Foundational Care Management Codes & Billing Opportunities

Welcome!!!

Housekeeping

Virtual Etiquette

Meeting participation:

We will be using the raise your hand feature by clicking on the little blue hand.

We will be using chat function

When we are taking breaks be sure not to leave the meeting but rather mute your audio and video

Environment:

Be aware of your backgrounds to not be distracting

Position yourself in the light

Successful Completion Requirements

- Attend the entire course, in person or live virtual

Attendance Criteria:

- If the learner misses > 30 minutes; the learner will not be counted as " attended" and will need to retake the course.
- If the learner misses <30 minutes; the learner will be counted as "attended". The learner will need to review the missed course content located here: https://micmt-cares.org/training
- If course is virtual – must attend by audio and video/internet.

Complete the Michigan Institute for Care Management and Transformation (MICMT) post-test and evaluation.

- Achieving a passing score on the post-test of 80% or greater. If needed, you may re-take.

Please take the post test within 5 days for credits!

Foundational Care Management Codes & Billing Opportunities

The nurse planner, content experts', faculty, and others in control of content have no relevant financial relationships with ineligible companies.

Successful completion of the Foundational Care Management Codes and Billing Opportunities course includes:

- Attendance at the entire session
- Completion of the course post test **within 5 business days post live event:** need to have a score of 80% or greater on the post-test
- Completion of the course evaluation **within 5 business days post live event**

Nursing:

- Upon successful completion of the Foundational Care Management Codes and Billing Opportunities the participant will earn 3.5 Nursing CE contact hour.
- Michigan Institute for Care Management and Transformation is approved as a provider of nursing continuing professional development by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. (OBN-001-91)

Social Work:

- Upon successful completion of the Foundational Care Management Codes and Billing Opportunities participants will earn 3.5 Social Work CE contact hours
- Michigan Institute for Care Management and Transformation is an approved provider with the Michigan Social Work Continuing Education Collaborative. Approved provider Number: MICEC 110216.

Billers/Coders:

- Upon successful completion of the Foundational Care Management Codes and Billing Opportunities the participant will earn 3.5 continuing education hours, American Academy of Professional Coders.

Curriculum development in partnership with

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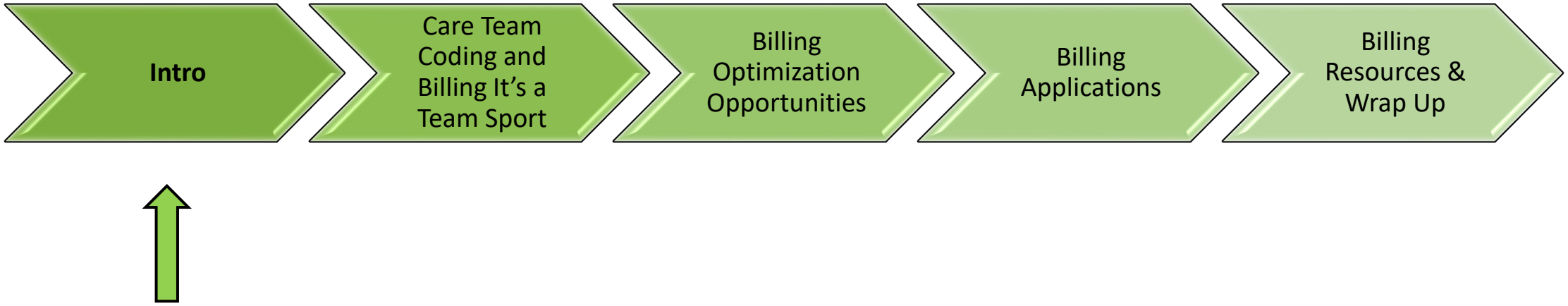
- Ruth Clark, Integrated Health Partners
- Ewa Matuszewski, MedNetOne & PTI
- Erika Perpich, Olympia Medical
- Anavia Mitchell, Olympia Medical

Reference Guidelines

- Please provide the following as an appropriate reference if you use this material: “Material based off of the Foundational Care Management Codes & Billing Opportunities course developed through a collaborative effort facilitated by Michigan Institute for Care Management and Transformation and participating Training Organizations.”
- Questions about using or replicating this curriculum should be sent to: https://micmt-cares.org/contact

- Please follow this link if you are interested in becoming an approved trainer for this curriculum: https://micmt-cares.org/contact

Agenda


Intro
Care Team Coding and Billing It's a Team Sport
Billing Optimization Opportunities
Billing Applications
Billing Resources & Wrap Up

Introductions

- Your name
- Your discipline
- Your practice location
- How long have you been in your role?
- What’s most important for you to learn today?

Learning Objectives and Learning Outcome

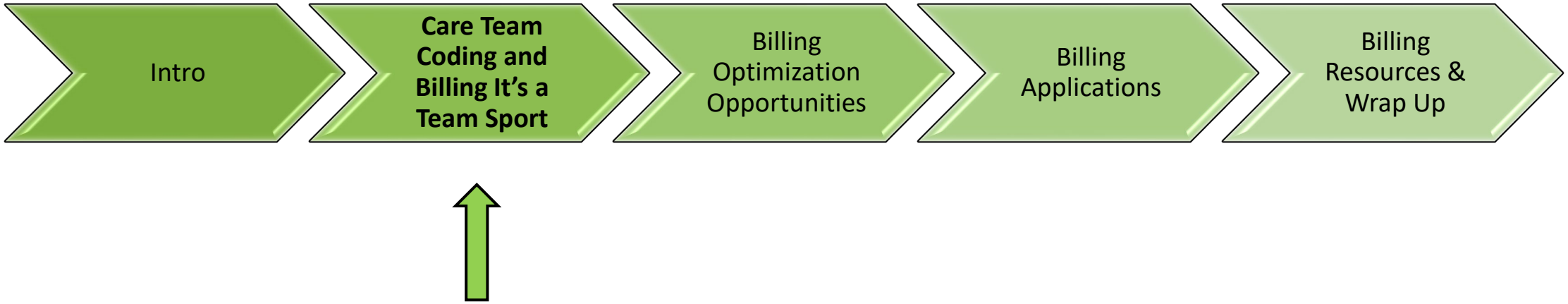
Learning Objective

- Identify members of a care team
- Define health care coding and health care billing
- Describe the two common health care coding classification systems
- Explain the importance of documenting the encounter
- Illustrate how a care team may impact risk adjustment and the financial model of a practice

Learning Outcome

- Participants can describe how documentation of the encounter, billing the encounter and utilizing the care team procedure codes contributes to successful team-based care and supports value-based reimbursement.

Agenda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Setting the Foundation

“The primary goal of medical teamwork is to optimize the timely and effective use of information, skills, and resources by teams of health care professionals for the purpose of enhancing the quality and safety of patient care”.

~Agency for Healthcare Research in Quality (AHRQ)

Team-Based Care - What Does it Take?

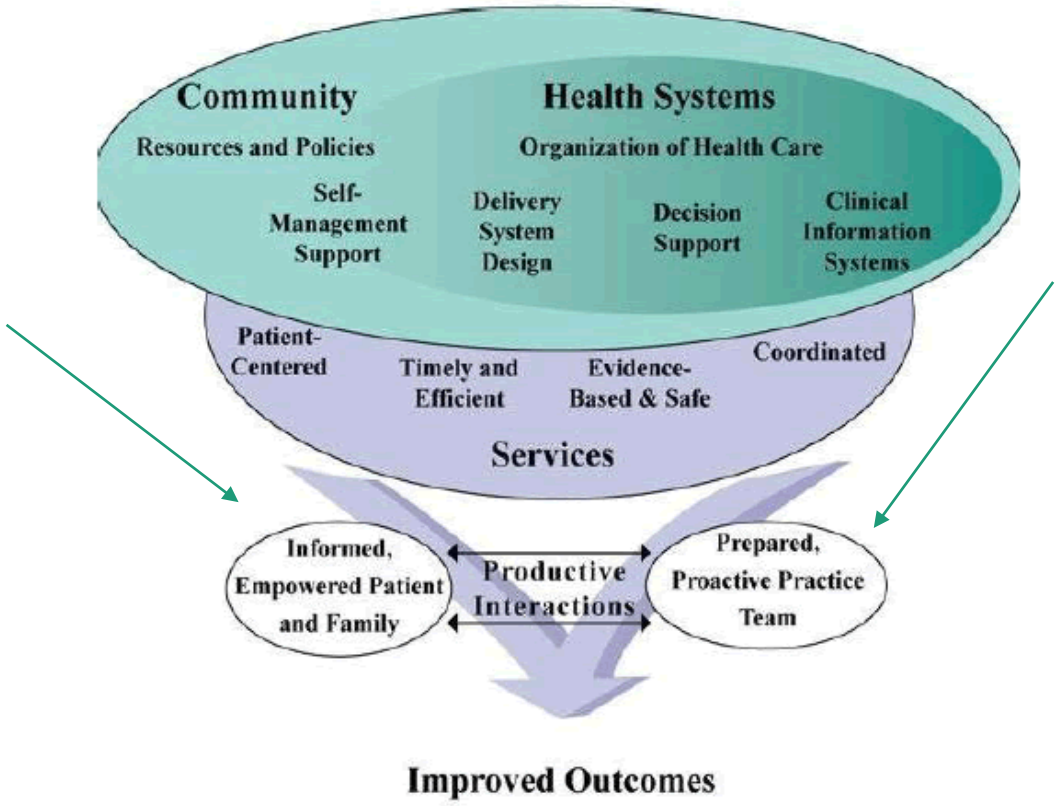
- Holistic, person-focused and family-centered approach to health including behavioral, social and physical aspects
- Care coordination across settings and organizations
- A common set of quality outcome metrics
- Reimbursement for care management services, care coordination
  - Shift from fee-for-service to value-based reimbursement
  - Billing the encounters contributes to successful value-based reimbursement

Care Team Coding and Billing It's a Team Sport

- Identify members of a care team
- Define health care coding and health care billing
- Describe the two common health care coding classification systems
- Explain the importance of documenting the encounter
- Illustrate how a care team member may impact risk adjustment and the financial model of a practice

Productive Interactions, Outcomes, and Sustainability

Many productive interactions with patients will lead to improved outcomes that can be measured at a *population level*



Productive interactions are *billable* interactions, which support the sustainability of the care management program through payments and successful incentive program participation

Fact Finding…

- What is your most pressing issue/question about coding and billing?
- What don’t you know about coding and billing?
- What concerns you about coding and billing?
- What do you know about the electronic health record (EHR) and the payment management system (PMS) you’ll be using and why is it important?
- Receptionist, biller and coder: friends or foes??

Care Team Member:

- Physician, Advanced Practice Providers (APP), Registered Nurse (RN), Pharmacist (PharmD), Master Social Worker(MSW), Registered Dietician (RD), and Certified Diabetic Educator (CDE)

- Virtual, telephonic and in-person visits:
  - Create individualized care plans
  - Identify barriers
  - Engage in care coordination activities
  - Provide health education and coaching
  - Catalog community resources
  - Oversee disease management activities
  - Communicate in between visits

- Federal Government beneficiaries – documentation of approval for care management is required at start of care

Care Team Member: Front Desk Staff or Scheduler

- Captures patient demographics
- Reviews current insurance information
- Verifies eligibility and benefits
  - Contract is effective
  - Care team services are a benefit
  - **Source of truth** for eligibility: webDenis **plus** care management exclusion list; monthly list is to help identify risk only
- Determines financial responsibility BEFORE the visit
- Sets financial expectations

Care Team Member: Unlicensed Professionals Medical Assistant (MA) & Community Health Worker (CHW)

- **BCBSM**: The care team is comprised of any health care or behavioral health professional the provider believes is qualified to serve on the care team.
  - Unlicensed professionals must work under a written protocol or standing orders signed by the physician or APP.
    - *Example*: Scope of service
  - Unlicensed care team members support licensed care team members through implementation of specific aspects of care plan, self-management support and follow-up, care coordination with other health care organizations, etc.
- **Priority Health:** The care team is comprised of PH designated qualified health professionals (QHPs)

Introducing a New Care Team Member

New Care Team Member: Coder

- Transforms the diagnosis and treatment provided into an appropriate numeric or alphanumeric code
- Liaison between the healthcare team and billing activities
- Proper procedure (CPT/HCPCS) and diagnosis (ICD-10) coding is critical for obtaining appropriate payment and ensuring proper compliance with the law

Define Coding

- Health care ***coding*** involves extracting billable information from the health care record after reviewing clinical documentation
- Health care ***billing*** uses codes to create insurance claims and bills for patients
- Health care ***claims*** is where health care billing and coding intersect to form the backbone of the practice's revenue

Roles and Responsibilities of the Biller & Coder

- Relies on front end activities to ensure clean claims
- Relies on electronic claim scrubbers
- Monitors lag time of charge entry
- Reviews claims submitted
- Ensures electronic remittance posting
- Pays close attention to adjustments- coded correctly.
- Denial management –
  - Develops experts with tiered levels of sophistication
  - Measures denial percentages
- Monitors aged trial balance
- Sends patient statements and conducts patient collections
- Adheres to key performance indicators (KPI) and benchmarking

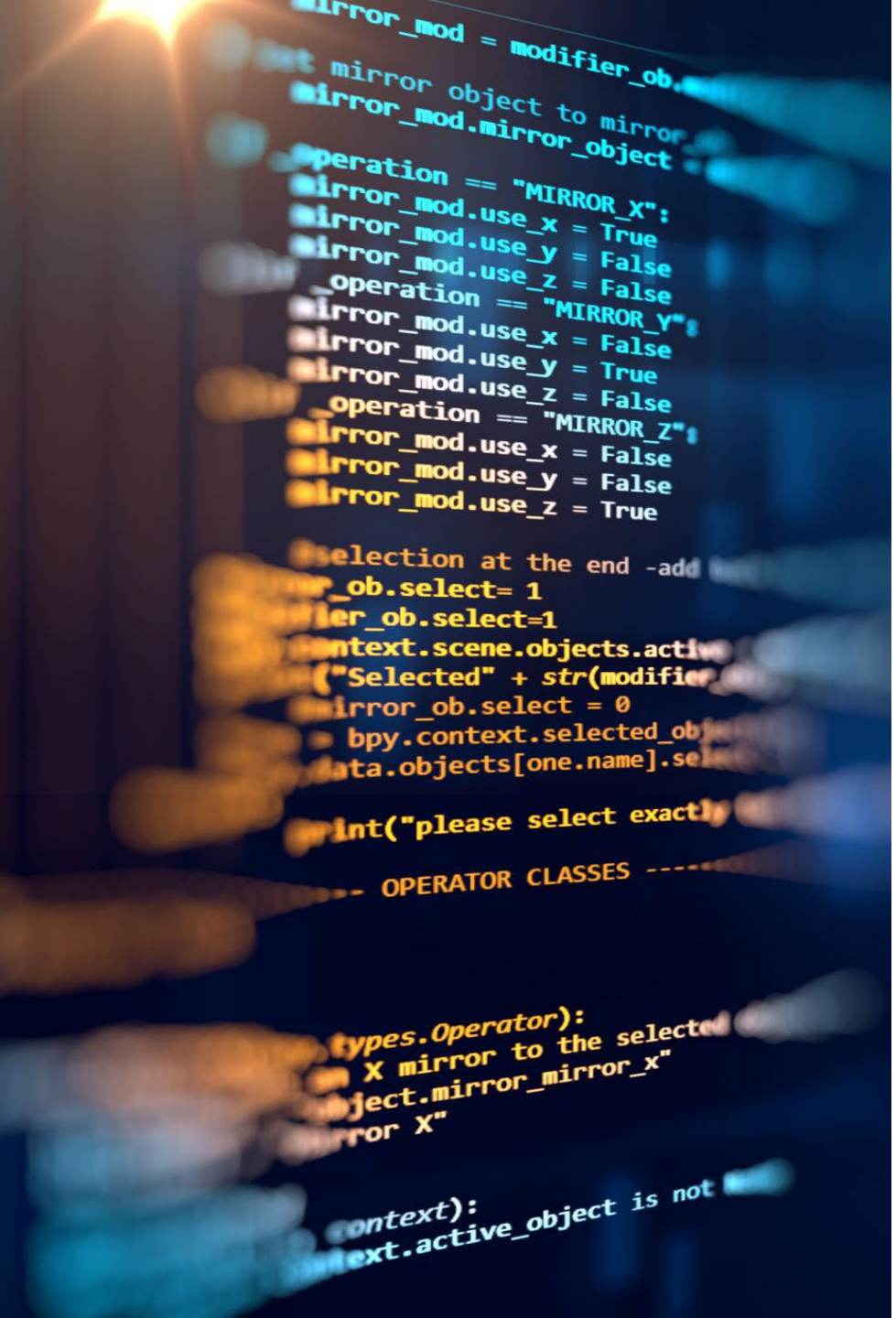
Questions for the Care Team

- Do all the care team members understand the significance of the CPT, ICD-10 and PDCM Codes?
- Do care team members engage in chart reviews?
- What is the purpose of a chart review?
- Do the care team members have a vested interest in coding correctly or is it “not my problem?”

