Provider Delivered Care Management
Payment Policy and Billing Guidelines for
Blue Cross Blue Shield of Michigan Medicare Advantage PPO

Purpose

Beginning April 1, 2012, BCBSM began accepting and paying claims for Provider Delivered Care Management services delivered by qualified primary care providers to patients in physician practices that participate with BCBSM.

As of April 1, 2013, four additional codes were added (G9007*, G9008*, 99487*, and 99489*).

Effective Nov. 1, 2013, BCBSM began accepting and paying claims for Provider-Delivered Care Management services delivered by qualified oncology practices. These PDCM payment policy and billing guidelines address Medicare Advantage requirements.

As of Jan.1, 2014, we added code S0257*.

These billing guidelines and payment policy are in regard to HCPCS codes G9001*, G9002*, G9007*, G9008*, and S0257* as well as CPT codes 98961*, 98962*, 98966*, 98967*, 98968* 99487* and 99489*.

Definition

Provider Delivered Care Management refers to a comprehensive array of patient education, coordination and other support services delivered face-to-face and over the telephone by ancillary health care professionals who work collaboratively with the patient, the patient's family, and the patient's primary physician. These professionals perform PDCM services designed to help patients with chronic and complex care issues and address medical, behavioral, and psychosocial needs. PDCM helps patients meet personal health care goals that contribute to optimal health outcomes and lower health care costs. Integrating provider delivered care management into the clinical practice setting is a key component of the patient centered medical home care model fostered by BCBSM in its efforts to transform Michigan's health care delivery.

General conditions of payment

To receive payment for billed PDCM services, the patient must be eligible for PDCM coverage. In addition, billed PDCM services must meet the following criteria:

- 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 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;
- Billed by the approved practice or the PO responsible for the care management team in accordance with BCBSM billing guidelines

Important: Non-approved providers billing for these services are subject to audit and recoveries.

Payment methodology

BCBSM will reimburse PDCM services on a fee-for-service basis. Payments are based on whichever is less – provider charges or BCBSM's MA PPO fee for identified PDCM services. We'll remit only to a physician practice or PO entity approved by BCBSM to bill for PDCM services. PDCM services must also be rendered by the care management team members delivering these services (identified as the "Billing Provider" on the claim).

You can view the approved BCBSM Medicare Advantage PPO fee amount for each of the payable PDCM codes in our fee schedules on web-DENIS. The amount payable to the provider for BCBSM Medicare Advantage PPO patients is paid at one rate.

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*.

Note: PDCM services provided for BCBSM Medicare Advantage PPO patients require specific and detailed documentation. Details about documentation are outlined in the *Billing and Documentation* section of this document.

Patient eligibility

BCBSM Medicare Advantage PPO patients must have active BCBSM Medicare Advantage PPO coverage and PDCM benefits. If the patient has an insurer other than BCBSM commercial or BCBSM Medicare Advantage PPO as his or her primary insurer, the BCBSM Medicare Advantage PPO member is not eligible for PDCM services.

Besides active BCBSM Medicare Advantage PPO coverage and eligibility for PDCM benefits, the patient receiving PDCM services must have:

- One or more clinical conditions that require care management services and that these services may improve patient's wellbeing and functional status.
- A referral for PDCM services from a physician, physician assistant or certified nurse practitioner in a PDCM-approved practice. The patient must have an established care relationship within that practice (or, a formalized standing order is in place between the clinician and care management team).
- Verbally agreed to actively participate in the PDCM care plan. This agreement must be documented in the medical record.

BCBSM will provide a monthly list to each PO 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. 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.

You may not hold the member liable for PDCM services.

PDCM benefit information is available on web-DENIS and CAREN-IVR to validate eligibility and coverage for BCBSM members prior to initiating and billing for PDCM services. In the event that PDCM service claims are submitted to BCBSM for patients that do not have PDCM coverage benefits, those claims will be rejected as a provider liability.

Provider requirements and expectations

BCBSM only pays for PDCM services delivered for an established and ongoing physician-patient relationship. That relationship must exist within a practice approved by BCBSM for PDCM reimbursement.

