Provider Delivered Care Management Billing

What is MiPCT and PDCM?

- MiPCT stands for Michigan Primary Care Transformation Project. It started as a 3 year multi-payer statewide project and now has been extended for another two years ending on 12/31/2016.
- PDCM means Provider Delivered Care Management. It began as a Pilot in 2010 and extends our BlueHealthConnection which is BCBSM's wellness and care management program to the doctor's office. There have been three phases to PDCM:
  - PDCM Phase 1 – the inception of PDCM
  - PDCM Phase 2 – the addition of codes to the PDCM program in 2012
  - PDCM Phase 3 – the expansion of PDCM services to all PCMH designated practice units in July, 2015.

PDCM Procedure Codes

G9001* - Initiation of Care Management (Comprehensive Assessment)
G9002* - Individual Face-to-Face Visit
98961* - Education and training for patient self-management for 2–4 patients; 30 minutes
98962* - Education and training for patient self-management for 5–8 patients; 30 minutes
98966* - Telephone assessment 5-10 minutes of medical discussion
98967* - Telephone assessment 11-20 minutes of medical discussion
98968* - Telephone assessment 21-30 minutes of medical discussion
99487* - First hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month
99489* - Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. (An add-on code that should be reported in conjunction with 99487)
G9007* - Coordinated care fee, scheduled team conference
G9008* - Physician Coordinated Care Oversight Services (Enrollment Fee)
S0257* - Counseling and discussion regarding advance directives or end of life care planning and decisions

General Conditions of Payment

- For billed services to be payable, the following conditions apply:
  - The patient must be eligible for PDCM coverage. Ordered by a physician, PA or CNP within the approved practice; a note indicating these services were ordered must be in the medical record.
  - Based on patient need
  - Performed by the appropriate qualified, non-physician health care professional employed or contracted with the approved practice or PO
  - Billed in accordance with BCBSM billing guidelines
  - There is no costshare (copay, coinsurance or deductible) for PDCM services.
  - Effective January 1, 2016, BCBSM has now waived the cost share for ALL PDCM services including those plans with a High Deductible Health Plan with a Health Savings Account. Prior to 1/1/216, members enrolled in an HDHP with an HSA had to meet their deductible requirement for their PDCM services to be payable at 100 percent.

- *Services billed for non-eligible members will be **rejected with provider liability**.*

Patient Eligibility

- The patient must have active BCBSM coverage. Patients are eligible depending on the program and phase that joined:

MiPCT **(participating since 2012)**	**PDCM Phases 1 & 2** **(participating since 2012)**	**PDCM Phase 3** **(participating since July 2015)**
BCN Commercial	BCN Commercial only	BCBSM Commercial only
BCBSM Commercial	BCBSM Commercial and Medicare Advantage	

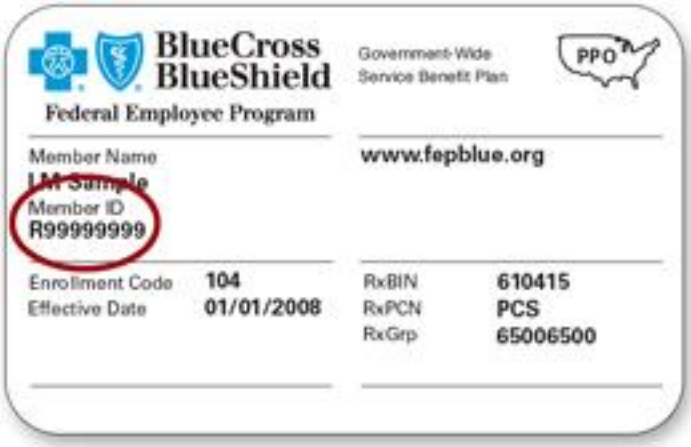
- Checking eligibility:
  - Providers should check normal eligibility channels (e.g., WebDENIS, PARS IVR) to confirm contract and benefit eligibility.
    - *A practice should follow its current process for determining patient eligibility*
      - *Determining patient eligibility for care management is not the responsibility of the care manager*
      - *For information on how to access eligibility information, practices should contact their BCBSM Provider Consultant or PO Consultant*
- The patient must be an active patient under the care of a physician, PA or CNP in a PDCM-approved practice and referred by that clinician for PDCM services.
- The patient must be an active participant in the care plan.

