Top 10 Documentation and Revenue Tips in Community Health

Offered through NACHC's Billing, Coding, Documentation, and Quality Webinar Series

Taught by the
Association for Rural & Community Health
Professional Coding (ArchProCoding)
Metro-Atlanta, GA

Part 1 of 2: January 20, 2022

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EDUCATION :: CERTIFICATION :: AUDIT SUPPORT ::
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Series participants will:

Review the essentials of clinical documentation, professional coding, and medical billing processes to minimize errors and denials.

Receive an overview of quality and accurate reporting for FQHCs and an explanation of frequently used key terms and concepts.

Gain access to resources for continued learning and growth.

Webinar session #2 of 2: Substance/Opioid Use Disorders via Medication-Assisted Treatment (MAT) in Community Health is on January 27, 2022

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Arch Pro Coding's
TARGET AUDIENCE

Clinical Providers

Document 100% of what is done (CPT/HCPCS-II) and why (ICD-10-CM) per the official guidelines?

Facility Leadership

Code 100% of your services by facilitating effective communications with clinical and business staff via the "encounter form."

Billing & Quality

Get paid 100% of what you should (*and no more than allowed*) by understanding differing payer rules?

MORE INTERNAL CONTROL :::::::::: **LESS INTERNAL CONTROL**

Top 10 Tips (#1-5)

1.) Determine the level of training needed by each job role and train together under an established CEU/CME budget.

2.) Know the difference between documentation>coding>billing and ensure that all providers are "coding" on superbills/encounter forms rather than "billing."

3.) Gather current printed copies of the HIPAA-approved code sets and be fully aware of CMS' Claims and Benefits Manual Chapters 9 and 13 and train from the source materials.

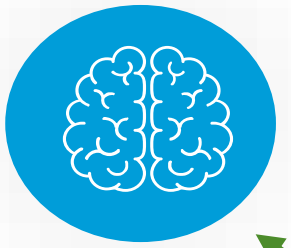
4.) Review participation contracts with key commercial carriers and seek out specific answers to specific questions before renewing your agreement.

5.) Perform internal audits on E/M services to confirm if you are following the 2021/2022 updates that changed for the first time since 1992.

Tip #1
Determine Type of Training Needed by Job Role

What Path Do We All Share?

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



PREPARE TO SEE THE PATIENT:
Are you truly ready to handle the advanced issues of operating in a 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.

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

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

POSSIBLE CHALLENGES AND ISSUES?

Documentation

Frustration with previous documentation requirements?

Know the CPT and ICD-10-CM guidelines?

Too many IT/EHR shortcuts?

Professional Coding

Insurance contracts signed not understanding the true impact on providers and billers?

Who is truly responsible for “coding”?

Do your IT and EHR systems work well together?

Billing and Quality

Easy to balance claims that pay FFS vs. daily encounter rates?

Tough to find info specific to FQHCs?

Routine communication with providers?

Estimate Your Performance In These Areas And Develop Plans To Improve Where Needed

Do clinical and revenue staff have a shared platform of knowledge on documentation, coding, and billing that fits your clinical and business needs?

Who?

Work together to code all encounters fully?

Are your clinical providers aware of the updated documentation guidelines found in the CPT and ICD-10-CM?

Getting paid 100% of the revenue you are entitled to and nothing more?

Tip #2

Know the differences between documentation, coding, and billing

Coding and billing are not the same!

- Coding turns medical documentation into useable data regardless of whether it generates $$$ or not.

- Just because you didn't get paid doesn't mean you did it wrong.

- Just because you got paid doesn't mean you get to keep the $$.

- Where Medicare goes with billing rules, which other payers tend to follow?

- Getting paid by insurers is a very trust-based be ready to support your services if medical documentation is requested by a payer or patient.

Current CMS Rules on FQHC Line-by-Line Billing

What "qualifies the (Medicare) service for an encounter-based payment" to an FQHC?

Specific Payment Codes for the Federally Qualified Health Center Prospective Payment System (FQHC PPS)

(Rev. 12-06-17)

In accordance with Section 1834(o)(1)(A) and 1834(o)(2)(C) of the Social Security Act, we established specific payment codes that FQHCs must use when submitting a claim for FQHC services for payment under the FQHC PPS. Detailed Healthcare Common Procedure Coding System (HCPCS) coding with the associated line item charges listing the visit that qualifies the service for an encounter-based payment and all other FQHC services furnished during the encounter are also required.

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

HYPERLINK

How do you move data from a provider to a coder/biller?

Make this a focus!

PATIENTS:

- Do you give patients something that tells what happened (CPT/HCPCS-II) and why (ICD-10-CM) **or** are they struggling trying to understand what happened using the EOB from their insurer?

PROVIDERS:

- Are you “coding” on the superbill or applying medical “billing” rules that may differ by carrier?
- Are you confident that providers are aware of the full code definition of CPT/HCPCS-II, or ICD-10-CM codes?

How do you move data from a provider to a coder/biller?

Make this a focus!

CFOs & MANAGERS:

- Are you under-reporting your **TRUE COSTS** (CPT/HCPCS-II) and the actual complexity of your patient population (ICD-10-CM)?
- Are you maximizing opportunities to get revenue from quality reporting & care management services?

CODING/BILLING/QUALITY:

- Is the clinical note closed and signed before codes are entered into your billing systems?
- Does anyone review the completed note before the bill is created?
- How do we keep encounter data for the cost report but not have it go out on a bill to a carrier?

COST REPORT:

Coding vs. Billing?

TOTAL ALLOWABLE COSTS based on "pure coding'

÷ = **Your "Cost"**

of "allowable" visits

EVERYTHING about cost reports is centered on how well you are truly capturing all of the services you provide based on CPT, HCPCS-II, and ICD-10-CM official coding guidelines.

Medicare Benefit Policy Manual
Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services
80.1 - RHC and FQHC Cost Report Requirements
(Rev. 252, Issued: 12- 07-18, Effective: 01-01-19, Implementation: 01- 02-19)

Tip #3

Gather HIPAA-approved code sets and key CMS materials.

Key resources to stay updated

Does each office/nurses station have each of the current federally-mandated HIPAA Code manuals used by FQHCs or are you too dependent on software?

Do you have access to and understand the contents of key CMS updates as well as their Policy and/or Benefits Manuals such as chapters 9, 13?

Insurance participation contracts should outline how to report quality, bill for services, charge patients, and outline coverage. Can you locate these in your current/future contracts?

Quality/Care Management Category	Use CPT	Use HCPCS-II	Use ICD-10-CM	Impact on FQHC Revenue
Care Management Services	✓	✓	✓	HIGH
CPT Category II Performance Measures	✓			LOW
Preventive Medicine Services	✓	✓	✓	HIGH
Hierarchal Conditions Categories (HCC)			✓	MEDIUM
HEDIS measures	✓	✓	✓	LOW
Population Health Prevention via Social Determinants of Health			✓	**HIGH (as of 2021)**
Primary Care & Behavioral Health Integration (ex. SUD/OUD/MAT/BHI/Psych CoCM)	✓	✓	✓	HIGH

Key CMS Resources to Download and Study!

