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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

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Funding and Support for ASPN

Rural Emergent Alternative Surgical Opioid Non-use

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Network Connections

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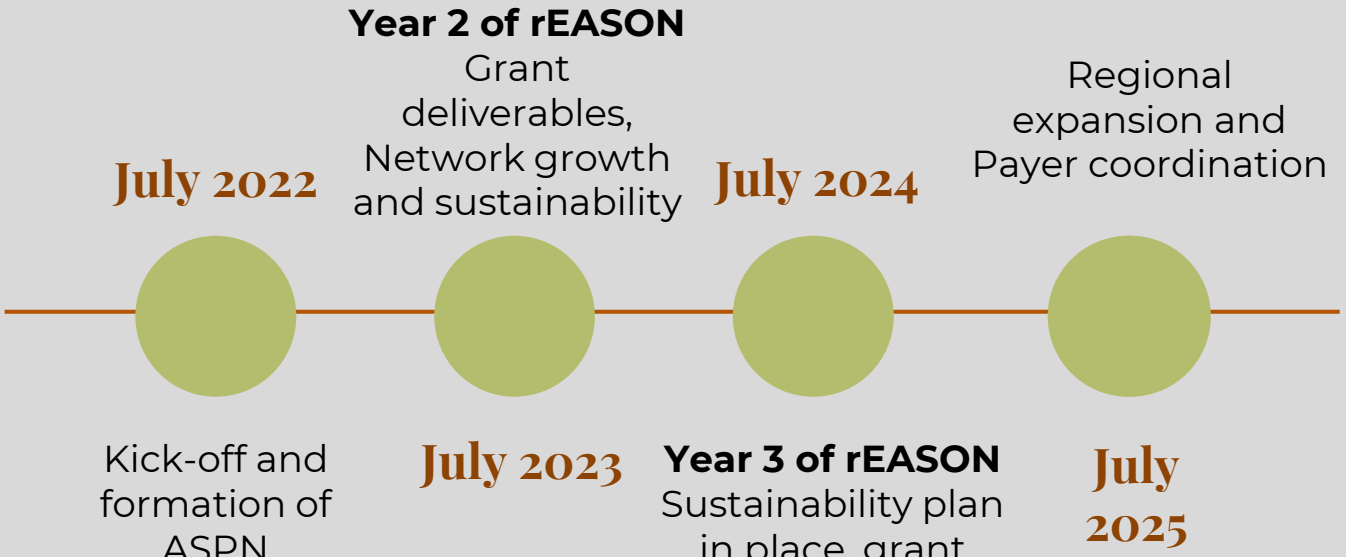
Timeline



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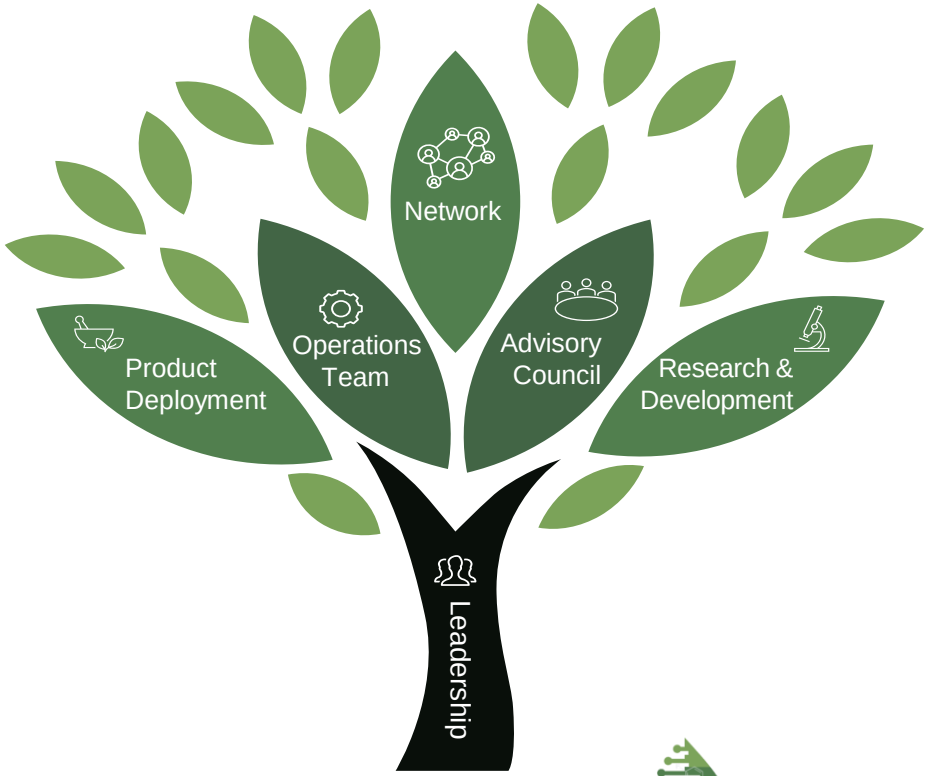
ASPN Framework



