Medication Therapy Management Pilot Program

Provider Operations Manual

https://provider.amerigroup.com/TN

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1 General information

1.1 Background

In 2022, TennCare authorized the design and implementation of medication therapy management (MTM) as cost-effective analysis (CEA) to improve therapeutic outcomes by optimizing responses to medication, managing treatment-related interactions or complications, and improving the adherence to drug therapy.

The MTM program has been defined as a distinct service or group of services that optimize therapeutic outcomes for individual patients. MTM services are independent of, but can occur in conjunction with, the provision of a medication product.

TennCare members eligible to receive program services are identified based on specific criteria and specific disease targeted states (pediatric members with asthma or diabetes mellitus [DM]).

Pharmacists participating in MTM will provide MTM services under a collaborative practice agreement (CPA) with TennCare patient centered medical home (PCMH) and Tennessee Health Link (Health Link) organizations to help patients maximize benefit from their medications. The goal of MTM is to work with patients in order to actively manage their drug therapy by identifying, preventing, and resolving medication-related problems.

The services provided to members by a qualified Tennessee MTM pharmacist may include:

1. Patient assessment (medical history as related by the patient).
2. Comprehensive patient medication therapy review.
3. Personal medication record (to be retained by the patient).
4. Medication action plan (for the patient to follow).
5. Document problems, resolutions, education, and evaluation of patient responses to medication therapy including adverse events.
6. Follow-up to ensure patient adherence with medication action plan and to encourage patient self-management.

MTM services will be provided to eligible members participating in a PCMH or Health Link (which are part of a Tennessee Health Care innovation initiative focused on value by providing high-quality and cost-effective care). Qualified MTM pharmacists for TennCare will be required to establish and maintain a working relationship with the PCMH and/or Health Link members.

2 Parameters and design

2.1 Framework

MTM program will function as CEA:

- Use Provider Relationship Management — not Provider Relations or Provider Solutions.

- Participation in MTM pilot program is voluntary for TennCare for PCMH and Health Link.

- Pharmacist must meet minimum requirements and have a CPA with a PCMH or Health Link from TennCare.

- TennCare members will be eligible for MTM services based on MTM criteria developed using care coordination tool (CCT) risk stratification criteria for critical, high, medium-high, moderate status, and targeted-disease states (TDS) (in other words, pediatric members with asthma or DM).

- During the initial MTM appointment, the pharmacist will conduct a member history interview and perform a medication regimen evaluation. The MTM pharmacist will address the member's understanding of medications and how they help manage their disease, adherence difficulties, inhaler techniques, adverse drug reactions, drug interactions, identification of any inappropriate drug therapy, as well as any member medication concerns.

- Following the initial visit, a report summarizing the MTM visit will be sent to the member's PCMH or Health Link. Per the professional judgement of the MTM pharmacist, copies of the report may be sent to other medical providers (for example, specialists) who may have prescribed medications to the member.

- The reimbursement model is based on a per month case rate (PMPM) for eligible TennCare members. Payment limits are based on the service description (based on MTM criteria) unless an exception is granted. Payment for services is contingent on continued TennCare eligibility.

- At each visit, the MTM pharmacist will deliver to the member educational resources (or handouts), a personalized medication list, and medication guidance.

- Following every MTM encounter, the pharmacist will document notes and outcomes in the CCT. The pharmacist will provide the PCMH/ Health Link with a complete and up-to-date medication list, a summary report of the visit, and any recommendations for potential changes to the current drug regimen, when appropriate.

- Communications between the pharmacist and PCMH or Health Link organizations is crucial and should be open, collaborative, and continue throughout the program.

3 MTM requirements

3.1 PCMH or Tennessee Health Link requirements

The MTM program is a **voluntary** program specifically for practices who are participating in the PCMH and Health Link initiative from TennCare.

A PCMH or Health Link must establish a written CPA with a qualified Tennessee pharmacist. The CPA is a great opportunity for the practice to establish pharmacist expectations, scope of practice, and parameters related to MTM services.

The pharmacist is required to document in the CCT all encounters related to MTM services. Due to issues of double documentation, the MTM program allows encounters to be documented in an **EHR/EMR as long as a *minimum reference to the service is notated in the CCT***. As such, the CCT administrator at the PCMH or Health Link will need to help facilitate with the CCT registration and onboarding of the pharmacist(s) as a new user within the team process.

3.2 Pharmacist requirements

Pharmacist(s) must meet the following criteria to qualify as an MTM Pharmacist for TennCare.

1. Pharmacist must have a valid Tennessee license and meet minimum insurance requirements (in other words, professional liability).

2. The participating pharmacist must acquire their own Medicaid ID for TennCare:
   - Information on provider registration and how to access the provider portal can be found on the TennCare website for provider registration at: **https://www.tn.gov/tenncare/providers/provider-registration.html**
   - **Important:** Individual providers will submit information that will place the provider on the Council for Affordable Quality Healthcare (CAQH) roster for TennCare/Tennessee Medicaid. Information and links, including a FAQ document, can be located at the website above. Once data is received from CAQH and approved, a Medicaid ID will be assigned. Note that TennCare will also automatically receive your profile data from CAQH each time you make an update.
   - CAQH: **https://proview.caqh.org/Login/Index?ReturnUrl=%2f**
   - For more information concerning provider registration, please contact Provider.Registration@tn.gov by email or by calling **800-852-2683, option 5**.

3. MTM pharmacist must have a written formal CPA in place with a PCMH or Health Link organization from TennCare:
   - The CPA establishes pharmacists to prescribing provider (supervising physician)
   - expectations from scope of practice to documentation. The Tennessee Board of Pharmacy rules can be located at the following webpage: **http://publications.tnsosfiles.com/rules/1140/1140-03.20170220.pdf**
   - CPA guidance and minimum requirements can be located at: **http://www.capitol.tn.gov/Bills/108/Amend/SA0839.pdf**
   - Additional information on CPA requirements can be located at the Tennessee Pharmacy Association (TPA) webpage: **http://www.tnpharm.org/wp-content/uploads/FINALTPACPA-guidance.pdf**

4. The MTM pharmacist participating in the MTM pilot program must document in the CCT and/or CCT and EHR/EMR, and must complete the onboarding registration, training, and access process for the CCT:
    - After a CPA is in place, the pharmacist may initiate CCT registration by emailing TennCare.Pharmacy.AdobeSign@tn.gov

   Please include the following information in the email request:
    - National Provider Identifier (NPI)
    - TennCare/Medicaid ID
    - Name of PCMH or Health Link organization from TennCare
    - Name(s) of pharmacist(s)
    - Email address (contact information)
    - Copy of CPA attestation/addendum signed by supervising physician and pharmacist providing services

5. MTM pharmacist must engage and complete the MCO credentialing and network agreements:
    - See **Section 3.3**

6. CCT access will be granted after the MCO credentialing and network process is completed.

7. *Acceptable Use Policy* and *Remote Access Request Forms* (electronic process) must be signed.

8. **All** registration steps listed above must be completed prior to providing MTM services and submitting claims for reimbursement.

3.3 MTM network contract

MTM pharmacists participating in the MTM program are required to engage and complete credentialing and sign network agreement. Amerigroup Community Care pharmacists should contact Provider Solutions to initiate the process:

- Website: **https://www.amerigroup.com**
- Phone: **800-454-3730**

4 Member eligibility

4.1 Member (patient) eligibility

TennCare members qualify for MTM services if they have a primary care provider (PCP) participating in a PCMH or Health Link organization from TennCare and have specific health risk problems or targeted disease states. An example might include a member who is categorized as high risk based on multiple chronic illnesses and taking multiple medications.

Member eligibility with risk stratification and TDS logic is described in Section 4.5.

4.2 MTM program opt-out

Members may select to stop participating in the MTM pilot program at any time. If an eligible member decides not to participate, they can opt out of the MTM program by notifying the pharmacist (and/or PCMH or Health Link)

The pharmacist (or PCMH/ Health Link) may ask a member to verify (through documentation) his or her desire to opt-out of the MTM program. However, if an eligible member decides to participate at a later time, members may reach out to the PCMH/ Health Link or pharmacist and notify them of their interest in the program.

