Planned Care

Case Management Case Study: Billing Opportunities

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.

Planned Visits

Billing & Coding: Planned Visits

BCBSM PCMH- N Capability

What is a planned Visit?

- Planned visits consist of a documented, proactive, comprehensive approach to ensure that patients receive needed care in an efficient and effective manner.
- Part of the Care Management Process
- Planned visits include the well-orchestrated, team-based approach to managing the patient's care during the visit, performed on a routine basis, as well as the tracking and scheduling of regular visits, and the guideline-based preparation that occurs prior to the visit.

Planned Visits

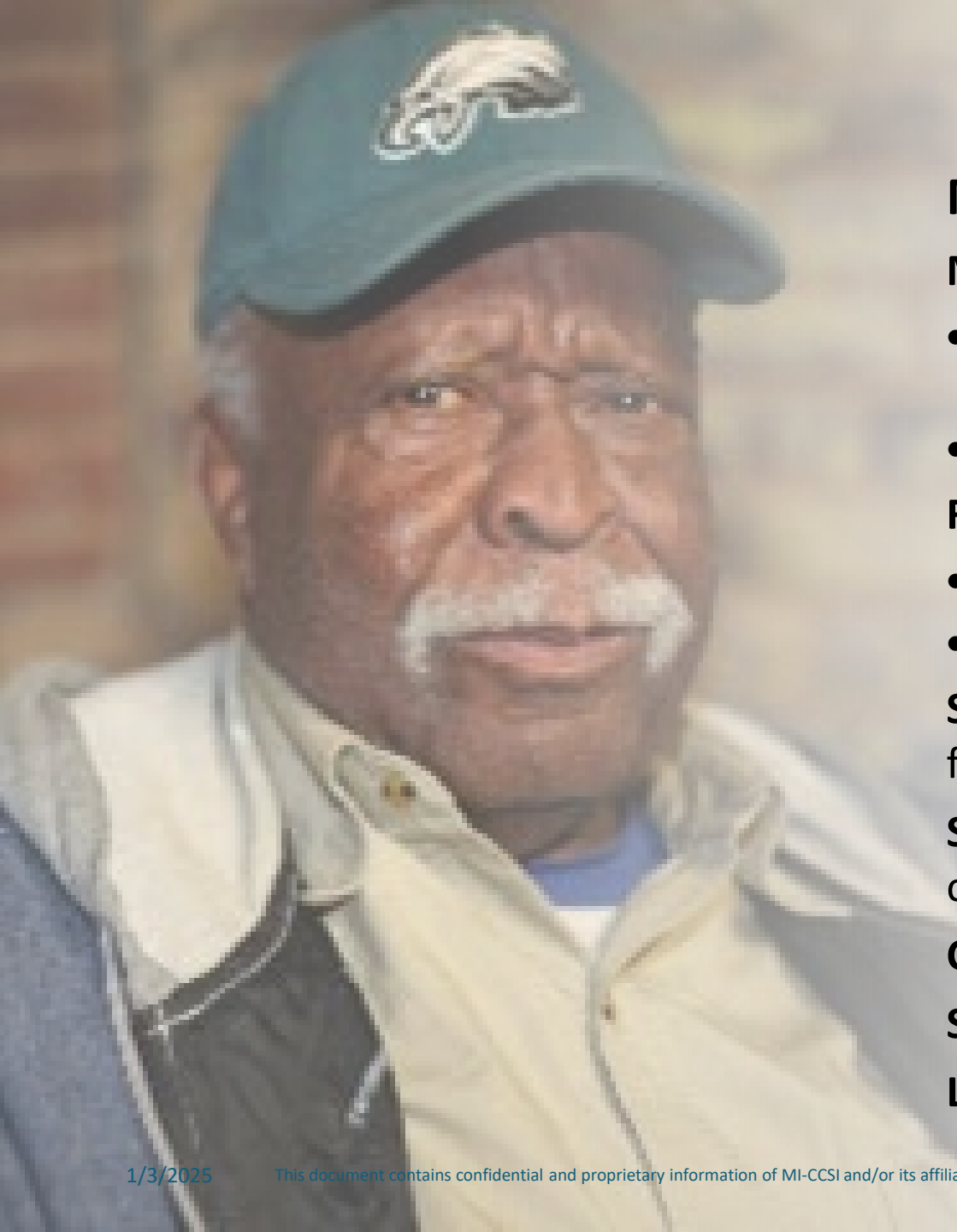
Key Components of a Planned Visit

- Assigned Team Roles and Responsibilities
- Team Communication to discuss patient management
- Contacting/outreach to patient for a visit
- Deliver clinical care and self-management support
- Uses evidence-based care (EBC-report)
- Offered to all patients with chronic conditions (specialists- all sub-acute conditions) prevalent in the practice

Planned Visits

Triggers to consider the need for a planned visit

- **Office visit in conjunction with a scheduled physician visit**
- **Missed/or delayed follow-up appointments for chronic disease** f/u on registry based on disease follow-up evidence based standard or office protocols. Clinic practice is a minimum follow-up every quarter.
- **Gap in care list from payer for not having BP in target**
  - HEDIS-C/Quality: Target gaps in care, disease burden, etc.
  - Payer related outcome measures: HbA1c, blood pressure control, others
  - ED/IP utilization
- **Need based triggered by evidence- based care targets or social needs**
- **Preventive health management / Performance Reporting**
  - Utilize EMR/registry to identify patients diagnosed with chronic conditions to address Action Plan (i.e. Asthma, COPD, Heart Disease), at-risk conditions and quality measures
- **Risk Factor Reduction: Counseling surveillance** to avoid conditions from worsening (i.e. Dietary, Obesity, Physical Activity, Tobacco Use)



Mr. Robert A.

