

Professional Coding System Overview



ACHIEVE REVENUE
MANAGEMENT

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International Classification of Diseases (ICD)



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May 26, 2022

International Classification of Diseases (ICD)



WHAT?



WHY?



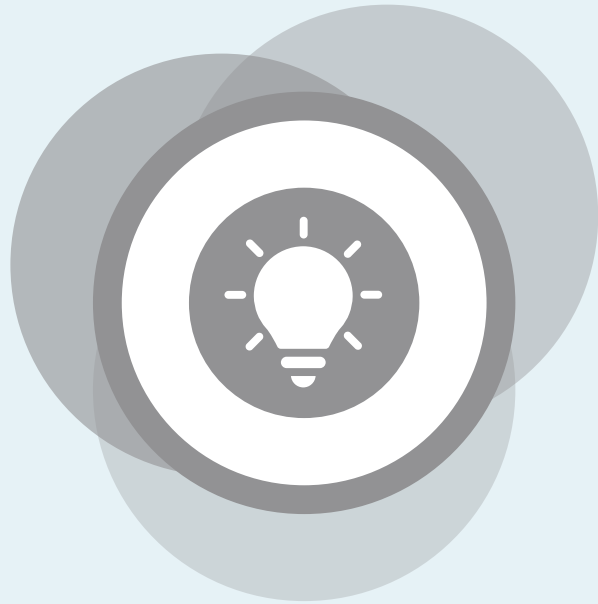
HOW?



WHAT are ICD-10 codes?

- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)
- ICD-10 codes were developed by the World Health Organization (WHO)
- ICD-10-CM codes were developed and are maintained by CDC's National Center for Health Statistics
- Alpha numeric code containing 3-7 characters
- Standardized method for capturing diseases, illnesses, injuries and health conditions

International Classification of Diseases (ICD)



WHAT?



WHY?

