AETHERA · SPECIALTY BILLING SERIES

Pharmacy Billing Solutions

Maximizing Revenue Across Medicare Part D, 340B, MTM, and Specialty Pharmacy Programs

- Prepared by: Aethera Healthcare Solutions · Lakeland, FL
- Scope: CMS Part D · HRSA 340B · MTM CPT 99605–99607 · Specialty REMS
- Updated: 2026 Edition · aetherahealthcare.com · +1 (863) 694-0325

ABOUT AETHERA

Maximizing Revenue. Minimizing Burden.

Aethera Healthcare Solutions is your full-service medical billing partner headquartered in Lakeland, FL. We handle coding, claims, payments, denials, and collections — so you can focus on patients.

500+
Practices Served
across 25+ medical specialties

$12M+
Revenue Recovered
denied & underbilled claims recouped

95%
Clean Claim Rate
vs 84% industry avg

< 30d
Average AR
days in accounts receivable

01 · DIFFERENTIATOR
Personal, Not Corporate
Dedicated account team with deep specialty/payer knowledge.

02 · DIFFERENTIATOR
Performance Targets, In Writing
96%+ net collection, <5% denial, 95%+ coding accuracy, 24h posting, 48h submission, 65%+ appeal success.

03 · DIFFERENTIATOR
Zero Risk to Start
No setup fees, no long-term contracts, 90-day cancel, free 5-day audit.

PHARMACY · MARKET CONTEXT

Why Pharmacy Billing Matters Now

Pharmacy sits at the intersection of drug pricing regulation, payer consolidation, and specialty drug explosion — every dollar requires navigating four distinct reimbursement tracks.

$643B

US prescription drug spend (2024)

Largest single category of medical spend after hospital care.

50.5M

Americans enrolled in Medicare Part D (2024)

Up from 47M in 2020; 2025 redesign capped OOP at $2,000/year.

$12K+

Average annual cost of a specialty drug

Driving prior auth volume and REMS compliance burden.

2,800+

Hospitals & clinics in 340B program (2024)

Contract pharmacy model now serves >70% of covered entities.

Net effect: pharmacies that capture every payable code under Part D, 340B, MTM, and specialty drug programs can recover **4–8% of total revenue** currently lost to documentation gaps, missed MTM enrollment, and 340B eligibility misclassification.

PHARMACY · OVERVIEW

The Four Pillars of Pharmacy Billing

Each pillar serves a distinct payer, regulatory framework, and revenue mechanic.

01

01 · PART D

Medicare Part D

Outpatient drug benefit administered by PBMs; covers 50M+ seniors. Reimbursement driven by formulary tiers, DIR fees, and the 2025 OOP cap redesign.

NCPDP telecommunication · 5 protected classes

02

02 · 340B

340B Drug Pricing Program

HRSA-administered discount program (7–50% off AMP) for eligible covered entities: DSH hospitals, RHCs, FQHCs, hemophilia treatment centers, and PHSAs.

Covered entities + contract pharmacies · HRSA audit

03

03 · MTM

Medication Therapy Management

CMS-mandated service for Part D enrollees meeting 3 criteria: 3+ chronic conditions, 4+ Part D covered drugs, annual drug cost >$4,696 (2025 threshold).

CPT 99605 · 99606 · 99607

04

04 · SPECIALTY RX

Specialty Pharmacy

High-cost drugs (>$600/month) requiring prior auth, REMS enrollment, and limited distribution network (LDN) accreditation. ~50% of pharmacy gross margin.

PA + REMS + LDN · URAC/ACHC accredited

PILLAR 01 · MEDICARE PART D

Outpatient Drug Benefit & 2025 Redesign

Medicare Part D covers outpatient prescription drugs for 50.5M seniors and disabled Americans through private plans administered by PBMs. The 2025 redesign — triggered by the Inflation Reduction Act — capped annual out-of-pocket spending at $2,000, eliminated the donut hole, and shifted manufacturer liability upward. Reimbursement flows through NCPDP electronic claims with DIR (direct and indirect remuneration) fees reconciled retroactively.

