Top 5 Documentation & Revenue Tips in Community Health

NACHC’s 2023 Billing, Coding, Documentation, and Quality Webinar Series

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~1900 courses taught in 46 states over 28 years
Disclaimers
American Medical Association

Coding software and non-AMA CPTs simply **DO NOT** contain the educationally valuable clinical documentation guidelines that should make up the core of your CPT coding knowledge. Therefore, you need a **printed version of the CPT every year** unless the AMA releases all CPT documentation guidance in an electronic format.

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Top 5 Documentation and Revenue Tips

Who is affected?

- Clinical Providers
- Clinic and Health Center Managers
- Coders
- Billers
- Electronic Health Records and IT/Billing System Integrations
<table>
<thead>
<tr>
<th>Tip #1</th>
<th>Tip #2</th>
<th>Tip #3</th>
<th>Tip #4</th>
<th>Tip #5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Understand all HIPAA Required Code Sets</strong>&lt;br&gt;Which HIPAA-approved code sets do we need to be aware of working in a FQHC?</td>
<td><strong>Know how FQHCs are Different</strong>&lt;br&gt;Why do some insurance companies enroll us as a regular FFS “office” while Medicare/Medicaid expect us to operate under the very different billing requirements of FQHCs?</td>
<td><strong>Monitor Key CMS Resources Often</strong>&lt;br&gt;Being fully aware of the content of key CMS manuals such as Chapter 9 of the Benefits Policy Manual and Chapter 13 of the Claims Processing manual is crucial!</td>
<td><strong>Separate FFS vs. CMS Valid Encounters</strong>&lt;br&gt;In order to generate a FQHC’s Prospective Payment System (PPS) rate it is vital to know how the billing rules differ from traditional commercial insurance.</td>
<td><strong>Know how Qualifying Visit Lists can Differ</strong>&lt;br&gt;Medicare has a FQHC-only list of CPT/HCPCS-II codes that must be present on all claims requesting encounter-based PPS payments. Medicaid is different?</td>
</tr>
</tbody>
</table>
Top 5 Tips for Clinical Providers

**Top Tip #1**
Increase provider knowledge of the AMA’s CPT guidelines, when HCPCS-II codes may be needed for billing, and how to apply the ICD-10-CM’s Official Guidelines for Coding & Reporting.

Providers are often asked to provide preliminary coding data to revenue staff before the encounter note is fully completed and signed off leading to missed revenue opportunities and potential compliance issues.

**Tip #2**
Be able to apply various “incident-to” rules that likely vary by payer to maximize nursing’s role in clinical documentation.

**Tip #3**
Update providers on the recent 2021 and 2023 Evaluation & Management documentation updates.

**Tip #4**
Perform internal/external documentation reviews to give providers data on their documentation compliance.

**Tip #5**
Ensure that documentation supports care coordination, quality reporting, and revenue cycle activities in a proactive manner.
Top 5 Tips for Professional Coders

Top Tip #1
Each clinical encounter should receive a complete professional coding review so each FQHCs can submit an accurate annual cost report, give the patient an accurate listing of what services were done and why, and allow the billing staff to format a unique bill after validating the presence of compliant supporting documentation.

Ensure that quality reporting data/statistics are captured and stored as close to the time the encounter was performed even though the code(s) may not ever leave the office on a medical claim for payment.

Tip #2
Carefully review the 2023 AMA’s CPT updates on hospital visits, observation, consultations, home visits, and more for significant coding changes.

Tip #3
Use a closed medical record to extract all data about what was done (CPT/HCPCS-II) and why (ICD-10-CM) whether payable or not.

Tip #4
Assist the billing department in identifying alternate codes that may be needed by payer policies for proper billing.

Tip #5
Work closely with clinical providers to establish a shared vocabulary of “annuals, physicals, check-ups, and well visits” and review the annual CMS covered G-codes.
Top 5 Tips for Medical Billers and Quality Reporting

Tip #1
If the same staff member has both coding and billing responsibilities, they completely should perform their “pure coding” responsibilities prior to any medical bill being created or submitted.