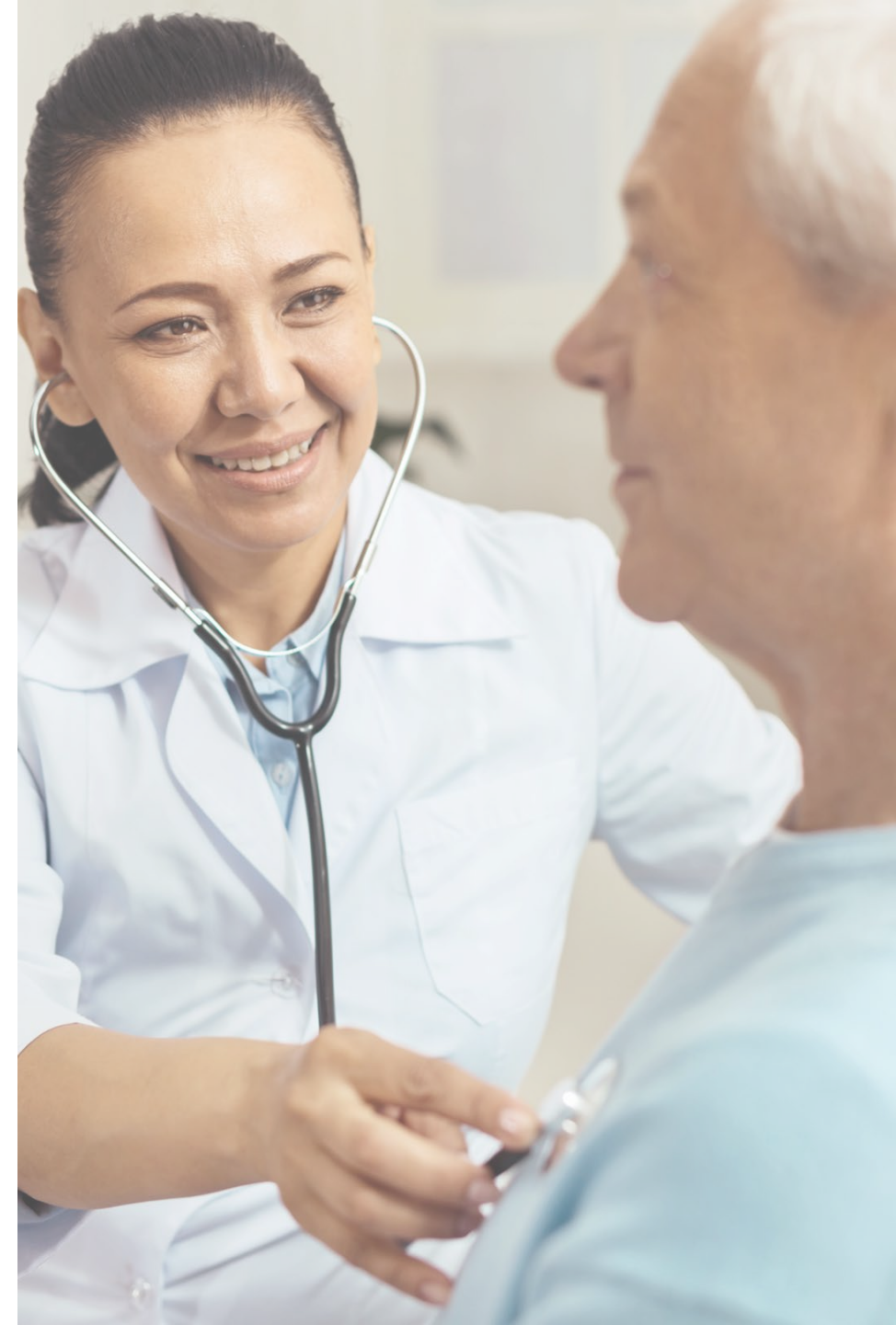


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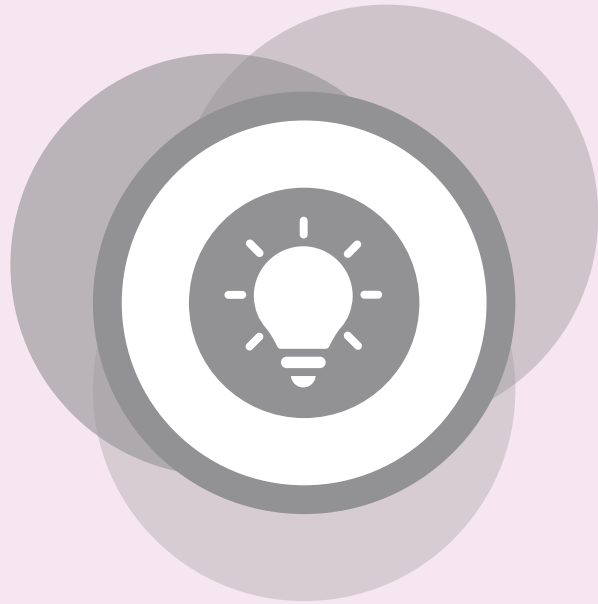


WHY **ICD-10-CM codes are important to FQHCs?**

- Utilized for a variety of purposes including:
 - Insurance claims submission and processing
 - Tracking public health conditions and assisting with population health management
 - Identifying care gaps and improving quality of care
 - Clinical research



International Classification of Diseases (ICD)



WHAT?



WHY?



HOW?



HOW:

ICD-10-CM codes are applied

- Criteria and instruction for code selection contained within:
 - ICD-10-CM Official Guidelines for Coding and Reporting
 - <https://www.cms.gov/files/document/fy-2022-icd-10-cm-coding-guidelines-updated-02012022.pdf>
 - ICD-10-CM coding reference
- Adherence is required and guidelines include instruction on:
 - Locating a code
 - Detail
 - Signs & symptoms
 - Conditions and disease process relation
 - Acute vs. Chronic
 - Laterality
 - Documentation



HOW: **ICD-10-CM codes are applied**

- Patient specific documentation (health record) describes applicable health conditions including Social Determinants of Health (SDoH)
- Codes are divided between 22 chapters with detailed selection instruction
- Individual chapters contain related injuries, illness, conditions, etc. including poisoning and external causes
 - Examples:
 - Chapter 1: Certain Infectious and Parasitic Diseases (A00-B99)
 - Human Immunodeficiency Virus (HIV) Infections
 - Methicillin Resistant Staphylococcus aureus (MRSA)
 - Chapter 21: Factors Influencing Health Status (Z00-Z99)
 - Social Determinants of Health (SDoH)
 - Encounters for screening purposes



HOW: ICD-10-CM codes are applied

- Codes describing social determinants of health (SDOH) should be assigned when this information is documented
- Persons with potential health hazards related to socioeconomic and psychosocial circumstances code assignment may be based on medical record documentation from clinicians involved in the care of the patient who are not the patient's provider
- Information represents social information, rather than medical diagnoses
- Social determinants of health codes are located primarily in code categories Z55-Z65
- Including:
 - 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



Healthcare Common Procedure Coding System (HCPCS)



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Healthcare Common Procedure Coding System (HCPCS)



WHAT?



WHY?



HOW?



WHAT Is the HCPCS?

- Healthcare Common Procedure Coding System (HCPCS) is a standardized coding system describing services, drugs, items and supplies provided or rendered to a patient
- HCPCS is divided into two subsystems
 - Level I
 - Current Procedural Terminology (CPT®)
 - Level II
 - Alpha-numeric coding system
 - Identifies drugs, biologicals, durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)



WHAT Is the CPT?

Current Procedural Terminology (CPT®)

- Coding system maintained by the American Medical Association (AMA)
- Divided into three categories
 - Category I
 - 5 numeric digit codes
 - Largest category of codes, primarily those commonly used by providers to report their services and procedures



WHAT Is the CPT?

Category I code ranges arranged by related services:

- Evaluation and Management 99201-99499
- Anesthesiology 00100-01999, 99100-99140
- Surgery 10021-69990
- Radiology 70010-79999
- Pathology & Laboratory 80047-89398
- Medicine 90281-99199, 99500-99607



WHAT Is the CPT?

Category II

- 5 digit codes ending with the letter “F”
- Supplemental codes to report and track performance measurements

Category III

- 5 digit codes ending with the letter “T”
- Temporary codes that represent new technologies, services and procedures

Healthcare Common Procedure Coding System (HCPCS)



WHAT?



WHY?



