GETTING PAID FOR TEAM CARE- "NEW CARE" AND NEW PAYMENTS!

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19th CNHN Pediatric Practice Management Seminar

Thursday, December 6, 2016

Faculty Disclosure Information

In the past 12 months, I have no relevant financial relationships with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in this CME activity.

I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.

CHANGES YOU MAY WISH TO MAKE IN PRACTICE

1. Review (again) opportunities to report (bill) for non face to Face services you already provide to your patients

2. Implement new work flows for team based care and care coordination/management as payment becomes available via rapidly changing payer policies or value based incentive programs

3. Prepare to engage in value based payment programs-"practice transformation" through people (team care), data , health technology (EHR, HIE, Care coordination Tools)

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DEFINING TEAM BASED CARE ATTRIBUTES

- Care allows pediatricians to connect with their patients on key clinical issues and provide ***comprehensive, continuous, coordinated care*** by involving more of the practice staff in patient care as appropriate to their training and capabilities. Team-based care can also increase a practice's *efficiency and productivity*.

- Care that engages a ***greater number of staff in patient care*** and affords physicians, as the leader of a practice team, additional time to listen, think deeply, and develop relationships with patients and their families.

- Care that is highly informed- Team members ***are aware of the health history, status, and unique needs of the patient and family***, and are assigned different responsibilities, which together are designed to result in continuous, comprehensive, coordinated care *during and between visits*. Team members feel engaged in their key role of caring for the patient.

OUR PATH TO BETTER PAYMENT

- **Today we review a set of existing, new , and proposed CPT codes and payment policies which support-**
  1. Team based care- physicians, other qualified health care professionals (psychology, nurse practitioner, physician assistants), and staff (nurses, assistants, social worker , nursing assistants , health educators)
  2. Non Face to face care (nf2f)- prolonged services, care coordination/management, Behavioral care management, complex care management
  3. Including important clinical services performed by solely by your office staff (not previously billable)

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POPULATION HEALTH IS KEY

- **Once you see your population, you will see the needs and design a better care model- the "right care, right place, right time" model**

    1. "See" your population- data analysis (claims, HRA, clinical)- risk stratified by risk or medical complexity (well, some risk, high risk)

    2. Define the needs of the population – "care opportunities"

        1. All get Bright Futures (well care, screening, vaccines)

        2. Those with Risk get more intense levels of care- care coordination

    3. Develop Models- include both "outreach" and "in-reach" to close care gaps and provide access to evidenced based pediatrics

    4. Value ($)-

        1. Close care gaps = High Quality

        2. Right care , place time = Cost savings

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NEW CONCEPTS THAT IMPROVE THE CARE

- **Integrated care models- develop the "integrated care plan" define medical behavioral and social needs in your population , and deliver on the care and the social solutions**
  - barriers to both quality and cost savings (value) are rooted in behavioral conditions – depression, schizophrenia, bipolar, substance use- must address BEFORE medical needs are met
  - or social determinants – food, shelter, and transportation come before medical care

- **Patient "engagement or activation"**
  1. Measure "engagement" in those with risk or non compliance- tools exist – the new science of compliance
  2. Brings need for Team Care – high touch, collaborative, family centered

