

Provider Incentive Group Chronic Care Model Reimbursement Policy - Use of T Codes 1015 and T1019 Questions and Answers

Q1: Do the ancillary providers have to be employed by a physician office?

Ancillary providers either have to be employed by the physician's office or under contract to the physician's office. 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.

Q2: Can we have a contractual relationship with person delivering care?

Yes.

Q3: Do co-payments and co-insurance apply to the T codes?

Co-payments do not apply to T codes. Co-insurance applies when it is in the member's benefit contract.

Q4: Are telephone calls covered? Yes, for **one** of the identified Allied Health Personnel when telephonic chronic illness management is provided subsequent to an office visit (cognitive E and M Code service) and in pursuance of chronic illness management and self-care skills education goals established for the patient by the physician. Physicians cannot bill for telephonic services that they personally provide to the patient. When allied health personnel use telephonic chronic care management subsequent to an office visit, the physician should bill under T1019.

Q5: Can the T codes be used for discharge planning or poly-pharmacy?

T codes may be used in the course of chronic illness management provided subsequent to an office visit (cognitive E and M code service) and in pursuance of chronic illness management and self-care skills education goals established for the patient by the physician, when medication use is the focus of attention and the use of multiple medications make it difficult for the patient to comply with treatment recommendations. When a Nurse Practitioner or Physician Assistant is acting in the role of an allied health professional providing T Code services in regards to poly-pharmacy management, they may not make changes to and/or prescribe new medications to the patient as this would be considered evaluation and management services and not in line with the nature of a T Code service.

For T code services in association with discharge planning to be covered, there is an expectation that they include explicit effort to plan and prepare the patient for follow-up care, self-care and ongoing care management of one of the chronic illnesses, which are a focus of attention of the PGIP program, and when related goals are established by the physician on discharge.

Q6: What if the patient doesn't have office visit coverage?

T codes are not payable for those patients who do not have office visit coverage. The products included in this program, Community Blue, Point of Service, and Blue Preferred Plus, MI Child, Blue Card Host, and Traditional do have office visit coverage.

Q7: What happens for patients coming back on subsequent days as part of the disease process; in-between office visits; if nurse visits, would office visit apply?

These services may be provided, and the appropriate codes billed, on a day subsequent to the office visit (E and M service) at which the physician established chronic illness management goals that represent the purpose of these services. There is no limit on the amount of T Code services between physician visits.

If the service provided by the nurse or other extender is an outgrowth of a prior E & M service delivered by the physician, that is coordination and/or provision of additional care driven by the physician, a T code would be applicable. If the service was provided by a CNP or PA, independent of the particular care coordination linked to the physician (e.g., care for other comorbidities), an office

visit would apply and should be billed as an office visit by the CNP as direct bill or indirect bill for an office visit for the PA.

Q8: Regarding E&M codes, what is primary ICD9 code?

Only one diagnosis code may be used on physician claims.

Report the appropriate ICD9 code for the chronic disease being treated. Major depression and obesity are **not** approved chronic conditions to be payable as a stand alone diagnosis/condition.

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 and which can be care managed.

Q9: Lots of offices do not hire RNs. For small, rural clinics, offices may also use mid-level providers such as medical assistants. Are these providers included?

No, "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.

When the CNP is providing an E&M service, the service should be reported under the CNP PIN. When the CNP is providing information/education, then that service is considered to be "incident to" and a T code should be billed under the physician PIN.

Q10: Can a Certified Diabetes Educator bill directly?

No, BCBSM doesn't have a PIN for certified diabetes educators.

Any provider with a BCBSM PIN delivering services and billing T1015 and/or T1019 should bill the service directly rather than "incident to".

Under this policy, the "incident to" services may be professional services provided by a certified diabetes educator billed by the physician. They are essential components of E&M services that are conducted by other professionals participating within the care team 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. These connections may include means such as standing orders, use of a common clinical record, and establishing joint goals of care.

Q11: Can an office waive copays for patients?

No. However, there are waivers for individual hardship that can be used.

Providers are entitled to only single member copay on any date of service, including any office visit service provided directly by the physician.

T1015 and T1019 will have coinsurance liabilities only, 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

Q12: Are all patients covered for these services?

These policies will apply to the entire book of business, (for all PPO TRUST and TRAD,) which includes members of all local Blue Card host and national groups where BCBSM is par to another Control Plan**, except for the following groups in which T Codes are not a covered benefit: 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).

Q13: What kind of documentation is needed?

The physician's notes must contain evidence that chronic illness management goals and/or self-care skill education goals have been established. The ancillary service provider's notes must contain content reflecting that those goals were the focus of attention of the service and that the services documented are pertinent to achieving those goals.

Q14: If the member does not have office visit coverage, can the provider bill the member for the approved amount?

Physicians may bill for services rendered if the patient does not have the full benefit level, with informed consent. It's up to the discretion of the physician whether they bill the allowed amount or the full amount in general circumstances. BCBSM encourages physicians to enroll all of their chronically ill patients in their disease management programs, when appropriate, and to not bill above what they are compensated for the PGIP program for those patients without office visit coverage.

Q15: Is it acceptable to routinely waive the co-payment if the service is delivered as the result of a telephonic outreach by the practice?

Routinely waiving copays would not be acceptable. There are no copays imposed upon telephonic (T 1019) services.