PDCM-eligible practice

Only those practices that are participants in the BCBSM PDCM program are eligible for PDCM reimbursement.

Eligible practices must have one or more qualified care managers who provide PDCM services. This formalized relationship may consist of an employee, leased employee or independent contractor of the practice. Alternatively, care management team members may be employed by or under contract with the PO with which the PDCM-approved practice is affiliated.

PDCM services should be billed by the approved practice or PO that formally employs or contracts with the care team. If a PO plans to bill BCBSM on behalf of a care management team, that PO must organize as a business entity with a clinical National Provider Identifier.

Further, that NPI must be registered with BCBSM and recognized as a physician practice. BCBSM's Provider Consulting team can help you with this enrollment process.

All care managers (whether employed by the practice or by the PO), must function in concert with the practice care team, resulting in an integrated clinical care process. Care managers should communicate with the practice care team frequently and regularly to share records regarding patient needs and progress.

Care Management Team

The care management team must consist of at least one individual who functions as the care manager. The care manager must:

- Be a licensed allied practitioner of one of the following disciplines: registered nurse, master of social work, certified nurse practitioner, or physician assistant;
- Have completed care management training from a local or national program that meets MiPCT established education and training requirements; 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.

In addition to a care manager, additional allied health practitioners of any of the following disciplines may be on the care management team:

- Registered nurse
- Certified nurse practitioner
- Licensed practical nurse
- Physician assistant
- Clinical pharmacist
- Licensed professional counselor
- Licensed mental health counselor
- Master of social work
- Registered dietician
- Certified diabetes educator
- Masters of science trained nutritionist
- Respiratory therapist
- Certified asthma educator
- Certified health educator specialist (Bachelor's degree or higher in health education)

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.

Each qualified care management team member delivering PDCM services must:

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

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 and documentation guidelines for PDCM codes

General billing guidelines

The following general billing guidelines apply:

- Only those practices or practice-affiliated PO approved for PDCM payments may submit claims for PDCM services.
- Bill PDCM services on a 1500 claim form or electronic equivalent using the appropriate procedure codes as identified in this document.
- Coordination of benefits
    - Bill BCBSM Medicare Advantage PPO directly when BCBSM Medicare Advantage PPO is the primary insurer
    - Bill BCBSM commercial directly when they are the primary insurer
    - **A Medicare Advantage member is not eligible for PDCM services if an insurer other than BCBSM is the primary insurer**
- Other medical services may be billed on the same claim as PDCM services.
- There are no location-of-service restrictions for PDCM. However, care management teams must be sure to clearly coordinate service provisions with the overall clinical care delivered in the physician practice. Teams must also accept overall responsibility for that patient. An example would be functioning as 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: Detailed requirements applicable to BCBSM Medicare Advantage PPO patients are specified under the *Code Specific Guidelines* section.

Rendering and Billing Provider

The billing provider reported on the claim should be the practice or the PO-entity that employs the care management team member performing the service. Payments are sent to the billing provider.

The rendering provider must have an NPI registered with BCBSM. However, BCBSM doesn't recognize many of the non-physician personnel furnishing PDCM services. 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. As such, the primary care provider's NPI may be reported in the rendering provider field on the claim.

For these codes, BCBSM will not require that ancillary personnel furnish PDCM services under direct supervision of that physician. Documentation must, however, demonstrate a previous related face-to-face clinical encounter between the identified primary provider and patient. Documentation must also show there is an active exchange of patient-specific information related to the PDCM services billed.

Code-specific guidelines

Billable PDCM Codes

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

- Care management services delivered by the care management team
- Billed by and paid to physicians for care management activities that they perform

The following chart summarizes the billable PDCM codes by who can bill for 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*
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 Centers for Medicare & Medicaid Services covers a one-time initial preventative physical exam for all Medicare Advantage members within the first 12 months after the effective date of their first Part B coverage period. CMS also covers an annual wellness visit for all Medicare Advantage members who are no longer within the first twelve months of their first Part B coverage period.