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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?!

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Grants are Scary – Please Help!

Cue Recording

[Grants are Scary 2022 Video]

Discussion and Grant Links

- https://cdn.pfizer.com/pfizercom/2022-10/GMG_2022-HOS-G_SupportingPatientPoweredResearch.pdf?MP8DqEsxZqXWQUF7jw1jJuMWno3rQYlS
- https://prevention.odp.idaho.gov/substance-abuse-block-grant-application-information/
- https://www.grants.gov/web/grants/view-opportunity.html?oppId=340889
- https://communitypharmacyfoundation.org/grants/grid.asp
- https://forms.benevity.org/34c71ce3-ac90-45e9-bea5-149980240bef

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Credentialing – Visit Types, Services and Documentation

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Pharmacist Value Proposition

Improved Satisfaction for Care Teams

Improved Outcomes with Lower Total Cost of Care

Improved Access to Healthcare Services

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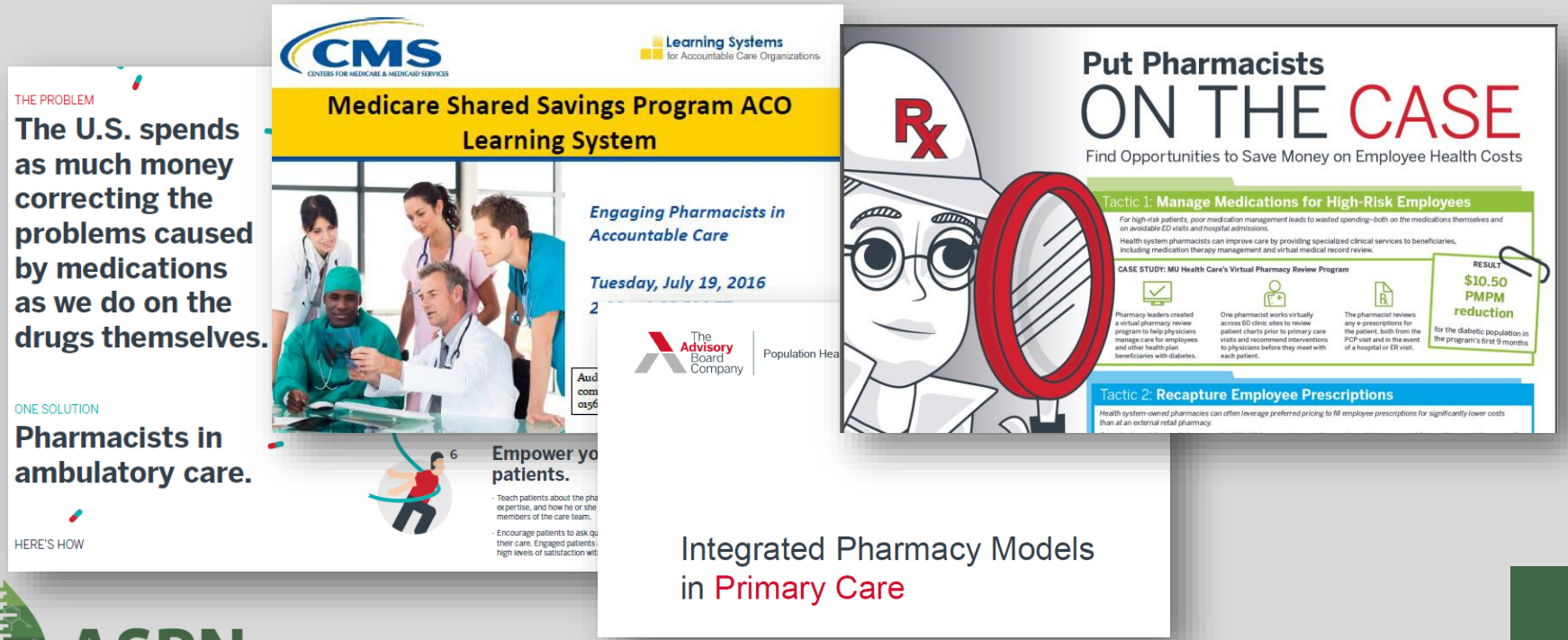
Support for Pharmacy Integration



