Michigan Department of Health & Human Services

# Initiative Care Management and Coordination Tracking Codes

*State Innovation Model*

*Patient Centered Medical Home Initiative*

Webinar Recording

Note: will require you to enter registration information to access recording

*Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.*

# Welcome!

The focus of this PCMH Initiative Office Hour Session is to:

- Discuss Initiative specific Care Management and Coordination Codes
- Kick-off the Billing and Coding Collaborative

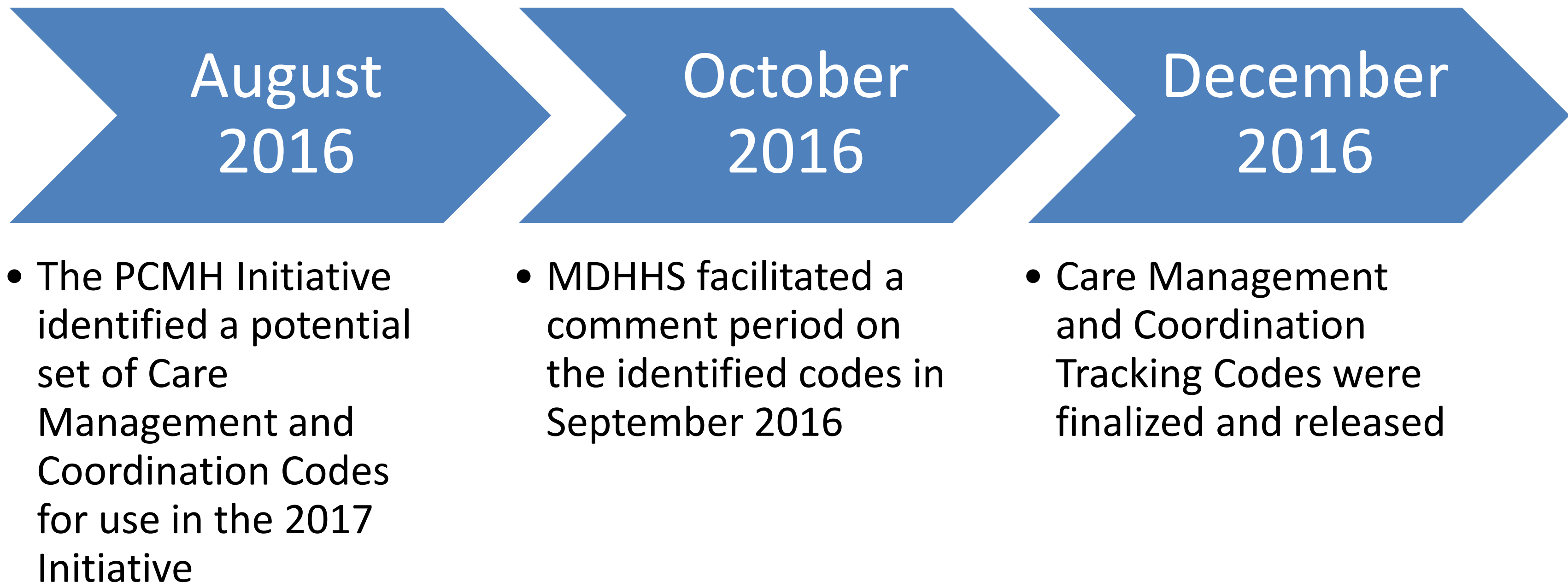
**Purpose of the Billing and Coding Collaborative:**

To support SIM PCMH Initiative practices and POs in understanding G and CPT care management and coordination code requirements for Medicare patients, as well as care management and tracking codes for Medicaid patients. The collaborative will assist practices and POs in:

- Building an understanding of characteristics of patients who may benefit from care management and coordination as per CMS definitions of payable codes; and
- Further developing and implementing robust coding and billing infrastructure and processes

# Background

Even though Medicaid funding is structured as a PMPM for the 2017 PCMH Initiative, practices are required to submit Healthcare Common Procedure Coding System (HCPCS) Care Management G and CPT codes and modifiers to participating Payers for care management and coordination services to provide insight into the type and intensity of Medicaid member services provided.



# Background: Supporting Taking the Next Step

Utilizing a set of Care Management and Coordination Codes takes us beyond support for a PMPM, accurate reporting of Care Management and Coordination Services provides:

- The ability to identify services at an individual patient level
- The ability to conduct more rigorous evaluation
- Discrete data to support the future sustainability of CM/CC services
- The ability to more directly link CM/CC services to impacts on an individual's health outcomes

# Refresher – PCMH Initiative Participation Agreement

- Practice and PO (as Applicable) Requirement: Assure that Billing Codes for Care Management and Coordination services delivered within the Practice are submitted to participating Payers as requested by the Payer(s).