Close Encounters of the Coding Kind

Trigger for Coding and Billing: Clinical Documentation

- Clinical Documentation Improvement (CDI) – is a process that continually looks for ways to best maximize the health care record integrity with the goal of providing a complete and accurate picture of a patient's condition(s) and the care services they receive most often specific to the setting where services were provided.



Let's Start with the Basics…

- What does "coding" mean to you?
- What does "billing" mean to you?

CPT Code Overview

- The Current Procedural Terminology (CPT®) codes offer health care professionals a uniform language for coding procedures to streamline reporting, increase accuracy and efficiency.

- CPT® Codes are used for administrative management purposes such as claims processing and data extraction

Types of Codes

ICD-10: International Classification of Disease version 10

CPT: Current Procedure Terminology, document the mental health, medical, and surgical procedures

HCPCS: Healthcare Common Procedure Coding System Level II (Supplies and products not directly related to providers such as ambulance services, drugs, etc..)

Billing and Coding Chain of Accountability

Physician

Advanced Practice Practitioner (APP)

Care Team Member

Biller and Coder

Why Code?

- Provide evidence for health care services rendered
- Track potential public health threats (such as COVID-19, influenza, lead poisoning, etc.)
- Measure quality of care
- Evaluate utilization of resources
- Exchange health data with other organizations including government agencies
- Drive program sustainability through accurate coding capture and billing

ICD- 10 Overview

21 Chapters of the ICD-10-CM

A00-B99 Certain Infections & Parasitic Diseases	L00-L99 Diseases of the Skin & Subcutaneous Tissue
C00-D49 Neoplasms	M00-M99 Diseases of the Musculoskeletal System
D50-D89 Diseases of the Blood & Blood-forming Organs & Certain Disorders involving Organs & Certain Disorders involving the Immune Mechanism	N00-N99 Diseases of the Genitourinary System
E00-E89 Endocrine, Nutritional & Metabolic Diseases	O00-O9a Pregnancy childbirth & the Puerperium
F01-F99 Mental & Behavioral Disorders	P00-P96 Certain Conditions Originating in the Perinatal Period
G00-G99 Diseases of the Nervous System	Q00-Q99 Congenital Malformations, Deformations & Chromosomal Abnormalities
H00-H59 Diseases of the Eye & Adnexa	R00-R99 Symptoms, Signs & Abnormal Clinical & Laboratory Findings, Not elsewhere Classified
H60-H95 Diseases of the Ear and Mastoid Process	S00-T88 Injury, Poisoning & Certain Other Consequences of External Causes
I00-I99 Diseases of the Circulatory System	V00-Y99 External Causes of Morbidity
J00-J99 Diseases of the Respiratory System	Z00-Z99 Factors Influencing Health Status & Contact With Health Services
K00-K94 Diseases of the Digestive System	

The Medical Management Institute

ICD-10 and Hierarchy of Chronic Conditions

- Facts about ICD- 10
  - 70,000 + ICD 10 Diagnosis Codes
  - 805 Disease Groups
  - 189 Condition Categories
  - 86 Hierarchical Condition Categories (HCCs)

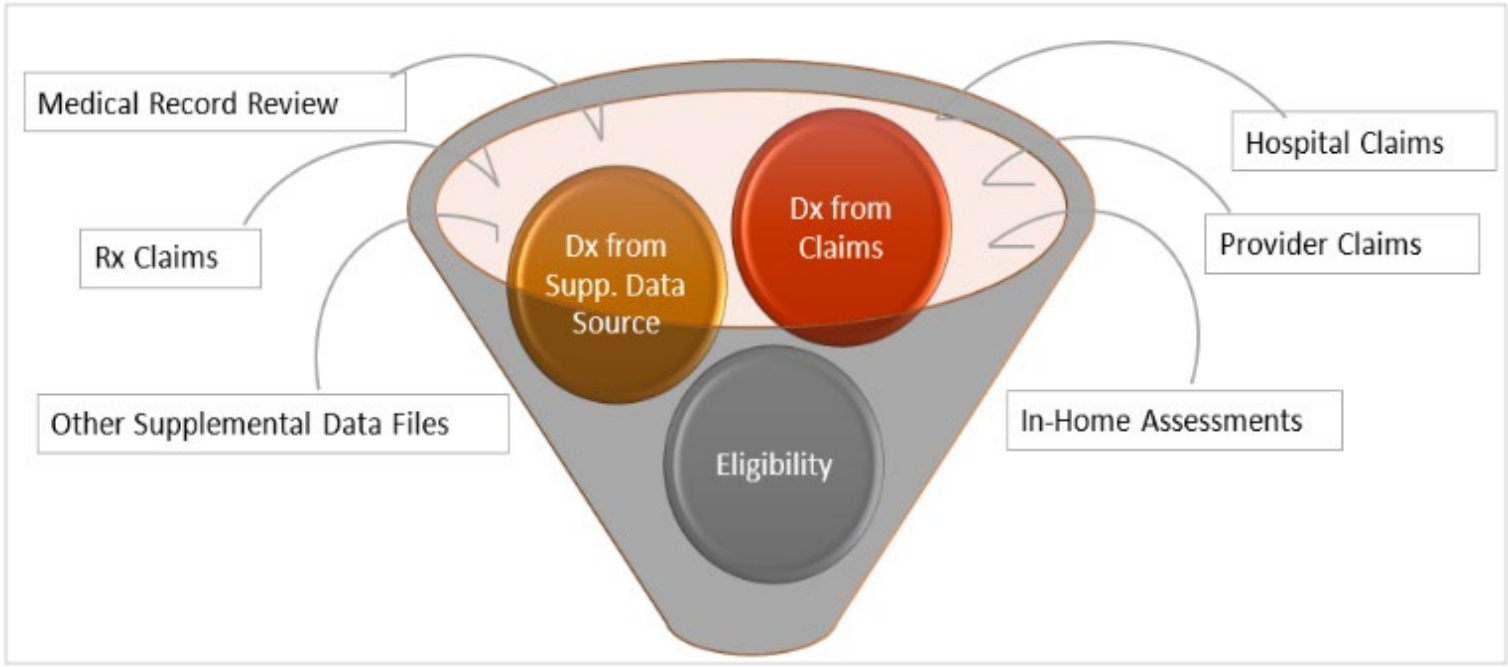
Coding for Specificity: ICD-10

Drill Down to Specifics

- Documentation should be as specific as possible
- Specific documentation and coding guidelines are mandated by **HIPAA**.

If you mean.....	Don't say.....
Chronic obstructive asthma with acute exacerbation	COPD
Hypertensive heart disease with heart failure	Heart failure/Hypertension
Lung cancer with metastasis to liver	Lung cancer
Alcohol Dependence	Alcohol abuse
Dominant side hemiplegia due to CVA	History of CVA Hemiplegia

Risk Score Calculation



HCC: Diabetes Care

TIPS:	ICD-10 Mapping & Education
➢ **ICD-10-CM**	E08 – E13 code series (Diabetes) O24 code series (Diabetes in Pregnancy)
➢ **Documentation should specify**	o Type of DM (Type 1, Type 2, Other) o Complication/manifestation affecting body system
➢ **Secondary diabetes (E08- series)**	Code first any underlying conditions, code second the type of diabetes: o Congenital rubella *(P35.0)* o Cystic fibrosis *(E84.-)* o Malnutrition *(E40-E46)* o Cushing's Syndrome *(E24.-)* o Malignant neoplasm *(C00-C96)* o Diseases of the pancreas *(K85.-, K86.-)* Example: *Secondary DM due to pancreatic malignancy (C25.9 + E08.9)*
➢ **Cause and effect relationship…**	State any relationship between DM and another condition such as: o *Diabetic* coma o Neuropathy *due to* diabetes o Gastroparesis *secondary to* diabetes o Foot ulcer *associated with* diabetes Example: *Diabetic retinopathy with macular edema (E11.311)* **Note: When type of diabetes is not documented, default to category E11 (type 2).*
➢ **Use additional code…**	… to identify: o Site of any ulcers *(L97.1-L97.9, L89.41-L98.49)* o Stage of chronic kidney disease *(N18.1-N18.6)* o Glaucoma *(H40-H42)*
➢ **Controlling Diabetes**	… be sure to add: o Long-term insulin use *(Z79.4)* o Oral antidiabetic drugs *(Z79.84)* or Oral hypoglycemic drugs *(Z79.84)*

HEDIS and Diabetes

Diabetes Care

Measure demonstrates the % of members ages 18-75 with diabetes (types 1 & 2) who were compliant.

HbA1c Test: is completed at least once per year (includes rapid A1c).

CPT	HCPCS
83036, 83037	—

Type 1	Type 2	Other	Description
E10.1-	E11.1-	E13.1-	DM with ketoacidosis
E10.2-	E11.2-	E13.2-	DM w/kidney complications
E10.3-	E11.3-	E13.3-	DM w/ophthalmic complications
E10.4-	E11.4-	E13.4-	DM w/neurological complications
E10.5-	E11.5-	E13.5-	DM w/circulatory complications
E10.6-	E11.6-	E13.6-	DM w/other specified complications
E10.8-	E11.8-	E13.8-	DM w/other specified complications
E10.9-	E11.9-	E13.9-	DM w/o complications

Be sure to add Z79.4, long-term insulin use if appropriate

Coding for Specificity: CPT and HCPCS

Care Team Procedures Codes

- G9001* - Coordinated Care Fee – Initial Assessment
- G9002 *- Coordinated Care Fee – Maintenance or follow up (quantity billed >45 minutes)
- 98961*- Group Education 2-4 patients for 30 minutes (quantity billed)
- 98962*- Group Education 5-8 patients for 30 minutes (quantity billed)
- 98966 *- Phone services 5-10 minutes
- 98967*- Phone services 11-20 minutes
- 98968 *– Phone services 21-30 minutes
- 99487 *– Care Management services 31-75 minutes per month (care coordination in the PCMH neighborhood)
- 99489* – Care Management services, every additional 30 minutes per month (care coordination in the PCMH neighborhood)
- G9007* - Team Conference
- G9008* - Physician Coordinated Care Oversight services (physician only service and can only be billed by the physician)
- S0257* - Counseling regarding Advance Directives

-

Billing for Care Team Activities is Important

- Billing for services and being paid for services places value on the patient care that you provide
- Billing, along with care team incentive programs, is how team-based care can be sustainable
- Sustainability comes from:
  - Engaging a minimum number of patients in a day
    - Minimum of 4 encounters on average per half day (8 or more/day)
    - Be sure there is a mix of encounter types to support staff expense
    - Could include telephone or virtual for in-person encounters
  - Billing consistently for services

Process or Revenue Generation

1. Document the encounter in the patient’s chart
2. Assign appropriate codes
3. Submit the claim electronically
4. Interpret the payer's response
5. Prepare for post-payment actions (audits, document requests, etc.)

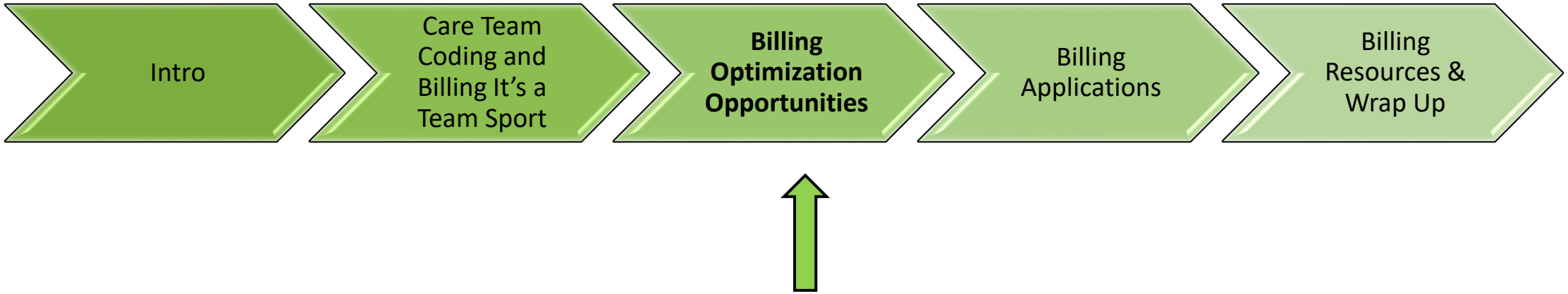
Key Takeaways

- Team-Based Care is derived from the chronic care model and patient- centered medical home.

- Sustainability of team-based care is identifying important members of the care team, assigning appropriate classification codes, documenting services rendered and billing consistently.

Break - 5 minutes

Agenda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Billing Optimization Opportunities

- This section is a practical review of how to optimize the use of billing diagnoses to support better billing and better participation in incentive programs.

- We'll review different patient examples and discuss the billing related to that patient flow, touching on several key optimization opportunities:
  - Preventive Care Support
  - Chronic Care Support
  - Social Determinants of Health (SDOH)
  - Hierarchical Care Coding (HCC)

Two different perspectives

- **Scenario 1** -- A patient's journey through a new diagnosis
- **Scenario 2 --** A clinician's typical day

We'll walk through each of these two perspectives and talk through the billing, documentation, and how to optimize coding

Lets’ start with a story about Mrs. Jones

- Mrs. Jones has a daughter who is getting married.
- Mrs. Jones was so busy worrying about the wedding and COVID that she hadn’t engaged with her PCP (Dr. Miller) in a long time.
- This caused her to show up on a list of patients who hadn’t been seen for their annual HME.

Mrs. Jones's Journey with her PCP…

1

At Dr. Miller's office, the Medical Assistant/Panel Manager (Renee) in the office pulls the list of patients who are due for a well visit the first Friday of the month and calls the patients.

Luckily, Mrs. Jones was available when called and Renee was able to set up an appointment . During that call, Renee talked with Mrs. Jones about the importance of preventive care and asked her to get some labs done before the visit. She also set up a mammogram and colonoscopy.

