

Community Pharmacist-Provided Chronic Care Management Toolkit

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Support Provided by the Community Pharmacy Foundation
Assistance Provided by the Tennessee Pharmacists Association



Tennessee Pharmacists Association
★ For Patients ★ For Pharmacists ★ For Tennessee

November 2017

Table of Contents

<u>Overview</u>	1
<u>The Community Pharmacist-Provided CCM Guide</u>	1
<i>Patient Eligibility</i>	1
<i>Certified Electronic Health Records (CEHR)</i>	2
<i>Initiating Visits</i>	3
<i>Patient Consent</i>	3
<i>Comprehensive Care Plan Creation</i>	4
<i>Provision of CCM Services</i>	5
Access to Care & Continuity.....	5
Comprehensive Care Management.....	6
Transitional Care Management.....	6
<i>Incident-To Billing Overview</i>	7
<u>Final Thoughts</u>	8
<u>Additional Resources</u>	9
<u>Appendix A: Example BAA</u>	10
<u>Appendix B: Example CPPA (Specific to TN)</u>	16
<u>Appendix C: Example CCM Comprehensive Care Plan</u>	20
<u>Appendix D: Medicare Preventive Service Checklist</u>	26

Overview

In 2015, the Centers for Medicare and Medicaid Services (CMS) began paying providers separately for Chronic Care Management (CCM) services. CCM is a time based, predominantly non-face-to-face, service provided to patients in between office visits. CCM is very similar to a per member per month (PBPM) payment strategy since it may be billed monthly if enough clinical staff time is spent providing care to enrolled patients. Clinical staff may include a pharmacist, and since CCM billing allows for general supervision under “incident to” billing rules, community pharmacists have an opportunity to provide these services outside of a physician’s office.

CCM has faced implementation challenges possibly due to the requirement to collect a copay and/or the low provider reimbursement rate relative to the time required to deliver the service. In 2015, Medicare claims data indicated that approximately 275,000 eligible Medicare beneficiaries received CCM services an average of 3 times during that year. However, with roughly 40 million Medicare beneficiaries who may be eligible for a monthly CCM, many of these Medicare patients failed to receive CCM and providers failed to deliver and bill for over \$18 billion in revenue.

With support from the Community Pharmacy Foundation (CPF) and assistance by the Tennessee Pharmacists Association (TPA), Seamless Healthcare PLLC explored the delivery of community pharmacist-provided CCM services with an endocrinologist. The Community Pharmacist-Provided Chronic Care Management Toolkit contains guidance, resources, and experiences to aid in the establishment and provision of CCM services by a community pharmacist. Additional materials found at the end of this toolkit include a sample Business Associate Agreement (BAA), Collaborative Pharmacy Practice Agreement (CPPA), and a comprehensive care plan. Hopefully this toolkit will create more provider collaboration, better patient health outcomes, and additional revenue to community pharmacists.

The Community Pharmacist-Provided CCM Guide

This guide provides all the steps necessary to perform community pharmacist-provided CCM services in conjunction with a physician. Each section will detail general information and requirements for the provision of CCM services followed by CPF pilot experiences. Sections include information regarding:

1. Patient Eligibility
2. Certified Electronic Health Records (CEHR)
3. Initiating Visits
4. Patient Consent
5. Comprehensive Care Plan Creation
6. Provision of CCM Services
 - a. Access to Care & Continuity
 - b. Comprehensive Care Management
 - c. Transitional Care Management
7. Incident-To Billing Overview

In general, providing and billing for CCM services includes six major steps that begin in the physician’s office and could end in the community pharmacy:

Physician’s Office

Determine Eligibility → Assist in Initiating Visit → Obtain Consent → Create Care Plan

Community Pharmacy

Provide Monthly CCM Services with Physician’s CEHR → Bill Incident to the Physician

Patient Eligibility

General Information/Requirements

The two main components that determine patient eligibility for CCM include insurance carrier and number of chronic conditions.

Patients with traditional Medicare coverage, including those who are Dual Eligible, are

guaranteed to be eligible for CCM services. If the patient has Medicare, but there is concern about eligibility, check with the state Medicare Administrative Contractor (see “Additional Resources”). While Medicare Advantage plans may allow for billing of CCM services, the provider will need to confirm directly with each carrier prior to delivering CCM services.

CMS states that patients must have multiple (two or more) chronic conditions expected to last at least 12 months, or until death, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. CMS does not limit which chronic conditions make a patient eligible for CCM, which gives providers flexibility to enroll patients who will benefit the most.

A few examples of chronic conditions include, but are not limited to, the following:

- Alzheimer’s Disease/Related Dementia
- Arthritis (OA and RA)
- Asthma
- Atrial Fibrillation
- Autism Spectrum Disorders
- Cancer
- Cardiovascular Disease
- COPD
- Depression
- Diabetes
- Hypertension
- HIV/AIDS

CPF Pilot Experience

To be applicable nationwide, this pilot focused on patients with traditional Medicare coverage since Medicare Advantage allowable services can vary based on locality and carrier. Using the physician’s CEHR, all scheduled patients with traditional Medicare coverage were flagged. Flagged patients were then selected for CCM if they had two or more disease states (e.g. type 2 diabetes, hypo/hyperthyroidism, obesity, hypertension, dyslipidemia) that the community pharmacist could manage under a CPPA.

Certified Electronic Health Record (CEHR)

General Information/Requirements

Starting in 2017, CMS relaxed the CEHR requirements related to CCM and only requires a CEHR be used to document core clinical information (i.e. demographics, problems, medications, medication allergies). Most physicians are already utilizing an acceptable CEHR because of their involvement in the EHR Incentive Programs (see “Additional Resources”). If a partnering physician has not been involved in the EHR Incentive Program, make sure to contact the physician’s CEHR vendor to ensure that all requirements will be met for provision of CCM services.

Certified technology is no longer required for other CCM documentation (i.e. CCM encounters, other providers labs), transitional care management documents, or when sharing care plan information within and outside the practice. These changes have allowed for the exchange of CCM information to be via fax. Additionally, individuals providing CCM after hours are no longer required to have access to the electronic care plan as long as they can access information in a timely manner. Reducing these requirements has decreased the administrative burden in a number of offices that provide CCM, since not all have interoperable CEHRs like larger health systems.

CPF Pilot Experience

Implementation of CCM services was very easy since the partnering physician was already set up with a CEHR. The 2017 changes were very beneficial when moving information between providers. While having an interoperable CEHR between all providers would be beneficial, this was not the current reality as faxing was still one of the easiest ways to exchange documentation.

The community pharmacist had 24/7 remote access to the CEHR even though it was no longer a requirement. All providers, including the community pharmacist, thought remote access was crucial to the delivery of high quality CCM since documentation was such an important element. Remote, 24/7 access to pertinent information proved to be important during CCM calls. This was especially true when modifying therapies and sending in new/refill prescriptions on the weekends.

Even though it is not a requirement, community pharmacists should insist on having remote access to the CEHR when establishing CCM services.