It's expected that Medicare Advantage patients will receive either an IPPE or an AWV (depending on where they are in the first part of their Part B coverage), and a comprehensive assessment if needed.

G0402* Initial Preventive Physical Exam

Also known as the “Welcome to Medicare” exam, the IPPE is a face-to-face visit for MA patients during the first twelve months of their first Part B coverage period. The IPPE goals are health promotion and disease prevention and detection.

The IPPE may be performed by a:

- Physician (doctor of medicine or osteopathy) or
- Other qualified non-physician practitioner (physician assistant, nurse practitioner or clinical nurse specialist)

Other HCPCS codes applicable to the IPPE are:

- G0403* – Electrocardiogram, routine ECG with 12 leads performed as a screening for the initial preventative physical exam
- G0404* – Electrocardiogram, routine ECG with 12 leads; tracing only , without interpretation and report performed as a screening for the initial preventative physical exam
- G0405* – Electrocardiogram, routine ECG with 12 leads interpretation and report only performed as a screening for the initial preventative physical exam

G0438* Annual Wellness Visit; Initial Visit
G0439* Annual Wellness Visit; Subsequent Visit

The annual wellness visit is *mandatory* for MA patients (who are no longer within the first twelve months of their first Part B coverage period) for planning and preventive care. It’s required regardless if the member is eligible for PDCM services. Annual wellness visits include personalized prevention plan services and a health risk assessment required under the Affordable Care Act and mandated by CMS.

The AWV may be performed by a physician (doctor of medicine or osteopathy) or qualified non-physician practitioners who are health care team members such as:

- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Or other medical professional (including a health educator, a registered dietitian, nutrition professional, or other licensed practitioner) or a medical professional team working under the direct supervision of a physician (doctor of medicine or osteopathy)

Note: This is updated information regarding eligible AWV and supercedes June 2012 information in which we stated the AWV can only be offered by a physician.

As mentioned, CMS now requires a health risk assessment as part of the AWV. The assessment aims to improve health behaviors and reduce disease and injury risks. Patients should bring their completed health risk assessments to their AWV. Providers may use their

own assessments or one from the list below until CMS issues a model form. Other resources include:

- A health risk assessment available to BCBSM Medicare Advantage PPO members through BCBSM's online Member Secured Services.
- The American College of Physicians website: **Health Risk Assessment - American College of Physicians**,** offering both paper and electronic assessment versions.

CMS' **Initial Preventive Physical Exam and Annual Wellness Visit Frequently Asked Questions**** document contains a link to a quick reference documents for the IPPE and AWV and defines:

- Who is eligible for the IPPE and AWV
- How to find out if a beneficiary has previously had
  - An IPPE
  - An AWV
  - When these services were performed
- Required elements of the exams

Initiation of Care Management (Comprehensive Assessment)

G9001* Coordinated Care Fee, initial rate (per case)

The comprehensive assessment (code G9001*) is *optional* for MA patients. It's performed by a non-physician care manager to determine whether care management is appropriate for the patient.

This code is includes contacts necessary to complete the full assessment and develop the individualized care plan for the patient. This also includes consultations with the patient's primary provider, other professionals, and care-givers, etc. Once G9001 is completed, the patient is considered to be enrolled/engaged in care management

If you have a BCBSM Medicare Advantage PPO patient who is a care management candidate, bill this code for the comprehensive assessment and care plan development activities conducted with the patient prior to enrollment. Use it annually thereafter. Information will be collected through with the member or member's representative or caregiver to develop a goal-based care management plan tailored to the patient's needs, interests and capabilities. Assessment and planning encounters may occur by phone or face-to-face. Multiple contacts may be necessary but must include at least one face-to-face component.

Note: For BCBSM Medicare Advantage PPO patients, assessment encounters must include a face-to-face component.

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In general, BCBSM does not require you to bill G9001* for the other PDCM codes (G9002* and identified CPT codes) to be payable. If a care management service is merely an incidental encounter and not part of a comprehensive care plan with long-term goal setting, then a previous billing of G9001* would not be necessary.