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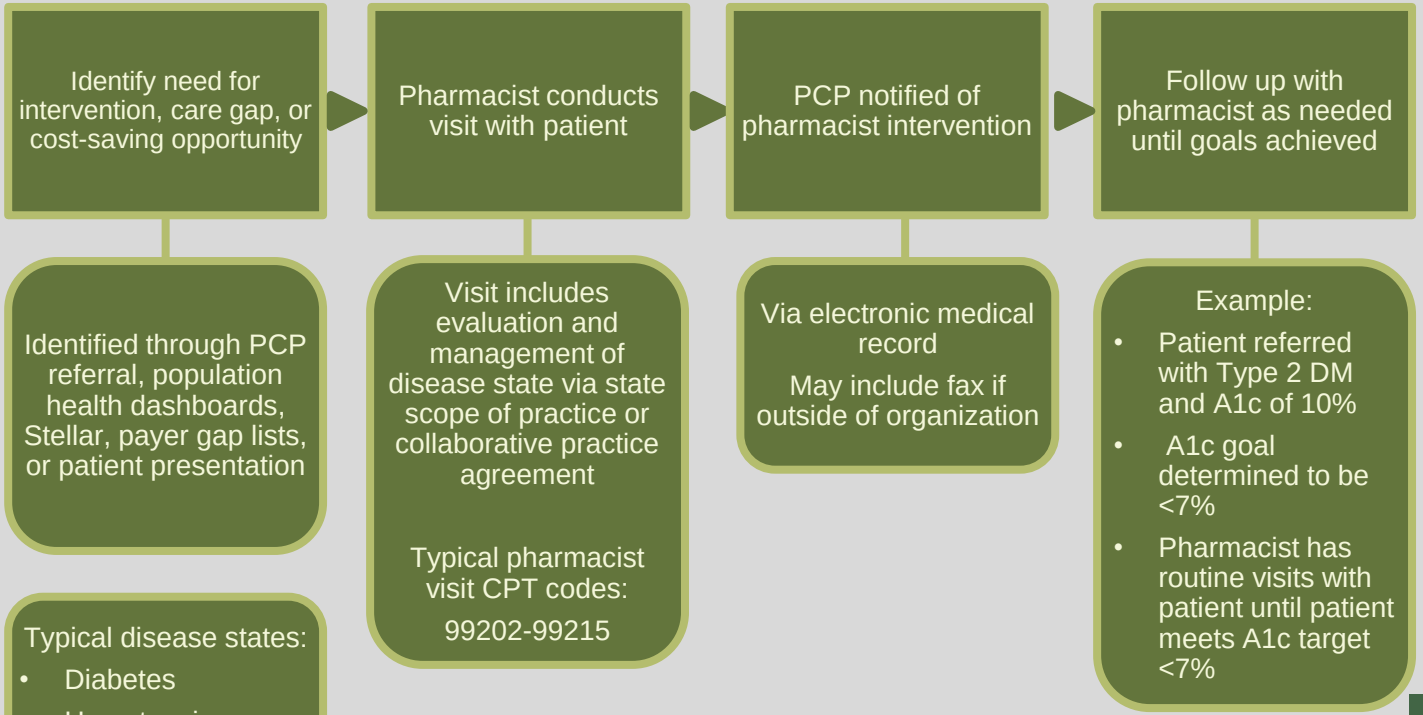
Challenges