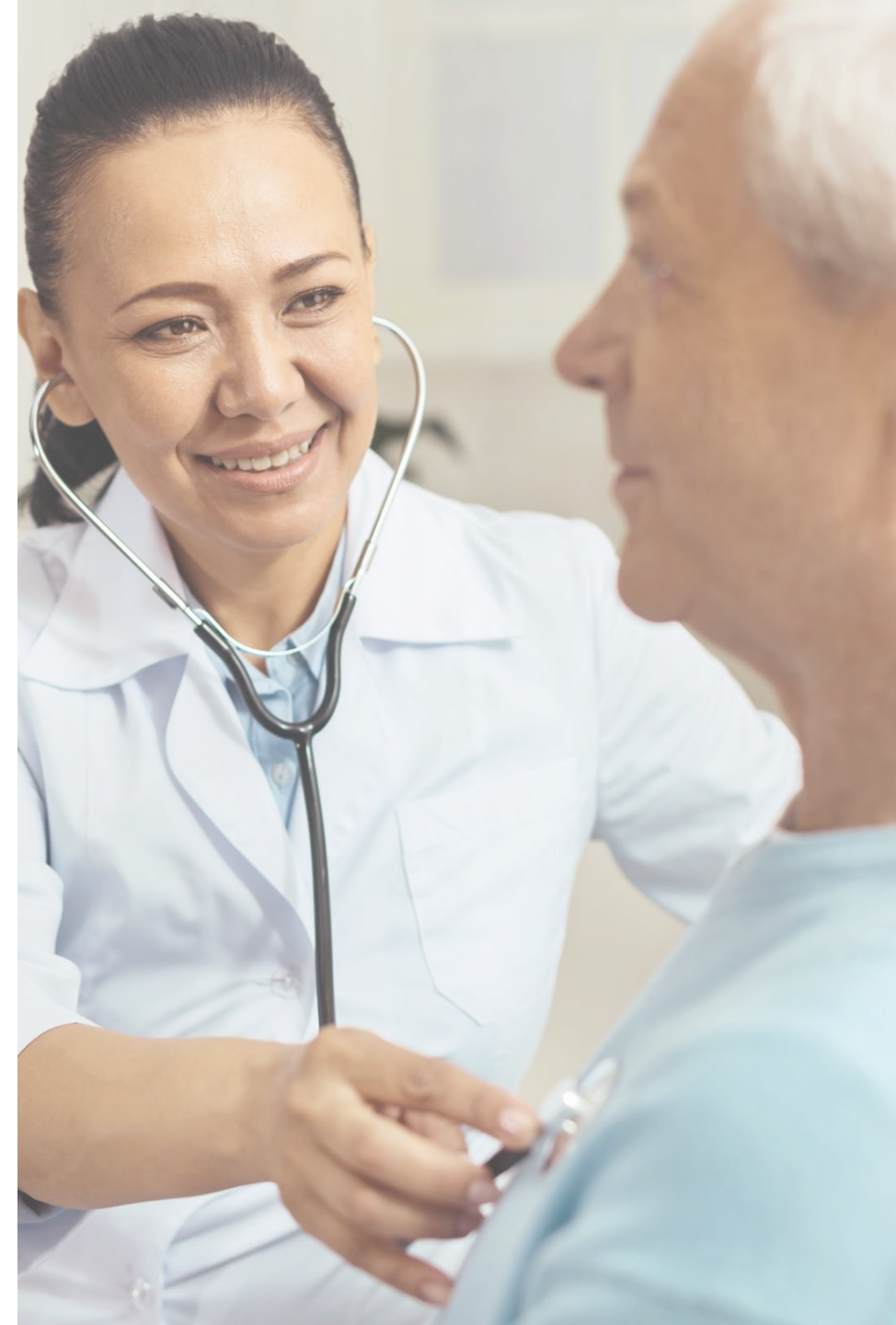
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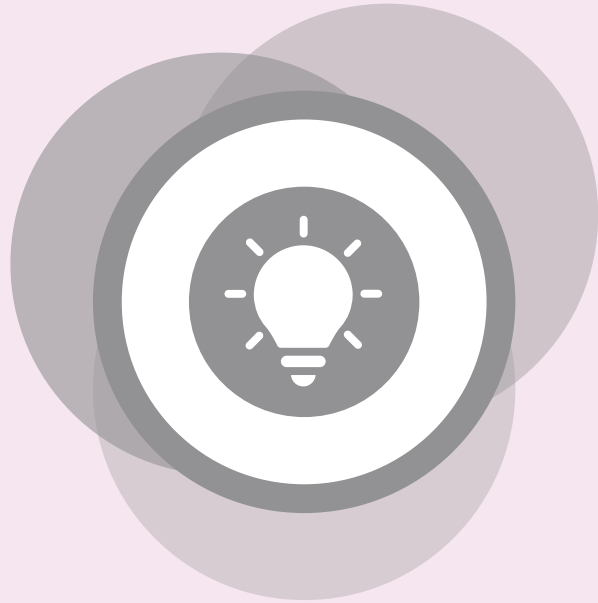
WHY **Is the HCPCS Level I codes important to FQHCs?**

Utilized for a variety of purposes including:

- Insurance claims submission and processing
- Tracking patient outcomes
- Identifying care gaps and improving quality of care
- Medical review
- Utilization comparison
- Establishing clinical protocols and outreach processes



Healthcare Common Procedure Coding System (HCPCS)



WHAT?



