Michigan Department of Health & Human Services

SIM PCMH Medicare and Medicaid Billing and Coding Collaborative

State Innovation Model

Patient Centered Medical Home Initiative

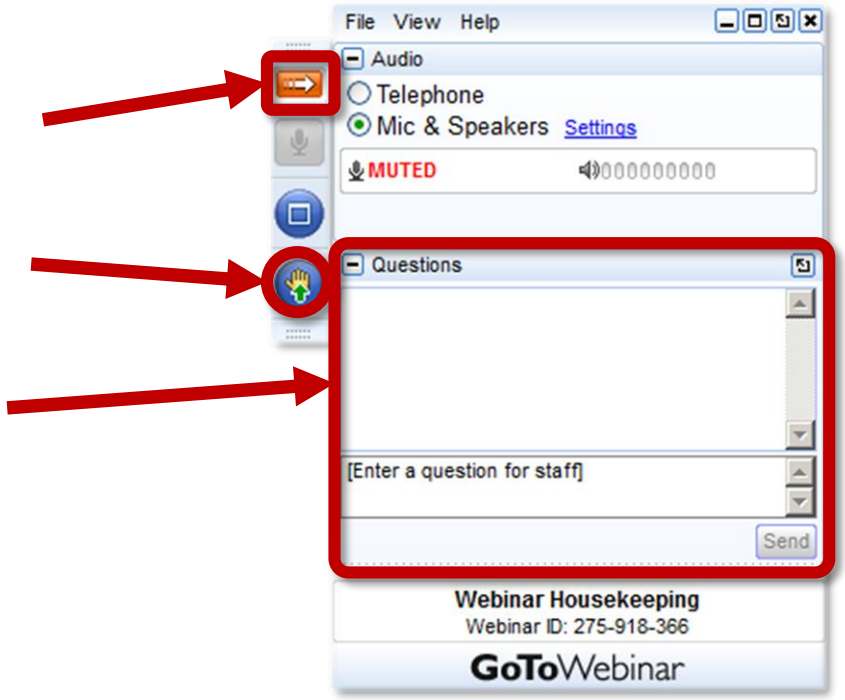
Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.

Housekeeping: Webinar Toolbar Features

Collapse Toolbar

Raise Your Hand

Ask a Question

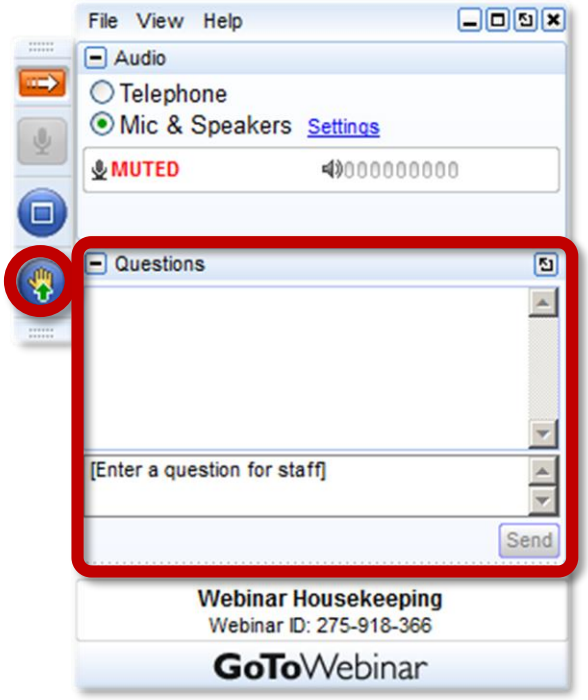


Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.

Housekeeping: Time for Questions

Your Participation

- Please continue to submit your text questions and comments using the Questions Panel
- Please raise your hand to be unmuted for verbal questions.



SIM PCMH Medicare and Medicaid Billing and Coding Collaborative

- Structure/Format
  - A series of six one-hour topical webinars about the Medicare CMS Care Management codes and their requirements with a subsequent half hour on Medicaid tracking codes
  - A series of six "Q&A Hours" one week after each topical webinars to address participant questions and case examples, as well as example workflows and process recommendations

- Key Partners: Clinovations/The Advisory Board (for Medicare Care Mgt G/CPT Codes) and Medicaid Leadership (for Medicaid Tracking Codes)

- What Is the Value in the Opportunity?
  - Of the six webinars, three are Initiative-selected and three will be based on participant needs
  - The May through July 2017 sessions will focus on:
    - TCM codes;
    - Complex Chronic Care Management and Chronic Care Management codes;
    - Strategies to overcome patient engagement challenges related to CMS' incorporation of patient financial liability
  - The August-October 2017 sessions will focus on topics selected by collaborative participants Potential topic ideas, for example, could include FQHC and RHC implications; integrated behavioral health care codes, etc.

