Medication Therapy Management Provider Operations Manual

BlueCare Tennessee

24PED2826000

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1 General Information

1.1 Background

In 2017, the Tennessee General Assembly authorized the design and implementation of the **Medication Therapy Management (MTM)** pilot. Its goals were to improve therapeutic outcomes by optimizing responses to medication, managing treatment-related interactions or complications, and improving 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 with, the delivery of medical services.

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

Pharmacists participating in the MTM program will provide MTM services under a **Collaborative Practice Agreement** with Patient-Centered Medical Home (PCMH) and Tennessee Health Link (THL) organizations. The goal of MTM is to work with patients to actively manage their drug therapy by identifying, preventing and resolving medication-related problems.

Qualified Tennessee MTM pharmacists may provide these services:

- Patient assessment (medical history as relayed by the patient)
- Comprehensive patient medication therapy review
- Personal medication record (from the patient)
- Medication action plan (for the patient to follow)
- Evaluation and documentation of medication-related problems, resolutions, education, and patient responses to medication therapy, including any adverse events
- Follow up to make sure patients are taking medications as prescribed and encourage patient self-management

MTM services are provided to eligible members participating in a PCMH or THL organization. The PCMH and THL programs are part of the Tennessee Health Care Innovation Initiative, which focuses on value by providing high-quality and cost-effective care. Qualified MTM pharmacists in our network must establish and maintain a working relationship with PCMH and THL organizations.

2 Parameters and Design

2.1 Framework

The MTM program began as a pilot program on Jan. 1, 2018, and the pilot ended June 30, 2021. Effective April 1, 2022, program administration transferred from TennCare to the managed care organizations (MCOs). Here's the framework as it stands today:

- Participation in the MTM program is **voluntary** for PCMH and THL organizations.
- Pharmacists must meet minimum requirements and have a collaborative practice agreement with a PCMH or THL organization.
- Our members are eligible for MTM services based on the MTM criteria developed using risk stratification for high-critical, medium-high and moderate status, as well as pediatric asthma or diabetes targeted disease states (low risk stratification).
- During the initial MTM appointment, the pharmacist will conduct a member history interview and evaluate the member's current medications. They'll also address the member's understanding of how the medications help manage disease, adherence difficulties, inhaler techniques, adverse drug reactions, drug interactions, any inappropriate drug therapy and any member medication concerns.
- Following the initial visit, pharmacists will send a report summarizing the MTM visit to the member's PCMH or THL organization. Per the professional judgement of the MTM pharmacist, copies of the report may be sent to other medical providers (e.g., specialists) who may have prescribed medications to the member.
- The reimbursement model is based on a **per member/per month (PMPM) case rate** for eligible 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 give members educational resources, a personalized medication list and medication guidance.
- Following every MTM encounter, pharmacists will document notes and outcomes in the electronic health/medical record. Additionally, pharmacists should share 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, with the member's PCMH or THL organization.
- Communication between the pharmacist and PCMH or THL organization is crucial and should be open, collaborative and continuous throughout the program.

3 MTM Requirements

3.1 PCMH or THL Requirements

The MTM program is a **voluntary** program specifically for practices who participate in TennCare PCMH and THL initiatives.

A PCMH or THL organization must establish a written collaborative practice agreement with a qualified Tennessee pharmacist. The collaborative practice agreement 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 all encounters related to MTM services in the electronic health/medical records.

3.2 Pharmacist Requirements

Pharmacists must meet the following criteria to qualify as a BlueCare Tennessee MTM pharmacist:

- Pharmacists must have a valid Tennessee license and meet minimum insurance requirements (i.e., professional liability). They must also get a TennCare Medicaid ID.
    - Individual providers will submit information that will place them on the Council for Affordable Quality Healthcare (CAQH) roster for TennCare/Tennessee Medicaid. Providers get their Medicaid ID once TennCare gets the data from CAQH. Moving forward, if providers update their data in CAQH, TennCare automatically receives those updates.
    - For more information about provider registration, how to access the provider portal and CAQH, please review these helpful links:
        - **TennCare Provider Registration:** tn.gov/tenncare/providers/provider-registration.html.
        - **CAQH:** proview.caqh.org/Login/Index?ReturnUrl=%2f
        - If you have questions about provider registration, please email Provider.Registration@tn.gov or call **1-800-852-2683, option 5**.
- MTM pharmacists must have a formal, written collaborative practice agreement in place with a TennCare PCMH or THL organization.
- The collaborative practice agreement establishes pharmacist-to-prescribing provider (supervising physician) expectations from scope of practice to documentation. You can find helpful information for creating a collaborative practice agreement at the links below.
    - The Tennessee Board of Pharmacy rules: publications.tnsosfiles.com/rules/1140/1140-03.20170220.pdf
    - Collaborative practice agreement guidance and minimum requirements: capitol.tn.gov/Bills/108/Amend/SA0839.pdf
    - Additional information on collaborative practice agreement requirements: tnpharm.org/wp-_content/uploads/FINALTPACPA-guidance.pdf
- Pharmacists participating in the MTM program must document information in the electronic health/medical record.

- MTM pharmacists must meet our credentialing and network agreement requirements.
    - See Section 3.3 for more information about contracting and credentialing.
- Pharmacists must sign the TennCare Acceptable Use Policy and Remote Access Request Forms, which outline electronic processes.
- All registration steps listed above must be complete before pharmacists provide MTM services and submit claims for reimbursement. If the number of eligible pharmacists interested in providing MTM services exceeds the capacity of the program, we may limit the number of pharmacists participating in each geographic location to make sure services are equally available throughout Tennessee.

3.3 MTM Network Contract

MTM pharmacists participating in the MTM program must complete our credentialing process and sign a network agreement. To request network participation, providers must submit a completed Provider Enrollment Form, which is available in Availity® under the **Provider Changes, Updates and Enrollment** tile within the **BlueCross Payer Space**. Once we receive the request, we'll review the data and work to credential providers if all requirements are met. As soon as credentialing is complete, providers receive their network agreement.

If you have questions about these processes, please contact your Provider Network Manager. You can find the name of your contact at: provider.bcbst.com/contact-us/my-contact.

4 Member Eligibility

4.1 Member (Patient) Eligibility

Our members qualify for MTM services if they have a primary care provider that participates in a TennCare PCMH or THL organization and have specific health problems or targeted disease states. An example might include a member who's categorized as high risk because of multiple chronic illnesses requiring multiple medications.

