Multi-payer G and CPT Care Management Code Summary v8.1   Note: This multi-payer table has interim updates (see green font below for updates). This version of the Multi-payer table is undergoing a review process and the updated version will be available by mid-March 2018)

Purpose

This document is a guide to help care management team members quickly understand the requirements and documentation fields required for billing care management-related G and CPT codes. Please note that in previous versions of this guide, coding and documentation requirements were contained on separate grids, but are now combined for ease   of use.   We express our appreciation to payers for their review of this updated guide. While this document is intended to be helpful in better understanding requirements, it   does not supersede individual plan detailed criteria.   Care Management team members should consult the latest materials from each health plan (BCBSM Commercial, BCBSM Medicare Advantage, Priority Health Commercial, Priority Health Medicare Advantage) for the most complete and up-to-date information regarding these codes and additional details. Many of the codes have the same requirements across payers. Where there are differences among payers, these are highlighted in the document.   This document is updated on a quarterly basis. Online versions can be found at the Michigan Care Management Resource Center website, www.micmrc.org, under the "Programs MiCMRC supports" link.

Update for SIM and CPC+ Participants

For CPC+ Participants: A number of Chronic Care Management (CCM) codes are not allowed for any attributed CPC+ Medicare beneficiary (traditional Medicare, not Medicare Advantage). Each quarter, CMS will review claims and initiate recoupment as detailed in the CPC+ guide. These codes include 99487, 99489, 99490, G0506 and G0507.
BCBSM: Previously, for the CPC+ participating practices only PCMH-designated practices could bill BCBSM for PDCM procedure codes.   Effective 1/1/18 BCBSM announced the ability to bill BCBSM for PDCM procedure codes was expanded to non-designated primary care practices that are participating in CPC+. A column has been inserted to indicate which codes can be billed under the BCBSM PDCM program.
For SIM Participants: SIM PCMH Initiative participants are required to submit tracking codes; these tracking codes are identified in the "SIM" column and in the "Payers" column. A link to these tracking codes can be found on the last page of this document where resources are referenced.

Selecting Care Management Patients

Before submitting G and CPT codes, it is important for care managers to understand the criteria for selecting care management patients. Please refer to the materials provided by the health plan and/or Demonstration program for details regarding G and CPT codes (examples include: State Innovation Model, Comprehensive Primary Care Plus, Blue Cross Blue Shield of Michigan Provider Delivered Care Management, Priority Health).

Qualified Health Professional Definition by Payer for G and CPT Code Submission

Before submitting G and CPT codes, it is important to understand the health professionals eligible to submit codes as these may differ by payer as shown below.

BCBSM:
Lead Care Manager: RN, NP, PA, LMSW
Qualified Health Professional (Care Team): Clinical pharmacist, LPN, Certified diabetes educator, Registered dietitian, Masters-of-science trained nutritionist, Respiratory therapist, Certified asthma educator specialist (bachelor's degree or higher in health education), Licensed professional counselor, Licensed mental health Counselor, Licensed bachelors level social worker.

PRIORITY HEALTH:
Qualified Health Professional: RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP

STATE INNOVATION MODEL PCMH INITIATIVE:
Care Manager: Registered Nurse, Licensed Practical Nurse, Nurse Practitioner, Licensed Master's Social Worker, Licensed Professional Counselor, Licensed Pharmacist,

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Registered Dietician, Physician Assistant

Care Coordinator: Licensed Bachelor's Social Worker, Certified Community Health Worker, Certified Medical Assistant, Social Service Technician

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Code	Who can provide service?	Payers	PDCM BCBSM	SIM	Notes	Documentation

G9001: Initiation of Care Management (Comprehensive Assessment)	BCBSM RN, LMSW, CNP or PA who meet the conditions of a lead care manager
	
	BCBSM MA Same as above, but RNs and LMSWs must be under direct physician supervision
	
	Priority Health QHP
	
	MHP SIM PCMH Initiative CM
		BCBSM Commercial, BCBSM Medicare Advantage, Priority Health, MHP SIM PCMH Initiative (tracking code)	Y	Y	**All Payers**
					Description: Comprehensive assessment and care plan development with patients, prior to enrollment in care management (and annually thereafter)
					G9001 is **not** required to be billed for the other PDCM codes to be payable (though it is an expectation that a G9001 be completed).
					Conditions of payment: Contacts must add up to at least 30 minutes of discussion with the member or member's representative/caregiver. Must include a face-to-face visit. Patient/caregiver must formally agree with care plan and this must be documented in the medical record.
					Claims Reporting Requirement: Date of service should be the date the assessment is completed for patients entering into care management. If patient
						Description: Comprehensive Assessment and Care Plan Development with Patients, Prior to Enrollment in Care Management (and annually thereafter).
						