The process to opt-out a member in the CCT can be found in the Care Coordination Training materials. Once a pharmacist confirms and completes the process to have a member's opt-out status triggered in the CCT, all required activities will be removed from the members MTM views.

4.3 General stratification

MTM eligibility criteria fall into the general program categories:

1. MTM-High CDPS-High Critical (members who have been identified with a risk stratification of critical and high)
2. MTM-High CDPS-Medium High
3. MTM-Moderate CDPS
4. Pediatric Asthma
5. Pediatric DM

4.4 Risk design

The MTM pilot program uses the Chronic Illness and Disability Payment System plus Pharmacy (CDPS + Rx), which combines medical diagnoses and prescription drugs to develop risk scores utilized within the CCT. The diagnostic classification system was developed by Richard Kronick and Tod Gilmer at University of California (UC)-San Diego to help Medicaid programs measure illness burden and to adjust calculated capitation rates to health plans that enroll Medicaid beneficiaries.

All cost for a population is accounted for in the model through claims. Members without any diagnosis category will be given a baseline for age/sex risk score. This type of scoring often happens more frequently with children. CDPS + Rx do provide separate models for different populations (for example, adults vs. children, disabled vs Temporary Assistance for Needy Families (TANF), different covered services). Relative risk weights are internal to each model and determined from separate claims data sets for each model (adults vs. children) and reflect actual diagnosis and treatment patterns in the separate populations used to develop each distinct

model and its calculated weights. Thus, identical diagnosis histories will produce different risk scores between, for example, adults and children.

An individual's risk score is the additive sum of age/sex base rate and the risk weights for each separate diagnosis category. Additional weight may be included for the interaction of two diagnosis categories where significant synergies have been identified.

For additional information on risk adjustment methodology, please see the following websites: **http://cdps.ucsd.edu/** and **https://www.tn.gov/content/dam/tn/tenncare/documents2/CDPSTennCareProvidersWebinar.pdf**

4.5 MTM identification (or eligibility) criteria: Risk stratification and targeted disease state

MTM hierarchy logic

Member eligibility criteria for the MTM pilot program has been divided into three risk categories (CDPS-High Critical, CDPS-Medium High, and CDPS-Moderate Risk) and two TDS defined as pediatric DM and pediatric asthma. In addition, the MTM pilot program has set age eligibility parameters for each of the MTM service categories.

The MTM pilot hierarchy logic first differentiates members by 1) risk stratification classifications (CDPS + Rx), followed by 2) MTM pilot specific age criteria, and then 3) targeted disease state for pediatric members with either asthma or DM who do not fall into the exclusion criteria. For example, if a pediatric member has asthma and does not fall into one of the risk stratification categories (for example, critical) then the pediatric member would be assigned to the asthma TDS.

It is important to note the MTM stratification categories are mutually exclusive and as such the member should only appear in one service category.

General MTM stratification

General MTM stratification will display in the CCT application as *MTM-High CDPS-High Critical*, *MTM-High CDPS-Medium High*, or *MTM-Moderate CDPS* program status.

1. **MTM-High CDPS-High Critical**

MTM-High CDPS-High Critical program identifies two risk levels (critical and high) as eligible for MTM pilot services. Members identified in *MTM-High CDPS-High Critical* include members with the age parameters of 2 years and 0 days to 64 years 364 days qualify for MTM services.

In addition, pediatric patients who have diagnoses of asthma and/or DM (with high or critical risk) will identify as *MTM-High CDPS-High Critical*.

2. **MTM-High CDPS-Medium High**

MTM-High CDPS-Medium High program status will identify those patients who have medium-high risk status as eligible for MTM pilot services. In addition, pediatric patients who

have diagnoses of asthma and DM (either with moderate, low, or no risk) will identify as *MTM-High CDPS-Medium High* program status. Additionally, pediatric patients who have diagnoses of asthma or DM (with medium high) will identify as *MTM-High CDPS-Medium High*. Members identified in *MTM-High CDPS-Medium High* include members with the age parameters of 2 years and 0 days to 64 years 364 days qualify for MTM services.

The MTM pilot program will also focus on two TDS that do not qualify in the *MTM-High CDPS- Medium High* category.

3. MTM-Moderate CDPS

Moderate CDPS program status includes patients with a risk stratification superior to low and inferior to medium high. Members in the *Moderate CDPS* category are aged 2 years and 0 days to 64 years and 364 days. The *Moderate CDPS* program encompasses patients with a moderate risk stratification without a diagnosis of DM and/or asthma, pediatrics or otherwise.

4. MTM-Pediatric Asthma

MTM-Pediatric Asthma will display in the CCT application for pediatric members (with moderate, low, or no risk) who have asthma as designated by the J45.XX (ICD-10-CM) codes. Members identified with age parameters in this category will be 2 years and 0 days to 17 years and 364 days. If a pediatric member has both asthma and DM diagnoses, they will be assigned to either the *MTM-High CDPS-High Critical* or *MTM-High CDPS-Medium High* category dependent on risk stratification.

5. MTM-Pediatric Diabetes

MTM-Pediatric Diabetes will display in the CCT application for pediatric members (with moderate, low, or no risk) who have DM as defined by the ICD-10-CM codes listed below. This category includes only members identified with age parameters between the ages of 2 years and 0 days to 17 years and 364 days. If a pediatric member has both DM and asthma diagnoses, they will be assigned to either the *MTM-High CDPS-High Critical* or *MTM-High CDPS-Medium High* category dependent on risk stratification.

The diagnoses (ICD-10) codes include in the *MTM-Pediatric Diabetes*:

- E08.XX (all) — DM due to underlying condition
- E09.XX (all) — Drug or chemical induced DM
- E10.XX (all) — Type 1 DM
- E11.XX (all) — Type 2 DM
- E12.XX (all) — Malnutrition-related DM
- E13.XX (all) — Other specified DM
- 024.XX (Gestational diabetes in pregnancy)

Table 4.1: Program status indicator and risk classification example

Example	Diagnosis	Risk	Program Status Indicator[1]
Member 1	Asthma, Diabetes[2] (pediatric)	Low	MTM-High CDPS-Medium High

Member 2	None	Critical	MTM-High CDPS-High Critical
Member 3	Pediatric Diabetes	Low	MTM-Pediatric DM
Member 4	None	Moderate	MTM-Moderate CDPS

[1] Rule Outcome [2] Concomitant

5 Care coordination tool

A shared multi-payer CCT will allow better coordination of care for assigned MTM eligible members. The tool is designed to offer useful and up-to-date information to PCMH and Health Link providers.

The state of Tennessee is contracted with HealthEC for development of the CCT, based on HealthEC's Guiding Care platform. Guiding Care is a cloud-based tool accessible online. Practices will not have to install any special programs.

Information in the tool will be populated by claims data from the state; MCOs; and Admission, Discharge, and Transfer data received from participating hospitals.

Using the CCT is a provider activity requirement for the MTM pilot program, however, we expect providers will each use the tool differently after assessing its capabilities and integrating its usage into their current workflows.

5.1 Care coordination tool functionalities

The CCT has several functionalities, including the following:

- Displays providers attributed member panels
- Calculates members risk scores and stratifies provider panels for more focused outreach
- Generates, displays, and records closure of gaps-in care
- Displays hospital and emergency department admissions, discharges, and transfers (ADTs)
- Assists pharmacists with:
    - Comprehensive medication review (CMR) assessments
    - General encounter assessments

The tool enables providers to see real-time information about members in need of follow-ups, which will allow providers to help close gaps in care. At this time, those manual gaps in care closures will not contribute to the quality performance reported from the MCOs each quarter unless a corresponding claim is received to verify the gap has been closed.

5.2 CCT user expectations

Participating MTM pharmacists for TennCare are required to use the CCT for documenting MTM services. All documentation from MTM encounters must be entered in the CCT and/or in the CCT and EHR/EMR. This includes any written and verbal contacts between the pharmacist and the member:

1. The CMR must be completed in full and documented in the CCT to qualify for reimbursement. A partially completed MTM form (for example, CMR) or unsaved (in other words, signed) document will not meet the minimum requirements for reimbursement. A comprehensive medication therapy review should document the member's use of all medications, including OTCs, herbals, and supplements as relayed by the member:
    a. For MTM exception: Pharmacist must complete and upload an MTM exception (ME) form to the CCT for any service limit exceptions:
        i. Completed ME form must comprise **two** signatures or is subject to recoupment.

ii. See Section 8.4, Section 8.5, Appendix 3, and Appendix 5 for additional information on ME.

