Multi-payer G and CPT Care Management Billing Code Summary April 2018 v10.3 c

Purpose

This document is a guide to help care management team members quickly understand the requirements and documentation fields required for the billing of G and CPT codes for fee-for-service (FFS) care management service payment. Please note that in previous versions of this guide, coding and documentation requirements were contained on separate grids, but are now combined for ease of use. We express our appreciation to payers for their review of this updated guide. While this document is intended to be helpful in understanding requirements, it does not supersede individual plan detailed criteria. Care Management team members should consult the latest materials from each health plan (BCBSM Commercial, BCBSM Medicare Advantage, Priority Health Commercial, Priority Health Medicare Advantage) for the most complete and up-to-date information regarding these codes and additional details. Many of the codes have the same requirements across payers. Where there are differences among payers, these are explained in the document. This document is updated on a quarterly basis. Online versions can be found at the Michigan Care Management Resource Center website, www.micmrc.org, under the "Programs MiCMRC supports" link. Updates since the last release appear in red font.

A Note for SIM Program Participants

State Innovation Model (SIM) PCMH Initiative practices receive reimbursement for care management and coordination services delivered to Managed Medicaid SIM patients (including those in RHCs and FQHCs) on a PMPM formula based on beneficiary characteristics (e.g., Healthy Michigan, ABD, etc.). To better understand the level and types of care management and coordination services delivered to Medicaid patients in the Initiative, participating practices are required to submit tracking codes. These tracking codes do not generate payment on a FFS basis, but rather are used to help ensure that care management services are provided to beneficiaries. A link to the SIM tracking codes can be found at the end of this document.

Key Billing Code Updates

For CPC+ Participants: A number of Chronic Care Management (CCM) codes are not allowed for any attributed CPC+ Medicare beneficiary (traditional Medicare, not Medicare Advantage). These codes include 99358, 99359, 99487, 99489, 99490, G0506 and G0507. Each quarter, CMS will review claims and initiate recoupment as detailed in the CPC+ guide.

BCBSM: Previously, for the CPC+ participating practices only PCMH-designated practices could bill BCBSM for PDCM procedure codes. Effective 1/1/18 BCBSM announced the ability to bill BCBSM for PDCM procedure codes was expanded to non-designated primary care practices that are participating in CPC+. A column has been inserted to indicate which codes can be billed under the BCBSM PDCM program.

Priority Health: Priority Health does allow for some CCM codes. You may access Priority Health's CPC+ program manual at *priorityhealth.com/provider/center/incentives*. Log in is required.

For Medicaid Beneficiaries: Medicare policy requires Medicaid Health Plans and Traditional Medicaid to reimburse select codes (e.g., 99495, 99496). Where applicable, Managed Medicaid and/or Traditional Medicaid are listed as payers in the billing table below. This policy applies regardless of whether the Medicaid beneficiary is a SIM program participant, or whether the beneficiary is in Traditional Medicaid or Managed Medicaid.

Selecting Care Management Patients

Before submitting G and CPT codes, it is important for care managers to understand the criteria for selecting care management patients. Please refer to the materials provided by the health plan and/or Demonstration program for details regarding G and CPT codes (examples include: State Innovation Model, Comprehensive Primary Care Plus, Blue Cross Blue Shield of Michigan Provider Delivered Care Management, Priority Health).

Qualified Health Professional Definition by Payer for G and CPT Code Submission

Before submitting G and CPT codes, it is important to understand the health professionals eligible to submit codes as these may differ by payer as shown below.

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Multi-payer G and CPT Care Management Billing Code Summary April 2018 v10.3 c

BCBSM:

Lead Care Manager: RN, CNP, PA, LMSW

Qualified Health Professional (Care Team): Clinical pharmacist, LPN, Certified diabetes educator, Registered dietitian, Masters-of-science trained nutritionist, Respiratory therapist, Certified asthma educator specialist (bachelor's degree or higher in health education), Licensed professional counselor, Licensed mental health Counselor, Licensed bachelors level social worker.

