



Playbook for Onboarding Pharmacists as Service Providers Across Commercial and Medicaid Health Plans

A practical, stakeholder-focused guide for
policy validation through go-live and performance monitoring

PHARMACIES **PHARMACISTS** **HEALTH PLANS** **TECH VENDORS**

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Overview

This playbook, developed by the [Pharmacy Interoperability and Clinical Services Alliance \(PICSA\)](#), provides a start-to-finish framework for onboarding pharmacists as recognized clinical service providers across commercial and Medicaid health plans. It supports pharmacists, health plans, and technology vendors in aligning workflows, policies, and technical infrastructure to enable billing and sustainable clinical service delivery.

PICSA is a membership-driven alliance of pharmacies, technology vendors, payers, electronic health record (EHR) vendors, and regulators led by Leavitt Partners. The Alliance is committed to advancing practical, scalable solutions that fully integrate pharmacists as clinical providers within care teams. PICSA leverages technical expertise, real-world implementation experience, and regulatory insight and leadership to advance interoperability, sustainable reimbursement, and standardized workflows that support pharmacist-provided clinical services.

Who Should Read This?

- **Pharmacists & Pharmacies** → Focus on [Phase 3 \(Clinical Encounters\)](#), [Phase 5 \(Enrollment & Directory Integration\)](#), and [Phase 6 \(Activation & Claims Readiness\)](#)
- **Health Plans** → Focus on [Phase 1](#) and [Phase 2 \(Policy & Credentialing\)](#), [Phase 5 \(Enrollment\)](#), and [Phase 6 \(Monitoring\)](#)
- **Tech Vendors** → Focus on [Phase 4 \(Technical Infrastructure, IT & Claims Configuration\)](#) and supporting [Phase 6 \(Go-Live Readiness\)](#)

Roadmap at a Glance

We begin with [section 1, the end goal: clinical encounters](#), so pharmacists and health plans know what they are building toward. Then, we move into [policy \(section 2\)](#), [technical setup \(section 3\)](#), and finally [go-live and monitoring \(section 4\)](#), representing a high-level pharmacist provider onboarding framework across stakeholder types. [Section 5](#) includes [Stakeholder Quick Guides](#) intended to clearly define phases, roles, and responsibilities to pharmacists, health plans, and tech vendors to ensure successful onboarding and ongoing clinical service delivery.

Each section corresponds to different phases of implementation relevant to specific stakeholders. For ease of navigation, each phase can be found in the below sections:

Section 1: Phase 3
Section 2: Phases 1 & 2
Section 3: Phase 4
Section 4: Phases 5 & 6
Section 5: Stakeholder Quick Guides (includes stakeholder-specific phases)

Value Proposition

Why Standardized Onboarding for Pharmacists as Providers Matters:

- **For Patients** → Improves access to care, enhances care coordination, supports medication optimization, and helps address gaps in chronic disease prevention and management.
- **For Health Plans** → Reduces avoidable utilization, improves medication adherence, supports value-based care initiatives, expands care team capacity, and helps close care gaps through pharmacist-led interventions aligned with quality measurement programs, such as HEDIS®, Medicare Star Ratings, and Medicaid Core Set measures where applicable (e.g., medication adherence, diabetes management, hypertension control, and preventive care interventions).
- **For Pharmacies & Pharmacists** → Enables sustainable reimbursement beyond dispensing margins, supports practice transformation, and creates opportunities to participate in value-based and population health programs.
- **For Tech Vendors** → Creates predictable workflows for clinical documentation, claims processing, interoperability, and performance reporting.

Section 1: The End Goal First – Clinical Encounter & Patient Care (Phase 3)

Before addressing policies and contracts, all stakeholders need to understand **what pharmacist clinical visits look like** to ensure alignment on workflows, documentation, and billing expectations.

