Phillip Stringfield (00:00:00):

Everyone, thank you for joining. My name is Phillip Stringfield, specialist of health center operations training here at NACHC, the National Association of Community Health Centers based in Bethesda. I'm also joined by my colleague April Lewis, director of health center operations and HR training. So, let's go ahead. And wanted to review the mission of NACHC. The National Association of Community Health Centers was founded in 1971 to promote efficient, high quality comprehensive healthcare that is accessible culturally and linguistically competent, community directed and patient centered for all. And, of course, we provide that service to over 1400 community health centers, PCAs, ACCNs across the nation, inclusive of its US and its territories. And we see that to over a 29 million patients per year. Of course, we cannot do that without people like you who are on the line and providing service to your communities day in and day out.

Phillip Stringfield (00:01:03):

So, today's webinar is Quality Reporting & Care Management for Community Health Centers. And this will focus on the stated objective and the common issues community health centers face when using CPT/HCPCS and ICD 10 coding and how that impacts operations. Also, want to remind you all that part two of this webinar series, A Focus on Performance Recording Chronic Disease Management Services, will be held next week, Tuesday, February 25th at 2 PM. So, if you're not registered for it yet, make sure to circle back to the NACHC once the webinar concludes so that way you are on track for next week.

Phillip Stringfield (00:01:45):

Today's webinar series is being presented by Gary Lucas with the Association for Rural and Community Health Professional Coding, a trusted partner of NACHC and to many health centers and PCAs alike.

Phillip Stringfield (00:01:58):

So, before I hand it over to Gary, I wanted to of course remind you all of a couple of housekeeping reminders. To ask any questions that you may have for today. Please use the Q&A or the chat feature. I'm going to be making sure to keep track of any and all questions that come in. And when we have time, toward the end of the presentation, we'll make sure to go ahead and get them answered for you.

Phillip Stringfield (00:02:26):

So, without further ado, I'm going to go ahead and hand it over to Gary Lucas and he will take it over for today. I'll go ahead and let you get your screen all set up.

Gary Lucas (00:02:49):

All set.

Gary Lucas (00:02:51):

All right, well thank you to Phillip, and April, and our partners there at NACHC. My name is Gary Lucas. The slides will be sent out after class, so that we can maintain our kind of a focus here on the screen, but when you are able to print the slides following today's session. That way you have a lot of information that you can utilize to go back and train some of the folks that maybe were not able to attend.

Gary Lucas (00:03:16):

We are based out of a Metro Atlanta and we provide education certification, and audit support, and continuing education specifically for rural health clinics and FQHCs, you in the community health world. I'll make sure to leave my contact information up here briefly during the Q&A at the end of the session. But I've been very lucky to have spent the past 25 years providing, in the neighborhood of, about 1600 workshops in 46 states. And the last eight or nine years, in particular, has been kind of matching and going shoulder to shoulder with what NACHC's mission is to advance the delivery of quality healthcare to America's medically underserved communities. But what we do is we provide this education specifically to you surrounded around the revenue cycle.

Gary Lucas (00:04:10):

And today's course is going to go over some of these new phrases and newer concepts that some of you that have been in the traditional medical world maybe have a little bit of a head start on us in community health on. But we're going to talk about how we are going to integrate the new needs in a value-based care world of risk adjustment, and shared savings and HCCs, and HEDIS, and yes, another couple dozen more abbreviations and acronyms that we're going to be getting used to here over the next couple of years.

Gary Lucas (00:04:43):

Our target audience really covers an area broader than we typically see in the industry. We have the opportunity to speak to coders and billers, and quality staff to help them reach their goals. And what we're really focusing on here is to bring providers into that discussion, of course, because you have responsibility to document what was done and why, and sometimes those guidelines aren't easily accessible. We'll help give you access to those rules today.

Gary Lucas (00:05:12):

Facility leadership, we recognize how valuable everybody's time is but, in particular, yours. We also respect the fact that you are in between, literally and somewhat figuratively, the front office in the back office, and the clinical needs and desires of your providers, and matching those with the reporting and revenue and billing needs that the folks on that side of things have to deal with. So, we do appreciate and recognize that we probably have people of different levels of experience that are involved in different areas. But regardless, we have to make sure that we're prepared and truly ready to provide the resources and operational knowhow to report quality.

Gary Lucas (00:05:58):

And I'm not going to read each of the items on this slide, but you're going to find out where you're fitting into this path. And we truly believe that the team based training idea is important so that folks have an understanding of what happens before them, and what happens after that process. Because this slide should look rather similar to a lot of the revenue operations you've been doing for years. But now at the end, after we bill, after we hopefully get paid everything we deserve, it may be necessary now to meet the obligations of some of our participation contracts to report quality. Sometimes that's going to be to generate revenue that we otherwise would not be able to generate. Or, in other circumstances, it may be a need, or a requirement of participation with some of our managed care entities.

Gary Lucas (00:06:49):

But as a quick little overview here, we want to make sure that we're going to give you an overview of the key terms, for example, a sentence that had I said six or seven years ago, I would have gotten a lot of funny looks, and that is that quality and ACOs for shared savings often measure quality in a value-based care world based on risk adjustment principles that focus on HCCs and HEDIS measures. That sentence is loaded with some new information. My goal, today, is how to help you prepare to be ready, how to dive into these key terms, and really recognize that it deals intimately with these processes that we've had and that we've undergone for years. But our goal is to assist you in managing that change that is inevitable because, of course, we can't continue to do things the same if they're always changing. And so, again, you'll get the chance to read these slides later. Let's just kind of provide some continued overview here.

Gary Lucas (00:07:50):

We appreciate any managers and providers for taking place here because you, of course, have primary responsibility, of course, among many other responsibilities that you have to track, and report, and document the valuable services you provide. So, for example, if you're responsible for the financial health of your facility, how familiar are you with those rules and regulations? We often find out that folks are put in positions of leadership due to staff turnover, or because they show wonderful management promise, but along the way nobody's explained those rules to them. Maybe you're just a provider who wants to know what rules I need to follow, so I can focus on my clinical care. That's a very difficult position for providers who are no longer owners of their own practice. And as employed providers they simply need to be exposed to these rules. And providers have shown that they can incorporate those rules and still maintain the quality of care that they define which, by the way, is likely and maybe different than how a patient may define it, or an insurance plan may define it. And so, one of the things that we need to be able to do is dive deeper into our participation contracts with insurance companies and, of course, I recognize those aren't always easy to read, and may not be updated too often, but we really are going to go dive deeply into understanding what those guidelines are, and understanding when we have a guideline that can generate revenue versus one that makes us stay in compliance.

Gary Lucas (00:09:29):

Now, recognizing that how difficult it is to get all of this integrated is going to be unique depending upon the IT systems, and EHR systems you use. We recognize those systems that were supposed to make life easier may make them more challenging, but the fine folks at NACHC, and at your state primary care associations are very well suited to help. And we hope that we can help provide that outline to get everybody to build that shared foundation of knowledge.

Gary Lucas (00:09:57):

Now, we're talking about the coders and billers, and quality staff they have a responsibility that before, and I really want to emphasize before, that before a bill, or a quality measure is sent out that you have a fully completed and timely medical records of each encounter that really captures everything that was done. But I don't want that to be looked at as a doing issue, this is purely a coding issue. I mean, if you go to the grocery store you want to understand what you bought and what the charge was for it. Now, adding that diagnosis element to it doesn't really work with that analogy that well, but do you think your patients need, or deserve a full listing of what was done? Or just a listing of what went on their bill?

Gary Lucas (00:10:44):

So, coding allows us to identify the true cost of our services, from a cost report perspective, helps give the patient a receipt of everything that was done and yes, often captures information such as quality measures, such as performance measures that we'll speak about later that are necessary to deal with some billing issues. And it's really the nursing staff that kind of is the largest beneficiary here of this type of education because you are likely the ones that travel that world of clinical professionals to the billing and business professionals most often. But, oftentimes, nurses are having to go dig and play detective looking back into the old medical record to find quality data, when our focus is to help ensure that we can get as much of that information done up front and in advance.

