ArchProCoding
RURAL & COMMUNITY HEALTH

Top 5 Documentation & Revenue Tips in Community Health

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

NATIONAL ASSOCIATION OF Community Health Centers®

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~1900 courses taught in 46 states over 28 years

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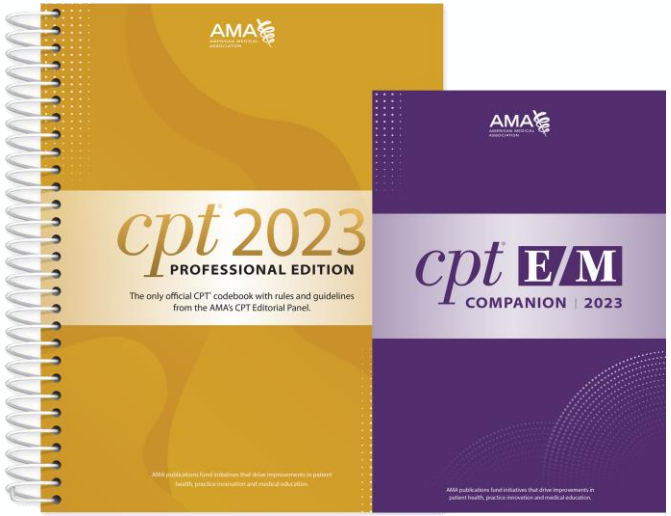
American Medical Association



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.

CPT® is a registered trademark of the American Medical Association. Use of the CPT codes and descriptions during this program is for educational purposes only. The CPT codes that are utilized in coding claims are produced and copyrighted by the American Medical Association (AMA). Specific questions regarding the use of CPT codes may be directed to the AMA.

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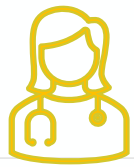
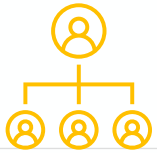
Top 5 Documentation and Revenue Tips
Who is affected?



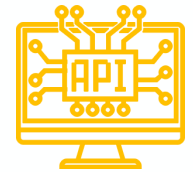
Clinical Providers



Clinic and Health Center Managers

Coders

Billers



Electronic Health Records and IT/Billing System Integrations

Top 5 Tips on Building Knowledge of FQHC Basics for Everyone

Tip #1

Understand all HIPAA Required Code Sets

Which HIPAA-approved code sets do we need to be aware of working in a FQHC?

Tip #2

Know how FQHCs are Different

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?

Tip #3

Monitor Key CMS Resources Often

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!

Tip #4

Separate FFS vs. CMS Valid Encounters

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.

Tip #5

Know how Qualifying Visit Lists can Differ

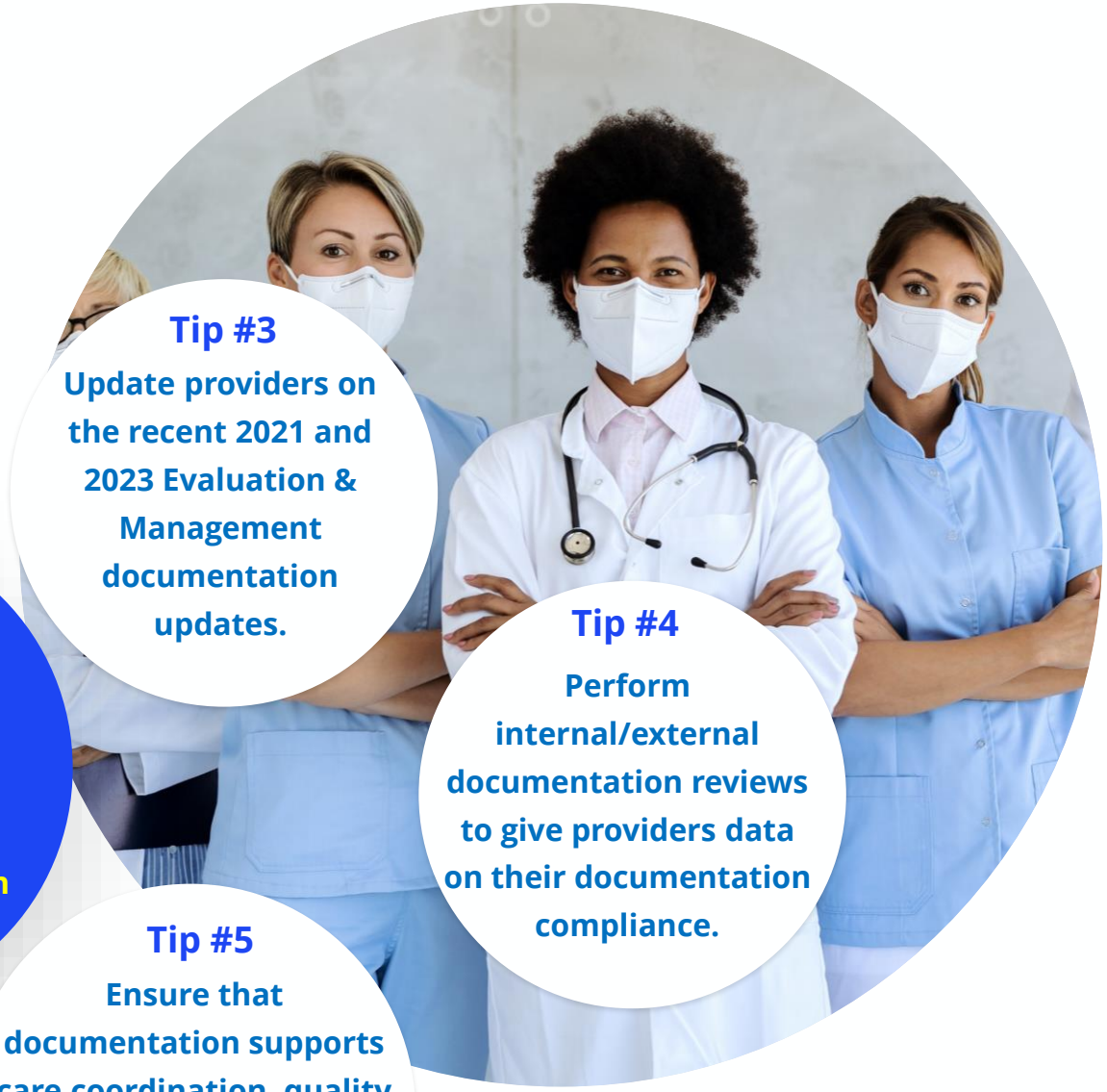
Medicare has a FQHC-only list of CPT/HCPCS-II codes that must be present on all claims requesting encounter-based PPS payments. Medicaid is different?

