2024 Coding and Documentation Webinar Series

Wednesday, January 31, 2024

NACHC's STRATEGIC PILLARS

1 Equity and Social Justice

Center everything we do in a renewed commitment to equity and social justice

2 Empowered Infrastructure

Strengthen and reinforce the infrastructure for leading and coordinating the Community Health Center movement, notably consumer boards and NACHC itself

3 Skilled and Mission-driven Workforce

Develop a highly skilled, adaptive, and mission-driven workforce reflecting the communities served

4 Reliable and Sustainable Funding

Secure reliable and sustainable funding to meet increasing demands for Community Health Center services

5 Improved Care Models

Update and improve care models to meet the evolving needs of the communities served

6 Supportive Partnerships

Cultivate new and strengthen existing mutually beneficial partnerships to advance the shared mission of improving community health

To learn more about NACHC's Strategic Pillars visit https://www.nachc.org/about/about-nachc/

THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

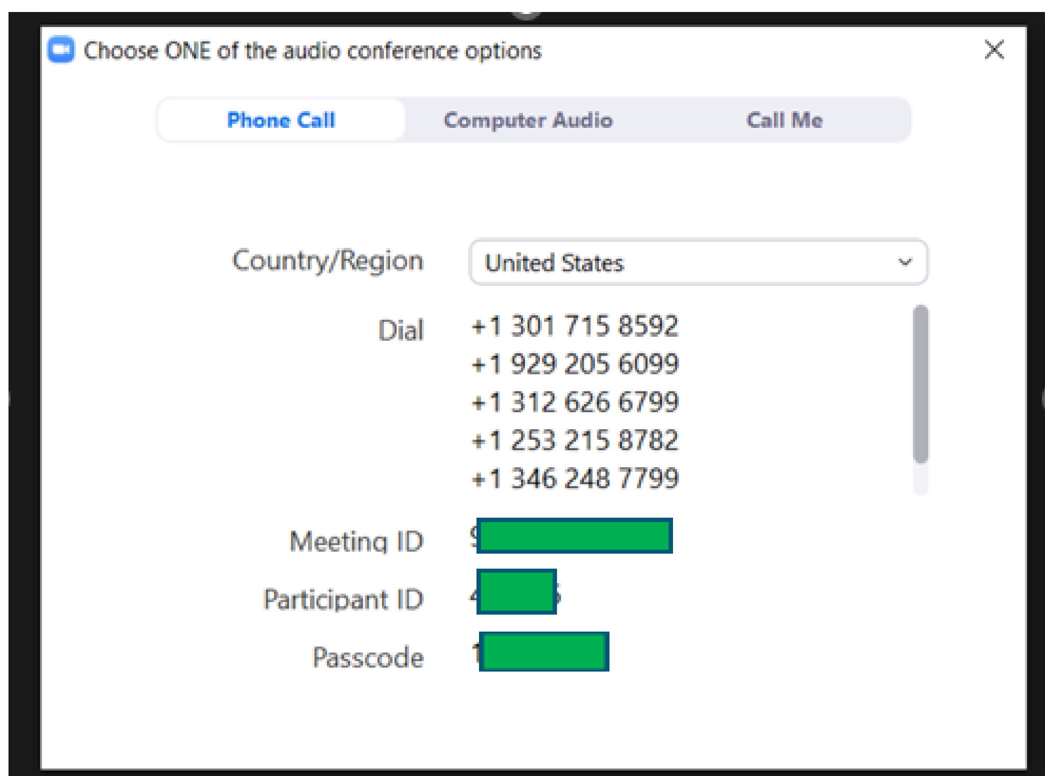
RECORDING DISCLAIMER

- This meeting will be recorded by the host. Individual participants are welcome to record this meeting on their personal device.
- Recordings and materials exchanged* during this meeting will be shared with others.
- By staying in this meeting, you automatically consent to be recorded.

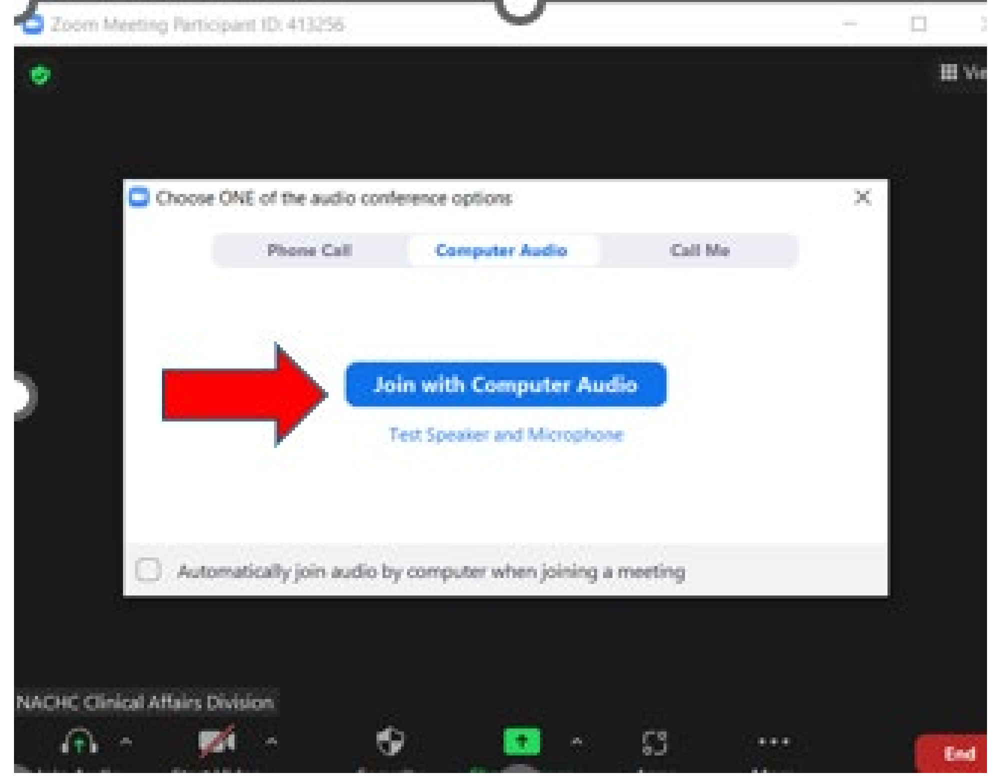
*Content shared today is the viewpoint of presenters and may not fully reflect the opinions of NACHC.

