	Documentation Guidelines		
UNM MedicalGroup, Inc. University of New Mexico Physicians	**Medication Therapy Management (MTM)**	Effective Date	**FINAL**
		Revision Letter	A
		Applies To:	**UNMMG**

1.0 Purpose

This document provides guidelines for Pharmacist Clinicians (PhC) and other practitioners who provide services in hospital-based clinics, non-hospital based clinics, inpatient settings, and all pharmacy practice environments dependent on specific payer policies. The UNM Medical Group, Inc. follows the specific documentation and billing guidelines of the Centers for Medicare and Medicaid Services (CMS) when applicable. AMA CPT created these CPT codes (99605-99607) specifically for Pharmacist Clinicians however other providers are able to provide Medication Therapy Management (MTM) services as well by reporting these CPT codes. CMS does not currently recognize Pharmacist Clinicians as healthcare providers/practitioners eligible for Medicare Part B reimbursement and are considered "ancillary" or "auxiliary" staff. New Mexico Medicaid recognizes Pharmacist Clinicians as providers but unable to bill under their own name and license. Other third party payers have the ability to develop their own criteria including who can provide these services (i.e., Registered Pharmacists (RPh), Doctor of Pharmacy (PharmD), Advanced Certified Nurse Practitioner (ACNP), Physician Assistant (PA), etc.) based on private contracts established under their available plans and coverage requirements.

2.0 Scope

This guidance applies to UNM Health System providers.

3.0 Statutory Requirements

- There are specific statutory requirements for Pharmacist Clinicians. See separate Guideline "Pharmacist Clinicians and Medication Therapy Management (MTM), Transitional Care Management (TCM), and Other Services.
- Providers must meet any applicable requirements imposed by the State of New Mexico.
- Must work within the scope of practice as outlined by the State of New Mexico

4.0 Types of Practice Models

- Third Party Contracts/Private Practitioners/Pharmacy Networks
- Traditional Medicare and Medicaid
- Part D Plans; Health Plans that provide MTM benefits

5.0 Types of Services Provided

Medication Therapy Management (MTM)

Immunization Administrations

Anticoagulation Therapy Management

Disease Management (i.e. Diabetes Education/Therapy Management)

Other Clinical Services (Based on individual training)

6.0 Medication Therapy Management (MTM) Services

Medication Therapy Management is a distinct service or group of services that optimize therapeutic outcomes for individual patients. Medication Therapy Management Services are independent of, but can occur in conjunction with, the provision of a medication product. Medication Therapy Management encompasses a broad range of professional activities and responsibilities within the pharmacist clinician's scope of practice as well as other types of practitioners. These services include but are not limited to the following, according to the individual needs of the patient.

6.1 Performing or obtaining necessary assessments of the patient's health status;

6.2 Formulating a medication treatment plan;

6.3 Selecting, initiating, modifying or administering medication therapy;

6.4 Monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

6.5 Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

6.6 Documenting the care delivered and communicating essential information to the patient's other primary care providers;

6.7 Providing verbal education and training designed to enhance patient understanding and appropriate use of his/her medications;

6.8 Providing information, support services and resources designed to enhance patient adherence with his/her therapeutic regimens;

6.9 Coordinating and integrating medication therapy management services within the broader health care-management services being provided to the patient.

6.10 Providing other services such as immunizations, anticoagulation management, disease management, etc.

7.0 Billing and Reimbursement for MTM Services

Billing for MTM services and the reimbursement is mostly dependent on the specific payer and the place of service. The American Medical Association (AMA) created CPT codes 99605-99607 specifically to report the provision of medication therapy management (MTM) services by a pharmacist but these codes are available for other practitioners to use as well. For a ***new patient***, **CPT 99605** would be reported for the initial 15 minutes. For an ***established patient***, **CPT 99606** would be reported for the initial 15 minutes. For each additional 15 minutes, **CPT 99606** would be reported regardless of whether the patient is ***new or established***. The specific payer and the type of contract will determine if these services can be billed with CPT codes 99605-99607. Medicare and Medicaid do not recognize these codes for separate payment.

7.1 **MTM CPT Codes 99605-99607**. Most third party contracts, private practitioners, Medicare Advantage Plans, and Part D Plans will require the use of these codes. Medicare Advantage/ Part D Plans are mandated by law to provide Medication Therapy Management coverage. Typically, there will be an arrangement between the Pharmacist Clinician and the entity. Every effort should be made to stay current with the billing guidelines for each contract/payer. If other third party payers do not accept these MTM codes, the Medicare/Medicaid billing strategies should apply.

7.2 Medicare and Medicaid (Traditional) - E&M Codes

7.2.1 **Physician-based Clinics** –Physician offices and Physician-based clinics providing services for Medicare patients are governed by a number of CMS rulings that can be found at http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html. This site includes the Medicare Benefit Policy Manual which describes who can bill under Medicare Part B for the services discussed in this Guidance document.

