Provider Delivered Care Management Payment Policy and Billing Guidelines for Blue Cross Blue Shield of Michigan Commercial

Purpose

Beginning April 1, 2012 BCBSM began accepting and paying claims for Provider Delivered Care Management services delivered by qualified Primary Care Practitioner to patients in physician practices that are designated by BCBSM to be reimbursed for these services. As of April 1, 2013, four additional codes were added (G9007*, G9008*, 99487*, and 99489*) and as of January 1, 2014 we added S0257*. Effective November 1, 2013, BCBSM began accepting and paying claims for Provider-Delivered Care Management services delivered by qualified oncology practices.

The following describes BCBSM's payment policy and billing guidelines for PDCM services. The applicable codes relevant to this policy are:

HCPCS Codes G9001*, G9002*, G9007*, G9008*, S0257*

CPT Codes 98961*, 98962*, 98966*, 98967*, 98968*, 99487*, 99489*

PDCM Definition

Provider Delivered Care Management refers to a comprehensive array of patient education, coordination and other support services delivered face-to-face and/or over the telephone by a variety of ancillary health care personnel who work collaboratively with the patient (and where indicated, the patient's family) in conjunction with the patient's personal primary care . Practitioner. Services can be performed within the context of an individualized care plan designed to help patients with chronic and complex care issues address medical, behavioral, and psychosocial needs such that the patient can be successful in meeting personal health care goals that contribute to optimal health outcomes and lower health care costs. The integration of PDCM services into the clinical practice setting is considered a key component of the patient centered medical home care model that BCBSM is fostering in its efforts to transform the way health care is delivered in Michigan.

General Conditions of Payment

For billed PDCM services to be payable, the following conditions apply:

- The patient must be eligible for PDCM coverage.

- The care management team services being billed must be:
    - Based on patient need and tied to patient care goals;
    - Ordered by a physician, physician assistant, or certified nurse practitioner practicing within a PDCM-approved practice who has an established relationship with and accepts overall clinical accountability for the clinical management of the patient;
    - Performed by a qualified non-physician care management team member employed by or under contract with a PDCM-approved practice or its affiliated Physician Organization; and
    - Billed by the approved practice or the Physician Organization responsible for the care management team in accordance with BCBSM billing guidelines.

    Physician services must be billed by a physician, CNP, or PA practicing within a PDCM-approved practice. Non-approved providers billing and receiving payment for these services are subject to audit and recovery processes.

Payment Methodology

Reimbursement for PDCM services will be paid on a fee-for-service basis. Payment will be based on the lesser of provider charges or BCBSM's maximum allowed amount for identified PDCM services and will be remitted only to a physician practice or PO entity that has been approved by BCBSM to bill for PDCM services on behalf of the care management team members delivering these services (identified as the Billing Provider on the claim).

You can view the fees (net of the PGIP allocation) for each of the care management codes in our fee schedules on web-DENIS. The dollar amounts listed reflect the amount indicated in the payment voucher BCBSM remits for each service.

To view our fee schedules:

- Log in to web-DENIS.
- Click on *BCBSM Provider Publications and Resources*.
- Click on *Entire Fee Schedules and Fee Changes.*

PDCM services are included among the codes eligible for Value Based Reimbursement (VBR) under BCBSM's Patient Centered Medical Home and specialty VBR programs. The actual maximum allowed amount payable to the provider shall be determined based upon the credentials and privileging status of the individual provider that is identified as the Rendering Provider on the claim.

Accordingly, if the individual identified as the Rendering Provider for a PDCM service line is a physician that has been deemed eligible for a VBR, then the applicable VBR amount will be applied to that PDCM service. If the individual identified as the Rendering Provider is a Certified Nurse Practitioner or Physician Assistant, then the maximum allowed amount to be remitted will be 85% of BCBSM's established allowed amount for the service.

Further detail about the Billing Provider, Rendering Provider and other requirements applicable to PDCM claims submission are outlined in the Billing and Documentation Section of this document.