- 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



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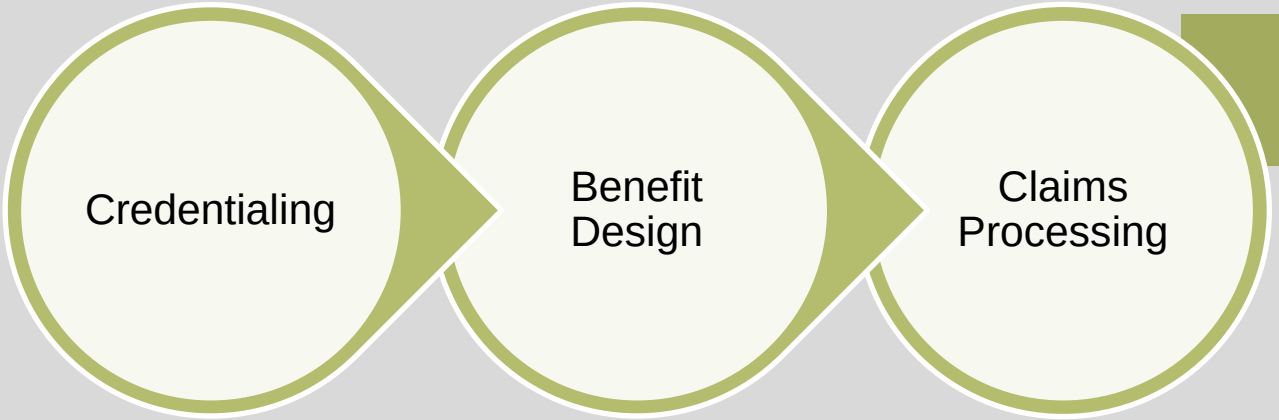
Pharmacist Provider Model – Payer Process



- 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

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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

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Discussion

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Break Discussion – Grant Opportunities

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Who's Who – Org Types and Key Players

