Philip Stringfield (00:00:00):

Good afternoon and good morning, everyone. As we get started, I just want to welcome you into part one of NACHC's coding and documentation webinar series. My name is Philip Stringfield and I serve as NACHC's manager of health center operations in our Training and Technical Assistance division. As we get started, I just wanted to remind you that slides were sent ahead of today's call, so you can check your email inbox. You should see a copy of those to follow along with today's training.

Philip Stringfield (00:00:28):

And in addition, if you could also look to the right side of your screen, you should see a poll that is open. It has about three questions, and we would love to get your feedback as we continue planning out our future training offering, we will definitely appreciate it. So the poll will stay open as we do our opening slides. And like I said, I would definitely appreciate your feedback.

Philip Stringfield (00:00:51):

All right, we can go ahead and move along. Just wanted to get a plug out for our upcoming 2022 Policy and Issues Forum happening February 14th through the 17th. Just wanted to remind you all that this has been moved to an all virtual offering, so you can visit nachc.org to find out more information, and you can see the schedule change in all the upcoming sessions as well.

Philip Stringfield (00:01:17):

And most importantly, you'll see that you are a large cohort today, I believe we have over 900 folks joined to call because in order to receive the CEUs you will have to attend this live training here. But as we do our questions, I definitely want to just make a point to please make sure you point your questions into the Q&A tap and not the chat. The chat, like I said, is going to be shared amongst 900 folks. So we want to make sure that the questions that are being asked that you completely ask your question and submit them in the Q&A box.

Philip Stringfield (00:01:51):

I'll be keeping track of the questions as we go throughout today's presentation, and we'll be making sure to get those questions answered for you. And I'll also make sure to supply the contact information for myself and today's faculty in case you all have additional questions or maybe if we did not get to your question at this time.

Philip Stringfield (00:02:12):

And so with that, I'm going to go ahead and hand things over to our esteemed faculty, Gary Lucas, with the Association of Rural & Community Health Professional Coding. And he's going go ahead and get us started with the top 10 documentation and revenue tips in community health centers. So we're glad to have him here. And like I said, in order to receive today's CEU information, you have to stay until the end of the call. So I'm going to go ahead and hand things over to Gary.

Gary Lucas (00:02:41):

All right. Hello everybody, my name is Gary Lucas, and I think we'll be getting me to full screen here in just to moment. There we are, hello everybody from Metro land. My name is Gary Lucas, and I serve as vice president of education for the Association for Rural & Community Health Professional Coding. I'm

located here in Metro Atlanta, and I'm extremely honored to be providing part one of the two part webinar series through NACHC's Billing, Coding, Documentation and Quality Webinar Series.

Gary Lucas (00:03:12):

I'll be switching between a couple different views here today, so you can see me full screen, and when there's information that may be more of a focus for providers or managers or coders and billers, I'll give you a little different view here so we can keep it as engaging and entertaining as possible. So I thank Philip Stringfield and everybody at the national association of community health centers to trust us at ArchProCoding with this information today.

Gary Lucas (00:03:43):

My contact information is here on the screen. As Philip mentioned earlier, if we do not have the chance to get to your individual question, because we have over 500 folks now closer to 900 will likely be on the session. We'll have email both myself and have you emailed me and Philip with any questions should I be able to help out. I've been lucky enough over the past 27 something years to teach about 1,900 sessions in 46 states on documentation, coding and billing with a particular focus on rural and community health centers.

Gary Lucas (00:04:20):

The three main objectives today is to review the essentials of clinical documentation, coding and billing, of course, with an effort to minimize errors and denials, to provide an overview of some quality and accurate reporting mechanisms for FQHC and an explanation of some frequently used key terms and concepts. Because in community health, it's not surprising that many folks who have joined a community health center from a traditional doctor's office often find some new and unique issues that they're encountering that you didn't encounter when you worked in traditional fee for service office.

Gary Lucas (00:05:04):

Next, we'll continue and I give you access to a variety of resources for continued learning and growth because as we all know, especially on the coding and billing side, you can understand everything today and a whole heck of a lot can certainly change tomorrow. So just to confirm here, there will be another webinar next week, a week from today on substance and opioid use disorders via medication assisted treatment in community health. That session is going to be, I think it's a one, one and a half hour session. It's actually a subversion of the full four hour presentation that I and ArchProCoding provide for the R Core Grant, the rural communities, opioid response program. And we provide a lot of that through the HRSA, our core grant. And we're going to give you a nice overview next week.

Gary Lucas (00:06:03):

So just to confirm our target audience here for today, and for all of our training starts with clinical providers. So clinical providers, of course, the primary focus as a clinical provider is for you to be documenting 100% of the services you perform. Because as you are an extremely valuable, if not one of the most valuable employees in a community health center, there is an obligation to document your work. But the key is that it's being done according to official guidelines that oftentimes providers may not be aware of.

Gary Lucas (00:06:42):

Next, we welcome those of you in facility leadership, whether you're a front desk manager, office manager, CFO or otherwise. I am going to sometimes controversially propose to you that I'm holding facility leadership responsible for coding. Because those managers have to create policies and workflow processes that engage both the clinical providers and those involved in billing and the contracts that are being signed with commercial insurance companies may differ than the billing we need for Medicaid or other carriers. And while documentation and coding are consistent across all insurance types, you better believe that the billing, of course does get difficult.

Gary Lucas (00:07:35):

And although you're going to treat all patients the same, therefore you will document the patients the same. Therefore, you will code each patient the same. When you have to cross this barrier into the billing side to get paid, you will often have to change your codes different than you had bill Medicare to get paid by commercial insurance. And that's one of the big challenges that's out there that we have to face. Sometimes you're using a 1,500 form or sometimes you have to use that old UB form. From some carriers you're getting paid per member per month, from some you're getting paid fee for service. And of course, with Medicare, you're getting paid or traditionally for most service getting paid your PPS amount or that per diem or encounter rate.

Gary Lucas (00:08:25):

So because we have an hour and a half here together, of course, we're going to hit a kind of a top 10 list here, but that provides the foundation for the top 10 tips today that will be reviewing. So to give you a quick outline of the first five, the first one we're going to do is really to build that foundation to determine the level of training needed by each job role, and to establish a team-based training concept under an established training budget so you can earn CEUs and CMEs alike.

Gary Lucas (00:09:02):

Next, confirming the difference between documentation, coding and billing. They are very different from each other, as well as ensuring that all providers are quote, "Coding on their super bills or the encounter forms rather than billing." Very, very important concept. Coding and billing are not the same.

Gary Lucas (00:09:25):

Next, we'll ensure and confirm you have access to the most important materials that a community health center has to deal with. Not only the HIPAA approved code sets; your CPT, your HCPCS Level II code book and the ICD-10 book, but the Medicare claims and benefits manuals from chapter nine and chapter 13. And I'll be providing you with specific sections in those document that you'll be able to use to perform follow up research in case you need to change and update any existing policies related to documentation or coding, and specifically billing.