Billing Deep Dive

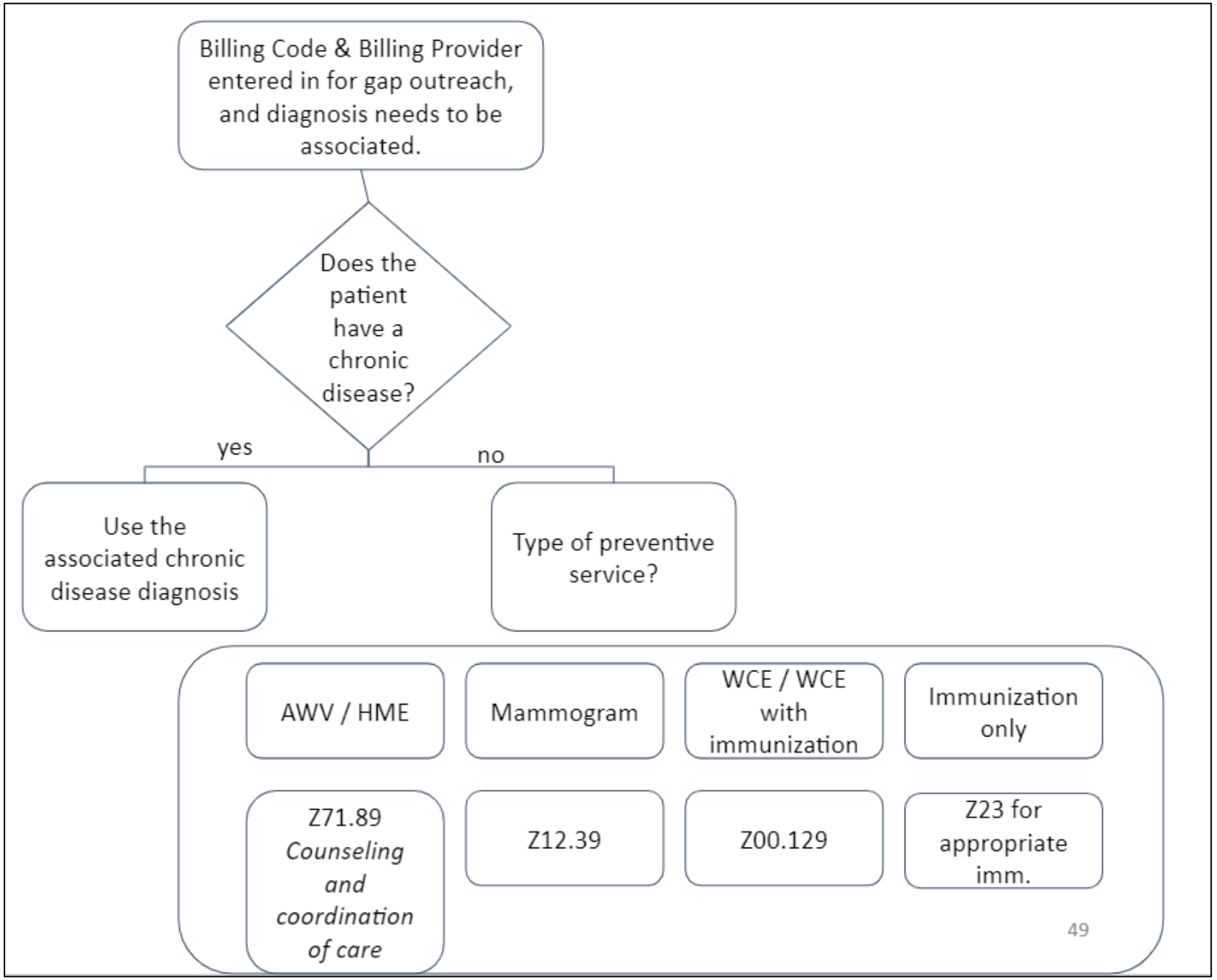
1

When Renee calls Mrs. Jones for the first time, she's reaching out to close the gaps in care. Scheduling the mammogram and colonoscopy took a little longer, so it was a 12- minute phone call.

- Appropriate code: 98967
- Appropriate DX: Z12.39 (for mammogram)

* See next slide for decision tree on dx codes for preventive care **

Preventive Care & Associated Diagnosis for gap outreach



Mrs. Jones's Journey (cont'd)

The week before Mrs. Jones's scheduled visit, Renee pulls another list: the patients who are coming in the next week and need reminders.

2

Mrs. Jones is on the list, as her appointment is the following week. Renee calls Mrs. Jones and reminds her to get her labs drawn before the visit. Renee also goes through Social Determinants of Health (SDOH) Screening tool questions. Mrs. Jones doesn't have any SDOH needs currently.

Billing Deep Dive

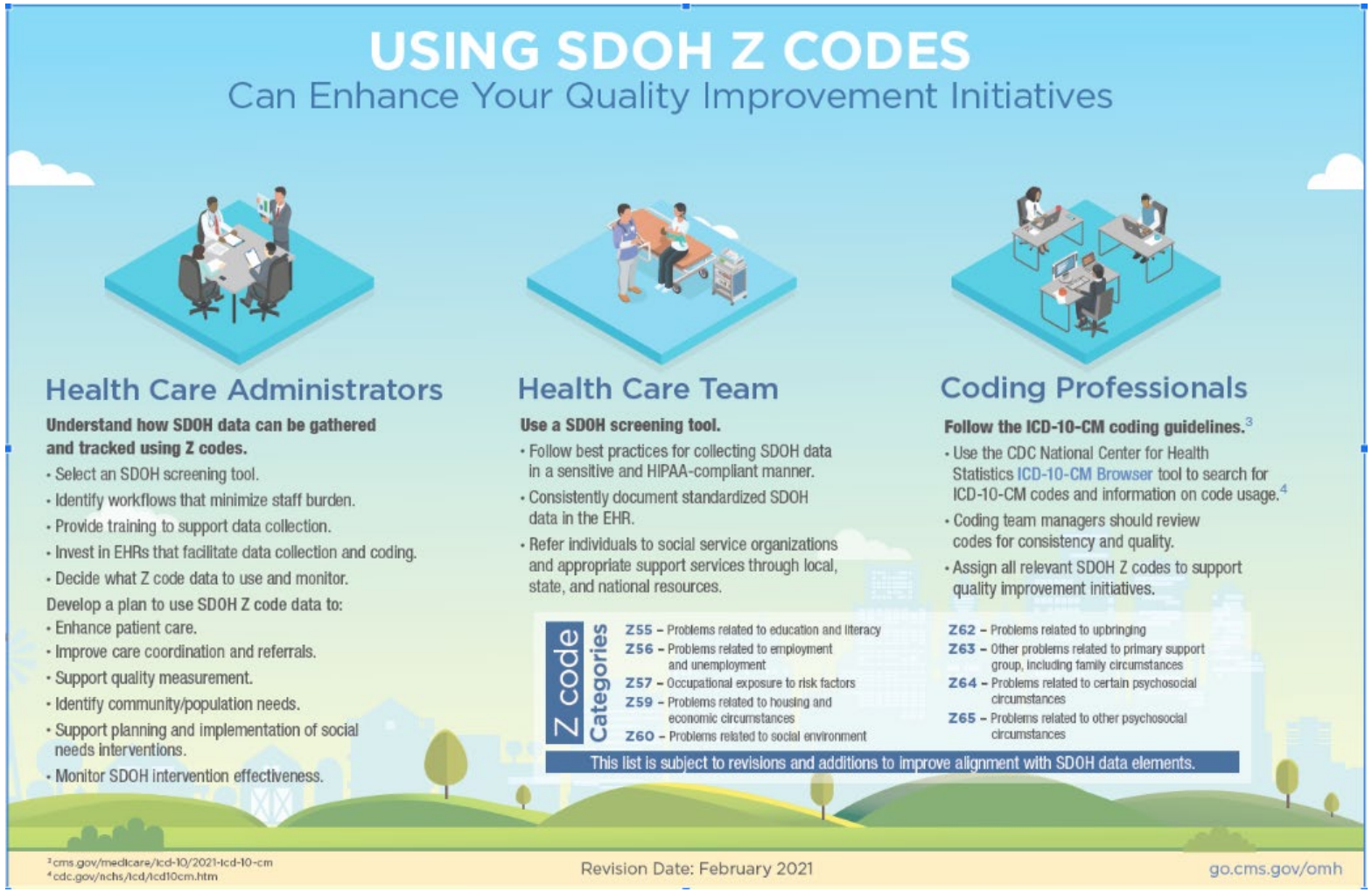
2

Renee's 2nd call with Mrs. Jones lasted 7 minutes. Renee reviewed the important things to do before the upcoming visit and conducted a SDOH screening.

- Appropriate code: 98966
- Appropriate DX: Z71.89 Counseling & Care Coordination for the well visit

* See slide - 49 for decision tree on dx codes for preventive care **

When to use a Z code for SDOH

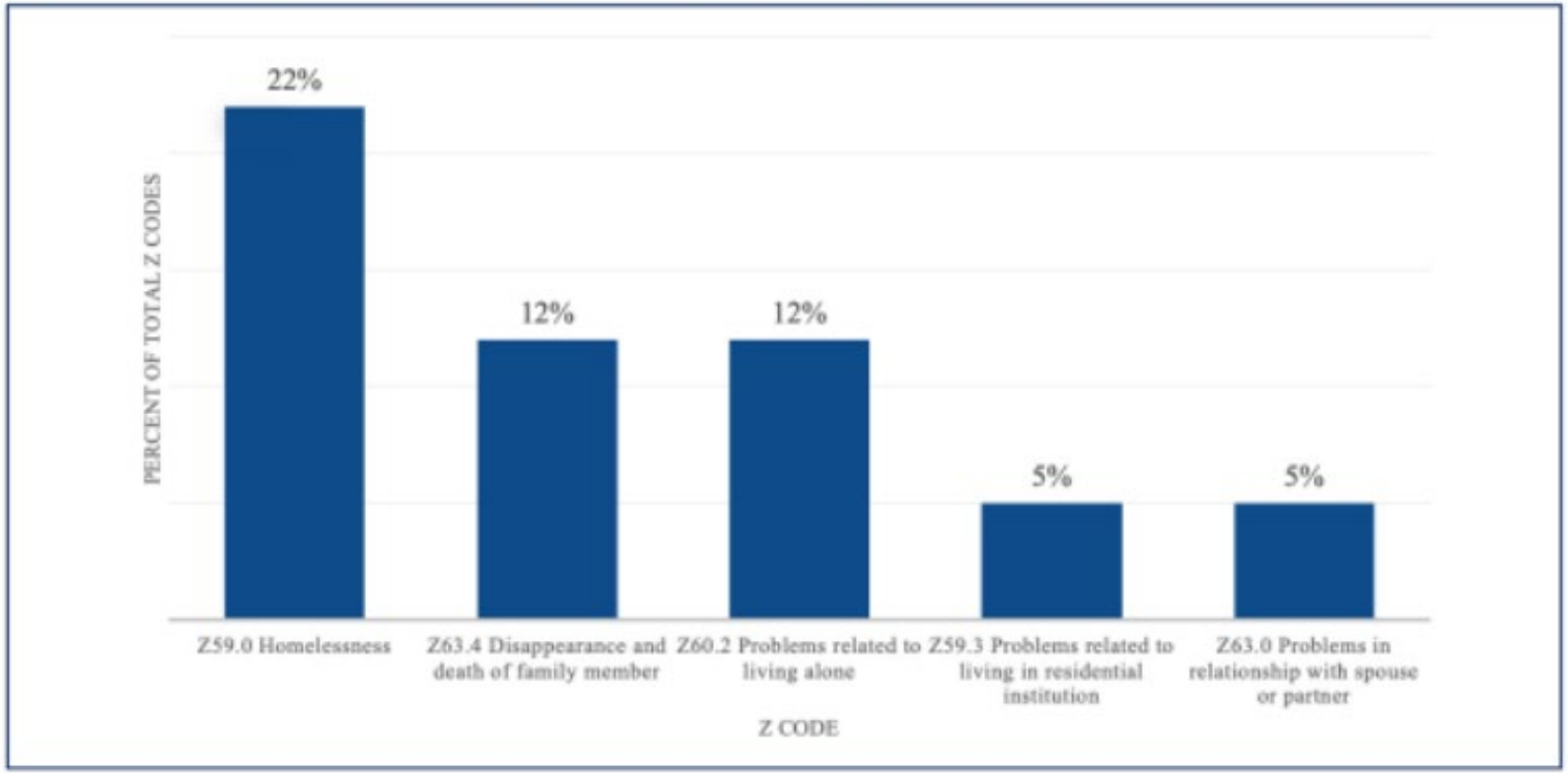


https://www.cms.gov/files/document/zcodes-infographic.pdf

The Most Common Z Codes:

- Care team members can add Z-codes as a diagnosis for billing purposes
- There are several payers with incentive plans around SDOH and Z-codes (Priority Health for Medicare/Medicaid, BCBSM both have incentive programs

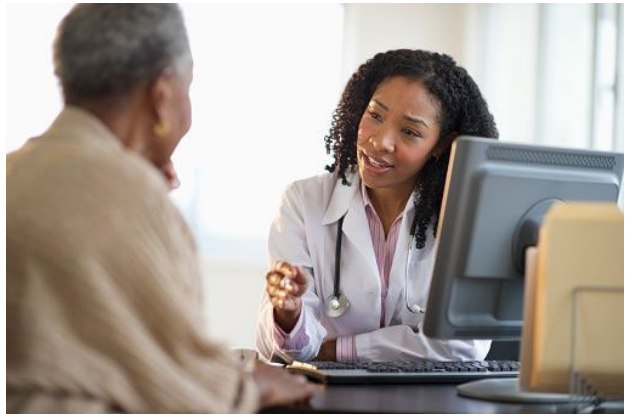
Figure 3. The Top Five Z Codes Representing the Largest Shares of All Z Code Claims, 2019.



The five Z codes that represented the largest shares of all Z code claims (N=1,262,563) in 2019 were:

Z code	Description	*n*	Proportion of all Z code claims
Z59.0	Homelessness	310,089	22%
Z63.4	Disappearance and death of family member	164,829	12%
Z60.2	Problems related to living alone	163,259	12%
Z59.3	Problems related to living in a residential institution	66,842	5%
Z63.0	Problems in relationship with spouse or partner	62,572	5%

Mrs. Jones's Journey (cont'd)



Day of the Visit

Mrs. Jones was able to get her labs drawn before the visit, that allowed Dr. Miller to diagnose Mrs. Jones with Diabetes. Dr. Miller decided to talk with Mrs. Jones about Theresa, the RN who helps follow up with new diagnoses. Dr. Miller asked Mrs. Jones if she had the time to stay and talk with Theresa. Unfortunately, Mrs. Jones was unable, so they discussed scheduling another appointment

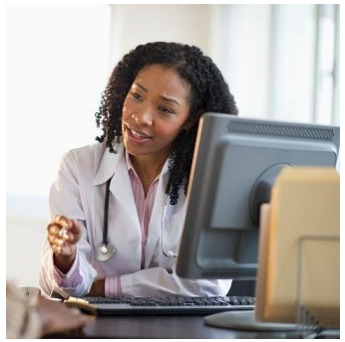
At Checkout, Renee helps Mrs. Jones schedule an appointment with Theresa for the next Thursday.

Mrs. Jones's Journey (cont'd)

3

On Monday of the following week, Dr. Miller, Renee, Theresa, and some other team members have set aside 15 minutes to talk about some of the patients who are coming in that week.

They discuss 3 patients that day: a patient who has been struggling with transportation and might need some extra support getting to their visit later that week; a patient who has been working on end-of-life planning and might need help with their Durable Power of Attorney (DPOA) coming in later that day; and finally, Mrs. Jones.



Billing Deep Dive

4

G9007 for each of the patients discussed

- This is a physician or APP code, BUT…
- It's preferable to bill under the physician rather than APP because the APP will be paid at 85% of the fee schedule while the physician will not only get the fee schedule but the value-based reimbursement for BCBSM.
- Care Team Members can do the documentation and send the bill through on behalf of the physician or APP.

