OUTCOMESMTM™

PROGRAM POLICY + PROCEDURE GUIDE

Updated 01.01.2014

Restricted Use

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Introduction

These policies and procedures outline requirements for providing MTM services in the OutcomesMTM program as well as instructions for documenting and billing covered services.

Contents

PROVIDER REQUIREMENTS

Pharmacies and other entities seeking to become authorized providers in the OutcomesMTM Personal Pharmacist Network must first complete a network participation agreement. In addition, all MTM pharmacists and MTM Center personnel are required to complete the OutcomesMTM training program. After completing contracting and training, MTM pharmacists will use the OutcomesMTM Connect™ Platform available at www.outcomesmtm.com to access MTM opportunities and document and bill for covered services.

User Access to Personal Health Information (PHI)

An administrator shall be designated by the MTM Center to provide oversight of user roles and access. It is the responsibility of the administrator for each MTM Center to monitor and approve/remove user access to PHI maintained on the OutcomesMTM Connect Platform on at least a monthly basis. Only pharmacists approved by the MTM Center shall perform, document and bill for MTM services in the OutcomesMTM program. User access to PHI will be restricted if the user has been inactive (has not logged in to the Connect platform) for 90 days or greater.

COVERED SERVICES

Standard Covered Services

The following MTM services are covered services in the OutcomesMTM program:

- Comprehensive Medication Review (CMR)
  - An interactive, person-to-person medication review and consultation of the patient's medications (including prescriptions, over-the-counter (OTC) medications, herbal therapies, and dietary supplements) performed in real-time by a pharmacist with a summary of the results of the review provided to the patient in the standardized format.
- Prescriber Consultation
  - A consultation between a pharmacist and a patient's prescriber to identify, resolve, and/or prevent the occurrence of one or more medication-related problems in which the prescriber's approval for a change in therapy is required.
- Patient Adherence Consultation
  - An interactive, person-to-person consultation between a pharmacist and a patient to identify, resolve, and/or prevent the occurrence of medication overuse, medication underuse or inappropriate medication administration.
- Patient Education & Monitoring
  - An interactive, person-to-person consultation between a pharmacist and a patient to provide education and monitoring under circumstances where the patient has received a new medication or change to an existing medication to identify, resolve, and/or prevent the occurrence of one or more medication-related problems.

Some plan-specific customizations to covered services may apply.

Patient Opt-Out Procedures

An MTM eligible patient may refuse or decline individual services without having to disenroll from the MTM program. However, if an MTM eligible patient requests to disenroll from the MTM program entirely, please contact OutcomesMTM at 877.237.0050. OutcomesMTM will notify the plan of the disenrollment.

Patient Health Plan Complaints

If an MTM eligible patient has a complaint about their health plan, please direct the patient to call the health plan customer service phone number on the back of the prescription drug card or call OutcomesMTM at 877.237.0050 to obtain the appropriate phone number to provide to the patient.

Long Term Care (LTC)

OutcomesMTM-eligible patients who reside in long-term care facilities or other types of institutional living quarters are eligible for a limited menu of covered services. Similarly, OutcomesMTM-eligible patients whose medications are administered by someone other than the patient may also only be eligible for select covered services.

In these unique circumstances, to determine if a patient is eligible for a covered service, first assess who is responsible for the patient's medication dosing/administration.

- If the patient or a family member/friend is responsible for their own medication dosing/administration, the patient is eligible for the standard covered services.
- If a facility staff member or healthcare professional is responsible for the patient's medication dosing/administration, the patient is only eligible for the Comprehensive Medication Review and Prescriber Consultations – Patient Adherence Consultations and Patient Education & Monitoring services are not covered.

DOCUMENTATION & BILLING REQUIREMENTS

Below are the requirements for MTM claims documented within the OutcomesMTM Connect™ Platform, accessible at www.outcomesmtm.com. OutcomesMTM provides MTM Providers with access to Technical Specialists via phone and email support from 7:00 am to 7:00 pm Central Standard Time Monday through Friday.

- Telephone support is available at 877-237-0050.
- Email support is available at info@outcomesmtm.com.

