Transition of Care

Case Study: Billing Opportunities

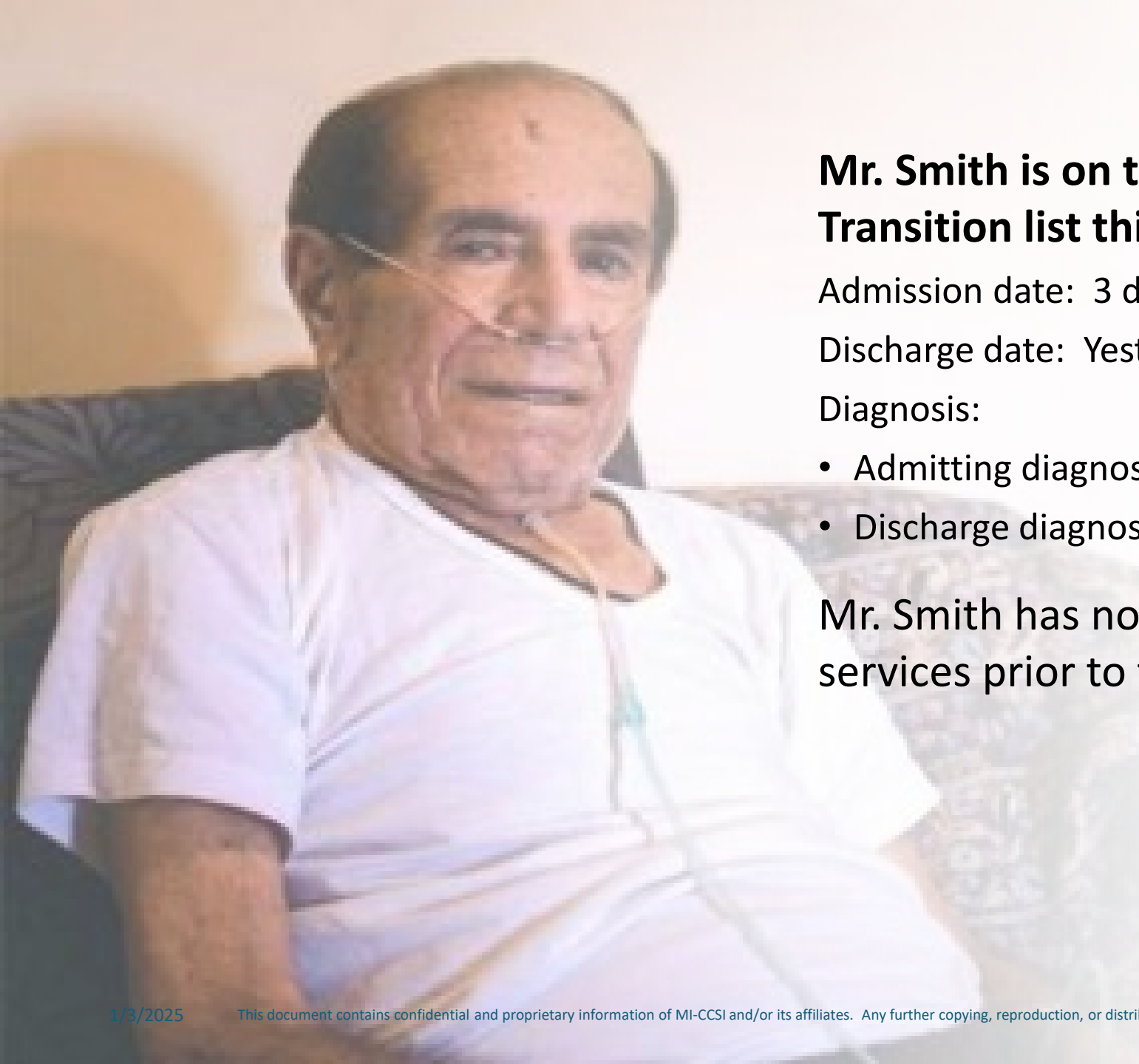
This document contains confidential and proprietary information of MI-CCSI and/or its affiliates. Any further copying, reproduction, or distribution outside of MI-CCSI without express written consent is strictly prohibited.

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.

This document contains confidential and proprietary information of MI-CCSI and/or its affiliates. Any further copying, reproduction, or distribution outside of MI-CCSI without express written consent is strictly prohibited.