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A TRIPLE AIM "VALUEGRAM"
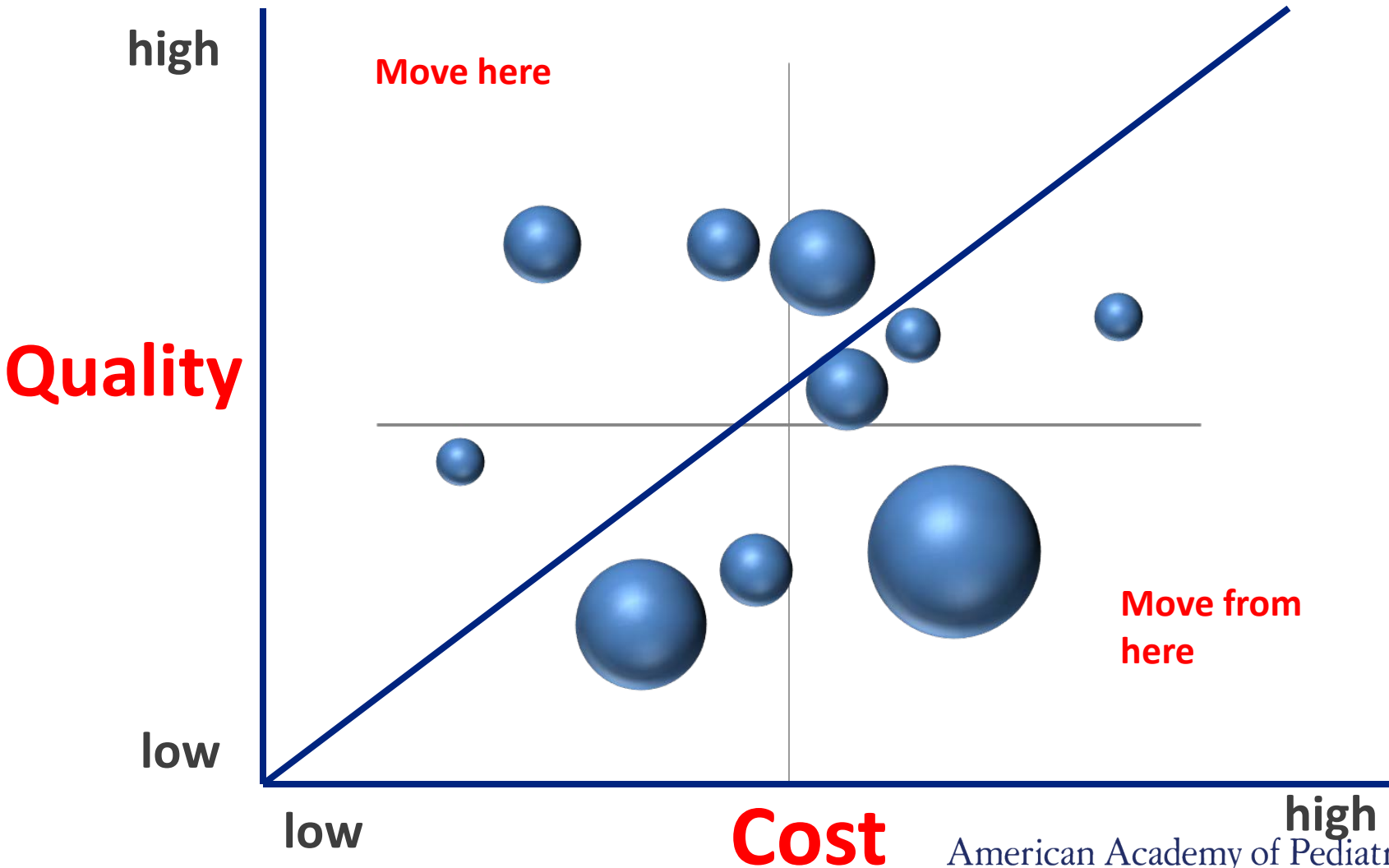
CSHCN – Children with Special Health Care Needs

- 13% of the pediatric population comprises children who meet the Maternal Child Health Bureau definition of special health care needs.

- CSHCN account for 70% of pediatric health care expenditures.

- Children with Medical Complexity, a subset of this population, are characterized by high service need, medical conditions associated with medical complexity, functional limitations, and high health care use.

Sadof et al, Clinical Pediatrics 1014; 1-5.