Patient Eligibility

For PDCM services to be payable, the patient receiving the services must have:

- Active BCBSM coverage that includes the PDCM benefits
- One or more clinical conditions for which care management services are warranted and believed to have the potential to improve that patient's wellbeing and functional status. This could include, but is not limited to: moderate, complex, or transition of care patients.
- A referral for PDCM services from a physician, PA, or CNP in a PDCM-approved practice with whom the patient has an established care relationship (or alternatively a formalized standing order is in place between the clinician and care management team)
- Agreed to actively participate in the PDCM care plan.

On a monthly basis, BCBSM will provide each Physician Organization a list of PDCM-eligible members attributed to the PDCM-participating PCPs in the PO. The list will include additional information based on claims history (e.g., risk scores, chronic condition flags, high cost flags, etc.) to help providers identify candidates for care management services. *Note that the monthly lists will not include those patients attributed to oncologists.*

When delivering care management services, please confirm that the member is a patient at one of the PDCM-participating practices and eligible for care management and has an active BCBSM contract. There is no costshare (deductible, coinsurance, copayment) associated with PDCM services.

PDCM benefit information is available on WebDENIS and PARS (formerly known as CAREN-IVR) so that providers will have a means to validate eligibility and coverage for BCBSM members prior to initiating and billing for PDCM services. In the event that claims are submitted to BCBSM for PDCM services for patients that do not have PDCM coverage for these services, BCBSM will reject these claims as a provider liability.

Provider Requirements and Expectations

PDCM services are only payable when delivered within the context of an established and ongoing qualified practitioner patient relationship that exists within a practice approved by BCBSM for PDCM reimbursement.

PDCM-Eligible Practice

Only those practices that are participants in the BCBSM Provider Delivered Care Management program are privileged for PDCM reimbursement.

Eligible practices must have engaged one or more qualified care managers to provide PDCM services. This formalized relationship may be as an employee, leased employee or

independent contractor of the practice. Alternatively, care management team members may be employed by or under contract with the Physician Organization with which the PDCM-approved practice is affiliated.

PDCM services should be billed by the approved practice or PO formally employing or contracting the care team. For a PO to bill BCBSM on behalf of a care management team, that PO must organize a business entity with a clinical NPI that is registered with BCBSM and recognized as a physician practice. BCBSM's Provider Consulting area is prepared to assist with this enrollment process.

Regardless of whether employed by the practice or by the Physician Organization, the care managers are expected to function in concert with the practice care team such that their actions are clearly integrated with the clinical care process and there is ongoing, frequent communication and record sharing occurring between the practice care team and care management team regarding patient needs and progress.

Care Management Team

All care managers must complete Self-management support training at a CMRC-approved program, such as MiCCSI or PTI. The care management team must consist of at least one individual who functions as a lead care manager. This lead care manager must:

- Be a licensed allied practitioner of one of the following disciplines: registered nurse, licensed masters of social work, certified nurse practitioner, or physician assistant; and
- Accept responsibility for ensuring that PDCM services being delivered by any care management team member are appropriate and aligned with the patient's overall plan of care, as applicable.

In addition to the care manager, additional allied health practitioners of any of the following disciplines may be on the care management team: registered nurse, masters of social work, certified nurse practitioner, physician assistant, licensed practical nurses, certified diabetes educators, registered dieticians, masters of science trained nutritionists, clinical pharmacists, respiratory therapists, certified asthma educators, certified health educator specialists (bachelor's degree, or higher, in health education), licensed professional counselors, licensed mental health counselors.

Every care management team member delivering PDCM services must:

- Function within their defined scope of practice;
- Work collaboratively with the patient's clinical management; and
- Work in concert with BCBSM care management nurses as appropriate.

PDCM care managers must have care management software or other automated tools (e.g., an EMR) with the capability to track patients and their progress, generate care plans, and record encounters available for their use.

Billing & Documentation Guidelines for PDCM Codes

General Billing Guidelines

The following general billing guidelines apply:

- Only those practices or practice-affiliated Physician Organizations approved for PDCM payments may submit claims for PDCM services.
- Billing for PDCM services must be done using the appropriate procedure codes as identified in this document.
- Any qua ntity limits are noted under each of the PDCM codes. There are no location restrictions for PDCM services. (Performance of these services, however, should be clearly integrated and coordinated with the overall clinical care delivered in the physician practice having overall responsibility for that patient (i.e., the patient's "medical home")).
- Providers must maintain a reasonable level of documentation (identified under the detail associated with each procedure code below) as evidence that services were necessary and delivered as reported to BCBSM

Note: More detailed requirements applicable to Medicare Advantage patients are available.

