MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Health and Human Services

Bulletin Number: MSA 17-09

Distribution: All Providers

Issued: February 24, 2017

Subject: Pharmacy Claim Reimbursement Changes and Coverage of Medication Therapy Management Services

Effective: April 1, 2017

Programs Affected: Medicaid, Healthy Michigan Plan, Maternity Outpatient Medical Services (MOMS), Children's Special Health Care Services (CSHCS)

NOTE: Implementation of this policy is dependent upon approval of a State Plan Amendment by the Centers for Medicare & Medicaid Services (CMS).

The purpose of this bulletin is to outline changes to pharmacy claim reimbursement and announce the coverage of Medication Therapy Management (MTM) services.

I. Changes to Pharmacy Claim Reimbursement

The Federal Rule on Covered Outpatient Drugs (CMS-2345-FC), issued February 1, 2016, directs states to implement certain changes to pharmacy claim reimbursement. These changes will be effective for claims processed on and after April 1, 2017. This policy applies to Fee-for-Service (FFS) pharmacy claims.

A. Ingredient Cost

The Rule stipulates that ingredient cost reimbursement must be based on Actual Acquisition Cost (AAC). CMS has created the National Average Drug Acquisition Cost (NADAC) for states to use in order to meet the AAC requirement. The NADAC is available at data.medicaid.gov. Claims will be paid at the lesser of NADAC, Wholesale Acquisition Cost, Maximum Allowable Cost, or the provider's usual and customary charge to the general public minus any other insurance and/or other monies collected toward the claim.

B. Professional Dispensing Fee

The Rule replaces the term "dispensing fee" with "professional dispensing fee" and requires states to provide data to support a new professional dispensing fee. In compliance with 42 CFR § 447.518 (d), the Michigan Department of Health and Human

Services (MDHHS) contracted with an independent government accounting firm to conduct a Cost of Dispensing Study among enrolled pharmacies in 2016 through a validated survey. The survey tool collected actual historical costs for all overhead and labor expenses incurred at each pharmacy using existing records, such as financial statements, federal income tax returns, and prescription summary reports. The average cost of dispensing was calculated by summing the allowable prescription-related costs at each pharmacy and dividing this sum by the number of prescriptions dispensed. This average was weighted by prescription volume. The weighted average cost of dispensing is the basis for the new professional dispensing fee.

The new professional dispensing fee rates are below:

- $20.02 for drugs indicated as specialty drugs on the Michigan Pharmaceutical Products List (MPPL) as well as compounds with at least one covered ingredient. This includes infusion/intravenous compounds.
- For drugs not indicated as specialty drugs on the MPPL:
  - $10.64 for drugs not on the MDHHS Preferred Drug List (PDL)
  - $10.80 for drugs indicated as preferred on the PDL
  - $9.00 for drugs indicated as non-preferred on the PDL
- Over-the-counter drugs must be dispensed in their original packaging and as such a professional dispensing fee should not be requested in the provider's usual and customary charge.

The current MPPL and PDL are available at michigan.fhsc.com >> Providers >> Drug Information.

II. Medication Therapy Management

MTM services are face-to-face consultations provided by pharmacists to optimize drug therapy and improve therapeutic outcomes for beneficiaries. Beneficiaries may elect MTM as an optional service provided by participating pharmacists (refer to *Eligible Providers* section for information on enrolling as an MTM provider). Coverage of MTM will be effective for dates of service on and after April 1, 2017. These services will be paid through the Fee-for-Service program for beneficiaries enrolled either in FFS or in a Medicaid Health Plan. There is no cost-sharing responsibility to the beneficiary for the MTM service.

The requirements outlined in the Pharmacy Chapter of the Medicaid Provider Manual, Section 4 – Counseling Requirements continue to apply and may not be billed as an MTM service.

A. Covered Services

MTM services include the following:

- Obtaining necessary assessments of the beneficiary's health status
- Formulating a medication treatment plan

- Monitoring and evaluating the beneficiary's response to therapy, including safety and effectiveness
- Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events
- Documenting the care delivered and communicating essential information to the beneficiary's other primary care providers
- Referring the beneficiary to his primary care provider or specialist, if necessary
- Providing verbal education and training designed to enhance beneficiary understanding and appropriate use of medications
- Providing information, support services, and resources designed to enhance adherence with the beneficiary's therapeutic regimens
- Providing an updated personal medication record and medication action plan for the beneficiary
- Coordinating and integrating MTM services within the broader health care management services being provided to the beneficiary

Any recommended changes to the beneficiary's drug therapy must be approved by the original prescriber(s) of the affected drugs.