AUDIO CONNECTIONS

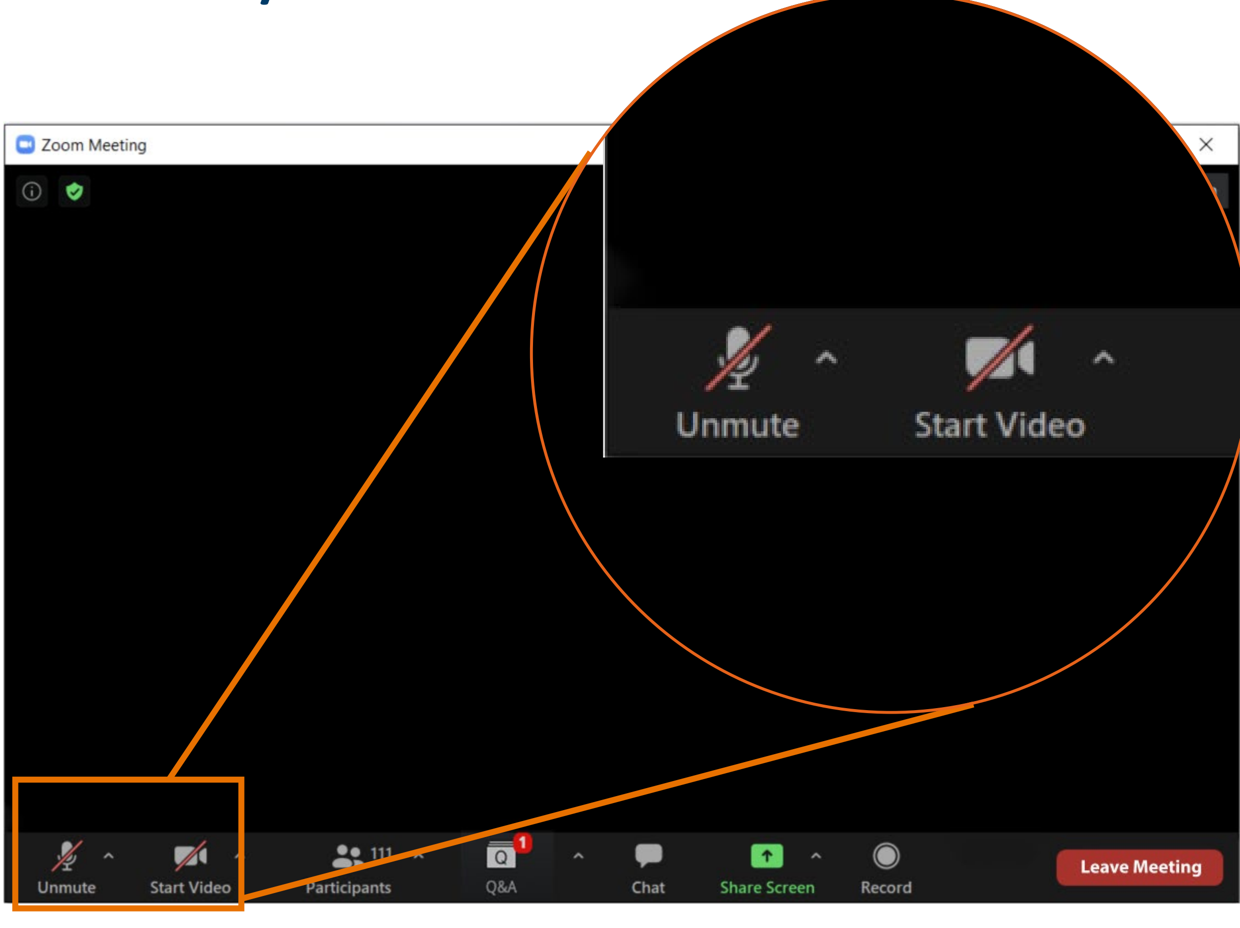
Option 1: "Phone Call"
Follow the unique process on your screen using your phone



Option 2: "Call Using Computer Audio "
You must have computer speakers and a microphone



MUTE / VIDEO



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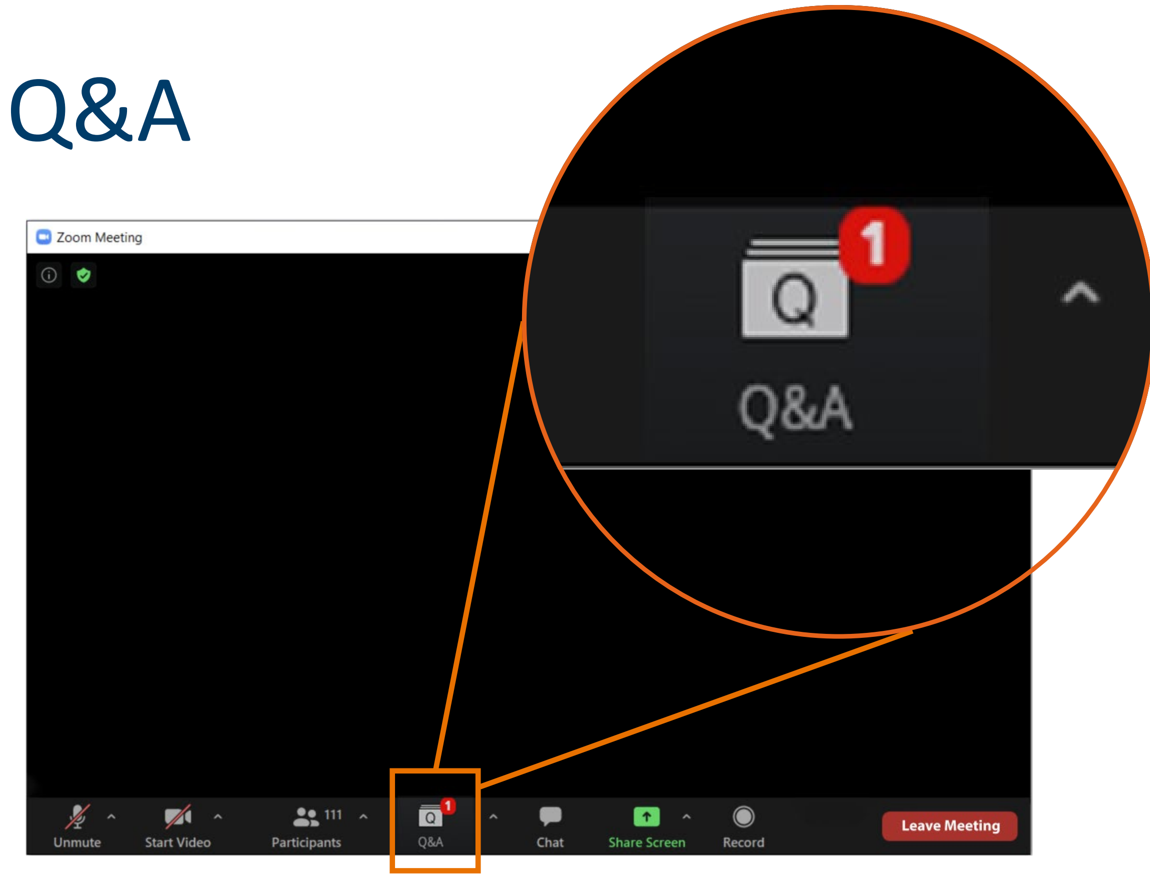
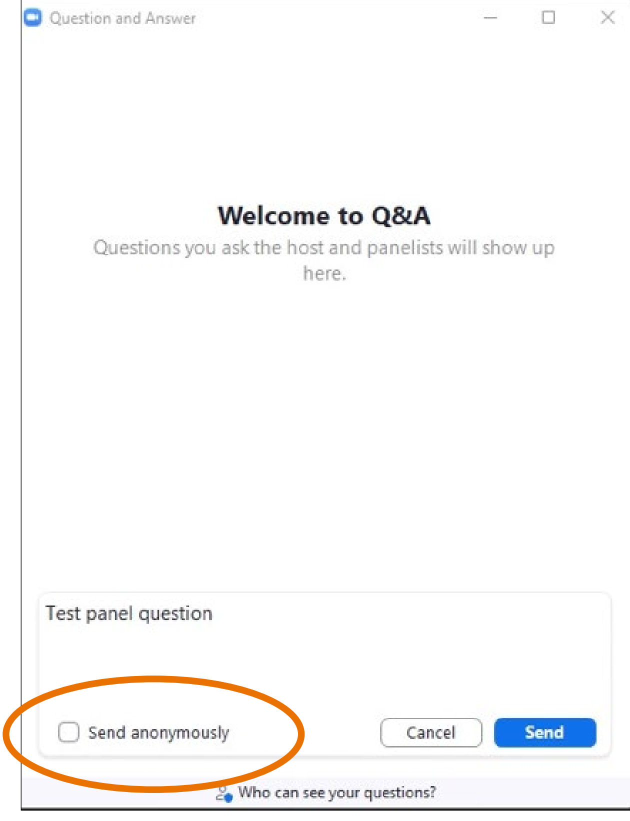
Q&A

