Alma:

It is my pleasure to introduce you to our distinguished presenter for today's 2024 Coding and Documentation series, part one, Mr. Gary Lucas from Arch Pro Coding. Gary brings, again a wealth of expertise and experience to our stage and we are fortunate to have him guide us through the intricacies and the updates. So get ready for a very insightful session that promises to elevate our understanding and skills.

Gary Lucas:

And I'd like to say thank you on behalf of the Association for Rural and Community Health Professional Coding. And most importantly to our friends and colleagues at NAC in giving me the opportunity to teach the top five documentation and revenue tips in community health. Now, of course, my top five may be different than your top five, and there's clearly enough information in our aspect thinking about documentation and professional coding and billing and revenue cycle. For example, although I am located, or excuse me, I live in Atlanta. I am in Mississippi right now providing and just finished a two day 10 hour boot camp that is focused on just helping folks become community health coding and billing specialists. I have this session today, and yes, two more hours to teach this afternoon for the Rural Communities Opioid Response Program. So my experiences on the bottom there.

Should I not get to your questions at the end of the session, considering we're going to be well over 600 folks by the time we get started, please feel free to reach out to my email address gary@archprocoding.com. And again, the Arch stands for the Association for Rural and Community Health, but it's a little easier way to say it. If my video gets a little laggy or something happens, drop a note to our hosts and I might just drop my video. I'm in a hotel room with not wonderful lighting, but I hope everything is going well with you. The audience, we were very impressed to see a pretty wide variety of folks in this session. Of course, one of the challenges over time is to get the providers whose time is of course extremely valuable, but we can talk coding and billing. We can get into the revenue side all day long, but everything we do is based or not on the presence of documentation being presented according to the guidelines that, let's be honest, some providers don't see.

From the AMA when we're talking the CPT. From Medicare when we talk HCPCS level two codes. And on the reimbursement side, of course, we have different billing using different claim forms when we're billing Medicare versus commercial insurance. So having providers be aware of the standard nature of their documentation is going to allow a health center manager to negotiate Medicaid contracts to become a member of an accountable care organization and recognize the valued role of professional coding. Clinic and health center managers, we welcome you have a tough job to balance both the clinical and the business goals of your facility. We hope to provide you with some insights into some 2024 issues or some that have carried on over the years, excuse me, and will continue. Now, one of the items we're going to be very clear on here at the beginning is the very important distinction between coding and billing. I've had 29 years in this industry. I write the nation's only certification exam for folks to be community health coding and billing specialists.

Keep in mind, we want you to hire certified coders folks, but as we move into this era of new EHRs and new IT systems, new quality reporting initiatives and things of the sort, establishing a shared foundation of knowledge between each of these folks is my primary goal. Now, of course, how we do that on your EHR and your IT infrastructure is a question we really can't answer, but what I want to be confident of is the statement that most folks teach. Before we dive into my top five tips for this year is that we've all probably heard this statement. And providers have certainly heard it from many folks in the revenue cycle. Hey, if you didn't document it, it didn't happen, but I firmly disagree. I urge you to consider

continuing to be a part of this movement because a lot of providers are reticent to get some of this training because that phrase quite honestly is not true.

And actually, if I want to be picky on myself here, you can still get paid for the service. The point is we can't keep it if upon a review or an audit, we don't have the documentation to support that service. So when you're thinking about the right-hand side there and you're considering the ideas, what level of professional coding responsibilities do you give your providers versus the revenue cycle staff. That changes a lot of the education and who we get this information back to. I think it's a safe bet that many folks ask their providers to give the revenue cycle staff a quick overview of what services were performed. Maybe you did an office visit, level four, maybe you did a joint injection of Synvisc and maybe you did an impacted earwax removal. Well, the question is, does the revenue cycle staff get that information and compare a closed medical record that allows a professional coder to confirm the documentation is in fact present?

Now, one school of thought is, "Hey, let's let providers document and let professional coders code." But more and more professionals on the clinical side are being asked to perform coding responsibilities. And unfortunately we've discovered over the years that the EHR does not necessarily provide those functions for us. So either inform providers of their coding issues or make sure they complete their note. But keep in mind when we talk about a general staffing question is how experienced is your coding and billing staff with the many nuances of documentation and especially billing in a federally qualified health center? So if you're thinking coding, coding turns documentation into usable data, whether we get paid for it or not, we have to document and capture many items that we won't get paid for via traditional revenue cycle activities like certain vaccine services if the patient doesn't see an authorized provider, but we get paid through our cost report.

A very unique and nuanced issue that those in regular private practice don't deal with. Keep in mind if you have a certified coder that is performing billing responsibilities, there was not one question on their coding exam on how to turn those codes into proper revenue. Even though there are some billing certifications out there in order to establish the theme before we get into the top five tips. Even though there are some billing certifications out there, keep in mind they likely had no questions about the unique issues that we deal with. So our focus in this session, as you see in the bottom right-hand box, is going to identify how to research and interpret and apply the ever adapting rules that are set forth by those that create the books and pay our claims. So regardless of where you find yourself, I described this as our common path.

Some of the issues that we talk about today are going to come down to, okay, what makes us different as an FQHC, how does the insurance the patient has change the claim form and how we get paid? Of course, a big focus in general education is how we treat and document. The issue is, does your facility truly perform forgetting about billing a professional coding review of a closed medical record? Because sometimes, and if any of you are in this situation, you know how tricky this gets. People in billing are told to use the information the providers give them to submit the bill. Maybe the billing folks are asked to submit a bill within let's say 48 hours of the encounter. But wait a minute, the providers through no fault of their own may not have that documentation completed for three or four days. So if you're using a provider's preliminary coding information to submit a bill before that note is closed and before that encounter receives a professional coding review, we're obviously holding ourselves up for some risk.

And my goal in this session, folks, as in all sessions that I teach, is to assist you in getting a hundred percent of the revenue you're entitled to, but no more than you're allowed, realizing that we will bill patients differently based on their insurance. Now you have to charge them the same, but some claims are submitted on a UB claim form. We get paid our PPS rate. When we bill a commercial insurance, it goes out on a 1500 form and we get paid fee for service. Heck, you might be a member of an

accountable care organization that itself is receiving per member per month payments from insurance companies. So keeping that in mind, if you ask questions in the Q&A box, is it a documentation question? Is it a coding question? Or if it's a billing question, are you asking Medicare commercial carriers or of course there's about 140 different Medicaid programs out there and we can't dive too deeply into that.

