Maximizing Diabetes Care – Alternative Models
Group Medical visits

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Objectives

1. Define current models for Chronic Disease Management.
2. Outline Benefits and Barriers with Group Model Implementation.
3. Review Essential Components of SMA or GMV.
4. Discuss Coding and Billing Guidelines.
Disclaimer

This presentation is intended for educational and reference purposes only.

Information is subject to change by the Centers for Medicare and Medicaid Services, other private health care insurance or professional associations.

Traditional Medical Care Model

HCP is in the Driver Seat

Adherence Driven

Planning FOR Patients
Traditional Medical Care Model

- Passive Participant
- Dependence Driven
- Professional Determines Needs

Medical-Centered Model

Access to Care Improved with Added Space and Providers
Declining Reimbursement for Services
Demand for Greater Productivity
Medical-Centered Model

Expert Providers “in demand”
Overbooking and Closed to New Patients
Increased Volume of Patients with Chronic Disease

Patient Centered Model

• Patient is in the driver seat
• Autonomy
• Patient participation
• Planning WITH patients
Patient Centered Model

- Empowerment
- Active patient
- Independence
- Patient defines needs with diabetes team

Patient-Centered Model

- Easy Access to patient focused medical care
- Improvement in patient satisfaction scores
- Enhanced provider/patient communication
Patient-Centered Model

- Socratic education approach
- Interactive patient participation
- Personal health engagement
- Patient Empowerment

The “Whys” of Group Medical Visits

- National Statistics:
  - 48% at A1C Goal
  - 33% at LDL & BP Goal
  - Only 7% at Goal for all Three
- Three – Four 15 to 20 min/year
- Need more time to empower
- Support & problem solving skills are essential
GMV or SMA vs Group Education

- How do these visits differ?
- Advantages
- Reimbursement
- Billing Codes
- Guidelines
- Current Research

Group Medical Visits (GMV)

- Shared Medical Appointment (SMA)
- Voluntary Group Model VS 1:1
- Interactive and Engaging
- Care Delivery System-NOT classes
- Empowered Participant
Group Medical Visits (GMV)

- Autonomous and Participatory
- Disease Oriented Medical Visit
- Group Patient Education
- Target Behaviors or Indicators
- Shared diabetes management experiences

SMA Models

- Cooperative Healthcare Clinic Model (CHCC) (John Scott)
- Drop In Group Medical (DIGMA) (Ed Noffsinger)
- Private Practice Model (Masley)
- Residency Model (Schrimer, Goldberg)
Patient Benefits to this Approach

- Engaging experience
- Group discussion and learning
- More satisfying experience
- Shared diabetes management experiences

Patient Benefits to this Approach

- Fosters adherence
- Patient is not alone
- Increased time with providers
Provider Benefits

Attention to “frequent flyers”
Fewer hospital admissions and ED visits
Enhanced billable hours

Provider Benefits

• Improved satisfaction with clinic visit experience
• Focus on guideline implementation and adherence
• Improved efficiency
Provider Experience

MD #1 patient load 14 patients per week with 3rd available appointment was 5 months out

Within 3 months after Group Medical Visit Model implemented, 3rd available appointment was reduced from 150 days to 66 days out and patients could get an upcoming group appointment within a week.

Provider Experience

- MD #2 went from a 3rd appointment availability of 105 days to 30 days out, and patients could be seen in a group within 1-1-1/2 wks. This MD began group visits in June with a 8 week backlog and his backlog was gone by August.
Value of Group Visit Model

- Increase productivity
- Decrease cost per visit
- Reduces backlogs in schedules clogged with low-acuity, recheck appointments

Increase patient and provider satisfaction

Provides a forum for group education during clinic visit
Value of Group Visit Model

Clinical algorithm development

Collaboratively provide effective care

Team approach

Value of Group Visit Model

Diabetes educators maximize contribution to patient health status

CDE broaden repertoire to expand scope of practice

Outlines the Role of CDE in Medical Home Model
How to get started

• Select group size (10-20)
• Determine time and visit frequency
• Enlist staff support MD, MA and APN
• Identify potential patients
• Compose letter to personally invite patients to the group

Getting Started

• During routine 1:1 clinic visit provider extends a personal invitation to participate in a group visit
• Chart review one week prior
• Document recent labs
• ABCs of diabetes
Phases of SMS(GMV)

- Check-in: Download devices, Vitals, Foot Screening, Lab & Med Review
- Introductions:
  - 1:1 sessions: Review labs, Review meds
  - Group Discussion: Problem solving, Behavior Change Strategies, AADE7
- Debriefing: Team building, Brainstorm and CQI

Suggested Group-Visit Format

**Pre-planning session**
allow 2 hours; includes logistics, discussion material with topic

**Group Visit Agenda**
- Introduction of group-visit concept (script), review agenda and confidentiality statement (10 minutes)
- Collection of subjective and objective data, discussion of potential changes in therapy, clinical and billing data entry (20 minutes)
Group-Visit Format Agenda

