

Advanced Services Pharmacy Network

November 4th, 2022

Agenda

**01 Grants are Scary –
Please Help!**
Rachel Blanton Harris

**02 Visit Types, Services
and Documentation**
Katie Erickson, Shelby
Lancaster and Tyler Hemsley

03 Break – Discussion
Prompt – Grant
Opportunities

**04 Who's Who – Org
Types and Key Players**
Denise Jensen and
Jennifer Yturriondobeitia

05 Break/Lunch
Prompt - Organizational
Coordination

**06 Billing for Services
– Deep Dive**
Jenilee Johnson

Funding and Support for ASPN

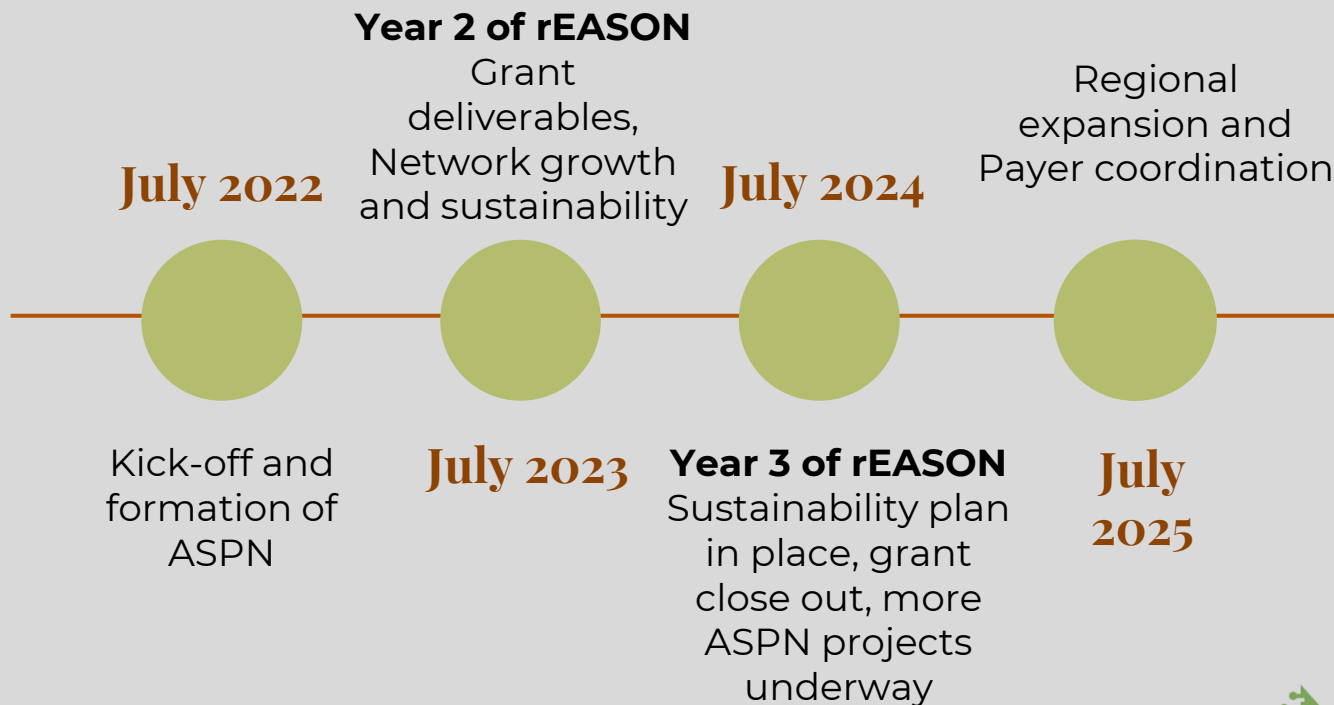


Rural Emergent
Alternative Surgical
Opioid Non-use

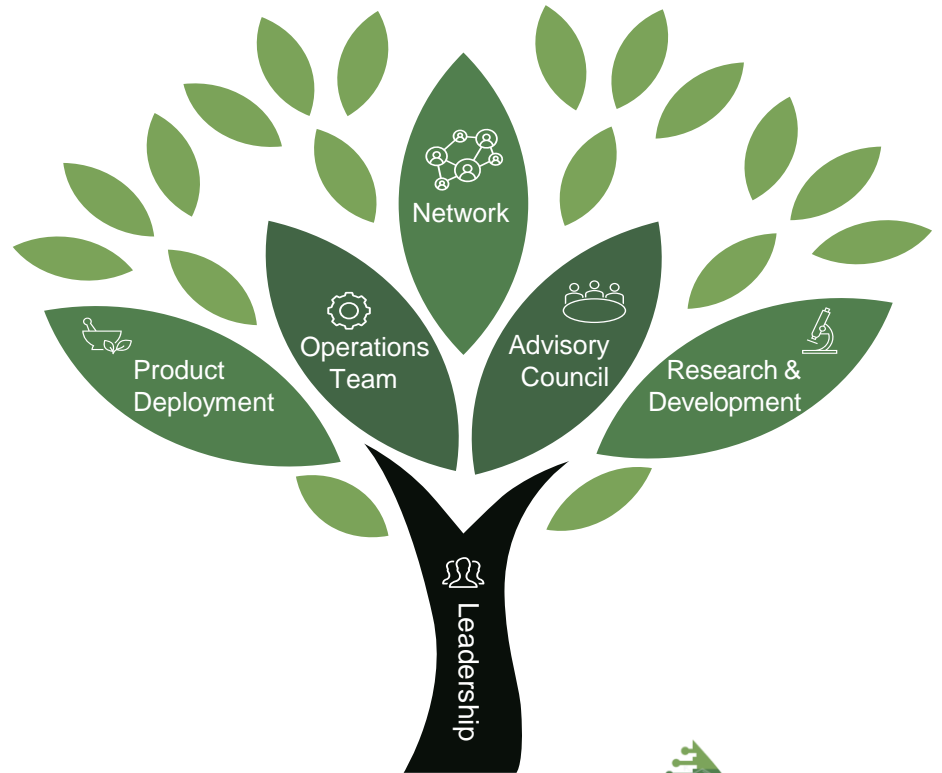
Network Connections



Timeline



ASPN Framework



ASPN Framework

Leadership

Tyler Hemsley
Sam Self
Sabrina Sherwood
Shelby Lancaster
Jenilee Johnson
Rachel Armstrong
Katie Erickson

Advisory Council

Jolie Jantz
Anthony Peterson
Trenton Jenks
Lindsay Crawford
MORE?!

Cue Recording

[Grants are Scary 2022 Video](#)

**Grants are
Scary
—
Please Help!**

Discussion and Grant Links

- https://cdn.pfizer.com/pfizercom/2022-10/GMG_2022-HOS-G_SupportingPatientPoweredResearch.pdf?MP8DqEsxZqXWQUF7jw1jJuMWno3rQYIS
- <https://prevention.odp.idaho.gov/substance-abuse-block-grant-application-information/>
- <https://www.grants.gov/web/grants/view-opportunity.html?oppld=340889>
- <https://communitypharmacyfoundation.org/grants/grid.asp>
- <https://forms.benevity.org/34c71ce3-ac90-45e9-bea5-149980240bef>

Credentialing – Visit Types, Services and Documentation

Pharmacist Value Proposition

**Improved
Satisfaction
for Care
Teams**

**Improved
Outcomes
with Lower
Total Cost
of Care**

**Improved
Access to
Healthcare
Services**

Support for Pharmacy Integration

THE PROBLEM

The U.S. spends as much money correcting the problems caused by medications as we do on the drugs themselves.

ONE SOLUTION