Additionally, many services not reimbursed by Medicare do not get paid via traditional claims – rather, reimbursement may be gained at the end of your fiscal year via the required cost report via annual reconciliation or wrap-around payments.

Tip #2
Use the results of a professional coding review to identify when quality reporting initiatives are met or need to be provided.

Tip #3
Maintain awareness of the reporting requirements related to UDS, HEDIS, CPT-II performance measures BY PAYER with senior management.

Tip #4
Submit claims and monitor EOBs that may need to be appealed or resubmitted based on knowledge of applicable billing guidelines.

Tip #5
Capture CPT/HCPCS-II data that may not be reimbursed under the PPS payment for annual cost report reconciliation or FFS billing.
BONUS Self-Study Information For Post-Class Research
Federally Qualified Health Center Focus

FQHCs are also referred to as Community Health Centers

- Instead of getting paid fee-for-service (FFS) Medicare, and possibly Medicaid, pays you ~80% of a Prospective Payment System (PPS) rate for “valid encounters.”

- To receive Medicare payment, you are required to perform, document, and bill a code on their Qualifying Visit List (QVL) as well as one of 5 FQHC-only G-codes G0466-G0470.

- Your FQHC will determine a fee for each of the FQHC-only G-codes that identifies your charge for a “typical bundle of Medicare-covered services.”

- Medicare will compare your charges for those 5 G-codes to your established PPS rate using the “lesser of” policy.
Federally Qualified Health Center Focus

FQHCs are also referred to as Community Health Centers

- Medicare Part B patients have no annual FQHC deductible.
- Medicare Part B patients owe 20% of the “lesser of” your G0466-G0470 charge compared to your PPS rate.
- Authorized providers are the same as RHC except for those that are allowed to perform Medical Nutrition Therapy (MNT) or Diabetes Self-Management Training (DSMT).
- Medicare should pay a **34.16% increase** for new patient medical or mental health visits and the performance of an IPPE code G0402 or Initial/Subsequent Annual Wellness Visit (AWV) codes G0438-G0439.
CMS Valid Encounters Defined

1. Face-to-Face Visit?
   - Exceptions?

2. Authorized Core Provider?
   - Slight differences for RHC vs. FQHC

3. “Medically Necessary”?
   - Familiar with NCDs vs. LCDs and where to get them?
   - [Try this hyperlink]

4. Authorized location?
   - Office, Part A SNF, patient’s residence, where else?

"An RHC or FQHC visit is a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, or a CSW during which time one or more RHC or FQHC services are rendered." – CMS Benefits Manual, Chapter 13, Section 40
Sample from the CMS FQHC Qualifying Visit List (QVL)

Qualifying Visits
The qualifying visits that correspond to the specific payment codes are as follows:

