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Blue Cross Blue Shield of Michigan

Care Management Billing

What are PDCM, HICM and BDTC?

- PDCM stands for Provider Delivered Care Management and includes the delivery of care management services by a care manager, working with a physician and care team, in the primary care or eligible specialist office.

- HICM stands for High Intensity Care Model and enables Medicare Advantage patients to receive care-management services. It currently is offered to seven Physician Organizations (POs).

- BDTC stands for Blue Distinction Total Care and is a way for value-based programs in different Blues plans to integrate so that employers have access to similar quality programs when they have employees in multiple states. This program will allow care management services for members whose coverage is provided through another Blues plan.

PDCM/BDTC Procedure Codes

- G9001* - Initiation of Care Management (Comprehensive Assessment)
- G9002* - Individual Face-to-Face Visit
- 98961* - Education and training for patient self-management for 2–4 patients; 30 minutes
- 98962* - Education and training for patient self-management for 5–8 patients; 30 minutes
- 98966* - Telephone assessment 5-10 minutes of medical discussion
- 98967* - Telephone assessment 11-20 minutes of medical discussion
- 98968* - Telephone assessment 21-30 minutes of medical discussion
- 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)
- G9007* - Coordinated care fee, scheduled team conference
- G9008* - Physician Coordinated Care Oversight Services (Enrollment Fee)
- S0257* - Counseling and discussion regarding advance directives or end of life care planning and decisions

HICM Procedure Codes

- G9001* - Initiation of care management (comprehensive assessment)
- G9002* - Individual face-to-face visit
- 98961* - Education and training for patient self-management for two to four patients; 30 minutes
- 98962*- Education and training for patient self-management for five to eight patients; 30 minute
- G9007* - Coordinated care fee, scheduled team conference
- G9008* - Physician coordinated care oversight services (enrollment fee)
- S0257* - Counseling and discussion regarding advance directives or end of life care planning and decisions
- S0280*-Medical home program, Comprehensive care coordination, initial plan
- S0281*-Medical home program, Comprehensive care coordination, maintenance of plan
- S0316*-Disease management program, follow-up/reassessment

General Conditions of Payment

- For billed services to be payable, the following conditions apply:
  - The patient must be eligible for PDCM/HICM/BDTC service. Ordered by a physician, PA or CNP within the approved practice; a note indicating these services were ordered must be in the medical record.
  - Based on patient need
  - Performed by the appropriate qualified, non-physician health care professional employed or contracted with the approved practice or PO
  - Billed in accordance with BCBSM billing guidelines
  - There is no costshare (copay, coinsurance or deductible) for PDCM, BDTC or HICM services.
- *Services billed for non-eligible members will be **rejected with provider liability**.*

Patient Eligibility

All patients must have an active eligible contract.

For PDCM Services:

- Providers should check normal eligibility channels (e.g., WebDENIS, PARS IVR) to confirm contract and benefit eligibility. *A practice should follow its current process for determining patient eligibility.*

For BDTC Services:

- These members will appear on a separate patient list called "hosted members." You will need to ensure that the members have an active contract (through normal eligibility channels) and that the group is participating in the BDTC program. The patient must be attributed to the practice unit/physician office to receive reimbursement.

For HICM Services:

- For a member to be eligible for HICM, they must be on the HICM patient list that is sent to the POs quarterly.
- Providers should also always check for contract eligibility by checking either WebDenis or calling the Provider Automated Response System (PARS) at 1-866-309-1719. The alpha prefix for BCBSM MA PPO is XYL.

BCBSM Medicare Advantage Patient Eligibility - PDCM

- If an insurer other than Blue Cross Medicare Advantage is the primary insurer, the patient is not eligible for PDCM services.

- BCBSM MA-PPO excluded ASC groups for PDCM are: BCBSM retirees, URMBT, MPSERS and Accident Fund retirees.

Billing and Documentation: General Guidelines

- The following general billing guidelines apply to PDCM/HICM/BDTC services:
  - Approved practices/POs only
  - All services may be billed under the PCP's NPI
  - Professional claim
  - No diagnostic restrictions.
    - All relevant diagnoses should be identified on the claim
  - Quantity limits apply to some codes
  - No location restrictions
  - Documentation demonstrating services were necessary and delivered as reported; must be maintained in medical records identifying the provider for each patient interaction

- Additional documentation requirements:
  - Dates, duration, name/credentials of care team member performing the call/service
  - Nature of the discussion and pertinent details regarding updates on patient's condition, needs, progress with goals and target dates

For HICM Billing:

- All services are billed under the Geriatrician or PCP's NPI except:
    - Nurse practitioners can bill for HICM services under the physician's NPI in the ***home*** or ***office*** locations except if the nurse practitioner is making a new diagnosis in the ***home*** location not previously documented in the medical records; then the NP needs to bill directly using their own NPI. If the NP was in the ***office*** and captures a new diagnosis, they could then bill under the physicians' NPI.
- In order for us to set up our billing system, we will need the names and NPIs of all of the CNPs who have completed Grace training. Please provide your name, NPI, PO and practice unit at Grace training.