Pharmacists in ambulatory care.

HERE'S HOW

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Learning Systems
for Accountable Care Organizations

Medicare Shared Savings Program ACO Learning System

Engaging Pharmacists in Accountable Care

Tuesday, July 19, 2016

The Advisory Board Company | Population Health

Empower your patients.

- Teach patients about the pharmacist's expertise, and how he or she is a member of the care team.
- Encourage patients to ask questions. Engaged patients have high levels of satisfaction with their care.

Put Pharmacists ON THE CASE
Find Opportunities to Save Money on Employee Health Costs

Tactic 1: Manage Medications for High-Risk Employees

For high-risk patients, poor medication management leads to wasted spending—both on the medications themselves and on avoidable ED visits and hospital admissions. Health system pharmacists can improve care by providing specialized clinical services to beneficiaries, including medication therapy management and virtual medical record review.

CASE STUDY: MU Health Care's Virtual Pharmacy Review Program

- Pharmacy leaders created a virtual pharmacy review program to help physicians manage care for employees and other health plan beneficiaries with diabetes.
- One pharmacist works virtually across 60 clinic sites to review patient charts prior to primary care visits and recommend interventions to physicians before they meet with each patient.
- The pharmacist reviews any e-prescriptions for the patient, both from the PCP visit and in the event of a hospital or ER visit.

RESULT
\$10.50 PMPM reduction
for the diabetic population in the program's first 9 months

Tactic 2: Recapture Employee Prescriptions

Health system-owned pharmacies can often leverage preferred pricing to fill employee prescriptions for significantly lower costs than at an external retail pharmacy.