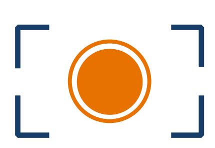




To ask a question or make a comment, please use the Q&A box, then click "Send".

Select **Send Anonymously** if you do not want your name attached to your question in the Q&A.

FRIENDLY REMINDERS



This meeting will be **RECORDED**.

All attendee video and audio functions will be **DISABLED** by the host

We encourage you to submit your questions and comments at any time in the **Q&A BOX**. Moderators and presenters will respond to questions as they can.

National Association of Community Health Centers

Top 5 Documentation and Revenue Tips in Community Health

2024 Coding & Documentation Webinar Series: Part 1
January 31, 2024

Instructor

Gary Lucas, MSHI

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University of Georgia – Bachelor in Business, Marketing (1994) + University of Illinois-Chicago – Master of Science in Health Informatics (2014)

~1900 courses taught onsite in 46 states over 29 years

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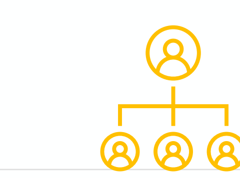
ArchProCoding Main Focus Areas

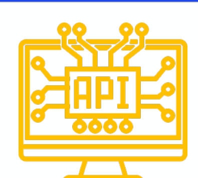
Clinical Providers



Clinic and Health Center Managers

Coders

Billers



Electronic Health Records and IT/Billing System Integrations

Key Themes for your Consideration

Documentation

We've all heard it before…but we disagree!

"If you didn't document it – it didn't happen"

You just can't get paid for it!

Coding

What level of professional coding is given to clinical providers ***vs.*** revenue cycle staff?

Let providers document and let professional coders code?

General Staffing Question

Do you have access to qualified and experienced coding/billing staff who are familiar with the many nuances of FQHC?

Billing

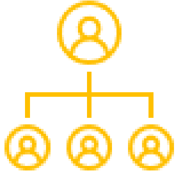
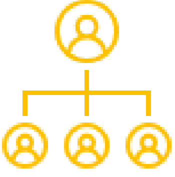
Remember – those certified in coding had **0** questions on their exam about generating proper revenue from public and private insurance – only coding.

OUR FOCUS

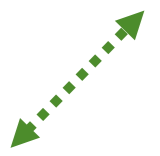
Identify how to research, interpret, and apply ever-adapting documentation guidelines set forth by the AMA, CMS, and the ICD-10-CM Cooperating Parties (AHA, AHIMA, CMS, and NCHS)

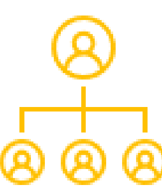
Our Common Path

GREET THE PATIENT:
How does insurance type impact which claim form we use, patient cost sharing, and our revenue?

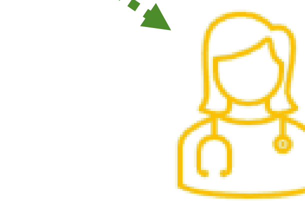



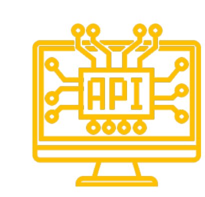
CODE THE FULL ENCOUNTER:
Manage the link(s) between the medical record and the "encounter form" and clarify who is truly "responsible" for coding.





PREPARE FOR PATIENT VISITS:
Are you truly ready to handle the advanced issues of operating in a RHC/FQHC?





TREAT AND DOCUMENT THE VISIT:
Train staff on the actual documentation guidelines found in CPT, HCPCS-II, and ICD-10-CM manuals rather than shortcuts.

CONFIRM DOCUMENTATION AND BILL:
Getting paid everything you deserve and meeting ACO/MCO quality reporting rules.

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Tip #1 – 2024 CMS Updates

Key 2024 CMS Updates for RHC/FQHC
Expect updates to Fact Sheets and Ch. 9/13!

See below for a list of policies affecting (RHCs/FQHCs) in the CY 2024 Medicare PFS Final Rule.

- Finalized conforming technical changes to extend payment for telehealth services
- Finalized conforming technical changes to delay the in-person requirements for mental health visits
- Extended the definition of direct supervision to permit virtual presence
- Finalized conforming technical changes to include Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) as RHC and FQHC practitioners
- Revised the required level of supervision for behavioral health services furnished “incident to” physician services from direct supervision to general supervision
- Added Remote Physiologic Monitoring (RPM), Remote Therapeutic Monitoring (RTM), Community Health Integration (CHI) and Principal Illness Navigation (PIN) to the general care management code, G0511
- Revised the methodology to calculate the payment rate for HCPCS code G0511
- Clarified that beneficiary consent for Chronic Care Management (CCM) and Virtual Communication may be obtained through general supervision

Read the CY 2024 Medicare Physician Fee Schedule (PFS) Final Rule fact sheet

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2024 Telehealth Updates from Medicare impacting FQHC

- Extended medical telehealth flexibilities using code G2025 through the end of 2024.
- Patients will have no geographic limitations and can essentially get telehealth from anywhere.
- Delays the proposed in-person visit requirement in order to begin billing for mental health telehealth visits through the end of 2024.
- Expands the list of telehealth to be provided by Mental Health Counselors and Marriage and Family Therapists.
- Adds the G0136 Social Determinants of Health Risk Assessment to Medicare’s covered via telehealth list!
- Continues to allow the use of audio/visual telecommunications when supervising residents and “direct supervision” for incident-to services through the end of 2024.

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Key CMS References for RHC/FQHC
Check often for likely 2024 updates!