G0466 - FQHC visit, new patient

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Qualifying Visits for G0466</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>92002</td>
<td>Eye exam new patient</td>
<td></td>
</tr>
<tr>
<td>92004</td>
<td>Eye exam new patient</td>
<td></td>
</tr>
<tr>
<td>97802</td>
<td>Medical nutrition indiv in</td>
<td></td>
</tr>
<tr>
<td>99201</td>
<td>Office/outpatient visit new</td>
<td></td>
</tr>
<tr>
<td>99202</td>
<td>Office/outpatient visit new</td>
<td></td>
</tr>
<tr>
<td>99203</td>
<td>Office/outpatient visit new</td>
<td></td>
</tr>
<tr>
<td>99204</td>
<td>Office/outpatient visit new</td>
<td></td>
</tr>
<tr>
<td>99205</td>
<td>Office/outpatient visit new</td>
<td></td>
</tr>
<tr>
<td>99304</td>
<td>Nursing facility care init</td>
<td>October 1, 2016</td>
</tr>
<tr>
<td>99305</td>
<td>Nursing facility care init</td>
<td>October 1, 2016</td>
</tr>
<tr>
<td>99306</td>
<td>Nursing facility care init</td>
<td>October 1, 2016</td>
</tr>
<tr>
<td>99324</td>
<td>Domicil/r-home visit new pat</td>
<td>October 1, 2016</td>
</tr>
<tr>
<td>99325</td>
<td>Domicil/r-home visit new pat</td>
<td>October 1, 2016</td>
</tr>
<tr>
<td>99326</td>
<td>Domicil/r-home visit new pat</td>
<td>October 1, 2016</td>
</tr>
<tr>
<td>99327</td>
<td>Domicil/r-home visit new pat</td>
<td>October 1, 2016</td>
</tr>
<tr>
<td>99328</td>
<td>Domicil/r-home visit new pat</td>
<td>October 1, 2016</td>
</tr>
<tr>
<td>99341</td>
<td>Home visit new patient</td>
<td></td>
</tr>
<tr>
<td>99342</td>
<td>Home visit new patient</td>
<td></td>
</tr>
<tr>
<td>99343</td>
<td>Home visit new patient</td>
<td></td>
</tr>
<tr>
<td>99344</td>
<td>Home visit new patient</td>
<td></td>
</tr>
<tr>
<td>99345</td>
<td>Home visit new patient</td>
<td></td>
</tr>
<tr>
<td>99406</td>
<td>Behav chng smoking 3-10 min</td>
<td>October 1, 2016</td>
</tr>
<tr>
<td>99407</td>
<td>Behav chng smoking &gt; 10 min</td>
<td>October 1, 2016</td>
</tr>
</tbody>
</table>

Heads-up, 99201 was deleted in the 2021 CPT!

G0469 – FQHC visit, mental health, new patient:

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Qualifying Visits for G0469</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>Psych diagnostic evaluation</td>
</tr>
<tr>
<td>90792</td>
<td>Psych diag eval w/med srvcs</td>
</tr>
<tr>
<td>90832</td>
<td>Psytx pt &amp;/family 30 minutes</td>
</tr>
<tr>
<td>90834</td>
<td>Psytx pt &amp;/family 45 minutes</td>
</tr>
<tr>
<td>90837</td>
<td>Psytx pt &amp;/family 60 minutes</td>
</tr>
<tr>
<td>90839</td>
<td>Psytx crisis initial 60 min</td>
</tr>
<tr>
<td>90845</td>
<td>Psychoanalysis</td>
</tr>
</tbody>
</table>

G0470 – FQHC visit, mental health, established patient:

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Qualifying Visits for G0470</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>Psych diagnostic evaluation</td>
</tr>
<tr>
<td>90792</td>
<td>Psych diag eval w/med srvcs</td>
</tr>
<tr>
<td>90832</td>
<td>Psytx pt &amp;/family 30 minutes</td>
</tr>
<tr>
<td>90834</td>
<td>Psytx pt &amp;/family 45 minutes</td>
</tr>
<tr>
<td>90837</td>
<td>Psytx pt &amp;/family 60 minutes</td>
</tr>
<tr>
<td>90839</td>
<td>Psytx crisis initial 60 min</td>
</tr>
<tr>
<td>90845</td>
<td>Psychoanalysis</td>
</tr>
</tbody>
</table>

...there are more codes...
Compare Sample CPT Codes

93000-93010 – EKG, 12 lead, global, professional component only, technical component only
99000 – Handling and/or conveyance of a specimen for transfer to a lab
99024 – Post-op follow up visit for a related reason...
99070 – Supplies and materials...over and above...drugs etc.
99202-99215 – FQHC E/M Services
99211 – “Nurse visit”
99381-99397 – Preventive Medicine Services
99424, 99487-99490 – Principal/Chronic Care Management
99460, 90461, and 90471-90474 – Vaccine Administration

