SSR Coding Review
Plan First and Patient First

Satellite Conference and Live Webcast
Friday, April 28, 2017
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Produced by the Alabama Department of Public Health
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Faculty

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SSR Policy

- **Page 5 of the SSR Manual states: Case Managers/Care Coordinators are required to key SSR entries in ACORN daily**
- **All entries are downloaded on the 6th of the month following the month of activity unless the 6th falls on a Saturday, Sunday, or holiday**

Documentation Requirements

- **All services are required to be documented within 5 working days (Protocol)**
- **All SSR entries coded to a patient must have supporting documentation in ACORN on or before the 6th of the following month in order to be coded to the patient (Documentation Policy)**

Documentation Requirements

- **If documentation is not entered by the 6th of the month following the DOS, time must be coded to the program as DPH and not to the patient**

Editing SSRs

- **Why is it questionable to edit the SSR?**
  - **It appears time was changed, why would the time need to be changed if the SSR was completed at the time of service?**

Editing SSRs

- What does that tell us when the SSR is edited?
  - If it is edited within a few minutes of the original entry, not a big deal
  - When it is edited several days later, that raises a red flag

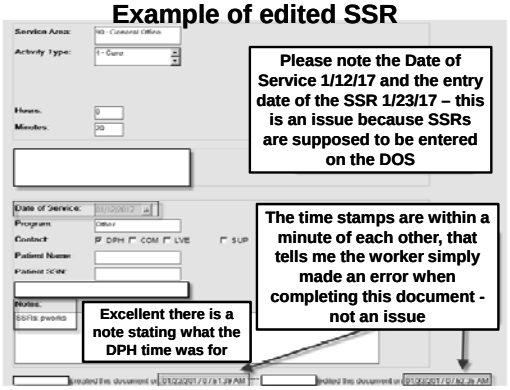
We Are So BUSY!!!

- We all have a life outside of ADPH, each of us have a family of our own, that family has needs, be it an aging parent that you have to get the meds distributed to, or a child that needs the field trip form filled out, these things take up space in our memory bank

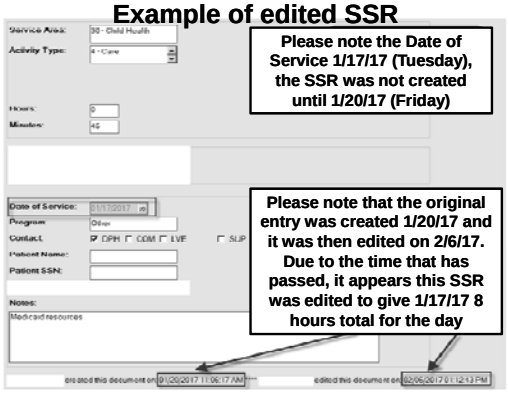
We Are So BUSY!!!

- Time with patients is accounted for in 5 minute increments - what a challenge!!!
- Think about what you were doing at 9:15 on Tuesday

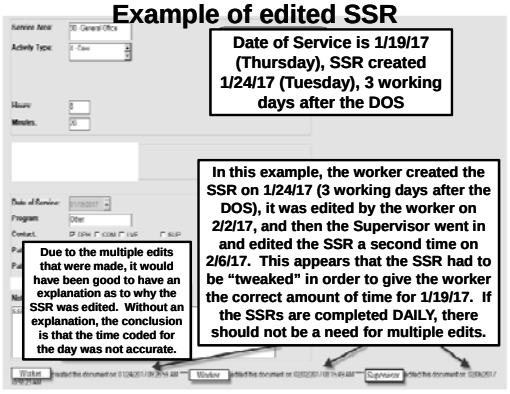
Example of edited SSR



Example of edited SSR



Example of edited SSR



Ideas of How to Keep Track of Time

- Pad of paper or sticky notes where times are written down with the start / stop times for work with a particular patient
- When we coded to eStart, I tracked that time to the minute

Ideas of How to Keep Track of Time

- I would get calls or someone would come into my office, I would write down what time I started and then what time I stopped
- Once I was done, I added up all the minutes so I would have an accurate recording in eCats of the time spent in eStart

General Coding

- Service Area 20: Patients not eligible for Plan First
- Service Area 30: Children not eligible for Patient First
- Service Area 40: Home Health Medicare
- Service Area 45: DHR/EHS Grant
- Service Area 48: Home Health Administrative

General Coding

- Service Area 70: Adults not eligible for Patient First
- Service Area 90: General office
- Service Area 91: Leave
- Service Area 92: Training

