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2024 Documentation, Coding, and Billing Bootcamp for Community Health

Montana Primary Care Association

Montana Primary Care Association Onsite Training

August 13-14, 2024

Instructor

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

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1

RHC/FQHC Foundations

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Documenting Patient Visits

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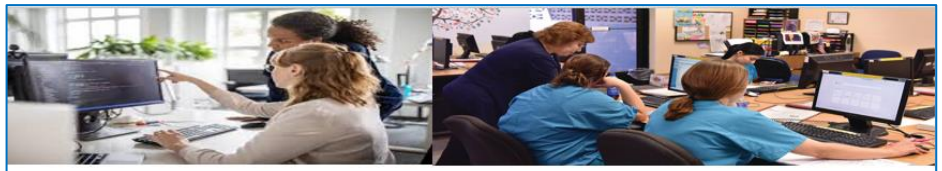

Coding the Full Encounter

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4

Billing for Optimal Reimbursement

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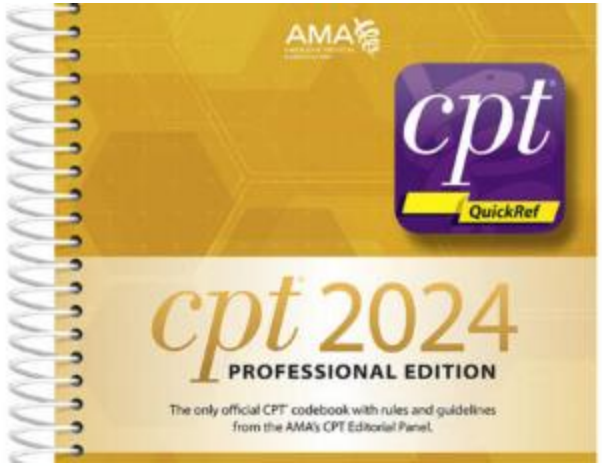
Plus, 20+ BONUS Self-Study slides on documentation related to 30+ common RHC/FQHC CMS-covered Preventive Services and the answers to the 5 ICD-10-CM Self-Study questions.

BONUS Self-Study Section on CMS-covered Preventive Services

Disclaimers
American Medical Association



Very few EHRs, coding software, and non-AMA CPTs contain the educationally valuable clinical documentation guidelines that should make up the core of your CPT coding knowledge; therefore, you need a **printed version of the CPT every year**. The AMA usually only licenses the code numbers and definitions **but not the educational text** on the documentation and coding guidelines.

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- Your organization is responsible for ensuring compliance with all relevant rules and regulations you are bound to. It is required that you verify all code selections and billing rules directly with payers to determine their specific guidance and requirements before submitting claims for payment.

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ArchProCoding
Who We Help

Rural Health Clinics

(RHC)

Can be either independent or provider-based and receive an ***All-Inclusive Rate (AIR)*** from Medicare and some Medicaid payers.

This Course

Federally Qualified Health Centers (FQHC)

Aka Community Health Centers that operate in rural or urban health professional shortage areas and receive a ***Prospective Payment System (PPS) rate*** from Medicare and some Medicaid payers.

Critical Access Hospitals

(CAH)

Also includes small rural hospitals and new Rural Emergency Hospitals who receive CAH Method I/II or PPS payments from Medicare and some Medicaid payers.

ArchProCoding
Certifications We Offer

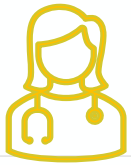
Rural Health – Coding and Billing Specialist (RH-CBS)

Community Health – Coding and Billing Specialist (CH-CBS)

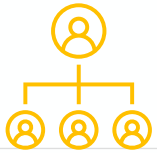
Critical Access Hospital – Coding and Billing Specialist (CAH-CBS)

Rural or Community Health – Credentialing Specialist (RH-CS or CH-CS)

