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MedsMatter!

Medication Therapy Management

08/20/2020

Logistics

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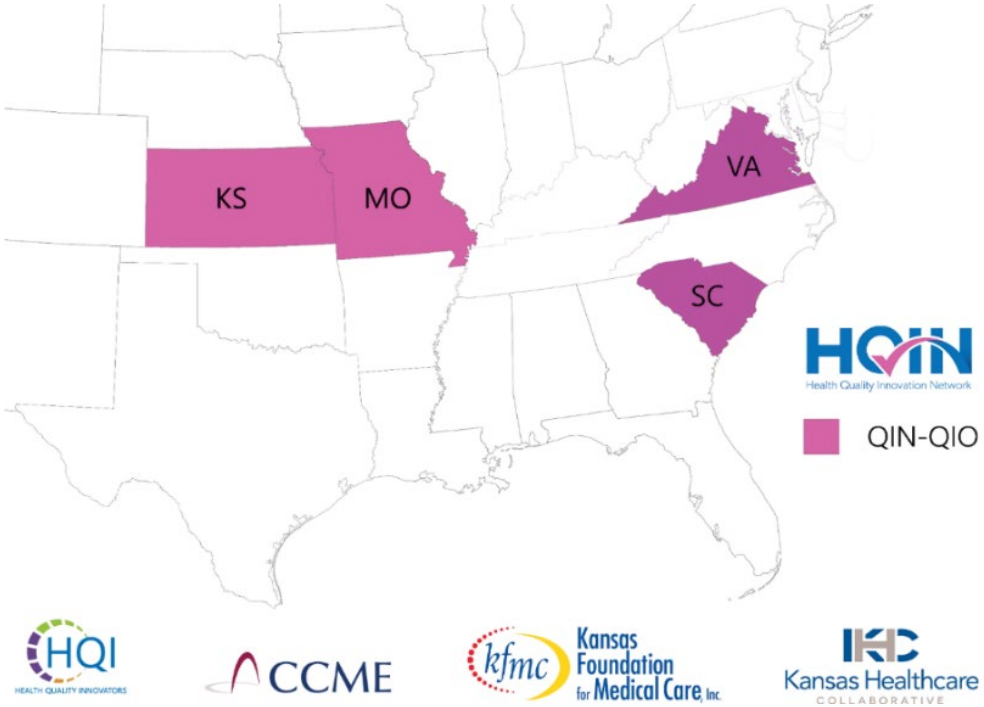
HQIN QIN-QIO Coverage Area



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Presenters

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Disclaimer

- The following presentation is for informational purposes only. The best practices and strategies shared are not formal recommendations from Health Quality Innovation Network (HQIN) on the medical management of patients. Nor does HQIN endorse any of the products, applications or resources mentioned in this presentation.

- HQIN would like to acknowledge and thank **GTMRx Institute (www.gtmr.org)** for allowing some of their resources to be used in this presentation.

Today's Objectives

- Identify components of a Medication Therapy Management (MTM) program.
- Determine how MTM is integrated into other programs such as chronic care and transitional care management.
- Share how providers are conducting MTM successfully and during COVID-19.
- Implement MTM in various formats and settings to maximize patient outcomes and reimbursement.
- YOUR NEXT STEPS….

