**PHARMACY BILLING CYCLE**

**Prescription Filling Process**
- Prescription Intake
- Order Entry and Verification
- Claim Generated
- Claim Transmitted
- Switch Vendor

**Claims/Transactions Process**
- PBM Adjudication
- REVIEW
  - ACCEPTED
    - Pharmacy
    - Filling and Recording of Dispensed Prescription
  - REJECTED
    - PBM Adjudication
    - Pharmacy
    - Collect Payment from Patient

**Patient Payment Process/Point of Service**
- Contact Patient or Prescriber
- Patient Pays Cash

**GAP ANALYSIS**
- **Gap:** Clinical documentation
  - **Challenge:** Need standard structured documentation templates to record, receive, and transmit patient information electronically
  - **Solution:** CCDA Certified EHR
- **Gap:** Coding and claims submission
  - **Challenge:** Need to use industry standards to code and submit claims
  - **Solution:** Clearinghouse; Billing Service
- **Gap:** Different adjudicator
  - **Challenge:** Need to understand contract requirements and medical necessity standards
  - **Solution:** Clearinghouse
- **Gap:** Provider payment determined after service is provided
  - **Challenge:** Need to track claims, review denials, and ensure payments
  - **Solution:** Revenue Cycle; Practice Management
- **Gap:** Payment collection
  - **Challenge:** Need to follow up with patients to collect payments
  - **Solution:** Revenue Cycle; Practice Management

---

**MEDICAL BILLING CYCLE**

**Patient Care Process**
- Pre-Visit and Visit
- Patient Care
- Documentation
- Claim Generated
- Billing Service
- Clearinghouse Vendor

**Claims/Transactions Process**
- Plan Adjudication
- REVIEW
  - ACCEPTED
    - Pharmacist
    - Bill?
  - REJECTED
    - EOB SENT
    - Patient

**Patient Payment Process/Invoicing**
- Pay?
  - YES
  - END
  - NO
  - Pay?
  - NO
  - END
<table>
<thead>
<tr>
<th>Pharmacy Dispensing Software</th>
<th>Clearinghouse</th>
<th>Billing Service</th>
<th>Practice Management and/or Revenue Cycle</th>
<th>Electronic Health Record</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIPAA &amp; Regulatory Compliance</td>
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</tr>
<tr>
<td>Order entry</td>
<td>Claims compliance</td>
<td>Scheduling and Appointment</td>
<td>Scheduling and Appointment</td>
<td></td>
</tr>
<tr>
<td>E-prescribing (receiving)</td>
<td>Secure compliance</td>
<td>Patient registration and management</td>
<td>Patient registration and management</td>
<td></td>
</tr>
<tr>
<td>Dispensing</td>
<td>Coding compliance</td>
<td>Billing, claim, and remittance management</td>
<td>Billing, claim, and remittance management</td>
<td></td>
</tr>
<tr>
<td>Medication reconciliation</td>
<td>Patient billing and collection</td>
<td>Patient billing and collection</td>
<td>Patient billing and collection</td>
<td></td>
</tr>
<tr>
<td>Inventory management</td>
<td>Report and Analysis</td>
<td>Report and Analysis</td>
<td>Report and Analysis</td>
<td></td>
</tr>
<tr>
<td>Point of Service system</td>
<td>Patient portal and engagement</td>
<td>Patient portal and engagement</td>
<td>Patient portal and engagement</td>
<td></td>
</tr>
<tr>
<td>Integration with:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Electronic Health Record</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Computerized physician order entry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Barcode technology for medication administration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**PHARMACY BILLING DOCUMENTATION PROCESS**