Gary Lucas (00:11:41):

So, when we're talking about which payers does quality apply to I really want to focus here on your Medicare Advantage organizations. Regular Medicare, regular old part B Medicare, and other types of facilities may be bound by things like MIPS, or MACRA, or several of these other remaining quality issues. But, most likely, you and I are not going to be responsible for reporting quality measures to pure Medicare patients. It's going to be our Medicare Advantage plans and I always laugh a little bit here that they're going to simplify the program by giving us a lot more rules and a lot more codes to submit. But the goal here, of course, is to ultimately meet the goals that we all have for our patients. But they deem that the reporting of these quality services is necessary to reflect the risks of people who enroll. Whether your state did or did not expand Medicaid, whether you have one or two Medicaid or Medicare Advantage plans that's the set of folks who are most likely asking you to support or, excuse me, report quality.

Gary Lucas (00:12:55):

So, part A Medicare, of course, has their rules, and we in FQHCs are a bit unique because we submit part B services typically on a claim form associated with part A, but we need you to maybe joyfully put that to the side today and focus on part C, which you are likely a participating provider in each of, if not most of your Medicare Advantage or, let's say, even Medicaid Advantage plans here, but you wouldn't really go to regular Medicare to go search and do research here. We're typically providers in parts B and C and of course part D is more dealing with prescription drugs, but make sure that we don't think that we have quality reporting requirements associated with more commercial patients. Our Medicare patients most likely Medicare and Medicaid managed care plans.

Gary Lucas (00:13:49):

So, I can tell that this picture is, hopefully, an accurate reflection of your mood today in terms of getting on a course floor for a little bit of time. But let's just dive into the overarching word and the phrase of value-based care is likely the broad umbrella term that you'll hear associated most often with each of these little sub points that we're going to be talking about here over the next hour or so. We will have a Q&A. Again, remember to either put yourself in the queue or place your question in the Q&A box. But please do note that I will not be able to read those as I'm teaching.

Gary Lucas (00:14:31):

But, of course, those of you that have moved into the community health side of things have noticed how kind of wacky some of the billing and reimbursement rules are for us compared to traditional offices. But this idea of value-based care is actually part of health and human services' mandatory transition towards upwards of 75 to 80% of the disbursements to these plans take place based on quality. Well, guess who they depend on for that information. You'll hear oftentimes, especially community health

centers that are a hair more advanced, and data savvy, and have updated processes, and hired certified billers and coders that have FQHC specific information, they're often looking to become part of, what's called, an accountable care organization. And in addition to some of the reimbursable issues I'll talk about here for you, even if you're not in an ACO, there is a way to generate, what are called, shared savings.

Gary Lucas (00:15:38):

Bottom line, if we can show that we, similar to a patient centered medical home, are sharing the risk with other providers, and hospitals, and home health agencies, et cetera, if we can come in underneath the expected spending that these Medicare managed care organizations expect us to see we may be able to share in that savings. Well folks, that comes from complete documentation, complete coding, and very detailed work on the quality issues we'll talk about today. But, of course, these outcomes are completely based, when the carriers are looking at these outcomes they're almost 100% dependent upon the level of veracity that we have given to our processes, so that we're not just using generalized diagnoses when a more specific multi-system diagnosis might be appropriate.

Gary Lucas (00:16:32):

But I will take a brief moment to give you my personal opinion. This is not the opinion of NACHC, et cetera, but there are some conflicting motivations because if we're not talking accountable care, we're talking about purely reporting information in this value-based world, occasionally, these insurance carriers that are offering these insurance products are using that information to go bill Medicare for more money. Now, of course, if they don't have that money, then they're going to have a hard time getting it to you. But do recognize that the word quality today is going to be in air quotes a whole heck of a lot because of the varying definitions that are used.

Gary Lucas (00:17:15):

So, when we're talking quality reporting, although some of these sentences use phrases and words that are new, essentially it's just going to be a deeper reflection, and a dive into the guidelines that we find, for example, in the ICD-10. So, when you hear about hierarchical condition categories, or HCCs, these are solely diagnosis codes. And, oftentimes, providers are using shortcuts, or favorites lists, or just using keyword searches to apply diagnoses, granted because they may be busy, but potentially without a focus on how important it is that the patient knows exactly what they have, that other providers that see our diagnoses know truly the true clinical picture of that patient. Because when as states and the federal government are splitting the risk for covering a big geographic area amongst a variety of different insurance companies it's vital that they make sure they have spread that risk equally and not done so and gave a particular insurance company patients that are more sick. And you see how that could go down the line. So, they're very dependent upon our data to understand the risk associated with treating our patients.

Gary Lucas (00:18:36):

Now, when you hear about HEDIS measures, because we're right now in HEDIS season kind of makes me laugh, I think about that like deer season, or whatever. But about the beginning of the year various plans are sending letters to you saying, "Hey, we need information about your CPT codes, HCPCS codes, and key ICD-10 codes because we expected last year for you to have provided, for example, 85% of your patients you got BMI measured on, and you did a risk assessment, and you did a preventive visit." And

those codes feed the quality reporting system but, quite honestly again, they should come from a very robust coding and billing process anyway.

Gary Lucas (00:19:21):

When we think performance measures, so the big categories are risk adjusted coding, HEDIS measures, and then performance measures what we do there is we end up talking about codes that have been in the back of the CPT for at least a decade now. They actually end with the letter F as in Frank and, heck it even says it in the CPT, these codes are optional, and are not required for proper coding. But they are now not so optional. There are requirements built into our participation contracts with Medicaid and Medicare organizations where we have to tell them sometimes that we measure the patient's BMI, or we asked if they were smoking. Or was there pain present when we asked? And we're potentially renewing a dangerous prescription there.

Gary Lucas (00:20:13):

Now, although these performance codes are not associated with specific fees and specific payments from carriers many of them are offering financial incentives. For example, when we talk about these towards the very end of the presentation today, when we dive deeper into the performance measurement issue and, what's called, the AMAs clinical topics listing, where these specific performance measures are categorized by the ones you need to get for diabetic patients, or those with coronary artery disease, or peripheral vascular disease, et cetera I'm finding carriers now, for example, starting to pay $10 four times a year just by reporting, or for reporting a patient's A1C levels, if they're diabetic. So, if you find you have diabetic patients in those patient populations there's significant revenue there. But how you submit those, and when you submit them, and on which claim form, we'll cover a little bit later. Unfortunately, don't expect a lot of consistency yet, but the industry's looking for that.

Gary Lucas (00:21:24):

The last one, or almost the last ones I want to mention here are, again, ICD-10 codes. And it's especially more prominent in FQHCs because of your very close relationship with public health, and your states' desires to make sure that the resources they have are getting to the right patients. But instead of waiting sometimes until they get sick, they're trying to help gather ICD-10 codes related to social determinants of care. For example, maybe they can track patients that don't have regular access to routine nutrition, or housing, et cetera. And be able to get those resources to those people, and identify which programs may or may not be working. So, instead of working at a very individual local level, and hoping those results translate across the population, potentially, what if every community health center could participate in getting that information? And because we're thoroughly coding our ICD-10 codes on each patient.

Gary Lucas (00:22:26):

So, as we move ahead, again, for those that are just joining us these slides will be given to you after the session. But this way we can not just have to stare at a whole large screen of texts, but can together work piece by piece. So, value-based care, again, the overarching item that's moving away from just daily payments, or fee for service towards outcomes should be very clear that we're moving away from, "Tell me what you did and we'll pay you," to, "Tell me how the patient's doing and we'll pay you." And so, obviously, there are a lot of issues built into that. But there are also opportunities, such as sharing in the savings by being a member of an accountable care organization by assuming some of the risk and staying under that benchmark of the expected costs of treating your patient population.