Pre-Encounter Preparation

- **Eligibility & Coverage** → Confirm patient eligibility and verify payer coverage for pharmacist-delivered services before the encounter.
 - Includes verifying benefit coverage, applicable service codes, prior authorization requirements, and any payer-specific limitations (e.g., visit frequency, eligible settings, or provider requirements). Ensure documentation aligns with payer policies and billing requirements to reduce the risk of claim denials.
- **Review of Patient Clinical Records** → Review available clinical information, including relevant diagnoses, laboratory results, medication history, care plans, and previous healthcare encounters, to support informed clinical decision-making and identify opportunities for intervention, care coordination, or follow-up.
 - Organizations should establish processes to access and review available clinical information through EHRs, health information exchanges, payer data sources, or other authorized channels consistent with applicable privacy and security requirements.
- **Medication Review** → Reconcile current therapies, identify adherence barriers, and complete Comprehensive Medication Reviews (CMRs) as a core patient safety and quality activity.
 - CMRs support medication optimization, identification of drug therapy problems, and closure of medication-related care gaps. Health plans may incorporate CMR completion and medication management activities into broader quality improvement and population health programs.

- **Health Equity & SDOH Screening** → Identify social, economic, and environmental factors that may affect a patient's ability to access care, adhere to treatment plans, or achieve desired health outcomes, such as transportation barriers, food insecurity, housing instability, and health literacy.
 - Organizations may use structured screening tools, existing clinical assessments, or other established workflows to identify potential barriers to care. When appropriate, document relevant findings and connect patients with available community resources, care management services, or care coordination programs.

Encounter Workflow

1. **Patient Identity & Consent:** Verify two identifiers and obtain informed consent
2. **Subjective & Objective Assessment:** Gather symptoms, history, and vitals
3. **Therapeutic Evaluation:** Assess safety, efficacy, and adherence.
4. **Patient Education & Shared Decision-Making:** Use plain language and teach-back methods.
5. **Care Plan Development:** Document in system of record, preferably an EHR with clear follow-up steps

Documentation & Billing

- **SOAP Note Structure** → Subjective, Objective, Assessment, Plan
- **Coding & Modifiers** → Evaluation and management (E/M) codes (e.g., 99211–99214) with -SA modifier, if needed
- **Care Coordination Notes** → Document communications with primary care providers (PCPs)/specialists

Follow-Up & Quality

- Schedule risk-based follow-ups
- Track adherence, monitor adverse events, and coordinate care
- Collect patient satisfaction feedback and monitor outcomes (e.g., BP control, A1C)

Section 2: Policy & Administrative Setup (Phases 1 & 2)

It is imperative that stakeholders understand not only the nuances between state-defined scope of practice and the separate, but related requirements for health plan credentialing and contracting. Scope of practice determines what pharmacists are legally allowed to do, while health plan policies determine whether and how these services are recognized, reimbursed, and integrated into provider networks. These requirements vary significantly across payer types and markets. This section highlights critical components necessary to ensure pharmacists, consistent with their state scope, are appropriately credentialed and contracted with health plans to enable reimbursement for clinical services.

Phase 1: Policy & Regulatory Validation

- Confirm **state scope of practice** and prescriptive authority
- Validate **Medicaid State Plan Amendments** (SPAs) and managed care organization (MCO) coverage
- Confirm **commercial payer policies** for pharmacist billing
- Reference **accepted codes** (e.g., 99401-99404 for preventive medicine counseling; 99406-99407 for tobacco/smoking cessation counseling; 99605-99607 for Medication Therapy Management and payer or state-specific billing modifiers (e.g., -SA for services by non-physician practitioners)

Phase 2: General Credentialing & Contracting

- Determine **credentialing model** (direct vs. delegated)
- Align with **National Committee for Quality Assurance (NCQA), DataSpring (formerly CAQH), or state or health plan credentialing requirements**
- Decide on **contracting structure** (individual, group, or facility billing)
- Negotiate **fee schedules** for E/M and related services:
 - **Health Plan Contacts and Escalation:** Pharmacies should identify the appropriate health plan contacts early in the credentialing and contracting process, recognizing that responsibilities may span Provider Contracting, Provider Enrollment, Network Management, Provider Relations, and Clinical Operations. Although Provider Relations may serve as an initial point of contact, successful implementation often requires engagement with the operational teams responsible for credentialing, enrollment, and claims configuration. When existing organizational relationships with a health plan are available, they should be leveraged to facilitate onboarding and resolve issues more efficiently. State pharmacy associations and other collaborative organizations may serve as valuable partners by providing established payer relationships, implementation guidance, or escalation support when onboarding challenges arise.
- **Medicaid-specific credentialing and contracting:**
 - Review and understand the **state-by-state variations** in Medicaid enrollment (e.g., some states require individual enrollment, others allow group/facility billing).
 - **Medicaid MCOs may have unique nuances that must be considered** (e.g., delegated credentialing vs. direct enrollment).
- Establish a **real-time mechanism to monitor and report** on Outcomes, Quality Measurement, and Contract service-level agreements (SLA).