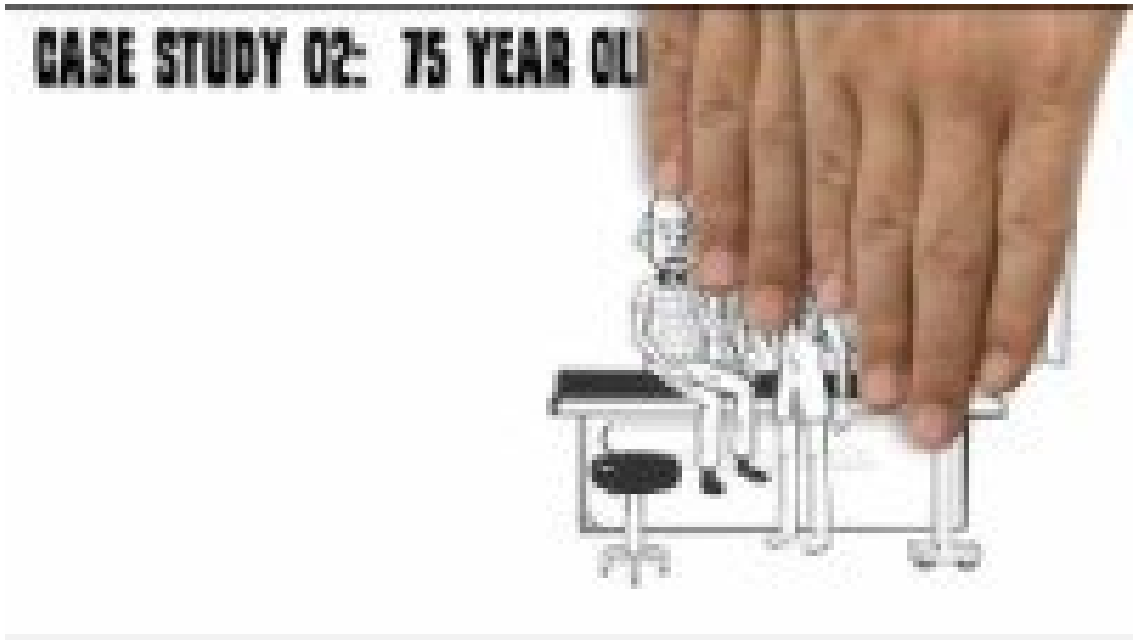
Billing Deep Dive

G9002 for the face-to-face visit

Diagnosis: All active diagnoses - and potentially a conversation with the provider if there are diagnoses that you consider to be missing. This will help with Hierarchical Condition Categories (HCC) effort that was discussed earlier.

Example: Mrs. Jones and Theresa Appointment

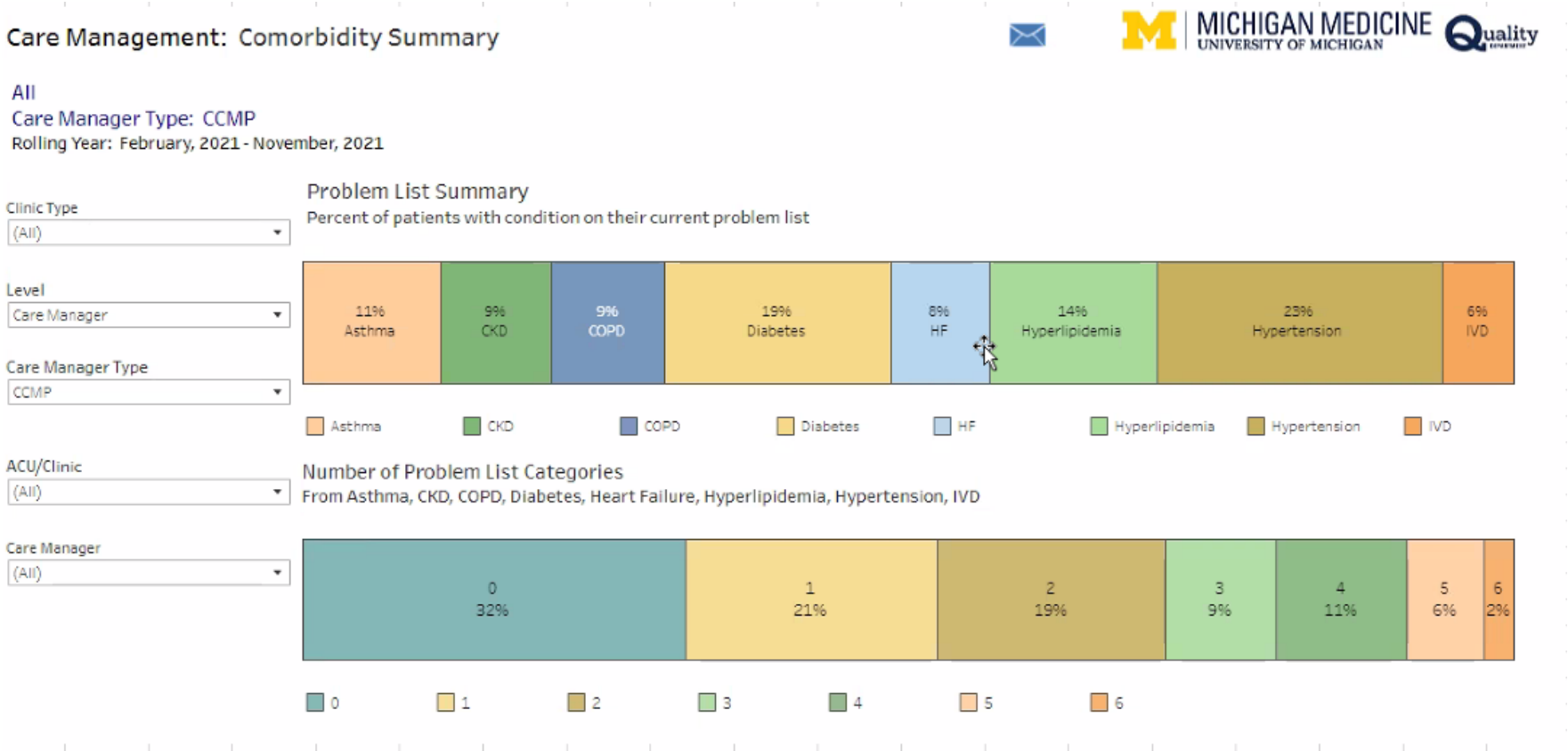
Hierarchical Condition Categories (HCC)



If you want to learn more, this video is very helpful!

- HCC coding is a way of predicting the cost of a population through assigning a risk score. Payers use the previous year's diagnoses to predict how much they anticipate that population to cost. Then, a risk contract is created that makes a deal with the physician organization to try to reduce the cost of care. The payer and PO can then 'share' in whatever savings are realized.
- If diagnoses aren't completely reported on patients on an annual basis, then the expected amount of expenditure is underestimated - which means that even if the care teams are working extremely hard, it will not show up in the numbers.
- Care team members can help with assuring that there is complete diagnosis reporting by conducting a comprehensive assessment and include all the diagnoses on their bills.

Complete Problem Lists are a Challenge



This example shows the comorbidities of the Complex Care Management Program (CCMP) at Michigan Medicine. These are the 250 most complex patients… but it looks like 32% of them don't have any of the major problem list categories on their problem list!

Scenario 2

Optimizing Billing From the Clinician’s Perspective --Theresa’s Monday

Monday Schedule

Time	Type of Work / Block
8a – 8:30a	Huddles with various team members / prep for the day
8:30a – 12:00p	Morning patient block; held for virtual patients (video and phone calls)
12:00 – 1:00p	Lunch Block – frequently also used for Care Coordination follow up.
1:00p – 4:30p	Afternoon patient block
4:30p – 5:00p	Finish documentation

8:30a -9:00a	Transitions of Care Phone Calls (Not scheduled)
9:00a-10:00a	New Patent Visit
10:00 - 10:30a	Return Visit
10:30a- 11:00a	*Not Scheduled*
11:00 - 12:00p	New Patient Visit

1:00p - 1:30p	Return Visit
1:30p - 2:00p	Return Visit
2:00p - 3:00p	New Patient Visit
3:00p- 3:30p	Urgent, ad hoc visit opportunity
3:30p- 4:00p	Extended Patient Visit

Optimization Through the Story

8:00 – 8:30am Timeframe:

- Huddle with Dr. Miller (total of 15 Minutes) to discuss complex patients for the week.
  - Discussed 3 patients this week, spending just a few minutes on each - remember the scenario from earlier?
    - Mrs. Jones
    - Patient who would need support with Advance Care Planning
    - Patient with identified SDOH needs
- Remember that while there is a limit of one G9007 per patient per day (BCBSM only), it's Ok to bill the G9007 and direct patient care code on the same day.
- Review patients' charts for morning patients.

Codes Applied
G9007 *3
Diagnosis: 1. Mrs. Jones- Diabetes 2. ACP patient - Discussed Diagnoses 3. SDOH patient - Appropriate SDOH need

Optimization through the Story

- **08:30- 9:00 Timeframe:**
  - Called 2 Transitions of Care Patients:
    - **Patient 1:**

      While this specific phone call isn't billable because Theresa is focusing on the TOC, Theresa also conducts a SDOH screening on all discharged patients. She discovered that this patient needed support with purchasing a new medication. Theresa told the patient she would investigate resources and call them back.
    - **Patient 2:**

      This patient had so many medication questions that Theresa decided to review all the medications during this call. Now, she can add 1111F to the mix. This a *Med Rec Code* that can be coded in a bundle with the TCM codes that the provider uses. 1111F is more for tracking code for payers, but it helps with the STARS incentives for Medicare Advantage and BCBSM Advantage will reimburse.

Best Practice:

- Confirm that both patients have a provider visit within 7-14 days so that the Transitions of Care Codes (99495/99496) can be billed).
- Schedule a follow-up visit post provider visit with the care team member to support avoiding a readmission.

Codes Applied
1111F
Diagnosis: Admission diagnosis

Optimization through the Story

09:00-10:00am- New Patient Visit

- Patient discussion took 35 Minutes
- Patient was referred because they had been going to the ED for frequent visits. After SDOH and depression screening, Theresa did an initial assessment of the patient. The SDOH screening showed that the patient was struggling with transportation; they couldn't use their shared car during the day to get to Dr. Miller's office.
- Theresa told the patient that she would review resources available and call them later today. They agreed that she would f/u around 3PM.
- Theresa used 10 more minutes to look up resources and send to patient.
- Theresa used 10 minutes to finish up documentation and send a portal message to the patient with all the information.

Codes Applied
G9001
Care Coordination – 10 Min
Diagnosis: All the diagnoses on the problem list, supporting HCC risk score completeness.

Optimization through the Story

- **10:00-10:30 AM - Return Visit**
  - Patient discussion took 15 minutes via phone because the patient's video wasn't working.
  - They discussed the patient's lifestyle goals, specifically how to exercise and eat better when the patient seemed to always have one of her kids home because of COVID exposure.
  - After the visit, Theresa followed up with Dr. Miller to discuss the goals that were set and to discuss the patient's situation. Theresa also asked if Dr. Miller wanted to update the problem list.

Codes Applied
G9002 G9007
Diagnosis: All relevant diagnoses on the problem list, assuring that any missing from the list are discussed with Dr. Miller

Optimization through the Story

10:30- 11:00AM – No Patients

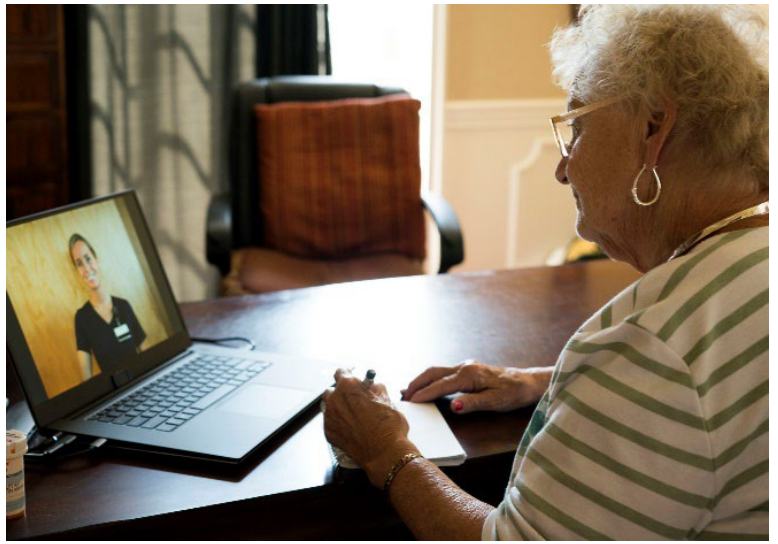
- Theresa took a quick walk around the block for a break, grabbed a snack and started to prep for her 11am visit.

Optimization through the Story

11:00am – 12:00pm – New Patient Visit

- Patient's daughter & patient were part of the video visit – this is one of the great benefits of video visits! The patient's daughter lives about an hour away from the patient, and this allows them to hear the same support together.
- As part of her initial visit, Theresa always does a SDOH screen and tries to get a sense for the patient's understanding of their health and ability to self-manage.
- This patient mentions that she doesn't always eat properly because she doesn't feel like going to the supermarket. They're just too big, and she's too tired. Plus, everything seems so much more expensive, and she doesn't always know if she can afford both food and medicine.
- Theresa asks if they'd like to set up Meals on Wheels, which both the patient and her daughter think is a good idea. So, Theresa says she'll send them some information on the portal and call back when it's set up.
- Theresa also mentioned Advance Care Planning, as the patient was over 65 years old. She explained what it was and wondered if they would be interested in going through the process of a DPOA. The patient and her daughter said they'd talk it over with some more family members.
- Theresa set up a return visit for two weeks from now, when both the patient and the patient's daughter could participate.
- That whole conversation took about 45 minutes, which left Theresa some time to contact Meals on Wheels and get things coordinated.