ArchProCoding
Main Focus Areas



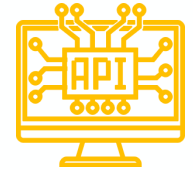
Clinical Providers



Clinic and Health Center Managers

Coders

Billers



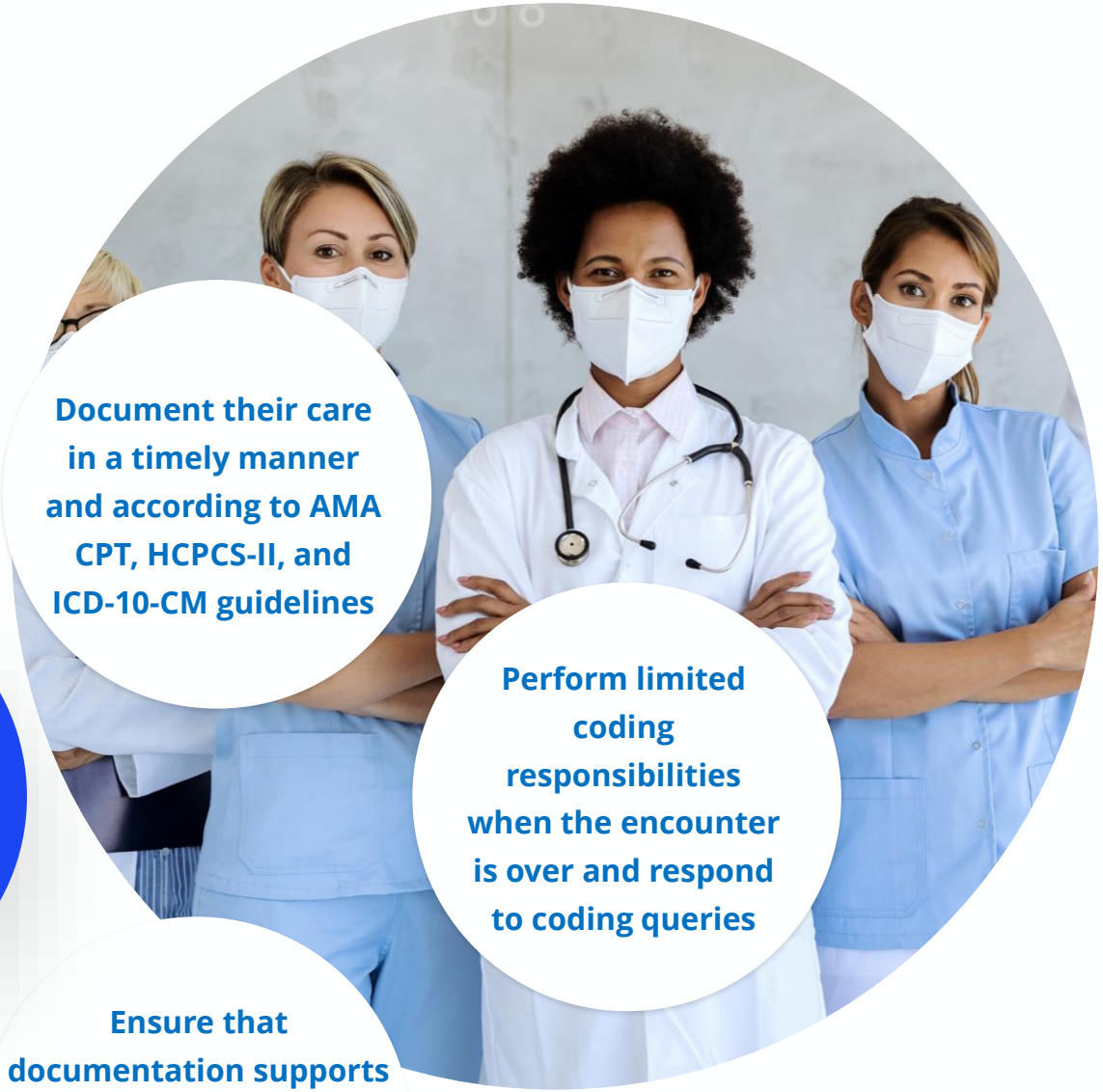
Electronic Health Records and IT/Billing System Integrations

Target Audience
Clinical Providers

Immediately following most patient visits many providers are likely asked to **submit coding information to the coding/billing staff** by performing a first pass of what services were performed (i.e., CPT and HCPCS-II) and why they were performed (i.e., ICD-10-CM).

This limited coding data is often unfortunately used by revenue staff before the encounter note is fully completed and signed off thus leading to missed revenue opportunities and potential compliance issues.

Provide optimal clinical care recognizing their vital role in how we track health and earn revenue



Document their care in a timely manner and according to AMA CPT, HCPCS-II, and ICD-10-CM guidelines

Perform limited coding responsibilities when the encounter is over and respond to coding queries

Ensure that documentation supports care coordination, quality reporting, and revenue cycle activities

Target Audience Clinic and Health Center Managers

Most state/federal payers expect you to follow CMS' unique RHC/FQHC billing rules while other payers ask you to operate under traditional office-based fee-for-service billing rules.

Ensuring that your clinic's and health center's EHR/IT environment supports these different approaches is vital to **meeting quality reporting requirements, achieving revenue enhancement, and submitting an accurate annual cost report**.