Gary Lucas (00:23:14):

You are the data providers and by no stretch am I taking any focus away from the clinical care you provide your patients. But, as it relates to this class, every member of an ACO must be able to ensure that we all are documenting well, coding well, and reporting those services the same because it affects everybody else in that ACO. So, whether you're talking about those coding diagnosis codes that reflect the complexity of your patients, please keep in mind that there are close to 70,000 diagnosis codes. But don't worry when we're dealing with HCCs there's only about 9500 of them that we need to worry about. And they've been nice enough to group them into about 70 to 80 categories for us. So, halfway joking here ...

PART 1 OF 4 ENDS [00:24:04]

Gary Lucas (00:24:03):

... 70 to 80 categories for us. So halfway joking here, but it's not all of your diagnosis codes, but they've identified some key diagnosis areas in order to make sure that they can track things at a patient level, a city, county, state, and even national level. So can you just measure, sometimes you'll hear the phrase to, "close gaps." Maybe there are levels of expected performance of some of these quality measures related to HEDIS. I'll show you some sample HEDIS measures here towards the middle to end of the presentation, but you'll notice that these codes are CPT, HCPCS and ICD-10 codes and truly involve providers, nurses and coders and billers together. We hope that this overview will provide continued assistance. As you notice on this next slide, please go to the very bottom of it.

Gary Lucas (00:24:55):

First, I think personally, the book on the subject of risk adjustment and documentation as it relates to coding is written by someone I was honored to meet, goodness, probably back in the late nineties, Ms. Sherry Poe Bernard. This idea in the left hand column shows you this particular patient who whose reimbursement is discussed at the bottom of the slide. Let's just say that CMS is paying that particular ACO or maybe Medicare is paying that managed care company $800 a month for the quote, "average patient," getting about $9,600 a year. But when you go back up to the reflection of the impact that those hierarchical condition categories have on the payments, the fact that the patient has congestive heart failure and notice it's not just kind of unspecified diabetes if you will, but it also indicates the peripheral vascular disease, obesity, et cetera, that are RAF or risk adjustment factor is what's used to increase, in this particular case, that patient's reimbursement. Again, possibly to the ACO or possibly to the insurance company by a pretty significant factor there over double the amount.

Gary Lucas (00:26:16):

All of this stuff is going on behind the scenes. This is not stuff you're going to be dealing with on a day to day basis; but if you're in an ACO, it's important to understand what impact that has on what you're collecting or if you're a member of a managed care organization, how the importance of accurate diagnosis coding is key not only to the patient, but also to them. Because there's a very, very interesting legal principle here that has changed and that is over the years, we've been completely responsible for the accuracy of our documentation because we were the ones getting paid directly, let's say by Medicare for example. However, these managed care organizations that themselves contract with uncle Sam look at this as a vital way to get paid correctly and accurately because when they're paying us for our services, they need to be able to show that that risk has been spread equally, but they now are responsible for the accuracy of our code.

Gary Lucas (00:27:22):

Whether they're pulling these codes from our historical claims that we've submitted, sometimes they come to us at the beginning of the year in heat of season and say, "We need documentation," or even some cases they are sending. The managed care organization is sending folks to your practice to perform what they call, a hybrid review. This hybrid review is essentially an audit, but instead of the kind of the connotation that the bad use of the word audit where, "Hey, if we didn't document it, then we may have to pay the money back," they are actually there to help us and make sure that we use the most specific diagnosis codes reflected in the documentation because again, it impacts their business goals significantly.

Gary Lucas (00:28:10):

Here's a sample interaction between what a HEDIS measure looks like measuring of the adult BMI there and yes, there are diagnosis codes in the Z-code section that are able to stratify and categorize the patient's BMI. But what you don't see on that HEDIS measure is there's also a category two code in the back of the CTT, 3008F, which is BMI document. We can understand that it's not as easy as just looking at a measure, running a report in your EHR and seeing if you performed that service or what the values were, but there's another way to do it; sample risk adjustments via those HCC there. Again, here's a comparison when you get a chance to dive a bit more deeper into this discussion on the impact of some of the social factors in terms of living in assisted living versus there, a higher level multisystem diagnosis issues and how it can impact the level of risk. So let me... I'm not advancing. Bear with me just a moment.

Gary Lucas (00:29:18):

All right, so real quickly to summarize because community health I find in the nation, are much more active in the accountable care organization side of things. I wanted to get a good quote and I wanted to get it from Medicare there as a group of docs hospitals or other providers who bond together voluntarily to give care to those patients. Got something popping up here. There we go. Using, again, quoting from Medicare, "When an ACO succeeds in delivering high quality care," and they'll do some more wisely and they'll share in the savings and remember, they're establishing the benchmark of what they expect it's going to cost you to provide the care by them looking at your, who knows, maybe last couple of years of data.

Gary Lucas (00:30:05):

If you're a CFO listening in and you're recognizing, "Wait a minute. We actually are not fully coding each of our encounters. Our providers put the codes on the superbill. Our bill is sort through it, figure out how to adjust the claim, but there are many codes that never make it into our system," I would pose to you that your benchmark is going to be very low, in many cases, compared to your peers because if you truly don't understand what code you provided, you only know which code you billed for, that benchmark is going to be low and it's going to be much more difficult to share in those savings. But if you've established documentation, coding and billing processes that fully code each encounter, that's probably not the provider, but in a shared effort, responsible or managed, I should say by your managers, we want that benchmark to be a true reflection of what was done. Then by working with our colleagues and other providers and hospitals in that ACO, we have the opportunity to reduce those costs, but maintain the high level of quality. Thus, encouraging more shared savings.

Gary Lucas (00:31:18):

We know this sounds like a lot of extra work, folks, but we hope that this movement in healthcare is going to truly show how complex our patients are. I'll continue to work our way down here. I'll even show you a sample of a risk score sheet for a sample PCA here that shows you what you might see in some of these management reports. But what we want the managers to do is understand where that data is coming from and is it complete? Bottom line, the higher your benchmark is, there's more room underneath it to achieve shared savings. I don't want to over do it here too much on the public health side of things, but I do ask, and I know that you know this, but I would like to state it that our role in providing information and data on the most medically underserved communities is designed to go somewhere. It's beyond the payment from the insurance.

Gary Lucas (00:32:15):

It's beyond the information we give to our patients and it's really being done at a much higher level, but when you look at the needs that these public health organizations have that kind of close the loop on those programs, they're very heavily dependent on what we are doing on a day to day basis. Obviously, that's never been more important and more relevant than this current public health crisis related to substance use and opioid use disorders and kind of providing that primary care and behavioral health integrated approach is something that should be seen as going on at the same time as a lot of the rules related to us reporting quality. So this is a big, just a big wall up of information there, but some of you may have seen these. You'll notice I got this a couple of years ago, but this format was really pretty good and if you look over there, please on the left side, based on however that particular ACO score risk, there's an outlier there. We can tell that something doesn't look right with this health center number 16.

Gary Lucas (00:33:24):

A couple of possibilities could be true. Those patients are two to three times more healthy than everybody else, or we're using too many unspecified diagnoses. Now, by the way, unspecified diagnoses are appropriate and there is an appropriate need for using them. But the example of kind of generalized type two diabetes in terms of its risk score compared to the patient who truly has type two diabetes with macular degeneration and diabetic neuropathy is very, very significant. There's research and there's little internal processes that need to be looked at because we'll look at these things up top and you see the denominator and the numerator, well, how are they getting to these numbers? How are they getting to these percentages?

Gary Lucas (00:34:11):

I will share with you at the end of this presentation what the AMA states these numerators and denominators are for because we're not going to likely have to measure quality on all of our patients, but specifically each year, they're likely going to ask you to focus on anywhere from five to eight measures, some of which that may pair up nicely to your UDS measures. Some may be tailored to the needs of that ACO or tailored to the needs of that particular managed care organization. So bottom line, the denominator is, okay, all patients that were eligible to have this measure pulled on, the numerator is going to be, well, how many people did we actually measure? Those percentages are sometimes skewed by patients that we would never measure, for example, BMI on. For example, like a pregnant patient or somebody that's wheelchair bound. You'll just notice that some of these little scores in here are going to help identify where there might be a need to go provide tailored education to these providers on colorectal cancer screening or mammography screening or even controlling high blood pressure because the scores are lower than expected.