Member eligibility with risk stratification and targeted disease state logic is described in Section 4.5.

4.2 MTM Program Opt-Out

Members may stop participating in the MTM program at any time. Eligible members who want to leave the program or decide not to participate should talk with their MTM pharmacist or PCMH or THL provider. If they have questions or concerns, please ask them to call us at the Customer Service number on the back of their Member ID card.

The pharmacist or PCMH or THL organization may ask a member to verify, in writing, that they

want to opt out of the MTM program. If an eligible member opts out of the program and then decides to participate at a later date, they should contact their PCMH or THL organization and let them know they're interested in the program.

4.3 General Stratification

MTM eligibility criteria falls into general program categories:

- High-critical (members who have a risk stratification of critical and high)
- Medium-high
- Moderate
- Low

4.4 Risk Design

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

All costs for a population are accounted for in the model through claims. Members without a diagnosis category will be given a baseline age/sex risk score. This type of scoring often happens with children. CDPS + Rx provides separate models for different populations (for example, adults vs. children, people with disabilities vs. those enrolled in temporary assistance for needy families, and different covered services). Relative risk weights are internal to each model and determined by separate claims data sets for each model (adults vs. children). The risk weights reflect actual diagnosis and treatment patterns in the separate populations used to develop each distinct model and its calculated weights. Identical diagnostic histories will produce different risk scores between, for example, adults and children.

An individual's risk score is the sum of their 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 if significant synergies are identified.

For more information on risk adjustment methods, please visit: cdps.ucsd.edu/ and tn.gov/content/dam/tn/tenncare/documents2/CDPSTennCareProvidersWebinar.pdf.

4.5 MTM Identification (or Eligibility) Criteria: Risk Stratification and Targeted Disease States

MTM Hierarchy Logic

Member eligibility criteria for the MTM program has been divided into four risk categories:

- High-critical

- Medium-high
- Moderate
- Low (pediatric members with asthma or diabetes)

The program has set age eligibility parameters for each of the MTM service categories.

Program hierarchy logic differentiates members by:

- Risk stratification classifications (CDPS + Rx)
- MTM age criteria
- Targeted disease states for pediatric members with asthma or diabetes who don't meet exclusion criteria. For example, if a pediatric member has asthma and doesn't meet one of the other risk stratification categories, the member would be assigned to the low risk category.

It's important to note the MTM stratification categories are mutually exclusive, and the member should only appear in one service category.

General MTM Stratification

We've included more information about how patients are classified into each risk category below:

1. High-critical

The High-critical program includes two risk levels (critical and high) eligible for MTM services. Members in the High-critical risk category include those ages 2 through 64 who qualify for MTM services. In addition, pediatric patients who have diagnoses of asthma and/or diabetes (with high or critical risk) are classified as High-critical.

2. Medium-high

Patients are included in the Medium-high program and qualify for MTM services if they're ages 2 through 64 and have a medium-high risk status. For inclusion in this category, pediatric patients must:

- Have diagnoses of asthma **and** diabetes (either with moderate, low or no risk); **or**
- Have a diagnosis of asthma **or** diabetes with medium-high risk

3. Moderate

Moderate program status includes patients ages 2 through 64 with a risk stratification that's superior to low and inferior to medium-high. This program status encompasses pediatric and adult patients with a moderate risk stratification who don't have a diagnosis of diabetes or

asthma.

4. Low

Pediatric members ages 2 through 17 are included in the Low program if:

- They have asthma (with moderate, low or no risk), as defined by the J.45.XX (ICD-10-CM) codes; **or**
- They have diabetes (with moderate, low or no risk), as defined by one of these ICD-10-CM codes:
    - E08.XX (all) – Diabetes mellitus due to underlying condition
    - E09.XX (all) – Drug or chemical induced diabetes mellitus
    - E10.XX (all) – Type 1 diabetes mellitus
    - E11.XX (all) – Type 2 diabetes mellitus
    - E12.XX (all) – Malnutrition-related diabetes mellitus
    - E13.XX (all) – Other specified diabetes mellitus
    - 024.XX – Gestational diabetes in pregnancy

If a pediatric member has both asthma and diabetes diagnoses, they'll be assigned to the High-critical or Medium-high category, depending on risk stratification.

Table 4.1: Program Status Indicator and Risk Classification Example

Example	Diagnosis	Risk	Program Status Indicator[1]
Member 1	Asthma, diabetes* (pediatric)	Low	Medium-high
Member 2	None	High-critical	High-critical
Member 3	Pediatric Diabetes	Low	Low
Member 4	None	Moderate	Moderate

[1]Rule Outcome *Concomitant

5 Quality Care Rewards

Providers can view BlueCare Tennessee member eligibility for the MTM program in our **Quality Care Rewards (QCR)** application in Availity. Previously, providers used the Care Coordination Tool powered by HealthEC to view this information. The data in our QCR application replaces the Care Coordination Tool.

5.1 Viewing Reports in the QCR Application

You can view MTM eligibility on two reports:

- TennCare MCO – Patient-Centered Medical Home (PCMH) Weekly Attribution Report
- TennCare MCO – Tennessee Health Link (THL) Attribution Report for PCMH and THL

These reports contain an MTM eligibility field. If the field displays "**Yes**," the member is eligible for the MTM program. The reports also have a field for each member's risk level to help you determine which modifier to use on claims.

For step-by-step instructions on viewing these reports, please see the **Medication Therapy Management: Viewing Reports in Availity** presentation in the **Resources** section of the **BlueCross Payer Space**.

If you don't have access to Availity or need help using the QCR application, please call eBusiness Service at **(423) 535-5717, option 2**, or email **eBusiness_Service@bcbst.com**.

6 Policy and Procedures

PCMH and THL organizations, and MTM pharmacists, must follow state and federal laws when providing MTM services to our members. Services should also adhere to the guidelines, rules and policies outlined in the BlueCare Tennessee Provider Administration Manual (PAM).

If we make updates to program guidelines or policies, we'll send an email to providers or include information about the update in our BlueAlert Newsletter or PAM.

