ATTENDEE HANDOUT

BILLING AND CODING

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BILLING AND CODING TRAINING

AGENDA

	Session	Objectives	Session Materials
7:45	**Welcome (log in)**		
8:00	**Evolution and Use of Codes**	*Review of pre-work and billing codes* • *Health Insurance Basics* • *Code history/linkages to Patient Centered Medical Home* • *PDCM and Support Billing Codes*	• Presentation • PCMH Guidelines • Completed Self-Study Activity • PDCM Code Description page 4-6
9:00	**Code Use Demonstration**	*3 Case Studies - identification of codes through* • *The registry* • *A planned care visit* • *Admission discharge transitions*	• Presentation • PDCM Code Description page 4-6, • Case Studies page 7-9
10:00	**Break**		
10:15	**Case Study (Break Out)**	*Create how a case would look in the practice. Identifying who on the team would be involved, outlining the activities for each of the team members and identifying what code(s) would apply based on the encounter(s).* • *Consider the steps of care management: Identification – assessment – monitoring - closure* • *Applicable codes for the various encounters* • *What outcomes are anticipated*	• Training Application Activity page 10-14 (case study instructions and template) • PDCM Code Description page 4-6.
11:15	**Break**		
11:30	**Case Study (Report Out)**	*Share Findings (each group has a designated Recorder and Presenter)*	• Completed Training Application Activity (completed case study template)
12:00	**Wrap up**	• *Putting it all together* • *Questions* • *Next steps and evaluations*	• Comprehensive Assessment page 15-17 • Post Training Activities page 18-19 • Week in the Life page 20-21
12:30	**Adjourn**		

PDCM Code description and requirements:	BCBSM/BCN specifics:	PH specifics:
Coordinated Care Fee-initial Assessment G9001		
• Individual, face to face-video or in person component (may do over >than 1 contact-but only bill when completed) • Comprehensive-medical, behavioral, psychosocial • Plan of care-self management, • ongoing monitoring, evaluation and adjustment of plan of care as needed	• Who can bill?-Licensed Care Team member • Telephonic- if it is documented why face to face is not possible • Once per day	• Who can bill?-Within Scope of Practice • Once annually
Coordinated Care fee-Maintenance or follow up G9002		
• Individual, face to face-video or in person • Follow up appointment, or • Focused on addressing a portion of the plan of care-not a comprehensive assessment. • Content-substantive to the plan of care • May occur before or after a G9001 • Billed once per day (for >1 team member providing these services-determine who will drop the code)	• Who can bill?-Licensed Care Team Member • Telephonic-if it is documented why face to face is not possible • May quantity bill: 1-45 minutes=1 quantity 46-75 minutes=2 quantity 76-105 minutes=3 quantity 106-135 minutes=4 quantity • May use 2P modifier-payable when contact with patient to discuss the program and the patient declines to enroll in Care Management. Allowed per condition per year. For Commercial PPO only.	• Who can bill?-Within Scope of Practice
Group Education: 98961--2 to 4 patients for 30 minutes | **98962**--5 to 8 patients for 30 minutes		
• Patient=the patient or their designee i.e. guardian, parent • Quantity of 1=30 minutes • Quantity of 2=60 minutes • Curriculum approved by Providers (Provider is not required to attend) • Team members conduct the classes • Documentation is required for each patient i.e. plan of care, progress toward goals, response to class material etc. • HIPAA policies apply	• Who can bill?-Licensed Care Team Member • Telephonic-if it is documented why face to face is not possible	• Who can bill?-Within Scope of Practice