Gary Lucas (00:35:28):

The benefit here is if a carrier, an ACO or a managed care organization says, "Hey, you guys need to focus on this particular area. It's not just going to benefit this area or these scores, it's going to benefit your reimbursement and your billing," and that kind of attention we believe is going to be something that we're all going to be dealing with for quite a while here. So a quick summary here of the ACO revenue issues. I'll leave these for you, but those ACOs are going to measure the entire performance of that ACO, not just you. If you don't have a mammography machine in your network, is going to get them for you. As a tie in to the webinar we're going to have next week on care management and the reporting of chronic diseases, many ACOs include a patient portal or a patient health record that patients are using to access information and even sometimes upload information for their providers. Maybe the provider says, "Look, I don't need you to take three buses or drive 40 miles to get to the facility. Just send me a picture of your elbow so I can see how it looks over the next couple of days." Well, there's a way called virtual communication services that we'll discuss in the session next week that is billable for looking at things in patient portals occasionally. Now, there are time limits and various hoops you need to jump through, but this was not, again, just little extra work. These virtual communication services are things that are sometimes covered by Medicare and we'll tie them together with some of the care management services next week. Now, chronic care management has been covered end to end by a lot of other folks. Next week, I'm going to dive into transitional care management and virtual communication services, but a real big part of the effort of the current CMS leadership to help providers have the rules be more simplified and get you paid for things that you do sometimes between visits. So these all somewhat tie in together.

Gary Lucas (00:37:39):

I'm going to leave this slide to you because I think I kind of covered most of them there. If you'll move with me. Additional slides in terms of the number of diagnoses, et cetera, related to risk adjustment. These are going to be for your self study and your reading and for example, if there are details related to some of these things in risk adjustments, I would refer you to it, I believe is the best book I've ever read on it, mentioned down there at the bottom and available from the AMA store. All right. Well, when we're submitting these services to CMS, they're often looking to see if any data or diagnoses are missing from claims with longstanding chronic conditions. Here's where those Medicare advantage organizations might commission those risk auditors to review your documentation. But again, they're trying to help you in this case, not necessarily take money back because they want you to be able to paint a very clear picture of your patient's care. You may hear these occasionally called sweeps as you run down there.

Gary Lucas (00:38:46):

Again, they're accountable for the contents of your claim so I bet you've never seen more of an effort from your managed care companies to provide you with education related to these items here. We're about to kind of show you some sample a HCC and HEIS measures. From there, we'll move into how to prepare yourself to report quality, dive deeper into performance measurement with category two codes, how you'll be able to review those category two codes and then we'll finish up with a summarizing table of all coding quality measures and some practical tips and actionable items that you'll be able to take to increase your awareness and application of these rules. I want to thank at the very bottom of this slide, a friend and colleague, Shaconah Bishop. She's an ACO practice specialist and she has had some of these wonderful examples built up here.

Gary Lucas (00:39:44):

We're even in the process of sometimes performing audits where we will assist from a diagnosis area in understanding where significant opportunities would be some more clearly not just use a favorites list or not just use an index search by providers to find quick diagnoses, but a thorough search to find the correct diagnoses. If you wanted to quiz anybody in your staff there, remember that these HCC categories are diagnosis related. They're looking at historical claims, those hybrid onsite reviews. It really, as I mentioned, doesn't take all codes. It does take a large number of them and they categorize them into about 80 different categories, but you don't have to worry about each. You'll need to find out which three, four or five each managed care plan, Medicare, I should say, or Medicare or Medicaid advantage plans that wants these diagnosis codes so they can assign that risk score to the patients.

Gary Lucas (00:40:52):

Well, at the very bottom of the slide here, surprise, surprise, that's going to come down to a requirement to make sure that your providers are aware of the ICD-10s what are called, "official guidelines for coding and reporting." These are not found in any of your EHRs. These ICD-10 guidelines are vital to providing the deeper level of education to your providers who have likely not received much detailed quality or even community health specific training since they became a member of your facility. We'll show you those guidelines here in a couple moments, but pardon the kind of jumble there on the bottom, but this categorizes and shows a summary of most of those 80 categories. I've put boxes around a couple of them, diabetes with acute or chronic complications on the left large in there. You'll notice the difference in the risk score to a patient without complications. By the way, we clearly want our patients to get more healthy. We want them to not have complications, and that's what we're working towards.

Gary Lucas (00:42:08):

None of this HCC information should have a significant impact on how or when you're getting paid for your services. Rather, the value based care world is demanding on different kinds of analysis because we've been audited on the money codes for years and never likely quote, "audited or reviewed," on the accuracy of our diagnosis codes. A patient may have multiple coexisting conditions and they may have six diagnoses when they show up for a particular visit, but if that visit was only for their skin problem, maybe it was their psoriasis, the fact that they have substance use disorder and a major organ transplant may or may not have anything to do with that. So the question becomes, "Do I really have to report every single diagnosis a patient has on every single date of service to meet these HCC requirements?" The answer is likely not.

Gary Lucas (00:43:06):

Now, there's not one set of unique guidelines that I can give you, but your annual wellness visits, your preventive medicine visits, your initial preventive physical exams that we'll discuss next week are going to be the perfect time where the ICD-10 guidelines do tell you to list all diagnoses that are there. But again, we don't need to over-report diagnoses. You need to know who they need to be reported for and when and which particular areas should there be a focus on. They're referred to as hierarchical condition categories because some are going to over trump other diagnoses. If you have a patient that has HCC number eight there with metastatic cancer and acute leukemia, then even though going to the right, those conditions will not contribute to the HCC score if they have some in the category nine or 10 or 11 or 12.

Gary Lucas (00:44:08):

The diagram over there on the right hand side shows you that it is particularly important to be aware of the categories that override or trump other conditions so that we don't spend too much time, effort and energy pulling diagnoses out of a particular patient's claim when they're not necessary if they weren't dealt with on that date of service. There's obviously a lot more education going on here, but it really gets down to things like can your providers see the notes that the ICD-10 give them in the actual printed manual? Now, we're kind of working our way towards the finish because I expect there to be a fair bit of questions there, but at least another 15-20 minutes here. But notes like this in terms of what order to place the diagnosis codes and become very important and are likely not visible to your providers when they're selecting them from within your EHR. I highly doubt you have an ICD-10 backpack there for your providers to walk around with. I'm just kidding there.

Gary Lucas (00:45:16):

But the order of the diagnosis codes often impacts your revenue undoubtedly, but when you consider the previous slide we just did that certain diagnoses may trump others in terms of a risk score calculation, we need to make sure that we're submitting them correctly the first time and before this claim goes out, that we know what order the diagnoses may need to be. Well, managers, that's where you have to ask what policy is established if a biller, coder or quality staff member notices that the diagnoses that a provider gave me may be different than what was in the medical record and could possibly be different than the statements in what's called the, "base code notes," that often precede those services. In this particular case, it's code first the underlying disease for any diagnosis beginning with M02 or any similar code like this. Well, you submit the claim in the wrong order; it may get denied, especially with a commercial insurance company.

Gary Lucas (00:46:23):

But those are the types of very quick and easy questions where we hope that the first level of education to providers on accurate diagnosis code comes literally from the manual that with all due respect, they likely have not ever looked at or seen. So the level of information that providers need to know is tremendous. The complexity doesn't become as complex once they're exposed to the information. Now, in terms of how to provide education to providers, I'd like you to, especially if you're sitting there with somebody in the room listening, I'd like you to show the other person how much, give me a good round number of how much education your providers have received related to proper documentation and professional coding. For anybody that's ever been in a class I taught, I hopefully got the hint there when I said with a nice round number, that round number typically begins and is zero.

Gary Lucas (00:47:27):

Start with the guidelines that are the beginning of the printed ICD- 10 book, but use caution, folks. Depending obviously, you should have the 2020 ICD-10 manual in your office and although everybody's books are different, the guidelines are the same for everybody. The problem is sometimes because the ICD-10 book goes into effect on October 1st, sometimes those guidelines that come out for that year were not available to the publishers, and they sometimes publish and have to publish last year's guidelines. So if you have an ICD-10 in front of you, don't be surprised...

