MCT2D Learning Community Monthly Calls

Billing Codes - Care Management Codes and Billing for Non-face-to-face Care

To receive CME/CE credit

TEXT 66503 to 833-256-8390

(by 1:00 PM on March 4)

Complete the evaluation online by March 19

at https://beaumont.cloud-cme.com

For assistance, email cme@beaumont.org

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This activity was planned by and for the healthcare team, and learners will receive 1.0 Interprofessional Continuing Education (IPCE) credit for learning and change.

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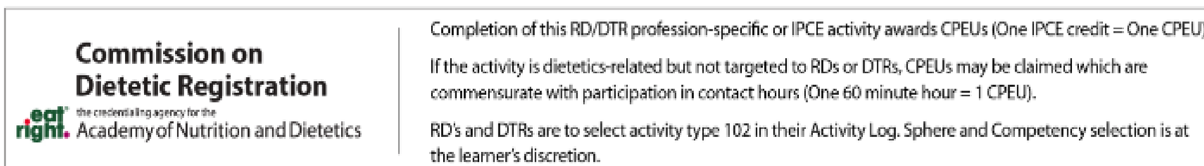
Dietetic CPEU:



Disclosure

The following speakers and/or planning committee members have identified the following relevant financial relationship(s) with ineligible companies. All other individuals involved with this activity have no relevant financial relationships with ineligible companies to disclose.

- Lauren Oshman, M.D.: Stocks in publicly traded companies or stock options, excluding diversified mutual funds – Abbott, AbbVie, Johnson & Johnson, Merck & Co.

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The Basics of Team-Based Care Billing and Coding

Reference Guidelines

- Please provide the following as an appropriate reference if you use this material: “Material based off of the Foundational Care Management Codes & Billing Opportunities course developed through a collaborative effort facilitated by Michigan Institute for Care Management and Transformation and participating Training Organizations.”
- Questions about using or replicating this content should be sent to: https://micmt-cares.org/contact
- Please follow this link if you are interested in becoming an approved trainer for this curriculum: https://micmt-cares.org/contact

Setting the Expectations

This course builds upon team-based care focusing on reimbursement for care management services for BCBSM and Priority Health. Some details discussed maybe like other payers.

Objectives

Identify
- Identify members of a care team

Define
- Define health care coding and health care billing

Describe
- Describe the two common health care coding classification systems

Explain
- Explain the importance of documenting the encounter

Illustrate
- Illustrate how a care team member may impact risk adjustment and the financial model of a practice

Setting the Foundation

“The primary goal of medical teamwork is to optimize the timely and effective use of information, skills, and resources by teams of health care professionals for the purpose of enhancing the quality and safety of patient care”.

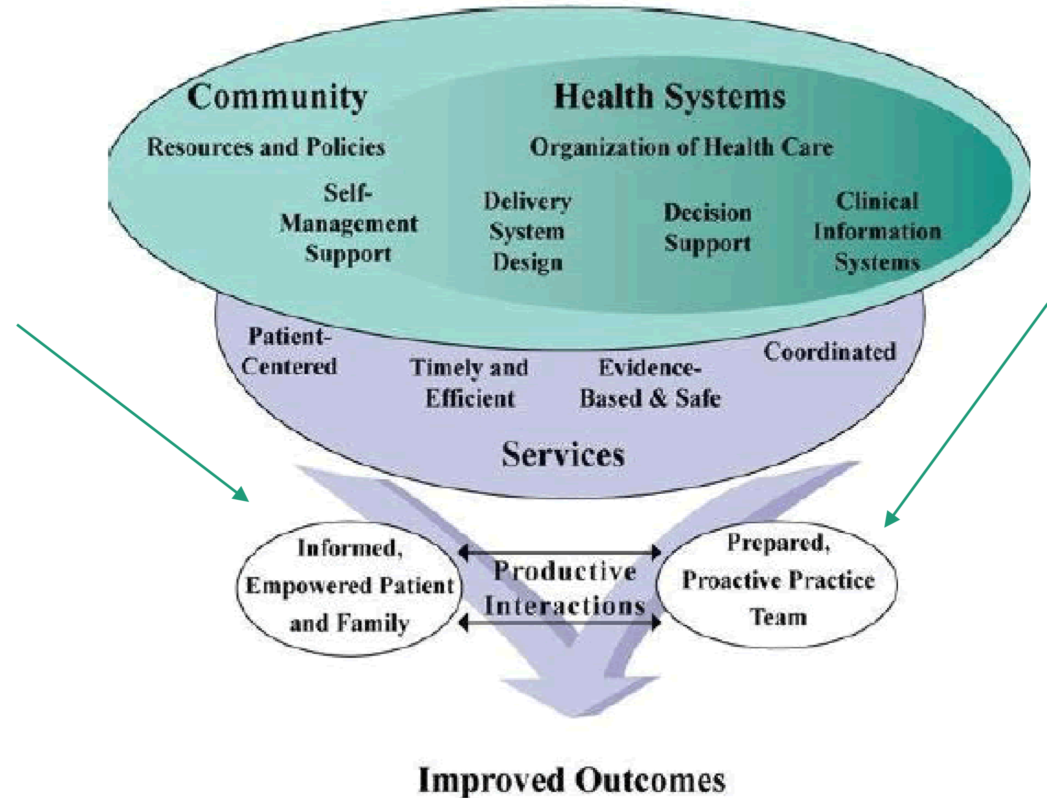
~Agency for Healthcare Research in Quality (AHRQ)

Team-Based Care - What Does it Take?