Integrated Pharmacy Models
in **Primary Care**

Challenges

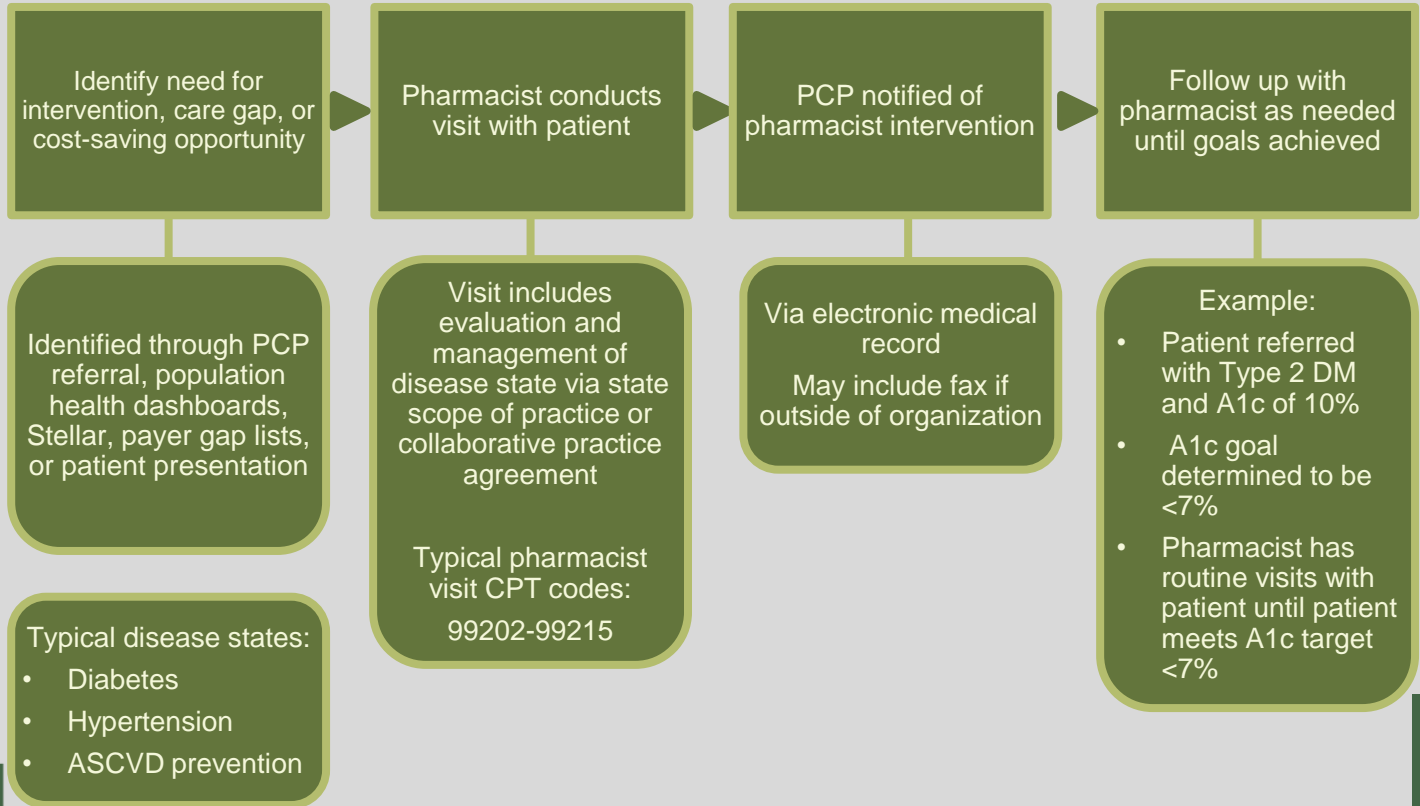
Legislation/Regulation vs Innovation

Pharmacists are recognized as providers by some states, still not by CMS

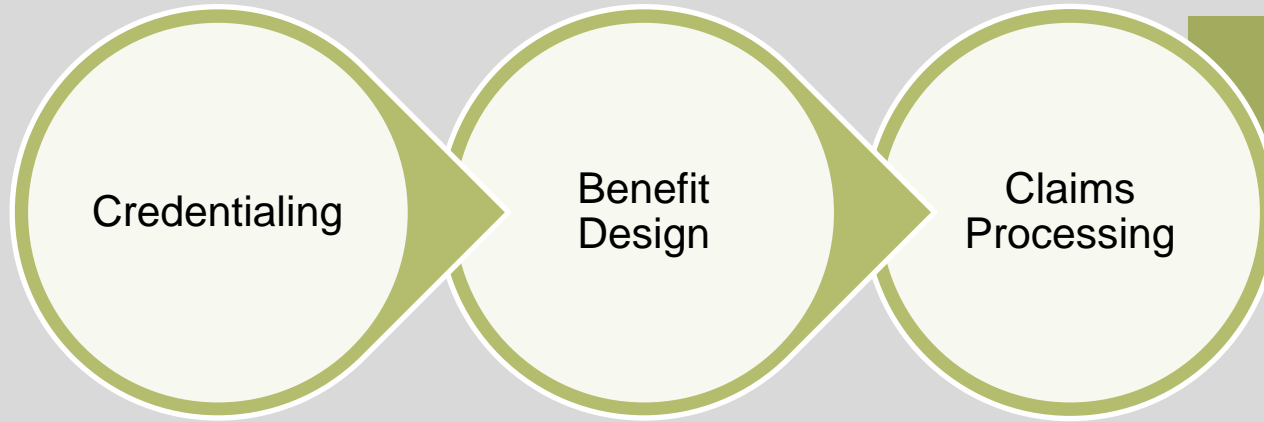
Credentialing challenges with organizations and payers

Fee-for-service vs Value-based approach to healthcare

Pharmacist Provider Model – Employed Pharmacist



Pharmacist Provider Model – Payer Process



- Commercial:
Add pharmacists as included provider type

- Medicare:
Can be added as a supplemental benefit for Medicare Advantage, CMS does not recognize pharmacists as providers

- Allow pharmacist visits at design level

- Ideally \$0 co-pay, majority of visits are considered primary care

- Ensure claims submitted by a pharmacist will go through medical benefit without rejections

- Ensure prescriptions written by a pharmacist will go through pharmacy benefit without rejections

