Case Management and Care Coordination Billing Opportunities

<table>
<tr><td rowspan="4">**Note differences per payer related to description of the CM vs. CC role</td><td colspan="3">Who on the team</td></tr>
<tr><td>Care Manager (CM)</td><td>Other team members</td><td>Provider</td></tr>
<tr><td><u>BCBSM</u>: Lead CM; RN, MSW, NP, PA

<u>SIM</u>: Care Manager; RN, MSW, NP, PA and LPN, Licensed Professional Counselor, Pharmacist, and Registered Dietician</td><td>BCBSM: Allied Health Professionals; registered nurse, masters of social work, certified nurse practitioner, physician assistant, licensed practical nurses, certified diabetes educators, registered dieticians, masters of science trained nutritionists, clinical pharmacists, respiratory therapists, certified asthma educators, certified health educator specialists (bachelor’s degree, or higher, in health education), licensed professional counselors, licensed mental health counselors.

SIM: Care coordinator; Bachelors in SW, Social Service Technician, Community Health Worker, and Certified MA</td><td>MD/DO, PA and NP

**Some provider codes are only applicable to the PCP</td></tr>
<tr><td>PH: QHP</td></tr>
<tr><td>Case Management Process</td><td colspan="3"></td></tr>
<tr><td>Patient Identification and pre-screening</td><td colspan="3">System, practice leads and care team – based on risk and criteria to achieve organization/practice stated goals – not billable
**Post Discharge Calls/Transitional Case Management is a screening process to determine the need for ongoing CM/CC. Although the action does not equate enrollment into CM, it is seen as a function and under the function is a billable entity.</td></tr>
<tr><td rowspan="3">Assessment and care planning</td><td>CM with input of the care team</td><td rowspan="2">Can provide input – CM is responsible with provider oversight</td><td>Oversight and approval of the Care Plan</td></tr>
<tr><td>*See above for description of the CM role</td><td rowspan="2">G9008 – only applicable to the PCP</td></tr>
<tr><td>Initial Assessment & Care Plan G9001</td><td>Ancillary care team cannot bill for this service</td></tr>
</table>

Implementation to include follow-up and monitoring	CM	Ancillary care team as defined by each payer **See above for descriptions per payer	Care conference
	Coordinated Care code **G9002** CPT Phone codes **98966, 98967, 98968** Group visits **98961, 98962** Team Conference participation – **see provider code G9007** Care Coordination codes **99487, 99489**	**G9002** CPT Phone codes (**98966, 98967, 98968**) Group visits (**98961, 98962**) Team Conference participation – see provider code G9007	**G9007**
Case closure And evaluation	CM	Ancillary care team as defined by each payer **See above for descriptions per payer	Care Conference
	Coordinated Care code **G9002** CPT Phone codes (**98966, 98967, 98968**) Group visits (**98961, 98962**) Team Conference participation – **see provider code G9007**	**G9002** CPT Phone codes (**98966, 98967, 98968**) Group visits (**98961, 98962**) Team Conference participation – see provider code	**G9007**

****See payer guidelines for specific requirements of each code. This document is meant to assist the care team in linking services to a potential billable entity. It is not meant to replace the payer guidelines.**