2. General encounter assessments are more targeted assessments available to providers in case a CMR or a CMR follow-up is unsuitable for an MTM member's needs.
3. All written and verbal contacts must be documented in the member's MTM record (in other words, CCT).
    a. Document member assessment including pertinent medical history using the CCT.
    b. Prepare the member's MTM summary report.
    c. Document drug therapy problems, recommended solutions, education, and evaluation of member's response to therapy.

Additional documentation expectations may be found in **Section 6.1** and **Appendix 1**. The CPA between the pharmacist and the PCMH/ Health Link may include added documentation policy and procedures specific to their organizations.

CCT documentation is a key component in tracking MTM services provided by pharmacists. It helps pharmacists avoid duplication (and claims denials). The model is designed where TennCare *members cannot receive MTM services from more than one MTM pharmacist from TennCare at a time to prevent duplicate services*. MTM documentation in the CCT is important for TennCare members enrolled in both a PCMH and Health Link organization, or members who switch PCT organizations (note: the service limits follow the member). When a pharmacist **completes** documentation in the CCT at the time of the MTM service, the process offers real-time tracking. Pharmacist will see an activity item (in other words, CMR) has been completed in the CCT and will not need to wait for claims to clear in order to know if a member has been seen by a pharmacist and is eligible for monthly MTM service.

Any staff using the CCT is expected to abide by patient privacy and confidentiality laws and regulations. This includes only using a secure network or wi-fi connection. Pharmacists may not use public wi-fi (for example, Starbucks) where there is no assurance of privacy.

5.3 CCT and double documentation

The MTM Pilot Program has temporarily allowed MTM encounters to be documented in the EHR/EMR if minimum references to said encounters are notated in the CCT. Therefore, a provider may document MTM services entirely in the CCT or in their EHR/EMR while still providing a reference in the CCT. This workaround was made in response to potential issues of double documentation for MTM services.

5.4 How to access the CCT

HealthEC will be responsible for setting up all users with logins and passwords. Each user will be required to sign the *Acceptable Use Policy* (security) and *Remote Access Request* forms from TennCare to ensure that health information is protected. This process is conducted electronically.

After a pharmacist submits a CPA to the MCOs with a designated PCMH or Health Link from TennCare, please email the MTM Pilot Network Team from TennCare at TennCare.Pharmacy.AdobeSign@tn.gov to initiate the user agreement (security) process.

Please include the following information in the email request:

- Name of PCMH or Health Link organization from TennCare
- Name(s) of pharmacist(s)

- Email address (contact information)
- Copy of the signed CPA attestation
- NPI
- TennCare Medicaid ID

Once login credentials have been created and sent to new users, the CCT landing page can be accessed at:
https://tn.guidingcare.com/TennCare/Account/Login?ReturnUrl=%2fTennCare%2f

Note, access to CCT will be granted after MCO credentialing process has been completed.

If you have any issues with or questions regarding the CCT, contact the HealthEC (CCT) Support Help Desk at TennCareCCTSupport@HealthEC.com or **877-344-9964**.

5.5 CCT training sessions and materials

TennCare has developed easy-to-understand online trainings — self-guided user materials so that pharmacists are comfortable with MTM functionalities available in the CCT. It is recommended that new users review Care Coordination Tool training materials prior to using the tool.

General CCT self-guided training materials can be found on the Amerigroup website at:
https://provider.amerigroup.com/tennessee-provider/home

Medication therapy management (MTM) CCT training materials and updates will be made available on an ongoing basis: **https://provider.amerigroup.com/tennessee-provider/home**

5.6 Data in care coordination tool

Member attribution data in the CCT is derived directly from the MCOs and is updated once per week. The primary source of data within the CCT is paid claims which determine patient diagnoses, pharmacy information, risk scores, and gaps in care for members. Please note that information regarding substance use or treatment is not available within the CCT due to federal regulations.

5.7 CCT MTM tab, service codes, and place of service options

During the MTM encounter, the pharmacist will select a *service code* in a dropdown box located in the CCT MTM tab. The service codes correlate to the CPT® codes and units associated with MTM services and are time related.

The service code options are:

- Less than 15 minutes
- 99605 (new, 15 minutes)
- 99605 + 99607 (new, 30 minutes)
- 99605 + 99607(x2) (new, 45 minutes)
- 99605 + 99607 (x3) (new, 60 minutes)
- 99606 (established, 15 minutes)
- 99606 + 99607 (established, 30 minutes)
- 99606 + 99607(x2) (established, 45 minutes)
- 99606 + 99607 (x3) (established, 60 minutes)
- Greater than 60 minutes

- 98966 telephone 5-10 minutes (established)
- 98967 telephone 11-20 minutes (established)
- 98968 telephone 21-30 minutes (established)
- Other

The pharmacist will update and select a place of service (for example, office) in the script pop-up display.

The place of service option examples:
- Community mental health center
- Office
- Telehealth (only for telephonic interaction)

6 Policy and procedures

PCMH, Health Link, and MTM pharmacists from TennCare shall at all times act in accordance with state and federal laws when providing MTM services to TennCare enrollees, and in a manner so as to assure quality of those services, including guidelines, rules, and policies as outlined in the MTM policy from TennCare and procedures provided in this manual. MTM pharmacists are responsible for adhering to all program updates provided by email, through the TennCare updates, Amerigroup provider manual for billing guidelines, and provider website.

6.1 PCMH, Health Link, and pharmacist expectations

1. MTM visits will be conducted in collaboration with a TennCare designated PCMH or Health Link.
2. A participating TennCare designated PCMH or Health Link must establish a CPA with an MTM qualified pharmacist to provide MTM services to MTM eligible members from TennCare.
3. TennCare members cannot receive MTM services from more than one MTM designated pharmacist from TennCare at one time.
4. The MTM pharmacist from TennCare must meet all requirements including successful completion of CCT training prior to providing MTM services to TennCare members.
5. The MTM pharmacist from TennCare must provide the MTM service in collaboration with a TennCare PCMH or Health Link.
6. The MTM pharmacist from TennCare will schedule MTM services appointments and conduct MTM visits in a private, distraction free environment.
    a. Secure wi-fi and network connections are required.
    b. The use of a public wi-fi is prohibited (for example, Starbucks).
    c. Conducting indirect services in a public area is prohibited.
7. Pharmacist must not provide MTM services in the dispensing area of the pharmacy.
8. Pharmacist must not be performing other duties at time of member MTM visit including dispensing.
9. To avoid conflicts of interest between dispensing and clinical activities, the pharmacist providing MTM services cannot be the only pharmacist scheduled on duty at the pharmacy.
    a. Exception is if a pharmacy only dispenses at a specified time. For example, prescription dispensing is scheduled from 8 a.m. to noon MTM services may be provided to members during non-dispensing activities, 1 to 5 p.m.
    b. May schedule members before or after retail hours.
10. The MTM pharmacist from TennCare should be fully prepared to conduct the MTM visit at the time of the member's appointment. The time required to prepare for the visit is not billable.
11. It's required that the MTM pharmacist document and complete the required MTM services in the CCT.
    a. **Exception:** Based on federal regulations (*CFR 42 section 2*), pharmacists are prohibited from documenting medication assisted therapy drugs, such as buprenorphine used to treat opioid addiction, due to privacy requirements.
12. Each MTM designated pharmacist from TennCare must retain a permanent record of the MTM encounter documentation and other documentation pertinent to the visit in accordance with federal and state medical record retention regulations.

