2017 SIM PCMH Initiative Billing and Coding FAQs

1. **What amount should be billed on a tracking code claim?**
   For tracking codes where the Medicaid Health Plan (MHP) makes a payment above $0.00 (99495 and 99496), the PCMH Initiative Participant should bill their usual and customary charge. Medicaid Health Plans pay for services related to transitions of care (codes 99495 and 99496) regardless of if the patient is SIM PCMH eligible or not.

   For codes that are not paid and used for tracking purposes only please use the instructions in the chart below:

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

2. **Do any of the tracking codes have an associated fee schedule?**
   Yes. Medicaid Health Plans pay for services related to transitions of care (codes 99495 and 99496) regardless of if the patient is SIM PCMH eligible or not. (Please refer to your PCMH Initiative Participant's contract with each MHP or other MHP provider information for relevant care management and coordination codes beyond these two.)

3. **Who can we submit claims for?**
   PCMH Initiative Participants are required to submit codes for all included Medicaid beneficiaries (please refer to PCMH Initiative Medicaid Beneficiary Inclusion-Exclusion), that are receiving a service represented by one of the tracking codes SIM PCMH Initiative Care Management and Coordination Tracking Codes. Additionally, many of these codes can be utilized for other populations (depending on payer specifications).

4. **Who are the participating payers?**
   Currently, all of the 11 Michigan Medicaid Health Plans are participating in the SIM PCMH Initiative payment model.

5. **What should be done in the case of a rejected claim?**
   If a claim is rejected, the PCMH Initiative will not be able to track services rendered as intended. Please alert MDHHS (SIMPCMH@mail.mihealth.org) to any billing barrier and resubmit the claim. Please also refer to the code submission process chart below.

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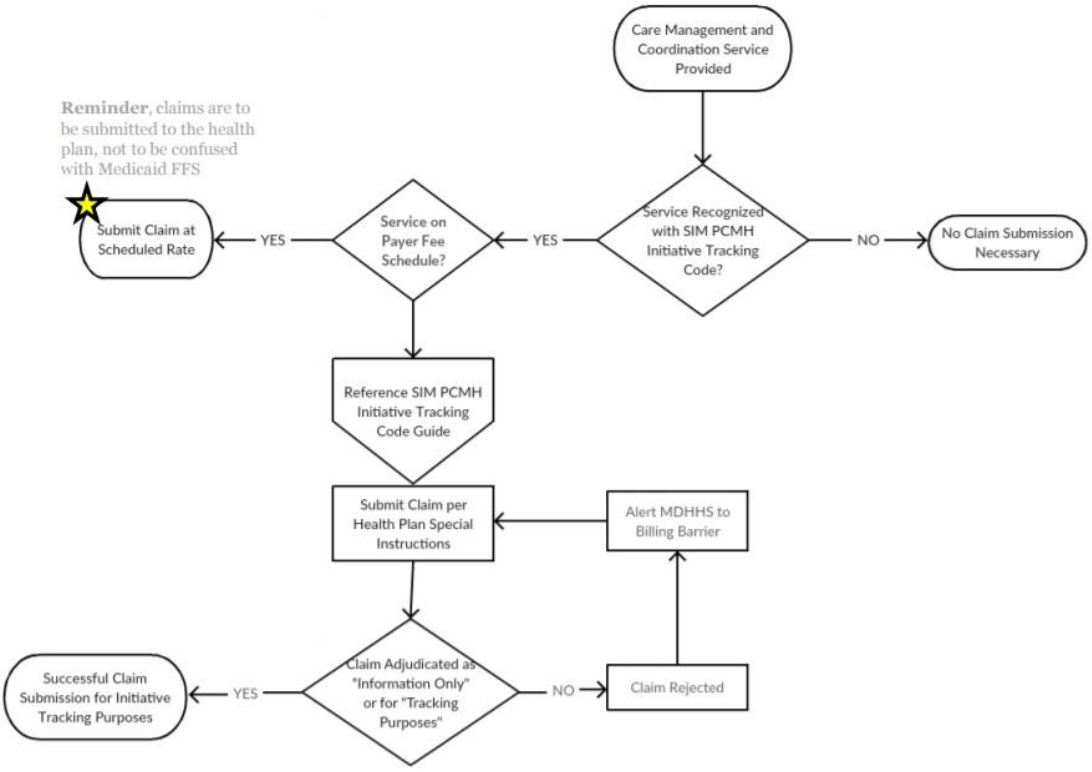

