

CASE STUDY EXAMPLES

Pharmacists Working in Collaboration With Physicians and Other Health Care Professionals



**Pharmacy Health Information
Technology Collaborative**



Table of Contents

1. Purpose.....	3
2. Overview	4
3. Discussion.....	5
3.1. PSTAC Use Case Submitted for MTM Services CPT Codes	5
3.2. National Council for Prescription Drug Programs MTM Specialized Transaction Uses.....	7
3.3. Research Briefs.....	8
4. Summary	11
5. Appendix	12
6. Acknowledgements.....	13
7. References	14



1. PURPOSE

The purpose of this guidance document is to outline case study examples of pharmacists working in collaboration with physicians and other health care professionals to achieve their practice goals in terms of improving patient care and quality and reducing total cost of care. The objective will be to feature medication therapy management (MTM) services in vignette form to illustrate the value of these services in future health care delivery and payment models.

Goals

- Expand the *Current Procedural Terminology* (CPT) vignettes of MTM services to more fully describe the services of team-based care.
- Align MTM services with the three-part national aim: better care, better health, and lower cost of care.
- Enhance and update content in use-case scenarios and to serve as a resource for health information technology (IT) implementation and adoption.
- Help external stakeholders understand MTM services in the context of redesigning health care delivery and financing models.

Recommendations for Action

- Further define the use-case studies of MTM services.
- Encourage the development of a resource guide to help other health care professionals, practices, and organizations to build a framework for accountable medication use of pharmacists in new health care delivery and financing systems.
- Discuss the value of pharmacists providing MTM services in terms of time and resources needed to demonstrate outcomes leading to improvement in patient care.

Recommendations for External Stakeholders

- Integrate pharmacists into pay-for-value and global, population-based health care delivery and financing (payment for performance).¹



2. OVERVIEW

Defining a resource guide for accountable medication use that integrates pharmacists into new health care delivery and financing models will help other health care professionals, practices, and organizations manage patient medication outcomes and improve patient care.

Background on Three-Part Aim

One of the goals of this paper is to align MTM services with the three-part aim of the Centers for Medicare & Medicaid Services (CMS): better care and better health at lower cost.

The Centers for Medicare & Medicaid Services has released a proposed rule that would implement the Patient Protection and Affordable Care Act (Affordable Care Act) provisions relating to Medicare payment to providers of services and suppliers participating in Accountable Care Organizations (ACOs). Under these provisions (found in Section 3022 of the Affordable Care Act) beginning January 1, 2012, providers of services and supplies may be eligible for additional Medicare payments based on meeting certain specified quality and savings requirements.

CMS states that ACOs are intended to be part of a program “that promotes accountability for a patient population and coordinates items and services under [Medicare] parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.” The aim of the program, referred to by CMS as the “three-part aim,” is (1) better care for individuals, (2) better health for populations, and (3) lower growth in expenditures. The quality standards for ACOs would focus on five key areas:

- *Patient/caregiver care experiences*
- *Care coordination*
- *Patient safety*
- *Preventive health*
- *At-risk population/frail elderly health*

Please contact any member of Dorsey’s Health group for more information regarding the proposed rule.

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http://www.dorsey.com/EU_ACOProposedRuleIssued_040111/,
accessed July 21, 2014.



3. DISCUSSION

- 3.1. PSTAC Use Case Submitted for MTM Services CPT Codes
- 3.2. National Council for Prescription Drug Programs MTM Specialized Transaction Uses
- 3.3. Research Briefs

3.1. PSTAC USE CASE SUBMITTED FOR MTM SERVICES CPT CODES

Pharmacist Services Technical Advisory Coalition (PSTAC) was founded in 2002 to improve the coding infrastructure necessary to support billing for pharmacists' professional services. In July 2011, PSTAC was renamed and its work was rolled into the Pharmacy HIT Collaborative initiatives. The Pharmacy HIT Collaborative (formerly PSTAC) works to provide the national leadership necessary to position and secure pharmacy's place in the electronic data interchange health encounter/claims processing and payment environment concerning all health care providers' professional services.

