UNM HEALTH SCIENCES CENTER	**Documentation Guidelines**		
	Pharmacist Clinicians/Doctors of Pharmacy/Registered Pharmacists and Medication Therapy Management (MTM), Transitional Care Management (TCM), And Other Services	Effective Date	**02/04/2015**
		Revision Letter	A
		Applies To:	**HSC/UNMMG**

1.0 Purpose

This document provides guidelines for Pharmacist Clinicians (PhC)/Doctors of Pharmacy (PharmD)/Registered Pharmacists (RPh) services in hospital-based clinics, non-hospital based clinics, inpatient settings, and all pharmacy practice environments dependent on specific payer policies. The UNM Health System follows the specific documentation and billing guidelines of the Centers for Medicare and Medicaid Services (CMS) when applicable. CMS does not currently recognize Pharmacists as healthcare providers/practitioners eligible for Medicare Part B reimbursement and are considered "ancillary" or "auxiliary" staff. New Mexico Medicaid recognizes Pharmacist Clinicians as providers but unable to bill under their own name and license. Other third party payers have the ability to develop their own criteria including who can provide these services (i.e., Registered Pharmacists (RPh), Doctor of Pharmacy (PharmD), Advanced Certified Nurse Practitioner (ACNP), Physician Assistant (PA), etc.) based on private contracts established under their available plans and coverage requirements.

2.0 Scope

This guidance applies to UNM Health System providers.

3.0 Statutory Requirements for Pharmacist Clinicians and Registered Pharmacists

- Pharmacists must be licensed pharmacists by the State of New Mexico.
- Pharmacist Clinicians must be licensed pharmacists by the State of New Mexico.
- Pharmacist Clinicians must be registered and certified as a Pharmacist Clinician by the State of New Mexico.
- Must meet any applicable requirements imposed by the State of New Mexico.
- Must work within the scope of practice as outlined by the State of New Mexico.
- Pharmacist Clinicians must develop Practice Guidelines/Prescriptive Authority Protocol between Pharmacist Clinician and Supervising Physician.

4.0 Types of Practice Models

- Third Party Contracts/Private Practitioners/Pharmacy Networks
- Traditional Medicare and Medicaid
- Part D Plans; Health Plans that provide MTM benefits

5.0 Types of Services Provided

Medication Therapy Management (MTM)

Transitional Care Management (TCM)

Annual Wellness Exams (AWV)

Immunization Administrations

Tobacco Cessation Counseling

Anticoagulation Therapy Management

Disease Management (i.e. Diabetes Education/Therapy Management)

Other Clinical Services (Based on individual training)

6.0 Medication Therapy Management (MTM) Services

Medication Therapy Management is a distinct service or group of services that optimize therapeutic outcomes for individual patients. Medication Therapy Management Services are independent of, but can occur in conjunction with, the provision of a medication product. Medication Therapy Management encompasses a broad range of professional activities and responsibilities within the pharmacist's scope of practice. These services include but are not limited to the following, according to the individual needs of the patient.

6.1 Performing or obtaining necessary assessments of the patient's health status;

6.2 Formulating a medication treatment plan;

6.3 Selecting, initiating, modifying or administering medication therapy;

6.4 Monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

6.5 Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

6.6 Documenting the care delivered and communicating essential information to the patient's other primary care providers;

6.7 Providing verbal education and training designed to enhance patient understanding and appropriate use of his/her medications;

6.8 Providing information, support services and resources designed to enhance patient adherence with his/her therapeutic regimens;

6.9 Coordinating and integrating medication therapy management services within the broader health care-management services being provided to the patient.

6.10 Providing other services such as immunizations, anticoagulation management, disease management, etc.

7.0 Billing and Reimbursement for MTM Services

Billing for MTM services and the reimbursement is mostly dependent on the specific payer and the place of service. The American Medical Association (AMA) created CPT codes 99605-99607 specifically to report the provision of medication therapy management (MTM) services by a pharmacist. For a ***new patient***, **CPT 99605** would be reported for the initial 15 minutes. For an ***established patient***, **CPT 99606** would be reported for the initial 15 minutes. For each additional 15 minutes, **CPT 99607** would be reported regardless of whether the patient is ***new or established***. The specific payer and the type of contract will determine if these services can be billed with CPT codes 99605-99607. Medicare B and Medicaid Fee-for-Service do not recognize these codes for separate payment. However, other payers such as Medicare Part D and other third party payers will allow these codes.