PDCM Code description and requirements:	BCBSM/BCN specifics:	PH specifics:
Counseling and discussion about advanced directives or end of life care planning and decisions with patient S0257		
• Individual face to face, video, telephone • Content-sharing information such as advanced directives, patient advocate etc. Discussion re patient wishes, quality of life etc.	• Who can bill?-Licensed Care Team Member • Providers-MD, DO, NP, PA • Conversations may be with patient or surrogate • One per patient per day	• Who can bill?-Within Scope of Practice • Providers-MD, DO,NP, PA • No Quantity limits
Phone services with patient or caregiver (HIPPA approved) **98966**-5 to 10 minutes | **98967**-11 to 20 minutes | **98968**-21-30 minutes		
• Content-to discuss care issues and progress toward goals-substantive to the plan of care (including addressing gaps for these complex enrolled patients) Not simply administrative tasks i.e. appointment reminders, to report lab results or routine gaps in care calls. • Billed once per day. May add up phone call minutes in a day and bill the code representing all the minutes up to the 98968 21-30 minutes.	• Who can bill?-Licensed and unlicensed Care Team Members • May use 2P modifier-payable when phone call with patient to discuss the program and the patient declines to enroll in Care Management. Allowed per condition per year. For Commercial PPO only.	• Who can bill?-Within Scope of Practice
Care management services (care coordination in medical neighborhood) codes **99487**-31 to 75 minutes per month | **99489**-every additional 30 minutes after 75 minutes per month		
• Billed at end of each calendar month-total of all care coordination call minutes accumulated that month once the minutes meet the threshold minimum number of minutes. • Care Coordination is between Care Team and the Medical neighborhood such as DME company, Community resource, specialist office-not with the patient, patient family or immediate care team. • Challenge-how to keep track of monthly minutes per patient example methods- spreadsheet, through EMR note type, tasked to the biller/coder	• Who can bill?-Licensed and unlicensed Care Team Members • Portal communication-may include minutes representing care coordination and communication between patient and care team members through the portal that is substantive to the plan of care.	• Who can bill?-Within Scope of Practice • Minimum threshold is 60 minutes not 31 minutes (PH does not recognize the CPT 50% rule which sets threshold at 31 minutes)

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PDCM Code description and requirements:	BCBSM/BCN specifics:	PH specifics:
Team Conference Code G9007		
• The team conference meeting must include the provider and at least once other immediate care team member. • Who may bill-MD, DO, NP or PA • Documentation may be done by a care team member as long as it is verified by the provider, and it is the provider who “drops” the billing code. • Once per day regardless of time spent • Content: formal discussion substantive to the patient’s plan of care who is enrolled in care management. Not for patient identification, or brief, routine, unplanned day- to-day communications.		
Physician Coordinated Care Oversight Services (Enrollment fee) G9008		
	• Who may bill?-MD, DO • Once per day-no quantity limit. • Face to face, video or telephonic (does not include email or communication through electronic medical record) • Emphasizes-**Coordinated care by the physician**: billed when Communication occurs for the purpose of consultation with health care professionals not part of the immediate care when consulting about the patient who is engaged in Care Management. Example-paramedic program, specialist, hospitalist. Also, may include conversation between physician and patient when introducing care management services. • May use 2P modifier-payable when contact with patient to discuss the program and the patient declines to enroll in Care Management. Allowed per condition per year. For Commercial PPO only.	• Who may bill?-MD, DO, NP, PA • One time per practice • Face to face or video • Emphasizes-**Oversight services/Enrollment fee**: billed when provider has discussed plan of care with patient, the care team has assessed and discussed the plan of care with the patient and the care team has discussed the plan of care with the provider. All are in agreement with the plan of care.
Liability-Who is responsible to pay?	If the patient does not have the benefit for PDCM codes but was provided and billed for a service, the claim will be rejected, and the patient will incur out of pocket costs. Coverage can be checked in “Availity”	There is a special payment process for some G and CPT care management codes. See Provider manual for specifics.

Last review date:

- BCBSM 11-
- Priority Health 11-

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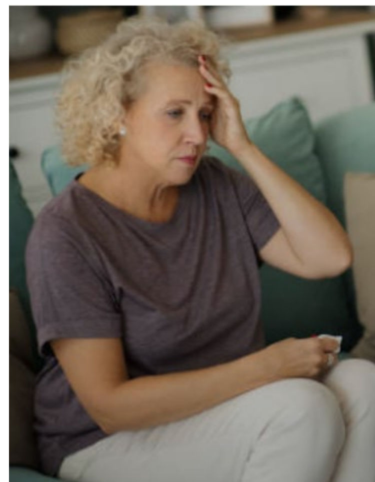

Mary is a 49-year-old woman attributed to the practice. She has a history of depression. Mary was identified as overdue for a PHQ9 through the registry. She has a history of depression and has been under treatment for this. It has been over 12 months since a PHQ9 has been recorded in the medical record. She does not have an upcoming appointment in the next 2 weeks, so an outreach call is scheduled.