13. Verify the members MTM pilot eligibility before each visit by using the CCT. The CCT is updated with member eligibility information weekly and MTM criteria are applied monthly. For more information on MTM eligibility, please see **Section 4.4**.
    a. If a patient is no longer eligible for MTM services, the MTM pharmacist may contact the member and inform him/her of the change in MTM eligibility status. Members may be directed to contact TennCare with any questions regarding their MTM service eligibility.
14. During the MTM encounter, the MTM pharmacist must use the CCT and relevant forms (for example, CMR) to gather information during the visit.
15. The MTM pharmacist will check the member's ID (photo identification, TennCare ID, or participation invitation letter) to confirm and identify MTM program eligibility.
16. The MTM pharmacist from TennCare will:
    a. Document member assessment including pertinent medical history using the CCT.
    b. Conduct a comprehensive medication therapy review which should document the member's use of all medications, including OTCs, herbals, and supplements as relayed by the member.
    c. Prepare the member's MTM summary report.
    d. Coordinate and assist the member in obtaining other healthcare resources (for example, asthma coalitions) and provide pertinent materials to assist member in managing their conditions.
    e. Document drug therapy problems, recommended solutions, education, and evaluation of member's response to therapy.
    f. Schedule follow-up appointments, as needed, to ensure member medication adherence in order to determine if the member's goals have been met.
    g. Collaborate and preserve a working relationship with member's PCMH or Health Link from TennCare.
    h. Provide the member with a copy of the MTM summary report.
17. The MTM pharmacist will enter all documentation from the visit into the CCT. The time required to document the visits are not billable.
18. The TennCare pharmacist will maintain a collaborative relationship with the member's PCMH or Health Link, including sending written summaries and recommendations of all MTM encounters.
19. PCMH or Health Link must be contacted for all interventions that require immediate attention.
20. All written and verbal contacts must be documented in the member's MTM record (in other words, CCT). Pharmacist must send a permanent record of MTM encounters via a secure method to member's PCMH/ Health Link (or prescriber's) health record.
    a. CPA may include additional guidance or outline documentation policies with procedures to ensure MTM documentation is retained and becomes a permanent part of the member's health record (for example, EHR).
        i. An organizational procedure example may include export MTM service documentation from CCT to excel and send (in a HIPAA secure manner) to organizations EHR.
21. MTM pharmacist should communicate any recommendations to PCMH or Health Link.
22. Medication recommendations by the MTM pharmacist should be based upon professional judgement and evidence-based guidelines. The MTM pharmacist should be familiar with the disease states and medications included in the recommendation and should refer to available evidence and guidelines.
    a. Sample references and list of member resources can be located in **Appendix 6**.

23. The MTM pharmacist from TennCare may bill using designated TennCare electronic claims processing systems such a clearing house, web portal, or may submit a bill using a paper claim using the designed MTM service modifiers and CPT codes. Methods of claim submission are dependent on Amerigroup policies.
24. General information:
    a. MTM pharmacist(s) are required to follow all established TennCare guidelines, rules, and policies.
    b. MTM pharmacists may work for more than one TennCare designated PCMH or Health Link.
    c. Reimbursement for MTM services will cover a per month case rate that includes an initial face to face, one-on-one visit with the TennCare member. Follow-up monthly case rate visits may be done face-to-face or indirect (in other words, telephonically) at the member's preference:
        i. Group visits are not permitted as part of the one-on-one MTM service for reimbursement. However, outside of the one-on-one visit, group education sessions may be conducted during the month as an integral part of care and interaction with the member (without additional MTM program reimbursement).
        ii. Time required for preparation of the MTM visit is not reimbursable.
        iii. Time required for follow-up/reminder telephone calls is not reimbursable.
        iv. Pharmacist cannot submit a claim for no show appointments.
    d. Reimbursements for MTM services are based on established case rates with service limits.
    e. TennCare members cannot receive MTM services from more than one MTM pharmacist from TennCare at a time.

6.3 Member expectations

1. The MTM program will select members based on specific risk and TDS criteria and offer eligible TennCare members MTM services.
2. TennCare members are expected to attend scheduled appointments.
3. TennCare members cannot receive MTM services from more than one MTM pharmacist at a time (during a month).
4. There are no member payments for MTM services from TennCare.

6.4 FQHC and RHC expectations

An MTM service involving behavioral health medications does not constitute a second visit due to FQHC/RHC rules on what constitutes a visit and is paid for outside regular RHC/FQHC payment methodology.

See TennCare policy for additional FQHC/RHC information.

7 Record retention, security, and compliance

7.1 Record retention and security

All MTM service encounter documentation (for example, comprehensive medication assessments) must be retained by the pharmacist for the required number of years as outlined by federal and state laws. The method of retention should comply with all federal and state *HIPAA* requirements. It is the MTM pharmacists' responsibility to retain documentation of MTM services delivered and should be readily available for audit requirements.

7.2 Compliance with legal regulations

Providers agree to recognize and abide by all state and federal laws, rules, regulations, and guidelines applicable to the *Agreement* and the Medicaid program. Including but not limited to, *Section 6032* of the *Deficit Reduction Act of 2005 (DRA)* with regard to policy development, employee training, and whistle blower protection related to the *False Claims Act, 31 USCA § 3729-3733, et seq.,* the *Tennessee State Plan, 42 CFR § 431.107, 42 CFR 455 subpart B, TCA §53-10-304*, and TennCare rules.

7.3 Incorporation by reference of federal and state law/regulation

The *Agreement* incorporates by reference all applicable federal and state laws and regulations, and any applicable court orders or consent decrees. All revisions of such laws or State of Tennessee Medicaid Policy and Guidelines, regulations, court orders, or consent decrees shall automatically be incorporated into the *Agreement* as they become effective.

8 Reimbursement methodologies

8.1 Activity requirements

Qualified MTM pharmacists are eligible for reimbursement based on a per month case rate for one-on-one encounter visits with TennCare members enrolled in the MTM program.

A pharmacist provides individual management therapy with assessment and intervention. This patient specific service includes the review of pertinent history and profiling of prescription and non-prescription medications. The pharmacist evaluates the medication profile for under or overdosing, duplication, and possible drug interactions and makes recommendations based on the assessment, including communication with the prescriber. Pharmacists should provide ongoing evaluation and monitoring to ensure optimal medication treatment. This information is then documented in the CCT and/or CCT and EHR/EMR and then included in the PCMH or Health Link health record.

8.2 Reimbursement information

The payment model for the MTM pilot is designed to reimburse at a per month case rate based on the risk stratification or targeted disease state of the TennCare member. Remember, MTM pharmacists may have as many interactions throughout the month as needed with members.

The MTM service modifier codes from TennCare (which identify the case rate) and payment limits are as follows:

Table 8.2: MTM service modifiers and limits

Service description	Modifier	Case rate	Payment limits (per pilot year)	Case units[3] (per month)
Targeted disease state (juvenile asthma and diabetes)	U1	$55.00	2 months	1 unit for each case rate
Medium high	U2	$55.00	3 months	1 unit for each case rate
Critical	U3	$75.00	6 months	1 unit for each case rate
High	U3	$75.00	6 months	1 unit for each case rate
Limit exception (requires attestation)	U4	Rate based on level of care modifier	Limit up to 2 (based on MCO approval)	1 unit for each case rate
Moderate	U5	$55.00	2 months	1 unit for each case rate

[2]Use appropriate CPT for service (in other words, encounter).

8.3 How to file a claim

Reimbursement for MTM services will cover a per month case rate that includes an initial face-to-face, one-on-one visit with the TennCare member. Follow-up monthly case rate visits may be done face-to-face or indirectly (in other words, telephonically) at the member's preference. Initial case rate is based on a minimum of at least 15 minutes per month:

- The CPA between the PCMH/ Health Link and MTM pharmacist may offer organizational requirements and expectations regarding MTM service delivery.

As part of MTM **reporting and tracking**, the pharmacist must use professional claim (*CMS-1500*) for billing MTM services and utilize the required CPT codes to submit for MCO reimbursement. It is important for participating pharmacists to submit the following CPT code(s) to identify the MTM service in conjunction with the service modifier (case rate) to properly receive reimbursement payments.

The MTM program is utilizing the CPT code description to identify medication therapy management service for reporting and tracking time associated with MTM services for reimbursement are:

- **CPT 99605:** MTM services provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, **new patient**.
- **CPT 99606:** MTM service(s) provided by a pharmacist, individual, face-to-face with patient with assessment and intervention if provided; initial 15 minutes, **established patient**.
- **CPT 99607:** MTM service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided, **each additional 15 minutes** (list separately in addition to code for primary service).