General Requirements

Documentation for each MTM claim follows a similar format, including documentation of the indication for service (reason), service provided (action), and outcome of service (result). Each MTM claim is required to be submitted within 7 days of the date the outcome of the service was determined; however, claim documentation and billing is encouraged to be completed immediately upon completion of the service to minimize the risk of the patient no longer being eligible at the time of billing. OutcomesMTM does not guarantee payment for services provided that were not billed while the patient was eligible. Any back-up documentation utilized during the provision of service is required to be retained on-site for 10 years, or as otherwise required by OutcomesMTM. Back-up documentation may include prescriber notes, Encounter Worksheets or anything not captured in the Connect platform which would support the claim result.

Each MTM claim submitted shall be documented and billed by the pharmacist (or a technician on their behalf) that provided the service. The use of student pharmacists and technicians in a supporting role is encouraged to maximize the time spent with the patient for the pharmacist; however, services are not allowed to be provided independently by a student pharmacist or pharmacy technician – all services are required to have direct supervision by a pharmacist.

Each MTM claim is required to meet the minimum documentation and billing requirements outlined below, by claim type, in order to be eligible for payment. Some plan-specific documentation and billing requirements may apply. All claims submitted are subject to quality assurance.

COMPREHENSIVE MEDICATION REVIEWS

Comprehensive Medication Review	Documentation & Billing Requirements
Needs CMR (100) Comprehensive Medication Review (200) CMR – Drug Therapy Problems Identified (300) OR Needs CMR (100) Comprehensive Medication Review (200) CMR – No Drug Therapy Problems Identified (301)	1. Review and update the patient's Medication Profile (PML) and document the following: a. Current Conditions b. Drug Allergies & Side Effects (include drug name and reaction) c. Medications (include all current prescription and non-prescription medications) i. Medication name and strength ii. Prescriber iii. Directions for use iv. Related Condition 2. Document each problem identified during the CMR on the Medication Action Plan (MAP)

	a. Include the following for each problem, in patient-directed language: i. Description of the problem ii. What the patient should do 3. Date the CMR was completed 4. Recipient of the CMR a. If someone other than the patient, document the following: i. Role of the CMR recipient (e.g. legally authorized representative) ii. Name of the CMR recipient iii. Patient's cognitive impairment status (yes/no) 5. Document where the patient takeaway should be sent a. If the takeaway should be sent to an address other than the patient's address, document the recipient's name, address, city, state and zip code. 6. Document pharmacist's availability for questions 7. Attest to reviewing the patient's drug allergies & side effects, medications and medication action plan and then print and deliver the Patient Takeaway a. Create the patient takeaway and deliver to the patient (or the recipient of the CMR) within 14 days of the date the CMR was completed b. Document the Date the Takeaway was Delivered 8. Submit the CMR claim a. Document if the CMR was related to a medication reconciliation post-hospital discharge b. Choose the appropriate method of delivery – face-to-face or phone i. If phone is selected, a prior authorization code is required (to obtain a prior authorization code, contact OutcomesMTM)

CMRs provided to patients not targeted for a CMR by OutcomesMTM are not payable. If a patient has already received a CMR within the last 12 months, but the pharmacist has identified the patient needs a second CMR (e.g. recently discharged from the hospital), a prior authorization is required. To obtain a prior authorization, please contact OutcomesMTM. Although not required, OutcomesMTM encourages pharmacists to provide the patient's primary care provider with a copy of the patient takeaway to maintain continuity of care.

PRESCRIBER CONSULTATIONS

Prescriber Consultations	Documentation & Billing Requirements
Cost Effective Alternative (105) Prescriber Consultation (205) Initiated Cost Effective Drug (305)	1. Date the outcome was determined 2. Initial prescription including quantity and days supply last prescribed 3. New prescription therapy including the quantity and days supply of the new prescription NOTE: Dispensing an A-rated generic equivalent when state law does not require a prescriber consultation does not constitute a payable claim.
Needs Drug Therapy (120) Prescriber Consultation (205) Initiated New Therapy (330)	1. Date the outcome was determined 2. New prescription therapy 3. Severity level 4. Rationale to support the severity level selected NOTE: For select OutcomesMTM Clients, TIP claims with this result code may be eligible for an additional validation payment when the newly initiated therapy appears in the plan's prescription claims data.
Needs Immunization (121)	1. Date the immunization was administered

