PCMH User Group Highlights 4/25/19

Slides from presentations are attached to email and on website (slides and highlights under PCMH User Group)

PLEASE REVIEW SLIDES AS THEY ARE NOT ALL REPEATED BELOW – just highlights

Lori Boctor, BCBSM spoke about Provider Delivered Care Management billing and Sandy Stimson, BCBSM updated on Member Transfer Process. Below is a transcript; Lori is the main speaker.

(Note: Q: denotes a question).
Good afternoon. I'm Lori Boctor with Blue Cross and Blue Shield of Michigan. I am part of the reimbursement team of Value Partnership. First, I do want to apologize for not being able to make it here in February, like it was initially planned. So, what I'd like to do today is just to make this very informal and interactive. We've had a lot of changes, which I'm sure everyone is aware of, with the CM program for the hosted members - I'll kind of talk about those issues that never seem to end. And then please feel free to ask questions as I go through the presentation. It's only five or six slides. I want to kind of make it very informal and very interactive because it's more of me coming here to answer your questions if you do have them.

Okay. So, for eligibility, Blue Cross and Blue Shield in Michigan, we do have two different benefits system. One is called MOS, which stands for the Michigan Operating System. And then the other one is NASCO. So, the Michigan Operating System actually houses all of our local groups. For example, as Blue Cross and Blue Shield of Michigan employees, we're considered a local group because there is no Blues office outside the State of Michigan. NASCO, on the other hand, houses all of our national groups, which would be like your Ford, your GM, your Chryslers. For the Michigan Operating System, how many of you guys are familiar with WebDenis? Okay. It's a little bit more challenging for local groups because when you log into WebDenis and you try to look and see if someone has the benefit, you go through something called benefit explainer and then you have to put in a procedure code and then you look under coverage. It's either covered status or coverage limitations and it will say payable or not payable.

Whereas the NASCO groups, it's black and white under the message section, it spells it out and says this member participates in the value-based programs/provider delivered care management program. To try to alleviate some of the headaches with eligibility, I did create a list of groups that are not participating in the Provider Delivered Care Management program. This list is available. Kris has sent it out, and will send out again. If you guys do not have this list, it does show the groups that are commercial that are not included as well as there's another tab for the Medicare Advantage population groups that are not included.

So, Medicare Advantage population, when you go in to check WebDenis, you're not going to see anything out there that says this member participates in provider delivered care management. And the reason being is because, and this is what I've been told, it's a CMS rule, you can only put the core benefits and provider delivered care management is considered like a little enhancement to the benefit.

There are four groups that are excluded. Two of those groups are the largest population of Medicare Flex Blue members. The first one is MPSERS which is school retirees. And then the other one is URMBT, which is the

automotive retirees. The third group is our own Blue Cross and Blue Shield of Michigan Retirees. It was a benefit that was overlooked during negotiations. So hopefully this year, in the contract year, it will be included or they will be included. And then the Accident Fund Retirees. So, this list, that I put together, it does give you the name of the group as well as the group number. So, you could actually look at the member's ID card. Now you will still need to make sure the member has an active contract, because you know, benefits change, people lose their job, people change jobs, etc. But hopefully this will assist and not be so cumbersome when trying to check eligibility. Okay. Any questions?

Value based programs aka hosted members. I get a lot of emails about the hosted members. So first and foremost, I'm going to try to explain the Blue Distinction Total Care program, which relates to the hosted members and a lot of the issues that are surrounding that program. BDTC started in 2016 and it was a mandate by the Blue Cross and Blue Shield Association that said: Blues plans, if you have some sort of care management in place, we want you to utilize this care management program for members that reside in your state, but have coverage through another Blue Cross plan. So as a result of that, most plans - out of the 36 there are only 34 that are doing a claim bank. Most plans are paying a per member per month attribution reimbursement to their providers.

Blue Cross and Blue Shield of Michigan is one of the four plans that are doing a fee for service model. So as a result of that, there's a lot of things that relate to BDTC. Number one is you're never going to be able to confirm eligibility for a member. All you can confirm on Web Dennis is that they have an active contract. If you were to call another Blue Cross plan, that other Blue Cross plan, their provider service representative may not even know what you're talking about because remember we're only one of 36 plans that are doing fee for service model. All the other ones are doing that per member per month reimbursement.