MTM Services Code Model

MTM services describe face-to-face patient assessment and intervention, as appropriate, by a pharmacist. MTM services is provided to optimize the response to medications or to manage treatment-related medication interactions or complications.

MTM services include the following documented elements: review of the pertinent patient history, medication profile (prescription and nonprescription), and recommendations for improving health outcomes and treatment adherence. The CPT codes are not to be used to describe the provision of product-specific information at the point of dispensing or any other routine dispensing-related activities.

99605 - MTM service(s) provided by a pharmacist, individual, face to face with patient, initial 15 minutes, with assessment, and intervention if provided; initial 15 minutes, new patient

99606 - initial 15 minutes, established patient

99607 - each additional 15 minutes (list separately in addition to code for the primary service)

(Use 99607 in conjunction with 99605, 99606)

Rationale

Three codes—99605, 99606, and add-on code 99607—and guidelines have been established to report the provision of MTM services. These services are provided by a pharmacist to optimize the response to medications or for the management of treatment-related medication problems or complications. MTM services are initiated at the request of the patient and/or caregiver, payer, pharmacist, and/or other health care provider. These codes are not to be used to describe the provision of product-specific information (e.g., product information leaflets) at the point of dispensing or any other routine dispensing-related activities (e.g., professional time related to preparation or delivery of the medication).

In provision of MTM services, the review of the pertinent patient history and medication profile will include the evaluation of prescription medications, over-the-counter (OTC) and herbal medications, and/or physician samples. The pharmacist will inventory the medication list to identify and/or resolve drug therapy problems such as duplications, under- or overdosing,



and drug interactions or other types of therapy-related issues. The pharmacist may discover medications that need to be added or stopped. This service may include communication of management recommendations to the prescriber.

Each medication is assessed to determine its effectiveness and adverse effects. A follow-up monitoring call is included in MTM services to determine if symptoms are resolving or the patient is experiencing adverse effects and to assess adherence.

Assessment will be performed to determine the patient's adherence to medication recommendations. The pharmacist will educate the patient and monitor reaction to new and changed prescriptions and to OTC medications.

Similar to other codes series in the CPT codebook, these codes have been structured to report the initial and more intensive encounter service with code 99605. The subsequent encounter, reported with code 99606, is intended to be reported for services provided that are similar to the initial encounter, with an emphasis on updating information provided at the initial encounter, assessment of patient adherence, and reactions and further evaluation of medications that have been added to the patient's therapy vis á vis those previously assessed. Add-on code 99607 is reported in addition to codes 99605 and 99606 for each additional 15 minutes of service beyond the initial service.

Clinical Vignettes

99605: A 66 year-old female with pre-existing osteoporosis has been diagnosed with type 2 diabetes and hyperlipidemia. Initial medication therapy assessment and intervention is performed.

Pre Service

Obtaining patient intake information, gathering or preparing materials that will be used during the patient encounter, and coordinating with other support staff.

Intra Service

Assessment of the patient may include obtaining a patient medical and medication (e.g., prescription and nonprescription) history; determining appropriateness of medication therapy (supra- or sub-optimal); performing a review of relevant systems; evaluating pertinent lab data; assessing potential or existing drug-drug, drug-disease, and drug-nutrient interactions; establishing and/or obtaining such additional information (e.g., obtaining information from other medical records) as may be necessary; and developing a care plan including recommendations for optimizing medication therapy.

Pharmacist interventions may include providing education, training, and resources; administering medication; formulating a treatment and/or follow-up plan; providing recommendations for disease prevention; and evaluating the patient's knowledge of medication and willingness to implement recommendations.

Post Service

Post service includes documentation of the patient encounter, non-face-to-face interventions and recommendations, referrals, communication with other health care professionals, administrative functions (including patient and family communications) relative to the patient's care, and as appropriate, scheduling of follow-up appointment(s).



99606: A 66-year-old female with osteoporosis, type 2 diabetes, and hyperlipidemia is receiving follow-up reassessment after receiving a prior MTM service.