Gary Lucas (00:10:08):

Keep in mind, you'll hear me mention Medicare quite often because where Medicare goes with billing rules and regulations, many other carriers tend to follow. But Medicare is one of the only or the primary entity that actually publishes a lot of these guidelines and we'll use those source documents to confirm that the information I'm giving you today is accurate, and so you can keep track of the information following today to keep track of the inevitable changes that will most certainly occur.

Gary Lucas (00:10:42):

Next, the emphasis on reviewing participation contracts with key carriers to seek out specific questions before you renew your participation agreements with them. I'll touch on one or two I ideas that will differ for commercial insurance companies compared with Medicare, specifically designed to help you generate more revenue with commercial insurance companies while making sure you're not getting more than you're allowed.

Gary Lucas (00:11:12):

We'll next then focus on an outline of how you can perform internal audits on your E/M services to make sure that you're following the 2021 and 2022 updates that changed your E/M code documentation for office and or outpatient visits. For the first time since 1992, there are some wonderful opportunities from a documentation perspective, pretty big glare on the glasses there so take those off. And there's going to be some opportunities for providers to become more active in the compliance and revenue areas while still maintaining full and complete control over the quality of the clinical care that they provide.

Gary Lucas (00:12:02):

So here we go, tip number one, determine the type of training needed by job role. Well, we all share the same path, regardless of whether we're a provider, a manager or a biller or a quality nurse or something to that effect. There are things we need to be prepared to do before we open our doors. Some of the advanced issues involved in being a federally qualified health center, and we'll use the initial FQHC and community health center interchangeably.

Gary Lucas (00:12:37):

What are some things we may need to be aware of as we greet the patient? How does their insurance type impact the claim form we use? The patient's deductible or co-insurance, or which types of preventive services may be covered? Okay, well, now the patient is in the exam room, training the staff on those actual guidelines that are only printed in many cases in the CPT book, we don't expect everybody to have their books with you, but for example, I don't know if this is going to show up well, if you have information related to psychiatry.

Gary Lucas (00:13:15):

I just got done this morning teaching a two hour session on substance and opioid use and mental, and excuse me, on primary care and behavioral health integration. And I had that page in my CPT highlighted because there's paragraph after paragraph of information that is only found in the printed version of the CPT so that if you are overusing EHR templates or EHR shortcuts, you're missing out on a lot of valuable information.

Gary Lucas (00:13:49):

Then we need to make sure that either the provider or the coder is then going to code that encounter fully, regardless of the patient's insurance. Please, please, please keep in mind managers that it is vital that each encounter be coded according to the coding guidelines, that by the way are likely different than what the billing guidelines of Medicare versus Medicaid versus managed care, et cetera. We don't just code to get paid. We code to identify to ourselves and to the patients and to other providers what we did, whether we get paid or not.

Gary Lucas (00:14:36):

And so coding for those of you familiar with the cost report, of course, is a big deal. Whether it's giving a patient a receipt and as you well know, you don't get paid for everything you do. And there may be a need, for example, even though Medicare does not reimburse the code 99211 for a traditional nurse visit, other insurance companies may. If we did the 99211 nurse visit, and that's all we did, even though we haven't met the definition of a valid encounter, according to Medicare's definition, it will make its way through our system if we captured it and make its way to the cost report, which would justify what our current encounter rate is and could generate additional payments through the cost report.

Gary Lucas (00:15:25):

Now, the tricky part of course, is confirming the documentation and getting everything you deserve and meeting the rules of those insurance contracts that you sign. So without going into too much detail, it is fair to say there're understandable challenges and issues related to getting a foundation of knowledge built between providers, managers, and billers. Maybe some of them are associated with your IT environment, or let's just be honest. A lot of providers for years have felt frustration with the impact that documentation requirements have in their time.

Gary Lucas (00:16:04):

So we understand that, we recognize that managers are often signing contracts without complete awareness of the impact on providers. A matter of fact, you may not have clarified in a clear manner who is responsible for coding. Yes, the providers document what they do. And yes, they transmit that information via some electronic form of what's done. But what if I have one provider doing pure coding on that super bill, but another provider who understands billing is actually submitting billing there.

Gary Lucas (00:16:44):

And so we understand that it's difficult to balance fee for service claims and encounter rates. And we're truly excited to be trusted by NACHC to help you find information specific to FQHCs. And so the need to have a foundation of training that is shared amongst all of these folks is tremendous. I've spent over half of my life traveling and doing this and I can talk to providers only, but then if the billers have heard something different or vice versa causes a lot of issues.

Gary Lucas (00:17:18):

And by training together from a reputable source that can provide you with the background references and background resources is going to be tremendous. So out of the 670 something folks we have here, we realize that some of these tips may need to be modified or adjusted based on your unique needs. And we'll make ourselves available following class to help out. But ask yourselves these questions; first of all, and you don't need to put it in the chat box or anything like that, but do your clinical and your revenue staff have a shared platform of knowledge in these areas that allows you to meet both your clinical and business needs.

Gary Lucas (00:17:59):

How aware or are your providers aware of those documentation guidelines that are printed in the CPT manual, but not even just the CPT manual. There's about 35 to 40 pages of information near the beginning of your ICD-10 book that actually gives you what are called the official guidelines for coding and reporting. And so when you're thinking about the documentation guidelines there, you're not often finding the full scope of information you need to help providers document, unless you're able to show

them the guidelines such as the official guidelines for coding and reporting that are designed to help providers bridge their clinical terminology with that terminology needed quite a often for revenue.

Gary Lucas (00:18:52):

Next item here, we have about three to four minutes for each of these, maybe four or five minutes per each of these 10 tips, but are you working together? Providers, managers, billers alike to make sure that each encounter is fully coded based on the guidelines. Whether it meets the billing issues or not, that has to start before you are able to get 100% of the revenue that you're entitled to and nothing more. And if any of the answers to these questions is no, or if the answer is well, it's not quite where we want it ladies and gentlemen, that is exactly the solution that will best kickstart your revenue opportunities.

Gary Lucas (00:19:41):

And making sure that folks are training together is interesting because everybody gets an idea about what they do impacts the others. And making sure that trains together is vital. Tip number two, as we've already hinted at here, knowing the differences between documentation, coding and billing. If you think about it, if you are a member of the quality staff that reports data through HEDIS measures or UDS measures, or a variety there, you're not concerned about revenue. You want to know if it was documented and coded correctly.

Gary Lucas (00:20:21):

And so as we've clarified, but I like these little items here. And this even turned out in my earlier session this morning to really generate a good set of conversations with the CFO and chief medical officer of the organization I was teaching with. Coding simply terms medical documentation into usable data, whether or not it generates revenue. So as you saw me hold up that CPT book earlier, there is not one thing in this book that has anything to do with money or insurance. That is a coding manual.

Gary Lucas (00:20:59):

Now, the next two items of course can be a little bit fun here, just because you didn't get paid, doesn't mean you did it wrong. Is it possible that insurance companies make mistakes? I think I can hear the laughter coming from across the country there, but we have to be able through an appeal of a denied claim to be able to quote the specific source documentation. Because as you've noticed insurance companies are not allowed to give you billing information when you call in.