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.

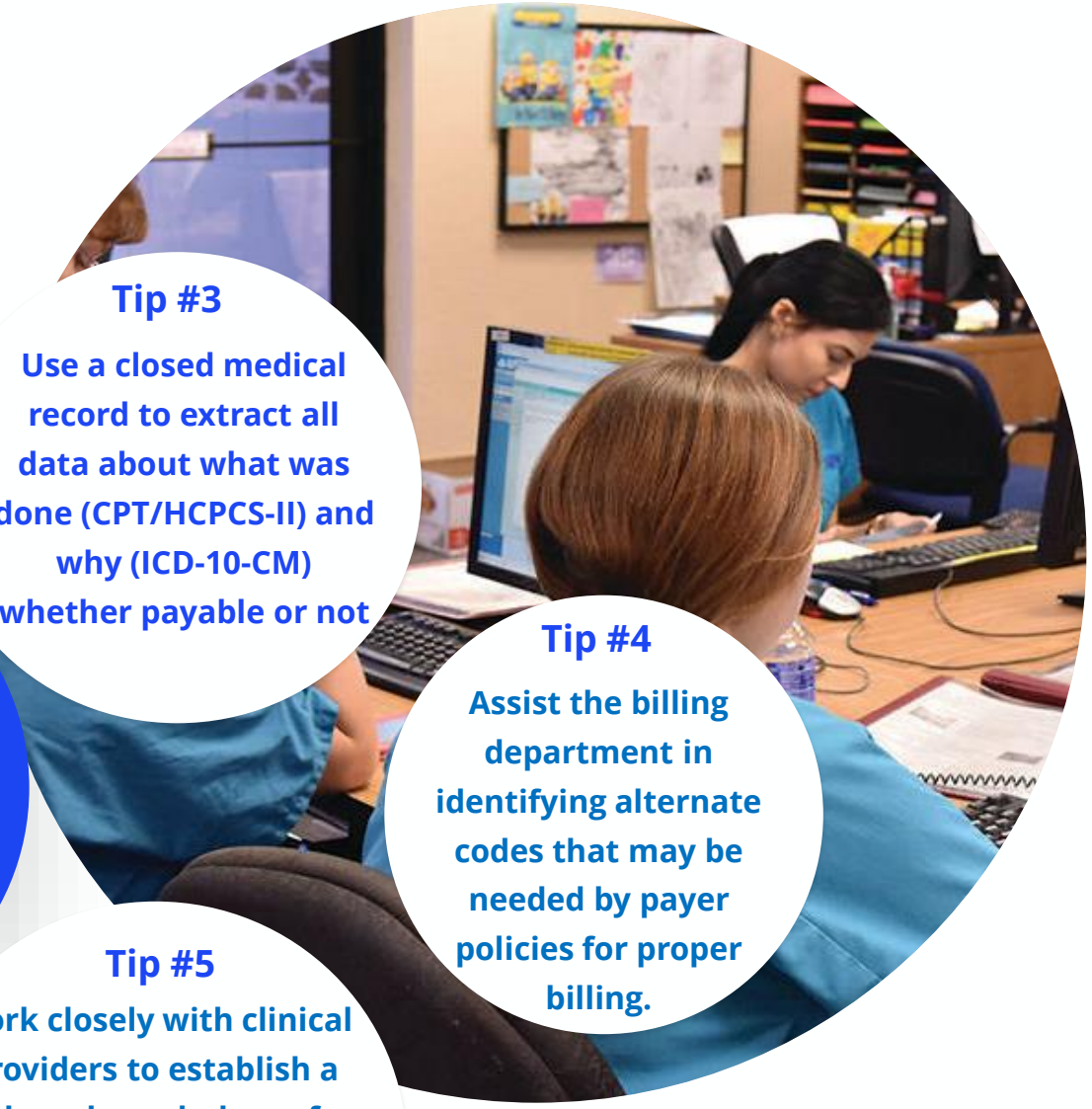
Tip #5

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

Top 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.