But where Medicare goes with billing rules and regulations, many if not most, insurance entities over time tend to follow. So obviously keeping track of our 2024 updates in no particular order. Tip number one, let's review at a high level some of these updates, and it's a little bit of a busy slide folks, but this comes at the very bottom from the Medicare physician fee schedule, which is a fact sheet that summarizes over, I think it's 2200 pages of information from Congress linked to appear on the physician fee schedule. Now, these items are specific to UNI and FQHCs, but as you've noticed over your career or if you're new to the world of community health or FQHCs, they tend to group our friends in rural health clinics along with us with some minor differences that I'll point out. Now, good news, I'll start with the first bullet, of course.

We are able to now continue to get reimbursed for telehealth services, finalizing some issues and potential deadlines that we have now gone past. And of course, telehealth is a supplement to care, not a substitute for care. But I warn you, in addition to some factual information I'll give today, I do have a couple opinions. But please note that regular fee for service doctor's offices had the ability to report telehealth for a couple years before we did, before COVID. It took a public health emergency to be included in our reimbursement. We'll elaborate on some of those issues as we move forward, but the good news is we have received an extension confirming telehealth for both medical and mental health services should continue, depending upon whether it's medical or mental health to the end of this year, if not the end of the next. There's been an issue that has kind of concerned mental health providers because last year they had been banting about an issue that would require any of you performing telehealth on mental health patients, telehealth mental health patients.

That they would periodically be a need to perform in-person visits to both initiate that care. And as I recall, one of the proposals was every six months to have a face-to-face visit, which I'm not a clinician, but it seems pretty reasonable to me. But again, we take care of people in underserved areas, so sometimes that gets a little bit clear. Now, I'll try to answer some of these live keeping my focus, but Dallas asks a great question. When I say telehealth, do I mean synchronous video and audio? It says, my understanding that telephone visits are no longer covered by the extension. Well, I don't want to dive too deeply, but I do want to answer his question. And that is that CMS puts a list out that as of my last recollection was updated on November 13th of last year, that identifies the services that may be performed via telehealth. Well, one of the columns over to the right, it's probably the third or fourth column on every version of that CMS covered list indicates which of those services can be done via audio only.

So the audio only issues, there are services, interestingly enough, most of them are mental health services, but there are office visits on that list, and a medical telehealth visit will still be reported with code G2025. Unlike the way we bill commercial insurance, we use what I call an umbrella code. If we perform the service on the CMS list of covered telehealth services on a Medicare patient, and that column says, "Yes, audio only is allowed." It's not just mental health services, it does include medical. You may continue to report that and get paid this year instead of 89 dollars and change about 95 dollars and change split between 80% from Medicare and 20% from the patient. The code you may be thinking of Dallas were those that were in the CPT for telephone only services, but those codes were patient-initiated, not pre-scheduled telehealth. So virtual communication services and telehealth sometimes get understandably overlapped.

We may provide medical and, so depending upon which service you're looking at and when you're looking at that service, my point is use the list, which by the way could change tomorrow and you may perform telehealth if the CMS list allows it. Okay, so that's the general idea here. We'll talk about additional services, but the anonymous attendee has identified an issue that will expand upon shortly. But of course, good news that marriage and family therapists and mental health counselors as of 2024 have been allowed to be FQHC authorized providers adding to the list of MDs, PA, NP, nurse midwife, clinical psychologist, and clinical social worker. And believe it or not, in an FQHC, but not an RHC, registered nutritionists and dieticians that in some cases might perform diabetes, self-management training and medical nutrition therapy. Well, welcome to a wonderful world of reporting services.

2023 allowed these folks to be authorized providers in regular fee for service offices, all right? However, it took another year and literally Congress had to go in along with CMS's input, receive public comments, and it took them a year. But we are now able to get these folks credentialed and enrolled and privileged and expand our provider types. We've had many folks like LPCs, licensed professional counselors, and folks, there is very little consistency across different states in what this category of mental health counselors is kind of a broad category. You probably don't have folks listed as an MHC. I'll give you some information that allows you to confirm whether your LPC or your LCSW or your EIEIO or your BINGO counts as a mental health counselor to possibly include addiction counselors in some states and in some areas. So that update is positive. So if you have these folks, no longer are they just a valued member of the clinical team, they may be a more direct reimbursable member of the clinical team. All right, so different services on that list, and I'm going to have to kind of just move forward.

I can't focus on the Q&A right now. I'll do so at the end, but I do appreciate the feedback of those of you that want to help folks out and look at some of the issues that we talked about. If at all possible, it would certainly be appreciated to utilize your name because if you need CEUs and we have you listed as an anonymous attendee, you will not be getting the CEU information. So if you have the opportunity to change your name under the participant's area, if you're looking for CEUs, which we'll describe at the end, please recognize that's going to be a need that we have and you will need to be shown in Zoom as attending for the full hour. So the supervision issues. In the next bullet, the required level of supervision for behavioral health services has been reserved and finalized there to allow that behavioral health incident to services move from direct supervision.

Essentially, meaning that a provider needed to be in the office suite to render emergency assistance has now been moved to general supervision kind of permanently, quote, unquote, "general supervision", essentially means it's done under the provider's orders. And boy, oh boy, if you have not in the past been billing for care management, which is kind of a general code, G0511. Again, I call this an umbrella code. But even though to commercial insurance and maybe standard private insurance, we use the CPT codes for things like principal care management or 99490 for complex or chronic care management. Or even behavioral health integration or the service in 2023 that got added for us, chronic monthly pain management. Well, prior to January of this year, prior to January of this year, we had eight CPT codes and HCPCS level two codes that we would report to commercial carriers. But when we bill Medicare, we use the umbrella code, G0511. Folks in 2024, there are 22 CPT and/or HCPCS level two codes that all roll up to code G0511.

Some of them are listed here, remote physiological monitoring, RTM, and two new codes that all expand on in a section in one of the other tips for community health integration and principal illness navigation. Now, you may have had community health workers or peer specialists or peer support specialists. There are now billable opportunities for them, but in the past, if I had 10 minutes of principal care management, 10 minutes of chronic care management and eight minutes of pain management, I rolled all of that up into G0511. Well, folks, the change in 2024 is as long as you're not overlapping and

duplicating time and resources, you can report multiple G0511s to get that $75 ish there. We'll break that down in more detail and they've revised the methodology and the reimbursement for that code. Because essentially prior to this year, we got paid the average of what Medicare paid fee for service providers for those eight CPT or HCPCS codes.

Now we get paid the average of what Medicare pays fee for service providers for 22 codes. Believe it or not, that actually ends up dropping our reimbursement for G0511. But we know you're doing care management in between patient visits to revise the care plan to reach out to the patient, to reach out to other providers and registries, and we want you to get reimbursed for that work. And a minor clarification, nothing earth-shattering that we can get. The beneficiary consent for care management and virtual communication services through general supervision. That's quite all right. So when Sibley asks, "Can we have a link to that list of qualified medical visits?" Keep in mind Sibley, but if I didn't see when your question came in, but if you're referring to the list of CMS covered telehealth services, a quick Google of that will pop up very quickly, literally CMS telehealth list, and you should be able to locate that pretty quickly.