Initiating Visit

General Information/Requirements

Initiating CCM depends on whether a patient is either:

- New to the practice
- An existing patient who has not been seen for a comprehensive visit within one year
- An existing patient who has been seen for a comprehensive visit within one year

For new patients or existing patients not seen for a comprehensive visit within one year prior to CCM enrollment, CMS requires CCM initiation during a face-to-face comprehensive visit with the billing practitioner. Comprehensive visits include an Annual Wellness Visit (AWV), Initial Preventive Physical Examination (IPPE), Transitions of Care Management (TCM), or a level 3, 4, or 5 Evaluation and Management (E/M) visit. Pharmacists can provide AWVs in full, or play a role in any of the other initiating visits, which can create an opportunity for split billing. The initiating visits build relationships and credibility with prescribers, and increase CCM enrollment through face-to-face patient-pharmacist relationships. More information about AWV, IPPE, TCM and E/M can be found in the “*Incident-To Billing Overview*” and “*Additional Resources*” sections below.

For existing patients seen for a comprehensive visit within one year, CCM may be initiated over the phone without an additional in-office visit. While this is allowed, a comprehensive care plan must still be created, which could be difficult if the patient has had drastic changes in their health status since their last visit.

CPF Pilot Experience

Immediately prior to being seen by the physician or nurse practitioner for an E/M visit, the community pharmacist provided medication reconciliation services to eligible patients. Medication reconciliation created an opportunity for the pharmacist to determine medication related issues and generate recommendations to be discussed with the patient and their corresponding provider. Face-to-face interaction with patients and providers created relationships, credibility, and trust that increased patient enrollment in CCM and pharmacist autonomy under the CPPA.

The community pharmacist reached out to some patients seen in the past year to discuss CCM enrollment. It was found that enrollment in CCM was non-existent when “cold calling” patients compared to meeting the community pharmacist in person during a face-to-face visit. Potential reasons why patients refused CCM over the phone included not knowing the pharmacist personally, feeling as though they are being sold something, or not recognizing the pharmacist’s relationship with the providers in the office.

Patient Consent

General Information/Requirements

To ensure patient engagement, obtaining consent during CCM enrollment is required by CMS prior to performing any CCM services. Patient consent must at least inform patients of:

- The availability of CCM services
 - 24-hour-a-day, 7-day-a-week access (explained in-depth under “*CCM Services*”)
- The applicable cost sharing (patient pays 20% when only covered with Medicare)
 - Private insurers providing standardized Medigap plans agree to cover the copay, unless the Medigap policy itself has a deductible that has not yet been met (e.g., high deductible Plan F)
 - Dual eligible patients who are considered “Qualified Medicare Beneficiaries,” or QMBs, are not responsible for cost sharing. Depending on the Medicaid state plan, the physician’s office may or may not have to absorb the copay for QMBs. All other Dual Eligible statuses (Non-QMB, SLMBs, QDWIs, QI-1, or QI-2) with

need to pay the applicable copay.

- That only one practitioner can furnish and be paid for CCM services during a calendar month
- The right to stop CCM services at any time (effective at the end of the calendar month)

Consent may be verbal or written, but must be documented in the CEHR.

CPF Pilot Experience

Immediately after the initiating visit with the provider, interested patients would meet again with the community pharmacist briefly to obtain verbal consent, additional information as needed for the comprehensive care plan, and a printed copy of their preliminary comprehensive care plan. As can be seen in the “Example CCM Comprehensive Care Plan” at the end of this toolkit, a disclaimer can be placed at the top of the care plan stating when the patient consented and what services will be provided. While verbal consent is allowed, some practices may want to consider having patients sign a consent form to ensure there is no patient misunderstanding.

Comprehensive Care Plan Creation

General Information/Requirements

The comprehensive care plan is not only a necessity for billing, but it helps guide the community pharmacist when treating patients enrolled in CCM. CMS emphasizes comprehensive care plans should be patient-centered and encompass all health issues, with a particular focus on the chronic conditions being managed. The care plan must be electronic, provided to the patient and/or caregiver to encourage patient engagement, and also to any other individuals involved in the patient's care.

Comprehensive care plans are practice site specific and typically include, but are not limited to, the following elements:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions and identification of individuals responsible for each intervention
- Medication Management
- Community/social services ordered
- A description of how services outside the practice will be directed/coordinated
- Schedule for periodic review and, when applicable, revision of the care plan

As stated above, comprehensive care plans will be dependent on the practice site (i.e. primary care, endocrinology, cardiology) but should encompass all issues even if scope is limited within the practice site. To account for this, CMS created an add-on code for patients who receive an initiating visit and the billing physician or qualified healthcare professional (i.e. nurse practitioner, physician assistant) personally performs extensive assessment and CCM care planning beyond the usual effort. This code is called “Comprehensive Assessment of and Care Planning for CCM” and its corresponding HCPCS code is G0506.

CPF Pilot Experience

Building a comprehensive care plan can be difficult if the patient is seeing multiple providers. During the pilot, patients received a printed care plan immediately after enrollment generated from information available in the office's CEHR. A list of providers was obtained prior to patients leaving and the community pharmacist contacted them for recent lab values, procedures, and/or patient notes. This information was included in the final care plan, disseminated back to the other providers, and an updated copy was mailed to the patient/caregiver. The example comprehensive care plan found at the end of this toolkit should be utilized as a guide to building a specific care plan template tailored to the physician's office. Offices utilize different CEHRs and have different ways of

documenting, so what is found in the example will expedite, but probably not replace, creating a unique comprehensive care plan template. The CEHR vendor that the physician utilizes should be contacted about the possibility of creating, or implementing existing, CCM templates. Utilization of CCM platform vendors outside of the physician's CEHR is not encouraged because of the possibility of fees and duplication of work (e.g. documenting in outside vendor and then scanning into physician's CEHR).

The G0506 code was not used during the pilot since the community pharmacist built the comprehensive care plans and the focus was on the 20 minute CCM billing code. While G0506 can be used with patients considered normal complexity, it has more value when patients are considered moderate/high complexity and require 60 or more minutes of clinical staff time during CCM. Misusing or abusing this code (i.e. using with every comprehensive care plan created) should not be considered and would most likely lead to CMS scrutiny and audits for overbilling.

Provision of CCM Services

General Information/Requirements

Providing CCM services encompasses three major elements that include:

1. Access to Care & Continuity
2. Comprehensive Care Management
3. Transitional Care Management

In general, these three elements create an access point for patients and/or caregivers to reach out to a healthcare provider (i.e. the community pharmacist) in a timely manner to prevent worsening conditions or hospitalizations.

Access to Care & Continuity

CMS states that access to care and continuity shall include:

- 24-hour-a-day, 7-day-a-week (24/7) access to physicians, other qualified health care professionals or clinical staff, while providing patients (and caregivers as appropriate) with a means to make contact with health care professionals in the practice to address urgent chronic care needs regardless of the time of day or day of the week.
 - While 24/7 access may seem overwhelming, achieving this requirement is typically not difficult as most physicians offices already have a system for after-hour calls. CMS also allows for "timely" return of phone calls, so phone calls can be missed as long as the patient is contacted as soon as possible. In case of missed calls, a voicemail should be set up that states "if this is an emergency, please hang up and call 911." Most patients are very conscientious of calling during business hours, but even so, they must have the ability to reach a provider anytime.
- Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments
 - Typically the designated member is the practitioner who provided the initiating visit, but it could include other practitioners involved in the patients care.
- Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care by telephone and also through secure messaging, secure Internet, or other asynchronous non-face-to-face consultation methods (for example, email or secure electronic patient portal)
 - Most physicians will have a CEHR program set up that allows for patients to securely reach a "patient portal" to email providers. Patients should have direct telephone access to the community pharmacist (i.e. business cell phone) involved in their care. Pharmacy managers might also consider training other community pharmacy personnel on CCM workflow for when the patient calls the pharmacy directly.