Pharmacist Provider Model – Employed Pharmacist

Health System Pharmacist

- Credentialing with payer(s)
- Credentialing and privileging with medical staff
- Established collaborative practice agreements and/or protocols

Community or Independent Clinic Pharmacist

- Credentialing with payer(s)
- Established collaborative practice agreements and/or protocols
- Ability to bill medical claim

Discussion

Break Discussion — Grant Opportunities

Who's Who — Org Types and Key Players

Who's Who

Within Organizations

Government Organizations

State

Regional

Public Health District

County-Based Services

School Districts

State Organizations

Idaho Department of Health and Welfare (IDHW)

Brad Little - Idaho Governor

Board of the Department of Health & Welfare (DHW)



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Medicaid Policy & Innovations
Clinical & Quality Management
Medicaid Operations
Long Term Care Services
Developmental Disability Services
Care Management
Medicaid Financial Operations
Medicaid Automated Systems



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Navigation Services
Idaho 211 CareLine
Child Protection (Child Welfare)
Foster Care & Adoption
Independent Living for Older Youth
Children's Developmental Disabilities
Crisis Prevention & Court Services
Infant Toddler Program
Head Start Collaboration
SW Idaho Treatment Center (SWITC)



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Adult Mental Health Services
Children's Mental Health Services
Substance Use Disorders Services
State Hospital North
State Hospital South
State Hospital West



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Eastern Idaho Area
Child Welfare Liaison



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Recruitment, Classification and Compensation
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Employee Relations and Performance
Civil Rights
Language Assistance
Privacy/Data Governance



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Maternal and Child Health
Family Planning
Home Visiting
HIV, STD & Hepatitis
Women, Infants & Children Nutrition (WIC)
Chronic Disease Prevention
Tobacco & Obesity Prevention
Sexual Violence Prevention
Environmental Health Services
Rural Health Care Access & Improvement
Vital Records and Health Statistics
State Communications Center
Emergency Medical Services Licensure
Public Health Preparedness & Response
Time Sensitive Emergency Systems of Care
Suicide & Drug Overdose Prevention
Public Health Laboratory Services
Disease Detection & Response
Refugee Health Screening
Food Protection
Immunizations
Healthcare Association Infection
Policy, Performance, & Strategy



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Food Stamps (SNAP)
Child Care Assistance
Medicaid Eligibility
Temporary Cash Assistance (TAFI)
Aid to the Aged, Blind & Disabled (AABD)
Child Support Services
The Emergency Food Assistance Program
Low-Income Home Energy Assistance
Tax Credit Subsidies (APTC)
Child Care Provider Education/Licensing
Weatherization Assistance
Community Services Grant (CSBG)



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Facility Standards
Certified Family Homes
Therapeutic Residential Programs
Residential Assisted Living Facilities
Administrative Rules Unit



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Finance
Contracting/Purchasing
Building & Support Operations
Audits & Investigations
Department and Division Budgets
Accounts Payable
Revenue Operations, Grants and Cash
Electronic Benefits and Financial Systems
Employee Services (payroll)



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Northern Idaho Area
Tribal Programs Manager
Legislative Liaison



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IDHW IT Infrastructure and Services
Application Development and Support
IT Service Desk (field support)
Statewide IT Collaboration
Cyber Security

Strategic Business Office

Project Management
Business - Technology Integrations
Enterprise Solution Support

<https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=19389&dbid=0&repo=PUBLIC-DOCUMENTS&cr=1>



ASPN
Advanced Services
Pharmacy Network

Welcome to the Idaho Office of Drug Policy

The Idaho Office of Drug Policy leads Idaho's substance use and misuse policy and prevention efforts by developing and implementing strategic action plans and collaborative partnerships to reduce drug use and related consequences.

Have old or unwanted prescriptions in your medicine cabinet? There are permanent prescription drug disposal locations in communities across Idaho where you can drop off your unused or expired medication year-round. To find a permanent prescription drug disposal location near you, [click here](#).



Policy

[Cannabidiol \(CBD\) Position Statement](#)

[Marijuana Legalization Policy Statement](#)

[2022 ODP Legislative Summary](#)

[How to Contact Your Legislator](#)



Partnership

[Idaho Opioid Misuse and Overdose Strategic Plan](#)

[State Epidemiological Outcomes Workgroup \(SEOW\)](#)

[Governor's Opioid and Substance Use Disorder Advisory Group](#)



Prevention

[Substance Abuse Prevention and Treatment Block Grant \(SABG\)](#)

[Strategic Prevention Framework Partnerships for Success Grant \(SPF PFS\)](#)

[Grant Opportunities](#)

<https://odp.idaho.gov/>

Find a Prescription Drug Take-Back Location Near You

Search by zipcode

Search



Office of Drug Policy

PO Box 83720
Boise, ID 83720

☎ (208) 854-3040

📠 (208) 854-3041

[Newsletter Sign-up](#)

ODP Resource Materials

[Prescription Opioid Misuse Prevention Materials](#)

[Be The Parents Underage Drinking Prevention Materials](#)



OVERVIEW OF DEPARTMENTS



<https://www.sde.idaho.gov/about.html>



The official website of the

Idaho Legislature



STATE OF IDAHO

WHO'S MY CURRENT LEGISLATOR?