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Gary Lucas (00:48:03):

... guidelines. So, if you have an ICD-10 in front of you, don't be surprised that you have 2019 guidelines in your 2020 book. And when you see, for example, that they define the word and as you go down that page, some of these things are so easy to skip and ignore, but believe it or not, and in both the ICD-9 book and the ICD-10 book, and actually means and/or or. So, the example they use is a patient that has, and the medical record says tuberculosis of bones, but not any of the joints. That's what's in the note. The provider says tuberculosis of bones, but not any joints. Well, a deep look into the ICD-10 shows, there's only one code in the ICD-10 book and that's tuberculosis of bones and joints. So I can understand how two reasoned coders and billers and providers might have a disagreement on whether or not that code can be applied properly.

Gary Lucas (00:49:03):

Well, the answer is yes it may because we have to read the diagnosis as tuberculosis of bones and/or joints. And so something so simple as punctuation and the word and is vital to accurate coding. But again, forget reimbursement, forget quality. Are we telling our patient what they have and that other providers are using that data? Do they truly know what the patient has or are they dependent upon our potentially ... anyway, a code that may not have gotten that level of detailed analysis. And so providers really end up liking section B because it answers a lot of questions about how to report multiple conditions.

Gary Lucas (00:49:46):

Now sometimes what used to be two or three codes in the ICD-9 is now one code in the ICD-10 or even vice versa. But let's think about it again. What does personal history mean to a provider? So before you go into too complex and a detailed educational journey on proper diagnosis coding, it's going to be important to recognize that when a provider says a patient has a history of high cholesterol, that could be interpreted as by providers, they had high cholesterol in the past and they have it today, and I'm treating them for it today. Whereas the way a coder or the way the ICD-10 guidelines were written, personal history means I've had it in the past, it's likely resolved and no longer existing. So please don't forget that instead of going to too high level of education, let's start and build that basic foundation. And the place you do that are in these ICD-10 guidelines.

Gary Lucas (00:50:54):

Now the first two sections gave you some higher level things, but if you need some detailed mental health and behavioral disorder, go to section C and look at chapter five. A couple paragraphs or pages on diabetes in chapter four and all the way through, excuse me, through chapter 21 with codes that we deal with in community health a lot, and that's your Z codes that are often part and parcel with the need to diagnose and show typically asymptomatic reasons that patients have a contact or a visit today. But be sure, please, when you're getting coding and billing education, that you're getting it from an organization that is stripping out all of the services and things that you don't deal with on a day-to-day basis. So obviously all this isn't necessary. Find your key parts.

Gary Lucas (00:51:53):

All right. Here on a transition to moving towards the how are we going to get you prepared and do a little deeper dive into performance measures. Wanted to give a little bit of definitions here as far as what HEDIS measures are. There are I think five different categories of HEDIS measures. Most likely you and I are only dealing with one or two of those. You might be part of a patient-centered medical home that is for example, serving their patients. That would be the patient satisfaction with the care. Maybe

those results are reported, for example, for hospitals. You might be in part of that, but specifically it's the effectiveness of treatment area that we're dealing with, and back down there at the bottom are those numbers, those references, excuse me, to the numbers, the numerator and the denominator. The numerator is how many people did we actually perform that measurement on, and the denominator is how many people who qualified to receive that service. And yes, there are even some unique modifiers that we'll have to deal with in particular for some patients here when we're looking at it.

Gary Lucas (00:53:08):

So here's a sample HEDIS measure that you might recognize. Some, many, I should say, are coming from The National Committee for Quality Assurance, but you may have some IT systems that help you capture this, but most likely is it documented by the provider, is it captured in the coding process, which is the responsibility of management, and was it reported by a biller depending upon how you've staffed your facility. So the percentage of adults 66 years and older who had each of the following. Well, the code 99483 is going to represent this functional status assessment. However, notice that it mentions HCPCS codes over there. Those HCPCS codes, level two codes I should say, are for the initial and subsequent annual wellness visit. So you may be asked to go back on a Medicare managed care plan and identify how many people got this functional status assessment.

Gary Lucas (00:54:08):

So, an oversimplified approach would be, well geez, let's just get somebody to go run a report in our EHR and see how many times we did CPT code 99483. You might not find any of those codes because those functional status assessments are often part of those annual wellness visits. And so, for a nurse who has never been exposed to some of the differences, for example, between coding and billing, we may not be catching each of the opportunities that we had to show that we've met this measure because of a lack of understanding of which codes are included in others, things like bundling, etc. And so whether you're dealing with Peds, and it could be 10 to 21, who knows. In this particular case, it's the percentage of enrolled members 12 to 21 who have had at least one comprehensive well visit with their primary care or OB/GYN practitioner during the year.

Gary Lucas (00:55:12):

But again, notice in the relationship between the CPT preventive codes versus the sometimes Medicare initial and subsequent annual wellness visits, the proper application of the diagnosis codes in the Z code section requires somebody that's touching this process that truly knows the backgrounds and intent of each of those manuals and how they inter react. Now for those of you that are in the nursing area and have this kind of knowledge, it's just absolutely invaluable from a workforce development perspective. You'll have a job anywhere you want it anywhere in the country. If you're looking to get this kind of education, leaders in this field are needed, but I'm hopefully helping to outline what kind of education would be necessary. For example, even to get you certified in quality, et cetera.

Gary Lucas (00:56:07):

And so provided various samples here, whether it's breast cancer screening for women's health and knowing the guidelines, and key, knowing the differences between coding and billing are important. You may have heard me mention the providers are responsible for documenting, billers are responsible for billing, and I kind of threw in there quickly that, " Management is responsible for coding." That catches a lot of managers off guard, but at the end of the year, that manager wants to make sure that their cost report is accurate. And there's a difference in capturing what was done and reporting what we're

allowed to get paid for, and clearly we can't do that in a a couple of webinars sessions, but I truly encourage you to seek out additional education from organizations that focus just on community health because there are some related areas outside of our scope that I'm sure some of you may need information on, whether you're the provider or the manager or you're that coder or biller or quality staff there in the cross-hairs.

Gary Lucas (00:57:12):

But you may be asked to voluntell some of these other quality issues and you may recognize instead of value-based care then being referred to as quality improvement plans or QPP or MIPS and MACRA, as I mentioned before, all under the broad umbrella of alternative, excuse me, payment models, but if you need to find out for sure if you are exempt from MIPS, one of the things they are going to primarily look at is what are your fee-for-service billings to Medicare. Remember, most of our services as FQHCs, as community health centers is based on a per diem, or I don't even like saying that, but an encounter rate.

Gary Lucas (00:57:56):

There are many things that Medicare pays a traditional FQHC for on fee- for-service. Maybe your provider goes to the hospital and there's a hospital visit, maybe it's the technical portion of a diagnostic test, etc., etc. So they're looking at those kinds of numbers, but if you're finding education on MIPS and MACRA but you're not required to meet those plans, I still encourage you to get that education plans, but make sure that you're not applying them if a carrier is using a different model or a different related quality area.

Gary Lucas (00:58:31):

So, as a gentleman who after I had probably already gone to 46 of the 50 states to teach and then I decided to go back and get a graduate degree in health informatics, etc., I had hoped that by this time there would be an IT solution to all of this, but unfortunately I haven't found it. Some of these are pretty extensive. I think that there are E-quality management systems and enterprise software systems that are doing a great job right now for hospitals. In particular, if you are provider-based or are owned by a hospital, especially if they have critical access hospitals, you may already have access to some human resources and IT resources to help extract some of this information from your EHRs, but most likely it's going to need to be a nurse that goes back into your system to play detective and find information that may or may not be there or to continue to work and maybe even look to the folks that write many of the measures and find out if they have information or options on how all our systems can talk together.