Contrast Sample HCPCS-II Codes

G0403-G0405 – EKG, 12 lead, global, professional component only, technical component only with an IPPE
Q0091 – Handling/conveyance of a screening Pap Smear for transfer to the lab
J3420 – Injection, vitamin B-12, up to 1000mcg
G0466-G0470 – FQHC-only PPS Visit Codes
G0101, G0402, G0438-G0439 – CMS pelvic and breast exam, Initial Preventive Physical and Initial/Subsequent Annual Wellness Visits (AWV)
G0511 – Principal/Chronic Care Management and Behavioral Health Integration for FQHC – (only 20+ minutes/month)
G0008-G0010 – Vaccine Administration (pneumo, flu, HepB)
### Compare Sample Behavioral Health CPT Codes

+ 90785 - Interactive Complexity add-on code for more revenue when dealing with barriers to communication

90791-90792 – Psychiatric Diagnostic Evaluations

90832-99838 – Psychotherapy with or without drug management 30/45/60 minutes

96127 – Brief emotional/behavioral assessment with scoring and documentation, per instrument likely used with diagnosis code Z13.89

99492-99494 – Psychiatric Collaborative Care Model

99484 – Care Management for Behavioral Health Conditions (ex. BHI)

### Contrast Sample Behavioral Health HCPCS-II Codes

G0210/G2250 + G0212/G2251-2 – Virtual check-ins and “store and forward” virtual check-ins for commercial commercial/Medicaid claims

G0512 – Psychiatric Collaborative Care Model *(FQHC-specific)*

H0038 – Self-help peer services, per 15 minutes

H2011-H2013, H2018-H2022 – Crisis interventions, behavioral/psychiatric health day treatments, psychosocial rehab, community-based wrap-around services *(time-based)*

H2034-H2036 – Alcohol and/or drug abuse halfway house
### Possible HCPCS-II T-codes RESERVED FOR MEDICAID

<table>
<thead>
<tr>
<th>T1001</th>
<th>T1002 - T1003</th>
<th>T1006 - T1007</th>
<th>T1014</th>
<th>T1015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Assessment and/or Evaluation</td>
<td>RN or LPN/LVN services, up to 15 minutes</td>
<td>Alcohol and or substance abuse services including family/couple counseling and assorted treatment plan development and or modification</td>
<td>Telehealth transmission, per minute, professional services billed separately</td>
<td>Clinic visit/encounter, all inclusive</td>
</tr>
</tbody>
</table>
Locating ICD-10-CM “base code notes” benefits providers and billers

**M02 Postinfective and reactive arthropathies**

**Code first** underlying disease, such as:
- congenital syphilis [Clutton's joints] (A50.5)
- enteritis due to Yersinia enterocolitica (A04.6)
- infective endocarditis (I133.0)
- viral hepatitis (B15-B19)

**Excludes1:** Behçet's disease (M35.2)
- direct infections of joint in infectious and parasitic diseases classified elsewhere (M01.-)

- postmeningococcal arthritis (A39.84)
- mumps arthritis (B26.85)
- rubella arthritis (B06.82)
- syphilis arthritis (late) (A52.77)
- rheumatic fever (100)
- tabetic arthropathy [Charcot's] (A52.16)

**M02.0 Arthropathy following intestinal bypass**

- **M02.00** Arthropathy following intestinal bypass, unspecified site
- **M02.01** Arthropathy following intestinal bypass, shoulder
- **M02.011** Arthropathy following intestinal bypass, right shoulder
Access your CMS Fact Sheets to get the Basics

Also - go to www.CMS.gov > Medicare> Provider Type> scroll down to FQHC and bookmark it for periodic updates.
Key CMS References

Chapter 9 - CMS Claims Processing Manual

Medicare Claims Processing Manual
Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers

Table of Contents (Rev. 11286, 01-12-22)