Gary Lucas (00:21:34):

So even if you got paid, here's the fun part. It doesn't mean you get to keep the money. So remember please, it is not the insurance company's responsibility to pay us correctly. It is our responsibility to be paid correctly. And this turns into a very interesting issue, especially along the lines of making sure that we don't bill until the documentation is complete. We understand that the, especially with COVID and your patient flows and the tremendous amount of changes you've had to deal with over the past couple years here, that it may be tough for providers to complete their documentation on the data service, maybe it's within 24, 48 hours or whatever 72 hours.

Gary Lucas (00:22:30):

Well, there's a danger, especially from the manager's perspective here in allowing providers, let's just say too much time to complete their documentation while at the same time, turning to billers and

saying, "Get the claim out of a door." Some of your IT systems will not even allow you to send a bill until the note is closed. That depends on your IT landscape. But in other systems where you have one company with your billing software, one company does your EHR, another does scheduling. There may be no IT checks and balances that prevents you from billing for a service, even though the note is not closed.

Gary Lucas (00:23:17):

Well, folks, that is a very important issue. And when we get to the tip about doing internal audits on the new E/M guidelines that show up, I'm going to give you some incentives that will show you the financial benefit of being able to have a provider complete as much of their documentation on the data service. And I think you'll see a positive issue related to E/M that primarily came from what's called the patient's over paperwork initiative a couple years ago where the new E/M guidelines were created to reduce the administrative burden on providers of documentation. Standby for that one.

Gary Lucas (00:24:04):

As we mentioned a moment ago, where Medicare goes with rules and regulations, others tend to follow. And the key issue there is, this is a very trust based industry. We've been typing a bunch of numbers into computers for years, and they've been mailing us checks and everything goes back to the documentation. So for me to each billing without ensuring that providers are aware of the guidelines would be me not doing my full job. And so we encourage you to locate the times and opportunities where you can get all the folks together. Because for example, years ago, actually 2016, Medicare made a pretty big change.

Gary Lucas (00:24:50):

Say, "Look, don't just list the 99213 code just because that's going to generate your PPS encounter." But years ago, using the hyperlink I give you here, it says you need to list the visit that qualifies the service for your encounter, but look at this next part and all other FQHC services furnished during the encounter. So had you only been billing the one, maybe two codes that identified, "Hey, we've done a valid encounter, please pay us." But you've left off the ear levi, you left off the joint injection or the incision and drainage of an abscess, et cetera.

Gary Lucas (00:25:37):

It's true that by leaving those codes off, it didn't change Medicare's payment to you. It's true that for a Medicare patient does not change the patient's co-insurance. But at the end of the year, when you do your cost report, if those items were not captured, were not in your system, therefore not able to be counted as an allowable visit. You're going to see your PPPs rate either not increase or not be increased enough to reflect your true reality. And making sure that you're listing all services on a line by line perspective is important, and that goes to the providers and the managers and the billers, and would require that cross-functional discussion between you because how you move the information or the data I should say from a provider to the coder and biller is a big time focus. And that likely changed for you a couple years ago.

Gary Lucas (00:26:46):

Back in the old days, you had that piece of paper that your provider would check or circle what he or she did. They'd check or circle the diagnosis codes. And they'd hand one copy to the patient to take to the checkout counter to maybe determine the patient coinsurance, but that piece of paper was really what

drove the billing department to build a claim. The problem is if I build a claim from something that is not medical records documentation, that super bill is not a legal document. That is an internal piece of paper, it's got to on the documentation itself.

Gary Lucas (00:27:25):

Well, likely you moved from a paper super bill or encounter form to an electronic version. And there may not be enough detail or awareness with providers that we're not only using this encounter form for ourselves, but our patients need something to tell them what happened with the CPT codes and the ICD-10 codes and why. There I should say with the ICD-10 codes. Are the patients really struggling to understand what they were actually provided because if all they see is the explanation of benefits from their insurance company, they're going to have a hard time telling other providers they may see what was actually done. And so think about it.

Gary Lucas (00:28:12):

Like you're almost giving the patient a receipt and after the insurance company replies back, "Hey, look at this three of the four things we did got paid by your insurance company, but there might be this other one that is your responsibility." Maybe we're looking at this on the provider's perspective, as we stated earlier, are you coding on the super bill or are you although with a kind heart, but confusing the issue by applying any medical billing rules that you know, okay. That apply any billing rules that you know when what we really need from providers is just tell us everything you did and why you did it based on the CPT guidelines that we've trained you on.

Gary Lucas (00:28:56):

So we want to make sure that when we're asking providers to complete the encounter form, are they able to see the full code definition or is it highly abbreviated 99213. It says EST, established patient level three that doesn't quite give the level of detail, all right. From that, however you're doing that for the CFOs and managers, if we're not capturing everything we are likely under-reporting our true costs. And when you get into the world of value based care, et cetera, we may be under-emphasizing the complexity of our patient population because we may only be given the providers access to the top 10 or top 20 diagnoses.

Gary Lucas (00:29:48):

And the provider may select that one because it's on the encounter form with no ill will, but there are more specific diagnoses that they should look at and review and do more than a simple keyword search. So we're going to need to move along to the next item here. So what I've done on slide 14, when you get the chance is some questions and comments like is your note closed and signed before you bill it? Does anybody review the completed note before the bill is created or sent? And how do we keep encounter data for our cost report? All right. Because when you get into that cost report, it's a very high level definition here, but the total allowable costs that you have to submit yearly to Medicare, maybe even Medicaid divided by the number of allowable visits is your cost.

Gary Lucas (00:30:39):

Now, I'm about to give you link to chapter thirteen's RHC and FQHC services in particular section 80.1 that will give you more detail on the cost reporting requirements. But if you look at the top item and all I reported was my office visit. At the end of the year, that's going to be a low number. If in fact, I actually did three or four services, that's going to make my cost truly reflect of what's going on. But if I left a

couple of them off, my cost looks like it's low. So we code for the cost report. We code for the patient, we code to gather data then, and only then do we move to billing. So everything about cost reports is centered on how well you're capturing all of the services you provide based on those guidelines.

Gary Lucas (00:31:33):

Tip number three. Tip number three. Gather those code sets and those key materials. It sounds like it obvious folks, but I can't tell you how often coders and billers come to a session or back in the old days when I would go travel out to see you. And they bring a CPT book that's two or three years old because quote, "My office won't buy me the new books each year." That is a very dangerous and has a huge impact, of course, not only on the accuracy of the information that we capture from a coding side, but from a billing perspective, we might be getting paid on an old definition of a code that had different documentation guidelines than the one that exists today.

Gary Lucas (00:32:23):

So may making sure that each of your facilities, whether it's your facility or the office or the nurses station that you have access, not just to the code books, but maybe this makes it sound a tad more, gives it a little more oomph. How about let's look at the slide here. The federally mandated HIPAA code sets or are you too dependent on software. While EHRs and IT systems do give you code lookup features, they do not contain the same educational value as the materials themselves. And I will make all of the coders and billers on this session a deal. If anybody in management that understandably not correctly, but understandably says, "Wow, we have all this fancy software. We're not going to get you their books."