- Holistic, person-focused and family-centered approach to health including behavioral, social and physical aspects
- Care coordination across settings and organizations
- A common set of quality outcome metrics
- Reimbursement for care management services, care coordination
  - Shift from fee-for-service to value-based reimbursement
  - Billing the encounters contributes to successful value-based reimbursement

Productive Interactions, Outcomes, and Sustainability

Many productive interactions with patients will lead to improved outcomes that can be measured at a *population level*



Productive interactions are *billable* interactions, which support the sustainability of the care management program through payments and successful incentive program participation

Introducing your Care Team Members

- Licensed Professionals:
  - Physician, Advanced Practice Providers (APP), Registered Nurse (RN), Pharmacist (PharmD), Master Social Worker(MSW), Registered Dietician (RD), and Certified Diabetic Educator (CDE)
- Unlicensed Professionals:
  - Medical Assistants & Community Health Workers (CHW)
    - Unlicensed professionals must work under a written protocol or standing orders signed by the physician or APP.

      Example: Scope of service
- Extended Members:
  - Front Desk staff or Schedulers
  - Biller and Coder

Billing and Coding Chain of Accountability

- Physician
- Advanced Practice Practitioner (APP)
- Care Team Member – Licensed/unlicensed
- Biller and Coder

Define Coding

- Health care ***coding*** involves extracting billable information from the health care record after reviewing clinical documentation
- Health care ***billing*** uses codes to create insurance claims and bills for patients
- Health care ***claims*** is where health care billing and coding intersect to form the backbone of the practice's revenue

Trigger for Coding and Billing: Clinical Documentation

Clinical Documentation Improvement (CDI) – is a process that continually looks for ways to best maximize the health care record integrity with the goal of providing a complete and accurate picture of a patient's condition(s) and the care services they receive most often specific to the setting where services were provided.

Coding for Specificity: ICD-10, CPT & HCPS

- Documentation should be as specific as possible. Drill down to specifics
- Specific documentation and coding guidelines are mandated by **HIPAA**.
- Specificity and coding has a significant impact on HEDIS metrics and risk scores

If you mean.....	Don't say.....
Chronic obstructive asthma with acute exacerbation	COPD
Hypertensive heart disease with heart failure	Heart failure/Hypertension
Lung cancer with metastasis to liver	Lung cancer
Alcohol Dependence	Alcohol abuse
Dominant side hemiplegia due to CVA	History of CVA Hemiplegia

TIPS:	ICD-10 Mapping & Education
➢ **ICD-10-CM**	E08 – E13 code series (Diabetes) O24 code series (Diabetes in Pregnancy)
➢ **Documentation should specify**	o Type of DM (Type 1, Type 2, Other) o Complication/manifestation affecting body system
➢ **Secondary diabetes (E08- series)**	Code first any underlying conditions, code second the type of diabetes: o Congenital rubella *(P35.0)* o Cystic fibrosis *(E84.-)* o Malnutrition *(E40-E46)* o Cushing's Syndrome *(E24.-)* o Malignant neoplasm *(C00-C96)* o Diseases of the pancreas *(K85.-, K86.-)* Example: *Secondary DM due to pancreatic malignancy (C25.9 + E08.9)*
➢ **Cause and effect relationship...**	State any relationship between DM and another condition such as: o *Diabetic* coma o Neuropathy *due to* diabetes o Gastroparesis *secondary to* diabetes o Foot ulcer *associated with* diabetes Example: *Diabetic retinopathy with macular edema (E11.311)* **Note: When type of diabetes is not documented, default to category E11 (type 2).*
➢ **Use additional code...**	... to identify: o Site of any ulcers *(L97.1-L97.9, L89.41-L98.49)* o Stage of chronic kidney disease *(N18.1-N18.6)* o Glaucoma *(H40-H42)*
➢ **Controlling Diabetes**	... be sure to add: o Long-term insulin use *(Z79.4)* o Oral antidiabetic drugs *(Z79.84)* or Oral hypoglycemic drugs *(Z79.84)*

Care Team Procedures 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 PCMH neighborhood)
- 99489* – Care Management services, every additional 30 minutes per month (care coordination in the PCMH neighborhood)
- G9007* - Team Conference
- G9008* - Physician Coordinated Care Oversight services (physician only service and can only be billed by the physician)
- S0257* - Counseling regarding Advance Directives

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Billing for Care Team Activities is Important

- Billing for services and being paid for services places value on the patient care that you provide
- Billing, along with care team incentive programs, is how team-based care can be sustainable
- Sustainability comes from:
  - Engaging a minimum number of patients in a day
    - Minimum of 4 encounters on average per half day (8 or more/day)
    - Be sure there is a mix of encounter types to support staff expense
    - Could include telephone or virtual for in-person encounters
  - Billing consistently for services

Process or Revenue Generation

1. Document the encounter in the patient's chart
2. Assign appropriate codes
3. Submit the claim electronically
4. Interpret the payer's response
5. Prepare for post-payment actions (audits, document requests, etc.)

Key Takeaways

- Team-Based Care is derived from the chronic care model and patient- centered medical home.