PRIORITY HEALTH:

Qualified Health Professional: RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP

STATE INNOVATION MODEL PCMH INITIATIVE:

Care Manager: Registered Nurse, Licensed Practical Nurse, Nurse Practitioner, Licensed Master's Social Worker, Licensed Professional Counselor, Licensed Pharmacist, Registered Dietician, Physician Assistant

Care Coordinator: Licensed Bachelor's Social Worker, Certified Community Health Worker, Certified Medical Assistant, Social Service Technician

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Multi-payer G and CPT Care Management Billing Code Summary April 2018 v10.3 c

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G9001: Initiation of Care Management (Comprehensive Assessment)	<u>BCBSM</u> RN, LMSW, CNP or PA who meet the conditions of a lead care manager <u>BCBSM MA</u> Same as above, but RNs and LMSWs must be under direct physician supervision <u>Priority Health</u> QHP	BCBSM Commercial, BCBSM Medicare Advantage, Priority Health	Y	**<u>All Payers</u>** **Description:** Comprehensive assessment and care plan development with patients, prior to enrollment in care management (and annually thereafter) G9001 is **not** required to be billed for the other PDCM codes to be payable (though it is an expectation that a G9001 be completed). **Conditions of payment:** Contacts must add up to at least 30 minutes of discussion with the member or member's representative/caregiver. Must include a face-to-face visit. Patient/caregiver must formally agree with care plan and this must be documented in the medical record. **Claims Reporting Requirement:** Date of service should be the date the assessment is completed for patients entering into care management. If patient	Description: Comprehensive Assessment and Care Plan Development with Patients, Prior to Enrollment in Care Management (and annually thereafter). Documentation: 1. Lead Care Manager Name, Licensure. BCBSM Only payable when service is delivered by a RN, LMSW, CNP or PA who meet the conditions of Lead Care Manager. Priority Health: RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP 2. Identify Primary Care Physician and Contact Information 3. Date of service = date assessment is completed. Duration, and Modality of Contact (face-to-face required, or can be combination of the face-to-face and phone). 4. Phone Visit, Face-to-Face Visit 5. Visit Duration: 30 min a. BCBSM- Contacts must total at least 30 minutes in duration with at least one face to face encounter with patient. b. Priority Health- Work must encompass minimum of 30 minutes, some of which may be without the patient present. 6. Specific Assessments such as depression, functionality, urologic, etc. 7. Medical Treatment Regimen 8. Risk Factors a. Physical Status (PH)(BCBSM) b. Emotional Status (PH)(BCBSM) 9. Unmet Needs/Available Resources 10. Perceived Barriers to Treatment Plan 11. Adherence 12. Anticipated interventions to help patient achieve their goals 13. Self-Management Activities

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				does not agree to enter into care management, the date of service should be the date of the face-to-face component. All active dx should be reported on the claim. **Quantity limit:** 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. **BCBSM MA** • MD/DO must sign the G9001 assessment and include their credentials • MD/DO's NPI must be reported on rendering provider field on the claim	14. All Active Diagnoses 15. Medication reconciliation 16. Care Plan including interventions (issues, outcome goals, and planned interventions) 17. Individualized Short-Term Goal, including target date 18. Individualized Long-Term Goal, including target date 19. Time Frame for Follow Up 20. Name of Other Individual(s) in Attendance, Relationship to Patient 21. Interventions to Help Patient Achieve Goals 22. Patient's Level of Understanding of his/her condition 23. Readiness for Change 24. Patient's Agreement and consent to Engage/Participate in Care Management 25. Physician coordination activities and approval of Care Plan BCBSM MA-include documentation fields listed above in "all payer" section plus the following: · MD/DO must sign the G9001 Assessment and include their credentials · MD/Dos NPI must be reported on rendering provider field on the claim · To comply with Medicare Star Program include urinary incontinence screen Priority Health-Include documentation fields listed above in "all payer" section, plus the following: · Diagnoses discussed Name of caregiver and relationship to patient, if caregiver is included with the visit · Treatment Plan, physical status, emotional status · Care Plan including challenges and interventions

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Multi-payer G and CPT Care Management Billing Code Summary April 2018 v10.3 c