Chapter 9 - CMS Claims Processing Manual

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

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(Rev. 12070, 06-07-23)

Transmittals for Chapter 9

10 - Rural Health Clinic (RHC) and Federally Qualified Health Center (F(Information
- 10.1 - RHC General Information
- 10.2 - FQHC General Information

20 - RHC and FQHC All-Inclusive Rate (AIR) Payment System
- 20.1 - Per Visit Payment and Exceptions under the AIR
- 20.2 - Payment Limit under the AIR

30 - FQHC Prospective Payment System (PPS) Payment System
- 30.1 - Per-Diem Payment and Exceptions under the PPS
- 30.2 - Adjustments under the PPS

40 - Deductible and Coinsurance
- 40.1 - Part B Deductible
- 40.2 - Part B Coinsurance

50 - General Requirements for RHC and FQHC Claims

60 - Billing and Payment Requirements for RHCs and FQHCs
- 60.1 - Billing Guidelines for RHC and FQHC Claims under the AIR System
- 60.2 - Billing for FQHC Claims Paid under the PPS
- 60.3 - Payments for FQHC PPS Claims
- 60.4 - Billing for Supplemental Payments to FQHCs under Contract with Medicare Advantage (MA) Plans
- 60.5 - PPS Payments to FQHCs under Contract with MA Plans
- 60.6 - RHCs and FQHCs for Billing Hospice Attending Physician Services

70 - General Billing Requirements for Preventive Services
- 70.1 - RHCs Billing Approved Preventive Services
- 70.2 - FQHCs Billing Approved Preventive Services under the AIR
- 70.3 - FQHCs Billing Approved Preventive Services under the PPS
- 70.4 - Vaccines
- 70.5 - Diabetes Self Management Training (DSMT) and Medical Nutrition Services (MNT)

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Chapter 13 - CMS Benefits Policy Manual

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

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(Rev. 11803, 01-26-23)

Transmittals for Chapter 13

Index of Acronyms

10 - RHC and FQHC General Information
- 10.1 - RHC General Information
- 10.2 - FQHC General Information

20 - RHC and FQHC Location Requirements
- 20.1 - Non-Urbanized Area Requirement for RHCs
- 20.2 - Designated Shortage Area Requirement for RHCs

30 - RHC and FQHC Staffing Requirements
- 30.1 - RHC Staffing Requirements
- 30.2 - RHC Temporary Staffing Waivers
- 30.3 - FQHC Staffing Requirements

40 - RHC and FQHC Visits
- 40.1 - Location
- 40.2 - Hours of Operation
- 40.3 - Multiple Visits on Same Day
- 40.4 - Global Billing
- 40.5 - 3 Day Payment Window

50 - RHC and FQHC Services
- 50.1 - RHC Services
- 50.2 - FQHC Services
- 50.3 - Emergency Services

60 - Non RHC/FQHC Services
- 60.1 - Description of Non RHC/FQHC Services

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(Rev. 11803, 01-26-23)

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CMS added new provider types for RHC/FQHC for 2024 – get the enrollment/credentialing process started!

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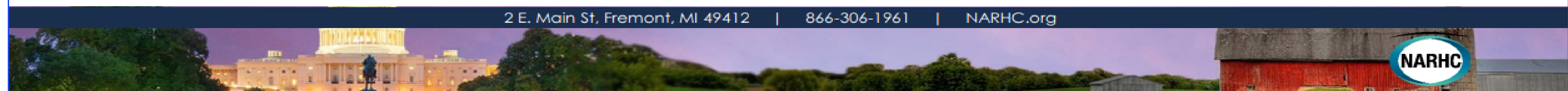
- Marriage and Family Therapist (MFT)
  - An individual who:
    - Possesses a master's or doctor's degree which qualifies for licensure or certification as a MFT pursuant to State law of the State in which such individual furnishes marriage and family therapist services;
    - Is licensed or certified as a MFT by the State in which such individual furnishes such services;
    - After obtaining such degree has performed at least 2 years (or 3,000 hours) of clinical supervised experience in marriage and family therapy; and
    - Meets such other requirements as specified by the Secretary.
- Mental Health Counselor (MHC)*
  - An individual who:
    - Possesses a master's or doctor's degree which qualifies for licensure or certification as a mental health counselor, clinical professional counselor, or professional counselor under State law of the State in which such individual furnishes MHC services;
    - Is licensed or certified as a mental health counselor, clinical professional counselor, or professional counselor by the State in which the services are furnished;
    - After obtaining such degree has performed at least 2 years (or 3,000 hours) of clinical supervised experience in mental health counseling; and
    - Meets such other requirements as specified by the Secretary.

***Addiction counselors who meet all applicable requirements can also enroll as Medicare providers under MHC category.**



Source: National Association of Rural Health Clinics 2024 Medicare Updates Webinar (12-11-23)

ArchProCoding (2024) Protected

2024 continues to allow for using technology to meet the definition of "direct supervision."

"b. RHCs and FQHCs

In section III.B. of this final rule, we finalized the policy ***to adopt the definition "immediate availability" as including real-time audio and visual interactive telecommunications for the direct supervision*** of services and supplies furnished incident to a physician's service through December 31, 2024 for RHCs and FQHCs.

We also finalized the policy change the required level of supervision for behavioral health services furnished "incident to" a physician or non-physician practitioner's services at RHCs and FQHCs to allow general supervision, rather than direct supervision, consistent with the policies finalized under the PFS for CY 2023."

Source: Page 1939 of the Federal Register - https://public-inspection.federalregister.gov/2023-24184.pdf

ArchProCoding (2024) Protected

NEW Evaluation & Management Codes for 2024!

#+ 99459: Pelvic Examination (List separately in addition to the code for the primary procedure)

- Use code in conjunction with 99202-99205, 99212-99215, 99242-99245, 99383-99387, 99393-99397)

New HCPCS-II code + G2211 – New complex Condition Add-on Code

- "This ***add-on code*** will better recognize the resource costs associated with evaluation and management visits for primary care and longitudinal care."
- "Can be reported ***in conjunction with E/M visit*** to better account for additional resources associated with the primary care, or similarly ongoing medical care related to a ***patient's single, serious condition, or complex condition.***
- Can be performed ***via telehealth*** and the code is on the CMS-approved list of covered telehealth services.

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TIP #2 – Proper Usage of CPT-II Codes

CPT Category I Codes

Introduction

Evaluation and Management (99xxx)

- ***Know the rules and new E/M guidelines!***

Anesthesia (0xxxx)

Surgery (1xxxx – 6xxxx)

- ***Varying surgical package definitions change billing!***
- ***For the Billing section – be prepared to review Ch.13 CMS Benefits Policy Manual, Section 40.4***

Radiology (7xxxx)

Pathology and Laboratory (8xxxx)

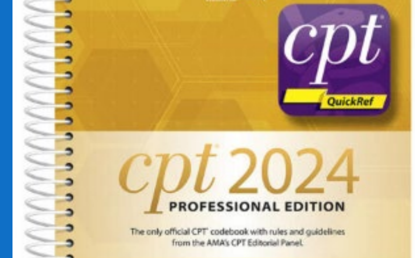
Medicine (9xxxx)

Appendix A-O – *check out A for modifiers and B for changes*

Alphabetic Index – *never code from the index!*

- ***Ex. Appendix A = Modifiers***
- ***Ex. Appendix B = 2024 changes and updates***
- ***There are several more!***

CPT Category II Codes



Modifiers – 1P, 2P, 3P, 8P

Composite Measures 0001F – 0015F

Patient Management 0500F – 0575F

Patient History 1000F – 1220F

Physical Examination 2000F – 2050F

Diagnostic/Screening Processes/ Results 3006F – 3573F

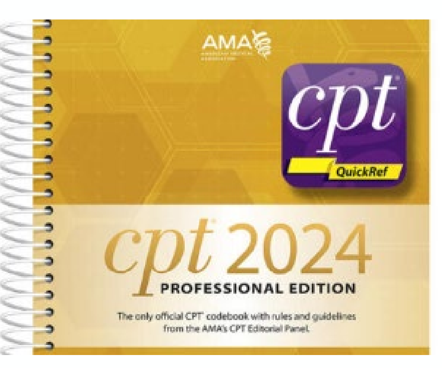
Therapeutic, Preventive, or Other Interventions 4000F – 4306F

Follow-Up or Other Outcomes 5005F – 5100F

Patient Safety 6005F – 6045F

Structural Measures 7010F – 7025F

Main research items for CPT-II codes used for “Performance Measurement” reporting



“Supplemental Tracking Codes”

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

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

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

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

Disease-specific?
Reported if patients have the abbreviated diagnoses appearing in parentheses.