Q16: Can the T-code be applied to a post hospital visit?

Yes

Q17: Can the T code be applied to a "group visit" or "shared appointment" and billed for each BCBSM patient participating?

Generally speaking, group visits are **not** covered services. However if services which are otherwise covered are provided to patients in the course of a group visit and if these services are **customized** for the individual patient, then they may be considered covered. To be payable, such services must include the required elements of the covered service (e.g., an E and M service code which includes individualized history and physical examination and diagnosis and management services or a T-code care management service which is guided by treatment goals established for the patient and are incident to a prior E and M service) and the services must be performed by a provider qualified and approved to provide the service.

Q18: Is there a time limit on the number of T codes billed? For example, if the patient is being case managed and receives a monthly phone call from the RN between quarterly PCP appointments, are these all payable? Or if the patient attends three group visits with an RN in-between PCP visits, are those billable?

There is no limit on the number of T codes billed between PCP appointments. Group visits remain a **non-covered** service. Effective March, 2008 the policy has been modified to remove the 90 day E&M visit restriction and require an E&M visit when the treating physician feels it is medically necessary.

Q19: Is the T-1019 billed in 15 minute increments? So, if the case manager is on the phone for 30 minutes, are two T codes billed? Or is it a minimum of 15 minutes before any billing of this code?

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. It can be used with phone counseling.

If the ancillary provider is on the phone for 10 minutes, they would bill for 1 unit. If the provider was on the phone for 17 minutes, they would bill for 2 increments. If the provider was on the phone for 35 minutes, they would also bill for 2 increments as 2 is the maximum.

- Q20: How does BCBSM define "privileging" as used in T Code policy?**
If the provider is qualified to provide the service, then the provider of the service is privileged.
- Q21: Does the T code policy apply to TRUST and Traditional Products?**
Yes.
- Q22: In previous documents, reporting was restricted to patients with the diagnoses listed (persistent asthma, COPD, Diabetes, major depression, chronic pain, heart failure, CHD, ADHD, hypertension). Is this the sole determining factor for using the codes?**
No. Expanded ability to use T codes in the care of all patients with chronic conditions for which care management services are believed to have the potential to improve patient wellbeing and functional status, or diminish the risk of increased severity of illness requiring more intensive services (e.g., ER or inpatient care). See question 8 for more detail regarding chronic conditions.
- Q23: What about co-morbid conditions like diabetes and coronary artery disease, which is common for (dual) lipid management?**
The T code service being reported must be directly related to the primary diagnosis for the disease management.
- Q24: If the patient is seen by the cardiologist and primary care doctor on the same day, can more than one T code be reported?**
Yes – as long as each subsequent visit to the ancillary provider(s) is based on care management services incident to a physician's evaluation and management service, for chronic medical conditions that can be care managed and comply with T Code policy.

The physician billing for the T Code service doesn't have to necessarily be the patient's primary care doctor.
- Q25: Are there any issues with charging one population and not others?**
This decision is the responsibility of the group to determine.
- Q26: Will BCBSM explore the possibility of adding exercise services rendered by physiologists as a payable service?**
The BCBSM T Code policy states which allied health professionals may provide T Code services. See question 9.
- Q27: Is the T 1015 intended for a face to face encounter? If a patient is just discharged and the nurse calls to follow up, would we use T1019?**
Yes, T1015 is intended for face to face and T1019 would be used for the telephone contact. Keep in mind the requirements of the T Code service stated in the policy referencing the specific elements required to bill for T Codes.
- Q28: Can physicians bill for T codes?**
Physicians participating in PGIP can bill for services "incident to" a previous evaluation and management visit they had with a patient. The actual T Code service is provided by a member of the allied health team.
- Q29: Can BCBS provide guidelines on what conditions would qualify for payment when addressing chronic pain syndrome and major depression? Also, will the payable diagnoses expand beyond the current chronic illness?**
For chronic pain, it is a well organized multipurpose medical, non-surgical approach to chronic pain like training, self care, exercise etc. In terms of major depression, depression, we would consider this to be a co-morbid condition of the primary diagnosis chronic diseases with training, self care and guidance etc. It is not the intent of the program to focus on major depression as a stand alone diagnosis.

Q30: For patients with diabetes, would medical nutritional therapy (procedure code G0270) be appropriate to report? This code more clearly defines the service.

This code is not appropriate to report at this time. The services provided would be appropriately reimbursed under the appropriate T code.

Q31: What are the group numbers excluded from the T code payment policy?

General Motors	83000 series
Daimler Chrysler	82000 series
FEP	FEP01 and FEP02
Ford	87000 series
Severstal	72280 and 72290
Visteon	73100 series
Delphi	72000 series

Q32: T 1019 requires reporting of units for every 15 minutes. What should we report if the telephone conference extends to 16 minutes?

Report a quantity of 2 in this situation.

Q33: If the patient calls the physician, can we report the T code?

No.

Q34: Is there information on a patient's product coverage including copayment and coinsurance information that the provider can access?

Web DENIS has this information available to the providers.

Q35 How can a provider bill for up to three different T1015 codes for the same patient on one day?

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.

If you have any additional questions that need to be addressed, please contact the appropriate staff at your Physician Organization.

You may also contact Jeff Burton, Health Care Analyst, BCBSM by email at jburton@bcbsm.com.

* 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