End of Year Blood Pressure Process for Optimal Readings Fall 2023

- Start this process in between September and November
- Blood Pressure check appointment can be completed by MA, RN, or Care Manager
- If the office has Care Managers, ask the patient if they will talk to a Care Manager about their blood pressure- This could be separate from the blood pressure cuff or in combination.
    - See Section: Care Manager tools for working with HTN patients on page 3.

Scenario 1: **1.** Patient has an office or telehealth visit **AND 2.** Patients are not expected to come into the office again until 2024 **AND 3.** Patients' blood pressure is above 140/90 or higher.

A. Patient has home blood pressure cuff and is provided the *Patient Blood Pressure Packet*. Staff goes over the handout with patient including keeping a home blood pressure log.
- Schedule the patient for virtual blood pressure check or in office blood pressure check.

B. Patient does not have at home blood pressure cuff:
- Encourage Patient to purchase one **AND/OR** Some offices will lend the patient a cuff. (*NPO tried to come up with a list of places a patient could call if they cannot afford a home blood pressure cuff but unfortunately the answers were, "no," they do not offer, or it is a very rare thing. NPO heard from one loan closet for example, "we have had one in four years". If a Care Manager wants to call for a patient, try googling Loan closets in Traverse City but again this is a rarity.)*
- Provide the *Patient Blood Pressure Packet* and go over the information with the patient including keeping a home blood pressure log in case the patient is able to get an at home blood pressure cuff.
- **1**. Schedule a phone follow-up to determine if patient was able to get an at home blood pressure cuff **AND 2.** Schedule an in-office blood pressure check appointment; this can be changed to a virtual appointment if patient was able to get a cuff.

Scenario 1 Scripting for Care Manager:
CM: Hi Mr. Smith! This is Kevin calling from your doctor's office. Dr. Jones wanted me to follow up with you on your last visit to make sure you didn't have any questions about your blood pressure. Is now a good time to talk?

Wonderful! Our docs give out a lot of information in those visits so we just like to follow up to make sure that it all makes sense. What sort of questions do you still have about managing your blood pressure? What was most helpful about the Patient Blood Pressure Packet? What questions do you have after looking it over?

Scenario 2: Patient has no scheduled visit and practice is working a HTN registry.

- If the patient has not had a visit in 2023, contact the patient for an annual appointment which will include a blood pressure check. **OR** If a patient had had annual visit but is due for HTN check with PCP call to schedule **OR** if the patient is not due for any or the appointments above, call and schedule the patient for a blood pressure check in person or virtual. If virtual, it needs to be determined if the patient has an at home blood pressure cuff: See steps 6-9 in scenario one.
- Repeat steps A Or B from Scenario 1. The *Patient Blood Pressure Packet* can be discussed via phone call and offered to be sent via snail mail **OR** Patient portal.

Scenario 2 Scripting for Care Manager:
Hi Ms. Smith! This is Kevin calling from your doctor's office. We have a new resource available for our patients who have high blood pressure. Dr. Jones thought it might be helpful to you so I'm going to get a copy in the mail for you. How has everything been going with your hypertension? What has been most helpful for you in managing your blood pressure? What has been the biggest challenge? We want to be sure we are giving you the best support possible to help manage your health - is it alright if I follow up with you in about two to three weeks to make sure you got our booklet and see if it has been helpful?

Blood Pressure Check for both scenarios: As many blood pressure checks can be scheduled as needed until proper reading is achieved and if proper reading is not achieved, the patient may benefit from working with a Care Manager on lifestyle changes.

A. 1-3 days before scheduled virtual check or office check call the patient and remind them of preparation steps in the *Patient Blood Pressure Packet.*
- Avoiding caffeine, exercise and smoking at least 30 minutes prior
- Bladder emptied.
- Be prepared to have loose fitting clothing around the arm so that no clothing will be covering the arm during the reading.