HYPERLINKS

Ch. 9 – CMS Claims Processing Manual
Updated 9-20-20

Ch. 13 – CMS Benefit Policy Manual
Updated 4-26-21

Ch. 18 – CMS Claims Processing Manual
For Preventive Medicine

2021 CMS Evaluation & Management Updates

New and Expanded Flexibility for FQHC during the COVID-19 PHE – MLM #SE20016 (last updated 2-23-21)

(Updated 5-6-21) COVID-19 FAQs - see pages 64-72 for FQHC

Tip #4

Review commercial participation contracts and emphasize differences with CMS rules

Sample CPT Codes

93000-93010 – EKG, 12 lead, global, professional component only, technical component only

99000 – Handling and/or conveyance of a specimen for transfer to a lab

99202-99215 – Evaluation & Management (office)

99211 – "Nurse visit"

99381-99397 – Preventive Medicine Services

99487-99490 – Chronic Care Management (*various times*)

99460, 90461, and 90471-90474 – Vaccine Administration

Sample HCPCS-II Codes

G0402, G0438-G0439 – CMS Initial Preventive Physical Exam (IPPE) & Init./Subseq. Annual Wellness Visits (AWV)

G0466-G0470 – Main FQHC PPS Visit Codes

G0008-G0010 – Vaccine Administration (pneumo, flu, HepB)

G0101 – Pelvic and breast Exam – "well-woman"

G0403-G0405 – EKG, 12 lead, global, professional component only, technical component only with an IPPE

G0511-G0512 – Chronic Care Management and Behavioral Health Integration for FQHC – (*only 20+ minutes/month*)

Q0091 – Handling/conveyance of a screening Pap Smear for transfer to the lab

T1001-T1015 – Various Medicaid nursing assessments and an "all inclusive" clinic visit

Compare/Contrast AMA vs. CMS Global Packages

- Identify the key procedures that begin with any CPT codes ranging from 1xxxx-6xxxx or various 9xxxx *codes* from the **Production Report** that shows your most common codes where this concept likely applies.

- Review the CPT definition of the Surgical Package that is on the green pages just before the first CPT surgical codes and after the anesthesia Section.

- In the billing section and other exercises, we will go through some key areas of CPT and highlight some important areas…making some distinction between “coding” and “billing” and highlighting how billing may be different by carrier.

- **Key revenue opportunity ::** Which definition of the global package do your commercial carriers follow? What about Medicaid?

Do Medicare lobal billing rules apply to FQHCs?

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

Table of Contents
(Rev. 230, 12-09-16)

40.4 - Global Billing
(Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16)

Surgical procedures furnished in a RHC or FQHC by a RHC or FQHC practitioner are considered RHC or FQHC services. Procedures are included in the payment of an otherwise qualified visit and are not separately billable. If a procedure is associated with a qualified visit, the charges for the procedure go on the claim with the visit. Payment is included in the AIR when the procedure is furnished in a RHC, and payment is included in the PPS methodology when furnished in a FQHC. The Medicare global billing requirements do not apply to RHCs and FQHCs, and global billing codes are not accepted for RHC or FQHC billing or payment.

Surgical procedures furnished at locations other than RHCs or FQHCs may be subject to Medicare global billing requirements. If a RHC or FQHC furnishes services to a patient who has had surgery elsewhere and is still in the global billing period, the RHC or FQHC must determine if these services have been included in the surgical global billing. RHCs and FQHCs may bill for a visit during the global surgical period if the visit is for a service not included in the global billing package. If the service furnished by the RHC or FQHC was included in the global payment for the surgery, the RHC or FQHC may not also bill for the same service.

CMS Surgical Package definition to use for FFS 3rd party carriers NOT MEDICARE for FQHCs!

Pre-operative

$

Minor – E/M day of surgery included

Major – E/M day of and day before surgery

Intra-operative

$

Post-operative

$

Minor adds either 0 or 10 days of follow-up

Major adds 90 days of follow-up

BE CAREFUL!!!
+1 day pre-op
+1 day of surgery
= 92 **TOTAL** global days

NOTE: Many FQHC providers perform "major" surgeries that are billed Fee-for-Service since they are not done in your office(s)

Most modifiers depend on your adjusting their usage based on which definition of the surgical package a commercial carrier uses

Pre-operative

Minor Procedure + E/M with -25

Major Procedure + E/M with -57

Day of the procedure

"Please pay this though you normally don't" = -32, -59, -76/-77

Changes payment amount:

- -22/-52 (pay me more or less than normal)
- -50, -51 (payment reductions)
- -53/-73*/-74*(incomplete service)
- -54/-55/-56 (splits pre-, op, post-)
- -62, -66, -80, -81, -82 (surgical teams)

Post-operative

E/M modifier -24

Procedures modifiers -58, -78, -79

Tip #5

Perform periodic internal E/M audits on new 2021-2022 guidelines

COMPARE :: 2022 CPT Guidelines for Office/Outpatient Visits

Perform a “medically appropriate history and/or exam”

Use time or medical decision making, whichever is supported by documentation and is the higher code

Understand which service are included in the updated definition of “time”

Review and study the detailed revisions to Medical Decision Making

CONTRAST :: 2022 CMS Guidelines for **non**-Office/Outpatient Visits

Determine if a category of E/M service requires “ 2 of 3” or “3 of 3” key components.

