



**Provider Delivered Care Management
Payment policy and billing guidelines
for Blue Cross Blue Shield of Michigan
Commercial Members
Policy updated March 1, 2019**

Background

Goal

Provider Delivered Care Management (PDCM) builds upon the Patient Centered Medical Home (PCMH) in transforming care delivery, enabling providers to deliver coordinated team-based care. The program allows physician-lead health care teams to deliver services that are billed by qualified practitioners. Program goals include improved outcomes such as lower emergency department use, fewer inpatient stays and consistent delivery of recommended services, such as cancer screening, hypertension and diabetes management.

Eligible providers

The following provider and practice types can bill Blue Cross Blue Shield of Michigan for PDCM services within the context of an ongoing established physician-patient relationship:

- PCMH-designated providers, including physician assistants and advanced practice nurses¹ within PCMH practices
- Comprehensive Primary Care Plus (CPC) - participating practices that are not PCMH designated
- Physician Group Incentive Program specialty practices that have the following six Patient-Centered Medical Home — Neighbor (PCMH-N) capabilities in place and actively in use within six months of starting to bill PDCM codes. For more information, please refer to the *PCMH Interpretive Guidelines*.
 - Evidence-based guidelines used at point of care (4.3)
 - Action plan and self-management goal setting (4.5)
 - Medication review and management (4.10)
 - Identify candidates for care management (4.19)
 - Systematic process to notify patients of availability of care management (4.20)
 - Conduct regular case reviews, update complex care plans (4.21)

Billable procedure codes

The applicable codes for PDCM service delivery include the following:

HCCPS Codes: G9001*, G9002*, G9007*, G9008*, S0257*

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

Note: Each of these codes are paid without cost share from the Blue Cross member. Claims rejections for these services are “provider liable,” meaning that the provider may not charge the member for the service.

General guidelines on PDCM

- Requirements:
 - Claims must be reported through the rendering provider (Physician, Physician Assistant, or Advanced Practice Nurse)

¹ “Advanced practice nurse” refers to a family nurse practitioner, certified nurse practitioner, certified nurse midwife, certified registered nurse anesthetist or any nurse who has received advanced training, degrees or certification.

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who accepts responsibility for the care delivered by team members. In addition to the quality and appropriateness of the service, this includes assuring that each participant is operating within scope of practice and clearly documenting the services provided, including information to support the medical necessity of the service.

- Medical staff acting as care team participants, such as medical assistants, community health workers and emergency medical technicians, who aren't required to be licensed under state of Michigan law, must be supported by a signed document that enumerates and authorizes the types and scope of services to be provided, procedures to be followed and instructions that may include standing orders. This documentation is also required to establish authority for licensed practitioners to act beyond their scope of practice (such as modifying the dose of medication or ordering tests).
- Blue Cross doesn't require that the rendering provider be present during the delivery of services performed by care team members, nor is it necessary to countersign their work when billing the above service codes.
- Documentation must be consistent with limitations to the person's scope of practice, if applicable.
- In all cases, the medical record must include sufficient documentation to establish that the billed services were provided and reason the services were medically necessary.

Value Based Reimbursement

PDCM services are included among the codes eligible for Value Based Reimbursement (VBR) under Blue Cross' Patient-Centered Medical Home. Accordingly, if the individual identified as the Rendering Provider for a PDCM service line is a physician that has been deemed eligible for the VBR, then the applicable VBR amount will be applied to that PDCM service.

Patient eligibility

Monthly, Blue Cross will provide each Physician Organization a list of members attributed to the PDCM-participating primary care doctors who were eligible for PDCM services on the day the list was produced. These lists are distributed monthly by the Michigan Data Collaborative. They include Commercial and Medicare Plus Blue patients. All patient lists include information based on claims history (e.g., risk scores, chronic condition flags, high cost flags, etc.) to help providers identify candidates for care management.

When delivering care management services, please confirm that the member is a patient at a PDCM-participating practice, is eligible for care management and has an active Blue Cross contract. A list of employer groups that don't participate in PDCM can be found on the PDCM page under the Initiatives tab on the PGIP Collaboration site.

The monthly patient list isn't an indicator of which patients are eligible for care management. It's a guide to assist clinical decision-makers in determining which patients are candidates for care management based on clinical indicators and previous health care utilization.

If claims are submitted to Blue Cross for PDCM services for patients who don't have the coverage for these services, Blue Cross will reject these claims as a provider liability.

Code specific guidelines

Billable PDCM codes

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

- Codes for care management services delivered by the care management team
- Codes billed by and paid to physicians for care management activities performed

Billing compendium

Code	Description	Delivery Method	Licensed Care Team*	Unlicensed Care Team*	Physician	Quantity Limits	Notes
G9001	Coordinated care fee — initial	Individual, face to face or video	X			One per patient per day	Appropriate for licensed staff engaging in care management. Must have completed training in complex care management. This is known as the Comprehensive Assessment.
G9002	Coordinated Care fee — maintenance	Individual, face to face or video	X			For visits >45 minutes may quantity-bill	Appropriate for licensed staff engaging in care management. After 45 minutes, you can quantity-bill in 30-minute increments.
G9007	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	Team conference does not include patient; email communication does not apply
G9008	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	This is a physician-delivered service, commonly used when the physician is talking to the patient about, engagement in care management, actively coordinating care with the team or interacting with another health care provider seeking guidance or background information to coordinate and inform about the care process.
S0257	End of Life Counseling	Individual face to face, video or telephone	X		X	One per patient per day	An evaluation and management service may be billed on the same day and interaction may be with the patient or “surrogate.”
*98961	Group education 2-4 patients for 30 minutes	Face to face with patient and caregivers	X			Quantity-bill per 30-minute increments	
*98962	Group education 5-8 patients for 30 minutes	Face to face with patient and caregivers	X			Quantity bill per 30-minute increments	
*98966	Phone services 5-10 minutes	Call with patient or caregiver	X	X		No quantity billing	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.
*98967	Phone services 11-20 minutes	Call with patient or caregiver	X			No quantity billing	Appropriate for licensed staff performing care management functions by phone. Not appropriate for appointment reminders or delivering lab results.
*98968	Phone services 21-30 minutes	Call with patient or caregiver	X			No quantity billing	Appropriate for licensed staff performing care management functions by phone. Not appropriate for appointment reminders or delivering lab results.
*99487	Care management services 31-75 minutes per month	Non-face-to-face clinical coordination	X	X		Once per patient per calendar month	
*99489	Care management services — every additional 30 minutes per month	Non-face-to-face clinical coordination	X	X		Time-based quantity-billing	After 75 minutes, this code can be quantity-billed in 30-minute increments.

***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.**

T codes

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

Medicare Plus Blue PPO patients

Please refer to the ***Provider Delivered Care Management (PDCM) Payment Policy and Billing Guidelines for Blue Cross Blue Shield of Michigan Medicare Plus Blue PPO Members***. PGIP physician organizations can find a copy on the PGIP Collaboration site under the *PDCM Initiative* tab; non-PGIP participating providers can obtain by sending an email to valuepartnerships@bcbsm.com.

For training and resource information, visit the Michigan Care Management Resource Center website at <http://micmrc.org/>.**

If you have questions about the PDCM program, contact your PO leadership, submit an inquiry through the issues log on the PGIP Collaboration site or send an email valuepartnerships@bcbsm.com.

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