7.1 MTM CPT Codes 99605-99607. Most third party contracts, private practitioners, Medicare Advantage Plans, and Part D Plans will require the use of these codes. Medicare Advantage/Part D Plans are mandated by law to provide Medication Therapy Management coverage. Typically, there will be an arrangement between the Pharmacist and the entity. Every effort should be made to stay current with the billing guidelines for each contract/payer. Depending on other third party payer arrangements for these MTM codes, the Medicare/Medicaid billing strategies may apply.

7.2 Medicare and Medicaid (Traditional) - E&M Codes

7.2.1 **Physician-based Clinics** –Physician offices and Physician-based clinics providing services for Medicare patients are governed by a number of CMS rulings that can be found at http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html. This site includes the Medicare Benefit Policy Manual which describes who can bill under Medicare Part B for the services discussed in this Guidance document.

7.2.1.1 Billing Method (Professional Claim submitted by Physician or other qualified health care provider- CMS 1500) - The Medicare Benefit Policy Manual, Chapter 15, Section 60 describes physician delegation to others working in their offices who provide care to Medicare patients and a mechanism for billing such services. These services are referred to as "incident to" services. A physician may bill for "incident to" services provided by a Pharmacist if all the requirements for "incident to" are met. See Paragraph 7.2.1.2 for more information related to "Incident to" billing.

7.2.1.2 "Incident to" – CMS defines incident to services as "services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness." In order to be covered as incident to the physician's service, the following criteria must be met:

- The services must be an integral, although incidental, part of the physician's professional service,
- The services are of the type commonly rendered without charge or included in the physician's bill,
- The services are of a type that are commonly furnished in physician's offices or clinics, and
- The services must be furnished by the physician or by auxiliary personnel under the physician's direct supervision who is present in the office suite, and immediately available to provide assistance and direction throughout the time the Pharmacist is performing the services. Effective in 2015, the non-face-to-face services will require only general supervision; therefore the Clinician is not required to be present in the same suite of offices and immediately available but can be available by telephone to provide assistance as required.
- The patient must be an established patient. The physician must personally perform the initial service for each new condition, make the initial diagnosis, and establish a plan of care which includes the subsequent incidental services. This is true for any new problems as well. This guideline cannot be overridden by physician protocols.
- The services provided are within the scope of practice for the Pharmacist as dictated by the State of New Mexico Statutes.
- There must be an employment relationship (W-2, leased employee, or independent contractor).

7.2.1.3 Reimbursement – Services provided by the Pharmacist as incident to the physician service in a physician-based clinic are typically reported as a low level E&M service (CPT 99211). Some payers may reimburse at the higher levels (CPT 99212-99215) dependent on the scope of services provided. If the Pharmacist service is provided during the same encounter as a Practitioner's E&M, the Practitioner would report the appropriate level of service based on CPT criteria. Since Pharmacists are billing "incident to" the physician or supervising physician, the National Provider Identifier (NPI) of the Medicare Part B-approved practitioner must be used on the paper or electronic CMS 1500 claim form.

7.2.1.4 Documentation Requirements – Document each and every patient encounter. Should there be an audit, there is a need for this information to justify time and services rendered. Be accurate and thorough in the documentation, as such information becomes a legal document and can be subpoenaed for use in court.

There is no requirement for the physician or supervising provider to sign off on all Pharmacist's notes. The "incident to" rule states that the physician or supervising provider establishes the plan of care for the patient that authorizes the Pharmacist's service, and the physician or supervising provider must continue to be actively involved in that plan of care at a reasonable frequency. As a part of ongoing care, "best practice" would include review by the physician of other health providers' documentation, including the pharmacists'.

Similar to the documentation requirements for other health care providers, the following elements should be documented in order to support the service provided:

- Progress note must substantiate the service performed (level of care) and be signed by the person performing it.
- When the physician is involved with a particular service, his/her contribution to the care must be documented. This will help to substantiate his/her continued involvement in the patient's care. The extent of physician involvement should reflect the patient's condition, increasing instability, or uncertainty of the situation.
- Review of the pertinent patient medical history; medication profile (prescription and non-prescription);
- Interventions and recommendations for optimizing medication therapy;
- Referrals and treatment compliance;
- Communications with other healthcare professionals;

- Administrative functions (including patient and family communications) relative to the patient's care;

- Follow-up care.