WHY?



HOW?



HOW: **HCPCS codes are applied**

- Criteria and instruction for code selection contained within:
 - Current Procedural Terminology (CPT®)
 - HCPCS Level II
 - American Medical Association (AMA)
 - Centers for Medicare & Medicaid Services
 - Payer guidelines and references
- Adherence is required and guidelines at the beginning of each section define items necessary to interpret and report on services in that section



HOW: **HCPCS codes are applied**

- Patient specific documentation (health record) describes procedures, services or supplies rendered
- Code describing applicable item or service is selected
- Modifying factors & Place of Service are also noted, taken into consideration and reported through two digit “Modifiers” and “POS” codes outlined within the HCPCS mechanism



HOW: **HCPCS codes are applied**

- When reporting CPT Category II codes to communicate supplemental information related to a patient/patient encounter selection, determine:
 - Numerator
 - Denominator
 - Exclusion(s)
 - Reporting instructions
- Alphabetic Measure Index found on the American Medical Association website
 - <https://www.ama-assn.org/system/files/2020-01/cpt-cat2-codes-alpha-listing-clinical-topics.pdf>



HOW:

CPT Category II codes are structured

Diabetes (DM)		
Brief Description of Performance Measure & Source and Reporting Instructions	CPT Category II Code(s)	Code Descriptor(s)
<p>A1c Management ⁴</p> <p>Whether or not patient received one or more A1c test(s)</p> <p>Numerator: Patients who received one or more A1c test(s)</p> <p>Denominator: Patients with diagnosed diabetes 18-75 years of age</p> <p>Percentage of patients with diagnosed diabetes aged 18-75 years with one or more A1c test(s).</p> <p>Exclusion(s): NONE</p> <p>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.</p> <p>▶ To report most recent hemoglobin A1c level ≤9.0%, see codes 3044F, 3051F, 3052F. ◀</p>	3044F	Most recent hemoglobin A1c (HbA1c) level < 7.0%
	▶ 3051F ◀	▶ Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% ◀
	▶ 3052F ◀	▶ Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% ◀
	3046F	Most recent hemoglobin A1c (HbA1c) level > 9.0%

<https://www.ama-assn.org/system/files/2020-01/cpt-cat2-codes-alpha-listing-clinical-topics.pdf>



Coding & Risk Adjustment



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Risk Adjustment



WHAT?



WHY?



HOW?



WHAT Is Risk Adjustment

Risk Adjustment

- System or method for which payment is based on an individual patient's:
- Demographics:
 - Age, sex, disability, Medicaid eligibility, etc.
- Health status or conditions:
 - Chronic conditions
 - Disease and disability interactions
- Various models and designs



WHAT

Are key terms used in Risk Adjustment models

Hierarchical Condition Categories (HCC)

- Categories of clinically similar diagnosis (ICD-10) codes arranged in a hierarchy by severity.

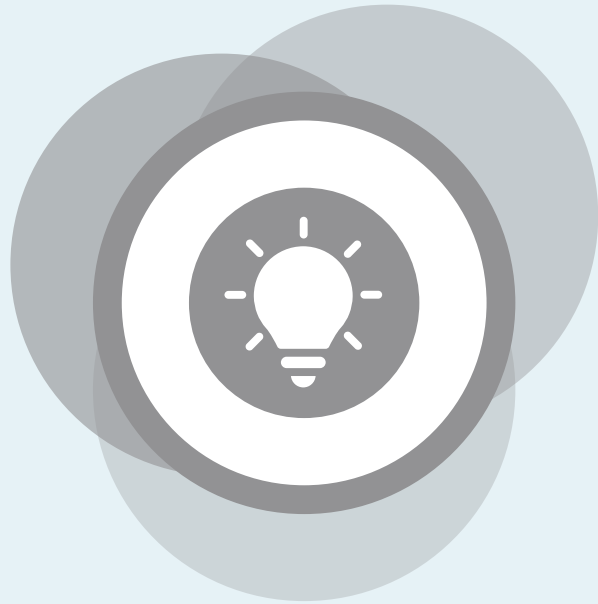
Risk Adjustment Factor (RAF)

- A numeric weight assigned to specific HCC or demographic category reflecting intensity or severity of health condition or status.

Risk Adjustment Factor Score

- Specific numeric score comprehensive (sum) of both the health and demographic RAF for an individual patient.

Risk Adjustment



WHAT?



WHY?