Medical History:

- HTN X 10 years; Hypercholesteremia; CAD, MI 1994; bypass in January 2022.
- Anxiety; depression.

Family Medical History:

- Mother: type 2 diabetes (died at 62)
- Father: type 2 diabetes; lung cancer (died at 74)

Social: retired UAW autoworker (pipefitter); married to Mrs. A for 55 years; 2 married daughters; live within driving distance.

Smoker- 30- year pack history, quit briefly after bypass but currently smokes 5-6 cigarettes a day.

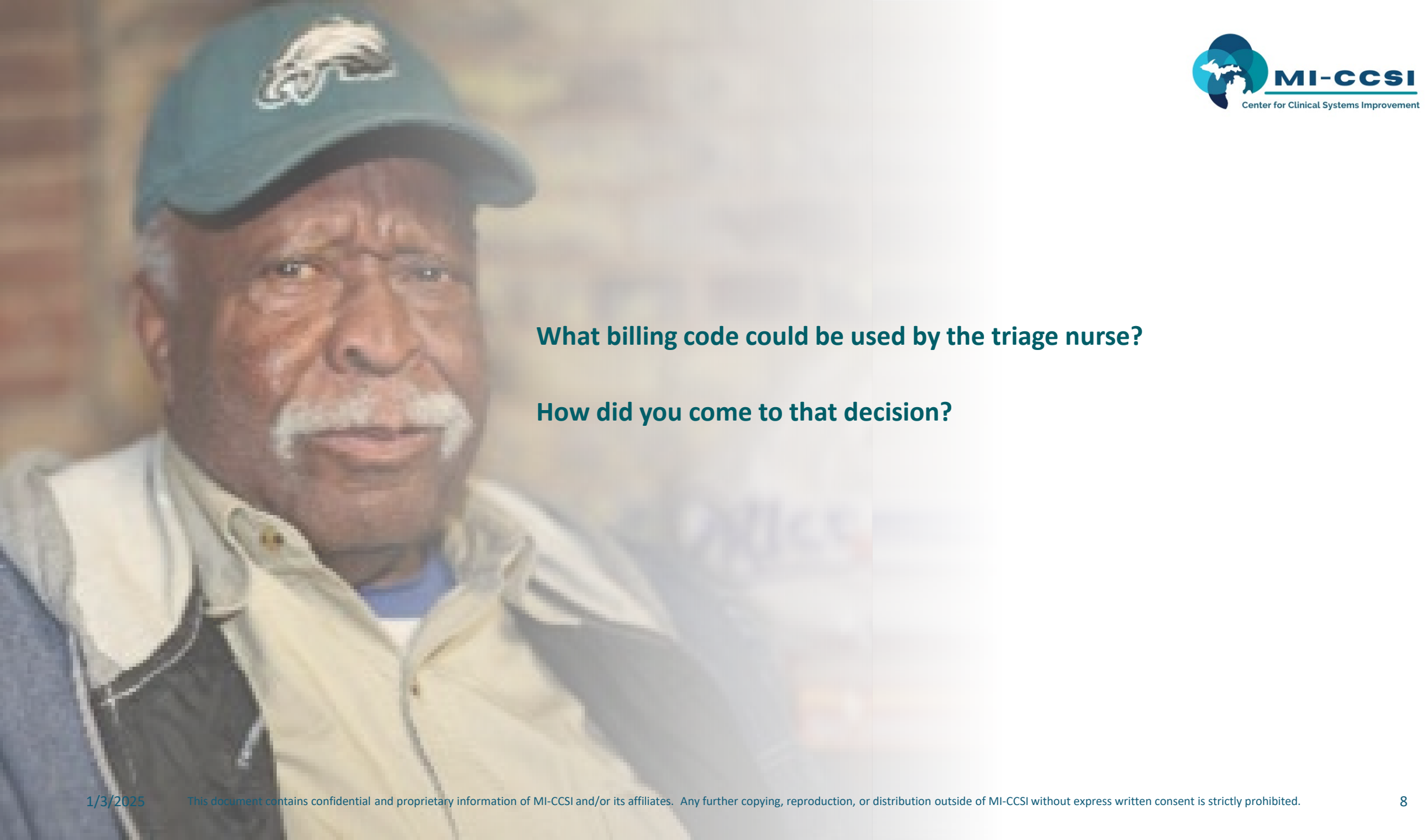
Current Medications: Zoloft, Lasix, and Lisinopril.

Specialty Providers: Cardiology

Last Visit: Last seen in the clinic 6 months ago.

Planned Visits
Starts with a Triage Call

Triage Nurse takes a call from Mr. A . He is requesting a refill of his Zoloft.	
Clinical Team Member and Actions	• Triage Nurse completes a chart review
Assessment Findings	• Last visit in the clinic was 6 months ago. • BP on that last visit was 160/98. • Pt. cancelled his last scheduled clinic appointment. • Consistently refills medications by calling triage. • Inconsistent use of medications- based on gaps in refill history
Next Steps	• The triage nurse schedules a clinic appointment for a PLANNED VISIT this week. • Pt. counseled on BP management needs; that he needs to come to the office (EBCR and practice guidelines). Pt. agreeable and appointment is scheduled.



What billing code could be used by the triage nurse?

How did you come to that decision?

Planned Visits

Office Visit

Mr. A is in the clinic for appointment with provider:	
Assessment Findings **Provider completes exam** His BP is out of control, he continues to smoke, and he is confused about his medications.	• WT- 215 BMI- 40 • BP: 182/102 • HR: 76 • Has not been taking Lasix or Lisinopril consistently- doesn't feel it helps. • FMH of AODM • Continues to smoke. **Treatment Plan**: • All current medications refilled • Labs ordered to check cholesterol, blood sugar, kidney function; electrolytes
Clinical team Member and actions	**Provider completes exam**. • Medication review completed • Engages patient in a discussion about CM. **Provider requests the patient be seen by the Care Manager today.** • Referral to the Care Manager • Care Manager reviews the health insurance to determine if PDCM is a covered benefit and details of the coverage.
Patient Action	Patient Consents and agrees to care management Patient will get labs done and presciptions filled.