You'll hit the zip file, you'll download it, you'll open it up in Excel, and you expect that to change over time. But there are more than just mental health services on that list that are allowable via telehealth. That's separate issue. Now interestingly enough, when Sibley said the list of qualifying or covered medical services, we'll talk about some updates in tip number two that we are waiting from our friends at CMS related to what qualifying visits are. Because we have new providers and new services we can bill for in 2024, but they don't show up on our qualifying visit list. I'm not talking about the telehealth list. I mean for services provided in an authorized location like your office or nursing facility. But please, when you do get access to the slides, anytime I have that .com thing and I point an arrow, that entire box is going to be a sheet rather than looking at the 2200 pages.

All right, you can go look at the actual summary there. So the extended telehealth flexibilities using code G2025. CMS has confirmed the patients will essentially have no geographic limitations and they can get telehealth anywhere they are. But by the way, a little side note, just because the patients at Disney World doesn't mean you can do telehealth if they're in Florida unless your license allows you to practice medicine in Florida. Now whether you have an actual license or they have reciprocal agreements and collaborative agreements, just because your patient can get telehealth from anywhere folks, you still have to have licensure, et cetera, et cetera. Where the patient's there, we talked about dropping the in-person requirements. They not only expanded mental health counselors and family therapists there, but they've added some of the services that they might be performing to the new set of codes. One of them GO136, I'll break out a little more specifically later. A new code doing a social determinants of health risk assessment and it has been added to the telehealth list.

Now, when you look at the new definition of this brand new code GO136, we'll look at it in another section here coming up in a bit. It indicates that this is going to be needing a structured screening tool and that it can be performed no more, excuse me, than every six months. So what happens if I end up performing, let's say a covered medical telehealth visit, meeting all the guidelines, I report G2025. What if on that visit I also perform the social determinants of health risk assessment? Well, since it's on the telehealth list, I now have two G2025s from the same data service, which essentially as the regs exist to our knowledge today, giving you 95 for the medical telehealth visit and a full 95 and change for performing that social determinant of health risk assessment. And so that's just kind of hitting in bullet form some of the things we had pointed out.

And the way we're going to really confirm rather than looking at the federal register, rather than looking at the 2200 pages of the new Medicare physician fee schedule, what we need in the FQHC world is these 2024 changes. I hope I'm being polite, but this hasn't been updated since June of last year. This item was

updated back in January of last year. So we are awaiting the guidance that we indicated on that previous slide to appear in the CMS claims processing manual. And most importantly in my eyes, on the claims of the billing side, if you will, the Medicare benefits policy manual. So they need to add our new therapists, they need to add, in my opinion, additional information related to telehealth that we talked about as well as potential new services. So these are linked in the PDF, but of course you can find them really easy with a Google CMS FQHC chapter 13. Folks, especially over the next couple of weeks, please every other day be on the lookout for these changes. Because although they're listed in the Federal Register, we need to see them in our guidelines.

And we certainly appreciate the heavy lift that CMS has in getting these things implemented, but we really need to see them here. All right, Chris, asked a question. "Chris Lopez will be able to bill for both LPC and LCPC." Hold that thought because LPC is a more unified abbreviation or credential across the country, but each state has different things for what LC and PC means. Short answer is, I'll give you a slide that will give you the Medicare regs of being a master's or a doctoral level individual or someone that meets state scope of practice rules that's had at least, what is it? Two or 3000 of supervised hours in that facility or in their career, excuse me, to do that. Now, Michelle say, "When I speak of Medicare rules, does that apply to Medicaid the answer?" I know I'm not trying to be silly here, Michelle. Yes, no, maybe, kind of, sort of, never. It depends. I live in Georgia even though I'm in Mississippi now, we have four or five managed care or Medicaid plans.

They might choose some of these, they may not. Some states have laws that require services to be covered. In other states, Medicaid carriers that differ from each other might offer new benefits that others won't cover. So when I say Medicare, I'm definitely only referring to Medicare, but at this point, folks, I am going to minimize the Q&A in order to complete my portion on time. And at the end of the presentation I'll go through and scroll through some of those items because for example, we had a question about a patient's A1C levels very unrelated to what we're talking about. And here's that slide. So mental health counselor, for those folks that have that question, this is coming from CMS's updates there. Possesses a master's or doctoral degree which qualifies for licensure as a mental health counselor, clinical professional counselor or professional counselor when such individual does these types of services.

So they're licensure certified and is performed at least two years, I misspoke a moment ago or 3000 hours of clinical supervised experience. The key part here is when you go through the enrollment/credentialing/privileging option, this is where we need to get started because it may take multiple months to get that done. Now because mental health counselor is kind of a broad category, whereas marriage and family therapist is more of a standardized designation across multiple states. Be aware that Medicare has identified that we should await future guidance to confirm that in some states. Even addiction counselors helping with substance and/or opioid use disorders may end up falling into this category as well and may not have that master's or doctoral degree. So it's still being hammered out, but we can likely speak to our friends in fee for service world who have gone through credentialing and enrollment, maybe not just with Medicare but with Medicaid and others to see what challenges are there.

Now, although this resource that I used for this slide comes from the National Association for Rural Health Clinics, it applies equally to FQHCs and I think is a valuable resource and I like their discussion. Of course, supplement that with NACs guidance on the issue. A little summary here of an additional 2024 issue, whereas during the public health emergency, we had the loose flexibility, if you will, that direct supervision, typically meaning I had to be immediately available in the office suite. During COVID, during the PHE, could be done during real time audio and visual interactive communications has been expanded through the end of this calendar year. And again, if you wanted to really get into the full

document, if your Ambien prescriptions running out, you can't get to sleep at night, go search all 400 references in the 2200 pages that I did by finding every time the letters FQHCs were mentioned.

But if you need an expansion on what I'm presenting in an overarching fashion, please do so. Now, another interesting issue, not necessarily related to CMS or billing, is the creation by the AMA of a new add-on code, which is why I am highlighting the plus sign for what is a pretty short definition, pelvic examination. It's out of order in the CPT book by the way, that's what the little hashtag or pound symbol indicates. It's the last code in your 2024 CPT book. But by being an add-on code notice, the CPT tells us if I do a pelvic examination that I should list it in addition to my new or established office visits, officer outpatient consultations and my initial or periodic preventive medicine services. Now, if I'm billing Medicare and I have performed a service on the qualifying visit list, which we'll look at in a moment, then I have my G code which tells Medicare, "Hey, pay me the PPS rates." Like putting a bat signal up in the sky except with a dollar sign.