Pre Service

Obtaining patient intake information, gathering or preparing materials that will be used during the patient encounter, and coordinating other support staff.

Intra Service

Assessment of the patient may include obtaining or updating a patient medical and medication (prescription and nonprescription) history; performing reviews of relevant systems; reviewing pertinent lab data; assessing potential or existing drug–drug, drug–disease, and drug–nutrient interactions; evaluating medication-related adverse events and toxicities; assessing medication effectiveness; organizing and interpreting the data; establishing and/or obtaining such additional information (e.g., obtaining information from other medical records) as may be necessary; assessing any recent change in medication therapy or a new medication therapy–related problem; and developing a care plan including recommendations for optimizing medication therapy.

Pharmacist interventions may include providing reinforcement of education, training, and resources; modifying therapy; administering medication; formulating a treatment and/or follow-up plan; providing recommendations for disease prevention; re-evaluating the patient’s knowledge of medication; and evaluating knowledge and willingness to follow new recommendations.

Post Service

Post service includes documentation of the patient encounter interventions and recommendations, referrals, communication with other health care professionals, administrative functions (including patient and family communications) relative to the patient’s care, and as appropriate, scheduling of follow-up appointment(s).

99607: Intra Service

The service(s) continued for an additional 15 minutes with the same patient.²

3.2. NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS MTM SPECIALIZED TRANSACTION USES

National Council for Prescription Drug Programs (NCPDP) Specialized Transaction was developed for transmitting information electronically among prescribers, providers, payers, pharmacies, and other entities for MTM, census events, central fill functions, and other transactions.

The request for MTM services may also be initiated by the treating or prescribing physician, pharmacist, a hospital or other facility and/or the patient or caregiver. A frequent trigger for the request for MTM services is the complexity of the medication regimen or considerations of the therapy in light of one or more chronic or multisystem impacting conditions. The requestor or receiving MTM provider will need to determine if the service is covered for the patient and if necessary obtain approval for the service as defined by the payer.

1. *Request for pharmacist consultation (e.g., practitioner requests that pharmacist counsel patient on medication usage, adverse effects, administration, etc.)*



2. *Request for medication reconciliation and patient instruction (e.g., primary care practitioner requests that pharmacist review medications prescribed by multiple practitioners, identify and resolve duplicate therapies, and consolidate into a medication regimen that the patient can understand and successfully follow)*
3. *Request for medication reconciliation and monitor ongoing therapy to ensure continuity of care (e.g., practitioner requests that pharmacist review medications of patient being discharged from a hospital to a supported living facility or from a post-acute care setting to home to ensure that the treatment regimen is maintained)*
4. *Medication administration (e.g., practitioner requests that pharmacist administer an injectable medication to patient)*
5. *Adherence (e.g., practitioner requests that pharmacist or MTM provider monitor patient's adherence to a particular medication or treatment regimen)*
6. *Lab testing (e.g., practitioner requests that pharmacist or MTM provider periodically monitor patient's blood levels while taking a certain medication)*
7. *Request by caregiver for patient with multiple chronic conditions for pharmacist assistance in consolidation of the medication regimen into a rational dosing plan (e.g., substitution of long-acting medication for multiple daily doses or adjustment of dose timing)³*
8. *Caregiver request to pharmacist for synchronization of medication fill dates, laboratory orders, and follow-up visits to support better adherence for fragile patients and those with limited transportation and/or other resources⁴*

3.3. RESEARCH BRIEFS

Hospital Readmissions

This topic covers care coordination and discharge planning that promotes medication adherence and helps avoid unplanned hospital readmissions.