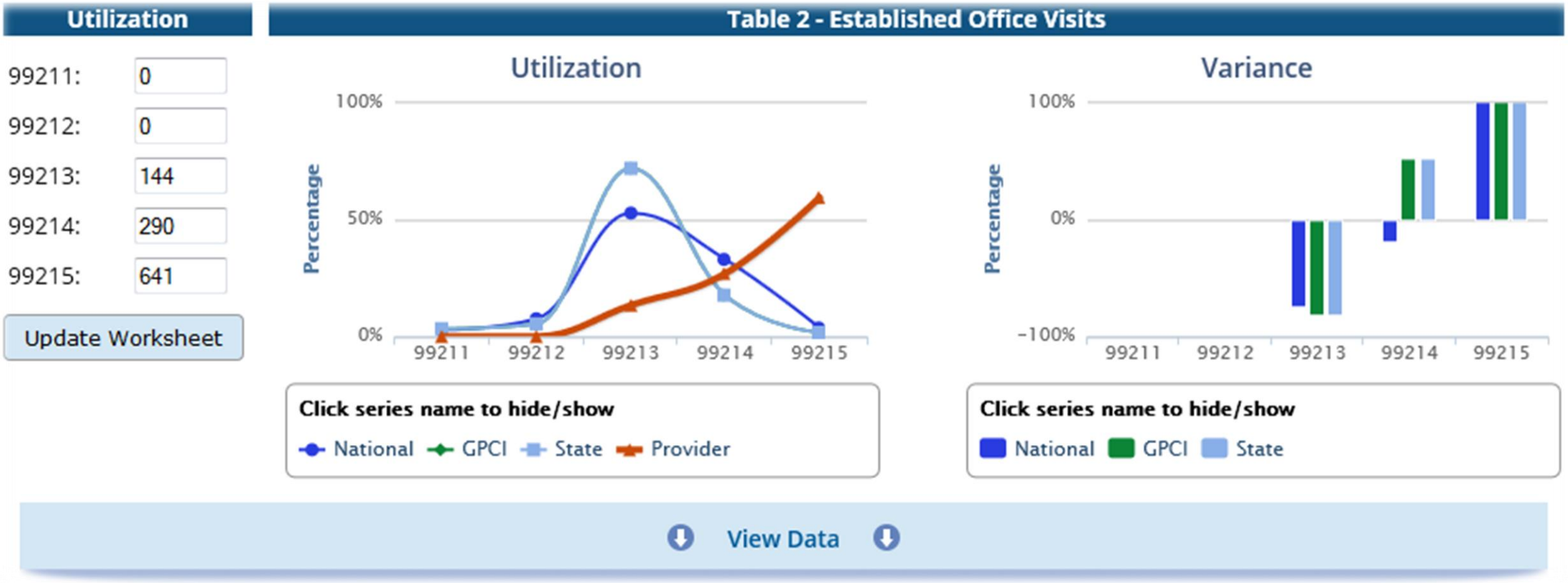
Use the existing 1995 and 1997 guidelines that remain intact for all non-Office/Outpatient visits.

View them here and be prepared to apply them:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

Have you Analyzed your E/M Code Patterns?



https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareFeeforSvcPartsAB/MedicareUtilizationforPartB.html

Overview of 2021-2022 E/M Changes

- Required levels of history and physical examination became obsolete in 2021 **only** when selecting codes 99202-99215. 99201 was deleted for 2021.

- Clinicians will be able to select new and established patient office/outpatient visits based on **time or medical decision making (MDM)**.

- Medical Decision Making **documentation details were greatly expanded** in the AMA's CPT and will require the most research, EHR template adjustments, and updated training for providers.

- Time is now defined as **"total time spent on the date of the encounter"**, and may include many non-face-to-face services done on the **same day**, and will no longer require time to be dominated by counseling and/or coordination of care.

What's included in Office/Outpatient "time"?

- preparing to see the patient (*e.g., review of tests*)
- obtaining and or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (*when not separately reported*)
- **documenting clinical information in the electronic or other health record**
- independently interpreting results (*not separately reported*) and communicating results to the patient/family/caregiver
- care coordination (*not separately reported*)

Updated Terms for Medical Decision Making

01

Number of Diagnosis and Management Options

Is Revised to:

"Number and Complexity of Problems to be Addressed at the Encounter"

02

Amount and/or Complexity of Data to be Reviewed

Is Revised to:

"Amount and/or Complexity of Data to be Reviewed and Analyzed"

03

Overall Risk of Complications and/or Morbidity or Mortality

Is Revised to:

"Risk of Complications and/or Morbidity or Mortality of Patient Management"

AMA's Medical Decision Making Revisions

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	**Amount and/or Complexity of Data to be Reviewed and Analyzed** **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  ▪ Review of prior external note(s) from each unique source*;
			  ▪ review of the result(s) of each unique test*;
			  ▪ ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• **2** or more stable chronic illnesses;
		or
		• **1** undiagnosed new problem with uncertain prognosis;
		or
		• **1** acute illness with systemic symptoms;
		or
		• **1** acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following**:
			  ▪ Review of prior external note(s) from each unique source*;
			  ▪ Review of the result(s) of each unique test*;
			  ▪ Ordering of each unique test*;
			  ▪ Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

99205
99215
	High	**High**
		• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• **1** acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following**:
			  ▪ Review of prior external note(s) from each unique source*;
			  ▪ Review of the result(s) of each unique test*;
			  ▪ Ordering of each unique test*;
			  ▪ Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

HYPERLINK

Top 10 Tips (#6-10)

6.) Report diagnoses in order of importance and link diagnoses for all encounters while considering the impact of billing on a CMS-1450/837i versus a CMS-1500/837p form.

7.) Educate providers on the "2022 ICD-10-CM Official Guidelines for Coding and Reporting" and only report diagnoses documented on that date of service.

8.) Know the differences between the CPT's and CMS' Preventive Medicine Services and how often Medicare pays for their sometimes-covered G-codes.

9.) Compare and contrast telehealth services and Virtual Communication Services (VCS) to get paid correctly for non-face-to-face services.

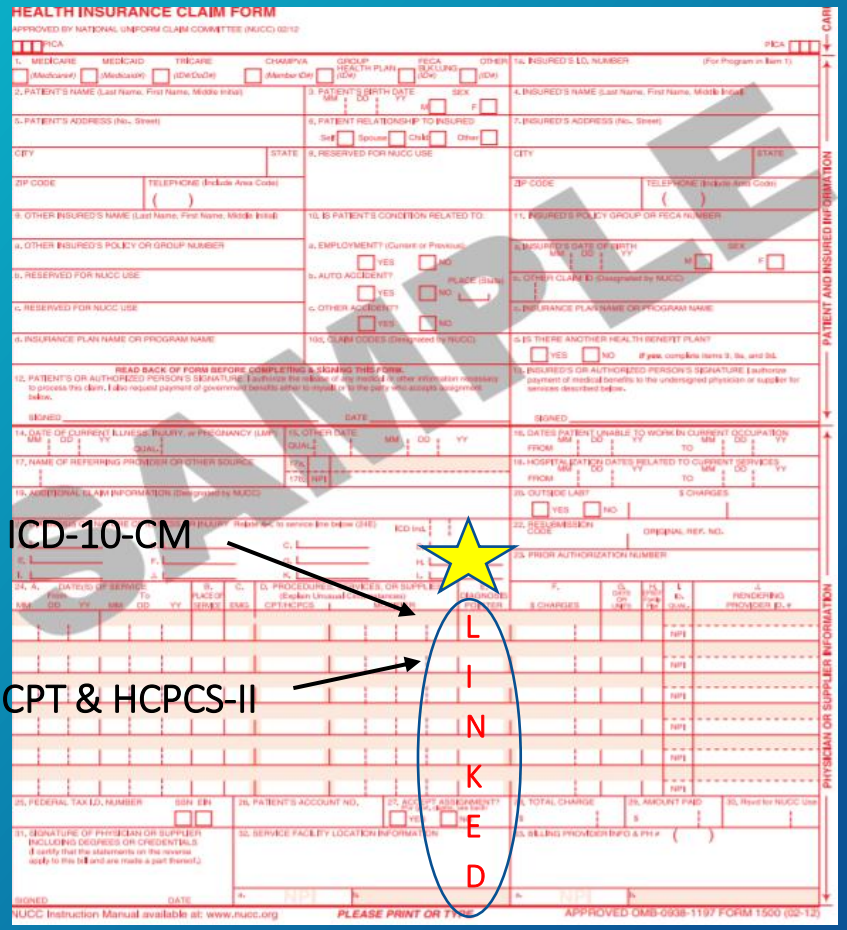
10.) Increase your awareness of when outside providers admit/discharge your patients, perform timely post-discharge medication reconciliation, and increase your revenue related to Transitional Care Management (TCM).