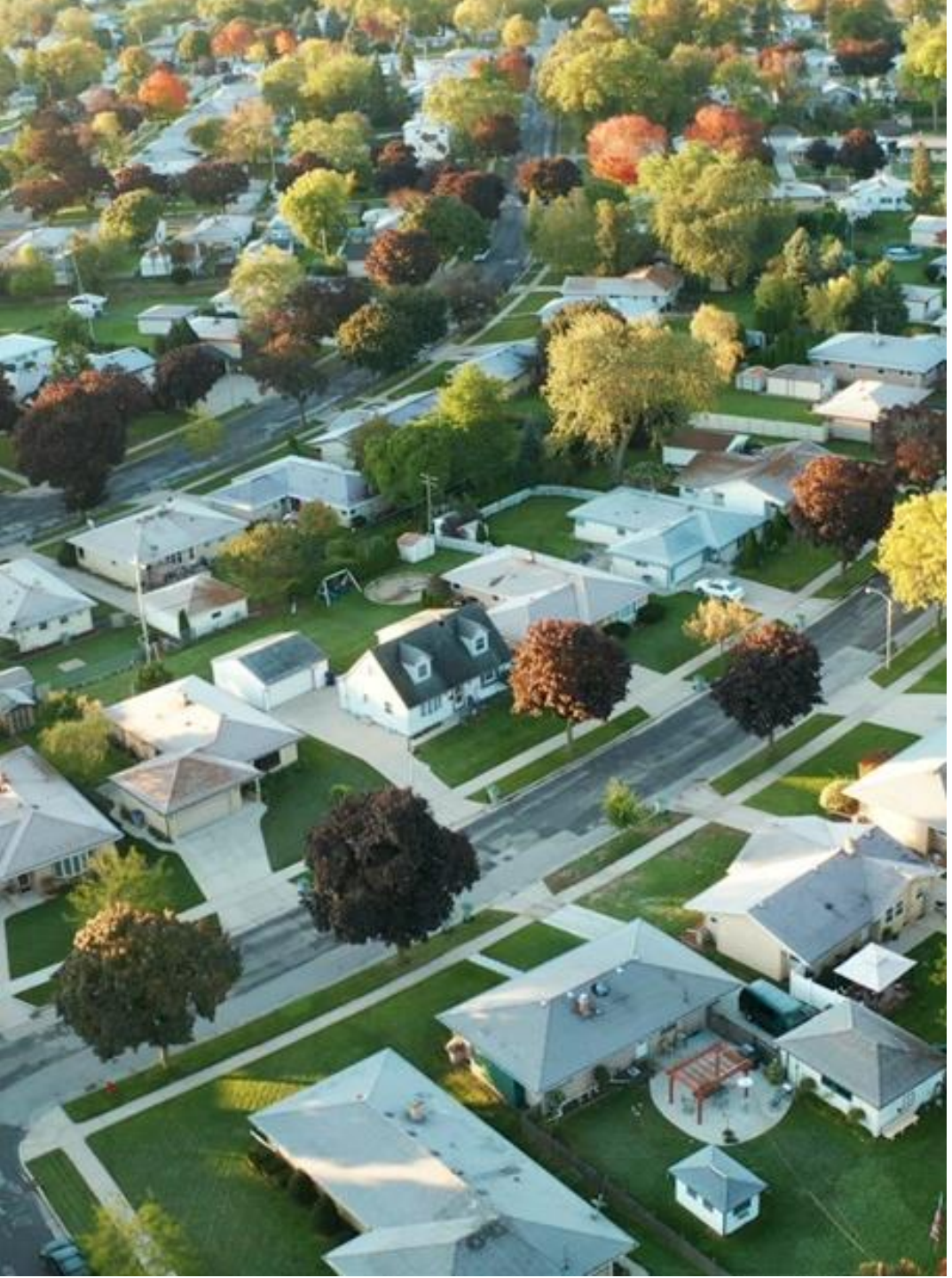
Tip #4

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.