Plan structure	5 protected drug classes (anticonvulsants, antineoplastics, antipsychotics, antidepressants, immunosuppressants) must be on formulary
Formulary tiers	Tier 1 (preferred generic) → Tier 6 (specialty); reimbursement drops sharply at higher tiers
DIR fees	Retroactive PBM fees; 2024 rule moved point-of-sale DIR; reconciliation window now 36 months

> Patient OOP cap of **$2,000 (2025)** shifts cost to plans — pharmacies see higher fill volume but tighter per-claim margins.

KEY METRICS

50.5M — **Part D enrollees (2024)**
Seniors & disabled Americans

$2,000 — **2025 OOP cap per patient**
Annual out-of-pocket maximum

6 — **Largest PBM market share**
CVS Caremark, Express Scripts, OptumRx = ~80% of lives

36mo — **DIR reconciliation lookback**
Window for retroactive PBM fee adjustments

PILLAR 02 · 340B DRUG PRICING

HRSA Discount Program & Contract Pharmacy Model

Created by the Veterans Health Care Act of 1992. Eligible covered entities purchase outpatient drugs at 7–50% below average manufacturer price (AMP) — savings used to expand services to underserved populations.

ELIGIBLE COVERED ENTITIES

01
DSH Hospitals
Disproportionate Share Hospital with ≥11.75% low-income utilization; largest 340B segment.

02
Critical Access Hospitals (CAH)
Rural hospitals with ≤25 beds; eligible regardless of DSH%.

03
Sole Community Hospitals (SCH)
Rural hospitals >35 miles from nearest comparable facility.

04
FQHCs & RHCs
Federally Qualified Health Centers and Rural Health Clinics; ~13,000 entities enrolled.

05
Hemophilia Treatment Centers & PHSAs
Specialized entities; Native Hawaiian, Title X clinics.

Contract Pharmacy Model
After 2010, covered entities without in-house pharmacies can contract with retail pharmacies to dispense 340B drugs. >70% of entities use contract pharmacies.

Compliance Triggers
Duplicate discounts (Medicaid + 340B), diversion to non-eligible patients, and improper recordkeeping are the top 3 OIG findings. Audits are annual.

Recent Litigation
2024 federal rulings limited HRSA enforcement over contract pharmacy restrictions; covered entities should still document intent to bill Medicaid.

PILLAR 03 · MTM

CMS-Mandated Service for High-Cost Part D Enrollees

MTM is a CMS-required service that Part D plans must offer to enrollees meeting three criteria. Pharmacists conduct comprehensive medication reviews (CMR), identify drug therapy problems, and create a personal medication list. The service generates billable CPT codes — and is dramatically under-utilized by community pharmacies.

ELIGIBILITY (ALL 3 REQUIRED)

- ≥ 3 chronic conditions
- ≥ 4 Part D covered drugs
- Annual drug cost >$4,696 (2025 threshold, adjusted yearly)

~10M Medicare beneficiaries qualify; only ~2.5M receive a CMR annually — a **75% gap**.

$ MTM is one of the only pharmacy services with direct CPT billing — every CMR represents **~ $58 in pharmacist revenue** that most pharmacies leave on the table.

CPT CODE MINI-TABLE

Code	Service	Time	Avg $
99605	Initial CMR, new patient	15 min	$58.21
99606	Follow-up CMR, established patient	15 min	$31.45
99607	Add'l 15-min increment (either code)	+15 min	$23.18

ANNUAL REVENUE PROJECTION

Per eligible patient per year: 1 initial + 3 follow-ups = ~ $152/year.

Per 1,000-patient panel: $152K/year.

PILLAR 04 · SPECIALTY PHARMACY

High-Cost Drugs, Prior Auth, REMS, and LDN Accreditation

Specialty drugs (>$600/month) treat complex chronic conditions: oncology, autoimmune, HIV, hepatitis C, MS. Despite being <2% of prescriptions, they generate ~55% of pharmacy gross margin.

Prior Authorization (PA)

Required by >85% of specialty claims. PA turnaround typically 5-15 business days; >40% of initial PAs are denied and require appeal.

REMS (Risk Evaluation & Mitigation Strategy)

FDA-mandated safety protocols for ~60 high-risk drugs (thalidomide, isotretinoin, clozapine, mifepristone). Pharmacies must enroll, document dispensing, and submit reports.

Limited Distribution Networks (LDN)

Manufacturers restrict specialty drug distribution to ~2-10 accredited pharmacies per drug. LDN accreditation requires URAC or ACHC specialty pharmacy accreditation.