Before initiating credentialing and contracting, ensure these foundational elements are complete to avoid delays:

• Confirm National Provider Identifier Assignment

- Individual pharmacists must have an active National Provider Identifier (NPI) Type 1.
- Pharmacy locations should have NPI Type 2 for group or facility billing.

• Complete DataSpring (CAQH) Profile

- Maintain an up-to-date CAQH ProView profile with:
 - Licensure details
 - DEA registration (if applicable)
 - Liability insurance
 - Practice location and taxonomy code (183500000X)
 - Board certification and specialty credentials (if applicable)
 - Education and training history
 - Work history and professional references, as required by participating payers
- Attest every 120 days and grant access to all participating payers.

• Gather Supporting Documentation

- State license and any prescriptive authority documentation
- Professional liability coverage certificate
- Organizational documents for group/facility enrollment

• Align Pharmacy Profile

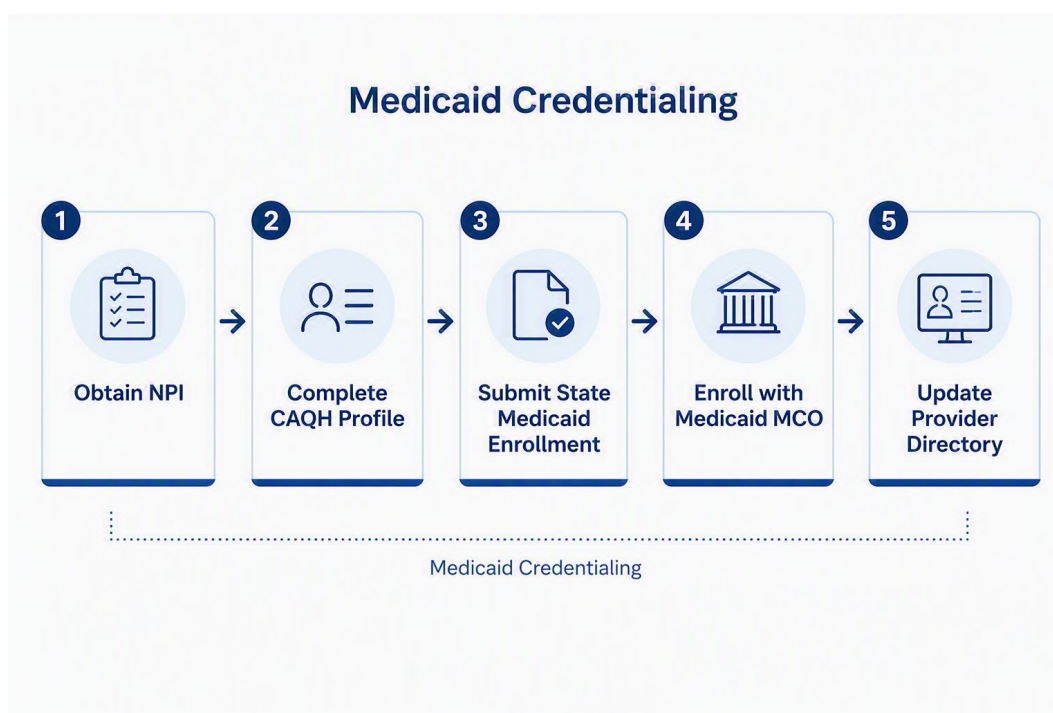
- Ensure pharmacy organizational profile matches payer requirements for delegated credentialing
- Verify address, service taxonomy, and contact details in payer portals
- Ensure consistency of demographic information across National Plan and Provider Enumeration System (NPPES, DataSpring, state Medicaid enrollment systems, and payer credentialing portals)

