Blue Cross Blue Shield Blue Care Network of Michigan

Provider Delivered Care Management Payment Policy and Billing Guidelines for BCBSM Commercial and Medicare Advantage Members

April 2019

Goals

- 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
  - consistent delivery of recommended services, such as cancer screening, hypertension and diabetes management

Eligible Providers

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- The following provider and practice types can bill for PDCM services within the context of an ongoing established physician-patient relationship:
  - PCMH-designated providers, including physician assistants and advanced practice nurses 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)

Procedure Codes

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- The applicable codes for PDCM service delivery include the following:

HCPCS Codes	CPT Codes
G9001*	98961*
G9002*	98962*
G9007*	98966*
G9008*	98967*
S0257*	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.

**HCPCS Level II and CPT codes, descriptions and two-digit numeric modifiers only are copyright 2019 American Medical Association. All rights reserved.*

General Guidelines

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

- PDCM services are included among the codes eligible for Value Based Reimbursement (VBR) under Blue Cross' Patient-Centered Medical Home.

- 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

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- 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

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- 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
- For specific details on each code, see the billing guidelines which are posted on the Collaboration site. If you are a Practice Unit that does not have access to the Collaboration site, please see your PO for these documents.
- All of these documents can also be found at the Michigan Care Management Resource Center website at https://micmrc.org/

Medicare Advantage Differences

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- The two main differences between the Commercial and Medicare Advantage Billing Guidelines are:
  - For Medicare Advantage, the G9001 has to have a face to face component in order for it to be billed. On the Commercial side, a face to face component could include video.
  - The Medicare Advantage Product for BCBSM PPO is now called **Medicare Plus Blue^{SM} PPO.**

Questions

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- For training and resource information, visit the Michigan Care Management Resource Center website at https://micmrc.org/

- The first Thursday of every month is a PDCM Q&A session that all practices and POs can call in and ask questions about PDCM. The call-in information is listed on the Calendar on the Collaboration site.

- 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.