Mr. Smith is on the Admission Discharge Transition list this morning.

Admission date: 3 days ago.

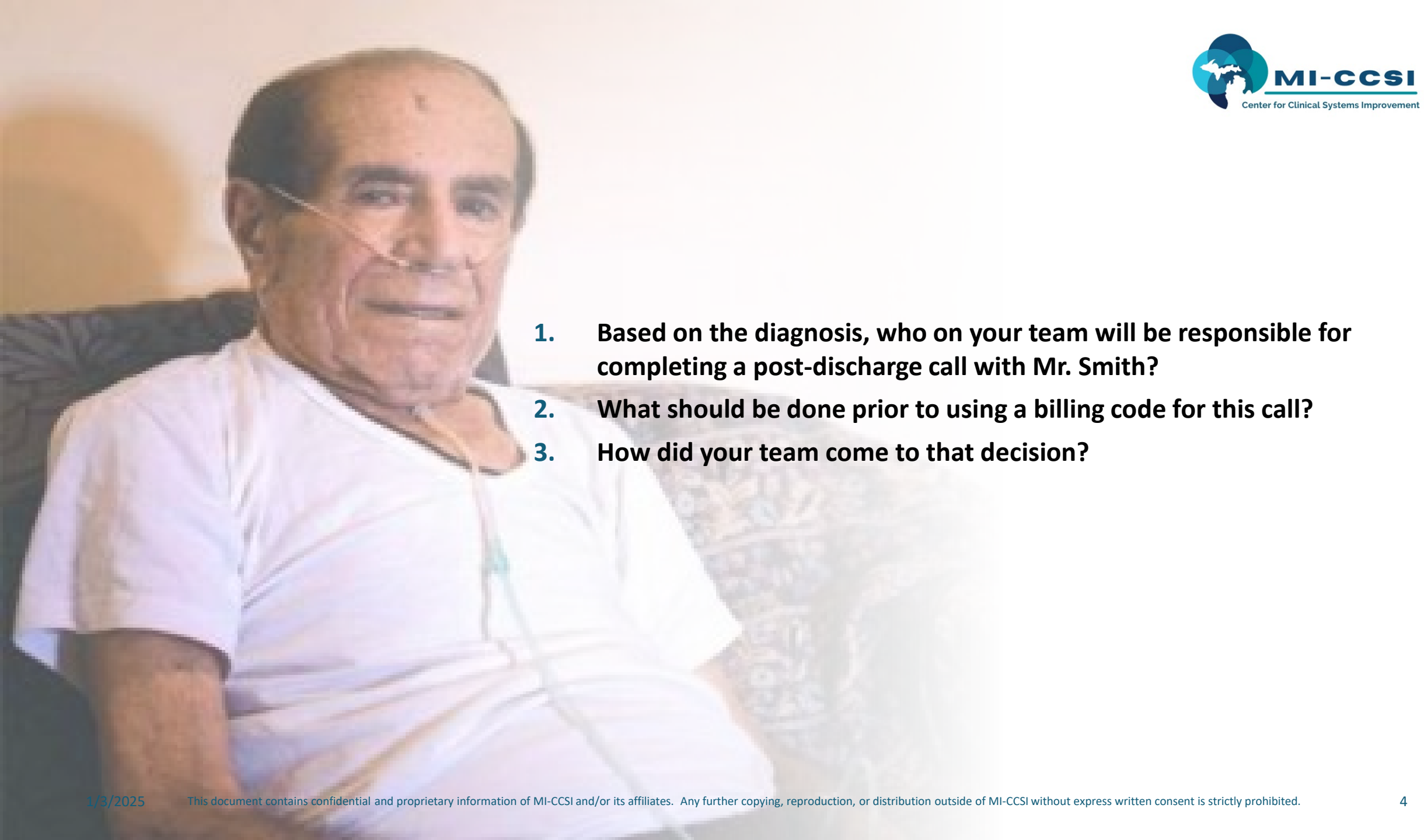
Discharge date: Yesterday

Diagnosis:

- Admitting diagnosis: Hypoxia, Shortness of Breath
- Discharge diagnosis: Hypoxia, COPD

Mr. Smith has not been in care management services prior to this admission – discharge.

This document contains confidential and proprietary information of MI-CCSI and/or its affiliates. Any further copying, reproduction, or distribution outside of MI-CCSI without express written consent is strictly prohibited.