Gary Lucas (00:33:17):

If any of your manager can convince me that you don't need a physical, let's just say CPT book each year, I'll send it to you for free. Now, just in case you're listening only, I'm winking here because that's never going to happen. You need to have those materials every year. Now, the HCPCS book, you can get away with some electronic lookups. In the ICD-10, you'd still need to know the guidelines, but for you and an FQHC, here's question number one related to this tip.

Gary Lucas (00:33:51):

Do you have access to and understand the contents of those key Medicare updates as well as the policy and benefits manual that I'll give you a link to here in a moment? So that, for example, in the previous tip, you can look up how Medicare thinks a community health center needs to look at cost reports. I will acknowledge that this is a question mark for me as well as you, but to help with this particular tip, we do need to be asking insurance companies, I'm talking commercial insurance companies, managed care companies, et cetera. Specifically when I resign that contract every year or every other year, if there are changes in patient coinsurance? Are there changes in coverage guidelines? How can we locate information that we need in order to stay up to date with the different billing rules from different carriers?

Gary Lucas (00:34:46):

Well, quite honestly, we need to be able to ask them several of the questions we'll generate in this session, as well as others, considering we only have about an hour and a half with each other. So what I wanted to share with you in this respect briefly on slide 18 is that if any of the concepts over here on the

left hand side apply to your job, again, be you a provider or coder, biller, manager, et cetera. Whether it's care management services.

Gary Lucas (00:35:17):

For those of my folks that are intimately involved in quality reporting or value based care, what are called hierarchical conditions, hierarchical, excuse me, conditions categories, maybe it's the social determinants of health or primary care and behavioral health integration. Each of these has something to do with one of those, at least one, I should say of those key code sets and the impact on reimbursement for some is very high. Whereas for example, the social determinants of health used to be low or actually in A, but as of the evaluation of management updates, we'll talk about here in a little bit. Those will have a big impact on reimbursement unlike a couple years ago.

Gary Lucas (00:36:07):

So having access to those code sets is vital for compliance and optimal efficiency in your operations. So having them would be vital. So what I've done on slide 19 is provided you with several key, excuse me, CMS resources that you can download and please study. Now, chapter nine of the CMS claims manual. I should be very careful. These are FQHC on the left hand side, especially FQHC specific resources. The claims processing manual in chapter 13, the CMS benefits policy manual, which was updated mid last year.

Gary Lucas (00:36:47):

So you see the coders and billers and managers on the left side. And then if you need information on preventive medicine, which we will outline at a high level, here's 250, I think it's actually 249 pages of information about how, when and where Medicare will pay for, I think it's like 17 or 18 different types of preventive medicine services. Maybe it's the E/M updates or some COVID-19 specific updates that came about last year that are specific to FQHCs. Now, there are many other to keep track of, but this is a great start.

Gary Lucas (00:37:30):

Next,, tip number four. Review commercial insurance participation contracts and emphasize the differences with CMS billing rules, because there has been for years an understandable pushback from some that especially providers and or managers that have not received a lot of in-depth FQHC or community health specific training. And they were told, "Well, wait a minute, buddy. I was told for years that we have to, 'Bill everybody the same.'" And that is just factually incorrect. You're going to treat everybody the same, therefore you should document it the same, therefore the coding is the same, but the moment we get into either a fee for service company that wants something on one claim form, Medicare wants it on a different claim form, we change and adjust the bills based on the coverage requirements of that particular carrier.

Gary Lucas (00:38:38):

Now, you do have to charge patients the same for the same codes, but billing is going to inherently be different. And allow me the opportunity to show you how some of the bills may change range based on a CPT code versus maybe one of those other codes. What are called the HCPCS Level II codes that were created by Medicare may be needed. So here we go. You all often report, I'm sorry, I'm Atlanta. I'm going to say you all. But you often or you may provide EKGs in your facility. There codes 93,000 through

93,010 that report either the entire EKG, right? Or just the technical component of the EKG, 93005 or the code for, "Hey, all I did was the interpretation and report of that 12 lead EKG." That's 9301.

Gary Lucas (00:39:47):

Well, commercial insurance companies may absolutely be perfect with code 9300 that says, "Hey, I did the technical component, meaning I own the equipment. And we did," excuse me, "The reading." So in that case, you only report 93000. Oh, wait a minute. But Medicare says when you bill for diagnostic tests like ultrasound or EKGs, radiology, that nothing on a Medicare claim requesting your per diem or your encounter rate can contain a code or any part of a code with a modifier that includes the technical component of a diagnostic test. That needs to be carved out, and while the office visit and interpretation of the EKG are included in your encounter rate for Medicare, that technical component needs to be billed separately, likely to part B Medicare to get paid fee for service.

Gary Lucas (00:40:59):

So right there, even using the same codes up there are going to be different by carrier, but look carefully. And let's see, did I put it up here? Yes. Let's get back to full screen here. What if I did that EKG as a part of an initial preventive physical exam? Medicare allows one screen EKG in the patient's lifetime, and if you used the CPT codes, it's going to be denied, whereas they may want one of or some of those G0403 to G0405 codes.

Gary Lucas (00:41:34):

On the left hand side, some commercial insurance companies might kick in a buck or two for 99000 for handling that lab specimen, not Medicare. And although these office visit codes are historically the codes that we use for office visits, those of you that know Medicare billing for a community health center realize that even though I did a 99215 level five established office visit, the first code on my claim has to be one of those what we call magic billing codes. Medicare doesn't pay a 99211, but so some carriers may.

Gary Lucas (00:42:15):

But wait a minute, in the T codes down here are some other nursing assessment codes that may only be used by Medicaid. And so I could make this slide look like a plate full of spaghetti, but this is how complicated billing is depending upon the insurance company and asking the carriers which one of or several of these are important to you? "Hey, how do you want us to report chronic care management? Do you want the CPT codes or since you're Medicaid and you pay us an encounter rate, they might want that code that Medicare wants instead G0511."

Gary Lucas (00:43:05):

Now, for those managers and providers that are like, "What in the world is this guy talking about?" This is the complexity that billers deal with. Imagine trying to submit a consistent set of bills across multiple providers who have been taught different levels or who have different levels of knowledge on the documentation requirements. There's sometimes a lot of pressure on them. We have vaccine administration codes unless it's Medicare and we're doing NUMO or Hep B, welcome to the wonderful wild wacky world of billing.

Gary Lucas (00:43:37):

What about when we get to comparing and contrasting Medicare's definition of how we get paid for procedures? When we get paid for procedures in the CPT that begin with the number one, two, three, four, five or six, the AMA has one definition of what's included in all of those codes. How and when can we get paid for preop work? How often can we get paid for postoperative work? Then we have Medicare's definition. So the CPT definitions in the CPT book, the question you have to ask commercial insurance companies is as, "Hey, when we are reporting procedures, do you use the AMAs definition of the surgical package or do you use Medicare's or," ladies and gentlemen, "Do you use your own?"