Patient First Coding - All Services Code to Activity Type 4

- Service Area 21: Patient First Adults
- Service Area 27: Adult Health Home/RCO
- Service Area 31: Patient First Children
- Service Area 39: Children's Health Home/RCO
- Service Area 56: CoIIN Children
- Service Area 57: CoIIN Adults

Patient First Coding - All Services Code to Activity Type 4

- Service Area 81: Maternity Children
- Service Area 82: Maternity Adult

Maternity Code

- For those counties where the Gift of Life is no longer providing maternity services and Health Department staff are working Maternity referrals
- Service Area 10 for the Maternity patients that are NOT Patient First eligible

How Many Codes Is That??!!!

- General codes: 9
- Patient First codes: 6
- Maternity related codes: 3
- Total: 18
- That doesn't include codes used for certain programs, like DHR, or county specific projects like educational classes

How to Code for a Family Planning Patient

- A family planning patient, applying for Medicaid
  - Code to Plan First instead of Patient First so if the patient gets Plan First the CC does not have to see her again in order to bill to Plan First

How to Code for a Family Planning Patient

- Remember, when a Plan First risk assessment is completed and the patient flips to full Medicaid, the risk assessment can be changed without seeing the patient face to face again

Plan First Coding

- Service Area 15
- Activity Types 1-9, except 8
- Activity Type 9 is being added for unsuccessful phone calls

Activity Type 1

- Recruitment
- Used in conjunction with a High Risk Assessment
- New patients only
- No more than 5 minutes per year can be coded to this activity type

Activity Type 2

- Time coded to a patient for Face to Face encounters
- All face to face interaction with a patient that is not associated with a risk assessment is coded to Activity Type 2

Activity Type 2

- No more than 2 hours per day per patient can be coded to this activity type
- Can not use this Activity Type in conjunction with Activity Type 6

Activity Type 3

- Time spent through Telephone contacts with the patient
- No more than 1 hour per day per patient can be coded to this Activity Type
- A separate SSR entry for the documentation of the successful phone call with the patient will be coded to Activity Type 4

Activity Type 4

- All other services that are not specified in another activity type
- This includes phone calls on behalf of the patient, documentation, filing, updating ticklers, and checking eligibility
- No more than 1 hour per day per patient can be coded to this activity type

Activity Type 5

- Low Risk Assessment
- Includes the time spent with the patient and time documenting
- All documentation needs to be completed on the DOS, if not, will have to be coded to DPH
- No more than 2 hours per patient, per year can be coded to this activity type

Activity Type 6

- High Risk Assessment
- All time associated with the face to face interaction with the patient during the annual family planning risk assessment will be coded to activity type 6

Activity Type 6

- All time spent completing the psychosocial assessment and any face to face time with the patient will be coded to the 6
- No more than 2 hours per patient per year can be coded to activity type 6

Activity Type 7

- Case closed
- Only used with High Risk patients

Activity Type 9

- Unsuccessful phone calls with the patient
- Documentation of the unsuccessful phone call attempt to the patient
- No more than 15 minutes per patient per day can be coded to this activity type

Example

- The worker completes an unsuccessful phone call to the patient, code to activity type 9
- The documentation of the unsuccessful phone call is coded to activity type 9
- The worker also mails a letter to the patient, code to activity type 4

Example

- The documentation of mailing the letter is coded to activity type 4
- Each SSR entry requires a separate progress note
  - This means the note for the letter being mailed will be separate from the note for the unsuccessful phone call

Guidance on Phone Calls

- Do not make multiple attempts every day
- Attempt in the morning one day, wait a day or two, attempt in the afternoon
- Try not to make more than 3 attempts in a week
- Wait until the next week to attempt again
- If the patient returns the call, but the CC is unavailable, attempt again and document that the patient returned the call in order to justify an additional attempt

Guidance on Phone Calls

- Mail a letter to the patient by the second missed attempt
- After 2 weeks of no returned calls from the patient, wait until the first day of the next month to attempt again
- Repeat attempt schedule

Guidance on Phone Calls

- After 2 weeks of attempts with the patient and no returned calls, mail a letter explaining to the patient that the case will be closed if the patient does not respond
- Monitor PHALCON and Crossroads for any return appointments

Guidance on Phone Calls

- If patient does not follow-up with the CC, or come in for an appointment, close the case 60 days after the initial unsuccessful attempt

Other Medicaid Changes

- Activity Type 4 is now being pointed at a new modifier
- This means it will show up as a different line item on the EOPs