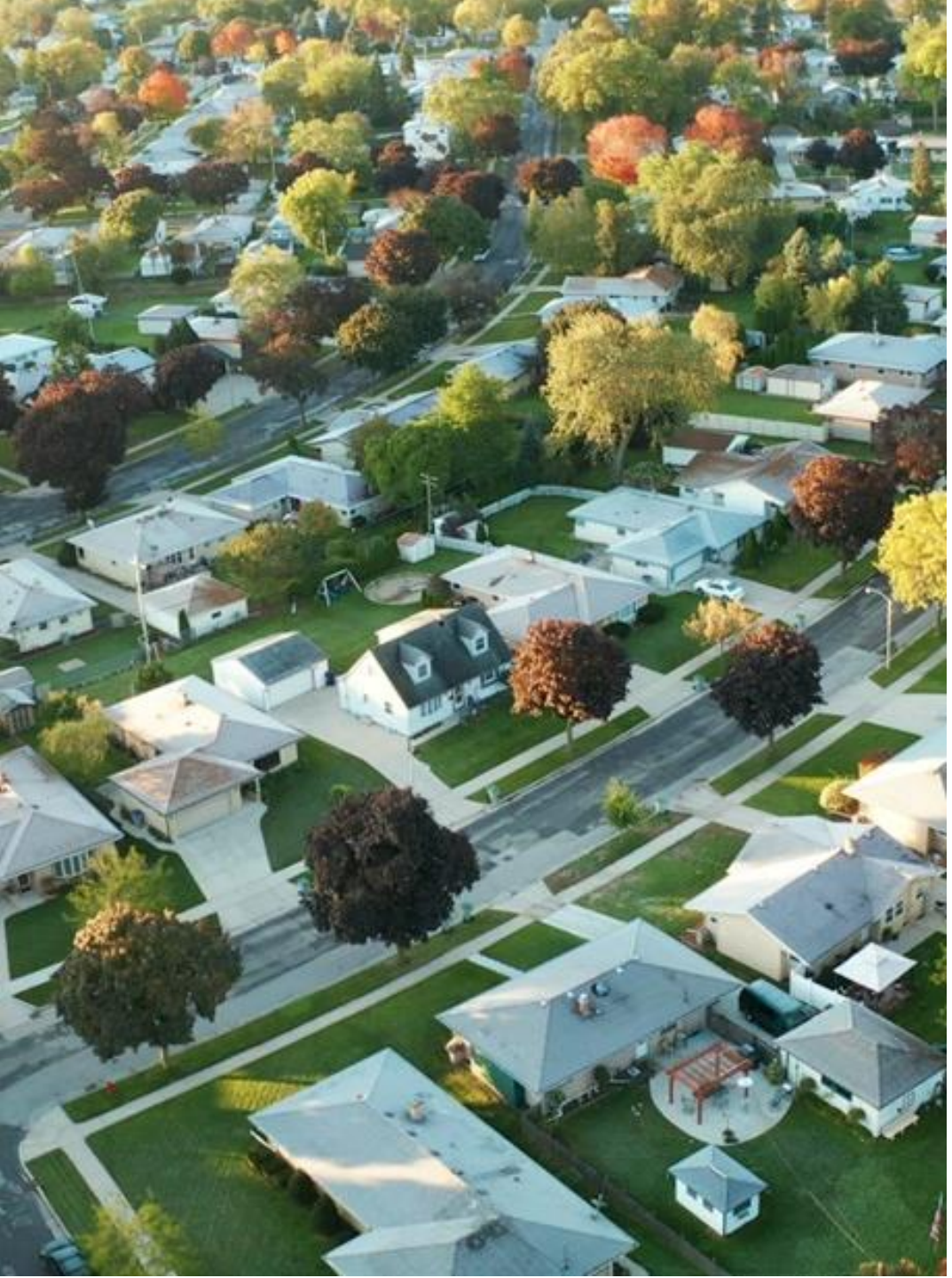
BONUS Self-Study Information For Post-Class Research



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

01

Face-to-Face Visit?

Exceptions?

02

Authorized Core Provider?

Slight differences for RHC vs. FQHC

03

"Medically Necessary"?

Familiar with NCDs vs. LCDs and where to get them?

Try this hyperlink

04

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)

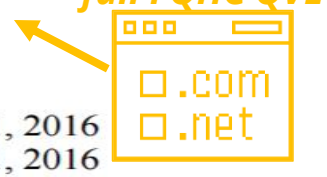
Qualifying Visits
The qualifying visits that correspond to the specific payment codes are as follows:

G0466 - FQHC visit, new patient

HCPCS	Qualifying Visits for G0466	Effective Date
92002	Eye exam new patient	
92004	Eye exam new patient	
97802	Medical nutrition indiv in	
~~99201~~	~~Office/outpatient visit new~~	
99202	Office/outpatient visit new	
99203	Office/outpatient visit new	
99204	Office/outpatient visit new	
99205	Office/outpatient visit new	
99304	Nursing facility care init	October 1, 2016
99305	Nursing facility care init	October 1, 2016
99306	Nursing facility care init	October 1, 2016
99324	Domicil/r-home visit new pat	
99325	Domicil/r-home visit new pat	
99326	Domicil/r-home visit new pat	
99327	Domicil/r-home visit new pat	
99328	Domicil/r-home visit new pat	
99341	Home visit new patient	
99342	Home visit new patient	
99343	Home visit new patient	
99344	Home visit new patient	
99345	Home visit new patient	
99406[2]	Behav chng smoking 3-10 min	October 1, 2016
99407[2]	Behav chng smoking > 10 min	October 1, 2016

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

HYPERLINK to full FQHC QVL



…there are more codes…

G0469 – FQHC visit, mental health, new patient:

HCPCS	Qualifying Visits for G0469
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt &/family 30 minutes
90834	Psytx pt &/family 45 minutes
90837	Psytx pt &/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

G0470 – FQHC visit, mental health, established patient:

HCPCS	Qualifying Visits for G0470
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt &/family 30 minutes
90834	Psytx pt &/family 45 minutes
90837	Psytx pt &/family 60 minutes
90839	Psytx crisis initial 60 min
90845	Psychoanalysis