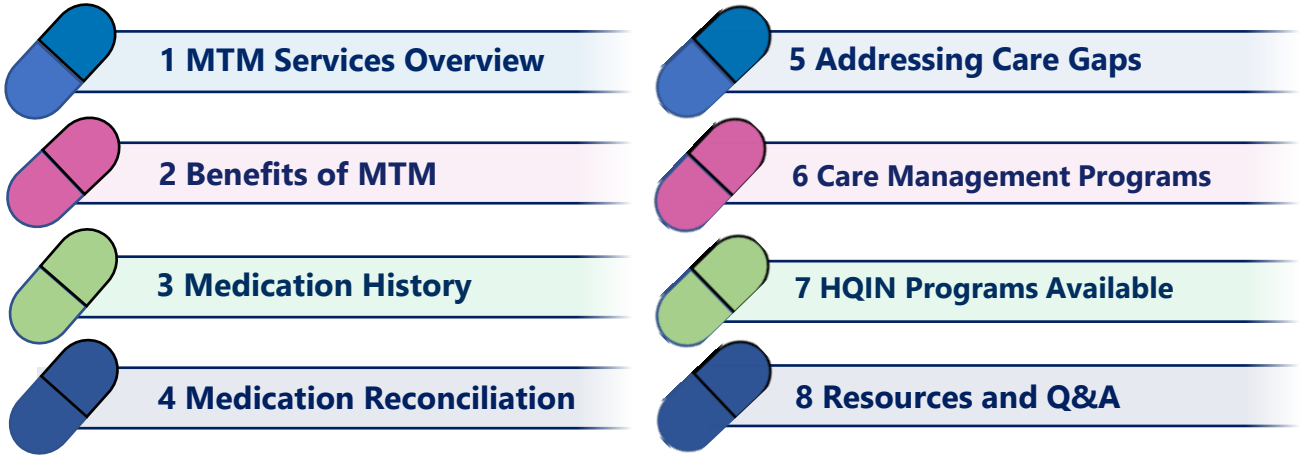
Question #1

Are you currently providing Medication Therapy Management Services?

1. Yes
2. Planning to
3. No
4. Not Sure

Medication Therapy Management: Improving Outcomes

Today's Agenda



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A Few Acronyms

1. **MTM** (Medication Therapy Management)
2. **CMR** (Comprehensive Medication Review)
3. **ADE** (Adverse Drug Event)
4. **TCM** (Transitional Care Management)
5. **CCM** (Chronic Care Management)

Background Stats

- Almost 30% of adults in the US take 5+ medications thus putting them in a high-risk category[1]/medications are involved in 80% of treatments[2]
- 10,000 Rx medications are available on the market[3]/ Medical errors are the third leading cause of death[4]
- Only 13% of PCPs consult with a pharmacist before prescribing new prescriptions[5] – collaboration can decrease workload/mental exhaustion and increase added efficiencies/skillsets/resources/patient satisfaction

[1] Medication Errors. June 2017, http://psnet.ahrq.gov/primers/primer/23/medication-errors. Accessed 4 Jan. 2018. AHRQ Patient Safety Network
[2] McInnis T, et al., editors. The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes. 2nd ed., Patient-Centered Primary Care Collaborative. PCPCC Medication Management Task Force collaborative document.
[3] Medication Errors. June 2017, http://psnet.ahrq.gov/primers/primer/23/medication-errors. Accessed 4 Jan. 2018. AHRQ Patient Safety Network
[4] "Study Suggests Medical Errors Now Third Leading Cause of Death in the U.S. - 05/03/2016." Johns Hopkins Medicine, based in Baltimore, Maryland, Mar. 5ADAD, 2016, Accessed 4 Jan. 2018. http://www.hopkinsmedicine.org/news/media/releases/study_suggests_medical_errors_now_third_leading_cause_of_death_in_the_us.
[5] Preventing Medication Errors: A $21 Billion Opportunity. Network for Excellence in Health Innovation, 2011. http://www.nehi.net/bendthecurve/sup/documents/Medication_Errors_%20Brief.pdf. Accessed 4 Jan. 2018.
Via *GTMRx Institute www.gtmr.org

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The Cost of Medication Errors

- 275,000+ lives are lost every year to medication errors
- $528.4 billion on non-optimized meds (2016)
- $174 billion in hospitalization costs
- $271.6 billion in long-term care admissions
- $37.2 billion in emergency room visits
- $37.8 billion in additional provider visits
- $7.8 billion in additional prescriptions