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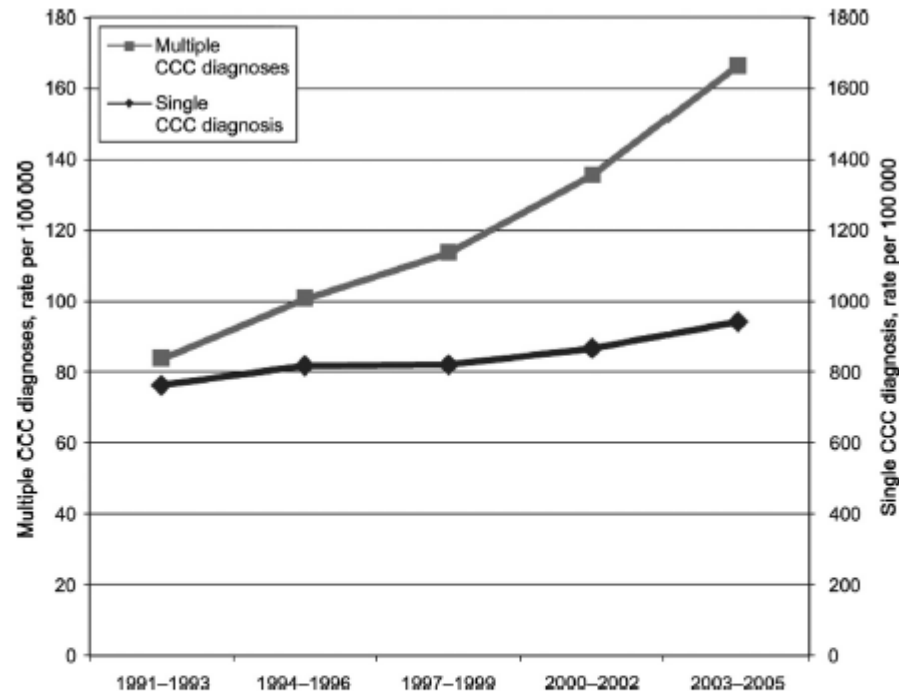# INCREASING PREVALENCE (COST)OF HOSPITALIZED MEDICAL COMPLEXITY

FIGURE 1

Hospitalization rates of children diagnosed with a single CCC and children diagnosed with more than 1 CCC. Hospitalization rates were adjusted for race, ethnicity, gender, insurance status, median income of zip code, and region of the country. The change in hospitalization rate for children with a single CCC diagnosis was 5.59% per year-group ($P < .05$), and the change in hospitalization rate for children with more than 1 CCC diagnoses was 17.6% per year-group ($P < .001$).

Burns et al. Pediatrics 2010; 126: 638-646.

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DOES TEAM CARE AS ENHANCED MEDICAL HOME CARE BRING VALUE?

Source: *Mosquera RA, Avritscher EBC, Samuels CL, et al. Effect of an enhanced medical home on serious illness and cost of care among high-risk children with chronic illness: a randomized trial. JAMA. 2014; 312(24): 2640– 2648; doi: 10.1001/jama.2014.16419*

Question: Among children with chronic illness, does comprehensive care through an enhanced medical home compared to standard care prevent serious illness and/or reduce costs? **Study design:** Randomized clinical trial

Researchers from multiple institutions evaluated whether children with chronic illness receiving care through an enhanced medical home (EMH) had improved outcomes compared to those receiving usual care (UC). Patients ≤18 years old with chronic illness and high health care use (defined as ≥3 emergency department [ED] visits, ≥2 hospitalizations, or ≥1 pediatric ICU admissions during the previous year) with a >50% estimated risk for hospitalization during the coming year were eligible for enrollment in the study. …

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EFFECTIVENESS OF CARE COORDINATION

