Patient Identification via Registry

Case Study: Billing & Coding

MI-CCSI
Center for Clinical Systems Improvement

Disclosure

MI-CCSI, or the presenter, does not have any financial interest, relationships, or other potential conflicts, with respect to the material which will be covered in this presentation.

Patient Identification via Registry

What is a patient registry?

A patient registry is a database that enables population-level management in addition to generating point of care information and allows providers to view patterns of care and gaps in care across their patient population. A registry contains several dimensions of clinical data on patients to enable providers to manage and improve the health of their population of patients. (2.2 PCP b.)

Patient identification via Registry

Key components of the patient registry:

- Relevant clinical information that is the focus of attention in generally accepted guidelines and is incorporated in common quality measures pertinent to the patient population must be incorporated in the registry (e.g., physiologic parameters, lab results, medication use, physical findings, and patient behaviors such as peak flow meter use or daily salt intake). (2.1 PCP c)
- Subsets of patients requiring active management refers to those patients with particular management needs including but not limited to those who have physiologic parameters out of control or who have not received specified, essential services. For example, for behavioral health providers, i.e., psychologists and psychiatrists, common relevant conditions would be depression and anxiety.(2.1 Specialist h1,11)
- Registry is being used to identify patients with concerns related to social determinants of health, such as transportation limitations, housing instability, interpersonal violence, or food insecurity (2.25)

Patient identification via Registry

How is a registry be used?

- The Registry produces population level information on gaps in care for chronic condition patients and is used to flag those gaps (2.7)
- Systematic process is in place to identify patients who would benefit from care management services based on clinical conditions and ED, inpatient, and other service use (4.19)
- Systematic process is in place to inform patients about availability of care management services (4.20)

The Goal of a Registry

Enable providers to manage their patients both at the population level and at point of care (2.0 Patient Registry)

Mary Smith

Medical History:

- Diagnosis of Major Depression with 2 occurrences in the past 8 years
- Diagnosis of Heart Failure. Under treatment for 10 years.

Family Medical History:

- Father described as always sad, isolated, no definitive diagnosis

Social:

- Works part-time as an administrator at an elementary school. She is divorced; 1 daughter 17 years, lives in own home with the daughter.

Current Medications: Zoloft, Lasix, an Angiotension Neprilysin Inhibitor (ARN)

Last Visit: Last seen in the clinic 12 months ago

- No PHQ9 screening for over 1 year

Patient Identification via Registry

Billing & Coding: Pre-work Review of Registry/Medical Records

Population Health Nurse, using the registry (RN in this practice) Identifies Mary as being overdue for a PHQ9 and provider visit	
Clinical Team Member and Actions	Population Health nurse reviews registry report for patients overdue or missing labs, tests, immunizations, and appointments
Findings	Last visit 12 months ago Last PHQ9 12 months ago
Next steps	Review schedule to see if Mary has an upcoming appoint. If no: • Call Mary to schedule an appointment • Complete a PHQ9 over the phone

What billing code could be used by the population health nurse?

How did you come to that decision?

