Revenue Implications for the Physician

Ewa Matuszewski
CEO
Medical Network One
May 19, 2022

Disclosure Statement

I have no actual or potential conflict of interest in relation to this program or presentation.

Learning Objectives

- Describe the benefits of paring a coder with the physician and care team
- Identify continuous quality improvement initiatives
- Explain recent changes in the Evaluation and Management Codes
- Identify five billing tips to maximize profit

Foundation for Success: Michigan Physician Organizations

- Not a professional society
- Community of healthcare professionals
- Contracting entity
- Provide infrastructure
- Share knowledge and learning
- Identify, engage in and oversee financial opportunities

Aligning with a Physicians Organization

- Pay for Performance
  - HEDIS
  - Stars
- Patient Centered Medical Home Recognition or Designation
  - Collaborative Quality Initiatives
  - Collaborative Care Model
  - Social Determinants of Health
- New relationships and new opportunities

Pay for Performance - P_4P

- PCMH Recognition or Designation not required
- Incentives support improving efficiency, quality and value of health care
- P_4P Programs initiated by managed care organizations
  - Process Measures
  - Process and Outcome Measures
  - Outcome Measure
  - Patient Experience of Care
- Upside and downside risks; penalties can be imposed

PCMH Recognition or Designation: Glide Path to Financial Opportunities

- Care delivery model in which a patient's treatment is coordinated through a primary care physician
- Comprised of initiatives or concepts that promote high quality team-based care including self-management support, extended office hours, specialist referrals, test tracking and addressing social needs
- Michigan payers support the PCMH recognition and designation through various funding models

Collaborative Care Model (CoCM)

- Behavioral health problems such as depression, anxiety, alcohol or substance abuse are among the most common and disabling health conditions worldwide
- Integrated care programs try to address behavioral health problems by providing both medical and mental health care in primary care

aims.uw.edu

Collaborative Care Model (CoCM)

- Collaborative Care focuses on a defined patient population tracked in a registry, measurement-based practice and treatment to target
- Michigan payer community supports CoCM through various incentives

aims.uw.edu

Collaborative Quality Improvement Initiatives

- Address most common and costly areas of surgical and medical care in Michigan
- Hospitals and physicians collect, share and analyze data on patient risk factors, processes of care and outcomes of care
- Participants design and implement changes to improve patient care
- Best practices are shared
- Two Michigan payers support the numerous initiatives through various incentives

Michigan Back Collaborative (MIBAC)

- Statewide, provider-led collaborative focuses on better care for low back pain
- Engage Primary Care Physicians
- Education
- Monitoring
- Best practices are shared
- Incentive for participation
- PCPs who meet requirements receive 2% VBR
- Two Michigan payers support the initiative through various incentives

Michigan Collaborative for Type 2 Diabetes (MCT2D)

- Focus to prevent, show and reverse the progress of Type 2 Diabetes
- Expand access to continuous glucose monitoring
- 760 participating primary care physicians
- Incentive for participation
- PCPs who meet the requirements receive a 5% VBR
- Two Michigan payers support the initiative through various incentives

l receive 5% VBR

Suicide Prevention (MIMIND)

- Engages psychiatrists, psychologists, and primary care physicians to improve suicide prevention across Michigan
- Implementation of system-specific suicide prevention elements
- Organizational phase
- Incentive for participation
- PCPs who meet requirements receive a VBR
- Two Michigan payers support the initiative through various incentives

Provider-Based Incentives for SDOH

- Rooted in State Innovation Model (SIM)initiative
- Community Health Innovation Regions (CHIR)
- Utilize an approved survey instrument
- Screen, collect and act on SDOH information collected
- Utilize and submit appropriate “Z” codes
- Michigan payers support the initiative through various incentives

A Primary Care Practice's Team

- Physician
- APP
- Pharmacist
- Nurse
- Dietitian
- Social Worker
- Medical Assistant
- Community Health Worker
- Front Desk/Scheduler

The Coder: A New Care Team Member

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

Explain Coding

- Health care coding: Pull out billable information from the health care documentation
- Health care billing: Identify codes to create claims to be sent to payer or patient
- Health care coding and billing overlap to create the spine of the practice's revenue

What We Know About Coders and Billers

- Rely on accurate documentation
- Identify and assess the codes that will be used for the encounter
- Monitor lag time of charge entry
- Review claims submitted
- Assess payments and denials
- Ensure electronic remittance information is current
- Ensure posting is done in a timely fashion
- Monitors aged trial balances

Questions for the Entire Care Team

- Do all the care team members understand the significance of the CPT, ICD-10 and payer developed 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?”

Coding & Compliance Initiatives, Inc.

Billing and Coding Accuracy: Who Is Accountable

- Physician
- APP
- Coder and or the Biller
- Other Care Team Member

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
- Reimbursement

Annual Evaluation and Management Code Changes

- Ensure practice coder/biller reviews changes in codes
    - CPT®
    - HCPS
    - ICD-10
- 2021 major changes in E/M office services
    - Level of the medical decision making as defined for each service
    - Total time for E/M services performed on date of encounter
- Refer to the CMS Table of Risk from Documentation Guidelines

Prepared, Proactive Care Team: Use of Appropriate CPT E/M Codes

- Review chart to prepare
- Obtain and review other components
- Discuss patient status with members of the care team including other QHP
- Monitor and record the amount of time used on care coordination non-face-to-face activities
- Perform examination of patient
- Counseling and education
- Ordering medication, tests and/or procedures

Five Tips To Take Home

1. What physicians' organization am I affiliated with?
2. What CQI initiatives is my physicians' organization engage in?
3. What should I know about value-based reimbursement (VBR)? What should I know about risk?
4. How does my care team enhance my practice's revenue?
5. How often do I review the CPT and ICD-10 codes used in my practice? When was the last time I reviewed them?

Reviewing Today's Learning Objectives

- Discuss three funding opportunities available to primary care physicians
- Explain recent changes in the Evaluation and Management Codes
- Describe the benefits of pairing a coder with the physician and care team
- Identify five billing tips to maximize profit

Any Questions

MedNetOne
HEALTH SOLUTIONS