- Practice Requirement: To receive the PMPM care management and coordination payment, Practices must:
  - Maintain care management and coordination expectations as defined in Appendix C. *(Embedded CM/CC staff, 2/5,000 ratio)*
  - Maintain care management and coordination performance above benchmarks established by the Initiative no later than June 30, 2017, on the following two metrics:
    - The percentage of a Practice's attributed patients receiving care management and coordination services; and
    - The percentage of a Practice's attributed patients receiving a timely (within 14 days) follow-up visit with a Provider following a hospital inpatient or emergency discharge or transfer from one care setting to another.

# Care Management and Coordination Metrics

- The percentage of a Practice’s attributed patients receiving care management and coordination services; and

$$\frac{\text{Any patient who has had a claim with one of the applicable codes during the reporting period}}{\text{SIM PCMH Initiative Eligible Population}}$$

- The percentage of a Practice’s attributed patients receiving a timely (within 14 days) follow-up visit with a Provider following a hospital inpatient or emergency discharge or transfer from one care setting to another.

$$\frac{\text{Any patient who sees a PCP, as defined by the SIM Provider Directory, within 14 days of the last discharge date on a room and board claim in the measurement period.}}{\text{SIM PCMH Initiative Eligible Population with and Inpatient Claim}}$$

Supporting Reports:

- Care Management and Coordination Reports available on the MDC SIM PCMH project portal alongside dashboard release #2

# Initiative Care Management and Coordination Tracking Codes

| Code | Quick Description | Code Purpose |
|---|---|---|
| **G9001** | Comprehensive Assessment | Document a comprehensive assessment and development of a care plan with a beneficiary |
| **G9002** | In-Person Encounter | Document any care management or coordination service provided |
| **98966** | Telephone Services | Document any care management or coordination service provided over the telephone or by other real-time interactive electronic communication; 5-10 minutes |
| **98967** | Telephone Services | Same as above: 11-20 minutes |
| **98968** | Telephone Services | Same as above; 21-30 minutes |
| **99495** | Care Transition | 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. |
| **99496** | Care Transition | Same as above |
| **G9007** | 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. |

# Defining Care Management and Coordination

- 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.)*

# Tracking Purposes v. Fee Schedule

- While the Initiative is using these codes for tracking purposes, some codes have an associated fee schedule that plans should be reimbursing:
  - *99495, and*
  - *99496*

- Additionally, many plans may support additional CM/CC claims on their fee schedule, and reimbursement may be possible for other codes (both Initiative specific and otherwise)
  - The best place to find information about potential reimbursement is the plan's provider manual, or by contacting the plan directly.
  - Billing practices for these codes (in order to obtain reimbursement purposes) may vary – the plan's provider manual can be a source of information

# Keep In Mind: General Billing Information

- Care Management and Coordination services rendered on, or after January 1, 2017 should be reported
- 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 Initiative identified codes must be under the general supervision of a beneficiary’s primary care provider.
- 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 identified codes 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.
- Documentation accessible to the entire care team is pertinent

# Addressing Barriers:

1. What amount should be billed on claim ($0.00 v. $0.01)

   *Refer to 2017 SIM PCMH Initiative Care Management and Coordination Tracking Codes Quick Guide*

1. Do any of the codes have an associated fee schedule?

   *Yes, 99495 and 99496 have an associated fee schedule, but are also included for tracking purposes related to the Care Management and Coordination PMPM**

   a. How should billing be handled if they do?

      *Refer to the flowchart on next slide*

1. Who can we submit claims for?

   *For the purposes of the Initiative, only claims for eligible beneficiary populations will be included in the review and calculation of the two Care Management and Coordination Metrics*