1. **Based on the diagnosis, who on your team will be responsible for completing a post-discharge call with Mr. Smith?**
2. **What should be done prior to using a billing code for this call?**
3. **How did your team come to that decision?**

This document contains confidential and proprietary information of MI-CCSI and/or its affiliates. Any further copying, reproduction, or distribution outside of MI-CCSI without express written consent is strictly prohibited.

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.

Transition of Care

Case Study – Billing: Completing the Call

1. **What is the primary goal of completing a post-discharge call?**
2. **What key information would be helpful in meeting that goal?**

Outreaching to Mr. Smith to complete a follow up and safety check from his hospitalization	
The call	The team member reaches Mr. Smith at his home. • Shares they are calling from the office (this could be a specialist or primary care provider office).
The goal	The team member shares they are calling to see how things are going, answer any questions and make sure he has everything he needs to be safe at home.

This document contains confidential and proprietary information of MI-CCSI and/or its affiliates. Any further copying, reproduction, or distribution outside of MI-CCSI without express written consent is strictly prohibited.

Transition of Care

Case Study – Billing: Completing the Call

The workflow in this practice is having the population health team complete the first call to make sure Mr. Jones has the follow up appointments on his schedule and he has transportation to get to the appointments.

1. **Are there any billing codes that could be submitted at this time?**
2. **How did you come up with your answer?**

- **This team includes medical assistance and community health workers**
- **The team has a list of "red flag" triggers to identify potential risks**
- **If a patient has a "red flag" the call is transferred to a licensed care team member to follow up with the patient. The expectation is the call will be completed before end of day.**

This document contains confidential and proprietary information of MI-CCSI and/or its affiliates. Any further copying, reproduction, or distribution outside of MI-CCSI without express written consent is strictly prohibited.

Patient Centered Medical Home Capacity

13.0 Care Coordination

13.0 Coordination of Care

Goal: Patient transitions are well-managed and patient care is coordinated across health care settings through a process of active communication and collaboration among providers, patients and their caregivers.

13.1 – Required (as of 2021)

- ***For patient population selected for initial focus, mechanism is established for being notified of each patient admit and discharge or other type of encounter, at facilities with which the physician has admitting privileges or other ongoing relationships.***

13.2

- ***Process is in place for exchanging necessary medical records and discussing continued care arrangements with other providers, including facilities, for patient population selected for initial focus***

13.4

- ***Process is in place to systematically flag for immediate attention any patient issue that indicates a potentially time-sensitive health issue for patient population selected for initial focus***

13.7

- ***Practice has written procedures and/or guidelines on care coordination processes, and appropriate members of care team are trained on care coordination processes and have clearly defined roles within that process***

This document contains confidential and proprietary information of MI-CCSI and/or its affiliates. Any further copying, reproduction, or distribution outside of MI-CCSI without express written consent is strictly prohibited.

Transition of Care

Case Study – Billing: Follow up from a Licensed Team Member

Findings from the post-discharge call:	
Mr. Smith's condition	Mr. Smith reports: • He is still a little short of breath • He couldn't afford the prescription the hospitalist gave him, so he did not pick it up.
MA	The MA identifies actions on the practice "Red Flag" trigger list: • Symptoms of shortness of breath • Not picking up prescribed medications
Actions	• Review the medication prescribed that was not picked up. • Transfer the call the nurse care manager for further evaluation

Triage nurse	The nurse care manager reviews:
	• Medication prescribed and will have the provider determine if there is an alternative that is covered by Mr. Smith's health insurance.
	  • She will call Mr. Smith back today with the decision.
	  • If a new prescription is order, verify Mr. Smith can have someone pick it up for him today.
	• Notes Mr. Smith is schedule for an appointment with the Nurse Practitioner tomorrow morning.
	  • Confirms Mr. Smith is planning to attend the appointment and that he has transportation to get to the appointment.

This document contains confidential and proprietary information of MI-CCSI and/or its affiliates. Any further copying, reproduction, or distribution outside of MI-CCSI without express written consent is strictly prohibited.