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

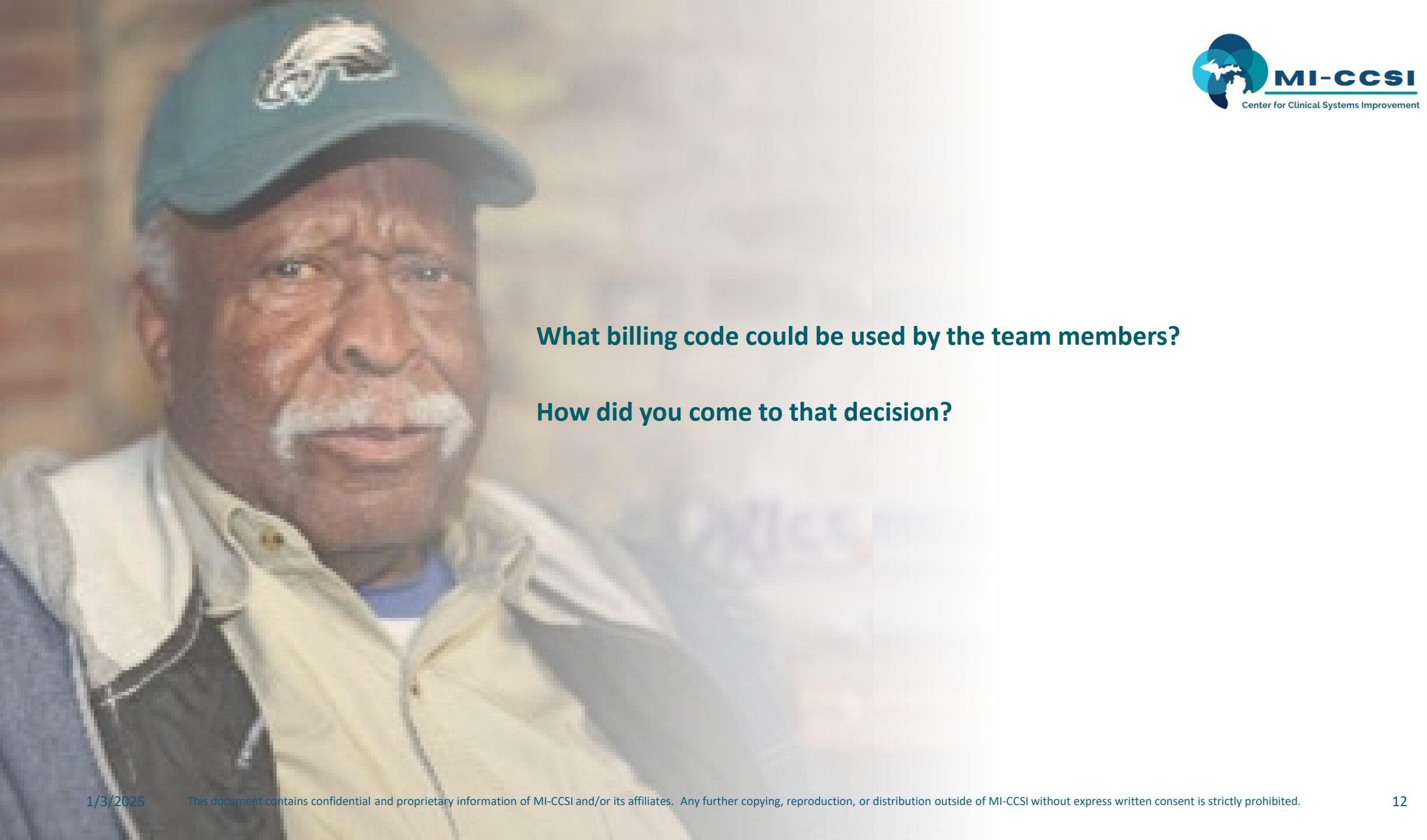
•Look for the following statement: This member's group allows coverage for provider delivered care management and total care.

•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.

Planned Visits

Office Visit

Mr. A meets with the CM during his visit:	
Clinical team Member and actions	**Care manager steps into the exam room and meets with the patient.** • The Care Manager completes the comprehensive assessment • Counseling on risks associated with high BP • Self-management action plan is set up with a focus on getting the patient's blood pressure under control. **Patient Actions**: • The patient would like to do home BP monitoring, so the patient will call back in each day with his BP to the team.
Assessment Findings	• (-)SDOH screen • (+)PHQ 2 Screen • Struggles with maintaining a health lifestyle and smoking cessation. Not interested in smoking cessation at this time • Confused about medications and connection to BP • He has BP monitoring equipment at home and knows how to use it.
Next Steps	• Follow-up visit in the office with the Care Manager in 1 week. • CM will discuss with SW the need for a PHQ 9 screening with SW on the team • Stroke Prevention/Risk counseling.



