

## **Personal Care Management (PCM) Services Duals Members Only**

### **Policy**

Mass General Brigham Health Plan reimburses medically necessary Personal Care Management (PCM) Services for dual-eligible (Medicare & Medicaid) members. A PCM provider must request prior authorization for all medically necessary, reimbursable services.

### **Reimbursement**

Providers are reimbursed according to the plan's network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Mass General Brigham Health Plan reimbursement is based on the line of business, unless otherwise specified within the medical policies; please follow the guidelines based on membership type. Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the Mass General Brigham Health Plan payment policy and by the provider's agreement with Mass General Brigham Health Plan. Member liability amounts may include but are not limited to: copayments; deductible(s); and/or co-insurance; and will be applied dependent upon the member's benefit plan.

Various services and procedures require referral and/or prior authorization. Referral and prior authorization requirement information can be located [here](#).

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, Revenue and ICD-10 codes and definitions.

Refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

Mass General Brigham Health Plan reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. Please refer to [General Coding and Billing](#) guidelines for more information.

## Provider Payment Guidelines

All claims are subject to audit services, and medical records may be requested from the provider.

### Service Codes and Descriptions

Code	Modifier	Service Description
99456		<p>Work related or medical disability examination by other than the treating physician that includes:</p> <ul style="list-style-type: none"> <li>• completion of a medical history commensurate with the patient's condition;</li> <li>• performance of an examination commensurate with the patient's condition;</li> <li>• formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment;</li> <li>• development of future medical treatment plan; and</li> <li>• Completion of necessary documentation/certificates and report. (Use this code when billing for initial evaluation of a member to determine the need and extent of the need for personal care services.) (per evaluation)</li> </ul>
99456	TS	<p>Work related or medical disability examination by other than the treating physician that includes:</p> <ul style="list-style-type: none"> <li>• completion of a medical history commensurate with the patient's condition;</li> <li>• performance of an examination commensurate with the patient's condition;</li> <li>• formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment;</li> <li>• development of future medical treatment plan; and</li> <li>• completion of necessary documentation/certificates and report. (follow-up service) (Use this code and modifier when billing for reevaluation of a member to determine the need and extent of the need for personal care services.) (per evaluation)</li> </ul>
T2022		Case management, per month (Current PA for PCA services required for each member.) (Use this code to bill for functional skills training.) (per member per month)
T1023		Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per

## Provider Payment Guidelines

		encounter (Use this code to bill a single per member per month charge for intake and orientation services provided to a member who does not yet have a PA for PCA services.) (maximum three consecutive months)
T1019		Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR, or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant) (P.A.) (Use this code to bill for PCA services provided during day or night.)
T1019	TU	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR, or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant), special payment rate, overtime (P.A.) (Use this code and modifier to bill for premium pay for overtime.)
T1019	TV	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR, or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant), special payment rate: holidays/weekends (P.A.) (Use this code and modifier to bill for premium pay for holidays.)
T1020		Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (Code may not be used to identify services provided by home health aide or certified nurse assistant.) (Use to bill for fiscal intermediary administrative charge; 1 unit per diem.) (Current P.A. for PCA services required for each member.)
99509	TU	Home visit for assistance with activities of daily living and personal care. (Use this code and modifier to bill for overtime, per 1-minute, special payment rate). (Current P.A. for PCA services required for each member.)
99509	U1	Home visit for assistance with activities of daily living and personal care. (per 15 minutes) (Use to bill for PCA earned sick time.) (Current PA for PCA services required for each member.)
99509	U3	Home visit for assistance with activities of daily living and personal care. (Personal Care Services.) (Use to bill for PCA new hire orientation, per diem, per eligible PCA.)
A0170		Transportation ancillary: parking fees, tolls, other (Use this code to bill for same-day travel time for PCA services, per 1 minute). (Current P.A. for PCA services required for each member.)
T1020	U1	Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant) (Medicaid level of care 1) (P.A.) (Use this code and modifier to bill for transitional living services.)

## Related Policies

[General Coding and Billing](#)

[Prior Authorization, Notification and Referral Guidelines](#)

## References

American Medical Association, *CPT current year, Professional Edition*

American Medical Association, *HCPCS Level II, current year, Professional Edition*

[MassHealth Provider Manual Series, All Provider Manuals](#)

[MassHealth Provider Manual Series, Personal Care Manual](#)

## Publication History

<b>Topic: Personal Care Management (PCM) Services</b>	<b>Owner: Network Management</b>
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*Original documentation*

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan ' payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc., and Mass General Brigham Health Plan Insurance Company.