Table 4. Estimated Costs per Child-Year

	Costs per Child-Year, Mean (95% CI), $[a]		Cost Ratio (95% CI)[d]	P Value[e]
	Comprehensive Care[b]	Usual Care[c]		
During trial				
Clinic	6713 (5616-8021)	1722 (1429-2075)	3.96 (3.12-5.01)	<.001
Hospital	9810 (7056-13 632)	25 059 (17 768-35 379)	0.35 (0.21-0.58)	<.001
Total	16 523 (12 526-21 789)	26 781 (20 061-35 787)	0.58 (0.38-0.88)	.01
During start-up period[f]				
Clinic	12 158 (9903-14 965)	2336 (1901-2865)	5.98 (4.82-7.42)	<.001
Hospital	11 413 (9195-23 257)	27 552 (21 324-52 296)	0.45 (0.26-0.78)	.005
Total	23 571 (16 066-34 639)	29 888 (20 390-43 730)	0.89 (0.57-1.38)	.59
After first year of enrollment				
Clinic	5124 (4101-6415)	1513 (1198-1913)	3.37 (2.42-4.69)	<.001
Hospital	9343 (6313-13 868)	24 213 (16 061-36 576)	0.34 (0.18-0.63)	.001
Total	14 467 (10 356-20 265)	25 726 (18 128-36 265)	0.54 (0.33-0.89)	.02

Mosquera et al. JAMA. 2014;312(24):2640-2648.

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CARE COORDINATION FINDING VALUE

1. **CMS** -recently released its CPC+ program- Monthly payments for care coordination, and upfront payment for EM services
2**. State Medicaid-** many paying for both CC and outcomes (quality and/or cost)
3. **Private payers-** all rapidly deploying value based programs- bundle payment, episode, PCMH

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TEAM BASED CARE ROLES THROUGH THE PAYMENT LENS

1. Office staff- all are directly or indirectly on a team
2. Clinical staff- nurses, nursing assistants
3. Physicians and "other qualified health care providers"- APN, PA, psychologists, LCSW,

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CARE MANAGEMENT
NON FACE TO FACE SERVICES

- **Staff Perform**

  - Nurse evaluation and management on established patients- 99211
  - Screening tests- developmental (96110), HRA 96160, Caregiver HRA 96161 , and Emotional behavioral screens (96127)
  - Chronic Care Management- Physical 99490, and Behavioral (?new)
  - Complex Chronic Care management 99487-8
  - Patient Education/Training for Self Management 98960-2
  - Medical Nutrition Therapy 97802-4
  - Health and Behavior Assessment/Intervention 96150-5
  - Telephone Services

- **Physicians and other qualified health care professionals**

  - Telephone Services 99441-3
  - Medical Team Conference
  - Interprofessional Telephone/Internet 99446-99449
  - Care Plan Oversight 99339-40-99358-9
  - Transitional Care Management 99495-96
  - Prolonged Services- face to face and non face to face 99358-9
  - Collaborative Care Model (new G code
  - Telehealth Services

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MEDICARE PHYSICIAN FEE SCHEDULE

- Indicates whether the code is in the fee schedule and whether it is separately payable if the service is covered.

- Active (A)= Active Code. These codes are paid separately under the physician fee schedule. There will be RVUs for codes with this status.

- Bundled (B)= Bundled Code. Payment for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment.

- Carrier Price (C)= Carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation.

- Noncovered (N)= Non-covered Services. These services are not covered by Medicare

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CMS- 2017 *PROPOSED*** RULE
BIG NEWS! "IMPROVING PAYMENT ACCURACY FOR PRIMARY CARE, CARE MANAGEMENT, AND PATIENT-CENTERED SERVICES"

- Simplify the chronic care management (CCM) billing rules
- Pay for complex Chronic Care Management (CCCM).
- Pay for advanced care plan development (Advanced directive).
- Pay for non-face-to-face prolonged evaluation & management (E/M) services.
- Implement G codes for Behavioral Health Integration-behavioral care management (like 99490), and the psychiatric Collaborative Care Model (CoCM)

** To be confirmed in the Final Rule expected end of October 2016

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CARE MANAGEMENT
NON FACE TO FACE SERVICES