Watanabe J, et al. Cost of Prescription Drug–Related Morbidity and Mortality Annals of Pharmacotherapy, March 26, 2018. Accessed 5 August 2020
https://journals.sagepub.com/eprint/ic2iH2maTdI5zfN5iUay/full via GTMRx

The Benefits of Medication Therapy Management

- Understand how MTM plays a role in community and patient outcomes
- Implement multiple HQIN intervention/program opportunities
  - Blue Bag
  - Mind Your Meds – General Medication List and Opioid Safe Use/Disposal
  - Chronic Care Management collaborations
- Increase patient engagement and understanding of medications
- Experience system cost savings and potential revenue streams for clinicians

Medication Therapy Management (MTM)

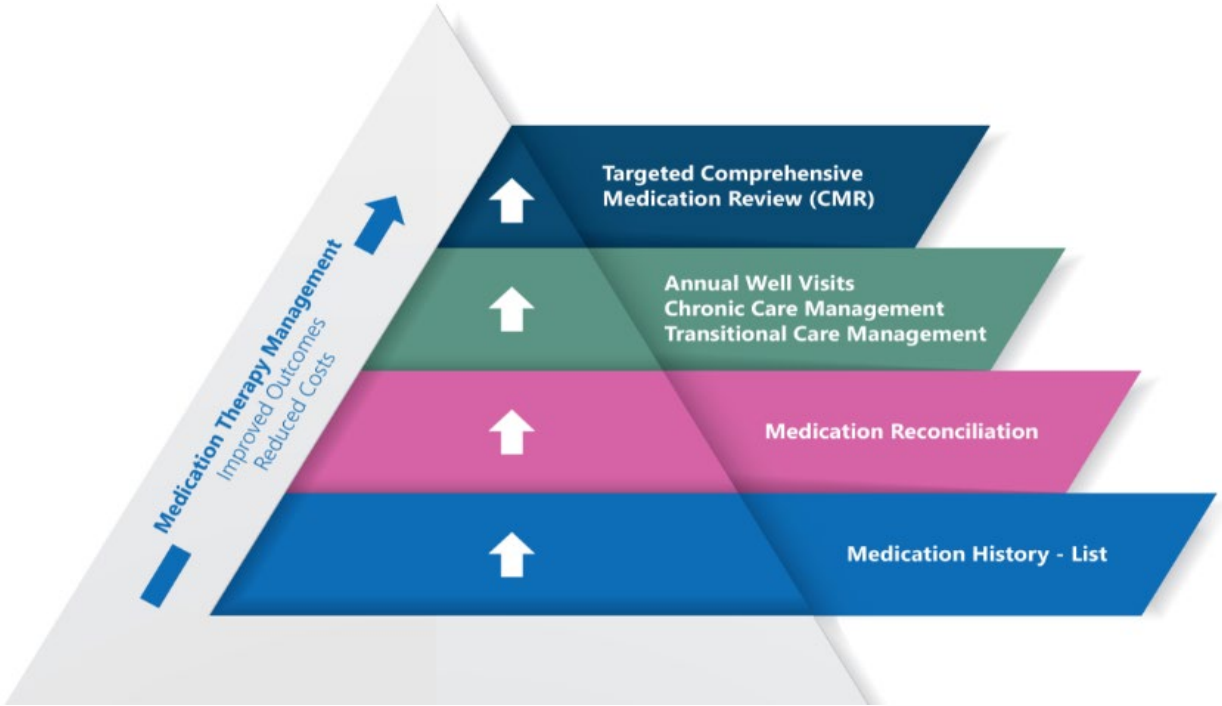
Definition: A distinct service or group of services provide by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients. MTM includes 5 core elements: medication therapy review, a personal medication record, a medication-related action plan, intervention or referral and documentation and follow-up.[1]

- MTM plays a role in community and patient outcomes
  - Increases patients' understanding of medications
  - Activates stronger patient engagement
  - Reduces Adverse Drug Events (ADEs)
  - Increases cost savings for patients and the system
  - Enhances care coordination between practicing pharmacists and providers
  - Adds potential revenue streams for clinicians