Patient Identification via Registry

Billing & Coding: Outreach Call

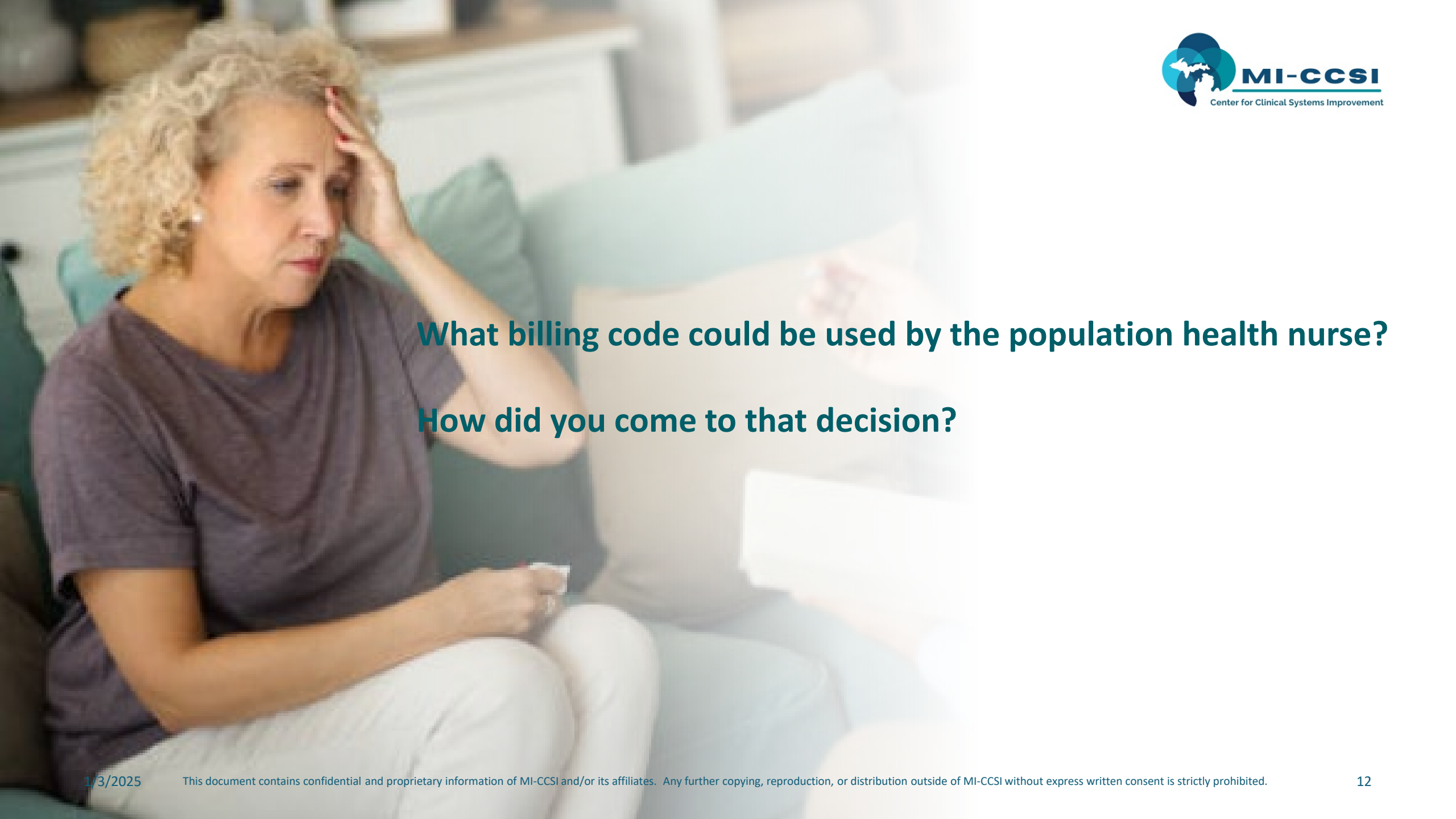
Working under a standing order the population health nurse makes an outreach to patients meeting high risk criteria and for potential care management services.

Completing the outreach call	**The population health nurse Introduces herself as part of Mary's medical team:** • **Relays provider's concern that she hasn't been in for 1 year** • **Relays the provider is also wondering about her mood, her heart failure, and anything else that might be concerning to Mary**
Findings	• **Mary is vague-feeling kind of "blah and stuck."** • **Nurse explains/reminds Mary what a PHQ9 is, asks permission to complete the screening over the phone** • **Mary agrees and the score is 15 but negative for suicidal ideation.** • **Mary has been on Prozac a long time but doesn't feel like it helps and only takes it when feeling particularly sad.**
Addressing concerns	• **Nurse explains how antidepressants work and the need for further evaluation in an appointment with her provider** • **At the appointment, the provider can further assess Mary's depressive symptoms, review how the medications work and complete an assessment of her overall well being.**

Patient Identification via Registry

Billing & Coding: Outreach Call

Addressing and reviewing available services of the Team-based Care (TBC) delivery model	
Review of TBC and the CM role.	• The Population Health Nurse explains what team care is, and the different roles available in the practice, to include provider delivered care management (PDCM) services. • The nurse shares the provider may recommend care management services by the other team members in the practice based on the assessment findings. • Mary might even be able to see them that same day so this could be a longer appointment. • The nurse explains there is a cost to these additional services and encourages Mary to check on coverage.
Actions	• Mary makes an appointment with the provider. • She will plan on staying an extra 30 minutes for the appointment, should the provider decide she would benefit from care management services. • Mary will check on coverage but she already agrees to additional team services because “this may be the boost she needs”
Overview of the call	This call takes 30 minutes. **Note, this practice has not implemented the Collaborative Care model for managing depression and anxiety.