Medical/Psychosocial History:

- Diagnosis of heart failure
- Diagnosis of Major Depression with 2 occurrences in the past 8 years
  - No PHQ9 screening for over 1 year

Medication Information:

- Fills antidepressant but is overdue for refill which may indicate she is not taking it as frequently as ordered
- Fills all cardiac medications on time

Specialty Provider:

- Cardiology follow up appointment 9 months ago

Primary Care :

- Last visit 1 year ago
- No hospitalizations or ED visits in the past year

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CASE STUDY – MR. A

Robert is a 65-year-old male patient coming in for a planned visit to follow-up on his HTN.

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 History:

- Retired UAW autoworker (pipefitter)
- Married to Mrs. A for 55 years
- Two married daughters; live within driving distance

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

Medications: Zoloft, Lasix, and Lisinopril

Specialty Providers: Cardiology

Last Visit: Last seen in the clinic 6 months ago

72-year-old male patient that was recently hospitalized

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

Current Status/Situation:

- Discharged from the hospital 1 day ago
- Due for a post-discharge call to assess safety and follow up care plans

Health History:

- Longstanding diagnosis of COPD, until recently, he has been able to manage on his own.
- Sees a pulmonologist for the COPD management. Last visit 9 months ago. Note in the chart indicates he is to schedule an appointment annually.
- Up to date with RSV, Covid, and Pneumovax vaccinations

Medications:

- Long-acting nebulizer/anticholinergic
- Short-acting Beta2-agonist
- Mucolytic for mucus thinning

Social History:

- Lives alone, does have a son who lives in the area and is on the HIPAA form
- Limited income – depends on SS check each month
- Does not drive

Last Office Visit: 3 months ago

TRAINING APPLICATION ACTIVITY

INSTRUCTIONS:

1. You will be assigned to a group and a type of “patient complexity” associated with working with patients in the medical home.

   ~ 5 minutes

A FACILITATOR WILL BE PRESENT TO ANSWER YOUR QUESTION FOR ITEMS 2 AND 3 BELOW.

2. Your group will create a scenario *using the worksheet on page 11.*

   ~ 10 minutes

   MINIMALLY
   - Define patient (age, gender, complexity and condition)
   - Medical history
   - Risk factors

   OPTIMALLY
   - Family history
   - Social history
   - Medications (as needed)
   - Specialty (as needed)

