT departments to identify available documentation options and optimize them to meet organizational, billing, and outcomes tracking needs. Utilize forms, check boxes, or buttons to support ease of reporting or dashboards.

Stage: 3: Implementation: Go live and first day considerations

A. **What must be in place for successful billing?**
   Practices that are new to billing for pharmacist patient care services will need to determine the services they intend to provide and the corresponding codes and charges for those services, as well as the type of payers providing reimbursement. Currently, Medicare does not recognize pharmacists as independent providers. Consider how patients with different insurance types will be managed to ensure equitable billing practices. Some organizations train pharmacy teams on billing and code selection based on payer type and service site (professional fee, facility fee, or incident-to billing). Other organizations use back-end financial edits to allow visits to be coded based on care provided, with the revenue team adjusting the codes for payer reimbursement. Discuss available options with your finance team before implementing professional billing.

B. **Does your EHR support pharmacist billing?**
   Some EHRs have checks to prevent pharmacists from inadvertently sending charges. Ensure your EHR supports pharmacist charges like other provider types, which may require IT updates.

C. **What resources does ASHP have to support pharmacist billing?**
   - Billing-quick-reference-sheet
   - Pharmacist Billing Using Incident-to Rules Non-Facility Ambulatory Clinic
   - Reimbursement for Clinical Pharmacy Services: Is There a Role for Facility Billing?
   - Alternatives to Incident to Billing for Revenue Generation in Non-Facility Ambulatory Clinics
   - Compensation and Sustainable Business Models
   - See additional resource above

D. **How will pharmacists be trained to bill for clinical services?**
   Health systems likely have existing coding and compliance programs to train and support pharmacists entering provider billing arrangements. Pharmacists will use standard codes (CPT, ICD 10, HCPCS) to bill for services and internal provider training programs can be leveraged to meet clinical pharmacist educational needs. National and state pharmacy organizations offer training programs for pharmacists implementing provider billing. The curriculum of the ASHP Billing & Reimbursement for Patient Care Clinical Services Certificate is designed to educate pharmacists and others involved in billing for pharmacist services (e.g., billing, compliance, and revenue cycle staff, including coders) about the rules surrounding reimbursement for pharmacist services and applicable codes for those services.
   Billing and Reimbursement for Patient Care Clinical Services Certificate (ashp.org)

E. **What do I need to know for accounting purposes?**
   Build relationships with accounting and/or finance departments to support the new billing model. Financial reports tracking charges placed and reimbursements received are necessary. Learn about your organization's revenue cycle processes and how they apply to billing and reimbursement for pharmacist patient care services.

Stage 4: Maintenance

A. How do I assess competency?

If credentialing and privileging services are available at your organization, follow the model developed for regularly privileging other healthcare providers. If you do not have these services available, consider internal methods to assess and document ongoing clinical competence. Departmental testing and peer reviews are examples of internal competency assessments. Compliance with billing practices also requires regular review. Codes and requirements for medical billing are regularly updated. Billing providers require ongoing training to ensure knowledge of the most up to date standards. Organizations with existing billing departments will likely offer ongoing training and competency review.

B. How do I demonstrate success? What data should I capture?

Assessing service outcomes is crucial for sustaining a practice post-provider status implementation. Healthcare metrics or key performance indicators (KPI) are typically classified into four dimensions: structure, process, financial, and outcomes. To learn more, see the ASHP FAQ: Identifying Ambulatory Pharmacist Practice Metrics

C. What is a key performance indicator?

KPIs are numeric indicators, each of which represent a priority of an organization. Ongoing monitoring of KPI data enables decision-making and facilitates the identification of opportunities for improvement. A clinical pharmacy KPI tracks advancements in specific clinical pharmacy activities.

D. What are examples of structure measures?

Structure measures assess the impact of resources and systems on patient care delivery.

- Staffing hours per clinic day
- Number of patient visits per clinic day
- Number of encounters including phone, video, and/or face-to-face visits
- Average wait times per patient in clinic
- Number of non-patient care activities (e.g., arranging transportation)
- Indirect impactive, changes to provider productivity or prescribing trends

E. What are examples of process measures?

Process measures evaluate the interaction of the ambulatory care pharmacist with the patient, or the care and services provided.

- Number of reconciled medication services provided per patients seen
- Number of blood pressure measurements performed compared to number of patients visits
- Percentage of time adherence to medications is documented per patient visit
- Number of visits with sufficient documentation compared to number of visits total
- Number of visits with comprehensive patient education
- Number and types of interventions (e.g., medication additions, discontinuations, changes)

- Number of prior authorizations, financial assistance, medication interchange

F. What are examples of financial measures?

Financial measures are related to return on investment (ROI), growth, and billing.

- Revenue generation
  - Utilization of face-to-face and telephonic billing codes
  - Percent of billable/reimbursable encounters
  - Charges billed vs reimbursed
  - Claim denial rates
- Cost savings
  - Payer/reimbursement specific outcomes
  - Staffing costs compared to cost savings from improved outcomes

G. What are examples of outcomes measures?

- **Clinical**
  - Number or percentage of patients who suffer an adverse drug event
  - Blood pressure at goal
  - Number of patients with 10% reduction in blood pressure
  - Number of patients with at-goal lipid values
  - Number of patients achieving 90% medication adherence for HIV medications
  - Number of patients with A1C values less than 7%
- **Humanistic**
  - Number of patients who report improved health
  - Number of patients who feel they have improved understanding of how to use medications
  - Number of patients who feel less anxiety regarding their medical care
- **Economic**
  - Percent reduction in hospitalizations or emergency room visits
  - Reduction in testing due to improved clinical disease control

H. How do I perform continuous improvement and sustain growth?

Examine processes to determine how they can be made more effective and efficient after implementing provider status. Utilize quality improvement methods and tools to identify opportunities for improvement and create action plans. Resources include:

- ASHP Discussion Guide on The Pharmacist's Role in Quality Improvement
- Applying LEAN to the Medication Use Process: Issues for Pharmacy
- Rapid Cycle Improvement: Controlling Change
- Quality Improvement for Pharmacy Professionals Certificate (ashp.org)

F. Where can I find additional information?

- Current and future state of quality metrics and performance indicators in comprehensive medication management for ambulatory care pharmacy practice
- Pharmacy Quality Alliance
- Value and Quality for Ambulatory Pharmacist Patient Care Practice

- HEDIS and Performance Measurement
- Child and Adult Health Quality Measures

Sources

1. Credentialing and privileging of pharmacists: A resource paper from the Council on Credentialing in Pharmacy. *Am J Health-Syst Pharm*. 2014;71(21):1891-1900. doi:https://doi.org/10.2146/ajhp140420
2. NPDB Guidebook, Chapter D: Queries, Delegated Credentialing. www.npdb.hrsa.gov. Accessed March 24, 2024. https://www.npdb.hrsa.gov/guidebook/DDelegatedCredentialing.jsp

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