						Documentation:
						
						1. Lead Care Manager Name, Licensure. BCBSM Only payable when service is delivered by a RN, LMSW, CNP or PA who meet the conditions of Lead Care Manager. Priority Health: RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP
						2. Identify Primary Care Physician and Contact Information
						3. Date of service = date assessment is completed. Duration, and Modality of Contact (face-to-face required, or can be combination of the face-to-face and phone).
						4. Phone Visit, Face-to-Face Visit
						5. Visit Duration: 30 min
						   a. BCBSM- Contacts must total at least 30 minutes in duration with at least one face to face encounter with patient.
						   b. Priority Health- Work must encompass minimum of 30 minutes, some of which may be without the patient present.
						6. Specific Assessments such as depression, functionality, urologic, etc.
						7. Medical Treatment Regimen
						8. Risk Factors
						   a. Physical Status (PH)(BCBSM)
						   b. Emotional Status (PH)(BCBSM)
						9. Unmet Needs/Available Resources
						10. Perceived Barriers to Treatment Plan
						11. Adherence
						12. Anticipated interventions to help patient achieve their goals
						13. Self-Management Activities

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					does not agree to enter into care management, the date of service should be the date of the face-to-face component. All active dx should be reported on the claim. **Quantity limit:** There is a limit of one G9001 paid per care manager, per practice, per patient, per year. This limit does not apply across specialty types. **BCBSM MA** • MD/DO must sign the G9001 assessment and include their credentials • MD/DO's NPI must be reported on rendering provider field on the claim	14. All Active Diagnoses 15. Medication reconciliation 16. Care Plan including interventions (issues, outcome goals, and planned interventions) 17. Individualized Short-Term Goal, including target date 18. Individualized Long-Term Goal, including target date 19. Time Frame for Follow Up 20. Name of Other Individual(s) in Attendance, Relationship to Patient 21. Interventions to Help Patient Achieve Goals 22. Patient's Level of Understanding of his/her condition 23. Readiness for Change 24. Patient's Agreement and consent to Engage/Participate in Care Management 25. Physician coordination activities and approval of Care Plan BCBSM MA-include documentation fields listed above in "all payer" section plus the following: · MD/DO must sign the G9001 Assessment and include their credentials · MD/Dos NPI must be reported on rendering provider field on the claim · To comply with Medicare Star Program include urinary incontinence screen Priority Health-Include documentation fields listed above in "all payer" section, plus the following: · Diagnoses discussed Name of caregiver and relationship to patient, if caregiver is included with the visit · Treatment Plan, physical status, emotional status · Care Plan including challenges and interventions

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Code	Who can provide service?	Payers	PDCM BCBSM	SIM	Notes	Documentation

G9002: Individual Face-to-Face Visit	BCBSM Lead Care Manager and Other Care Team Members
	
	Priority Health QHP
	
	MHP SIM PCMH Initiative CM/CC
		BCBSM Commercial, BCBSM Medicare Advantage, Priority Health, MHP SIM PCMH (tracking code)	Y	Y	**All payers**
					   Description: Individual face-to-face care management intervention visits
					   Conditions of payment:
					• Only conducted/billed when patient circumstances and/or the nature of the service require person-to-person interaction to be successful.
					• May include the patient's caregiver/family
					• Must include focused discussion of patient's care plan
					• Can also include treatment plan, self-management education, medication therapy, risk factors, unmet care, physical status, emotional status, community resources, readiness to change and ongoing care plan development
					
					BCBSM/BCBSM MA
					   Code may be billed one time per day. If multiple members of the care team provide this service on the same date, to the same patient, this procedure code can be quantity billed. For example: 1-45 minutes (1), 46-75 minutes (2), 76-105 minutes (3), or 106-135 minutes (4).
						Description: Individual face-to-face care management intervention visits
						
						Documentation:
						1. Name/credentials of team member performing the service
						2. Date of Service
						3. Duration of Face-to-Face Visit
						4. All Diagnoses pertinent to encounter
						5. Medication reconciliation
						6. Focused discussion pertinent to the patients Care Plan (BCBSM) - progress, changes
						7. Short-Term Goal, including target date
						8. Long-Term Goal, including target date
						9. Time Frame for Follow Up
						   a. Name of Other Individual(s) in Attendance, Relationship to Patient
						10. Nature of the Discussion and Pertinent Details
						11. Updated Status on Patient's Medical Condition, care needs and progress to goal
						12. Care Needs and progress to goal(s)
						13. Any revisions to the Care Plan Goals, Interventions, and Target Dates
						14. Patient/Care Giver's Level of Understanding
						15. Readiness for Change
						
						Priority Health- include documentation fields listed above in "all payer" section plus the following:
						· Diagnosis Discussed, Treatment Plan, Self-Management Education, Risk Factors, Unmet Care, Emotional Status, Community Resources

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					Priority Health
					  Code may be billed one time per day.
					
