Shared Appointments Offer Financial Benefits

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ORLANDO – Shared medical appointments offer an effective way to manage patients with diabetes, providing them with personal and professional interactions that improve clinical outcomes and self-care as well as fostering personal growth.

The programs, which usually include seeing 5-15 patients during a 1.5- to 2-hour period, allow providers to maximize their teaching and clinical care time and can actually be a lucrative way of managing this population, Mary Ann Hodorowicz said.

This newer method for managing office patients with chronic conditions allows providers to maximize their clinical care and face-to-face time with their patients. Diabetes self-management training or medical nutrition therapy is also offered during the visit by a diabetes educator or a registered dietician; patients interact with one another to help further their learning.

Shared medical appointments are not only cost effective but also much more profitable in terms of payer reimbursement, compared with individual visits, said Ms. Hodorowicz, a certified diabetes educator and registered dietician who specializes in reimbursement for diabetes services.

"I'm the queen of acronyms, and 'MORE' is a great one to describe the shared medical appointment for diabetes care. You and your patients get MORE results: Maximization of Outcomes, Revenue, and Empowerment of patients."

Because Medicare and most private payers recognize the group treatment approach, providers can bill for individual patient follow-up visits for the evaluation and management services they deliver to each patient during a shared medical appointment (SMA).

"This is the good news. If you have 10 patients in an SMA that lasts 2 hours – 1 hour of which is with the physician – you can bill for 10 individual follow-up visits for evaluation and management services," said Ms. Hodorowicz of Palos Heights, Ill.

For example, she said, if the reimbursement is $100 per patient, the physician will receive $1,000 for 1 hour of work. "Compare that to seeing 10 patients one on one in the traditional office setting, and spending about 20 minutes with each patient. It would take you more than 3 hours to make the same $1,000. In an SMA, this 1 hour translates to $17 a minute; the 3.3 hours in the office setting translates to 50 cents a minute. Do the math."

But the SMA includes more than a clinical care component. Different programs have different formats, but evaluation, management, and medication titration are just part of a much more holistic package.

"Everyone who comes in gets a blood pressure check, a foot screen, and a retinal screen," said Sharon Watts, a diabetes nurse practitioner who created an SMA program for the Louis Stokes Cleveland Veterans Affairs Medical Center. "The providers come in and give a brief talk on the importance of the [hemoglobin] $A_{1c,}$ blood pressure, and LDL cholesterol, and we go through the rest of the ABCs of diabetes care. And we get out of there," and let the educators and patients take over. Registered dieticians, diabetes educators, and behavioral specialists can all be part of the team. A 1-hour lecture, however, is not the goal.

"It is all patient driven," said Susan Cornell, Pharm.D, a certified diabetes educator and pharmacist who helped create the SMA program at Midwestern University in Downers Grove, Ill. "We know it's going well when the patients – not the health care professionals – are doing most of the talking. Allowing the patients to take the lead is key, because we stress the importance of self-management. We want to make sure they take ownership of their condition. The more they do, the better they can control it."

COURTESY SUSAN CORNELL

Session at DuPage Community Clinic in Wheaton, Ill. (L-R) Sarah Slater, pharmacy student 3rd year, and Tony Appello, pharmacy student 3rd year, presenting.

Unlike Ms. Watts' program, which focuses exclusively on high-risk patients, Dr. Cornell's CHAT (Collaborative Health Advocate Team) program includes patients of other risk levels who have been referred by their primary care provider. She makes sure to keep the groups homogeneous. "You really can't have type 1s, type 2s and 'gestationals' all in the same group because they have very different needs," she said.

This program includes some clinical care, such as blood pressure checks and blood glucose levels, but it focuses more on self-management tools. Topics might include nutrition, medical therapy, cardiovascular disease, depression, self-monitoring of diabetes, or how to deal with complications.

Because it's within a university setting, CHAT is run by students who are supervised by the preceptors in their specialty, whether that's nutrition, psychology, pharmacology, or medicine.