6.1 PCMH, THL and Pharmacist Expectations

Please keep these expectations in mind when administering MTM services:

- MTM visits will be conducted in collaboration with a TennCare-designated PCMH or THL provider.
- A participating TennCare-designated PCMH or THL provider must establish a collaborative practice agreement with an MTM-qualified pharmacist to provide MTM services to eligible members.
- Our members can't receive MTM services from more than one MTM-designated pharmacist at one time.
- MTM pharmacists must meet all credentialing and training requirements before providing services to our members.
- MTM pharmacists will schedule and conduct MTM service appointments in a private, distraction-free environment.
    - Conducting services in a public area, such as the dispensing area of the pharmacy, isn't allowed.
    - Secure Wi-Fi and network connections are required (pharmacists shouldn't use public Wi-Fi).
    - Pharmacists shouldn't perform other duties, like dispensing, during MTM visits. To avoid conflicts between dispensing and clinical activities, consider scheduling MTM visits before or after retail hours or when another pharmacist will also be on duty.
- The time required to prepare for and document MTM services isn't billable.

- Each MTM-designated pharmacist must follow federal and state medical record retention regulations and keep a permanent record of each MTM visit and all related documentation.
- Consider using the **QCR** application to verify members' MTM program eligibility before each visit. The QCR application is updated with member eligibility information weekly. For more information about MTM eligibility, please see **Section 4.4**.
    - If a patient is no longer eligible for MTM services, the MTM pharmacist may contact the member to let them know about their change in eligibility status. Please direct members to TennCare if they have questions about their MTM service eligibility.
- During the MTM visit, the pharmacist must use the relevant forms (comprehensive medication review, etc.) to gather information.
- To confirm MTM program eligibility, pharmacists must verify the member's ID by asking for photo identification, their member ID, or their MTM program participation invitation letter.
- MTM pharmacists should:
    - Document member assessments, including pertinent medical history, in the electronic health/medical records.
    - Conduct a comprehensive medication review, which should document self-reported use of over-the-counter medications, herbs and supplements.
    - Prepare the member's MTM summary report.
    - Help connect members with other health care resources, such as asthma coalitions, and provide materials to help members manage their conditions.
    - Document drug therapy problems, recommended solutions, education and evaluation of each member's response to therapy.
    - Schedule follow-up appointments, as needed, to ensure member medication adherence and determine if the member's goals have been met.
    - Collaborate and preserve a working relationship with each member's PCMH or THL provider.
    - Give the member a copy of their MTM summary report.
- Pharmacists will maintain a collaborative relationship with the member's PCMH or THL provider, including sending written summaries and recommendations from all MTM encounters.
- Pharmacists must contact the member's PCMH or THL provider for all interventions that require immediate attention.
- All written and verbal contact with members must be documented in the member's MTM record. Pharmacists must then send a permanent record of MTM encounters through a secure method to the member's PCMH or THL health record.
- The collaborative practice agreement may include additional guidance or outline

documentation policies and procedures to ensure MTM documentation is kept and becomes a permanent part of the member's health record.

- MTM pharmacists should base medication recommendations on professional judgement and evidence-based guidelines. Pharmacists should be familiar with the targeted disease states and medications included in the recommendation and refer to available evidence and guidelines.
    - **Appendix 5** includes sample references and a list of member resources.
- MTM pharmacists may submit claims in Availity. We don't accept paper claim submissions.
- Reimbursement for MTM services covers a per month case rate and includes an initial face-to-face, one-on-one visit with the member. Follow-up monthly case rate visits may be done face-to-face or remotely at the member's preference.
    - Group visits don't qualify for MTM reimbursement.
    - The time required to prepare for MTM visits, follow up with members or place reminder calls isn't reimbursable.
    - Pharmacists can't submit a claim for no-show appointments.
    - Reimbursement is based on established case rates with service limits.
- Pharmacists are required to follow all established TennCare guidelines, rules and policies, and may work for more than one TennCare PCMH or THL organization.

6.2 Member Expectations

Please see below for more information about the member experience in the MTM program:

- The TennCare MTM program will select members based on specific risk and targeted disease state criteria and offer MTM services to eligible members.
- Members are expected to attend scheduled appointments.
- Members can't receive MTM services from more than one pharmacist during a month.
- There are no member payments for MTM services.

6.3 Federally Qualified Health Center and Rural Health Clinic Expectations

An MTM service involving behavioral health medications doesn't count as a second visit due to Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) rules. Such services are paid outside of regular FQHC/RHC payment methodology.

Please see the TennCare Policy for additional FQHC/RHC information.

7 Record Retention, Security and Compliance

7.1 Record Retention and Security

Pharmacists must keep all documents associated with MTM services for the required number of

years outlined in federal and state laws. The retention method should comply with federal and state HIPAA requirements. It's the MTM pharmacists' responsibility to maintain records of the MTM services they deliver. These records should be readily available for audit requirements.

7.2 Compliance with Legal Regulations

We, along with our network providers, agree to recognize and abide by all state and federal laws, rules, regulations and guidelines applicable to the MTM agreement and the Medicaid program. These rules and regulations include, but aren't limited to:

- Section 6032 of the Deficit Reduction Act of 2005 (DRA), which outlines policy, development, employee training and whistleblower 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
- The TennCare rules

7.3 Incorporation by Reference of Federal and State Law/Regulation

The MTM 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 will be automatically incorporated into the agreement as they become effective.

8 Reimbursement Methods

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 our members enrolled in the MTM program.

A pharmacist provides individual management therapy with assessment and intervention. This patient-specific service includes reviewing relevant history and prescription and non-prescription medications. The pharmacist evaluates the medication profile for underdosing or overdosing, duplications, and possible drug interactions, and makes recommendations based on the assessment, including communication with the prescriber if necessary. Pharmacists should provide ongoing evaluation and monitoring to ensure optimal medication treatment. This information should be documented in the electronic health/medical, and then included in the PCMH or THL health record.

8.2 Reimbursement Information

The payment model for the MTM program is designed to reimburse at a **per month case rate**

based on the member's risk stratification or targeted disease state. MTM pharmacists may have as many conversations with members as needed throughout the month.

MTM service modifier codes (which identify the case rate) and payment limits are listed in the table below.

TABLE 8.2: MTM Service Modifiers and Limits

Service Description	Modifier	Case Rate	Payment Limits (Per Calendar Year)	Case Units[2] (Per Month)
Low	U1	$55.00	2 months	1 unit for each case rate
Medium-high	U2	$55.00	3 months	1 unit for each case rate
High-critical	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 (i.e., 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 member. Follow-up monthly case rate visits may be done face-to-face or remotely, depending on the member's preference. The initial case rate is based on a minimum of at least 15 minutes per month.