In order to bill "incident to" services provided by the Pharmacist with a CPT 99211 (or higher, in some cases), the E&M service has to be supported by the documentation. To meet the requirements for a CPT 99211 you have to provide a face-to-face encounter with a patient that consists of elements of **both** evaluation AND management. Novitas-Solutions, Inc. (New Mexico's Medicare Administrative Contractor) states that the "**evaluation**" is supported when the record includes documentation of a clinically relevant and necessary exchange of information (historical information and/or physical data) between the provider and the patient. The **"management"** portion of a 99211 is supported when the record demonstrates an influence on patient care (medical decision making, provision of patient education, etc.).

7.2.2 **Facility-based Clinics** – For Medicare patients, hospital-based outpatient services (including clinics and the ED) are governed by the Hospital Outpatient Prospective Payment System (HOPPS) regulations. See The Medicare Benefit Policy Manual, Chapter 6, Hospital Services Covered Under Part B for more information. Since CMS does not recognize Pharmacists as eligible providers, the use of the MTM CPT Codes 99605-99607 cannot be reported for reimbursement to Medicare Part B by the Pharmacists when MTM is provided within a facility-based clinic or outpatient department. However, these services may be recognized by Medicare Part D or other third party payers. Pharmacists are considered "auxiliary" staff under Medicare Part B, providing hospital services under a physician's supervision.

7.2.2.1 Billing Method (Institutional Claim submitted by Hospital/Other Institution) – CMS 1450 – The Medicare Benefit Policy Manual, Chapter 6, Section 20.5, Outpatient Therapeutic Services, describes these services as "incident to the services of physicians in the treatment of patients." The Pharmacist Clinician or the Supervising Physician (or other qualified health care practitioner) cannot bill as "incident to" his/her services; therefore, the Hospital reports these services as performed incident to the services of physicians and practitioners and which aid in the treatment of hospital patients. See paragraph 7.2.2.2 for more information related to "incident to" hospital-based billing.

7.2.2.2 "Incident To" – "Incident to" in an inpatient Part B or outpatient hospital setting under HOPPS regulations does not have the same meaning as it does on the professional side (physician-based clinics). A physician or other qualified practitioner cannot bill "incident to" for services provided by the hospital or clinic (by hospital personnel). However, the hospital will bill for services provided by auxiliary personnel that were "incident to" a physician's order or care plan. The following criteria must be met:

- There must be a physician's order. The physician is not required to see the patient at each encounter the Pharmacist is providing subsequent service; however during any course of treatment the physician must personally see the patient periodically to assess the course of treatment, patient's progress, and when necessary, change the plan of care. If the physician merely writes an order and is not sufficiently involved in the management of the patient's care, Novitas will not allow reimbursement based on "incident to".

- The services must be an integral, although incidental, part of the physician's professional service in the course of diagnosis or treatment of an illness or injury. Therefore, in this setting utilizing the "incident to" billing, the Pharmacist cannot provide these services for a new patient or a new problem. This guideline cannot be overridden by facility protocols.

- Must be furnished in the facility or department for which the facility submits charges.

- Must be furnished under direct supervision of a physician or nonphysician practititioner. The physician supervision requirement is generally met when the services are provided on hospital premises; the hospital medical staff that supervises the services does not need to be in the same department as the ordering physician. However, if the services are furnished outside the hospital, they must be rendered under the **direct personal supervision** of a physician who is treating the patient.

- The services provided are within the scope of practice for the Pharmacist as dictated by State of New Mexico Statutes.

- There must be an "arrangement" with the hospital for the Pharmacist to provide services within the hospital's facilities. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c05.pdf.

7.2.2.3 Reimbursement – Services provided by the Pharmacist as incident to the physician service in a facility-based clinic are embedded in the hospital clinic criteria for calculating a Visit Level. If the MTM service is the only service provided, the level would typically be the lowest level (CPT 99211). In order to bill for this, there must have been an Evaluation & Management service provided which is consistent with the description of 99211 (or higher levels if the encounter supports them according to Clinic Levels criteria). For Medicare billing, these Clinic Levels utilizing the CPT codes have been deleted and providers are to bill a HCPCS code G0463 for all clinic visits regardless of criteria level. Other payers may reimburse for higher level E&M codes (CPT 99212-99215).

7.2.2.4 Documentation Requirements – Document each and every patient encounter. Should there be an audit, there is a need for this information to justify time and services rendered. Be accurate and thorough in the documentation, as such information becomes a legal document and can be subpoenaed for use in court.