Gary Lucas (00:59:45):

So I realize you can't cut and paste this here. You'll get the slides afterwards. But I did want to provide at least one avenue of research for those that are more on the IT and EHR side as we work towards interoperability standards in this country. And bottom line, they're looking for that evidence-based data.

Gary Lucas (01:00:05):

So to begin our last section here, I want to just ask you to, of course these percentages are completely made up, but when you get the opportunity, ask yourself, analyze your operations, which IT systems are involved. Really engage your vendors. I am not anti vendor. These folks are working hard to help provide you with tools and resources that are hopefully making your life easier over time. However, if you're finding they were far more active before the contract was signed than they are now, please make sure before you sign these contracts that you include statements about ongoing education, people able to

train new providers who didn't get trained on the original system, etc., etc. But we understand this is going to be pretty variable, but these are four decent questions to ask.

Gary Lucas (01:01:01):

First, before our patient gets there, are we truly ready? How prepared and educated a staff are we? Do we have knowledge of the reference materials? Have we shared information with other people who may not deal with it directly? But if I'm at the front desk, for example, and I know that I have an ABC, let's just call them an ABC insurance company, who requires quality measures, I may be oversimplifying here, but what we've written down for our front desk staff is if a patient comes in with ABC insurance and they're over 65, here are the three quality measures or here are the big disease categories they want me to measure. I'd go to the Dollar Store. I'd get a purple set of construction paper. I cut them into fours and I give it to the patient. When the patient goes back to the nurse, I'm going to hand that nurse the purple card. That tells the nurse, these are the measures that need to be followed.

Gary Lucas (01:02:01):

The clinical team has already worked together to understand who needs to capture and gather and document that information and if it happens to be a patient coming in with a yellow piece of construction paper, then there's another set of measures that can and need to be followed. So granted, that's an over simplified version of what a complex electronic system would do, but we understand that many of you have to really work hard to survive the day. We acknowledge your efforts and look forward to making sure that that level of preparation gets to where you want it to be.

Gary Lucas (01:02:39):

Next, how closely are the providers documenting according to the guidelines? For example, there are notes in the CPT book printed by the AMA that talk about preventive medicine services, but those notes don't appear in any coding software. And so we need to make sure we exposed our providers to those guidelines, that we code all encounters fully and of course that we get paid everything we deserve, but not anything more. And if they're going to pay me to report the patient's A1C levels, I highly doubt they're going to send us a flower bouquet and tell us that we didn't take advantage of that this year. It's up to us to find out when we may report those performance measures.

Gary Lucas (01:03:23):

So the three overarching summary areas here in order to be prepared to document and report quality, does at least each nurse's station have the current federally mandated HIPAA code set used in medically underserved areas. I deal with rural health clinics as well. Obviously our focus here is on community health. Or are we too dependent on software shortcuts? Again, the AMA documentation guidelines are only visible within an AMA published book, not another publisher. So I highly professionally recommend that you only get AMA CPTs, HCPCS book, etc., and ICD-10 you can get from any publisher. Any HCPCS level two code book, any ICD-10 code book from anybody, but it needs to be an AMA CPT because they don't license those notes to software vendors for software.

Gary Lucas (01:04:17):

Do you have access to some key Medicare guidelines like the policy and benefits manual? We spend a lot of time on these in our certification boot camps, but chapter 9, chapter 13, chapter 15 and chapter 18 ... Chapter 18 is almost a 300 page document printed by CMS that goes into beautiful detail on the documentation and reporting needs related to preventive medicine services. So making sure that yes,

you need new code books every year. And I know this is dangerous to offer. I think we have 500, 600, 700 people on this webinar today, but if anybody can convince me why you should not have, with all the spec, please, why you should not have updated and current year coding manuals, I will send them to you for free. Smile, wink, wink, nudge, nudge there. But also on the right hand side there, do you have full awareness of how your participation contracts require you to report quality? And that's going to be a lot of detailed work.

Gary Lucas (01:05:24):

So what I've done here is outline what the coding software will not do because we recognize there may be people that weren't able to hear the course. But for example, many of these G codes we live on in community health are found within that HCPCS book and it goes through updates and revisions throughout the course of the year, of course, and even annually, but if you've never looked in the manual, you wouldn't know what word to look up. I think it's very possible there are significant G codes from the HCPCS level two code book that are not on people's superbills. So if the provider is never going to select it or check it, the coder or biller may not know that it's needed and we've now not gotten paid or not reported everything we're entitled to.

Gary Lucas (01:06:13):

Again, a little summary there as it relates to ICD-10 codes. I appreciate your patience on the questions. I'm not able to see the questions in the panel yet. But here's a quick outline there of the CPT. I wanted to be careful when I mentioned on the right side of the screen CPT Category II codes. I want to be very careful to distinguish those from HCPCS level two codes. The AMA CPT book is actually referred to as HCPCS level. One it's not printed on the manual anywhere, but HCPCS refers to a family of codes. HCPCS level one is the CPT, and within the CPT there's actually three different levels of codes. Category one, excuse me, HCPCS level one, CPT category one codes are the codes we know and love, ENM codes, procedures, our medicine codes, etc. But then at the back of the book, are codes that end with the letter F, and these are your performance measure codes. And what I'd like to do is go through a couple, I don't know, five, six slides here.

Gary Lucas (01:07:23):

I'm just going to show you how to research each of these services, each of these codes, understand which diagnoses they need to be reported for and through, and then make sure you have access to the current listing because believe it or not, these codes can be updated at essentially any time. Even though you may have a 2020 CPT book that has these codes listed, they can be changed throughout the year as professional organizations and associations and clinical professionals revise and tweak these measures to make them most effective. But when you're looking at these performance measurement codes, you'll see that some of them are simply just pulling out things that you did when you were looking at the patient's history. They're simply reporting that you performed certain physical exams, but maybe there was no existing code for those elements of history, but you asked if they smoke or not, or something like that. Maybe it's just the results of their cholesterol test, which never had ICD-10 codes. So how could we report high cholesterol to an insurance company giving the actual levels rather than just the more broad definitions there?

Gary Lucas (01:08:42):

And so we want you to know the source material well as it relates to CPT Category II codes. I've provided a couple quotes here that really outline why we've been telling community health for several years,

"Hey, we haven't had to report these over the years. Everybody else out there in the medical community is going to get a couple of year head start on us." Well, our time is now. So, it's a set of supplemental tracking codes, meaning they're not going to get reimbursed. They're intended to facilitate data collection by coding certain services and test results, notice this, that support nationally established measures, meaning from professional associations like the American Diabetes Association, etc, and that have an evidence base as contributing to quality patient care.

Gary Lucas (01:09:32):

So the AMA has done a good job of putting these all in one place. But when you look in the CPT, it does say that use of these codes is optional and not required for correct coding and may not be used as a substitute for category one codes. So this is on the side. And wait until I tell you a couple of stories about the troubles people have had getting these accurately reported. So if I were going to ask you a question, are these performance measurement codes used for revenue or are these codes used for quality reporting compliance? The answer is yes. Both. It's for both. And so notice sometimes in the CPT, when you look at your AMA CPT, you'll notice that they'll talk about whether tobacco use was assessed, but what folks easily miss is at the end of it, it's telling you the types of patients that that should typically be measured for. It's not 100%.

Gary Lucas (01:10:36):

So as you work through the next item, so you notice it's coronary artery disease, what is it, COPD. PV is preventive medicine, diabetes, etc. You continue running down the line here. And I just wanted to provide a couple samples from the history section. BMI, excuse me, blood pressure being measured for chronic kidney disease and diabetes, potentially not every single patient. I want to share with you here in a moment how to go research each of these codes. So I'm just going to throw them down there. The ability to report the patient's specific blood pressure reading, any interventions that have been provided, like vaccinations or tobacco cessation or counseled on the self-examination of, excuse me, mold, etc.