CPT 99605 code is used for new patients and is *only allowed once per member* for MTM pilot. To understand the difference between a new and established patient, please refer to the Current Procedural Terminology (AMA) book. In addition, a brief definition of a new and established patient can be found in **Section 10: Definitions and Acronyms**.

The use of CPT 99607 is an add-on code for tracking each additional 15-minute increments of time spent with the member providing MTM services. Remember, add-on codes must be accompanied with either 99605 or 99606. **It is important to know the CPT 99607 code is used for information only and no additional reimbursement is associated with this code.**

Submission of this code is required so that Amerigroup can track member usage patterns for purposes of the program. (**Recall, the MTM program is only reimbursing pharmacist a per month case rate based on a service modifier.**)

Only one case rate payment will be made per member per month based on the pharmacist who submits the first claim for the billing month.

Pharmacist will follow customary reimbursement and place of service (POS) guidelines. CMS POS code set can be found at **https://www.cms.gov/Medicare/Coding/place-of- service-codes/Place_of_Service_Code_Set.html**. Example: POS 11 for MTM service provided in the PCMH or Health Link office. POS 53 for MTM service provided in a CMHC. POS 02 for MTM services provided telephonically.

If MTM services are provided by indirect (or telephonic) services, the call must be interactive in real time (voicemails, text messages, and/or emails to enrolled members are not a billable encounter). Indirect services must be completed in a private area. To identify indirect (telephonic) MTM services for tracking and reporting, the pharmacists are required to utilize the following CPT codes for reimbursement:

- **CPT 98966:** Telephone assessment and management services provided by a qualified non-physician health care professional to an established patient, parent, or guardian not

originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment, 5 to 10 minutes of medical discussion.

- **CPT 98967:** Telephone assessment and management services provided by a qualified non-physician healthcare professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment, 11 to 20 minutes of medical discussion.
- **CPT 98968:** Telephone assessment and management services provided by a qualified non-physician healthcare professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment, 21 to 30 minutes of medical discussion.

8.4 Exception criteria

Exceptions to the service limits state previously may be granted at the discretion of the MCO based upon a request from either the MTM pharmacist or the member. Exceptions will be considered for significant changes to a member's medical condition (for example, in the event of an accident, unexpected surgery or change in medication):

- Pharmacist must complete and upload an ME form to the CCT for any service limit exceptions.
- The MCOs will review the ME form for completeness to determine reimbursement appropriateness based on the guidelines provided by TennCare.
- The pharmacist might need to submit MTM exception form to each MCO subject to MCO requirements.
- See **Appendix 5** for *MTM Exception (ME) Form*.

8.5 General billing requirements

MTM Pharmacists must bill according to usual and customary standards:

1. Pharmacists must verify TennCare member MTM program eligibility in the CCT.
    a. MTM eligible criteria can be located in **Section 4.3** and **Section 4.5**.
2. Must use professional claim (CMS-1500) for billing MTM services
3. The **NPI of the pharmacist** that performed the service should be reported in the rendering provider ID field.
4. In cases where the billing and rendering provider are the same, the rendering (performing) provider information should not be reported. However, it is required when the rendering provider information is different from the billing provider. The billing provider should contain the employer's tax ID and NPI on the claim as required per NUCC billing standards and X12 5010 requirements:
    a. Please reference the Division of TennCare IS Policy titled Provider Identification Usage on Submitted Transactions which can be located at: **https://www.tn.gov/content/dam/tn/tenncare/documents/provideridentificationusage.pdf**

5. The appropriate place of service (POS) must be submitted with claims (for example, POS 11 for MTM service provided in an office; POS 53 for service provided in a Community Mental Health Center):
    a. See CMS and MCOs for additional information and guidance.
    b. POS 02 must be used in conjunction with CPT codes 98966, 98967, or 98968.
    c. An MTM service involving behavioral health medications does not constitute a second visit for purposes of the FQHC/RHC rules on what constitutes a visit and is paid for
    d. outside regular RHC/FQHC payment methodology. See TennCare policy for additional FQHC/RHC information.
6. The MTM CPT code(s) are used for **reporting** and **tracking** for reimbursement. To appropriately track time and use of resources for MTM services. CPT codes 99605-99607 are time-based and submitted in 15-minute increments. 99607 billing code (is an add-on) and must be used in conjunction with 99605 and 99606. Please note, CPT 99607 code is for informational purposes only and does not impact the claims payment.
7. The service description modifier (for example, U3 = critical/high risk) must be used to identify the covered MTM service and case rate:
    a. Frequency limitations are associated with each service category modifier.
    b. See **Table 8.2** for service modifier and limit description.
8. Verify number of MTM service visit. Case rates will not be paid past the limits as described in this section:
    a. For example, pediatric members with a diagnosis of asthma that stratify into the TDS category have an MTM service limit of 2 months.
    b. See Table 8.2 for service modifier and limit description.
9. Members who change risk categories (in other words, from medium high to critical) are eligible for service limits equal to the higher risk service payment limit:
    a. For example, a member's initial risk is evaluated at medium-high but is later re-evaluated and is risk adjusted to critical. The member would convert from the medium- high to high-risk service limit. Any previous MTM services would count toward the high-risk service payment limit for the year.
10. **Pharmacist must complete and upload an MTM exception (ME) form to the CCT for any service limit exceptions:**
    a. To bill for exception services, the U4 modifier should be billed on the claim as a second modifier.
    b. The MCOs will review the ME form for completeness to determine reimbursement appropriateness based on the guidelines provided by TennCare.
        i. Completed ME form must comprise two signatures or is subject to recoupment.
        ii. Please refer to each MCO for exception process.
    c. Appendix 5: *MTM Exception (ME) Form*
11. Only one case rate payment will be made per member per month based on the pharmacist who submits the first claim for the billing month. (The CCT is used for documentation and tracking of MTM services.)
12. Reimbursement for initial MTM services will only cover face-to-face, one-on-one contact with the member. Follow up MTM monthly visits may be done face-to-face or indirectly (telephonically) at the member's preference.
13. If the member switches pharmacist in the middle of year the limit will follow the member (in other words, high-risk level member had two visits with first pharmacist, the new pharmacist only has four visits remaining).

14. The MTM service claim must be submitted within timely filling guidelines outlined in the provider manuals to be reimbursed.
15. If MTM service is provided by indirect (telephone) services:
    a. The telephone call must be interactive in real time.
    b. Voicemails, text messages, and/or emails to enrolled members are not a billable encounter.
    c. 98966, 98967, or 98968 must be used for reimbursement:
        i. POS 02 must be used in conjunction with CPT codes 98966, 98967, or 98968.
16. The MTM pilot service claim must include the referring/ordering/prescribing provider and NPI to receive reimbursement.
17. Appendix 4: Billing, Reporting, and Tracking MTM Pilot Service Sample Chart
18. The pharmacist will maintain a collaborative relationship with the member's PCMH or Health Link, including sending written summaries and recommendations of all MTM encounters.
19. PCMH or Health Link must be contacted for all interventions that require immediate attention.
20. All written and verbal contacts must be documented in the member's MTM record (in other words, CCT). Pharmacist must send a permanent record of MTM encounters via a secure method to member's PCMH/ Health Link (or prescriber's) health record:
    a. CPA may include additional guidance or outline documentation policies with procedures to ensure MTM documentation is retained and becomes a permanent part of the member's health record (for example, EHR):
        i. An organizational procedure example may include – export MTM service documentation from CCT to excel and send (in a HIPAA secure manner) to organizations EHR.
21. MTM pharmacist should communicate any recommendations to PCMH or Health Link.
22. Medication recommendations by the MTM pharmacist should be based upon professional judgement and evidence-based guidelines. The MTM pharmacist should be familiar with the disease states and medications included in the recommendation and should refer to available evidence and guidelines:
    a. Sample references and list of member resources can be located in Appendix 6.
23. The MTM pharmacist may bill using designated TennCare electronic claims processing systems such a clearing house, MCO web portal, or may submit a bill using a paper claim or handwritten claim using the designed MTM service modifiers and CPT codes.
24. General information:
    a. MTM pharmacist(s) are required to follow all established TennCare guidelines, rules, and policies.
    b. MTM pharmacist may work for more than one TennCare designated PCMH or Health Link.
    c. Reimbursement for MTM services will cover a per month case rate that includes an initial face to face, one-on-one visit with the TennCare member. Follow-up monthly case rate visits may be done face-to-face or indirect (in other words, telephonically) at the member's preference:
        i. Group visits are not permitted as part of the one-on-one MTM service for reimbursement. However, outside of the one-on-one visit, group education sessions may be conducted during the month as an integral part of care and interaction with the member (without additional MTM Pilot Program reimbursement).

    ii. Time required for preparation of the MTM visit is not reimbursable.
    iii. Time required for follow-up/reminder telephone calls is not reimbursable.
    iv. Pharmacist cannot submit a claim for no show appointments.
d. Reimbursements for MTM pilot services from TennCare are based on established case rates with service limits.
e. TennCare members cannot receive MTM services from more than one MTM pharmacist at a time.