- Reported per calendar month
  - Chronic care management
  - Complex chronic care management
  - Care plan oversight

- Reported per 30 day period
  - Transitional care management

- Reported per episode based on time
  - Prolonged service without direct contact
  - Medical team conference
  - Telephone services
  - On-line services
  - Interprofessional telephone/internet consult

CARE MANAGEMENT SERVICES

- Chronic (99490) and Complex Chronic Care (99487, 99489)

- Provided ***by clinical staff*** under direction of physician or QHP

- Patient at home, rest home, or assisted living facility

- A ***plan of care must be documented*** and shared with the patient and/or caregiver.

- Reported only ***once per calendar month*** and only by the physician/QHP who assumes the care management role

- Do not count any clinical staff time on E/M visit day for time that would otherwise bundled into the E/M

- ***Medicare Fee Schedule payment- 2016- $40.82***

CHRONIC CARE MANAGEMENT: REQUIRED ELEMENTS

CPT **99490**

- At least <u>20 minutes of clinical staff time</u> directed by a physician/QHP, per calendar month, with the following required elements:

- At least <u>2 chronic conditions</u> expected to last at least 12 months, or until the death of the patient

- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline

- Comprehensive care plan established, implemented, revised, or monitored

99490

- A 12 year old patient *has severe atopic dermatitis* and *recurrent asthma exacerbations* which has led to multiple emergency room visits, hospital admissions, lost school days and behavioral adjustment reactions.

- Clinical staff spend 30 minutes in the calendar month providing education and care plan monitoring and facilitating access to community services.

TYPICAL CLINICAL STAFF CARE MANAGEMENT ACTIVITIES

- Communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care

- Communication with home health agencies and other community services utilized by the patient

- Collection of health outcomes data and registry documentation

- Patient and/or family/caregiver education to support self-management, independent living, and activities of daily living

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COMPLEX CHRONIC CARE MANAGEMENT: REQUIRED ELEMENTS

CPT: **99487**

- At least <u>2 chronic conditions</u> expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Establish or substantial revision of comprehensive care plan (do not report CCCM if the care plan is unchanged or minimal change)
- Moderate or high complexity medical decision making
- <u>60 minutes of clinical staff time</u> directed by a physician or other qualified health care professional, per calendar month

+99489: each additional 30 mi clinical staff time

Medicare Fee Schedule- 2016- Considers these bundled and non payable- subject to change to payable 1-1-17

99487 PLUS 99489

- A 6 year old patient with spastic quadriplegia, chronic seizure disorder with severe developmental delay, gastrostomy, gastroesophageal reflux with recurrent bouts of aspiration pneumonia and reactive airways disease and failure to thrive receives home occupational, physical, and speech therapy services.

- During the course of a calendar month, the care plan is substantially revised. Clinical staff time of CCM services is 90 minutes.

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HOW WOULD YOU BILL FOR THESE SERVICES?

- 99487 for the first 60 minutes PLUS 99489 for each additional 30 minutes for the nursing time.

- Appropriate E&M service(s) for the physician care rendered throughout the month.

- Continue to bill monthly until John's condition improves.

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CCCM PATIENT SELECTION

- Identify patients by practice-specific or other published (risk stratification) algorithms that recognize multiple illnesses, multiple medication use, inability to perform activities of daily living, requirement for a caregiver, and/or repeat admissions or emergency department visits.

- Typical adult patients are treated with three or more prescription medications and may be receiving other types of therapeutic interventions (eg, physical therapy, occupational therapy).

- Typical pediatric patients receive three or more therapeutic interventions (eg, medications, nutritional support, respiratory therapy).