<table>
<thead>
<tr>
<th>Order Entry Process</th>
<th>Claims and Transactions Process</th>
<th>Fill Prescription and Point of Service Approved Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Prescription Origin Codes</td>
<td>a. Eligibility</td>
<td>2. Collecting patient payment</td>
</tr>
<tr>
<td>b. Patient contact information</td>
<td>b. Co-insurance/co-pays</td>
<td>3. Counsel patient on medication</td>
</tr>
<tr>
<td>c. Patient medication, history, and disease information</td>
<td>c. Deductibles</td>
<td>Denied Payment</td>
</tr>
<tr>
<td>d. Prescriber’s information</td>
<td>d. Benefit caps</td>
<td>1. Contact PBM to resolve denial of claim; begin prior authorization process</td>
</tr>
<tr>
<td>e. Prescription information</td>
<td>e. Claim address</td>
<td>2. Contact patient and prescriber</td>
</tr>
<tr>
<td>f. Drug Information</td>
<td>f. Formulary</td>
<td>3. Patient can opt to pay out of pocket</td>
</tr>
<tr>
<td>g. Dispense as Written Codes</td>
<td>2. Submit claims</td>
<td></td>
</tr>
</tbody>
</table>

**MEDICAL BILLING DOCUMENTATION PROCESS**

<table>
<thead>
<tr>
<th>Pre-Visit and Visit</th>
<th>Patient Care</th>
<th>Claims and Transactions Process</th>
<th>Patient Invoicing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient history, prescriptions &amp; demographics</td>
<td>1. Collect: reason for encounter; medical and medication history; physical assessments; findings; &amp; lifestyle habits; diagnostic test results</td>
<td>Post Service</td>
<td>1. Review and determine contract limitations and restrictions on amounts and services patients can be billed</td>
</tr>
<tr>
<td>a. Eligibility</td>
<td>3. Plan: develop evidence based treatment plan; establish goals to achieve clinical outcomes; educate patient; &amp; follow up as appropriate</td>
<td>8. Verify deposits &amp; match 835 remittances</td>
<td>3. Provide printed copies of Billing Policy to patients when setting up payments for deferred billing process</td>
</tr>
<tr>
<td>b. Co-insurance/co-pays</td>
<td>4. Implement: initiate, modify, or discontinue medication therapy; provide self-management and education training; &amp; schedule additional appointments as needed</td>
<td>9. Resubmit claim with right insurance, prior authorization number or CCD attached</td>
<td>4. Corrective actions for non-payments</td>
</tr>
<tr>
<td>c. Deductibles</td>
<td>5. Post-visit: monitor and modify plan of care as needed; ensure clinical outcomes are consistent with treatment objectives</td>
<td>Post Payment</td>
<td>5. Collection</td>
</tr>
<tr>
<td>d. Benefit caps</td>
<td>6. Patient follow up</td>
<td>8. Resolve denials (common denials: wrong insurance, no prior authorization submitted or additional clinical documentation needed to justify severity)</td>
<td></td>
</tr>
<tr>
<td>e. Claim address</td>
<td>7. Review and determine contract limitations and restrictions on amounts and services patients can be billed</td>
<td>9. Recalculate or adjust amounts debited or credited; &amp; submit claim</td>
<td></td>
</tr>
<tr>
<td>3. Revenue cycle management:</td>
<td>1. Collect: reason for encounter; medical and medication history; physical assessments; findings; &amp; lifestyle habits; diagnostic test results</td>
<td>Post Payment</td>
<td>10. Patient follow up</td>
</tr>
<tr>
<td>a. Verify patient address &amp; obtain permission to contact for bill delivery</td>
<td>2. Verify insurance in real-time</td>
<td>8. Resolve denials (common denials: wrong insurance, no prior authorization submitted or additional clinical documentation needed to justify severity)</td>
<td></td>
</tr>
<tr>
<td>b. Provide real-time out of pocket cost estimation</td>
<td>a. Eligibility</td>
<td>9. Resubmit claim with right insurance, prior authorization number or CCD attached</td>
<td></td>
</tr>
<tr>
<td>c. Collect co-pays upfront &amp; deductibles if possible</td>
<td>b. Co-insurance/co-pays</td>
<td>Post Payment</td>
<td>10. Patient follow up</td>
</tr>
<tr>
<td>d. Obtain credit card with approval to charge up to a defined amount per co-insurance &amp; deductibles</td>
<td>c. Deductibles</td>
<td>8. Resolve denials (common denials: wrong insurance, no prior authorization submitted or additional clinical documentation needed to justify severity)</td>
<td></td>
</tr>
<tr>
<td>4. Obtain additional documents, referral, prior authorization and other approvals, if needed</td>
<td>d. Benefit caps</td>
<td>9. Resubmit claim with right insurance, prior authorization number or CCD attached</td>
<td></td>
</tr>
<tr>
<td>5. Obtain balance billing document</td>
<td>e. Claim address</td>
<td>Post Payment</td>
<td>10. Patient follow up</td>
</tr>
</tbody>
</table>