- Clinical topic discussion
- Interactive approach
- Select resources
- (e.g., US Conversation Map” tool (60 minutes)
- Individual patient evaluations (30 minutes)

Post Group-Visit Meeting
- Debriefing with staff. Prepare for next session and group needs

Basic Guidelines: Nuts and Bolts

- Ample space to accommodate at least 15 people
- Designated staff for 2-2.5 hour block
- Insist on confidentiality
Basic Guidelines: Nuts and Bolts

Maintain interactive conversation rather than didactic lecture

Review billing criteria with coding specialist

Majority of time spent addressing group concerns and educational needs

Avoiding Pitfalls

Group member dominating session

Facilitation skills need to be sharpened

Stay focused from beginning and explain timeline
Avoiding Pitfalls

Low attendance-avoid “classroom” approach

One day prior to visit reminder (script)

Documentation issues - Template should be developed to enhance efficiency and accuracy

Pitfalls to Avoid

Conversion to didactic approach when clinical questions arise

Refer clinical questions back to the group for discussion and feedback

Builds self-care confidence
Pitfalls to Avoid

- Helps patients shift from a passive role to active role in their own care
- Billing issues
- Thorough review of billing codes and private insurance

Essential Preparation

- Billing: complete forms and review charts prior to group visits
- Review billing policies with departmental coding specialist
- Bill for group visits using the most appropriate office-visit code depending on level of care provided in the individualized portion of the visit
Code 99091 Defined

“Collection and interpretation of physiologic data (e.g., ECG, Blood pressure, BGM) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, requiring a minimum of 30 minutes.

Code 99091 created for CPT 2002 unchanged since created

Payment: Medicare does not make a separate payment for code 99091 either to MDs or hospitals; however the charges cannot be billed to patient.

Use of 99091

Directed at management of chronic conditions where routine or periodic monitoring is necessary

MD reviews and interprets physiologic data transmitted remotely by the patient

Multiple transmissions of physiologic data can be involved

MD must interact with patient to convey the results of review with recommendations.
Coding Guidelines for 99091

AMA stated that code 99091 cannot be used as a stand-alone code but must always be reported with the code for a primary service.

Cannot be reported more than once in a 30-day period.

If Code 99091 services are performed on the same day as an E&M service, the services are subsumed into the E&M code and the 99091 is not reported.

Code **Guidelines**

- Code 99091 is also not reported when it takes place within 30 days of an E&M care plan oversight service (99374-99380).
- Code 99091 is not used when a more specific CPT code exists, specifically including 95250 for continuous glucose monitoring.
- The Provider must spend at least 30 minutes on the service to report 99091.
- No NCCI edits related to 99091.
E/M Code Guidelines

- Physician must be present during the entire group visit.
- Physician must either document or review and sign off documentation.
- Only ONE E/M code for patient on day of group visit.
- If patient needs to see physician after group visit: Code 1:1 visit only.

E/M Visit Codes

- 99212: Documentation must include 2 of 3 key components.
  - Problem Focused History (PFH)
  - Problem Focused Exam (PFE)
  - Medical Decision Making
Documentation Requirements

- 99213: History CC, 1-3 elements HPI, ROS – Pertinent, low complexity
- 99214: History CC, 4+ elements HPI, ROS – 2-9 elements (or 3+ chronic diseases) HPFSH: 1 element moderate complexity

Billing for Group Visits

- 99214 – Documentation not at target and plan to reach goal
- Moderate Complexity - documentation attempt to bring patient into control
- Uncontrolled - Moderate Complexity - numbers out of range:
  - A1C, LDL, BP
  - No eye or other consults
  - Complications present
Uncontrolled-Moderate Complexity

• Modifications in care:
  • More exercise, diet, eye exam, urine examination
• Three problems:
  • Diabetes
  • Hypertension
  • Dyslipidemia

Billing Codes

• Level 2
  • 250.00 Type 2 DM on Target
  • 250.01 Type 1 DM on Target
• Level 4
  • 250.02 Type 2 DM Uncontrolled
  • 250.03 Type 1 DM Uncontrolled
• Level 5
  • 250.92 Type 2 DM Uncontrolled Unspecified
  • 250.93 Type 1 DM Uncontrolled Unspecified


Group Medical Visits

Group Visits = win-win  more $$,  team approach,  patient satisfaction, QI and outcome driven

Just because you can teach 1:1 doesn’t mean you know how to facilitate a group medical visit

Just because you are knowledgeable about the process, doesn’t mean you’ll get support from others on your team

Just because it’s covered, doesn’t mean you can bill for it

Just because you’ve gone to a group medical visit class, doesn’t mean you know all the rules

Just because you’ve been paid in one state, doesn’t mean you’ll get paid in another state

Questions?