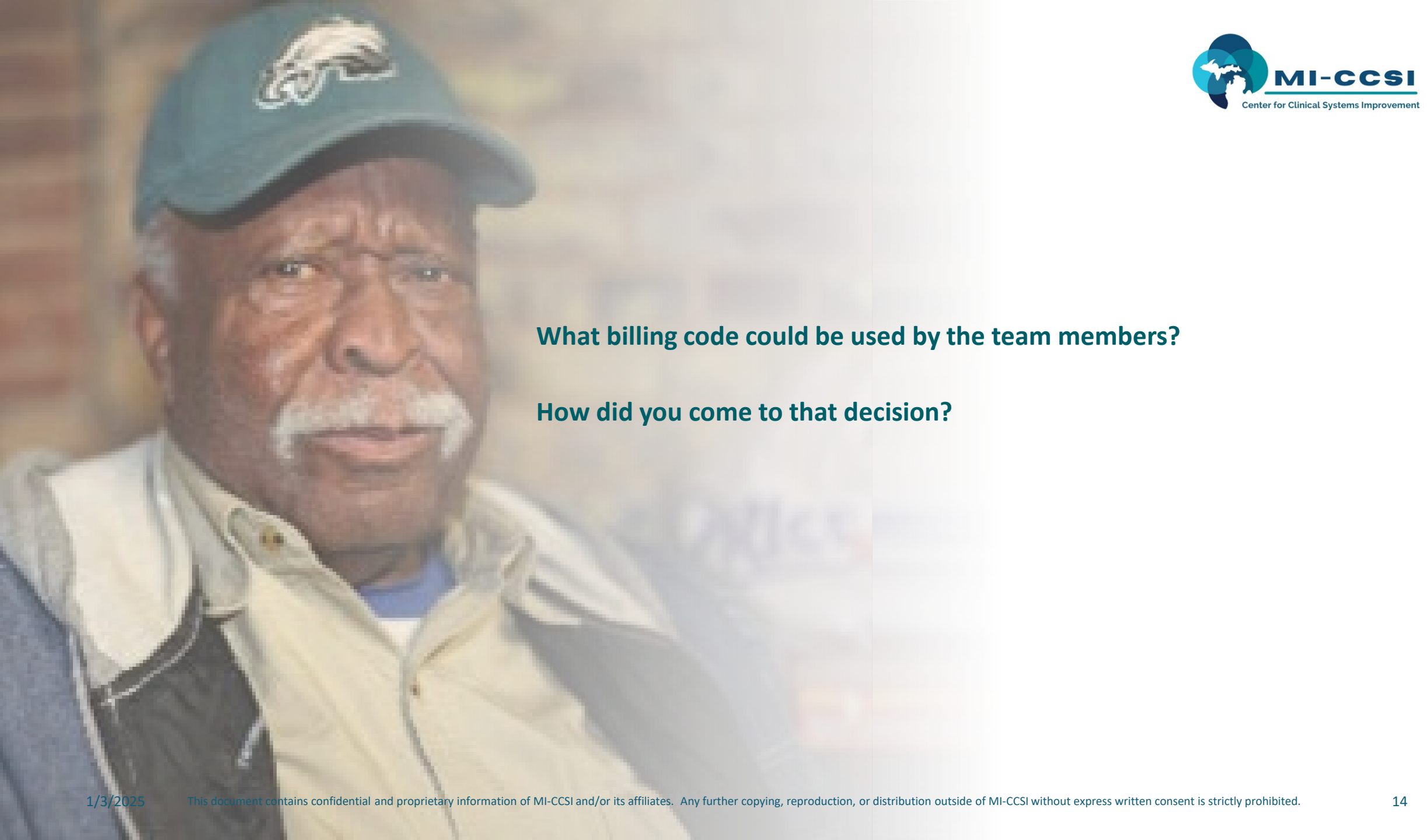
What billing code could be used by the team members?

How did you come to that decision?

Planned Visits

Post Visit Care Coordination

Care Manager Plans with the Team	
Clinical team Member and actions	**The care manager** follows-up with the MD after the visit to discuss concerns with the patient and his “mood”. • He screened positive on the PHQ2. • They determine there is a need to have a team meeting and include the SW to discuss the case and have a PHQ9 to be completed.
	The next day: The CM, SW & MA meet the following day to discuss the CM’s findings and outline the next steps with their team.



What billing code could be used by the team members?

How did you come to that decision?

Planned Visits

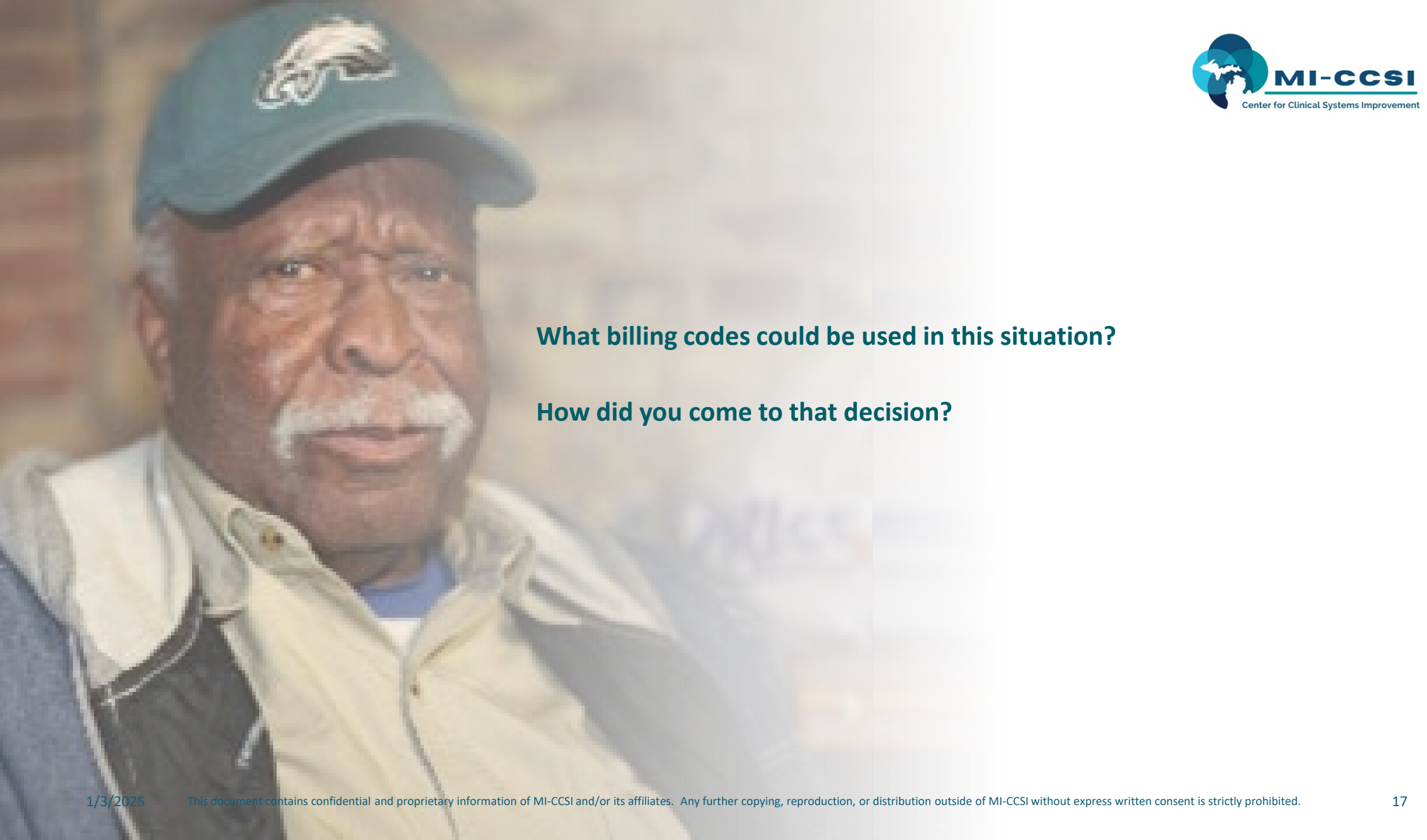
Patient Calls the Clinic as outlined in his action plan