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G9002: Individual Face-to-Face Visit	BCBSM Lead Care Manager and Other Care Team Members Priority Health QHP	BCBSM Commercial, BCBSM Medicare Advantage, Priority Health	Y	**All payers** **Description:** Individual face-to-face care management intervention visits **Conditions of payment:** • Only conducted/billed when patient circumstances and/or the nature of the service require person-to-person interaction to be successful. • May include the patient's caregiver/family • Must include focused discussion of patient's care plan • Can also include treatment plan, self-management education, medication therapy, risk factors, unmet care, physical status, emotional status, community resources, readiness to change and ongoing care plan development **BCBSM/BCBSM MA** Code may be billed one time per day. If multiple members of the care team provide this service on the same date, to the same patient, this procedure code can be quantity billed. For example: 1-45 minutes (1), 46-75 minutes (2), 76-105 minutes (3), or 106-135 minutes (4). **Priority Health** Code may be billed one time per day.	Description: Individual face-to-face care management intervention visits Documentation: · Name/credentials of team member performing the service · Date of Service · Duration of Face-to-Face Visit · All Diagnoses pertinent to encounter · Medication reconciliation · Focused discussion pertinent to the patients Care Plan (BCBSM) - progress, changes · Short-Term Goal, including target date · Long-Term Goal, including target date · Time Frame for Follow Up • Name of Other Individual(s) in Attendance, Relationship to Patient · Nature of the Discussion and Pertinent Details · Updated Status on Patient's Medical Condition, care needs and progress to goal · Care Needs and progress to goal(s) · Any revisions to the Care Plan Goals, Interventions, and Target Dates · Patient/Care Giver's Level of Understanding · Readiness for Change Priority Health- include documentation fields listed above in "all payer" section plus the following: · Diagnosis Discussed, Treatment Plan, Self-Management Education, Risk Factors, Unmet Care, Emotional Status, Community Resources · Name of Patient's PCP · Physician coordination activities and approval of Care Plan · Patients agreement with care plan

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Multi-payer G and CPT Care Management Billing Code Summary April 2018 v10.3 c

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98961, 98962: Group Education and Training	98961: Education and training for patient self-management for 2–4 patients; each 30 minutes 98962: Education and training for patient self-management for 5–8 patients; each 30 minutes	BCBSM/BCBSM MA Lead Care Manager and Other Care Team Members Priority Health QHP	BCBSM Commercial, BCBSM Medicare Advantage, Priority Health all plan with the exception of Medicaid	Y	**All Payers** **Description:** Formalized educational sessions led by qualified non-physician personnel delivered in a group setting **Conditions of Payment:** • At least two, but no more than 8 patients present • There must be some level of individualized interaction included in the session • Must use a standardized curriculum. **Claims Reporting Requirements:** • Family members should not be counted as patients • All active dx should be reported • Bill separately for each individual patient **Quantity Limits:** None. May be quantity billed.	Description: Formalized educational sessions led by qualified non-physician personnel delivered in a group setting Documentation: 1. Name, Licensure of Group Visit Facilitator(s) Primary Care Physician 2. Date of Class 3. Total Number of Patients in Attendance: 2-4 patients or 5-8 patients 4. Group Visit Duration: 30 min 60 min 90 min if >90 min, indicate total minutes 5. Diagnoses Relevant to the Group Visit 6. Location of Class 7. Nature and Content of Group Visit 8. Objective(s) of the Training 9. Status Update: Medical Condition, Care Needs, Progress to Goal, Interventions, and Target Dates 10. Have some level of individualized interaction(BCBSM) 11. All active diagnosis

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Multi-payer G and CPT Care Management Billing Code Summary April 2018 v10.3 c

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98966, 98967, 98968: 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	<u>BCBSM/BCBSM MA</u> Lead Care Manager and Other Care Team Members <u>Priority Health</u> QHP	BCBSM Commercial, BCBSM Medicare Advantage, Priority Health (all PH plans)	Y	**<u>All payers</u>** **Description:** Non-face-to-face care management services provided to a patient or patient's representative/caregiver using the telephone or by other real-time interactive electronic communication **Conditions of Payment:** • Not for reminder calls about appointments or conveying test results. • For substantive discussions focused on the patient's care plan and goal achievement. **Claims Reporting Requirements:** • Code selection depends on total time spent in discussion with the patient • Report all active dx **<u>BCBSM/BCBSM MA</u>** • Documented consent from patient agreeing to phone contacts initiated by the care manager • You may not quantity bill these codes • Only one of these codes may be billed per day. **<u>Priority Health</u>** • Codes cannot be quantity billed	Description: Non-face-to-face care management services provided to a patient or patient's representative/caregiver using the telephone or by other real-time interactive electronic communication Documentation: 1. Lead Care Manager Name, Licensure (payable when delivered by any of the qualified allied personnel approved for PDCM) 2. Date, Time, and Duration of Call 3. Phone Visit 4. All active diagnoses relevant to the encounter 5. Medications 6. Short-Term Goal, target date 7. Long-Term Goal, target date 8. Care Needs and Progress to Goal(s) 9. Nature of the Discussion and Pertinent Details 10. Updated Status on Patient's Medical Condition 11. Care Needs and Progress to Goal 12. Any revisions to the Care Plan Goals, Interventions, and Target Dates 13. Patient/Care Giver's Level of Understanding 14. Readiness for Change a. Name of Other Individual(s) in attendance, relationship with patient

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						15. Time Frame for Follow Up 16. Visit Duration: 5-10 min 11-20 min 21- 30 min (total time of all calls on a single date of service) 17. Documentation supports consent from the Patient that reflects they have agreed to such phone contacts being initiated by Care Managers or care team.