1. https://www.cdc.gov/dhdsp/pubs/guides/best-practices/pharmacist-mtm.htm

Medication Therapy Management

Pathway for Optimal Outcomes



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Medication History (MH)

Definition: Accurate account of medication orders, medication list and directions for use

- Best possible MH draws information from multiple sources, including the patient and other healthcare providers
- Med Bag reviews, or physical inspections of medications can reveal discrepancies between medication orders and actual use

Medication Reconciliation (MR)

Definition: Compare actual medication use to the Best Possible Medication History

- Investigate and resolve missing or duplicate therapies
- Ongoing process, but especially needed at times of care transitions, changes in condition and changes in medication use.
- Use Med Bag tool to accomplish a full medication reconciliation, including designating meds/supplements/herbs no longer taken, on hold or needed.

Annual Well Visits / Chronic Care Management / Transitional Care Management

Definition: Medical services requiring thorough review of medication use and ability to manage medication. Medication problems are identified and may be addressed, or the patient referred for a CMR.

- **Annual Well Visits (AWV)** can be conducted every 12 months to develop or update a personalized prevention plan based on current health and risk factors. It requires direct supervision and sign-off from the billing provider, usually a primary care provider.
- **Transitional Care Management (TCM)** designed for patients needing either "moderate or high complexity decision making" and is designated to last 30 days after release from the hospital or other institution – to meet the patient's minimum needs.
- **Chronic Care Management (CCM)** are services provided to Medicare beneficiaries who have two or more chronic conditions lasting longer than 12 months. This service may be provided under general supervision and calendar monthly billings.

Type of Service	CPT Code		Oversight/Care Delivery	Limitations	Required Elements	Reimburse-ment

Annual Well Visits	**Initial Visit: G0438**
	
	Next visit: G0439
		Can be billed every 12 months
		
		Medically necessary E/M services in addition to the AWV, must be coded with a -25 modifier
		
		FQHCs and RHCs can bill for the AWV under their all- inclusive payment model
			A physician who is a Doctor of Medicine or osteopathy (MD or DO)
			
			A physician assistance, nurse practitioner, or clinical nurse specialist (advance practice professional-APP)
			
			A licensed medical professional or a team of such medical professionals, pharmacists, etc. working under the direct supervision of a physician
				Eligible for patients with Medicare Part B coverage for at least 12 months and have not had either an initial Preventative Physical exam (IPPE), or an AWV within the past 12 months
				
				Coverage includes one initial AWV per beneficiary per lifetime and one subsequent visit per year thereafter
					G0438:
					• Complete Health Risk Assessment (HRA)
					• Perform assessment:
					  ○ Appropriate measurements
					  ○ Cognitive function
					• Establish written preventative screening schedules and address risk factors, conditions, and recommended treatments
					• Provide personalized health advice to the patient and as appropriate, referrals to health education programs or preventive counseling services.
					
					G0439:
					• Update the information provided in the previous visit
					  ○ HRA
					  ○ List of current providers and suppliers
					  ○ Patient/family medical history
					• Update written preventative screening schedules and address risk factors, conditions, and recommended treatments
					• Provide personalized health advice to the patient and as appropriate, referrals to health education programs or preventative counseling services.
						G0438- Approxi. $172
						
