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Origination: November 1, 2022
Last Review: November 7, 2024
Next Review: November 2025
Effective Date: February 01, 2025

Description

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

Policy & Guidelines

Eligible

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.
3. Enrolled credentialed Pharmacists may deliver MTM services remotely, via telemedicine.

Not Eligible

Blue Cross VT does not cover codes in Table 1 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.

Provider Billing Guidelines and Documentation

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

Table 1 Coding Table

Procedure Code	Description	Frequency Limit
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.	One (1) per Calendar Year
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.	Three (3) Per Calendar Year
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).	Up to Three (3) Per Encounter NOT to Exceed (12) per Calendar Year

* Code(s) not in 'Appendix P' /CPT®

Benefit Determination Guidance

Payment for 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 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 (Blue Cross VT 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.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Eligible Providers

This policy applies to all providers/facilities contracted with the Plan's Network (participating/in- network) and any non-participating/out-of-network providers/facilities.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure adherence with the guidelines stated in the payment policy. If an audit identifies instances of non-adherence with this payment policy, Blue Cross VT reserves the right to recover all non-adherence payments.

Legislative and Regulatory Guidelines

N/A

Related Policies

Telemedicine and Telehealth Corporate Medical Policy

Document Precedence

The Blue Cross VT 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 contracts and employer benefit documents, provider contracts, Blue Cross VT corporate medical policies, and Plan's claim editing 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 or employer benefit document language takes 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 takes 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 takes precedence.
4) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the Plan's claim editing solutions, the Plan's claim editing solution takes precedence.

Policy Implementation/Update Information

This policy was originally implemented on November 1, 2022.

Date of Change	**Effective Date**	**Overview of Change**
November 07,2024	February 01, 2025	Payment policy updated new template format; related policy section added. Added visit limits to coding table.

Approved by **Update Approved: 11/07/2024**

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