PCMH User Group Highlights 2/22/17

Slides from presentations are attached to email and on website (slides and highlights under PCMH User Group)

BCBSM PDCM Billing: Sandy Stimson & Kathy Grinsteiner BCBSM Provider Relations

- Sandy will be contacting all PCP practices soon to discuss:
  - Updates
  - E-Referrals
  - PDCM
  - Provider Recognition programs
- PDCM Billing:
  - The PDCM list is sent by NPO (NPO just sent out the most current lists)
    - The list is to be used as a reference only
    - All patients must have their benefit checked on WebDenis; it is a provider liability if the patient does not have the benefit. The benefit can be checked on WebDenis using;
      - NASCO
        - Benefits are listed alphabetically
        - Will state "no reference to PDCM" which means NO benefit
        - If there is a benefit – will give a message that includes "no cost share" meaning there is no deductible/copay.
      - Benefit Explainer
        - Put in the procedure code and search
        - Will have a message that states: not covered or covered
      - Benefit can also be checked using the PARS/IVR (formerly CAREN) telephone system
        - Will receive a message stating either;
          - This member is eligible, no copay, no deductible
          - This member is not eligible
  - Sandy gave a demo of how to search the eligibility using the benefit explainer
  - Some contracts will not show the benefit on WebDenis, but the patient has the benefit. These include:
    - FEP (Federal Employee Program) has the benefit – the contracts that begin with "R"
      - Exception is if the patient has Medicare Part B – DO NOT have coverage
    - Medicare Advantage – All covered EXCEPT:
      - BCBSM Retirees
      - Public School Retirees (prefix of XYL)
      - URMBT (prefix of U)
  - **Starting in 2017, as employers/purchasers renew contracts, the PDCM benefit will be automatic unless purchaser opts out. (This does NOT apply to BCN renewals)**
  - When checking benefits for out of state Blue Cross, most out of state Blue Cross plans have the benefit, but do not recognize the "PDCM" instead call it "Blue Distinction Total Care" or "Value Based Programs"
  - If you have had a claim rejected for the reason of "applied to deductible" or a FEP claim has been rejected:
    - Notify Kris Elliott or Sandy Stimson.
  - Questions/Concerns raised by a physician:
    - As a busy physician, referring patients to CM, there are some barriers:
      - List of CM patients is inaccurate
      - Not having a staff member who has time to look in WebDenis
      - At least 5 exclusions just given regarding why the patient may have the benefit, but will not show in WebDenis
      - Policies vary
      - Complicated and frustrating (due to the reasons above) to implement a process for referring patients to CM

        - Have had many patients who were on the list, only to have claims denied.
    - Has any information gone to billers about reprocessing claims that have been denied for "applied to deductible"?
    - How does this affect our CM numbers? There is no way to check what the practices % is to meet the threshold.
    - In reference to the exceptions, is this information written down anywhere?
        - *Sandy's replies: Information was provided to whomever in the office that attend the training last year. It has been said many times that even if you receive the list of PDCM patients, WebDenis still needs to be checked for the benefit.*
    - Trying to work out a process to refer patients to CM, as a physician, and spend more time with those patients, and the provider does not know if they are covered.
        - Clinical staff does not have time to run and check WebDenis while they are seeing the patient in the room and conclude that they would benefit from CM.
    - Again, where are the exceptions written down?
        - *Sandy's replies: In the full training presentation*
        - *Attached to email is the training document Sandy refers to.*
        - *Kathy and Sandy offered to have someone, perhaps a Medical Director come up and meet with physicians and billing staff.*
    - If we provide proof of a denied patient on the CM list, that we provided CM to them, could they be counted toward the 2% threshold?
        - *Sandy's replies: Sandy agreed that this should be the case, but that is not the current process. She will advocate for that, and again offered to have a Medical Director come up to hear the concerns.*
    - How will the re-bill process be communicated to practices?
        - *Sandy's replies: When she meets with the practices, as planned to do in next couple of months, it will be communicated.*
    - Is there a report that practices could have to see how close to the threshold for CM they are?
        - *Sandy's replies: BCBSM is working on developing a report and she has relayed concerns from practices about why they need this report.*