Codes Applied
G9001 Diagnoses: All that apply from problem list, adding SDOH diagnosis
Care Coordination – 10 Minutes * 1 patient 8 Minutes – *1 Patient
S0257

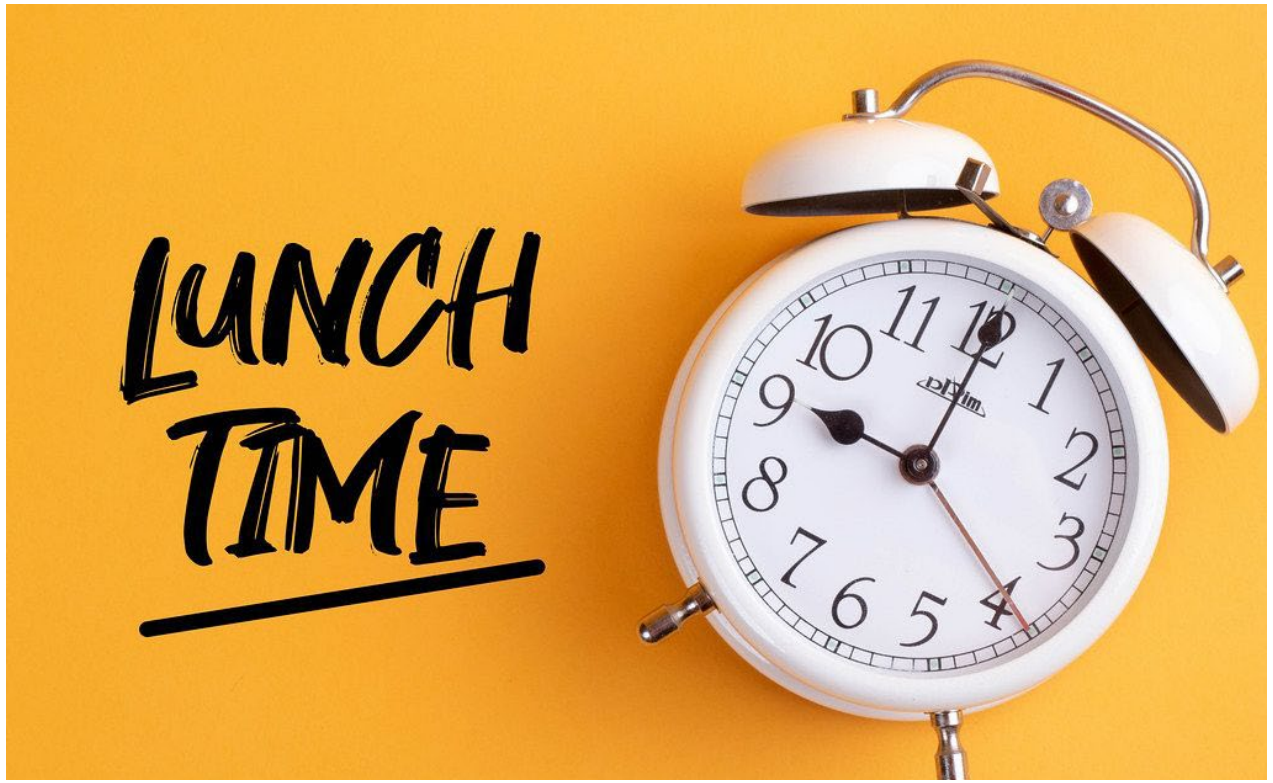


Morning Block Summary

Discussion- How close does this mirror the experience in the clinics you support? What other kinds of barriers do you see?

Time	Appointment Type	Billing Codes
8:00 – 8:30a	Huddle with Dr. Rachel	G9007*3
8:30a – 9:00a	Transitions of Care Phone Calls	1111F
9:00a – 10:00a	New Patient Visit	G9001 Care Coordination minutes: 10
10:00a – 10:30a	Return Visit	G9002 G9007
10:30a – 11:00a	*Not scheduled*	*None*
11:00a – 12:00p	New Patient Visit	G9001 Care Coordination minutes: 8 S0257

Optimization through the Story



Lunchtime:

- 20 minutes of eating
- Finished some documentation
- Began prepping for the afternoon

Optimization through the Story

1:00 - 1:30pm – Return Patient Visit

• The scheduled Return Patient Visit took 10 minutes via phone; patient didn't want a video visit. Theresa and the patient discussed the previous goal, which was to take his medications at the same time every single day – thereby helping make sure that they were all taken appropriately. So far, this worked! Theresa set up a follow up meeting for 3 weeks from now.

• Dr. Miller had a patient who was already in the office and needed some additional support with a new Diabetes diagnosis. Theresa used the rest of this visit time to see this patient, set up some time for a full initial visit, and provide some additional education.

Codes Applied
G9002 * 2 (1 for each patient)
Diagnosis: All relevant diagnoses on the problem list

Optimization through the Story

1:30 - 2:00pm – Return Patient Visit

- This patient is Theresa's first scheduled in-person visit of the day.
- Theresa and this patient have been seeing each other for the past 6 months for weight management and lifestyle changes. This patient had some serious trauma in her history, and she opened up to Theresa about it. Theresa recently connected her with a community Social Worker, and they discuss how that's going and next steps.
- This patient visit takes up nearly the entire time slot, leaving just enough time for Theresa to schedule their next visit in a month.

Codes Applied
G9002
Diagnosis: All relevant diagnoses on the problem list

Optimization through the Story

2:00 - 3:00pm – New Patient Visit

- Theresa's 2pm patient is a new geriatric patient, who just moved across the State and is living with his son and daughter-in-law. The patient is still able to drive and is relatively good health, but because of his age (75 years old) and several diagnoses, Dr. Miller wanted him to meet with Theresa.
- Theresa reviewed the patient's understanding of his diagnoses, medications, and ability to self-manage. The patient has a good understanding of his health situation. However, when Theresa asks if he has completed a DPOA or if the patient has a plan for potential end of life care, the patient indicates that he's avoided doing that because he's worried about how it will affect his family.
- Theresa takes the opportunity to review the benefits of Advance Care Planning, and she offers to mediate a family meeting to help explain to more of his immediate family about why it's a good idea.
- The patient agrees, and they set up a time in 2 weeks when she'll be able to at least speak with him, his son, and his daughter-in law.
- The whole visit takes 25 minutes, so Theresa has some time to catch up on documentation.
- She also has a chance to call back her 9am patient and let them know about her success with setting up Meals on Wheels. She confirmed their upcoming appointment during that call.

Codes Applied
G9001 S0257
Diagnosis: All relevant diagnoses on the problem list
98966

Optimization through the Story

3:00 - 3:30pm – No scheduled visits – open for Ad Hoc patient needs

- Today, Theresa doesn't have any scheduled visits during this time. Also, she was able to connect with the patient who Dr. Miller wanted her to see that day.
- Therefore, Theresa pulls up a list of patients who are high risk and who haven't engaged her services yet. Theresa calls 2 people. The first patient declines her support. The second patient is worried about a COVID exposure, and she talks through with Theresa about what she should do. Theresa recommends a PCR test, and she reviews with the patient how to contact either the PCP office, an urgent care, or the ED based on the patient's symptoms.

Codes Applied
98967
Diagnosis: All relevant diagnoses on the problem list

Optimization through the Story

3:30 - 4:30pm – Extended Return Patient Visit

- This patient has health literacy challenges that were identified after his first referral from Dr. Miller.
- Ever since these were identified, Theresa schedules an extended return visit after each of his return visits with Dr. Miller so that they can review the information, the visit, and the next steps. This is Theresa's 3rd visit with the patient, and he's beginning to better understand what's going on with his health.
- Theresa and the patient set an interim goal for before the next visit with Dr. Miller, and she suggests a visit between the next visit with Dr. Miller. The patient agrees, and they schedule it.
- The visit takes nearly the full hour (55 minutes), but Theresa finishes the day with a sense of accomplishment with this patient!

Codes Applied
G9002*2
Diagnosis: All relevant diagnoses

Afternoon Block Summary

In person opportunities as need

Time	Appointment Type	Billing Codes
1:00p – 1:30p	Return Visit	G9002 G9002
1:30p – 2:00p	Return Visit	G9002
2:00p – 3:00p	New Patient Visit	G9001 S0257 98966
3:00p – 3:30p	*Urgent, ad hoc visit opportunity*	*98967*
3:30p – 4:30p	Extended Patient Visit	G9002 *2

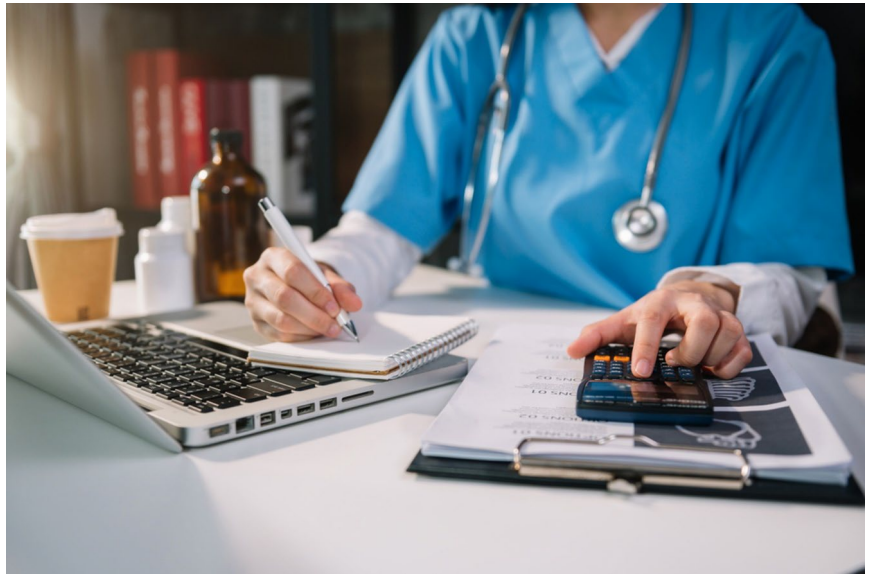
Theresa's Billing Summary

Morning

- 1111F
- G9001 *2
- Care Coordination
  - 10 minutes *1
  - 8 minutes * 1
- G9002
- S0257

Afternoon

- G9002 * 5
- G9001
- S0257
- 98966
- 98967



14 billable activities for the day!

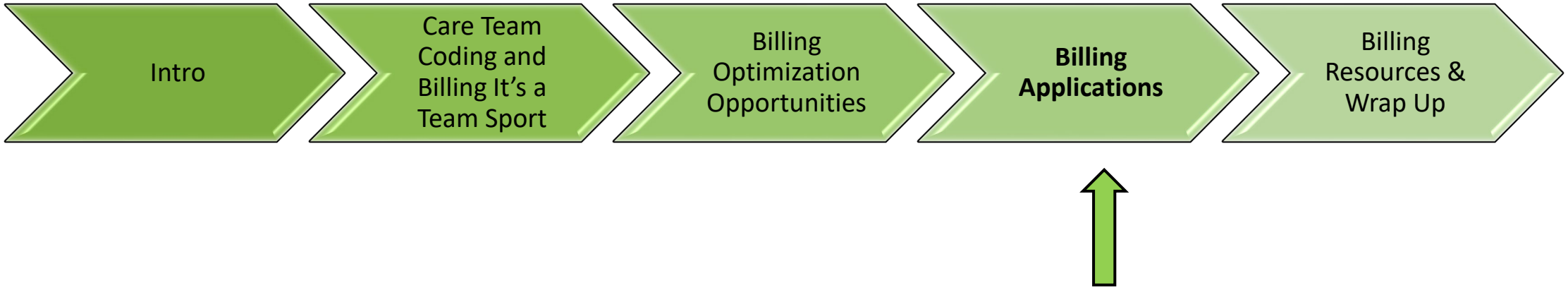
Key Takeaways

- It’s important to match the diagnosis with what’s going on in the visit, but Care Team Members can also take the opportunity to make sure that the patient’s diagnoses are correct by reviewing the problem list and making recommendations to the provider.

- Care Team Members should make sure to comprehensively bill for all their interactions. The frame of mind should be that **ALL** interactions are billable. - So, the question is **HOW** do I bill, not **SHOULD** I bill.

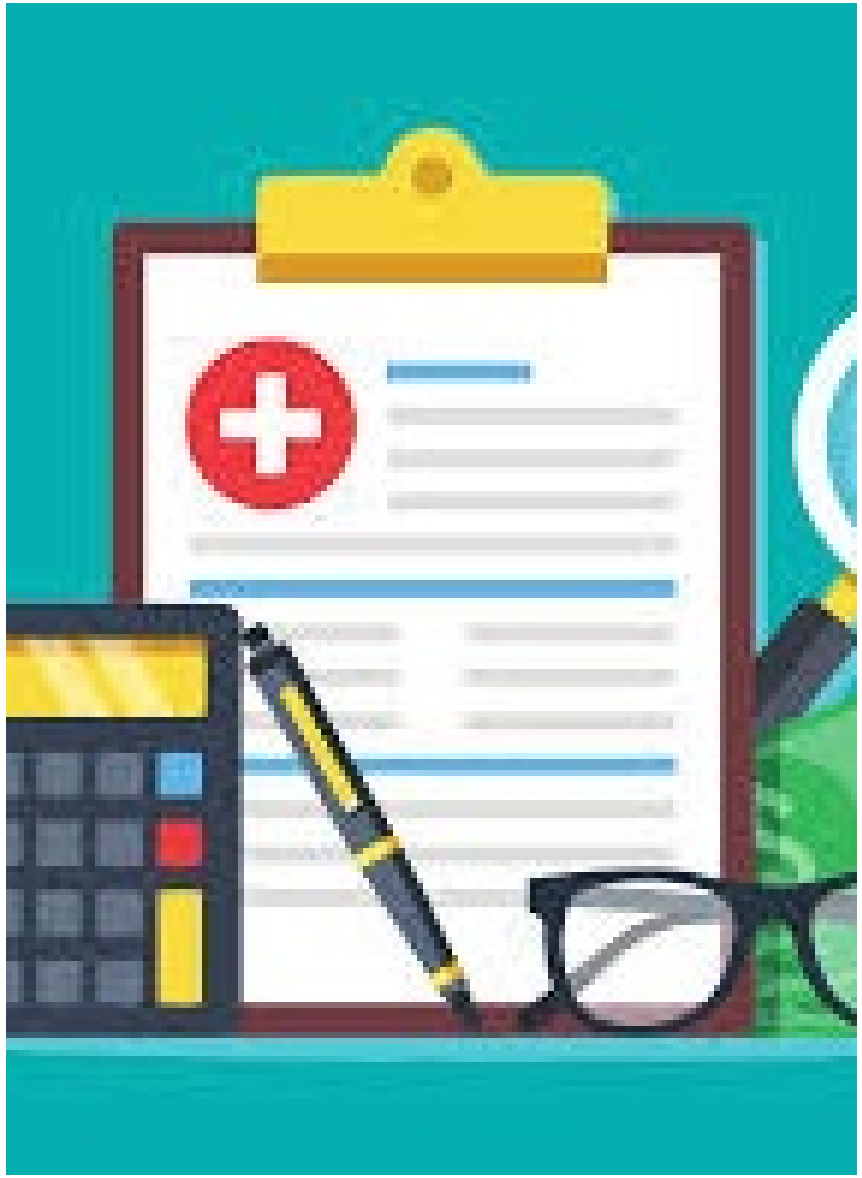
Break

Next up!


Intro
Care Team Coding and Billing It's a Team Sport
Billing Optimization Opportunities
Billing Applications
Billing Resources & Wrap Up

Billing Applications: Applying Care Management Codes to Clinical Practice

- Review and understand the PDCM billing codes and their application in care management to work performed in the practice
- Select the appropriate billing code in various clinical scenarios
- Examine documentation examples for the PDCM billing Codes



Billing Scenarios

- Transitions of Care
- Chronic Disease
- Social Determinants of Health Screening
- Specialty/Primary Care Interactions
- Gaps in Care
- Substance Use Disorder

Documentation Suggestions

Documentation should include at minimum:

- Patient name, MRN, DOB, PCP Name
- Date of visit and type (face-to-face, virtual, telephone)
- Duration of visit
- Care team members name and credentials
- Name of caregiver/relationship (if included in visit)
- Diagnoses discussed
- Consent for services: Yes, verbal consent, or decline
- Treatment plan, medication therapy, risk factors, unmet care, physical, emotional status, community resources, readiness to change (as applicable)
- Care plan, including challenges and interventions and patient's understanding of agreement with plan
- Patient SMART goals identified
- S.O.A.P format when applicable

Meet Mrs. Johnson

- Mrs. Johnson is a 70-year-old African American female who recently complains of increased shortness of breath (SOB) and severe difficulty breathing, increased weight gain, and fatigue. She is concerned with these worsening symptoms.
- Chronic conditions include CHF, HTN, pre-diabetes, gout, chronic back pain
- Medications include furosemide, losartan, metoprolol succinate, aspirin, oxycodone/acetaminophen, allopurinol, and multivitamin
- She is followed closely by her PCP and cardiologist, for management of her CHF

ED Admission

- Mrs. Johnson decides to call 911 and is brought to the ED where she is admitted for observation and further workup.
- In the meantime, her PCP is alerted of her ED admission.
- Her PCP telephones the ED physician managing Mrs. Johnson's care and discusses the case, care plan, and medical interventions.
- Her PCP documents her conversation with the ED physician in Mrs. Johnson's chart.