Comprehensive Care Management

CMS states that comprehensive care management shall include:

- Systematic assessment of the patient's medical, functional, and psychosocial needs
 - While community pharmacists are not diagnosticians, they do have the ability triage care when notice medical, functional, and/or psychosocial changes. Community pharmacies that provide point-of-care testing and other clinical services will be able to assess potential problems in a more efficient manner.
- System-based approaches to ensure timely receipt of all recommended preventive care services
 - After determining patient-specific preventive care services, creating a system of feedback loops is important. All providers should be listed in the care plan and matched with their corresponding scope of services. During CCM calls, patients should be reminded of recommended services and assisted with coordinating this care.
- Medication reconciliation with review of adherence and potential interactions
 - During the initial visit, community pharmacists could consider selecting MTM eligible patients. This would allow for a pharmacy to bill for the CMR through Part D, while also providing other clinical services in the physician's office through Part B.
- Oversight of patient self-management of medications
 - Community pharmacists are in an optimal position to ensure patients are compliant to therapy through CCM. Enrolling patients in medication synchronization and delivery could aid in a patient's self-management of their medications.
- Coordinating care with home and community based clinical service providers
 - Most community pharmacists know of available home and community based service providers in their area. If this is not the case, utilizing your state pharmacy association or local aging and disability resource can provide a starting point to learning about the potential options available.

Transitional Care Management

CMS states that transitional care management shall include:

- Manage transitions between and among health care providers and settings, including referrals to other clinicians, follow-up after an emergency department visit, or facility discharge
 - Managing transitions through CCM is not the same as providing the TCM Medicare Part B billable service (see under "*Incident-To Billing Overview*"), but it is an opportunity to possibly set TCM services up with the partnering PCP or health system. While this toolkit does not get into the specifics of TCM billing, elements do include patient contact within 48 hours of discharge and medication reconciliation prior to the face-to-face visit with the provider.
- Timely creation and exchange of continuity of care document(s) with other practitioners and providers
 - See section "*CEHR Requirements*" for more information.

CPF Pilot Experience

Many patients were hesitant of community pharmacist-provided CCM during enrollment, but those that did enroll really enjoyed the access to a community pharmacist who had a total understanding of their current health status. The provider who conducted the initiating visit was crucial to reinforcing the benefits of CCM services and boosting enrollment. Patients trust their providers, and this trust translates into credibility for the community pharmacist-provided CCM

services. After enrollment, the community pharmacist could easily modify therapies, order refills, and/or coordinate care with their other providers while practicing under the CPPA.

Providing 24/7 access was not too burdensome during the pilot since an existing system was already in place through the physician's office. No patients called during the middle of the night and most calls were during the week in typical business hours. While patients had the ability to contact the community pharmacist or providers through email or a patient portal, most patients preferred non-face-to-face consultation via phone with the community pharmacist. When patients called, having remote access to the physician's CEHR was crucial to access the care plan, modify therapies, issue prescriptions or refills, and document the encounter. Using the same CEHR as the physician ensures no limitations when providing patient care.

The average time spent providing CCM clinical services was roughly 25 minutes per patient each month. Even though some patients required over 40 minutes of time, 99490 could not be billed multiple times (i.e. billing two 99490 codes for 40 minutes of time). This presents an issue when patients are not moderate or high complexity but utilize the service more than 20 minutes per month. Community pharmacists and the partnering practice need to consider developing a system for referring a normal complexity patient to an office visit (i.e. if the patient reaches the 40 minute mark, they will need to schedule a visit). If the patient can be deemed moderate or high complexity, utilization of billing codes 99487 and 99489 should be considered. These codes are discussed below in *"Incident-To Billing Overview."*

To ensure timely receipt of all preventive care services, all providers were sent a "Medicare Preventive Service Checklist" created during the grant (see also "Additional Resources"). The checklist allowed the providers an opportunity to select which services the patient needed to receive. The checklist was a great guide for patients to know which services they needed to have completed, and should be attached with the care plan. The "Medicare Preventive Service Checklist" can be found in Appendix D.

No patients enrolled in CCM were hospitalized during the grant, which hopefully was attributed by the delivery of CCM services.

Incident-To Billing Overview

General Information/Requirements

"Incident to" services are defined as those services that are furnished by a non-physician practitioner, or other clinical staff (pharmacists included), incident to a physician's professional services. These services are billed as though the physician personally provided them and are paid the full rate under the physician fee schedule (PFS). "Incident to" services are also relevant to services supervised by certain non-physician practitioners (i.e. physician assistants, nurse practitioners, clinical nurse specialists). These services are subject to the same requirements as physician-supervised services, but reimbursement is 85 percent of the PFS. Since non-physician practitioners typically practice under a physician in some capacity, it is always best to try and bill incident to the physician so the practice can receive the full PFS.

To qualify as "incident to," services must be part of the patient's normal course of treatment, during which a physician personally performed an initial service and remains actively involved in the course of treatment. Supervision requirements are based on the service provided and will require either direct or general supervision. Direct supervision means the service is provided in the office suite where the billing physician is present. The physician must be present to render assistance, as necessary, but it does not have to be physically present in the patient's treatment room while these services are provided. General supervision means the service is furnished under the physician's overall direction and control, but the physician's presence is not required during the service. Thus, general supervision allows for services to be conducted outside the physician's office, but the practitioner providing the service must be able to reach the supervising physician in a timely manner.

Table 1 presents current Part B services where pharmacists could play a role. Pharmacists can provide all components of the AWW or CCM without physician involvement (i.e. "incident to"). All

other services listed must be provided in a “split billing” fashion, where a pharmacist provides elements of a service that still requires physician involvement. While this toolkit focuses on CCM in patients with normal complexity, the “Additional Resources” section of this document provides links to other Part B service guides. This toolkit, plus the additional resources, can be utilized together to create a hybrid model of community pharmacist-provided care in an ambulatory care setting.

Table 1: Part Billing Codes for Pharmacist-Provided Services			
Billing Code Description	Supervision	Billing Code	Payment*
Chronic Care Management - Normal (20 min)	General	99490	\$43
Chronic Care Management - Moderate/High (60 min)	General	99487	\$94
Chronic Care Management - Moderate/High (30 min)	General	99489**	\$47
Comprehensive Assessment/Care Planning for CCM	N/A	G0506	\$64
Annual Wellness Visit (Initial)	Direct	G0438	\$166
Annual Wellness Visit (Subsequent)	Direct	G0439	\$111
Initial Preventive Physical Examination	Direct	G0402	\$159
Transitional Care Management - Moderate	Direct	99495	\$164
Transitional Care Management - High	Direct	99496	\$231
Evaluation and Management	Direct	99211***	\$20
	Direct	99212	\$37
	Direct	99213	\$59
	Direct	99214	\$88
	Direct	99215	\$119

*Payment is based on current rates in Tennessee as of this writing. Payments vary based on geographic region and if the service is performed in a hospital or physician’s office. The CMS PFS tool (see “Additional Resources”) can be utilized to determine payment in your area.

**Code is only reported in conjunction with 99487

***Code can bill billed by a pharmacist directly (i.e. without “incident to” billing methods)

CPF Pilot Experience

The endocrinologist’s patient insurance mix included Medicare only, Medicare plus supplement, and Dual Eligibles. All patients billed for CCM service 99490 (20 minutes) were successfully reimbursed by Medicare. All supplement plans paid the applicable copay and patients paid nothing out of pocket if they had met their deductible. For those without a supplement, the copay was collected at the next office visit. If the scheduled office visit was over three months away, patients were sent a bill through the mail. The copay was absorbed by the practice for Dual eligible patients who were considered QMBs.