What billing code could be used by the population health nurse?

How did you come to that decision?

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Billing & Coding: Appointment with provider, one week later

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Mary's appointment	
Preparing for the provider visit	Check-in: The front desk has Mary fill out the Social Determinants of Health screening and other paperwork. MA: • Notes the population health nurse had Mary complete a PHQ9 during the call last week. The score was 15. The screening was less than 2 weeks ago, so no need to repeat it. • Reviews with the patient her long list of medications. Mary: • Confides money is tight. To save money on prescriptions she has not been taking the antidepressant regularly. She's not sure if it's still needed. • Takes her heart medication regularly. • Is concerned about obtaining adequate propane for heat as the weather gets colder. MA: • Updates the results of the SDOH and Mary's concerns in the medical record and sends a note to the provider. • Verifies benefits for PDCM (see next slide)
Provider appointment and findings	The provider: • Reviews the screening results and note from the MA, and completes the assessment and examination. • Discusses with Mary the importance of taking her medication regularly, and why this is important to keeping the depression in remission. • Based on the examination, diagnoses Mary with Major Depression, recurrent • Recommends a referral to the PDCM team: Pharmacist, Nurse CM'er, and Social Worker

Checking the Provider Delivered Care Management Benefit in Availity

How do I check that the patient has PDCM Provider Delivered Care Management (PDCM) benefits?

You can check that a patient has PDCM benefits through the Availity portal.

•Select Eligibility and Benefits Inquiry

•Enter information on the doctor and the patient

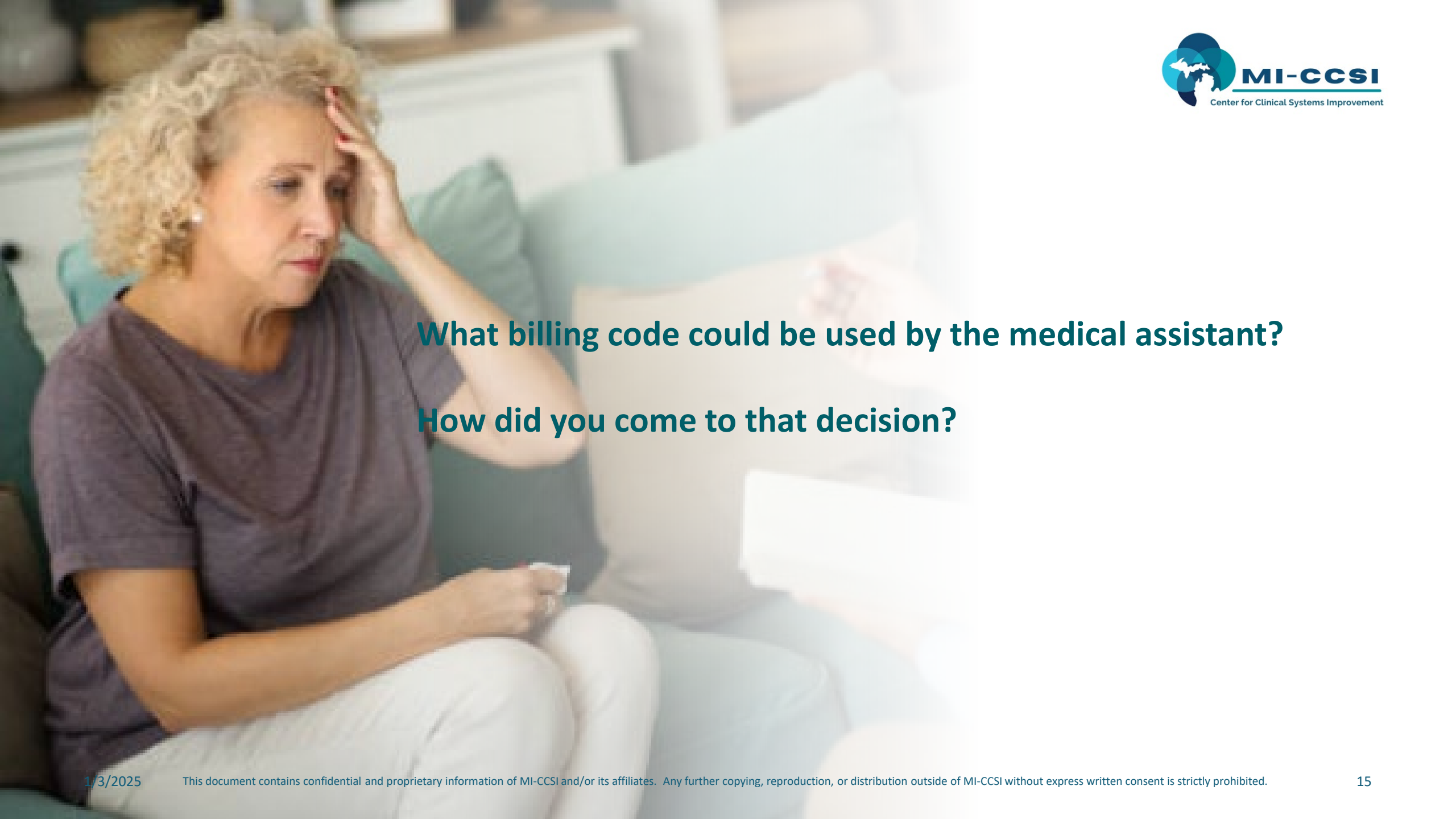
•Select Benefit Information and expand the category