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Multi-payer G and CPT Care Management Billing Code Summary April 2018 v10.3 c

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99358, 99359: Prolonged E/M Service	99358: Prolonged E/M service before and/or after direct patient care, first 60 minutes 99359: Prolonged E/M service before and/or after direct patient care, each additional 30 minutes (listed separately with 99358)	Physicians; Nurse Practitioners; Physician Assistants	Medicare [except CPC+ patients]	N	**Medicare** CCM and complex CCM reimburse providers for clinical staff time spent providing care management services, not time spent by physicians. For those cases in which a physician spends a significant amount of time outside the usual office visit addressing an individual patient's needs, CMS will make payment under these two codes beginning in 2017. In discussing these services, CMS warns the time counted toward these codes must be separate and distinct from time spent providing any other service reimbursable under the MPFS including, but not limited to, new and established patient office visits, transitional or chronic care management services or care plan development. The CPT prefatory language and reporting rules apply for the Medicare billing of these codes, for example, CPT codes 99358 and 99359:	Description: CCM and complex CCM reimburse providers for clinical staff time spent providing care management services, not time spent by physicians. For those cases in which a physician spends a significant amount of time outside the usual office visit addressing an individual patient's needs Documentation: 1. Duration of visit 2. Content of the medically necessary evaluation and management service and prolonged services that you bill 3. Direct face-to-face time with the patient 4. Start and end times of the visit 5. Date of service. For details and complete listing of Prolonged E/M service elements: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm5972.pdf

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					• Cannot be reported during the same service period as complex Chronic Care Management (CCM) services or transitional care management services • Are not reported for time spent in non-face-to-face care described by more specific codes having no upper time limit in the CPT code set.	

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Multi-payer G and CPT Care Management Billing Code Summary April 2018 v10.3 c

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99487, 99489: Complex Chronic Care Coordination Services	99487: <u>BCBSM/Priority Health</u> 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: <u>BCBSM/Priority Health</u> Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. (An	<u>BCBSM/BCBSMA</u> Lead Care Manager and Other Care Team Members <u>Priority Health</u> QHP <u>Medicare</u> Physicians; Certified Nurse Midwives; Clinical Nurse Specialists; Nurse Practitioners; or Physician Assistants working in a practice that meets all CCM program requirements- *"Incident to" applies.	BCBSM Commercial, BCBSM Medicare Advantage, Priority Health (all plans except Medicaid), Medicare [except CPC+ patients]	Y	**<u>BCBSM/Priority Health</u>** **Description:** For time spent interacting with other providers and/or community agencies in the medical neighborhood to coordinate services needed to manage the patient (time spent communicating with the patient, the patient's PCP or the patient's primary care giver is not included) **Conditions of Payment:** • May be by phone or person-to-person • Accumulated time must be 31 minutes to bill 99487 **Claims Reporting Requirements:** • Reported once per calendar month to encompass accumulated time. Bill at the end of the month	Description: For time spent interacting with other providers and/or community agencies in the medical neighborhood to coordinate services needed to manage the patient (time spent communicating with the patient, the patient's PCP or the patient's primary care giver is not included) Documentation: 1. Date of Contact 2. Duration of Contact 3. Name and Credentials of the allied professional on the Care Team making the contact 4. Identification of the Provider or community agency with whom the discussion is taking place 5. Nature of the discussion and pertinent to the patient's individualized care plan and goal achievement. Priority Health- Include documentation fields listed above in "all payer" section, plus the following: · Diagnoses discussed · Care Team coordination activities · Names of providers contacted in the course of coordinating care. · Development and/or maintenance of the Care Plan

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	Medicare Add-on code to 99487, for each 30-minute increment that does beyond 60 minutes				utilizing the last encounter date **Quantity Limits:** • 99487 may only be billed once per calendar month, per patient • 99489 may be quantity billed **Medicare** The billing rules for CCM (CPT 99490) and complex CCM are the same, except complex CCM requires 60 minutes of non-face-to-face care management services per month, as compared to 20 minutes for CCM. CMS also will pay for an add-on code for complex CCM, CPT 99489, for each 30-minute increment that goes beyond the initial 60 minutes.	Medicare- Include documentation fields listed above in "all payer" section, plus the following: · Verbal consent is documented in the medical record, and information must be explained to the patient for transparency · Comprehensive Care Plan for all health issues Problem list · Expected outcome and prognosis · Measurable treatment goals · Symptom management · Planned interventions and identification of the individuals responsible for each intervention · Measurable treatment goals · Medication management · Community/social services ordered · A description of how services of agencies and specialists outside the practice will be directed/coordinated · Schedule for periodic review and, when applicable, revision of the care plan "Incident to applies" For details and complete listing of CCM service elements: 1) https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf 2) https://www.cms.gov/Medicare/Medicare-Fee-for- Service-Payment/HospitalOutpatientPPS/Downloads/Payme nt-Chronic-Care-Management-Services-FAQs.pdf

