# PDCM Billing Linkages to Patient Centered Medical Home Neighborhood (PCMH-N)

### Instructions:

In this Self-Study Module, you will

1. Complete the *Basics of Insurance* learning module

2. Complete the *Foundational CM Codes and Billing Opportunities* learning module

3. The following activity as part of the Foundational CM Codes and Billing Opportunities learning module

### Self Study Activity:

The tables below contains the PCMH Domain and Domain Goal. It also contains columns How the Capabilities fit into the PDCM role and Where there would be potential for PDCM billing code use.

1.Review Table 1 which is prepopulated for Domains 2.0, 9.0, and 3.0.

2.Complete Table 2 which contains Domains 4.0, 11.0, 13.0, and 10.0.

**Table 1**

| **Domain** | **Goal** | **HOW the capabilities fit into the PDCM role.** | **WHERE there would be potential for PDCM billing code use.** |
| --- | --- | --- | --- |
| 2.0  Patient Registry | Enable providers to manage their patients both at the population level and at point of care through use of a comprehensive patient registry. A paper or electronic all-payer registry is being used to manage all established patients in the Practice Unit for diabetes or relevant chronic conditions alongside preventative screening) | A care team member within the practice/organization regularly conducts the “population level” reporting. The practice/organization would use a registry report to identify patients in the practice who are out-of-scope within the evidence-based quality metrics (based on evidence-care guidelines) for the condition(s) they selected based on the practice goals. With a diagnosis of diabetes, the fields of the report would include HEDIS measures: A1C, Eye Exam, Urine Protein, and Blood Pressure. For patients with out-of-scope measures, a care team member may refer patients to PDCM services. | * None |
| 9.0  Preventive Services | Primary prevention program is in place that focuses on identifying and educating patients about personal health behaviors to reduce their risk of disease and injury. Actively screens, educates, and counsels patients on preventive care and health behaviors. | Example:  A nurse care manager works with a patient to address education, social supports and behavioral challenges. The nurse care manager reviews the patients gaps in care and notes the patient is due for a wellness visit, mammogram, and colonoscopy. While supporting the patient with services to problem-solve and resolve the identified challenge, the care team member would also address any gaps related to preventive care. | Billable service opportunities:   * Patient is established with PDCM care management, an assessment is completed and there is a plan of care in place. * While managing the complexities of the diabetes, the nurse care manager takes the opportunity to address the preventive needs with the patient and includes this in the care plan. * PDCM nurse care manager outreaches to the patient to review the plan of care and reminds the patient she is due for the preventive services. |
| 3.0  Performance Reporting | All-patient/payer reports enable POs and providers to monitor their population level performance over time, close gaps in care, and improve patient outcomes. Reports that allow tracking and comparison of results at a specific point in time across the population of patients are generated for diabetes or relevant patient populations. | Care manager identifies the “treat-to-target” measures and apply those that are out-of-scope to the plan of care. Over time, the care manager monitors outcomes to determine the trends towards improvement. This will inform the care manager and provider on the impact of the care plan. | Billable opportunities:   * Monitoring the performance report measures for treat-to target goals.   + Use of PDCM phone codes or in-person/video codes. |

Table 2

| **Domain** | **Goal** | **HOW the capabilities fit into the PDCM role.** | **WHERE there would be potential for PDCM billing code use.** |
| --- | --- | --- | --- |
| 4.0  Individual Care Management | **Patients receive organized,** **planned care** that empowers them to take greater responsibility for their health. The practice uses an integrated team of interprofessional providers with a systematic approach for delivering care to all patients. | Planned Visits are offered to patients with chronic conditions and Group Visit option is available for conditions prevalent in practice’s patient population. Patient case reviews for medically complex patients (comprehensive care plans).  Coordinated services, appointment tracking/reminders, follow-up, med review and management (on every visit for conditions requiring management). Written action plans and goal setting (patients with chronic conditions or other complex health care needs). And signed advance care plan with each patient who wishes to do so. Written survivorship plan once treatment is completed.  Inform patients who would benefit from care management services based on clinical conditions and ED, inpatient, and other service use. Ensure patient receive palliative care services as needed. |  |
| 11.0  Self-management | Systematic approach to **empowering patients to understand their central role** in effectively managing their illness, making informed decisions about care, and engaging in healthy behaviors. |  |  |
| 13.0  Care Coordination | 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. |  |  |
| 10.0  Community Linkages | Expand the PCMH-Neighborhood to include **community resources** into patients’ care plans and assist patients in accessing community services. |  |  |

*Reference: BCBSM Physician Group Incentive Program Patient-Centered Medical Home and Patient-Centered Medical Home-Neighbor Interpretive Guidelines 2023-2024*