There is no requirement for the physician or supervising provider to sign off on all Pharmacist's notes. The "incident to" rule states that the physician or supervising provider establishes the plan of care for the patient that authorizes the Pharmacist's service, and the physician or supervising provider must continue to be actively involved in that plan of care at a reasonable frequency. As a part of ongoing care, "best practice" would include review by the physician of other health providers' documentation, including the pharmacists'.

The following information should be documented by the Pharmacist in order to support the service provided:

- A physician's specific order for the subsequent incidental service (MTM) is required and must be documented in the medical record for outpatient hospital services and shall be written according to the policies that apply to orders at UNM Health System facilities.

- The documentation should provide a linkage between the Pharmacist's service and the physician's service to which the Pharmacist's service is incidental and show that the services were under a physician's supervision. It should reflect the physician's involvement with the patient care by including documentation from other dates of service that show the link between the services of the two providers.

- The documentation should also include recording of phone calls, letters, faxes, etc. to/with/from the patient's physician communicating the "incident to" services.

- Progress notes must substantiate the service performed (level of care) and be signed by the Pharmacist.

- Documentation must show a review of the pertinent patient medical history, medication profile (prescription and non-prescription), interventions, recommendations for optimizing medication therapy, referrals, treatment compliance, and communications with other healthcare professionals.

- Documentation should show any administrative functions (including patient and family communications) relative to the patient's care.

- Any follow-up care planned should be recorded in the medical record.

In order to bill "incident to" services provided by the Pharmacist with a CPT 99211 (or higher, in some cases), the E&M service has to be supported by the

documentation. To meet the requirements for a CPT 99211 you have to provide a face-to-face encounter with a patient that consists of elements of **both** evaluation AND management. Novitas-Solutions, Inc. (New Mexico's Medicare Administrative Contractor) states that the "**evaluation**" is supported when the record includes documentation of a clinically relevant and necessary exchange of information (historical information and/or physical data) between the provider and the patient. The **"management"** portion of a 99211 is supported when the record demonstrates an influence on patient care (medical decision making, provision of patient education, etc.).
https://www.novitas-solutions.com/bulletins/parta/archive/mpr03145.html

8.0 Transitional Care Management (TCM) Services

Non-face-to-face transitional care management services have been available for reimbursement since January 2013. Current Procedural Terminology (CPT) codes were created that allows physicians and other qualified providers to report their transitional care management services, including the non-face-to-face time they and their clinical staff spend on patient cases. Prior to January 2013, only the face-to-face care was eligible for reimbursement. Fortunately, CMS decided to utilize these CPT codes and agreed that providers should follow CPT's guidelines.

These services are for a **new** or **established** patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care **from** an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility **to** the patient's community setting (home, domiciliary, rest home, or assisted living). Beginning on the date the patient is discharged from a hospital inpatient setting and extending for an additional 29 days (for a total of 30 days), Transitional Care Management services will consist of: 1) an interactive contact; 2) non-face-to-face services; and 3) a face-to-face visit.

Transitional Care Management CPT codes are (AMA Professional Edition CPT 2014):

CPT 99495 – Transitional care management services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of at least moderate complexity during the service period
- Face-to-face visit, within 14 calendar days of discharge

CPT 99496 – Transitional care management services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of high complexity during the service period
- Face-to-face visit, within 7 calendar days of discharge

8.1 Types of Transitional Care Management Services

An interactive contact with the patient within two business days of discharge -

This involves communicating (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care and can be provided by the physician or pharmacist clinician by either phone, email, or face-to-face. If two or more attempts to reach the patient have been made, the TCM provider must continue attempts to make direct contact until successful and document each attempt and outcome.

Non-face-to-face Services by physicians or non-physician providers (NPPs) –

- Obtain and review discharge information (for example, discharge summary or continuity of care documents);
- Review need for or follow-up on pending diagnostic tests and treatments;
- Interact with other health care professionals who will assume or reassume care of the patient's system-specific problems;
- Provide education to the patient, family, guardian, and/or caregiver;
- Establish or re-establish referrals and arrange for needed community resources; and
- Assist in scheduling required follow-up with community providers and services.

Non-face-to-face Services by Licensed Clinical Staff Under the Direction of a Physician or NPP –

- Communicate with agencies and community services used by the patient;
- Provide education to the patient, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living;
- Assess and support treatment regimen adherence and medication management;
- Identify available community and health resources; and
- Assist the patient and/or family in accessing needed care and services.

