

Blue Cross Blue Shield of Michigan T- Code Reimbursement Policy

Effective Date: 01/01/2006
Updated: 1/8/2010

SUBJECT: Provider Group Incentive Program Chronic Care Model T Code

1.0 Background

Chronic disease management challenges the organization, structure, information support, process flow, and professional skills operating within the clinical setting.

Blue Cross Blue Shield of Michigan is partnering with physician groups within Michigan to achieve consistent delivery of evidence-based recommendations in caring for patients with chronic illness. This creates an alternative to vendor-based disease management programs that operate outside the usual process of care. Physician groups have invested significant resources in developing the infrastructure to support chronic disease management and must invest significantly more to achieve the goal. This can succeed only if the payment practices of health plans sustain both these investments and the ongoing cost of delivering the care needed for managing patients with chronic disease.

“Partnering for value” is a vehicle of rewarding physicians who can demonstrate improvements in care management based upon measures of evidence-based care. It includes both a reward component and an expansion of the types of services that fall within the definition of a payable “office visit.” This modification of BCBSM reimbursement policies currently applies to physician groups participating in the Physician Group Incentive Program (PGIP) that have demonstrated their commitment and readiness to implement the chronic disease model. BCBSM reimbursement policy may include other providers who demonstrate a similar level of commitment and readiness.

The following describes changes to BCBSM reimbursement policy that apply to professional office or clinic visits provided by only PGIP physicians that have been approved by BCBSM. The billing changes relate to specific procedure codes delivered by ancillary providers as defined in the Reimbursement Policy Statement of this document. These are all “incident to” services.

“Incident to”

- Pays for services incident to a physician’s services
- Is an integral, though incidental, part of the service of a physician in a course of diagnosis or treatment of an injury or illness
- Is of a type that would be commonly furnished in the office or clinic of a physician
- Is performed by an ancillary healthcare professional (not a physician)

Reimbursement for “incident to” services is limited to professional providers and locations of service that are specifically approved through a privileging process and does not extend to non-privileged providers within the same organization or location of services unless specifically approved by BCBSM. Locations that qualify for reimbursement under the “incident to” rules include:

- Physician office
- Facility or hospital outpatient,
- In patients’ homes

“Facility or hospital outpatient” refers to any facility with which BCBSM contracts for health care services. The service provided must be performed by an ancillary member of the health care team who has established a contractual agreement, or employment relationship, with the PGIP physician who originally established patient-specific chronic illness management goals (treatment or self-management) for a chronic condition(s) with the member in a previous encounter (evaluation and management service). In practice, the ancillary member of the health care team and the physician must actively exchange patient-specific information relating to the established goals, patient’s progress, and any other information pertinent to the T Code service.

The “incident to” services are professional services billed by the physician. They are essential components of evaluation and management services that are conducted (provided) by other professionals (allied health personnel defined in the Reimbursement Policy Statement below) participating within the care team, on behalf of the physician, to achieve consistent delivery of evidence-based recommendations and increase patient understanding of and adherence to these recommendations. Physicians billing for these “incident to” services must establish a clinical process that clearly connects these services with the physician’s Evaluation and Management services.

2.0 Reimbursement Policy Statement

T codes may be used in the care of patients with chronic conditions for which care management services are believed to have the potential to improve patient wellbeing and functional status. These T code services can be provided by the identified allied health personnel for care management services incident to a physician's evaluation and management service, for chronic medical conditions that can be care managed and for which the member has benefit coverage. Chronic conditions in this instance refer to any chronic condition of sufficient complexity to warrant further management and or/self-management training, beyond the guidance which is usually provided in standard Evaluation and Management visits. Obesity and major depression are excluded as stand alone chronic conditions that would qualify as a payable. They may be included as co-morbid conditions if billing for T Code services. Diagnoses should be reported using the standard ICD-9 code for the chronic condition that is being managed.

The services provided by the multi-disciplinary team must be bona fide, individualized, goal driven care management or self management training/education services. Group visits do not apply.

“Incident to” services may be provided by the following practitioners: licensed nurses (registered nurses and licensed practical nurses), masters of social work, certified diabetes educators, registered dietitians or masters of science trained nutritionists, clinical pharmacists, respiratory therapists, certified asthma educators, and certified health educator specialists who received a bachelor’s degree, or higher, in health education*.

This reimbursement fee also applies to services “incident to” and directly billed by a certified nurse practitioner [CNP] or a physician assistant [PA]. The service provided by the CNP or PA may not include clinical decision making such as ordering tests, medication updates, making diagnoses etc., as these are considered evaluation and management services and should be billed as such, rather than as T Code services.

Two procedure codes are billable by the PGIP physician for allied health professional activities:

- T1015 – Clinic visit/encounter (face to face), all-inclusive.
- T1019 – Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, part of the individualized plan of treatment. This code is “quantity” processed with a maximum of 2 units. Can be used with phone counseling.

BCBSM has modified the claims processing systems to allow payment for more than one visit of procedure code T1015 on the same date of service when “**modifier 59**” is appended to the second and third T code service line. There is a maximum use of three T1015 procedure codes (service lines) per day, per patient. Each service line would constitute a different discipline (member of the allied health care team associated with the PCP) providing face to face care management, self management, or education services for chronic disease management. There is no time quantity associated with T1015 as it is all-inclusive.

There is no limit on the number of T Codes billed between physician visits.

These services are defined within the scope of the members’ office and clinic visit benefits and do not comprise a unique benefit category. Providers should apply the same level of member liability applicable within this benefit category. Providers are entitled to only single member co pay on any date of service, including any office visit service provided directly by the physician. Thus, no copay will be imposed on T1015 (clinic visit) services when provided on the same date of service as the physician’s primary office visit nor would it apply to any subsequent T1015 services. When services include telephonic chronic disease

management subsequent to an office visit, providers may not collect additional copay for services such as T1019.

“Subsequent to” is the billing and reporting function that links services to each other and therefore eliminates inappropriate copay liabilities. These services are directly linked to the physician’s office visit. The T1015 (clinic visit) and T1019 (personal care services, 15 minute intervals) are “subsequent to” services.

T1015 and T1019 will have coinsurance liabilities imposed when part of the members’ benefit. Physician staff will inform the member of these coinsurance liabilities so as to give the member the option of declining the service.

3.0 Scope

This reimbursement policy applies only to physicians participating in the PGIP, including primary care providers and any PGIP defined specialty.

This policy is applicable to Local and NASCO systems to recognize and pay procedure codes T1015 and T1019. The codes should be processed according to existing office visit coverage criteria.

These policies will apply to the following products in which members have office visit coverage: PPO Trust (Blue Preferred Plus, Community Blue, MI Child, Point of Service, Blue Card host**) and Traditional.

Excluded from coverage are the following members belonging to: FEP (FEP01 and FEP02), General Motors (83000 series), Delphi (72000 series), Ford (87000 series), Visteon (73100 series), Daimler Chrysler (82000 series) and Severstal (72280 and 72290).

* Certified Health Educator Specialists credentialing information is available at <http://www.nchec.org>.

** BCBSM and Inter-plan Administration and Relations working to coordinate efforts for all inclusive coverage of Blue Card host and national groups where BCBSM is par to another Control Plan