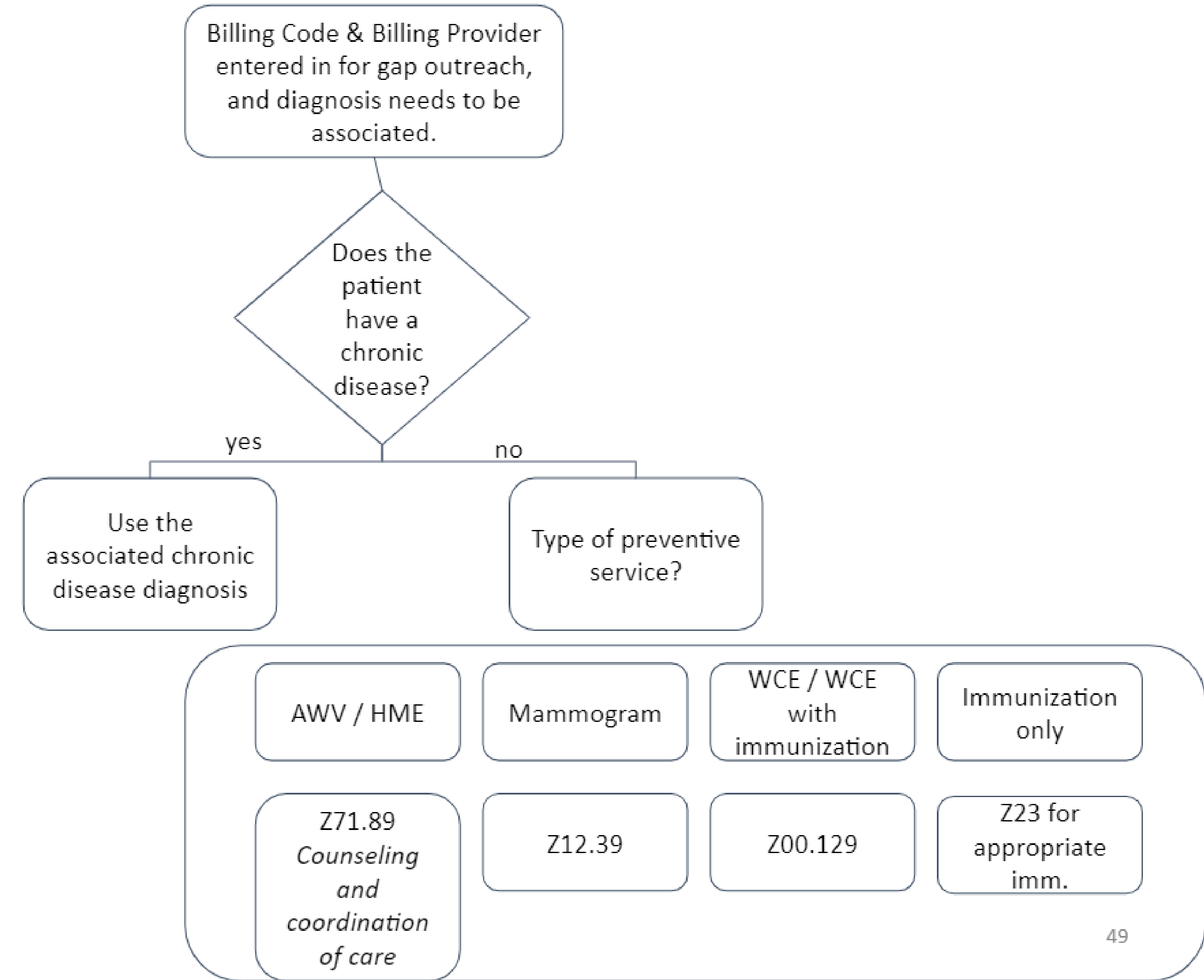
- Sustainability of team-based care is identifying important members of the care team, assigning appropriate classification codes, documenting services rendered and billing consistently.

Billing Optimization Opportunities

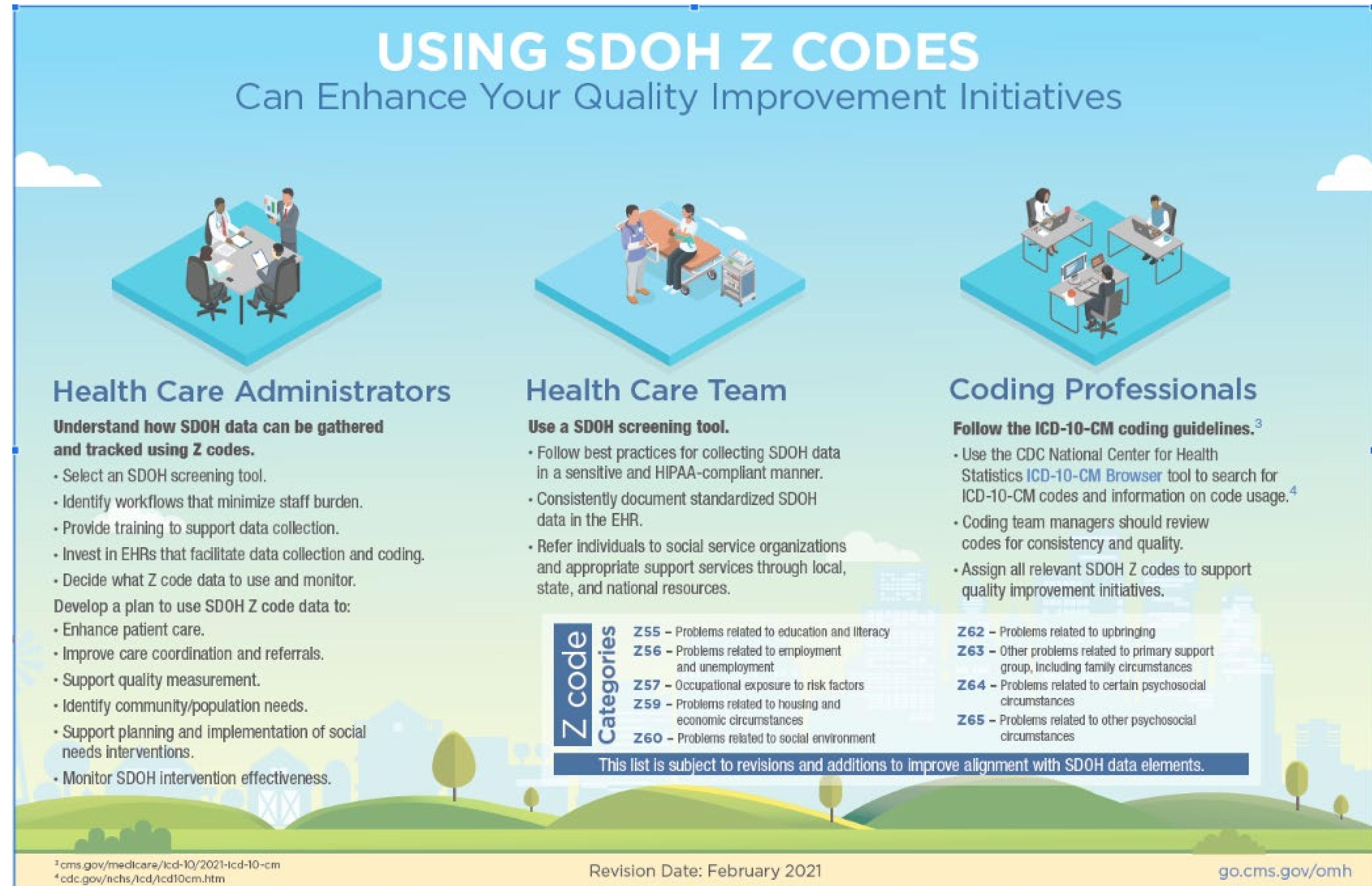
- Its important to match the diagnosis with what's going on in the visit! Care Team Members can take the opportunity to make sure that the patient's diagnoses are correct by reviewing the problem list and making recommendations to the provider.