					MHP SIM PCMH Initiative
					  Code may be billed one time per day. This procedure can be quantity billed: 1-45 minutes (1), 46-75 minutes (2), 76-105 minutes (3), or 106-135 minutes (4). Can be reported on the same date of service as G9001 if care management and coordination service(s) in addition to the comprehensive assessment are provided.
						· Name of Patient's PCP
						· Physician coordination activities and approval of Care Plan
						· Patients agreement with care plan

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Code	Description	Who can provide service?	Payers	PDCM BCBSM	SIM	Notes	Documentation
98961, 98962: Group Education and Training	98961: Education and training for patient self-management for 2–4 patients; each 30 minutes

98962: Education and training for patient self-management for 5–8 patients; each 30 minutes | BCBSM/BCBSM MA Lead Care Manager and Other Care Team Members

Priority Health QHP | BCBSM Commercial, BCBSM Medicare Advantage, Priority Health all plan with the exception of Medicaid | Y | N | **All Payers** **Description:** Formalized educational sessions led by qualified non-physician personnel delivered in a group setting **Conditions of Payment:** • At least two, but no more than 8 patients present • There must be some level of individualized interaction included in the session • Must use a standardized curriculum. **Claims Reporting Requirements:** • Family members should not be counted as patients • All active dx should be reported • Bill separately for each individual patient **Quantity Limits:** None. May be quantity billed. | Description: Formalized educational sessions led by qualified non-physician personnel delivered in a group setting

Documentation: 1. Name, Licensure of Group Visit Facilitator(s) Primary Care Physician 2. Date of Class 3. Total Number of Patients in Attendance: 2-4 patients or 5-8 patients 4. Group Visit Duration: 30 min 60 min 90 min if >90 min, indicate total minutes 5. Diagnoses Relevant to the Group Visit 6. Location of Class 7. Nature and Content of Group Visit 8. Objective(s) of the Training 9. Status Update: Medical Condition, Care Needs, Progress to Goal, Interventions, and Target Dates 10. Have some level of individualized interaction(BCBSM) 11. All active diagnosis |

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Code	Description	Who can provide service?	Payers	PDCM BCBSM	SIM	Notes	Documentation
98966, 98967, 98968: Telephone Services: Telephone assessment and management services provided by a qualified non-physician health care professional	98966: 5-10 minutes of medical discussion 98967: 11-20 minutes of medical discussion 98968: 21-30 minutes of medical discussion	BCBSM/BCBSM MA Lead Care Manager and Other Care Team Members Priority Health QHP MHP SIM PCMH Initiative CM/CC	BCBSM Commercial, BCBSM Medicare Advantage, Priority Health (all PH plans), MHP SIM PCMH (tracking code)	Y	N	**All payers** **Description:** Non-face-to-face care management services provided to a patient or patient's representative/caregiver using the telephone or by other real-time interactive electronic communication **Conditions of Payment:** • Not for reminder calls about appointments or conveying test results. • For substantive discussions focused on the patient's care plan and goal achievement. **Claims Reporting Requirements:** • Code selection depends on total time spent in discussion with the patient • Report all active dx **BCBSM/BCBSM MA** • Documented consent from patient agreeing to phone contacts initiated by the care manager • You may not quantity bill these codes • Only one of these codes may be billed per day. **Priority Health** • Priority investigating whether this can be quantity billed **MHP SIM PCMH Initiative**	Description: Non-face-to-face care management services provided to a patient or patient's representative/caregiver using the telephone or by other real-time interactive electronic communication Documentation: 1. Lead Care Manager Name, Licensure (payable when delivered by any of the qualified allied personnel approved for PDCM) 2. Date, Time, and Duration of Call 3. Phone Visit 4. All active diagnoses relevant to the encounter 5. Medications 6. Short-Term Goal, target date 7. Long-Term Goal, target date 8. Care Needs and Progress to Goal(s) 9. Nature of the Discussion and Pertinent Details 10. Updated Status on Patient's Medical Condition 11. Care Needs and Progress to Goal 12. Any revisions to the Care Plan Goals, Interventions, and Target Dates 13. Patient/Care Giver's Level of Understanding 14. Readiness for Change a. Name of Other Individual(s) in attendance, relationship with

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					• Code may be billed once per day. Can be reported on the same day of service as G9001.	patient 15. Time Frame for Follow Up 16. Visit Duration: 5-10 min 11-20 min 21-30 min (total time of all calls on a single date of service) 17. Documentation supports consent from the Patient that reflects they have agreed to such phone contacts being initiated by Care Managers or care team.

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Code	Description	Who can provide service?	Payers	PDCM BCBSM	SIM	Notes	Documentation
99358, 99359: Prolonged E/M Service	99358: Prolonged E/M service before and/or after direct patient care, first 60 minutes 99359: Prolonged E/M service before and/or after direct patient care, each additional 30 minutes (listed separately with 99358)	Physicians; Nurse Practitioners; Physician Assistants	Medicare	N	N	**Medicare** CCM and complex CCM reimburse providers for clinical staff time spent providing care management services, not time spent by physicians. For those cases in which a physician spends a significant amount of time outside the usual office visit addressing an individual patient's needs, CMS will make payment under these two codes beginning in 2017. In discussing these services, CMS warns the time counted toward these codes must be separate and distinct from time spent providing any other service reimbursable under the MPFS including, but not limited to, new and established patient office visits, transitional or chronic care management services or care plan development. The CPT prefatory language and reporting rules apply for the Medicare billing of these codes, for example, CPT codes 99358 and 99359:	Description: CCM and complex CCM reimburse providers for clinical staff time spent providing care management services, not time spent by physicians. For those cases in which a physician spends a significant amount of time outside the usual office visit addressing an individual patient's needs Documentation: 1. Duration of visit 2. Content of the medically necessary evaluation and management service and prolonged services that you bill 3. Direct face-to-face time with the patient 4. Start and end times of the visit 5. Date of service. For details and complete listing of Prolonged E/M service elements: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm5972.pdf

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					• Cannot be reported during the same service period as complex Chronic Care Management (CCM) services or transitional care management services • Are not reported for time spent in non-face-to-face care described by more specific codes having no upper time limit in the CPT code set.	