So, we don't provide a list of eligible patients. When we first started doing BDTC, we were providing a list of eligible patients, right? Because we receive a file every single month from the various plans and we've put it all together and make that pretty little patient list. We all know that that patient list was wrong. It was incorrect. People were showing up as being eligible but when claims were submitted, they were being denied. So, about a year and a half ago, we did post an announcement on our collaboration site that said, if you render services for members that are hosted, keep in mind you may get paid and you may not get paid. So, we were recommending that practices don't reach out to those members because I have no way of getting those claims paid unfortunately.

Secondly, as I mentioned before, there's no way to confirm eligibility for care management in WebDenis. All you can do is confirm that they have an active contract. The majority of other Blues plans are reimbursing at a per member per month reimbursement to their providers. As I mentioned, we're only one of 36 plans that are actually doing a fee for service model.

Some Blues plans reimburse one care coordination service per month. That's the way that they have set it up. So, if you do a G9002 as well as, say, a telephone call in that same month and you submit those claims, whatever claim comes in first it's going to get paid. But the second claim is going to get denied.

Anthem and HCSC, which are the two largest conglomerates of Blues plans do not pay for any of the telephone-based services. The 98966,67,68 and 99487 and 89 codes. Those are considered, according to those plans, a specific exclusion. If you submit a telephone call for a member that has Blue Cross of Illinois coverage, that claim is going to reject.

Procedure codes for care management services, they must be submitted on separate claim form. So, for example, if you do two services in one day, you actually have to submit two separate claims form. It's just the way the program was set up. Unfortunately, I had no say in that.

And then lastly, if the practice or the physician chooses to render the care management services, just keep in mind, that there is no guarantee of payment as the coverage is through another Blues plan and it's based on their benefits and their protocol.

So how many practices here render services for the hosted members? Quite a few. Okay. Are there any questions about that?

Q: Is there an easy way to look on their card and how many are they hosted or not?

- There is not.
- I'll give you an example. Anthem typically will have a AN in the ID number that identify as it might be an Anthem member. As to which plan, which state, I have no idea.
- There is not an easy way to identify hosted members.
- The only thing I can recommend is, you know, you can ask your patients when they come to the office. "Do you have Blue Cross and Blue Shield of Michigan coverage or do you have coverage through another Blue Cross plan?"
- AUDIENCE stated that card will say whether it is Michigan BCBS or not

I am not going to go into a lot of detail relative to the codes that are eligible for reimbursement for the provider delivered care management program. The good news is it's still the same 12 procedure codes. We have made a lot of changes relative to those procedure codes and the reimbursement and criteria for reimbursement. Let me clarify that.

- The first one is the G9001, which is that comprehensive assessment.
- The next code is the G9002, which is that coordinated care fee. Basically, like a follow up. Some people actually use the G9002 to do a small goal setting care plan.
- We have two group education/meeting codes and they are the 98961 and 98962. The only difference is in the nomenclature is the number of patients that you may have within that group setting. Does anybody do any types of group visits right now in your practice?
- We have three telephone-based services. They're the 98966, 98967 and 98968, and again, the only difference in the nomenclature is the number of minutes that you may be talking to your patient during that phone call.
- The next two are the 99487 and 99489 and those are care coordination. When you're coordinating care on behalf of your patient in the medical neighborhood. Perhaps you are calling that DME company or you are calling meals on wheels or a transportation service.
- We have the team conference, which is the G9007,and that is when you're discussing any type of positive or negative changes in your patient with your physician.

- G9008, that is the coordinated care oversight, basically known as the enrollment fee. We've made a number of changes for the G9008 this year.
- The last code is the SO257 which is that end of life counseling or advance directive.

So, basically the same codes; the criteria have changed on a number of the codes.

All right, so these are the big changes for 2019 to the PDCM program.