- Other optimization opportunities include:
  - Preventive care support
  - Chronic care support
  - Social Determinants of Health (SDOH)
  - Hierarchical Care Coding (HCC)

Preventive Care & Associated Diagnosis for gap outreach



When to use a Z code for SDOH

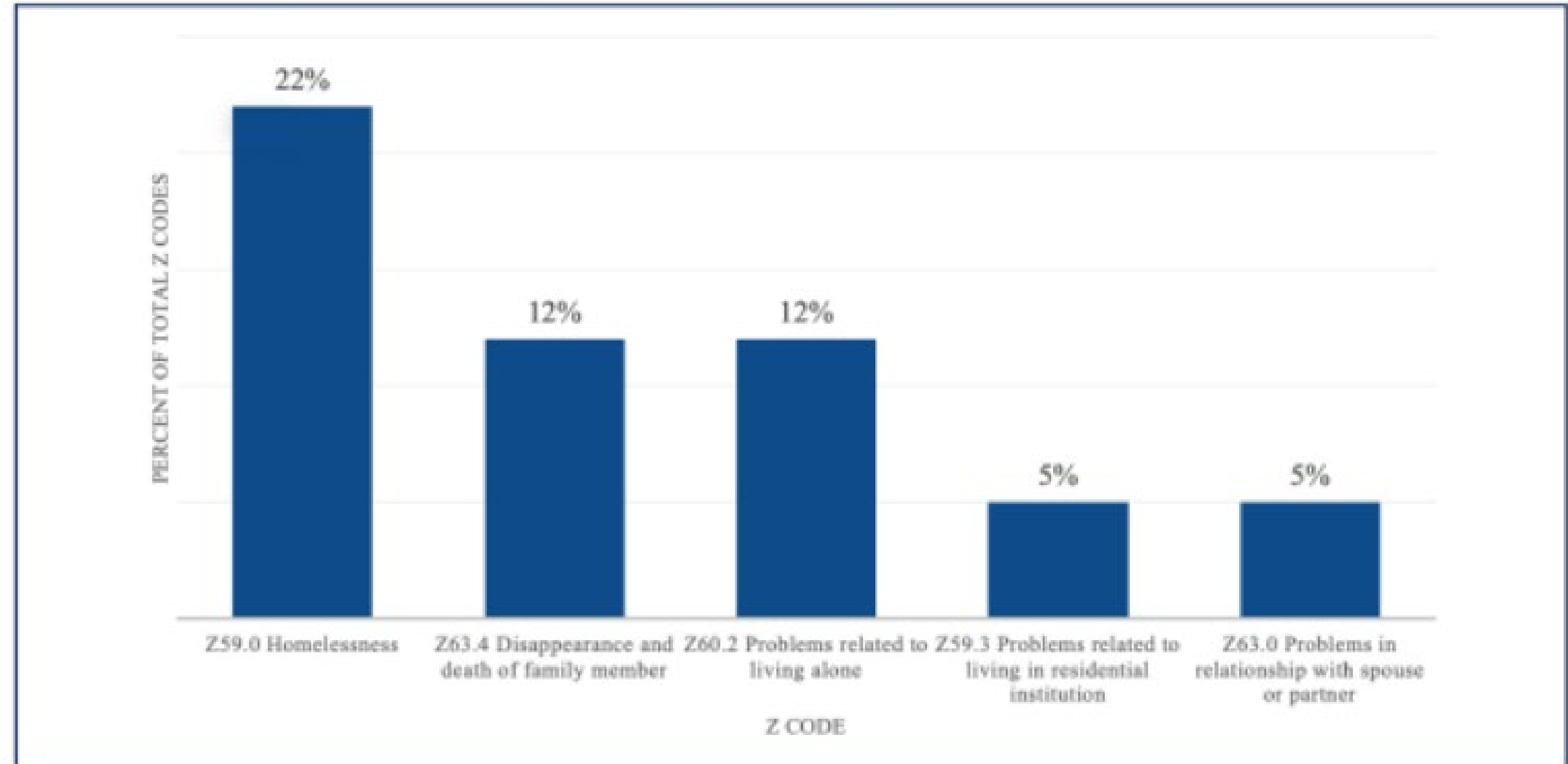


https://www.cms.gov/files/document/zcodes-infographic.pdf

The Most Common Z Codes:

- Care team members can add Z-codes as a diagnosis for billing purposes
- There are several payers with incentive plans around SDOH and Z-codes (Priority Health for Medicare/Medicaid, BCBSM both have incentive programs

Figure 3. The Top Five Z Codes Representing the Largest Shares of All Z Code Claims, 2019.