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

Know your contracts
Carriers should provide you with reporting requirements!

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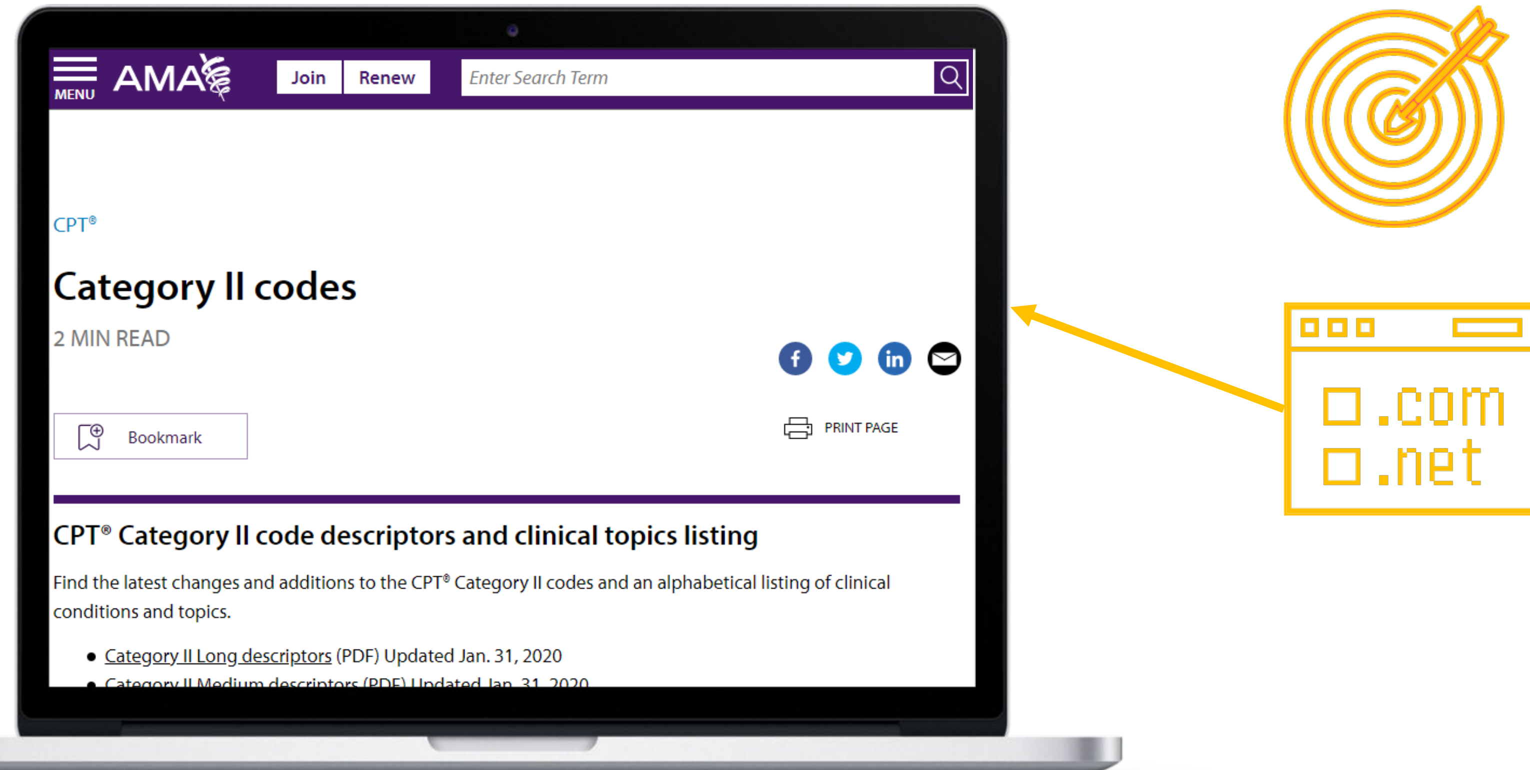
Review your insurance contracts to see who may "require" or "encourage" CPT Category II codes

- **Patient History 1000F** = Tobacco use assessed (CAD, CAP, COPD, PV)[1] (DM)[4]
- **Patient History 1031F** = Smoking status and exposure to 2nd hand smoke in the home assessed (Asthma)[1] – see also 1032F-1039F
- **Patient History 1040F** = DSM-5 criteria for major depressive disorder documented at the initial evaluation. (MDD, MDD ADOL)[1]
- **Patient History 1125F and 1126F** = Pain severity quantified: (pain present vs. not present) (COA)[2] (ONC)[1]

Before submitting any CPT-II codes

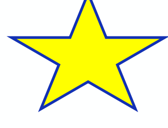
In addition to researching the performance measurement code in the CPT manual, you will gain key insights by going to the measure developer's websites that are listed in the CPT as well as new codes not in the CPT yet **by going to the AMA's Clinical Topics Listing**.



Sample from a past AMA Clinical Topics Listing on Diabetes and A1C measurement

These codes are an example of those that some managed care companies have incentivized RHCs/FQHCs with to report ~four times a year and pays ~$10!

Diabetes (DM)		
Brief Description of Performance Measure & Source and Reporting Instructions	**CPT Category II Code(s)**	**Code Descriptor(s)**
A1c Management [4] Whether or not patient received one or more A1c test(s) **Numerator:** Patients who received one or more A1c test(s) **Denominator:** Patients with diagnosed diabetes 18-75 years of age **Percentage** of patients with diagnosed diabetes aged 18-75 years with one or more A1c test(s). **Exclusion(s):** NONE **Reporting Instructions:** In order to meet this measure, the date of test, when it was performed, and the corresponding result are required. For this reason, report one of the three Category II codes listed and use the date of service as the date of the test, not the date of the reporting of the Category II code. The measure may also be met by reporting the Category I code, 83036 Hemoglobin; glycosylated (A1C), when performed. ►To report most recent hemoglobin A1c level ≤9.0%, see codes 3044F, 3051F, 3052F.◄	*3044F* ►3051F◄ ►3052F◄ *3046F*	*Most recent hemoglobin A1c (HbA1c) level < 7.0%* ►Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%◄ ►Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%◄ *Most recent hemoglobin A1c (HbA1c) level > 9.0%*



Tip #3 – Next Updates to the CMS FQHC Qualifying Visit List?

Qualifying Visit List For FQHC

"To qualify for Medicare payment, all the coverage requirements for a FQHC visit must be met. A FQHC visit must be furnished in accordance with the applicable regulations at 42 CFR Part 405 Subpart X, including 42 CFR 405.2463"

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf

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The 5 FQHC-only "Magic Billing Codes" Required for PPS Payments

Why are these 3 special?