"Hey, please pay me our PPS rate. We've done a new or an established medical visit or a newer established mental health visit." In this context on the medical side, then we have our G0467 code. Then we list the code on our qualifying visit list. Maybe it was a level four office visit and we list the pelvic examination. Now that doesn't change any money. Medicare is not going to pay us more. The patient does not owe us more. But when we consider our cost report and our market basket, maybe even some different measures or quality measures that come out, not only will that fully explain to Medicare that you've done what they've asked, "Tell us what you did that qualifies this for your PPS rate, but list all other services provided." And now we're going to be in the habit, cross your fingers, the commercial insurance companies may chip in a couple more bucks if we have 99459.

So 2024 update, go to your major carriers, be they Blue Shield, Humana, Travelers, Etna, whomever, and see if code 99459 has been added to the fee schedule. Remember, it can never be reported by itself, but must be added to these other codes and a new code created by CMS, also an add-on code because it has the plus signed by it to, quote, "better recognize" the resource costs associated with E&M visits for both primary care. And when they're referring to longitudinal care over time, you're kind of thinking care management ish there. This code, quote, "can" be reported in conjunction with the E&M visit to account for additional resources notice associated with the primary care providers for the patient's single serious condition or complex condition. It is as of today, not entirely clear of what and if how many folks can report this.

I would venture to lean towards if you have a provider who is the patient's chronic or care manager, principal or chronic care manager, this is likely going to be a code that is listed in addition to your visit for the patient's single complex condition considering a lot of the additional resources and work we have to do. And it is also added to the newly updated telehealth list. So that would've been done after November 13th there, get that updated list. All right, but if I'm reporting a medical visit G2025 and if we're following the guidance that we are waiting from CMS and so forth, looking in the updates to chapter nine, most importantly, looking for the updates in chapter 13, we expect for more guidance on this. This session is being recorded the last day of January. If you listen to this in June, they have likely issued that additional guidance and we encourage you to do it, but even as of now, that would have another G2025.

So we're not really clear if that is their intent and they would want both of those to be coded to get two telehealth lists. Please be on the lookout for CMS guidance. Now, tip number two, an absolute need, the more managed care Medicare and Medicaid managed care plans are asking us in all of our free time, I kid, to properly use CPT category two codes. The CPT category two codes are not the codes we know and love in terms of office visits and minor procedures and mental health services and radiology. Rather, they appear at the end of the CPT book and end with an alphanumeric character of the letter F. Now,

these codes were created years ago because they can provide insurance companies with data that otherwise they wouldn't have found in the CPT codes and our HCPCS level two codes and our ICD 10 codes.

Maybe they just want to find out if you would please report the patient's A1C levels if they're diabetic so they can see how things are going or track the patient's cholesterol levels. Or yes, we did as promised, assess tobacco use for patients with coronary artery disease and pneumonia, etc. The key thing about these codes is we likely should not expect reimbursement for them, but although we might not receive direct reimbursement for the them, heck, maybe they do incentivize us. At the end of the year if we've met the correct percentage of patients that these services should be reported to, maybe they, quote, "pay" for performance. Or maybe some carriers I've seen in the southeast paying 10 bucks four times a year for patients if you just submit the A1C levels or cholesterol, if that's a focus of that managed care company. But what I want to do is share what I hope to be, some insight to address concerns folks have had over time.

Now in your CPT book, I think it's page 857, don't quote me on that, but the CPT book has two key pages before all of these codes you need to review. And that's my source for slide 15. Quote, "These are supplemental tracking codes that are used to facilitate data collection from 12 outside organizations that are located on the second page of the CPT explanation for category two codes. These 12 organizations run from the National Committee for Quality Insurance, the physician consortium for process improvement, the Thoracic Surgeon Society, et cetera, et cetera." But rather than have us go to these 12 different organizations websites, the AMA has aggregated them and put them in one place. And although the AMA says the use of these codes is optional, I bet we have entered into contractual agreements with Medicare and Medicaid and/or Medicaid managed care companies that may require them to be done.

So the CPT reminds us these codes are not used for correct coding, are definitely not a substitute for regular CPT codes. But what I want to show you here in a moment is when a lot of training materials are developed for providers or you create tip sheets or education, or heck, you might even put some of these codes in your billing tab for providers to select. What happens is typically there's a little superscripted number we'll look at that gets dropped. Well, folks, that superscripted number tells you which of the 12 organizations actually wrote and maintained this measure over time. So in addition to the pretty short definition we see in the CPT book for these codes that end with the letter F, step number one of additional education is go to the organization that wrote it. Now in this scenario also after each one of those category two codes, it identifies in parentheses which type of condition the patient has to have.

I'll show that to you in just a moment. But when it says things like tobacco use assessed, they're not asking us to assess tobacco use on everybody, just folks that have the conditions in parentheses. So if you're doing it for everybody and getting a lot of them kicked back, hopefully this helps provide some assistance. Now, the CPT book is not concerned with the insurance side of things, so the CPT book doesn't give us any guidance on how to report these. And I have seen every possible variation. I have seen some carriers that want them on your UB form with your billable codes. I've seen other carriers say they want them on the UB by themselves. Some say put them on a 1500 form at two cents. Others say, put them on at one cent. Some say put them in at zero cents. I've told the story in the past, a facility in Louisiana reported an office visit and two procedures, and then they listed three of these category two codes at a penny as they thought that that would be seen as informational only.

Folks, they got paid three cents and they denied the visit and procedures as being bundled. That's the day I gave up. So we need to know our contracts, expect a variation, but in order to properly apply these codes. Remember that the folks that wrote these measures are saying, only look for tobacco or only

your required place to submit tobacco use being assessed if they have coronary artery disease, community acquired pneumonia, chronic obstructive pulmonary disease, preventative visits or diabetes. If it's for the first four, go find superscript organization number one, and they'll tell you what you need to document. If it's for diabetes, go look at organization number four, who may have a different approach on who and how long. So whether it's smoking status, more on the mental health side of things or pain management. These opportunities to use the full codes and the full definitions will hopefully streamline your submission of these performance measurement codes.

Now additionally, now the AMA sometimes keeps track of measures that will be in next year's CPT, but they've already printed the book. And so you can go to the AMA's clinical topics listing to get what they call long descriptors, medium descriptors of items that are going to be in next year's CPT but are not in the CPT yet. But you may be able to go back and locate information for example on that A1C levels. And this is kind of an older slide from a past document and it says, "For this reason in the blue box report one of the three codes listed and use the date of service as the date of the test, not the date you're reporting the code." Now, is that why the lady in Louisiana got denied, et cetera? We don't know. But what this does is certainly a better job of showing us that they're asking us to do this assessment for patients between 18 and 75 years of age, doesn't mean everybody with diabetes.

