PCMH User Group Highlights 4/28/2015

Thank you to all who attended in person or via dial-in.

4/28/15 Tuesday 11:30-1P- Care Coordination Models

- **Bethany Oberhaus BSN, RN**, Clinical Operations Manager from Wexford/Crawford Mercy PHO spoke about the Care Coordination models they are using (and have been using for a while) and some new pilots they have underway.
- **Kevin DeBruyn, MSW,** from ACCM spoke about the Care Coordination models ACCM and NPO practices are implementing.
- **Stacie J. Saylor, CPC, CPB**, Reimbursement Advocate, Health Care Delivery from Michigan State Medical Society participated via dial-in and answered Care Coordination billing questions.

Bethany Oberhaus BSN, RN, Clinical Operations Manager from Wexford/Crawford Mercy PHO

Bethany Oberhaus BSN, RN shared their successes and opportunities with new care delivery models.

- November 2011 Wexford/Crawford Mercy PHO started their work after being accepted in the 3 year Michigan Primary Care Transformation (MiPCT) Project.
- Bethany referred to their experience as "building the bridge through experience" by using registered nurses as case managers to manage complex chronic conditions in the ambulatory setting.
- MiPCT project allows the use of *nurses and social workers*. MiPCT project does not allow the use of MAs.

Included in this email please see the Power Point slides which explain the different models being used and discusses lessons learned.

Bethany also provided the document, *Providing and Billing Medicare for CCM*.

Kevin DeBruyn, MSW, Adaptive Counseling & Case Management, LLC

Kevin leads ACCM and works with NPO to provide a resource for Case Management for member practices in the northern Michigan region.

- Kevin and his staff have formal agreements and have integrated as case managers into the office flow in 6 NPO PCMH practices including an NPO PCMH MiPCT practice.
- Currently, ACCM is accepting more referrals from other NPO practices and is available to all practices and accepts all patients *regardless of insurance coverage*.

- ACCM care managers, are seeing patients with single or multiple chronic illnesses ***in addition*** they provide additional skill sets such as ***supporting the psychological components*** of patients managing their care.
- Supporting the psychological component with counseling services support the patient and family which improves the combined efforts of the care team's *cycle of care.*

Stacie J. Saylor, CPC, CPB, Reimbursement Advocate, Health Care Delivery from Michigan State Medical Society

Questions for Stacie:

1) ***Can an AWV & CCM 99490 be billed on the same day?***

Response:

Please see the Medicare Chronic Care Management Services guide included in the email.

Page 7 is the CCM Scope of Service and Billing Requirements. It appears to state that CCM is initiated during an AWV, which can be billed separately. I do not find any CCI edits that say they cannot be billed on the same date.

Page 5 provides the Comprehensive Care Plan, which must be documented and shared with the patient and/or caregiver. It is based on a physical, mental, cognitive, social, functional, and environmental assessment.

A comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:

Problem list;
Expected outcome and prognosis;
Measurable treatment goals;
Symptom management;
Planned interventions and identification of the individuals responsible for each intervention;
Medication management;
Community/social services ordered;
A description of how services of agencies and specialists outside the practice will be directed/coordinated; and
Schedule for periodic review and, when applicable, revision of the care plan.

This is what the CPT manual states, as well.

Questions for Stacie:

2) ***A provider has a patient that is being seen in the home by Chronic Care Management LLC. I believe palliative care etc. Provider wants to bill Medicare for CCM. The $47.00 per month for time related services. The provider realizes the patient still needs to be seen and the patient will need to agree. Is this correct?***

Response:

Please see the document that WPS provided for their January CCM call as a source reference.

Page 5 provides restrictions.

Some of the codes that cannot be billed during the same month as CCM services are:

Transitional Care Management (TCM) 99495-99496
Home Health Care supervision/Hospice Care supervision G0181 & G0182
ERSD Services 90951-90970
Care Plan Oversight 99374-99380

Otherwise, check NCCI edits to see what the rules are.

Next Meeting: Thursday, May 28, 2015, 11:30 – 1PM

- **Deb Schepperly from Thirlby Clinic (50 minutes)**
  - Will be presenting their systematic process for managing registry reports.
  - Deb is currently participating in the Lean Championship Training at NMC and will be discussing Thirlby's experience with examples about implementing the Lean process to process at the practice.
- **Video from 11/14 PCMH Symposium - Dr. Jill Vollbrecht, Munson Endocrinology Metabolism (20 minutes)** Population Management Utilizing a Registry
- **Topic Suggestions – what ideas do you have? (10 minutes)**

PLEASE NOTE: If you plan to attend the May meeting either in-person or telephonically, please either email kelliott@npoinc.org or call NPO at 231-421-8505 to RSVP. After we receive your RSVP, we send you an Outlook appointment. Please bring in parking garage tickets for validation.

Kris

Kris Elliott, MS, CPHIMS
Director, Quality Northern Physicians Organization (NPO)
☎ 231-421-8505 C: 231-360-0183 email: kelliott@npoinc.org Fax: 231-421-8506