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Code	Description	Who can provide service?	Payers	PDCM BCBSM	SIM	Notes	Documentation
99487, 99489: Complex Chronic Care Coordination Services	99487: BCBSM/Priority Health 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. Medicare 60 minutes of care management services each 99489: BCBSM/Priority Health 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)	BCBSM/BCBSM MA Lead Care Manager and Other Care Team Members Priority Health QHP Medicare Physicians; Certified Nurse Midwives; Clinical Nurse Specialists; Nurse Practitioners; or Physician Assistants working in a practice that meets all CCM program requirements- *"Incident to" applies.	BCBSM Commercial, BCBSM Medicare Advantage, Priority Health (all plans except Medicaid), Medicare	Y	N	**BCBSM/Priority Health Description:** For time spent interacting with other providers and/or community agencies in the medical neighborhood to coordinate services needed to manage the patient (time spent communicating with the patient, the patient's PCP or the patient's primary care giver is not included) **Conditions of Payment:** • May be by phone or person-to-person • Accumulated time must be 31 minutes to bill 99487 **Claims Reporting Requirements:** • Reported once per calendar month to encompass accumulated time. Bill at the end of the month	Description: For time spent interacting with other providers and/or community agencies in the medical neighborhood to coordinate services needed to manage the patient (time spent communicating with the patient, the patient's PCP or the patient's primary care giver is not included) Documentation: 1. Date of Contact 2. Duration of Contact 3. Name and Credentials of the allied professional on the Care Team making the contact 4. Identification of the Provider or community agency with whom the discussion is taking place 5. Nature of the discussion and pertinent to the patient's individualized care plan and goal achievement. Priority Health- Include documentation fields listed above in "all payer" section, plus the following: · Diagnoses discussed · Care Team coordination activities · Names of providers contacted in the course of coordinating care. · Development and/or maintenance of the Care Plan

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	Medicare Add-on code to 99487, for each 30-minute increment that does beyond 60 minutes					utilizing the last encounter date **Quantity Limits:** • 99487 may only be billed once per calendar month, per patient • 99489 may be quantity billed **Medicare** The billing rules for CCM (CPT 99490) and complex CCM are the same, except complex CCM requires 60 minutes of non-face-to-face care management services per month, as compared to 20 minutes for CCM. CMS also will pay for an add-on code for complex CCM, CPT 99489, for each 30-minute increment that goes beyond the initial 60 minutes.	Medicare- Include documentation fields listed above in "all payer" section, plus the following: · Verbal consent is documented in the medical record, and information must be explained to the patient for transparency · Comprehensive Care Plan for all health issues Problem list · Expected outcome and prognosis · Measurable treatment goals · Symptom management · Planned interventions and identification of the individuals responsible for each intervention · Measurable treatment goals · Medication management · Community/social services ordered · A description of how services of agencies and specialists outside the practice will be directed/coordinated · Schedule for periodic review and, when applicable, revision of the care plan "Incident to applies" For details and complete listing of CCM service elements: 1) https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf 2) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Payment-Chronic-Care-Management-Services-FAQs.pdf

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G9007: Coordinated care fee, scheduled team conference	Primary Care Practitioner __BCBSM/BCBSM MA__ Lead Care Manager and Other Care Team Members __Priority Health__ Physician __MHP SIM PCMH__ Initiative 1. PCP+CM/CC OR 2. Primary CM/CC + Specialty CM/CC OR 3. PCP+CM/CC+SCP	BCBSM Commercial, BCBSM Medicare Advantage, Priority Health, MHP SIM PCMH (tracking code)	Y	Y	__All Payers__ __Description:__ Scheduled meetings between PCP and care manager to discuss a patient's care plan (without the patient present). Can be conducted face-to-face, by telephone or by secured video conference. __Conditions of Payment:__ • To be billed by the primary care practitioner and payable only to the primary care practitioner. • Based on a change in the patient's care plan • Discussions must be focused on the patient's individualized care plan (including significant change in patient status and/or unresolved barriers) and goal achievement • Outcomes and next steps for each patient must be agreed upon and documented • Documentation can be completed by the physician or the care manager __Claims Reporting Requirements:__ Bill separately for each patient discussed __Quantity Limits:__ Limit of one G9007 paid per primary care practitioner, per practice, per patient, per day. This limit does not apply across specialty types; for example, when a patient is being managed by both a PCP care manager and an oncology care manager, both care managers	Description: Scheduled meetings between Primary Care Practitioner and care manager to discuss a patient's care plan (without the patient present). Can be conducted face-to-face, by telephone or by secured video conference. Documentation: 1. Date of Team Meeting 2. Duration of discussion for individual Patient 3. Name and credentials of allied professionals present for Team Conference 4. Nature of the discussion and pertinent details 5. Any revisions to the Care Plan Goals, Outcomes, Interventions, and Target Dates. Outcomes and next steps for each patient must be agreed upon and documented. Priority Health- Include documentation fields listed above in "all payer" section, plus the following: · Diagnoses discussed · Treatment Plan, Self-Management Education, Medication Therapy, Risk Factors, Unmet Care, Physical Status, Emotional Status, Community Resources, Readiness to Change. Tip: self-management goals. · Physician coordination activities and approval of Care Plan · Billed under the physician and is payable only to the physician · Physician approval of care plan