So that's how we can research these and check to see if there's any incentives. As we continue to push forward, tip number three is identifying to me the single most important update I am hoping for from our friends at CMS and of course the affiliated folks with Health and Human Services and HRSA and the Bureau of primary care. All the folks that help look after us is to identify, please respectfully smile on my face to update the qualifying visit list, which if you want to get the full text of what is a requirement for an FQHC visit. In order to get reimbursed for an FQHC visit, we have to go to 42, the code of federal Register, part 405 subpart X, and that'll get you a little sleepy. But rather what you might want to do is use the link on the bottom to go get access and remind yourself that when I'm going to use one of my five magic billing codes, I call them magic billing codes.

Like I said, these codes put a bat signal in the air with a dollar sign. I'm saying I'm performing either a new patient visit, a new, excuse me, a new medical visit, or an established medical visit. And sometimes if it's a covered dental service, this is where they want you to go. I'm going to list one of these two codes. If I'm doing the welcome to Medicare Physical or the annual wellness visit, I'm going to use G0468, if it's a newer established mental health patient. For those of you that have worked in fee for service, these look like wackadoodle codes. This is wacky. This is not something that traditional doctor's offices, heck, even rural health clinics deal with. We've got to put up the bat signal. Now, why did I put a blue line next to these three items? Because if you properly document and perform a medically necessary visit with an authorized provider doing a face-to-face visit in an approved location, codes G0466468 and 469 should generate a 34.16% increase in your PPS payments.

Oh, by the way, did I forget to mention that you should not use the definition of new versus established patient in the CPT book? What we need to do is look section 70.3 of chapter 13 of the CMS benefits policy manual to see that our definition says that they've seen anybody for any Medicare covered service in any location regardless of specialty, they're established to the institution. We don't look at it as whether they're established to that provider or that specialty. They're established to the institution. Well, if I use the bat signal to put my dollar sign up in the sky, the next code on that claim better be on that CMS qualifying visit list. Here's an example, code G0466. The next code on the claim better be either an intermediate or a comprehensive eye exam or a valid medical nutrition visit performed on an individual, not in a group.

But folks, again, I don't know if they're listening or not, I have the utmost respect for the folks that are trying to make the Medicare program last to protect those of us that are providing care to those in

underserved areas. But to my knowledge, this list was updated last in 2017 and has codes on it that were deleted from the CPT two, three, four years ago. These nursing home, nursing facility, home visits and home, some of those codes were deleted and combined together. Some of them no longer exist. Now the actual list for the medical side is a bit longer. Of course, I couldn't fit everything on there, but if we have a valid behavioral change, smoking cessation visit three to 10 minutes or greater than 10 minutes, we've qualified for care. And actually, you know what I did do? Excuse me. I actually put them back over here.

Excuse me. Look at that, advanced care planning, wonderful. They added advanced care planning to the list years ago. Cancer screening, qualifying visits, alcohol misuse, depression screening, obtaining a pap smear, all this good stuff. But folks, several of the services that I've already mentioned, such as principal illness navigation, the risk assessment for the social determinants of health or the community health navigation, in my brain until they appear on the qualifying visit list, it's not on the list that drives our reimbursement. So please look carefully at potential and hopeful upcoming updates, not only to the regs in chapters nine and 15, but the list that has not received an update since 2017 and has codes that have been deleted or had their definitions revised. Or adding those new services that we've identified already and will continue to do so that are added in 2024.

As the CPT updates that qualifying visit list should move along. Well, for those of you in mental health, it's a little bit of a shorter list. We have a psychiatric diagnostic evaluation, an evaluation with medical or medication services or psychotherapy for a patient in crisis. But the more and more I ask people, "Are you still doing psychoanalysis?" 80% of folks I talked to in mental health, 90% say we haven't done that service in forever. But the gathering of those social determinants of health was indicated in the federal register that it could be provided by mental health. Those codes aren't on this list. So we need to look for and prepare for updates because some of the services listed on this page, a brief alcohol misuse counseling or behavioral counseling for obesity or intensive behavioral therapy for cardiovascular disease may actually be performed by qualified individuals on the mental health side.

Are they going to be added or do they have to be done over on the medical side, in which case we might have some issues to face. So I have about almost the top of the hour. We had planned on getting to about top of the hour, if not about 10 or 15 minutes later to handle a Q&A. Again, I've hidden the Q&A because it's tad distracting, but I'll go back here in a little bit when we finished the fifth tip that we have had, as we pointed out, significant care management updates, right? I think I saw in the original answers that when the recording is available, the slides will be made available, and I encourage you to access these updates. It looks like I did a double there. Excuse me. Sorry about the double up, but significant updates to CMS covered FQHC care management services.

And the idea on slide 26 here is that prior to this year, here are the eight ish codes that all rolled up to that G0511 code when we bill Medicare. But for commercial carriers, if the patient had two chronic conditions expected to last a year or until the end of their life, we bill one of those. A couple of years ago, we got the ability to report principal care management. In the CPT and automatic care if the patient only has a single high risk diagnosis, expected to be the focus of care for at least the next three months, hello substance and opioid use disorders. Behavioral health integration is when our behavioral health folks work with the primary care provider that's been designated by the patient as their care manager. That again, getting up to 20 minutes a month, the much more detailed psychiatric collaborative care model that has its own roll up code.

But everything other than that psychiatric collaborative care model that requires 60 minutes per month of work we've done to update, revise, and implement a care plan, reach out to the patient and other providers. Keep in mind, I do actually provide training on another HRSA project, which is exactly that. Designed to provide training to FQHCs who are trying to integrate primary care and behavioral health.

It's a specific project where we do just that. Now, last year in 2023, the new codes G3002 to G3003 were added. But again, we use those for commercial and probable non-Medicare payers because everything rolls up to the umbrella code G0511. But like I said, last year, if I had 10 minutes here, 10 minutes there, five minutes there, I could aggregate them and put them up into G0511. The distinction now, as I mentioned, is that they have added many more codes that would all roll up under the G0511.

Now, as you look at slide 27 in bold face and italics, what I've added here when I highlight would be my personal or professional preference to include in the proper definition of code G0511. It's written specifically for us, federally qualified health center only. But now this year it only says general care management. So we need to know which of the services fall under general care management, and that's why I added them to this definition. But in its proper definition, folks, it just says general care management. And that's why they separate and distinguish the larger, more integrated, not just co-located, but integrated model, bringing the worlds of primary care and mental health together. So these services are almost exclusively reported by primary care providers, even though they may sometimes deal with behavioral health. But here are, and I realize it's tiny, y'all, but this was a slide I loved from my friends at NARC because the top codes listed between these arrows.