3. Your group will create a case *using the worksheet on pages 12 and 13.*

   ~ 45 minutes

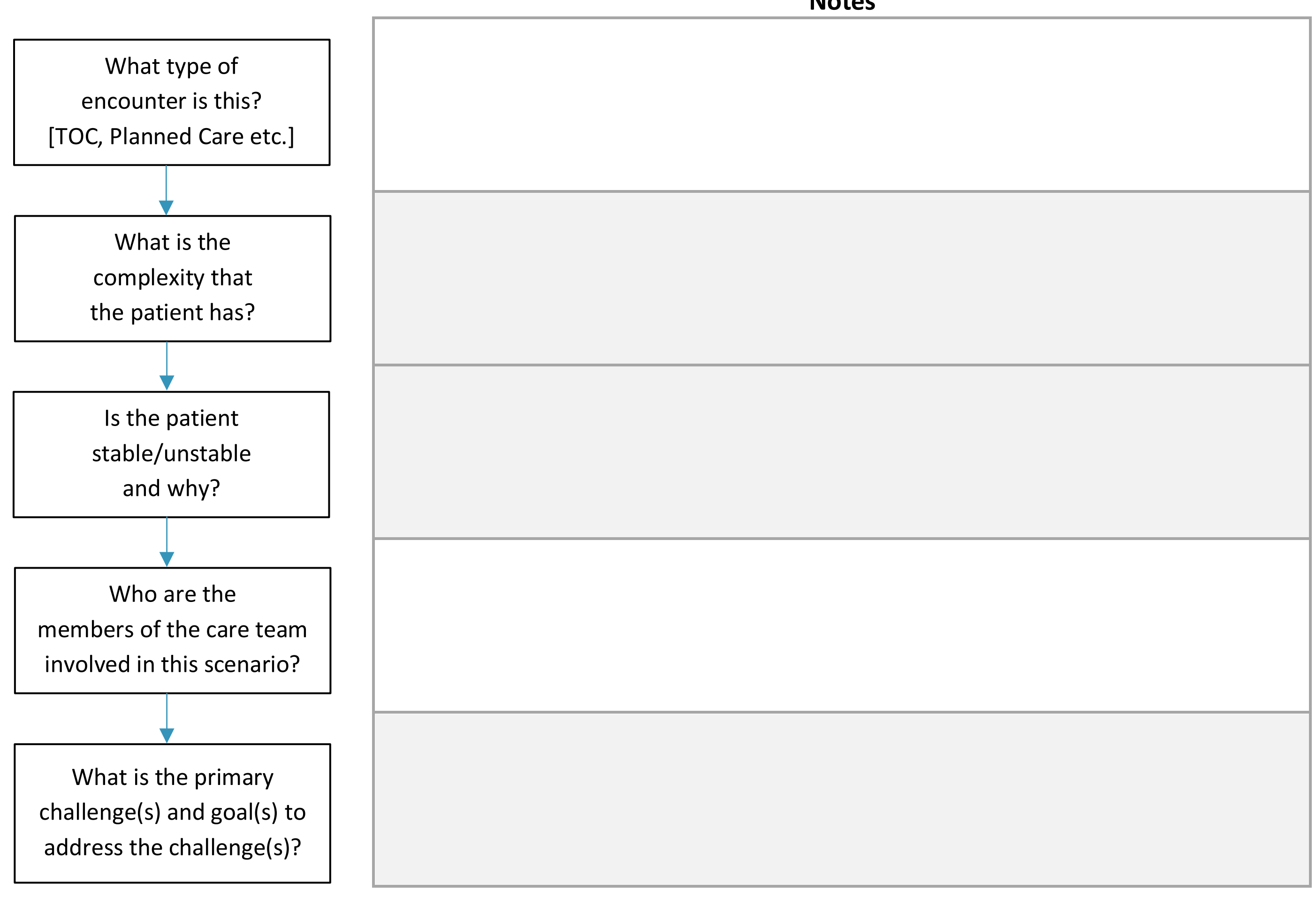
- Define the work entailed for the encounter(s)
- Who the team members will be and their role on supporting this patient
- Pertinent assessment findings based on the encounter
- Actions of the team members
- Follow-up actions of the team and patient
- Identify PCMH capabilities and PDCM codes associated with the work and rationale.