•Scroll down to Physician Visit Office Well

•Select Physician Visit Office Well Additional Details

•Look for the following statement: This member's group allows coverage for provider delivered care management and total care.

•If this statement is present, the member has PDCM benefits. If this statement is not present, the member does not have PDCM benefits. Please note, the benefit information can be found in multiple sections on Availity, as anything relating to medical care will feed into different categories.



What billing code could be used by the medical assistant?

How did you come to that decision?

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Billing & Coding: Appointment with provider, one week later

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Mary's provider appointment	
Mary's response to provider treatment plan recommendations	Mary expresses some interest in seeing a therapist and if the Social worker can assist with this referral she would appreciate it. Mary agrees to the providers treatment plan, though has some concerns regarding the cost of the antidepressant.
Review of recommendations for PDCM	The provider describes the benefits of PDCM services and makes the following recommendations: • Referral and meeting with the social worker to learn strategies for managing her depression ie medications and community resources. Assist with arranging counseling. • Referral to the community health worker (CHW) for community resources available to address propane heat today. A message is sent to the CHW'er to meet today after the provider visit. • Meeting with the pharmacist to assist with medication management to include managing side effects.
Next steps	• Video appointment is set up with the Pharmacist in 3 days. Mary agrees to have all the medications she has been taking set out for the call. • Meet with the community health worker (CHW) and social worker today. • Review options to address the cost of propane heating, counseling services, and any other needs identified by Mary and the social worker.