There's the eight codes that now can roll up to G0511, but there's a set of codes using an FDA-approved physiological monitoring device to monitor respiratory rate, blood pressure, weight, pulse ox, et cetera. Several codes for what's called remote treatment management, very similar to remote therapeutic monitoring. And then, yes, the two codes I'm going to focus on here in a moment, community health integration and the new codes for principal illness navigation. So that's the one I'm going to expand upon here. But what I did want to do is bring these two codes together, considering we only have about an hour, hour and 15 minutes together that the range of codes, G0019, to G0024 are new codes that will kind of put the money where the mouth is. They in the public health industry and CMS and everybody's been asking us to provide social determinants of health diagnostic information to supplement our ICD-10 codes to identify social and economic issues that might have an impact on the patient's ability to receive care.

Well, instead of just including those and saying, please, they included... Let me go back, they included the presence. If you have a social determinant of health diagnosis documented on that data service that impacts the care, that helps you support higher levels of decision-making, thus higher levels of office visits. Too much for us to go into in this session. Well, now they're providing us with opportunity 60 minutes per month is the definition of codes G0019 and G0022. FQHCs have been given according to the Federal Register, the capability to report those and/or utilizing folks that traditionally had not been as reversible members of the care team, our patient navigators and peer support resources. But again, as of the recording of this, we haven't seen the specific shortened language in chapter 13's updates, nor have I seen these show up on what I hope is coming soon. And that is updates to the qualifying visit list.

So at this point, recall, if I have met this service, then I report G0511. If I also provided this service, then I also report another G0511. And by the way, if I also performed by itself remote physiological monitoring. CMS as of 2024 has given all indications that as of today, they will allow multiple G0511s as long as we're not duplicating resources and duplicating time. It says, "As long as all the requirements met and resource costs, namely the time spent by your providers is not counted more than once." So there are not even theoretical, as I see it there are opportunities should you document this carefully, to justify the hiring of a nurse or multiple individuals to handle care management as well as the services that happen in between often patients visits. But this community health integration and principal wellness navigation is a face-to-face visit, but they're asking us to bill it under a care management code.

My issue with allowing multiple G0511s is it's going to be difficult for the state and federal organizations to track how well we're performing or even what kinds of care management we're performing because

we're not using the CPT codes or the HCPCS codes that specifically identifies what was done. We just say, "Hey, give us our G0511s reimbursement." And we obviously this month did multiple different types, but I would like it if possible for our overriding authorities to have more detailed data rather than using an umbrella code. But we are extremely gracious to be brought into the world of different types of care management that regular fee-for-service providers have been able to bill likely prior to us. One of the items I was asked to bring up and I thought was an absolutely wonderful recommendation is to focus on the ICD-10 guidelines and how to establish medical necessity.

One of the main issues that I run into for those that joined in a little bit late, I just finished a ten-hour day-and-a-half-long program with the Community Health Center Association of Mississippi. And along with this and other colleagues and other trainings we've done, we had a lot of clinical providers in, and they acknowledged that they can go into their EHRs and they can locate a code by points and clicks, but that they often have difficulty locating the information that appears at the beginning of many of these sections. That gives both your providers and your billers information and coders on potentially what order diagnosis codes go on claims. Now for my advanced billers out there, when you're submitting a UB claim form, remember that you're putting all the medical and mental health services done by everybody on one claim form and all of their diagnoses on the bottom of that UB claim form.

And we're not linking them together. But any insurance entity we bill where services go on the CMS 1500 form, also known as the 837P form for my historians, the old HCFA form. You better believe that the order the diagnosis codes get listed directly across from each CPT code has a huge impact on whether the carrier deems what we've done as medically necessary. We can list the diagnoses in any order on the claim, but when we bring them down to point to CPT and HCPCS codes, I can't use M02.011 as the primary diagnosis. Because the notes that I would've had to turn back a couple pages to see, or your EHR vendors may not have this capability for providers, or they might've turned that switch off. Or let's be honest, the people that were in your office that were there when the EHR came, got the training, anybody that came six months later might be on their own learning on the fly. When in fact it says code first, the underlying disease.

So in order to get paid after denial, maybe we just flip the flop. What is the difference between what they call excludes one and excludes two? Now, I know I'm just asking these questions, but I assure you the answers to these questions as well as how to select appropriate episodes of care, whether it's the initial care, subsequent care, or sequela can be found in the guidelines. But folks, if you have a patient that on Sunday broke their arm and went to the ER, they're going to report initial treatment because they did the initial active treatment. If they say follow up with your PCP, they show up to you on Monday morning and you don't manipulate the fracture or you don't put in stitches if they cut themselves up, your first visit should have the seventh digit of subsequent. So those kinds of issues. But look at this. There's been this idea that thou shalt ensure that thy diagnosis matches the documentation exactly. No, the ICD-10 guidelines and the base codes, the instructional notes give us often options for alternate wording. Now, they're telling us, use an additional code to defy a defect if applicable.

Like when you report asthma, you might use an additional code to report smoking exposure at work. When can I report this diagnosis with these and when may I not? So what are the of the concepts we want to acknowledge? And then I'll start going here in a little while through the Q&A to answer items relevant to what we're talking about here today is folks are managed care companies in my opinion, it's not the opinion of NAC. That's why Alma said the opinions of Arch Pro Coding are not necessarily NACs, I kid. But managed care companies are hammering y'all to put every darn diagnosis that patient has on the master problem list, on every data service. And quite honestly, that violates traditional coding guidelines. We know that managed care companies that are getting paid per member per month, got some people laughing down there or crying. I don't know which one there. But we know managed care

companies are using our diagnoses correctly in many cases to what's called risk adjust their payments, not our payments, but I'm making it up.

They might get a hundred dollars a month from the state or from the federal government to pay claims. But if the patient has a lot of high level super-duper important diagnoses, it's going to have more cost to us. Patients will have more visits, more energy, more expenses, and they're going to have to pay more claims. So yes, those insurance entities need to see those super-duper high level diagnoses at least once a year. Just please stop including every one of them on every claim form. If the patient has four acute and for chronic problems, but the only information that shows up in today's note is they had a boo-boo on their arm. There was no indication that any of those other acute and chronic conditions impacts this boo-boo. I don't know if you know that diagnosis code. All right, then that's the only code that goes on the claim.

