2017 PCMH Initiative Care Management and Coordination Tracking Codes Quick Guide

Code	Quick Description	Formal Description	Code Purpose	Provider	Method	Max Frequency (/Beneficiary)	Length (minutes, quantity)	PCP Signature Required	Associated Fee Schedule*	Note
G9001	Comprehensive Assessment	Coordinated Care Fee Initial Rate	Document a comprehensive assessment and development of a care plan with a beneficiary	CM	In-person	Once/year	> 30 minutes	Yes	No	
G9002	In-person Encounter	Coordinated Care Fee Maintenance Rate	Document any care management or coordination service provided	CM/CC	In-person	Once/day	1-45 minutes, quantity of one; 46-75 minutes, quantity of two; 76-105 minutes, quantity of three; 106-135 minutes, quantity of four.	No	No	Can be reported on the same date of service as G9001 if care management and coordination service(s) in addition to the comprehensive assessment are provided.
98966	Telephone Services	Telephone assessment and management service to an established patient, parent or guardian	Document any care management or coordination service provided over the telephone or by other real-time interactive electronic communication.	CM/CC	Phone or Real-time interactive electronic communication	Once/day	5-10 minutes	No	No	1. Can be reported on the same date of service as G9001 if care management and coordination service(s) in addition to the comprehensive assessment are provided. 2. Should not be used to report routine provider communication such as appointment reminders or test results.
98967	Telephone Services	Same as above	Same as above	CM/CC	Same as above	Once/day	11-20 minutes	No	No	Same as above
98968	Telephone Services	Same as above	Same as above	CM/CC	Same as above	Once/day	21-30 minutes	No	No	Same as above
99495	Care Transition	1. Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; AND 2. Medical decision making of at least moderate complexity during the service period; AND 3. Face to face visit within 14 calendar days of discharge	Document supportive services for patients experiencing discharge from an inpatient, long term care, skilled nursing, rehabilitation or emergency department environment to a home or community setting.	CM/CC	1. Direct contact, telephone, or electronic communication within 2 business days of discharge; AND 2. Face to face visit within 14 calendar days of discharge	Once/ transitional care management period	N/A	No	Yes	1. Can be reported on the same date of service as G9001 if care management and coordination service(s) in addition to the comprehensive assessment are provided. 2. Reasonable and necessary evaluation and management services (other than the required face-to- face visit) to manage the beneficiary may be reported separately. 3. Other care management and coordination service(s) may be reported during the transitional care management period.
99496	Care Transition	1. Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; AND 2. Medical decision making of high complexity during the service period; AND 3. Face to face visit within 7 calendar days of discharge	Same as above	CM/CC	1.Direct contact, telephone, or electronic communication within 2 business days of discharge; AND 2. Face to face visit within 7 calendar days of discharge	Once/ transitional care management period	N/A	No	Yes	Same as above
G9007	Team Conference	Coordinated Care Fee Scheduled Team Conference	Document meetings between, at minimum, a beneficiary's primary care provider and care manager or coordinator during which formal discussion of a patient's care plan occurs.	1.PCP+CM/CC; OR 2.Primary CM/CC+Specialty CM/CC; OR 3.PCP+SCP+CM/CC	Face-to-face, via secure live video conference or telephone	Once/day	N/A	No	No	Communication should include substantive, focused conversation pertinent to each patient's individualized care plan and goal achievement.

*Associated Fee Schedule is determined individually by each Medicaid Health Plan, additionally, MHPs may choose to include codes beyond 99495 and 99496 on their fee schedule.

CM: Care Manager
CC: Care Coordinator
PCP: Primary Care Provider
SCP: Specialty Care Provider

General Requirements:

- For the purposes of the PCMH Initiative, care management and coordination services are “the application of systems, science, incentives, and information to improve clinical practice and assist patients and their support system to become engaged in a collaborative process designed to manage medical, social, and/or behavioral health needs more effectively.” It includes services such as (but it not limited to):
  - Comprehensive assessment of the patient’s medical, functional, and psychosocial needs;
  - System-based approaches to ensure timely receipt of all recommended preventive care services;
  - Medication reconciliation with review of adherence and potential interactions and oversight of patient self-management of medications;
  - Management of care transitions between and among health care providers and settings, including referrals to other providers, follow-up after emergency department visits, and discharges from inpatient settings; and
  - Coordination of care with and linkages to home and community-based service providers.
  - *(The level of intensity of care management will vary based on the needs of the patients, as to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.)*
- All care management and coordination tracking codes must be reported using the NPI of the primary care provider assigned to / selected by the beneficiary.
- Care management and coordination services reported using the codes above must be under the general supervision of a beneficiary’s primary care provider.
- Please consult the PCMH Initiative Participation Agreement for definition of the types of team members eligible to fulfill the role of Care Manager and Care Coordinator in addition to required training.
- The date of service reported should be the date the care management and coordination service took place. If a service took place over the course of more than one day, the date of service reported should be the date the service was completed.
- All diagnoses relevant to the care management and coordination encounter should be reported. Diagnosis codes should be reported in the appropriate order to indicate primary diagnosis.
- Care management and coordination services reported using the codes above may (with the patient’s consent) involve or be provided to a patient’s representative, caregiver(s) and other members of the patient’s support system in pursuance of that patient’s personalized care goals.
- All care management services provided by a participating provider and reported using the tracking codes above should be documented in an electronic care management and coordination documentation tool accessible to all members of a care team. The tool must be either a component of an EHR, or able to communicate with an EHR, to ensure pertinent care management and coordination information is visible to care team members at the point of care. Care management and coordination documentation should include the following information:
  - Date of Contact
  - Duration of Contact
  - Method of Contact
  - Name(s) of Care Team Member(s) Involved in Service
  - Nature of Discussion and Pertinent Details
  - For G9001- Comprehensive assessment results and detailed, individualized care plan
  - For G9007- Update(s) and/or additions made to individualized care plan

Special Billing Instructions for PCMH Initiative Care Management and Coordination Tracking Codes

Health Plan Name	Special Instructions
Aetna Better Health of Michigan	*Awaiting further details*
Blue Cross Complete of Michigan	• None (Billed amount has no impact on claim adjudication.)
Harbor Health Plan	*Awaiting further details*
McLaren Health Plan	• None (Billed amount has no impact on claim adjudication.)
Meridian Health Plan of Michigan	• Bill with a $0.00 charge amount.
HAP Midwest Health Plan	• Bill with a $0.00 charge amount
Molina Healthcare of Michigan	• None (Billed amount has no impact on claim adjudication.)
Priority Health Choice	• Bill full service charge amount
Total Health Care	• Bill with a $0.00 charge amount
United Healthcare Community Plan	• None (Billed amount has no impact on claim adjudication.)
Upper Peninsula Health Plan	• Bill with a $0.01 charge amount

**Keep in mind that each payer’s fee schedule should be consulted to determine if service is covered, if the payer does not cover the service, follow the special instructions above for the submission of the claim.*