The five Z codes that represented the largest shares of all Z code claims (N=1,262,563) in 2019 were:

Z code	Description	*n*	Proportion of all Z code claims
Z59.0	Homelessness	310,089	22%
Z63.4	Disappearance and death of family member	164,829	12%
Z60.2	Problems related to living alone	163,259	12%
Z59.3	Problems related to living in a residential institution	66,842	5%
Z63.0	Problems in relationship with spouse or partner	62,572	5%

Optimizing Billing From the Clinician's Perspective

Care Team Members should make sure to comprehensively bill for all their interactions. The frame of mind should be that **ALL** interactions are billable. - So, the question is **HOW** do I bill, not **SHOULD** I bill.

Time	Type of Work / Block
8a – 8:30a	Huddles with various team members / prep for the day
8:30a – 12:00p	Morning patient block; held for virtual patients (video and phone calls) 8:30a -9:00a — Transitions of Care Phone Calls (Not scheduled) 9:00a-10:00a — New Patent Visit 10:00 - 10:30a — Return Visit 10:30a- 11:00a — *Not Scheduled* 11:00 - 12:00p — New Patient Visit
12:00 – 1:00p	Lunch Block – frequently also used for Care Coordination follow up.
1:00p – 4:30p	Afternoon patient block 1:00p - 1:30p — Return Visit 1:30p - 2:00p — Return Visit 2:00p - 3:00p — New Patient Visit 3:00p- 3:30p — Urgent, ad hoc visit opportunity 3:30p- 4:00p — Extended Patient Visit
4:30p – 5:00p	Finish documentation

Morning Block Summary

Time	Appointment Type	Billing Codes
8:00 – 8:30a	Huddle with Dr. Rachel	G9007*3
8:30a – 9:00a	Transitions of Care Phone Calls	1111F
9:00a – 10:00a	New Patient Visit	G9001 Care Coordination minutes: 10
10:00a – 10:30a	Return Visit	G9002 G9007
10:30a – 11:00a	*Not scheduled*	*None*
11:00a – 12:00p	New Patient Visit	G9001 Care Coordination minutes: 8 S0257

Afternoon Block Summary

Time	Appointment Type	Billing Codes
1:00p – 1:30p	Return Visit	G9002 G9002
1:30p – 2:00p	Return Visit	G9002
2:00p – 3:00p	New Patient Visit	G9001 S0257 98966
3:00p – 3:30p	*Urgent, ad hoc visit opportunity*	*98967*
3:30p – 4:30p	Extended Patient Visit	G9002 *2

Discussion- How close does this mirror the experience in your clinic? What barriers do you see?

(1) Care Team Members - Billing Summary

Morning

- 1111F
- G9001 *2
- Care Coordination
  - 10 minutes *1
  - 8 minutes * 1
- G9002
- S0257

Afternoon

- G9002 * 5
- G9001
- S0257
- 98966
- 98967

14 billable activities for the day!

Applying Care Management Codes to Clinical Practice

Review and understand the PDCM billing codes and their application in care management to work performed in the practice

Select the appropriate billing code in various clinical scenarios

Documentation is key

Care Team Procedures Codes

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Billing Scenarios

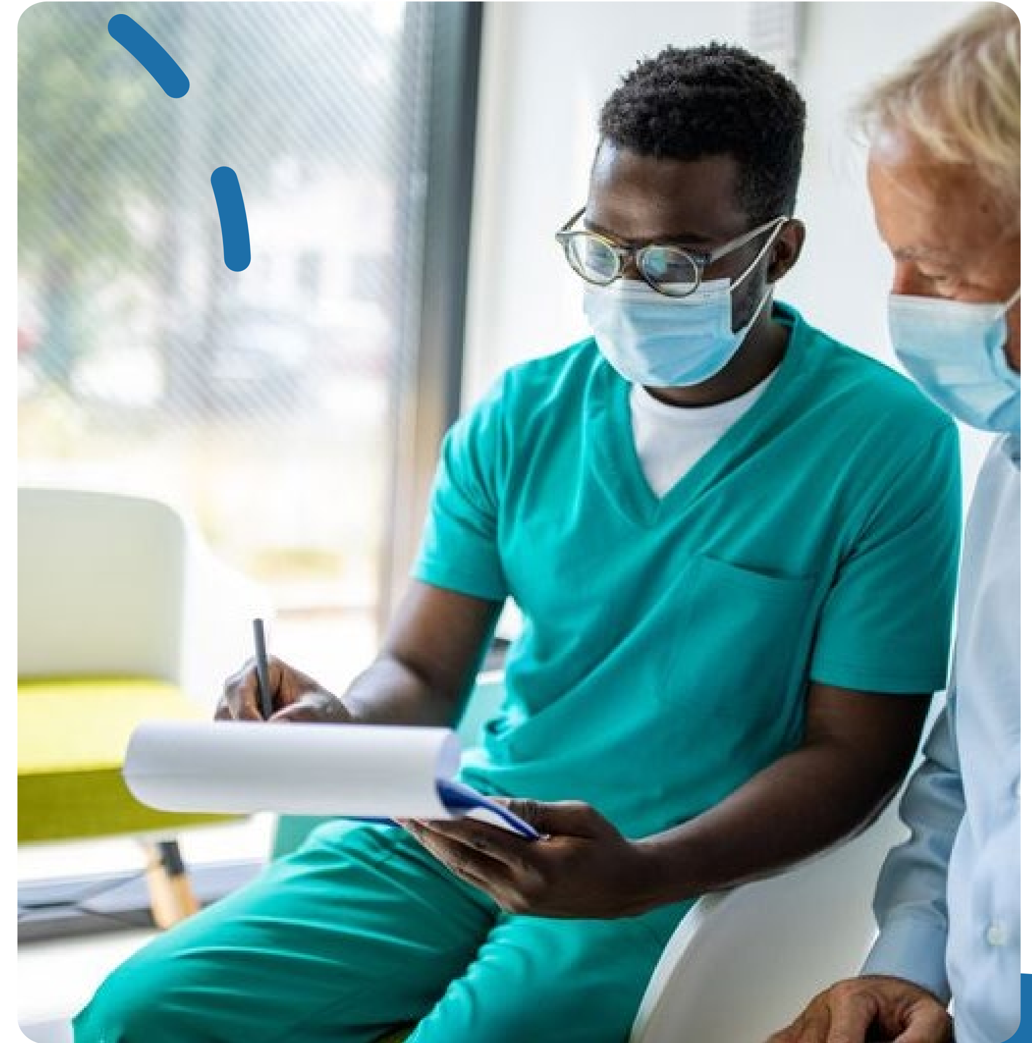
- Transitions of Care
- Chronic Disease
- Social Determinants of Health Screening
- Specialty/Primary Care Interactions
- Gaps in Care
- Substance Use Disorder