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G9008: Engagement Fee for Physician Coordinated Care Oversight Services	Physician BCBSM/BCBSM MA Physician Priority Health Physician	BCBSM Commercial, BCBSM Medicare Advantage, Priority Health (all PH plans)	Y	N	**All Payers** **Description**: Engagement fee billed by physician at the initiation of care management. Differs from G9001 in that G9001 is the comprehensive assessment and care plan development activities conducted by the care manager. **Conditions of Payment:** • E&M visit performed by the physician must be simultaneously or previously billed for the patient (for Priority Health: in close proximity to the visit date) • A G9001 or G9002 performed by the care manager must be (for BCBSM: simultaneously or previously billed for the patient) or (for Priority Health: billed in close proximity to this visit date) • Patient/care giver understanding and agreement to care plan • Service must include completion of patient assessment. • Bill code after the patient enrolls in a care management program. **BCBSM/BCBSM MA** • Care plan must be formally shared between the physician and care manager and patient via direct interaction. Ideally, this interaction will be face-to-face with all three parties present; however, if not simultaneous, the patient must have received at least one face-to-face care	Description: Engagement fee billed by physician at the initiation of care management. Differs from G9001 in that G9001 is the comprehensive assessment and care plan development activities conducted by the care manager. Documentation: 1. A written, shared action plan for the patient developed by the Lead Care Manager that has been reviewed and approved by the billing physician 2. Formal acknowledgement by the Patient that they understand and consent to the Care Plan and associated goal, and that they agree to be actively engaged in the activities identified in that plan to meet identified goals 3. Documentation reflects Patient's agreement to participate in Care Management Priority Health- Include documentation fields listed above in "all payer" section, plus the following: · PCP approval of care plan · Date of Visit · Appointment Duration · Care Team Member Names and Credentials · Name of Care Giver and Relationship to Patient if caregiver is included with the visit · Diagnoses discussed · Treatment Plan, Self-Management Education, Medication Therapy, Risk Factors, Unmet Care,

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					management service, and the physician needs to have bridged the patient and care manager through direct interaction with both. • **Quantity Limits:** May be billed only one time per patient, per lifetime, per physician. If a patient switches physicians, the new physician may also bill this procedure code **Priority Health** • Service must include patient face-to-face: Either face-to-face with PCP, patient and care manager, OR face-to-face with patient and care manager, with care manager/PCP direct involvement on a separate occasion. **Quantity Limits**: Billable one time per practice during the time the patient is a member of the practice	Physical Status, Emotional Status, Community Resources, Readiness to Change · Physician coordination activities and approval of Care Plan

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Multi-payer G and CPT Care Management Code Summary v8.1 Note: This multi-payer table has interim updates (see green font below for updates). This version of the Multi-payer table is undergoing a review process and the updated version will be available by mid-March 2018)

Code	Who can provide service?	Payers	PDCM BCBSM	SIM	Notes	Documentation
99490: Chronic Care Management Code	Physicians; Certified Nurse Midwives; Clinical Nurse Specialists; Nurse Practitioners; Physician Assistants working in a practice that meets CCM program requirements Priority Health Medicare Physicians	All Medicare Advantage plans, Medicare FFS, Priority Health Medicare *"Incident to" applies.	N	N	**All Payers** **Description:** Non-face-to-face care coordination services furnished to beneficiaries with multiple chronic conditions **Conditions of Payment:** • A physician may simply document in the medical record that certain information regarding CCM was furnished to the patient. • Must take at least 20 minutes of staff time over the course of one month • Work must be directed by a physician or qualified health professional • Patients must have two or more chronic conditions that place them at a significant risk of death, acute exacerbation/decompensation, or functional decline • Care plan must be implemented, revised or monitored during the course of care • Clinical staff incident to the billing physician or non-physician practitioner (under general supervision) count toward the minimum amount of service time required to bill the CCM service • CMS requires the billing practitioner to furnish an Annual Wellness Visit (AWV), Initial Preventive Physical Examination (IPPE), or comprehensive evaluation and management visit to the patient prior to billing the CCM service, and to initiate the CCM service as part of this Patient Agreement exam/visit. **Quantity Limits:** Can be billed once per month	Description: Non-face-to-face care coordination services furnished to beneficiaries with multiple chronic conditions Documentation: 1. Verbal consent is documented in the medical record, and information must be explained to the patient for transparency 2. Comprehensive Care Plan for all health issues typically includes, but is not limited to, the following elements: 3. Problem list 4. Expected outcome and prognosis 5. Measurable treatment goals 6. Symptom management 7. Planned interventions and identification of the individuals responsible for each intervention 8. Measurable treatment goals 9. Medication management 10. Community/social services ordered 11. A description of how services of agencies and specialists outside the practice will be directed/coordinated 12. A person centered, electronic care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment, and an inventory of resources (a comprehensive plan of care for all health issues, with particular focus on the chronic conditions being managed) 13. Schedule for periodic review and, when applicable, revision of the care plan For details and complete listing of CCM service elements:

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*For BCBSM code applies to PDCM, BDTC and HICM services as stated above.