While the grant focused on 99490, this guide is applicable to providing and billing for 99487 and 99489. The main difference is the physician or non-physician practitioner will need to deem the patient as moderate/high complexity in the care plan. Once deemed moderate/high complexity based on E/M rules (see “Additional Resources”), the community pharmacist can bill for up to 60 minutes time (99487) with an additional 30 minute modifier (99489). It should be noted that 99489 can not be billed in conjunction with 99490. Community pharmacists should work closely with the partnering physician or non-physician practitioner each month to determine a patients’ changing health status and necessary time spent providing care through CCM.

Final Thoughts

This grant confirmed that community pharmacists are able to provide and bill for CCM outside of a physician’s office. CCM should be considered as one of many services a community pharmacist can provide to physicians and their patient panel. Community pharmacists should utilize this toolkit to as a resource to expedite the formation of CCM services and should consider utilizing other toolkits found on the CPF website to supplement and diversify revenue streams.

Additional Resources

Resource	Website
AWV Guide	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf
CCM Overview	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf
CCM Webpage	https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/chronic-care-management.html
CCM 2017 Changes	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagementServicesChanges2017.pdf
CCM Billing FAQ	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment_for_CCM_Services_FAQ.pdf
CEHR Requirements	https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/
CMS MAC Website	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/
E/M Guide	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf
IPPE Guide	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf
Medicare Preventive Service Website	https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html
PFS Look-Up Tool	https://www.cms.gov/apps/physician-fee-schedule/overview.aspx
TCM Guide	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf
Tennessee Pharmacist Association Practice-Based Resources	https://www.tnpharm.org/events-resources/practice-based-resources/

Appendix A

BUSINESS ASSOCIATE AGREEMENT

This BUSINESS ASSOCIATE AGREEMENT (the "Agreement") is entered into this ____ day of _____, _____, by and between _____ (hereinafter the "Covered Physician"), _____, (hereinafter the "Covered Pharmacy"), _____ (hereinafter the "Community Pharmacist").

WHEREAS, the Community Pharmacist is contracted with the Covered Physician to provide Patient Care Services (as herein defined) requiring "direct supervision" in the Covered Physician's office.

WHEREAS, the Community Pharmacist is contracted with the Covered Physician and Covered Pharmacy to provide Patient Care Services requiring "general supervision" outside the Covered Physician's office.

WHEREAS, in connection with all the Part B billable services provided by the Community Pharmacist, the Covered Physician will bill for these services through the Covered Physician's NPI number.

WHEREAS, the Covered Physician grants the Community Pharmacist access to their electronic health record to facilitate patient care services provided by the Community Pharmacist to the Covered Physician's current and prospective patients.

THEREFORE, the parties agree to enter into this Agreement to allow for the Community Pharmacist to provide care and services authorized under a collaborative pharmacy practice agreement.

1. Definitions.

For purposes of this Agreement:

- "Confidential Information" shall mean all business records, patient data (including Protected Health Information), contract documents or other materials furnished or made available to Community Pharmacist by Covered Physician or Covered Pharmacy in conjunction with the performance of this agreement.
- "Patient" shall mean an individual patient of Covered Physician who has been identified as eligible to receive Patient Care Services.
- "Patient Care Services" includes Chronic Care Management services and other preventive services, as jointly agreed upon by the Community Pharmacist and Covered Physician.
- "Protected Health Information" will have the same meaning as the term definition set forth in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the HIPAA Privacy Rules and Regulations.
- "Required by Law" will have the same meaning as the term "required by law" in 45 C.F.R. § 164.501.
- "Collaborative Pharmacy Practice Agreement" is a written and signed agreement entered into voluntarily between one (1) or more licensed pharmacists in this state, and one (1) or more prescribers licensed in this state, each of whom is in active practice in this state providing patient care services in this state, that provides for collaborative pharmacy practice, as defined by law

2. Responsibilities of Involved Parties.

2.1 Responsibilities of Community Pharmacist

In conjunction with this Agreement, Community Pharmacist has the following specific responsibilities:

1. Community Pharmacist shall maintain proper licensure to engage in the professional practice of Pharmacy in the State of Tennessee. All services provided by Community Pharmacist to Patients shall comply with the standard of care for professional pharmacy practice in the State of Tennessee. Community Pharmacist shall provide immediate notice to Covered Pharmacy and Covered Physician of any limitation or qualification upon his/her right to engage in the professional practice of pharmacy in the State of Tennessee.
2. Community Pharmacist shall enter into a valid Collaborative Practice Agreement with Covered Physician to facilitate the delivery of Patient Care Services.
3. Community Pharmacist shall communicate patient care activities to Covered Physician as stated in the signed Collaborative Practice Agreement. Community Pharmacist shall communicate, as necessary, with Covered Pharmacy to coordinate care with regards to Chronic Care Management needs.
4. Community Pharmacist is authorized to provide Patient Care Services both inside and outside of the Covered Physician's office. Community Pharmacist shall ensure all CMS requirements are met or exceeded for billing purposes and to provide optimal patient care.
5. Community Pharmacist will take all steps necessary to avoid the dissemination of Protected Health Information of Patients. In accordance with this undertaking, Community Pharmacist shall comply with all applicable federal and state laws, rules, and regulations regarding confidential patient information a/k/a Protected Health Information.
6. Community Pharmacist will not engage in the unauthorized use of any intellectual property rights maintained by Covered Physician or Covered Pharmacy. This includes but it is not limited to copyrights, trademarks, service marks and related intellectual property. Additionally, Community Pharmacist acknowledges and agrees that he/she is not the legal representative or agent of Covered Physician or Covered Pharmacy for any purpose and shall have no right or authority to assume or create any obligation on behalf of or in the name of Covered Physician or Covered Pharmacy or to bind Covered Physician or Covered Pharmacy in any matter whatsoever, except for such purposes and matters as are specifically contemplated by this Agreement.
7. Community Pharmacist will take steps necessary to avoid the unnecessary dissemination of Covered Physician or Covered Pharmacy Confidential Information. Additionally, upon termination of this Agreement, Community Pharmacist shall return to Covered Physician or Covered Pharmacy all respective Confidential Information together with any patient records or information acquired by Community Pharmacist during the term of the Agreement.
8. Community Pharmacist shall obtain and maintain in effect a policy of professional liability insurance from a recognized professional liability insurance carrier. The minimum acceptable limits for said professional liability policy shall be: \$1,000,000 for each occurrence and \$3,000,000 in the aggregate. Covered Physician and Covered Pharmacy may also be named as certificate holders upon request.

9. Community Pharmacist shall indemnify, defend and hold harmless Covered Physician or Covered Pharmacy from and against any and all claims arising or resulting from any breach, violation or noncompliance with any of the terms of this agreement by Community Pharmacist. Additionally, Community Pharmacist shall indemnify, defend and hold harmless Covered Physician or Covered Pharmacy in conjunction with any negligent, wrongful act or omission on the part of Community Pharmacist; however, this indemnification shall not extend to any claim that arises from the negligence, wrongful act or omission of Covered Physician or Covered Pharmacy in conjunction with the delivery of the services to be rendered hereunder.