Patient Centered Medical Home Capability

3.0 Performance Reporting and 13.0 Coordination of Care

3.21

Performance reports are generated for the population of patients with: concerns related to social determinants of health, such as transportation limitations, housing instability, interpersonal violence, or food insecurity

3.24

- ***Performance reports are generated for the population of patients with: Chronic Obstructive Pulmonary Disease (COPD)***
  - The practice must demo how they are using these performance reports to improve population management.
  - Are the relevant measures included in the performance reports?
  - What sort of review is being done with these reports?
  - What actions are taken?

13.10

- ***Following hospital discharge, a tracking method is in place to apply the practice's defined hospital discharge follow-up criteria, and those patients who are eligible receive individualized transition of care phone call or face-to-face visit within 24-48 hours***

This document contains confidential and proprietary information of MI-CCSI and/or its affiliates. Any further copying, reproduction, or distribution outside of MI-CCSI without express written consent is strictly prohibited.

Transition of Care

1. **Are there any billing codes that could be submitted at this time?**
2. **How did you come up with your answer?**

This document contains confidential and proprietary information of MI-CCSI and/or its affiliates. Any further copying, reproduction, or distribution outside of MI-CCSI without express written consent is strictly prohibited.

Transition of Care

Post-discharge follow up in the office	

Prior to the provider appointment	**Using SBAR, the nurse care manager shared updated the provider of Mr. Smith's status:**
	• Situation
	  • Discharge 2 days ago from an exacerbation of his COPD
	  • Symptoms worsening
	  • Did not pick up his prescription – new antibiotic prescribed and he took the first dose last night
	• Background
	  • Lives along
	  • Unable to drive
	  • Can care for himself/complete ADL's
	• Assessment
	  • Shortness of breath less than it appeared on the call yesterday
	  • If stable and returning to home
	• Recommendations
	  • Refer to care management services for regular follow up and monitoring until stable

NP Visit	**The nurse practitioner completes an assessment and evaluation:** • Reviews the team-based care approach at the office and recommends Mr. Smith enroll in care management with the nurse at the office.
Nurse care manager	**Following the visit with the NP, the nurse CM'er meets with Mr. Smith:** • Reviews the role and what to expect from the nurse care manager. • Reviews potential cost, together they make a call and confirm the service is covered. • Completes a safety check and education on antibiotic use. • Schedules a follow up call in 2 days.
Billing	In-person visit, no assessment by the nurse care manager.

Transition of Care – Office visit

1. **Are there any billing codes that could be submitted at this time?**
2. **How did you come up with your answer?**

This document contains confidential and proprietary information of MI-CCSI and/or its affiliates. Any further copying, reproduction, or distribution outside of MI-CCSI without express written consent is strictly prohibited.

Transition of Care
Case Study – Billing: Follow Up Call

MI-CCSI
Center for Clinical Systems Improvement

Telephone follow up call from the nurse care manager to Mr. Smith	
Care Manager	Calls Mr. Smith and reviews the following: • Safety check on symptoms, medication review and care needs • Starts the assessment by reviewing his behavioral, medical and social needs, past treatment and response to treatment recommendations. • Review of his current treatment plan related to the COPD hospitalization • Confirms his upcoming follow up visit with the provider and ability to get there.
Mr. Smith	Mr. Smith provides the following information: • He is taking his antibiotic – no problems • He does have the appointment but will need assistance with transportation. His son works fulltime and will not be able to take off from work again. He used up his vacation time for the last visit, when he brought Mr. Smith in.

Actions	Nurse care manager:
	• Will send a ticket in to the referral coordinator to arrange transportation. Mr. Smith will hear from her within the next 2 days.
	• The total time for the call with the nurse care manager and Mr. Smith was 35 minutes.
	Referral coordinator:
	• Arranges transportation with the VA
	  • The total time of the call is 10 minutes
	  • Calls Mr. Smith with the arrangements. Total time of the call is 5 minutes

Transition of Care: Follow up and Monitoring

Are there any billing codes that could be submitted at this time?

How did you come up with your answer?

This document contains confidential and proprietary information of MI-CCSI and/or its affiliates. Any further copying, reproduction, or distribution outside of MI-CCSI without express written consent is strictly prohibited.

Transition of Care

Second follow up appointment post-hospitalization	

Mr. Smith	Mr. Smith comes into for his scheduled appointment:
	• The transportation agency picked him up and is waiting for him to transport him home.
	• He meets with the provider
	  • He reports he is going to need oxygen tank, and doesn't know how to do that.
	  • He will need transportation to the pulmonologist visit that is scheduled next week.