• Monitor Payer Portals

- Track credentialing status and respond promptly to requests for additional information
- Confirm effective dates for participation before scheduling patient encounters

• Reporting of Outcomes, Quality Measures, and Contractual SLAs

- Health plans and pharmacy organizations may use a variety of performance indicators, quality measures, contractual SLAs, and care gap metrics to evaluate pharmacist-delivered services. Reporting requirements will vary by payer, state, and contract arrangement; therefore, organizations should establish processes that support ongoing performance monitoring, quality improvement, and contractual reporting obligations.
- Establish processes to track contractual quality measures, performance guarantees, and SLAs specified in payer contracts.
- Identify reporting requirements for Medicaid agencies, MCOs, and commercial health plans.
- Develop internal reporting capabilities to monitor:
 - Clinical outcomes (e.g., A1C control, blood pressure control)
 - Medication adherence measures
 - Care gap closure activities
 - Encounter volume and service utilization
 - Contract-specific quality metrics
- Reconcile internal pharmacy performance reports with reports received from health plans or state agencies to validate accuracy and identify discrepancies.
- Establish routine review processes to assess performance trends and support quality improvement initiatives.



KEY INSIGHTS

- Credentialing and contracting vary widely across plans.
- Delegated agreements may be required if pharmacists cannot be directly credentialed.
- Include network access goals in early discussions.

Section 3: Technical Infrastructure (Phase 4)

To facilitate end-to-end clinical workflows, the technical infrastructure must be in place across pharmacies, EHRs, and health plans to adequately support patient coverage and eligibility checks, house and exchange clinical data, and enable claims and billing processes.

IT & Claims Configuration

- **Taxonomy Codes & NPI Setup** → Ensure plans accept pharmacist taxonomy codes (183500000X). Ensure payer systems recognize pharmacist taxonomy codes and are configured to support pharmacist provider enrollment, credentialing, claims adjudication, and directory display.
- **Place of Service (POS) Codes** → Map correct place of service (e.g., 01 = Pharmacy, 11 = Office). Validate payer-specific requirements regarding acceptable POS codes for pharmacist-delivered services, including in-person, telehealth, and pharmacy-based encounters.
- **Billing Workflow Integration** → Link EHR with clearinghouse for 837P submission.
- **Fast Healthcare Interoperability Resources (FHIR)/Continuity of Care Document (CCD) Exchange** → Ensure clinical documentation exchange requirements are understood and align with payer contractual obligations, including CCD, FHIR-based exchange, or other approved methods of clinical data submission (e.g., within 45 days).
- **Claims Testing** → Validate claim formats with payers.
 - **Note:** Many payers treat initial claims as live submissions.

Standards for Data Exchange and Claims

- As a new provider type, pharmacist will need clarity on how standard transactions will be used for eligibility, claims, and remittance. Health plans and pharmacies should jointly review these standards.
 - **Defined Industry Standard Transactions:**
 - **Note:** Not intended to infer that these processes/standards will or will not have to always be a batch standard/process.
 - **270/271** → Eligibility inquiry and response for pharmacist-delivered services.
 - **Digital Insurance Cards:** Digital insurance card initiatives continue to expand across the industry and may improve access to coverage and benefit information through interoperable digital formats.
 - In production and implemented by large health plans, United Health Group, Humana, Elevance, Highmark, and Blue Cross Blue Shield Independence
 - **837** → Professional claim submission for clinical/medical services.
 - **835** → Remittance advice (EOB) for payment reconciliation.
 - This information is also included in Patient Access APIs (FHIR) required to be maintained by Medicare Advantage and Medicaid Managed Care, CHIP and Marketplace health plans (clinical, claims, and encounter data and prior authorization (decision and status) information.
 - **278** → Prior Authorization Request and Response (where applicable) for pharmacist-delivered services.
 - Supports the electronic submission, review, and communication of prior authorization requests and determinations for services requiring payer approval before delivery or reimbursement.
 - Health plans, pharmacies, and technology vendors should determine when the HIPAA 278 transaction is supported versus when payer-specific prior authorization portals, FHIR Prior Authorization APIs, or other electronic submission methods are required.
 - Prior authorization decisions and status updates should be integrated into pharmacy workflows to reduce administrative burden, improve care coordination, and minimize avoidable claim denials.
 - The Centers for Medicare & Medicaid Services (CMS) Interoperability and Prior Authorization Final Rule (CMS-0057-F) was released to enhance health information exchange and improve patient access to their health records. This rule builds on previous regulations and introduces new requirements for payers to facilitate better data sharing and reduce administrative burdens related to prior authorizations. Health plans, pharmacies, and technology vendors should evaluate how interoperability requirements may support exchange of claims, encounter, prior authorization, and clinical information needed for pharmacist-delivered services.