However, if care management services are not incidental, you must conduct an evaluation to identify and develop a comprehensive care plan addressing the full range of patient care needs.

Conditions of Payment

- This code is payable only if the service is delivered by an RN, MSW, CNP or PA who meets the conditions of a care manager (for example, a clinical pharmacist is not a payable provider type for this service).
- The service must be delivered under direct physician supervision if provided by an RN or MSW per CMS requirements. Also:
    - The patient's physician must review and sign the G9001 assessment medical record and include their credentials,
    - The physician's NPI must be reported in the rendering provider field on the claim.
- To be billable, contacts must total at least 30 minutes of discussion with the member or member's representative or caregiver.
- At least one encounter must be face-to-face.
- Treatment for chronic conditions identified during the comprehensive assessment should be handled by the physician and care management team.
- If a patient is entering into care management, the patient must verbally agree to the plan of care that is developed. This agreement must be documented in the medical record.

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.)
- 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 PCP 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. Care plans should be revised as needed for the patient.
- For all BCBSM Medicare Advantage PPO patients, a full re-evaluation should be conducted once every 12 months (and billed under this same code, i.e., G9001*).

Documentation Requirements

Record and maintain the following information in the patient's record:

- Care manager responsible for the overall care plan
- Patient's primary care provider and contact information
- Encounter details, including:
    - care manager's name and title
    - date, duration and modality of contact (face-to-face or phone)
    - If contact is made with a person other than the patient, include the name of the individual and their relationship with the patient
- 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 (such as lifestyle issues, health behaviors or self-management activities)
    - Available resources and unmet needs
    - Level of the patient's understanding of his/her condition(s)
    - If entering into care management:
        - 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 verbal agreement and consent to engage/participate in care management. This agreement must be documented in the medical record.
- If the service is delivered by an RN or MSW, service must be delivered under direct supervision of the patients' physician to meet CMS requirements.
    - The patient's physician must review and sign the G9001 assessment medical record and include their credentials,
    - The physician's NPI must be reported in the rendering provider field on the claim.

Individual Face-to-Face Visit

G9002* Coordinated Care Fee, maintenance rate

Use this code to bill for individual face-to-face care management intervention visits conducted by qualified allied health personnel on the care management team for patients enrolled in care management (may include the patient's caregiver/family). Encounters may involve topics such as self-management training, skill development, education or counseling regarding risks, problem solving, and health or lifestyle coaching by one or more members of the care

management team. Face-to-face care management interventions should only be conducted and billed when the patient and the service merits this level of person-to-person interaction to be successful.

Conditions of Payment

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

Claims Reporting Requirements

- All diagnoses relevant to the encounter should be reported.
- 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. If more than one care management team member has a separate face-to-face with the same patient 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 to 45 minutes, report a quantity of one
        - 46 to 75 minutes, report a quantity of two
        - 76 to 105 minutes, report a quantity of three
        - 106 to 135 minutes, report a quantity of four

Note: For providers submitting paper claims or with limitations regarding the number of diagnoses that can be billed and submitted via a claim, no supplemental method is required to submit additional diagnoses when billing G9002*.

Quantity Limitations

If multiple members of the care team provide this service on the same date, to the same patient, you should quantity bill this procedure code.

Documentation Requirements

Record and maintain the following documentation associated with G9002* in the patient's record:

- Details 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, nonphysician 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, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients**

Use these codes to bill for formalized educational sessions led by one or more qualified allied health personnel delivered in a group setting (more than one patient present). Patient family members can also be included (but do not count as patients). In addition to a given topic, there should be active participation and each session should be customized to address relevant personal needs and issues of each participant.

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 eight, 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 diagnoses relevant to the encounter should be reported.

  Note: For providers submitting paper claims or with limitations regarding the number of diagnoses that can be billed and submitted via a claim, no supplemental method is required to submit additional diagnoses when billing codes 98961* or 98962*.

- Separately billed for each individual patient participating in the group session.