2.2 Responsibilities of Covered Pharmacy

In conjunction with this Agreement, Covered Pharmacy has the following specific responsibilities:

1. Covered Pharmacy shall continue to maintain all appropriate licensure to engage in the business of pharmacy in the State of Tennessee. Covered Pharmacy shall provide immediate notice to Community Pharmacist and Covered Physician of any limitation or qualification upon such right.
2. Covered Pharmacy shall provide Community Pharmacist with appropriate staff, including but not limited to certified pharmacy technician(s) and/or pharmacist(s), trained in providing elements of Patient Care Services.
3. Covered Pharmacy shall allow the Community Pharmacist access to pharmacy system both in-office and remotely.
4. Covered Pharmacy shall provide Community Pharmacist with a private or semi-private area to conduct Patient Care Services.
5. Covered Pharmacy shall obtain and maintain in effect a policy of professional liability insurance from a recognized professional liability insurance carrier. The minimum acceptable limits for said professional liability policy shall be: \$1,000,000 for each occurrence and \$3,000,000 in the aggregate. Covered Physician and Covered Pharmacist may also be named as certificate holders upon request.
6. Covered Pharmacy shall indemnify, defend and hold harmless Community Pharmacist or Covered Physician from and against any and all claims arising or resulting from any breach, violation or noncompliance with any of the terms of this Agreement by Covered Pharmacy or its agents, employees or representatives. Additionally, Covered Pharmacy shall indemnify, defend and hold harmless Community Pharmacist or Covered Physician in conjunction with any negligent, wrongful act or omission on the part of Covered Pharmacy or its agents, employees or representatives; however, this indemnification shall not extend to any claim that arises from the negligence, wrongful act or omission of Community Pharmacist or Covered Physician in performing the services to be rendered hereunder.

2.3 Responsibilities of Covered Physician

In conjunction with this Agreement, Covered Physician has the following specific responsibilities:

1. Covered Physician shall continue to maintain all appropriate licensure to engage in the business of pharmacy in the State of Tennessee. Covered Physician shall provide immediate notice to Community Pharmacist and Covered Pharmacy of any limitation or qualification upon such right.

2. Covered Physician shall provide Community Pharmacist with adequate private meeting space within Covered Physician's office for delivery of Patient Care Services.
3. Covered Physician shall enter into a valid collaborative pharmacy practice agreement with Community Pharmacist to facilitate the delivery of Patient Care Services.
4. Covered Physician shall provide Community Pharmacist access, both on-site and remote, to the Covered Physician's electronic health record used for documentation and to manage patient encounters.
5. Covered Physician is authorized to bill to Medicare utilizing Covered Physician's NPI number for services provided by Community Pharmacist under this agreement.
6. Covered Physician retains the right to collect any reimbursements which are billed as a result of patient care provided by Community Pharmacist. Covered Physician, Covered Pharmacy, and Covered Pharmacist may contractually agree upon allocation of reimbursements to Covered Pharmacist, which are billed as a result of Patient Care Services provided by Covered Pharmacist.
7. Covered Physician shall obtain and maintain in effect a policy of professional liability insurance from a recognized professional liability insurance carrier. The minimum acceptable limits for said professional liability policy shall be: \$1,000,000 for each occurrence and \$3,000,000 in the aggregate. Covered Pharmacy and Covered Pharmacist may also be named as certificate holders upon request.
8. Covered Physician shall indemnify, defend and hold harmless Community Pharmacist or Covered Pharmacy from and against any and all claims arising or resulting from any breach, violation or noncompliance with any of the terms of this Agreement by Covered Physician or its agents, employees or representatives. Additionally, Covered Physician shall indemnify, defend and hold harmless Community Pharmacist or Covered Pharmacy in conjunction with any negligent, wrongful act or omission on the part of Covered Physician or its agents, employees or representatives; however, this indemnification shall not extend to any claim that arises from the negligence, wrongful act or omission of Community Pharmacist or Covered Pharmacy in performing the services to be rendered hereunder.

3. Term/Termination.

3.1 Term. This Agreement shall be effective as of the later of January 1, 20__, or the date set forth above, and will continue for a period of 12 months. Any party may terminate this Agreement upon thirty (30) days written notice to the other parties, by either the Covered Physician, Covered Pharmacy, or Community Pharmacist.

3.2 Termination for Cause. Upon Covered Physician or Covered Pharmacy knowledge of a material breach of this Agreement by Community Pharmacist, the Covered Physician or Covered Pharmacy shall either:

1. Provide specific notice of the alleged breach and furnish an opportunity for Community Pharmacist to cure the breach or end the violation and/or terminate this Agreement; or
2. Immediately terminate this Agreement if Community Pharmacist has breached a material term of this Agreement and cure is not possible.

3.3 Effect of Termination. Upon termination of this Agreement, for any reason, Community Pharmacist shall return or destroy, and relinquish access to, all Confidential Information received from the Covered Physician or Covered Pharmacy, or created by Community Pharmacist on behalf of Covered Physician or Covered Pharmacy.

4. **No Third Party Beneficiaries.** Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than Covered Pharmacy, Covered Physician, and Community Pharmacist, any rights, remedies or obligations whatsoever.
5. **Notices.** All notices, requests, consents and other communications hereunder will be in writing, will be addressed to the receiving party's address set forth below or to such other address as a party may designate by notice hereunder, and will be either (i) delivered by hand, (ii) made by facsimile transmission, (iii) sent by overnight courier, or (iv) sent by registered or certified mail, return receipt requested, postage prepaid.

If to the Covered Physician:

If to the Covered Pharmacy:

If to the Community Pharmacist:

6. **Entire Agreement.** This Agreement embodies the entire agreement and understanding between the parties hereto with respect to the subject matter hereof and supersedes all prior oral or written agreements and understandings relating to the subject matter hereof. No statement, representation, warranty, covenant or agreement of any kind not expressly set forth in this Agreement will affect, or be used to interpret, change or restrict, the express terms and provisions of this Agreement.
7. **Modifications and Amendments.** The terms and provisions of this Agreement may be modified or amended only by written agreement executed by the parties hereto.
8. **Severability.** The parties intend this Agreement to be enforced as written. However, (i) if any portion or provision of this Agreement will to any extent be declared illegal or unenforceable by a duly authorized court having jurisdiction, then the remainder of this Agreement, or the application of such portion or provision in circumstances other than those as to which it is so declared illegal or unenforceable, will not be affected thereby, and each portion and provision of this Agreement will be valid and enforceable to the fullest extent permitted by law; and (ii) if any provision, or part thereof, is held to be unenforceable because of the duration of such provision, the parties hereto agree that the court making such determination will have the power to reduce the duration of such provision, and/or to delete specific words and phrases, and in its reduced form such provision will then be enforceable and will be enforced.
9. **Interpretation.** The parties hereto acknowledge and agree that both (i) the rule of construction to the effect that any ambiguities are resolved against the drafting party and (ii) the terms and provisions of this Agreement, will be construed fairly as to all

parties hereto and not in favor of or against a party, regardless of which party was generally responsible for the preparation of this Agreement.