Gary Lucas (00:44:34):

Because several of you might be aware for example, that let's say your community health provider goes and delivers a baby or goes to the hospital and does a total hip replacement or a hysterectomy or some major service. You may have heard that Medicare has what you hear of as a 90 day global period. Meaning when we get paid for the procedure, not only are we getting paid for prepping the patient, not only are we getting paid for the procedure, but we've already been paid for the 90 days of follow up.

Gary Lucas (00:45:09):

Well, wait a minute, not in an FQHC. Even though that 10 day surgical package, if it's a minor procedure or 90 day, you hear 90 day global package and it's a Medicare patient, they have Medicare part B. If you are a community health center, section 40.4 of chapter thirteen's guideline right here says the Medicare global billing requirements do not apply to you and I. So it's a complex discussion to have. You may recognize slide 24 as a summary of Medicare surgical package definition, but you are going to be using it for third party payers and not Medicare.

Gary Lucas (00:46:02):

Now, in the one and a half hours we have here doing a top 10 list, obviously we can't do a huge deep dive here, but be careful when I talked about a 90 day global, maybe that insurance company says, "Yeah, we use Medicare's definition." Well, it's actually 92 days because the day of or day before is included and the procedure, and then 90 days of follow up. I think some of the most significant revenue opportunities for community health deals with the performance of minor and major procedures, both in your office or outside of your facility to non-Medicare carriers. Because many of you often have to get on the telephone and call an insurance company to get prior approval. And you give them all the information they need and they say, "Okay, here is your referral number. Here is preauthorization number, put it on the claim and will pay you for that service."

Gary Lucas (00:47:00):

What you need to say is, "Hey, insurance company, before I hang up, how many days of global or postop at least how many days of postop is included in that procedure when we bill it?" What is their answer? "Please hold," because they may not know. Maybe it's 60 days, so you can start billing for follow up after the 60th day. Maybe it's 120 days. That's where a lot of our money is hidden if we don't ask commercial insurance companies at a macro level, and sometimes even on a claim by claim perspective what their preferences are.

Gary Lucas (00:47:39):

And so, again, we're not going to review each bullet here, but slide 25 is going to go into some of where these modifiers might live. You don't need a bunch of modifiers on Medicare claims. You just simply don't, not many at all. But you better believe commercial insurance companies want them. And almost

each and every one of these modifiers goes back to this idea of which surgical package they use. So there's many other possible issues that are occurring out there, but we are going to move ahead to tip number five.

Gary Lucas (00:48:20):

Perform periodic internal E/M audits on those new guidelines. Hopefully, each and every one of you are as excited as all the people on this slide. Hopefully, we're making this a bit more engaging than a lot of your traditional webinars. So we appreciate you taking time from your day here today. But one of the main things I want to share with you here on the left hand side is that the current 2022 guidelines for office or outpatient visits changed how you determine your level of service effective last year and continued into this year.

Gary Lucas (00:49:03):

Now, we are not worried about what level of history did our providers document, and I'll get the box out of the way of this bottom item in just a moment. But man, for those of you that have been around for years as providers and coders and billers, we used to for office visits, have to do a lot of training on how was your documentation of history determined? How many elements from the history of present illness were present? How many systems did you review? How many items from past family and social history were documented? Oh, and it's different. If it's a new or an established patient.

Gary Lucas (00:49:42):

Those guidelines are now gone for eight of your most common CPT codes, in that you now perform a medically appropriate history or exam. You don't have to worry about what we're called those 1995 and 1997 guidelines, which by the way, still apply to non officer outpatient visits, whoops, sorry about that. But for 2022, here we go. We will now use time or medical decision making to determine our level of service.

Gary Lucas (00:50:21):

But we have to understand what is included in time. Is it just the time we spend face to face with the patient? And what does medical decision making mean? So this is the crux of tip number five. So hopefully, you've analyzed your evaluation and management code patterns. It looks like this provider is reporting a lot more 99215s than their peers. They probably need some education because I'll bet you had some nurse visits here, I wouldn't eliminate a low code just because we have complex patients. We don't bill based on our ICD-10 code, we bill now based on the decision making that was involved.

Gary Lucas (00:51:08):

And so understanding the variance your providers may have with their peers does not automatically mean they're doing something wrong, but it does justify not waiting until an insurance company says, "Give me 40 dates of service, we're going to look and make sure you have documented what you bill for and got paid for." But rather, you're using your provider's own notes to provide case studies on patients they're familiar with that may identify when they code not only higher than they document, but I pose to you many providers code themselves lower than they should.

Gary Lucas (00:51:49):

So as you look at an overview of the 2021 and 2022 changes, as I mentioned, the required levels of history and exam became obsolete, but only for those eight codes, new officer outpatient visits and established officer outpatient visit. 99201, the lowest level E/M for a new patient was deleted. And remember for Medicare, I should say 99211 doesn't require physician presence. So you're going to report services based on time or decision making. And here's the key, medical decision making was greatly updated. It will require the most research, the most updates to your EHR templates and potentially updated training for providers, all right?

Gary Lucas (00:52:43):

Look at this one right here, man this is a biggie. Unlike in the past, whoops, let me go this way. Unlike in the past, when we spoke with providers that there were opportunities to code higher, if over half of your encounter was spent counseling the patient or coordinating the care with other providers. Well, that rule about counseling and coordination of care impacting your level of service was only the time the provider spent face to face with the patient.

Gary Lucas (00:53:16):

Now, in 2021 and carrying over to 2022, time is now defined as the total time, look at this, spent on the date of the encounter and may include many non face to face services done on that same day. And doesn't require time to be dominated by counseling and or coordination of care. So let's look at and see what's included when your providers are reporting 99202 to 99215, be it to Medicare or commercial insurance companies because these changes took place in the CPT book, they apply to all carriers.

Gary Lucas (00:54:01):

But I think it's a safe bet that even though I'm thinking about this like a paper for chunk, we grab a prop here, that before your provider walks into the exam room, whether your chart is paper or electronic, the concept here is the same. They're going to maybe grab that chart and they're going to look at the last couple dates of service, right? To help reorient themselves with the treatment plan. They might go look at the report from the cardiologist and the mental health provider. They might go look at the labs and they do a lot of work before they walk in that encounter.

Gary Lucas (00:54:38):

Well, now starting in 2021, the time spent preparing to see the patient is included. So whether you're thinking about your PE coach with their stopwatch around their neck or you're thinking about Flavor Flav with his alarm clock around his neck, whatever visual image works for you here, I bet you didn't expect Flavor Flav to be discussed in a coding and billing session. What you'll find is we are going to not ask your providers to be nose down into a clock, but recognize that the work they're getting paid for now includes a lot more than is done just looking at the patient and documenting in the medical record.

Gary Lucas (00:55:24):

So it's the time they spend preparing to see the patient, the time the provider spends reviewing or obtaining a separately obtained history. If the nurses in the exam room gathering the history, the provider's time, the PA the NP, the MD, that clock's not ticking. But the time I spend even looking at it before I walk in the exam room, the clock is ticking. The time I spent performing a medically appropriate exam included. The time I spent counseling and educating the patient family or caregiver, now, by the way, in the past, if I left the patient in the office and went out to the waiting room to talk to a family member, that didn't count as counseling, because it wasn't done face to face with the patient.