G0466 FQHC visit, New Patient A medically-necessary, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit

G0467 FQHC visit, Established Patient A medically-necessary, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.

G0468 FQHC visit, IPPE or AWV A FQHC visit that includes an IPPE or AWV and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV.

G0469 FQHC visit, Mental health, New Patient A medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

G0470 FQHC visit, Mental Health, Established Patient A medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

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Sample from the CMS FQHC Qualifying Visit List (QVL) for Medical visits

Qualifying Visits

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

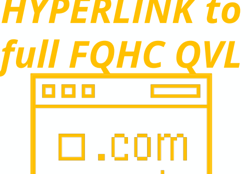
G0466 - FQHC visit, new patient

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

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

HCPCS	Qualifying Visits for G0466
99497	Advncd care plan 30 min
G0101	Ca screen; pelvic/breast exam
G0102	Prostate ca screening; dre
G0108	Diab manage trn per indiv
G0117	Glaucoma scrn hgh risk direc
G0118	Glaucoma scrn hgh risk direc
G0296	Visit to determ LDCT elig
G0442	Annual alcohol screen 15 min
G0443	Brief alcohol misuse counsel
G0444	Depression screen annual
G0445	High inten beh couns std 30 min
G0446	Intens behave ther cardio dx
G0447	Behavior counsel obesity 15 min
G0490	Home visit RN, LPN by RHC/FQ
Q0091	Obtaining screen pap smear

HYPERLINK to full FQHC QVL



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Sample from the CMS FQHC Qualifying Visit List (QVL) for Mental Health

G0469 – FQHC visit, mental health, new patient:

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

G0470 – FQHC visit, mental health, established patient:

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

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Tip # 4
Significant Care Management Updates for 2024

ArchProCoding (2024) Protected

Tip #4 – Significant Updates to CMS-covered FQHC Care Management Services

General Care Management
Codes for Clinical Providers Managing Care Plans

Get patient verbal/written consent to be their ONLY care manager

For RHCs/FQHCs to bill Medicare patients it is necessary to get their approval of being their single care manager as well as **performing an "Initiating Visit" within 1 year prior** to first billing Care Management.

Chronic Care Management

99487-99491, +99439

+

Principal Care Management

99424-99427

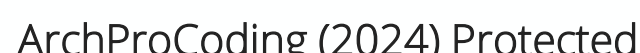
Behavioral Health Integration (BHI) or Psychiatric Collaborative Care Model (Psych CoCM)

99484, 99492-99494

Monthly Chronic Pain Management

See G3002 and +G3003 for consideration with commercial and non-Medicare payers.

Many more related monthly Care Management options for RHC/FQHC were added by CMS effective 2024!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Care Management Coding/Billing information for consideration

Medicare asks RHC/FQHC to report the unique G0511 or G0512 codes that now encompass chronic/principal care management, chronic pain management, BHI, and the Psych CoCM

G0511 = Rural Health Clinic or Federally Qualified Health Center only, ***general care management (aka principal/chronic), monthly chronic pain management, assorted remote monitoring services, community health integration, principal illness navigation, OR behavioral health integration*** services 20 minutes or more of clinical staff time for chronic care management services directed by RHC or FQHC practitioner (MD, NP, PA, or CNM), per calendar month. In 2024 it pays $71.68 (*down from 2023's $77.94*) split 80/20% between Medicare and the patient.

G0512 = Rural Health Clinic or Federally Qualified Health Center only, Psychiatric Collaborative Care Model, 60 minutes or more of clinical staff time for psychiatric CoCM services directed by a RHC/FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month. In 2024 it pays $144.07 (*down from 2023's $146.73*) split 80/20% between Medicare and the patient.

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Care Management now has 20+ codes
Be aware of them all and read the CPT notes!

Physician Fee Schedule Code	Description
G0323	General Behavioral Health Integration (BHI)
99487	Complex CCM (over 60 minutes of care management per month)
99490	Basic CCM (20 minutes of care management)
99491	30 minutes or more of CCM furnished by a physician or other qualified health professional
99424	30 minutes or more of Principal Care Management furnished by physicians or non-physician practitioners
99426	30 minutes or more of PCM services furnished by clinical staff under the supervision of a physician or non-physician practitioner
G3002	Chronic pain management first 30 minutes
G3003	Chronic Pain Management (each additional 15 minutes)
99453	**Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment**
99454	**Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, ea**
99457	**Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes**
99458	**Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes**
99091	**Collection and interpretation of physiologic data (e.g. Blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days**
98975	**Remote therapeutic monitoring (eg, therapy adherence, therapy response); initial set-up and patient education on use of equipment**
98976	**Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each**
98977	**Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days**
98980	**Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes**
98981	**Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the ... additional 20 minutes**
G0019	**Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes pe... social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit**
G0022	**Community health integration services, each additional 30 minutes per calendar month**
G0023	**Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a pa... per calendar month,**
G0024	**Principal Illness Navigation services, additional 30 minutes per calendar month**

General Care Management

Remote Physiologic Monitoring

Remote Treatment Management

Remote Therapeutic Monitoring

Community Health Integration

Principle Illness Navigation

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Source: National Association of Rural Health Clinics 2024 Medicare Updates Webinar (12-11-23)

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Codes designed to provide patient support
Community Health Integration (CHI)
Principal Illness Navigation (PIN)

New for 2024!

Community health integration and principal illness navigation services codes G0019-G0024 are the new codes that will allow providers to report time spent on Social Determinants of Health (SDOH) data collection.

G0019 and G0022

Community Health Integration services are to address unmet SDOH needs that affect the diagnosis and treatment of the patient's medical problems, 60 minutes per month and each additional 30 minutes.

G0023 and G0024

Principal Illness Navigation services are to help people with Medicare diagnosed with high-risk conditions (*ex., SUD/OUD, dementia, HIV/AIDS, and cancer*) identify and connect ***with patient navigators and peer support resources*** 60 minutes per month and each additional 30 minutes.

New for 2024!

For Medicare claims - billing staff will convert each general care management, some remote monitoring services, CHI, and PIN into a single code – G0511.

Major Changes to Care Management Services (G0511)

- Adding in four new buckets of care management:
  - Remote Physiologic Monitoring (RPM)
  - Remote Therapeutic Monitoring (RTM)
  - Community Health Integration (CHI)
  - Principal Illness Navigation (PIN)
- Allowing multiple G0511s per patient per month

.com
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Source: National Association of Rural Health Clinics 2024 Medicare Updates Webinar (12-11-23)

Per CMS Final Rule: "multiple times in a calendar month, as long as all of the requirements are met and resource costs are not counted more than once."