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Who's Who

Within Organizations

Government Organizations

State

Regional

Public Health District

County-Based Services

School Districts

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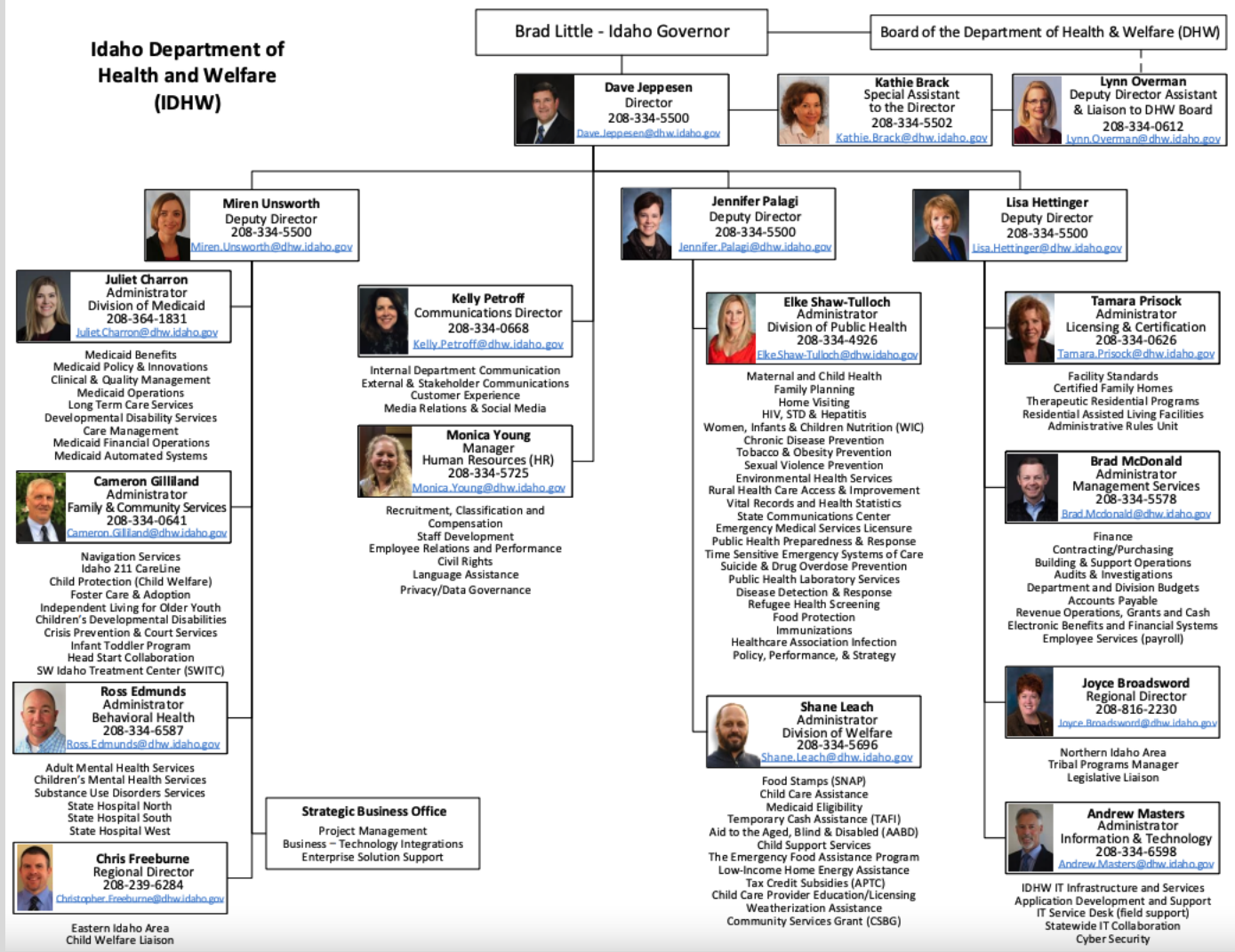
State Organizations