Rendering and Billing Provider

The Billing Provider reported on the claim should be the practice or the PO-entity employing the care management team member performing the service. Payments are directed to the entity reported in this field.

The Rendering and Billing Providers must have an NPI registered with BCBSM. Many of the non-physician personnel furnishing PDCM services, however, are not recognized by BCBSM as payable provider types. Under BCBSM policy guidelines, PDCM services are considered an integral part of the patient's overall care and treatment overseen by the patient's primary care physician, and as such, the primary care physician may be reported as "incident to" services with the primary care provider's NPI reported in the Rendering Provider field on the claim. For purposes of these codes, BCBSM will not require that the ancillary personnel furnish PDCM services under direct supervision of that physician (i.e., with the physician present in the same office suite). Documentation must, however, demonstrate that there has been a previous related face-to-face clinical encounter between the identified primary care practitioner and patient and that there is an active exchange of patient-specific information pertinent to those PDCM services being billed.

Code Specific Guidelines

Billable PDCM Codes

There are two categories of codes that can be billed for PDCM services:

- Codes to be billed for care management services delivered by the care management team.
- Codes to be billed for care management services delivered by the Physician.

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

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

***This includes physicians and mid-level providers, such as certified nurse practitioners and physician assistants, who are acting as the primary care provider. These encounters should be billed as Evaluation and Management visits.*

The following sections provide further billing instructions and details.

Codes for Care Management Team Services:

Initiation of Care Management (Comprehensive Assessment) G9001* Coordinated Care Fee, initial rate (per case)

This code should be used to bill for the comprehensive assessment and care plan development activities conducted with any patient regardless of complexity. Once G9001* is completed, the patient is considered to be enrolled/engaged in care management. Information is collected through interaction and communication with the member or member's representative/caregiver for the purpose of developing a goal-based care management plan tailored to the patient's unique personal needs, interests and capabilities. Assessment and planning may consist of multiple encounters, some of which may be by phone, but at least one encounter must be face- to-face. This code is inclusive of the totality of contacts necessary to complete the full assessment and develop the individualized care plan for the patient, including consultations with the patient's Primary Care Practitioner, other professionals, and/or care-givers, etc.

Note: This code is intended to cover the care manager's efforts to complete the assessment. Physicians are entitled to bill G9008* as a patient engagement fee.

Conditions of Payment

- This code is payable only if the service is delivered by a RN, LMSW, CNP or PA who meets the conditions of a lead care manager. (A pharmacist, for example, is not a payable provider type for this service.)
- Contacts must add up to at least 30 minutes of discussion with the member to be billable.
- At least one encounter must be face-to-face.

Claims Reporting Requirements

- For patients not entering into care management, the claim date of service reported should be the date of the face-to-face component.
- For patients who are entering care management, the claim date of service reported should be the patient enrollment date. (Note: Prior to enrollment, patients must formally agree they understand and consent to the care plan and its goals, and agree to be actively engaged in the activities identified to meet goals.)
- The date of service reported on the claim for this code should be the date the assessment was completed.
- All active diagnoses for the patient should be identified in the assessment process and reported on the claim.

Quantity Limitations

- 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; for example, when a patient is being managed by both a Primary Care Practitioner care manager and an oncology care manager, both care managers may conduct a comprehensive assessment as needed and bill G9001*. (Although this service is billable only once annually per practice, monitoring and evaluation of the member's health status and related circumstances should be an ongoing process, and care plans should be revised as warranted consistent with the patient' changing needs.)
- For patients enrolled in ongoing care management, a full re-evaluation should be conducted annually (and billed under this same code, i.e., G9001*).