B. During virtual or office visit blood pressure check: *(The patients reported blood pressure can also be sued if appointment is over the phone with no video)*
- Make sure the correct size cuff is being used.
- Asked patient the questions from the *Patient Blood Pressure Packet* and listed under section "A."
- Follow Step 2 of the *Patient Blood Pressure Packet.*

C. If blood pressure still not controlled:
- Schedule another follow-up
- Discuss with the patient what helps them relax or if there is a certain time of day, they are more relaxed. The patient can be encouraged to practice their relaxing habits before the next appointment. If they are more relaxed in the mornings, an appointment can be made for this time.
- If there is time, before the blood pressure reading spend a few minutes talking to the patient allowing more time for the patient to relax.

Billing Information:

- Blood pressure readings can be billed for with CPT Code 992211 however, Co pays may apply.
  - For more information on CPT Code 992211 please review: https://healthcare.trainingleader.com/2019/10/cpt-code-99211-blood-pressure/#:~:text=ANSWER%3A%20You%20may%20bill%20CPT,the%20presence%20of%20the%20physician.
- Some offices may decide not to bill for this service so that the patient is not charged.
- If the office uses Care Managers, Care Manager billing would be a great option including G9002 for an in office or virtual setting.
  - A Team Based Care trained MA can bill phone codes for phone blood pressure checks.
  - Using Care Managers and Care Management billing is also a great way for the practice to gain more Care Management billing encounters to assist in meeting both BCBSM and PH targets.

Other Tips from NPO's 2023 Quality Measure Guide:

Patients, from the Denominator, whose most recent BP reading during the measurement year (01/01/2023 - 12/31/2023) is adequately controlled (systolic BP <140 mm Hg AND diastolic BP < 90 mm Hg)
• The blood pressure reading must occur on or after the second date of the diagnosis of Hypertension.
• Blood pressure readings do not need to be associated with a billable visit.
• Only the last (i.e., most recent) blood pressure reading of the measurement year (i.e., 2023) is used.
• The following blood pressure readings qualify:
- Those taken by a PCP or specialist provider during an in-person, telehealth, or urgent care visit
- Those taken by clinical staff (e.g., RN, MA etc.) during a non-provider visit (e.g., Blood Pressure check)
- Those taken, and reported, by the patient using a digital device
- Those taken during remote monitoring
• The BP reading must be documented in the patient's medical record to be eligible for this measure.
• The systolic and diastolic results don't need to be from the same reading. If multiple BP measurements occur on the same date, or are noted in the chart on the same date, report the lowest systolic and the lowest diastolic result.
• If no BP is recorded during the measurement year, or if the reading is incomplete (e.g., the systolic or diastolic result is missing), the patient is assumed to be "not controlled" and non-compliant for the measure.
• Do not include blood pressure readings that meet the following criteria:
- Taken during an acute inpatient stay or an ED visit
- Taken on the same day as a diagnostic test or procedure that requires a change in diet or medication on, or one day before, the day of the test or procedure, with the exception of fasting blood tests (e.g., colonoscopy, dialysis, infusions, chemotherapy, or nebulizer treatments with albuterol)
- Taken by the member using a non-digital device, such as a manual blood pressure cuff and stethoscope
• The following CPT II codes can submitted on claims to report Blood Pressure values:
- **3074F** (systolic < 130 mm Hg)
- **3075F** (systolic 130-139 mm Hg)
- **3077F** (systolic ≥ 140 mm Hg)
- **3078F** (diastolic < 80 mm Hg)
- **3079F** (diastolic 80-89 mm Hg)
- **3080F** (diastolic ≥ 90 mm Hg)

More information on blood pressure can be found in NPOs Quality Measure Guide or NPOs Quality Measures Quick Reference for PCPs: https://www.npoinc.org/resources/quality/