Tip #6

Report diagnoses carefully and link them to tests/procedures depending on which claim form you will be billing on.

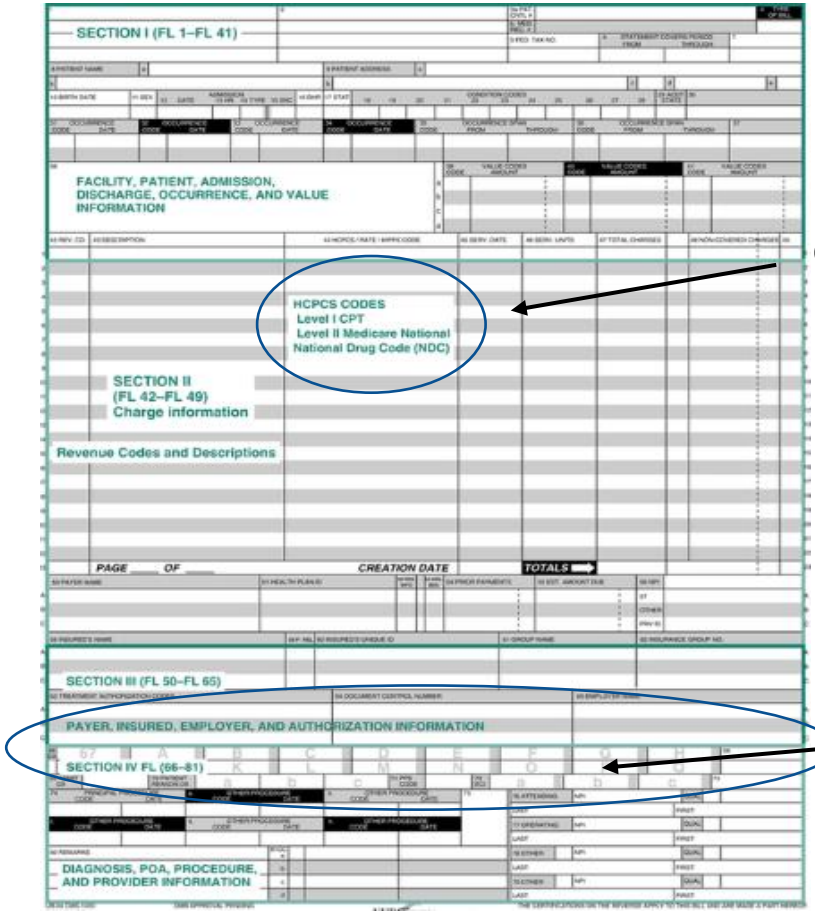
COMPARE :: CMS 1500 form
(aka the "HCFA" or 837p)

Used by FQHC reporting claims to commercial and non-Medicare carriers expecting to receive a Fee-for-Service payment OR for non-/FQHC services including the technical component of diagnostic tests to Medicare.



CONTRAST :: CMS 1450 form
(aka the "UB" or 837i)

Used by FQHC submitting claims to Medicare (*and some Medicaid carriers*) for "valid encounters" when expecting the AIR/PPS rate and unlike the other form requires Type of Bill Codes and Revenue Codes.



CPT & HCPCS-II

CPT & HCPCS-II and ICD-10-CM are NOT LINKED !

ICD-10-CM

Sample FFS Claim for a Primary Care Provider

Sample CMS 1500

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO W MM DD YY FROM

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a

17b NPI

18. HOSPITALIZATION DATES RELA MM DD YY FROM

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO

Opioid Dependence **Depression** **Screening for Mental/Behavioral Disorder**

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. **F11.20** B. **F33.1** C. **Z13.39** D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORI

23. PRIOR AUTHORIZATION NUMBE

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSD Family Plan
1 07	01	21	07	01	21	11		99214		A,B	210.00		
2 07	01	21	07	01	21	11		96372		C	20.00	2	
3													

Sample FFS Claim for a Mental Health Provider

Sample CMS 1500

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO W MM DD YY FROM

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a

17b NPI

18. HOSPITALIZATION DATES RELA MM DD YY FROM

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO

Opioid Dependence **Depression** **Screening for Mental/Behavioral Disorder**

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A.	F11.20	B.	F33.1	C.	Z13.39	D.	
E.		F.		G.		H.	
I.		J.		K.		L.	