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Tip #5 – ICD-10-CM Guidelines and "Medical Necessity"

Locating ICD-10-CM "instructional notations" benefits providers and billers

M02 Postinfective and reactive arthropathies

Code first underlying disease, such as:
congenital syphilis [Clutton's joints] (A50.5)
enteritis due to Yersinia enterocolitica (A04.6)
infective endocarditis (I33.0)
viral hepatitis (B15-B19)

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

postmeningococcal arthritis (A39.84)
mumps arthritis (B26.85)
rubella arthritis (B06.82)
syphilis arthritis (late) (A52.77)
rheumatic fever (I00)
tabetic arthropathy [Charcôt's] (A52.16)

M02.0 Arthropathy following intestinal bypass

M02.00 Arthropathy following intestinal bypass, unspecified site

M02.01 Arthropathy following intestinal bypass, shoulder

M02.011 Arthropathy following intestinal bypass, right shoulder

ArchProCoding (2024) Protected

Use caution when identifying the "episode of care" and assigning a 7th digit to an ICD-10-CM code

M80 Osteoporosis with current pathological fracture

Includes: osteoporosis with current fragility fracture

Use additional code to identify major osseous defect, if applicable (M89.7-)

Excludes1: collapsed vertebra NOS (M48.5)
pathological fracture NOS (M84.4)
wedging of vertebra NOS (M48.5)

Excludes2: personal history of (healed) osteoporosis fracture (Z87.310)

The appropriate 7th character is to be added to each code from category M80:
- A - initial encounter for fracture
- D - subsequent encounter for fracture with routine healing
- G - subsequent encounter for fracture with delayed healing
- K - subsequent encounter for fracture with nonunion
- P - subsequent encounter for fracture with malunion
- S - sequela

M80.0 Age-related osteoporosis with current pathological fracture
Involutional osteoporosis with current pathological fracture
Osteoporosis NOS with current pathological fracture
Postmenopausal osteoporosis with current pathological fracture
Senile osteoporosis with current pathological fracture

M80.00 Age-related osteoporosis with current pathological fracture, unspecified site

M80.01 Age-related osteoporosis with current pathological fracture, shoulder

M80.011 Age-related osteoporosis with current pathological fracture, right shoulder

Initial = Providing active treatment on that date.

Subsequent = During period of healing and recovery.

Sequela = A "late effect" of a **previous** injury, poisoning, or trauma.

ArchProCoding (2024) Protected

Use the "MEAT" concept to help when deciding which of the patient's conditions from the master problem list should be coded

TABLE 3.1 Examples of Support as Described by MEAT

MEAT ELEMENT	PROBLEM	SUPPORT
Measured, monitored	Morbid obesity	George is still unwilling to consider bariatric surgery, even though it would help his knees considerably
	Diabetes mellitus	A1C today is 6.7
Evaluated	CHF	+3 LE edema
	Pneumonia	Film shows R lung is clearing
Assessed, addressed	HTN	Blood pressure is controlled
	Moderate reactive asthma	Continue low sodium diet
		Breathing improved with weather change
Treated	Assessment: Hypothyroidism	New Rx for levothyroxine 125 mcg daily
	New diagnosis of Stage 3 CKD	Referred to nephrology clinic

Abbreviations: CHF indicates congestive heart failure; CKD = chronic kidney disease; HTN = hypertension; LE = lower extremity; and Rx = prescription.

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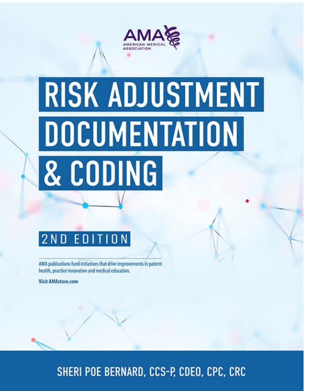

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Get more coding documentation samples from this great reference!

Risk Adjustment Documentation & Coding — Training/Teaching Tools

BEST PRACTICES

Physician Documentation Tips

Minor changes to documentation habits can lead to greater accuracy in abstraction, better compliance, and more appropriate risk scores, quality ratings, and reimbursement.

- **Do not use "history of"** to describe a known, active condition or one requiring any form of treatment. In ICD-10-CM, "history of" always describes a condition that is resolved or not being treated. Instead of saying "history of," quantify the continuum of care (eg, "Mr. Doe is being seen today for his Parkinson's disease, first diagnosed 7 years ago.").
- **Consider each encounter** as a stand-alone account of the patient's health and document accordingly. Coders are not permitted to assign ICD-10-CM codes based on documentation found in previous encounter notes.
- **Use an Assessment/Plan format** that clearly aligns each diagnosis to a treatment plan. Example:

Assessment	Plan
1. Type 2 diabetes mellitus	1. Metformin, 500 mg bid; draw A1C in 3 months
2. CKD, stage 3	2. Staff set up appointment with nephrology clinic
3. Bilateral osteoarthritis, knees	3. Patient to continue naproxen as directed

- **Think in ink.** Chronic conditions affect the chief complaint in almost all cases, and while physicians often think about them, they may not write about them. Document how each chronic condition is monitored, assessed, evaluated, or treated or its impact on the chief complaint (eg, "Diabetes is in good control despite pneumonia. Blood glucose today is 105.").
- **Use linking language, such as "due to" or "resulting in" for related conditions:** "Aphagia due to CVA" rather than "Aphagia and CVA,"" Pancytopenia due to cancer chemotherapy" rather than "pancytopenia status post cancer chemotherapy"; "Bleeding due to warfarin" rather than "Bleeding, on warfarin."
- **Specifically identify any complication** of surgery or procedures and clearly document what the complication entailed. Adverse effects of medications, medical conditions, or trauma should not be coded as complications.
- **Assign diagnoses to documented clinical indicators.** Do not document "GFR of 48." Instead, document, "Chronic kidney disease (CKD) stage 3, GFR of 48." Coders are not permitted to connect the dots or code from laboratory values.
- **Ensure documentation is unique to the encounter.** Use cut-and-paste function with caution.
- **Be specific.** Is the condition acute or chronic? What is the cause? Where is the bleeding? Drug "abuse" or "dependence"? Details yield different diagnostic codes and affect risk scores.
- **Acknowledge pertinent laboratory or radiology results** in the body of the documentation and document their associated diagnoses in the assessment and plan.
- **Document status conditions** at least twice a year and whenever they affect care and/or are evaluated:

Document These Status Conditions Regularly	
Amputation	Asymptomatic HIV status
Dependence on respirator	Dialysis
Ostomy	Transplant
Intellectual disability	History of myocardial infarction

- **Do not say "All systems negative."** Name specific systems reviewed.
- **Document time** when more than 10 minutes have been spent face-to-face with the patient and what percentage of this time was involved in coordination of care or counseling.
- **Tell the whole story.** If physicians do not record what they did, they cannot be paid for it.
- **Review and update problem lists and medication lists** and document having done so.

Risk Adjustment Documentation & Coding — Training/Teaching Tools

DIABETES MELLITUS (DM)

Coder Abstraction Tips

Comorbidities found under "Diabetes/with" are considered complications of diabetes, unless the physician specifically documents otherwise. No linkage language from the physician is specifically required, as identified by the "with" rule in the guidelines.

- **If the type of diabetes is not stated,** the guidelines tell us to report DM, type 2, unless the patient has diabetic ketoacidosis (DKA), in which case, according to the AHA's *Coding Clinic*, the default is type 1.