SENATE

HOUSE

COMMITTEES

LEGISLATORS

LAWS/RULES

LEGISLATIVE SESSIONS

LIVE AUDIO/VIDEO STREAMING

HOME | COMMITTEES

Committees

The House of Representatives has 14 committees and the Senate has 10. When appointments of committee chairmanships are made, it is customary to appoint a member of the majority party as chairman.



Senate Standing
Committees



House Standing
Committees



Joint Standing
Committees



Interim & Special
Committees



Change in Employee
Compensation



Legislative Compensation
Committee



Testifying before Legislative
Committees



Legislative Council

Who's My Current Legislator?

Enter street address and zip code

State Senate

P.O. Box 83720
Boise, ID 83720-0081
P: 208-332-1000 | F: 208-334-2320

House of Representatives

P.O. Box 83720
Boise, ID 83720-0038
P: 208-332-1000 | F: 208-334-2491

Legislative Services Office

P.O. Box 83720
Boise, ID 83720-0054
P: 208-334-2475

Regional Organizations

Regional Behavioral Health Boards

A behavioral health board exists in each region of the state. For more information on each regional board, community outreach and events, as well as specific meeting dates and times, please visit the regional behavioral health board websites.

Regional behavioral health boards:

- Advise the state behavioral health authority and the state Behavioral Health Planning Council on the local behavioral health needs of adults and children within the region.
- Advise the state behavioral health authority and the Behavioral Health Planning Council of the progress, problems, and proposed projects of the regional service.
- Promote improvements in the delivery of behavioral health services and coordinate and exchange information regarding behavioral health services in the region.
- Identify gaps in available services and recommend service enhancements that address identified needs for consideration to the state behavioral health authority.
- Assist the Behavioral Health Planning Council with planning for service system improvements. The council will incorporate the recommendations from the regional behavioral health boards into an annual report to the Governor and Idaho Legislature.
- Annually provide a report to the Behavioral Health Planning Council, the regional behavioral health centers and the state behavioral health authority of progress toward building a comprehensive community family support and recovery support system that shall include performance and outcome data as defined and in a format established by the planning council.
- The regional board may establish subcommittees as it determines necessary and will, at a minimum, establish and maintain a children's mental health subcommittee.



Regional behavioral health board websites

[Region 1 Behavioral Health Board](#)

[Region 2 Behavioral Health Board](#)

[Region 3 Behavioral Health Board](#)

[Region 4 Behavioral Health Board](#)

[Region 5 Behavioral Health Board](#)

[Region 6 Behavioral Health Board](#)

[Region 7 Behavioral Health Board](#)

Board Resources

[Regional Behavioral Health Board FAQs](#)

[Idaho Behavioral Health Planning Council \(BHPC\)](#)

[Governor's Reports](#)

<https://healthandwelfare.idaho.gov/about-dhw/boards-councils-committees/regional-behavioral-health-boards>

Regional DHW Offices

- Crisis Response
 - Mobile Crisis
 - Designated Examinations
 - Misc. Mental Health Services

Public Health Districts

Idaho public health districts

PUBLIC HEALTH DISTRICTS

District 1: Panhandle Health District →

Director: Don Duffy
8500 N. Atlas Road
Hayden, ID 83835
1-208-415-5100
FAX: 1-208-415-5101

[Visit Panhandle Health District](#) ↗

PUBLIC HEALTH DISTRICTS

District 4: Central District Health →

Director: Russell A. Duke
707 North Armstrong Place
Boise, ID 83704-0825
1-208-375-5211
FAX: 1-208-327-1100

[Visit Central District Health](#) ↗

PUBLIC HEALTH DISTRICTS

District 7: Eastern Idaho Public Health →

Director: James Corbett
1250 Hollipark Drive
Idaho Falls, ID 83401
1-208-522-0310
FAX: 1-208-525-7063

[Visit Eastern Idaho Public Health](#) ↗

PUBLIC HEALTH DISTRICTS

District 2: Public Health-Idaho North Central Health District →

Director: Carol M. Moehrlie
215 10th Street
Lewiston, ID 83501
1-208-799-3100
FAX: 1-208-799-0349

[Visit Public Health-Idaho North Central Health District](#) ↗

PUBLIC HEALTH DISTRICTS

District 5: South Central Public Health District →

District Director: Melody Bowyer
1020 Washington Street N.
Twin Falls, ID 83301-3156
1-208-737-5900
FAX: 1-208-734-9502

[Visit South Central Public Health District](#) ↗

PUBLIC HEALTH DISTRICTS

District 3: Southwest District Health →

Director: Nikole Zogg
13307 Miami Lane
Caldwell, ID 83607
1-208-455-5300
FAX: 1-208-454-7722

[Visit Southwest District Health](#) ↗

PUBLIC HEALTH DISTRICTS

District 6: Southeastern Idaho Public Health →

Director: Maggie Mann
1901 Alvin Ricken Drive
Pocatello, ID 83201
1-208-233-9080
FAX: 1-208-234-7169

[Visit Southeastern Idaho Public Health](#) ↗

Public Health Districts

As independent agencies, Idaho's seven health districts are primary outlets for public health services.