Mr. A calls the clinic to review his BP readings	
Clinical Team Member and Actions	The MA speaks with the patient and takes is BP readings from the last two days. • Mr. A tells the MA that he hasn't been taking his BP medications at all. • BP 172/90- yesterday • BP 188/96- this morning • He reports that he did get his labs drawn yesterday. • The MA places Mr. A on hold, and gets a Triage Nurse to talk with Mr. A. • The Triage Nurse gets on the phone to speak to Mr. A.
Assessment Findings	The Triage Nurse completes a chart review and speaks with Mr. A. • He reports not having any dizziness, headaches, chest discomfort. • He shares that he has not started his BP medications because when he went to the pharmacy, he couldn't afford the cost of the medication due to the cost and that it is not covered.
Clinical team Member and actions	Triage Nurse speaks tells the patient that she will speak with the Dr. and call him back to discuss what to do with his medications. She encourages the patient to keep monitoring his blood pressure, confirm taking the rest of his medications, and symptoms to report back to the clinic. • This call was 20 minutes

Planned Visits
Coordination of Care

CM meets with the provider and the clinic pharmacist	

Clinical team Member and actions	After the call, the MA and the triage nurse discuss the concerns with the patient's medication adherence.
	• The triage nurse contacts the CM to discuss the findings.
	• The CM contacts the clinic pharmacist and the MD to recommend they evaluate a more cost-effective medication.
	• The MD reviews med profile, current VS, and recent labs (elevated LDL, others normal)
	  • The MD calls the cardiologist to verify a consult that was done a few months ago and gain perspective on medication management/ options within financial constraints.
	  • They agree to change his ACE inhibitor to one that is covered by his benefits and has a lower co-pay.
	  • The MD communicates these changes to the care team.
	• The pharmacist will contact the patient's pharmacy to assure there will be no issues with filling the new medication based on coverage.



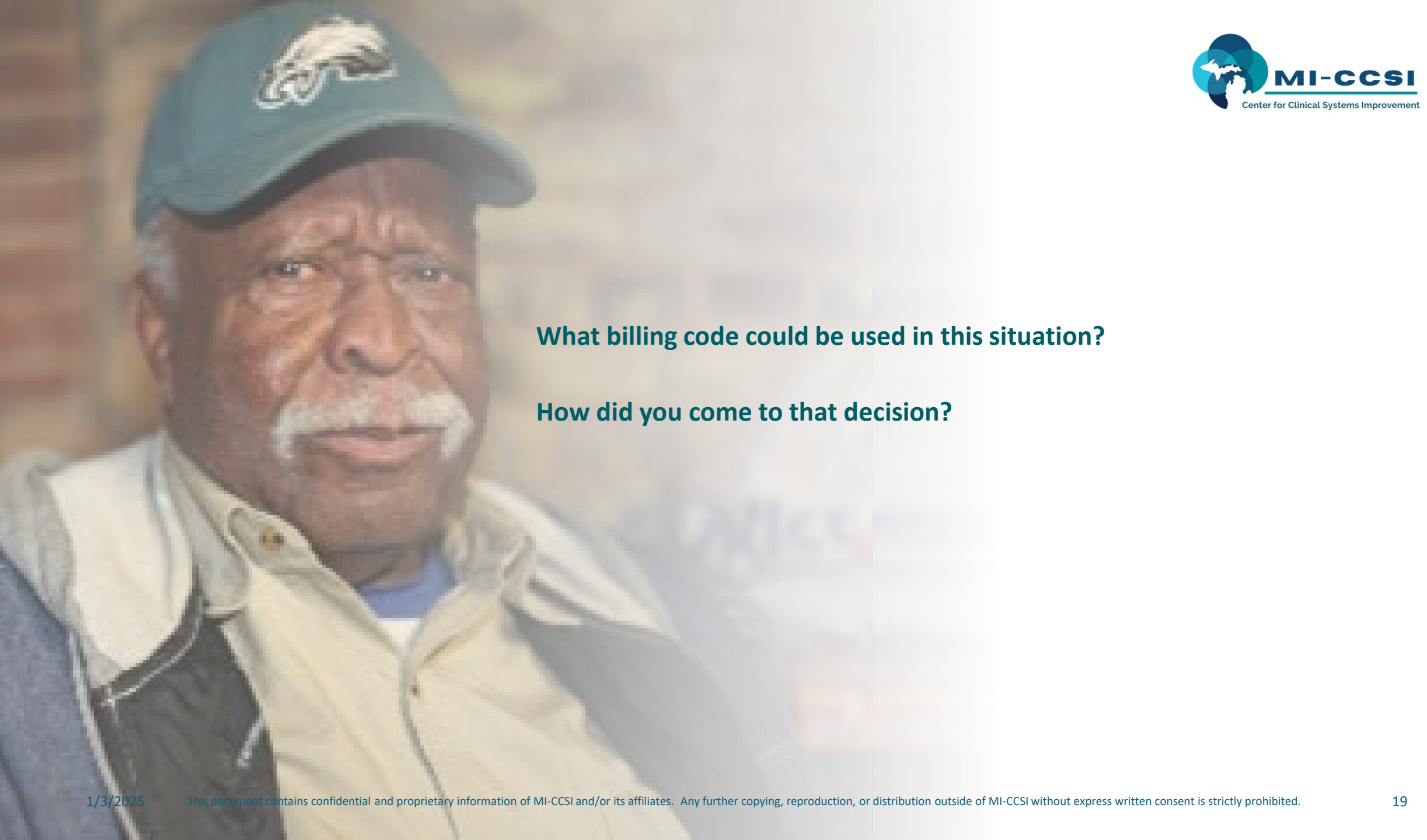
What billing codes could be used in this situation?