- The collaborative practice agreement between the PCMH or THL provider and MTM pharmacist may include organizational requirements and expectations about service delivery.

As part of **reporting and tracking**, pharmacists must use the professional claim form (CMS-1500) to bill MTM services and include the required CPT® codes and service modifiers (case rate). The following CPT® codes are used to identify MTM services, report and track time associated with services, and for reimbursement:

- **CPT® 99605 –** MTM service(s) 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 the code for the primary service).

CPT® 99605 code is used for new patients and is **only allowed once per member**.

CPT® 99607 is an add-on code for tracking each additional 15-minute increment of time spent providing MTM services to the member. Add-on codes must be billed with either **99605** or **99606**. **CPT® code 99607 is used for information only, and no additional reimbursement is associated with this code**. We require providers to submit this code so we can track member usage patterns.

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.

Pharmacists should follow customary reimbursement and place of service guidelines. The CMS place of service code set can be found at cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.

Here are a few examples:

- Place of service 11 for MTM services provided in the PCMH or THL office
- Place of service 53 for MTM services provided in a community mental health center
- Place of service 02 for MTM services provided telephonically

If MTM services are provided remotely, the call must be interactive in real time. (Voicemails, text messages and emails to enrolled members aren't billable encounters.) Remote services must be completed in a private area.

To identify remote MTM services for tracking and reporting, please use these 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 seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion
- **CPT® 98967 –** 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 seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment, 11-20 minutes of medical discussion

- **CPT® 98968 –** 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 seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment, 21-30 minutes of medical discussion

Exception Criteria

Exceptions to the service limits stated previously may be granted at the request of either the MTM pharmacist or the member. We'll consider exceptions if there are significant changes to a member's medical condition. Please complete an MTM exception form and send it to us.

- We'll review the MTM exception form for completeness to determine reimbursement appropriateness.
- See **Appendix 4** for more information about the MTM exception form.

8.4 General Billing Requirements

Pharmacists in the MTM program must bill claims according to usual and customary standards:

- Use the **QCR** application to confirm the member is eligible to receive MTM services.
  - You can find eligibility criteria in **Sections 4.3 and 4.5**.
- Use the professional claim form (CMS – 1500) for billing MTM services.
- Report the **National Provider Identifier of the pharmacist** who performed the service in the rendering provider ID field.
  - If the billing and rendering provider are the same, you don't have to report the rendering provider information. For the billing provider, include the employer's tax ID and National Provider Identifier on the claim as required per National Uniform Claim Committee billing standards and X12 5010 requirements.
  - Please see the Division of TennCare Information Systems Policy titled **Provider Identification Usage on Submitted Transactions**: tn.gov/content/dam/tn/tenncare/documents/provideridentificationusage.pdf
- The appropriate place of service must be submitted with claims (for example, place of service 11 for an MTM service provided in an office or place of service 53 for a service provided in a community mental health center).
  - Please review CMS guidelines and our PAM for more information.
  - Place of service 02 must be used with CPT® codes 98966, 98967 or 98968 for telehealth services.

    - An MTM service involving behavioral health medications doesn't count as a second visit for purposes of the FQHC/RHC rules and is paid for outside of regular FQHC/RHC payment methodology. See the TennCare Policy for more information.
- MTM CPT® codes are used for reimbursement **reporting** and **tracking** and help ensure the time spent on and use of resources for MTM services are recorded appropriately. CPT® codes 99605-99607 are time-based and submitted in 15-minute increments. Code 99607 is an add-on and must be used with 99605 and 99606. CPT® code 99607 is for informational purposes only and doesn't impact claims payment.
- The service description modifier (e.g., U3 = high-critical risk) must be used to identify the covered MTM service and case rate.
    - Frequency limitations are associated with each service category modifier.
    - See **Table 8.2** for service modifier and limit descriptions.
- Verify the number of MTM service visits. Case rates won't be paid past the authorized limits, as described in this section.
    - For example, pediatric members with a diagnosis of asthma in the targeted disease state category have an MTM service limit of two months.
    - See **Table 8.2** for service modifier and limit descriptions.
- Members who change risk categories (i.e., from medium-high to high-critical) are eligible for service limits equal to the higher risk service payment limit.
    - For example, if a member's initial risk is evaluated at medium-high but is later re-evaluated and risk-adjusted to high-critical, the member would move from the medium-high to the high-critical risk service limit. Any previous MTM services would count toward the high-risk service payment limit.
- **If pharmacists want to request an exception to the existing service limits, they must complete and submit an MTM exception form.**
    - To bill for exception services, include the U4 modifier on the claim as a second modifier.
    - We'll review the MTM exception form to determine if reimbursement is appropriate.
        - **Please note:** The completed MTM exception form must include two signatures.
    - See **Appendix 4** for the MTM exception form.
- 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.
- Reimbursement for initial MTM services will only cover face-to-face, one-on-one contact with the member. MTM monthly follow-up visits may be done face-to-face or remotely at the member's preference.
- If the member switches pharmacists, the limit will follow the member (i.e., if a

member in the high-critical risk level had two visits with first pharmacist, the new pharmacist can only provide four visits).

- The MTM service claim must be submitted according to our guidelines for timely filing.
- If an MTM service is provided remotely:
    - The telephone call must be interactive in real-time. Voicemails, text messages and emails to enrolled members aren't billable encounters.
    - 98966, 98967 or 98968 must be used for claims reimbursement.
        - Place of service 02 must be used with CPT® codes 98966, 98967 or 98968.
- The MTM service claim must include the referring/ordering/prescribing provider and a National Provider Identifier to receive reimbursement.
    - Please refer to **Appendix 3: Billing, Reporting and Tracking MTM Service Sample Chart**.
- MTM pharmacists should bill claims in Availity using our guidelines for electronic billing. Please see the **Digital Resources** section of **bluecare.bcbst.com/providers** for information about using Availity.
- Reimbursement for MTM services will cover a per month case rate that includes an initial face-to-face, one-on-one visit with the member. Follow-up monthly case rate visits may be performed face-to-face or remotely, based on the member's preference.
- Group education sessions may be conducted during the month as an integral part of care and interaction with members, but these visits shouldn't replace the one-on-one MTM service visit. **Please note:** These group education sessions aren't reimbursable.
- MTM pharmacists shouldn't bill for the amounts of time required to prepare for visits and place follow-up/reminder phone calls. This time isn't reimbursable.
- Pharmacists can't submit claims for no-show appointments.
- Please review the BlueCare Tennessee Provider Administration Manual for all current and final billing and reimbursement guidelines.
- We'll periodically audit claims and recoup any identified overpayments.