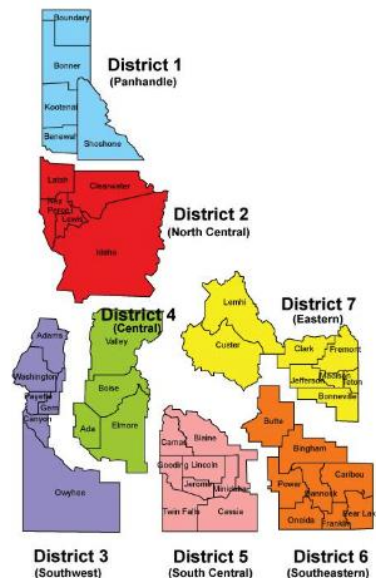
About public health districts

Idaho public health districts work closely with Health and Welfare and other state and local agencies. Each district has a board of health appointed by county commissioners within that region. The districts are not part of any state agency.

Each district responds to local needs to provide services that may vary from district to district, ranging from community health nursing and home health nursing to environmental health, dental hygiene, and nutrition. Many services are provided through contracts with the department.

For information about services in your community, click on your district below to go to that public health district's website.

Public health districts map



Healthcare Organizations

CAH's

FQHC's

RHC's

Critical Access Hospitals

- Designation – 27 out of 40 hospitals in Idaho are designated CAH's
 - 25 beds or less
 - Improve access to healthcare and reduce financial vulnerability
 - Allows for cost-based reimbursement from Medicare to offset costs associated with a smaller/rural hospital to help reduce hospital closures
 - Are certified under a different set of Medicare Conditions of Participation (CoP) that are more flexible than acute care hospitals CoP's.
- CAH Criteria:
 - Over 35 mile distance from another hospital, or
 - 15 miles from another hospital in mountainous terrain or areas with only secondary roads, or
 - State-certified as a necessary provider of health care services to residents in the area

Rural Health Clinics

- Designation – 45 Rural Health Clinics in Idaho
- Must be located in a non-urbanized area and
- Must be located in a medically underserved area or HSPA area
- Must provide routine diagnostic and lab services and employ mid-level practitioners 50% of the time the clinic is open.
- Certification happens through IDHW, Division of Medicaid, Bureau of Facility Standards
- Enhanced reimbursement rates (Medi/Medi) and these visits are reimbursed under a Prospective Payment System (PPS) rather than a Fee for Service System (FFS).

Bureau of Rural Health

- CAH's and RHC's
- 450 W State Street – 4th Floor
- PO Box 83720-0036
- Phone: 208-334-0669
- Email: RuralHealth@dhw.idaho.gov

Federally Qualified Healthcare Clinics (FQHC's)

16 in Idaho

According to the [Health Resources and Services Administration \(HRSA\)](#), FQHCs:

- Qualify for funding under [Section 330 of the Public Health Service Act \(PHS\)](#).
- Qualify for enhanced reimbursement from Medicare and Medicaid*, as well as other benefits
- Serve an underserved area or population
- Offer a sliding fee scale
- Provide comprehensive services (either on-site or by arrangement with another provider), including:
 - Preventive health services
 - Dental services
 - Mental health and substance abuse services
 - Transportation services necessary for adequate patient care
 - Hospital and specialty care
- Have an ongoing [quality assurance program](#)
- Have a [governing board of directors](#)

Idaho Community Health Center Association

- FQHC's
- 1087 W. River Street, Ste
160, Boise, ID, 83702
- Phone: 208-345-2335

Break / Lunch — Organizational Coordination

Billing for Services – Deep Dive

Advanced Services Pharmacy Network

Transitions of Care
Jenilee Johnson, PharmD

Background



CMS GUIDELINES

1.

QUALIFICATIONS

patient must be admitted for at least 24 hours or more in an inpatient setting

2.

CONTACT

contact by licensed healthcare professional to take place within 48 hours from date of discharge (business days)

3.

THE CALL

medication reconciliation
care management needs, schedule appointments, etc.

4.

APPOINTMENT

needs to take place within 14 days of discharge date (calendar days)

5.

BILLING

99496
(1-7 days, complex);
99495
(8-14 days, moderate) -
based on complexity

Documentation



"HOW DO I DOCUMENT?"

1.

HOSPITALIZATION

ensure hospitalization is addressed & reason for follow-up; document plan of care & admission/discharge date

2.

MED REC

document any/all changes of medications & any start of medications

3.

ICD-10 CODES

hospital diagnosis and/or all conditions; ensure to document the plan of care for each; this will determine complexity for 99496 or 99495

Example

Assessments

1. Pneumonia of left lung due to infectious organism, unspecified part of lung - J18.9 (Primary)
2. Chronic obstructive pulmonary disease with acute exacerbation - J44.1
3. External nasal lesion - L98.9
4. Chronic respiratory failure with hypoxia - J96.11

Treatment

1. Pneumonia of left lung due to infectious organism, unspecified part of lung

Notes: I think clinically you have recovered well from the pneumonia. Your lungs do not have any focal sounds of consolidation. I do not think you need follow-up chest x-ray at this point. You seem to have tolerated the antibiotics without rash or stomach irritation.