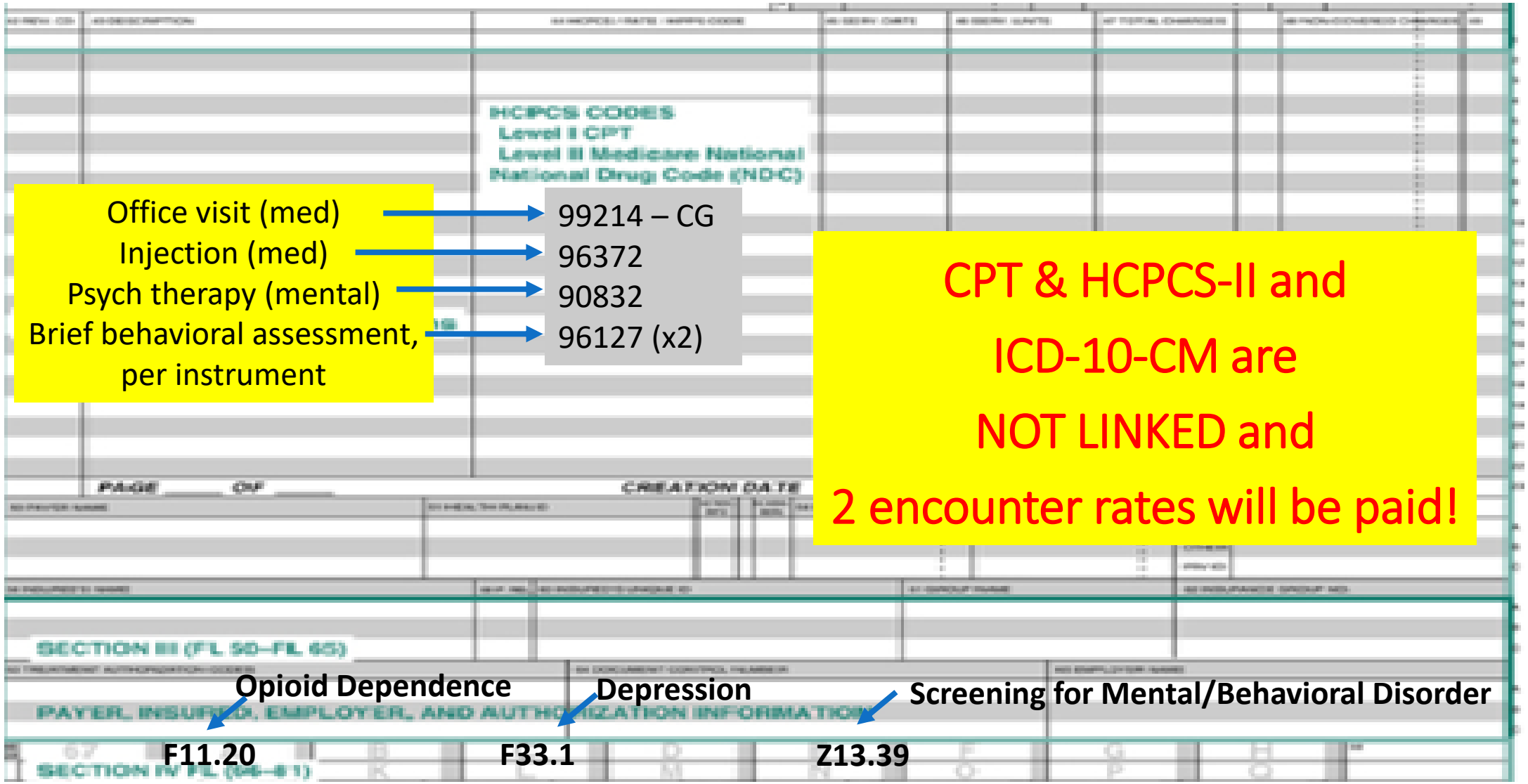
22. RESUBMISSION CODE ORI

23. PRIOR AUTHORIZATION NUMBE

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSD Family Plan
1 07	01	21	07	01	21	11		90832		B, A	210.00		
2 07	01	21	07	01	21	11		96127		C	20.00	2	
3													

Same Day Services by a Medical Provider & a Mental Health Provider in a FQHC to Medicare

Sample CMS 1450



Required Information on FQHC Medicare Claims

Medicare Claims Processing Manual

Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers

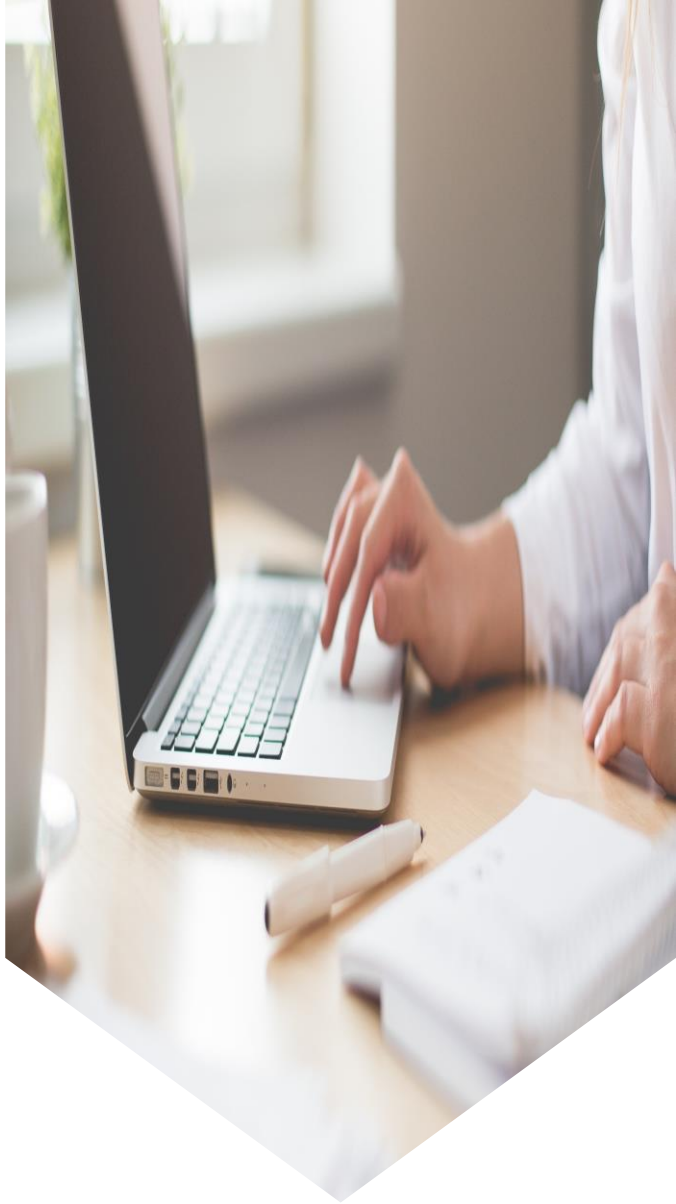
50 - General Requirements for RHC and FQHC Claims
(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

60 - Billing Requirements for RHCs and FQHCs
(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

Tip #7

Educate providers on the "2022 ICD-10-CM Official Guidelines for Coding and Reporting"

Assumptions and Prerequisites on your use of the ICD-10-CM



- Your providers have experience navigating the physical ICD-10-CM manuals and are trained on the "Official Guidelines for Coding & Reporting."
  - Check to see which version of the Official Guideline you have in your 2021 manual – you may be surprised!
  - Using codes from Table of Drugs/Chemicals? Familiar with External Cause codes?
  - For poisonings, traumas, and injuries – how do you define the 7th digits for Initial Visit, Subsequent Visit, and Sequela?

- You have performed a comparison between what your printed manual and your EHR/IT code look-up tools and understand the differences and their impact on proper diagnostic coding and revenue.
  - How do providers and coders/billers locate vital documentation notes located at each ICD-10-CM "Base Code" rather than just doing a basic index look-up.

Can your Providers see their "Base Code" Notes in the EHR?

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)