Prescriber Consultation (205) Immunization Administered (331)	2. Date the outcome was determined a. This date cannot be greater than 30 days from the date the immunization was administered 3. Immunization administered (prescription information) NOTE: A successful CMR claim within the last 12 months is a pre-requisite for a patient to be eligible for an immunization MTM service.
Unnecessary Prescription Therapy (125) Prescriber Consultation (205) Discontinued Therapy (335)	1. Date the outcome was determined 2. Unnecessary prescription including quantity and days supply last prescribed 3. Severity level Rationale to support the severity level selected
Suboptimal Drug (130) Prescriber Consultation (205) Discontinued Therapy (335)	1. Date the outcome was determined 2. Suboptimal prescription including quantity and days supply last prescribed 3. Severity level 4. Rationale to support the severity level selected
Suboptimal Drug (130) Prescriber Consultation (205) Changed Drug (340)	1. Date the outcome was determined 2. Suboptimal prescription including quantity and days supply last prescribed 3. New prescription therapy including the quantity and days supply of the new prescription 4. Severity level 5. Rationale to support the severity level selected
Dose Too Low (135) Prescriber Consultation (205) Increased Dose (345)	1. Date the outcome was determined 2. Initial prescription including quantity and days supply last prescribed 3. New prescription therapy including the quantity and days supply of the new prescription 4. Severity level 5. Rationale to support the severity level selected
Adverse Drug Reaction (140) Prescriber Consultation (205) Discontinued Therapy (335)	1. Date the outcome was determined 2. Prescription related to the adverse drug reaction including quantity and days supply last prescribed 3. Severity level 4. Rationale to support the severity level selected
Adverse Drug Reaction (140) Prescriber Consultation (205) Decreased Dose (355)	1. Date the outcome was determined 2. Prescription related to the adverse drug reaction including quantity and days supply last prescribed 3. New prescription therapy including the quantity and days supply of the new prescription 4. Severity level 5. Rationale to support the severity level selected
Adverse Drug Reaction (140) Prescriber Consultation (205) Changed Drug (340)	1. Date the outcome was determined 2. Prescription related to the adverse drug reaction including quantity and days supply last prescribed 3. New prescription therapy including the quantity and days supply of the new prescription 4. Severity level 5. Rationale to support the severity level selected
Drug Interaction (145) Prescriber Consultation (205) Decreased Dose (355)	1. Date the outcome was determined 2. Prescription related to the drug interaction including quantity and days supply last prescribed 3. New prescription therapy including the quantity and days supply of the new prescription 4. Severity level 5. Rationale to support the severity level selected
Drug Interaction (145) Prescriber Consultation (205)	1. Date the outcome was determined 2. Prescription related to the drug interaction including

Discontinued Therapy (335)	quantity and days supply last prescribed 3. Severity level 4. Rationale to support the severity level selected
Drug Interaction (145) Prescriber Consultation (205) Changed Drug (340)	1. Date the outcome was determined 2. Prescription related to the drug interaction including quantity and days supply last prescribed 3. New prescription therapy including the quantity and days supply of the new prescription 4. Severity level 5. Rationale to support the severity level selected
Dose Too High (150) Prescriber Consultation (205) Decreased Dose (355)	1. Date the outcome was determined 2. Initial prescription including quantity and days supply last prescribed 3. New prescription therapy including the quantity and days supply of the new prescription 4. Severity level 5. Rationale to support the severity level selected
Dose Too High (150) Prescriber Consultation (205) Changed Drug (340)	1. Date the outcome was determined 2. Initial prescription including quantity and days supply last prescribed 3. New prescription therapy including the quantity and days supply of the new prescription 4. Severity level 5. Rationale to support the severity level selected

PATIENT ADHERENCE CONSULTATIONS

Patient Adherence Consultations	Documentation & Billing Requirements
Adherence – Overuse of Medication (155) Patient Consultation (215) Altered Adherence (360)	1. Date the non-adherence was identified 2. Attestation that the patient refilled the prescription in an appropriate interval following the intervention 3. Attestation that the patient reported to be using the medication as prescribed 4. Date the non-adherence was resolved 5. Prescription information 6. Severity Level 7. Rationale to support the severity level selected
Adherence – Underuse of Medication (160) Patient Consultation (215) Altered Adherence (360)	1. Barriers that resulted in the non-adherence issue (select all that apply) 2. Date the non-adherence was identified 3. Attestation that the patient refilled the prescription in an appropriate interval following the intervention a. The on-time refill must be after the date the non-adherence was identified, but cannot be the same day 4. Attestation that the patient reported to be using the medication as prescribed a. This attestation must occur at least 14 days following the date the non-adherence was identified 5. Date the non-adherence was resolved 6. Prescription information 7. Severity Level 8. Rationale to support the severity level selected
Adherence – Underuse of Medication (160) Patient Consultation (215) Altered Adherence + 90 day fill (368)	1. Barriers that resulted in the non-adherence issue (select all that apply) 2. Date the non-adherence was identified 3. Attestation that the patient refilled the prescription in an appropriate interval following the intervention a. The on-time refill must be after the date the

