SIM PCMH Initiative:
Care Management and Coordination Tracking Codes
Questions and Answers

The Following Questions and Answers Document has been developed for SIM PCMH Initiative Participants as a result of the March 2018 Office Hour Session: PCMH Initiative Care Management and Coordination Tracking Codes. During the live Office Hour Session, guidance for each tracking code was provided as a general information, however as the code set is being used for tracking purposes within the PCMH Initiative the guidance was provided not as a mechanism to change billing requirements in the midst of the program, but with the consideration of the following:

The SIM PCMH Initiative as a program within the Michigan Department of Health and Human Services Medical Services Administration would like to set the following expectations for the usage of the CM/CC Codes:

1. **The code set being supported within the SIM PCMH Initiative are meant to be utilized specifically to support the core competencies around Care Management and Coordination Services.**
2. **The code set being used within the SIM PCMH Initiative are for tracking purposes only, however:**
    a. **The submission of these codes have a connection to SIM PCMH Initiative participant payments (Per Member Per Month payments)**
    b. **Some codes used within the PCMH Initiative (specifically 99495 and 99496) are used within other programs or payment mechanisms supported by MDHHS for the Medicaid Managed Care and/or Medicaid Fee-For-Service population (therefore adherence to service provision and coding standards would be required for these codes, and participants may receive reimbursement beyond the SIM PCMH Initiative PMPM payments for the provision of these services).**

Care Transition

1. **Do any of the 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 contract with each MHP or other MHP provider information for relevant Care Management and Coordination codes beyond these two.)

2. **Can a 99495 (Care Transition) and a G9002 (In-person encounter) be billed on the same day?**
   Other care management and coordination service(s) may be reported during the transitional care management period (as billed with 99495 or 99496), however, if the in-person encounter (G9002) is related to the Transition of Care then it should not be billed on the same day or during the transitional care management period.

3. **Can we bill a Transitional Care Management/Care Transition code (99495 or 99496) following an Emergency Room visit?**
   No, Transitional Care Management services are not meant to be billed for an Emergency Room follow-up. These codes (99495 or 99496) can be billed for patients transitioning out of an inpatient hospital, skilled nursing facility, outpatient observation, or partial hospitalization setting.

4. **Is there a required time frame between a care transition (99495 or 99496) and other Care Management and Coordination G/CPT Codes being used within the PCMH Initiative?**
   While a comprehensive assessment (G9001) could occur on the same date of service as a completed care transition (99495 or 99496), other care management services should not be billed on the same date of service. There is no limitation or specified timeframe for providing and billing other Care Management Services in relation to a care transition, with the exception of telephone services (98966, 98967, or 98968) and in-person encounters (G9002), which should not be billed during the transitional care management period, if the work is related to the transition of care.

5. **Please review the difference between the care transition codes (99496 and 99495).**
   The difference between the care transition codes is the level of medical decision making necessary, and the timeframe in which the service is completed. 99496 indicates a patient's needs are high complexity and requires a face-to-face visit within 7 days. Alternatively, 99495 indicates a patient's needs may be medium or low risk and requires a face-to-face visit within 14 days. As with any code, this is based on a clinician's judgement of medical risk.

Telephone Services

6. **For time-based codes, does the PCMH Initiative require that the entire time be completed to report the code (e.g. 98966, 98967, or 98968) or 51% of the time as is customary with other CPT time-based codes?**
   While the PCMH Initiative provides guidance on the duration of specific services (G9001, G9002), this guidance represents the expected amount of time for completion of that service, not a required amount of time. The telephone services (98966, 98967, and 98968) are an exception in which the guidance on service length/duration should be followed, and participants must complete the entire length of time represented by the lower end of the duration timeframe in order to bill that code.

7. **Can SIM PCMH Initiative Participants bill a telephone visit (98966, 98967, or 98968) if related to Care Plan monitoring, not just follow up on visit?**
   Yes, it would be appropriate to bill a telephone service (98966, 98967, or 98968) visit if related to the Care Management care plan, however it is expected that telephone services are being provided to established patients, therefore would not occur on the same day as a comprehensive assessment and care plan development (G9001).

8. **For telephone services 98966, 98967, or 98968, the March 2018 presentation indicated that these telephone assessments should not be reported if the telephone service is related to a service provided within the previous 7 days or within the postoperative period of a previously completed procedure. Does this mean these claims will not be counted in the Percentage of Patients with a Care Management Claim report generated by Michigan Data Collaborative (MDC) if completed prior to that 7 days?**
   The Percentage of Patients with a Care Management Claim report produced by MDC counts the number of patients with a Care Management and Coordination Service as represented by the code set used within the PCMH Initiative (with exception of G9007). Therefore if a patient has received a Care Management and Coordination Service such as an in-person encounter (G9002) and later in the reporting timeframe a telephone service (98966, 98967, or 98968) was provided to the same individual, that individual would only be counted in the numerator of the Percentage of Patients with a Care Management Claim report once no matter the timeframe between services in that reporting period.

9. **Regarding the telephone services, we are a pediatrics office as well an if we have a patient complete a Social Determinants of Health (SDoH) survey and it comes back positive for needing assistance, if our care manager calls them later that day or the next day is that billable as a telephone service?**
   In general, Care Management and Coordination Services may include coordinating care of other professionals and agencies for/with patients, this extends beyond medical conditions to support a patient's psychosocial needs, and activities of daily living. Therefore, a telephone service (98966, 98967, or 98968) to further assess a patient's need and coordinate care (either internally or with an external partner organization) would meet the definition of this service.