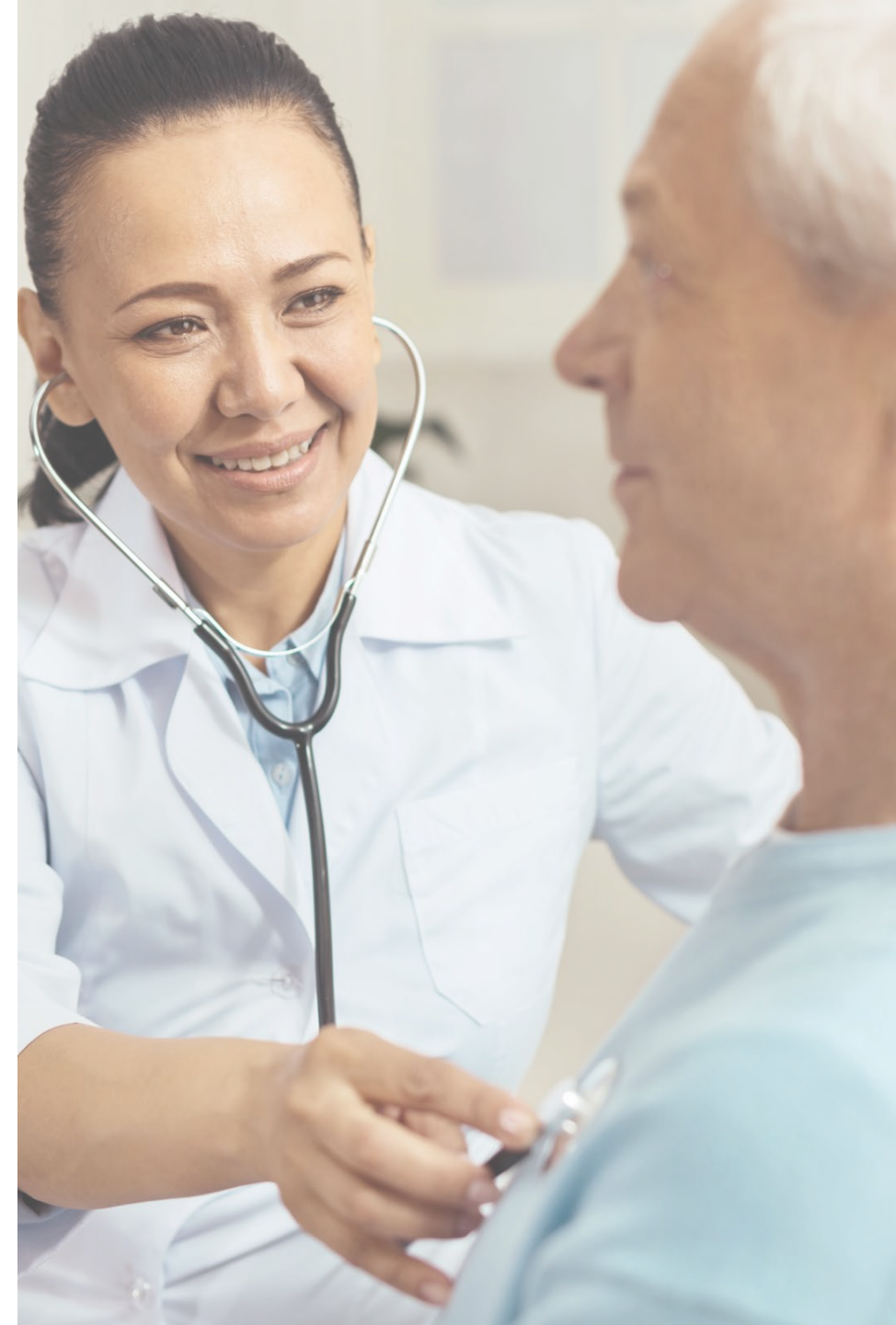
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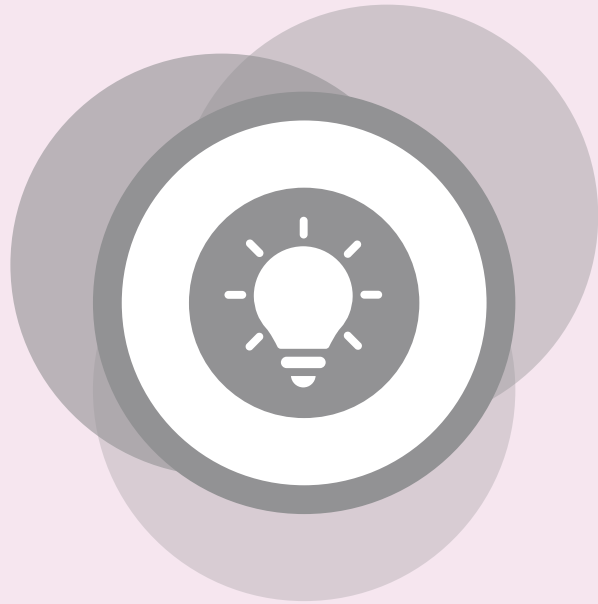
WHY

Is risk adjustment important to FQHCs?

- Transitions away from standard fee-for-service considerations to a system based on predicted cost or “risk” of a patient
- May impact reimbursement from:
 - Payers (directly or indirectly)
 - Shared savings plans
- Considered to be an avenue for various value based arrangements
- Opportunity to address comprehensive care for patient
- Predictive modeling



Risk Adjustment



WHAT?



WHY?



HOW?



HOW:

Risk Adjusted Methods are determined

- Provider renders a face-to-face encounter with the patient
- Chronic conditions, health status, and other applicable factors are documented
- Appropriate ICD-10-CM codes are selected
- ICD-10-CM codes are cross walked to associated HCC
- RAFs from patient's HCC and demographic data are summed to calculate the patient's risk score
- Risk score may then be used for payment or other reporting or care purposes



Hierarchical Condition Categories



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Hierarchical Condition Categories (HCC)



WHAT?