How many of you guys received the new billing guidelines? I'm sure everyone received the new billing guidelines. Okay. We used to have about a 25-page document of criteria that you had to meet in order to bill. We made this program, I think, a little too challenging for practices. You guys know your patients better than Blue Cross and Blue Shield of Michigan does. Right? Right. We were very prescriptive, which we are not prescriptive on any other programs or any other code. So, as a result of that, a year and a half of going back and forth, we condensed the billing guidelines down to less than five pages. To make it easier and a lot less challenging for you guys to render care management services to our members. So, the big change is the onus is really on your physician or your provider. That provider knows their patients. That provider knows what that patient needs and the goals that need to be set.

And you're going to see, well, you may have already seen this. If you sent any type of question to me and you asked me “Lori, can I bill 98966 if I'm an LPN”. The response I send back now is if your physician is in agreement, you're working within your scope of licensure, and you're meeting their requirement of the code, bill it. Okay. That's the bottom line because the provider knows their patients better than Blue Cross.

The second thing is there's no longer a distinction between a lead care manager. Lead care managers, it can be anybody, and they do have to go through certain training requirements. There was a document that was put out. How many of you guys were considered the lead care manager previously? Okay, so you don't have to do any type of training other than the norm. The normal, you know the eight hours of continuing ed. Right, but is there a pharmacist here in the room? AUDIENCE: on the phone. Okay. The pharmacist that is on the telephone: you could actually be considered a lead care manager now. Okay. So long as you do one of two things. The complex care management training, the online Blue Cross and Blue Shield of Michigan billing webinar, as well as the eight hours of continuing ed. The self-management training that used to be a requirement for lead care managers is now an option for Blue Cross. If you are not going to bill the G9001, that comprehensive assessment, all you have to complete is the complex care management training or self-management training, the online billing course, as well as the eight hours of continuing ed.

That would apply to all the other codes, the G9002, the telephone based services, the SO257, the care coordination, etc. If you're not going to bill for the G9001 and do a comprehensive assessment, those are your requirements. If you're billing and doing the comprehensive assessment, you must take the complex care management course and I know is Marie coming up this way, do you have people that need to be trained?

NPO: there is a self-management training in Cadillac next week, and I have sent that out. NPO has been told that POs will be able to offer the training and we plan to move forward with applying to be able to do that.

So, both community health workers and medical assistants can now actually render and bill for the 98966 that five to 10 minute conversation with the patient. That's a big change for this year. Medical Assistants used to only be able to build for what, the 99487 and 99489, care coordination in the medical neighborhood. We have expanded it to allow them to bill more, at least one of the telephone based services. Who knows, it may be expanded in the future to allow all three codes, but at this point, community health workers and medical assistants can only do the 98966 code. Additionally, the medical assistant will also have to go through the training in order to bill for those services: the billing training, the eight hours of continuing ed, and then the complex care or self-management. AUDIENCE: the online billing course is very short and interesting.

So, the quantity limits for the G9001 have been removed. Remember, prior to January of this year, a G9001 could only be conducted what, once a year? Once a year. That is no longer the case. So, I always get the question: well, when would I ever bill another comprehensive assessment in a year's time? You could have a patient that has a change in health status

And then this one I'm going to spend a lot of time talking about. The G9008 that is the physician code only, which means only the MD or DO can actually render the service but we have expanded to code to allow it to be billed multiple times.

- There's no longer a quantity limit of one per patient per physician, per lifetime
- We have a couple of questions then about the code:
- Can APPs bill that Code (mid levels)?
    - No.
- Please confirm it does count towards care management.
    - It does count towards care management
- Can it be billed within the 30 day global while the TCM code?
    - It is my understanding there should be able to bill TCM code as well as the G9008, as long as the service is separate and distinct. However, if you do have claim examples where the TCM code is the only one that is getting paid and the G9008 is rejecting, please send those to me because I have confirmed at our system with our systems area, there's nothing to stop it.
      AUDIENCE: well we had one come through, and it had to be billed separately.

LORI: And the TCM code, you were told that it had to be billed on a separate claim? I will confirm that because it was my understanding that they can both be billed on the same claim form.