	non-adherence was identified, but cannot be the same day 4. Attestation that the patient reported to be using the medication as prescribed a. This attestation must occur at least 14 days following the date the non-adherence was identified 5. Date the non-adherence was resolved 6. Prescription information 7. Severity Level 8. Rationale to support the severity level selected NOTE: The result code Altered Adherence + 90 day fill is associated with the Targeted Intervention Program (TIP®) and only available for select OutcomesMTM Clients. Selection of result code Altered Adherence + 90 day fill indicates the patient's adherence has improved, the patient is agreeable to transitioning to a 90 day supply of the medication and an updated prescription has been obtained from the prescriber for a 90 day supply, 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.
Adherence – Inappropriate Admin/Technique (165) Patient Consultation (215) Altered Administration or Technique (365)	1. Date the non-adherence was identified 2. Did the patient report using the medication as directed upon follow up? (Yes or No) 3. Date the non-adherence was resolved 4. Prescription information 5. Severity Level 6. Rationale to support the severity level selected
Adherence – Needs Check-in (171) Patient Consultation (215) Adherence Check-in Completed (371)	1. Date the outcome was determined 2. Prescription information NOTE: This billing code is associated with the Targeted Intervention Program (TIP®) and only available for select OutcomesMTM Clients.
Adherence – Needs Check-in + 90 day fill (172) Patient Consultation (215) Adherence Check-in Completed + 90 day fill (372)	1. Date the outcome was determined 2. Prescription information NOTE: This billing code is associated with the Targeted Intervention Program (TIP®) and only available for select OutcomesMTM Clients. Selection of result code Adherence Check-in Completed + 90 day fill indicates the patient is agreeable to transitioning to a 90 day supply of the medication and an updated prescription has been obtained from the prescriber for a 90 day supply, 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.

PATIENT EDUCATION & MONITORING

Patient Education & Monitoring	Documentation & Billing Requirements
New or Changed Prescription Therapy (110) Patient Education & Monitoring (210) Therapy Success (310) OR New or Changed Prescription Therapy (110) Patient Education & Monitoring (210) Therapy Failure (320)	1. Initial consultation date 2. Date the follow-up occurred 3. Complete the following Yes/No Questions: a. Is the patient satisfied with the therapy? b. Did the symptoms improve? c. Were any adverse reactions reported? d. Is the patient adherence with therapy? 4. Prescription information NOTE: All claims with a reason code of New or Changed Prescription

	Therapy where the prescription information submitted with the claim cannot be validated via prescription claims data as a "new or changed" therapy for the patient will be rejected.
New or Changed OTC Therapy (117) Patient Education & Monitoring (210) Therapy Success (310) OR New or Changed OTC Therapy (117) Patient Education & Monitoring (210) Therapy Failure (320)	1. Name of OTC product involved 2. Initial consultation date 3. Date the follow-up occurred 4. Complete the following Yes/No Questions: a. Is the patient satisfied with the therapy? b. Did the symptoms improve? c. Were any adverse reactions reported? d. Is the patient adherence with therapy? 5. Severity Level 6. Rationale to support the severity level selected NOTE: All claims for medications not classified as Rx only or are available over-the-counter are required to be submitted with a reason of New or Changed OTC Therapy. New or Changed OTC Therapy recommendations are required to have evidence-based and patient-specific clinical rationale, including documented deficiencies and/or patient symptoms, which is subject to quality assurance.