B. Non-covered Services

The following are not eligible to be covered as MTM services:

- Services provided by telephone, email or US Postal Service mail
- Services provided in skilled nursing facilities
- Services provided to more than one patient at a time (i.e., group services)
- Services provided in an inpatient, institutional, or incarceration setting

C. Eligible Recipients

Beneficiaries are eligible for MTM services if they are not eligible for Medicare Part D and are taking a medication to treat or prevent one or more chronic conditions as identified in the List of Chronic Conditions for MTM Eligibility (see attachment).

MTM services must be provided face-to-face with the beneficiary whenever possible. If the beneficiary is a child who is younger than the age of consent per state law, or has physical or cognitive impairments that preclude the beneficiary from managing his or her own medications, MTM services may be provided face-to-face to a caregiver (e.g., caretaker relative, legal guardian, power of attorney, licensed health professional) on the beneficiary's behalf.

D. Eligible Providers

To provide MTM services, a pharmacist must be licensed and have successfully completed either the American Pharmacists Association's "Delivering Medication Therapy Management Services" certificate training program or other MTM program(s) approved by the Accreditation Council of Pharmacy Education.

Pharmacists who meet these requirements must enroll in the Community Health Automated Medicaid Processing System (CHAMPS) with an Individual (Type 1) National Provider Identifier (NPI) Number as a Rendering/Servicing-Only provider. Under this type of enrollment, pharmacists are required to affiliate themselves with the billing NPI of a pharmacy, Federally Qualified Health Center (FQHC), Tribal Health Center (THC), or Rural Health Clinic (RHC). The pharmacist must enroll as a Non-Physician, with a Pharmacist specialty and the subspecialty of Medication Therapy Management. Individual pharmacists are not eligible for direct Medicaid reimbursement; payment for MTM services will be issued to the affiliated pharmacy, FQHC, THC and/or RHC NPI. To begin the enrollment process visit www.michigan.gov/medicaidproviders >> Provider Enrollment.

These services may not be delegated by pharmacists to pharmacy technicians or other healthcare professionals.

E. Location Requirements

MTM services may be provided in the following settings:

- Ambulatory care outpatient setting
- Clinic
- Pharmacy
- Beneficiary's home if the beneficiary does not reside in a non-covered services setting

These services must be provided face-to-face in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings.

F. Telepractice for MTM Services

In the event that the beneficiary is unable to physically access a face-to-face care setting, an eligible pharmacist may provide MTM services via telepractice. Telepractice is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of services. Telepractice must be obtained through real-time interactions between the beneficiary's physical location (origin site) and the pharmacist provider's physical location (distant site). Telepractice services are provided to beneficiaries through hardwire or internet connection. It is the expectation that providers and facilitators involved in telepractice are trained in the use of equipment and software prior to servicing beneficiaries. The arrangements for telepractice will be

made by the pharmacist. The administration of telepractice services are subject to the same provision of services that are provided to a beneficiary in person. Providers must ensure the privacy of the beneficiary and secure any information shared via telepractice.

Refer to the Billing Instructions section of this policy for instructions on indicating the MTM service was provided through telepractice.

G. Documentation Requirements

Pharmacists must document each MTM service provided. Documentation must include, but is not limited to the following:

- Beneficiary's information
  - Name
  - Address and telephone number
  - Medicaid identification number
  - Gender
  - Date of birth
  - Beneficiary's consent for the MTM service, indicated by the beneficiary's signature and date
    - If the beneficiary is a child who is younger than the age of consent per state law, or has physical or cognitive impairments that preclude the beneficiary from managing his or her own medications, a caregiver (e.g., caretaker relative, legal guardian, power of attorney, licensed health professional) may provide written consent on the beneficiary's behalf.
- Pharmacist information
  - Name
  - Pharmacist National Provider Identifier (NPI)
  - Pharmacy Name and NPI
- Date of service
- Place of Service
- Indication of how the beneficiary meets the criteria to receive an MTM service (e.g., meets the chronic condition requirement)
- Indication if this is an initial assessment or follow-up assessment
- Current medical conditions
- Allergies
- Primary physician and contact information

