

ASHP Guidelines for Implementing and Obtaining Compensation for Clinical Services by Pharmacists

For some time, pharmacies in organized health-care settings have been moving from a product-centered structure to a more patient-oriented clinical practice. Clinical pharmacy services or patient-oriented pharmaceutical services are now a recognized and necessary component of health care. However, new trends in reimbursement, such as prospective pricing and capitation payments, provide different incentives for hospitals—to manage in terms of product lines instead of patient services.

In such a financial environment, it is essential that the value of any nonproduct-centered service be well documented and that the service be cost-justifiable. Pharmacists planning to initiate new clinical services may have to meet certain administrative requirements, including the following: (1) to provide an accurate accounting of all of the resources required; (2) to delineate the costs of the service and its effect on patient outcomes; (3) to obtain approval from the institution's administration and medical staff for provision of the service on a routine basis; and (4) to identify an appropriate mechanism for patient charging and for obtaining reimbursement or payment^d from the third-party payer.

Generally, third-party payers do not have formal policies that prohibit their reimbursing and paying providers for clinical pharmacy services. However, payment is predicated on acceptance and endorsement of the service by the involved administrative and medical staffs and by the third-party payer's formal review and approval of the benefit coverage (and, in the case of patients covered by private insurance plans, by the provision of the service as a covered benefit of their plan). Approval of reimbursement for clinical services, however, varies from area to area and from carrier to carrier.

This document presents a set of general guidelines for use in obtaining administrative support and subsequent reimbursement or payment for a new pharmaceutical service. Often, many steps of the process may be omitted. For example, it should not be necessary to conduct a preliminary trial of a widely accepted, though not universally adopted, service (such as use of patient medication profiles). However, a careful review of the literature may be necessary for documenting the direct impact of the new service on expenses and determining whether or not the proposed new service will generate a revenue surplus. With fixed reimbursement, hospital administrators are unlikely to approve any new service unless its benefits are fully documented and unless its result is an overall savings.

When clinical pharmacy services are initially established in the hospital, they should be viewed as an important component of the drug use continuum, not as a separate entity. After establishment of the initial clinical services at the hospital, the approach to obtaining additional clinical services should focus on patient audit results and on the approval of the pharmacy and therapeutics (P&T) committee.

These guidelines are written for use by pharmacy directors in hospitals. However, they can be adapted for use in other situations (e.g., by a pharmacist providing services as part of a medical group practice or a health maintenance organization).

The guidelines are as follows:

1. Prepare, for the provider's administration, a written proposal for short-term (e.g., 3 months) implementation of the proposed service. The proposal should include the following elements:
 - a. A clear, concise description of the service.
 - b. The rationale for the service, including published references if available.
 - c. Written support for the service by the P&T committee and other appropriate parties (e.g., infections committee, department of nursing, and applicable medical services).
 - d. The expected benefits of the service to patients and the institution in terms of costs and quality of care, as measured by indices such as decrease in length of stay, decrease in incidence of therapeutic failures, decrease in duration of therapy, and decrease in drug expenditures. *This is the most important section of the document; for the proposal to receive administration approval, the available information and calculations must prove that the benefits exceed the costs of providing the service.*
 - e. Estimated startup and operating expenses and revenue^b of the service, plus its personnel, equipment, and material requirements.
2. Obtain the administration's formal approval of the implementation project.
3. Initiate the project, keeping complete records of all expenses, outputs (e.g., the number of patient consultations), and personnel hours devoted to it. In addition to the indices listed in Item 1d, the following elements should be documented: changes in length of stay, costs of treatment, and changes in levels of personnel productivity. This information will be needed to develop charges for the service and to obtain reimbursement or payment.
4. On completion of the project, prepare a report of its implementation for the administration. This report should focus on fiscal and workload data, including total pharmacy cost per patient, service unit, or diagnosis-related group, and a suggested charge based on these data. Information on acceptance of the program by patients and staff should be included when possible. This report should also project the manpower and financial resources needed to perform the service as a routine pharmacy function.
5. Obtain formal approval from administration to implement the service on an institutionwide basis.
6. Assist the institution's administration and financial manager in developing the information needed to include the costs of the service in its compensation agreements with third-party carriers. To obtain compensation, certain administrative requirements (such as formal approval of the service by the P&T committee) may have to be met.
7. Regularly evaluate the objectives and impact of the new program or service, based on changes in payment

mechanisms, and prepare annual updates on these clinical pharmacy services. For example, it will become important to report annual cost savings or decreased readmissions over a baseline figure.

^aGenerally, payment refers to prospective compensation, and reimbursement refers to retrospective compensation.

^bIn cooperation with the provider's fiscal offices, and depending on the acceptance of the service within the health-care system, the pharmacy department should determine whether payment for the service can or should be received.

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