KEY INSIGHTS

- Automating eligibility and coverage checks and denial tracking improves collection rates.
- Utilization management (UM)/prior authorization rules must be updated to recognize pharmacist-authorized services.

Section 4: Go-Live & Ongoing Management (Phases 5 & 6)

This section highlights critical elements required for deployment and sustained implementation, including enrollment processes, care team integration, and claims readiness.

Phase 5: Enrollment, Directory, and Care Team Integration

Submit **pharmacist enrollment** with Medicaid agencies and commercial plans.

- **Provider Communication & Care Team Integration:**
 - Establish processes for routine communication between pharmacists, PCPs, specialists, care managers, and other members of the care team.
 - Define methods for sharing clinical recommendations, medication-related interventions, and follow-up plans.
 - Ensure documentation and care plans are communicated through approved channels, such as:
 - EHR messaging
 - Clinical data exchange platforms
 - Develop workflows for notification of:
 - Medication therapy changes
 - Identified medication-related problems
 - Care gap interventions
 - Referrals and escalation of clinical concerns
 - Establish expectations for response times and communication responsibilities among participating providers to support continuity of care.
- Update **provider directories** for visibility in care coordination tools.

KEY INSIGHTS

- Effective pharmacist to other provider communication supports care coordination, reduces duplication of services, and improves continuity of care.

Phase 6: Activation & Claims Readiness

- Setup EHR system.
- Train providers on **billing/coding guides** and EHR workflows.
- **Pilot first claims**, monitor denials, and adjust workflows → Establish integration and testing with clearinghouses to ensure accurate 837/835 transactions. Confirm business and legal agreements with clearinghouse partners before go-live. Validate connectivity, claim routing, and remittance processes during pilot submissions to prevent downstream payment issues.
- Understand and plan for **common denial reasons** (e.g., taxonomy mismatch, missing modifier, prior authorization).
 - During initial implementation, pharmacies and health plans should jointly review denial trends to identify payer configuration issues, enrollment gaps, and workflow opportunities. Early collaboration between the pharmacy, health plan, and clearinghouse can significantly reduce payment delays and improve claims acceptance during go-live.
 - **Referring provider required:** Some health plan or clearinghouse pre-edits may incorrectly require a referring provider because system logic has not been updated to recognize pharmacists as billing providers. Health plans should review and modify these edits, as appropriate, to align with pharmacist provider policies and billing requirements.
 - **Provider not enrolled:** This denial may occur when the pharmacist has yet to complete enrollment or when enrollment is still being processed. Pharmacies should verify enrollment status and effective dates before billing. If enrollment documentation has already been submitted, pharmacies should work directly with the health plan's Provider Enrollment or Provider Relations team to reconcile enrollment records and resolve processing delays.
- **Establish reporting processes** to monitor quality measures, care gap closure activities, medication adherence outcomes, and other payer-specific performance metrics.
- **Review health plan performance reports regularly and reconcile against pharmacy-generated reports** to support quality assurance and contractual reporting obligations.
- Establish **audit readiness** with structured documentation templates. Ensure SOAP notes include elements required by Medicaid and MCOs (e.g., time spent, method of assessment).
- Track **first 60–90 days** for performance and payment consistency.