Gary Lucas (00:56:13):

Now, anything done on the date of the encounter, even if it's not face to face with the patient is included. The time spent, let me get my picture out of the way here. The time spent ordering medications, tests and procedures, by the way, you may close the office at 4:00, the provider goes into their office and then goes in and orders everybody's meds and orders tests and procedures. The clock is ticky. If that takes 10 minutes for one patient to complete. The time spent referring and communicating with other professionals on that date is included, and look at this one.

Gary Lucas (00:56:53):

If we can establish a process by which our providers have enough time to complete their documentation, maybe that's giving them more office hours, who knows. Fewer patients, that's obviously dependent upon your patient flow, et cetera. But even if that's them going home and at 10:00 o'clock at night, before they wind down for the night, they go complete a couple of those notes. That time alone could increase the code for those things that were not done face to face with the patient.

Gary Lucas (00:57:22):

Now, if I complete the note tomorrow, I'm out of luck. But the time spent actually documenting in the record, even if it's after the patient's visit is included. So independently interpreting results, et cetera, and the care coordination that may be necessary is potentially included. So please take these ideas, excuse me, with you as you also increase your provider's awareness of medical decision making. Those terms were adjusted as I'm sharing with you on slide 31, a good thorough review of medical decision making in and of itself could likely take at least 30 minutes to an hour.

Gary Lucas (00:58:07):

So the source information for all of this surprise, surprise is back there in that CPT book, there's about 15 pages in the CPT book, not visible in an EHR, not licensed by the AMA to be printed anywhere else are vital. Now, what I'm going to show with you on slide 32, it's going to be hard to read depending upon your monitor size, but it's going to be the AMA's version of how we look at the number and complexity of problems and the mountain complexity of data and the risks of complication.

Gary Lucas (00:58:45):

I'll bet you, just looking at this one, some provider visits that are being coded as a level two or three maybe a four, maybe a five through proper application of these updated guidelines. Even if the time you spent with the patient was associated with a level two visit. By properly documenting what was done, you might end up with a level four visit, but making sure that documentation is present should only be done or is best done by having the providers review their own notes based on our review of what a Medicare auditor may say.

Gary Lucas (00:59:21):

So we anticipated group six through 10 to be done a little quicker. So what I want to do is outline the concept of reporting diagnoses in order of importance and linking those diagnoses while considering the impact on which claim form we're using. You see a lot of these issues towards the end, we've already hinted at, at the beginning of our discussion. Such as educating providers on the ICD-10 guidelines, and only reporting the diagnoses that were documented on that date of service. For example, providers although some managed care companies have been harping for years that at least once a year you need

to give them a listing of every diagnosis the patient has that causes claim backup and confusion when billers, although that patient might have four, five, six diagnoses, you only saw them for this little cut on their forehead today, then that is likely the only diagnosis that goes on the claim form, unless there were other diagnoses documented as affecting payer.

Gary Lucas (01:00:30):

But when you give billing two or three procedures and three, four, five, six, eight diagnoses, that biller A, may not have access to the medical record. B, may not have the clinical information or understanding to know what goes with what and the claims just get denied because I'm pressured to get the claim out. Keep this in mind as we move forward.

Gary Lucas (01:00:54):

Tip eight, knowing the differences between the CPTs and Medicares preventive guidelines and those quote, "Sometimes covered G codes." We'll give you an outline of those, we'll then compare and contrast traditional telehealth services with virtual communication services to help you get paid for a lot of things that you're doing in between visits and will end with you being able to maintain as much awareness of when other providers admit and discharge your patients by performing transitional care management that cannot only help you with reimbursement, but most importantly, making that other providers let you know when your patients are put in the hospital so you don't have to find out on their next visit three weeks from now.

Gary Lucas (01:01:51):

And there was a potential that the medications they received in the facility conflict with your treatments. For example, substance use disorders and patients that just went into the facility last week for back pain and we're prescribed opioids. We'll give you this outline, we'll make sure to finish on time and leave a little room for questions. We've got about another 27 minutes to go, so I think we're doing great on time.

Gary Lucas (01:02:18):

So here's tip six, report diagnoses carefully and link them to the tests and procedures depending upon which claim form you'll be billing on. Now, by the way, I have to even mention this right now. I don't expect providers to know which claim form we're reporting the services on. I wouldn't mind if they had an understanding of the impact of what we're talking about.

Gary Lucas (01:02:42):

So even though one of the claim forms, namely the one we build Medicare for most of our covered services for doesn't require us to link the diagnoses managers, you should have a policy that dictates that it be done in all cases. Let's visit the tip number six. Here are the claim forms that you deal with. Now, I know you don't submit paper forms, but most folks call these by the form number. The CMS 1500 form used by FQHC that are getting fee for service claims to commercial insurance companies, and probably most non-Medicare carriers versus the CMS 1450 form, which is used by an FQHC submitting claims for most Medicare services.

Gary Lucas (01:03:33):

Well, watch what I'm about to add please on slide 35. Now, might be a little tough depending on your monitor size, but the diagnoses that you give me as a provider, I put in this neighborhood of the claim form and there's 12 different line items, please, please, please, please, please. And in case I forget to mention it, please only list the diagnosis on today's claim that we're documented it in the record is affecting care on today's visit. If the patient has hypertension, diabetes and gout, and it has nothing to do with that little cut on their forehead, they likely do not need to be included on the form.

Gary Lucas (01:04:15):

At the bottom of the claim form is where I put the what did I do. But you notice these arrow, whoops, drive you to link those diagnosis codes in order of importance. Now, watch the difference here. It doesn't matter what order I put the diagnosis in down here. Matters which ones I bring to each CPT code and in what order versus the right hand side. Now, let me just stop here for a brief moment. Because from the coding and billing perspective, let's say I had a primary care provider and a mental health provider. Each did a service on the same day to the same patient, irrespective of insurance.

Gary Lucas (01:05:01):

If it's a commercial insurance company, each provider will send out his or her own claim form. Whoop, see if I can point the correct direction. Nope, that way, on their own 1500 form. But what if this was a Medicare patient and we have a medical visit and a mental health visit on the same day? In that case, we're going to submit one claim form, this one, right, oops. This one right over here with everybody's services on it. So check this example out, please.

Gary Lucas (01:05:32):

Over on the right hand side, all of the codes done by all providers are listed up top. Each of the diagnosis codes from all of your providers are listed there and never the twain shall meet. There is no requirement to link the diagnosis. So clearly the biggest revenue issue is likely going to be for all of your non-Medicare insurance companies. Let's look at a sample. Here's your primary care provider listing opioid dependence, depression and screening for a mental and behavioral disorder. Let me say it again. It does not matter, excuse me, what order those diagnoses are listed up there. What matters is how am I bringing them down.