Alright. The G9008 can now be used for multiple purposes. It's no longer just considered to be payable to get the patient engaged into the PDCM program by that provider. The provider can actually bill that if they are talking with a paramedic to alleviate an emergency department transportation or to another physician. Dr Simmer did give two examples in the March meeting. He gave: I'm a physician talking to a pathologist about what genetic testing is needed. And he gave the example of a physician talking to the ED physician while the patient is there in the ED to coordinate the care and determine follow-up.

- Q: What about if we have a patient in the office that we're sending to the ED and we called the ED Physician to let them know that history and facilitate?
    - If the physician is the one that's actually doing that, then it can be billed. That is my understanding.
- Q: And what kind of documentation is needed?
    - Do the same documentation that you've always done.
- Q: Within the progress note as a visit, or a separate telephone encounter?
    - I would say do it within the context of the visit.
    - So, bill, for the visit and bill the G9008.
- Q: As mid-levels we do this all the time as the PCP of our patient. So, we can't bill the G9008. Can we bill a care coordination code?
    - So, the question was for mid-levels that are doing this all the time, the G9008 cannot be billed by mid-levels, it has to be the MD or DO. The nomenclature of the G9008 specifically says physicians, which is why we can't change it. So, she wanted to know if she should be billing the care coordination or if you have the patient in the office you would be doing the G9002 right?
- Q: Well No. So, say I'm not seeing him for a care management. I've seen them for a regular visit and I'm sending him to the ER and I'm calling the doctor in the ER and I'm giving them the whole low down and

that kind of stuff. Or I'm coordinating with the pharmacist or whatever else beyond my visit. So, I've done my visit and then extra coordination stuff.
    - You could bill a 99487. Keep in mind that those are monthly codes. So, you have to add up to total time that you spent on that patient for that month. Right. But yes, you could do that.
- Q: But then those have copays and deductibles?
    - 99487 and 99489 should not have copayments or deductibles or coinsurance. They are part of the 12 PDCM codes where cost share is totally waived. So, if you have examples and they're not a hosted member, let me know that. I will tell you the group list that I have here. There are some groups that are considered flex linked groups, which means that they utilize our benefits, but they process their own claims. I have seen where these groups that are not participating, if a Care Management Service is billed, they either paid it and applied it to the deductible for that patient or they take cost share for that patient. And unfortunately, I have no way of getting them to correct it because they do their own claims processing. It's not Blue Cross processing. They're supposed to follow our rules and benefits, but that's not always the case. But please feel free, you know my email, just send me your example. Please send everything secure, or fax it to me; my fax number is listed on the bottom of my signature and it's an automatic fax that goes into my email.

Okay, so the G9008 can also be used to engage that patient in care management. One thing I do want to point out that the primary care PCMH designated physician that's doing provider delivered care management can bill for the G9008, as well as that pathologist, even though we know that pathologist is never going to have any type of care plan with the patient. Both of them can actually bill for the G9008 it has been expanded to allow those doctors that are doing this stuff daily get some sort of reimbursement for it.

NPO: So the question that has come up, and I said no, is they're getting a call from the radiologist or the pathologist about the abnormal or critical test result, and I said that's just an alert, and my description was there had to be a conversation.

- There does have to be a conversation, but I'd be happy to take the question back because we do meet every week and talk about the various questions that I receive and Barb Brady received or Lisa Rajt may receive and try to come up with an answer. For example, one of the ones that I've been getting a lot of is: if I have a practice and it's a fairly large practice with multiple specialties. So, you have a primary care physician who may be talking with an orthopedic surgeon about one of their patients even though they're in the same practice. Can they both bill the G9008? That has yet to be determined because we haven't met in the last couple of weeks and we're not meeting this Monday just so you know, I'm out of the office.

- Q: What about rounding at the hospital and speaking with a specialist on the floor?
    - So, I'm going to take that question back too, okay.
    - NPO: Just so you know, you're talking to a practice which is a residency program. That's why they're talking about rounds.
- Q: And that brings up another point. Can our residents bill the code?
    - I don't think residents can.
- Q: Just to clarify, I get a phone call from a radiologist wanting to discuss results and recommend further testing or whatever that constitutes conversation?
    - Yes
- Q: With the documentation, we could bill the G9008?