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

T1001

Nursing Assessment and/or Evaluation

T1002 - T1003

RN or LPN/LVN services, up to 15 minutes

T1006 - T1007

Alcohol and or substance abuse services including family/couple counseling and assorted treatment plan development and or modification

T1014

Telehealth transmission, per minute, professional services billed separately

T1015

Clinic visit/encounter, all inclusive

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 (I33.0)
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 (I00)
tabetic arthropathy [Charcôt's] (A52.16)

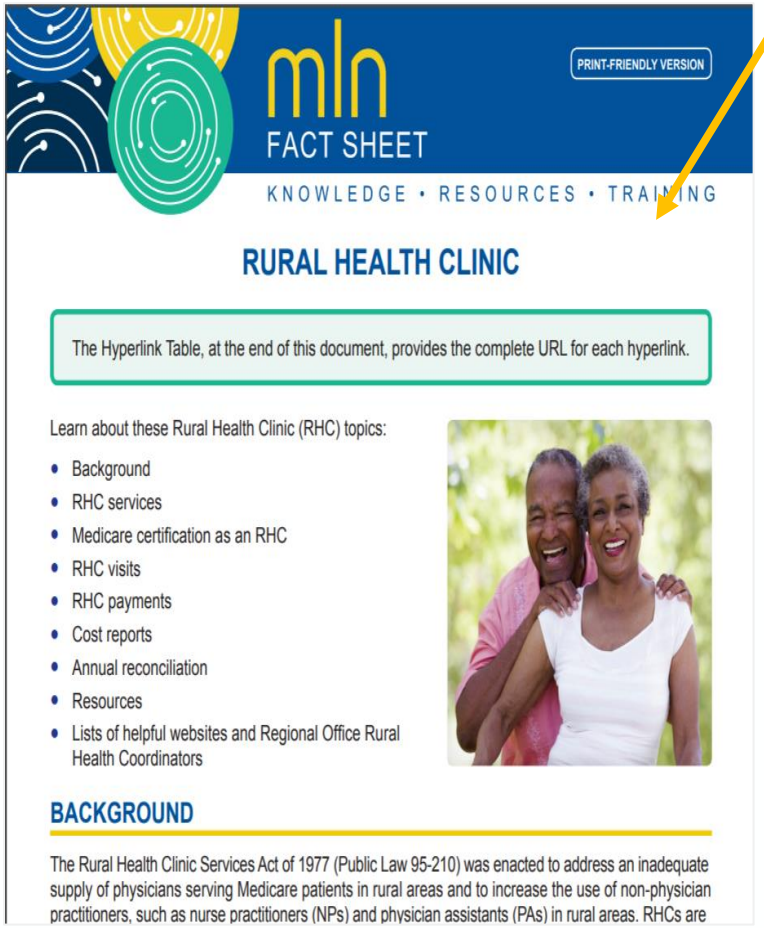
M02.0 Arthropathy following intestinal bypass

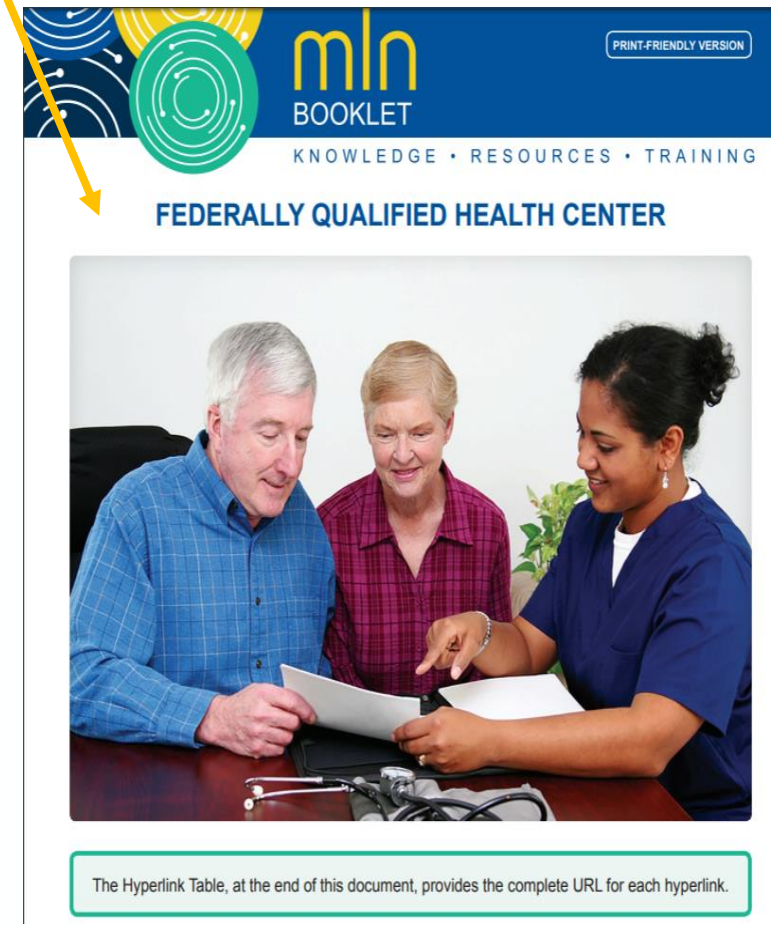
M02.00 Arthropathy following intestinal bypass, unspecified site