Care Management Workflow

*Depending on time quantity for the month

Team-Based Care Scenario

- Mrs. Smith completes in-person office visit with PCP (Dr. Jones) at 9am. During that visit, Dr. Jones refers Mrs. Smith to **Eric, Nurse Care Manager** for diabetic management. Ms. Smith indicates she consents to meet Eric same-day.
- Eric and Mrs. Smith discuss previous diabetic management including diet, medication management, risks, symptoms, and home support.
- Eric and Mrs. Smith establish a care plan/goals related to medication, diet and coordinate her follow-up appointments to see Dr. Jones in 6-8 weeks and complete telephone calls with Eric weekly.
- *Total time spent : 40 minutes*



G9001 – Comprehensive Assessment

Face-to-Face or video visit lasting at least 30 minutes, results in a care management plan that all team members and the patient will follow.

Team-Based Care Scenario

- Mrs. Smith calls Eric in 2-weeks reporting symptoms of dizziness, lightheadedness, blurred vision and times of confusion. Mrs. Smith and Eric review her medications and she reports her recent blood sugars from her CGM report. *(15 min)*

- Eric generates CGM report and contacts Dr. Jones regarding concerns. Dr. Jones modifies Mrs. Smith's treatment plan, medication regime and recommends a 1-week follow-up apt. *(10min)*

- Eric calls Mrs. Smith to educate on changes of medication regimen and side effects (signs/symptoms) that could occur. Erics assist with scheduling 1 week follow-up with Dr. Jones and schedules follow-up call in 2 days with Mrs. Smith. *(15min)*

98968 - Telephone Service
G9007 - Care Conference
95251 – MD Interpretation of CGM Test

Call with patient or caregiver to discuss care issues and progress towards goals. **98968** for 21-30 minutes

Discussion between care-team member and managing provider addressing individualized care plan and goal achievement. **G9007 -** Face to face, video, or telephone (excludes email or EMR messaging)

Care-team generates CGM report and documents/prep for physician review & interpretation of CGM data. **95251**

Documentation Suggestions

Documentation should include at minimum:

- Patient name, MRN, DOB, PCP Name
- Date of visit and type (face-to-face, virtual, telephone)
- **Duration of visit**
- Care team members name and credentials
- Name of caregiver/relationship (if included in visit)
- Diagnoses discussed
- Consent for services: Yes, verbal consent, or decline
- Treatment plan, medication therapy, risk factors, unmet care, physical, emotional status, community resources, readiness to change (as applicable)
- Care plan, including challenges and interventions and patient's understanding of agreement with plan
- Patient SMART goals identified
- S.O.A.P format when applicable
- CGM Report - Brand of CGM, Senor placement and removal dates, analysis data (screenshot if applicable), physician interpretation

Key Takeaways

- The billing codes can be utilized in many common clinical workflows within your office settings, including but not limited to:
  - Transition of Care
  - Social Determinants of Health screening
  - Interactions between specialty and primary care teams interactions
  - Gaps in Care
  - Substance Use Disorder
- Be sure to appropriately document your encounters in detail and according to the billing rules specified by each individual insurance carrier.

Frequently Asked Questions

Q: Can unlicensed care-team members bill PDCM CPT codes?

A: Yes, unlicensed care-team members such as medical assistance or community health workers (CHW's) can bill for telephonic services (98966-98968) and care coordination codes (99487-99489).

Q: Can a care-team member bill for advance care planning conversations? Is a PCP referral required?

A: Yes, care-team members who conduct end-of life (advance care planning) conversations with either the patient or "surrogate" can bill S0257. No, a PCP referral is not required.

Q: How can I get reimbursed for time spent coordinating services with other providers/services (i.e., home health, specialty offices, community resources, etc.)?

A: When providing non-face-to-face clinical coordination with the patient-centered medical neighborhood, a care team member must accumulate at least 31 minutes of time spent within a calendar month and submit code: 99487 or 99489. Individual organizations will need to develop internal workflows for capturing and tracking each contact until the total time is collected.