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



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https://odp.idaho.gov/

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

OVERVIEW OF DEPARTMENTS

Updated April 1, 2022

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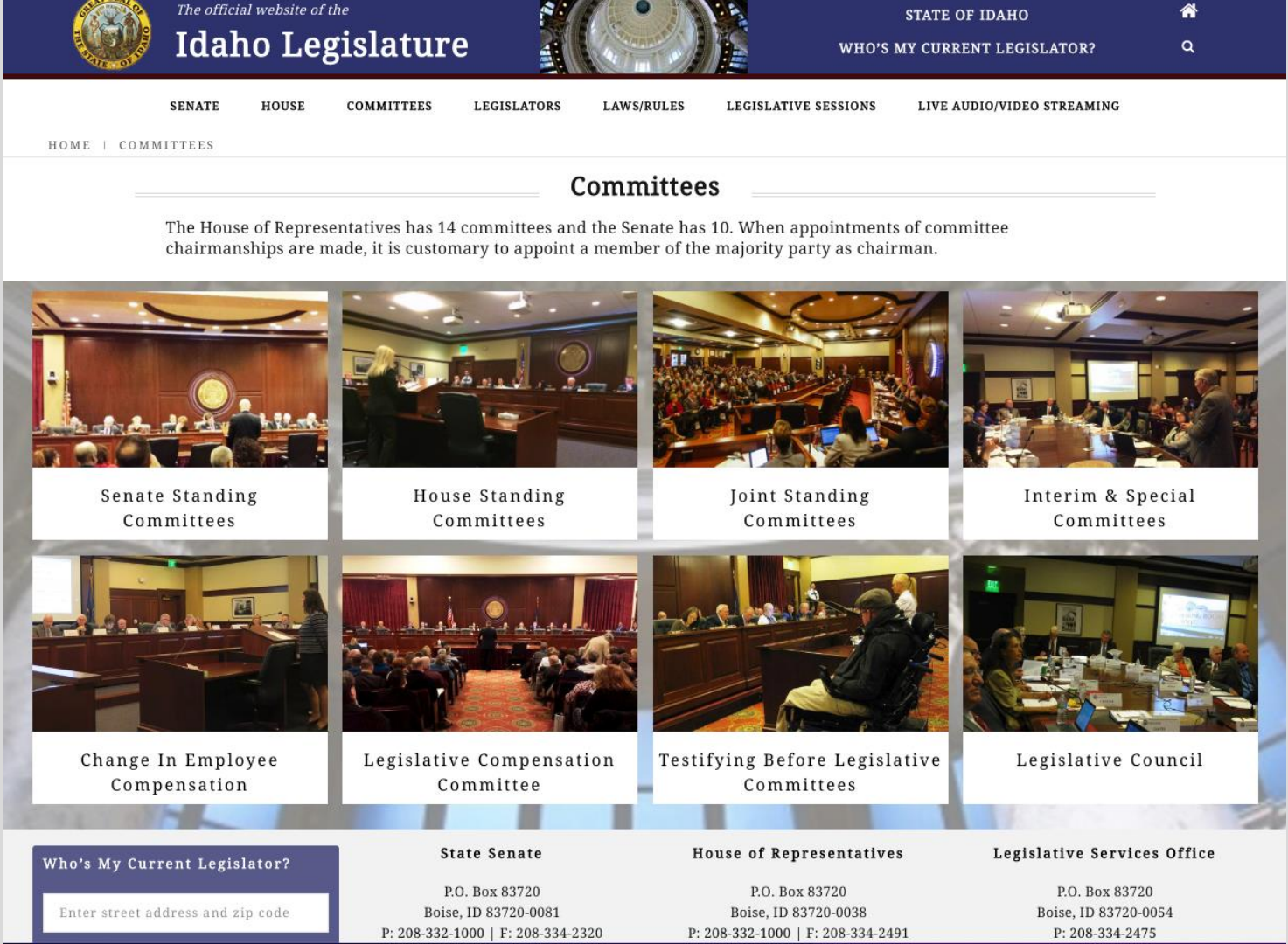
https://legislature.idaho.gov/committees/



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Regional Organizations

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

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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.

Additionally, regional behavioral health boards may accept the responsibility to develop and provide community family support and recovery support services in their region. Each board must demonstrate readiness to accept this responsibility. The boards may also develop, or obtain proposals for, a petition for regional services for consideration by the state behavioral health authority.

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

Regional DHW Offices

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

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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 2: Public Health-Idaho North Central Health District →

Director: Carol M. Moehrle
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 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 4: Central District Health →

Director: Russell A. Duke
707 North Armstrong Place
Boise, ID 83704-0825
1-208-375-5211
FAX: 1-208-327-7100

Visit Central District Health

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 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

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

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https://healthandwelfare.idaho.gov/health-wellness/community-health/public-health-districts

Public Health Districts

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

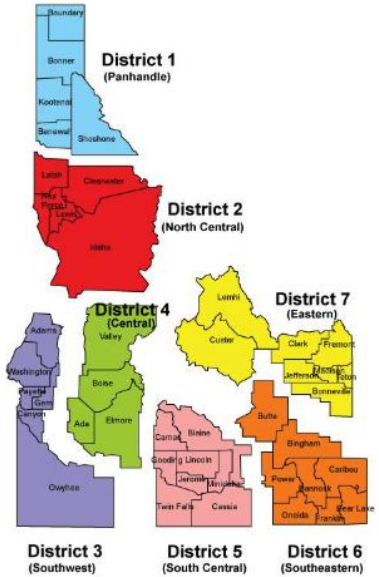
About public health districts

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

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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

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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).

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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

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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

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Idaho Community Health Center Association

- FQHC’s

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

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Break / Lunch – Organizational Coordination

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Billing for Services - Deep Dive

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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

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.

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

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, pcp 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

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?

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

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

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

Jenilee Johnson, PharmD.
Bingham Healthcare
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Discussion

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Wrap up