Face-to-face Visit –

The TCM service requires at least one face-to-face visit by the physician or NPP (Certified Nurse Midwife, Clinical Nurse Specialist, Nurse Practitioner, or Physician Assistant). This initial face-to-face visit is not reported separately; however, any additional face-to-face (E/M) visits that are medically necessary and occur on subsequent dates after the initial visit should be reported separately.

Medical decision making and the date of the first face-to-face visit are used to select and report the appropriate TCM code. CPT 99495 requires the face-to-face visit occur within 14 days with a medical decision making of at least "moderate" complexity. CPT 99496 requires a face-to-face visit within 7 days with a medical decision making of "high" complexity. The medical decision making over the 30 day service period reported is used to define the medical decision making of Transitional Care Management service. To determine the level of medical decision making, use the same process detailed in the Evaluation and Management guidelines.

Selection of TCM Code

Type of Medical Decision Making	Face-to-face Visit within 7 Days	Face-to-face Visit within 8 - 14 days
Moderate Complexity	99495	99495
High Complexity	99496	99495

Elements for Each Level of Medical Decision Making
(Two of the three elements must be either met or exceeded)

Type of Decision Making	Number of Possible Diagnoses and/or Management Options	Amount and/or Complexity of Data to Be Reviewed	Risk of Significant Complications, Morbidity, and/or Mortality
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

8.2 Medication Reconciliation and Management

Medication reconciliation and management must be furnished no later than the date you furnish the face-to-face visit.

8.3 Billing TCM Services

- There can be only one health care provider reporting TCM services for any given 30-day period.
- The same health care provider can discharge the patient from the hospital, report hospital/ observation services, and bill for TCM services. (The required face-to-face visit cannot occur on the same day of the discharge day management services.)
- Other medically necessary E/M services for addressing the patient's clinical issues are reported separately (only the initial face-to-face visit is included in the TCM services).

- TCM services cannot be billed if any of the 30-day TCM period falls within a post-operative global period for a procedure billed by the same provider.

- TCM services can only be reported for a specific patient once during the TCM period.

- The Date of Service reported on the claim for TCM services should be the 30th day (TCM begins on the day of discharge and continues for the next 29 days).

- Place of Service reported for any TCM claim should reflect the place of service of the required face-to-face visit. CMS has established both a facility and non-facility payment for this service.

- "Incident To" rules must be followed as they are for the Medication Therapy Management billing strategies (See Paragraphs 8.2.1.2 and 8.2.2.2) with the following exception: Effective in 2015, the non-face-to-face services will require only general supervision; therefore the Clinician is not required to be present in the same suite of offices and immediately available but can be available by telephone to provide assistance as required.

- TCM CPT codes cannot be reported during the TCM period with certain other types of services (i.e., care plan oversight, prolonged services without direct patient contact, anticoagulant management, end stage renal disease management, complex chronic care coordination services, medication therapy management services, etc.).

- If a patient should die prior to the 30th day of TCM care, providers should not report TCM services. Instead, report any face-to-face visits that were provided by using the appropriate E/M code.

- If the patient is readmitted within the 30-day period, you can still report TCM services if the services described by the CPT code were furnished during the 30-day period, including the time following the second discharge. Also, TCM services can be reported after the second discharge for a full 30-day period as long as no other provider has billed TCM for the first discharge.

- Under the Teaching Physician rules, TCM does not apply to the Primary Care Exception Rule; however, if a physician applies the –GC modifier, he/she is attesting compliance with the Teaching Physician requirements.

8.4 Documentation

At a minimum, the following information should be documented in the patient's record:

- Date the patient was discharged.

- Date and timing of the interactive contact (post-discharge communication) with the patient and/or caregiver.

- Date of the face-to-face visit.

- Complexity of the medical decision making (details of thought process).

- Usual evaluation and management documentation to support the face-to-face visit.
- Medication reconciliation and subsequent management notes.

9.0 References:

9.1 **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf**

9.2 **http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html**

9.3 **https://www.novitas-solutions.com/bulletins/parta/archive/mpr03145.html**

10.0 Revision History

Effective Date	Rev Letter	Document Author	Description of Change
02/04/2015	A	Sandy Colson	Initial Release.