Multi-payer G and CPT Care Management Code Summary v8.1   Note: This multi-payer table has interim updates (see green font below for updates). This version of the Multi-payer table is undergoing a review process and the updated version will be available by mid-March 2018)

						• https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf • https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Payment-Chronic-Care-Management-Services-FAQs.pdf

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Code	Who can provide service?	Payers	PDCM BCBSM	SIM	Notes	Documentation
G0506: Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services, including assessment during the provision of a face-to-face service	Billing Practitioner Priority Health Physician	Medicare, Priority Health Medicare	N	N	This code extends payment for CCM initiating visits that require extensive face-to-face assessment and care planning by the billing provider: When the provider billing and initiating CCM personally performs extensive assessment and care planning beyond the usual effort described by the E/M, AWV, or IPPE code, the provider could also bill G0506. This is considered an add-on code and does not require a modifier. You can bill this code separately from the monthly care management service codes (99490, 99487, and 99489). However, the time and effort described by G0506 cannot also be counted toward another code. G0506 can only be billed once per patient per provider.	Description: Comprehensive assessment of and care planning for patients requiring chronic care management services, extends payment for CCM initiating visits that require extensive face-to-face assessment and care planning by the billing provider: Documentation: 1. Extensive assessment and CCM care planning beyond the usual effort described by the separately billable CCM initiating visit

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Multi-payer G and CPT Care Management Code Summary v8.1 Note: This multi-payer table has interim updates (see green font below for updates). This version of the Multi-payer table is undergoing a review process and the updated version will be available by mid-March 2018)

Code	Who can provide service?	Payers	PDCM BCBSM	SIM	Notes	Documentation
99495: Transitional Care Management	MD and DO of any specialty, NP, PA, CNS, or CNM. Provider does not need to have an established relationship with the patient. MHP SIM PCMH Initiative CM/CC	Medicare, Medicare Advantage, Medicaid, Priority Health (all plans), Medicaid SIM PCMH (tracking code) *"Incident to" applies.	N	Y	**All Payers** **Description:** Transitional care management services for patients whose medical and/or psychosocial problems require **moderate** complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domicile, rest home, or assisted living). **Conditions of Payment:** • The practitioner must communicate with the patient by the end of the day on the second business day following the day of discharge. Communication can be face-to-face, phone, or email. • Face–to-face visit is required **within 14 days of discharge** • The first face-to-face visit is not reported separately, though E&M services provided after the first face-to-face visit can be billed (with some exceptions)	Description: Transitional care management services for patients whose medical and/or psychosocial problems require **moderate** complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domicile, rest home, or assisted living). Documentation: 1. Date of visit 2. Date of interactive contact with the beneficiary and/or caregiver 3. Electronic, telephone or face to face 4. Place of service 5. Complexity of medical decision making moderate. Documentation of any medical or psychosocial problems. Testing ordered, reviewed. Consultations with other providers. Indication of number of problems (established or new) 6. Diagnosis: Report the diagnosis(s) for the conditions requiring TCM services. General conditions the patient at the time of discharge. 7. Medication reconciliation and management no later than the date of the face-to face visit

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Multi-payer G and CPT Care Management Code Summary v8.1   Note: This multi-payer table has interim updates (see green font below for updates). This version of the Multi-payer table is undergoing a review process and the updated version will be available by mid-March 2018)

					Quantity Limits and other Limitations: • Medicare and Priority Health will only pay one physician or qualified practitioner for TCM services per beneficiary per 30-day period following a discharge • The provider who reports a service with a global period of 010 or 090 days may not also report the TCM service **MHP SIM PCMH Initiative** • Can be reported on the same day of service as G9001.	CMS-Include documentation fields listed above in "all payer" section, plus the following: · Date of beneficiary discharge · Applicable physical exam findings For details and complete listing of TCM service elements: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

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Multi-payer G and CPT Care Management Code Summary v8.1

Note: This multi-payer table has interim updates (see green font below for updates). This version of the Multi-payer table is undergoing a review process and the updated version will be available by mid-March 2018)