6. **Will claim rejection affect PMPM payment?**
   The PCMH Initiative does not have the ability to track claims that are rejected, and therefore cannot be counted in a Participant's Care Management and Coordination performance metric (Percent of Patients Receiving Care Management Services, and Timely Follow-up after Discharge). The PCMH Initiative will take billing process errors into account when establishing and monitoring Care Management and Coordination performance, but it is important that Participants promptly report those process challenges so they can be resolved. If a PCMH Initiative Participant is experiencing issues with claims submissions, please alert the PCMH Initiative at SIMPCMH@mail.mihealth.org.

7. **Should FQHC's be submitting the Care Management and Coordination Tracking Codes as well?**
   Yes, the Care Management and Coordination tracking codes should be used by all participating practices, including FQHCs. However, these codes do not represent FQHC encounters and will not paid an encounter rate. (Furthermore, PMPM payments received by FQHCs through the Initiative will not be reconciled as part of a FQHC's settlement process.)

8. **Where can I find detailed tracking code guidance and billing instructions?**
   The PCMH Initiative maintains a Care Management and Coordination Tracking Codes Quick Guide, it can be accessed here.

9. **What is the timeframe for submitting claims?**

Tracking code claims for Care Management and Coordination services performed on or after January 1, 2017 can be submitted. As general guidance, claims can be submitted within one year after the date of service. However, the claims run out period for Initiative performance metrics is 60-90 days long and claims should be submitted within that time period (or preferably sooner) to ensure they are captured for the purposes of tracking within the Initiative.

10. Can our organization use "shadow codes," so they don't produce a bill that goes to the health plan?

All claims need to be submitted to the appropriate MHP in order for the Initiative to appropriately track services rendered. For this reason, a shadow code should not be used for Initiative tracking purposes. If a PCMH Initiative Participant has been using shadow codes as opposed to processing claims, the claims should to be submitted as soon as possible.

11. Is it acceptable to submit codes under a provider who isn't the designated PCP but in the same practice?

Yes, a claim can be submitted under the rendering provider.

12. Are offices not enrolled/signed up with SIM project still able to bill care management codes for reimbursement?

Practices that are not SIM PCMH Initiative Participants are not eligible for the Initiative PMPM payment model, however they can bill the appropriate Care Management Codes as covered by a payer (for example, all 11 Medicaid Health Plans cover 99495 and 99496).

13. Since there is no monetary amount on the claim will it be audited by the insurance company?

As general guidance, any claim submitted could be subject to an audit, therefore normal documentation and billing practices should be followed. Please see the 2017 PCMH Initiative Care Management and Coordination Tracking Codes Guide for more details.

14. For time-based codes, do you require that the entire time be completed to report the code (e.g. 98966, 98967, 98968) or 51% of the time as is customary with other CPT time-based codes?

The PCMH Initiative is following normal/customary billing practices for the Care Management and Coordination Tracking Codes.

15. Can we bill an E&M on the same date as a G9002?

Yes, a PCMH Initiative Participant can bill an E&M code on the same date of services as a G9002.

16. If a PO does not have a contract with a health plan how can we receive a fee schedule?

In order to bill MHPs for services, a provider contract must be in place with each applicable health plan.

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17. If the provider is coding TCM, do they need the MiCMRC education as well?