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CCCM PATIENT SELECTION

- Typical patients with complex diseases demonstrate one or more of the following:
  - Need for the coordination of a number of specialties and services
  - Inability to perform activities of daily living and/or cognitive impairment resulting in poor adherence to the treatment plan without substantial assistance from a caregiver
  - Psychiatric and other medical comorbidities that complicates care
  - Social support requirements or difficulty with access to care

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CCCM PROPOSED PAYMENT BY CMS FOR 1/1/17

- 99487- $92.66 (outpatient- non-facility)

- 99489- $46.87 (outpatient – non facility)

- 99490- $42.21 (outpatient- non-facility)

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IMPLEMENTING CM/CCM

- Identify patients
- Design CM/CCM process and schedule
    - Clinical staff assessment calls
    - Designation of time frames
    - Designation of clinical staff responsibilities
- Inform patient
- Document comprehensive care plan
- Develop and Provide patient with copy of care plan
- Systematize recording of time spent

American College of Physicians
Chronic Care Management Toolkit, 2015

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OPERATIONALIZING CCM

Sample Log of CCM Patients

Patient Name	Primary Clinician	Date Enrolled	Care Plan Review Date	Date Terminated	Notes

American College of Physicians
Chronic Care Management Toolkit, 2015

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TRANSITIONAL CARE MANAGEMENT

Transition in care from:
- In-patient hospital
- Partial hospital
- Observation status
- Skilled nursing facility

Established or New Patient

To the patient's community setting:
- Home
- Domiciliary
- Rest home
- Assisted living

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TRANSITIONAL CARE MANAGEMENT

99495: requires the following:
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge

- Medical decision making of at least moderate complexity during the service period

- Face-to-face visit, within 14 calendar days of discharge

- And per Medicare: certain non-F2F services as medically indicated

99496: requires the following:
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge

- Medical decision making of high complexity during the service period

- Face-to-face visit, within 7 calendar days of discharge

- And per Medicare: certain non-F2F services as medically indicated

99496

- A 6 week old baby discharges from the NICU with chronic lungs disease, home oxygen therapy, and hard to control seizures.

- Clinical staff call the patient two days after discharge to schedule a visit and review care and medications and schedule the follow up appointment which is performed 4 days later by the pediatrician .

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POST-DISCHARGE PATIENT CONTACT

- Contact with the patient or caregiver.

- By the physician, qualified health care professional, or clinical staff.

- Within two business days of discharge   (Monday through Friday except holidays).

- Must include capacity for prompt interactive communication addressing patient status and needs.

- If two or more separate attempts are made in a timely manner, but are unsuccessful and other transitional care management criteria are met, the service may be reported.

- The 2 day post-discharge contact and the face-to-face visit can occur on the same day

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MEDICATION RECONCILIATION

- CMS definition: the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider

- Occurs no later than date of F2F visit

- Rationale: medication regimen prescribed at the time of discharge may inadvertently omit needed medications, unnecessarily duplicate existing therapies, or contain incorrect dosages—thus increasing risk for post-discharge adverse drug events.

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RELATIVE VALUES

Visit type	CPT	Non-facility RVU	Non-facility Medicare
TCM Moderate	99495	4.62	$165.42
Established-Moderate	99214	3.02	$108.13
New-Moderate	99204	4.64	$166.13
TCM-High	99496	6.51	$233.09
Established-High	99215	4.07	$145.72
New-High	99205	5.82	$208.38

TCM COMPLIANCE

- Documentation
  - Date of discharge
  - Timing of the initial post discharge communication with the patient or caregivers
  - Date of the face-to-face visit
  - Complexity of medical decision making.
- Only one individual may report these services and only once per patient within 30 days of discharge.
- Another TCM may not be reported by the same individual or group for any subsequent discharge(s) within the 30 days.
- The same individual should not report TCM services provided in the postoperative period of a service that the individual reported

CARE PLAN OVERSIGHT OF PATIENT AT HOME

- **99339:** 15-29 min per calendar month

- **99340:** ≥ 30 min per calendar month

- _Physician supervision_ of a patient requiring complex and multidisciplinary care modalities such as:

