

Provider-Delivered Care Management

Frequently Asked Questions

Revised – April 2019

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Useful Links

[PDCM Page on PGIP Collaboration Site](#) (approved users only)
[Michigan Care Management Resource Center](#)
[Comprehensive Primary Care Plus - Michigan](#)
[State Innovation Model - Michigan](#)
[Value Partnerships](#)

BACKGROUND and PARTICIPATION REQUIREMENTS

1. What is Provider-Delivered Care Management?

Provider-Delivered Care Management is an integral part of Blue Cross Blue Shield of Michigan's Patient-Centered Medical Home program, which is a core element of Value Partnerships' Physician Group Incentive Program.

Provider-Delivered Care Management involves the delivery of care management services by a trained care team working with a physician in an eligible primary care or specialist office.

2. Which physicians can participate in PDCM?

All Blue Cross Patient-Centered Medical Home designated physicians are eligible to bill for PDCM services, as well as non-designated physicians participating in the Comprehensive Primary Care Plus (CPC+) Initiative.

For more information on CPC+, please refer to the CPC+ FAQ or the CPC+ website.

Specialists are also eligible to bill for PDCM services.

3. Did the definition of "PDCM provider" change for the purpose of communicating to customer groups?

Yes. Previously, we defined a PDCM provider as any provider receiving PDCM VBR. Those providers will be noted in the bcsm.com provider search effective April 2019 as offering care management as an "area of focus."

Effective fall 2019, we will define a PDCM provider in our provider search as any physician delivering PDCM to 1% of their eligible commercial population with two or more PDCM codes billed on different days.

This revised definition is also relevant for the PDCM outcomes VBR described in the VBR section, because the PDCM Outcomes VBR opportunity is not based on the 3% population management criteria, but rather, the 1% criteria.

PATIENT ELIGIBILITY

4. Do members have to pay for PDCM services?

There are no member coinsurance, co-pays or deductibles associated with the PDCM program; it is delivered at ***no cost to eligible members***. This includes members with a high-deductible health plan. Services that are billed for members that are not eligible will reject as provider liable.

5. How will primary care practices identify patients eligible for PDCM?

Over 80 percent of BCBSM's customer groups now participate in PDCM. Patient lists are provided to POs monthly to help practices identify which patients are best-suited for care management.

The patient list is 2-3 months old by the time it reaches the practices, *and should not be used to confirm eligibility*; please confirm the contract is still active and that the patient is still part of an eligible group via webDENIS or PARS.

In addition, a list is available on the PDCM Initiative page on the PGIP Collaboration site indicating which groups do not currently participate in PDCM. Offices can assume that if a patient's coverage is not under one of those non-participating groups, they likely have the PDCM benefit.

BILLING

6. Can non-designated primary care physicians participate in PDCM?

Non-designated primary care physicians in the CPC+ program can bill PDCM; however, they are *not* eligible to receive PDCM value-based reimbursement. All other non-designated, non-CPC+ physicians are ineligible to participate in the PDCM program.

7. How are providers reimbursed for PDCM?

Providers who participate in PDCM receive reimbursement for care management services rendered through 12 procedure codes.

In addition, primary care practices that meet additional Blue Cross criteria will become eligible for PDCM value-based reimbursement. Eligibility for PDCM value-based reimbursement is re-evaluated annually and goes into effect on 9/1 of each year.

8. What are the PDCM procedure codes?

The codes are G9001, G9002, G9007, G9008, 98961, 98962, 98966, 98967, 98968, 99487, 99489, and S0257. Additional information about the PDCM procedure codes is in the PDCM billing guidelines, available on the PDCM Initiative page under the *Initiative/Projects/Workgroup* tab on the PGIP Collaboration site.

9. Can non-PDCM providers bill the G9008 even if they are not doing care management?

Yes. The G9008 code has been expanded and is now more than a PDCM code. The G9008 can be billed by specialist and primary care physicians who do not meet the PDCM criteria, in order to reflect that they provided consultation and guidance to their colleagues. The conversation must be documented in the medical record.