Coordinate clinical providers and revenue staff efforts to create, validate, and report accurate data about the services we perform

Maintain awareness of how different payer contracts impact documentation and billing policies

Ensure that the EHR/IT environment supports revenue cycle, cost reporting, and quality reporting initiatives

Provide compliance oversight ensuring that medical services aren't paid without supporting clinical documentation

Target Audience
Professional Coders

Each clinical encounter **should receive a complete professional coding review** so each RHC/FQHC can submit an accurate annual cost report, give the patient an accurate listing of what services were done and why, and allow the billing staff to format a unique bill after validating the presence of compliant supporting documentation.

Quality reporting data/statistics are captured and stored as close to the time the encounter was performed and are available to be reported on a monthly, quarterly, or annual basis as required by our participation agreements even though the code(s) may not ever leave the office on a medical claim for payment.

Use a closed medical record to extract all data about what was done (CPT/HCPCS-II) and why (ICD-10-CM) whether payable or not

Provide raw data for use by the patient, the cost report, quality reporting, and revenue cycle activities

Confirm that available documentation supports CPT, HCPCS-II, and ICD-10-CM guidelines

Assist the billing department in identifying alternate codes that may be needed by varying payer policies for proper billing

Target Audience Quality Reporting and Cost Report Staff

Many RHCs/FQHCs have agreed to submit quality data on a periodic basis primarily through CPT/HCPCS-II, and/or ICD-10-CM codes rather then medical claims. For example, FQHCs have specific requirements to capture and report Uniform Data System (UDS) in order to maintain their FQHC status.

Additionally, many services not reimbursed by Medicare do not get paid via traditional claims – rather reimbursement may be gained at the end of your fiscal year via the required cost report via annual reconciliation or wrap-around payments.

- Maintain awareness of the reporting requirements related to UDS, HEDIS, CPT-II performance measures
- Use the results of a professional coding review to identify when quality reporting initiatives are met or need to be provided
- Capture CPT/HCPCS-II data that may not be reimbursed under the AIR/PPS payment for annual cost report reconciliation
- Submit required data gathered via proactive coding policies on a periodic basis as required by payers

Target Audience
Medical Billers

Medical billers are responsible for generating and processing valid claims for payment from commercial, state, and federal payers based on existing medical records documentation and **from the validated results of a professional coding review process**.

If the same staff member has both coding and billing responsibilities, they completely should perform their “pure coding” responsibilities prior to any medical bill being created or submitted.

Coding and billing are not the same!

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

Professional coding guidelines related to CPT and ICD-10-CM codes apply equally to all types of medical facilities.

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

+

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

Predicting varying commercial insurance and Medicaid billing rules is very tricky especially since some payers see us as a regular doctor's office rather than a RHC/FQHC.

We will, therefore, focus on CMS/Medicare RHC/FQHC billing rules since they can be taught at a national level. Expect variations and different billing codes and reimbursement rules!

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 keep the money!

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 RHC/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

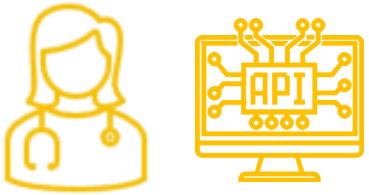
Identify how to research, interpret, and apply ever-adapting documentation guidelines set forth by the AMA, CMS, and the ICD-10-CM Cooperating Parties (AHA, AHIMA, CMS, and NCHS)

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?

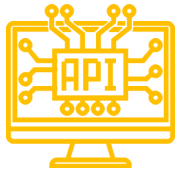


TREAT AND DOCUMENT THE VISIT:
Train staff on the actual documentation guidelines found in CPT, HCPCS-II, and ICD-10-CM manuals rather than shortcuts.

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

How will YOU share key information with those who could not attend this session?

Clinical Providers



EHR/IT Issues

Notes/Key Slides

How will YOU share key information with those who could not attend this session?

Notes /Key Slides

Clinic and Health Center Managers

How will YOU share key information with those who could not attend this session?

Coders

Billers

Notes /Key Slides

RHC/FQHC Foundations

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Section Overview
RHC/FQHC Basics

HIPAA Required Code Sets

Which HIPAA-approved code sets do we need to be aware of working in a RHC/FQHC?

How RHCs/FQHCs are Different

Why do some insurance companies enroll us as a regular FFS “office” while Medicare/Medicaid expect us to operate under the very different billing requirements of RHCs/FQHCs?

Key CMS Resources to Monitor

Being fully aware of the content of key CMS manuals such as Chapter 13 of the Benefits Policy Manual and Chapter 9 of the Claims Processing manual is crucial!