  - Regular physician development and/or revision of _care plans_

  - Review of subsequent reports of patient status

  - Review of related laboratory and other studies

  - Communication for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) and/or key caregiver(s)

  - Integration of new information into the medical treatment plan and/or adjustment of medical therapy

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CPO OF PATIENT AT HOME

- For children with special healthcare needs and chronic medical conditions
- Example: monthly CPO for patient with Down's syndrome
  - Review of audiology/endocrine consultation reports
  - Telephone call to the audiologist
  - Completion of medical forms
  - Telephone call to the family regarding patient's habits after new treatment and to the psychiatric nurse practitioner
  - Review of endocrine recommendations with subsequent telephone calls to family and pharmacy to change prescription's dose.
- If very low-intensity or infrequent supervision services, the physician work is included in the pre- and post-service work of office/outpatient visit E/M codes

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Care Plan Oversight

Type of CPO	CPT	Time (per calendar month)
Supervision of a patient in home or assisted living facility (patient not present)	99339	15-29 min
	99340	≥ 30 min
Supervision of patient under care of home health agency in home or assisted living facility (patient not present)	99374	15-29 min
	99375	≥ 30 min
Supervision of hospice patient (patient not present)	99377	15-29 min
	99378	≥ 30 min
Supervision of nursing facility patient (patient not present)	99379	15-29 min
	99380	≥ 30 min

CPO REGULATORY

- Code selection based on type of supervision, complexity, and time of services provided during the month.

- Only one individual may report services for a given period of time, to reflect the sole or predominant supervisory role with a particular patient

- Medicare PFS: B status with published RVUs
  - But addresses CPO with G0181
  - And high level of commercial coverage of CPO

- Not reported when also reporting CCM, CCCM, TCM

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TELEPHONE SERVICES

- Telephone service by a physician provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

CPT	Time
99441	5-10 min
99442	11-20 min
99443	21-30 min

- Call is initiated by patient—not physician.
- Not reportable if already performed within previous 7 days
- Medicare: Non-Covered status with published RVUs

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ON-LINE MEDICAL EVALUATION

- 99444: online non-F2F service provided by a physician/QHP in response to an established (not new) patient or guardian's on-line inquiry, not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network

- Medicare status: Non-covered; no published RVUs

- May trigger a co-pay

- Not reportable if the on-line medical evaluation refers to an E/M service previously performed and reported by the physician within the previous seven days or within the postoperative period of the previously completed procedure.

- Not used when also reporting care plan oversight, CCM, CCCM, TCM

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ON-LINE MEDICAL EVALUATION: ELEMENTS

- 99444-

- Response to patient's e-mail inquiries in a timely manner.

- Permanent storage of an electronic or paper copy of the encounter.

- Reported only once for the same episode of care during a seven-day period, although multiple physicians could report their exchange with the same patient

- Include any related telephone calls, prescription provision, and laboratory orders in 99444.

- Medicare Physician Fee Schedule 2016- No RVU /fee published

INTERPROFESSIONAL TELEPHONE/INTERNET CONSULTATIONS

- Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician/QHP or other qualified health care professional

CPT	Discussion/review time
99446	5-10 min
99447	11-20 min
99448	21-30 min
99449	≥ 31 min

The written or verbal request for telephone/Internet advice by the treating/requesting physician or other qualified health care professional should be documented in the patient's medical record and written report provided to requesting physician

- Medicare Fee Schedule 2016: "B" without published RVUs

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INTERPROFESSIONAL TELEPHONE/INTERNET CONSULTATIONS

- Not reportable if consultant has had F2F encounter in past 14 days

- Not reportable by a consultant who has agreed to accept transfer of care before the telephone/Internet assessment, but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial interprofessional telephone/Internet consultation

- Not reportable when the telephone/Internet consultation leads to an immediate transfer of care or other face-to-face service within the next 14 days or next available appointment date of the consultant, these codes are not reported

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INTERPROFESSIONAL TELEPHONE/INTERNET CONSULTATIONS

- Review of pertinent medical records such as laboratory studies, imaging studies, medication profile, pathology specimens, and other patient data is included in the telephone/Internet consultation service and is not be reported separately. This review should be performed immediately before or after the telephone/Internet consultation.

