Michigan Institute for Care Management & Transformation

MAT Reimbursement Opportunities

Objective

- Describe the PDCM billing Codes
- Illustrate how to use the codes in daily care team activities related to MAT.




Different payers, Different rules!

Not all of the payers interpret/pay for these codes in the same way. As we discuss each code, please refer to the **Multi-Payer handout** for additional detail regarding how the two main payers (Priority Health and BCBSM) interpret these codes and who they pay to deliver service.

micmt-cares.org/resources

Care Management Codes for Licensed and Unlicensed Care Team Members

Telephone with patient	**98966:** Telephone visit 5-10 minutes of medical discussion **98967:** Telephone visit 11-20 minutes of medical discussion **98968:** Telephone visit 21-30 minutes of medical discussion
Care Coordination* (not with patient or provider)	**99487:** First 31 to 75 minutes of clinical staff time directed by a physician or other qualified healthcare professional with no face-to-face visit, per calendar month **99489:** Each additional 30 minutes after initial 75 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month. (An add-on code that should be reported in conjunction with 99487)

*Summed throughout the calendar month

Provider liability if patient does not have the Care Management Benefit.

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98966, 98967, 98968
Phone Service Codes

BCBSM		Priority	
Licensed	X	Licensed	X
Unlicensed MA, CHW	X	Unlicensed QHP: RD, CDE, CAE	X

Call with patient or caregiver to discuss care issues and progress towards goals.

98966 for 5-10 minutes

98967 for 11-20 minutes

98968 for 21-30 minutes

BCBSM: 2P Modifier for 98966-68- Payable when contact is made with patient to discuss the program and patient does not enroll in care management

99487, 99489 Care Coordination Codes

BCBSM		Priority	
Licensed	X	Licensed	X
Unlicensed MA, CHW	X	Unlicensed QHP: RD, CDE, CAE	X

Call on behalf of the Patient to coordinate care.

- **99487** for first 31 to 75 minutes of clinical staff time working on behalf of the patient with someone other than the patient or provider.
  - Example: reaching out to a community resource to help support a SDOH need
- **99489** for each additional 30 minutes after 75 minutes per calendar month.

Care Management Codes for Care Team Members

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW			

Face to Face w/ patient	**G9001:** Initiation of Care Management (Comprehensive Assessment) **G9002:** Individual Face-to-Face Visit
Group Visits w/ patient	**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

Provider liability if patient does not have the Care Management Benefit.

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G9001 Comprehensive Assessment Code

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW			

The **Comprehensive Assessment** (**G9001**) is a face to face meeting that results in a patient centered care plan that the care team and the patient agree upon and follow.

- The comprehensive assessment is a holistic approach and involves screenings (ex. SDOH, PQ 2), understanding and discussion of patient's concerns/goals and the medical treatment plan.
- The care plan:
  - Guides the patient and care giver towards **self-management**
  - Requires **monitoring and evaluation** of the effectiveness of the plan over time
  - **Adjust goals and interventions as needed**, until goals are met

G9001 Comprehensive Assessment Code

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW			

- **BCBSM**
  - Individual, face to face (or video for commercial)
  - One per patient per day
- **Priority Health**
  - Individual, face to face
  - May be billed once annually for patients with on-going care management.

G9002

Face-to-Face Visit Code

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW			

BCBSM (Commercial and Medicare Advantage):
Quantity Billing

- Individual, face to face or video
- If the total cumulative time with the patient adds up to:
  - 1 to 45 minutes, report a quantity of one; 46 to 75 minutes, report a quantity of two; 76 to 105 minutes, report a quantity of three; 106 to 135 minutes, report a quantity of four.

BCBSM: 2P Modifier for G 9002- Payable when contact is made with patient to discuss the program and patient does not enroll in care management

Priority Health (Commercial, Medicare Advantage, Medicaid):
No Quantity Billing

- In person visit with patient, may include caregiver involvement.
- Used for treatment plan, self management education, medication therapy, risk factors, unmet care, physical status, emotional status, community resources, readiness to change.

G9001 / G9002 Comparison

G9001 Comprehensive Assessment

- A face to face or video meeting
- Duration at least 30 minutes, that results in a care management plan that all care management team members and the patient will follow.
- This is a **holistic, encompassing** type of patient visit that helps define a significant change in how the patient approaches managing their health: new diagnosis, transition of care, addressing a symptom that requires a significant change to the previous care plan.

G9002 Patient Visit

- A face to face or video meeting that is focused on addressing a piece of the care management plan.
- This type of visit should additionally address patient goals and a follow up plan.

98961, 98962
Group Education Code

BCBSM		Priority	
Licensed	X	QHP	X
Unlicensed MA, CHW			

- **98961 Group Education**
  - 2-4 patients for 30 minutes
  - Face to Face with patient or caregivers
  - Quantity bill per 30 minutes
- **98962 Group Education**
  - 5-8 patients for 30 minutes
  - Face to Face with patient or caregivers
  - Quantity bill per 30 minutes

*Note that these codes may also be completed via video.