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Multi-payer G and CPT Care Management Billing Code Summary April 2018 v10.3 c

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G9007: Coordinated care fee, scheduled team conference	Primary Care Practitioner BCBSM/BCBSM MA Lead Care Manager and Other Care Team Members Priority Health Physician	BCBSM Commercial, BCBSM Medicare Advantage, Priority Health	Y	**All Payers** **Description:** Scheduled meetings between PCP and care manager to discuss a patient's care plan (without the patient present). Can be conducted face-to-face, by telephone or by secured video conference. **Conditions of Payment:** • To be billed by the primary care practitioner and payable only to the primary care practitioner. • Based on a change in the patient's care plan • Discussions must be focused on the patient's individualized care plan (including significant change in patient status and/or unresolved barriers) 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:** Bill separately for each patient discussed **Quantity Limits:** Limit of one G9007 paid per primary care practitioner, 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	Description: Scheduled meetings between Primary Care Practitioner and care manager to discuss a patient's care plan (without the patient present). Can be conducted face-to-face, by telephone or by secured video conference. Documentation: 1. Date of Team Meeting 2. Duration of discussion for individual Patient 3. Name and credentials of allied professionals present for Team Conference 4. Nature of the discussion and pertinent details 5. Any revisions to the Care Plan Goals, Outcomes, Interventions, and Target Dates. Outcomes and next steps for each patient must be agreed upon and documented. Priority Health- Include documentation fields listed above in "all payer" section, plus the following: · Diagnoses discussed · Treatment Plan, Self-Management Education, Medication Therapy, Risk Factors, Unmet Care, Physical Status, Emotional Status, Community Resources, Readiness to Change. Tip: self- management goals. · Physician coordination activities and approval of Care Plan · Billed under the physician and is payable only to the physician · Physician approval of care plan

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Multi-payer G and CPT Care Management Billing Code Summary April 2018 v10.3 c

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G9008: Engagement Fee for Physician Coordinated Care Oversight Services	Physician <u>BCBSM/BCBSM MA</u> Physician <u>Priority Health</u> Physician	BCBSM Commercial, BCBSM Medicare Advantage, Priority Health (all PH plans)	Y	**<u>All Payers</u>** **Description**: Engagement fee billed by physician at the initiation of care management. Differs from G9001 in that G9001 is the comprehensive assessment and care plan development activities conducted by the care manager. **Conditions of Payment:** • E&M visit performed by the physician must be simultaneously or previously billed for the patient (for Priority Health: in close proximity to the visit date) • A G9001 or G9002 performed by the care manager must be (for BCBSM: simultaneously or previously billed for the patient) or (for Priority Health: billed in close proximity to this visit date) • Patient/care giver understanding and agreement to care plan • Service must include completion of patient assessment. • Bill code after the patient enrolls in a care management program. **<u>BCBSM/BCBSM MA</u>** • Care plan must be 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	Description: Engagement fee billed by physician at the initiation of care management. Differs from G9001 in that G9001 is the comprehensive assessment and care plan development activities conducted by the care manager. Documentation: 1. A written, shared action plan for the patient developed by the Lead Care Manager that has been reviewed and approved by the billing physician 2. 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 identified goals 3. Documentation reflects Patient's agreement to participate in Care Management Priority Health- Include documentation fields listed above in "all payer" section, plus the following: · PCP approval of care plan · Date of Visit · Appointment Duration · Care Team Member Names and Credentials · Name of Care Giver and Relationship to Patient if caregiver is included with the visit · Diagnoses discussed Treatment Plan, Self-Management Education, Medication Therapy, Risk Factors, Unmet Care, Physical Status, Emotional Status, Community Resources, Readiness to Change · Physician coordination activities & approval of Care Plan

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				management service, and the physician needs to have bridged the patient and care manager through direct interaction with both. • **Quantity Limits:** 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 **<u>Priority Health</u>** • Service must include patient face-to-face: Either face-to-face with PCP, patient and care manager, OR face-to-face with patient and care manager, with care manager/PCP direct involvement on a separate occasion. **Quantity Limits**: Billable one time per practice during the time the patient is a member of the practice	.