10. Headings and Captions. The headings and captions of the various subdivisions of this Agreement are for convenience of reference only and will in no way modify, or affect the meaning or construction of any of the terms or provisions hereof.
11. No Waiver of Rights, Powers and Remedies. No failure or delay by a party hereto in exercising any right, power or remedy under this Agreement, and no course of dealing between the parties hereto, will operate as a waiver of any such right, power or remedy of the party. No single or partial exercise of any right, power or remedy under this Agreement by a party hereto, nor any abandonment or discontinuance of steps to enforce any such right, power or remedy, will preclude such party from any other or further exercise thereof or the exercise of any other right, power or remedy hereunder. The election of any remedy by a party hereto will not constitute a waiver of the right of such party to pursue other available remedies. No notice to or demand on a party not expressly required under this Agreement will entitle the party receiving such notice or demand to any other or further notice or demand in similar or other circumstances or constitute a waiver of the rights of the party giving such notice or demand to any other or further action in any circumstances without such notice or demand. The terms and provisions of this Agreement may be waived, or consent for the departure there from granted, only by written document executed by the party entitled to the benefits of such terms or provisions. No such waiver or consent will be deemed to be or will constitute a waiver or consent with respect to any other terms or provisions of this Agreement, whether or not similar. Each such waiver or consent will be effective only in the specific instance and for the purpose for which it was given, and will not constitute a continuing waiver or consent.
12. Governing Law. This Agreement will be governed by and construed in accordance with the laws of the State of Tennessee.
13. Attorney's Fees. If any action at law or in equity is brought to enforce or interpret the provisions of this Agreement, the prevailing party in such action will be entitled to reimbursement for reasonable attorneys' fees and cost

IN WITNESS WHEREOF, the parties have caused this Agreement to be signed by their duly authorized representatives or officers, effective as of the date first listed above in the preamble to this Agreement.

COVERED PHYSICIAN: _____

DATE _____

COVERED PHARMACY: _____

DATE _____

COMMUNITY PHARMACIST: _____

DATE _____

Appendix B (Specific to Tennessee)

Collaborative Pharmacy Practice Agreement

A. AUTHORITY

As the authorizing physician, I, _____, authorize the community pharmacist named herein, who holds an active license to practice from the Tennessee Board of Pharmacy, to manage and/or treat patients of the collaborating prescribers named herein pursuant to a Collaborative Pharmacy Practice Agreement (further referred to as Agreement). This authority follows TCA §63-10-204 and Tennessee Board of Pharmacy rule 1140-03-.17.

B. SCOPE OF PRACTICE

Patients who receive patient care services from the clinic will be notified that delivery of these services could be provided by a community pharmacist working in collaboration with the authorizing physician or collaborating prescriber. This notification will take place before any services are provided that comply with all applicable by-laws, policies, and procedures of _____. The community pharmacist will have the authority to manage and/or treat patients that receive patient care services in accordance with this section:

Sections 1-4 will correspond to drugs related to the following conditions/disease states:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(1) Executing therapeutic plans utilizing the most effective, safest, and most economical medication treatments.

(2) Identifying and taking specific corrective action for drug-induced problems according to protocol, procedure, guideline or standard of care.

(3) Ordering, subsequent review, and action on appropriate laboratory tests and other diagnostic studies necessary to monitor, support, and modify the patient's drug therapy.

(4) Prescribing medications, devices, and supplies to include: initiation, continuation, discontinuation,

monitoring and altering therapy related to conditions/disease states selected above. (The community pharmacist shall not initiate or modify controlled, scheduled substances without a written prescription from the authorizing physician or collaborating prescriber).

(5) Utilizing appropriate techniques and/or screening tools to perform physical measurements and objective assessments necessary to complete patient care services.

(6) Establishing comprehensive patient-centered care plans that include, but not limited to, all patient-specific health issues, environmental issues, resources and supports, and a preventive checklist based on identified risk factors.

(7) Ordering referrals (e.g., dietician, social work, specialty provider), as appropriate, to maximize positive outcomes and ensure all necessary preventive services are received.

C. PROCESS OF CARE

Patients who receive care from the community pharmacist will sign informed consent prior to any services provided. New and existing, eligible patients, will be referred to the community pharmacist by the authorizing physician or collaborating prescriber for patient care services if desired. All patients will continue to see the authorizing physician or collaborating prescriber for new conditions, acute complaints, and as necessary for any new or ongoing health problems as deemed appropriate by the community pharmacist, authorizing physician or collaborating prescriber. Patients requiring services or further diagnosis in addition to patient care services will be scheduled for additional appointments with the authorizing physician or collaborating prescriber.

D. PATIENT INFORMED CONSENT

The facility shall obtain verbal and/or written informed consent from the patient, or patient's authorized representative, stating the patient is to receive services from a healthcare team, including a clinical pharmacist. A patient can withdraw from treatment under this agreement at any time.

E. DOCUMENTATION

The clinical pharmacist shall have 24/7 access to the clinic's electronic health record (EHR) and document each patient encounter in the clinic's EHR. That documentation will include, at a minimum, the reason for the encounter, any changes in the patient's condition, any test results, and any changes in the patient's treatment plan. The authorizing physician shall, at a minimum each month, review five percent (5%) of the patients treated pursuant to the Agreement.

F. REPORTING

The community pharmacist shall report any new patient complaints and/or deterioration in the patient's condition and any resulting change in the patient's treatment plan to the authorizing physician or collaborating prescriber immediately after learning of the new condition or as soon as

possible thereafter through various means including, but not limited to, telephone, text, and email.

H. AGREEMENT REVIEW AND DURATION

This agreement shall be valid for a period not to exceed twelve (12) months from the effective date. However, it may be reviewed and revised at any time at the request of any signatories. Signatories must be informed of any collaborating prescribers that want to be added to this agreement.

I. RECORD RETENTION

Each signatory to this agreement shall keep a signed copy of this agreement on file at their primary place of practice. All documentation, including but not limited to patient interaction and quality assurance, shall be kept for a period of not less than ten (10) years after last patient encounter by the participating parties.

J. TERMINATION OR ALTERATION OF AGREEMENT

A signatory may modify or terminate this agreement at any time and shall include written notification to all affected parties when modification or termination is sought. Modifications to the agreement will occur upon mutual approval by all original signatories and modifications executed shall not automatically void the terms and conditions of the existing Agreement unless expressly stated.

K. OVERRIDE CLAUSE

The authorizing physician or collaborating prescriber may override this agreement whenever he or she deems such action necessary or essential to the optimal health outcomes of the patient. Agreement overrides must be documented in the clinic's EHR and communicated to the community pharmacist immediately or as soon as possible thereafter through various means including, but not limited to, telephone, text, and email.

L. AUTOMATIC EXCLUSIONS

Any signatory will be automatically excluded from participation in the Agreement upon death, suspension, surrender, revocation, or retirement of license; loss or restriction of prescriptive authority; the suspension or revocation of a Drug Enforcement Administration registration, or exclusion from any federally-funded health programs.

N. AGREEMENT SIGNATURES

This agreement includes patients under the care of these practitioner(s) and extends for a period of twelve (12) months from this date unless rescinded earlier in writing.

_____, M.D
(Authorizing Physician)

License # : _____

Date: _____

_____, Pharm.D
(Collaborating Pharmacist)

License # : _____

Date: _____

_____, _____
(Collaborating Prescriber)

License # : _____

Date: _____

_____, _____
(Collaborating Prescriber)

License # : _____

Date: _____

_____, _____
(Collaborating Prescriber)

License # : _____

Date: _____

_____, _____
(Collaborating Prescriber)

License # : _____

Date: _____

Appendix C

Example CCM Comprehensive Care Plan

*** This is an example comprehensive care plan and should guide, but not replace, creating a specific care plan template tailored to your practice site.**

Thank you for enrolling in Chronic Care Management services. All of the providers are excited about the benefits this service can provide between face-to-face office visits. The main point of contact will be the pharmacist, who will reach out to you each month to get an update on your current health status. The pharmacist can also be reached any other time that your health status changes, or when you have questions regarding your health. A comprehensive care plan has been created specifically for you to make sure everyone involved in your care has the most up-to-date information about your health status.