10. How do I learn more about billing for PDCM?

The "PDCM billing webinar" is available as a pre-recorded training module on the PGIP Collaboration Site and the MiCMRC website. A revised version of the webinar,

consistent with changes made to the billing guidelines effective 1/1/19, became available April 2019.

You may also direct questions about PDCM billing or other PDCM matters to valuepartnerships@bcbsm.com, submit an inquiry through the PGIP Collaboration site, or visit the PDCM page under the *Initiatives/Projects/Workgroups* tab on the PGIP Collaboration site for more information.

VALUE-BASED REIMBURSEMENT

11. How does a PCP practice qualify for PDCM value-based reimbursement?

For the PDCM VBR effective 9/1/19 (based on 2018 calendar year data), practices must deliver PDCM services to 3% of their attributed commercial and Medicare Advantage population, with at least 2 care management “touches” on different days for the engaged population. The analysis includes the 12 PDCM codes, as well as non-PDCM codes 1111F, G0511, 99495, and 99496. Therefore, the criteria for the PDCM VBR effective 9/1/19 has not changed, and the Advanced Practice VBR effective 9/1/19 also remains unchanged.

The PDCM reimbursement methodology – and the Advanced Practice VBR methodology – have both changed *for the following two VBR periods*, effective 9/1/20 (based on calendar year 2019 data) and 9/1/21 (based on calendar year 2020 data). The table below provides an overview.

Measurement Year	Payment Period	Measurement Criteria	
		PDCM Population Management VBR (5%) <i>Replaces current 5% PDCM VBR</i>	PDCM Outcomes VBR (6%) <i>Replaces current 5% Advanced Practice VBR</i>
2019	9/1/2020-8/31/2021	3% + 2 Touches*	Quality and Utilization
2020	9/1/2021-8/31/2022	4% + 2 Touches*	Quality and Utilization

PCMH designation is required to receive both forms of PDCM VBR.

The *PDCM population management VBR* will continue to be based on percent of population engaged and having the appropriate amount of outreach, for both commercial and MA members.

The *PDCM Outcomes VBR* replaces the Advanced Practice VBR. The four metrics for the PDCM Outcomes VBR are each worth 1.5% VBR and will be based on clinical quality (HEDIS blood pressure control and HbA1c control), and utilization (ED use and inpatient discharge) for commercial members. Benchmarks are still TBD.

Unlike the Advanced Practice VBR, the PDCM Outcomes VBR opportunity does not require that a practice receive the other PDCM VBR opportunity (which is now called “PDCM population management”) to qualify; rather, a practice will be considered for the PDCM Outcomes VBR as long as they are PCMH designated and are delivering PDCM to at least 1% of their population with two touches on different days.

12. Will pediatricians be held to the same metrics for the PDCM Outcomes VBR as their counterparts in adult medicine and family medicine?

For the PDCM Outcomes VBR effective 9/1/2020 (based on 2019 calendar year data), pediatricians will be eligible for VBR based on their performance on the same four quality and utilization metrics as adult practices. For the two utilization metrics, data will be used for their attributed pediatric population. For the two quality metrics, pediatricians will assume the performance of the adult population for their sub-PO. In this way, pediatricians will not be disadvantaged by not having a measurable population.

For the VBR effective 9/1/2021 (based on 2020 calendar year data) we are exploring other metrics that can be used to effectively measure appropriate utilization in the pediatric population.

13. How will I know if my primary care practices are on track to meet the claims requirement for PDCM?

Blue Cross provides claims reporting to help POs assess how their practices are tracking towards meeting the claims requirement. *Please note that the reports have a 2 to 3-month time lag due to claims runout; the percentages may fluctuate from one reporting period to the next due to member movement; we do not track patient-level detail and it is not used in our calculations, we only provide that information because POs requested it; hosted members are not included on the reports; the 3% is a minimum, not a ceiling; and we expect practices will exceed 3%.*

The overall goal of the PDCM program continues to be engaging eligible patients in care management services as appropriate for their health care needs.