7.2.1.1 Billing Method (Professional Claim submitted by Physician or other qualified health care provider- CMS 1500) - The Medicare Benefit Policy Manual, Chapter 15, Section 60 describes physician delegation to others working in their offices who provide care to Medicare patients and a mechanism for billing such services. These services are referred to as "incident to" services. A physician may bill for "incident to" services provided by a PhC (or other qualified provider) if all the requirements for "incident to" are met. See Paragraph 7.2.1.3 for more information related to "Incident to" billing.

7.2.1.2 Reimbursement – Services provided by the PhC (or other qualified provider) as incident to the physician service in a physician-based clinic are typically reported as a low level E&M service (CPT 99211). Payers other than Medicare may reimburse at the higher levels (CPT 99212-99215) when the PhC service is included in the physician's level of service for same date of service. Since PhCs/other qualified providers are billing "incident to" the physician or supervising physician, the National Provider Identifier (NPI) of the Medicare

Part B-approved practitioner must be used on the paper or electronic CMS 1500 claim form.

7.2.1.3 "Incident to" – CMS defines incident to services as "services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness." In order to be covered as incident to the physician's service, the following criteria must be met:

- The services must be an integral, although incidental, part of the physician's professional service,
- The services are of the type commonly rendered without charge or included in the physician's bill,
- The services are of a type that are commonly furnished in physician's offices or clinics, and
- The services must be furnished by the physician or by auxiliary personnel under the physician's direct supervision who is present in the office suite and immediately available to provide assistance and direction throughout the time the PhC/other qualified provider is performing the services.
- The patient must be an established patient. The physician must personally perform the initial service for each new condition, make the initial diagnosis, and establish a plan of care which includes the subsequent incidental services. This is true for any new problems as well. This guideline cannot be overridden by physician protocols.
- The services provided are within the scope of practice for the PhC or other designated "qualified" provider as dictated by the State of New Mexico Statutes.
- There must be an employment relationship (W-2, leased employee, or independent contractor).

7.2.1.4 Documentation Requirements – Document each and every patient encounter. Should there be an audit, there is a need for this information to justify time and services rendered. Be accurate and thorough in the documentation, as such information becomes a legal document and can be subpoenaed for use in court.

There is no requirement for the physician or supervising provider to sign off on all PhC's (or other qualified provider's) notes. The "incident to" rule states that the physician or supervising provider establishes the plan of care for the patient that authorizes the PhC/other qualified provider's service, and the physician or supervising provider must continue to be actively involved in that plan of care at

a reasonable frequency. It would be "Best Practice" to have the Physician sign off on all PhC's (or other non-physician provider's notes.

Similar to the documentation requirements for other health care providers, the following elements should be documented in order to support the service provided:

- Progress note must substantiate the service performed (level of care) and be signed by the person performing it.
- When the physician is involved with a particular service, his/her contribution to the care must be documented. This will help to substantiate his/her continued involvement in the patient's care. The extent of physician involvement should reflect the patient's condition, increasing instability, or uncertainty of the situation.
- Review of the pertinent patient medical history; medication profile (prescription and non-prescription);
- Interventions and recommendations for optimizing medication therapy;
- Referrals and treatment compliance;
- Communications with other healthcare professionals;
- Administrative functions (including patient and family communications) relative to the patient's care;
- Follow-up care.

In order to bill "incident to" services provided by a PhC/other provider with a CPT 99211 (or higher, in some cases), the E&M service has to be supported by the documentation. To meet the requirements for a CPT 99211 you have to provide a face-to-face encounter with a patient that consists of elements of **both** evaluation AND management. Novitas-Solutions, Inc. (New Mexico's Medicare Administrative Contractor) states that the "**evaluation**" is supported when the record includes documentation of a clinically relevant and necessary exchange of information (i.e., historical information and/or physical data) between the provider and the patient. The **"management"** portion of a 99211 is supported when the record demonstrates an influence on patient care (medical decision making, provision of patient education, etc.).

7.2.2 **Facility-based Clinics** – For Medicare patients, hospital-based outpatient services (including clinics and the ED) are governed by the Hospital Outpatient Prospective Payment System (HOPPS) regulations. See The Medicare Benefit Policy Manual, Chapter 6, Hospital Services Covered Under Part B for more information. Since CMS does not recognize Pharmacist Clinicians as eligible providers, the use of the MTM CPT

Codes 99605-99607 cannot be reported for reimbursement by the PhCs/other providers when MTM is provided within a facility-based clinic or outpatient department. The PhCs/other qualified providers are considered "auxiliary" staff providing hospital services under a physician's supervision.

7.2.2.1 Billing Method (Institutional Claim submitted by Hospital/Other Institution) – CMS 1450 – The Medicare Benefit Policy Manual, Chapter 6, Section 20.5, Outpatient Therapeutic Services, describes these services as "incident to the services of physicians in the treatment of patients." The Pharmacist Clinician or the Supervising Physician (or other qualified health care practitioner) cannot bill as "incident to" the physician's services; therefore, the Hospital reports these services as performed incident to the services of physicians and practitioners and which aid in the treatment of hospital patients. See paragraph 7.2.2.3 for more information related to "incident to" hospital-based billing.