General criteria to bill TCM codes does not require a provider to complete training offered by MiCMRC. However, the PCMH Initiative does require participating practices to have Care Management and Coordination Staff (see the 2017 PCMH Initiative Participation Agreement for more details), both CMs and CCs may or may not be involved in rendering some TCM services. Therefore, the PCMH Initiative requires both CCs and CMs to complete self-management training by an MiCMRC vendor, additionally, MiCMRC Complex Care Management training is required for Care Managers.

The SIM Billing and Coding Collaboarative, recently provided a webinar focused on TCM. For details regarding TCM criteria click here to view the TCM recorded webinars and slide deck.

18. Can we use the 2017 SIM PCMH Initiative Care Management and Coordination Tracking codes for single event/interaction...OR must the client be "enrolled" in Care Management services on a longer time basis?

The codes being utilized for the 2017 SIM PCMH Initiative should follow customary billing practices. Most codes require enrollment into Care Management Services (multiple chronic conditions, provider referral, etc.) and documented client consent, the same is true in using the codes for the Initiative.

19. Should we be dropping claims with the tracking codes for CPC+ beneficiaries or are these codes only to be used for the SIM PCMH Initiative?

The tracking codes and accompanying instructions posted on the SIM Care Delivery website pertain to Medicaid Health Plan claims for care management and coordination used by the PCMH Initiative. These codes are not currently used as part of the CPC+ program.

20. I thought that patients were not supposed to be billed for any of these care management services? Or was that just through CPC+? It seems wrong to charge patients for an initiative that they aren't really aware of.

Medicaid beneficiaries should not receive a charge for the services related to the 2017 PCMH Initiative Care Management and Coordination Tracking Codes. For CPC+ beneficiaries, there is not a patient financial liability for the upfront care management payments. Medicare FFS (“Traditional Medicare”) patients will be assessed a copayment and deductible (where applicable) whenever CCM services are billed. The July SIM PCMH Billing and Coding sessions will focus on this topic specifically and ways to address the barrier of patient financial obligation.

21. Will Federally Qualified Health Centers be required to include the Care Management and Coordination PMPM (and the Practice Transformation PMPM) on their annual cost wrap report to Medicaid?

The Care Management and Coordination codes that are being utilized for the PCMH Initiative do not meet the requirements for an encounter, and cannot be counted towards

the FQHC encounter rate. Therefore, FQHCs participating in the SIM PCMH Initiative are to exclude the SIM PCMH Initiative PMPM payments (Care Management and Coordination PMPM and Practice Transformation PMPM) from their annual Medicaid Reconciliation Report. However, if the FQHC bills for the two transitions of care codes (99495 and 99496), and the Medicaid Health Plan reimburses for the services (in addition to the PCMH Initiative PMPM) then the reimbursement would need to be counted towards revenue and reported.

22. Can Care Coordinators (including CHWs) provide a service covered by one of the 2017 PCMH Initiative Care Management and Coordination Tracking Codes, and submit a claim for it?

While a Care Coordinator as defined by the PCMH Initiative (see the 2017 PCMH Initiative Participant Guide for definition) cannot submit a claim directly (as an independent provider), they are considered a part of the Care Team, which can support the provision of Care Management and Coordination services. As noted in the 2017 PCMH Initiative Care Management and Coordination Tracking Codes Quick Guide, all claims would need to be submitted/reported under the NPI of the patient/beneficiary's primary care provider, as the service must be rendered under the general supervision of a PCP. For the purposes of the Initiative, a PCP is defined as a primary care physician, physician assistants and licensed nurses certified as advanced practice registered nurses, who are working under supervision of a physician, as defined in the Michigan Public Health Code, Act 368.

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Revision History

Revision Date	Version	Author	Section(s)	Summary
6.20.2017	V1	Katie Commey	All	Initial Release
8.8.2017	V2	Katie Commey	Added item #21	Federally Qualified Health Center updates.
8.9.2017	V3	Katie Commey	Added item #22	Care Coordinator billing