Code	Who can provide service?	Payers	PDCM BCBSM	SIM	Notes	Documentation
99496: Transitional Care Management	MD and DO of any specialty, NP, PA, CNS, or CNM. Provider does not need to have an established relationship with the patient. __MHP SIM PCMH Initiative CM/CC__	BCBSM, Medicare, Medicare Advantage, Medicaid, Priority Health (all plans). Medicaid SIM PCMH (tracking code) *"Incident to" applies.	N	Y	__All Payers__ __Description:__ Transitional care management services for patients whose medical and/or psychosocial problems require __high__ complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domicile, rest home, or assisted living). __Conditions of Payment:__ • The practitioner must communicate with the patient by the end of the day on the second business day following the day of discharge. Communication can be face-to-face, phone, or email. • Face–to-face visit is required __within 7 days of discharge__ • The first face-to-face visit is not reported separately, though E&M services provided after the first face-to-face visit can be billed	Description: Transitional care management services for patients whose medical and/or psychosocial problems require __high__ complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domicile, rest home, or assisted living). Documentation: 1. Date of visit 2. Date of interactive contact with the beneficiary and/or caregiver 3. Electronic, telephone or face to face 4. Place of service 5. Complexity of medical decision making high. Documentation of any medical or psychosocial problems. Testing ordered, reviewed. Consultations with other providers. Indication of number of problems (established or new) 6. Diagnosis: Report the diagnosis(s) for the conditions requiring TCM services. General conditions the patient at the time of discharge. 7. Medication reconciliation and management no later than the date of the face-to face visit CMS-Include documentation fields listed above in "all payer" section, plus the following: · Date of beneficiary discharge · Applicable physical exam findings

Note: Practices in the SIM PCMH Initiative are required to submit tracking codes to the Medicaid Health Plans in order to track the level of participation and services rendered.
*For BCBSM code applies to PDCM, BDTC and HICM services as stated above.

						(with some exceptions) **Quantity Limits and other Limitations:** • Medicare and Priority Health will only pay one physician or qualified practitioner for TCM services per beneficiary per 30-day period following a discharge • The provider who reports a service with a global period of 010 or 090 days may not also report the TCM service **MHP SIM PCMH Initiative** • Can be reported on the same day of service as G9001. **BCBSM** 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 (G 9002, 98966, 98967, 98968) at the same time if the work is related to "Transition of Care."	For details and complete listing of TCM service elements: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf BCBSM 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" 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 (G 9002, 98966, 98967, 98968) at the same time if the work is related to "Transition of Care."

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Code	Description	Who can provide service?	Payers	PDCM BCBSM	SIM	Documentation
99497, 99498: Advanced Care Planning	99497: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; **first 30 minutes**, face-to-face with the patient, family member(s), and/or surrogate. 99498: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; **each additional 30 minutes** (List separately in addition to code for primary procedure.)	RNs, Certified NPs, PA-Cs, Licensed Masters Social Workers (LMSWs), Psychologists (LLPs and PhDs), Certified Diabetic Educators (CDEs), Registered Dieticians and Masters'-trained nutritionists, Clinical Pharmacists, Respiratory Therapists *"Incident to" applies.	Medicare, Medicare Advantage, Priority Health Commercial and Medicare, BCBSM Commercial	N	N	Description: The explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional. Documentation: 1. Total time in minutes 2. Patient/surrogate/family "given opportunity to decline" 3. Details of content/discussion a. (e.g. Who was involved? What was discussed? Understanding of illness, spiritual factors.) 4. Why are they making the decisions they are making? 5. Was any advance directive offered/filled out, if yes describe? 6. Follow-up Priority Health- Include documentation fields listed above in "all payer" section, plus the following: · A person designated to make decisions for the patient if the patient cannot speak for him or herself · The types of medical care preferred · The comfort level that is preferred · (Required for Medicare Advantage only): Patient consent for ACP performed as part of an annual wellness visit · How the patient prefers to be treated by others · What the patient wishes others to know Adequate documentation also requires an indication of whether or not an advance directive or POLST (physician orders for life-sustaining treatment) document has been completed For more information on Medicare Advance Care Planning: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

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Code	Description	Who can provide service?	Payers	PDCM BCBSM	SIM	Notes	Documentation
G0502, G0503, G0504: Behavioral Health Integration (BHI): Monthly services furnished using the Psychiatric Collaborative Care Model (CoCM)	G0502: First 70 minutes in the first calendar month to allow for the add on code. Assumed Billing Practitioner Time 30 min G0503: First 60 minutes in the subsequent calendar month to allow for the add on code Assumed Billing Practitioner Time 26 min G0504: Add-On CoCM (Any month) Each additional 30 minutes per calendar month; Assumed Billing Practitioner Time 13 min	A physician and/or non-physician practitioner (PA, NP, CNS, CNM); typically, primary care, but may be of another specialty (e.g., cardiology, oncology) Priority Health Physician	Medicare, Priority Health Commercial and Medicare	N	N	CoCM is a model of behavioral health integration that enhances "usual" primary care by adding two key services: care management support for patients receiving behavioral health treatment; and regular psychiatric inter-specialty consultation to the primary care team, particularly regarding patients whose conditions are not improving. Care Team Members • Treating (Billing) Practitioner – A physician and/or non-physician practitioner (PA, NP, CNS, CNM); typically primary care, but may be of another specialty (e.g., cardiology, oncology) • Behavioral Health Care Manager – A designated individual with formal education or specialized training in behavioral health (including social work, nursing, or psychology), working under the oversight and direction of the billing practitioner	1. Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan 2. Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant 3. Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies. 4. Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers 5. Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant 6. Monitoring of patient outcomes using