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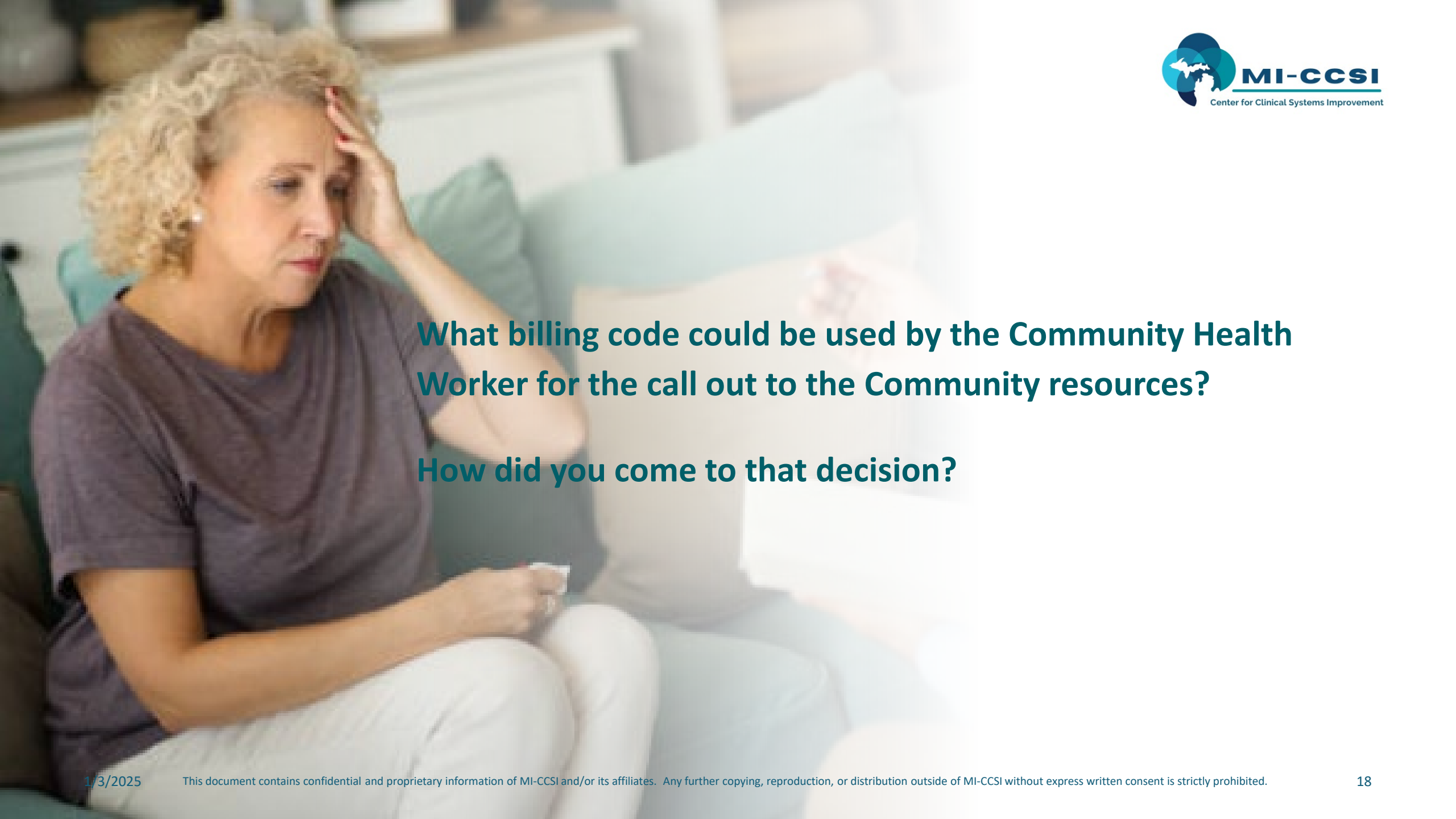
Billing & Coding: CHW'er

CHW'er referral management and care coordination. Same day visit as provider appointment	
Responding to the messaging from the provider	The CHW makes some calls on Mary's behalf regarding obtaining propane gas for heating. She does this while Mary is finishing up the appointment with the Provider. Mary speaks with the Community health worker as she leaves the appointment. CHW meets with Mary after the visit and provides the name of a community assistance program for propane heat. CHW will have the social worker also follow up with Mary
Next steps	Mary feels she can make the call to the community agency to review payment options and services available for low-income individuals. • The CHW'er will call Mary in a week to find out how the call went.
Billing code use	The calls with the community agency took 20 minutes.



What billing code could be used by the Community Health Worker for the call out to the Community resources?

How did you come to that decision?

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Billing & Coding: Social Worker Initial Visit

Details of the Social Worker visit	
Initial Assessment	The Social Worker meets with Mary that same day: • Conducts a comprehensive assessment. • He and Mary come up with a plan of care that works for Mary. • He provides a list of behavioral providers that Mary can choose from. • He inquires on the meeting with the CHW'er and let's Mary know he will follow up on this at their next meeting. See how it went with options for heating.
Next steps	The social worker: • Based on Mary's decision on the behavioral health providers, the SW will set up the referral. • He will continue to follow up with Mary at least until she feels settled into therapy and feels comfortable with the antidepressant. Mary: • Mary will work on the care plan and be prepared to update the SW at the next follow up meeting.
	This meeting takes 45 minutes

What billing code could be used by the social worker?