KEY INSIGHTS

- Health plans may request **encounter records** for audits within seven days.
- Early denial management and payer communication prevent downstream payment issues.

Section 5: Stakeholder Quick Guides

This section provides **role-based mini guides** so each stakeholder can easily navigate their responsibilities without needing to read the full playbook. Each guide includes **key actions, named checklists, and references to relevant phases**.

Pharmacist Quick Guide

Your Mission: Deliver payer-recognized clinical services, document them to medical standards, and ensure reimbursement.

Key Phases for You:

- **Phase 3:** Clinical Encounter & Patient Care
- **Phase 5:** Enrollment & Directory Integration
- **Phase 6:** Activation & Claims Readiness

Step-by-Step Actions:

1. **Learn the Clinical Encounter Workflow (Phase 3)**
 - Review standardized patient visit flow (preparation, encounter, documentation, follow-up)
 - Understand SOAP documentation requirements
 - Become familiar with payer expectations to verify medical necessity
2. **Prepare for Credentialing & Contracting (Phase 2)**
 - Collect required personal and organizational credentials (NPI, licensure)
 - Submit documents to health plans per their process
3. **Align Documentation & Billing Practices (Phases 3 & 4)**
 - Adopt SOAP templates aligned with payer policies
 - Understand E/M codes and required modifiers
4. **Complete Enrollment (Phase 5)**
 - Enroll as a provider with Medicaid agencies and commercial plans
 - Ensure correct taxonomy codes and directory listings
5. **Go-Live & Deliver Services (Phase 6)**
 - Begin patient encounters
 - Pilot claims and address early denials
 - Track quality metrics and patient feedback

Named Checklists:

- Clinical Workflow Readiness Checklist
- Credentialing Document Checklist
- SOAP Documentation Standards Checklist
- Billing Codes & Modifier Reference Checklist
- Payer Enrollment Checklist
- Pilot Claims Submission Checklist

Essential Tools:

- SOAP note template
- Pre-visit checklist
- Billing & coding quick reference
- Patient education materials
- Care plan & follow-up tracker

Health Plan Quick Guide

Your Mission: Enable pharmacists to function as recognized clinical providers within your network while ensuring quality and auditability.

Key Phases for You:

- **Phase 1:** Policy & Regulatory Validation
- **Phase 2:** Credentialing & Contracting
- **Phase 4:** IT & Claims Configuration
- **Phase 5–6:** Enrollment, Monitoring, & Auditing

Step-by-Step Actions:

1. **Validate Policy Alignment (Phase 1).**
 - Confirm state scope of practice for pharmacist services
 - Review of Medicaid State Plan Amendments and MCO policies
2. **Define Credentialing & Contracting Model (Phase 2).**
 - Decide if pharmacists will be individually credentialed or via delegated agreements
 - Set reimbursement rates for E/M and chronic disease management codes
3. **Configure Claims Engine (Phase 4).**
 - Add taxonomy codes for pharmacists
 - Update UM and prior authorization rules to include pharmacist-authorized services
4. **Enroll & Publicize (Phase 5).**
 - Add pharmacists to provider directories
 - Ensure network visibility for members

5. Monitor & Audit (Phase 6).

- Audit documentation for medical necessities and SOAP standards
- Collect quality metrics and patient experience data

Named Checklists:

- Policy Alignment Checklist
- Credentialing Pathway Checklist
- Reimbursement & Fee Schedule Checklist
- Claims Engine Configuration Checklist
- Provider Directory Update Checklist
- Quality Monitoring & Audit Checklist

Essential Tools:

- Credentialing checklist
- Sample contract terms
- Audit-ready documentation standards
- Provider directory update guide

Tech Vendor Quick Guide

Your Mission: Provide the technical backbone to support pharmacist billing, claims submission, and documentation workflows.

Key Phases for You:

- **Phase 4:** IT & Claims Configuration
- **Phase 6:** Go-Live Support & Denial Tracking

Step-by-Step Actions:

1. Configure Provider Setup (Phase 4).

- Add pharmacist NPI and taxonomy codes into systems.
- Map correct POS codes for pharmacy-based encounters.