Referral To: Miscellaneous

Reason: Portable oxygen concentrator

2. Chronic obstructive pulmonary disease with acute exacerbation

Continue Symbicort Aerosol, 80-4.5, 2 puffs, Inhalation, Twice a day
Continue Spiriva Respimat Aerosol Solution, 1.25 MCG/ACT, 2 puffs, Inhalation, Once a day
Continue Ventolin HFA Aerosol Solution, 108 (90 Base) MCG/ACT, 2 puffs as needed, Inhalation, every 4 hrs

Notes:

From a COPD standpoint, you are doing fairly well. Continue using the 2 liters of oxygen. You should continue using the oxygen to help with the shortness of breath and follow up with pulmonology. I agree with the resumption of the Symbicort but I think it would be reasonable to also try taking the Spiriva concurrently to see if this would provide more improvement in your breathing. The Ventolin (albuterol) should be used on an as needed basis for increasing wheezing or shortness of breath.

Referral To: Miscellaneous

Reason: Portable oxygen concentrator

Current Medications

Taking

- Symbicort 80-4.5 Aerosol 2 puffs Inhalation Twice a day
- Finasteride 5MG Tablet 1 tablet Orally Once a day
- Flomax 0.4 MG Capsule 1 capsule Orally Once a day
- PreserVision/Lutein CAPS 2 caps by mouth daily
- M2 Zinc-50 50 MG TABS 1 tab by mouth daily
- Centrum Silver TABS 1 tab by mouth daily
- Ventolin HFA 108 (90 Base) MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs
- Doxycycline Hyclate 50 MG Capsule 1 capsule Orally every 12 hrs
- Spiriva Respimat 1.25 MCG/ACT Aerosol Solution 2 puffs Inhalation Once a day

Not-Taking/PRN

- Ibuprofen 800 MG Tablet Orally q8 hours as needed

Reason for Appointment

1. TCM Follow up

History of Present Illness

New symptom(s):

who presents today for a follow up after a recent hospitalization for pneumonia in the setting of COPD exacerbation. He was in the hospital for pneumonia from 03/11/19-03/13/19. He is feeling better each day. They did add on 2 liters of oxygen for the next 30 days. They did send a CBC to pathology which tested negative for CLL. They did give him a Spiriva inhaler in the hospital, but he did not begin using this regularly. He went back to using the Symbicort on a regular daily basis, and Ventolin for asthma needed use. He has completed all his antibiotics. He does remain on O2 at 2 LPM. He has a home oximeter and checks this periodically and finds is resting O2 saturation with the supplemental O2 is in the low 90s. Without the supplemental O2 his oxygenation is borderline.

He reports that he does need an order for a portable oxygen concentrator as well.

He does have a spot on the tip of his nose. He reports that he has had this for a while and it comes and goes. He doesn't have a dermatologist that he sees. It is suspicious for a pearly lesion skin cancer.

Billing



PROCESS

1.

CODER

requires an experience
coder/biller to review
documentation to justify
complexity for audit purposes;
providers to sign-off upon audit

2.

CLAIMS

will need to submit discharge
summary; proof of TCM
outreach & completed TCM
note

3.

TIMING

due to delays in hospital/SNRC
billing, considering waiting to
after 14 days from visit to avoid
denials from insurance payers

Reimbursement



"Is it even worth it?"




MEDICARE

99496 (COMPLEX): \$221

99215 (COMPLEX): \$127

99495 (MODERATE): \$157

99214 (MODERATE): \$102



ALTIUS

99496 (COMPLEX): \$220

99215 (COMPLEX): \$129

99495 (MODERATE): \$155

99214 (MODERATE): \$122



SELECT HEALTH

99496 (COMPLEX): \$278

99215 (COMPLEX): \$104

99495 (MODERATE): \$188

99214 (MODERATE): \$137



REGENCE BCBS

99496 (COMPLEX): \$280

99215 (COMPLEX): \$150

99495 (MODERATE): \$198

99214 (MODERATE): \$124

Ineligibility



TRANSITIONAL CARE MANAGEMENT

1.

GLOBAL FEE

provider who rendered the surgery cannot bill for tcm (ortho, surgeons, uro, L&D); if transitioned to snf, pcip can bill as tcm, if necessary

2.

CLAIMS

if tcm was billed within the past 30 days, tcm cannot be billed again

3.

TCM CALL

if tcm call was not initiated within two days from the date of discharge & patient was seen within 14 days

Lessons learned



HELPFUL TIPS

1.

INSURANCES

all insurances
reimburse for TCM
codes; including
Medicaid; different fee
schedules

2.

SOCIAL WORKER/CM NOTES

review SW/CM notes to
identify which post-acute
care setting patient
transferred to

3.

VISIT TYPE

have all providers
identify the length for
TCM visits; avoid
scheduling errors

4.

TCM PROVIDERS

any provider (MD, DO,
NP, PA) can bill for
TCM; only one
provider within 30-day
window

5.

DAY 1

day of discharge is
considered as day 1;
when considering
appointment date; if office
is closed for holiday, that
is not considered a
business day

Calendar tip



INSTANT DOWNLOAD

Discharge Home



Case

1

Patient Lois was admitted to EIRMC on 12/30/21 due to pneumonia and discharged on 1/2/22 back home with homecare services. She was encouraged to follow-up with her primary care provider with the next 3-5 days, however, an appointment was not scheduled for her. EIRMC is aware that her PCP is at Bingham Clinic. Jenilee has provided all discharge records. She has multiple comorbidities and has visited the ER on several occasions within the past three months.