Advisory Board

Medicare (CMS) Transitional Care Management Webinar

May 2017

Today's Presenter

Janice Morrow, CPC, Associate Clinical Director

Janice Morrow, CPC, brings more than 20 years of health care experience to her role as an Advisory Board Associate Clinical Director. In this role, Ms. Morrow is responsible for physician practice operations and positioning physician practices for successful growth and long-term stability. This includes enhancing practice efficiencies and strengthening the overall practice management team and supporting developing strategies and decision-making processes.

During her time at the Advisory Board, Ms. Morrow served as Project Manager for ICD-10 provider education for a health system in the West, where she created a project plan for the transition; delivered provider education; provided reports from compass; worked with the program director to create educational fliers to announce upcoming training sessions; and collaborated with the organization's internal corporate trainer to create the initial outline for provider education. Ms. Morrow was also responsible for auditing records for a large, multispecialty pediatric health care system in the south where she provides both statistical and educational feedback based on educational content she created. Additionally, Ms. Morrow presented ICD-10 educational seminars to providers in a large multi-specialty health system in Western North Carolina; audited records and provided feedback for large healthcare system in New Jersey, assisted with onsite support for newly implemented front end revenue cycle policy and procedures at a large healthcare system in Philadelphia, is providing subject matter expertise for a healthcare system in South Dakota on centralization of their coding department and in New Jersey to assess their Provider Medical Group coding operations

Prior to joining the Advisory Board, Ms. Morrow served in multiple positions for Accenture in Albany and New York City, N.Y. In her most recent role as Consulting Manager, Ms. Morrow provided subject-matter expertise for medical record and practice management systems validation, training and implementation. In this position, she focused mainly on medical coding, medical terminology and revenue cycle. Additionally, Ms. Morrow served as an Assessment Manager for a large, teaching health system, focused on inpatient and outpatient ICD-10 remediation, as well as leading and supervising assessment teams to determine client readiness for ICD-10 transformation.

Previously, Ms. Morrow served as a Project Manager / System Trainer for Etransmedia Technology in Troy, N.Y. In this position, she successfully managed Allscripts MyWay medical record and practice management implementation projects, provided system training, and oversaw a five-person training and project management staff. Additionally, Ms. Morrow delivered physician and staff web-based and on-site training, as well as designed, developed and deployed project plans for medical record and practice management system training. Ms. Morrow began her career in health care as a Practice Manager for a small pediatric medical group before serving with Prime Care Physicians in Albany, N.Y. During her time at Prime Care Physicians, Ms. Morrow served in a variety of roles such as Practice Administrator where she managed all aspects of physician revenue cycle, medical coding initiatives, budgeting, regulatory requirements, facility management, marketing trends, strategic planning and quality metrics. In addition, Ms. Morrow facilitated staff efficiency and improved revenue and operational workflow through implementation of revamped physician schedules. Ms. Morrow also served as a Corporate Training Manager / System Trainer and a Central Business Office ("CBO") Customer Service Revenue Cycle Team Manager.

Ms. Morrow is a Certified Professional Coder ("CPC") and is a member of the American Association of Professional Coders. Ms. Morrow earned a Bachelor of Science in human development from SUNY Empire State College in Saratoga Springs, N.Y.; an associate degree in applied science in medical secretarial science from Albany Business College located in Albany, N.Y.; and an associate degree in liberal arts from Harriman College in Harriman, N.Y.

1 Transitional Care Management Basics

2 Transitional Care Management Components

3 Transitional Care Management Coding and Billing

Transitional Care Management (TCM) Services

Care Coordination for Medicare Beneficiaries

CMS.gov
Centers for Medicare & Medicaid Services

CPT 99495

- Communication with patient or caregiver within 2 business days of discharge
- Medical Decision Making - Moderate
- Face-to-face* visit within 14 calendar days of discharge
- **Average Reimbursement - $165**