Care Management Codes for Providers / Physicians

Care Team Member and Provider Discussion	**G9007:** Coordinated care fee, scheduled team conference
Physician discussion with patient, other physicians, extended care team members not part of the care team.	**G9008:** Physician Coordinated Care Oversight Services (Enrollment Fee)

Provider liability if patient does not have the Care Management Benefit.

Provider Code:
G9007 Team Conference Code

- PCP and a care team member formally discuss a patient's care plan.
- Can be billed once per day per patient regardless of time spent.
- May be billed by a physician or APP.

Physician Code: G9008 Physician Coordinated Care Oversight Services (Enrollment Fee)

BCBSM – by Physician only

- **No quantity limit.**
- May be conducted face to face, via video, or by telephone. (NO email / messaging)
- Communication with paramedic, patient, other health care professionals not part of the care team when consulting about patient who is engaged in care management.

Priority Health – Physician only

- **One time per practice.**
- Only be conducted face to face.
- Only for when the physician has discussed the care plan with the patient and if the licensed care team member has had a face to face with the patient on or before the day of the physician's discussion with the patient.

Coding Examples

MAT Care Management

Before we start…

- The following series of examples are intended to show a couple of common situations for using the billable codes. They are NOT comprehensive.
- Resources offered by BCBSM
  - Monthly Billing Q&A session
    1st Thursday of every month at noon
  - Questions on specific situations
    valuepartnerships@bcbsm.com

New MAT Patient

- **Patient Presents:** PCP sees a 50 yo M requesting treatment for his heroin addiction.
  - Patient history includes chronic back pain, knee replacement in 2015, HTN, tobacco use, depression, and COPD.
  - Patient became addicted to prescription pain meds and later switched to heroin.
  - Legal and financial trouble. Patient wants to stop using ASAP.
  - PCP agrees to start buprenorphine.
- **Induction:** Office-based induction completed. Referral to Care Manager for assistance with follow-up.
- **Establish care with care manager** (may include development of comprehensive care plan)
- **Care Manager Follow-up:** Phone vs Face-to-Face
- **Group education** - Optional

Care Manager Visit

Identify the codes: G9007, G9001

- 3 days after induction - Care Manager sees patient.
  - Patient agrees to care management services
  - Care manager reviews screenings (SDOH, PHQ-9), problem list, medications, ED/ hospital utilization history, and patient goals with patient to create a care plan.
  - Patient has transportation issues and financial concerns: behind on housing payment and utilities
  - Patient wants to quit using heroin to help him get out of his legal and financial troubles and also to help him re-establish relationships with family.
  - Care plan with self-management goals is created; resources are discussed for financial and transportation issues.
  - Face-to-face follow-up with care manager scheduled in 1 week.
- Care Manager discusses care plan with the provider. Provider agrees with the care plan.

GOAL – Assist patient in his OUD recovery and try to remove barriers to his success

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Face to Face Visit

Identify the code: G9002
Note how this is different from the G9001!

Patient returns to clinic in 1 week to meet with care manager.

- Acknowledges 1 episode of heroin use. He was "hanging around old friends" and had a craving leading to use. Feels ashamed. He is worried that PCP will "give up" on him.
- Reports increasing anxiety over his family relationships the longer he is sober.
- Care Manager identifies that patient lacks good understanding of relapse, provides education, and assures him that the team will not give up on him. Care manager tells patient that she would like to discuss his episode of use with PCP so that they can discuss whether or not he may benefit from a higher dose of buprenorphine to decrease cravings. He agrees.
- Care manager discusses case briefly with PCP. PCP agrees to increased dose of buprenorphine and to refer to behavioral therapy for his anxiety.
- PCP meets with patient briefly to communicate new buprenorphine dosing instructions and the addition of behavioral therapy as part of his care plan. Patient agrees to participate in behavioral therapy.
- Care manager schedules phone follow-up in 1 week.

Coordination of Care

Identify the code: 99487

- Care manager contacts the local bus system to obtain a bus pass for the patient to assist with transportation
- Care manager connects patient with community resources to assist with utilities and housing concern.

- Time spent coordinating care was 35 minutes.

Phone Service

Identify the code: 98967

- Care manager calls patient for scheduled phone visit.
- Verifies that patient is taking buprenorphine correctly.
- Patient is pleased to report that he has not had any episodes of opioid use over the past week.
- Care manager reviews upcoming appointments including behavioral therapy, PCP for HME, and PharmD for med review and BP check. Verifies patient has transportation.
- Care manager offers opportunity to participate in a recovery group hosted by care manager. Patient agrees.
- CM and patient agree on follow up in one week via in person visit at the office.
- Time Spent: 20 minutes.

Group Education Visit

Identify the codes:
4 patients: 98961
6 patients: 98962, x2 quantity bill

- Patient attends OUD Recovery Group Class hosted by site care manager
  - Patient attends with 3 other patients for 30 minutes.
  - Patient attends a second class with 5 other patients for 60 minutes.

Resources
Care Management Services

- Michigan Institute for Care Management and Transformation
- BCBSM
  - PDCM Billing online course
  - PDCM Billing Guidelines for Commercial
  - Medicare Advantage
- Priority Health
- Centers for Medicare & Medicaid
  - Transitional Care Management
  - Chronic Care Management
  - Behavioral Health Integration

Questions?