Below are some additional examples of what is included in time spent coordinating care on behalf of the patient without the direct interaction of the patient.

- Finding drug financial programs
- Applying for patient assistance programs
- Confirming treatments indicated for diagnosis
- Coordinating the first prescription fill within specialty pharmacy.

- **Below are some examples of what is not included in time spent coordinating care on behalf of the patient without the direct interaction of the patient.**
  - Checking benefit coverage
  - Prior Authorization
  - Completing documentation

MICMT Billing Resources

- Codes and Descriptions
- Reference Documents
- Frequently Asked Questions

MICMT
Michigan Institute for Care Management & Transformation

Log in search

HOME PROGRAMS BILLING TRAINING EVENTS WEBINAR LIBRARY CONTACT

ADVANCING
TEAM-BASED CARE

SHARING
best practices with statewide

ENGAGING
providers through trainings,

MEASURING
impact on quality and utilization

MICMT
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HOME PROGRAMS BILLING

Billing Codes

G9001: Comprehensive Assessment
G9002: Maintenance
98966-98968: Telephonic
99487, 99489: Care Coordination (without patient)
G9007: Team Conference
98961, 98962: Group Education
G9008: Care Oversight
S0257: End-of-Life Counseling

Reference Documents

FAQs

Resources: Care Management Services & Billing

- Michigan Institute for Care Management and Transformation
- **BCBSM**
  - PDCM Billing Guidelines (Commercial & Medicare Plus Blue PPO)
  - Groups not Participating in PDCM
  - PARS IVR - Webdenis PDCM PPT
- Priority Health
- **Centers for Medicare & Medicaid**
  - Chronic Care Management
  - Behavioral Health Integration

Additional Training Opportunities

- **Patient Engagement Training**: learn how to use evidence based motivational interviewing and self-management support skills to engage with patients. This training is reimbursable to your affiliated Physician Organization.
- **CM Fundamentals MICMT Webinar Series**: participate in monthly on-going educational webinars for care management teams new to their role by addressing topics relevant to their daily work.
- **General MICMT Webinar Series**: participate in multiple monthly webinars on various topics.

MICMT webinars are free of charge and recorded/posted to the MICMT website. Feel free to send MICMT your ideas at https://micmt-cares.org/contact

For additional information on the Training Framework and Training Opportunities

Billing for Non Face-to-Face Care for Type 2 Diabetes

Codes to Know

- Online Digital Evaluation & Management Services (Physician or other QHCP): 99421-99423
- Telehealth CPT codes: 99441-99443
- CGM interpretation: 95251

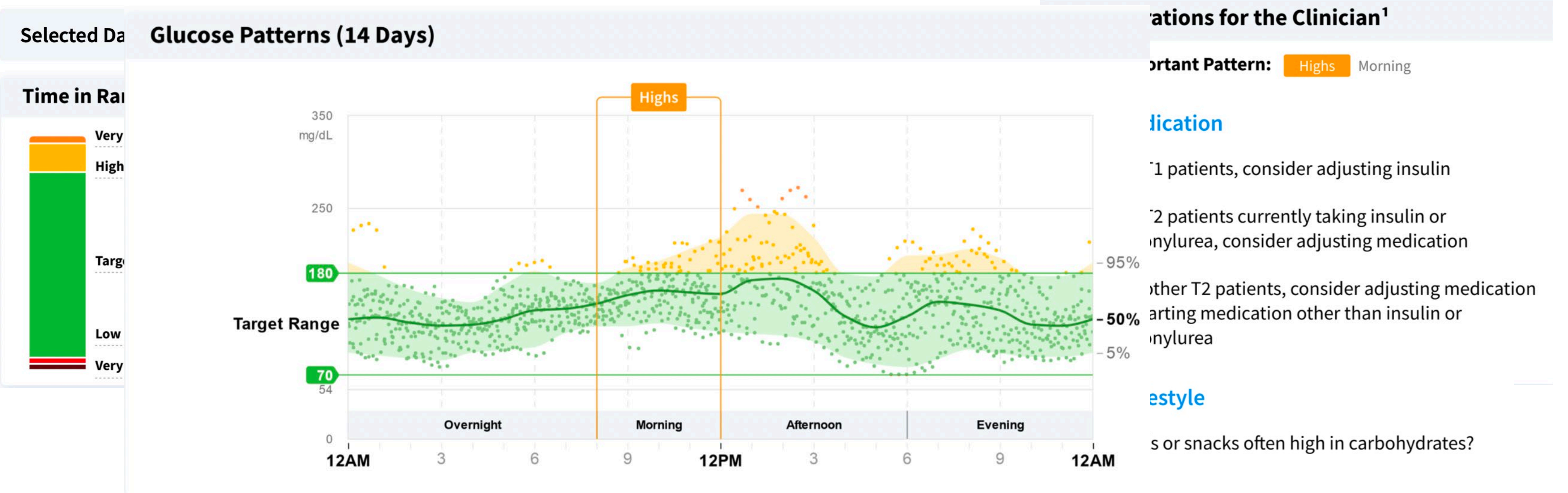
Example 1:

- J.G. is a 62 year old female with Type 2 Diabetes and obesity, BMI 36. She is currently managed on Semaglutide 2.0 mg SQ weekly, Metformin XR 1000 mg BID, and Glipizide 5 mg PO BID. She uses a CGM and has seen the nutritionist in your practice.

- You receive her lab results and her HbA1C is now 7.8% up from 6.4% one year ago. You don't have any visit availability for the next two weeks. She sends you a portal message, "Dr. Oshman, do you think we could change my Semaglutide to that new medication?"