1. The Effect of a Collaborative Pharmacist–Hospital Care Transition Program on the Likelihood of 30-Day Readmission was published in the May 2014 edition of the *American Journal of Health-System Pharmacy*. This study evaluated the effect of a collaborative pharmacist–hospital care transition program on the likelihood of 30-day readmission.⁵
2. Reducing Preventable Hospital Readmissions Through a Pharmacist-Led Care Transition Intervention, a poster presentation delivered at the American Pharmacists Association (APhA) Annual Meeting in March 2014, shows how our care transition program, WellTransitions[®], encompasses the retrieval of community pharmacy medication histories, delivery of medications to the bedside at discharge, prescription therapy planning, and follow-up reminder calls to encourage medication adherence and to monitor health outcomes.⁶
3. How Health Systems Could Avert ‘Triple Fail’ Events That Are Harmful, Are Costly, and Result In Poor Patient Satisfaction, published in the April 2013 edition of *Health Affairs*, discusses a novel approach to tackling the triple aim that identifies, stratifies, and prioritizes groups of patients who are at risk for health outcomes that are simultaneously expensive, low quality, and represent a poor patient experience.⁷

Medication Assessment and Reconciliation

4. Post Discharge Pharmacist Medication Reconciliation: Impact on Readmission Rates and Financial Savings was published in the *Journal of the American Pharmacists Association (2003)*. The objective of this article is to assess the impact of ambulatory



clinical pharmacist medication therapy assessment and reconciliation for patients post discharge in terms of hospital readmission rates, financial savings, and medication discrepancies.⁸

Immunizations

5. Increasing the Uptake of Herpes Zoster Vaccinations via Community Pharmacies, a poster presentation at the American Academy of Dermatology 72nd Annual Meeting, investigated the uptake of herpes zoster vaccinations in community pharmacies and the influence of state-authorized pharmacist immunization privileges on vaccination uptake rates.⁹

Medication Adherence

6. An Evaluation of a Retrospective Drug Utilization Review Program for the Treatment of Psoriasis, a poster presentation at the Academy of Managed Care Pharmacy 2013 Annual Meeting, evaluated a retrospective drug utilization review program designed to identify patients with psoriasis prescribed a dose inconsistent with the manufacturer recommended dosing for psoriasis.

Worksite Clinics

7. The Impact of a Worksite Weight Management Program on Obesity: A Retrospective Analysis, published online in the April 2014 edition of *Population Health Management*, examined the efficacy of a worksite weight management program on the reduction of weight and lipid levels in employees and their dependents.¹⁰

Other Resource Briefs

8. Economics of using pharmacists as advisers to physicians in risk-sharing contracts. *Am J Health Syst Pharm*. April 1, 2000;57:753-5. Available at <http://www.ajhp.org/content/57/8/753.abstract?sid=ee249805-44a1-43a1-af92-db9bdc5264e7>.
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13. Integrating medication therapy management in the primary care medical home: a review of randomized controlled trials. *Am J Health Syst Pharm*. February 15, 2011;68:335-45. Available at <http://www.ajhp.org/content/68/4/335.abstract?sid=3b836c50-5bbb-4593-acbe-4e53351216b9>.
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15. Hospital Pharmacist-Hospitalist Collaboration: Improving Glycemic Control



in Hospitalized Patients. Available at <http://www.ashpfoundation.org/HospitalistPublishedResearch>.

16. Hospitalist and Pharmacist VTE Treatment Protocol Collaborative. Available at <http://www.ashpfoundation.org/HospitalistPublishedResearch>.



4. SUMMARY

This guidance document provides case study examples of pharmacists working in collaboration with physicians and other health care professionals to achieve their practice goals in terms of improving patient care and quality and reducing total cost of care. The objective will be to feature MTM services in vignette form to illustrate the value of these services in future health care delivery and payment models. The goals of the document are to (1) expand the CPT vignettes of MTM services to more fully describe the services of team-based care, (2) to align MTM services with the three-part national aim; better care, better health, and at lower cost, (3) to enhance and update content in use-case scenarios and to serve as a resource for health IT implementation and adoption, and (4) to help external stakeholders understand MTM services in the context of redesigning health care delivery and financing models.