8.6 Additional information

For additional information on billing procedures, please contact individual MCO:

- Provider manual: **https://providers.amerigroup.com/ProviderDocuments/TNTN_CAID_Prov_Man.pdf**
    - For MTM claims submission instructions, go to **https://www.availity.com/**:
        - Click on **Register**, in the upper right corner
        - Once registered, you can access the *Availity Learning for Web Portal*
        - In this section, pharmacists can access all the tools that can walk them through claims submission to Amerigroup. (screenshot below)
        - Other functionality through Availity includes:
            - Eligibility inquiries
            - Claim status inquiries
        - To start the electronic claims submission process or if you have questions, please contact our EDI hotline at **800-590-5745**.
        - Availity support is available at **800-Availity** (**800-282-4548**) or Support@availity.com

9 How will quality and efficiency be measured?

9.1 MTM quality metrics

Quality metrics will be based on PCMH/ Health Link metrics, Star measure ratings, and Health Care Effectiveness Data and Information Set (HEDIS).®

9.2 Detailed business requirement (DBR)

The business requirements for the Tennessee MTM program evaluation are available in a separate document. The DBR details the logic, provides definitions, sources of data, and qualifying criteria (in other words, eligible population) of the core metrics proposed to evaluate the MTM pilot program.

The framework for MTM evaluation is:

1. Total Cost of Care (TCOC):
    - The measure of *total cost of care* to be used in evaluating the MTM includes the program-paid amounts for all covered services associated with treating a patient including inpatient, outpatient, professional, pharmacy, and ancillary services adjusted for the number of months those members were enrolled in TennCare.
2. HEDIS Specific Metrics (adapted from 2018 HEDIS technical specifications)
    - Ambulatory care visits (AMB):
        - The measure summarizes utilization of ambulatory care in outpatient and emergency department (ED) visits per 1,000 member-months.
    - Medication Management for people with Asthma (MMA):
        - Percentage of MTM pilot eligible members from TennCare who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:
            - Percentage of members who remained on an asthma controller medication for at least 50% of their treatment period.
            - Percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.
    - Antidepressant Medication Management (AMM):
        - The measure summarizes the percentage of TennCare members who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on antidepressant medication treatment. Two rates are reported: 1) Effective acute phase treatment. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). 2) Effective continuation phase. The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).
3. Star rating metrics (adapted from the 2018 CMS Part D and Star measure rating specifications):
    - Medication Adherence for Diabetes Medication (D11):
        - Percent of TennCare members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. One of the most important ways people with diabetes can manage their health is by taking their medication as directed.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

- Comprehensive medication review completion rate (D14):
    - The measure shows how many members in the program had an assessment of their medications from the plan. The assessment includes a discussion between the member and a pharmacist (or other healthcare professional) about all the member's medications.
    - The measure is defined as the percent of MTM program members from TennCare who received a CMR during the reporting period.

4. Potential informational metrics for consideration (PCMH, Health Link, state Medicaid, HEDIS, and Star ratings):
    - All hospitalizations
    - All-cause readmission pharmacy spending
    - Generic drug utilization rates
    - Adverse drug events
    - Appropriate use of high-risk medications
    - Annual monitoring for patient on persistent medications
    - Behavioral health proportion of days covered
    - Depression proportion of days covered
    - Follow-up visits
    - Congestive heart failure proportion of days covered
    - Coronary artery disease (CAD) proportion of days covered
    - Cholesterol proportion of days covered
    - Respiratory proportion of days covered
    - Gaps in therapy
    - Hypertension proportion of days covered
    - Statin therapy and diabetes

The selected quality and efficiency metrics used to evaluate MTM pilot program may be subject to change.

10 Definitions and acronyms

CAQH: Coalition for Affordable Quality Healthcare

Case Rate: A payment method in which a flat amount, which covers a defined service or group of services.

CCT: Care Coordination Tool

Comprehensive Medication Review: Systemic review and evaluation of patient's medication regimen, encompassing prescription and OTC agents. Includes any actions or recommendations need to optimize treatment.

CPT Billing Increments: For the MTM pilot program, 1 unit (1 billing increment) will equal 15 minutes of time spent with a member for MTM services.

CPT: Current Procedural Terminology

Dual Eligible: Refer to members (beneficiaries) who qualify for both Medicare and Medicaid benefits.

Established Patient: An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

EHR: Electronic health record

EMR: Electronic medical record

EOB: *Explanation of Benefits* is a statement sent by a health insurance company to covered individuals explaining what medical treatments and/or services were paid for on their behalf. *EOB* typically describes the service performed, date of service, amount of the provider's fee and insurer allowable, and any adjustments with reasons.

Face-to-face: Face-to-face time for services is defined as only the time spent face-to-face with the patient and/or family. This includes time spent performing such tasks as obtaining a history and counseling the patient.

FQHC: Federally Qualified Health Center

HIPAA: *Health Information Portability and Accountability Act*

ICD-10-CM: International Classification of Disease, Tenth Revision, Clinical Modification is a system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with health care in the United States.

ME: MTM Exception

MTM: Medication Therapy Management

NPI: National Provider Identifier is a *HIPAA* administration simplification standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under *HIPAA*. The NPI is a 10 position, intelligence-free numeric identifier (10-digit number).

New Patient: A new patient is one who has not received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

OTC: Over the counter

PCP: Primary care provider

PCMH: Patient-centered medical home

POS: Place of service

RHC: Rural health clinic

TMR: Targeted medication review

TDS: Targeted disease states

MTM pharmacist: Pharmacist designated by Amerigroup who can conduct and submit claims for MTM pilot services and has a collaborative practice agreement with a TennCare designated PCMH or Health Link.

11 MTM pilot questions and answers

1. Can I provide the member with additional educational information?

   Yes, if a pharmacist feels that the member would benefit from additional educational information, you may select material based on professional judgement.

2. Can I bill for my time if the member did not show up for their scheduled appointment?

   No, only time spent with a member can be billed. If a member fails to show, then the time is not payable.

3. Can I bill for my preparation time to get ready for the MTM visit?

   No, preparation time should not be billed (only time spent directly with the member can be billed).

4. Are all members eligible for MTM services?

   No, only members that meet the MTM eligibility criteria can receive pilot MTM services. The CCT tool will help to identify members' program status eligibility. Patients are eligible if they meet risk categories (members with multiple chronic conditions and multiple medications) or pediatric members diagnosed with asthma or diabetes mellitus.

5. Can a patient's caregiver attend the MTM visit with patient?

   Yes, with patient's permission.

