

Clinical Conundrums: Three Common Challenges You May Be Facing Webinar Questions and Answers

Q: Regarding COPD treatment, there is recent literature regarding the effectiveness of combined LABA-LAMA inhalers versus LABA-ICS inhalers. Can you elaborate on this?

A: There was a recent article about this in Chest. LABA-LAMA combo seems better than LABA-ICS combo. In a real-world clinical practice setting of COPD treatment, combined LABA-LAMA inhalers appear to be as effective as combined LABA-ICS inhalers in preventing COPD exacerbations. However, a LABA-LAMA combination may be preferred because it is associated with fewer pneumonias. Here is a link to the article:

[https://journal.chestnet.org/article/S0012-3692\(19\)30696-8/fulltext](https://journal.chestnet.org/article/S0012-3692(19)30696-8/fulltext)

Q: Do you have any tips for how to appropriately manage medications in such complex patients?

A: When it comes to caring for complex patients who are faced with so many abnormalities (in labs, on exams) and symptoms, prioritize by looking at what is the most acute issue at hand - what can be done to diagnose this, and what medications can bring the patient immediate relief? While other things can be looked at down the line, focus on the important and acute symptoms for the patient first.

There are four recommended steps of medication management in the home:

- **Reconciliation:** Determine what medications the patient is taking versus the hospital discharge summary or previous office medication list.
- **Justification:** Review and justify that all medications have a documented medical condition that requires that medication therapy and is consistent with their goals of care.
- **Optimize:** Ensure proper dosing of medications based upon renal, hepatic functions, and consider drug-to-drug interactions; deprescribe (does the patient need all the medications?), PDCA cycles
- **Demonstration:** Ask the patient/caregiver to demonstrate proper use and administration of their medications to ensure accuracy and appropriate use.

Polypharmacy can be harmful physically as well as financially.

Q: When seeing a complex patient for the first time in the home, how do you even start to develop a care plan? It seems overwhelming.

A: It can be a challenge. Ask questions such as what are the acute issues or symptoms that need to be addressed and what are the patient's goals? These will help you get answers and determine next steps. It may also help to speak with the family to help determine what the patient's specific goals of care are.

Q: What local technology resources have you found in your area? Do you utilize mobile diagnostic and phlebotomy services and how reliable have they been? Also, what about other specialists for the homebound?

A: It's helpful to have mobile x-ray and ultra-sound services and to form relationships with these resources so you're able to get reports quickly, sometimes by the end of the day when on call. EKG can be more difficult but do your best to explore local resources or determine the best option for your patients. Some practices may have access to a separate mobile phlebotomy service that draws labs and follows up with the office.

The use of EHR's with record sharing capabilities can allow some specialists to provide feedback and "curb-side" counsel to help give the best possible care without seeing the patient. There are some optometrists and podiatrists who will provide in-home services. It is important to network within the community. If you are newer to house calls – home health agencies and local social workers can be a great resource to assist in finding community-based services to go to the home.

Q: Do you utilize any tools to assess caregiver burden?

A: Some use the Zarit Care Giver Burden interview scale. Others use the PHQ2. A review of new patient history helps gain valuable information. Consider asking the following two questions to caregivers: 1) do you feel you are able to provide the care your relative needs? and 2) do you feel you have time to take care of yourself? These questions allow valuable discussions to take place and help the caregiver feel supported in often difficult situations.

Q: Can you talk a little bit about the environmental assessment in the home? How do you go about this and how often to you reassess?

A: This is one of the unique advantages to making a house-call. Consider doing a regular walk-through with the patient's permission. This provides a sense of the challenges and potential interventions. This is done on the first visit as well as after an event – a fall, visit to the hospital - something that has impacted the patient since the last time they were seen. In cooperation with the Administration on Aging and the American Occupational Therapy Association, there is a two-page environmental checklist titled, "[Safe at Home Checklist](#)," that can be useful. It addresses numerous items and can be left with the patient/caregivers to help them address any potential safety issues and keep them aware of their environment.

Q: What kind of care-planning tools do your teams use? What elements does it include and is it a part of the patient's chart?

A: It may be helpful to write down the patient instructions on a carbon-copy sheet, whether it is a medication change or ordering a durable medical equipment (DME). The patient keeps one copy and the other is kept by the provider and entered into the EHR. EPIC or other EHRs can also be used to help access a wealth of information on patients. Review the chart before the visit. If at least 31 minutes are spent preparing and conducting chart review prior to a visit, use billing code 99358. Take time to ensure the medications match the diagnosis and discuss or review advanced directives on the first visit in a non-threatening way. You can bill for advance care planning should the conversation last at least 16 minutes. Utilizing all the information gathered from these conversations, create an assessment/plan. Several providers that do house calls print the after-visit summary before they go out on the next visit to the patient. Changes can be hand-written and provided to the patient/caregiver then updated in their record later. In this age of technology, don't forget the power of a phone call. Treat your patients with respect and compassion. A phone call can help answer additional questions, build the human connection, and enhance the relationship. For additional information and supplemental handouts for billing guidance, please visit the HCCIntelligence™ Resource page: <https://www.hccinstitute.org/resources/hccintelligence/>.

Q: For Transitional Care Management, can you still bill if you're unable to reach the patient or caregiver within two business days after multiple failed attempts?

A: One of the requirements for Transitional Care Management (TCM) is that clinical staff must make direct contact (interactive contact), either verbal or electronic, with the patient or caregiver within two business days of discharge. However, if you've documented two failed attempts to reach the patient or caregiver and all other TCM requirements are met when the provider arrives and completes their post-discharge visit then yes, you can still bill.

CMS expects attempts will continue until you're successful. However, they do allow you to bill for TCM if there have been at least two documented attempts prior to the post-discharge visit that occurs within 7 to 14 calendar days of discharge.

Q: Can the cognitive assessment and care planning code be reported in addition to your E/M code?

A: No, CPT code 99483 is for the assessment and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient setting (home, rest home), which can be billed once every 180 days per provider.

This service cannot be billed in conjunction with E/M, TCM, or CCM. However, the CMS national payment rate is \$241.92, and it can be a very beneficial service to provide if the focus of your visit is to assess, try to establish a diagnosis, or create a new care plan for a patient with cognitive impairment. Be sure to review the documentation requirements and create a template to ensure all required elements are completed and documented.

Q: Are there any methods you've found helpful to promote documentation efficiency?

A: There are several ways to promote documentation efficiency. It is strongly recommended to create custom documentation templates specific to your practice and care management style. This will also help capture quality metrics and other meaningful outcome data. Additionally, the use of MACRO's or smart phrases can save time and ensure you provide excellent care for services such as advance care planning, documenting chronic care management consent, and transitional care management.

Conducting pre-chart review prior to the visit promotes efficiency in order to maximize your time in the home and increase overall productivity. Some practices use a medical history form to gather extremely beneficial past medical history and other information prior to seeing all new patients. Clinical staff can help document or update the history within the EHR so the provider can review it during their first visit.