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Multi-payer G and CPT Care Management Billing Code Summary April 2018 v10.3 c

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99490: Chronic Care Management Code	Physicians; Certified Nurse Midwives; Clinical Nurse Specialists; Nurse Practitioners; Physician Assistants working in a practice that meets CCM program requirements Priority Health Medicare Physicians	All Medicare Advantage plans, Medicare [except CPC+ patients], Priority Health Medicare *"Incident to" applies.	N	**All Payers** **Description:** Non-face-to-face care coordination services furnished to beneficiaries with multiple chronic conditions **Conditions of Payment:** • A physician may simply document in the medical record that certain information regarding CCM was furnished to the patient. • Must take at least 20 minutes of staff time over the course of one month • Work must be directed by a physician or qualified health professional • Patients must have two or more chronic conditions that place them at a significant risk of death, acute exacerbation/decompensation, or functional decline • Care plan must be implemented, revised or monitored during the course of care • Clinical staff incident to the billing physician or non-physician practitioner (under general supervision) count toward the minimum amount of service time required to bill the CCM service • CMS requires the billing practitioner to furnish an Annual Wellness Visit (AWV), Initial Preventive Physical Examination (IPPE), or comprehensive evaluation and management visit to the patient prior to billing the CCM service, and to initiate the CCM service as part of this Patient Agreement exam/visit. **Quantity Limits:** Can be billed once per month	Description: Non-face-to-face care coordination services furnished to beneficiaries with multiple chronic conditions Documentation: 1. Verbal consent is documented in the medical record, and information must be explained to the patient for transparency 2. Comprehensive Care Plan for all health issues typically includes, but is not limited to, the following elements: 3. Problem list 4. Expected outcome and prognosis 5. Measurable treatment goals 6. Symptom management 7. Planned interventions and identification of the individuals responsible for each intervention 8. Measurable treatment goals 9. Medication management 10. Community/social services ordered 11. A description of how services of agencies and specialists outside the practice will be directed/coordinated 12. A person centered, electronic care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment, and an inventory of resources (a comprehensive plan of care for all health issues, with particular focus on the chronic conditions being managed) 13. Schedule for periodic review and, when applicable, revision of the care plan For details and complete listing of CCM service elements:

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					• https://www.cms.gov/Outreach-and- Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManag ement.pdf • https://www.cms.gov/Medicare/Medicare-Fee-for- Service-Payment/HospitalOutpatientPPS/Downloads/Payme nt-Chronic-Care-Management-Services-FAQs.pdf

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Multi-payer G and CPT Care Management Billing Code Summary April 2018 v10.3 c

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G0506: Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services, including assessment during the provision of a face-to-face service	Billing Practitioner Priority Health Physician	Medicare [except CPC+ patients], Priority Health Medicare	N	This code extends payment for CCM initiating visits that require extensive face-to-face assessment and care planning by the billing provider: When the provider billing and initiating CCM personally performs extensive assessment and care planning beyond the usual effort described by the E/M, AWV, or IPPE code, the provider could also bill G0506. This is considered an add-on code and does not require a modifier. You can bill this code separately from the monthly care management service codes (99490, 99487, and 99489). However, the time and effort described by G0506 cannot also be counted toward another code. G0506 can only be billed once per patient per provider.	Description: Comprehensive assessment of and care planning for patients requiring chronic care management services, extends payment for CCM initiating visits that require extensive face-to-face assessment and care planning by the billing provider: Documentation: 1. Extensive assessment and CCM care planning beyond the usual effort described by the separately billable CCM initiating visit

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Multi-payer G and CPT Care Management Billing Code Summary April 2018 v10.3 c

Code	Who can provide service?	Payers	PDCM BCBSM	Notes	Documentation
99495: Transitional Care Management	MD and DO of any specialty, NP, PA, CNS, or CNM. Provider does not need to have an established relationship with the patient.	BCBSM, Medicare (including CPC+ patients), Medicare Advantage, Medicaid, Priority Health (all plans), Managed Medicaid Health Plans, Traditional 99 Medicaid *"Incident to" applies.	N	**All Payers** **Description:** Transitional care management services for patients whose medical and/or psychosocial problems require **moderate** complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domicile, rest home, or assisted living). **Conditions of Payment:** • The practitioner must communicate with the patient by the end of the day on the second business day following the day of discharge. Communication can be face-to-face, phone, or email. • Face–to-face visit is required **within 14 days of discharge** • The first face-to-face visit is not reported separately, though E&M services provided after the first face-to-face visit can be billed (with some exceptions)	Description: Transitional care management services for patients whose medical and/or psychosocial problems require **moderate** complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domicile, rest home, or assisted living). Documentation: 1. Date of visit 2. Date of interactive contact with the beneficiary and/or caregiver 3. Electronic, telephone or face to face 4. Place of service 5. Complexity of medical decision making moderate. Documentation of any medical or psychosocial problems. Testing ordered, reviewed. Consultations with other providers. Indication of number of problems (established or new) 6. Diagnosis: Report the diagnosis(s) for the conditions requiring TCM services. General conditions the patient at the time of discharge. 7. Medication reconciliation and management no later than the date of the face-to face visit