						G0439 Approx. $117

Type of Service	CPT Code		Oversight/ Care Delivery	Limitations	Required Elements	Reimburse-ment
TCM	**99495 TCM services** (moderate complexity) **99496 TCM Services** (high complexity)	Coding frequency is once per patient per admission Only one provider can bill per patient Additional e/m services provided after the face to face visit can be billed using a standard E/M office visit code (99213/99214) Services such as care plan oversite, end-stage renal disease, and chronic care management cannot be billed at all during the service period Ancillary services to include labs, radiology, EKG, etc. can be billed on the same day.	Non face-to-face services can be provided by licensed clinical staff under the direction of a physician.	• TCM service period is 30 days beginning on the date the beneficiary is discharged from a hospital inpatient setting • Discharge must be from one of the following: Acute Care Hospital, Psychiatric Hospital, Rehabilitation Hospital, Long term Care hospital, skilled nursing facility, partial hospitalization, hospital outpatient observation. - Patient must be returned to his or her community setting (e.g. patient home, rest home, or assisted living) • Required face-to-face visit is part of the TCM service and not reported separately. It also cannot take place the same day as discharge day management services • Communication with patient/caregiver within 2 business days **99495:** • Face to face visit within 14 calendar days of discharge **99496:** • Face to face visit within 7 calendar days of discharge	Both codes require medication reconciliation and management Documentation must include: ○ Date the beneficiary was discharged ○ Date interactive communication was made or attempted ○ Date of required face to face visit ○ Complexity of medical decision making (moderate or high)	**99495- approx. $166** **99496- approx. $234**

Question #2

CMS estimates that approximately _____ of Medicare beneficiaries meet the requirement for Chronic Care Management Services.

1. One-fourth
2. One-third
3. Half
4. Two-thirds

CCM Services

CMS estimates that approximately two-thirds of Medicare beneficiaries meet the requirement for CCM Services.

CCM Rationale

- Contributes to better health outcomes and higher patient satisfaction
- Practices are already coordinating care – get reimbursed for your time and effort
- Due to COVID-19, patients at higher risk of death
- +COVID related data:

40% decrease in treatment for severe heart attacks

Estimated **150,000 missed** cancer diagnoses

600% increase in suicide hotline calls

Chronic Care Management can be a solution!

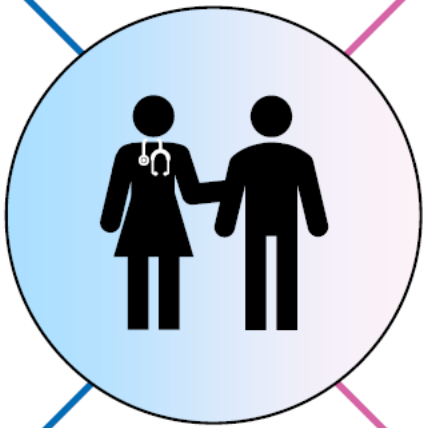
Source:; https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2015-02-18-CCM-Transcript.pdf & https://www.forbes.com/sites/gracemarieturner/2020/05/22/600-physicians-say-lockdowns-are-a-mass-casualty-incident/#b636dd350fa5

CCM Value

Benefits of Participation

Practice Benefits

- Improved care coordination
- Better patient compliance
- Patient loyalty and trust
- Enhanced office visit efficiency
- Additional revenue stream
- MIPS: Improvement Activity



Patient Benefits

- 24/7 access to care team
- Personalized, comprehensive care plan
- Support between visits to stay on track and engage in treatment plan
- Personal assistance with referrals and coordination of care

CCM Coding and Billing

CCM Type	CPT Code	Time	Oversight/ Delivery of Care	Billing Limitations	Required Elements	Transitional Care Mgt	Reimburse-ment
Non-Complex	99490	At least 20 minutes	Directed by a physician or other qualified healthcare professional	Once per calendar month	- Two or more chronic conditions expected to last at least 12 months or until death - Patient at significant risk of death, acute exacerbation/decompensation, or functional decline - Comprehensive care plan established, implemented, revised, or monitored	Can bill concurrently ☑	$42.22
	G2058 (add on code for 99490)	Each additional 20 minutes	Directed by a physician or other qualified healthcare professional	Up to twice per calendar month			$37.89
	99491	At least 30 minutes	Provided directly by a physician or other qualified healthcare professional	Once per calendar month			$84.09
Complex	99487	At least 60 minutes	Directed by a physician or other qualified healthcare professional	Once per calendar month	- Two or more chronic conditions expected to last at least 12 months or until death - Patient at significant risk of death, acute exacerbation/decompensation, or functional decline - Establishment or substantial revision* of a comprehensive care plan, moderate or high complexity medical decision making	Can NOT bill concurrently ☒	$92.39
	99489 (add on code for 99487)	Each additional 30 minutes	Directed by a physician or other qualified healthcare professional	Once per calendar month			$44.75