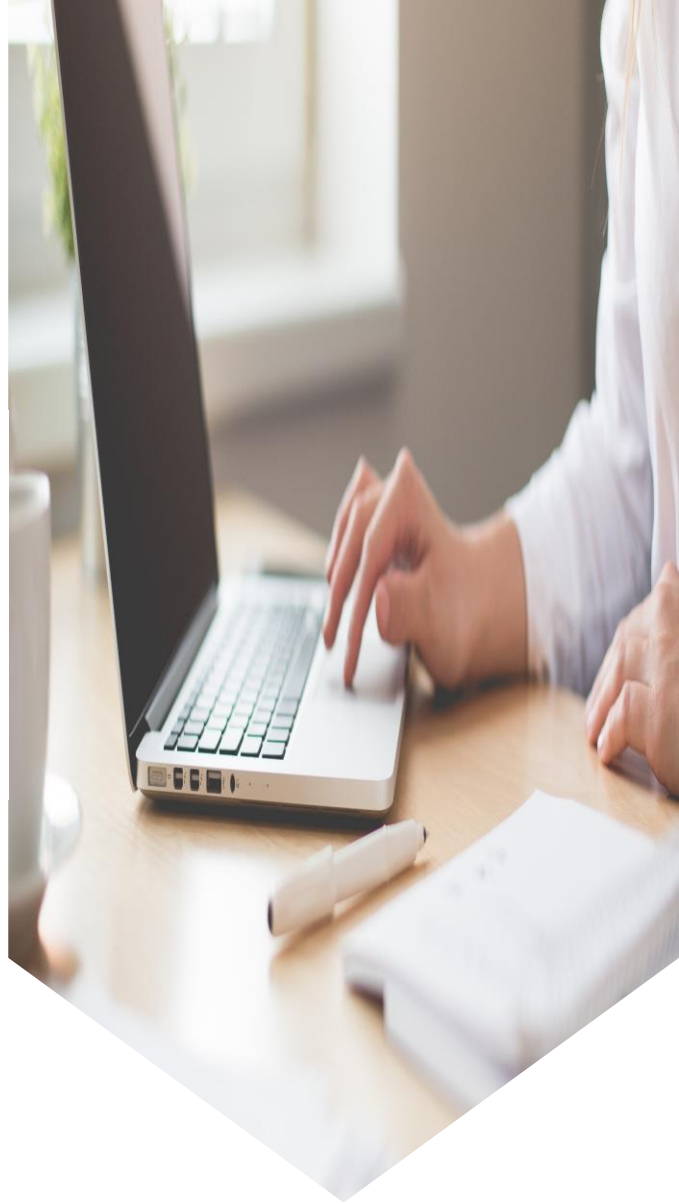
Excludes1: Behçet's disease (M35.2)
direct infections of joint in infectious and parasitic diseases classified elsewhere (M01.-)
postmeningococcal arthritis (A39.84)
mumps arthritis (B26.85)
rubella arthritis (B06.82)
syphilis arthritis (late) (A52.77)
rheumatic fever (I00)
tabetic arthropathy [Charcôt's] (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



ICD-10-CM –7th Character Extensions for injuries, poisonings, and traumas

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.

Official ICD-10-CM Guidelines Review

Section I: A. Conventions of ICD-10

- Conventions of ICD-10-CM
- Alphabetic Indexing and Tabular Listings
- Format and Structure
- Use of Codes for Reporting Purposes
- Placeholder Character
- 7th Digit Characters
- Abbreviations (Index and Tabular)
- Punctuation
- Use of “And”, “With”, “See Also”, “Code Also”
- “Unspecified” Codes, “Includes” and “Excludes”
- Etiology/Manifestation Conventions (e.g., *“code first”, “use additional code”, “in diseases classified elsewhere”)*
- Default codes and Syndromes

Official ICD-10-CM Guidelines Review

Section I: B. General Coding Guidelines

- Locating ICD-10 codes, levels of detail in coding
- Codes A00.0-T88.9, Z00-Z99.8
- Signs and Symptoms
- Conditions that are integral part of disease process
- Conditions that are not integral part of disease process
- Multiple coding for a single condition
- Acute and Chronic conditions
- Combination codes
- Late effects (sequela)
- Impending or threatened conditions
- Reporting same diagnostic code more than once
- Laterality
- Documentation for BMI and Pressure Ulcer stages

Official ICD-10-CM Guidelines Review

Section I: C. Chapter Specific Coding Guidelines

Chapter 1: Infectious and Parasitic Disease (A00-B99)

Chapter 2: Neoplasms (C00-D49)

Chapter 3: Diseases of Blood and Blood Forming Organs (D50-D89)

Chapter 4: Endocrine, Nutritional and Metabolic Diseases (E00-E89)

- Diabetes is located in this Section (E08-E13)

Chapter 5: Mental and Behavioral Disorders (F01-F99)

Chapter 6: Diseases of the Nervous System and Sense Organs (G00-G99)

Chapter 7: Diseases of the Eye and Adnexa (H00-H59)

Chapter 8: Diseases of the Ear and Mastoid Process (H60-H95)

Chapter 9: Disease of the Circulatory System (I00-I99)

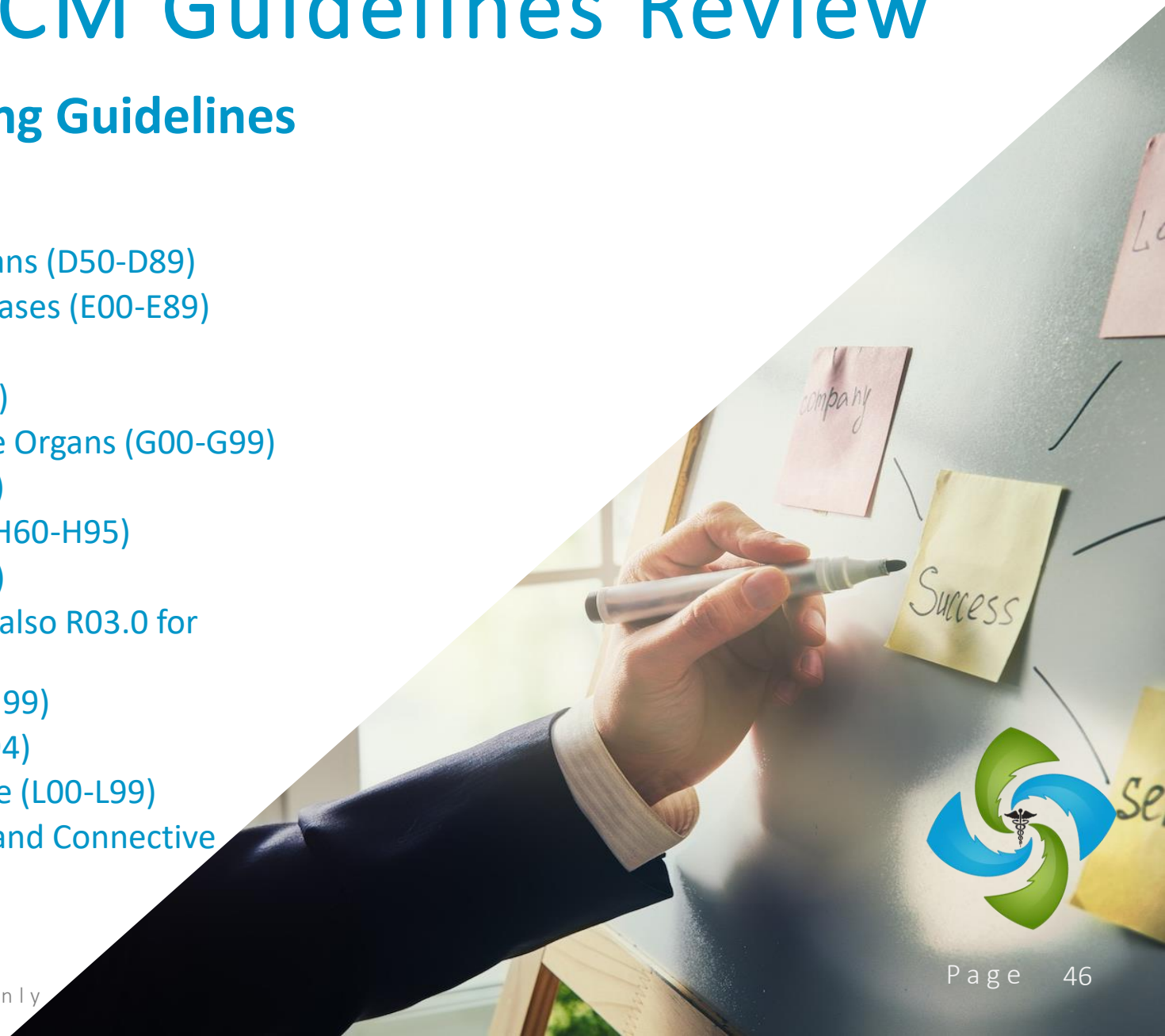
- Hypertension is in this Section (I10-I15) but see also R03.0 for elevated BP w/out hypertension