    - Only if that conversation is physician to physician. I just want to make sure that it is okay that it's somebody else calling that Physician. So that's why I'm going to take the question back.
- Q: These patients do not need to otherwise be involved in the care management program?
    - They should be involved in the care management program.
- Q: Already before all this happens?
    - Keep in mind initially the G9008 was for the enrollment fee to get that doctor engaged and talking to the patients about provider delivered care management. The hope is with us expanding the role of the G9008 that it will get more and more of the patients that are eligible for care management involved in care management.
- Q: What if the care plan has not been created and agreed upon by the patient for example transfer by ambulance, can the physician bill the G9008? Jamie, I'm guessing you mean the physician did talk to the ED physicians but then the patient backed out of care plan? I think that's the scenario
    - In that instance, yes. I mean, and again the hope is that the patient will get engaged in the care plan or engaged in care management.

I have three takeaways for the G9008

- TCM code on separate claim forms if they bill a TCM and a G9008
- Rounding on patients while they're inpatient can the physician bill for a G9008?
- And then the last one: If you have a radiologist is calling the physician and talking about the patient, can that physician bill for the G9008 as well as the radiologist?

- Q: Can limited licensed social worker bill for G9001?
    - Yes. Because we no longer have the distinction about the lead care manager. The lead care manager no longer has to be that RN, LMSW, CMP or PA. So long as that person is working within their scope of license, sure they meet the training requirements. That's the key thing for billing the G9001, then yes, they can do that.

Lastly, there are some physician organizations downstate that are actually partnering with ambulance companies. So, paramedics can now bill for a G9001 and a G9002 as well as the telephone based services if they're working in conjunction with that provider delivered care management position to alleviate a patient from being transported to the emergency room.

NPO: One of the first programs I read about was from New York and it's really great. The paramedic will see the patient and talk to the doctor as needed. They often don't need to transport. Wouldn't that be great in our community?

- Q: I have one more question, on the G9008, when we have our monthly care meetings on patients. If we have two physicians in there and we conference in a specialist such as cardiologists can both our physician bill that?
    - So, if you're doing a team conference, talking about your different patients, you would actually bill a G9007.

I'm going to ask you guys some questions, to see how well I did.

- For the G9001, the comprehensive assessment. Can you bill it multiple times throughout the year?
    - Yes
- Do we have technically a lead care manager anymore?
    - No

NPO: What's the biggest opportunities you see in billing that practices miss?

- So, I think the G9008 is because of the way it has been expanded. And like I said, physicians are doing this daily on a daily basis now. That's a big opportunity.
- I also think that a lot of, we see a lot of the telephone codes that are billed every single month. I think there's a lot of missed opportunities with the care coordination code. We don't see those very often and you know, they pay decently.
- I also think, too, that expanding the G9001 now to allow it based on patient need throughout the year instead of just once - there is some good opportunity with that.
- Q: So, I could see that could be used like a patient goes into the hospital, the discharge and there's the health, their health status is changed and then they go in for open heart, whatever. So, your care management team would do a reassessment on them, but you wouldn't bill that till after 30 days. Correct?
    - So, if you're doing a TCM, let me make sure I understand this question. If you're doing a transitional care management code, the 99495 and 99496, you can bill a PDCM code so long as the services are separate and distinct from that TCM code. Here's the example that I use all the time. You'd have a patient that was admitted, and they had a hernia operation. That patient gets discharged, you bring him into the office for their follow-up. And in the interim, you may have reached out to that patient and said, "Hey Lori, how is your A1C doing?" It's something that you were working with her on. Okay. Those are two separate and distinct diagnoses and services.

What's the most frequent issue or problem besides hosted?

- Telemedicine. We share some of the 12 PDCM codes with the telemedicine policy, the telephone-based services, the 98966, 67 and 68, as well as I want to say the G9002 if it is billed with the GT modifier. Last year we did have an issue where telephone services were, I believe, rejecting requesting a modifier. Unfortunately when we submit a defect in these, it takes a while for the system to get fixed and then claims to get reprocessed. So, speaking for provider delivered care management, I wish we would just leave these 12 codes strictly for PDCM and not expand them to other programs.

So, any other questions? Concerns?