* As of 1/1/2020, a substantial revision of the care plan is no longer required to bill complex CCM for Medicare patients

Source:; https://www.federalregister.gov/documents/2019/11/15/2019-24086/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other

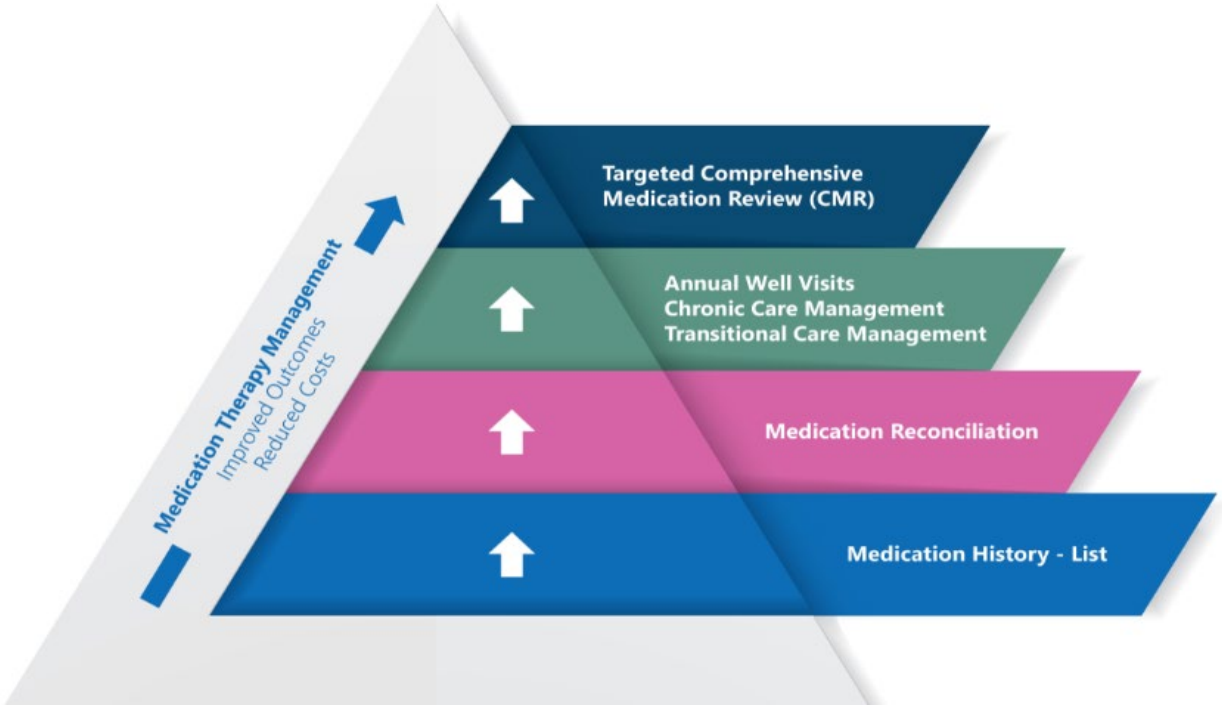
Targeted Comprehensive Medication Review (CMR)

Definition: Focused, interactive follow-up to medication reconciliation that usually involves the multiple members health care team.

