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Advanced Coding and Billing – Discussion Guide with Facilitator Notes

Thank you for leading a group discussion regarding key learning points from the HCCI online education activity, *Advanced Coding and Billing: Beyond E/M for House Calls.* This guide is intended to help you prepare to facilitate this discussion.

OVERVIEW

Purpose: The discussion guide aims to help home-based primary care (HBPC) providers take advantage of coding opportunities to capture revenue for services performed.

Audience: This discussion is intended for learners who have completed the online education activity *Advanced Coding and Billing: Beyond E/M for House Calls.* The discussion should take no longer than 60 minutes to complete.

Materials:

- Hard copies of the *Next Steps* handout from the Resources screen in the course.
- *Optional:* A handout or flipchart of the definitions for Transitional Care Management, Chronic Care Management, Advance Care Planning, and Prolonged Services.
- *Optional:* A flipchart to capture comments and ideas to help focus discussions and save for future consideration.

Instructions: Use the question prompts provided to initiate group discussions.

Learning objectives:

- Describe the regulatory compliance requirements for Transitional Care Management, Chronic Care Management, Advance Care Planning, and Prolonged Services.
- Identify implications at the practice and at the individual provider level that must be considered when implementing the described codes and services.

AGENDA

#	Topic	~Minutes
1	Introduction	5 min
2	Transitional Care Management (TCM)	10 min
3	Chronic Care Management (CCM)	10 min
4	Advance Care Planning (ACP)	5 min
5	Prolonged Services	5 min
6	Debrief	5 min

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TOPIC 1: INTRODUCTION

Question prompts:

- Do you feel that coding accurately is equally or more important in HBPC than in an outpatient/office setting? Why?
- Do you feel that coding accurately is equally or more of a challenge in HBPC than in an in-patient setting? Why?

TOPIC 2: TRANSITIONAL CARE MANAGEMENT (TCM)

Question prompts:

- Can anyone recall the definition of Transitional Care Management from the course? *(Check against the definition provided in the course.)*
- What are example scenarios where a patient may need TCM services?
- What are the pros and cons of furnishing and billing for TCM services versus typical home E/M codes?
- What processes would you need to implement to fulfill the care coordination and non-face-to-face requirements? Consider which staff members should be involved and how that might work for your practice.
- Can anyone recall the three required elements for TCM? *(1) Interactive Contact, (2) non-face-to-face services, (3) face-to-face services.* Can you think of examples of each?
- Do you use a standard set of questions when interacting with patients while providing TCM services? What questions do you think are good ones to ask? *(Refer to the questions in the course if you need prompts.)*
- What do non-face-to-face services look like in clinical practice? *(Refer to the services discussed in the course.)* Can anyone provide an example?
- What discussion or additional care planning services may be conducted during a TCM face-to-face visit? *(Discuss comprehensive medication reconciliation, review and discuss hospital admission and discharge summary, and coordinate follow-up orders for procedures, labs, or specialists.)*
- What levels of medical decision-making must be met to bill TCM services?
- How quickly do you typically see post-discharge patients? What barriers might you face in seeing the patient within seven days, and how could you resolve them?

TOPIC 3: CHRONIC CARE MANAGEMENT

Question prompts:

- Can anyone recall the definition of Chronic Care Management from the course? *(Check against the definition provided in the course.)*
- What are some examples of chronic conditions that would qualify under CCM?
- What are some benefits of CCM for our patient population?
- There are several requirements for practices that want to bill for CCM services. Are we currently able to satisfy them all? If not, which ones are challenging for us, and how can we resolve them?

- Do you currently create Comprehensive Care Plans for patients? Do you have any strategies to ensure you capture all the elements so they can be shared on time?
- What kind of non-physician practitioners can bill CCM services?
- What kind of EMR optimizations or enhancements do you need to capture clinical staff and provider time spent throughout the month?

TOPIC 4: ADVANCE CARE PLANNING (ACP)

Question prompts:

- Can anyone explain the difference between advance care planning and an advance directive?
- Why do you think this type of service is essential in home-based primary care?
- Under what circumstances would it be essential to ask the patient/caregiver to engage in an advance care planning discussion?
- What benefits does ACP present to providers and patients?
- Under what circumstances would a patient's copay be waived when you furnish ACP services in addition to this kind of visit?

TOPIC 5: PROLONGED SERVICES

Question prompts:

- How can home-based primary care providers use prolonged services with their patients?
- Which patient scenarios are the best candidates for prolonged services and why?
- How can prolonged non-face-to-face services benefit HBPC patients and their providers?
- Prolonged services cannot be reported during the same service period as complex chronic care or transitional care management services. What challenges might this present to providers?

TOPIC 6: DEBRIEF

Question prompts:

- Refer to the *Next Steps* handout. Review and mark which steps you would like to commit to taking next. Share your ideas for implementation.