Code-Specific Requirements: G9001* Initiation of Care Management (Comprehensive Assessment)

- Payable only when performed by an RN, LMSW, CNP or PA
- Quantity limit: One assessment per patient, per care manager, per year
- Contacts must add up to at least 30 minutes of discussion
- Must include a face to face encounter
- Assessment should include:
  - Identification of all active diagnoses
  - Assessment of treatment regimens, medications, risk factors, unmet needs, etc.
  - Care plan creation (issues, outcome goals, and planned interventions)
  - Current physical and mental/emotional status and treatment
  - Level of patient's understanding of his/her condition and readiness for change
  - Perceived barriers to treatment plan adherence
- Documentation must include:
  - Date of service (date assessment is completed)
  - Dates, duration, and modality (face to face or phone), name/credentials of care manager performing the service
  - Formal indication of patient engagement/enrollment
  - Physician coordination and agreement

- This code applies to PDCM, BDTC and HICM services.

Note: Only lead care managers may perform the initial assessment services (G9001*)

G9001* (Comprehensive Assessment) Care Plan

A care plan should be created for every patient, but that does not mean every patient needs a G9001 assessment. The care plan can be:

- A focused care plan (e.g., asthma action plan, notes in medical record about care transitions management), if clinically appropriate (G9002)

OR

- A comprehensive care plan developed as part of the comprehensive assessment (G9001)

Please note that most complex patients are likely to benefit from a comprehensive assessment

Code-Specific Requirements: G9008*
Patient Enrollment

- Payable only when performed by the physician
- Quantity limit: G9008 may be billed only one time per patient, per physician (MD or DO).
- This code can be submitted on behalf of the physician.
- An established relationship between the Primary Care Practitioner and patient must already exist
- A written care plan with action steps and goals accepted by the physician, care manager and patient is in place
- This code applies to PDCM, BDTC and HICM services.

G9002* Coordinated Care Fee, Maintenance rate (per encounter)

- Payable when performed by any qualified care management team member
- Quantity limit: The appropriate quantity is based on the total cumulative time the patient spends with a care management team member(s) 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 1
    - 46 to 75 minutes, report a quantity of 2
    - 76 to 105 minutes, report a quantity of 3
    - 106 to135 minutes, report a quantity of 4
- This code applies to PDCM, BDTC and HICM services.

G9002* Coordinated Care Fee, Maintenance rate (per encounter), *Continued*

- Encounters must:
  - Be conducted in person
  - Be a substantive, focused discussion pertinent to patient's care plan
- Claims reporting requirements:
  - The code should be reported once for a single date of service
  - All diagnoses relevant to the encounter should be reported
- Documentation must additionally include:
  - Date, duration, name/credentials of team member performing the service
  - Nature of discussion and pertinent details relevant to care plan (progress, changes, etc.)

Code-Specific Requirements: G9007* Team Conference

- This code should be used to bill for scheduled face-to-face meetings, telephone calls or secured video conferencing between, at minimum, the primary care practitioner and the care manager to formally discuss a patient's care plan
- Quantity limit: There is a limit of one G9007* paid per primary care practitioner, per practice, per patient, per day.
- The scheduled discussion should include sufficient time to discuss changes to the patient's status.
- The interaction can be conducted in person, by phone or secure video exchange. Email is not acceptable.
- Outcomes and next steps for each patient must be agreed upon and documented.
- Documentation can be completed by the primary care practitioner or the care manager
- Separately billed for each individual patient discussed during team conference.
- This code applies to PDCM, BDTC and HICM services.

Code-Specific Requirements: 98961*, 98962*
Group Education & Training Visit

98961* Education and training for patient self-management for 2-4 patients, 30 minutes
98962* Education and training for patient self-management for 5-8 patients, 30 minutes

- Payable when performed by any qualified care management team member
- No quantity limits
- Each session must:
  - Be conducted in person
  - Have at least two, but no more than eight patients present
  - Include some level of individualized interaction
- Claims reporting requirements:
  - Services should be separately billed for each individual patient
  - Code selection depends upon total number of patient participants in the session
  - Quantity depends upon length of session (reported in thirty minute increments)
  - All diagnoses relevant to the encounter should be reported
- This code applies to PDCM, BDTC and HICM services.

Code-Specific Requirements: 98966*, 98967*, 98968* Telephone-based Services

98966* Telephone assessment and management, 5-10 minutes
98967* Telephone assessment and management, 11-20 minutes
98968* Telephone assessment and management, 21-30 minutes

- Payable when performed by any qualified care management team member for discussions with the patient
- Quantity limit: No more than one per date of service (if multiple calls are made on the same day, the times spent on each call should be combined and reported as a single call)
- Each encounter must:
  - Be conducted by phone
  - Be at least 5 minutes in duration
  - Include a substantive, focused discussion pertinent to patient's care plan
- Claims reporting requirements
  - Code selection depends upon duration of phone call
  - All diagnoses relevant to the encounter should be reported
- This code applies to PDCM and BDTC services.