REFUSALS AND THREE ATTEMPTS – UNABLE TO REACH

Refusals and Three Attempts – Unable to Reach	Documentation & Billing Requirements
Comprehensive Medication Review (200) Patient Refusal (380) OR Patient Education & Monitoring (210) Patient Refusal (380) OR Patient Consultation (215) Patient Refusal (380)	1. Date the patient refused the recommendation 2. Reason the patient refused the recommendation
Prescriber Consultation (205) Prescriber Refusal (375)	1. Date the prescriber refused the recommendation 2. Reason the prescriber refused the recommendation 3. Medication(s) related to the intervention 4. Prescriber NPI
Comprehensive Medication Review (200) Three Attempts – Unable to Reach Patient (379) OR Patient Education & Monitoring (210) Three Attempts – Unable to Reach Patient (379) OR Patient Consultation (215) Three Attempts – Unable to Reach Patient (379)	1. Date of the last attempt to reach the patient (after three successful attempts)
Prescriber Consultation (205) Three Attempts – Unable to Reach Prescriber (378)	1. Date of the last attempt to reach the prescriber (after three unsuccessful attempts) 2. Medication(s) related to the intervention 3. Prescriber NPI

Severity Level

A severity level is assigned to every MTM claim documented in the Connect platform. The severity level is the highest reasonable and foreseeable healthcare benefit (or avoidance) the patient received as a result of the pharmacist's intervention. OutcomesMTM pre-assigns severity levels for:

- All Comprehensive Medication Reviews
- Patient Education & Monitoring claims pertaining to new or changed prescription therapy
- All patient/prescriber refusals
- All three-attempts unable to reach claims
- All TIP claims

The following claim types require the pharmacist to document a severity level and provide patient-specific information to support the severity level selected.

- Prescriber Consultations
- Patient Adherence Consultations
- Patient Education & Monitoring claims pertaining to OTC therapy

The OutcomesMTM Connect Platform accommodates seven severity levels.

Level 1: Adherence Support
Automatically applies to all completed Comprehensive Medication Reviews and patient education and monitoring services (with the exception of New or Changed OTC Therapy). A pharmacist should select this severity level for all other interventions that do not result in any other reasonable and foreseeable cost avoidance.

Level 2: Reduced Medication Costs
Automatically applies to all successful Cost-Effective Alternative services in combination with prescriber consultations that result in changes in prescribed therapy. A pharmacist should select this severity level for all other interventions that result in reasonable and foreseeable savings in medication costs.

Level 3: Prevented a Physician Visit
Applies to a drug therapy problem identified and resolved by the pharmacist for which it is reasonable and foreseeable that the patient would have visited a physician if not addressed by the pharmacist.

Level 4: Prevented an Additional Prescription Order
Applies to a drug therapy problem identified and resolved by the pharmacist for which it is reasonable and foreseeable that the patient would have obtained a new prescription order if not addressed by the pharmacist.

Level 5: Prevented an Emergency Room Visit
Applies to a drug therapy problem identified and resolved by the pharmacist for which it is reasonable and foreseeable that the patient would have needed to visit the ER if not addressed by the pharmacist.

Level 6: Prevented a Hospital Admission
Applies to a drug therapy problem identified and resolved by the pharmacist for which it is reasonable and foreseeable that the patient would have been admitted to the hospital if not addressed by the pharmacist.

Level 7: Prevented a Life-Threatening Situation
Applies to a drug therapy problem identified and resolved by the pharmacist for which it is reasonable and foreseeable that the patient would have faced a life-threatening situation if not addressed by the pharmacist.

QUALITY ASSURANCE

OutcomesMTM contracts with a third-party quality assurance (QA) entity to ensure that MTM claims are documented according to the established Policies and Procedures outlined within this document and that the Severity Level assigned to each MTM claim is reasonable and foreseeable based on the supporting documentation provided. The status of an MTM claim indicates where the claim is within the claim submission, quality assurance and payment processes.

The OutcomesMTM Connect platform accommodates the following claim status categories:

Claim Status Categories

- **Unfinished**: This status indicates the claim is still in progress by the provider. Pharmacists have 120 days to complete any unfinished claim.
- **Pending Approval:** This status indicates the claim has been submitted by the provider and the claim is ready to be reviewed for approval.
- **Review & Resubmit:** This status indicates the claim has been submitted by the provider and has been reviewed by a claims reviewer but is incomplete and requires further attention by the provider.
- **Rejected:** This status indicates the claim has been submitted by the provider and has been reviewed by a claims reviewer but the claim cannot be approved for payment.
- **Approved & Pending Payment:** This status indicates the claim has been submitted by the provider and has been approved for payment but payment has not yet been processed.

- **Approved & Paid**: This status indicates the claim has been submitted by the provider, approved for payment and payment has been processed

Claims left in review & resubmit status for longer than 30 days will be rejected. Claims left unfinished for longer than 120 days will be deleted. Claims that are re-submitted twice without addressing the claim deficiency noted within the administrative note will be rejected.