4. Your group will present the case to all.

   ~ 10-15 minutes each group

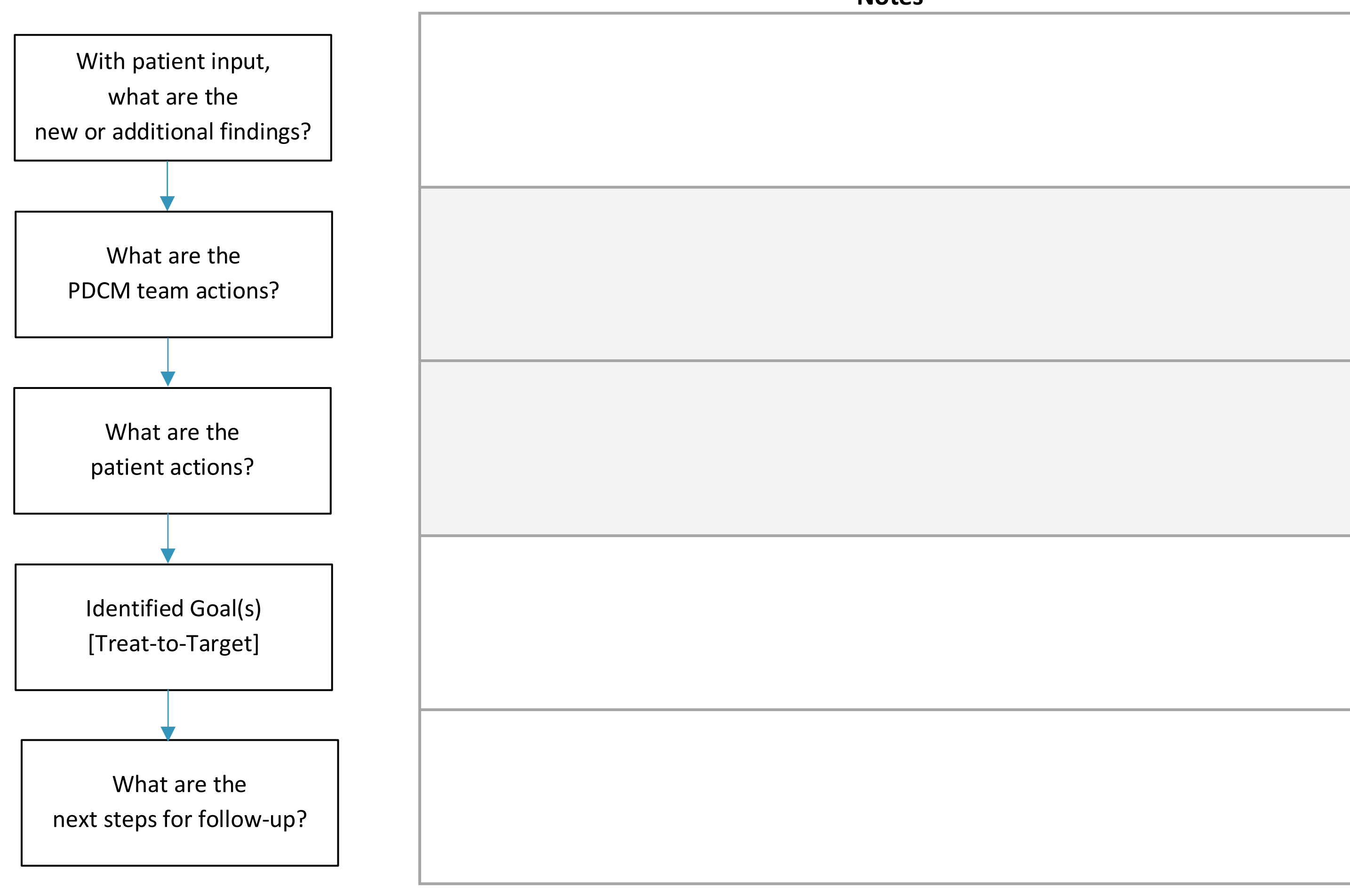
Patient	
Scenario	
Age, ethnicity, gender?	
Complexity requiring PDCM?	
Challenge requiring problem-solving (behavioral, medical, social)?	
Medical *Background / Situation / History*	
Family Medical *Background / Situation / History*	
Social *Challenges / Support*	
Risk Factors	
Current Medications *If applicable*	
Specialty Providers *If applicable*	
Last Visit *and/or* **Hospitalization Date**	

BACKGROUND AND CHALLENGES



Actions/Activity from the Scenario	PCMH Capability	PDCM Code PHCM Codes	Rationale	Total Encounters

INITIAL PATIENT ENCOUNTER (CALL OR IN-PERSON)



Actions/Activity from the Scenario	PCMH Capability	PDCM Code PHCM Codes	Rationale	Total Encounters