Care Manager Tools for Working with HTN Patients: Fall 2023

- This document follows the, *Care Manger Working with HTN Patient Fall 2023.*

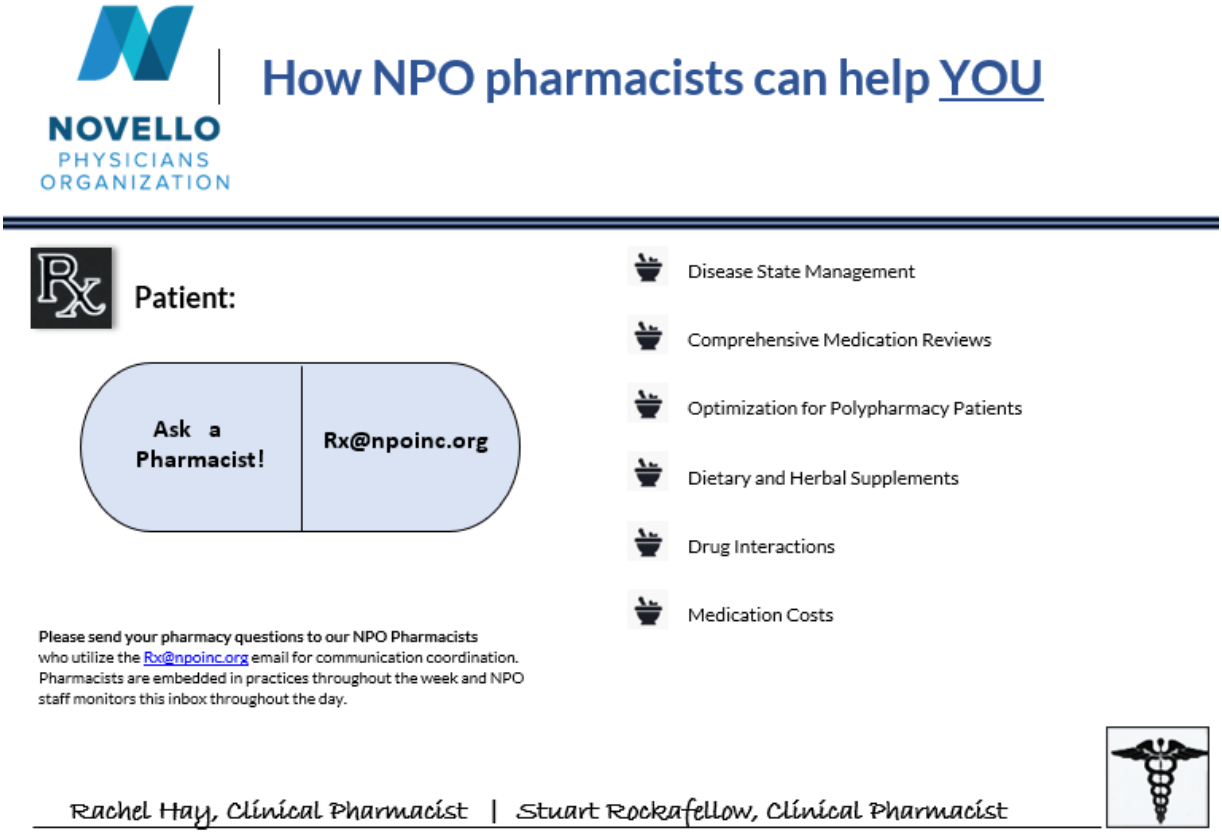
HTN Pharmacology and Counseling Points (Located in *Patient Blood Pressure Packet*)

- At each touch point ask the patient if they are experiencing any of the side effects mentioned related to the medications they are prescribed and educate them on potential side effects and the counseling points listed.
  - This is especially important when a patient is newly diagnosed or starting a new medication.

  Tip: Have providers notify Care Manager's each time a patient has a new HTN medication or if they are newly diagnosed. The Care Manager can do one education visit following the handout; if patient questions or concerns become out of scope, the care manager can reach out to the PCP or an NPO pharmacist for a consultation.

  What a great way to get more Care Management touches and it is great for patient care!

NPO pharmacist for a consult information:



<u>Nonpharmacologic Interventions for Prevention and Treatment of Hypertension (Located in *Patient Blood Pressure Packet*)</u>

- Ask patients about their habits related to this document.
- Educate patients related to this document (See **Tip** above)
- This can also be given to the patient as a handout, it may be motivating to some.
- Encourage the patient to pick one thing to focus on, at least to start.
    - For example, the patient decides to work on salt intake. Keep it simple: Maybe they decide to not add any salt to their already prepared food. You could encourage them to do this slowly by paying attention to how many times they usually shake the saltshaker and then cut that in half; they can wean off.

<u>HTN Care Plan for Care Management</u>

- *See Handout*