OutcomesMTM™ 2014 Network Updates & New Covered Services FAQ

OutcomesMTM recently held webinars regarding 2014 network updates and new covered services within the OutcomesMTM program. We have compiled the answers to frequently asked questions regarding these changes. A copy of the webinar is provided below. Simply click the registration link and follow the prompts to view the recording. For additional questions, please contact our Provider Resources team at (877) 237-0050.

OutcomesMTM 2014 Network Updates & New Covered Services Webinar
Recording link: https://www3.gotomeeting.com/register/548219086

OutcomesMTM Service Expectations and Claim Documentation

1. How are the two successful Adherence Check-in result codes different?
   a. Two successful result codes are available for the Adherence Check-in service:
      i. Adherence Check-in Completed
         1. Select this result if the reason code of the TIP® is Adherence – Needs Check-in, and you successfully complete the service.
         2. Select this result if the reason code of the TIP is Adherence – Needs Check-in + 90-day fill, and you successfully complete the check-in but did not successfully transition the patient to a 90-day fill.
      ii. Adherence Check-in Completed + 90-day fill.
         1. The 90-day fill result code will only be available for TIPs with the reason code Adherence – Needs Check-in + 90-day fill.
         2. Selection of result code Adherence Check-in Completed + 90-day fill indicates the patient is agreeable to transitioning to a 90-day supply for the medication and an updated prescription for a 90-day supply has been obtained from the prescriber, where necessary. Claims with this result code may be eligible for an additional validation payment when the 90-day supply appears in the plan’s prescription claims data.

2. Does the Adherence Check-in service require a follow-up?
   a. Each Adherence Check-in TIP requires one conversation with the patient. During the discussion, pharmacists should evaluate current adherence, address existing or potential adherence barriers and reinforce the importance of taking the medication as prescribed. The pharmacist should also ensure the patient understands the medication’s purpose, how to determine effectiveness and potential side effects or interactions.

3. When would I do an attestation for an Adherence Check-in?
   a. Refill attestation is not a required documentation element for the Adherence Check-in service. However, the on-time refill and patient adherence attestations are still required for Adherence – Underuse of Medication claims.
4. **When would no intervention be needed for an Adherence Check-in TIP?**
   a. If the patient is no longer taking the medication cited in the TIP or the patient is deceased, you may select *Remove-No Intervention Needed* for the Adherence Check-in TIP.

5. **How long do I have to bill a Needs Immunization claim?**
   a. The Encounter Date of Needs Immunization claims must be within 30 days of the date the "needle hits the arm." The 7-day billing window (from the Encounter Date) applies to Needs Immunization claims, as well as all other claims.

6. **Which interventions must occur face-to-face?**
   a. OutcomesMTM prefers Comprehensive Medication Reviews (CMRs) to occur face-to-face. Prior authorization for a phone-based CMR may be approved on a case-by-case basis when the pharmacist calls OutcomesMTM at (877) 237-0050. All other MTM services may be provided face-to-face or over the phone.

7. **Please clarify the attestation to an on-time refill.**
   a. Claims with the reason code *Adherence – Underuse of Medication* require two attestations:
      i. The pharmacist must attest that the patient picked up the next refill on time, defined as +/- 20% of the days supply previously dispensed.
         1. The on-time refill must be after the date the non-adherence was identified but cannot be the same day.
      ii. The pharmacists must attest that the patient reported using the medication as prescribed during follow-up.
         1. Follow-up must occur at least 14 days after the date the non-adherence was identified.

**Claim Validation**

8. **When will the 90-day fill be validated for select TIP types?**
   a. Claims offering a validation payment for switching a patient to 90-day fills will be validated approximately four months following the Encounter Date of the MTM claim.

9. **Will I need to bill the claim validation or is that automatically completed?**
   a. You do not have to submit an additional validation claim. For claims offering a validation payment, OutcomesMTM will work to validate the relevant result via prescription claims data.

10. **How will validation payments be made and where will I be able to view them on the platform?**
    a. Validated claims and payments will be viewable in the Connect™ Platform at a later date in the second quarter of 2014.
11. If a patient pays for the 90-day fill out of pocket, will I receive a validation payment?
   a. Prescription claim validation is based upon health plan data. If the patient’s prescription is not run through insurance, there is no way to validate the MTM claim, and a validation payment will not be paid.

**UnitedHealthcare (UHC) Program**

12. How do I start a claim for a UHC patient?
   a. UHC patients are part of a TIPs-only program and currently are not eligible for any pharmacist-initiated (pull) claims. As a result, the "Start a Claim" option is not visible for these patients.

13. Are all UHC patients eligible for a 90-day fill at the retail level?
   a. Yes, UHC patients are able to receive 90-day fills at the retail level for medications specified in the TIPs.

14. What is the co-pay differential between three 30-day fills and one 90-day fill?
   a. UHC patients pay the same co-pay for a 90-day fill as they would for three 30-day fills.

**General OutcomesMTM Questions**

15. Are all claims required to be billed within 7 days?
   a. We have changed the billing window to 7 days for all claims starting in 2014. This change occurred to help alleviate frustrations with changes in eligibility and to shorten the payment cycle to pharmacies.

16. Will patient labs be available in 2014?
   a. Patient labs are not currently available within our platform but may be added in the future.

17. Are there resources regarding STAR ratings and STAR measures?
   a. Yes! Visit CMS.gov and search “Part C and D Performance Data” to download “Medicare Star Ratings Data.” After downloading, you can view the “Medicare 2014 Part C & D Star Rating Technical Notes.” OutcomesMTM has resources that highlight the relevance of STAR Ratings for pharmacists, which are available in the Resources section of the Connect platform.

18. How is the primary patient indicator applied?
   a. The primary patient indicator is calculated based upon the past 12 months of prescription fills.

19. Do patients appear at multiple pharmacies?
   a. Yes, a patient will appear on the patient lists for each pharmacy that filled at least one prescription for the patient during the past 12 months.
20. Is there a fee to register my pharmacy or myself with OutcomesMTM?
   a. No, there is no fee to register with OutcomesMTM as a participating pharmacy or as a provider of services in the network.

21. How will TIPs be identified and made available to pharmacies to work on?
   a. TIPs will be identified based upon patient prescription history and the need for an intervention. To view pending TIP opportunities and submit claims, please log in at www.outcomesmtm.com. If you do not see your pharmacy within your Provider role, you may request access to the pharmacy. To request access, click your name in the upper right corner. From the drop-down menu, select Manage Pharmacies. Submit the NABP for your pharmacy. For assistance, please contact (877) 237-0050.