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| | | | | | | • Psychiatric Consultant – A medical professional trained in psychiatry and qualified to prescribe the full range of medications
 Beneficiary – The beneficiary is a member of the care team | validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment. |

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Code	Who can provide service?	Payers	PDCM BCBSM	SIM	Notes	Documentation
G0507: Behavioral Health Integration (BHI): Monthly care management services furnished using BHI models of care other than CoCM	A physician and/or non-physician practitioner (PA, NP, CNS, CNM); typically, primary care, but may be of another specialty (e.g., cardiology, oncology, psychiatry) Priority Health Physician	Medicare, Priority Health Commercial and Medicare	N	N	This code is used to bill monthly services furnished using BHI models of care other than CoCM that similarly include "core" service elements such as systematic assessment and monitoring, care plan revision for patients whose condition is not improving adequately, and a continuous relationship with a designated care team member. G0507 may be used to report models of care that do not involve a psychiatric consultant, nor a designated behavioral health care manager (although such personnel may furnish General BHI services). The service may be provided in full by the billing practitioner. Alternatively, the billing practitioner may use qualified clinical staff to provide certain services using a team-based approach. These clinical staff may- but are not required to- include a designated behavioral health care manager or psychiatric consultant. Staff Threshold Time: At least 20 minutes per calendar month Assumed Billing Practitioner Time: 15 min	Description: Care management services for behavioral health conditions Documentation: 1. Initial assessment or follow-up monitoring, including the use of applicable validated rating scales; 2. Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes 3. Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team

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Code	Who can provide service?	Payers	PDCM BCBSM	SIM	Notes	Documentation

S0257: Face to face or telephonic counseling and discussion regarding advance directives or end of life care planning and decisions	Lead Care Manager, Physician and other care team members	BCBSM Commercial, BCBSM Medicare Advantage, Priority Health Commercial and Medicare Advantage Products	Y	N	**All Payers**
					Description: Individual face-to-face or telephonic conversations regarding end-of-life care issues and treatment options conducted by qualified allied health personnel on the care management team with patients enrolled in care management (and may include the patient's caregiver/family) for purposes of developing or revising a documented advance care plan.
					Claims Reporting Requirements: All active dx should be reported.
					Quantity Limits: None.
						Description: Individual face-to-face or telephonic conversations regarding end-of-life care issues and treatment options conducted by qualified allied health personnel on the care management team with patients enrolled in care management (and may include the patient's caregiver/family) for purposes of developing or revising a documented advance care plan.
						
						Documentation:
						1. Enumeration of each Encounter including:
						   a. Date of Service
						   b. Duration of Contact
						   c. Name and credentials of the allied professional delivering service
						   d. Other individuals in attendance (if any) and their relationship with the Patient
						   e. All active Diagnoses
						2. Pertinent details of the discussion (and resulting Advance Care Plan decisions), which, at a minimum, must include the following:
						   a. A person designated to make decisions for the Patient if the Patient cannot speak for him or herself
						   b. The types of medical care preferred
						   c. The comfort level that is preferred
						3. Advance Care Planning discussions/decisions may also include:
						   a. How the Patient prefers to be treated by others
						   b. What the Patient wishes others to know
						4. Indication of whether or not an Advance Directive or Physician Orders for Life-Sustaining Treatment (POLST) document has been completed

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BILLING AND CODING RESOURCES

ELECTRONIC VERSION OF THIS GUIDE AND FUTURE UPDATES: This guide is updated quarterly and placed electronically on the Care Management Resource Center's Care Management Billing Resources link at : http://micmrc.org/training/care-management-billing-resources.   Additional resources specific to individual payers can also be found here.

MEDICAID SIM PCMH Tracking Code Guide (for submitting tracking codes to Medicaid Health Plans for eligible care coordination and management SIM PCMH Initiative services). The MEDICAID SIM PCMH Tracking Code Guide is available in the 2018 SIM PCMH Participation Guide: http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64491_76092_77452---,00.html

CMS has published an electronic resource called "CMS Connected Care: The CCM Toolkit for Professionals" that offers : https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/chronic-care-management.html

PRIORITY HEALTH also makes available online two resources:
- An online provider manual with care management service codes in the "Procedures and services section" of https://www.priorityhealth.com/provider/manual/billing-and-payment/services/care-management-codes
- A printable version of contracted billable codes at: https://www.priorityhealth.com/provider/manual/billing-and-payment/services/~/media/documents/provider-billing/expanded-services-billable-codes.pdf
- Please note that certain care management code claims submitted for services delivered are batched and paid by Priority every 60 days to allow for the claim to be processed and for any member liability to be removed. This important step allows for care management services to be delivered without members incurring financial liability, reducing barriers to engaging patients in care management. This batching/delayed payment process affects the following care management codes: G codes, telephonic CPT, and collaborative care management CPT codes. If you have questions about any of this information, please contact your Provider Performance Specialist.

Reference: This document is produced by the Michigan Care Management Resource Center and Statewide Multipayer Initiative Support, University of Michigan

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*For BCBSM code applies to PDCM, BDTC and HICM services as stated above.