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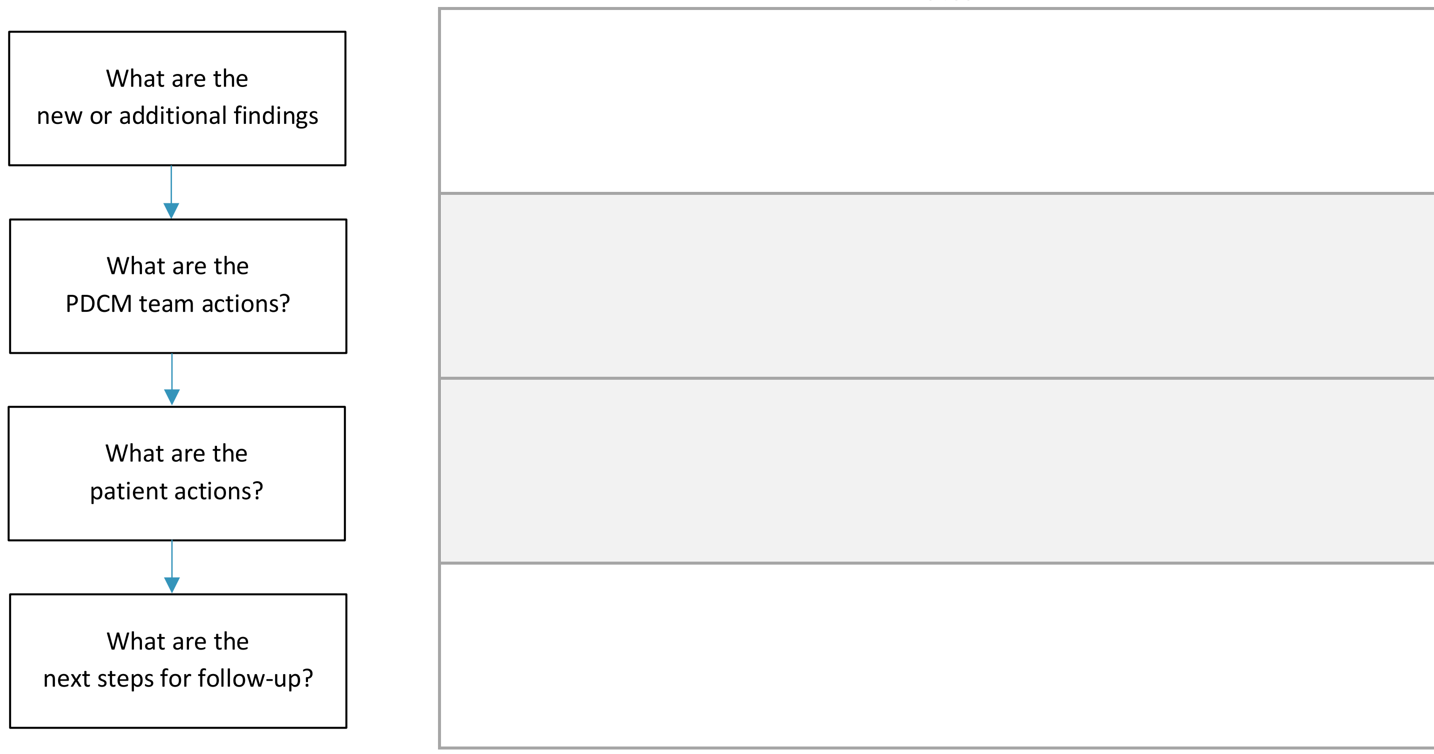
ONGOING PATIENT ENCOUNTER(S) (CALL OR IN-PERSON)



Actions/Activity from the Scenario	PCMH Capability	PDCM Code PHCM Codes	Rationale	Total Encounters

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Patient Demographics

- Full name, date of birth, and gender
- Preferred name
- Marital status/ family
    - Location of family members
- Contact information
- Address
- Insurance details
- Providers involved in care
- Primary language and communication needs
- Pharmacy used
- DME/Equipment Company used
- Advanced Directives completed and on file

Medical History

- Past medical history (chronic illnesses, surgeries, hospitalizations)
- Hospitalization/ER use history

- Family medical history (immediate family members, genetic predisposition)
    - Notable diseases in the family (eg- diabetes, heart disease, cancer)
- Current medical conditions and treatments

- Current medications (including dosages and adherence)
    - Over the counter meds, herbals and holistic treatments
- Allergies (medications, food, environmental)
- Preventive Services for age group completed?
- Immunization status

Health Status Assessment

- Current health status (including vital signs)

- Any deficits: Ability to hear/see- do they use assistive devices?
    - Last hearing check
    - Last eye exam

- Functional status (mobility, gait, transfer ability, activities of daily living)
    - Assistive device use?
- Cognitive function (memory, problem-solving skills)
- Mental health assessment (screen for mood/depression, anxiety)
- Pain assessment and management
- Fall risk/home safety assessment
- DME/equipment supplies use at home?
- **Review of Systems (ROS) if appropriate:**
    - Comprehensive inquiry into each body system to identify potential issues.