Addendum to Pharmacist Clinician and Pharmacist Guidelines
Table 1: Payors Reimbursing Pharmacist Services

		Medicare Fee-for-Service[ǂ]	**Medicare Fee-for-Service** [ǂ]	**Medicare Fee-for-Service**	**Medicare Fee-for-Service**	**Fee-for-Service Medicaid***		**Presbyterian MTM Contract** **(On hold pending PHS/UNMHSC new Master Agreement**		**Molina MTM (Medicaid) Telephonic Contract**	**Molina MTM (Medicaid) Contract (Face-to-face)**	**Molina MTM Contract (Molina Exchange)-Pending**			**BCBS Contract** **(excludes Medicare)**	**United Healthcare (Dual eligible and Centennial Care-Medicaid)-Pending**	**United Healthcare (Medicaid and Medicare) Pending**
	Location	UNMMG Clinics	UNMH or UNMMG Clinics	UNMH or UNMMG Clinics	UNMH Clinics	UNMH Clinics	UNMMG Clinics	UNMH Clinics	UNMMG Clinics	MTM Call Center	UNMH Clinics	UNMMG Clinics	UNMH Clinics	MTM Call Center	UNMH or UNMMG Clinics	Nurse Advice Line	Medication Management Of Care Transitions Post Hospital Discharge
	Code	E&M 99211 99212 99213 99214 99215	TCM	Annual Wellness	G-code (facility fee) G0463	Facility fee (APC code or G0463)	E&M 99211 99212 99213 99214 99215	99605 99606 99607 plus facility fee	99605 99606 99607	S5185	99605 99606 99607 plus facility fee	99605 99606 99607	99605 99606 99607 plus facility fee	S5185	99605 99606 99607	Per member/per month contract	Unique billing code issued by Medicaid
Pharmacist Clinician (Pharm.D and Ph.C.)		X	X	X	X	X	X	X		X	X	X			X	X	X
Clinical Pharmacist (Pharm.D. Only)		X	X	X	X			X		X	X	X				X	X

*Bill submitted by physician as provider on behalf of pharmacist

[ǂ] Bill submitted incident to physician, must follow CMS “incident to” requirements; Shared-lease agreement between UNM College of Pharmacy and UNMMG pending

Privilege's Full Contents (includes attached criteria & example procedures)

CORE PRIVILEGES: *Pharmacist Clinician*

Pharmacist Clinicians may provide pharmaceutical care to patients at the University Hospital and associated clinics. May provide medication therapy management to patients at the University of New Mexico Hospital and associated clinics. PhCs will collaborate with a physician or physicians who are currently appointed to the active or consulting medical staff within a scope of practice in the same area or specialty practice as the PhC. The supervising physician will provide collaboration with the PhC, provide consultation when requested, and assume responsibility for the care of the patient when requested by the PhC or in the interest of patient care. A PhC may provide other health care professionals with medication information and provide patient education materials and counseling concerning their disease state, risk factors, therapeutic lifestyle change recommendations, medication regimens, and monitoring parameters.

Qualifications for Pharmacist Clinician

Initial Applicant *- To be eligible to apply for privileges in pharmacist clinician, the initial applicant must meet the following criteria:*

Professional PharmD degree from an ACPE-accredited school or college of pharmacy, and current New Mexico Pharmacist (RPh) License, and current Pharmacist Clinician (PhC) license

AND

Successful completion of a one year professional pharmaceutical (clinical residency or fellowship) training in clinical pharmacotherapy within a clinical setting OR one year of commensurate clinical work experience

AND

New Mexico Board of Pharmacy Pharmacist Clinician Approved Protocol copy submitted as attachment with UNMH credentialed supervisor

***Required previous experience*:** Applicants must be able to demonstrate active clinical practice since completion of postgraduate training in the provision of services, reflective of the scope of privileges requested, or successful completion of a hospital affiliated residency, special clinical fellowship, or research within the past 12 months.

Reappointment (Renewal of Privileges) Requirements **-** *To be eligible to renew privileges in clinical pharmacy, the re-applicant must continue to meet the appointment criteria and must meet the following maintenance of privilege criteria:*

Current demonstrated competence and an adequate volume of experience with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Included documentation of PhC registration with NM State Medical Board. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

1. Generate referrals for smoking cessation, patient education classes or other programs as deemed clinically necessary
2. May initiate, modify or discontinue therapy as per attached NMBOP protocol
3. Measure and review routine patient vital signs including pulse, temperature, blood pressure and respirations
4. Medication Therapy Management (MTM)
5. Ordering appropriate laboratory tests and diagnostics according to NMBOP protocol
6. Prescriptive authority as outlined in NMBOP protocol
7. Focused history and physical as outlined in NMBOP protocol