Documentation Requirements

Documentation associated with G9001* that must be recorded and maintained in the patient's record should include:

- Identification of the care manager responsible for the overall care plan
- Identification of the patient's provider and contact information

- Enumeration of each encounter to include:
    - the care manager's name and credentials
    - the date, duration and modality of contact (face-to-face or phone)
    - If contact is made with a person other than the patient, the name of the individual and their relationship with the patient must be documented.
- Overall findings from the assessment of patient's medical condition and personal circumstances including, but not limited to:
    - All active diagnoses
    - Current physical and mental/emotional status (capabilities, limitations)
    - Current medical treatment regimens and medications
    - Risk factors (lifestyle issues, health behaviors, self-management activities, etc.)
    - Available resources and unmet needs
    - Level of the patient's understanding of his/her condition(s) and readiness for change
    - Perceived barriers to treatment plan adherence
- Individualized long and short term desired outcomes and target goal dates
- Anticipated interventions to help the patient achieve their goals and timeframes for follow-up
- Patient's agreement and consent to engage/participate in care management

Individual Face-to-Face Visit
G9002* Coordinated Care Fee, maintenance rate

This code should be used to bill for individual face-to-face care management intervention visits conducted by qualified allied health personnel on the care management team for patients eligible for care management (and may include the patient's caregiver/family). Encounters may involve self-management training, skill development, education or counseling regarding risks, problem solving, health or lifestyle coaching, etc., by one or more members of the care management team. Face-to-face care management interventions should only be conducted and billed when the circumstances of the patient and/or the nature of the service content merits this level of person-to-person interaction in order to be successful. This code should only be reported once for a single date of service to reflect the total cumulative time a patient receives face-to-face care management inventions on that date, regardless of the number of team members involved.

<u>Conditions of Payment</u>

- This code is payable when delivered by any of the qualified allied personnel approved for PDCM.
- Discussions must be substantive and focused on content pertinent to the patient's care plan and goal achievement.
- This code should not be billed on that same date as procedure code G9001*.

<u>Claims Reporting Requirements</u>

- The code should be reported once for a single date of service.
- The appropriate quantity is based on the total cumulative time the patient spends with a care management team member(s) on that day. The length of time spent with the

patient during each interaction should be added together to determine the correct quantity to bill.
    - If the total cumulative time with the patient adds up to:
        - 1-45 minutes, report a quantity of 1
        - 46-75 minutes, report a quantity of 2
        - 76-105 minutes, report a quantity of 3
        - 106-135 minutes, report a quantity of 4

- All active diagnoses should be reported

Quantity Limitations

If the total time spent by one or more team members exceeds 45 minutes, on the same date, to the same patient, you should quantity bill this procedure code as noted above.

Documentation Requirements

Documentation associated with G9002* that must be recorded and maintained in the patient's record should include:

- Enumeration of each encounter including:
    - Date of service
    - Duration of contact
    - Name and credentials of the allied professional delivering the service
    - Other individuals in attendance (if any) and their relationship with the patient
- Nature of the discussion and pertinent details
- Updated status on patient's medical condition, care needs, and progress to goal
- Any revisions to the care plan goals, interventions, and target dates (if necessary)

Group Education and Training

98961* **Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients**

98962* **Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients**

These codes are used to bill for formalized educational sessions led by one or more qualified allied health personnel delivered in a group setting (i.e., with more than one patient present). Patient family members can also be included (but do not count as "patients"). In addition to delivering instruction on a given topic, there should be active engagement of the participants, and each session should be customized to ensure attention is given to the relevant personal needs and issues of each participating patient.

Conditions of Payment

- This code is payable when delivered by any of the qualified allied personnel approved for PDCM.

- There must be at least two, but no more than 8 patients present.
- There must be some level of individualized interaction included in the session.

Claims Reporting Requirements

- The appropriate code depends upon the length of instruction and the total number of patients participating in the educational session. (Any family members in attendance should not be included in this count).
- All active diagnoses should be reported.
- Separately billed for each individual patient participating in the group session.

Quantity Limitations

98961* and 98962* may be quantity billed.

Documentation Requirements

Documentation associated with these codes that must be recorded and maintained in the patient's record should include:

- Enumeration of each session including:
  - Date and location of class
  - Name and credentials of the allied professional(s) facilitating the class
  - Duration of class
  - Nature and content and objective(s) of the training
  - Total number of patients in attendance
- Any updated status on patient's medical condition, care needs, and progress to goal

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

These codes are for non-face-to-face care management services provided to a *patient* or *patient's* representative/caregiver using the telephone in pursuance of that patient's personalized care goals. It is not appropriate to bill this code for calls that are simply reminding a patient of an appointment or to convey a test result. The interaction must be a conversation between the care management professional and the patient that is substantively relevant to the plan of care established for that patient (e.g., self-management training, skill development, education or counseling regarding risks, problem solving, health or lifestyle coaching, etc.).