Fraud, Waste and Abuse

The detection and resolution of drug therapy problems is central to the OutcomesMTM program. Therefore, OutcomesMTM assigns each pharmacy a "Quality Assurance Zone" to prevent fraud, waste and abuse. These zones are designed to identify pharmacies whose activity is atypical in OutcomesMTM programs.

- **Red Zone**: A Pharmacy in the red zone has submitted a disproportionate number of CMR and Patient Education and Monitoring claims, without subsequent documentation of resolution of drug therapy problems, and is unable to document these types of claims until the pharmacy's claims are brought back into balance.
- **Yellow Zone**: A pharmacy in the yellow zone is beginning to reflect a disproportionate number of CMR and Patient Education and Monitoring claims, without subsequent documentation of resolution of drug therapy problems, and receives notice that if they want to continue to be able to document these types of claims, they need to bring the pharmacy's claims back into balance. In order to bring a pharmacy's claims back into balance, the pharmacy needs to document any successful patient adherence consultation or prescriber consultation to resolve drug therapy problems.
- **Green Zone**: A pharmacy in the green zone is demonstrating typical claim activity in the OutcomesMTM program

Compliance with Applicable Laws and Regulations

The Centers for Medicare & Medicaid Services ("CMS") mandates that plan sponsors administering a Medicare Advantage program or Medicare Part D prescription drug plan must implement an effective compliance program that meets the regulatory requirements. As an entity with direct contractual relationships with Medicare Advantage Plans and Medicare Part D prescription drug plans, OutcomesMTM has an obligation to ensure that its downstream entities performing Medicare Advantage or Medicare Part D services are in compliance with all applicable laws, including having policies and procedures in place for preventing fraud, waste, and abuse or conflicts of interest as well as training and education on applicable Medicare laws, rules, regulations and CMS guidance.

Each MTM Center is required to abide by all applicable federal and state laws and regulations and is required to notify OutcomesMTM if it does not meet any of the following requirements. MTM Center network status is subject to approval by OutcomesMTM.

- OutcomesMTM requires MTM Center to requires its MTM providers to complete general CMS compliance and HIPAA/HITECH training within the first ninety (90) days of employment/contracting, and annually thereafter
- OutcomesMTM requires MTM Center to require MTM providers to complete the standardized Fraud, Waste and Abuse training and education module developed by the Centers for Medicare & Medicaid Services ("CMS") (See: CMS Medicare Learning Network at http://www.cms.gov.MLNProducts) or a similar training to identify, correct, and prevent potential fraud, waste, and abuse that meets CMS requirements within the first ninety (90) days of employment/contracting, and annually thereafter
- OutcomesMTM requires MTM Center to obtain attestation from its MTM providers to receipt and agreement to comply with OutcomesMTM's Standards of Conduct and Ethics policy or has adopted its own or another entity's Standards of Conduct and Ethics policy that meets applicable CMS requirements
- OutcomesMTM requires MTM Center to implement policies and procedures to document the review of the Office of Inspector General ("OIG") and General Services Administration ("GSA") exclusion lists prior to initial hire/contracting and monthly thereafter to ensure that all of MTM Center's downstream entities (including their employees, officers and governing body directors) and employees, including managers, officers, and governing body directors responsible for delivering Medicare Part D or Medicare Advantage services are not excluded from participating in federally funded healthcare programs according to the OIG and GSA exclusion lists. MTM Center further warrants that MTM Center will promptly remove from providing such services on behalf of OutcomesMTM

any of MTM Center's MTM Providers or employees and/or any of MTM Center's downstream entities or their employees that are excluded from participating in federally funded healthcare programs according to the OIG and GSA exclusion lists

- OutcomesMTM requires MTM Center to attest it has received and agrees to comply, and all employees performing the Part D or Medicare Advantage services relative to a Part D Plan Sponsor or Medicare Advantage Organization shall read and agree to comply, with any written compliance policies and procedures and standards of conduct made available by Outcomes, or comparable policies, procedures, or standards of conduct of its own that meet applicable CMS requirements
- OutcomesMTM requires MTM Center to implement written record retention policies and procedures to ensure that any documents, books and records that substantiate compliance with this attestation or related to MTM Center's performance of its obligations as a provider of Medicare Part D or Medicare Advantage services are retained for a period of at least ten (10) years and MTM Center will provide CMS, or its designee with access to such records if requested
- OutcomesMTM requires MTM Center to warrant that neither MTM Center nor any downstream or related entity utilized by MTM Center to provide MTM to Medicare beneficiaries on behalf of OutcomesMTM utilizes an offshore vendor and/or subcontractor to provide said services. MTM Center further attests that neither Vendor nor any downstream or related entity utilized by MTM Center provides protected health information or "PHI" (as such term is defined at 45 C.F.R. §160.103) of a Medicare beneficiary to any offshore vendor and/or subcontractor. For the purposes of this attestation, the term "offshore" shall refer to any country that is not one of the fifty United States or one of the following United States Territories: American Samoa, Guam, Northern Marianas, Puerto Rico and the Virgin Islands.