WHY?



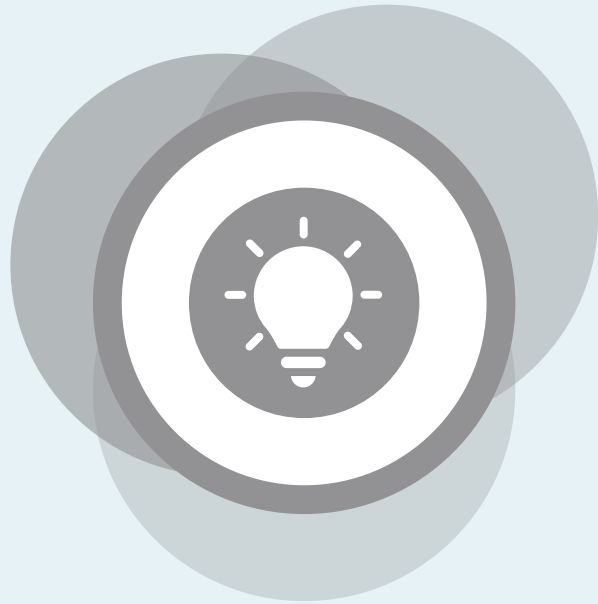
HOW?



WHAT are Hierarchical Condition Categories (HCCs)?

- Groupings of clinically similar diagnoses
- Conditions are categorized hierarchically
- Each HCC is assigned a value relative to other conditions
- Used by CMS (and others) as part of determining risk or conducting a risk adjustments model

Hierarchical Condition Categories (HCC)



WHAT?



WHY?

