
MI-CCSI
Center for Clinical Systems Improvement

PDCM Billing Code overview

The PDCM Procedure Codes

- G9001* - Coordinated Care Fee – Initial Assessment
- G9002* - Coordinated Care Fee – Maintenance or follow up (quantity billed >45 minutes)
- 98961* - Group Education 2–4 patients for 30 minutes (quantity billed)
- 98962* - Group Education 5–8 patients for 30 minutes (quantity billed)
- 98966* - Phone Services 5-10 minutes
- 98967* - Phone Services 11-20 minutes
- 98968* - Phone Services 21-30 minutes
- 99487* - Care Management Services 31-75 minutes per month (care coordination in the medical neighborhood)
- 99489* - Care Management Services, every additional 30 minutes per month (care coordination in the medical neighborhood)
- G9007* - Team Conference
- G9008* - Physician Coordinated Care Oversight Services (physician only service and can only be billed by the physician)
- S0257* - End of Life Counseling

Coordinated Care Fee-initial Assessment

- **G9001**
  - Individual, face to face-video or in person component (may occur over more than 1 encounter.
  - The code is submitted for payment when the assessment is completed
  - The intent is to use this when conducting a comprehensive assessment (medical, behavioral, psychosocial)
  - The code includes development of a plan of care. Self-management plan.
    - Best practice would be plans for ongoing monitoring, evaluation and adjustment of plan of care as needed until the patient's condition required a different level of care, declines services, or meets the intended target.

Differences:

BCBSM/BCN

Who can bill?-Licensed Care Team member

Telephonic- if it is documented why face to face is not possible

Once per day

PH

- Who can bill?-Within Scope of Practice
- Once annually

Coordinated Care fee-Maintenance or follow up G9002

- Individual, face to face-video or in person
- Use for:
  - A follow up appointment/visit
  - Focused on addressing a portion of the plan of care-not a comprehensive assessment.
- Content-substantive to the plan of care
- May occur before or after a G9001

- For BCBSM/BCN Billed once per day (for >1 team member providing these services-determine who will drop the code)

Differences:

BCBSM/BCN

Who can bill?-Licensed Care Team Member

Telephonic- if it is documented why face to face is not possible

May quantity bill:

1-45 minutes=1 quantity, 46-75 minutes=2 quantity, 76-105 minutes=3 quantity, 106-135 minutes=4 quantity

May use 2P modifier-payable when contact with patient to discuss the program and the patient declines to enroll in Care Management. Allowed per condition per year. For Commercial PPO only.

PH

- Who can bill?-Within Scope of Practice
- No 2P modifier is available

Group Education

- **98961**--2 to 4 patients for 30 minutes
- **98962**--5 to 8 patients for 30 minutes
  - Patient is defined as the patient or their designee (ie guardian, parent)
  - Quantity of 1=30 minutes
  - Quantity of 2=60 minutes
  - Curriculum approved by Providers (Provider is not required to attend)
  - Team members conduct the classes
  - Documentation is required for each patient ie plan of care, progress toward goals, response to class material etc
  - HIPAA policies apply

Differences:

BCBSM/BCN

Who can bill?-Licensed Care Team member

Telephonic- if it is documented why face to face is not possible

The code used is based on the number of patients in attendance

PH

- Who can bill?-Within Scope of Practice

Counseling and discussion about Advanced Directives or end of life care planning and decisions with patient

- **S0257**
  - Individual face to face, video, telephone
  - Content-sharing information such as Advanced Directives, patient advocate etc. Discussion focused on patient wishes, quality of life etc

Differences:

BCBSM/BCN

Who can bill?-Licensed Care Team Member and MD, DO, PA and NP

Conversations may be in-person, telephonic or video with patient or surrogate

One per patient per day

PH

- Who can bill?-Within Scope of Practice, to include MD, DO, PA and NP
- No quantity limits

Phone services with patient or caregiver (HIPAA approved)

- **98966**-5 to 10 minutes
- **98967**-11 to 20 minutes
- **98968-**21-30 minutes

Content-to discuss care issues and progress toward goal(s)

- Substantive to the plan of care (including addressing gaps for these complex enrolled patients)
- More than simply administrative tasks ie appointment reminders, to report lab results or routine gaps in care calls independent of being enrolled in PDCM
- Billed once per day. May add up phone call minutes in a day and bill the code representing all the minutes up to the 98968 21-30 minutes.

Differences:

BCBSM/BCN

Who can bill?-Licensed Care Team Member and MD, DO, PA and NP

May use 2P modifier-payable when the phone call with the patient to discuss the program and the patient declines PDCM serivces.

2P Modifier allowed per condition per year. For Commercial PPO only.

PH

- Who can bill?-Within Scope of Practice

Care management services (care coordination) codes

- **99487**-31 to 75 minutes per month (care coordination in the medical neighborhood)
- **99489**-every additional 30 minutes after 75 minutes per month (care coordination in the medical neighborhood)
  - Billed at the end of each calendar month
    - It is a total of all care coordination call minutes accumulated that month
    - Once the minutes meet the threshold minimum number of minutes, the code can be submitted for payment
  - Care Coordination is between a care team member and external entities such as DME company, community resource, specialist office
  - It does not include time with the patient, patient family, or those within the immediate care team completing the care coordination calls

Differences

BCBSM/BCN

Who can bill?-Licensed and unlicensed Care Team Members

Portal communication-may include minutes representing care coordination and communication between patient and care team members through the portal that is substantive to the plan of care.

PH

- Who can bill?-Within Scope of Practice
- Minimum threshold is 60 minutes not 31 minutes (PH does not recognize the CPT 50% rule which sets threshold at 31 minutes)

Team Conference Code

- **G9007**
  - The team conference meeting must include the provider and at least once other immediate care team member.
  - Who may bill-MD, DO, NP or PA
  - Documentation may be done by a care team member as long as it is verified by the provider and it is the provider who “drops” the billing code.
  - Once per day regardless of time spent
  - Content: formal discussion substansive to the patient’s plan of care who is enrolled in care management. Not for patient identification, or brief, routine, unplanned day-to-day communications.

Differences

There are no known differences between BCBSM/BCN and Priority Health for this code.

Physician Coordinated Care Oversight Services (Enrollment fee)

G9008

Differences:

BCBSM/BCN

Who may bill?-MD, DO

Once per day-no quantity limit.

Emphasizes-**Coordinated care by the physician**: billed when Communication occurs for the purpose of consultation with health care professionals not part of the immediate care team. Goal is consulting about a patient with complex care needs, and coordination of provider services..

May use 2P modifier-payable when contact with patient to discuss the program and the patient declines to enroll in Care Management. Allowed per condition per year. For Commercial PPO only

PH

- Who can bill?-Within Scope of Practice