

Blue Cross Blue Shield of Michigan Reimbursement Policy

Effectiveness Date: 01/01/2006

Updated: 3/26/2008

SUBJECT: Provider Incentive Group 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 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

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

The “incident to” services are professional services billed by the physician. They are essential components of evaluation and management 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 standing orders, use of a common clinical record, establishing joint goals of care, etc.

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, or diminish the risk of increased severity of illness requiring more intensive services (e.g., ER or inpatient care). These codes can be used by multiple disciplines for care management services incident to a physician's evaluation and management service, for chronic medical conditions for which the member has coverage. They can be distinguished by use of the 59 modifier for billing and reporting.

T codes may be used for a diagnosis of major depression when it is a co-morbid condition. They can not be used for obesity as a stand alone diagnosis.

Two procedure codes are billable for nurse and 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.

“Incident to” services may be provided by the following practitioners: registered nurses, masters of social work, certified diabetes educators, registered dietician or master of science trained nutritionist, clinical pharmacists, respiratory therapists,

This reimbursement fee also applies to services “incident to” and directly billed by a certified nurse practitioner [CNP] or a physician assistant [PA] also.,

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 per day, per patient

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. 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.

These policies will apply to the entire book of business which includes members of all local Blue Card host and national groups where BCBSM is par to another Control Plan except for FEP, General Motors/Delphi, Ford, Severstal, and Chrysler.

This policy applies only to physician groups participating in the PGIP.

3.0 Scope

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.