12 Contact information and other resources

MTM Program from TennCare
https://provider.amerigroup.com/tennessee-provider/home

Primary Care Transformation

- Web: **https://www.tn.gov/tenncare/health-care-innovation/primary-care-transformation.html**

Information Systems Policies from TennCare

- Web: **https://www.tn.gov/tenncare/policy-guidelines/information-systems-policies.html**
- Division of TennCare IS Policy Manual: **https://www.tn.gov/content/dam/tn/tenncare/documents/provideridentificationusage.pdf**

13 List of appendices

Appendix 1: Member Encounter and Pharmacist Task Guideline

Appendix 2: Reimbursement Guidelines

Appendix 3: AH and MTM Crosswalk

Appendix 4: Billing, Reporting, and Tracking MTM Pilot Service Sample Chart

Appendix 5: Attestation

Appendix 6: Resources and References

Appendix 1: Member encounter and pharmacist task guidelines

1. Verify member meets MTM eligibility criteria in the CCT MTM tab. This can also be verified by reviewing the program functionality status in the CCT:
    a. Risk stratification (critical, high, medium-high, moderate)
    b. Targeted disease state (pediatric asthma or pediatric DM)

2. Review CCT to verify encounter as initial visit or follow-up visit.

3. Schedule encounter with member:
    a. CCT offers a schedule functionality to utilize

4. Review member's medication history in the CCT. Check for the *flags* which could indicate lack of disease control:
    a. Early or frequent request for or fills of short-acting asthma medications such as albuterol inhaler or nebulizer, Xopenex inhaler or nebulizer.
    b. Inconsistent fills of maintenance medications. For example, a 30-day supply of oral antidiabetic is filled every 45 days.

5. Review and document member's profile for previously documented allergies in the CCT.
    a. Note: Allergy information is provided by the patient and may not be documented in the CCT prior to the first MTM visit, so in preparation for the initial MTM visit, allergy information may not be available.

6. Review member's medication profile for medications that could indicate mismanaged triggers:
    a. Check the controlled substance database: **https://www.tncsmd.com/Login.aspx?ReturnUrl=%2fdefault.aspx**
    b. Frequent fills or OTC purchases of antacids, H-2 blockers, proton pump inhibitors
    c. Frequent fill of allergy medications, either OTC or prescription

7. Based on federal regulations (*CFR 42 section 2*), pharmacists are prohibited from documenting medication assisted therapy drugs such as buprenorphine used to treat opioid addition in the CCT.

8. Review member's medication profile for **potential** drug interactions:
    a. Non-selective beta-blockers in patient with asthma
    b. Phenytoin and bupropion
    c. Verapamil and simvastatin

9. If possible, have applicable medication devices available for demonstration of administration technique.

10. Print applicable and anticipated patient education materials to share with member.

11. Review and discuss any over-the-counter medications.

12. The MTM pharmacist should complete and document all encounter information in the CCT or in an EMR/EHR with a minimum reference notation in the CCT, and provide the following assistance to the member:
    - Medication reconciliation
    - Review of drug delivery techniques
    - Review of triggers and trigger avoidance
    - Specific education handouts provided to the patient
    - Next appointment date
    - Possible medication adjustments, if needed, to be discussed with the PCP
    - Specific topics to be discussed at next visit

13. Provide an MTM summary report to the member. Include any education handouts, schedule next appointment date (if necessary), and contact information.

14. Provide an MTM summary report to the medical provider (PCP) and specialists as needed. If medication changes are recommended, a follow-up communication to the prescriber's office is required to discuss recommendations and patient progress.

15. If making medication recommendations, check the *Preferred Drug List (PDL)* from TennCare first.

16. Must retain a permanent copy for each MTM encounter and other documentation pertinent to the visit in accordance with federal and state medical record retention regulations. (Pharmacist must develop a plan in collaboration with PCMH/ Health Link to ensure MTM encounter documentation from CCT is delivered to the member's health record at PCMH/ Health Link [EHR]).

Appendix 2: Reimbursement guidelines

MTM Reimbursement Guidelines: The case rates for MTM covered services are described below:

Service description	Modifier code	Case rate	Payment limits	Units
Targeted disease states (juvenile asthma or diabetes)	U1	$55.00	2 months	1 unit for each case rate
Medium-high risk	U2	$55.00	3 months	1 unit for each case rate
Critical, high risk	U3	$75.00	6 months	1 unit for each case rate
Exceptions (requires appropriate approval)	U4	Rate based on level of care	Limit based on appropriate approval	1 unit for each case rate
Moderate risk	U5	modifier	2 months	1 unit for each case rate

The below CPT codes will be used to indicate the services the member received:

CPT code	CPT code description
99605	MTM service(s) provided by pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; new patient visit, initial 15 minutes
99606	Medication therapy management service(s) provided by pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; established patient visit, initial 15 minutes
99607	Add-on code for each additional 15-minute increment
98966	Telephone assessment and management services provided by a qualified non-physician healthcare professional to an established patient. 5 to 10 minutes
98967	Telephone assessment and management services provided by a qualified non-physician healthcare professional to an established patient. 11 to 20 minutes
98968	Telephone assessment and management services provided by a qualified non-physician healthcare professional to an established patient. 21 to 30 minutes

Pharmacist will bill the appropriate CPT code (99605 for a new patient or 99606 for an established patient) in conjunction with the service modifier to receive appropriate case rate reimbursement. To track and report time, if a visit lasts more than 15 minutes, pharmacist will also submit 99607 with an additional unit for each 15-minute increment. Please note, CPT 99607 code is for informational purposes only and does not impact the claims payment. MTM services provided by Indirect (telephonic) must be submitted using 98966, 98967, or 98968.

Pharmacist must complete and upload an ME form to the CCT for any service limit exceptions. Claims submitted beyond the risk-based maximum limit as described in this section may be subject to recoupment unless an ME form is received. The MCOs will review the ME form for completeness to determine reimbursement appropriateness based on the guidelines provided by

TennCare. Upon billing, the U4 modifier is to be addressed on the claim as the second modifier. The pharmacist might need to submit ME form to each MCO subject to MCO requirements.

Only one case rate payment will be made per member per month based on the pharmacist who submits the first claim for the billing month. If member switches pharmacist in the middle of treatment the limit will follow the member (for example, high-risk level member had two visits with first pharmacist. The new pharmacist only has four visits remaining). Members who change risk categories (in other words, from medium high to critical) are eligible for service limits equal to the higher risk service payment limit.

The claim must be submitted within the timely filing guidelines outlined in the provider administration manual.

Billing examples:

High risk level member:

- Example one: **new high-risk** member has one-hour visit with pharmacist in January:
  - Bills 99605, modifier U3
  - Bills 99607 x3
- Example two: Same member as above has fifteen-minute visit with pharmacist for February:
  - Bills 99606, modifier U3
- Example three: Same member as above has thirty-minute visit with pharmacist for March:
  - Bills 99606, modifier U3
  - Bills 99607
- Example four: Same member as above has forty-five-minute visit with pharmacist for April:
  - Bills 99606, modifier U3
  - Bills 99607, x2

Medium-high level member:

- Example five: **new medium-high** level member has thirty-minute visit with the pharmacist for March:
  - Bills 99605, modifier U2
  - Bills 99607
- Example six: Same member as above has thirty-minute visit with the pharmacist for April:
  - Bills 99606, modifier U2
  - Bills 99607
- Example seven: Same member as above has fifteen-minute visit with the pharmacist for May:
  - Bills 99606, modifier U2

Targeted disease states level member:

- Example eight: **new targeted disease states** level member has thirty-minute visit with the pharmacist for March:

  - Bills 99605, modifier U1
  - Bills 99607
- Example nine: Same member as above has thirty-minute visit with the pharmacist for April:
  - Bills 99606, modifier U1
  - Bills 99607
- Example 10: Same member as above has one-hour visit with the pharmacist for May:
  - Note: If it is determined that additional clinical services are needed, pharmacist must complete and upload an ME form to the CCT and use the appropriate billing codes.
  - Bills 99606, modifier U1, U4 and bills 99607, x3

Appendix 3: Crosswalk: Risk stratification file and MTM reimbursement

Crosswalk between the MTM_MCO_Data file and reimbursement document									
	Targeted disease states (TDS) and risk stratifications								
Care coordination tool	Asthma (Yes) low or moderate risk (pediatric)	DM (Yes) low or moderate risk (pediatric)	Asthma and DM (pediatric) low, moderate, and medium high	Asthma and DM (pediatric) High or Critical Risk	Critical	High	Medium-High	Moderate	Low
Reimbursement	TDS	TDS	Medium High	High	Critical	High	Medium-High*	Moderate	N/A
# Maximum services (per pilot year)	2	2	3	6	6	6	3	2	N/A
Modifier	U1	U1	U2	U3	U3	U3	U2	U5	N/A

(*This change was implemented to be consistent between AH and Billing reimbursement terminology. Note, this was previously designated as moderate for reimbursement)

Appendix 4: Billing, reporting, and tracking MTM pilot service

Sample chart

MTM example	Time (minutes)	Location	CPT	CPT (add-on)	POS[1] service code	MTM Modifier[3]
New, Critical	45	Office	99605	99607 x2	11	U3
New, High	30	CMHC	99605	99607	53	U3
Est, Asthma	15	Office	99606		11	U1
Est, Asthma	15	Indirect[2]	98967		02	U1
Est, Medium-High	30	Indirect[2]	98968		02	U2
Est, DM	45	f/u office	99606	99607 x2	11	U1
New, Moderate	30	CMHC	99605	99607	53	U5

[1] CMS Place of Service Code Set is available at website: **https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html**

[2]
The telephone call must be to a member and must be associated with MTM services. The telephone call must be interactive. Voicemails, text
messages and/or emails to enrolled members are not a billable encounter.