CPT 99496

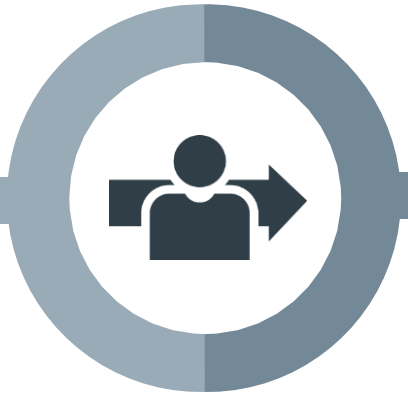
- Communication with patient or caregiver within 2 business days of discharge
- Medical Decision Making - High
- Face-to-face* visit within 7 calendar days of discharge
- **Average Reimbursement - $233**

*Face-to-face visits may be in the office or another location where the patient resides

Transitional Care Management Basics

What

Services provided to patients whose medical and/or psychosocial problems require moderate to high complexity medical decision making during transition of care



Transitioning From

- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long Term Care Hospital
- Skilled Nursing Facility
- Inpatient Rehabilitation Facility
- Hospital Outpatient Observation or Partial Hospitalization
- Partial Hospitalization at Community Mental Health Center

Transitioning To

- Home
- Domiciliary
- Rest Home
- Assisted Living

Transitional Care Management Basics

Who & When

The following health care professionals may furnish TCM services

- ✓✓Physicians (any specialty)
- ✓✓Non Physician Providers (NPPs*):
  - ✓✓Certified Nurse Midwife
  - ✓✓Clinical Nurse Specialists
  - ✓✓Nurse Practitioner
  - ✓✓Physician Assistants
  - ✓✓*Face-to-Face provided with minimum of direct supervision*
  - ✓✓*Non Face-to-Face provided under general supervision*

- ✓✓Post discharge from facility setting without a gap
- ✓✓Within 30 business days of discharge from hospital

*Applicable to state law, scope of practice, “incident to” rules and regulations

Transitional Care Management Basics

Interactive Contact

- Made within 2 business days following discharge to community setting
- Telephonic, electronic, or face-to-face
- Made by clinical staff with capacity for prompt interactive communication
- Addresses patient status and needs beyond scheduling follow-up care
- Attempts to communication should continue after first 2 days until successful contact is made

Provider Communication

- Obtain and review discharge information
- Review need of or follow-up on pending testing or treatment
- Interact with other clinicians who will assume or resume care of the patient's system-specific conditions
- Educate the patient and / or caregiver
- Establish or re-establish referrals for specialized care
- Assist in scheduling follow-up with other health services

Clinical Staff Communication

- Communication with the patient or caregiver (telephonic, electronic, or in-person)
- Communication with a home health agency or other community service that the patient needs
- Educate the patient and / or caregiver to support self-management and activities of daily living
- Provide assessment and support for treatment adherence and medication management
- Identify available community and health resources
- Facilitate access to services needed by the patient and / or caregivers

1 Transitional Care Management Basics

2 Transitional Care Management Components

3 Transitional Care Management Coding and Billing

Transitional Care Management Components

Minimum Documentation Requirements

- Date of beneficiary discharge
- Date of interactive contact with the beneficiary and / or caregiver
- Date of face–to–face visit
- Place of service
- Complexity of medical decision making (moderate or high)
  - Documentation of any medical or psychosocial problems
    - Testing ordered, reviewed
    - Consultations with other providers
  - Indication of number of problems (established or new)
- Applicable physical exam findings
- Diagnosis:
    - Report the diagnosis(es) for the conditions requiring TCM services
    - General conditions the patient had at the time of discharge

Transitional Care Management Components

Medical Decision Making

The complexity of establishing a diagnosis and/or selecting a management option determined by consideration of these factors:

- Number of possible diagnoses and management options that must be considered
- Amount and complexity of medical records, diagnostic tests, and other information that must be obtained, reviewed and analyzed
- Risk of significant complications, morbidity and / or mortality as well as comorbidities associated with the patient's presenting problem(s), diagnostic procedure(s), and possible management options

Transitional Care Management Components

Complexity of Medical Decision Making - Considerations

Diagnoses	Number
Established Problem Stable- Improved	Total Problems
Established Problem Worsening	Total Problems
New problem No additional workup planned	Max (1)
New problem Additional workup planned	Total Problems

Transitional Care Management Components

Complexity of Medical Decision Making - Considerations

Amount and Complexity of Data to be Reviewed
Review and/or order clinical lab tests
Review and/or order tests in the radiology section CPT
Review and/or order tests in the medicine section CPT
Discussion of test results with performing physician
Decision to obtain old records and/or obtain history from someone other than the patient
Review and summarization of old records and/or obtaining history from someone other than the patient and/or discussion of case with another health care provider
Independent visualization of image, tracing or specimen itself, not simply a review of report