The document outlines industry recommendation to (1) further define the use case studies of MTM services, (2) encourage the development of a resource guide to help other health care professionals, practices, and organizations build a framework for accountable medication use of pharmacists in new health care delivery and financing systems, and (3) to discuss the value of pharmacists providing MTM services in terms of time and resources needed to demonstrate outcomes leading to improvement in patient care. In addition, the document recommends that external stakeholders use this guidance document to integrate pharmacists into pay-for-value and global, population-based health care delivery and financing (payment for performance).

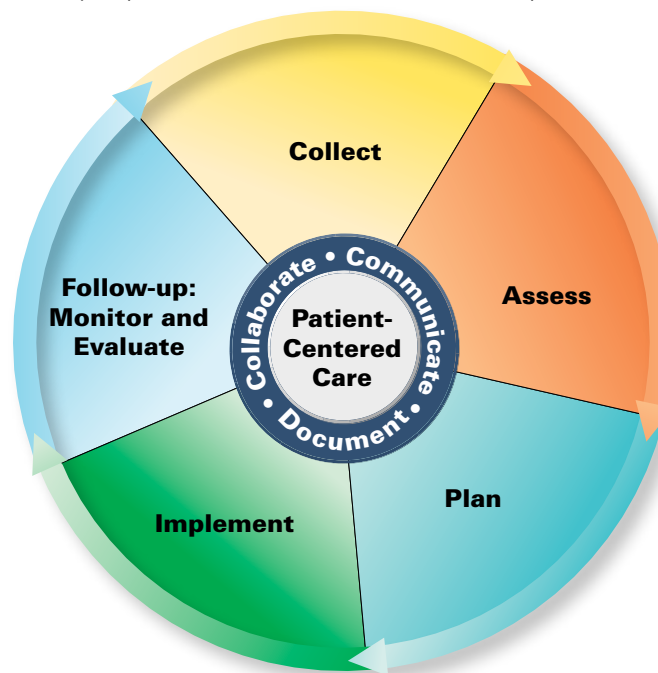


5. APPENDIX: DIAGRAM OF A STANDARDIZED PHARMACIST PATIENT-CENTERED COLLABORATIVE CARE PROCESS

The figure depicts a proposed standardized pharmacist patient-centered collaborative care process for pharmacists providing medication therapy management (MTM) services. The pharmacists' patient care process described in this illustration was developed by examining a number of key source documents on pharmaceutical care and MTM. Patient care process components in each of these resources were catalogued and compared to create the following process that encompasses a contemporary and comprehensive approach to patient-centered care that is delivered in collaboration with other members of the health care team. [Source: Pharmacists' Patient Care Process, May 29, 2014. http://www.pharmacist.com/sites/default/files/JCPP_Pharmacists_Patient_Care_Process.pdf]

Pharmacists' Patient Care Process

The Joint Commission of Pharmacy Practitioners, a coalition of national pharmacy associations that includes APhA, recently adopted the Pharmacists' Patient Care Process to promote consistency in patient care delivery within the profession.



Source: http://www.pharmacist.com/sites/default/files/JCPP_Pharmacists_Patient_Care_Process.pdf

Pharmacists' Patient Care Process

Pharmacists use a patient-centered approach in collaboration with other providers on the health care team to optimize patient health and medication outcomes.

Using principles of evidence-based practice, pharmacists:

Collect

The pharmacist assures the collection of the necessary subjective and objective information about the patient in order to understand the relevant medical/medication history and clinical status of the patient.

Assess

The pharmacist assesses the information collected and analyzes the clinical effects of the patient's therapy in the context of the patient's overall health goals in order to identify and prioritize problems and achieve optimal care.

Plan

The pharmacist develops an individualized patient-centered care plan, in collaboration with other health care professionals and the patient or caregiver that is evidence-based and cost-effective.

Implement

The pharmacist implements the care plan in collaboration with other health care professionals and the patient or caregiver.

Follow-up: Monitor and Evaluate

The pharmacist monitors and evaluates the effectiveness of the care plan and modifies the plan in collaboration with other health care professionals and the patient or caregiver as needed.



6. ACKNOWLEDGEMENTS

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