Gary Lucas (01:11:28):

But you're going to really have to work closely with people like your clearing house and your software folks to see what information can be auto-magically, and yes, I said auto-magically, not automatically, auto-magically pulled from, in some cases, completely different systems and then what dollar amount you need to put on them. Because I'll tell you that right now, I wish I can give you one set of guidance to community health and say, "Okay, put it on the 1450 form. Use this revenue code. Put this charge amount on it. Bill it on the same claim as your regular visits." And for some folks, that'll work-

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Gary Lucas (01:12:03):

... same claim as your regular visits and for some folks that'll work just fine. But in other cases maybe they pay you on a per diem basis, they require you to submit your qualifying visit, et cetera, they pay you your per diem, your encounter rate, and then they say, "Please, on a monthly basis report the quality data." Could be per patient, maybe it's on a 1500 form, maybe it's a 1 cent or even 2 cents a line, but there's information you need to put on the claim form.

Gary Lucas (01:12:31):

As a matter of fact, I was in the great state of Louisiana, we've done a lot of work with their community health center. I consider them national leaders in education outreach for the state. And one person raised their hand and said that they submitted an office visit and a procedure, and then they put three category two codes on that claim at one penny simply for reporting purposes. And I kid you not folks, the insurance company paid them 3 cents for the quality measures and denied the office visit and denied the procedure as being bundled into the quality measures. After teaching a lot and meeting a lot of fun folks out there, that's the day I finally gave up. I'm kidding. But as I hear stories like that, it means we have continued work to do.

Gary Lucas (01:13:23):

So surround yourself with qualified, well-educated, supported, and hopefully certified staff who are going to work together to help you meet these requirements. If we simply use this world of value based care to encompass processes and things we're already trying to do well, rather than seeing it as a separate issue, rather than seeing this as just compliance, "But wait a minute, I can get 40 bucks potentially for all my diabetic patients in this particular insurance company," or maybe for cholesterol or whatever. We might find a lot of significant benefits down the road.

Gary Lucas (01:14:01):

But I would like to share with you something that often goes unseen and then we'll finish it up and open up for questions. The AMA in their instructions on their website for this, describe that in order for a patient to be included in the numerator for a particular measure, they must meet what they call the denomination inclusion criteria. And it says "before coding, check this out." Users must review the complete description of the code from the website and the associated documents that are found on the measure developers website. But the AMA has done a good job of assisting you in putting those in one place. But please remember the example where I said, for for example, you may not be required to do BMI on a pregnant patient, of course.

Gary Lucas (01:14:49):

I mentioned that there were modifiers, and in order to have a full and complete, beyond a one and a half hour long webinar, make sure you're going into the CPT and going to the website, or at least to Google this in a moment, to understand what those exclusion modifiers are. Because one common theme I get from providers is, "How in the world am I going to be measured on quality, for example, sometimes when there's a patient who's not following my treatment plan?" And that's a good point. And so these modifiers are there for some of those circumstances.

Gary Lucas (01:15:25):

But by the way, a deep review of those ICD-10 official guidelines will show for example that in the ICD-10, different than what was available in the ICD-9, there are codes that specifically report a patient who is underdosing a medication. Now we're not trying to get the patients in trouble, but we are identifying the quality is going to be impacted if they're underdosing their metformin. So rather than it being a generalized diagnosis such as "patient noncompliant with treatment plan", we actually have the ability to report that on a drug by drug level.

Gary Lucas (01:16:04):

So just to outline this for you, and get to the questions here in about just a couple of minutes, you'll go to the AMA's clinical topics listing there. If you just Google those, you'll notice on the bottom right-hand

section that this is the only listing on where these codes are completely found. It mentions here the codes in this listing will include only those that are not listed in the latest edition of the CPT book. So in other words, to get a complete list of them, you need to have the book and this website. I recommend looking at what are called the long code descriptors. And you're going to find stuff like this: here's when an A1C management code might need to be reported. And then of course at the bottom I've given you some of the 2020 updates there.

Gary Lucas (01:16:53):

But as you look here, it says, "In order to meet this measure, the date of the test and when it was performed are required." Use the date of the test, not the date of when you reported the category two. This is where that additional information is going to come from that will not just show up in your CPT book, will most certainly almost assuredly not show up in your EHR or billing software. So whether you're looking for information on blood pressure control, they're going to give you when your exclusion, when you're not needed, for example, to measure blood pressure. If they have documentation of their not being prescribed two or more antihypertensive medications. And some of the reporting instructions and coding items are there.

Gary Lucas (01:17:47):

So notice that in addition to just going by the code, occasionally you can look this up in the AMA's clinical topics listing by disease category, and say, "Hey, for coronary artery disease, diabetes or chronic kidney disease, which measures will I often be asked to look for?" And so notice in the middle of the page that this is a 387 page document, and I've just done a little cutting and pasting here from the AMA's clinical topic listing. But this is where the vital information is going to be found for you.

Gary Lucas (01:18:21):

And in summary, if you are using or looking to report performance measures, you need to be a super user of your EHR and really understand the differences in documentation and coding and billing. Although these codes are supplemental, more and more are asking for them for specific disease category. But they can generate revenue, that's the key I want to give you here. You just have to unfortunately find out when and how based on their requirements. And some of them are going to be submitted on the same date of services other visits and some want it on a separate claim. So I wish I had a better answer there, but I haven't seen standardization there yet.

Gary Lucas (01:19:04):

So in summary, what do we need? When we're looking at care management services, that we'll talk about next week, that are absolutely slam dunked revenue issues, they're going to deal with CPT codes and primarily HCPCS level two codes. And whether you're talking about category two measurements, preventive medicine, or each of the various subjects we've talked about, my goal along this slide is to point out how a good knowledge of each of those manuals will allow you better knowledge of each of those quality or care management categories. But over there on the right side, of course, you do need to know whether or not your motivation is compliance, or is it revenue, or is it potentially a little bit of both?

Gary Lucas (01:19:47):

So in summary here, it's likely that almost all of the focus of how we're capturing information from our documentation and then coding it, passing that on to billing, is coming from that superbill or encounter

form. It should not be surprising that I find way too many practices that have codes on their superbill or encounter form that no longer exists. And those tend to be the practices that don't get the updated code books often enough, but that's a different story.

Gary Lucas (01:20:19):

So when you're looking at the purpose of that superbill or encounter form, whether it was generated by your EHR or maybe they pulled in a scan of your paper document, et cetera, does it serve as the patient's receipt? Do they get something that shows what was done and why? When your providers are filling that out, are they just coding the services, or are they billing the services? You may have individual providers who came from their own practice and they knew the billing rules for regular old Medicare or regular old Medicaid backwards and forwards. And regardless of the services that were provided and why, they knew bundling in their head, they added the modifiers from their knowledge.

Gary Lucas (01:21:07):

But the point is, in your community health center, if you have one provider that's purely coding, which is what we want, which doesn't take billing into effect for that much versus another provider that's billing it, how accurate is your cost report? How accurate are your bills? So please place an extra focus here, because for CFOs and managers, how possible is it that we're not capturing everything, that we're under-reporting our true costs and the true complexity of our patient population?

Gary Lucas (01:21:41):

Of course, coders, billers, quality folks, knowing if the note has been closed and signed, and has anybody reviewed the completed note before it's billed? Is it possible that we left something off the encounter form, et cetera? Could be based on how detailed the superbill is for the providers. I won't blame a provider, for example, for not knowing that they need to include the margins of benign and malignant excisions, because that's only printed in the CPT book. If we didn't tell them, we may be under-reporting those. But that's just an example about the importance of the supberbill from revenue and compliance.

Gary Lucas (01:22:20):

Please recognize in my last three slides here, that depending upon what claim form you're using, the 1500 form on the left, that those of you that have been around a little while still call the HCFA there, requires you to link the diagnosis codes to your procedural codes in that red star section, where we're actually having to specifically say, "I did this service for these reasons." Whereas if you're being asked to submit services on a 1450 form or that old UB form, these diagnosis codes don't get directly linked to those CPT and HCPCS codes. So how that superbill is completed, how that information makes it to the bill is understandably difficult and oftentimes requires some high level critical analysis skills by coders and billers. And if they're doing that well, support them, and please continue to treat them as the high level professionals they are.

