Summary BCBSM and Priority Health Billable Procedure codes – Care Management applicable CPT codes and HCPCS Codes v6
This multipayer table offers a high level summary for BCBSM Provider Delivered Care Management and Priority Health

Code	Description	Delivery Method	Licensed Care Team*	Unlicensed Care Team*	Physician	Quantity Limits	Notes/Documentation
G9001 **BCBSM**	Coordinated care fee — initial	Individual, face to face or video	X			One per patient per day	Notes: Initiation of Care Management (Comprehensive Assessment) Appropriate for licensed staff engaging in care management. Must have completed training in complex care management.
G9001 **Priority Health**	Coordinated care fee — initial	Individual, face to face	**QHP** -RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP	**QHP:** CDE, CAE		May be billed once annually for patients with ongoing care management	Notes: Must have completed required care management training Documentation: 1. Date(s) of visit(s) Appointment duration 2. Care manager name and credentials Comprehensive patient assessment 3. Name of the caregiver and relationship to patient, if caregiver is included with the visit 4. Diagnoses discussed 5. Treatment plan, medication therapy, risk factors, unmet care, physical status, emotional status, community resources, readiness to change 6. Care plan, including challenges and interventions Patient understanding and agreement with care plan 7. Physician coordination activities and approval of care plan 8. Name of member's PCP
G9002 **BCBSM**	Coordinated Care fee — maintenance	Individual, face to face or video	X			For visits >45 minutes may quantity bill	Notes: Individual face to face visit. Appropriate for licensed staff engaging in care management. After 45 minutes, you can quantity bill in 30-minute increments
G9002 **Priority Health**	Coordinated Care fee — Individual face to face visit	In person visit with patient, may include caregiver involvement	**QHP** -RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP	**QHP:** CDE, CAE		Code may be billed one time per day	Documentation: 1. Date(s) of visit(s) Appointment duration 2. Care manager name and credentials 3. Name of the caregiver and relationship to patient, if caregiver is included with the visit 4. Diagnoses discussed 5. Treatment plan, self-management education, medication therapy, risk factors, unmet care, physical status, emotional status, community resources, readiness to change 6. Care plan update 7. Patient understanding and agreement with care plan 8. Physician coordination activities and approval of care plan 9. Name of member's PCP
G9007 **BCBSM**	Team conference	Face to face, video, telephone or secure web conf. between physician, physician assistant, or advance practice nurse and care team			X	1 per patient per practitioner per day	Notes: Team conference does not include patient; email communication doesn't apply.
G9007 **Priority Health**	Coordinated care fee, scheduled team conference	Scheduled care team meetings: physician, care manager and other QHPs*	physician, care manager and other QHPs*		X	One time per day	Documentation: 1. Date(s) of conference(s) Conference duration 2. Care team names and credentials Diagnoses discussed 3. Treatment plan, self-management education, medication therapy, risk factors, unmet care, physical status, emotional status, community resources, readiness to change 4. Care plan updates 5. Physician coordination activities and approval of care plan

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G9008 **BCBSM**	Physician coordinated care oversight services	Face to Face, video or by telephone; physician discussion with Paramedic, patient, or other health care professionals not part of the care team			X	None	Notes: This is a physician-delivered service, commonly used when the physician engages patient into PDCM, physician is actively coordinating care with the team or interacting with another health care provider seeking guidance or background information to coordinate and inform the care process
G9008 **Priority Health**	Coordinated care fee, scheduled conference, physician oversight service	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.			X	This code may only be billed one time, per practice, during the time that patient is a member of the practice	Documentation: 1. Date(s) of visit Appointment duration 2. Care team member names and credentials 3. Name of the caregiver and relationship to patient, if caregiver is included with the visit 4. Diagnoses discussed 5. Treatment plan, self-management education, medication therapy, risk factors, unmet care, physical status, emotional status, community resources, readiness to change 6. Preparation of shared care plan written by care manager PCP approval of care plan 7. Patient understanding and agreement with care plan Physician coordination activities and approval of care plan
S0257 **BCBSM**	End of Life Counseling	Individual face to face, video or telephone	X		X	One per patient per day	Notes: An evaluation and management service may be billed on the same day and interaction may be with the patient or "surrogate."
S0257 **Priority Health**	Counseling and discussion regarding advance directives or	Individual face to face, video, or telephone	**QHP** -RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP		X	None	Documentation: 1. Enumeration of each Encounter including: a. Date of Service