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

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(Rev. 11200, 01-12-22)

Transmittals for Chapter 9

Chapter 13 - CMS Benefits Policy Manual

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

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Transmittals for Chapter 13

Sample information from Chapter 13 for FQHC Visits

40.3 - Multiple Visits on Same Day

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

Except as noted below, encounters with more than one RHC or FQHC practitioner on the same day, or multiple encounters with the same RHC or FQHC practitioner on the same day, constitute a single RHC or FQHC visit and is payable as one visit. This policy applies regardless of the length or complexity of the visit, the number or type of practitioners seen, whether the second visit is a scheduled or unscheduled appointment, or whether the first visit is related or unrelated to the subsequent visit. This would include situations where *an* RHC or FQHC patient has a medically-necessary face-to-face visit with *an* RHC or FQHC practitioner, and is then seen by another RHC or FQHC practitioner, including a specialist, for further evaluation of the same condition on the same day, or is then seen by another RHC or FQHC practitioner, including a specialist, for evaluation of a different condition on the same day.

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

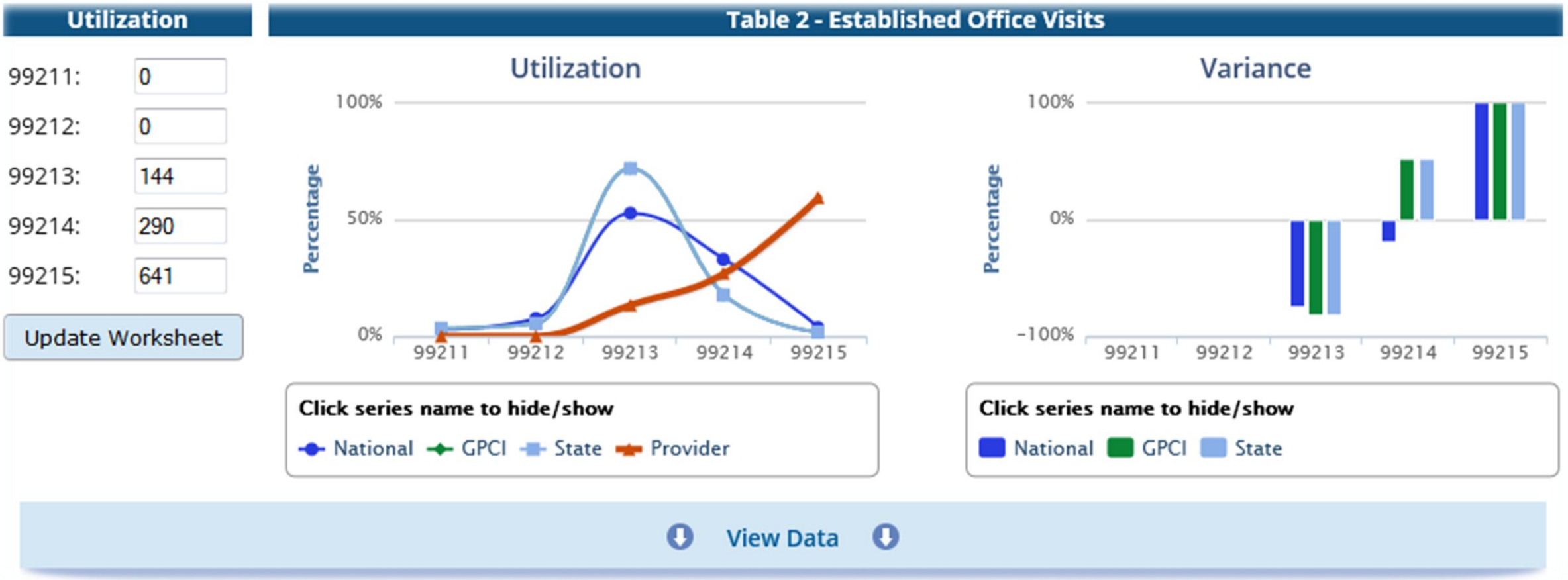
If any of the services on the previous slide occur without a CMS-authorized FQHC provider seeing the Medicare patient face-to-face, the services should be documented, coded, and stored in your EHR/IT environment but should not go on a claim form for AIR/PPS payments.

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.