8.5 Additional Information

Please refer to the resources below if you have questions or would like to learn more about our billing procedures.

- **BlueCare Tennessee Provider Manual:**
  bcbst.com/providers/manuals/BCT_PAM.pdf
- **Real-Time Claim Adjudication (RTCA) Quick Guide:**
  Let your eBusiness consultant know if you'd like a copy of this guide to help with claims submission.
- **Help Using Availity**
  Email eBusiness_Service@bcbst.com if you have questions or would like training on electronic billing.
- **eBusiness Technical Support:**
  Call **(423) 535-5717, option 2** or contact your eBusiness Consultant:

- Faith Daniel (East region): Faith_Daniel@bcbst.com
- Faye Mangold (Middle region): Faye_Mangold@bcbst.com
- Vivian Williams (West region): Vivian_Williams@bcbst.com

- **Availity:**
  Support Phone: 1-800-282-4548

9 How Will We Measure Quality and Efficiency?

9.1 MTM Quality Metrics

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

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

9.2 Detailed Business Requirements

The business requirements for MTM program evaluation are available in a separate document. The detailed business requirement document details the program logic and provides definitions, sources of data, and qualifying eligibility criteria for the core metrics used to evaluate the MTM program.

The framework for MTM evaluation is:

- **Total Cost of Care (TCOC)**
  - The total cost of care measure includes the program-paid amounts for all covered services associated with treating a patient, including inpatient, outpatient, professional, pharmacy and ancillary services. These services are adjusted for the number of months members were enrolled in TennCare.
- **Star Rating Metrics (adapted from the CMS Part D and Star measure rating specifications)**
  - **Medication Adherence for Diabetes Medication (D11)**
    - This measure evaluates the percentage of members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they're 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.
  - **Comprehensive Medication Review Completion Rate (D14)**
    - This measure shows how many members in the program had a medication assessment. The assessment includes a discussion between the member and a pharmacist (or other health care professional) about their medications.
    - The measure is defined as the percentage of members in the MTM program who received a comprehensive medication review

during the reporting period.

- **Potential informational metrics for consideration (PCMH, THL, 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 patients 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 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 the MTM program may change. We'll let you know about any changes before they take effect.

10 TennCare Nondiscrimination Compliance Requirements

10.1 Nondiscrimination

TennCare members should receive culturally competent care that is free from discrimination due to a person's race, color, national origin, language, sex, age, religion, disability, or any status protected by federal or state civil rights laws in TennCare program activities and benefits. Discrimination can take the following forms:

- Not letting a person take part in the same things as other people
- A patient not getting the help they needed to fill a prescription
- A patient not getting the care they needed during a health care encounter

Under disability nondiscrimination laws, qualified individuals with disabilities must be given an equal opportunity to participate in a program, service or activity. This means a patient may need a mitigating measure, like a reasonable accommodation or auxiliary aids and services, during a service encounter. You can learn more about Titles II and III of the Americans with Disabilities Act (ADA), Section 1557 of the Patient Protection and Affordable Care Act, and

Section 504 of the Rehabilitation Act of 1973 at:

- ada.gov
- Civil Rights for Providers of Health Care and Human Services | HHS.gov

Please give members proper accommodations for any disabilities. In determining what types of auxiliary aids and services are necessary, please give primary consideration to the requests of individuals with disabilities in line with 28 C.F.R. § 35.160 and 28 C.F.R. § 36.303. To be effective, auxiliary aids and services must be provided in accessible formats, in a timely manner, and in such a way as to protect the privacy and independence of the individual with a disability. If an individual requests an auxiliary aid or service that you can demonstrate would result in a fundamental alteration in the nature of its services or result in an undue financial and administrative burden, you don't have to provide the requested auxiliary aid or service. However, if available, you should provide the individual another form of an auxiliary aid or service that would achieve effective communication with the individual and not result in a fundamental alteration in the nature of your services or result in an undue financial and administrative burden.

Nondiscrimination laws require effective communication with individuals. This means that a provider must provide the translation or interpretation services needed to effectively communicate with an individual with Limited English Proficiency (LEP) or an auxiliary aid or service to effectively communicate with an individual with a disability. The National Institute of Minority Health and Health Disparities created a Language Access Portal (LAP). The LAP contains information, in multiple languages, for six disease areas (cancer, diabetes, asthma, cardiovascular disease and more) where major health disparities have been identified in non-English speaking populations. To learn more, visit nimhd.nih.gov/programs/edu-training/language-access/index.html.

MTM pharmacists are responsible for ensuring members have a full understanding of their prescription treatment guidelines, regardless of their cultural background, which includes the person's preferred language, literacy level or disability status. To ensure all members receive appropriate access to their pharmacy benefits, pharmacists are expected to comply with federal and state requirements regarding cultural and linguistic services. It's not permissible to:

- Turn a member away
- Limit an individual's participation or access to services because of cultural or communication barriers
- Subject individuals to unreasonable delays due to cultural and language barriers
- Provide a lower quality level of service to individuals with LEP, low literacy levels,

disabilities or different cultural backgrounds

You must have written procedures for the provision of free language and communication assistance services, like interpretation and translation services for any member who needs such services, including, but not limited to, members with LEP. We provide free language and communication assistance services to members during direct contact with our staff. We don't reimburse language and communication assistance services offered to TennCare members in pharmacy settings. You're responsible for offering these services without charging the member. This is a requirement under the federal civil rights regulations, which apply to any provider who accepts TennCare funds.

