 **PDCM Coding and Billing Presentation with Lori Boctor 07/15/20**

*Handouts from presentations attached to email and on website (handouts and highlights under Care Manager User Group, handouts also under Care Manager Resources, also under PCMH User Group). This was strictly a virtual meeting due to COVID-19 from 12:00- 1:30*

**Introduction:** **Rachael Smart, MSN, MHA, NPO Quality Support Specialist**

**Speaker: Lori Boctor, BCBSM, Value Partnerships- Reimbursement Team**

**Guest: Christy Allison, Works with Barb Brady. Barb Brady took over Lisa Rajt’s position. Christy and Barb work together and can be a good resource regarding development, analytics and initiative work regarding PDCM.**

*Please Review PowerPoint with the highlights*

**Eligibility Commercial**

* BCBSM produced a list of groups not participating in the PDCM program
	+ Available on the PGIP Collaboration site by your PO as well as the MICMT website (*Attached: Groups Not Participating in PDCM 3-2020)*
	+ 14 groups are included
	+ The list is updated as needed
	+ Make sure the member has an active contract when checking Web-DENIS
	+ This is only a guide for those not participating in PDCM
* BCBSM has 2 different benefit systems
	+ Michigan Operating System (MOS)- houses all local groups. Local means those in the state of MI without any facilities outside the State of MI.
		- BCBSM employees are considered a MOS group
		- MOS group always starts with 007 and has a coverage code
	+ NASCO – national accounts such as FORD, GM, Chrysler
		- Easier when checking Web Dennis

**Eligibility Medicare Advantage**

* Included in PDCM except for 3 different groups (See attached PowerPoint)
	+ URMBT- as of May these patients are now included on the patient lists as being eligible for PDCM services
* Like the commercial eligibility just ensure the patient has an active contract. The list will include 2 tabs. One list is commercial, and the other list is MA
	+ Traditional Medicare enrollees are not eligible for the PDCM.
		- Traditional means those that are enrolled with part A and Part B and then they purchase an additional part separately

**PDCM Procedure Codes**

* G9001
	+ Now eligible for reimbursement multiple times through the year. Previously you could only use this code once a year
* G9002
	+ Can quantity bill
		- A F2F Meeting in the office when more than 45 minutes is spent a quantity of 2 can be billed (See attached PDCM Commercial Billing Guidelines 2020)
* 98961 & 98962
	+ Eligible to be quantity billed. For example, if 60 minutes is spent with a group bill and indicate quantity of 2
* 98966, 98967, 98968
	+ Medical assistance can now utilize these codes (See attached NPO CM Education Requirements 3-18-20)
* 99487 & 99489
	+ Monthly codes
	+ Capture the amount of time spent with each patient on Care Management each month
		- Can track in your EHR or and Excel document. Whatever works for the practice?
* G9007
	+ Discuss patient status with physician weather the status is negative or positive
		- Does not include conversation with the patient
* G9008
	+ This code is eligible for reimbursement whenever the provider is trying to engage the patient in PDCM, provider is discussing/coordinating care with another provider, or for example a patient requests an ambulance and there is conversation between the paramedic and provider to possibly avoid a transport charge.
		- Previously this code was only eligible per patient, per provider, per lifetime- now there are multiple uses
* S0257
	+ Advanced Directive

**Changes to the PDCM Program**

* BCBSM made some changes to the PDCM program recognizing the challenges that COVID has caused (See PowerPoint)
	+ This will be reviewed by BCBSM closer to August 31st, 2020 to determine if these changes will continue or end
* Please utilize the 2P modifier. BCBSM is trying to track how often CM services are declined (See Attached PDCM Commercial Billing Guideline 2020)