Other information may include the following (items are required if relevant):

- Date of documentation
- Location of beneficiary if service is provided through telepractice
- Time spent with beneficiary
- Resolved medical conditions
- List of all prescription drugs, along with prescriber information and name of dispensing pharmacy

- List of nonprescription drugs with their indications
- List of drug doses, directions and intended use
- List of all relevant medical devices
- List of all dietary supplements and herbal products
- Alcohol and tobacco use history
- List of environmental factors that impact the beneficiary
- Assessment of drug problems identified, including but not limited to:
  - Determining that the medications are appropriately indicated
  - Determining if the recipient needs additional medications
  - Determining if the medications are the most effective products available for the conditions
  - Determining if the medications are dosed appropriately to meet goals of therapy
  - Identifying adverse effects caused by medications
  - Determining if the medications are dosed excessively and causing toxicities
  - Determining if the recipient is taking the medications appropriately to meet goals of therapy
  - Evaluating effectiveness and safety of current drug therapy
  - Written plan including goals and actions needed to resolve issues of current drug therapy
  - Evaluation of success in meeting goals of medication treatment plan
  - Information, instructions and resources delivered to the beneficiary
  - Content of pharmacist's communications to beneficiary's other health care providers
- Description of what was discussed with the beneficiary during the assessment, and whether that information was communicated to the beneficiary's primary care providers

This documentation must be made available to MDHHS upon request. In addition, this documentation and any other relevant documentation may be collected by MDHHS or its designee on an annual basis for the purposes of program evaluation.

H. Billing Instructions

Pharmacy-based MTM claims must be submitted on the professional claim format (HIPAA 837P). The Billing Provider reported on the claim must be the Pharmacy's (Type 2) NPI and be actively enrolled in CHAMPS to be paid. The Rendering Provider reported on the claim must be the Pharmacist's (Type 1) NPI and be actively enrolled in CHAMPS. Services will be reimbursed based on published rates for the procedure codes listed below.

Current Procedural Terminology (CPT) Code	Service	Rate
99605	Initial assessment performed face-to-face with a beneficiary in a time increment of up to 15 minutes	$50

Current Procedural Terminology (CPT) Code	Service	Rate
99606	Follow-up assessment of the same beneficiary in a time increment of up to 15 minutes	$25
99607	Additional increments of 15 minutes of time for 99605 or 99606	$10

At least one diagnosis on the claim must be a diagnosis code from the List of Chronic Conditions for MTM Eligibility.

The following billing limitations will apply:

- Only one CPT 99605 will be covered per provider per beneficiary in a 365-day period
- Up to seven CPT 99606 will be covered per provider per beneficiary in a 365-day period
- Up to four CPT 99607 will be covered per provider per beneficiary per date of service

For services provided through telepractice, each procedure code must include the modifier GT.

As of the date of this bulletin, FQHC/RHC/THC-based MTM claims may also be submitted on the professional claim format (HIPAA 837P). Refer to subsequent Medicaid bulletins for any changes to this process.

Providers can submit HIPAA 837P electronic claims to CHAMPS through a billing agent, through a batch upload process or through Direct Data Entry (DDE). Providers can also view claims online and complete claim replacements or voids within CHAMPS. Tutorials and instructions are available at www.michigan.gov/medicaidproviders (click the CHAMPS logo in the middle of the page).

Additional information on submitting claims using the 837P format for FFS claims, as well as the Electronic Submissions Manual, can be found at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Electronic Billing >> HIPAA Companion Guides.

Public Comment

The public comment portion of the policy promulgation process is being conducted concurrently with the implementation of the change noted in this bulletin. Any interested party wishing to comment on the change may do so by submitting comments in writing to:

Attn: Rita Subhedar
MDHHS/MSA
PO Box 30479
Lansing, Michigan 48909-7979
Or
E-mail: SubhedarR1@michigan.gov

If responding by e-mail, please include "Pharmacy Claim Reimbursement Changes" in the subject line.

Comments received will be considered for revisions to the change implemented by this bulletin.