Health literacy also plays an important role in effective communication and culturally competent care. The U.S. Department of Health and Human Services has health literacy and communication tools and resources at:

- Health Literacy | health.gov
- Consumer Health Content on MyHealthfinder | health.gov

You can learn more about civil rights compliance and cultural competency, and find resources like trainings, toolkits, forms, policies and notices here:

- tn.gov/tenncare/providers/programs-and-facilities/civil-rights-information.html
- tn.gov/tenncare/members-applicants/civil-rights-compliance.html

10.2 Discrimination Complaints

When a program or entity receives federal funding, beneficiaries, like TennCare members, and participants, like providers, in the program have the right to receive services or participate in the program free from discrimination because of their race, color, national origin, disability, age, sex, conscience and religious freedom, or other statuses protected by federal and/or state law. By law, no one can retaliate against a person for making a complaint.

You can find information on how to file a complaint and real-time and PDF versions of the TennCare discrimination complaint forms at tn.gov/tenncare/members-applicants/civil-rights-compliance.html. You can also file complaints by calling TennCare Connect at **1-855-259-0701** or mailing completed complaint forms to:

TennCare, Office of Civil Rights Compliance
310 Great Circle Rd, Floor 3W
Nashville, TN 37243

10.3 Cultural Competency

We'll ensure that all TennCare members receive equitable and effective treatment in a culturally and linguistically appropriate manner. We expect providers to be culturally sensitive to the diverse population they serve by effectively and appropriately providing services to people of all races, cultures, religions, ethnic backgrounds, education and medical status in a manner that recognizes values, affirms and respects the worth of each individual member, and protects and preserves the dignity of each.

Everyone has the right to receive culturally and linguistically appropriate services (CLAS). The care delivered needs to be respectful of each member's beliefs, practices and unique needs. For more information, including national standards and training, we encourage you to visit thinkculturalhealth.hhs.gov.

What is cultural competency?

Culture refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, values and institutions that unite a group of people. It impacts the care given to members because it describes:

- Concepts of health and healing
- How illness, disease and their causes are perceived
- The behaviors of patients seeking health care
- Attitudes toward health care providers

It also defines health care expectations, such as:

- Who provides treatment
- What's considered a health problem
- The type of treatment
- Where care is sought
- How symptoms are expressed
- How rights and protections are understood

Why is it important?

Cultural competency is one of the main ingredients in closing the disparities gap in health care. It's the way patients and providers can come together and talk about health concerns without cultural differences hindering the conversation but enhancing it. Quite simply, health care services that are respectful of and responsive to the health beliefs, practices, and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.

Cultural competence emphasizes the idea of effectively operating in different cultural contexts and altering practices to reach different cultural groups. Cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings to increase the quality of services. This helps produce better outcomes.

A cultural competency program can help you respectfully and sensitively address the needs of members who have been marginalized because of their race, gender, sex, age and other protected statuses. There are many cultural influences that impact the delivery of health care services. Some cultural preferences to remember include:

- Do patients feel their privacy is respected?
- Are they the health care decision maker?
- Does the patient's belief in botanical treatments and healers contradict standard medical practices, and does it impact their decisions?
- What type of language skills and preferences does the patient use in their interactions?

Because health care is a cultural construct based in beliefs about the nature of disease and the human body, cultural issues are central in the delivery of health services. Culture impacts every health care encounter. By understanding these influences and communicating clearly at each visit, you fulfill the opportunity to build rapport and help improve adherence and safety.

11 Glossary

CAQH: Council for Affordable Quality Healthcare

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

Comprehensive Medication Review: The systemic review and evaluation of a patient's medication regimen, encompassing prescription and over-the-counter agents

- This review includes any actions/recommendations needed to optimize treatment.

CPT® Billing Increments: For the MTM program, one unit (one billing increment) equals 15 minutes of time spent with a member for MTM services.

CPT®: Current Procedural Terminology

Dual Eligible: Refers to members who qualify for Medicare and Medicaid benefits

Established Patient: A patient who has received professional services from the physician/qualified health care professional, or another physician/qualified health care professional in the same specialty and subspecialty who belongs to the same group practice, within the past three years

EHR: Electronic Health Record

EMR: Electronic Medical Record

Explanation of Benefits: A statement sent to covered members explaining what medical treatments and services were paid on their behalf

- The explanation of benefits typically describes the service performed, date of service, amount of the provider's fee and insurer allowable, and any adjustments (with explanations for those adjustments).

Face-to-face Time for Services: The face-to-face time spent with the patient and/or family

- This includes time spent on tasks like obtaining a history and patient counseling.

FQHC: Federally Qualified Health Center

HIPAA: Health Information Portability and Accountability Act

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

MCO: Managed Care Organizations

MTM: Medication Therapy Management

NPI: National Provider Identifier, a 10-digit, intelligence-free, unique identification number for covered health care providers

- The NPI is a HIPAA administration simplification standard. Covered health care providers and all health plans and health care clearinghouses must use the NPI in administrative and financial transactions adopted under HIPAA.

New Patient: A patient who hasn't received any professional services from the physician/qualified health care professional, or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years

PCMH: Patient-Centered Medical Home

THL: Tennessee Health Link

MTM Pharmacist: A BlueCare Tennessee network pharmacist who can conduct and submit claims for MTM services and has a collaborative practice agreement with a designated PCMH or THL organization

12 Questions and Answers about the MTM Program

1. **Can I share additional educational information with my patients?**

   Yes. You may share educational material based on your professional judgement.

2. **Can I bill for my time if a member doesn't attend their scheduled appointment?**

   No. If a member doesn't show up for their appointment, the time isn't payable. Pharmacists can only bill for time spent with the member.

3. **Can I bill for the time it takes to get ready for the MTM visit?**

   No. Preparation time shouldn't be billed. Only time spent directly with the member is payable.

4. **Are all members eligible for MTM services?**

   No. Only members that meet MTM eligibility criteria can receive services. You can use our **QCR** application to identify members' program eligibility. Patients are eligible if they meet risk category criteria (for example, if they have multiple chronic conditions and take multiple medications). Pediatric members are eligible if they're diagnosed with asthma or diabetes mellitus.

5. **Can a patient's caregiver attend the MTM visit with patient?**
   Yes. Caregivers are welcome with the patient's permission.

For more information, please review our Provider Administration Manual.