2. Integrate Documentation & Billing (Phase 4).

- Ensure SOAP documentation can generate billable claims.
- Maintain documentation retention policies consistent with payer, state Medicaid, and federal program requirements. Ensure records are readily retrievable for audits, medical record requests, quality reviews, and payment validation activities.
- Align EHR workflows with clearinghouse submission standards.

3. Validate Claims (Phase 4).

- Test 837P claim submissions with payers.
- Ensure CCD/FHIR exchange aligns with payer timelines.

4. Go-Live Support (Phase 6).

- Monitor early claims for denials.
- Provide denial reason reporting and resolution support.

5. Sustainability & Reporting (Phase 6).

- Enable reporting dashboards for pharmacists and payers.
- Support updates for payer rule changes.

Named Checklists:

- NPI & Taxonomy Configuration Checklist
- POS Mapping Checklist
- EHR & Billing Workflow Integration Checklist
- Claims Testing Validation Checklist
- Denial Tracking & Reporting Checklist

Essential Tools:

- IT integration checklist
- Claim testing guide
- Sample CCD schema
- Reporting and analytics templates

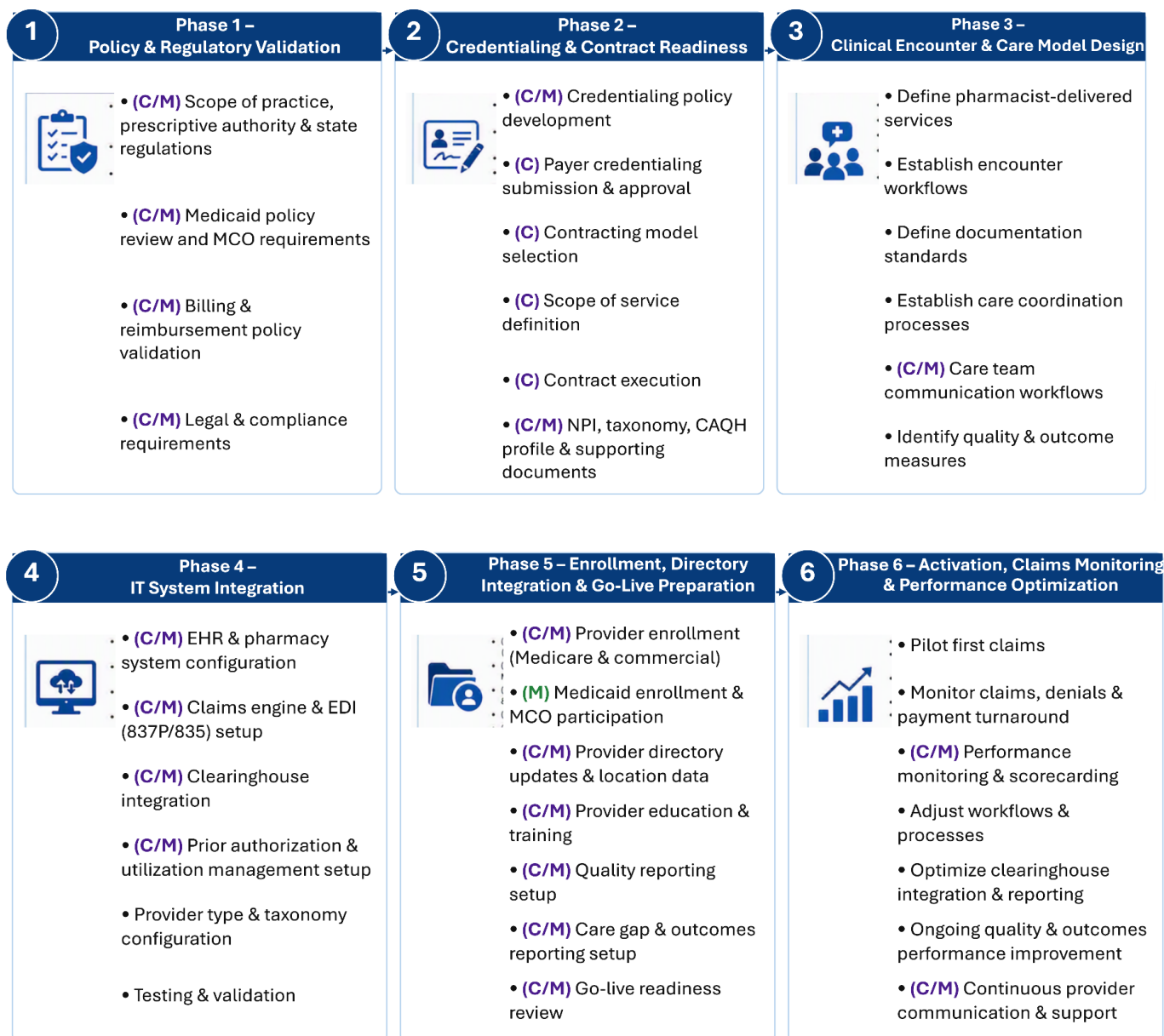
Additional Resources

In this section, find additional stakeholder resources, including the [Onboarding Workflow](#), [Pre and Go-Live Checklists](#), and [Checklist Examples](#).

Onboarding Workflow

Pharmacist Provider Onboarding Roadmap

End-to-End Workflow from Policy to Performance



Pre- and Go-Live Checklists

This timeline organizes the **20 essential checklists** required to onboard pharmacists as recognized clinical service providers. It is structured into **three phases** to ensure a smooth and compliant rollout:

- **Before Go-Live:** Foundational policy, credentialing, and workflow readiness steps
- **Go-Live Prep:** Final enrollment, system integration, and testing activities
- **Post Go-Live:** Execution, claims monitoring, and continuous quality improvement

Each checklist item builds on the previous step, ensuring pharmacists, health plans, and technology vendors are aligned for successful implementation.