TRAINING REQUIREMENTS AND THE CARE TEAM

14. What are the training requirements for Provider Delivered Care Management?

The PDCM training requirements are summarized below. Please note that these training requirements are applicable to both primary care and specialty practices, and training

requirements must be completed within 6 months of when a care team member first bills the codes.

Provider-Delivered Care Management Training Requirements		
Role	What training do they need?	Who can deliver the training?*
Care team members that deliver the G9001 code	<p>These care team members must complete all three training requirements:</p> <ul style="list-style-type: none"> • Complex care management training (once) • PDCM online billing course (once) • 8 hours of continuing education per year, pro-rated based on when care team member started billing PDCM services (annually) <p><i>Note: Previously, self-management support training was required for staff billing the G9001; it is now optional.</i></p>	<ul style="list-style-type: none"> • CCM can be delivered by any training entity in the state that is approved by MICMT • Online billing course available at https://micmrc.org/ • Continuing education can be delivered by PO, MiCMRC, or independent training body
Care team members that deliver the other 11 PDCM codes	<p>These care team members must complete all three training requirements:</p> <ul style="list-style-type: none"> • Complex care management training OR self-management support training (selection is at PO/provider/care team discretion and should be based on preference, interest, role in the practice, etc.) (Once) • PDCM online billing course (once) • 8 hours of continuing education per year, pro-rated based on when care team member started billing PDCM services (annually) 	<ul style="list-style-type: none"> • CCM and self-management support training can be delivered by any training entity in the state that is approved by MICMT • Online billing course available at https://micmrc.org/ • Continuing education can be delivered by PO, MiCMRC, or independent training body
<p>*If you are unsure about whether your preferred training vendor is approved, or to submit your training entity for approval to deliver training, please contact MiCMRC by clicking here.</p> <p>*For a list of approved self-management support courses, click here.</p>		

15. Medical Assistants and Community Health workers can now bill for patient care using the shortest phone code. What training do they need?

MAs and CHWs fall into the “care team members that deliver the other 11 phone codes” category, and must complete the three required training components listed in the table above.

16. My care team member was trained under the old training requirements. Do they need to be re-trained?

A care team member who was trained under old training requirements, and whose role has stayed the same, does not need to re-do training they have previously taken.

If their role has changed (for example, they previously did not bill the G9001 but now they intend to, or they are a MA/CHW delivering patient care), they *would* need to meet the training requirements as specified in the table above. Note that every care team member must complete the 8 hours of annual continuing education.

17. Who can be on the care team?

We have removed the distinction between lead care managers and qualified health professionals – now we simply have “physicians” and “care team members,” and those care team members are either licensed (e.g., social workers, nurses) or unlicensed (e.g., MAs, CHWs).

Effective 1/1/19, the care team can be comprised of any health care or behavioral health professional the provider believes is qualified to serve on the care team.

18. Do practices still need a lead care manager to bill the PDCM codes?

No. For example, a practice that only has a medical assistant can bill the three PDCM codes that medical assistants can bill. However, because the medical assistant cannot bill a G9001 or G9002, this means the practice would not be able to deliver comprehensive care plans and engage patients in longitudinal care management. In those cases, it is important that a practice has access to other licensed care team members (such as pharmacists, social workers, or dieticians).

19. How do paramedics fit into the care team?

Paramedics can now be part of the care team and bill the PDCM codes, when they are working in conjunction with a physician to deliver patient care and avoid a visit to the emergency room. Paramedics must be trained fully within 6 months of starting to bill PDCM codes, like other care team members.

PDCM SPECIALTY

20. Which specialists are eligible to bill PDCM codes?

Effective 1/1/19, all specialty types are eligible to bill the PDCM codes, provided they meet all three of the following requirements:

- Have access to a care team
- Members of the care team have been trained appropriately or will receive training within 6 months of starting to bill the codes
- Practice worked with PO to implement the six PCMH capabilities listed below.