Gary Lucas (01:23:23):

And you see now hopefully we've identified that quality starts at check-in, managers and quality reporting and nurses along with very close coordination with the chief medical officer is vitally important. Nurses are going to be asked to help out on revenue and on quality measures, and they're going to be put in an interesting position. So please do ask that honest question about what level of education everybody has, and has everybody received education from a bunch of different sources, or a couple trusted sources, is going to be important.

Gary Lucas (01:23:59):

So hopefully we've identified a couple areas for additional research for you and given you a way to go do that. Hopefully you now have access to some key references and resources related to quality and the differences in documentation, coding and billing. Hopefully you are aware, or kind of reinforced, I should say, of possible areas where your different payers may interpret rules differently but still be legally binding. Coding rules pretty much are the same for everybody. Billing rules very different depending on how you get paid. Quality reporting rules, same boat. Different people want it in different formats, but essentially it's coming from the same core and that is our medical record.

Gary Lucas (01:24:44):

So hopefully you can help think of other folks at your facility that would benefit from this training. You get the opportunity to expose this to them through the NACHC recordings that they'll have down the line. If you are certified through us as a community health coding and billing specialist, through either our live or online options there, everybody will be sent the CEU certificate showing that you've earned continuing education from us, the Association for Rural and Community Health Professional Coding.

Gary Lucas (01:25:13):

We do want to thank NACHC for the opportunity to present today and next week. So if you would go ahead and register for part two, we'll talk about transitional care management, patient consent for chronic management, chronic and behavioral health integration, and a full listing of preventive medicine options that are available.

Gary Lucas (01:25:35):

So I want to thank you for your attention. I honestly wish you your best year yet/ and we're here along with NAC and along with your folks to provide that education and training to you at this time. I think I'm going to pull it and move it back over to Philip. I appreciate your time. Thank you.

Philip Stringfield (01:25:58):

All right. Thank you so much, Gary, our pro coding for today's webinar presentation. So just have a few more minutes, wanted to see if we can knock out a couple of questions, all right? So the first question we received was, "Participation contracts, are these specific for FQHC billing with payers?" Hi Gary, are you still there?

Gary Lucas (01:26:34):

Oh there you go. I accidentally hit the mute button because I sneezed. I apologize. Yeah, please don't think of the participation contract as being anything different than what any doctor's office or hospital would do if they were signing up to be a Blue Shield member, an Aetna Traveler's, Greater American Life, or a particular Medicaid contract. It's essentially becoming a quote unquote "in network provider". And the odd part for FQHCs is that your Medicare and Medicaid managed care organizations, some of them are going to pay you an encounter rate like regular Medicare does, and you're going to use the place of service on your claim form that says you're an FQHC. Whereas people that are paying your fee for service may just see you as another regular old doctor's office. So the Medicaid, Medicare contracts will likely be different, because you're most likely the only regular old provider office getting paid on an encounter rate.

Philip Stringfield (01:27:38):

Thank you so much. The next question is, "Are the HEDIS codes supposed to be reported on claims that have been billed to insurance companies or is this a back end audit that will always be done?"

Gary Lucas (01:27:51):

Great question. I think the straightforward answer is, sometimes, always, kind of, sort of, never. I'm joking there somewhat. The HEDIS measures are gathered by whichever insurance company wants you to submit them, and I've got to acknowledge that there's no way for me to know there, but they are looking at that information based on your historical claims. So they're able to go back a year or so. But if they don't see what they need, if they look at your score and they say, "Why are these folks a score higher than others?" Or, "Why are they lower than others?" Et cetera. That's when they might come in to do a documentation review to assist you in getting that information.

Gary Lucas (01:28:37):

So there's just no consistency on whether they want it on the claims. For those carriers that pay you fee for service, they're likely going to be okay with it just going on a subsequent line item at the bottom of the claim and report it as one penny, so they know you're not asking for money. But if you are getting paid a per diem amount by a managed care organization and they see you put a code on it that ends with the letter F, those codes aren't typically associated with revenue codes and type of bill codes, it could blow the claim up like the mistake I unfortunately saw in Louisiana. So that's an area of research that is central to understanding who we have to do this for, when and how.

Philip Stringfield (01:29:23):

All right, so it looks like we're right at 3:30, so I'll go ahead and ask a couple more questions. But then the remaining questions will be asked during the second segment of the webinar series, since we are at short for time. So the next question we do have, "Are the performance measurements should also be included on the claim form?"

Gary Lucas (01:29:44):

Yeah, they might've typed that question of course before I had a chance to answer it. It's yes, no, maybe, most likely. It just depends. But that would go with the same answer as the previous question. That's got to be based on what those specific company's rules are. There's no overarching kind of Medicare, if you will, umbrella that mandates, to my knowledge, is the frequency and process that these individual managed care companies need to get that data. It depends on how they submit it to CMS, et cetera. There's too much variability, from my knowledge, to be one theory.

Philip Stringfield (01:30:21):

All right, and this says, "For the slide sample impacts of HCC coding on payments to MCL/MAO, does this info relate to the carve out fees that we are being asked to identify in our billing practices?"

Gary Lucas (01:30:37):

I've heard of several definitions there of carve-outs and how some of these tie into various Medicaid wraparound payments, et cetera. If that ties in more to Medicaid, that gets difficult for me because of the number of States we travel and the variability that's out there. But please feel free to just email me

directly with that question, and if it's easier just to have a little quick 10 minute chat, we might be able to wrap that up a little better, be able to get it more specific than we can with such a broad audience.

Philip Stringfield (01:31:10):

Awesome. And then the last question that we'll ask, and then if anyone else is asking questions, I'll make sure to put them in this document, but we did get a couple of questions around BMI. So the first question we received was, "When coding a diagnosis such as BMI, should we also be coding the category two code?"

Gary Lucas (01:31:32):

Oh, okay. I see where I see where you are at. What I would say is, I would identify it as a possibility. The fact that there is an ICD-10 code for BMI, for example, it would never be used as a primary diagnosis. Obviously, the primary service diagnosis code would be that which is documented as being chiefly responsible for the clinical and medical services we provided. I just wanted to let folks know that although ICD-10 is one way to report BMI, for carriers that are more adept or prefer there to be a notification simply that the BMI was recorded, that F code would record that it was reported, but it doesn't give a value. If a company would rather see what the value is, then you would have to use the ICD-10 code. So it depends on the parameters of what the particular Medicaid managed care organization wants.

Philip Stringfield (01:32:31):

All right, and then also before we go, I had a couple of folks that added comments, they wanted a free manual. So could you just put a clarity back into the reference you made regarding getting the free manual?

Gary Lucas (01:32:47):

Yes. Please don't ask people to perform this year's work using any other year's code books than these. The AMA's documentation guidelines are the only ones that are HIPAA approved. And if you're using another manual, or especially an older manual, you don't have access to this year's manuals. So the idea was, I don't think I can ever be convinced that it's okay to use old manuals to either document, code, or bill for services. I have too many people coming up in class, and they have a lot of revenue problems, and I asked them to bring their book up, and their ICD-10 is two years old, and their CPT is four years old, and their superbill was written nine years ago. So, I mean, somebody can give it a shot, but they're going to have to do it on the phone, if I can be convinced that it's okay to use old manuals, yeah, we'll see what we can do. But that was really tongue in cheek and meant from somebody that cares a whole bunch. But I don't think I'll be buzzed on that one.

Philip Stringfield (01:33:50):

All right, and thank you again, Gary. We really appreciate your time, everyone. Thank you for sharing your jewels with our network. Everyone, again, we will be connecting next week at the same time. That's going to be the February 25th at 2:00 PM Eastern Standard Time for part two of our webinar series. So once again, you can visit the NACHC to get registered for that. In addition, you will also receive a followup email with your CEU and a copy of today's presentation in addition to a link to complete today's survey. So please make sure to do that, folks, how we did, anything that you would like to see presented on in the future around coding and documentation, and we'll make sure to put that in for

consideration. So without further ado, I'll go ahead and let you get back to your day. Thanks again, and have a good one.

PART 4 OF 4 ENDS [01:34:39]