How did you come to that decision?

Planned Visits

Care Coordination in the Medical Neighborhood

Pharmacist Contacts Community Pharmacist to discuss the plan	
Clinical team Member and actions	The pharmacist contacts the patients' pharmacy to discuss medications that are covered under his benefits, and they determine the most-cost effective medication. • The pharmacist then collaborates with the MD to write a new prescription. • The pharmacist updates the patient's medication profile and adds a note on pharmacy cost issues in his plan of care. • The community pharmacist arranges for the prescription to be delivered to the patient.

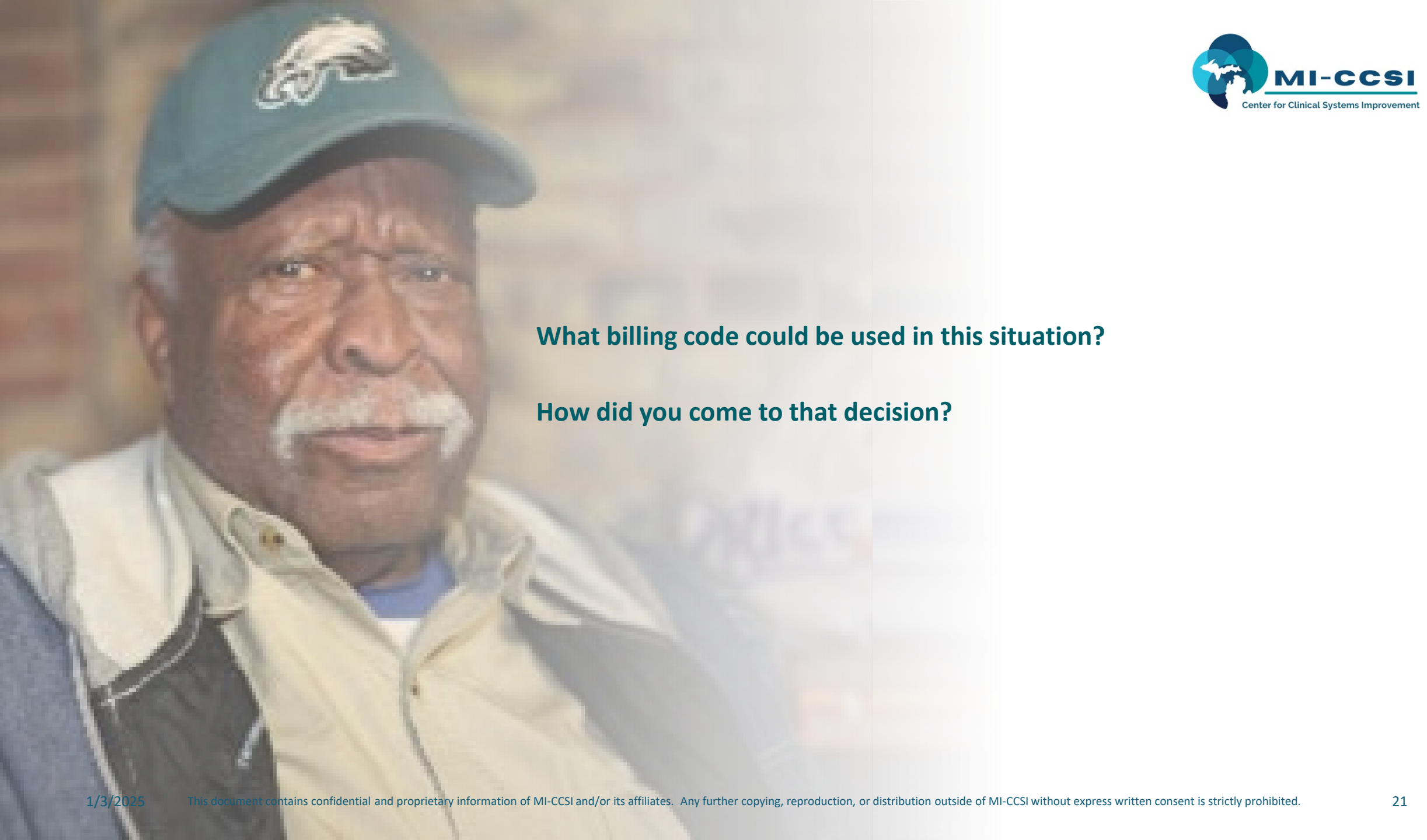


What billing code could be used in this situation?