Transitional Care Management Components

Complexity of Medical Decision Making – Assessment of Risk Level

Level	Presenting Problem	Diagnostic procedures ordered	Management options selected
Minimal	One self – limited, minor problem	*Lab requiring venipuncture *Chest x-rays *KOH Prep *Ultrasound, Echo	*Two or more self-limited or minor problems *One stable chronic illness *Acute uncomplicated illness
Low	*Two or more self-limited or minor problems *One stable chronic illness *Acute uncomplicated illness	*Physiologic test not under stress *Noncardiovascular imaging studies with contrast *superficial needs biopsies *Clinical lab test requiring arterial puncture *Skin biopsies	Over the counter drugs, Prescription drug *Minor surgery – no identified risk factors *Physical or Occupational Therapy *IV fluids without additives
Moderate	*One or more chronic illnesses with mild exacerbation, progression or side effect soft treatment *Undiagnosed new problem with uncertain prognosis *Acute illness with systematic symptoms *Acute complicated injury	*Physiologic test under stress *Diagnostic endoscopies with no identified risk factors *Deep needles or incision biopsy *CV imaging studies with contrast and no identified risk factors *Obtain fluid from body cavity	*Minor surgery – identified risk factors *Elective major surgery no-identified risk factors *Prescription Drug Management *Therapeutic nuclear med *IV fluids with additives *Closed of fracture or dislocation without manipulations
High	*One or more chronic illnesses with sever exacerbation, progression, or side effects *Acute or Chronic illnesses or injuries that may pose a threat to bodily functions *An abrupt change in neurological status	*CV imaging studies with contrast with identified risk factors *Cardiac electrophysiological tests *Diagnostic endoscopies with identified risk factors *Discography	*Elective major surgery – identified risk factors *Emergency major surgery *Parenteral controlled substances *High Toxicity – drug mgmt *Decision not to resuscitate or de-escalate care because of poor prognosis

ROAD MAP

1 Transitional Care Management Basics

2 Transitional Care Management Components

3 Transitional Care Management Coding and Billing

Transitional Care CDI / Coding Components

TCM Billing Services per MCR Guidelines

Who

- Only one health care professional (who assumes responsibility for the patients post discharge service) may report TCM services

When

- Billing should occur at the conclusion of the 30 day post discharge period
- Payable only once in 30 days following discharge, per patient, per discharge - i.e. if patient is readmitted TCM cannot be billed again
- Two or more attempts timely, without success must be documented and can be billed
- Face-to-face visits cannot be billed as TCM if not completed within required timeframe

TCM services are not applicable for every patient that has a follow-up appointment after discharge. TCM codes were designed to reimburse providers for significant extra work on the complex multidisciplinary patient

Transitional Care CDI / Coding Components

TCM Billing Services per MCR Guidelines

Billing Requirements

- Codes apply to both new and established patients
- Same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. However the required face-to-face visit may not take place on the same day your report discharge day management services.
- Subsequent E/M services outside the required face-to-face report separately
- You may not bill TCM services if within a global period by the same practitioner
- TCM services are subject to co-insurance and deductibles under Medicare
- TCM CPT codes 99495 and 99496 can be furnished through tele-health

Patient financial responsibility:

- TCM codes 99495 and 99496 are subject to Medicare deductible and copay

! TCM services are not applicable for every patient that has a follow-up appointment after discharge. TCM codes were designed to reimburse providers for significant extra work on the complex multidisciplinary patient

Transitional Care CDI / Coding Components

TCM Billing Services per MCR Guidelines

When you report CPT codes 99495 and 99496 for Medicare Payment, you **may not** also report the following codes during the TCM service period:

- Care Plan Oversight Services 99339-993340, 99374-99380
- Home health or hospice supervision: HCPCS codes G0181 and G0182
- End-State Renal Disease services: CPT codes 90951-90970
- **Chronic Care Management (CCM) services 99487-99489; 99490 (CCM and TCM service periods cannot overlap)**
- Prolonged E/M services without direct patient contact: CPT codes 99358 and 99359
- Prolonged services without direct patient contact 99358, 99359
- Anticoagulant management 99363, 99364
- Medical Team conferences 99366, 99368
- Education and training 98960-98962, 99071, 99078
- Telephone services
- Other services excluded by CPT reporting rules