Gary Lucas (01:06:21):

The office visit may have been done by the primary care provider, first for opioid dependence. Maybe they provide buprenorphine, Suboxone, naltrexone, whatever, to a patient because they have opioid dependence. And in that documentation, they mentioned the patient also suffers from depression. So they should both be listed. But the primary reason that visit was done was opioid dependence. They did a health and behavioral assessment, actually that's an injection there. So pardon that example there, but notice that's A and B.

Gary Lucas (01:06:59):

When right here, this other code should have been 96127. So that's my apology there, 96127. Whereas here on the same day, the mental health provider did 30 minutes of inside oriented or behavior supporting psychotherapy. And although they did mention opioid dependence in their documentation for psychotherapy, the primary reason that service was done was for depression. So we went from a AB to a BA and that has everything to do with whether you're going to get paid or not, just that movement is vital.

Gary Lucas (01:07:43):

Whereas whoops, on the claim form, if it's an FQHC providing a service to Medicare everybody's services go at the top, everybody's diagnoses go at the bottom and we should be able to generate two encounters as Medicare does allow a medical and a mental health visit on the same day, assuming all other guidelines are met. That it's done by an authorized provider, et cetera on that claim form, but I don't have to link these diagnoses at all.

Gary Lucas (01:08:12):

So I bet there's somebody in the office spending a lot of time going back and changing or adjusting or moving these diagnoses on your fee for service claims that ladies and gentlemen is a vital tip when it really comes down to brass tax on why we may be getting denied for services that we feel like we've reported correctly.

Gary Lucas (01:08:33):

All right, let's keep moving here. Whoops. And then you see at the top, those items are not linked. So what I've done here again, is outline for you some places in this particular case for chapter nine and notice how they combine rural health clinics and FQHCs together. But section 50 and section 60 will be your follow up items there for you for additional research.

Gary Lucas (01:09:00):

Tip seven. I hope this format is beneficial for you, that it's fast paced enough to be interesting and it may also identify additional training you may need. We'll talk about that at the end of the session. Next, educating providers on the actual quote, "2022 ICD-10 Official Guidelines for Coding and Reporting." So my assumption and my prerequisite is that I hope you have already confirmed to notice which set of, let me rephrase that, how different it may be navigating the index of the ICD-10 in the manual versus in the actual index or keyword search that they provide.

Gary Lucas (01:09:55):

But heads up, in or 2022 manual, you may have last year's guidelines. So the overall issue here is making sure that whatever method your providers are using to report a diagnosis code that is not already listed on their encounter form, is your provider doing more than just finding something an in an index? The ICD-10 book is broken into two halves. Half is an index, the other half is the listing of codes. The guideline state don't code from an index. You have to actually go look at the full code to make sure there are not better options available and an understanding of which codes need to be primary or is there another code needed.

Gary Lucas (01:10:40):

And what I've called this down on the bottom is making sure that they can locate what we call the base code notes, because clicking on a diagnosis in an index search is easy without seeing if it matches the actual documentation. Here's a sample. Although my provider might do a very detailed index look and they have a patient who has an arthropathy following intestinal bypass of the right shoulder. The question is, do they have the ability to click on something to find these notes? Because by the way, there could be 433 codes that all start with M02, but for every one of those codes, look at this, the book is telling you code first the underlying condition.

Gary Lucas (01:11:32):

Now, go back and picture that claim form where if we have whatever A, B or BA that may determine whether or we get paid or not. This is the information on where the guidelines will be valuable. It also tells you which ones to not diagnose at the same time as any code beginning M02, those excludes notes. Another sample, we may have found a patient with age related osteoporosis with current pathological fracture. But wait a minute, they may only pull up the code for the initial encounter, when in fact maybe the patient was seen at the ER, the ER is going to report the initial encounter because the emergency room is the one that did the active treatment when in fact we're only seeing the patient during the period of healing and recovery.

Gary Lucas (01:12:32):

Today, I wouldn't expect that to cause a significant amount of denials, but it may be and could be in the future and we want to avoid making it appear like we did an active treatment on that day, as opposed to seeing them during healing and recovery. So when you get the opportunity to go look at those guidelines folks from your provider's perspective, actually let me go back a slide too, look up here. Use additional code.

Gary Lucas (01:13:05):

Maybe we don't get paid if we only use one, we may need that other if documented correctly. So understanding code first, the underlying condition, use additional codes, et cetera. Heck, did you know that the word and in the ICD-10 actually means and or you will only find that in section one Subsection A number eight of the official guidelines. So clearly there's a more need for further a training, section B is only a couple pages that's going to give you access to a lot of important information.

Gary Lucas (01:13:44):

Section A was about a page and a half. This is about two pages so it's not a tremendously overwhelming amount of information to review, but compared to section C, which gives you chapter specific guidelines where you may have questions on mental and behavioral disorders, you need to know how to code hypertension or diabetes, et cetera, or "Hey, which of those Z codes must be a primary diagnosis." There's a whole list of stuff back there.

Gary Lucas (01:14:19):

So we need to finish up here folks tip eight, knowing the differences between CPT preventive services and the sometimes covered G codes. So before your providers consider the CPTs preventive codes. Go access that link I gave you earlier on Medicare's preventive and screening services to get information on those quote, "Sometimes covered diagnoses." All right. Here's a summary, this is not a full list. This is just a set of sample guidelines. And even though you'll often find Medicare group FQHCs and RHCS or rural health clinics together, there is some unique specific information just for FQHCs.

Gary Lucas (01:15:09):

So for example, you can report diabetes, self management training and medical nutrition therapy, but a rural health clinic can't. So who can participate in an initial preventive physical exam, which is very different than the annual wellness visit? By the way, that's a physical exam. The annual wellness visit I've heard called a keep your clothes on visit. It doesn't even include a physical exam. How often does Medicare pay for the breast and or cervical cancer exam, smoking cessation, digital rectal exam versus

prostate cancer screening, alcohol and depression screening, et cetera? That comes from that chapter 18, but the most important or one of the most important sources for you with Medicare is right here.

Gary Lucas (01:16:00):

This is a link. This whole picture here is a hyperlink, so see if I can hover over it. You see that hyperlink pops up and it will tell you Medicare preventive service chart, whether those codes will be paid under the PPS methodology, you might be entitled to a 34% increase over your PPS rate, whether or not the coinsurance is waived and where in chapter nine and chapter 18 can you find additional information? Chapter nine, section 70.3 and chapter 13, sections 220.3 will also lead you to great educational materials.

Gary Lucas (01:16:47):

Last two item folks, we're going to keep this right on target with time. Compare and contrast telehealth service and virtual communication services. They are different. We have to use caution in making these all fall into the category of E-visits because they are different. So let's compare and contrast telemedicine, which is typically prescheduled using code G2025, now that's for Medicare.

Gary Lucas (01:17:25):

We did not in previous years have to use modify or 95. Every indication I'm getting for 2022 is actually that you may need to use modify or 95 or if it's an audio only visit maybe the new modify FQ cetera. But you do want to go check for periodic updates that Medicare makes to their list of telehealth services, which was last of updated a couple weeks ago. And the main source document for Medicare telehealth visit is linked right there.

