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# **Medication Therapy Management**

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This section contains information about Pharmacist Services – Medication Therapy Management (MTM) policy and reimbursement for Medi-Cal Providers.

## **Pharmacist Services – Medication Therapy Management**

*Welfare and Institution Code (W&I Code) Section 14132.969 and W&I Code Section 14132.968* authorize the Department of Health Care Services (DHCS) to establish policy and reimbursement for pharmacist services provided to a Medi-Cal recipient.

### **Billing Pharmacy**

«MTM Pharmacy Services must be billed by a Medi-Cal enrolled outpatient pharmacy and have a signed supplemental contract with the DHCS to provide MTM services.

DHCS will contract with any outpatient pharmacy that will sign a contract to meet a list of performance obligations». These include, but are not limited to, recipient identification requirements, service documentation requirements and submitting quarterly and yearly reports to DHCS. A provider who does not sign a contract will not be reimbursed for MTM services.

### **Eligible Recipient**

«Eligible Medi-Cal members are those who have been identified by the contractor to have complex medication therapies, chronic diseases, high prescription costs, or having other risk factors that may result in impediments to patient adherence, and positive clinical outcomes of medication therapy management.

Eligible members must meet ALL of the criteria as defined in items A, B, C, D, F and G; or as defined in items A, B, C, E, F and G below.»

«Members must be:

- A. An outpatient (not inpatient or in an institutional setting).
- B. Not eligible for Medicare Part D.
- C. Prescribed and currently taking a qualified specialty drug within the covered specialty drug categories as identified by the following disease state categories:
  - Diabetes
  - Asthma/Chronic Obstructive Pulmonary Diseases (COPD)
  - Hypertension
  - Cardiovascular diseases
  - Severe mental health disorders
  - HIV/AIDS
  - Hepatitis C (HCV)
  - Cancer
  - Blood Factors or Hemlibra for the treatment of Bleeding disorders
  - Dyslipidemia
  - Bone Disease-Arthritis (for example: Osteoporosis, Osteoarthritis)
  - Alzheimer’s Disease
  - End-Stage Renal Disease (ESRD)
  - Cystic Fibrosis
  - Multiple Sclerosis
  - Autoimmune disorders (for example: Rheumatoid Arthritis)
- D. Patient is taking five or more chronic medications (including prescription and nonprescription medications, herbal products, and other dietary supplements).»

E. «Patient is taking a single medication which Medi-Cal reimbursement exceeds \$75,000 per year.

F. Patient meets at least one of the following risks of treatment failure criteria:

- Patient is receiving care from more than one prescriber
- Patient has laboratory values outside the normal range that could be caused by or may be improved with medication therapy
- Patient has demonstrated non-adherence (including underuse and overuse) to a medication regimen for more than three months
- Patient has limited health literacy or socio-cultural challenges, requiring special communication strategies to optimize care
- Patient has recently experienced an adverse event (medication or non-medication-related) while receiving care
- Patient is taking high-risk medication(s), including narrow therapeutic index drugs (for example: warfarin, phenytoin, methotrexate, digoxin)
- Patient has history of erectile dysfunction (E.D). visits/hospitalization related to medication compliance/adherence
- Patient was recently discharged from a hospital or Skilled Nursing Facility (SNF) within 14 days and prescribed a new medication regimen
- Patient was referred to MTM services by a health care provider.

G. An eligible member must agree to participate and can choose to opt out at any time.»

## Covered Services

### Billing Code Chart

«Pharmacy providers are advised not to submit MTM claims to Medi-Cal Rx, as MTM claims are categorized as medical claims rather than pharmacy claims.»

The following CPT® codes should be used by the pharmacy to bill for the corresponding services on the *CMS-1500* health claim form or ASC X12N 837P v.5010 transaction.

Specific requirements to administer each service and required documentation are explained in detail in following pages.

**Billing Code Chart Table**

<b>CPT Code</b>	<b>CPT Code Description</b>
99605	Medication therapy management service(s) provided by pharmacist, individual, face-to-face with recipient, with assessment and intervention if provided; initial 15 minutes, new recipient.
99606	Medication therapy management service(s) provided by pharmacist, individual, face-to-face with recipient, with assessment and intervention if provided, initial 15 minutes, established recipient.
99607	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with recipient, with assessment and intervention if provided; each additional 15-minutes.

