

ASHP Statement on Third-Party Compensation for Clinical Services by Pharmacists

Historically, institutional pharmacists have been concerned primarily with dispensing drugs and secondarily with providing drug-related information. With the major increase in the number, potency, and toxicity of drugs in recent years, pharmacists are increasingly providing clinical services. This means that the primary focus of institutional pharmacy practice is shifting from a system of drug distribution to one of drug use control, which includes both drug distribution and provision of information. Therefore, a substantial portion of many pharmacies' total expenses and workload relates to patient service activities. These activities, which are not directly related to drug dispensing, are described in the "ASHP Statement on Clinical Functions in Institutional Pharmacy Practice."¹

Clinical pharmacy services and rational drug therapy are essential components of total patient care and contributing factors to the reduction of patient-care costs. Federal and state legislation and regulations and numerous private standards^a recognize the benefits of clinical pharmacy services and strongly encourage, if not require, the provision of these services to patients in organized health-care settings. To maintain clinical pharmacy services in organized health-care settings, the following principles should be noted by health-care administrators, third-party payers, and pharmacy managers:

1. Currently, many types of third-party payment systems are in use, including such diverse payment mechanisms as Medicare prospective pricing (e.g., diagnosis-related groups), capitated payments for health maintenance organizations, and cost-based reimbursement for commercial third-party insurance. Each third-party payer may use different payment or reimbursement mechanisms,^b and each hospital's reimbursement may vary by its location, its primary third-party payer, and its case mix. Therefore, pharmacy managers must be cognizant of the types of compensation received by their individual hospitals and must structure their pharmaceutical services in a manner that permits identification and monitoring of costs versus benefits under each payment mechanism.
2. Regardless of the payment mechanism, clinical services are generally considered reimbursable or payable items when they are integral to the case management plan for each patient and when the costs and benefits of the service are carefully documented. Payment for clinical services may also be determined by the third-party payer's review and approval of the service. In the case of commercial insurers, those who are insured can direct that payment for clinical services be included in their policies.
3. Pharmacists should take the initiative in proposing clinical programs and documenting the health-care benefits of such programs. They should develop such services and cooperate with provider fiscal officers to document accurately the related costs. Services should also be consistent with regulatory agency, industry, and institutional standards of cost identification and

allocation. Likewise, pharmacists should document the cost impact of such services on the entire drug use continuum, which includes the selection of a drug regimen, delivery of the drug product, its administration to the patient, and the monitoring of its effects. Pharmacy administrators must play a central role in identifying the clinical services that should be provided by their institution and ensuring that each service is consistent with professional standards.

4. Methods used to determine costs of clinical pharmacy services should be consistent with the methods used to determine costs of other patient-care services. The costs and charges associated with clinical pharmacy services should reflect the provider's reasonable fiscal needs for providing such services.
5. Mechanisms for charging patients for pharmaceutical services may take one of several forms. A patient charge mechanism for pharmaceutical services should be developed by the provider's fiscal officer and pharmacists, taking into account professional trends, management philosophy, and the implications of that patient charging mechanism for reimbursement or payment.
6. Reimbursement or payment for clinical services will usually be to the provider (i.e., the institution), not directly to the pharmacist. Generally, charges for pharmaceutical services will be rendered as part of the provider's bill to the patient. Pharmacy or pharmacist compensation for services generally should be resolved with the provider and may take any form that is acceptable to both parties.

Reference

1. American Society of Hospital Pharmacists. ASHP statement on clinical functions in institutional pharmacy practice. *Am J Hosp Pharm.* 1978; 35:813.

^aAn example is the "ASHP Statement on Clinical Pharmacy and Its Relationship to the Hospital" (*Am J Hosp Pharm.* 1971; 28:357).

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

Approved by the ASHP House of Delegates, June 3, 1985, and by the Board of Directors, April 25, 1985. Developed by the ASHP Council on Administrative Affairs. Supersedes the "ASHP Statement on Reimbursement and Payment for Clinical Pharmacy Services," which was approved June 8, 1981.

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