Code-Specific Requirements: 99487* and 99489* Care Coordination

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*)

- Discussions must be substantive and focused on coordinating services, within the medical neighborhood, that are pertinent to the patient's individualized care plan and goal achievement.

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

- This code applies to PDCM and BDTC services.

Code-Specific Requirements: S0257* Advance Care / End of Life Planning

- This code should be used to bill for individual face-to-face or telephonic conversations regarding end-of-life care issues and treatment options
- Billable when performed by any qualified member of the care management team
- Quantity limit: No limits on number of services per patient per year
- Documentation associated with S0257* that must be recorded and maintained in the patient's record should include:
  - Enumeration 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
    - All active diagnoses
- This code applies to PDCM, BDTC and HICM services.

Transitional Care Management (TCM) Codes
(informational only – not part of PDCM, HICM or BDTC)

- There are two TCM codes (99495 and 99496) that can be billed for your patients transitioning out of an inpatient hospital, SNF, outpatient observation or partial hospitalization.
- Currently, BCBSM only reimburses for 99496 for all cases of transitional care management.
- To bill this code:
  - The provider must communicate directly, electronically or by telephone with the patient or caregiver within two days of discharge from an inpatient hospital, skilled nursing facility or community mental health center stay, outpatient observation or partial hospitalization.
  - A face-to-face visit must occur within seven business days of the patient's discharge.
  - 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."

- *Note: 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 (G9002 or 98966, 98967, 98968) at the same time if the work is related to "Transition of Care."*

HICM ONLY PROCEDURE CODES

Code-Specific Requirements: S0280* Medical Home Program, Comprehensive Care Coordination, initial plan (Comprehensive Assessment)

- Payable only when performed by the Lead Care Manager who is an RN, LMSW, CNP or PA with approved level of care management training
- Must be conducted in the home location
- Quantity limit: One assessment per patient, per care manager, per year
  - This code can be quantity billed (maximum of 2) if there are separate and distinct services rendered when two clinicians contribute to the comprehensive assessment
- Contacts must add up to at least 30 minutes of discussion
- Must include a face to face encounter
- The expectation is that all initial assessments be conducted in the home
- This code only applies to HICM services.

Code-Specific Requirements: S0281* Medical Home Program, Comprehensive Care Coordination, maintenance of plan

- Payable when performed by any qualified care management team member
- Quantity limit: The appropriate quantity is based on the total cumulative time the patient spends with a care management team member(s) on that day. This code can now be billed for the total cumulative time **multiple** care team members spend with a patient.
- The length of time spent with the patient during each interaction should be added together to determine the correct quantity to bill.

	1-45 Minutes	46-75	76-105	106-135
1 person	1	2	3	4
2 people	2	4	6	8
3 people	3	6	9	12

S0281* Medical Home Program, Comprehensive Care Coordination, maintenance of plan

- Encounters must:
  - Be conducted in person
  - Be a substantive, focused discussion pertinent to patient's care plan
- Claims reporting requirements:
  - The code should be reported once for a single date of service
  - All diagnoses relevant to the encounter should be reported
- Documentation must additionally include:
  - Date, duration, name/credentials of team member performing the service
  - Nature of discussion and pertinent details relevant to care plan (progress, changes, etc.)
  - This code only applies to HICM services.

Code-Specific Requirements: S0316* Disease management program, follow-up/reassessment

- Payable when performed by any qualified care management team member.
- Quantity limit: Payable once per month per patient.
- The following are requirements for this code to be billed during a calendar month:
  - A telephone call to the patient
  - Care coordination in the medical neighborhood regarding the patient
  - Care coordination amongst the care team can be billed as long as a face to face visit with the patient has been conducted during that month
- Claims reporting requirements:
  - All interactions with the patient or those in the medical neighborhood must be documented in the medical record.
  - All diagnoses relevant to the encounter should be reported
- Additional documentation requirements:
  - Dates, duration, name/credentials of care team member performing the call
  - Nature of the discussion and pertinent details regarding updates on patient's condition, needs, progress with goals and target dates

This code only applies to HICM services.

Code Summary – PDCM and BDTC

The following chart summarizes the billable PDCM/BDTC codes and who can render 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*		G9007*
Complex care coordination	99487*, 99489*		--
Advance directives or end of life care planning	S0257*		S0257*

Code Summary – HICM

The following chart summarizes the billable HICM codes and who can render each service:

	Provider Type		
Service	Care Manager	Other Care Team Members	Physician
Initial assessment	G9001*/S0280*	--	G9008*
Face-to-face encounter	G9002*/S0281*		**
Group	98961*, 98962*		**
Team conference	G9007*		G9007*
Advance directives or end of life care planning	S0257*		S0257*
Monthly Non Face to Face	S0316*		**

Questions?

- How can we identify the BCBSM Care manager if the patient is not sure? Contact the BCBSM Engagement Center at 800-775-2583.

- You may direct questions about PDCM/HICM/BDTC billing or other matters to valuepartnerships@bcbsm.com, submit an inquiry through the PGIP collaboration site, or visit the PDCM/HICM/BDTC page on the PGIP collaboration site for the latest billing guidelines.