13 Contact Information and Other Resources

TennCare MTM Program
tn.gov/tenncare/providers/managed-care-contractors/pharmacy-benefits-manager/medication-therapy-management-pilot-program.html

Primary Care Transformation
tn.gov/tenncare/health-care-innovation/primary-care-transformation.html

TennCare Information Systems Policies

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

BlueCare Tennessee

- bluecare.bcbst.com/providers
- **BlueCare℠ Phone:** 1-800-468-9698
- **TennCare*Select* Phone**: 1-800-263-5479
- **BlueCross Real Time Claim Adjudication (RTCA) Quick Guide:**
- tn.gov/content/dam/tn/tenncare/documents/rtcaTtutorial.pdf

14 List of Appendices

Appendix 1: Member Encounter and Pharmacist Task Guideline

Appendix 2: Reimbursement Guidelines

Appendix 3: Billing, Reporting and Tracking MTM Service Sample Chart

Appendix 4: Attestation

Appendix 5: Resources and References

Appendix 1: Member Encounter and Pharmacist Task Guidelines

1. Verify the member meets MTM eligibility criteria in our **QCR** application.
    a. Risk stratification (High-critical, Medium-high, Moderate or Low)
    b. Targeted disease state (Pediatric Asthma or Pediatric Diabetes)

2. Schedule the encounter with the member.

3. Discuss the member's medication history with their PCMH or THL. Check for "red flags" that may indicate a disease is uncontrolled. Examples may include:
    a. Early or frequent requests for or fills of short-acting asthma medications, such as an albuterol inhaler or nebulizer or Xopenex inhaler or nebulizer.
    b. Inconsistent fills of maintenance medications. For example, a 30-day supply of an oral antidiabetic is filled every 45 days.

4. Document any allergies in the member's medical record.

5. Review the member's medication profile for medications that could indicate mismanaged triggers:
    a. Check the medical profile against the controlled substance database at tncsmd.com/Login.aspx?ReturnUrl=%2fdefault.aspx.
    b. Watch for frequent fills or over-the-counter purchases of antacids, H-2 blockers or proton pump inhibitors.
    c. Note frequent fills of over-the-counter or prescription allergy medications.

6. 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.

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

8. If possible, have applicable medication devices available so you can demonstrate proper administration techniques.

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

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

11. Complete and document all encounter information in the patient's electronic health/medical record. Additionally, please review these topics during member encounters:

- Medication reconciliation
- Drug delivery techniques
- Triggers and trigger avoidance
- Specific educational handouts given
- Next appointment date
- Possible medication adjustments, if needed, to be discussed with the primary care provider
- Specific topics to be discussed at the next visit

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

13. Send an MTM summary report to the patient's primary care provider and specialists as needed. If you recommend medication changes, you're required to follow up with the prescriber's office to discuss recommendations and patient progress.

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

15. Keep a permanent copy of documentation from each MTM encounter and other pertinent records, in accordance with federal and state medical record retention regulations. Work with the member's PCMH/THL to make sure encounter documentation is delivered to the member's health record and available to the PCMH/THL provider.

Appendix 2: Reimbursement Guidelines

Medication Therapy Management (MTM) Reimbursement Guidelines: The Case Rates for MTM-covered services are described below:

Service Description	Modifier Code	Case Rate	Payment Limits	Units
Low	U1	$55.00 (Eff. Jan. 1, 2020)	Two months	One unit for each case rate
Moderate	U5 (Eff. July 6, 2020)	$55.00 (Eff. July 6, 2020)	Two months	One unit for each case rate
Medium-high	U2	$55.00 (Eff. Jan. 1, 2020)	Three months	One unit for each case rate
High-critical	U3	$75.00 (Eff. Jan. 1, 2020)	Six months	One unit for each case rate
Exceptions (Requires Appropriate Approval)	U4	Rate based on level of care modifier	Limit based on appropriate approval	One 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 a pharmacist **face-to-face** with the patient, with assessment and intervention if provided; **new** patient visit, initial 15 minutes
99606	MTM service(s) provided by a pharmacist **face-to-face** with the 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 health care professional to an established patient. 5-10 minutes
98967	**Telephone** assessment and management services provided by a qualified non- physician health care professional to an established patient. 11-20 minutes
98968	**Telephone** assessment and management services provided by a qualified non-physician health care professional to an established patient. 21-30 minutes

Pharmacists will bill the appropriate CPT® code (99605 for a new patient or 99606 for an established patient) with the service modifier to receive appropriate case rate reimbursement. To track and report time, if a visit lasts more than 15 minutes, pharmacists will also submit 99607 with an additional unit for each 15-minute increment. **Please note:** CPT® 99607 code is for informational purposes only and doesn't impact claims payment. MTM services provided indirectly (by telephone) must be submitted using 98966, 98967 or 98968.

Pharmacists must complete and submit an MTM exception form for any service limit exceptions. Claims submitted for services beyond the risk-based maximum limit as described in this section may be subject to recoupment unless we get an MTM exception form. We'll review the MTM exception form for completeness to determine if reimbursement is appropriate based on TennCare guidelines. If you're billing for services beyond the risk-based maximum limit, use the U4 modifier on claims as the second modifier.

Only one case rate payment will be made per member per month based on the pharmacist who submits the first claim during the billing month. If a member switches pharmacists in the middle of treatment, the limit will follow the member. For example, if a member in the high-risk level had two visits with the first pharmacist, the new pharmacist may complete four visits. Members who change risk categories (i.e., from medium high to critical) are eligible for service limits equal to the higher risk service payment limit.

All claims for MTM services must meet the timely filing guidelines outlined in our Provider Administration Manual.

Billing Examples:

High-critical Risk Level Member

- **Example one:** A new high-critical risk member has a one-hour visit with a pharmacist in January. The pharmacist:
  - Bills 99605, Modifier U3
  - Bills 99607 x3
- **Example two:** The member above has a 15-minute visit with a pharmacist in February. The pharmacist:
  - Bills 99606, Modifier U3
- **Example three:** The same member a 30-minute visit with a pharmacist in March. The pharmacist:
  - Bills 99606, Modifier U3
  - Bills 99607
- **Example four:** The same member has a 45-minute visit with a pharmacist in April. The pharmacist:
  - Bills 99606, Modifier U3
  - Bills 99607, x 2

Medium-high Level Member

- **Example five:** A new medium-high level member has a 30-minute visit with the pharmacist in March. The pharmacist:
  - Bills 99605, Modifier U2
  - Bills 99607
- **Example six:** The same member has a 30-minute visit with the pharmacist in April. The pharmacist:
  - Bills 99606, Modifier U2

- Bills 99607

- **Example seven:** The same member has a 15-minute visit with the pharmacist in May. The pharmacist:
  - Bills 99606, Modifier U2

Members with Targeted Disease States

- **Example eight:** A new member with a targeted disease state has 30-minute visit with the pharmacist in March. The pharmacist:
  - Bills 99605, Modifier U1
  - Bills 99607
- **Example nine:** The same member has a 30-minute visit with the pharmacist in April. The pharmacist:
  - Bills 99606, Modifier U1
  - Bills 99607
- **Example 10:** The same member has a one-hour visit with the pharmacist in May. The pharmacist:
  - Bills 99606, Modifier U1, U4
  - Bills 99607 x3
  - **Note:** If the pharmacist feels that additional clinical services are needed, they must complete and upload an MTM exception (ME) form and use the appropriate billing codes.