Appendix A. Glossary of Terms

Action: The Professional Service associated with an OutcomesMTM claim.

Adherence – Needs Check-in (171): Applies to a TIP generated by OutcomesMTM for a patient who is taking a medication for which adherence to the medication has been identified by the health plan as important. The patient may or may not be adherent to the medication at the time of TIP generation, and the intervention should be tailored to the patient but primarily involve education about the medication and the importance of adherence. Applicable for select OutcomesMTM Clients. (Reason code)

Adherence – Needs Check-in+ 90 day fill (172): Applies to a TIP generated by OutcomesMTM for a patient who is taking a medication for which adherence to the medication has been identified by the health plan as important and the patient is eligible for a 90 day supply. The patient may or may not be adherent to the medication at the time of TIP generation, and the intervention should be tailored to the patient but primarily involve education about the medication and the importance of adherence, offering the patient a 90 day supply, where appropriate. Applicable for select OutcomesMTM Clients. (Reason code)

Adherence – Inappropriate Administration/Technique (165): Applies to the presentation of a patient who has demonstrated inappropriate administration/technique of a drug product and as a result is non-adherent. (Reason code)

Adherence - Overuse of a medication (155): Applies to the presentation of a patient who has demonstrated overuse of a drug product and as a result is non- adherent. (Reason code)

Adherence - Underuse of a medication (160): Applies to the presentation of a patient who has demonstrated underuse of a drug product and as a result is non-adherent. (Reason code)

Adherence Check-in Completed (371): Applies to the completion of a check-in with the patient where medication education was provided with an emphasis on the importance of adherence. Applicable for select OutcomesMTM Clients. (Result code)

Adherence Check-in Completed + 90 day fill (372): Applies to the completion of a check-in with the patient where medication education was provided with an emphasis on the importance to adherence. In addition the patient is agreeable to transitioning to a 90 day supply of the medication and an updated prescription has been obtained from the prescriber for a 90 day supply. Claims with this result code are eligible for an additional validation payment when the 90 day supply appears in the plan's prescription claims data. Applicable for select OutcomesMTM Clients. (Result code)

Altered Adherence (360): Applies to the altering of a patient's behavior to become adherent with a drug therapy that they had previously been overusing or underusing. (Result code)

Altered Adherence + 90 day fill (368): Applies to the altering of a patient's behavior to become adherent with a drug therapy that they had previously been underusing. In addition the patient is agreeable to transitioning to a 90 day supply of the medication and an updated prescription has been obtained from the prescriber for a 90 day supply. Claims with this result code are eligible for an additional validation payment when the 90 day supply appears in the plan's prescription claims data. Applicable for select OutcomesMTM Clients. (Result code)

Altered Administration or Technique (365): Applies to the altering of a patient's behavior to become adherent with a drug therapy that had previously been administered with inappropriate technique. (Result code)

Adverse Drug Reaction (140): Applies to the presentation of a drug order with an adverse reaction risk significant enough to render the therapy unsafe, including side effects and allergic or idiosyncratic reactions. (Reason code)

Changed Drug (340): Applies to the prescriber approval of a pharmacist recommendation to change a drug order that has suboptimal efficacy. (Result code)

CMR – Drug Therapy Problems Identified (300): Applies to the completion of a Comprehensive Medication Review that results in an additional intervention being conducted due to the identification of a cost-efficacy issue or a drug therapy problem. (Result code)

CMR – No Drug Therapy Problems Identified (301): Applies to the completion of a Comprehensive Medication Review that does not result in an additional intervention being conducted due to the identification of a cost-efficacy issue or a drug therapy problem. (Result code)

Complex Drug Therapy (100): Typically applies to the presentation of a patient taking three or more medications.