Your consent to enroll in Chronic Care Management services was obtained in person on 6/22/2017. You understand the availability of CCM services (access to the pharmacist over telephone and/or email), the applicable cost-sharing, that only one practitioner can furnish and be paid for CCM services during a calendar month, and your right to stop CCM services at any time (effective at the end of the calendar month).

A description of how services of agencies and specialists outside the practice will be directed/coordinated

- Services will be coordinated through the pharmacist, who will be monitoring patients between visits with providers at this office. The pharmacist will ensure that other providers receive patient care plan information as necessary to optimize patient care
- Providers at this office will periodically review the care plan prior to face-to-face visits. Revision of the care plan will take place as necessary during the provision of chronic care management services or at in-office visits.

Other Evaluation and Management Services

CCM Normal Complexity

Visit Date: Thu, Jun 29, 2017 01:44 pm

Provider: Pharmacist, (Supervisor: Physician)

Location: Endocrinologists Office

Other Providers: PCP, Pulmonologist

Labs/notes received 6/23/2017

SUBJECTIVE:

CC:

76 year old Black or African American female.

CCM Documentation for the month of July. Non-Complex

Verbal consent has been obtained by the patient for participation in the Chronic Care Management program.

PMH/FMH/SH:

Last Reviewed on 6/22/2017 04:00 PM by Physician

Past Medical History: HTN; depression; GERD; allergies; asthma (has taken chronic steroids)

Surgical History: right foot mole removed; heel spur; TAH/USO; last ovary removed in 1998

Family History: HTN, stroke; DM brother had colon cancer

Social History: drives a forklift for bridgestone tire comp; single; two children

Tobacco/Alcohol/Supplements: no tobacco or etoh
Last Reviewed on 6/22/2017 08:58 AM by Medical Assistant

Substance Abuse History:
Last Reviewed on 6/22/2017 08:58 AM by Medical Assistant
None

Mental Health History: NO MHCs
Last Reviewed on 6/22/2017 08:58 AM by Medical Assistant

Communicable Diseases (eg STDs): NO STDs
Last Reviewed on 6/22/2017 08:58 AM by Medical Assistant

Current Problems:
Acquired hypothyroidism, unspecified cause
Fatigue
Long-term (current) use of steroids
Prediabetes
Thyroid nodule
Impaired fasting glucose
Depression
Postablative ovarian failure
Nontoxic nodular goiter, multinodular
Dry skin

Immunizations:
None

Allergies:
Last Reviewed on 6/22/2017 02:56 PM by Pharmacist
Penicillins:
Lactose intolerance:

Current Medications:
Last Reviewed on 9/11/2017 03:58 PM by Pharmacist
Levothyroxine Sodium 0.1mg Tablet – Take 1 tablet in the morning on an empty stomach
Lancets* Round Ascencia Contour – Check blood sugar once daily
Losartan 25mg Tablet - Take 1 tablet by mouth daily
Advair Diskus 250mcg/50mcg Inhalation Powder – Take 1 puff twice daily
Estradiol 0.1mg Transdermal Patch - Apply 1 patch to lower abdomen every week
Prednisone 2.5mg Tablet – Take 1 tablet by mouth daily
Oxybutynin Chloride 5mg Tablet – Take 1/2 tablet by mouth daily

Zyrtec 10mg Tablet - Take 1 tablet by mouth as needed
Singulair 10mg Tablet – Take 1 tablet by mouth every evening
Albuterol – Take 2 puffs every 4-6 hours as needed

OBJECTIVE:

Lab/Test Results:

T3, Free, Serum: 2.3 (pg/mL) (05/11/2017), 2.73 (07/05/2017),
T4 Free, Direct, Serum: 0.8 (ng/dL) (06/13/2017), 0.78 (07/05/2017),
HgbA1c: 5.8 (07/05/2017),
Creatinine, Serum: 0.91 (mg/dL) (09/08/2015),
eGFR NON-AFR. AMERICAN: 62 (mL/min/1.73m2) (09/08/2015),
GLUCOSE: 116 (mg/dL) (09/08/2015),
TSH: 0.78 (mIU/L) (05/11/2017), 0.85 (mIU/L) (06/13/2017), 2.63 (07/05/2017),
Weight (lb): 201.6 (06/22/2017),
BMI: 36.3 (06/22/2017),
Systolic BP: 120 (06/22/2017),
Diastolic BP: 84 (05/11/2017), **82** (06/22/2017),
Pulse: 84 (09/08/2015), 84 (06/22/2017),

ASSESSMENT

244.9 E03.9 Acquired hypothyroidism, unspecified cause
DDx:
V58.65 Z79.52 Long-term (current) use of steroids
DDx:
790.29 R73.09 Prediabetes
DDx:
256.2 E89.40 E89.41 Postablative ovarian failure
DDx:

PLAN:

Acquired hypothyroidism, unspecified cause

Encounter 1:

Date of Encounter: 07/06/17

Person providing services: Pharmacist clinical labor for today's encounter was performed via phone conversation with patient.

Pt saw PCP on 7/5/17 and had blood work to check her thyroid because she is starting to feel itchy, tired and have headaches again. Pt was on Armour 30mg for the past couple of years but just recently started to feel cold and believed Armour was causing. Will call PCP office on 7/7/17 to obtain lab results. Instructed pt to use pill cutter and start back on half tablet of Armour (15mg) qam because of her concern of going back on previous full dose. Instructed pt to increase to whole tablet in 10 days if not having SE. Will follow up with pt on 7/7/17 with lab results and on 7/20/17 to assess therapy. CCM Coding:

15 minutes clinical labor time today minutes of clinical labor time spent today.

Encounter 2:

Date of Encounter: 7/10/17

Person providing services: Pharmacist clinical labor for today's encounter was performed via phone conversation with patient.

Received pt lab data from PCP on 7/10/17 and had faxed to office. TSH went from 0.85 to 2.63 over a 1 month period without taking Armour and T3/T4 were 2.73 and 0.78 respectively. Informed pt of how an increase in TSH and low free T3/T4 means she isn't making thyroid hormone and needs to continue on Armour 15mg. Pt understood and will continue splitting 30mg tablets until she picks up new prescription for Armour 15mg. CCM Coding: 11 minutes clinical labor time today minutes of clinical labor time spent today.

Encounter 3:

Date of Encounter: 7/18/17

Person providing services: Pharmacist clinical labor for today's encounter was performed via phone conversation with patient.

Pt is still fatigued and having headaches but worried about increasing Armour and chills coming back. Suggested switching to levothyroxine and see how that works. Pt agreed. She will D/C Armour 15mg and start levothyroxine 50mcg. Will follow up to see how pt is doing in 1-2 weeks. CCM Coding:

5 minutes of clinical labor time spent today.