 Before Go-Live	 Go-Live Prep	 Post-Go-Live
1 Policy Alignment Checklist	1 Payer Enrollment Checklist	1 Pilot Claims Submission Checklist
2 Credentialing Pathway Checklist	2 EHR & Billing Workflow Integration Checklist	2 Denial Tracking & Reporting Checklist
3 Credentialing Document Checklist	3 Claims Testing Validation Checklist	3 Quality Monitoring & Audit Checklist
4 Reimbursement & Fee Schedule Checklist	4	4 Care Plan & Follow-Up Tracker Checklist
5 NPI & Taxonomy Configuration Checklist	5	5
6 Place of Service (POS) Mapping Checklist	6	6
7 Claims Engine Configuration Checklist	7	7
8 Provider Directory Update Checklist	8	8
9 Clinical Workflow Readiness Checklist	9	9
10 SOAP Documentation Standards Checklist	10	10
11 Billing Codes & Modifier Reference Checklist	11	11
12 Pre-Visit SDOH & Adherence Checklist	12	12
13 Patient Education Material Readiness Checklist	13	13

Checklist Examples

1. Policy Alignment Checklist
2. Credentialing Pathway Checklist
3. Credentialing Document Checklist
4. Reimbursement & Fee Schedule Checklist
5. NPI & Taxonomy Configuration Checklist
6. POS Mapping Checklist
7. Claims Engine Configuration Checklist
8. Provider Directory Update Checklist
9. Clinical Workflow Readiness Checklist
10. SOAP Documentation Standards Checklist
11. Billing Codes & Modifier Reference Checklist
12. Pre-Visit SDOH & Adherence Checklist
13. Patient Education Material Readiness Checklist
14. Payer Enrollment Checklist
15. EHR & Billing Workflow Integration Checklist
16. Claims Testing Validation Checklist
17. Pilot Claims Submission Checklist
18. Denial Tracking & Reporting Checklist
19. Quality Monitoring & Audit Checklist
20. Care Plan & Follow-Up Tracker Checklist

Closing Notes

This playbook is designed to be **iterative**. Health plans, pharmacists, and tech vendors can adapt it based on feedback and local policy. The ultimate goal is to create a **sustainable, scalable model for pharmacist clinical services** that aligns with the clinical expertise of the pharmacist, current payer expectations, and improved patient care.