Provider	After the provider completes her assessment and evaluation, she sends a note to the referral coordinator to arrange for the transportation and oxygen delivery.
Care manager	After the visit with the NP, the nurse care manager meets with Mr. Smith: • Reviews the referral coordinator is making arrangement for the transportation and oxygen. • Completes the CM assessment and develops a care plan with Mr. Smith. • She let's Mr. Smith know she will review the plan with the NP. If there are any changes, she will call Mr. Smith with the updates.
Referral Coordinator	The referral coordinator: • Calls the transportation agency and arranges transportation to the pulmonologist. • Calls the Oxygen supplier and arranges regularly scheduled delivery.
Billing	The nurse care manager completed the assessment, care plan and plans to review with the provider. The referral nurse spent 10 minutes with the transportation agency. The referral nurse spent 15 minutes with the oxygen supplier. The referral nurse reviewed the plans with Mr. Smith prior to leaving the office. This took 15 minutes.

Patient Centered Medical Home Capability

3.21

- ***Performance reports are generated for the population of patients with: concerns related to social determinants of health, such as transportation limitations, housing instability, interpersonal violence, or food insecurity***

3.24

- ***Performance reports are generated for the population of patients with: Chronic Obstructive Pulmonary Disease (COPD)***
  - The practice must demo how they are using these performance reports to improve population management.
  - Are the relevant measures included in the performance reports?
  - What sort of review is being done with these reports?
  - What actions are taken?

This document contains confidential and proprietary information of MI-CCSI and/or its affiliates. Any further copying, reproduction, or distribution outside of MI-CCSI without express written consent is strictly prohibited.

Transition of Care – Office visit

1. **Are there any billing codes that could be submitted at this time?**
2. **How did you come up with your answer?**

This document contains confidential and proprietary information of MI-CCSI and/or its affiliates. Any further copying, reproduction, or distribution outside of MI-CCSI without express written consent is strictly prohibited.

Transition of Care

Case Study – Billing: Follow up and Monitoring

The care manager has regular follow up calls with Mr. Smith. During each call, she completes a safety check and works with Mr. Smith to empower him in self-managing.

16. **What codes can be used for these follow up and monitoring phone calls?**
17. **What code could be used if Mr. Smith came into the office for the follow up?**
18. **How did you come to this decision?**

This document contains confidential and proprietary information of MI-CCSI and/or its affiliates. Any further copying, reproduction, or distribution outside of MI-CCSI without express written consent is strictly prohibited.

Transition of Care

Case Study – Billing: Closure

Case closure discussion and decision	

Care manager	The nurse care manager:
	• Reviews the stutus of Mr. Smith and the progress he has made with the NP.
	• She reports Mr. Smith understands his diagnosis and has a good handle on what to do when he starts experiencing and how to prevent an exacerbation to include managing:
	  • Fever
	  • Shortness of breath
	  • Pacing himself to conserve energy

Provider	Based on the CM report, the provider agrees it is appropriate for the CM to discharge Mr. Smith from her services
Mr. Smith	During the call with the nurse CM, Mr. Smith feels confident in his self-management and agrees he can manage on his own.
Billing	The CM and provider discussed the case. The CM'er completing a 25-minute call with Mr. Smith

This document contains confidential and proprietary information of MI-CCSI and/or its affiliates. Any further copying, reproduction, or distribution outside of MI-CCSI without express written consent is strictly prohibited.

Day In the Life

Use of the ADT to Identify Patients for PDCM

1. Start each day with reviewing the ADT report for individuals who will require a post-discharge call. This is based on the practices protocol/policy.
2. Review the list with the provider or using a standing order prepare to outreach to the identified individuals. Have available the discharge instructions to review with the patient.
3. After the call, complete the documentation.
4. Review patients who may benefit from PDCM with the care team.
5. Verify PDCM benefits with the patient's health insurance employer plan.
6. Using the practice protocol complete the referral to the PDCM team member.

This document contains confidential and proprietary information of MI-CCSI and/or its affiliates. Any further copying, reproduction, or distribution outside of MI-CCSI without express written consent is strictly prohibited.

MI-CCSI
Center for Clinical Systems Improvement

Q & A

This document contains confidential and proprietary information of MI-CCSI and/or its affiliates. Any further copying, reproduction, or distribution outside of MI-CCSI without express written consent is strictly prohibited.