When would she need to be contacted by a licensed healthcare professional?

What is the last date she can be seen, in order to be considered TCM eligible?

1/4/22 and/or 1/5/22 or seen by a provider on either of these dates.

1/15/22 is considered the 14th day. If seen between 1/2 and 1/8, you may bill as 99496 (high complexity), but if seen on 1/9 to 1/15, it will need to be bill as 99495 (moderate complexity).

Both codes will reimburse much higher than using 99215.

Case

2

Patient Lois was admitted to EIRMC on 12/30/21 due to pneumonia and discharged on 1/2/22 back home with homecare services. She was encouraged to follow-up with her primary care provider with the next 3-5 days, however, an appointment was not scheduled for her. EIRMC is aware that her PCP is at Bingham Clinic. Jenilee has provided all discharge records. She has multiple comorbidities and has visited the ER on several occasions within the past three months.

Upon her TCM call, the pharmacist identified that she is not able to locate transportation until 1/10/22, can this still be considered TCM?

Yes, if the hospitalization is addressed, provider can bill as a 99495.

Transferred to Skilled
Nursing Facility



Case

3

Upon discharge from the hospital, Lois was transferred to a Skilled Nursing Facility in Blackfoot for further oversight. She is anticipated to stay for at least 2 weeks (ends up leaving on 1/24/22).

While at her stay in a SNF, does the TCM team need to reach out?

No, she is still considered inpatient. Jenilee to continue to follow-up on her until her discharge. Upon discharge, the licensed healthcare professional will reach out within 48 hours from her discharge date. In this case, the patient was discharged on 1/24/22 from the SNF. The SNF Discharge Date will be the date referenced in terms of when the patient will need to be seen for TCM.

TCM team to make contact on 1/26/22 and/or 1/27/22 or seen by a provider on either of these dates.

Patient would need to be seen on or before 2/6/22.

Case

4

If patient was discharged from the SNF on 1/24/22 and the patient was seen on 1/25/22 by Dr. Hansen; does the TCM team need to reach out to meet the guidelines?

No, TCM requires for the patient to be contacted by a licensed healthcare professional within 48 hours OR seen by a healthcare provider within those 48 hours, TCM can be billed.

Case

5

TCM Team reached out to the patient on 1/26/22 and 1/27/22, but had to leave a message on both occasions. Patient was scheduled for a TCM visit on 1/31/22 upon discharged from the hospital. Will the two unsuccessful attempts still be considered TCM eligible on 1/31/22?

Yes, as long as the attempt was documented on both dates, it meets the 48-hour outreach requirement. In the documentation, it helps to write something along the lines of –
“Attempted to reach patient for TCM to discuss her recent hospitalization and left a HIPAA compliant message to call back.”

Discharged Home –
Readmitted to Hospital



Case

6

Patient was for TCM by Dr. Hansen on 1/27/22 and upon her visit, the patient exhibited signs of shortness of breath, weakness and altered mental status. Her provider helped to facilitate a transportation back to the EIRMC where she was hospitalized from 1/27/22 to 1/31/22.

How should Dr. Hansen's note be addressed?

For this particular scenario, if Dr. Hansen did not provide a full examination, she can bill for the visit as a standard visit rather than TCM. Since patient discharged on 1/31/22, she can be seen again on or before 2/13/22 for TCM, as long as TCM has not been billed once already in the past 30 days.

Case

7

Let's say that Dr. Hansen did do a full examination and addressed the hospitalization on 1/27/22 and the patient was progressing and bill for TCM. On 1/28/21, the patient was readmitted back to the hospital from her home setting and was hospitalized from 1/28/21 to 2/3/21.

Can the TCM team reach out again and have her scheduled for TCM?

The TCM team should reach out to ensure patient is doing better and/or has any needs. If a follow-up is needed, we can schedule her for one, however, this would be billed as a standard office visit, as TCM has already been billed within the past 30 days.

Case

8

Let's say that Dr. Hansen did do a full examination and addressed the hospitalization on 1/27/22 and the patient was progressing but not billed for TCM. On 1/27/22, the patient was readmitted back to the hospital from her home setting and was hospitalized from 1/27/22 to 2/3/22.

If necessary, when could Dr. Hansen or any other provider bill for TCM post hospitalization?

If the patient was hospitalized and discharged and is eligible for TCM again, TCM can be billed on 2/4/22-2/16/22.

Case

9

A cardiologist was able to see the patient as well for a cardiac follow-up upon discharge from the hospital. The cardiologist billed for TCM. Can Bingham Clinic also bill for TCM? How will you know if it was billed within the past 30 days?

No, only one provider can bill for TCM in a 30-day window – it does not matter which provider, as long as the requirements are met. We would not know if the cardiologist billed for TCM (unless we have access to their records), but I have often recommended we just bill for TCM – if it gets denied, they will just request to be billed at a standard visit. Chances are, many providers are not billing for this.

Questions



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Discussion

Wrap up