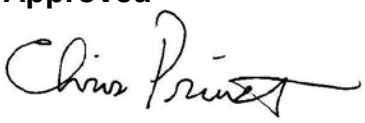
Manual Maintenance

Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved



Chris Priest, Director
Medical Services Administration

Michigan Department of Health and Human Services
Chronic Conditions for Medication Therapy Management Benefit Eligibility

Condition	ICD-10 Code
Alcohol Use Disorder	F10.1-F10.2
	K29.2
	K70
Alzheimer's Disease and Related Disorders or Senile Dementia	F01-F05
	F06.1
	F06.8
	G13.2
	G13.8
	G30
	G31.0
	G31.1
	G31.2
	G91.4
	G94
	R41.81
	R54
Anemia (Includes Sickle Cell Disease)	D50-D53
	D55-D59
	D60-D64
Atrial Fibrillation	I48.0
	I48.1
	I48.2
	I48.91
Asthma	J45
Bipolar Disorder	F30-F31
	F32.8
	F33.8
	F34.8
	F34.9
	F39
Cancer - All Inclusive	C00-D09
	Z08
Cataract	H25
	H26
	H27
	H43.0
	Q12.0
Chronic Kidney Disease	A18.11
	A52.75
	B52.0
	D59.3
	E08.2, E09.2, E10.2, E11.2, E13.2
	E74.8
	I12.0, I13.11, I13.2
	I70.1

Note: This list may be updated on an annual basis. For a current list visit www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Pharmacy.

Michigan Department of Health and Human Services

Chronic Conditions for Medication Therapy Management Benefit Eligibility

Condition	ICD-10 Code
	I72.2
	K76.7
	M10.3
	M32.14-M32.15
	M35.04
	N00-N08
	N13.1-N13.3
	N14
	N15
	N16
	N17-N19
	N25
	N26.1, N26.9
	Q61.02
	Q61.11
	Q61.19
	Q61.2
	Q61.3
	Q61.4
	Q61.5
	Q61.8
	Q62.0
	Q62.1
	Q62.2
	Q62.3
Chronic Obstructive Pulmonary Disease and Bronchiectasis	J40-J42
	J43
	J44
	J47
Cystic Fibrosis	E84
Deep Venous Thrombosis (DVT) (while on anticoagulation)/Pulmonary Embolism (PE) (chronic anticoagulation)	I26
	I27.82
	I80.1-I80.2
	I82.4
	I82.5
Depression	F31.3-F31.6
	F31.75-F31.78
	F31.81
	F32
	F33
	F34.1
	F43.21
Diabetes Mellitus	E08-E13
Glaucoma	H35.89
	H40

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Chronic Conditions for Medication Therapy Management Benefit Eligibility

Condition	ICD-10 Code
	H47.23
Heart Failure	I09.81
	I11.0, I13.0, I13.2
	I50
Hemophilia	D66-D68
HIV	B20
	B97.35
	Z21
Hyperlipidemia	E78.0-E78.5
Hypertension	H35.03
	N26.2
	I10-I15
	I67.4
Ischemic Heart Disease	I20-I22
	I24
	I25.1
	I25.2
	I25.42
	I25.5
	I25.6
	I25.7
	I25.81-I25.84, I25.89, I25.9
Lead Exposure	T56.0
Liver Disease, Cirrhosis and Other Liver Conditions (except Viral Hepatitis)	K70
	K71.11
	K72-K75
	K76.0-K76.3
	K76.5-K76.8
	K77
	K83.0
	Z48.23
Obesity	E66
Osteoporosis	M81
RA/OA (Rheumatoid Arthritis/Osteoarthritis)	M05-M06
	M08
	M15-M19
	M45
	M47
	M48.8
Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders	F20-F29
	F44.89
Stroke/Transient Ischemic Attack	G45
	G46.0-G46.2
	I60-I61
	I63

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Michigan Department of Health and Human Services
Chronic Conditions for Medication Therapy Management Benefit Eligibility

Condition	ICD-10 Code
	I66
	I67.84, I67.89
	I97.81-I97.82
Substance Use Disorder	F11-F16
	F18-F19
Tobacco Use Disorder	F17
	Z72.0
Viral Hepatitis	B18

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