Types of Diabetes	
E08 Secondary diabetes	due to Cushing's, CF, cancer, pancreatitis, malnutrition
E09 Secondary diabetes	due to drugs or chemicals (code also with T36-T65)
E10 Type 1 diabetes	due to autoimmune process
E11 Type 2 diabetes	due to shortage of insulin or poor insulin transport
E13 Other specified DM	due to genetic defect, Type 1.5, pancreatectomy, NEC

- **Don't stop with one code.** Use as many codes as required to describe all the complications of diabetes documented for the patient. However, all codes for a patient encounter should be in the same diabetes category (eg, do not report code E11.65 with code E10.43).
- **Report treatment with insulin** (Z79.4) or antidiabetic drugs (Z79.84). If patient is on insulin and oral drugs, report only the insulin.
- **Insulin may be given temporarily** for hyperglycemia therapy. This is not "long-term use." "Long- term use" describes daily injection of prescribed insulin. Code presence of an insulin pump (Z96.41).

Type 1 Diabetes and Insulin

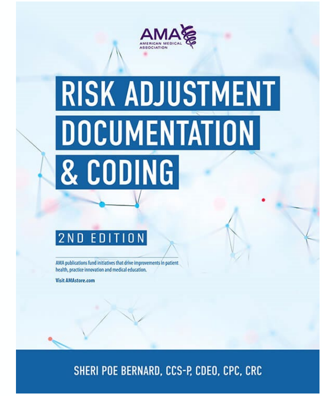
Because type 1 DM requires insulin injections multiple times daily, there is no need to code Z79.4 with type 1 diabetes.

- **Do not overlook documented hyperglycemia or hypoglycemia.** While these conditions were once considered incidental to diabetes, if they are documented and treated, they should be reported. Both conditions risk-adjust.
- **Diabetic gastroparesis** is reported as autonomic polyneuropathy (E--.43). Because there are other forms of autonomic polyneuropathy, also report code K31.84, *Gastroparesis*.

Pregnant Patients with DM

For patients with gestational diabetes, report a code from category O24.4-, plus code Z79.84 for use of oral antidiabetic medications, if appropriate. For other forms of diabetes in pregnancy, report a code from category O24, as well as an "E" code to describe the type of diabetes.

- **Causal links are required** for comorbidities not specifically identified in the Alphabetic Index entries under "Diabetes/with." Beware of the NEC designation; ICD-10-CM requires that these general conditions be linked to diabetes in the documentation. "Diabetes" documented in the same encounter as "candidiasis infection of skin of groin" does not represent a causal relationship because "Diabetes/with/other specified disorder of skin" is not specific to candidal skin infection. "Diabetic candidiasis of skin" shows a causal link.
- **Poorly controlled/out-of-control diabetes** is reported as hyperglycemia, according to the ICD-10-CM Alphabetic Index; uncontrolled diabetes is not.



Source:
AMA Risk Adjustment Documentation and Coding 2nd Edition– by Sheri Poe Bernard (2020)

Social Determinants of Health (SDoH)

- Z55 Problems related to education and literacy
- Z56 Problems related to employment and unemployment
- Z57 Occupational exposure to risk factors
- Z58 Problems related to physical environment
- Z59 Problems related to housing and economic circumstances
- Z60 Problems related to social environment
- Z62 Problems related to upbringing
- Z63 Other problems related to primary support group, including family circumstances
- Z64 Problems related to certain psychosocial circumstances
- Z65 Problems related to other psychosocial circumstances

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Social Determinants of Health (SDoH) should never be the primary diagnosis

- Those were only the main categories of codes – each section on the previous slide contains anywhere from 6-12 specific codes that may be needed for state/federal grant projects, limited Medicaid coverage restrictions, or any other administrative reason to identify how a patient's social factors can influence their overall health.

- Consider SDoH's possible impact on documentation of Medical Decision Making and E/M coding. How often do they need to be reviewed and documented in order to make it on a claim form?

- Research the "PRAPARE" tool for a ton of valuable SDoH information from national leaders including webinars, templates, and additional resources to capture key data by clinical staff for inclusion on claims at: https://prapare.org/

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Research the PRAPARE tool for excellent information and patient tools for SDOH and their *"social drivers of health"*

PRAPARE Screening Tool

National standardized patient risk assessment tool designed to engage patients in assessing and addressing SDOH. Multiple languages available.

1 Item

Show All

PRAPARE Implementation and Action Toolkit

Provides resources, best practices, and lessons learned to guide implementation, data collection, and responses to social determinants of health needs using PRAPARE.

12 Items

Show All

Data Documentation and Clinical Integration Resources

Resources to help develop a data coding, analysis and integration strategy.

6 Items

Show All

PRAPARE Infographic Fact Sheets

Multiple fact sheets provide a high-level snapshot of PRAPARE and its development, use, and impact.

18 Items

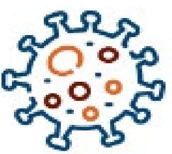
Show All

White Papers and Publications

Multiple whitepapers and publications that go into detail on topics related to PRAPARE and SDOH.

5 Items

Show All



COVID Resources

Resources on understanding and responding to growing social needs during the COVID-19 pandemic.

9 Items

Show All

Recorded Webinars

Podcasts

Health Equity Community of Practice

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Performing Social Determinants of Health (SDOH) Assessments

"SDOH risk assessment refers to the review of the individual's SDOH or identified ***social risk factors that influence the diagnosis and treatment*** of medical conditions and recognizes the time and resources spent by practitioners when assessing SDOH."

Source: 2024 Physician Fee Schedule Final Rule Released – APA Services, Inc.

New for 2024!

Use **G0136** to report the administration of a standardized, evidence-based risk assessment, 5 to 15 minutes, ***not more often than every six months***.

CMS has indicated that this service may be reported as an optional element in Initial/Subsequent Annual Wellness Visits (AWV) similar to Advanced Care Planning and is on the updated CMS approved telehealth list.

The SDOH risk assessment can also be performed by an authorized mental health provider and billed with behavioral health visits" such as traditional diagnostic evaluations or therapy services.

Although Medicare now covers training patient caregivers –does this affect RHC vs. FQHC?

Caregiver Behavior Management Services (96202 and +96203):
Multiple family group training **for parents/guardians/caregivers of patients with a mental or physical health diagnosis** where *“the intended clinical outcome for this treatment approach is to replace unwanted or problematic behaviors with more positive, desirable behaviors through the use of evidence-based techniques and methods.”*

Use these in conjunction with 97550-97552 for non-Medicare payers.

Chapter 21 - Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

Caregiver's Noncompliance– New Codes

Z91.A4 -Caregiver's other noncompliance with patient's medication regimen
Caregiver's underdosing of patient's medication NOS
Caregiver's underdosing with patient's medication NOS

- Z91.A41, Caregiver's other noncompliance with patient's medication regimen due to financial hardship
- Z91.A48,Caregiver's other noncompliance with patient's medication regimen for other reason

Z91.A5- Caregiver's noncompliance with patient's renal dialysis

- Z91.A51, Caregiver's noncompliance with patient's renal dialysis due to financial hardship
- Z91.A58, Caregiver's noncompliance with patient's renal dialysis for other reason

Z91.A9- Caregiver's noncompliance with patient's other medical treatment and regimen
Caregiver's nonadherence to patient's medical treatment

- Z91.A91, Caregiver's noncompliance with patient's other medical treatment and regimen due to financial hardship
- Z91.A98, Caregiver's noncompliance with patient's other medical treatment and regimen for other reason

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