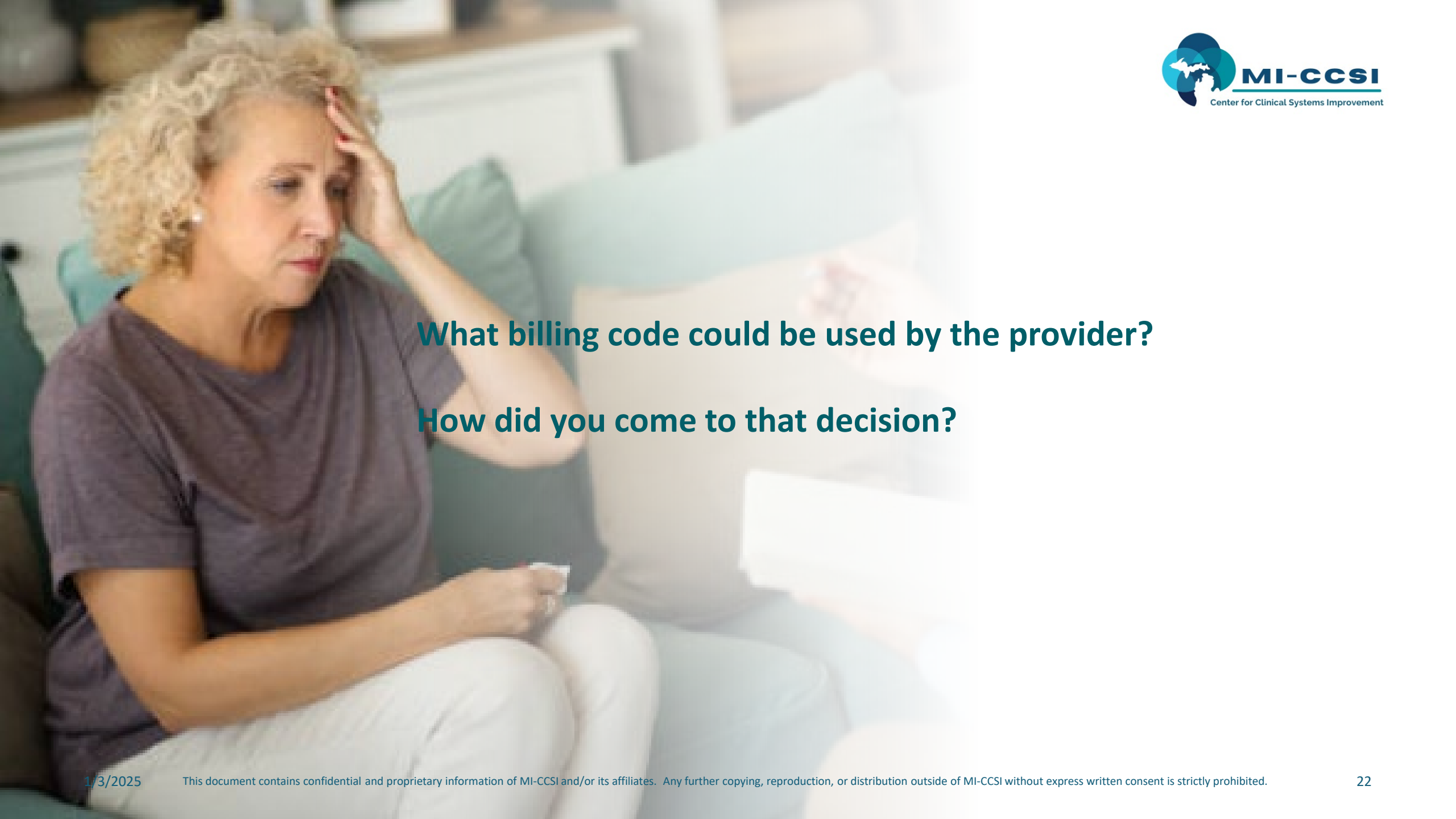
How did you come to that decision?