- Prescription benefit through Medicare Part C/D.
- Develop medication action plan to resolve medication problems including adverse effects, duplicate or missing therapies, cost, patient/person preference and guideline adherence.
- Comprehensive Medication Management (CMM) follow CMRs as a regularly scheduled follow-up to the medication action plan and coordinated patient care.
- HQIN interventions/programs Mind Your Meds, Blue Bag, CCM feed into patient activation and improved outcomes

Medication Therapy Management

Pathway for Optimal Outcomes



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MTM Programs for your Consideration

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“Mind Your Meds”

Direct Patient Education Modules feature the following:

Mind Your Meds - General Medication Safety

1. Safe medication use
2. Importance of connections with local pharmacist
3. Inventory of all prescriptions, supplements, eye-drops or over-the-counter medications
4. Creation of a patient medication list to use with prescribers

Mind Your Meds - Opioids

1. Safe Opioid medication use
2. Safe disposal of Opioids
3. Beneficiaries to clean out their “medicine cabinets”

Blue Bag Initiative

Turning the Brown Bag.....Blue

The **Blue Bag Initiative** can be integrated into numerous programs to support MTM.

When pharmacists are included in a team-based approach, chronic disease outcomes improve and adverse drug events (ADE) decrease.

Blue Bag Initiative

- Turn-key program
- Facilitates the creation of an accurate medication list
- Helps participants take an active role in managing their medications
- Identifies and addresses medication errors which can calculate cost savings
- Can include a reusable bag for carrying medications
- Separates discontinued/expired drugs from “active” drugs
- Can be used with CCM, TCM and med safety events

Contact bluebag@hqi.solutions for more information

Chronic Care Management

Chronic Care Management Services During COVID-19

Program link:

HQIN CCM in COVID-19 Recorded Webinar

- Don't let perfection get in the way of progress
- Environmental scanning
- Learn from your peers
- Community partnerships
- Communicate and Outreach
- Post COVID-19 care model strategies

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Medication Therapy Management: Improving Outcomes

*image courtesy GTMRx

How can you or your community partners be "Agents of Change"?

- **Open the doors of communication –** PCPs, Pharmacists, AAAs, Agencies, Hospitals, etc.
- **Think outside the box –** COVID-19 has "forced" this issue and we can use that for positive results
- **Everyone on the care team has a role to play to improve patient outcomes**
- **Implement a trial to try something new – JUST DO IT !**

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Question #3

Which HQIN intervention/program interests you and will be your next step?

1. Mind Your Meds – General Med Safety (Medication List)
2. Mind Your Meds – Opioid Safe Use/Disposal
3. Blue Bag Initiative
4. Chronic Care Management

HQIN can provide more specific resources and technical assistance in any of choices listed above

MTM Resources

Clinical Resources

1. Blue Bag Initiative Q&A
2. Potential cost savings by prevention of adverse drug events with a novel medication review program
3. Senior Navigator - Mind Your Meds Opioid
4. Allied Against Opioid Abuse Website
5. AHRQ Med Management
6. FDA Drug Safety and Availability
7. AAFP/FPM CCM Coding Updates for 2020
8. CMS Care Management Resources
9. Chronic Care Management Services
10. Chronic Care Management (CCM): An Overview for Pharmacists
11. Forbes.com Mass Casualty Event Article
12. CMS Care Management Services: FQHC/RHC 2019
13. CMS FQHC/RHC COVID-19 Flexibilities

MTM Resources & COVID-19

Patient & Family Resources

1. Allied Against Opioid Use
2. Senior Navigator - Mind Your Meds Opioid
3. National Boards of Pharmacy Safe Medication
4. FDA How to Dispose of Medications
5. AHRQ Blood Thinner Pills Safety Guide
6. AHRQ Spanish Blood Thinner Pills Safety Guide
7. CMS CCM Patient Resources
8. NAMI-Helpline
9. ADAA Anxiety & Depression Brochures
10. NIH Safe Use of Medication for Older Adults
11. BeMedWise.org Think It Through Brochure

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