Encounter 1:

Date of Encounter: 8/11/17

Person providing services: Pharmacist clinical labor for today's encounter was performed via phone conversation with patient. Pt has been doing well with Levothyroxine 50mcg for two weeks. No headaches, less fatigue, and little to no itching. No chills as compared to Armour. Pt did state she is still groggy most morning. Possibly attributed to subtherapeutic dose of levothyroxine, but also to sleep apnea. Will move pt to 75mcg levothyroxine after 50mcg prescription runs out at end of month. CCM Coding:

15 minutes clinical labor time today minutes of clinical labor time spent today.

20 minutes or more of clinical labor time spent this calendar month.

Encounter 2:

Date of Encounter: 8/31/17

Person providing services: Pharmacist clinical labor for today's encounter was performed via phone conversation with patient. Pt stated she has been doing well since last call. She has been taking the 75mcg for about a week and feels fine. TSH and T4 levels will be assessed at next in office visit in September. CCM Coding:

3 minutes clinical labor time today minutes of clinical labor time spent today.

Encounter 1:

Date of Encounter: 9/11/17

Person providing services: Pharmacist clinical labor for today's encounter was performed via phone conversation with patient. CCM Coding:

10 minutes clinical labor time today minutes of clinical labor time spent today. Pt stated she has not had much energy still and feels that the 75mcg of levothyroxine is still not enough. Pt has three days left of 75mcg so instructed to continue dose until finished and a new script for

88mcg will be sent in. Comfortable with increasing dose prior to lab work since her starting dose based on weight could have been 145mcg. Pt will be seen on 9/28 for in office visit and blood work. Will reassess dosage at that point.

Long-term (current) use of steroids

Encounter 1:

Date of Encounter: 7/18/17

Person providing services: Pharmacist clinical labor for today's encounter was performed via phone conversation with patient. CCM Coding:

3 minutes of clinical labor time spent today.

Discussed D/C of long-term use of prednisone. Pt wants to discuss with pulmonologist who would like to keep her on it at this point. Instructed that if she was to ever stop it, she would need to slowly wean off of the medication.

Encounter 1:

Date of Encounter: 8/11/17

Person providing services: Pharmacist clinical labor for today's encounter was performed via phone conversation with patient. CCM Coding:

5 minutes clinical labor time today minutes of clinical labor time spent today. Pt had a steroid injection in her shoulder two weeks ago and has had stomach pains ever since. Pt concerned of ulcer formation due to long term oral steroid use. Pt voiced concern over steroid use and wanting to try and come off the medication. Instructed that she would need to slowly wean herself off. The prednisone 5mg can be split and the patient wants to do that (i.e. 2.5mg/day). I instructed her to wait until I received confirmation from her pulmonologist that this was ok. Informed that if she notices any worsening of breathing symptoms she would probably have to increase dose again and should be sure to have her short acting inhaler with her.

Encounter 1:

Date of Encounter: 9/11/17

Person providing services: Pharmacist clinical labor for today's encounter was performed via phone conversation with patient. CCM Coding:

2 minutes clinical labor time today minutes of clinical labor time spent today. Pt stated she is still using 2.5mg prednisone qd. States she has had no worsening in her breathing except for the poor air quality with the hurricanes. Instructed her to continue at this dose but be cognizant of her breathing. She confirms she is still adherent to advair and that it is working well.

Prediabetes

Encounter 1:

Date of Encounter: 7/18/17

Person providing services: Pharmacist clinical labor for today's encounter was performed via phone conversation with patient. CCM Coding:

3 minutes of clinical labor time spent today.

Discussed last A1c of 5.8% and how she is technically considered prediabetic and how this can lead to diabetes. Counseled on diet/exercise and how these things can lower her A1c. Counseled on limiting carb intake and try to get at least 150min/wk of moderate intensity exercise. Informed her of the possibility of prednisone keeping her BS up, which could be

leading to the elevated A1c. Pt will discuss coming off prednisone with pulmonologist.

Postablative ovarian failure

Encounter 1:

Date of Encounter: 7/18/17

Person providing services: Pharmacist clinical labor for today's encounter was performed via phone conversation with patient. Discussed the amount of estrogen pt is currently taking (patch with 1mg estradiol po qd). Informed her of the risk of blood clots with high levels of estrogen therapy and suggested at least eliminating the oral estradiol. Pt wants to discuss with her PCP at next visit. CCM Coding:
2 minutes of clinical labor time spent today.

Orders:

20 minutes spent on CCM related clinical tasks (In-House)

Preventive Services - Not Addressed:

INFLUENZA VACCINE yearly for all patients age 65 and older

MAMMOGRAM yearly for all female patients 50 and older

PAP TEST yearly for all female patients age 18 and older

PNEUMOCOCCAL VACCINE : all patients age 65 and older require 1 dose

COLONOSCOPY every 5-10 years for patient's age 50 and older

SIGMOIDOSCOPY every 3 years for all patients age 50 and older

TETANUS / DIPHTHERIA required every 10 years for all adult patients

No Service Orders at this time

CHARGE CAPTURE

****Please note: ICD descriptions below are intended for billing purposes only and may not represent clinical diagnoses****

Primary Diagnosis:

244.9 Acquired hypothyroidism, unspecified cause

E03.9 Hypothyroidism, unspecified

V58.65 Long-term (current) use of steroids

Z79.52 Long term (current) use of systemic steroids

790.29 Prediabetes

R73.09 Other abnormal glucose

256.2 Postablative ovarian failure

E89.40 Asymptomatic postprocedural ovarian failure

E89.41 Symptomatic postprocedural ovarian failure

Appendix D

Medicare Preventive Services Checklist			
Recommended	Preventive Service	Scheduled	Completed
<input type="checkbox"/>	Alcohol Misuse Screening and Counseling		
<input type="checkbox"/>	Annual Wellness Visit		
<input type="checkbox"/>	Bone Mass Measurements		
<input type="checkbox"/>	Cardiovascular Disease Screening Test		
<input type="checkbox"/>	Colorectal Cancer Screening		
<input type="checkbox"/>	Counseling to Prevent Tobacco Use		
<input type="checkbox"/>	Depression Screening		
<input type="checkbox"/>	Diabetes Screening		
<input type="checkbox"/>	Diabetes Self-Management Training (DSMT)		
<input type="checkbox"/>	Glaucoma Screening		
<input type="checkbox"/>	Hepatitis C Virus (HCV) Screening		
<input type="checkbox"/>	Human Immunodeficiency Virus (HIV) Screening		
<input type="checkbox"/>	Vaccinations and their Administration		
<input type="checkbox"/>	<ul style="list-style-type: none"> • Influenza 		
<input type="checkbox"/>	<ul style="list-style-type: none"> • Pneumococcal 		
<input type="checkbox"/>	<ul style="list-style-type: none"> • Hepatitis B 		
<input type="checkbox"/>	<ul style="list-style-type: none"> • Herpes Zoster (Shingles) 		
<input type="checkbox"/>	Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD), also know as a CVD risk reduction visit		
<input type="checkbox"/>	Intensive Behavioral Therapy (IBT) for Obesity		
<input type="checkbox"/>	Medical Nutrition Therapy (MNT)		
<input type="checkbox"/>	Prostate Cancer Screening		
<input type="checkbox"/>	Sexually Transmitted Infections (STIs) Screening and High Intensity Behavioral Counseling (HIBC) to Prevent STIs		
<input type="checkbox"/>	Screening Mammography		
<input type="checkbox"/>	Screening Pap Tests		
<input type="checkbox"/>	Screening Pelvic Exams (includes a clinical breast exam)		
<input type="checkbox"/>	Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)		