Patient Identification via Registry

Billing & Coding: Care Conference

Care Conference with the team

- The meeting includes- the provider, pharmacist, social worker and Community Health worker.
- All agreed on the plan of care



What billing code could be used by the provider?

How did you come to that decision?

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Billing & Coding: Pharmacist

Pharmacist outreach through secured video	
The video appointment 3 days after the provider appointment	Over a secured video, the pharmacist and Mary review all of the medications she is prescribed and taking. Findings: • Mary has some meds that are outdated and are no longer on order. • She is also taking several different brands of the same vitamin supplements
Actions	Pharmacist working under a Collaborative Practice Agreement: • Discontinues some of the medications • Simplifies Mary's medication regimen, and based on this the new antidepressant will be affordable.
Billing	The video call was 50 minutes.

What billing code could be used by the pharmacist?

How did you come to that decision?

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Billing & Coding: Social Worker Follow up

Social Worker Follow Up	
Follow up call focusing on treat-to-target and care coordination	Review of progress to target: • Conducts a PHQ9 to monitor progress. The score today is12 • Inquires how Mary is tolerating the medication Care coordination • Inquires if Mary has been able to reach the community resource for propane heat-Mary has called but hasn't gotten a definite answer yet
Mary's input	Mary is very pleased with the outcome of her Pharmacist appointment Mary takes down 2 names of available therapists social worker offers Mary sets a goal to make phone calls to follow up on the propane cost and the therapists.
Billing	They talked for 20 minutes. She would like to talk again in 2 weeks.

What billing code could be used by the social worker?

How did you come to that decision?

Patient Identification via Registry

Billing & Coding: Social Worker Follow up

Ongoing monitor and follow up contacts with Mary by the social worker.

- These contacts can be by phone or face to face/video meetings

What billing code could be used by the social worker?

How did you come to that decision?

Patient Identification via Registry

Billing & Coding: Social Worker Follow up

Ongoing care coordination by the social worker on behalf of Mary:

- Call with therapist
- Call with the propane resources
- Call with other outside entities as needed

What billing code could be used by the social worker?

How did you come to that decision?

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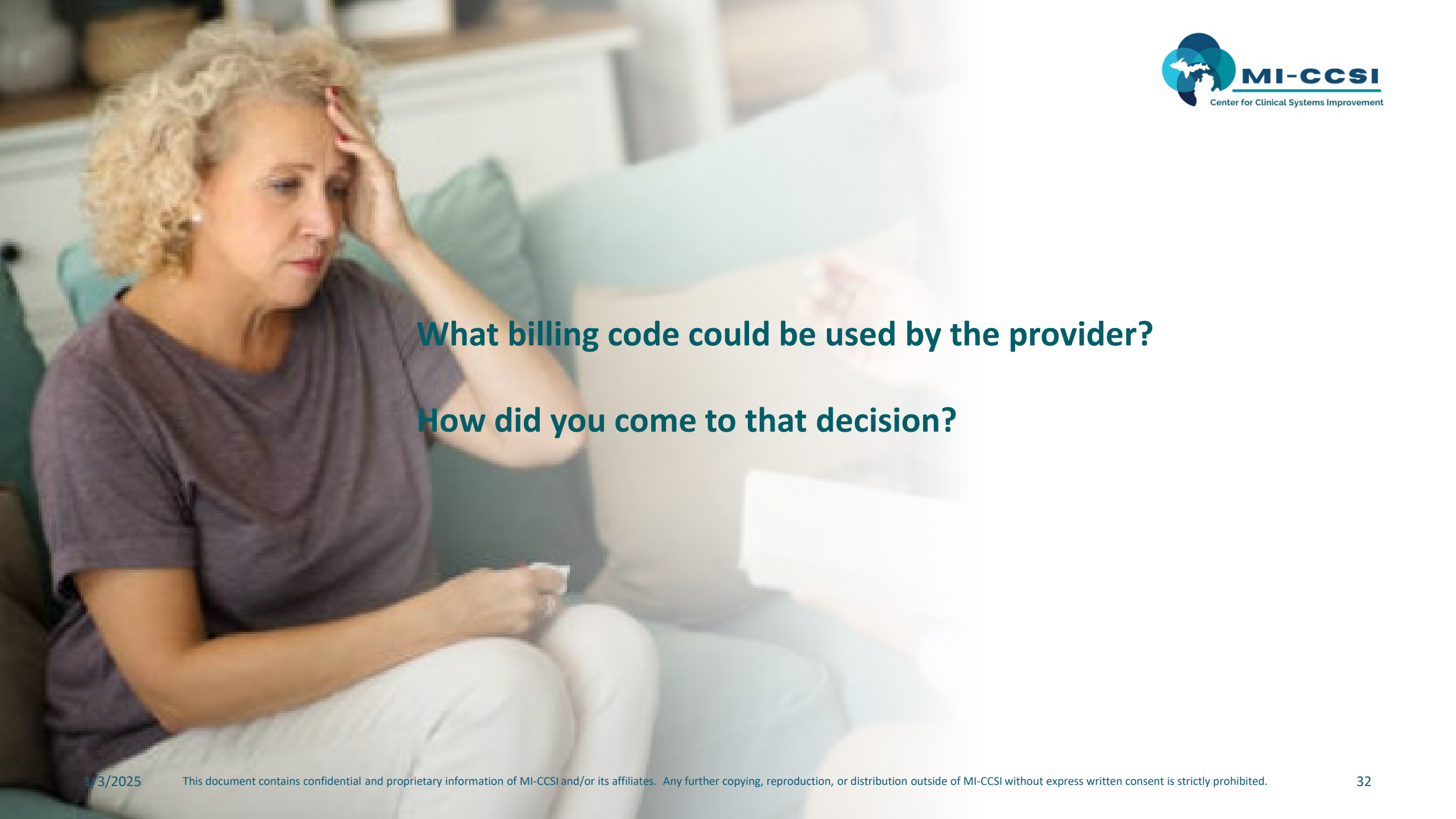
Billing & Coding: Care Conference