Comprehensive Medication Review (CMR) (200): Applies to comprehensive review of a patient's drug profile to identify any cost-efficacy issues or drug therapy problems. (Action code)

Cost-Effective Alternative (105): Applies to the presentation of an order for a drug product where a more cost-effective therapeutic alternative is available. (Reason code)

Decreased Dose (355): Applies to the prescriber approval of a pharmacist recommendation to change a drug order that has a dose or duration too excessive to be safe. (Result code)

Discontinued Therapy (335): Applies to the prescriber approval of a pharmacist recommendation to discontinue a drug order that is not indicated. (Result code)

Dose Too High (150): Applies to the presentation of an order to initiate or continue drug therapy at a dose or duration too excessive to be safe. (Reason code)

Dose Too Low (135): Applies to the presentation of an order to initiate or continue drug therapy at a dose or duration insufficient to be effective. (Reason code)

Drug Interaction (145): Applies to the presentation of a drug order with a drug interaction risk significant enough to render the therapy unsafe. (Reason code)

Increased Dose (345): Applies to the prescriber approval of a pharmacist recommendation to change a drug order that has a dose or duration insufficient to be effective. (Result code)

Initiated New Therapy (330): Applies to the prescriber approval of a drug therapy change following a pharmacist recommendation to initiate a drug order due to an untreated indication for prescription therapy. (Result code)

Initiation of Cost Effective Drug (305): Applies to the prescriber approval of a more cost effective drug following a pharmacist recommendation to change a drug order due to a cost-efficacy issue. (Result code)

Needs Drug Therapy (120): Applies to the presentation of a patient with an untreated indication for prescription therapy. (Reason code)

New or Changed Prescription Therapy (110): Applies to the presentation of an order to initiate new or changed prescription therapy. (Reason code)

New or Changed OTC Therapy (117): Applies to the presentation of a patient with an untreated indication for over-the-counter therapy. (Reason code)

No Intervention Necessary: Applies to TIPs generated by OutcomesMTM for which the proposed intervention is obsolete (i.e. the drug therapy problem never existed, no longer exists, or has already been resolved and no action by the pharmacist is necessary)

Patient Consultation (215): Applies to consulting a patient to address a drug therapy problem. (Action code)

Patient Education and Monitoring (210): Applies to patient education and monitoring of a drug therapy. Minimum patient education includes information related to the name of the drug, therapeutic class, directions for use, side effects, warnings, storage requirements, missed dose actions, and appropriate written material. Minimum patient monitoring includes collecting information about change in patient satisfaction with therapy, symptom improvement where applicable, side effects and adherence. (Action code)

Patient Refusal (380): Applies to the patient refusal to participate in a Comprehensive Medication Review, receive Patient Education/Monitoring, permit a physician consultation on cost-efficacy issues, or alter compliance- related behavior. (Result code)

Prescriber Consultation (205): Applies to consulting a prescriber to recommend a drug order change due to either a cost-efficacy issue or drug therapy problem. (Action code)

Prescriber Refusal (375): Applies to the prescriber refusal of a pharmacist recommendation to change a drug order due to either a cost-efficacy issue or a drug therapy problem. (Result code)

Reason: The Indication for Service associated with an OutcomesMTM claim.

Result: The Outcome of Service associated with an OutcomesMTM claim.

Suboptimal Drug (130): Applies to the presentation of an order to initiate or continue drug therapy with suboptimal efficacy. (Reason code)

Therapy Failure (320): Applies to a monitoring situation whereby a pharmacist has determined that a patient's condition(s) are unresolved, unstable, or worsened as a result of drug therapy. (Result code)

Therapy Success (310): Applies to a monitoring situation whereby a pharmacist has determined that a patient's condition(s) are resolved or stabilized as a result of drug therapy. (Result code)

TIP®: References the OutcomesMTM Targeted Intervention Program (TIP). TIPs are pre-identified possible drug therapy problems identified by OutcomesMTM and available in the MTM Opportunity list in the Connect platform.

Unable to reach prescriber after 3 attempts (378): Applies to a situation where a pharmacist has attempted to reach a prescriber at least three times without success. (Result Code)

Unable to reach patient after 3 attempts (379): Applies to a situation where a pharmacist has attempted to reach a patient at least three times without success. (Result Code)

Unnecessary Prescription Therapy (125): Applies to the presentation of an order to initiate or continue drug therapy that is not indicated. (Reason code)