- Q: So, we're at two touches and 3% this year, right?
    - Yes. Nothing changed for this year and I will be honest. Lisa Rajt is the one that handles the administrative part of provider delivered care management. If you do have a specific question relating to the value-based reimbursement and the program year in 2019 feel free to send that to me and I can, you know, send it on to Lisa or you can send it to Kris. 3% this year and 4% next year.

Any questions from anybody on the phone?

- Q: The G0511 which is the Medicare code for care management for Rural Health Clinics, what do you do with that code as it relates to the PDCM program?
    - We do count it towards the touch point for the value based reimbursement. I know a question has come up recently of how can we know who is attributed to us when, you're billing that code and I think Lisa is actually looking into that aspect. But we would count it towards the value based reimbursement for those Rural Health Clinics that have to bill it.
- Q: Then we had a question about whether the g codes can be billed for end of life planning conversation.

    - No. The G code should not be billed for the end of life planning or advanced directives discussions. You should be billing the SO257. You can bill a SO257 multiple times throughout the year. It's not a one and done kind of conversation.
- Q: Is there a specific time?
    - No there's no specific time, I don't think so unless it's in the nomenclature of the code. And it was always my understanding that anytime you have a conversation about advanced directives or end of life counseling, whether it starts with the physician or starts with the care team member, that code should be billed.
- Q: We have another question asking whether the g-codes can be billed with SO257.
    - Yeah, it could. You're, dealing with one condition, and then you might be talking about the advanced directives or end of life counseling. So yes, you can actually bill a G9002 and SO257 because there is no time limit. I'm talking about relating to care management. I'm talking about Blue Cross and Blue Shield of Michigan.

NPO and Lori: In the Multi-payer documents, one per patient per day per Blue Cross and it doesn't have a time requirement. Medicare certainly has the time requirements, but doesn't Medicare have their own code though? Yes, 99497

- Q: Say I have a Blue Cross Medicare am I having can I do the SO257 or do I have to do the Medicare one?
    - If you have a patient that is Medicare Plus Blue, which is our Medicare advantage plan, you can actually do the SO257 so long as that patient is eligible for the provider delivered care management program.

- Q: So, I have a lot of patients that are inpatient and the social work department saw them. If a patient is inpatient and I am following, I can still bill all these codes, right?
    - Yes. I mean you can do that because we don't have any location restriction. And I would assume that you would have some sort of care plan in place already with that patient and that patient is already enrolled and are engaged in care management.

- Q: Can you give an example of that along with the transition of care?
    - So, the transition of care would be after that patient is discharged and they're seen within either seven or 14 days.
    - If you wanted to bill for any of the 12 PDCM codes, you would have to make sure if you're doing the TCM and one of the 12 codes that there's a separate and distinct service. Remember I gave the example of the hernia, but yet you've been working with that patient on their A1C.

Well, if you do think of questions after I leave here today, I am out of the office for the next week, but please feel free to send them to Kris or you can send them directly to me, Lori Boctor and my email address is lboctor@bcbsm.com.

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NPO: Thank you very much, Lori.

NPO: Sandy, did you have anything you wanted to say today?

I just want to make note for primary care practices, on , the healthy blue portion, there is a NEW member transfer policy procedure and I don't know if all of you know. So, don't keep the old information. Just go on to the Blue Care Network, Healthy Blue, and on the very bottom under the resources (right hand side), there is a new member transfer process, there is a form, it goes into more detail, but my main thing that I tell practices is: before you start that process, always check WebDenis first because the member could have changed the PCP or the policy is canceled. On the Healthy Blue tool, that is a delay until the next refresh. That's not your most accurate. Before processing or going through all that procedure, check that first and that'll help. Hopefully, you know, maybe the member has already changed that, before you start those outreaches.

2019 meeting dates:

- Tues, 6/18/19 – 3 agenda items:
    - Cherie Bostwick, RN, Munson Family Practice – Reducing ED visits
    - Deb Schepperly, Thirlby – Transition of Care Visit Process
    - Christina Cicchelli – A1C and Nephropathy Measure Processes
- Wed, 8/21/19
- Thu, 9/26/19
- Tues, 10/22/19
- Wed, 11/20/19