**Questions**

* Q: What is acceptable use for G9007?
	+ Needs to be some sort of verbal communication- no texting or email. F2F, video, telephone are acceptable
* Q: Regarding,billing for Pediatrics Patients, especially when working strictly with parents. More specifically if a practice is thinking of interventions geared towards at risk newborns. Can F2F interactions with parents be billed as a G9002 with a diagnosis code
	+ Yes, a newborn is like a patient with dementia or Alzheimer’s. BCBSM recognizes that they won’t understand anything so if a conversation is being had with the caregiver, bill using the patient/ the newborns name
	+ Q: What diagnosis code
		- Whatever the care plan is being discussed about. For example, failure to thrive. The claim would be billed as the newborn name and failure to thrive.
	+ Q: What about when newborn education is being discussed with the parents and there is not an actual issue?
		- For example, the parents are being educated on feeding. Whatever diagnosis code is being used for the visit that day would be the diagnosis code used for the G9002.
		- Z00.110 health examination for newborn 8 days and under is an example of a diagnosis code used for newborn parent education
			* If a visit gets rejected make sure a routine service was not used. For example, the Z00.110 will get rejected if attempted to bill for more than once. If there is an issue, please send to NPO who will reach out to BCBSM
* Q: Is the information from today BCBSM only or does it include other out of state?
	+ In 2017 BCBSM tried to bring on Hosted populations. Hosted population means those who reside in the state of MI but have coverage through another state’s BCBS plan. Unfortunately, most other plans set-up their Care Manager plans to be paid PMPM and BCBSM is set-up as claims so when claims submitted end up getting rejected. A lot of the larger plans such as Anthem and Health Care Service Corporation Plans don’t pay any of the telephone codes. As a result, BCBSM stopped including hosted members on the patient lists. You can still offer services, but the practice has about a 50/50 chance of getting paid.
* Q: Do practices need to adjust their fee schedule to get the increased fee amount that runs through November?
	+ Yes! For example, the G9001 pays $145 now through November 30th. So, if you are only charging $100 you would need to increase it to more than the $145. The exact amount for each would be:
		- G9001 Base fee amount it $145.10
		- G9002 Base fee amount 72.56
		- G9008 Base fee 84.00
			* The charge change needs to be more than the base fee amount
			* This was put into effect 5/1/2020
	+ Q: Is the VBR on top of these fees?
		- Yes
* Q: Do MAs need to be certified to bill telephonic and care coordination services
	+ The State of MI can have team members that are not certified so BCBSM has broken it down between licensed and unlicensed care team members. The only thing they need to do is attend the training that is offered through MICMT or NPO and then obtain eight hours of CE each year (See pg. 6 of the attached PDCM FAQ March 2020 and/or NPO CM Education Requirements 3-18-20).
		- NPO plans to offer a Care Management training course again sometime in December.
* Q: 99487 & 99489 what and how can a CM utilize these codes
	+ For example, a patient has a SDOH need. The CM calls meals on wheels and sets up a daily or weekly meal delivery.
* Do you know of any organizations using the group education and training codes? What does that look like?
	+ Some practices will do a nutrition session, diabetes, or mental health and set them up in their office during the evening or lunch hour anywhere from 30-60 minutes.
* 99487 & 99489 – does anyone have a suggestion on how to track the time?
	+ Example 1: Create a fake employee "zztime tracking".  Then Create the Telephone Encounter (TE) for the actual patient.  Log the time in this TE all month long.  Then at the end of the month check all the TEs for "zztime tracking" and go through them.  If they met the requirement, it's sent to the physician who does the claim and passes it on to billing.  Then a new TE is made for that patient to keep the process going.  If they didn't meet the requirement, then recycle for the next month by changing the date at the top so it stays higher up in the encounter page.
	+ Example 2: For eClinicalWorks: ECW has a built-in timer. The service cost $1 per claim. Start and stop the timer as needed and the ECW PCMH Module creates the claim based on time.
		- If the practice does not when to pay the $1 service per claim, they can manually track by timestamping in the beginning and time stamping at the end of the conversation. Then, manually enter in the time to create the claim.
	+ Example 3: One practice uses their intake Information (example; this information is in the EMR but could be paper or excel if need be):
		- Provider progress note:

Health goal: lose 15# in the next 3 months.

Starting weight: #
Starting BMI:
A1C:
Avg Glucose:

Time Spent:  Total for Month:
Appt Update:
Barriers to change:
Nutrition:
Weight: goal of 1-2# a week, 3-4# a month for healthy sustainable weight loss.
Activity:
Specific Health Goals:

Pt will benefit from continued participation with CM services for accountability, motivation, and education.

* + - * This form is altered to fit the patient’s diagnosis and goals whether it be for weight loss, diabetes, cholesterol, hypertension, heart failure etc. **The form is used for the Care Managers personal tracking. The red fount gets changed each visit to reflect the time of the current visit and then total for the month. At the end of the month the appropriate billing code is submitted and the tracking process starts over.**
			* It is also labeled as Care Management with\_\_\_, credentials or Care Management Follow Up with \_\_\_, credentials