

CORPORATE PAYMENT POLICY 35

MEDICATION THERAPY MANAGEMENT (MTM) PHARMACY SERVICES

Original Effective Date: November 1, 2022

Next Review: As needed

Document Precedence

The Blue Cross and Blue Shield of Vermont (Blue Cross VT or Plan) Payment Policy Manual was developed to provide guidance for providers regarding Blue Cross VT payment practices and facilitates the systematic application of Blue Cross VT member/employer contracts, provider contracts, Blue Cross VT corporate medical policies, and ClaimsXten-Select™ logic. Document precedence is as follows:

- 1) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the member contracts or employer benefit documents, the member contract/employer benefit document language shall take precedence.
- 2) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and provider contract language, the provider contract language shall take precedence.
- 3) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and corporate medical policy, the corporate medical policy shall take precedence.
- 4) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the ClaimsXten-Select™ audit solution, the ClaimsXten-Select™ audit solution shall take precedence.

Description

Blue Cross and Blue Shield of Vermont (Blue Cross VT) reimburses participating pharmacists embedded in group practice settings for Medication Therapy Management (MTM) services as outlined in this policy.

Policy

Provider groups may bill for MTM services as follows:

1. The MTM services must be provided by a non-dispensing pharmacist embedded in the group practice.
2. The pharmacist must enroll in the Blue Cross VT provider network (in addition to meeting credentialing requirements listed in the Practitioner Credentialing Policy), the group must complete a Provider Enrollment and Change Form and include "MTM Pharmacist" in the comment field.

Provider Billing Guidelines and Documentation

Provider groups may bill for MTM services delivered by their enrolled and credentialed pharmacists using the codes below:

Code	Description
99605*	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient
99606*	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient with assessment and intervention if provided; initial 15 minutes, established patient
+99607*	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; each additional 15 minutes (List separately in addition to code for primary service)

* Code not in 'Appendix P' /CPT®

Blue Cross VT does not cover these codes if billed by providers other than enrolled and credentialed, non-dispensing pharmacists. Blue Cross VT will either deny or recover claims billed by non-pharmacists, to the provider's liability.

Pharmacists may deliver these services remotely, via telemedicine.

Benefit Determination Guidance

Payment for MTM services is determined by the member's benefits. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Eligible MTM services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (BCBSVT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment it is important to verify the member's

benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Policy Implementation/Update Information

New policy effective November 1, 2022.

Approved by

Date Approved: August 19, 2022



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