If Mrs. Johnson has BCBSM insurance, what billing code may the PCP bill?

And the answer is….

G9008 - Physician Code

G9008: Physician Coordinated Care Oversight Services (Enrollment Fee)

Communication with paramedic, patient, **other health care professionals** not part of the care team when consulting about patient

Face to face, video, or telephone (excludes email or EMR messaging)

Documentation Example

Transitions of Care

G9008 – Physician Visit

Telephone encounter:
Patient Name: Mrs. Johnson DOB: 2/12/52 MRN: 123456 PCP Name: Dr. Johns
Diagnosis: Acute on Chronic CHF: 150.23

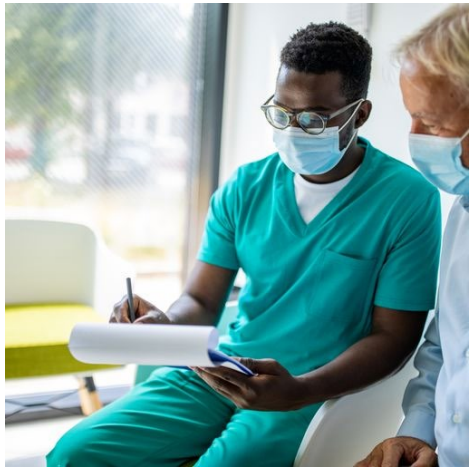
Care Team Member Name & Licensure: Dr. Johns, MD
Date of service: 12/18/21

Patient presented to ED today complaining of SOB, difficulty breathing, increased weight gain and fatigue. Called ED and spoke with medical resident managing patient's care. Reviewed medications and treatment plan. Agreed upon care plan and adjustments were made to patient's medications. Increased furosemide. Patient scheduled for urgent clinic follow-up in 2 days. Patient not to be admitted to hospital; plan to discharge from ED later today. Will obtain repeat labs in office at follow-up appointment.

Total time of visit: 10 min
Time stamp. Signature.

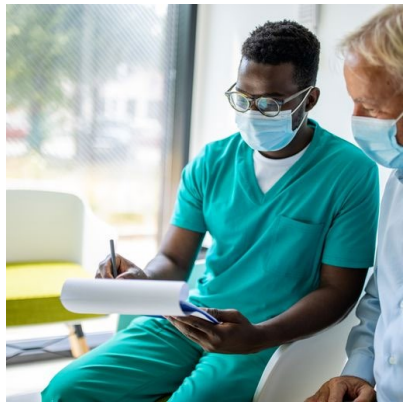
Transition of Care

- Mrs. Johnson returns home from the ED feeling a little better.
- The next day, **Eric**, a **medical assistant** from her PCP's office calls Mrs. Johnson to check-in. He asks Mrs. Johnson about symptoms, coordinates her follow-up appointment to see PCP tomorrow and encourages a follow-up with her cardiologist as well.
- Mrs. Johnson reports better breathing, not feeling as tired. Her weight has returned to baseline.
- Eric encourages Mrs. Johnson to bring in all medications to her appt. Call takes 12 minutes.



If BCBSM insurance, what billing code may the PCP bill?

And the answer is….



98967- Telephone Code

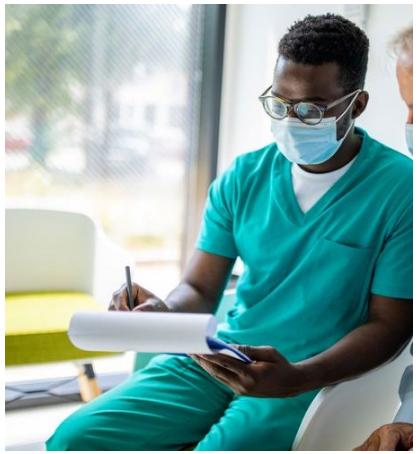
Call with patient or caregiver to discuss care issues and progress towards goals.

98967 for 11-20 minutes

Documentation Example

Transitions of Care

98967 – Telephone Visit



Telephone Encounter:
Patient Name: Mrs. Johnson DOB: 2/12/52 MRN: 123456 PCP Name: Dr. Johns
Diagnosis: Acute on Chronic CHF: 150.23

Care Team Member Name & Licensure: Eric, MA
Date of service: 12/19/21
Consent for care management: Yes, verbal consent

Pertinent details of visit: Spoke to patient today regarding her recent ED visit. She reports feeling better overall, with improved breathing and her weight has returned to baseline. Patient with no questions or concerns.
Reminded her to schedule follow-up appt with her cardiologist. Scheduled PCP visit for tomorrow for repeat blood work. Reviewed all medications with patient. Reminded her to bring all medications to PCP appt tomorrow. Patient verbalized understanding.

Total time of visit: 12 min
Time stamp. Signature.

PCP ED Follow-Up Visit

Transitions of Care

- Mrs. Johnson presents to PCP's office for scheduled appointment.
- PCP draws repeat labs and adjusts her BP and diuretic medications. PCP assesses Mrs. Johnson's understanding of CHF and determines she would benefit significantly from education on CHF management and care management (CM) program.
- PCP introduces Mrs. Johnson to the CM program and obtains verbal consent from Mrs. Johnson to participate.
- PCP refers Mrs. Johnson to the RN care manager, Laura, for **CHF education and chronic care management**.

What code applies?

And the answer is….

G9008 - Physician Code

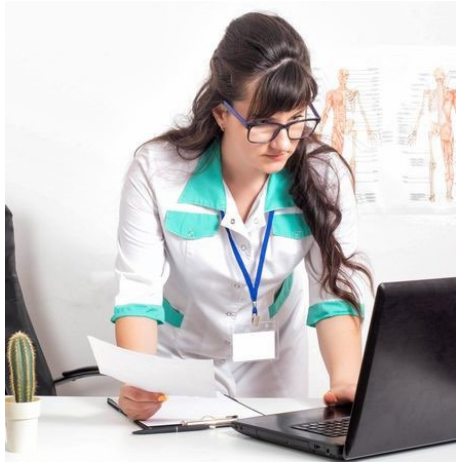
G9008: Physician Coordinated Care Oversight Services (Enrollment Fee)

Communication with paramedic, patient, **other health care professionals** not part of the care team when consulting about patient

Face to face, video, or telephone (excludes email or EMR messaging)

Care Management (CM) Office Visit

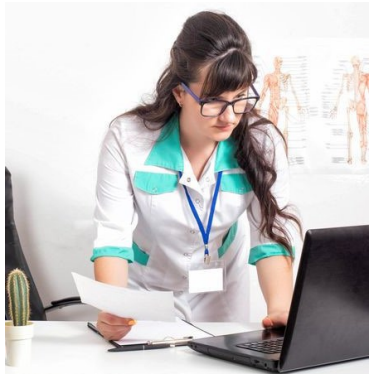
- RN Care Manager Laura meets with Mrs. Johnson face to face that same day, and provides education on CHF, reviews CHF action plan, and monitoring parameters for Mrs. Johnson to follow at home.
- Time spent together was 20 min. Mrs. Johnson agrees to come into the office next week for follow-up.



What code applies?

Symptom	Action
Best weight: ☐ If you have: ▪ No trouble breathing ▪ No chest pain ▪ No weight change overnight or over the last week ▪ The usual amount of ankle swelling ▪ No change in ability to be active	Your symptoms are under control. ▪ Keep taking your medications every day, as ordered ▪ Keep weighing yourself every day and writing down your weight ▪ Keep all your medical appointments
If you: ▪ Need more pillows than usual to sleep ▪ Have more trouble breathing when you are active ▪ Have more coughing than usual ▪ Increased shortness of breath with activity ▪ Gain 2 to 3 pounds overnight, or 5 pounds in one week ▪ Have more swelling than usual	You might need to take extra medicine. Call your doctor's office to find out what you should do. Doctor name: _____ Phone #: _____
If you: ▪ Have trouble breathing when you are resting, or you can't stop coughing ▪ Wheeze or feel chest tightness when you are resting ▪ Wake up at night because you can't breathe well ▪ Feel dizzy, very tired, or like you might fall ▪ Gain or lose more than 5 pounds compared to your normal weight	You probably need to **see** a doctor right away. Call your doctor **now**. Doctor name: _____ Phone #: _____
If you: ▪ Have trouble breathing that does not get better no matter what you do ▪ Feel like you can't breathe, or start to turn blue ▪ Cough up frothy or pink saliva ▪ Have pain or pressure in your chest, or you have other signs of a heart attack ▪ Have a fast or uneven heartbeat that will not go away or makes you feel dizzy or lightheaded ▪ Feel very confused ▪ Faint	 Call 9-1-1 for an ambulance **right away**

And the answer is….



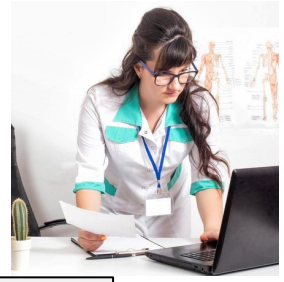
G9002 – Patient Visit Code

Face-to-Face or video visit that is focused on addressing a piece of the care management plan.

Also address the patient's goals and follow-up plan

Documentation Example

Chronic Disease



G9002 – Patient Visit

Care Management Encounter: Face to face
Patient Name: Mrs. Johnson DOB: 2/12/52
MRN: 123456 PCP Name: Dr. Johns

Care Team Member Name & Licensure: Laura, RN
Date of service: 12/20/21
Consent for care management: Yes, verbal consent
Current Diagnoses: CHF-150. 23, HTN-I11, pre-DM-R73.09, gout-M10.9, chronic back pain-G89.4

Patient self-reported problems and concerns: Mrs. Johnson asking questions today about when and how often to check her weight and BP at home.

Medication List Reviewed with patient:
furosemide 40 mg daily, losartan 25 mg daily, metoprolol succinate 50 mg daily, aspirin 81 mg daily, oxycodone/acetaminophen 5/325 mg every 6 hrs as needed for pain, allopurinol 100 mg daily, and multivitamin tablet daily

Adherence Assessment: Patient is adherent to her medications

Self-management Action Plan: CHF
Short team goal identified: Track weights daily at home, track home BPs daily

Pertinent details of visit: Provided detailed education on CHF dx including management, monitoring parameters.
Reviewed CHF action plan in detail with patient.

Follow-up planned: *2* weeks face to face
Level of understanding: Good
Readiness for change: 8 out of 10

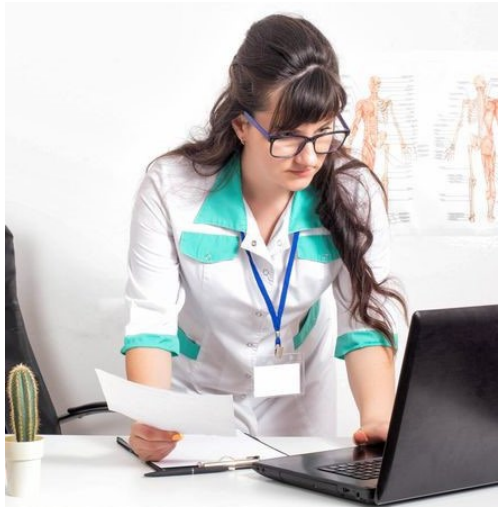
Total time of visit: 20 min
Time stamp. Signature.

Office Visit - Comprehensive Assessment

Social Determinants of Health Screening

Chronic Disease

- Mrs. Johnson presents 1 week later for face-to-face follow-up with Laura, care manager. Laura completes a comprehensive assessment.
- Laura provides Mrs. Johnson with two screenings to complete: Social Determinants of Health Screening (SDOH), as well as a Patient Health Questionnaire -2 (PHQ-2) Screening
- Her SDOH screening is positive for difficulty reading and understanding medical language as well as transportation issues, as she does not drive and relies on family/friends to take her to appointments. Her PHQ-2 screening is negative for depression.
- Her CHF management is discussed further, and Mrs. Johnson identifies a SMART goal to reduce her salt intake.
- They also discuss Advance Care planning. Mrs. Johnson states she has an advance directive and living will in place.
- Laura connects Mrs. Johnson with various resources to help address her identified barriers.
- Patient and care manager agree on a follow-up plan. Mrs. Johnson will meet with PharmD via phone in 2 weeks to follow-up on patient identified goals.
- Total time of visit 45 min



What code applies?

And the answer is….

Chronic Disease

Social Determinants of Health Screening

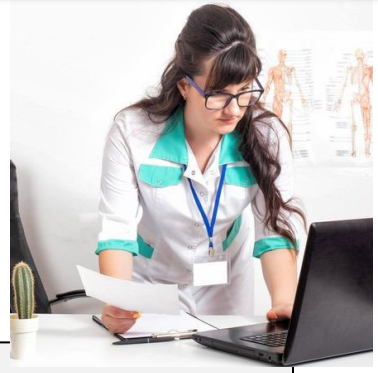
G9001 – Comprehensive Assessment

Face-to-Face or video visit lasting at least 30 minutes, results in a care management plan that all team members and the patient will follow.

And…

Chronic Disease

Social Determinants of Health Screening



S0257- Counseling Regarding Advance Directives

Face-to-Face, video or telephone visit counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate

Documentation Example

Chronic Disease

Social Determinants of Health Screening

G9001 & S0257- Comprehensive Visit & End of Life Counseling

Care Management Encounter: Face to face
Patient Name: Mrs. Johnson DOB: 2/12/52 MRN: 123456 PCP Name: Dr. Johns

Care Team Member Name & Licensure: Laura, RN
Date of service: 1/3/22 ***Consent for care management:*** Yes, verbal consent
Current Diagnoses: CHF-150. 23, HTN-I11, pre-DM-R73.09, gout-M10.9, chronic back pain-G89.4
Hospitalization/ED Summary: 1 ED visit in last 6 months
Review of outpatient services: none
SDOH Screening: positive for reading difficulty and transportation limitations
Social History: lives alone, husband passed away, has a daughter who visits once a week
Mobility Status: able to walk with some limitation
Diet: eggs and toast for breakfast, canned soups for lunch most days and frozen meals for dinner, sometimes will cook steak with potato and mixed veggies
Exercise: none, limited due to her chronic back pain
Cognitive Assessment: no reported problems with memory
Mental health assessment: negative for depression on PHQ-2 screening
Smoking: non-smoker
Advance Care Planning: Advance Directive reviewed and placed in chart
Screenings Up to date: mammogram, influenza, pneumococcal vaccines, etc.

Patient self-reported problems and concerns: Mrs. Johnson is doing well, no major concerns or questions today. Reports doing well at monitoring her daily weights and BP.

Medication List Reviewed with patient:
furosemide 40 mg daily, losartan 25 mg daily, metoprolol succinate 50 mg daily, aspirin 81 mg daily, oxycodone/acetaminophen 5/325 mg every 6 hrs as needed for pain, allopurinol 100 mg daily, and multivitamin tablet daily
Adherence Assessment: Patient is adherent to her medications

Care Management assessment:
Self-management Action Plan: CHF
Short term goal identified: Maintain good tracking of daily weights and BPs
Short term goal identified: reduce salt intake to <2g/day
Barriers identified: difficulty buying fresh food from grocery store; easy to buy canned foods that have longer shelf-life

***Follow-up planned*:** 2 weeks telephone
Level of understanding: Good Readiness for change: 8 out of 10

Total time of visit: 45 min
Time stamp. Signature.