*For BCBSM, code applies to PDCM, BDTC, and HICM services, as stated above.

					Quantity Limits and other Limitations: • Medicare and Priority Health will only pay one physician or qualified practitioner for TCM services per beneficiary per 30-day period following a discharge • The provider who reports a service with a global period of 010 or 090 days may not also report the TCM service	CMS-Include documentation fields listed above in "all payer" section, plus the following: · Date of beneficiary discharge · Applicable physical exam findings For details and complete listing of TCM service elements: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

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Multi-payer G and CPT Care Management Billing Code Summary April 2018 v10.3 c

Code	Who can provide service?	Payers	PDCM BCBSM	Notes	Documentation
99496: Transitional Care Management	MD and DO of any specialty, NP, PA, CNS, or CNM. Provider does not need to have an established relationship with the patient.	BCBSM, Medicare (including CPC+ patients), Medicare Advantage, Medicaid, Priority Health (all plans), Managed Medicaid Health Plans, Traditional Medicaid *"Incident to" applies.	N	**All Payers** **Description:** Transitional care management services for patients whose medical and/or psychosocial problems require **high** complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domicile, rest home, or assisted living). **Conditions of Payment:** • The practitioner must communicate with the patient by the end of the day on the second business day following the day of discharge. Communication can be face-to-face, phone, or email. • Face–to-face visit is required **within 7 days of discharge** • The first face-to-face visit is not reported separately, though E&M services provided after the first face-to-face visit can be billed	Description: Transitional care management services for patients whose medical and/or psychosocial problems require **high** complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domicile, rest home, or assisted living). Documentation: 1. Date of visit 2. Date of interactive contact with the beneficiary and/or caregiver 3. Electronic, telephone or face to face 4. Place of service 5. Complexity of medical decision making high. Documentation of any medical or psychosocial problems. Testing ordered, reviewed. Consultations with other providers. Indication of number of problems (established or new) 6. Diagnosis: Report the diagnosis(s) for the conditions requiring TCM services. General conditions the patient at the time of discharge. 7. Medication reconciliation and management no later than the date of the face-to face visit CMS-Include documentation fields listed above in "all payer" section, plus the following: · Date of beneficiary discharge · Applicable physical exam findings

*For BCBSM, code applies to PDCM, BDTC, and HICM services, as stated above.

				(with some exceptions) **Quantity Limits and other Limitations:** • Medicare and Priority Health will only pay one physician or qualified practitioner for TCM services per beneficiary per 30-day period following a discharge • The provider who reports a service with a global period of 010 or 090 days may not also report the TCM service **BCBSM** Not all practices are using the Transitional Care Management (99495 and 99496) codes at this time. For the practices who are using the TCM codes 99495 and 99496; the practice cannot bill TCM and G/CPT code (G 9002, 98966, 98967, 98968) at the same time if the work is related to "Transition of Care."	For details and complete listing of TCM service elements: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNProducts/Downloads/Transitional-Care- Management-Services-Fact-Sheet-ICN908628.pdf **BCBSM** Services performed during the face to face visit must take place in conjunction with the appropriate non-face-to- face TCM services outlined within the "Transitional Care Management Services" section of the CPT manual" Not all practices are using the Transitional Care Management (99495 and 99496) codes at this time. For the practices who are using the TCM codes 99495 and 99496; the practice cannot bill TCM and G/CPT code (G 9002, 98966, 98967, 98968) at the same time if the work is related to "Transition of Care."