So risk adjustment is vital to insurance companies and they have understandable goals. Well, by the way, there's a name for that list of super-duper important ICD-10 codes. They're called HCCs. You may have heard them called hierarchical condition categories. And these pieces of information are used not only to help that managed care company get more money to pay more claims. But it's also being helped to make sure they assigned the patients in a fair manner to different insurance companies. That we didn't do it geographically, we didn't give this insurance company more healthy patients. We didn't give this insurance company less healthy patients on average. So what I like, and I didn't make the source as obvious as I would've liked to please, but Ms. Sheri Poe Bernard literally wrote the book for the AMA. She's on her second edition now called Risk Adjustment Documentation and Coding, where she posits an industry standard along with others that is called Meet.

If a diagnosis was measured or monitored today, evaluated today, assessed and addressed or treated, then it makes it to today's claim. But folks, if we're using more diagnoses that weren't documented, it is not helping and it is actually harming our ability to point diagnoses, establish medical need, and even get paid for things like virtual communication services. We're not getting into VCS services, but Medicare will give me 13 bucks last year 26, but they've adjusted some things. So $13 this year when a patient initiates reaching out to you, doing a virtual check-in, or uploading information in the patient portal. Well, one of the rules for us to get paid for that patient initiated check-in is that it can't be related to something I've treated in the previous seven days. So if I have a valid scenario on Friday where I should get paid for this virtual patient check-in because I actually haven't treated or measured or monitored or assessed it in the past seven days.

But you know what? I brought all the diagnoses in on the visit on Monday. It sure looks to them like you've treated in the last seven days. So the downstream impacts are tremendous. Here's the proper sourcing, the AMA's risk adjustment book folks, for many of those super-duper categories of insurance, she has a wonderful set of tips. It might be the same tips you give your providers. It might be the same tips you give your colleagues in the coding department. But have you ever noticed that if it comes from a resource like the AMA or somebody like me talking from out of town, people tend to believe it. And so I would like you to supplement these issues, all right? Here's our social determinants of health. And as we wind up and get ready to move to our questions, many of your patients are going to fit in one of these social determinants of health, all right?

There are many patients that live alone, but that doesn't mean that they like to live alone. That doesn't mean that's having a negative impact on their care. Oh, by the way, they're a post-op total hip replacement, and they live alone and they might need some help from a home nurse for the first two weeks. So for these never, ever, ever being the primary diagnosis, these categories might be useful in painting that more detailed picture of a patient. We're not going to give the patient a 30-day prescription because they don't have access to regular housing. So we bring them in every two or three

days. The patient may have a difficult time overcoming their addiction because they live with other users. They may not be able to make three trips to your office for therapy because they don't have access to transportation or can't have a nutritional diet because they're homeless, et cetera.

So understanding these are useful for a wide variety of purposes, including our ability to support high levels of medical decision-making. If you're performing those services or that new code for the social determinants of health assessment every six months, they require you to use a structured tool. I recommend because NAC and other primary care associations were involved in this using and researching the prepare tool. They are actually calling them now the social drivers of health as opposed to social determinants. But the same thing. This does not mean you have to use this tool, but there's great webinars, the tool itself, implementation toolkits and fact sheets. And you will see this more and more as the previous administration, current administration and future administrations on the legislative side and the executive branch are going to continue to try to tie this together folks. And they count on us to give them that data. So in that scenario, I'll end with this code new for 2024 code G0136.

I liked this explanation for the American Psychological Association or Psychiatric association, but not more often than every six months using that structured tool. I can see a patient answering questions on a tablet in the waiting room and then discussing relevant items with the nurse and providers and PAs and nurse practitioners. And we have to wait, in my opinion, until that qualifying visit list comes out to see where it is. Is it just on the mental health side? Is it also on the medical side? If so, it would be a standalone billable service. What if we happen to perform that on the same day as an annual wellness visit? Well, just like we would report our annual wellness visit and everything else we did like advanced care planning, we would report our annual wellness visit and code G0136. Wouldn't change our payment, but shows everything we did and the potential increase in our market basket and hopeful raises in our PPS rate because we're giving them more detail.

Now, interestingly enough, there are some new for 2024, I hope we've given you good 2024 updates, new social determinants of health if the caregiver is not in compliance. So I tell the story of a cousin of mine who helped raise her brother who has severe autism, is in his early twenties, and she is dedicated her clinical career not to helping the patient, well, that came out wrong. But providing multiple group training for the parents, for the guardians, and for the caregivers to give them training on how to help their family member or the individual they're responsible for. So these items might help justify medical need because it's multiple family group training. I don't expect Medicare to reimburse us at this point, but for non-Medicare payers, I've given you two sets of options. And at this point, I want to give you my information again, if I'm not able to get to a question, folks, I'm doing three different sessions today, finished a Mississippi session doing this one, and then I have a two-hour session this afternoon for the Rural Communities Opioid response program.

Then I travel home, excuse me, fly home to Atlanta tomorrow, have another session tomorrow afternoon. But if you give me to the beginning of the week, if it's good to set up a phone call, if it's... I can answer it via email, I would love to. You see that I've had the chance to talk to a lot of folks in a lot of places over a lot of years. You may notice I and my colleagues have a lot of passion for what we do at this point Ms. Alma, let's get you and I to maybe join in. And let me get the pen off of my video, remove the pen and Ms. Alma wish me luck because I'm going to scroll up and try to answer as many as I can. If I skip your question. For example, "Can POCA1C be billed with a medical provider encounter?" That's not in this particular case, quite relevant to what we're looking at, okay? But I don't want to ask you to ignore it, just email it. But I got to stick with what we're talking about here and Alma, I'm not sure how.

Alma:

Yeah, I was going to say while you scroll through and pick out the ones we can actually address right now, let me share that. I know everyone who is waiting for CEU information, let me just provide you with this update. So we will be sending it out to everyone that is on the call right now that is still tuned in, which is to the end. And so at 3:18, we've caught you at your attendance and you will receive that via email from our tech support host. And with that said, I'll turn it back over to you for any questions that you can address, and then we'll go ahead and let me wrap it up and close out.

Gary Lucas:

Thank you Ms. Alma. And I'm going to tell you what she wouldn't tell you. It's my fault I don't have the CEU certificate. I drove at 84 miles an hour from my Mississippi class to get over here and I didn't have it ready. So I appreciate NAC's flexibility there. So Erica, "Can LMFTs bill for group therapy of several different patients, not a family at an FQHC?" I'm not aware of Medicare paying an FQHC for group anything. Although food for thought, group therapies on the CMS covered list for telehealth, I'll let you interpret that one on your own there. I don't know how I would indicate that this is done and I'm clicking the wrong button.