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Social Determinants of Health

- Socioeconomic status (employment, education)
- Occupation and work environment (exposure history)
- Education and Literacy level
- Where does the patient live? (community, safety etc)
- Access to healthcare
- Access to food/groceries
- Living situation (alone, with family, in a facility)
- Support systems (family, friends, community resources)
- Access to transportation and healthcare services

Lifestyle and Behavioral Factors

- Nutrition and diet habits
- Physical activity levels
- Substance use (smoking, vaping, alcohol, drugs)
- Sleep patterns and quality
- Occupation and work environment (exposure history)
- Travel history
- Living situation (alone, with family, assisted living)
- Support systems (friends, family, community resources)

Personal Goals and Preferences

- Patient's health goals and priorities
- Preferences for treatment and care approaches
- Advance care planning and end-of-life wishes

Care Coordination Needs

- Current care providers and specialists involved
- Need for referrals to other services (e.g., physical therapy, social work)
- Patient education and self-management support

Cultural and Spiritual Considerations

- Cultural beliefs and practices that may impact care
- Sensitivity to language and communication barriers
- **Spiritual Needs:** Exploration of spiritual beliefs and their impact on the patient's health and care preferences.

Patient and Family Education

- Understand patient's learning needs and preferences.
- What do they currently know/or how are they managing their current medical problems?
- Provide relevant education on health promotion, disease prevention, and self-management.

If Part of Role:

Physical Assessment

- **Vital Signs:** blood pressure, heart rate, respiratory rate, temperature, oxygen saturation
- **Head-to-Toe Examination:**
    - Inspection (appearance, posture, hygiene)
    - Palpation (tenderness, temperature)
    - Auscultation (heart and lung sounds)
    - Percussion (if applicable)
- Assess areas such as skin, eyes, ears, nose, throat, abdomen, extremities, and neurological function

Comprehensive Plan of Care

- Develop a personalized care plan based on assessment findings
- Set measurable goals and objectives
- Identify interventions and resources needed for patient success

Carolyn Jarvis's comprehensive nursing assessment model emphasizes a thorough, systematic approach to assessing patients in both physical and holistic dimensions. Regular use of this framework helps ensure that nurses capture essential information, facilitating effective diagnosis, care planning, and patient-centered care.

Reference:

Jarvis, C. (2020). PHYSICAL EXAMINATION AND HEALTH ASSESSMENT (8th ed.). Elsevier.

POST TRAINING ACTIVITY

Below are recommended activities to support you post training. The column # refers to the column in the worksheet on the next page.

WEEKS 1-3

☐ 1. ***IDENTIFY THE BILLING AND CODING STAFF*** responsible for submitting billing codes

☐ 2. ***DETERMINE IF YOUR LEADERSHIP HAS PROVIDED INFORMATION AND WORKFLOWS*** for submission of PDCM CM Codes

- *If not, set up a meeting to review the codes and identify any challenges or barriers to process the codes*

☐ 3. ***TRACK YOUR ACTIVITY OVER A 1 WEEK PERIOD***

- *Identify the activities that are attributed to PDCM* - COLUMN 1
- *Of the activities aligned/attributed with PDCM, how many codes were submitted for processing?* - COLUMN 2
- *Review the activities for any missed opportunities.* - COLUMN 3
- *If there additional work/documentation you could do in the future to meet the billing code requirements?* - COLUMN 4

WEEK 4-6

☐ 4. ***HOW MANY OF THE BILLING CODES YOU SUBMITTED FOR PROCESSING WERE SENT TO THE PAYER*** from the billing/coding department? COLUMN 5

- *If there are codes that did not get submitted, schedule a meeting with the billing department to identify and problem-solve any discrepancies.*

WEEKS 7-8

☐ 5. Meet with the billing department/organization to ***REVIEW ANY DENIALS FROM THE SUBMITTED CODES***. - COLUMN 6

- **Discuss the reasons. Does there need to be documentation changes?** - COLUMN 7

☐ 6. ***REVIEW THE PCMH-N INTERPRETIVE GUIDELINES WORKSHEET*** you completed during the self-study.

- **Any additions you would add to the worksheet? Was the correct code submitted?**

☐ 7. Arrange an appointment with your manager to ***DISCUSS HOW YOUR ROLE AND OTHERS ON THE TEAM ARE COLLABORATING TO STRENGTHEN A PATIENT-CENTERED APPROACH*** that meets the capabilities of the PCMH N-Interpretive guidelines.