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### CONSOLIDATED CLINICAL DOCUMENT ARCHITECTURE (C-CDA) TEMPLATES

<table>
<thead>
<tr>
<th>Continuity of Care Document (CCD)</th>
<th>Consultation Notes</th>
<th>Diagnostic Imaging Report</th>
<th>Discharge Summary</th>
<th>History and Physical Notes</th>
<th>Operative Notes</th>
<th>Procedure Notes</th>
<th>Progress Notes</th>
<th>Unstructured Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical, demographic, and administrative patient information</td>
<td>Results from a provider’s request for opinion or advice from another provider</td>
<td>N/A to Pharmacists</td>
<td>Patient information for continuation of care after discharge</td>
<td>Medical report of patient’s current and past conditions</td>
<td>N/A to Pharmacists</td>
<td>Broad, encompassing patient’s non-operative procedures</td>
<td>Patient’s clinical status during an outpatient visit or hospitalization</td>
<td></td>
</tr>
</tbody>
</table>

**Required**
- Allergies
- Medications
- Problem List
- Procedures
- Results

**Optional**
- Advance Directives
- Encounters
- Family History
- Functional Status
- Immunizations
- Medical Equipment
- Payors
- Plan of Care
- Social History
- Vital Signs

**Required**
- Allergies
- Assessment
- History of Present Illness
- Physical Examination
- Plan of Care
- Reason for Visit OR Reason for Referral

**Optional**
- Personality
- Chief Complaint
- Discharge Diet
- Family History
- Functional Status
- History of Present Illness
- Immunizations
- Medications
- Problem List
- Procedures
- Results
- Review of Systems
- Social History
- Vital Signs

**Required**
- Allergies
- Assessment
- History of Present Illness
- Physical Examination
- Plan of Care
- Reason for Visit OR Reason for Referral

**Optional**
- Personality
- Chief Complaint
- Discharge Diet
- Family History
- Functional Status
- History of Present Illness
- Immunizations
- Medications
- Problem List
- Procedures
- Results
- Review of Systems
- Social History
- Vital Signs

**Required**
- Allergies
- Assessment
- Chief Complaint
- Family History
- General Status
- History of Past Illness
- Medications
- Physical Examination
- Plan of Care
- Reason for Visit OR Reason for Referral

**Optional**
- Personality
- History of Present Illness
- Immunizations
- Medications
- Problem List
- Procedures
- Results
- Review of Systems
- Social History
- Vital Signs

**Required**
- Allergies
- Assessment
- Chief Complaint
- Family History
- General Status
- History of Past Illness
- Medications
- Physical Examination
- Plan of Care
- Reason for Visit OR Reason for Referral

**Optional**
- Personality
- History of Present Illness
- Immunizations
- Medications
- Problem List
- Procedures
- Results
- Review of Systems
- Social History
- Vital Signs

**Required**
- Assessment
- Complications
- Plan of Care
- Post-procedure Diagnosis
- Procedure Description
- Procedure Indications

**Optional**
- Family History
- Functional Status
- Immunizations
- Medications
- Objective
- Physical Examination
- Problem List
- Results
- Review of Systems
- Subjective
- Vital Signs

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<table>
<thead>
<tr>
<th>Service</th>
<th>Transition of Care</th>
<th>Pharmacist Care Note</th>
</tr>
</thead>
</table>
| 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 |

<table>
<thead>
<tr>
<th>CCDA Template</th>
<th>Continuity of Care Document (CCD)</th>
<th>Progress Note</th>
</tr>
</thead>
</table>
| 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 | **Required:** 
- **Assessment:** Clinician’s impressions and diagnoses 
- **Plan of Care:** Patient care including orders, referrals, interventions, encounters, & procedures |
| | **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. | **Include:** 
- **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 |

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

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