Transmittals for Chapter 9

10 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) General Information
10.1 - RHC General Information
10.2 - FQHC General Information
20 - RHC and FQHC All-Inclusive Rate (AIR) Payment System
20.1 - Pos Visit Payment and Exceptions under the AIR
20.2 - Payment Limit under the AIR
30 - FQHC Prospective Payment System (PPS) Payment System
30.1 - PPS-Deductible Payment and Exceptions under the PPS
30.2 - Adjustments under the PPS
40 - Deductible and Coinsurance
40.1 - Part B Deductible
40.2 - Part B Coinsurance
50 - General Requirements for RHC and FQHC Claims
60 - Billing and Payment Requirements for RHCs and FQHCs
60.1 - Billing Guidelines for RHC and FQHC Claims under the AIR System
60.2 - Billing for FQHC Claims Paid under the PPS
60.3 - Payments for FQHC PPS Claims
60.4 - Billing for Supplemental Payments to FQHCs under Contract w/ Medicare Advantage (MA) Plans
60.5 - PPS Payments to FQHCs under Contract w/ MA Plans
60.5 - RHC’s and FQHC’s for Billing Hospitals Attending Physician Services
70 - General Billing Requirements for Preventive Services
70.1 - RHC’s Billing Approved Preventive Services
70.2 - FQHC’s Billing Approved Preventive Services under the AIR
70.3 - FQHC’s Billing Approved Preventive Services under the PPS
70.4 - Vaccines
70.5 - Diabetes Self Management Training (DSMT) and Medical Nutrition Services (MNT)

Chapter 13 - CMS Benefits Policy Manual

Medicare Benefit Policy Manual
Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

Table of Contents (Rev. 10729, 04-26-21)

Transmittals for Chapter 13

Index of Acronyms
10 - RHC and FQHC General Information
10.1 - RHC General Information
10.2 - FQHC General Information
20 - RHC and FQHC Location Requirements
20.1 - Non-Urbanized Area Requirement for RHCs
20.2 - Designated Shortage Area Requirement for RHCs
30 - RHC and FQHC Staffing Requirements
30.1 - RHC Staffing Requirements
30.2 - RHC Temporary Staffing Waivers
30.3 - FQHC Staffing Requirements
40 - RHC and FQHC Visits
40.1 - Location
40.2 - Hours of Operation
40.3 - Multiple Visits on Same Day
40.4 - Global Billing
40.5 - 3 Day Payment Window
50 - RHC and FQHC Services
50.1 - RHC Services
50.2 - FQHC Services
50.3 - Emergency Services
60 - Non-RHC/FQHC Services
60.1 - Description of Non RHC/FQHC Services
70 - RHC and FQHC Payment Rate
70.1 - RHC’s Billing Under the AIR
When should FQHCs use modifier -59 for multiple encounter rates on the same patient on the same day?
Billing incident-to services when nurses perform Medicare visits on their own

If any of the services on the previous slide occur without a CMS-authorized FQHC provider seeing the Medicare patient face-to-face, the services should be documented, coded, and stored in your EHR/IT environment but should not go on a claim form for AIR/PPS payments.

Medicare Benefit Policy Manual
Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

120.1 - Provision of Incident to Services and Supplies
(Rev. 263, Issued: Effective: 01-01-20, Implementation: 01-23-20)

When services and supplies are furnished incident to an RHC or FQHC visit, payment for the services are included in the RHC AIR or the FQHC PPS rate. An encounter that includes only an incident to service(s) is not a stand-alone billable visit for RHCs or FQHCs.
Have you analyzed your E/M code patterns for each provider, specialty, and location?
Continue to require a medically appropriate history and/or examination

Use either MDM level or Total Time on the date of the encounter

Codes 99201 and 99202 both required straightforward MDM in 2020

Established components for code selection

Deleted code 99201 and revised codes 99202-99215

Created guidelines

Specific to E/M office and other outpatient services

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Clinical Providers

Does your EHR have templates that reflect the updated E/M guidelines?

Managers

The way that past EHR office note templates are organized likely are based on the old days where history and exam areas of EHR matched the very detailed (no longer in effect) history of present illness, review of systems, past/family/social history and detailed general- and single-system specialty exams.