Conditions of Payment

- This code is payable when delivered by any of the qualified allied personnel approved for PDCM.

- Discussions must be substantive and focused on content pertinent to the patient's individualized care plan and goal achievement.

Claims Reporting Requirements

- Code selection depends on the total time spent in discussion with the patient, on each date of service. Time documenting the discussion is excluded.
- All active diagnoses should be reported.

Quantity Limitations

Code selection depends on the total time spent in discussion with the patient, on each date of service. You may not quantity bill these codes.

Documentation Requirements

Documentation associated with these codes that must be recorded and maintained in the patient's record should include:

- Enumeration of each call including:
  - Date, time and duration of call
  - Name and credentials of the allied professional(s) delivering the educational service
  - Nature of discussion and pertinent details
- Updated status on patient's medical condition, care needs, and progress to goal
- Any revisions to the care plan goals, interventions, and target dates (if necessary)

Care Coordination

Complex chronic care coordination services

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

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

These codes are intended to be used by qualified allied health personnel on the care management team to bill for the work and time spent interacting with other providers and/or community agencies in order to coordinate different services and medical specialties needed to manage the complex nature of the patient's medical condition, psychosocial needs and activities of daily living. Contacts may be by phone or person-to-person. These codes are reported only once per calendar month to encompass the total accumulation of time spent communicating with other providers or agencies over the period of the calendar month. A code may be billed when at least 51% of the time designated in the descriptor of that code is met. Time spent by the care management team communicating with the patient's physician, primary care giver and/or care team is not included.

Conditions of Payment

- This code is payable for contacts made by any of the qualified allied personnel approved for PDCM on the care management team.
- If necessary, other personnel not identified on the list of qualified provider types (such as medical assistants) may be used to deliver some subsets of care management services, but they may not be the sole provider of a PDCM service. In cases where such personnel are used, they must be actively supervised by an appropriate practitioner from the list of qualified providers.
- The cumulative duration of communication time to bill 99487* must be at least 31 minutes in duration to be billable (i.e., 51% of an hour)
- Discussions must be substantive and focused on coordinating services that are pertinent to the patient's individualized care plan and goal achievement.

Claims Reporting Requirements

- These codes should be billed at the end of each calendar month utilizing the last encounter date for that month.
- Appropriate coding and quantities are dependent upon the cumulative amount of time spent on care coordination activities in that month.
- A code may be billed when at least 51% of the time designated in the descriptor of that code is met.
    - To bill the first hour, the cumulative amount of time must equal at least 31 minutes
    - To bill an additional 30 minutes, the cumulative amount of time must equal at least 16 minutes
- The code 99487* should be billed for the first 31 to 75 minutes of care coordination services for a patient in a month
- The code 99489* is billed in addition to 99487* for each additional 30 minutes of interactions.
    - 99487* and 99489* would be billed if the total time spent was 76+ minutes of care coordination
    - 99489* may be quantity billed if the total coordination time exceeds 105 minutes in a single month

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

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

166-195	99487* +99489*	1 4
196-225	99487* 99489*	1 5

Quantity Limitations

99487* may only be billed once per calendar month, per patient
99489* may be quantity billed (see chart above)

Documentation Requirements

When billing these codes, documentation in the patient record should include the following for each contact made:

- Date of contact
- Duration of contact
- Name and credentials of the allied professional on the care team making the contact
- Identification of the provider or community agency with whom the discussion is taking place
- Nature of the discussion and pertinent details

Codes for Physician Services

Team Conference
G9007* Coordinated care fee, scheduled team conference

This code should be used to bill for scheduled face-to-face meetings, telephone calls or secured video conferencing between, at minimum, the primary care practitioner and the care manager to formally discuss a patient's care plan. Other team members, such as a pharmacist, dietician, mental health provider, etc. may also be present. The patient should not be present. The team conference should be based on need (e.g., a change in the care plan is needed because a patient is not progressing on goals, or there is a change in the patient's status). Relevant data, concerns, gaps in care, and other pertinent details should be gathered prior to the meeting to share with the physician for his/her input. Decisions and next steps must be agreed upon and documented into the patient's care plan.