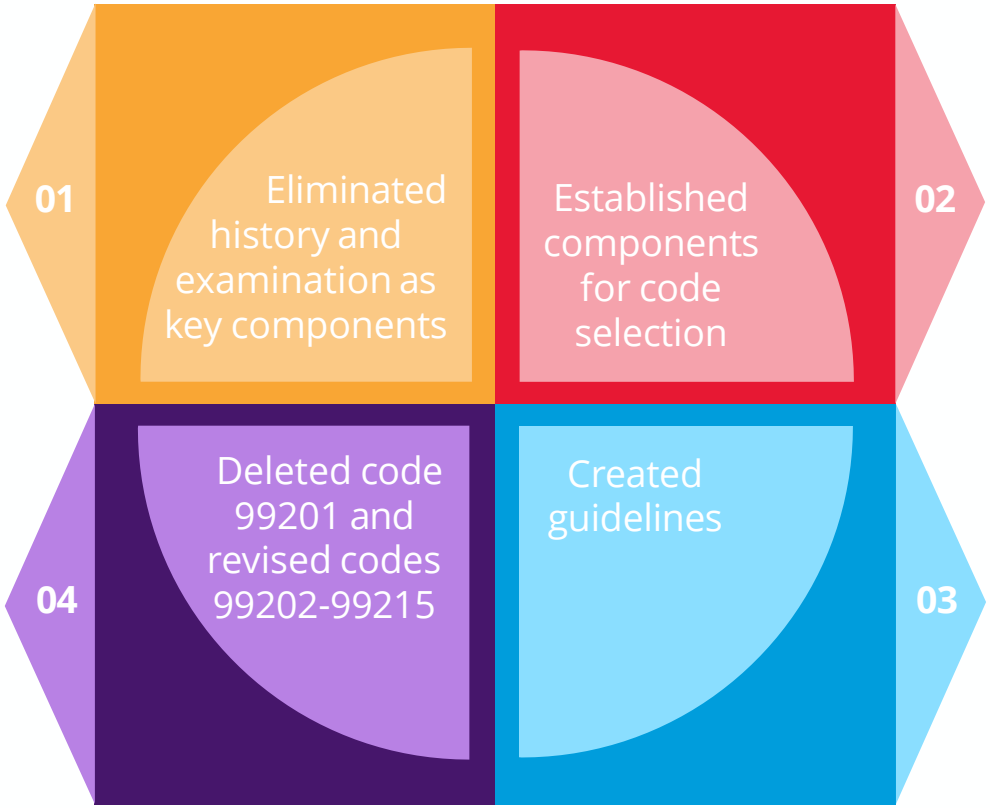
Have you analyzed your E/M code patterns for each provider, specialty, and location?



Summary of Major E/M Revisions starting in 2021: Office or Other Outpatient Services

Continue to require a **medically appropriate history and/or examination**

Codes 99201 and 99202 both required straightforward MDM in 2020



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

Specific to E/M office and other outpatient services

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

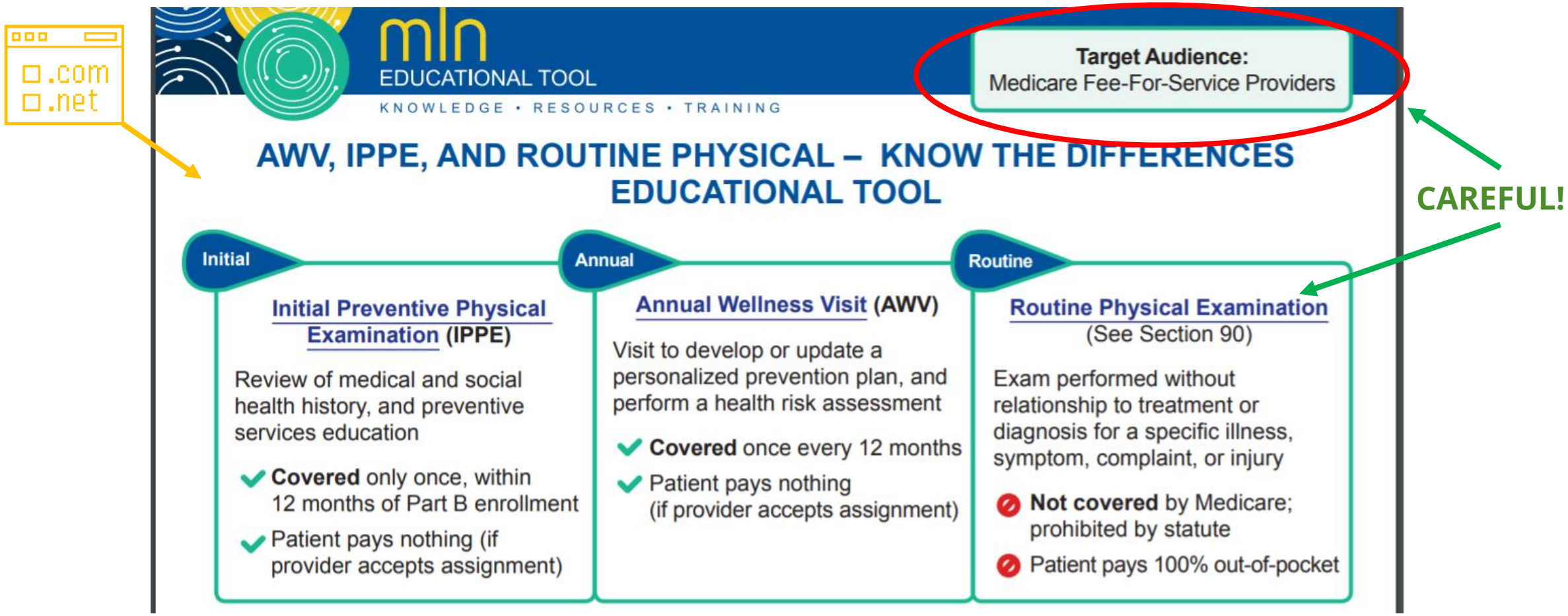
Clinical Providers

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



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!