- Of course, history and exam areas will still be present but is there a way for time to be easily captured and included?
- Does the billing tab used by your provider give them a little checklist or reminder of newly updated MDM items?
CPT Initial/Periodic Comprehensive Preventive Medicine Services vs. IPPE/AWV

**Target Audience:** Medicare Fee-For-Service Providers

**Initial Preventive Physical Examination (IPPE)**
- Review of medical and social health history, and preventive services education
- **Covered** only once, within 12 months of Part B enrollment
- Patient pays nothing (if provider accepts assignment)

**Annual Wellness Visit (AWV)**
- Visit to develop or update a personalized prevention plan, and perform a health risk assessment
- **Covered** once every 12 months
- Patient pays nothing (if provider accepts assignment)

**Routine Physical Examination**
- Exam performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury
- **Not covered** by Medicare; prohibited by statute
- Patient pays 100% out-of-pocket
Avoid calling these services “physicals, general health exams, well-checks, and annuals visits”

CPT codes 9938x-9938x (new)
CPT code 9939x-9939x (established)
Let’s CAREFULLY REVIEW the notes in the AMA’s CPT before these codes are found!

<table>
<thead>
<tr>
<th>CPT code’s 7th character</th>
<th>Patient’s age at time of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>&lt; 1</td>
</tr>
<tr>
<td>2</td>
<td>1-4</td>
</tr>
<tr>
<td>3</td>
<td>5-11</td>
</tr>
<tr>
<td>4</td>
<td>12-17</td>
</tr>
<tr>
<td>5</td>
<td>18-39</td>
</tr>
<tr>
<td>6</td>
<td>40-64</td>
</tr>
<tr>
<td>7</td>
<td>65+</td>
</tr>
</tbody>
</table>
Please review the key details around each CMS sometimes-covered G-code in Chapter 18

Use caution as this document is not written specifically for FQHCs. It will, however, contain the key documentation guidelines for providers as well as helpful coverage information for coders/billers.
FQHC Details
Telehealth and Virtual Communication Services

Medicare Claims Processing Manual
Chapter 9 - Rural Health Clinics/
Federally Qualified Health Centers

70.7 - Virtual Communication Services

Medicare Benefit Policy Manual
Chapter 13 - Rural Health Clinic (RHC) and
Federally Qualified Health Center (FQHC) Services

200 - Telehealth Services
(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

240 – Virtual Communication Services
(Rev. 252, Issued: 12-07-18, Effective: 01-01-19, Implementation: 01-02-19)
Section I: A. Conventions of ICD-10

- Conventions of ICD-10-CM
- Alphabetic Indexing and Tabular Listings
- Format and Structure
- Use of Codes for Reporting Purposes
- Placeholder Character
- 7th Digit Characters
- Abbreviations (Index and Tabular)
- Punctuation
- Use of “And”, “With”, “See Also”, “Code Also”
- “Unspecified” Codes, “Includes” and “Excludes”
- Etiology/Manifestation Conventions (e.g., “code first”, “use additional code”, “in diseases classified elsewhere”)
- Default codes and Syndromes
How are your providers moving preliminary coding info to coders/billers?

Is this information a part of the actual medical record or just internal billing data?

Is this info only used internally for a professional coding review?

Contains enough info for patients to self-file insurance, if needed, or just as a receipt?

Does each procedure have at least one ICD-10-CM code identified as being primarily responsible for each CPT/HCPCS-II code?
### Main research items for CPT-II codes used for “Performance Measurement” reporting

<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Supplemental Tracking Codes”</td>
<td>Codes that have an evidence base from 12 external organizations.</td>
</tr>
<tr>
<td>“Facilitate data collection”</td>
<td>Codes that have an evidence base from 12 external organizations.</td>
</tr>
<tr>
<td>“Use of these codes is optional”</td>
<td>Which carriers “require” which codes and how often?</td>
</tr>
<tr>
<td>Codes xxxxF</td>
<td>“These codes are not required for correct coding and are not a substitute for CPT-I codes.”</td>
</tr>
</tbody>
</table>

### Superscripted numbers in each code
- Which professional organization creates and maintains the codes?

### Disease-specific?
- Reported if patients have the diagnoses appearing in parentheses, if applicable.

### No guidance on how to report is in the CPT
- Significant variation in how/when to report and on which claim form.

### Know your contracts
- Carriers should provide you with reporting requirements!
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