Chapter 10: Diseases of the Respiratory System (J00-J99)

Chapter 11: Diseases of the Digestive System (K00-K94)

Chapter 12: Diseases of Skin and Subcutaneous Tissue (L00-L99)

Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)



Official ICD-10-CM Guidelines Review

Section I: C. Chapter Specific Coding Guidelines (cont'd)

Chapter 14: Diseases of the Genitourinary System (N00-N99)

Chapter 15: Pregnancy, Childbirth, Pueperium (O00-O9A) OB, Delivery and Postpartum Services

Chapter 16: Newborn (Perinatal) Guidelines (P00-P96) Newborn services and reporting stillborns

Chapter 17: Congenital Malformations, Deformations, and Chromosomal Abnormalities (Q00-Q99)

Chapter 18: Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00-R99)

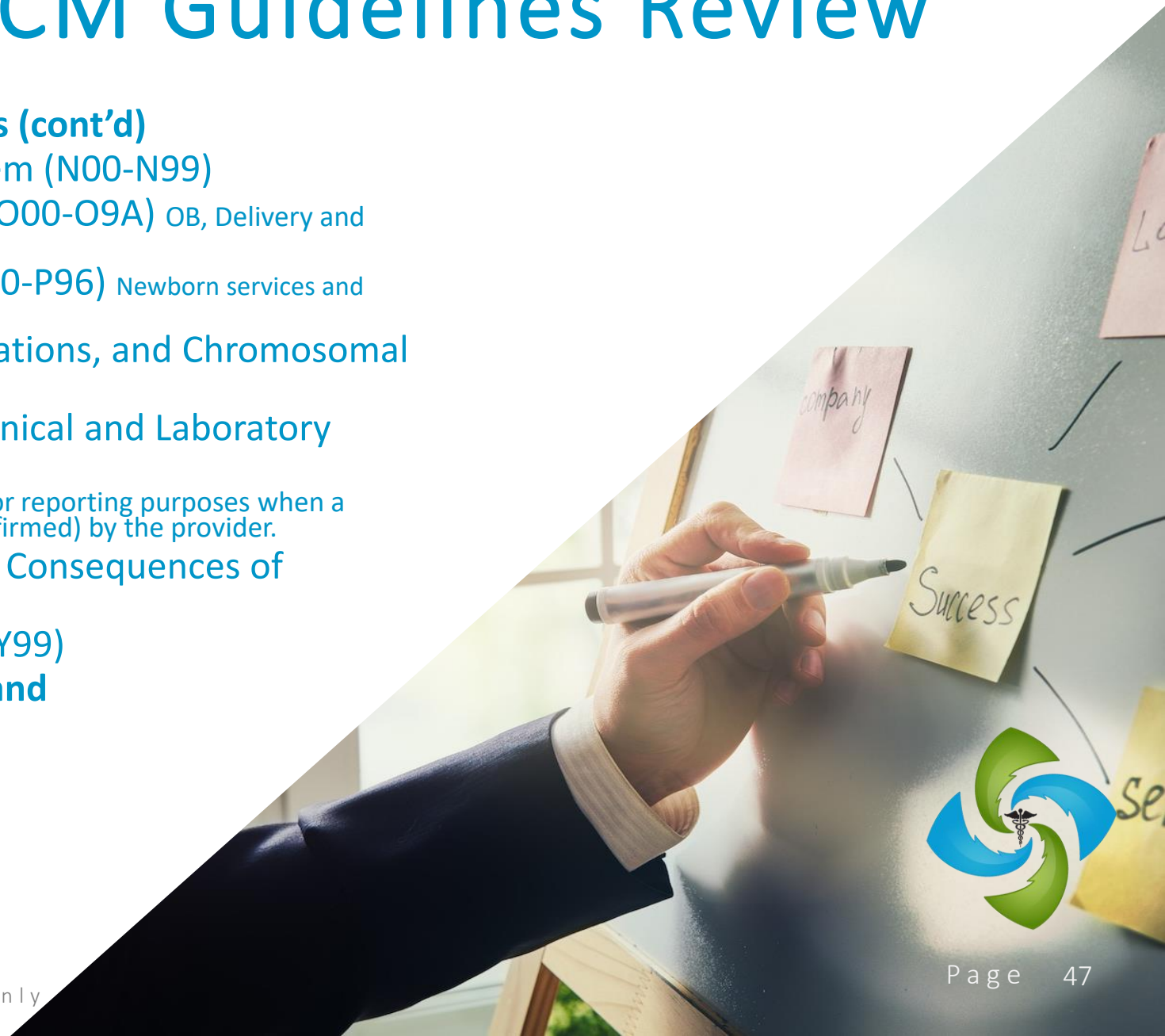
> Codes that describe symptoms and signs are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.

Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00-T88)

Chapter 20: External Causes of Morbidity (V01-Y99)

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

Chapter 22: Codes for Special Purposes



Tip #8

Know the differences between CPT Preventive Medicine Services and CMS' sometimes-covered Preventive G-codes.

Before Considering CPT Preventive Medicine Services, Check Out the G-codes

Each “sometime covered” service has detailed documentation requirements, covered diagnoses, and frequency restrictions.

Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

Table of Contents
(Rev. 4364, 08-16-19)

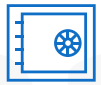
SOURCE: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf

Sample FQHC “sometimes covered” Preventive Services

FQHC ONLY :: Diabetes Self-Management Training & Medical Nutrition Therapy use G0108, G0270, 97802-3

Initial Preventive Physical Exam (IPPE) and Screening EKG

G0402-G0405



Annual Wellness Visits (initial and subseq.)