BCBSM Medicare Advantage – Patient Eligibility

- **<u>Only applicable to BCBSM PDCM Phases 1 & 2 practices:</u>**
  - If an insurer other than Blue Cross or BCN Medicare Advantage is the primary insurer, the patient is not eligible for PDCM services.
  - BCBSM MA-PPO excluded ASC groups are: BCBSM retirees, URMBT, MPSERS and Accident Fund retirees
  - WebDENIS/PARS IVR will not speak to the PDCM benefit. Determine eligibility by looking at the group and determining who is primary. The patient list is a good start however, you need to ensure that the patient is not one of the groups mentioned above or does not have Medicare Advantage as primary.

Federal Employee Program (FEP)

These members will *NOT* be on your patient list; rather, you will be able to identify them by their unique identification number. Their identification number will start with "R". Below is an example of their identification card. Please also note that FEP members who are enrolled in Medicare (A&B or just B) are not eligible for the PDCM program through Blue Cross Blue Shield of Michigan.



Provider Requirements: Care Management Team

- Individuals performing PDCM services must be qualified non-physician practitioners employed by practices or practice-affiliated POs approved for PDCM payments
- The team must consist of:
  - A lead care manager who:
    - Is an RN, LMSW, CNP or PA
    - Has completed lead care manager training program
    - Has completed a self-management support training program
  - Other qualified allied health professionals:
    - Any of the above, plus…
    - Licensed practical nurse, certified diabetes educator, registered dietician, masters of science trained nutritionist, clinical pharmacist, respiratory therapist, certified asthma educator, certified health educator specialist (bachelor's degree or higher), licensed professional counselor, licensed mental health counselor.
- Each qualified care team member must:
  - Function within their defined scope of practice
  - Work closely and collaboratively with the patient's clinical care team
  - Work in concert with BCBSM care management nurses as appropriate

Billing and Documentation: General Guidelines

- The following general billing guidelines apply to PDCM services:
  - Approved PCMH and MiPCT practices/POs only
  - All services may be billed under the PCP's NPI
  - Professional claim
    - 12 procedure codes
  - No diagnostic restrictions. However, we do know there are certain diagnoses that may reject for certain groups. See next slide for more information.
    - All relevant diagnoses should be identified on the claim
  - Quantity limits apply to some codes
  - No location restrictions
  - Documentation demonstrating services were necessary and delivered as reported
  - Documentation identifying the CM isn't required, but documentation must be maintained in medical records identifying the provider for each patient interaction

- Additional documentation requirements:
  - Dates, duration, name/credentials of care team member performing the call/service
  - Nature of the discussion and pertinent details regarding updates on patient's condition, needs, progress with goals and target dates

Denied Obesity/Mental Health Claims

- Some groups reject obesity and/or mental health. Unfortunately, for these groups if a claim is submitted with either of these diagnosis codes, it will reject. However, since PDCM has no diagnostic restrictions, these claims are eligible for reimbursement. There are two options of how reimbursement can be issued:
  1. If there is another diagnosis that can be billed in the "first/primary" diagnosis position on the claim form, please status those claims with that information and payment should be issued. Please keep the obesity or mental diagnosis, but not in the first/primary position.
  2. However, if there is no other diagnosis that can be billed, BCBSM will need to be notified of that denied claim. You can open an issue on the Collaboration site (if you have access to it), send an email to valuepartnerships@bcbsm.com or contact Lori Boctor at lboctor@bcbsm.com or by phone at 313-448-3341.