Follow-up CM Phone Visit

- 2 weeks later, Mrs. Johnson speaks with **Monica, Ambulatory Care Pharmacist**, for their scheduled telephone visit
- Monica reviews patient's medication list and discovers Gloria is not taking her furosemide as prescribed.
- They discuss Mrs. Johnson's progress with her short-term goals and explore ways to overcome barriers, as well as provide education
- Total time of visit 25 min

What code applies?

And the answer is….

98968- Telephone Code

Call with patient or caregiver to discuss care issues and progress towards goals.

98968 for 21-30 minutes

Documentation Example

Chronic Disease

98968- Telephone Code

Telephone Encounter
Patient Name: Mrs. Johnson DOB: 2/12/52 MRN: 123456
PCP Name: Dr. Johns

Care Team Member Name & Licensure: Monica, PharmD
Date of service: 1/18/22
Consent for care management: Yes, verbal consent
Current Diagnoses: CHF-150. 23, HTN-I11, pre-DM-R73.09, gout-M10.9, chronic back pain-G89.4

Patient self-reported problems and concerns: Mrs. Johnson doing well, no major concerns or questions today. Reports doing well at monitoring her daily weights and BP. Having some difficulty reducing salt intake. She likes the taste as well as difficult to change her "easy meals" like canned soup which are easier to prepare.

Medication List Reviewed with patient:
furosemide 40 mg daily, losartan 25 mg daily, metoprolol succinate 50 mg daily, aspirin 81 mg daily, oxycodone/acetaminophen 5/325 mg every 6 hrs as needed for pain, allopurinol 100 mg daily, and multivitamin tablet daily

Adherence Assessment: After prompting, discovered that patient does not always take her furosemide due to frequent urination. Misses dose about 3 times per week.

Self-management Action Plan: CHF
Short term goal identified: Maintain good tracking of daily weights and BPs
Short term goal identified: reduce salt intake to <2g/day
Barriers identified: difficulty buying fresh food from grocery store

Pertinent details of visit: Provided alternative canned soup brands that have less sodium. Provided education and counseled patient on furosemide side effects and importance of taking consistently. Encouraged her to always take in the morning to avoid overnight urinating.

CHF medication assessment: patient taking ARB, BB, diuretic which are appropriate

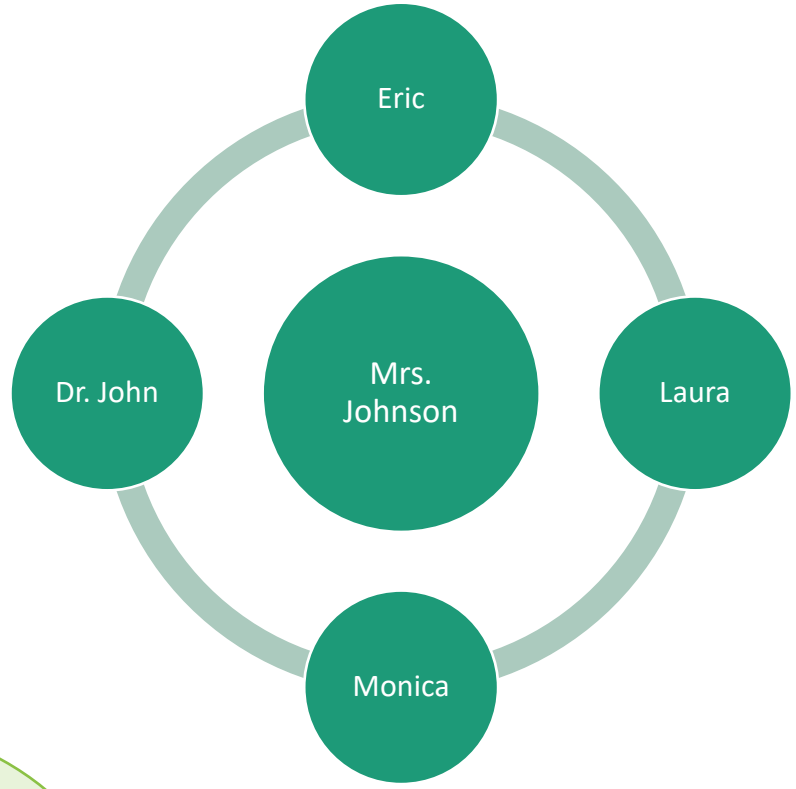
Follow-up planned: 1 month phone visit with Laura, RN
Level of understanding: Good
Readiness for change: 8 out of 10

Total time of visit: 25 min
Time stamp. Signature.

Care Team Conference

Chronic Disease

- Dr. Johns meets with Eric, Laura, and Monica to discuss Mrs. Johnson's care plan and progress towards her goals
- They explore additional ways to assist Mrs. Johnson with her goals. Laura will take the suggestions and discuss them with Mrs. Johnson at their follow-up visit together.



What billing code can the physician submit?

And the answer is….

G9007 - Team Conference

Face to face, video, telephone or secure web conference **between PCP and care team members** to formally discuss a patient's care plan.

Documentation Example

G9007- Team Conference

Team Conference Encounter: Face to face
Patient Name: Mrs. Johnson DOB: 2/12/52 MRN: 123456 PCP Name: Dr. Johns

Care Team Members Present: Laura RN, Eric MA, Dr. Johns MD, Monica PharmD
Date of service: 1/21/22

Diagnoses discussed: CHF-150.03

Pertinent details of visit: Care team presented and discussed patient's progress towards her identified self-management goals including monitoring daily BP and weights, along with her goal to reduce salt intake to <2 g/day. Explored ways to assist patient, including shopping around for food sales and referral to dietitian for additional dietary management given her pre-diabetes diagnosis. Monica discussed patient's non-adherence with furosemide. Dr. Johns will re-check labs and assess fluid status at next PCP follow-up visit to assess if dose should be adjusted.

Total time of visit: 10 min
Time stamp. Signature.

Specialty/PCP Interactions

- In the meantime, Mrs. Johnson went to see her cardiologist, Dr. Davis, to update him on changes to her medications.
- Mrs. Johnson mentions to Dr. Davis that she now has a care management team with her PCP who have been helping her with self-management goals and optimizing her medications.
- Cardiologist proceeds to call Mrs. Johnson's PCP to discuss patient's plan of care and offer recommendations and streamline care.
- They discuss her medication regimen and care plan. Telephone call lasts 6 min.

If Mrs. Johnson has BCBSM insurance, what billing code can the cardiologist submit?

And the answer is….

G9008 - Physician Code

G9008: Physician Coordinated Care Oversight Services (Enrollment Fee)

Communication with paramedic, patient, **other health care professionals** not part of the care team when consulting about patient

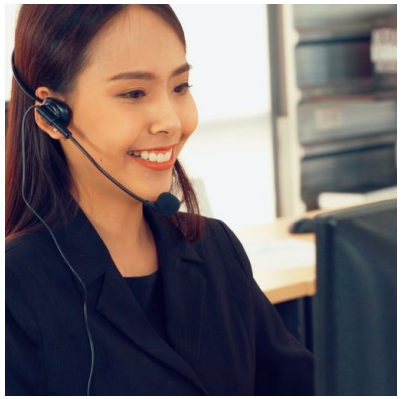
Face to face, video, or telephone (excludes email or EMR messaging)

Take Note!

- For BCBSM, G9008 is a physician-delivered service, commonly used when the physician engages the patient into PDCM, physician is actively coordinating care with the team or interacting with **another health care provider** seeking guidance or background information to coordinate and inform the care process.
- Specialists can take advantage of this code, same as would the PCP if she made the call to the specialist.
- Documentation would appear like the example above when Dr. Johns called the ED physician.

Specialty/PCP Interactions

- After speaking with Dr. Davis, Dr. Johns (PCP) wishes to increase coordination between practices to streamline care between the care teams. She asks Eric, MA to reach out to the office and speak with Maria, care coordinator, at cardiologist office.
- Eric calls Maria and the two of them discuss how to combine their resources to help Mrs. Johnson with her CHF management and overcome some of her SDOH barriers. Eric agrees to explore resources to aid with Mrs. Johnson's identified transportation issue. Phone call lasts 20 min.
- Eric then spends 15 min researching bus/taxi services that specifically help the elderly.
- Eric documents his conversation and additional work in the medical record.



If BCBSM insurance, what billing code can Eric submit?

Specialty/Primary Care Interactions

Chronic Disease

And the answer is....

99487 - Clinical Coordination

99487 Non-face-to-face Clinical Coordination:

Total clinical staff time per month working on behalf of the patient with someone other than the patient or provider.

Documentation Example

Specialty/Primary Care Interactions

Chronic Disease

99487 - Clinical Coordination

Care Coordination Encounter:
Patient Name: Mrs. Johnson DOB: 2/12/52 MRN: 123456 PCP Name: Dr. Johns

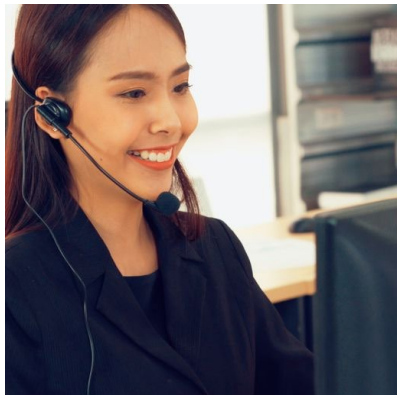
Care Team Members Present: Eric, MA
Date of service: 1/26/22
Diagnoses discussed: CHF-150.03

1/26/22: Spoke with Maria, care coordinator at Dr. Davis's, cardiologist office (contact number 313-222-4466). Spent time discussing patient's self-management goals and plan of care. Addressed the concerns identified from SDOH assessment including difficulty with transportation and health literacy.

Total time of phone visit: 20 min

1/26/22: Explored transportation resources to aid Mrs. Johnson in getting to doctor appointments as well as go to grocery when needed. See attached services available. Will provide printed resources to patient during next clinic visit. Total time spent: 15 min

Total time of visit for January: 35 min
Time stamp, Signature.

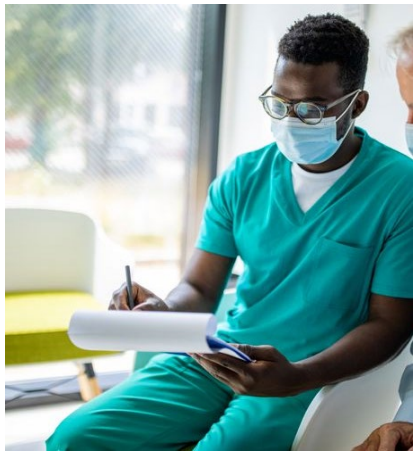


Gaps in Care

Gaps in Care

Chronic Disease

- Eric, MA, runs quality reports in the office and identifies Gaps in Care for 20 BCBSM patients. He notices Mrs. Johnson's name on the list and sees she is overdue for her mammogram and routine A1c to assess if her pre-diabetes has worsened.
- Eric calls Mrs. Johnson and phone call lasts 6 min.

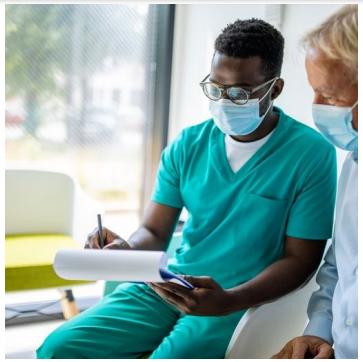


If BCBSM insurance, what billing code can Eric submit?

Chronic Disease

Gaps in Care

And the answer is….



98966- Telephone Code

Call with patient or caregiver to discuss care issues and progress towards goals.

98966 for 5-10 minutes

Substance Use Disorder

- 3 months later, Mrs. Johnson's CHF is now stable and controlled.
- Unfortunately, Mrs. Johnson's chronic back pain has worsened, and she now relies heavily on her oxycodone/acetaminophen prescription. She takes it consistently every day around the clock (no longer as needed). She requests an appointment with her PCP and asks for a higher dose to manage her pain.
- During the office visit, Mrs. Johnson meets with PCP to assess her back pain. PCP suggests a few non-pharmacologic therapies, but Mrs. Johnson is insistent on wanting an increased opioid dose.

Substance Use Disorder

Substance Use Disorder

- Noticing the red flags for substance abuse, PCP asks Mrs. Johnson to complete the CAGE-AID Substance Use Screening Tool. She answers yes to two questions, indicating further assessment is advised. PCP completes the full assessment.
- PCP asks Monica, PharmD to also speak with Mrs. Johnson today for medication counseling.
- Monica shares information about opioids and the risks associated with long-term use, including tolerance and addiction. She counsels patient on both pharmacologic and non-pharmacologic therapy used to treat chronic back pain.
- Monica also addresses briefly Mrs. Johnson's CHF care plan and self-management goals.
- Duration of visit with PharmD was 25 min.

What billing code applies?

And the answer is….

Substance Use Disorder

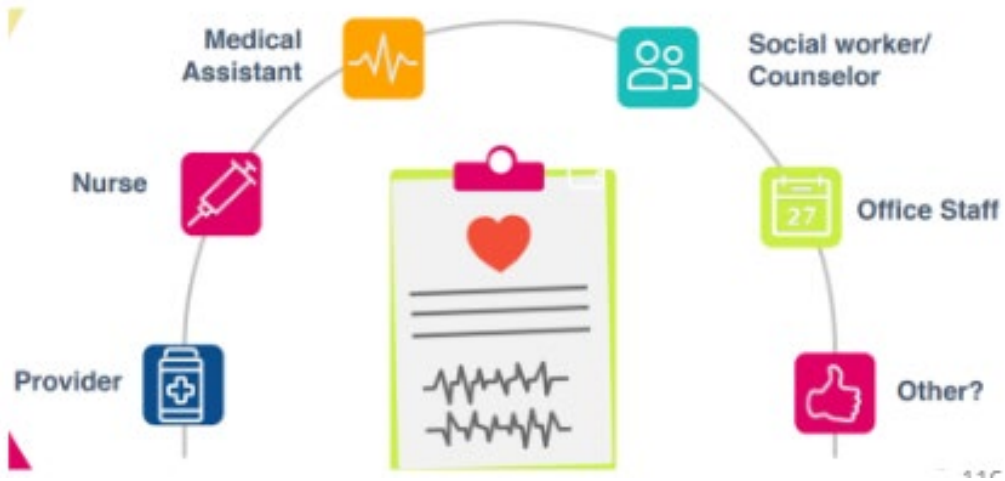
G9002 – Patient Visit Code

Face-to-Face or video visit that is focused on addressing a piece of the care management plan.

Also address the patient's goals and follow-up plan

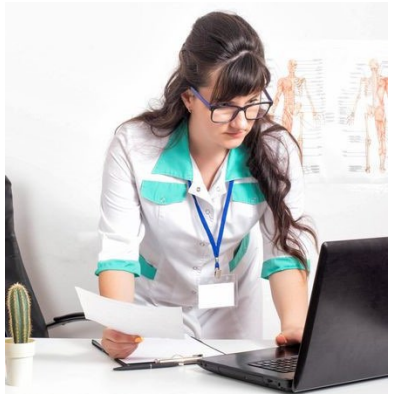
Medication Assisted Treatment & Care Management

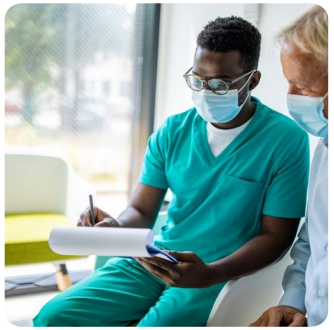
- Medication Assisted Treatment (MAT) for opioid use disorder can be done in the primary care setting with proper licensure and training and integrated within an existing care management program.
- Work done by care team members as part of MAT can be captured using CM billing codes.