How did you come to that decision?

Planned Visits
Video Visit

Mr. A completes a video visit with the Care Manager and the Pharmacist	
Clinical team Member and actions	• The Care Manager and Pharmacist contact the patient and do a joint video visit with the patient to discuss the changes. • Visit is 20 minutes • The pharmacy is going to deliver the new medication to Mr. A today.
Patient Action	• Mr. A agrees to the changes. He denies having any questions. He will let the CM know if there is a problem with the medication.

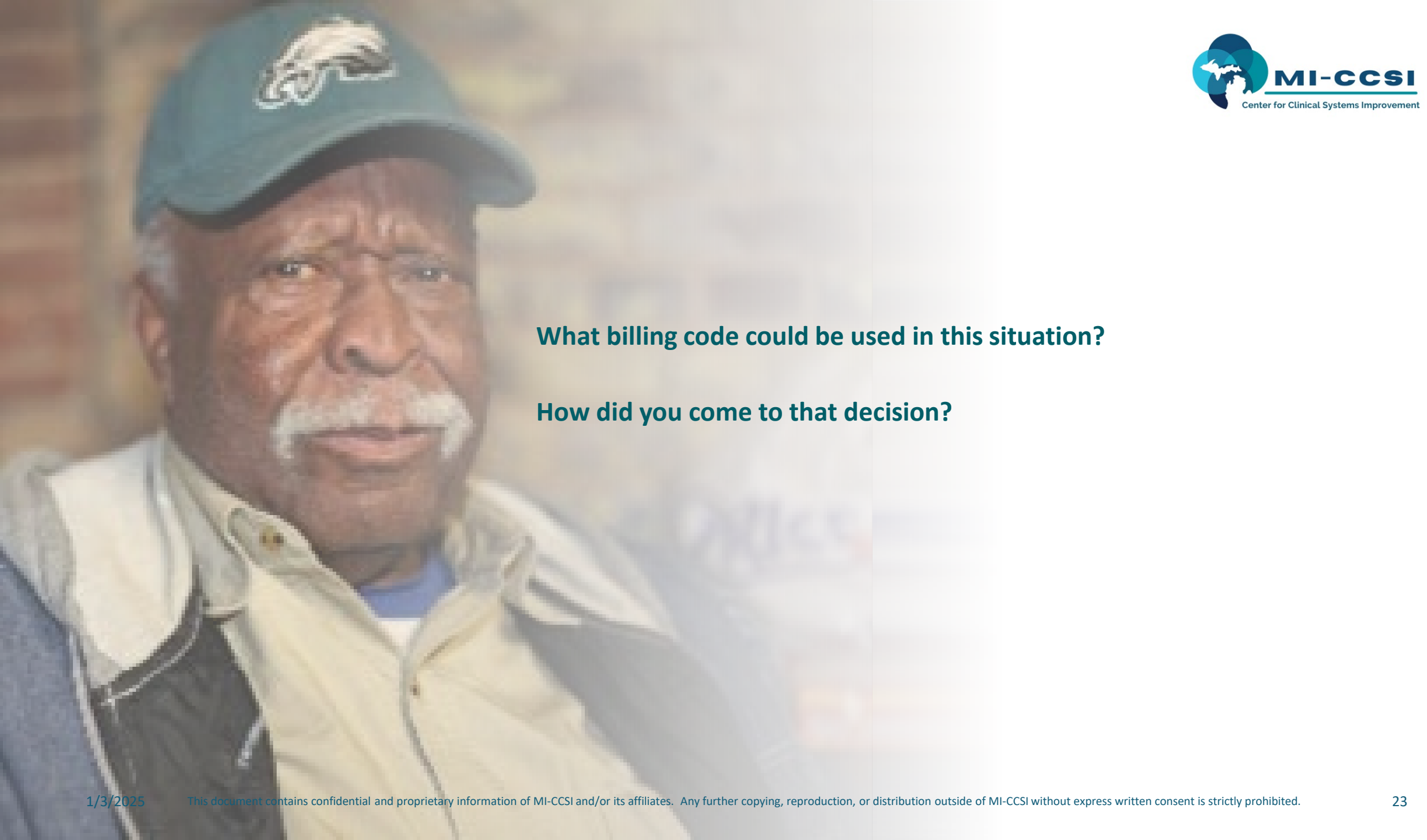


What billing code could be used in this situation?

How did you come to that decision?

Planned Visits
Patient Self-Management

Mr. A speaks with MA every day about his blood pressure readings by phone:	
Clinical team Member and actions	• MA and Patient have a phone call and review BP daily until his next CM visit- these are calls less than 10 minutes each. • The blood pressures are documented in the chart by the MA. The values are within range. • The patient reports he is taking the medications as prescribed.



What billing code could be used in this situation?

How did you come to that decision?