Clinical Adherence Programs

Specialty pharmacies must document 80%+ adherence (PDC) for HIV, oral oncology, MS drugs; reimbursement tied to outcomes in many payer contracts.

$600+
Minimum monthly cost to qualify as specialty (industry threshold)

~55%
Share of pharmacy gross margin from specialty drugs

5-15 days
Typical prior auth turnaround for specialty Rx

Accreditation: Aethera partners with URAC-accredited and ACHC-accredited specialty pharmacies; we manage PA, REMS, LDN enrollment, and adherence documentation end-to-end.

PHARMACY · BILLING CODES

CPT/HCPCS Codes & 2026 National Average Reimbursement

Codes for pharmacist-provided services. Drug product billing uses NCPDP D.0 telecommunication claims (not shown here).

Code	Service Description	Setting	Avg $	Documentation Required
99605	Initial MTM/CMR, new patient, 15 min	Outpatient pharmacy	$58.21	Personal medication list + written summary to patient
99606	Follow-up MTM, established patient, 15 min	Outpatient pharmacy	$31.45	Updated medication list + intervention notes
99607	Add'l 15-min MTM increment (append to 99605/99606)	Outpatient pharmacy	$23.18	Time log + intervention documentation
90471	Immunization administration, first vaccine	Pharmacy/clinic	$25.96	Vaccine type, lot #, manufacturer, site, route
90472	Immunization administration, each additional vaccine	Pharmacy/clinic	$16.36	Same as 90471 for each additional vaccine given same visit
90630	Influenza vaccine, quadrivalent, preservative-free	Pharmacy product	$20.94	Lot #, expiration, manufacturer
90686	Fluzone high-dose influenza vaccine, ≥65 yrs	Pharmacy product	$66.86	Patient age verification
90715	Tdap vaccine, ≥7 yrs	Pharmacy product	$48.55	Patient age + prior Tdap history
90371	RSV monoclonal antibody (nirsevimab) administration	Pharmacy/clinic	$449.10	Patient age, weight, RSV season documentation
G2010	Real-time benefit check (RTBC) by pharmacy	Pharmacy	$0.10	NCPDP transaction with payer RTBC response
G2012	Real-time benefit check w/ alternative drug	Pharmacy	$0.10	RTBC response including formulary alternatives

Modifier 25 — Append to E/M services on the same day as a procedure (e.g., MTM + vaccine admin).

NCPDP D.0 — Pharmacy claims use NCPDP telecommunication format, NOT CMS-1500. Pharmacy claims bypass CPT for drug product billing.

PHARMACY · DENIAL PREVENTION

Top 8 Denial Reasons & How Aethera Prevents Each

Pharmacy denial rates average 6-9%; each denied claim costs $25-118 to rework. Prevention is 10-20× cheaper than appeal.

RED — 23%
Prior auth missing
Root cause: Specialty drug billed without PA on file or PA expired
Aethera: Submits PA before dispensing; auto-flags 5-day renewals

RED — 18%
Drug not on formulary
Root cause: Patient plan formulary tier > drug billed
Aethera: Real-time benefit check (RTBC) at point-of-sale; alternative drug suggestion

AMBER — 14%
Refill too soon
Root cause: Days supply overlap with previous fill
Aethera: Eligibility check verifies last fill date before claim submission

AMBER — 11%
340B duplicate discount
Root cause: Drug billed to Medicaid as both 340B and rebate-eligible
Aethera: Medicaid billing flag prevents duplicate claim submission

AMBER — 9%
REMS documentation missing
Root cause: Specialty drug requires REMS enrollment; pharmacy didn't document
Aethera: REMS database tracks enrollment + auto-prompts at fill

GREEN — 8%
MTM time threshold not met
Root cause: 99605/99606 billed without 15-min time log
Aethera: Pharmacist time tracking with 1-min granularity

GREEN — 7%
Invalid days supply
Root cause: Days supply > maximum allowed by plan (typically 90 days)
Aethera: Days-supply rules engine enforces plan limits

GREEN — 6%
Patient coverage terminated
Root cause: Plan eligibility lapsed between fill and claim adjudication
Aethera: Daily eligibility verification for chronic-fill patients

Cumulative impact: Aethera's denial prevention workflow reduces pharmacy denial rate from industry avg 8% to < 4% — recovering ~$45K/year per 10,000 fills.