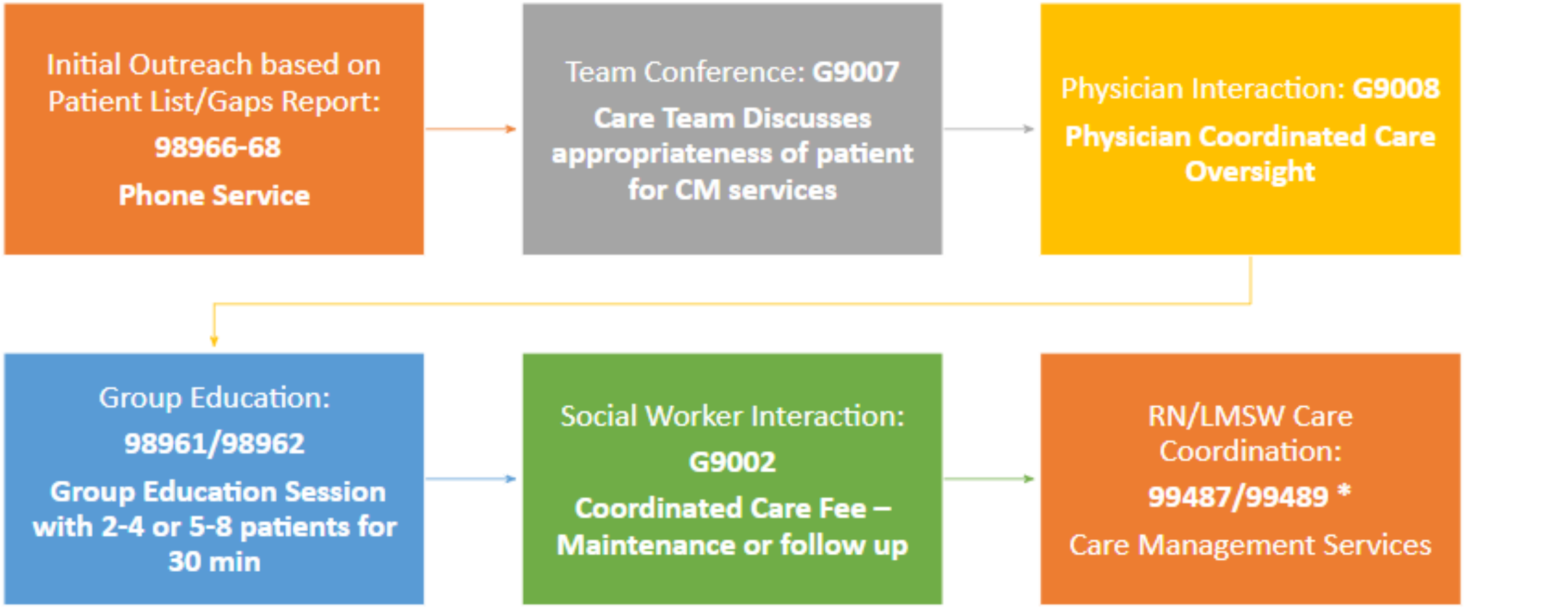
Longitudinal Care Management

- Mrs. Johnson agrees to try alternative therapies for her chronic back pain.
- PCP continues to manage Mrs. Johnson's pain management and assesses whether medication assisted treatment (MAT) is needed.
- Care team continues to schedule ongoing follow-up visits to monitor her progress towards her self-management goals, close gaps in care, address her SDOH needs, and help avoid hospitalization.





Additional Care Management

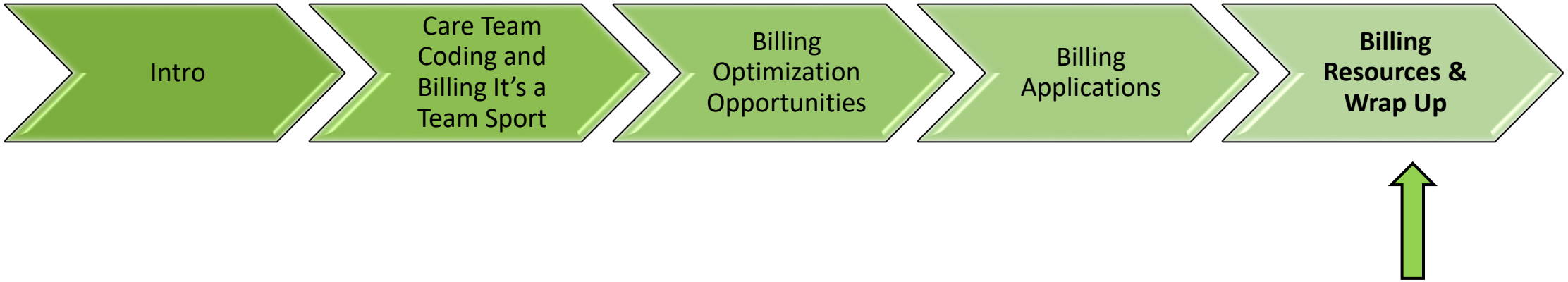


*Depending on time quantity for the month

Key Takeaways

- The PDCM billing codes can be utilized in many common clinical workflows within your office setting, including but not limited to: transition of care, social determinants of health screening, within specialty and primary care team interactions, gaps in care and substance use disorder.
- Be sure to appropriately document your care management encounters in detail and according to the billing rules specified by each individual insurance carrier.

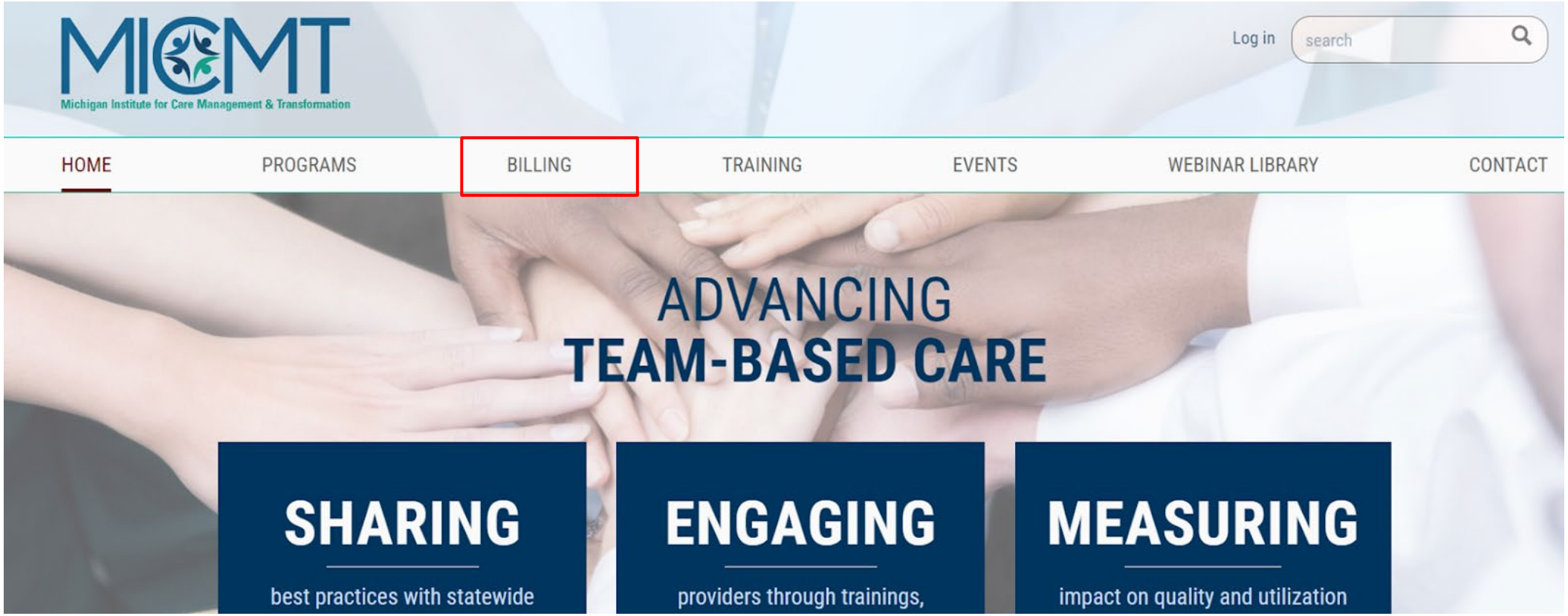
And now!!!!


Intro
Care Team Coding and Billing It's a Team Sport
Billing Optimization Opportunities
Billing Applications
Billing Resources & Wrap Up

Knowing that billing encounters contributes to successful team-based care and supports value-based reimbursement, what will you start doing differently in your role?

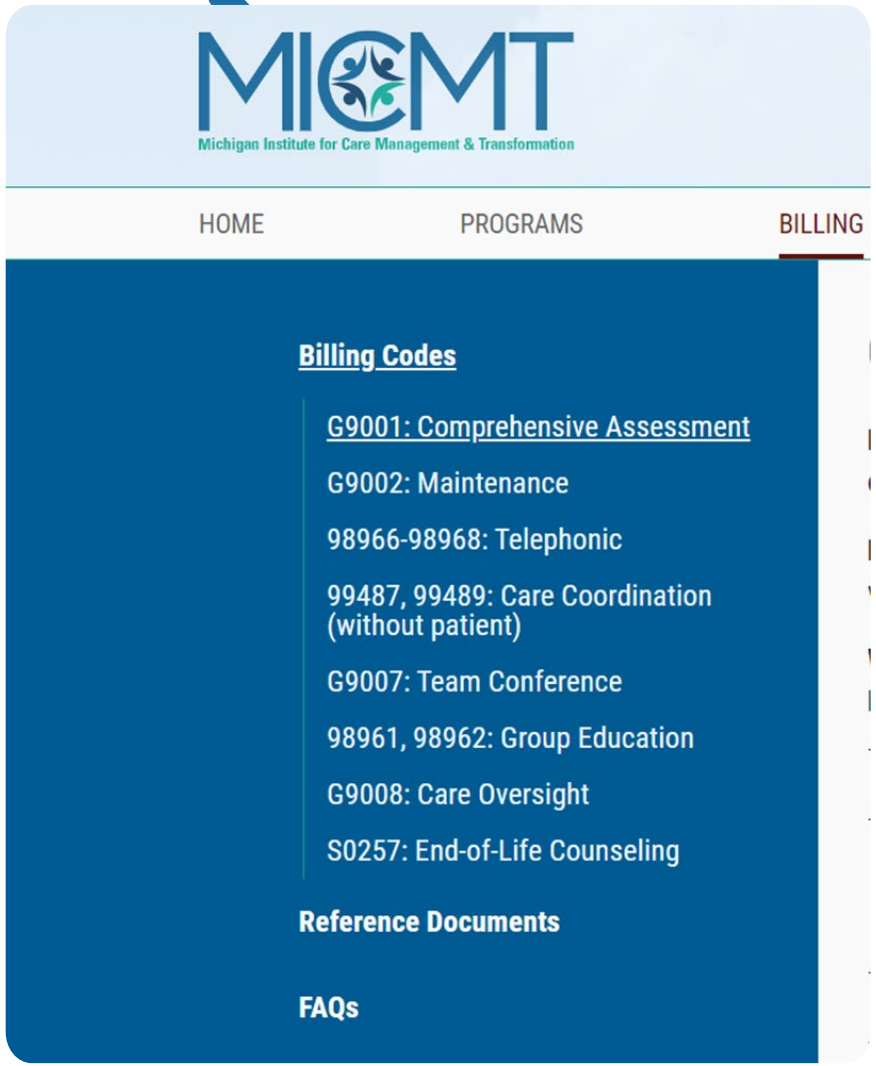
Resources

MICMT Billing Resources



MICMT- Billing Resources

- Billing Codes
- Reference Documents
- FAQ’s



MICMT- Billing Resources

Code Descriptions

G9001: COMPREHENSIVE ASSESSMENT

Description: Initiation of care management services (Comprehensive Assessment) and comprehensive (focused) care plan

Delivery Method: Face-to-face, via video, or telephone (note: telephone can only be utilized if video was declined by patient)

Who Can Bill? Any licensed care-team member who has completed **Introduction to Team-Based Care** within 6 months of billing

Payer	Billing Allowance	Requirement
BCBSM	Once per patient, per day, per practice	Provider liability if patient does not have care management benefit
Priority Health	Limited to once per practice annually	Must include patient
Medicaid (varies by HMO)	Limited to once per year with same diagnosis; cannot be billed in the same month as G9002	Must be a face-to-face encounter

Billing opportunities and reimbursement may vary depending upon organization's specific payer value-based contracts. All services should be billed in accordance with CPT and Center for Medicare & Medicaid service guidelines.

MICMT- Billing Resources

Documentation & FAQs

Recommended Documentation

- Identify care manager responsible for overall care plan, his/her credentials, and patient's provider and contact information
- Date, duration, and modality of contact (face-to-face or video)
- Name and relationship of person contacted if other than patient
- All active diagnoses assessed (and reported on claim)
- Current physical and mental/emotional status
- Current medical treatment regimen and medications
- Risk factors
- Available resources and unmet needs
- Level of patient's understanding of condition and readiness for change
- Perceived barriers to treatment plan adherence
- Individualized long and short-term desired outcomes and target dates
- Anticipated interventions and timeframe for follow-up
- Patient consent to engage/participate in care management

G9001 FAQS

Q: Can a care team member bill a G9002 without a preceding G9001?

A: Yes, care team members are not required to bill a G9001 prior to billing G9002.

Q: Does submitting a G9001 or G9002 require a time limit?

A: No; however, if you're submitting a G9002 and a coordinated care visit is >45 minutes, you may quantity bill. A G9001 cannot be quantity-billed.

MICMT- Billing Resources

Scenarios

G9001 SCENARIO

The MD refers the patient with a BMI for age >95%ile. Upon working with the patient, there are identifiable nutrition goals the patient would like to work on. However, the RD feels there is opportunity for this patient to work with Social Work to best address some barriers to optimal success with nutrition goals, so talks with patient and Social Work. This results in the RD referring the patient to SW for an appointment the following week. The RD fills the Social Worker in on progress from the initial RD visit and feels Social Work's involvement will support the patient in being successful with nutrition-related goals.

- *RD and SW are working toward the same goal of supporting the patient to be successful with nutrition-related goals, with the optimal outcome of addressing the BMI for age >95%ile.*
- *This is focused communication and coordination among two care managers to support patient goals.*

Resources: Care Management Services & Billing

- Michigan Institute for Care Management and Transformation
- **BCBSM**
  - PDCM Billing Guidelines (Commercial & Medicare Plus Blue PPO)
  - Groups not Participating in PDCM
  - PARS_IVR - Webdenis PDCM PPT
- Priority Health
- **Centers for Medicare & Medicaid**
  - Chronic Care Management
  - Behavioral Health Integration

Additional Training Opportunities

- **Patient Engagement Training**: learn how to use evidence based motivational interviewing and self-management support skills to engage with patients. This training is reimbursable to your affiliated Physician Organization.
- **CM Fundamentals MICMT Webinar Series**: participate in monthly on-going educational webinars for care management teams new to their role by addressing topics relevant to their daily work.
- **General MICMT Webinar Series**: participate in multiple monthly webinars on various topics.

MICMT webinars are free of charge and recorded/posted to the MICMT website. Feel free to send MICMT your ideas at **https://micmt-cares.org/contact**

For additional information on the Training Framework and Training Opportunities

REMINDER!

Successful completion of this course includes:

- Completion of the one day in-person/virtual training.
- Completion of the Michigan Institute for Care Management and Transformation (MICMT) post-test and evaluation.
- Achieve a passing score on the post-test of 80% of greater.

*If needed, you may retake the post-test.

You will have (5) business days to complete the post-test