Gary Lucas (01:17:59):

Typically, prescheduled. Usually takes place with audio and video, but hold that thought, we'll take a quick peek about that list looks like in a moment, but I want to distinguish telehealth visits where I see PA Jones in the hallway. "Hey, don't forget you've got a telehealth visit at 2:30." Different than me going over the intercom, "PA Jones, you've got a patient on the phone doing a virtual check in." Or their EHR gives them a trigger, "Hey, patient Smith uploaded audio and video of that potential spider bite." Or, "They showed a picture of them taking their Suboxone where there's going to be different codes."

Gary Lucas (01:18:47):

What commercial insurance might have wanted with the G2010 and G2012. Notice community health uses code G0071, payment is about 24 bucks for virtual communication services. In order to know the difference, here's the list of CMF or a obviously short version of what CMS approves and notice that something we've never been able to report. This is just two examples are now reimbursable during the public health emergency using code G2025, likely with modifier 95 to indicate that we get paid for telehealth visits.

Gary Lucas (01:19:39):

During the public health emergency, the same as all other fee for service providers, and that means there's several things we have not been able to report for a long, long time. So this list will give you how often and how long that code will be on the list. And also are you allowed to do these services with

audio only, which might correspond to this new modifier FQ, but as of the date of today's course, it's still a little bit unclear as to which modifier may be needed.

Gary Lucas (01:20:12):

You have questions on virtual communication services, I've given you two sets of guidelines here, or I should say access to two hyperlinks. And the virtual communication services were designed as a part of the patients over paperwork initiative to prevent patients, especially those who have to travel a significant distance to see you or there's difficulties getting to you to potentially eliminate the need for a face to face visit.

Gary Lucas (01:20:42):

You see virtual communication services are initiated by patient and you'll see different codes for commercial insurance than you may for Medicare, we've established that theme. And I'm going to give you a couple slides here, slide 57 for virtual check-ins and some additional areas of research in chapter nine and chapter 13 on both telehealth and virtual communication services. So you can get properly paid for non face to face visits.

Gary Lucas (01:21:19):

Lastly, folks tip 10, increase your clinical awareness and reimbursement through transitional care management, whose purpose is shared across a variety of facility types designed by Medicare to lower preventable hospital readmissions. To establish a smooth transition from an inpatient stay by you establishing a coordinated plan even if another provider admits and discharges your patients that you reach to them within two days of the discharge with a nurse or somebody clinical, because you're going to be performing some medication reconciliation, understanding what services they were ordered to receive, et cetera.

Gary Lucas (01:22:04):

And as long as that patient is not readmitted for that same reason in the next 30 days, you may be able to be reimbursed for transitional care management and in 20, whoops, and in 2022 Medicare now allows this year for the first time for you to report transitional care management at the same time as other care management services that may have been provided. So before you report the transitional management codes 99495 and 99496, you need to make sure that you're meeting each of these guidelines and identifying new and revised prescriptions, et cetera.

Gary Lucas (01:22:44):

Well folks, here's your coding based on not only communicating to the patient within two days, but that you then schedule an in-person visit based on decision making. Remember we talked about that briefly a while ago in order to schedule that face to face visit and get paid for transitional care management. Folks, looking at my time, let's see here, we've got about five minutes for questions. Philip, I'd like to turn it back over to you for any closing comments, please. And or any questions that you may have. And if you'll bear with me, for some reason, I've got about four people getting ready to knock on my front door. If I could borrow 38 seconds from you so they don't ring the doorbell, I'll be right back.

Philip Stringfield (01:23:32):

Awesome. Well, while we take that quick break, we want to thank Gary Lucas with ArchProCoding for this great presentation and getting everything in all these top 10 tips within this given time. I do want to make sure that we do make time for a couple of questions. And for those that are staying on the line, waiting for the CEU information, we will give it out in just a few minutes. So if you're able to stick with us, we'll make sure to put it on the chat. And then I have to confirm with my team if we're allowed to verbalize it as well. So that way we can give you the index number and you can self report on your own. So with that, I'm just going to take a quick look at the question and wait for Gary to return and we'll get started on the questions.

Gary Lucas (01:24:20):

Yeah, go ahead, shoot.

Philip Stringfield (01:24:23):

Awesome. So the first one that came in, well, I'm just going to go through a couple of them because we can't really just do the first one. We had a total of 21 questions come in, so thanks everyone for your questions. So one question they wanted to know your opinion on using resources, such as codify through the AAPC in lieu of our hard copy coding manuals.

Gary Lucas (01:24:51):

Excellent. Short version is that those are shortcuts, right? We like shortcuts. Shortcuts are helpful. But as I told my oldest son, when he got old enough to walk to school and go by his buddy's house after school or drop by the convenience store to get a Coke or something. I said, "Buddy, the first thing I'm going to do," well, I said, "Let me tell you this. I'm going to teach you every shortcut you need to know if it starts raining or zombies attack, I'll tell you whose yards you can cut through. I'll tell you whose house you can throw a chair through their window to get saved by the zombies." I said, "But the first thing I'm going to do is teach you the right way to do it."

Gary Lucas (01:25:29):

And when I go out this CPT book, there are a lot of wonderful tools. I'm not going to pick any of them out at all. Every one of those tools takes the CPT book and they are licensed to use the CPT code number and the CPT definition. The AMA does not license to anybody, let's see if I got lucky here. But for anybody, for example, the eight paragraphs of information in the CPT book that tell you when you can report and code preventive medicine services at the same time as an office visit.

Gary Lucas (01:26:02):

The AMA only puts that information in the printed manual. So the CPT book, I have to have a printed copy period. HCPCS Level II code book, because they only have codes and not a lot of definitions, as long as you know what keyword to type in, you'll find what you're looking for. But I think if you have that code book or at least online, you can go look at all of your G codes, all of your T codes or if you're doing substance and opioid use all of your H codes. That one may be not as much on the ICD-10, it depends on your provider's level of experience. So I don't mind using all of those at shortcuts, but if we haven't taught providers, managers and coders and billers the right way from the source material, it's incredibly difficult. So they are supportive shortcuts, not substitutes.

Philip Stringfield (01:26:58):

And then we'll end with just this one last question, and then we'll go ahead and include Gary's information and my contact information in case you would like to submit your questions outside of this webinar today. So for a more technical question, I guess we'll go with this one. It says, "Does the G0071 get billed to part on A, on a UB form or on a 1500 to part B?"

Gary Lucas (01:27:24):

Gut says it's going on that darn UB form. I know it's kind of a weird way to think about it, but it gets confusing when you say do you build part A or part B. Keep in mind, we and community health centers, we are part B providers, period. The only reason your credentialed with part A is because part A knows how to pay daily encounter rates. But top of my head, I'm saying, it's going to go out on that UB form just as per normal to get a $24 payment. I may need to double check that one, but that is a covered FQHC service that likely is going to be reported in that manner. It just won't generate the full payment, but I need to look that one up. That's a good question, and I don't want to answer, even if I've got a microscopic piece of hesitation there.

Philip Stringfield (01:28:14):

Perfect. Well, thank you for that, Gary. Thanks everyone for submitting their questions and attending. So we're going to go ahead and conclude today's webinar session.