CASE STUDY · INTEGRATED PHARMACY RCM

Independent Community Pharmacy — Annual Revenue Impact

A 12,000-patient pharmacy models the combined upside of disciplined MTM billing, 340B optimization, and specialty drug prior auth recovery.

MTM Enrollment

- 2,400 eligible Part D patients (20% of panel)
- 60% enrolled in MTM (1,440 patients)
- Avg 1 initial CMR + 3 follow-ups per year

Per patient/year: $152

$218,880
ANNUAL REVENUE

340B Optimization

- Contract pharmacy for 1 FQHC, 3,200 340B-eligible patients

Avg 340B margin: $12/Rx (after PBM fees)

- 3,200 patients × 8 Rxs/year × $12

$307,200
ANNUAL REVENUE

Specialty PA Recovery

- 180 specialty Rx patients

PA approval before Aethera: 58%
PA approval after Aethera: 84%

- Recovered specialty fills: 47/year

Avg specialty margin: $325/fill

$15,275
ANNUAL REVENUE

Combined annual revenue recovery: $541,355. *Implementation cost (year 1): ~ $84K (MTM platform + pharmacist FTE). Year-1 net: $457,355. Per-pharmacist per-year: ~$114K.*

PHARMACY · COMPLIANCE HOTSPOTS

Where OIG, HRSA, and FDA Auditors Look First

Top compliance risks across the four pharmacy pillars. Quarterly self-audits on each are non-optional.

Medicare Part D	340B Drug Pricing	MTM	Specialty Pharmacy
RED **DIR reconciliation errors** — retroactive fees not properly booked, leading to overstated revenue.	RED **Duplicate discounts** — same drug billed to Medicaid as both 340B and rebate-eligible; HRSA recovers 3× the discount.	HIGH **Time documentation fraud** — 99605/99606 billed without 15-minute time log; OIG Work Plan 2025-2026.	RED **REMS non-compliance** — dispensing REMS drug without pharmacy enrollment or patient enrollment documentation.
AMBER **Protected class formulary gaps** — plan not covering one of the 6 protected classes; beneficiary access complaint.	RED **Diversion to non-eligible patients** — 340B drug dispensed to patient of non-covered entity; recordkeeping audit.	MEDIUM **Eligibility misclassification** — patient enrolled in MTM without meeting 3+ chronic / 4+ drug threshold.	AMBER **LDN accreditation lapse** — dispensing limited distribution drug after accreditation expiration.
GREEN **Refill-too-soon overrides** — pharmacist override frequency flagged in PBM audit.	AMBER **Contract pharmacy arrangement documentation** — missing contract, missing patient eligibility attestations.	LOW **CMR documentation stale** — personal medication list not updated within 12 months.	LOW **Adherence documentation gaps** — PDC <80% not flagged in payer outcome report.

HRSA 340B audits recovered > $2.3B from covered entities in 2023; OIG Work Plan 2025-2026 explicitly lists 340B duplicate discounts and MTM time documentation as active audit targets.

CLOSING · KEY TAKEAWAYS

Three Actions to Capture Pharmacy Revenue

For pharmacy directors and owners leading the next 90 days.

01

Stand up an MTM enrollment pipeline

Query Part D eligibility files for patients meeting 3+ chronic / 4+ drug / $4,696+ thresholds. Assign pharmacist to enroll 20 patients/week. Target 60% enrollment of eligible panel — worth ~$150K/year per 1,000 eligible patients.

02

Audit 340B contract pharmacy claims

Review last 100 340B claims for patient eligibility, drug eligibility, and site-of-service documentation. Run Medicaid cross-billing report monthly to prevent duplicate discounts. HRSA recovers 3× the discount on confirmed duplicates.

03

Automate specialty PA workflows

Build EHR alert for every specialty Rx requiring PA. Auto-submit within 24h of prescriber order. Track 5/10/15-day turnarounds; escalate appeals at day 12. Recovering 25% of currently-denied specialty PAs adds ~$15K per 180 specialty patients.

Questions & Discussion

Optimizing Pharmacy Revenue Across Part D, 340B, MTM & Specialty

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