Code-Specific Requirements: G9001* Initiation of Care Management (Comprehensive Assessment)

- Payable only when performed by an RN, LMSW, CNP or PA with approved level of care management training (i.e., lead care manager)
- Quantity limit: One assessment per patient, per care manager, per year
- Contacts must add up to at least 30 minutes of discussion
- Must include a face to face encounter
- Assessment should include:
  - Identification of all active diagnoses
  - Assessment of treatment regimens, medications, risk factors, unmet needs, etc.
  - Care plan creation (issues, outcome goals, and planned interventions)
  - Current physical and mental/emotional status and treatment
  - Level of patient's understanding of his/her condition and readiness for change
  - Perceived barriers to treatment plan adherence
- Documentation must include:
  - Date of service (date assessment is completed)
  - Dates, duration, and modality (face to face or phone), name/credentials of care manager performing the service
  - Formal indication of patient engagement/enrollment
  - Physician coordination and agreement

Note: Only lead care managers may perform the initial assessment services (G9001*)

Code-Specific Requirements: G9008*
Patient Enrollment

- Payable only when performed by the physician
- Quantity limit: G9008 may be billed only one time per patient, per physician
- This code can be submitted on behalf of the physician.
- An established relationship between the Primary Care Practitioner and patient must already exist
- A written care plan with action steps and goals accepted by the physician, care manager and patient is in place

G9002* Coordinated Care Fee, Maintenance rate (per encounter)

- Payable when performed by any qualified care management team member
- Quantity limit: The appropriate quantity is based on the total cumulative time the patient spends with a care management team member(s) on that day. The length of time spent with the patient during each interaction should be added together to determine the correct quantity to bill.
  - If the total cumulative time with the patient adds up to:
    - 1 to 45 minutes, report a quantity of 1
    - 46 to 75 minutes, report a quantity of 2
    - 76 to 105 minutes, report a quantity of 3
    - 106 to135 minutes, report a quantity of 4

G9002* Coordinated Care Fee, Maintenance rate (per encounter), *Continued*

- Encounters must:
  - Be conducted in person
  - Be a substantive, focused discussion pertinent to patient's care plan
- Claims reporting requirements:
  - The code should be reported once for a single date of service
  - All diagnoses relevant to the encounter should be reported
- Documentation must additionally include:
  - Date, duration, name/credentials of team member performing the service
  - Nature of discussion and pertinent details relevant to care plan (progress, changes, etc.)

Do I have to complete/bill a G9001 before I bill other Care Management Codes?

- For patients not enrolled in care management (completion of a G9001 Initial Assessment):
  - BCBSM recognizes the fact that at times there is a need to reach out to a patient transitioning from the Hospital or Emergency Department who may definitely require care management services. This may be a needed first step to getting a patient enrolled into care management services.
  - Therefore, we will reimburse for a G9002 (in person visit) or 98966, 98967 or 98968 (phone codes) prior to a care plan being created. Subsequent completion of the G9001 for patients who will be enrolled in care management is expected and considered best practice.

Transitional Care Management (TCM) Codes

- There are two TCM codes (99495 and 99496) that can be billed for your patients transitioning out of an inpatient hospital, SNF, outpatient observation or partial hospitalization.
- Currently, BCBSM only reimburses for 99496 for all cases of transitional care management.
- To bill this code:
  - The provider must communicate directly, electronically or by telephone with the patient or caregiver within two days of discharge from an inpatient hospital, skilled nursing facility or community mental health center stay, outpatient observation or partial hospitalization.
  - A face-to-face visit must occur within seven business days of the patient's discharge.
  - Services performed during the face-to-face visit must take place in conjunction with the appropriate non-face-to-face TCM services outlined within the "Transitional Care Management Services" section of the CPT manual."

- *Note: Not all practices are using the Transitional Care Management (99495 and 99496) codes at this time. For the practices who are using the TCM codes 99495 and 99496; the practice cannot bill TCM and G/CPT code (G9002 or 98966, 98967, 98968) at the same time if the work is related to "Transition of Care."*

Code-Specific Requirements: 98961*, 98962*
Group Education & Training Visit

98961* Education and training for patient self-management for 2-4 patients, 30 minutes
98962* Education and training for patient self-management for 5-8 patients, 30 minutes

- Payable when performed by any qualified care management team member
- No quantity limits
- Each session must:
  - Be conducted in person
  - Have at least two, but no more than eight patients present
  - Include some level of individualized interaction
- Claims reporting requirements:
  - Services should be separately billed for each individual patient
  - Code selection depends upon total number of patient participants in the session
  - Quantity depends upon length of session (reported in thirty minute increments)
  - All diagnoses relevant to the encounter should be reported