Team Care Conference	
Monthly care conference	The entire Team meets monthly to review the following: • The registry list for potential candidates that are on the payer high risk list and or have potential challenges that would benefit from PDCM • Follow up and reporting up on patients that have been enrolled into PDCM, including Mary
Mary's progress	Mary has made good progress over the past 6 months as evidenced in the past 3 PHQ9 scores below 5. She is considered in remission Mary has tolerated the antidepressant well and will continue to take it because of her history of recurrent depressive episodes Mary has made great progress with her therapist in short term therapy and feels much more able to cope and self-manage on a day-to- day basis Mary has taken a part time job and money is less tight. Mary was able to obtain propane for the winter Mary and the team feel ready to close her case to Care Management services knowing that she can access these services again if needed.
Billing	Total number of patients reviewed in 1 hour = 10 • 5 potential new patients requiring outreach as potential PDCM enrollement • 5 patients currently enrolled - updates of status of PDCM and next steps



What billing code could be used by the provider?

How did you come to that decision?

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Billing & Coding: Social Worker Follow up

Discharging from SW'er PDCM	
SW'er and Mary final visit	Follow up face to face visit with social worker: • Mary and Social worker review her relapse prevention plan-noting new coping skills that have worked well for her and resources she can access as needed.
Actions	The Social worker will close her case from his services. The Social worker will update the team, and Mary will be monitored for relapse by the population health nurse.
Billing	This appointment was 25 minutes long.

What billing code could be used by the social worker?

How did you come to that decision?

Day In the Life

Use of the Registry to Identify Patients for PDCM

1. Start each month with reviewing the registry report for out-of- scope measures for individuals with 1 or more chronic conditions.
2. Review the list with the provider to identify potential candidates.
3. Review the patients who are identified as good candidates for PDCM health insurance and confirm benefits for PDCM
4. Document care conference discussions in each individual chart to meet G9007 billing code.
5. Determine how many new patients will be enrolled per month.
    1. Anticipate 45 – 60 minutes for the comprehensive assessment per patient
    2. Follow up and monitoring approximately 11 times in a year. Frequency depends on clinical status. Some guidance:
        1. Weekly weeks 1-4, every other week weeks 5-8, monthly as patient gains the ability to self-manage/meets targeted or “as good as it gets” goals.

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Q & A