Jennifer Coleman – Grand Traverse Radiology – Clinical Decision Support Presentation (slides with email)

- Understanding the Legislative and quality imperatives related to Clinical Decision Support (CDS) for radiology.
    - At the National Level:
        - Protecting Access to Medicare Act of 2014
        - Mandates that providers consult with appropriate use criteria when ordering advanced diagnostic imaging for traditional Medicare patients
        - Is effective January 1, 2018.
            - Excludes in-patient orders
            - Does NOT exclude Emergency Room studies that are ordered.
            - Non-compliant providers (2 years post "go-live") will be subject to a prior authorization process.
    - Quality
        - CDS provides real-time point-of-care approach to provide the right test at the right time.
        - Jen reviewed a "simplified" CDS sample workflow
    - Implementation considerations
        - Comprehensive coverage – call the radiologist if you are not sure about the correct test to order (if more than one test could be appropriate for the patient according to the tool)
            - This removes the guess work about appropriate use criteria
        - Should Radiologist consult the appropriate use criteria on behalf of the ordering provider?
            - This is not supported by the legislation; one of the purposes of this tool is to educate the ordering providers
        - Structured indication
            - Reduces rework
            - Closes loop with ordering physician
            - Reduces changed orders
            - Improves interpretation vs. confusing free text

        - Reduces denials from commercial carriers
    - Jennifer showed the flow for both those with the tool imbedded in the EMR and not imbedded in the EMR.
        - The EMRs with the tool either already imbedded or in production:
            - Cerner, Epic, Meditech, Mckesson, Allscripts, Next Gen, EcW
    - Jennifer discussed the pilot that was conducted through NPO.
        - Results overall very positive
        - Ordering providers found utility and sustainability in using the tool.
        - Lessons learned from pilot
            - Do not use free-text, require structured reason
            - Spend the time on the front end in order to have structured data.
            - The tool is for provider use, not to be delegated to other staff
    - The next steps for Radiology
        - R-SCAN project with Munson Emergency Department to help develop protocols for ER imaging ordering for specific indications
        - Engaging the Physician Organization, Payer discussions, Legislative
        - MRS and RBMM (the two Michigan Radiologic Societies) are working together on initiatives.
        - Leading the CDS initiative for facilities
            - Upcoming meeting with Munson Hospital
    - **If you are interested in the using the tool or learning more, contact Jennifer: jkcgtr@gmail.com or let Kris know and she will send your information to Jennifer**

Ed Worthington – NPO – Medication Reconciliation (Med Rec) update:

- Med-Rec is an HIE use case/integration available to practices.
- When a patient leaves the hospital, within 3 hours a document will be sent to PCP with problem list, labs, meds, procedures, allergies from the hospital EMR directly to the direct trust email in the practice EMR.
    - Messages come to the providers' direct trust email
    - Is a document that can be stored in "patient documents" in the patient's electronic record
    - With most EMRs, also possible to have a discrete import for data such as med list, allergies and problem list.
    - Currently covers 70% of hospital beds in the State.
- Meets a PCMH capability
    - Must have a direct trust email; NPO can assist with that.
- **If interested in more information, please contact Ed: eworthington@npoinc.org.**

2017 Meeting Dates – all meetings from 11:30 AM – 1PM:

- April 27, Thursday – Clinical Quality Metrics: Deb Schepperly, from Thirlby Clinic, will talk about practices she has found effective to close care quality gaps. NPO will provide some Clinical Quality Metric updates.
- May 23, Tuesday
- August 23, Wednesday
- Sept 28, Thursday
- October 24, Tuesday

PLEASE NOTE: If you plan to attend the next meeting either in-person or telephonically, please either email kelliott@npoinc.org or call NPO at 231-421-8505 to RSVP. After we receive your RSVP, we send you an Outlook appointment. Please bring in parking garage tickets for validation.