Code-Specific Requirements: 98966*, 98967*, 98968* Telephone-based Services

98966* Telephone assessment and management, 5-10 minutes
98967* Telephone assessment and management, 11-20 minutes
98968* Telephone assessment and management, 21-30 minutes

- Payable when performed by any qualified care management team member for discussions with the patient
- Quantity limit: No more than one per date of service (if multiple calls are made on the same day, the times spent on each call should be combined and reported as a single call)
- Each encounter must:
  - Be conducted by phone
  - Be at least 5 minutes in duration
  - Include a substantive, focused discussion pertinent to patient's care plan
- Claims reporting requirements
  - Code selection depends upon duration of phone call
  - All diagnoses relevant to the encounter should be reported

Code-Specific Requirements: 99487* and 99489* Care Coordination

99487* First hour of clinical staff time directed by a physician or other qualified health care professional with no face–to–face visit, per calendar month.

99489* Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. (An add-on code that should be reported in conjunction with 99487*)

- Discussions must be substantive and focused on coordinating services, within the medical neighborhood, that are pertinent to the patient's individualized care plan and goal achievement.
- 99487* may only be billed once per calendar month, per patient
- 99489* may be quantity billed
- These codes should be billed at the end of each calendar month utilizing the last encounter date for that month.
- Appropriate coding and quantities are dependent upon the cumulative amount of time spend on care coordination activities in that month.
- You will need to determine a method for tracking this time each month.

Code-Specific Requirements: 99487* and 99489* *continued*

The following chart is intended to help determine the appropriate codes and quantities for different periods of time.

Total time (in minutes)	Code(s) to bill	Quantity
1-30	Cannot be billed	--
31-75	99487	1
76-105	99487 +99489	1 1
106-135	99487 +99489	1 2
136-165	99487 +99489	1 3
166-195	99487 +99489	1 4
196-225	99487 99489	1 5

Code-Specific Requirements: G9007* Team Conference

- This code should be used to bill for scheduled face-to-face meetings, telephone calls or secured video conferencing between, at minimum, the primary care practitioner and the care manager to formally discuss a patient's care plan
- Quantity limit: There is a limit of one G9007* paid per primary care practitioner, per practice, per patient, per day.
- The scheduled discussion should include sufficient time to discuss changes to the patient's status.
- The interaction can be conducted in person, by phone or secure video exchange. Email is not acceptable.
- Discussions must be substantive and focused on content pertinent to the patient's individualized care plan, interventions, goal achievement, target dates.
- Outcomes and next steps for each patient must be agreed upon and documented.
- Documentation can be completed by the primary care practitioner or the care manager
- Separately billed for each individual patient discussed during team conference.

Code-Specific Requirements: S0257* Advance Care / End of Life Planning

- This code should be used to bill for individual face-to-face or telephonic conversations regarding end-of-life care issues and treatment options
- Billable when performed by any qualified member of the care management team
- Quantity limit: No limits on number of services per patient per year
- Documentation associated with S0257* that must be recorded and maintained in the patient's record should include:
  - Enumeration of each encounter including:
    - Date of service
    - Duration of contact
    - Name and credentials of the allied professional delivering the service
    - Other individuals in attendance (if any) and their relationship with the patient
    - All active diagnoses

Code Summary

The following chart summarizes the billable PDCM codes and who can render each service:

Provider Type			
Service	Care Manager	Other Care Team Members	Physician
Initial assessment	G9001*	--	G9008*
Face-to-face encounter	G9002*		**
Phone	98966*, 98967*, 98968*		--
Group	98961*, 98962*		**
Team conference	G9007*		G9007*
Complex care coordination	99487*, 99489*		--
Advance directives or end of life care planning	S0257*		S0257*

Questions?

- How can we identify the BCBSM/BCN Care manager if the patient is not sure? Contact the BCBSM Engagement Center at 800-775-2583 and Contact the BCN DM/Nurse call line at 800-392-4247
- For BCBSM practices, please submit an issue through the PGIP Collaboration Site or send an email to ValuePartnerships@bcbsm.com
- BCN practices with questions should contact their provider consultants. For the PO's with questions, please contact your PO Consultant.

QUESTIONS