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	end of life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management 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
98961 **BCBSM**	Group education 2-4 patients for 30 minutes	Face to face with patient and caregivers	X			Quantity bill per 30-minute increments	

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98961 **Priority Health**	Group education and training, 2-4 patients, each 30 min.	Face to face with patient and caregivers	**QHP** -RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP	**QHP:** CDE, CAE		Quantity bill per 30-minute increments	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
98962 **BCBSM**	Group education 5-8 patients for 30 Minutes	Face to face with patient and caregivers	X			Quantity bill per 30-minute increments	
98962 **Priority Health**	Group education and training, 5-8 patients, each 30 min.	Face to face with patient and caregivers	**QHP** -RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP	**QHP:** CDE, CAE		Quantity bill per 30-minute increments	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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Code	Description	Delivery Method	Licensed Care Team*	Unlicensed Care Team*	Physician	Quantity Limits	Notes/Documentation
98966 **BCBSM**	Phone services 5-10 minutes	Call with patient or caregiver	X	X		No quantity billing	Notes: Not appropriate for appointment reminders or delivering lab results. Generally used to discuss care issues, such as progress toward goals, update of patient's condition, follow up to emergency department visit or hospitalization when not part of transition of care service.
98966 **Priority Health**	Telephone assessment and management service provided by a qualified non-physician health care professional* to an established patient, parent or guardian; 5-10 minutes of medical discussion	Call with established patient, parent or guardian	**QHP** -RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP	**QHP:** CDE, CAE			Documentation: 1. Date(s) of contacts 2. Contact duration 3. Care team names and credentials 4. Diagnoses discussed 5. Development and/or maintenance of a shared care plan 6. Care team coordination activities 7. Names of providers contacted in the course of coordinating care 8. Discussion notes for each contact
98967 **BCBSM**	Phone services 11-20 minutes	Call with patient or caregiver	X			No quantity billing	Notes: Appropriate for licensed staff performing care management functions by phone. Not appropriate for appointment reminders or delivering lab results.
98967 **Priority Health**	Telephone assessment (see above), 11-20 minutes of medical discussion	Call with established patient, parent or guardian	**QHP** -RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP	**QHP:** CDE, CAE			Documentation: 1. Date(s) of contacts 2. Contact duration 3. Care team names and credentials 4. Diagnoses discussed 5. Development and/or maintenance of a shared care plan 6. Care team coordination activities 7. Names of providers contacted in the course of coordinating care 8. Discussion notes for each contact
98968 **BCBSM**	Phone services 21-30 minutes	Call with patient or caregiver	X			No quantity billing	Notes: Appropriate for licensed staff performing care management functions by phone. Not appropriate for appointment reminders or delivering lab results.
98968 **Priority Health**	Telephone assessment (see above), 21-30 minutes of medical discussion	Call with established patient, parent or guardian	**QHP** -RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP	**QHP:** CDE, CAE			Documentation: 1. Date(s) of contacts 2. Contact duration 3. Care team names and credentials 4. Diagnoses discussed 5. Development and/or maintenance of a shared care plan 6. Care team coordination activities 7. Names of providers contacted in the course of coordinating care 8. Discussion notes for each contact

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99078 **Priority Health**	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)	Group setting	QHP	QHP	X		
99484 **Priority Health**	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional				X directed by a physician or other qualified health care professional	Once per calendar month	Required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team. General behavioral health integration care management services are provided face-to-face by clinical staff, under the direct supervision of a qualified clinician, to a patient with a diagnosed health care condition, including substance abuse issues requiring care management services for a minimum of 20 minutes per month.
99487 **BCBSM**	Care management services 31-75 Minutes per Month	Non-face-to- face clinical coordination	X	X		Once per patient per calendar month	Care Coordination
99487 **Priority Health**	Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	Care must be coordinated by a physician and the care team. Patient does not need to be present				Once per patient per calendar month	Documentation: 1. Date(s) of contacts Contact duration 2. Care team names and credentials Diagnoses discussed 3. Development and/or maintenance of a shared care plan Care team coordination activities 4. Names of providers contacted in the course of coordinating care Discussion notes for each contact