Example:

- You ask the patient to attach a 7-day food log and ask your medical assistant to download her CGM report to her medical chart and route it to you for review.



CGM Interpretation

- Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation, and report.
- Performed by Physician, NP, PA, or clinical nurse specialist
- Maximum of once per month
- Not required to have a face-to-face visit

- 95251
- Medicare RVU non-facility: 1.02
- Private payer (2021 average): $97

CGM Documentation

Documentation requirements may vary by payor.

Standard documentation:

- Indication: poor glycemic control
- Assessment and interpretation of CGM
  - Screenshot of CGM or dot-phrase
- Recommendations and plan

Example:

- You analyze her CGM report and note adherence to her meal plan on her diet log. Rather than wait for your next scheduled visit in one month, you send her a return portal message with your recommendation.

- “Dear Ms. G, I agree that you would benefit from Tirzepatide (the new medication) for better glucose control and to help you with weight loss. I am going to send the prescription to your pharmacy. Please message me if it is covered and we can review safe use.”

Example:

- Ms. G messages you back that the medication is covered and she was able to pick it up.

- You message her to swap out Tirzepatide for Semaglutide next week. Your route the note to your nurse to message her back instructions for pen use, side effect instructions, and monitoring for hypoglycemia.
- Your administrative staff schedule a follow-up in one month for dose adjustment.

Online Digital Evaluation & Management Services (Physician or other QHCP)

Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days:

99421: 5 – 10 Minutes 0.25 RVU

99422: 11 – 20 Minutes 0.50 RVU

99423: 21+ Minutes 0.80 RVU

You spent a totally of 15 minutes on her care over the week.

Key Points:

Patient **must have initiated the request** for service through HIPAA compliant secure platform (secure EHR portal or secure email)

Must be an established patient with the physician / practice (may be used for a new patient during the pandemic).

Must be a physician or qualified HCP (nurse practitioner, physician assistant).

Must have **verbal consent** for use of communication-based technology (CBTS) services documented annually.

New Medical Question

New message

Messaging Disclaimer

business days. Messages sent after hours or during the weekend will be reviewed on the next business day. Depending on the specific request, it may require additional time or information to complete. If you feel that this matter is urgent, please call the office.

- All messages will become part of your medical record.
- If you attach a file to your message (such as a clinical photo, a form to be completed, or an outside record), only attach files for an individual patient since files may become part of this medical record. Some attached clinical photos may not allow for reliable diagnosis and may require a visit instead.
- Most Medical Group message responses from your provider are free. If a message response requires **medical advice**—when a provider provides their medical expertise and more than a few minutes of their time—we may request that you either schedule a visit with us or we will bill your insurance for providing that medical advice. You may contact your other healthcare providers regarding their fees for online visits.

Next

Key Points:

- These are ‘messaging’ codes, not phone, video, or in-person.
- Cumulative of work done over 7 days
- Cannot be related to a problem managed at an E/M service within the last seven days.
- Does not include staff time, only physician / QHCP time. Do not double count CGM interpretation time.

Example 2:

- B.D. is a 35-year-old female with new onset T2D with HbA1C 8.0%, HTN and HL. At your last visit you discussed starting metformin and a very low carbohydrate meal plan.

- She calls the office because she has some questions about GI side effects and she's not sure if they are due to the metformin or the meal plan.

- You have a cancellation in your schedule and decide to call her back to check on her dietary adherence and side effects. You talk to her for five minutes, advise a change to her medication timing and help her troubleshoot snack selection on her new meal plan.

Telephone Evaluation & Management Services (Physician or other QHCP)

Telephonic evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days:

Code	Time	RVU
99441:	5 – 10 Minutes	0.25 RVU
99442:	11–20 Minutes	0.50 RVU
99443:	21+ Minutes	0.80 RVU

Key Points:

- **Telephone Calls** for “unscheduled” calls back to patient.
- Patient **must have initiated the request** for service (either by portal message / phone)
- Physician or qualified HCP must return the call to the patient.
- Problem must not relate to an office visit within the prior seven days or result in recommending an office visit.

Key Points:

- Call must be initiated / requested by patient (either by portal message / phone) and physician or qualified HCP must return the call to the patient.

- Problem must not relate to an office visit within the prior seven days or result in recommending an office visit.

Other Thoughts:

- If you are **scheduling** a call back to a patient, use 99213-99215 with audio modifier.

- Building out administrative blocks for physicians to return calls and portal messages gives us **options** to increase revenue for managing team-based care for patients with diabetes.
- Using non face-to-face codes for messaging (99421-99423) and phone calls (99441-99443) helps show the **value** of this time and service through revenue generation for our practices.

Codes to Know

- Online Digital Evaluation & Management Services (Physician or other QHCP): 99421-99423
- Telehealth CPT codes: 99441-99443
- CGM interpretation: 95251

Pre-Submitted Questions

- Any codes physicians can use to bill for extensive phone time counseling pts about meds, completing prior auth paperwork etc. ?
- Are there any billing opportunities for non-licensed staff? Can they bill in person visits as telephone codes?
- Is a referral from the PCP and a patient discussion with the PCP required to bill for S0257, by phone or in person?
- It would be great if you could address CM codes being billed with the codes for review of CGM and if is allowable to bill

Pre-Submitted Questions

- Provide documentation templates for codes, How to bill for Prior Auth. troubleshooting CGMS, titrating and monitoring meds etc

- What insurances will cover non face to face care mgt for diabetic management?

- Will BCBS pay for a telephonic G9001 and/ or G9002?
    - Yes, they can bill this code if the member doesn’t feel comfortable coming into the office, has no transportation, and it’s documented in that patient’s medical record.