# Provider-Delivered Care Management

# Payment policy and billing guidelines

# for Blue Cross Blue Shield of Michigan and Blue Care Network/ BCNA

# Commercial Members and

# Medicare Plus Blue$^{SM}$ PPO members

# Policy updated June 1, 2024

## 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 and Blue Care Network (effective 01/01/2023) for PDCM services within the context of an ongoing established physician-patient relationship:

- PCMH-designated providers, including physician assistants and advanced practice nurses[1] within PCMH practices
- Specialists practice units performing PDCM services.
- Physician Group Incentive Program specialty practices that have the following five 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)

### Billable procedure codes

The applicable codes for PDCM service delivery include the following:
HCPCS Codes: G9001*, G9002*, G9007*, G9008*, S0257*
CPT Codes: 98961*, 98962*, 98966*, 98967*, 98968*, 99487*, 99489*

**Note:** Blue Cross or Blue Care Network (BCN) nor BCNA members pay no cost share for any of these codes. Claims rejections for these services are “provider liable,” meaning that the provider may not charge the member for the service. For BCBSM employer groups that are not participating

[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.

in PDCM, claims will deny as member liable. You can find a list of these non-participating groups for BCBSM and BCN on the PGIP Collaboration Site under the PDCM tab. Additionally, you can confirm the member's PDCM benefit in Availity for BCBSM Commercial and Medicare Plus Blue; however, BCN and BCNA PDCM benefit information is not listed for PDCM. You will also need to confirm that the member has an active contract.

**General guidelines on PDCM**

- Requirements:
  - Claims must be reported through the rendering provider (Physician (MD/DO) 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 nor BCN 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.

**Patient eligibility**

Monthly, Blue Cross and BCN 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. They include Blue Cross' commercial, Medicare Plus Blue, BCN and BCNA 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.***

A Medicare Plus Blue member is not eligible for PDCM services if an insurer other than Blue Cross is the primary insurer.

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 member 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 | Modifier | Notes |
|---|---|---|---|---|---|---|---|---|
| G9001 | Coordinated care fee — initial | Individual, face to face video or telephonic** | X | | | One per patient per day | | Appropriate for licensed staff engaging in care management. Must have completed training in complex care management.<br><br>This is known as the Comprehensive Assessment.<br><br>**It must be documented in the patient's medical record why the services were conducted telephonically, i.e., no smart phone, doesn't know how to use video, or uncomfortable coming into the office |
| G9002 | Coordinated Care fee — maintenance | Individual, face to face, video or telephonic** | X | | | For visits >45 minutes may quantity bill | 2P -Payable when PDCM program is discussed with patient and patient declines engagement. Billable once per condition per year. | Appropriate for licensed staff engaging in care management.<br><br>After 45 minutes, you can quantity-bill in 30-minute increments<br><br>Only bill the 2P modifier for services rendered to our Commercial PPO members. This is not applicable to Medicare Plus Blue PPO (Medicare Advantage).<br><br>**It must be documented in the patient's medical record why the services were conducted telephonically, i.e., no smart phone, doesn't know how to use video, or uncomfortable coming into the office |
| G9007 | Team conference | Face to face, video, telephone or secure web conf. between physician and care team | | | X | 1 per patient per practitioner per day | | Team conference does not include patient; email communication doesn't apply. |

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| G9008 | Physician coordinated care oversight services | Face to Face, video or by telephone; physician discussion with EMT, 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 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. |
| 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, or telephonic** | X | | | | Quantity bill per 30-minute increments | **It must be documented in the patient's medical record why the services were conducted telephonically, i.e., no smart phone, doesn't know how to use video, or uncomfortable coming into the office |
| 98962 | Group education 5-8 patients for 30 minutes | Face to face with patient and caregivers, or telephonic** | X | | | | Quantity bill per 30-minute increments | **It must be documented in the patient's medical record why the services were conducted telephonically, i.e., no smart phone, doesn't know how to use video, or uncomfortable coming into the office |
| 98966 | Phone services 5-10 minutes | Call with patient or caregiver | X | X | | 2P - Payable when contact is made with patient to discuss the program and patient declines engagement. Billable once per condition per year. | 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.<br><br>Only bill the 2P modifier for services rendered to our Commercial PPO members. This is not applicable to Medicare Plus Blue PPO (Medicare Advantage). |
| 98967 | Phone services 11-20 minutes | Call with patient or caregiver | X | X | | 2P - Payable when contact is made with patient to discuss the program and patient declines engagement. Billable once per condition per year. | 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.<br><br>Only bill the 2P modifier for services rendered to our Commercial PPO members. This is not applicable to Medicare Plus Blue PPO (Medicare Advantage). |
| 98968 | Phone services 21-30 minutes | Call with patient or caregiver | X | X | | 2P - Payable when contact is made with patient to discuss the program and patient declines engagement. Billable once | 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.<br><br>Only bill the 2P modifier for services rendered to our Commercial PPO members. This is not applicable to |

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| | | | | | | per condition per year. | | Medicare Plus Blue PPO (Medicare Advantage). |
| 99487 | Care management services 31-75 minutes per month | Non-face-to-face clinical coordination | X | X | | | Once per patient per calendar month | May be used for portal communication and care coordination between the patient and the care team. |
| 99489 | Care management services — every additional 30 minutes per month | Non-face-to-face clinical coordination | X | X | | | Time-based quantity billing | May be used for portal communication and care coordination between the patient and the care team.<br><br>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.**

For training and resource information, visit the Michigan Institute for Care Management and Transformation website at https://micmt-cares.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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