- The majority of the service time reported (greater than 50%) must be devoted to the medical consultative verbal/Internet discussion.

- This service should not be reported more than once within a seven-day interval

- If more than one telephone/Internet contact(s) is required to complete the consultation request, the entirety of the service and the cumulative discussion and information review time should be reported with a single code.

SO.....TEAM CARE

- Recognizes the broad contribution many can make in your practice

- Care Coordination and Care Management by clinical staff now being paid fee for service

- A key stepping stone to clinical transformation to Population Health

- Population health is a stepping stone to Value Based Payments-going beyond fee schedules

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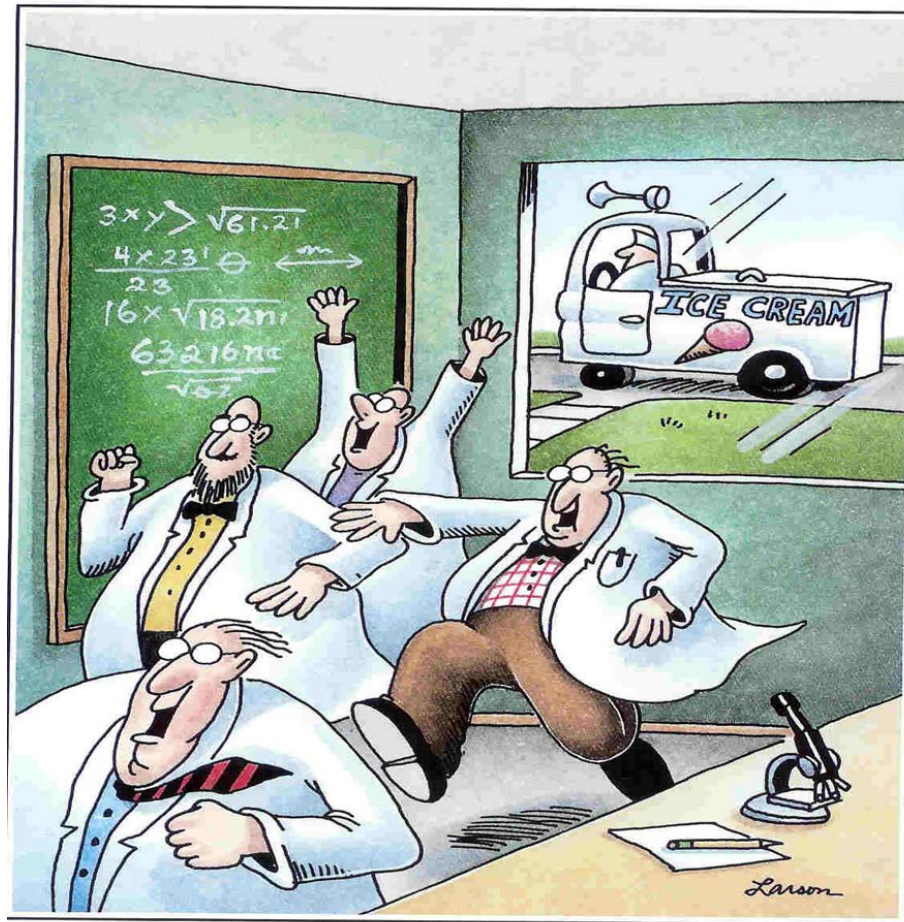
CHANGE…IS CONSTANT IN HEALTH CARE

"It is not necessary to change… Survival is not mandatory"

- Edward Deming
- Speaking to a group of Detroit automaker executives 1970s

(there will likely be no "Pediatric" bailout)

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THANK YOU!!