- **Are there any activities that the team could strategically formulate a plan and goals to expand the capabilities further?** Added diseases/conditions, protocol/policies, workflows?
- **What additional processes or training would be needed to get to the plan goals?**

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Date post work started ______________________

Who are the staff responsible for submitting billing codes? ______________________

Do you have information and workflows for submission of PDCM CM Codes? ☐ Yes ☐ No

WEEKS 1-3				***WEEKS*** 4-6	WEEKS 7-8	
1 ***Activities attributed to PDCM (1 week period)***	***2*** ***# Codes submitted for processing***	***3*** ***# Missed opportunities***	***4*** ***Additional work or documentation to meet code in future?***	***5*** ***# Codes submitted to payer***	***6*** ***# Codes denied by payer***	***7*** ***Reasons for Denial***

Notes:

A "WEEK" IN THE LIFE – GETTING STARTED WITH CARE MANAGEMENT

HOW DO I FIND PATIENTS?

- Health plan lists
- Gap in care registry
- Admit/discharge list
- Provider / Care Team
- Specialty offices

CHRONIC DISEASE! SOMETHING FOR EVERYONE.

	Newly Diagnosed • Counseling • Referrals • Education
	Gaps in Care • Disease specific • Specialty Care
	Not at Target • Obesity/BMI • LDL/Cholesterol • BP/HTN • A1C/Diabetes • Multiple Co-Morbidities
	Transition Management • ER Follow-Up • Post Hospitalization

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<table>
<tr><th></th><th>Monday</th><th>Tuesday</th><th>Wednesday</th><th>Thursday</th><th>Friday</th></tr>
<tr><td>8:00 AM- 9:00 AM</td><td>Weekly Clinic Team Meeting- review weekly schedule; high risk patients, patient care updates</td><td>Huddle/Team Conferences</td><td>Huddle/Team Care Conferences
On high- risk patients</td><td colspan="2">Review Cases for Upcoming Week: Create schedule of patients who would benefit and discuss with provider.
GAPS report
Provider Schedule</td></tr>
<tr><td>9:00 AM- 12:00 PM:
• Case Finding
• Assessment</td><td>Patient Follow-Up Calls
ADT List - TOC Calls
Call High Risk patients tucked in for the weekend</td><td colspan="4">Patient Follow-Up Calls
ADT List for TOC Calls</td></tr>
<tr><td></td><td colspan="5">Medication Reconciliation
Review medication lists for patients scheduled for upcoming visits, reconciling any discrepancies and ensuring they align with treatment plans.</td></tr>
<tr><td></td><td colspan="5">Care Coordination
Work with a patient diagnosed with multiple chronic illnesses to coordinate care among different specialists, ensuring all providers are aligned in treatment and follow-up.</td></tr>
<tr><td></td><td colspan="5">Community Outreach Calls
Follow up with community partners to assess the impact and reach of collaborative programs designed to improve patient outcomes.</td></tr>
<tr><td>10:00 am- 12:00PM</td><td></td><td></td><td>New Patient Appointments</td><td></td><td>Administrative Tasks
Review & respond to emails, update patient records, and prepare for the next week's appointments and workshops.</td></tr>
<tr><td>1:00 PM- 5:30 PM
• Assessment
• Care Coordination
• Care Planning
• Implementation
• Monitoring
• Evaluation</td><td colspan="3">Patient Appointments
Meet with patients to provide one-on-one education on medication management and lifestyle changes based on their specific health needs.</td><td>New Patient Appointments</td><td>Touch Base Calls for High -Risk patients to "tuck in" for the weekend</td></tr>
<tr><td></td><td colspan="5">Care Coordination
Work with a patient diagnosed with multiple chronic illnesses to coordinate care among different specialists, ensuring all providers are aligned in treatment and follow-up.</td></tr>
<tr><td></td><td colspan="5">Community Outreach Calls
Follow up with community partners to assess the impact and reach of collaborative programs designed to improve patient outcomes.</td></tr>
<tr><td>6:00pm- 9:00PM</td><td></td><td></td><td>Group Education Visits (Monthly)</td><td></td><td></td></tr>
</table>