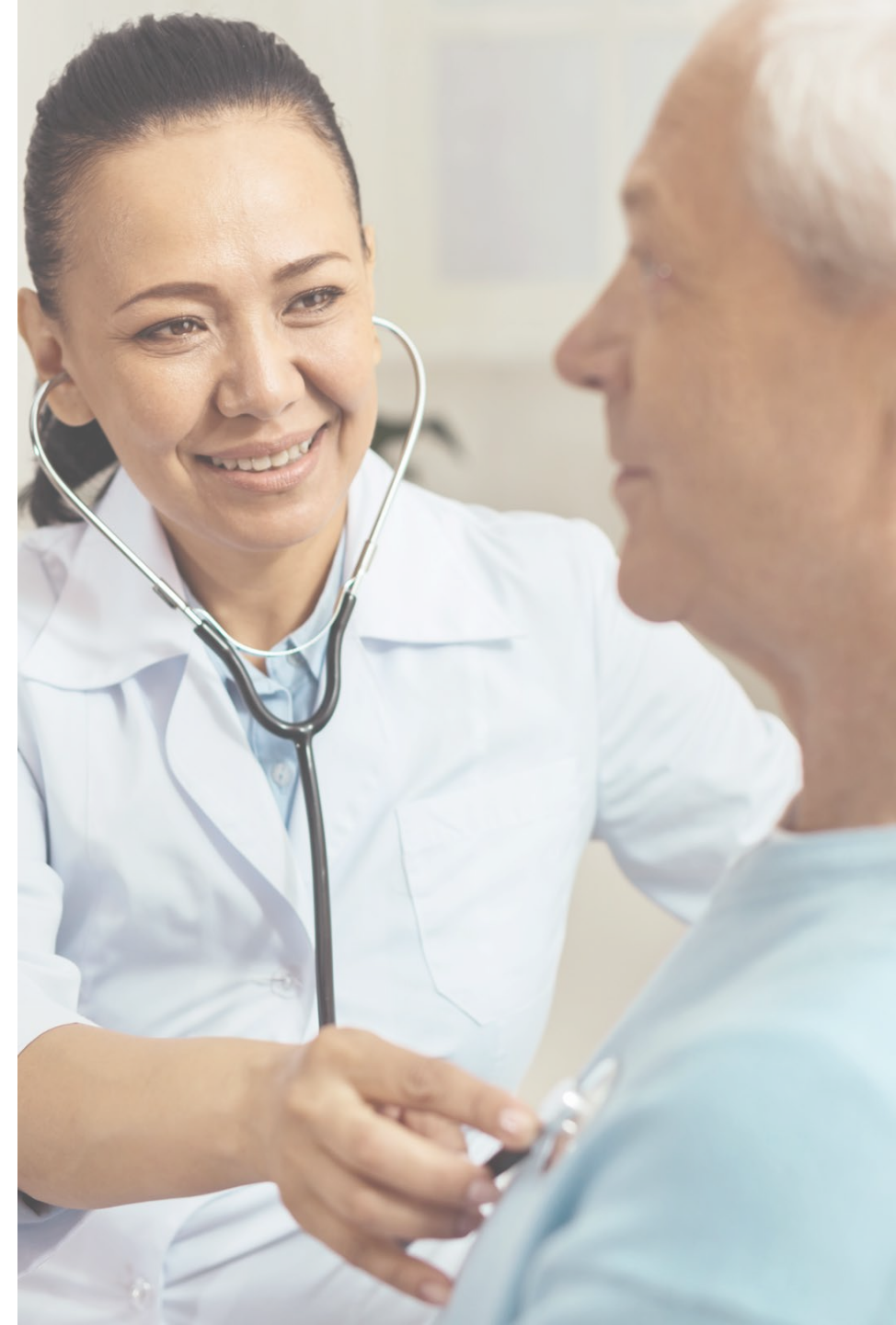


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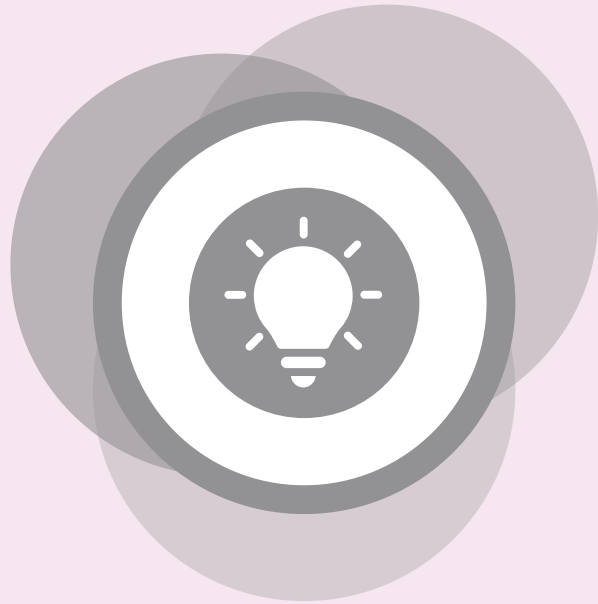


WHY **HCC codes are important to FQHCs?**

- Accurate HCCs should translate to better determination of risk score associated with individual patients
- Often impact Accountable Care Organization (ACO) benchmarking
- Can be used internally to determine specific scores to target for services or resources
- Providers directly impact HCC assigned to patient



Hierarchical Condition Categories (HCC)



WHAT?



WHY?



HOW?



HOW: **HCC codes are determined**

- Health conditions are identified via International Classification of Diseases–10 (ICD–10-CM) diagnoses that are submitted by providers on incoming claims
- ICD-10 codes map to HCC category
- Distinct HCCs are assigned specific values used to calculate individual patient risk score



HOW:

HCC coding and ICD-10-CM codes work together

ICD-10-CM Codes	HCC Category Description	HCC	Disease Hierarchy
B20, B97.35, Z21	HIV/AIDS	1	
A02.1, A20.7, A22.7, A26.7, A32.7, A39.2-A39.4, A40.-, A41.-, A42.7, A48.3, A54.86, B00.7, B37.7, P36.-, R57.1, R57.8, R65.1-, R65.2-, T81.12XA	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/ Shock	2	
A07.2, A31.0, A31.2, B25.-, B37.1, B37.7, B37.81, B44.0-B44.7, B44.89, B44.9, B45.-, B46.-, B48.4, B48.8, B58.2, B58.3, B59	Opportunistic Infections	6	
C77.1-C77.2, C77.4-C77.8, C78.-, C79.00-C79.72, C79.89, C79.9, C7B.-, C80.0, C91.0-, C92.00-C92.02, C92.40-C92.A2, C93.0-, C94.00-C94.22, C94.40-C94.42, C95.0-	Metastatic Cancer and Acute Leukemia	8	9, 10, 11, 12
C15.-, C16.-, C17.-, C22.-, C23, C24.-, C25.-, C33, C34.-, C38.4, C45.-, C48.-, C90.00-C90.22, C92.10-C92.32, C92.Z0-C92.92, C93.10-C93.92, C94.30-C94.32, C94.80-C94.82	Lung and Other Severe Cancers	9	10, 11, 12
C40.-, C41.-, C46.-, C47.-, C49.-, C56.-, C57.00-C57.4, C58, C70.-, C71.-, C72.-, C74.-, C75.1-C75.3, C77.3, C77.9, C79.2, C79.81, C79.82, C81.-, C82.-, C83.-, C84.-, C85.-, C86.-, C88.2-C88.9, C90.3-, C91.-, C95.10-C95.92, C96.-	Lymphoma and Other Cancers	10	11, 12
C01, C02.-, C03.-, C04.-, C05.-, C06.-, C07, C08.-, C09.-, C10.-, C11.-, C12, C13.-, C14.-, C18.-, C19, C20, C21.-, C26.-, C30.-, C31.-, C32.-, C37, C38.0-C38.3, C38.8, C39.-, C51.-, C52, C53.-, C57.7-C57.9, C64.-, C65.-, C66.-, C67.-, C68.-	Colorectal, Bladder, and Other Cancers	11	12
C43.-, C4A.-, C50.-, C54.-, C55, C60.-, C61, C62.-, C63.-, C69.-, C73, C75.0, C75.4-C75.9, C76.-, C7A.-, C80.1, C80.2, D03.-, D18.02, D32.-, D33.-, D35.2-D35.4, D42.-, D43.-, D44.3-D44.7, D49.6, E34.0, Q85.-	Breast, Prostate, and Other Cancers and Tumors	12	
E20.0, E20.1, E20.01, E20.0, E20.1, E20.01, E10.1, E10.01, E11.0, E11.1, E11.01	Diabetes with Acute	17	10, 12