[3] MTM Case rate or service modifier.

Appendix 5: *MTM Exception Form*

MTM Exception (ME) Form

Name of attesting provider (PCMH or HL):

____

Patient Name:

____

Patient MCO ID number:

____

Description of circumstances leading to request for exception. Attach medical records if needed.

____

____

____

____

I,_________________________________,am requesting an exception to the benefit limit for the above enrollee. I anticipate that (please circle)____1 or 2____additional units of MTM therapy will be required.

Attesting pharmacist (NPI or Tax ID) and date

____

Attesting PCMH or HL provider signature (NPI or tax ID) and date

____

Appendix 6: Sample* resources for MTM program

Tennessee
TN Department of Health website: **https://www.tn.gov/health**
Medicaid.gov: **https://www.medicaid.gov/medicaid/by-state/stateprofile.html?state=tennessee**
Tennessee Medicaid Program Preferred Drug List: **https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennC are_PDL.pdf**
TennCare/Pharmacy Division: **https://www.tn.gov/tenncare/providers/pharmacy.html**
OptumRx /TennCare Pharmacy Program **https://www.optumrx.com/oe_tenncare/landing**
State Link: **https://www.tn.gov**
Asthma
National Asthma Education and Prevention Program **https://www.nhlbi.nih.gov/health-topics/asthma**
Asthma NHLBI quick reference guide 2011 **https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf**
Asthma NHLBI clinical guidelines 2007 **https://www.nhlbi.nih.gov/sites/default/files/media/docs/asthgdln_1.pdf**
Asthma Management program **https://www.childrens.com/specialties-services/specialty-centers-and-programs/pulmonology/programs-and-services/asthma-program/asthma-management-program**
Chronic obstructive pulmonary disease (COPD)
COPD GOLD 2017 clinical guidelines **http://goldcopd.org/gold-2017-global-strategy-diagnosis-management-prevention-copd/**
COPD Gold pocket guide 2017 **http://goldcopd.org/wp-content/uploads/2016/12/wms-GOLD-2017-Pocket-Guide.pdf**
Heart disease
American Heart Association **http://www.heart.org/HEARTORG/**
Tennessee Heart & Vascular **https://tennheart.com/service/heart-failure**
2013 ACCF/AHA Guideline for the Management of Heart Failure Guidelines **http://circ.ahajournals.org/content/128/16/e240**
2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure **http://www.onlinejacc.org/content/70/6/776?_ga=2.148619383.158575615.1515514627-331575729.1495415471**
Diabetes mellitus
AACE/ACE Guidelines **https://www.aace.com/files/dm-guidelines-ccp.pdf**
AACE/ACE diabetes algorithm **https://www.aace.com/files/aace_algorithm.pdf**

ADA Standards of Medical Care in Diabetes 2017 **https://professional.diabetes.org/sites/professional.diabetes.org/files/media/dc_40_s1_final.pdf**
American Association of Diabetes Educators **https://www.diabeteseducator.org/prevention**
Children's Diabetes Program **http://www.childrenshospital.vanderbilt.org/interior.php?mid=729**
East Tennessee Pediatric Endocrinology **https://www.etch.com/Specialties/Pediatric-Endocrinology.aspx**
Strategies for Insulin Injection Therapy in Diabetes Self-Management **https://www.diabeteseducator.org/docs/default-source/legacy-docs/_resources/pdf/research/aade_meded.pdf?sfvrsn=2**
Comprehensive Foot Examination and Risk Assessment **http://care.diabetesjournals.org/content/31/8/1679**
Hypercholesterolemia
National Human Genome Research Institute **https://www.genome.gov/25520184/learning-about- familial-hypercholesterolemia/**
American Heart Association **http://www.heart.org/HEARTORG/Conditions/Cholesterol/Cholesterol_UCM_001089_SubHom ePage.jsp**
2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults **http://circ.ahajournals.org/content/circulationaha/early/2013/11/11/01.cir.0000437738.63853.7a.f ull.pdf**
Lifestyle Full Work Group Report **http://circ.ahajournals.org/content/suppl/2013/11/07/01.cir.0000437740.48606.d1.DC1**
Triglycerides and Cardiovascular Disease **http://circ.ahajournals.org/content/123/20/2292**
National Lipid Association 2014 guidelines **https://www.lipid.org/recommendations**
Hypertension
Hypertension Management Program **http://www.fepblue.org/en/wellness-resources-and- tools/wellness-resources/hypertension-mgmt-program/**
Hypertension Institute **http://hypertensioninstitute.com/**
2017 High Blood Pressure Clinical Practice Guideline **http://www.onlinejacc.org/content/accj/early/2017/11/04/j.jacc.2017.11.006.full.pdf**
2013 AHA/ACC Guideline on Lifestyle Management to Reduce Cardiovascular Risk **http://circ.ahajournals.org/content/circulationaha/early/2013/11/11/01.cir.0000437740.48606.d1. full.pdf**
Mental health
American Psychiatric Association guidelines **https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines**
DSM-5 ICD codes **https://www.psychiatry.org/psychiatrists/practice/dsm**
Migraine

American Academy of Neurology **http://patients.aan.com/disorders/**
American Headache Society **http://www.ahspicme.com/**
Clinical Practice Guideline for Chronic Headache 2013 **http://www.jhsnet.org/english/guideline2013.pdf**
Myocardial infarction
American Heart Association **http://www.heart.org/HEARTORG/**
American College of Cardiology (ACC) Clinical Guidelines Non-ST-Elevation Myocardial Infarction (NSTEMI) **http://www.onlinejacc.org/content/64/24/e139?_ga=2.103077440.1750408609.1515607605-393126105.1515607605** ST-Elevation Myocardial Infarction (STEMI) **http://www.onlinejacc.org/content/61/4/e78?_ga=2.7149170.1750408609.1515607605-393126105.1515607605**
2011 AHA_ACCF Secondary Prevention Update **http://circ.ahajournals.org/content/circulationaha/124/22/2458.full.pdf**
Smoking cessation
American Lung Association **http://www.lung.org/stop-smoking/**
Tobacco Control Initiative in Davidson County **http://www.nashville.gov/Health-Department/Tobacco-Control.aspx**
Smoking Cessation **https://bluecare.bcbst.com/Health-Programs/Smoking-Cessation.html**
Smoking Cessation Program **http://tristarcentennial.com/service/smoking-cessation-program/**
Treating Tobacco Use and Dependence AHRQ 2008 **https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/quickref/index.html**
Treating Smokers in Healthcare Settings **http://www.nejm.org/doi/full/10.1056/NEJMcp1101512**
Stroke
The Heart Attack & Stroke Prevention Center **http://theheartattackandstrokepreventioncenter.com**
Brain and Spine Institute **https://www.utmedicalcenter.org/brain-and-spine-institute/medical-services/stroke-center/**
AHA/ASA Guideline — Guidelines for the Prevention of Stroke in Patients with Stroke and Transient Ischemic Attack **http://stroke.ahajournals.org/content/45/7/2160**

*sample of reference and is not considered an all-inclusive list