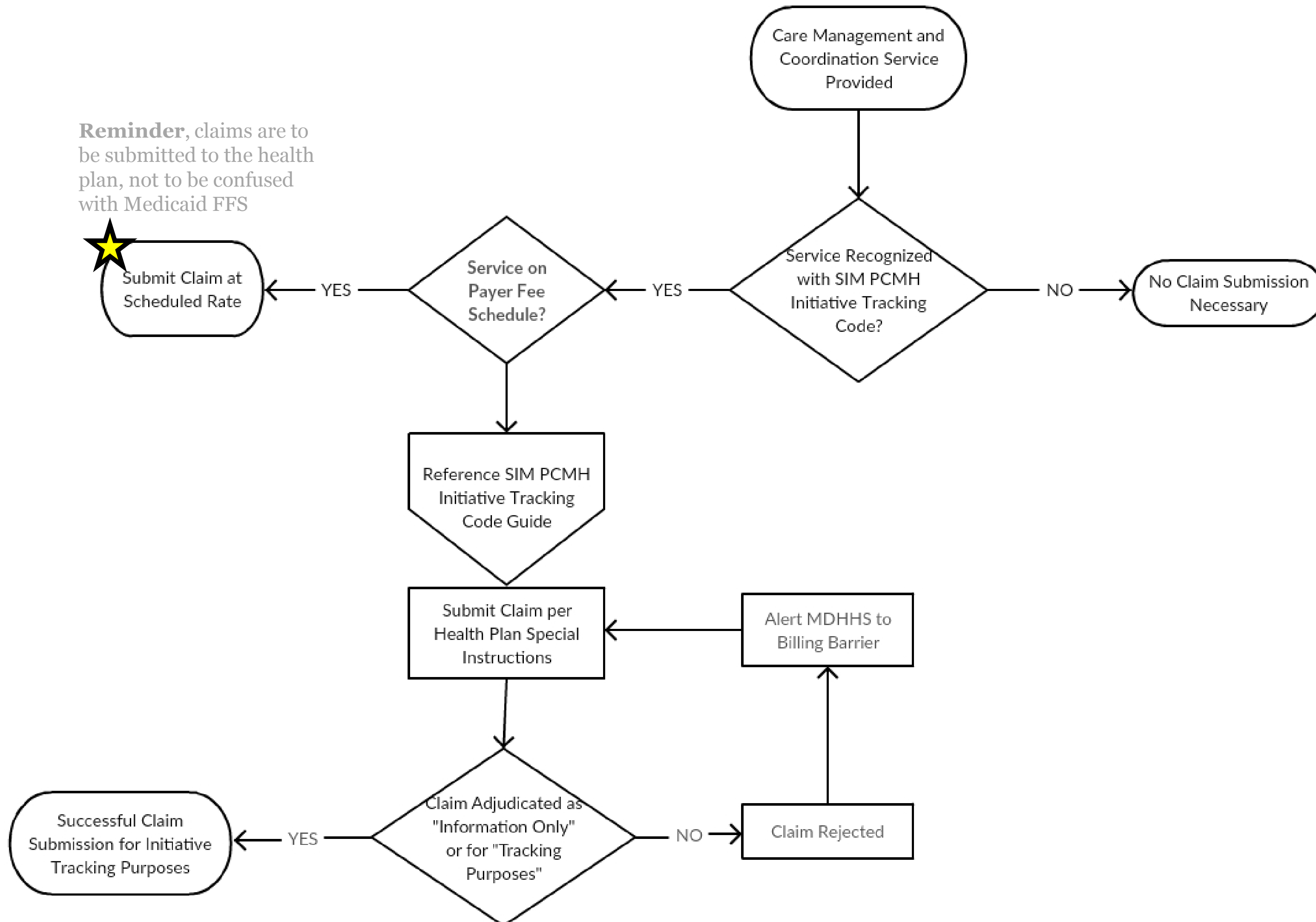
1. Who are the participating Payers?

   *Currently, all 11 MHPs are participating*

1. What should be done in the case of a rejected claim?

   *Refer to tracking code quick reference guide and resubmit*

# Code Submission Process



# Next Steps

- Continue (or begin) submitting claims
- Resubmit any rejected claims

- Learn More about billing and coding beyond the Initiative CM/CC codes:
  - Join us for upcoming Billing and Coding Collaborative Events

Billing and Coding Collaborative Webinars

Expert led session detailing requirements for billing and coding, each session focused on a specific Care Management and Coordination G and CPT code. Will support billing and coding services for Medicare patients.

**CMS Transitional Care Management Codes | May 23, 2017| 11:30 AM – 1:00 PM**

Billing and Coding Q & A Office Hours

Session focused on responding to participant questions/barriers/case studies related to previous webinar topic. Will occur approximately one week after topic focused webinar.

**Q/A Re: CMS Transitional Care Management Codes | May 30, 2017| 11:30 AM – 1:00 PM**

Michigan Department of Health & Human Services

# Questions?

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