21. What are the PCMH-N capability requirements for PDCM-Specialist?

The specialty practice must have the following six PCMH-N capabilities in place and actively in use within six months of starting to bill PDCM codes. Blue Cross reserves the right to validate that these capabilities are in place for any practice that has billed the PDCM codes. For more information, please refer to the PCMH Interpretive Guidelines:

- Evidence-based guidelines used at point of care (4.3)
- Action plan and self-management goal setting (4.5)
- Medication review and management (4.10)
- Identify candidates for care management (4.19)

- Systematic process to notify patients of availability of care management (4.20)
- Conduct regular case reviews, update complex care plans (4.21)

22. What are the training requirements for PDCM-Specialist?

The training requirements for specialist practices are now identical to the training requirements for primary care practices. Please refer to the table above for details. Note that the previously required specialist care manager training was a three-hour course, and does not count towards meeting the new training requirements. If the three-hour course was taken previously, the complex care management or self-management support course must now be taken depending on role and licensure within 6 months of billing the codes.

NATIONAL PROGRAMS

23. What is Comprehensive Primary Care Plus (CPC+)?

CPC+ is a regional, multi-payer, five-year CMS-supported initiative intended to strengthen primary care through efforts to transform payment reform and the care delivery system. CPC+ started on January 1, 2017. Michigan is a participating region. For detailed information on CPC+, please review the CPC+ FAQ available at the [Michigan Multipayer CPC+ website](#), or visit the CMS Innovation Center [website](#).

Participation in this multi-payer opportunity has been a catalyst for BCBSM to consider what's next in BCBSM's evolving value-based payment model. Given the need to continue to advance practice transformation across the state, BCBSM VBR opportunities available to CPC+ practices are potentially available to all PGIP practices. *Practices must meet BCBSM's criteria for each VBR to qualify for the additional payment. Participation in CPC+ does not automatically qualify a practice for any additional BCBSM reimbursement.*

24. What is SIM and how does it relate to PDCM?

The State Innovation Model (SIM) is a program funded by CMS and run by the State of Michigan which focuses on developing and testing multi-payer health care payment and service delivery models to achieve better care coordination, lower costs, and improved health outcomes for Michiganders. BCBSM is in active conversations with the State to assure that PDCM, CPC+ and SIM work in concert. Please visit the [MDHHS website](#) for more information.

MICHIGAN INSTITUTE FOR CARE MANAGEMENT AND TRANSFORMATION

25. What is the MICMT?

The Michigan Institute for Care Management and Transformation combines the work of the Michigan Care Management Resource Center with the MPTCQ pharmacy care management CQI. The mission is to work with Physician Organizations to expand the provider delivered care management model within outpatient primary and specialty

care clinics, to improve quality of care and decrease the cost of care for Michigan residents.

Starting in 2019, physician organizations will be asked to engage with the MICMT through use of the MICMT scorecard and also by submitting potential awards for the Care Management Recognition Program, which is funded by Blue Cross Blue Shield of Michigan.

The MICMT will also offer training support for care team members, capped by PO and funded by Blue Cross Blue Shield of Michigan, based on care team members passing a training post-test. Stay tuned to the PGIP collaboration site and the forthcoming MICMT website for more information.

PDCM ENGAGEMENT

26. What is the PDCM Engagement Initiative?

PDCM engagement is a PGIP initiative from 2018. *Please note, this one-time funding opportunity is distinct from PDCM value-based reimbursement and is evaluated differently, as described below.* The purpose of the initiative was to increase care management in primary care practices.

Physician organizations elected to sign up in March 2018, then received base funding plus an additional one-time per member funding amount in April 2018, contingent upon number of PCMH designated practices and attributed members. Physician organizations have two years to meet the criteria, and must meet both to retain funding; if the criteria are not met, 70% of funds will be paid back to Blue Cross in January 2021.

The PDCM engagement criteria are:

- *Expand the number of members engaged in PDCM:* Minimum of 3% PDCM-eligible attributed commercial members engaged in PDCM in both PCMH designated practices and CPC+ non-designated practices (averaged across the PO).
- *Expand the number of practices engaged in PDCM:* 90% of PCMH designated practices and CPC+ non-designated practices billing at least one paid claim. Evaluated at PO level; analysis will only use 12 PDCM codes.

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