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99489 **BCBSM**	Care management services — every additional 30 minutes per month	Non-face-to-face clinical coordination	X	X		Time-based quantity billing	Notes: After 75 minutes, this code can be quantity billed in 30 minute increments.
99489 **Priority Health**	Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	Care must be coordinated by a physician and the care team. Patient does not need to be present	physician or other qualified health care professional		X	Billed in cases where the cumulative time exceeds 90 minutes. Multiple units may be billed	Documentation: 1. Date(s) of contacts Contact duration 2. Care team names and credentials Diagnoses discussed 3. Development and/or maintenance of a shared care plan Care team coordination activities 4. Names of providers contacted in the course of coordinating care Discussion notes for each contact
99490 Priority Health	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.	Face to face/non face to face	X clinical staff under the direction of a qualified healthcare professional			Once per calendar month	Time spent face-to-face or non-face-to-face with clinical staff communicating with the patient, family, caregivers, other health care professionals, and agencies revising, documenting, and putting into action the care plan or teaching the patient self-management skills or techniques may be used to determine the care management staff time for that one-month time period. Time with clinical staff is reported only when there are two or more staff members meeting regarding the specific patient. Additionally, time with clinical staff should not be counted if the clinician has reported an E/M service for that same date

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Code	Description	Delivery Method	Licensed Care Team*	Unlicensed Care Team*	Physician	Quantity Limits	Notes/Documentation
99492 Priority Health	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; review by the psychiatric consultant with modifications of the plan if recommended; entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.	Non face to face	X qualified clinician overseeing a behavioral health care manager and psychiatric consultant. The psychiatric consultant contracts directly with the qualified clinician to render the consultation portion of the service				The required elements include outreach and engagement; initial patient assessment that involves the administration of a validated rating scale; development of an individual patient care plan; psychiatric consultant review and modifications, as needed; input of patient data into a registry and tracking of patient progress and follow-up; and provision of brief interventions using evidence-based techniques
99493 Priority Health	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the	Non face to face	X qualified clinician overseeing a behavioral health care manager and psychiatric consultant. The psychiatric consultant contracts directly with the qualified clinician to render the consultation portion of the service				The required elements include tracking patient follow-up and progress via registry; weekly caseload participation with a psychiatric consultant; working together and coordinating with the qualified clinician on a regular basis; additional ongoing review of the patient's progress and recommendations for treatment changes, including medications with the psychiatric consultant; provision of brief interventions with the use of evidence-based techniques; monitoring patient outcomes using validated rating scales; and relapse prevention planning

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	psychiatric consultant; ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.						
99494 Priority Health	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)	Non face to face	X qualified clinician overseeing a behavioral health care manager and psychiatric consultant. The psychiatric consultant contracts directly with the qualified clinician to render the consultation portion of the service			2 per day	99494 for each additional 30 minutes of initial or subsequent care in a calendar month.
99495 Priority Health	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period	one face-to-face encounter in addition to other services performed within the specific timeframe by licensed clinical staff	physician or other qualified health care professional			may only be reported one time within 30 days of discharge and by only one provider.	Transitional care management services are reported for patients requiring moderate to high complex medical decision making who are transitioning from an inpatient facility to a home or community type setting, such as a domiciliary or assisted living facility

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	Face-to-face visit, within 14 calendar days of discharge						
99496 Priority Health	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge	one face-to-face encounter in addition to other services performed within the specific timeframe by licensed clinical staff	physician or other qualified health care professional			may only be reported one time within 30 days of discharge and by only one provider.	Transitional care management services are reported for patients requiring moderate to high complex medical decision making who are transitioning from an inpatient facility to a home or community type setting, such as a domiciliary or assisted living facility

***BCBSM Note: It is expected that all team members act within their scope of licensure, certification, or authorization by the Physician, Physician Assistant or Advanced Practice Nurse.**

BCBSM: To access BCBSM PDCM Billing guidelines and resources **https://micmrc.org/training/care-management-billing-resources**

PRIORITY HEALTH 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 Priority Health's printable Expanded Services Contracted Billable Codes listing.

MEDICAID SIM PCMH Tracking Code Guide: please refer to the SIM PCMH Tracking Code table located in the 2019 SIM PCMH Participation Guide. This document has information regarding submitting tracking codes to Medicaid Health Plans for eligible care coordination and management SIM PCMH Initiative services. Also, for additional information please access The SIM PCMH Care Management Tracking Codes Q and A

Reference: This document is produced by the Michigan Institute for Care Management and Transformation