Planned Visits

Care Management Office Visit

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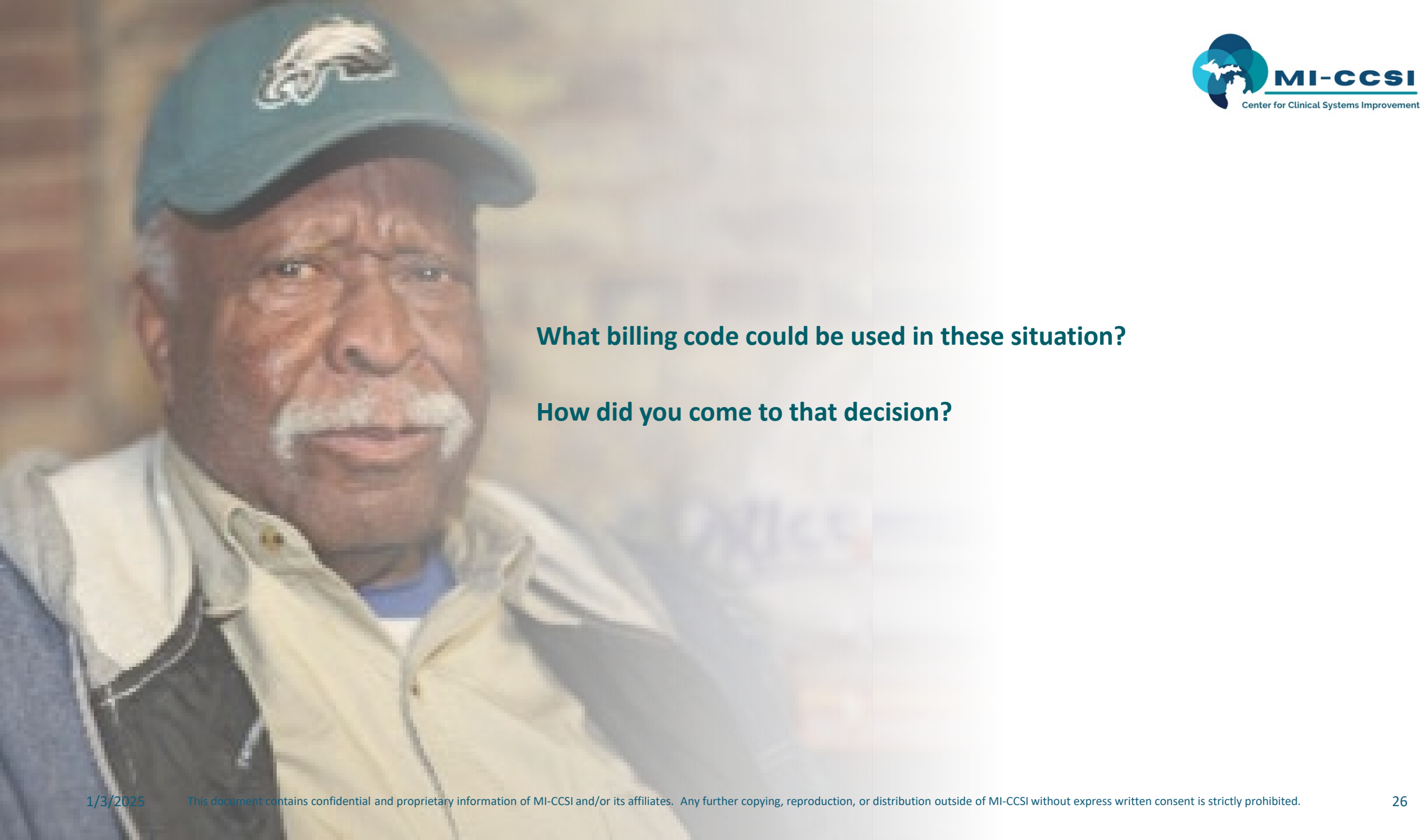
Mr. A returns to the office for a visit with the Care Manager and the SW	
Assessment Findings	• **PHQ 9- 5/9** • **BP 140/60** • **HR - 20** • **BMI 40** • **LDL Cholesterol *180** • **Smoking cessation addressed- pt. is not interested at this time.**
Clinical team Member and actions	**CM and MSW meet with the patient together along with his wife.** • The CM follows up on the BP and lab values. BP is better but still not at target; LDL high. • Discuss concerns with PHQ2 and the desire to explore more. **SW spends the rest of the visit with patient.** • The PHQ9 is completed, the SW shares the results with the provider to confirm diagnosis for depression. **The patients SM action plan is updated, and new goals established.** • The priority is to work with the MSW on his stress and anxiety around his health. • The SW will continue to monitor, based on response will determine when to close to services. • Visit is 90 minutes. **The SW reviews with the patient the lifestyle group visit offering at this practice (**based on BP, weight and cholesterol level). The patient agrees and schedules to attend the next group visit.

Planned Visits
Patient Attends Group Visit

Mr. A attends a group visit at the office	
Clinical team Member and actions	**The patient attends the first visit with 3 other patients.** **CM and Dietician lead the group visit**. • Group visit offering at this practice based on BP, weight and cholesterol level. **In the visit**: • Pt vital signs are taken, and medications are reviewed • The group is focused on making lifestyle changes to improve health outcomes. • The class lasts 30 minutes.



What billing code could be used in these situation?

How did you come to that decision?

Planned Visits
Encounters

How many encounters took place with Mr. A and on behalf of him to assist him with the identified problems:

- Uncontrolled blood pressure
- Social needs related to finances for the medication
- Behavioral challenges with depression
- Support of life-style changes

Who was on this patient's team?

- Patient, wife
- MD, CM, SW, Triage Nurse, Pharmacist, MA
- Medical Neighbors: Specialist, Community Pharmacist

Care team members that billed for services for Mr. A

- Triage nurse, MA
- Care Manager, SW, Pharmacist
- MD/Provider

Day In the Life

Identifying Patients for PDCM During the Planned Visits

1. Review the registry for patient's who have potential challenges that may benefit from PDCM>
2. Review the weekly schedule – are any of the patients from the registry list coming in for an appointment? If yes, flag them for a potential referral and review with the provider to address the need during the provider visit.
3. If agreeable, introduce self and make arrangements for the enrollment. Review patients who may benefit from PDCM with the care team.
4. Verify PDCM benefits with the patient's health insurance employer plan, review the coverage with the patient.

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Q & A