Yes, you have to have your LMFTs and your licensed professional counselors and all that enrolled, I think in PECOS and eligible and credentialed and all that good stuff. Same idea. Okay, so somebody's... Oh, look at that. Shalonda helped answer, the group visit option Ms. Amber. Give me a moment. Oh, great question. She says, "For the G0511, it stated," she says, "that it can be billed every 30 days per calendar month. Is there now a new frequency on these for RPM? And how is it detected by CMS? What is billed when it's under the same code?" They don't have that ability, y'all. It is in theory, possible that my chronic care management runs from the first of the month to the 30th of the month. And that my remote physiological monitoring runs from the 15th of the month to the 15th of next month. And I acknowledge that I am extremely happy that we get reimbursed fee for service offices.

But when they start seeing a G0511 coming in on an infrequent basis, my gut says it's going to cause problems at the carriers. So we may need to, again, await future guidance on how that happens. So they have extremely complicated decisions to make and sometimes they have to select one that doesn't give them the ability to truly know what we've done. Same thing with telehealth, isn't that right? They don't know what we did on the medical side, they see G2025. So at this point, I'm not aware of any modifiers to go on that. In that case, that ties on Mary and Abby's claim. And yes, I could in theory report multiple G0511s on the same claim form. And as of today, everything we've heard is that that's the way we need to roll with it. Now, should they create a modifier for RPM, RTM different than chronic care?

That's one option. But again, they've got insight into these complexities that I can't really even imagine. Mary asks, "How many times in the course of a year can you report this code?" I'm not sure if she's talking about the care management, but yes, that's essentially every month or 30 days. The CMS telecode list for Sibley. Very quick Google on that one, you should be able to find that. Bear with me as I continue to read. All right, not positive. George says, "Do you know if the Medicare PPS qualifying visit list will be updated?" Oh, by the way, that's hilarious, George, I may have had that on my slide after you put that up. I'm just saying with pretty please with sugar on top, please update the qualifying visit list respectfully to remove codes that have been deleted and have had their definitions revised. Or brand new codes as of 2024 that we get every appearance that we can bill it, but hasn't shown up in either chapter 13 yet, nor have they appeared in the qualifying visit list.

And so George, in terms of sending the email with today's presentation when I'm done, Alma will remind you about how and when you can get the slides and access to this recording if needed. Good question anonymous attendee, please register as your name so you can get CEUs. She says, I think I may know who it is, we'll see, "But is G2025 used for mental health telehealth visits?" No. As of last April,

although many of us didn't hear until June, when you perform, if it's Medicare now, when you perform a mental health telehealth visit, we no longer should use the G2025. We actually do the service we performed, the psychiatric diagnostic evaluation or insight oriented behavior modifying or supportive therapy, whatever it was. And then we need to add a modifier. The modifiers options are 93, modifier 95, modifier FR or modifier FQ that your billers will look at that tells them you did it via telehealth.

And as of, let's call it early to mid last year, we are now entitled to our full PPS rate, 80 for Medicare, 20% from the patients for approved mental health telehealth visits that occur or show up on that most updated list. Okay, continuing to move forward here. Got to keep going past a couple. Patricia says, "Is that new add on code G2211 billable for FQHCs?" It's billable folks, but remember, because it's an add-on code for that complex condition, it's not going to impact our Medicare reimbursement. We are obligated to indicate our magic G code, identify which code on the qualifying visit list we've done, and then all other services. So as of now, I recommend that it is usually and primarily a primary care physician, if not the one who is managing the central care plan for that patient. Don't overuse G2211. But if you performed it, make sure you add it as an additional code there. All right.

I'm not sure what this one, "Does a chaperone need to be present in order to bill 99459 or can it be billed even if done by a physician?" Claudia, I may need you to follow up with me on that. Oh, and by the way, every time anybody says the words incident two, incident two visits, incident two is kind of a concept owned by Medicare. Incident two means you're thinking Medicare. Well, folks, section 120.1 or off the top of my head, section 120.3 of chapter 13 of the CMS benefits manual identifies that if you have a visit that is incident two only. So maybe I have the patient come in on Friday, don't worry, nurse Gary's going to take care of you. "Hey, I'm a psychologist, so I'm going to delegate this service to my limited clinical social worker." Well, folks, if they don't see an authorized provider, you don't have a billable visit incident two, only visits are not billable to Medicare period. End of story.

We must have the face-to-face presence of an authorized provider that meets medical necessity and is done in an approved location. Then I can say, "Hey nurse Gary, please go give this patient this injection." "Hey, affiliate counselor, who does not yet have enough training to be billable on your own, I've gone in to see the patient. You may now come in." But if they don't see an authorized provider, we don't have a billable service. Incident two only visits are not billable by an FQHC to Medicare. And again, off the top of my head, it's either section 120.1 or 120.3 of chapter 13, rather than this Gary guy reading slides off of PowerPoint. So a couple good questions from Shalonda, Claudia and some other services. All right, good question from Ms. White, "Shouldn't we or should we continue to use code G0101 and/or Q0091 for traditional Medicare, rather than using that 99459?" Folks those are three different services. But Charmaine, that is a great question. I got to do this quickly. Code G0101 is the every other year, cervical cancer, vaginal cancer, or breast cancer screening.

In chapter 18 of the Preventive Service manual, Medicare describes 11 items. Seven of which, if you document seven of 11 items, you've met the definition of G0101. And so that includes the breasts and other areas of the body beyond just doing a, quote, "pelvic exam". Q0091 is the handling and/or conveyance of a screening pap smear, definitely different than the full seven of the 11 items. Pelvic exam is if you're just doing a pelvic exam. So they are related to each other, but each of the codes G0101, Q0091 and 99459 are definitely different. Jonathan agrees it's a good question and we got to go that. Tracy says, "When billing Medicare for Medicare medical services, we list both the 99214, and the G0467." Well yeah, G0467 is your magic billing code up top followed by 99214.

She says, "CCM billing, do we bill both codes, 99490 and the G0511?" Good question. Just code G0511. So it feels weird submitting a claim without one of your G-codes, but when I use the G-code to get my PPS rate. Remember when I get paid for G0511, I'm getting a flat $75 ish split 80/20 between Medicare and the patient. All right folks, I know I have two more minutes. I'm trying to get to as many folks as I

can get to, hang tight because everything just re-scrolled up on me. Michelle has a good point. "The Federal Register indicates that it captures four minutes of clinical staff time associated with chaperoning a pelvic exam." But again, I'm talking about billable services by approved folks. Not sure the category of chaperone here. Somebody said they didn't mean to be anonymous, but as soon as I clicked there, it just disappeared, folks. So there's just too many questions, Alma. Sorry.

Alma:

Yes, I was going to say, let's go ahead and pause right here. And as we conclude for today's webinar, I want to express our gratitude for every attendee that joined today. Your participation is truly enriching.