CPT code’s 7th character	Patient’s age at time of service
1	< 1
2	1-4
3	5-11
4	12-17
5	18-39
6	40-64
7	65+

Please review the key details around each CMS sometimes-covered G-code in Chapter 18

Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

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(Rev. 4364, 08-16-19)

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
(Rev. 10357, Issued: 09-18-2020, Effective: 10-19-2020, Implementation: 10-19-2020)

+

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)

2023 ICD-10-CM Official Guidelines for Coding and Reporting

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?

CPSP Obstetrics/Gynecology

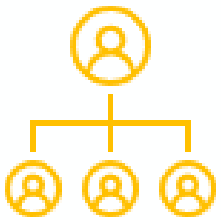
ENCOUNTER FORM

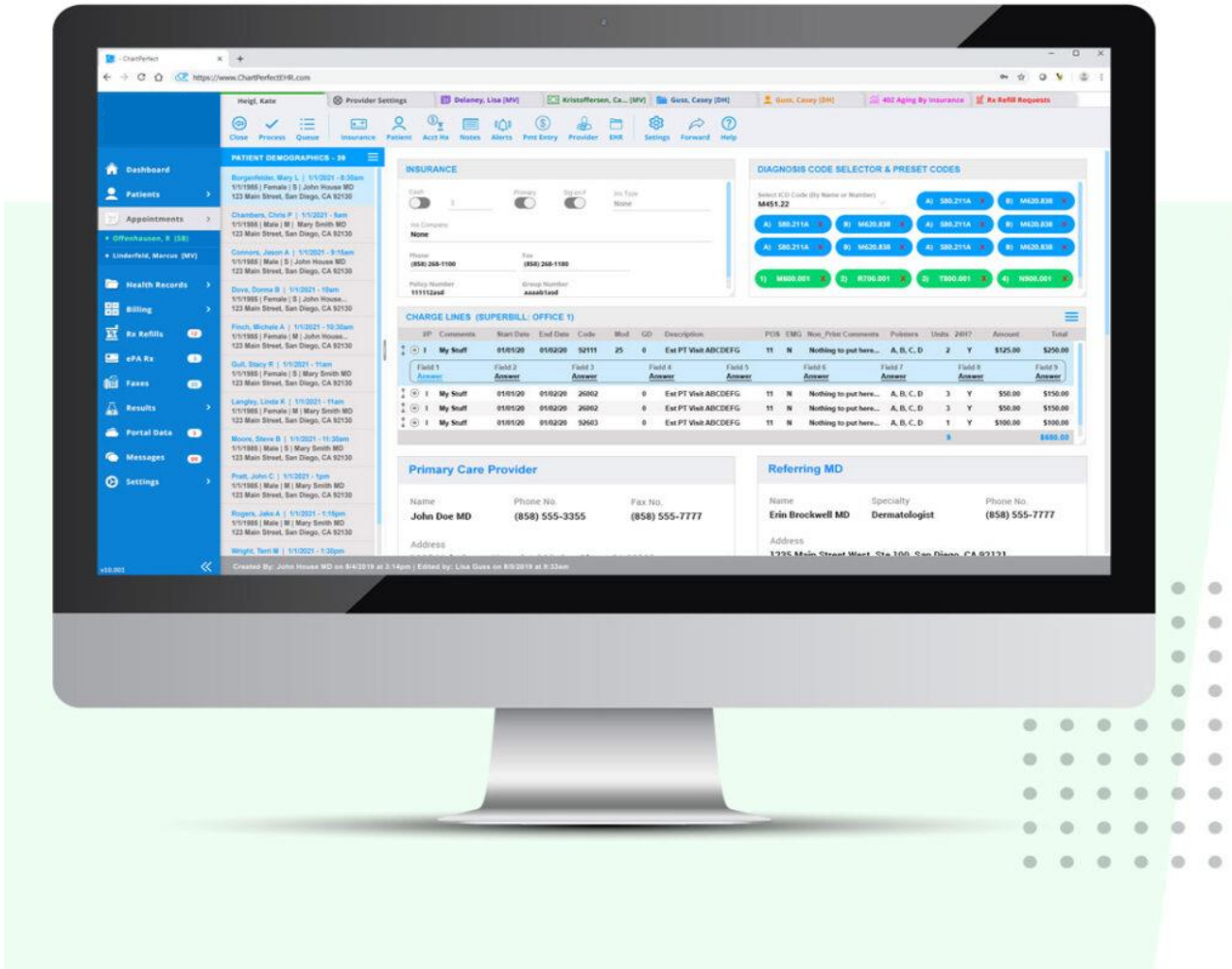
Is this information a part of the actual medical record or just internal billing data?

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

"Supplemental Tracking Codes"

"Facilitate data collection"
Codes that have an evidence base from 12 external organizations.

"Use of these codes is optional"
Which carriers "require" which codes and how often?

Codes xxxxF
"These codes are not required for correct coding and are not a substitute for CPT-I codes."

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!

Instructor

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Vice President of Research and Development

Metro-Atlanta

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