**Note:** 99607 must be billed in conjunction with either 99605 or 99606

### Billing Calculations

<b>Time</b>	<b>CPT Code</b>	<b>Billed Units</b>	<b>CPT Code</b>	<b>Billed Units</b>
Less than 15 minutes	99605 or 99606	1	N/A	N/A
16 to 30 minutes	99605 or 99606	1	99607	1
31 to 45 minutes	99605 or 99606	1	99607	2
46 to 60 minutes	99605 or 99606	1	99607	3

CPT codes 99605 and 99606 are subject to frequency limitations. To calculate the amount of time that is reimbursable for prolonged outpatient services, take the total face-to-face time and divided by 15 minutes. The first 15 minutes of each session is billed using either 99605 or 99606, additional time is billed using 99607. MTM sessions may not exceed one hour per session.

## **Frequency limits**

A Medi-Cal recipient eligible for MTM services may receive up to six, one hour encounters per 365-day period without prior authorization. When the treatment duration of a medication is less than six months, coverage is limited to one encounter per month of treatment.

Medical justification is required for MTM services that exceed six visits per recipient in a 365-day period.

The maximum frequency limit for 99605 is one per recipient per provider per 365-day period. The maximum frequency limit for 99606 is five per recipient per 365-day period for all billing providers. CPT code 99607 must be billed in combination of 99605 or 99606 and cannot exceed three units per claim.

## **Documentation Requirements**

Documentation is required to be retained for all MTM pharmacist services. All providers should be aware that if the service was not documented, then the service will not be considered to have been provided.

Medical record documentation is required to record an individual's applicable health history including applicable past and present illnesses, self-screening questionnaires, tests, treatments and outcomes. The medical record chronologically documents the care of the recipient and is an important element that contributes to high-quality care.

An appropriately documented medical record may serve as a legal document to verify the care provided. Documentation should be complete, legible and concise. At a minimum, the records must include:

- Criteria recipient was provided MTM
  - Specialty drug category/Disease state
- Referral source (if applicable)
- Reason for encounter
- Assessment of recipient's primary and secondary conditions
- Documentation of clinical history
- Medication (drug and non-drug) history
- Documentation of interventions tried and failed
- Documentation of past and present lab and test results
- Development and documentation of a recipient specific problem list
- Clinical notes from the electronic health record (EHR) (if applicable)
- Appropriateness of therapeutic services provided
- Test results (blood pressure/pulse) if applicable and available
- Relevant medical history
- Site of service
- Total time spent with recipient
- Date and time of service and identity of pharmacist providing the service
- Action taken as a result of the encounter
- Evaluation plan
  - Post MTM surveillance on appropriateness, effectiveness, safety and lab end points

## **Other Health Coverage**

Providers should follow existing Medi-Cal billing practices when billing for services rendered to recipients with Other Health Coverage (OHC). For example, if a recipient has a commercial insurance plan that will not cover pharmacy services, providers should bill the commercial insurance plan, receive a denial and then bill Medi-Cal with the OHC denial.

## **Share of Cost**

Some Medi-Cal recipients must pay, or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. This dollar amount is called Share of Cost (SOC). Providers should follow existing Medi-Cal billing practices when billing for services rendered to recipients with a SOC.

## **New Recipient**

A new recipient is one who has not received MTM professional services from the pharmacist or pharmacy within the past three years. If a new recipient visit has been reimbursed, any subsequent claim for a new recipient service by the same provider, for the same recipient, received within three years, will be reimbursed at the level of the comparable established recipient procedure.

## **Established Recipient**

An established recipient is one who has received applicable professional services from a pharmacist at the same pharmacy location within the past three years.

Determination of new or established recipient status is based on the owner of the medical record, which is generally the pharmacy and not the individual pharmacist providing the service at the time.

## **Telehealth**

MTM pharmacist services can be rendered via telecommunication systems provided the pharmacy is meeting the contractual requirements for telehealth. When MTM services are provided or received, through a telecommunication system, the provider must indicate on the claim by entering the most applicable Place of Service code in the *Place of Service Code field (Box 24b)*.

## **CMS-1500 Claim Form Example**

This is a sample only. Please adapt each submission to your specific billing situation.

In this example, a pharmacy is billing for MTM services associated with a new recipient for a one-hour MTM session. CPT codes 99605 and 99607 are entered in the Procedures, Services or Supplies field (Box 24D).

For detailed instructions on how to complete a CMS-1500 claim form, providers should refer to the CMS-1500 Completion/Modifier section in this manual.

	24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	JR SUPPLIER INFORMATION
	From MM DD YY	To MM DD YY				CPT/HCPCS	MODIFIER							
1	04	12	22	01		99605			185.00	1		NPI		
2	04	12	22	01		99607			200.00	3		NPI		
3												NPI		
4												NPI		

**Figure 1:** Sample Claim for billing one hour of MTM for a new recipient.



## **Legend**

Symbols used in the document above are explained in the following table.

<b>Symbol</b>	<b>Description</b>
«	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
»	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.