Conditions of Payment

- The scheduled discussion should include sufficient time to discuss changes to the patient's status.
- Discussions must be substantive and focused on content pertinent to the patient's individualized care plan 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

- Separately billed for each individual patient discussed during team conference.

Quantity Limitations

There is a limit of one G9007* paid per primary care practitioner, per practice, per patient, per day.

Documentation Requirements

Documentation associated with G9007* that must be recorded and maintained in the patient's record should include:

- Enumeration of each encounter including:
  - Date of team meeting
  - Duration of discussion for individual patient
  - Name and credentials of allied professionals present for team conference
- Nature of the discussion and pertinent details
- Any revisions to the care plan goals, interventions, and target dates (if necessary)

Engagement Fee
G9008* Physician Coordinated Care Oversight Services

This code is billable by the ***physician*** at the initiation of care management as an "enrollment fee." (Note: Enrollment requires 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 the identified goals. Formal acknowledgement is documented in the patient record, by practice standing order, or provider patient agreement). An assessment must be complete and a care plan developed that has been agreed to by the patient and which has been 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 management service, and the physician needs to have bridged the patient and care manager through direct interaction with both. The G9008* code differs from G9001* in that G9001* is the comprehensive assessment and care plan development activities conducted by the **care manager** with the patient *prior to enrollment in care management*.

Conditions of Payment

- An E&M visit performed by the primary care practitioner must be simultaneously or previously billed for the patient
- A G9001*or G9002* performed by the care manager must be simultaneously or previously billed for the patient
- A written care plan with action steps and goals accepted by the primary care practitioner, care manager and patient is in place

Quantity Limitations

G9008* 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.

Documentation Requirements

When billing this code, documentation in the patient record should reflect evidence of a written shared action plan for the patient developed by the care manager that has been reviewed and approved by the billing physician.

End of Life Counseling

S0257* Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service)

This code should be used to bill for 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.

Conditions of Payment

- This code is payable when delivered by any of the qualified allied personnel approved for PDCM.

Claims Reporting Requirements

- All active diagnoses should be reported

Quantity Limitations

None

Documentation Requirements

Documentation associated with S0257* that must be recorded and maintained in the patient's record should include:

- Enumeration of each encounter including:
  - Date of service
  - Duration of contact
  - Name and credentials of the allied professional delivering the service
  - Other individuals in attendance (if any) and their relationship with the patient
- Pertinent details of the discussion (and resulting advance care plan decisions), which, at a minimum, must include 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
- Advanced care planning discussions/decisions may also include:
  - How the patient prefers to be treated by others
  - What the patient wishes others to know

- Indication of whether or not an advance directive or Physician Orders for Life-Sustaining Treatment (POLST) document has been completed

T Codes

If a patient is engaged in PDCM and you are billing the PDCM codes indicated above, you should not also be billing the T codes for the same patient.

For Medicare Advantage patients please refer to the
Provider Delivered Care Management
Payment Policy and Billing Guidelines for Medicare Advantage PPO

For additional information about the MiPCT Program, please visit
http://mipctdemo.wordpress.com/

If you have questions about the program, feel free to contact your PO Leadership, or submit a question through the PGIP Collaboration Site, located at:
http://sps-pgip/default.aspx or send an email to valuepartnerships@bcbsm.com

*For questions specific to **PDCM-Oncology**,*
please submit them to our dedicated mailbox:
PDCMOncologyExpansion@bcbsm.com

Changes to Document

July 9, 2014

Page 7: Updated G9001 to clarify annual frequency
Page 9: Updated nomenclature for the Group Visits
Page 12: Updated chart to correct time increments

July 18, 2014

Page 7: Updated G9001 claims reporting requirements

August 27, 2014

Page 6: Updated asterisk (**) statement following chart

May 8, 2015

Page 3: Changed CAREN to PARS
Page 7: Changed MSW to LMSW
Page 16: Added email address for questions

September 2015
Page 5: updated general billing guidelines
Page 7: updated conditions of payment