HOW: **to assist with accurate HCC coding**

- Assign all ICD-10 codes to the highest level of specificity possible
- Maintain an accurate and up-to-date problem list
- Address (in face-to-face encounter), document and code for all chronic conditions every year
 - Scores are reset January 1st of each year in some plans



HOW: **to assist with accurate HCC coding**

Tips or Tools for documenting chronic conditions:

- M** Monitoring signs, symptoms, disease progression, disease regression
- E** Evaluated test results, medication effectiveness, response to treatment
- A** Addressed ordered tests, discussion, review records, counseling
- T** Treated medications, therapies, other modalities



HOW: **to assist with accurate HCC coding**

Tips or Tools for documenting chronic conditions:

TAMPER

- T** Treatment
- A** Assessment
- M** Monitoring or Medicate
- P** Plan
- E** Evaluate
- R** Referral

<https://ionhealthcarepulse.com/2016/09/28/faqs-on-risk-adjustment/>

Reimbursement Tips: CMS/Medicare Care Management

This compendium of care management tools is available free of charge on NACHC's Elevate platform



PAYMENT Reimbursement Tips:
FQHC Requirements for Medicare Behavioral Health

The general Behavioral Health Integration (BHI) model of care refers to the BHI and behavioral health services similar to core services offered under the Care Model (CoCM), but without several additional components.

Program Requirements
General Behavioral Health Integration (BHI) covers models of care that focus on integrative treatment for patients with mental or behavioral health conditions that do not require, though they may use, the services of a behavioral health care manager or psychiatric consultant as required under the Psychiatric Collaborative Care Model (CoCM).

Patient Eligibility & Consent
Eligible patients are those requiring integrated behavioral health and primary care services, but not a psychiatric consultation or designated behavioral health manager. The patient must provide consent prior to initiating services. Consent may be verbal but must be documented in the medical record. The billing provider must inform the beneficiary that cost sharing (e.g., co-insurance) applies.

Timeframe & Services
Start-up An initiating visit with the billing provider (separately billable) required for new patients or patients not seen within one year prior to the start of BHI services.
Subsequent Months Minimum of 20 minutes of behavioral health services.
BHI services are billed based on the calendar month rather than per 30 days. Reporting can occur any time in the calendar month after the 20-minute time threshold is met. Face-to-face services are not required during the calendar month. Patients should periodically be reminded

PAYMENT Reimbursement Tips:
FQHC Requirements for Medicare Chronic Care Mgmt. (CCM)

The Chronic Care Management (CCM) model of care refers to personalized and supportive services for individuals with multiple (two or more) chronic conditions to coordinate care and develop a care plan to achieve health goals.

Program Requirements
Chronic Care Management (CCM) refers to a comprehensive set of services administered to help a patient coordinate and manage multiple chronic conditions. CCM services are typically provided outside of face-to-face visits. CCM services include:

- Comprehensive assessment
- Comprehensive care plan
- Medication management
- Preventive care
- Care plan sharing
- Care coordination
- Continuity of care
- Care transition management
- 24/7 access
- Resources
- Electronic communication options
- Electronic health record documentation

Patient Eligibility & Consent
Eligible patients include those who have multiple (two or more) chronic conditions expected to last at least 12 months or until the patient dies, or that place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.

- Medication
- Non-Physician Assistants (PA), Certified Nurse Practitioners (CNS)
- Behavioral Health Care Manager (specialized training in behavioral health psychology) and at least a bachelor's degree, oversight and direction of the billing practitioner.
- Psychiatric Consultant: Medical professional trained in qualified to prescribe the full range of medications.

Timeframe & Services
CMS/Medicare covers several types of chronic care management services. These include CCM and complex CCM. These services vary in the amount of clinical staff time provided, the level of involvement of the billing practitioner, and the extent of care planning performed. CCM services include:

- Non-complex (CPT 99490)** 20 mins or more of CCM services in a month (ancillary staff + provider)
- Complex (CPT 99487)** 60 mins or more of CCM services in a month (ancillary staff + provider)
- Provider only (CPT 99491)** 30 mins or more of CCM services in a month (provider only)
- Additional time (CPT +99489)** Each add'l 30 mins; only added to complex/99487 (ancillary staff + provider)

CCM services (see Program Requirements) are extensive and require the development of a care plan that is shared with outside providers, the patient, and/or caregiver. The care plan must be coordinated with the management of transitions between and among health care providers and settings. (See Transitional Care Management information for reimbursement guidance.) Patients/caregivers are to be offered the ability to communicate with the provider through a variety of electronic communication options, including: secure

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UPCOMING EVENTS

June 2022

SUN	MON	TUE	WED	THU	FRI	SAT
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

June 14. Learning Forum

VTF Change Area: Care Management (Part 2)

CMS Chronic Care Management (CCM), Complex Chronic Care Management (CCCM), & Principal Care Management

June 23. Elevate Connect

VTF Change Area: Evidence-Based Care, Diabetes Self-Management Education and Support



Use this link to receive calendar invitations for all upcoming learning forums:

bit.ly/Webinars22

FEEDBACK

Don't forget! Let us know what you thought about today's session.

FOR MORE INFORMATION CONTACT:

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Next Monthly Forum Call:

June 14, 2022
1-2 pm ET

Next *Connect* Call:

June 23, 2022
1-1:45 pm ET