# Billing Code Practice Activity 7

Focus:
Directions:

1. **High Risk Patient:**
   - Patient is flagged as high risk by a payer list.
   - Care manager discusses overall care plan goals with provider, and it is determined the patient is appropriate for care management.
   - Care manager reviews the chart, recent screenings (SDOH, PHQ-9), problem list, medications, and utilization history.
   - Care manager sees the patient in a face to face visit and evaluates the patient's current ability to steward their health, identifying strengths, weaknesses, opportunities, and barriers.
   - Patient develops a SMART goal, and the care manager connects the patient with various resources that address identified barriers.
   - Care manager discusses care plan with the provider. Provider agrees with the care plan
   - Patient and care manager agree on a follow up plan.
   - Care manager documents in the chart and adds the appropriate billing codes.

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2. **Face to Face and Follow Up Care**
   - A patient comes onto the office to be evaluated by their PCP. After the evaluation the PCP introduces the patient to the care manager (CM).
   - During the conversation with the patient the CM assesses that there is not a clear understanding about asthma management.
   - CM conducts a medication review, teaches how to use peak flow and keep a log, provides an asthma action plan.
   - CM and patient agree to follow up in one week via a phone visit.
   - This initial visit with the patient was 60 minutes. PCP and patient agree with the care plan.

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3. **Coordination of Care**
   - Care manager contacts the home health agency to schedule in-home visits and conduct a safety assessment.
   - In addition, a call was made to the DME provider to arrange for delivery of home O2.
   - Time spent coordinating care was 35 minutes**.**

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4. **Gaps in Care**
    - RN notices during chart review that several of the patients who are in his/her patient population have not received their cancer screenings, even though the RN and provider reminded them.
    - RN shows the list to the Medical Assistant.
    - Medical Assistant calls the patient to discuss gaps in care and facilitate closing the gaps.

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5. **Interdisciplinary Team**
    - Patient with diagnosis of diabetes, COPD and HTN. Patient screens positive for SDOH – food insecurity, struggling to afford medications, lacks caregiver support.
    - An interdisciplinary team conference was held with the Clinical Pharmacist, SW CM and PCP to modify the plan and discuss the initial plan of care with the team, which includes:
    - The SW CM schedules a virtual face to face visit with the patient regarding the lack of caregiver support and social isolation, which is linked with readmissions.
    - The Clinical Pharmacist follows up on the ability to afford medications and the chronic diseases, conducting a comprehensive assessment of the patient.
    - Both SW CM and Clinical Pharmacist follow up with the team at their regular huddle.

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6. **Advanced Directives**
    - CM conducts a 20 minute in person* meeting with a patient regarding their advance directives.
    - During the discussion information is given to the patient to review regarding advance directives.
    - Discussion includes:
        - How the patient prefers to be treated?
        - What the patient wishes others to know
    - CM and patient agree to follow up via a phone call in 2 weeks.

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7. **Reduces ED visits**
    - Proactive patient education to consider the PCMH practice first for acute healthcare needs, suggesting nearby urgent care, or ED for true emergency.
    - Follow up each ED visit with a call to identify issues, coordinate follow up care, and encourage seeking care through the practice rather than the ED when appropriate. Often, this can be performed by a medical assistant.
    - Medical assistants, operating under a protocol, may call patients, ask if the ED physician recommended follow up care, coordinate the needed care, transfer to clinician for issues requiring immediate medical assessment or guidance, encourage the patient to bring in all medications, etc.

8. **Phone Service**
    - CM speaks with a patient via the telephone.
    - CM reviews the patient's asthma action plan and reviews the symptoms that indicate worsening symptoms and asthma exacerbation.
    - Also reinforces when to call the office.
    - In addition, CM asks the patient about interest in attending an asthma Group Visit. Patient indicates interest and CM provides the information regarding the asthma Group Visit.
    - CM and patient agree on follow up in one week via in person visit at the office.
    - This meeting takes 20 minutes.

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9. **Patient Visit Face to Face**
    - The patient returns to the office one week later to meet with CM:
    - During the visit CM and patient discuss symptoms, medications, SMART goals.
    - Patient states he/she has not needed to use the rescue inhaler and feels they now have a better understanding of how to care for his/her self. You again review the action plan and state you will follow up in one month.

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## G/CPT Billing Code Resources – Care Management Services

Billing Resources – Michigan Care Management Resource Center website

- BCBSM - PDCM Billing online course, PDCM Billing Guidelines for Commercial and Medicare Advantage
- Priority Health
- State Innovation Model
- Centers for Medicare & Medicaid – Transitional Care Management, Chronic Care Management, Behavioral Health Integration
- Additional Billing resources: https://micmrc.org/training/care-management-billing-resources