10. **If a PCMH Initiative Participant calls a patient after an Emergency Room visit and the patient agrees to care management, is it possible to bill the phone visits codes (98966, 98967, or 98968)?**
    Yes, it is appropriate to bill the appropriate telephone services code for tracking purposes within the PCMH Initiative. Developing a patient relationship is imperative to the delivery of Care Management and Coordination services, therefore the PCMH Initiative would expect to see a continued relationship with the patient as demonstrated through subsequent Care Management and Coordination claims.

Other Care Management and Coordination Services

11. **Is G9001 (Comprehensive Assessment) required to be at least 30 minutes?**
    It is expected a Comprehensive Assessment (as represented by G9001) would take 30 minutes to complete, however it could take less time. As G9001 is used as a tracking code (not reimbursable in other MDHHS Medicaid Managed Care programs) PCMH Initiative participants could submit this code for a Comprehensive Assessment that last less than the expected 30 minutes.

12. **How is "direct supervision" specifically related to G9002 (In-person Encounter) defined?**
    Direct supervision indicates that a physician must be immediately available but doesn't need to be in the room. This definition is applicable to all of the codes being used within the PCMH Initiative, and any other code that requires direct supervision.

13. **Is G9007 (Team Conference) included in the calculation of the "Percentage of Patients with a Care Management Claim" measure and required 3% benchmark?**
    For purposes of counting a care management claim in the development of this measure, G9007 (Team Conference) is not counted if it is the patient's only Care Management and Coordination service within the measurement period.

14. **Is there a required duration for team conference (G9007)?**
    There is no required expectation for duration of discussion related to single patient during a care team conference in order to submit G9007, however, discussion should be sufficient to address the patient's care plan and requires documentation of any updates and/or additions made to the individualized care plan as a result of the discussion.

15. **Can a Nurse Practitioner that serves as a Care Manager deliver group education and training (98961 or 98962)?**
    For the purposes of the SIM PCMH Initiative, Care Managers (please see the 2018 Participation Agreement for full list of individuals recognized as Care Managers and Care Coordinators within the SIM PCMH Initiative), including Nurse Practitioners may deliver group training and education for Medicaid beneficiaries noted on the PCMH Patient List.

Federally Qualified Health Center and Rural Health Center Claim Submission

16. Do the Care Management and Coordination Tracking Codes used within the SIM PCMH Initiative apply to Federally Qualified Health Centers (FQHC) or Rural Health Centers (RHC)?

Yes, Care Management and Coordination Tracking Codes used within the SIM PCMH Initiative apply to all SIM PCMH Initiative Participants including FQHCs and RHCs.

FQHCs must submit the codes using the Institutional billing format, with no associated payment code or qualifying visit code (with the exception of the care transition codes, 99495 and 99496). As the codes used within the PCMH Initiative are tracking codes (with exception of 99495 and 99496) they do not apply to Prospective Payment/cost settlement.

RHCs should submit claims on the professional claims format without the Payment (T) code, or a qualifying visit. The only exception is for the care transition codes (99495 and 99496) which are both qualifying visits therefore should be submitted with a payment code.

17. Can RHCs bill Procedure Code T1015 for all non-payable tracking codes BUT with a zero dollars on the claim code? For example, an RHC would bill G9001 under T1015 but be sure to apply zero dollars to the claim?

The non-payable claims (all services/codes used within the PCMH Initiative with the exception of care transition codes 99495 and 99496) should be submitted independently, and not include T1015.

18. Can a claim be submitted to a participating Medicaid Health Plan without a qualifying visit code?

Yes, FQHCs must submit the codes using the Institutional billing format, with no associated payment code or qualifying visit code (with the exception of the care transition codes, 99495 and 99496). All 11 of Michigan's Medicaid Health Plans are participating in the PCMH Initiative and are aware of the tracking codes, which require a claim to be submitted without a qualifying visit code.

General Questions

19. Who can we submit claims for?

PCMH Initiative Participants are required to submit codes for all included Medicaid beneficiaries (please refer to Appendix D of 2018 PCMH Initiative Participation Guide), 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). Specifically, the Care Transition services (99495 and 99496) can be provided as applicable to all Medicaid Beneficiaries.

20. **For the newly added tracking codes from CMCC, are we paid different for these? (98961, 98962, G9008, S0257)?**
    The codes being added to the tracking code set for 2018 do not come with any additional payment, similar to 2017, these codes are a part of the tracking code set which feed the CMCC metrics, and are built into the CMCC PMPM payment you receive.

21. **How to bill the payers? What amount should be billed on claim?**
    Participating practices/Physician Organizations should submit CMCC claims at their customary amount (i.e. do not set specific charges based on payer). Payers should accept claims and pay $0.00 on the claim (with the exception of Care Transition codes 99495 and 99496, which would be paid according to the Medicaid Fee Schedule). In the adjudication process participants may receive a response that a claim was accepted for informational purposes only, or similar.

22. **Can Care Coordinators (including CHWs) provide a service covered by one of the 2018 PCMH Initiative Care Management and Coordination Tracking Codes, and submit a claim for it?**
    While a Care Coordinator as defined by the PCMH Initiative 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. 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.

23. **What is the timeframe for submitting claims?**
    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. For more details on the claims runout period used in measure calculation, see the Care Coordination Report Quick Reference developed by the Michigan Data Collaborative.

24. **Can a Care Manager initiate care management services without a physician's request noted in the record?**
    Yes, initiation of Care Management and Coordination services does not require a physician request noted in the patient's electronic health record.

25. **Why is the Children's Special Health Care Services (CSHCS) population, not included in the SIM PCMH Initiative eligible patient population?**
    The SIM PCMH Initiative does not include the CSHCS population, as this population is covered under the family centered Per Member Per Month (PMPM) payment.