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Multi-payer G and CPT Care Management Billing Code Summary April 2018 v10.3 c

Code	Description	Who can provide service?	Payers	PDCM BCBSM	Documentation
99497, 99498: Advanced Care Planning	99497: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; **first 30 minutes**, face-to-face with the patient, family member(s), and/or surrogate. 99498: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; **each additional 30 minutes** (List separately in addition to code for primary procedure.)	RNs, Certified NPs, PA-Cs, Licensed Masters Social Workers (LMSWs), Psychologists (LLPs and PhDs), Certified Diabetic Educators (CDEs), Registered Dieticians and Masters'-trained nutritionists, Clinical Pharmacists, Respiratory Therapists *"Incident to" applies.	Medicare, Medicare Advantage, Priority Health Commercial and Medicare, BCBSM Commercial	N	Description: The explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional. Documentation: 1. Total time in minutes 2. Patient/surrogate/family "given opportunity to decline" 3. Details of content/discussion a. (e.g. Who was involved? What was discussed? Understanding of illness, spiritual factors.) 4. Why are they making the decisions they are making? 5. Was any advance directive offered/filled out, if yes describe? 6. Follow-up Priority Health- Include documentation fields listed above in "all payer" section, plus 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 · (Required for Medicare Advantage only): Patient consent for ACP performed as part of an annual wellness visit · How the patient prefers to be treated by others · What the patient wishes others to know Adequate documentation also requires an indication of whether or not an advance directive or POLST (physician orders for life-sustaining treatment) document has been completed For more information on Medicare Advance Care Planning: https://www.cms.gov/Outreach-and-Education/Medicare-Learning- Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

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Multi-payer G and CPT Care Management Billing Code Summary April 2018 v10.3 c

Code	Who can provide service?	Payers	PDCM BCBSM	Notes	Documentation
S0257: Face to face or telephonic counseling and discussion regarding advance directives or end of life care planning and decisions	Lead Care Manager, Physician and other care team members	BCBSM Commercial, BCBSM Medicare Advantage, Priority Health Commercial and Medicare Advantage Products	Y	**<u>All Payers</u>** **Description:** 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. **Claims Reporting Requirements:** All active dx should be reported. **Quantity Limits:** None.	Description**:** 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. Documentation: 1. Enumeration of each Encounter including: a. Date of Service b. Duration of Contact c. Name and credentials of the allied professional delivering service d. Other individuals in attendance (if any) and their relationship with the Patient e. All active Diagnoses 2. Pertinent details of the discussion (and resulting Advance Care Plan decisions), which, at a minimum, must include the following: a. A person designated to make decisions for the Patient if the Patient cannot speak for him or herself b. The types of medical care preferred c. The comfort level that is preferred 3. Advance Care Planning discussions/decisions may also include: a. How the Patient prefers to be treated by others b. What the Patient wishes others to know 4. Indication of whether or not an Advance Directive or Physician Orders for Life-Sustaining Treatment (POLST) document has been completed

*For BCBSM, code applies to PDCM, BDTC, and HICM services, as stated above.

BILLING AND CODING RESOURCES

ELECTRONIC VERSION OF THIS GUIDE AND FUTURE UPDATES: This guide is updated quarterly and placed electronically on the Care Management Resource Center's Care Management Billing Resources link at : http://micmrc.org/training/care-management-billing-resources. Additional resources specific to individual payers can also be found here.

MEDICAID SIM PCMH TRACKING CODE GUIDE (for submitting tracking codes to Medicaid Health Plans for eligible care coordination and management SIM PCMH Initiative services). The Medicaid SIM PCMH Tracking Code Guide is being updated, but will soon be available as part of the the 2018 SIM PCMH Participation Guide. A link to the updated guide, as well as the March 2018 webinar with further explanation, will be available shortly.

CMS has published an electronic resource called "CMS Connected Care: The CCM Toolkit for Professionals" that offers : https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/chronic-care-management.html

PRIORITY HEALTH also makes available useful online resources:

- Log in online at *priorityhealth.com/provider*. You'll find care management information and more in Procedures & Services > Medical/Surgical Services > Care Management. Here, you'll also find a link to our printable Expanded Services Contracted Billable Codes listing.
- Please note that certain care management code claims submitted for services delivered are batched and paid by Priority every 60 days to allow for the claim to be processed and for any member liability to be removed. This important step allows for care management services to be delivered without members incurring financial liability, reducing barriers to engaging patients in care management. This batching/delayed payment process affects the following care management codes: G codes, telephonic CPT, and collaborative care management CPT codes. If you have questions about any of this information, please contact your Provider Performance Specialist.

Behavioral Health Codes: To access information regarding the Medicare Behavioral codes visit the Medicare Learning Network by Clicking Here . For an FAQ regarding Behavioral Health codes Click Here

Reference: This document is produced by the University of Michigan's Multipayer Primary Care and Michigan Care Management Resource Center teams.

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