Appendix 3: Billing, Reporting and Tracking MTM Service

Sample Chart

MTM Example	Time (Minutes)	Location	CPT®	CPT® (Add-On)	Place of Service[1] Service Code	MTM Modifier[3]
New, High-critical	45	Office	99605	99607 x2	11	U3
New, High-Critical	30	CMHC	99605	99607	53	U3
Established, Low	15	Office	99606		11	U1
Established, Low	15	Indirect[2]	98967		02	U1
Established, Medium-high	30	Indirect[2]	98968		02	U2
Established, Low	45	Follow up office	99606	99607 x2	11	U1
New, moderate	30	CMHC	99605	99607	53	U5

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

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

[3] MTM case rate or service modifier

Appendix 4: MTM Exception (ME) Form

Division of TennCare

MTM Exception (ME) Form

Name of attesting provider (PCMH or THL): _____

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 5: Sample* Resources for MTM Program

Tennessee
Tennessee 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 optumrx.com/content/dam/openenrollment/pdfs/Tenncare/home-page/preferred-drug-list/Preferred%20Drug%20List%20(PDL).pdf
Tennessee MTM Program tn.gov/tenncare/providers/managed-care-contractors/pharmacy-benefits-manager/medication-therapy-management-pilot-program.html
TennCare Pharmacy Benefits Manager optumrx.com/oe_tenncare/landing
State Government tn.gov
Asthma
National Asthma Education and Prevention Program nhlbi.nih.gov/health-topics/asthma
Asthma NHLBI Quick Reference Guide nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf
Asthma NHLBI Clinical Guidelines nhlbi.nih.gov/sites/default/files/media/docs/asthgdln_1.pdf
Chronic Obstructive Pulmonary Disease (COPD)
COPD GOLD 2020 Clinical Guidelines goldcopd.org/gold-reports/
COPD Gold Pocket Guide 2020 goldcopd.org/wp-content/uploads/2020/03/GOLD-2020-POCKET-GUIDE-ver1.0_FINAL-WMV.pdf

Heart Disease
American Heart Association heart.org/en
2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure professional.heart.org/en/science-news/2022-guideline-for-the-management-of-heart-failure
Diabetes Mellitus
AACE Diabetes Resource Center pro.aace.com/disease-state-resources/diabetes
American Diabetes Association Standards of Medical Care in Diabetes 2017 professional.diabetes.org/sites/professional.diabetes.org/files/media/dc_40_s1_final.pdf
Association of Diabetes Care & Education Specialists diabeteseducator.org/prevention
NIH Taking Care of Youth with Diabetes niddk.nih.gov/health-information/professionals/diabetes-discoveries-practice/taking-care-of-youth-who-have-diabetes
Strategies for Insulin Injection Therapy in Diabetes Self-Management diabeteseducator.org/docs/default-source/legacy-docs/_resources/pdf/research/aade_meded.pdf?sfvrsn=2
Comprehensive Foot Examination and Risk Assessment care.diabetesjournals.org/content/31/8/1679
Hypercholesterolemia
National Human Genome Research Institute genome.gov/Genetic-Disorders/Familial-Hypercholesterolemia
American Heart Association heart.org/en/health-topics/cholesterol
2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults ahajournals.org/doi/pdf/10.1161/01.cir.0000437738.63853.7a
Lifestyle Full Work Group Report http://circ.ahajournals.org/content/suppl/2013/11/07/01.cir.0000437740.48606.d1.DC1
Triglycerides and Cardiovascular Disease ahajournals.org/doi/10.1161/cir.0b013e3182160726
National Lipid Association Guidelines lipid.org/recommendations
Hypertension

Hypertension Management Program fepblue.org/manage-your-health/managing-specific-conditions/hypertension-management-program
2017 High Blood Pressure Clinical Practice Guideline jacc.org/doi/10.1016/j.jacc.2017.11.006
2013 AHA/ACC Guideline on Lifestyle Management to Reduce Cardiovascular Risk ahajournals.org/doi/pdf/10.1161/01.cir.0000437740.48606.d1
Mental Health
American Psychiatric Association Guidelines psychiatry.org/psychiatrists/practice/clinical-practice-guidelines
DSM-5 ICD codes psychiatry.org/psychiatrists/practice/dsm
Migraine
American Academy of Neurology aan.com
American Headache Society americanheadachesociety.org
Clinical Practice Guideline for Chronic Headache 2013 neurology-jp.org/guidelinem/ch/documents/guideline2013.pdf
Myocardial Infarction
American Heart Association heart.org/en
ACC Clinical Guidelines NSTEMI http://www.onlinejacc.org/content/64/24/e139?_ga=2.103077440.1750408609.1515607605-393126105.1515607605 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 lung.org/stop-smoking/
Tennessee Tobacco Use Prevention and Control Programhttp://www.nashville.gov/Health-Department/Tobacco-

Control.aspx
Tennessee Tobacco Use Prevention and Control Program tn.gov/health/health-program-areas/tennessee-tobacco-program.html
Treating Tobacco Use and Dependence AHRQ ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/references/quickref/index.html
Treating Smokers in Healthcare Settings nejm.org/doi/full/10.1056/NEJMcp1101512
Stroke
AHA/ASA GUIDELINE Guidelines for the Prevention of Stroke in Patients with Stroke and Transient Ischemic Attack ahajournals.org/doi/10.1161/str.0000000000000024

*This is only a sample of references and isn't an all-inclusive list.

BlueCare Tennessee

1 Cameron Hill Circle | Chattanooga, TN 37402 | bluecare.bcbst.com

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