7.2.2.2 Reimbursement – Services provided by the PhC/other provider as incident to the physician service in a facility-based clinic are embedded in the hospital clinic criteria for calculating a Visit Level. If the MTM service is the only service provided, the level would typically be the lowest level (CPT 99211). In order to bill for this, there must have been an Evaluation & Management service provided which is consistent with the description of 99211 (or higher levels if the encounter supports them according to Clinic Levels criteria). Other payers may reimburse for higher level E&M codes (CPT 99212-99215).

7.2.2.3 "Incident To" – "Incident to" in an inpatient Part B or outpatient hospital setting under HOPPS regulations does not have the same meaning as it does on the professional side (physician-based clinics). A physician or other qualified practitioner cannot bill "incident to" for services provided by the hospital or clinic (by hospital personnel). However, the hospital will bill for services provided by auxiliary personnel that were "incident to" a physician's order or care plan. The following criteria must be met:

- There must be a physician's order. The physician is not required to see the patient at each encounter the PhC/other provider is providing subsequent service; however during any course of treatment the physician must personally see the patient periodically to assess the course of treatment, patient's progress, and when necessary, change the plan of care. If the physician merely writes an order and is not sufficiently involved in the management of the patient's care, Novitas will not allow reimbursement based on "incident to".

- The services must be an integral, although incidental, part of the physician's professional service in the course of diagnosis or treatment of an illness or injury. Therefore, in this setting utilizing the "incident to" billing, the PhC/ other provider cannot provide these services for a new patient or a new problem. This guideline cannot be overridden by facility protocols.

- Must be furnished in the facility or department for which the facility submits charges.

- Must be furnished under direct supervision of a physician or nonphysician practititioner. The physician supervision requirement is generally met when the services are provided on hospital premises; the hospital medical staff that supervises the services does not need to be in the same department as the ordering physician. However, if the services are furnished outside the hospital, they must be rendered under the **direct personal supervision** of a physician who is treating the patient.

- The services provided are within the scope of practice for the PhC/practitioner as dictated by State of New Mexico Statutes.

- There must be an "arrangement" with the hospital for the PhC/provider to provide services within the hospital's facilities. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c05.pdf.

7.2.2.4 Documentation Requirements – Document each and every patient encounter. Should there be an audit, there is a need for this information to justify time and services rendered. Be accurate and thorough in the documentation, as such information becomes a legal document and can be subpoenaed for use in court.

There is no requirement for the physician or supervising provider to sign off on all PhC's/other provider's notes. The "incident to" rule states that the physician or supervising provider establishes the plan of care for the patient that authorizes the MTM service, and the physician or supervising provider must continue to be actively involved in that plan of care at a reasonable frequency. It would be "Best Practice" to have the Physician sign off on all PhC's/other provider's notes.

The following information should be documented by the PhC/other provider in order to support the service provided:

- A physician's specific order for the subsequent incidental service (MTM) is required and must be documented in the medical record for outpatient hospital services and shall be written according to the policies that apply to orders at UNM Health System facilities.

- The documentation should provide a linkage between the MTM service and the physician's service to which the PhC's/other provider's service is incidental and show that the services were under a physician's supervision. It should reflect the physician's involvement with the patient care by including documentation from other dates of service that show the link between the services of the two providers.

- The documentation should also include recording of phone calls, letters, faxes, etc. to/with/from the patient's physician communicating the "incident to" services.

- Progress notes must substantiate the service performed (level of care) and be signed by the PhC/other provider.

- Documentation must show a review of the pertinent patient medical history, medication profile (prescription and non-prescription), interventions, recommendations for optimizing medication therapy, referrals, treatment compliance, and communications with other healthcare professionals.

- Documentation should show any administrative functions (including patient and family communications) relative to the patient's care.

- Any follow-up care planned should be recorded in the medical record.

In order to bill "incident to" services provided by the PhC or other provider with a CPT 99211 (or higher, in some cases), the E&M service has to be supported by the documentation. To meet the requirements for a CPT 99211 you have to provide a face-to-face encounter with a patient that consists of elements of **both** evaluation AND management. Novitas-Solutions, Inc. (New Mexico's Medicare Administrative Contractor) states that the "**evaluation**" is supported when the record includes documentation of a clinically relevant and necessary exchange of information (i.e., historical information and/or physical data) between the provider and the patient. The **"management"** portion of a 99211 is supported when the record demonstrates an influence on patient care (medical decision making, provision of patient education, etc.).
https://www.novitas-solutions.com/bulletins/parta/archive/mpr03145.html

8.0 Revision History

Effective Date	Rev Letter	Document Author	Description of Change
07/30/2014	A	Sandy Colson	Initial Release.