Operational Considerations

1 Enable Your People

- Educate and train providers and staff to increase engagement and services capture
- Establish relationships with your acute facilities and any Transitions in Care Programs

2 Make Processes Efficient

- Evaluate workflow and optimize to leverage existing staff to the full extent of their licensure
- Promote proactive patient outreach

3 Get the Most From Technology

- Automated identification of eligible patients
- Standard documentation tools and templates
- Work queue support for billing and coding

Overview of Basic and Advanced Approaches to Transitions

Questions Highlight Major Decision Points to Advance Program Design

Process Step	Basic Approach	Advanced Approach	Questions To Consider
Initial Patient Assessment	• Physician referral-based • Automatic referral based on clinical criteria (e.g., specific diagnosis, number of medications, number of hospital visits this year)	• LACE tool or other acuity-based risk stratification tool • Predictive modeling algorithm	• What risk-stratification tool will we use? • Who is responsible for conducting the assessment? • How do we integrate the assessment into existing workflow to ensure completion soon after admission? • Are there patient groups we want to automatically consider for additional transitions support (e.g., specific payer contracts or chronic conditions)?
In-Depth Patient Assessment	• Basic questionnaire primarily focused on clinical risk factors, with some acknowledgement of non-clinical risk	• Multidimensional assessment that incorporates data from multiple sites of care	• Who will administer the in-depth assessment and how will we integrate into existing workflow? • Where will the information be recorded? • How do we ensure the discharge planner and providers across care sites have access to the information?
Discharge Planning Process	• Focus is on patient discharge • Next care site determined; discharge summary generated • Medication reconciliation performed and educational materials provided	• Focus is on patient transition • Provider or caregiver at next site of care is identified, contact information documented, and information shared prior to discharge • Patient and caregiver engaged in care plan development and education	• Who will own this step? • How can we support the person doing this by creating a more standardized way to complete the discharge summary? • Will staff need additional training around motivational interviewing and engaging patients and caregivers in care planning? • How will we assess patient/caregiver's comprehension and readiness to carry out discharge instructions?
Handoff to Transitions Lead	• Discharge summary sent virtually • No dedicated transitions lead—just a contact at next site of care	• Warm handoff with all stakeholders present (in-person or virtual) • Dedicated transitions lead	• How will we integrate into existing workflow and EMR? • Is there a standard checklist we would like to create for handoff meetings to promote consistency?
Post-discharge Patient Care	• Basic self-management education • Telephonic medication reconciliation • Single follow-up call within 24-72 hrs • Primary care and PAC connections as needed	• Basic support for all, plus additional support for moderate- and high-risk patients (e.g., weekly or semi-weekly follow-up calls, telephonic nurse support, community resource connections, home visits)	• Do we have existing staff we can deploy? • How will we prioritize home visits? • Are there specific PAC providers we should prioritize for additional transitions support?
Handoff to Primary Care	• Patient or discharge planner schedules follow-up PCP appointment	• Transitions lead completes a full handoff to PCP for ongoing care management • Warm handoff ideal	• How will we introduce new transitions processes and staff to existing primary care practices? • How should appointment scheduling be handled to support warm handoffs when possible?

Source: Population Health Advisor interviews and analysis.

Case Study

Care Coordinators Meet Patients Across Care Settings

Resources Provided by Ambulatory Care Transition Team (ACTT)

- Community services
- DME medical supplies
- Financial services
- Linkages to primary care
- Medication reconciliation
- Transportation assistance

Types of Patient Contact among ACTT Care Coordinators

Inpatient Warm Handoff

- Meet with inpatient case manager and patient prior to discharge

Patient Home Visit

- Conduct home assessments
- Assist patients with medication management, DME services

Primary Care Appointment

- Help patients prepare for visit, reinforce teaching points
- Participate in joint visits with primary care provider

Telephonic Coaching

- Provide self-management education and support
- Monitor patient needs over time (e.g., transportation)

Referral Coordination

- Facilitate referrals between primary care and specialist practices
- Track and monitor follow-up for recommended services

Case in Brief: Palmetto Health

- Five-hospital (1,100+ beds) integrated health system based in Columbia, South Carolina
- In 2011, formed the ambulatory care transition team, which offers care coordination services to recently discharged high-risk patients
- From 2011 to 2014, ACTT care coordinators have worked with nearly 1,000 patients and have reduced the 30-day readmission rate by 63% (from 16% to 6%)

Questions for Q&A Hours?