G0438-G0439

Screening Pelvic/Breast & Screening Pap Handling

G0101/Q0091

Smoking/Tobacco Cessation Counseling

99406-99407

Prostate Cancer Screening

G0102

Glaucoma Screening

G0117-G0118

Alcohol and/or Depression Screening or Counseling

G0442-G0444

Screening for STD/High Intensity Behavioral Counseling

G0445-G0447

Service	HCPCS Code	Short Descriptor	Paid under the PPS methodology	Increase in the PPS rate by 34%[1]	Coinsurance	CMS Pub 100-04
Diabetes Self-Management Training (DSMT)	G0108	Diab manage trn per indiv	Yes	No	Not Waived	Ch. 9 §181 Ch. 18 §120
Medical Nutrition Therapy (MNT)	97802	Medical nutrition indiv in	Yes	No	Waived	Ch. 9 §182
	97803	Med nutrition indiv subseq	Yes	No	Waived	
	G0270	Mnt subs tx for change dx	Yes	No	Waived	
AWV	G0438	Ppps, initial visit	Yes	Yes	Waived	Ch. 18 §140
	G0439	Ppps, subseq visit	Yes	Yes	Waived	
Screening Pelvic Exam	G0101	Ca screen; pelvic/breast exam	Yes	No	Waived	Ch. 18 §40
Prostate Cancer Screening	G0102	Prostate ca screening; dre	Yes	No	Not Waived	Ch. 18 §50
Glaucoma Screening	G0117	Glaucoma scrn hgh risk direc	Yes	No	Not W	Ch. 18 §70
	G0118	Glaucoma scrn hgh risk direc	Yes	No	Not Waived	

HYPERLINK

Review and Monitor CMS' Preventive Service Chart for FQHCs

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

70.3 - FQHC Billing Approved Preventive Services under the PPS
(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

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

220.3 - Preventive Health Services in FQHCs
(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

FQHC Billing of Approved Preventive Services Under the PPS

Tip #9

Compare and contrast Telehealth Services vs. Virtual Communication Services

Compare/Contrast
Telemedicine vs. Virtual Communication Services

- **Telehealth visits (*typically pre-scheduled*)**
  - For Medicare, FQHCs must refer to G2025 (*modifier -95 not required*) and expect $97.24 in reimbursement from your MAC and patients.
  - Check for periodic updates to CMS' List of Telehealth Services for 2022 last updated 1/5/22
  - Get the CMS Med Learn Matters #SE20016 for updates, revenue code info, modifiers, and other great billing info – https://www.cms.gov/files/document/se20016.pdf

- **Virtual Communication Services – Virtual Check-ins, "Store and Forward", and Digital E-visits (*typically initiated by the patient*)**
  - Via telephone (HCPCS II code G2012) – **FQHC use G0071 to Medicare**
  - Video/images may be sent to a physician (HCPCS II code G2010) – **FQHC use G0071 to Medicare**
  - Communication between patient and provider using a patient portal reported using G0071 (*new total rate of $23.88 effective Jan. 2022)*

Excerpt From CMS Approved Telehealth List

		LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2022 - updated January 5, 2022	
Code	Short Descriptor	Status	Can Audio-only Interaction Meet the Requirements
97804	Medical nutrition group		Yes
99202	Office/outpatient visit new		
99203	Office/outpatient visit new		
99204	Office/outpatient visit new		
99205	Office/outpatient visit new		
99211	Office/outpatient visit est		
99212	Office/outpatient visit est		
99213	Office/outpatient visit est		
99214	Office/outpatient visit est		
99215	Office/outpatient visit est		
99217	Observation care discharge	Available up Through December 31, 2023	
99218	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic	
99219	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic	
99220	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic	

Be sure to the other columns that don't appear on this slide!

There are many codes on this list that we are NOT used to getting paid for. Also – what about audio-only visit?

Virtual Communications Services (VCS)

Purpose: The purpose of VCS is to aid community/rural health providers who engage in "virtual check-ins" via phone and or the "store and forward" via a patient portal interpret images/audio submitted by patients for over 5 minutes for condition(s) unrelated to recent visits and that do not result in an immediate visit.

HYPERLINK

Research: For Medicare's guidelines for reporting Virtual Communication Services in the CMS Benefits Policy Manual Chapter 13 – section 240

HYPERLINK

FAQs: CMS prepared an 8-page set of frequently asked questions (FAQ) that is specific for FQHC providers. Go get it at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf

Documentation & Coding for VCS "Virtual Check-in"

- VCS refers to providers who receive contact via non-face-to-face "communication technology-based" (*i.e. a virtual check-in via phone*) from an established patient lasting more than 5 minutes or more regarding a condition(s) NOT related to a visit in the past 7 days and that does not result in an appointment in the next 24 hours or next available appointment slot.

- The contact must be initiated by the patient if using the "virtual check-in" element.

- For commercial carriers or non-FQHC providers this info refers to code G2012 whereas a FQHC would use code G0071.

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

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

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

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

240 – Virtual Communication Services
(Rev. 252, Issued: 12-07-18, Effective: 01-01-19, Implementation: 01- 02-19)

CMS Guidance on Virtual Communication Services and Telehealth (Ch. 9 and 13)

Tip #10

Increase clinical awareness and reimbursement and through Transitional Care Management.

Transitional Care Management (TCM)

- The goal of TCM is often stated to lower preventable hospital readmissions by:
  - establishing a smooth transition from an inpatient stay between various care providers,
  - establishing a coordinated plan with the patient's primary care provider(s) via direct patient contact within 2 days of the discharge and performing a face-to-face visit occurs within either 7 or 14 days following the discharge.
- If the patient is readmitted within 30 days of the discharge – TCM may not be billed.
- For FQHC billing Medicare - if the TCM face-to-face visit occurs on the same date as another payable service only one PPS/AIR rate will be paid.

Prior to reporting TCM (99495-99496)

- Direct and interactive communication (*phone, in person, or electronic*) with the patient must be within 2 days of their discharge date. If two or more reasonable attempts to reach the patient within 2 days of discharge are made but are unsuccessful and all other TCM criteria are met TCM may be reported making sure to document that the attempts were made.

- The contact within the 2-day window must be more than simply scheduling the follow-up appointment and would typically include and document the type(s) of services they had during their admission, what the discharge diagnosis was, and what follow-up services they may need.
  - Be sure to carefully identify any new, revised, or expected prescriptions and/or expected drug interactions that may arise from the inpatient stay in order to meet medication reconciliation requirements that should be performed at least by time of the patient visit.

Coding for TCM

- **Assign CPT code 99495 if:**
  - Documenting medical decision making of at least *moderate* complexity during the service period.
  - Performed a face-to-face visit, **within 14 calendar days** of discharge.
- **Assign CPT code 99496 if:**
  - Documenting medical decision making of at least *high* complexity during the service period.
  - Performed a face-to-face visit, **within *7* calendar days** of discharge.

NOTES:

- Only one qualified clinical provider may report TCM services on a patient following a discharge. The same provider who discharged the patient may report TCM services, but the required face-to-face visit cannot take place on the same day as the actual discharge day management services.
- The phone call and visit should include documentation about the type(s) of services they had during their admission, what the discharge diagnosis was, and what follow-up services they may need or were ordered by the discharging provider.

Thanks for your attention!
Now is our time to shine!

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