Quantity Limitations

None

Documentation Requirements

Record and maintain the following documentation associated with these codes in the patient's record:

- Details 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 to 10 minutes of medical discussion**
98967* **11 to 20 minutes of medical discussion**
98968* **21 to 30 minutes of medical discussion**

Use these codes for care management services when calling the patient to meet personalized care goals. Don't bill this code for calls to simply remind a patient of an appointment or to share a test result. The interaction must be a genuine conversation between the care management professional and the patient that is substantively relevant to the plan of care established for that patient. Examples include self-management training, skill development, education or counseling regarding risks, problem solving or health or lifestyle coaching.

Conditions of Payment

- This code is payable when delivered by any of the qualified allied personnel approved for PDCM.
- There must be documented consent from the patient that reflects they have agreed to such phone contacts being initiated by care managers.
- Discussions must be substantive and focused on the patient's individualized care plan and goal achievement.

Claims Reporting Requirements

- Code selection depends of the time spent in discussion with the patient. Don't include documentation time.
- All diagnoses relevant to the encounter should be reported.

Note: For providers submitting paper claims or with limitations regarding the number of diagnoses that can be billed and submitted via a claim, no supplemental method is required to submit additional diagnoses when billing codes 98966*, 98967* or 98968*.

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.

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Documentation Requirements

Record and maintain documentation associated with these codes in the patient's record:

- Details 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 should 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. This could include coordinating needed services and medical specialties to manage the patient's complex medical condition, psychosocial needs and daily living. Contacts may be by phone or person-to-person. These codes are reported only once per calendar month for the total accumulation of time spent communicating. Don't include time communicating with the patient's physician or primary care giver.

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.
- The cumulative duration of communication time must be at least 31 minutes to be billable.

- Discussions must be focused on coordinating services for the patient's individualized care plan and goal achievement.

Claims Reporting Requirements

- These codes should be billed at the end of each calendar month.
- 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 helps 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

Documentation Requirements

When billing these codes, patient record documentations should include the following for each contact:

- 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

Team Conference

G9007* **Coordinated care fee, scheduled team conference**

Use this code to bill for scheduled face-to-face meetings between, at minimum, the patient's PCP 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 shouldn't be present. A face-to-face 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

- This code should be billed by the physician and is payable only to the physician.
- The scheduled discussion duration must be at least 10 minutes per patient in duration.
- Discussions must be focused on the patient's individualized care plan and goal achievement.
- Outcomes and next steps for each patient must be agreed upon and documented.

Claims Reporting Requirements

- Should be billed separately for each patient discussed during team conference.

Quantity Limitations

- There is a limit of one G9007 paid per physician, per practice, per patient, per day. This limit does not apply across specialty types; for example, when a patient is being managed by both a PCP care manager and an oncology care manager, both care managers may conduct a team conference as needed and the physician may bill G9007.

Documentation Requirements

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

- Each encounter:
    - 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 when care management is initiated. Complete an assessment and a care plan. The patient must agree to the care plan and formally shared with the physician, care manager and patient directly (ideally, face-to-face). The patient must have received at least one face-to-face care management service, and the physician needs to have connected both the patient and care manager directly. 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 physician 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 physician, care manager and patient is in place.

Quantity Limitations

G9008* may be billed only one time per patient, per physician, per lifetime.

Documentation Requirements

When billing this code, the patient's record documentation should reflect include a written shared action plan developed by the care manager. It should show it's 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)

Use this code to bill for individual face-to-face or phone conversations regarding end-of-life care issues and treatment options. These should be conducted by qualified allied health personnel on the care management team for patients enrolled in care management (and may include the patient's caregiver/family). It should be used to develop or revise 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 includes the following:

- Each encounter should detail:
    - 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 document has been completed.

T Codes

If a patient is engaged in PDCM and you are billing the PDCM codes as outlined in this document, you shouldn't bill the T codes for the same patient.

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

For additional information about the MiPCT/PDCM 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

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

If you have any questions about Provider Delivered Care Management, please contact your BCBSM MA provider consultant.