The VA program has a slightly different take on the SMA. For example, Ms. Watts' program is not open to all comers. "I populate these groups myself," she said at the meeting. "I want to go after those who aren't being gone after by anyone else – those who are at really high risk of problems."

To enter this program, patients have to have an HbA_{1c} of at least 9%, a systolic blood pressure of at least 160 mm Hg, and an LDL cholesterol level of more than 140 mg/dL. Because it focuses on nonadherent, high-risk patients, this program has more clinical components.

When patients come in, they have some initial exams (blood pressure, foot, and retina screening) and get copies of their most recent labs, including HbA_{1c}, blood pressure, and LDL cholesterol. After a group review of diabetes-care issues, the ancillary staff takes over. Diet and nutrition, erectile dysfunction, mood disorders, barriers to care – any of these topics, and more, can become fodder for discussion. Open-ended questions from the facilitators usually help establish the group discussion themes.

During group time, patients are individually called into a separate room to review their labs, set treatment goals, and have their medications titrated. "Yes, there is a huge educational component to it, but this is not just an education class," Ms. Watts said. "I want more. I want those blood sugars, blood pressures, and LDL numbers under control."

She started the program in 2003, and her early assessments indicate that most patients (who attend about two or three sessions) are able to reduce their HbA_{1c} levels by 1%-2%. This improvement is directly related to increased medication adherence, Ms. Watts said.

Billing for the educational part of the SMA can be more than a little tricky, Ms. Hodorowicz said. "Medicare reimbursement for diabetes self-management training (DSMT) and medical nutrition therapy (MNT) is convoluted, confusing, complicated, and constantly changing."

It's important to note that although Medicare does cover both DSMT and diabetes MNT, it will not pay for both when they are furnished on the same day to the same beneficiary. Although registered dieticians, certified diabetes educators, nurse practitioners, physician assistants, and others involved in the SMA can all bill for their services, either with their own national provider identification number or that of their group practice, Medicare requires some key codes for payment.

One of these is the five-digit diabetes ICD-9 diagnosis code. "This is really important on any claim you are billing," she said. "Without a five-digit code to enhance the specificity of the diabetes diagnosis, you have a 99% chance that Medicare is going to deny that claim."

For group DSMT, the procedure code is G0109, and time is billed in 30-minute units. But for this service to be covered by Medicare, the DSMT program has to be certified by the American Association of Diabetes Educators, the American Diabetes Association, or Indian Health Services.

Private payers also will cover group DSMT but may require different procedure codes. "It's best just to call them and ask what they want rather than guessing and getting a payment denied," Ms. Hodorowicz said.

The procedure code for group diabetes MNT is 97804. Again, time is billed in 30-minute units. Registered dieticians who are Medicare providers are the only individuals who can furnish diabetes MNT and be reimbursed, although private practices, outpatient hospital departments, and some other entities also can bill on behalf of the dietician. Again, many private payers do cover MNT, but might require different procedure codes.

The SMA is an evidence-based practice paradigm that can work well for everyone involved, Ms. Hodorowicz said. "It's a highly effective way to deliver quality follow-up medical care and quality self-management education."

Ms. Hodorowicz is on the faculty of the Johnson & Johnson Diabetes Institute, San Jose, Calif., and the DASPA (Diabetes Accreditation Standards–Practical Applications) program, which is sponsored jointly by the National Community Pharmacists Association and the American Association of Diabetes Educators; she also is on the speakers bureau of Nestle HealthCare Nutrition. Dr. Cornell is on the speakers bureau of Merck & Co. Inc., Abbott Diabetes Care, Novo Nordisk, the Johnson & Johnson Diabetes Institute, and Takeda Pharmaceutical Co. ■

Resources: *A manual written by Ms. Watts describes how to establish and run a diabetes SMA program. Requests for the manual can be made to her at sharon.watts@va.gov. Ms. Hodorowicz, owner of a consulting company, offers a continually updated guide to reimbursement for DSMT and MNT on her Web site (www.maryannhodorowicz.com) at a cost of $45.99, as well as other resources. She can be reached via e-mail at hodorowicz@comcast.net.*