CMS Valid Encounters

In order to generate a RHC’s All-inclusive Rate (AIR) or a FQHC’s Prospective Payment System (PPS) rate it is vital to know how the billing rules differ from traditional commercial insurance.

Qualifying Visit List

Medicare has a FQHC-only list of CPT/HCPCS-II codes that must be present on all claims requesting encounter-based PPS payments.

Section Overview
RHC/FQHC Basics

CMS Patient Cost Sharing

In order to generate a RHC's All-inclusive Rate (AIR) or a FQHC's Prospective Payment System (PPS) rate it is vital to know how the billing rules differ from traditional commercial insurance.

Claim Examples

What would sample claims look like for a same day medical and mental health encounter to a typical Medicare patient **vs.** a fee-for-service claim?

Are they required to be submitted on the same claim and/or same day?

Expected Variations with Non-Medicare Billing

Commercial insurance companies, Medicare/Medicaid managed care organizations, and other payers have markedly different billing rules to be aware of.

Non-Medicare Payer Contracting Considerations

What important questions should we research/ask insurance carriers when becoming a participating provider with a non-Medicare insurance companies?

HIPAA Required Code Sets

HIPAA Required Code Sets
Using the manuals vs. software

AMA's Current Procedural Terminology (CPT) Level I code set has 3 categories

- **CPT Category I** codes identify services performed in all medical settings that are 5-digit numeric codes (99214) or 2-digit modifiers (ex. -59).
- **CPT Category II codes** are used for performance measurement (ex. xxxxF) and are often required by managed care companies to report "quality reporting."
- **Category III codes** for emerging technologies (ex.xxxxT) that may one day become CPT I code and are not typically associated with RHC/FQHC. Check out codes 0591T-0593T for CMS covered telehealth options for "*health and well-being coaching services*" as of February 2024.
- **Per the CPT Introduction section** - Just because there is a code in the CPT it "*does not imply any health insurance coverage or reimbursement policy.*"

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)

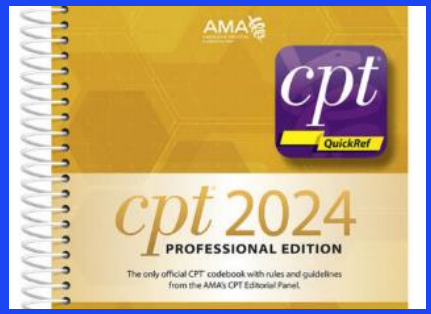
Pathology and Laboratory (8xxxx)

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

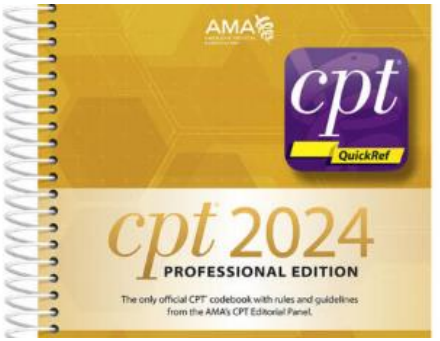
Here is an overview on how codes appear in the AMA's CPT

ORGANIZATION OF CPT® CODES

Section Numbers and Their Sequences

Evaluation and Management	99202-99499
Anesthesiology	00100-01999, 99100-99140
Surgery	10004-69990
Radiology (Including Nuclear Medicine and Diagnostic Ultrasound)	70010-79999
Pathology and Laboratory	80047-89398, 0001U-0419U
Medicine (except Anesthesiology)	90281-99199, 99500-99607, 0001A-0174A

Symbols of the AMA's CPT

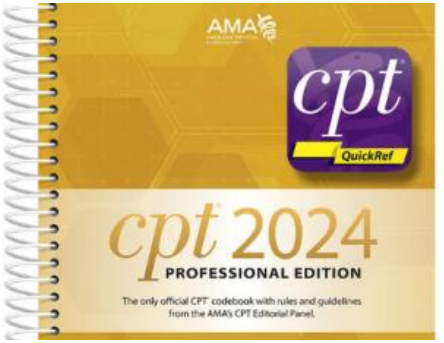


- ● New code (Appendix B) – **Fee schedule impact?**
- ▲ Revised code/definition changed (Appendix B) – **Fee schedule impact?**
- ; Separates "base definition" from subset
- ▶◀ New or revised text –**documentation guidelines changes, not code changes**
- \+ Add-On Codes (Appendix D)
- ⃠ Modifier "–51" exempt (Appendix E) – **FFS revenue impact!**
- FDA approval pending (Appendix K)
- \# Re-sequenced codes (Appendix N) – **Not all codes are in numerical order!**
- ○ Recycled or Reinstated code
- ★ Telemedicine
- Audio-only

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]

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?

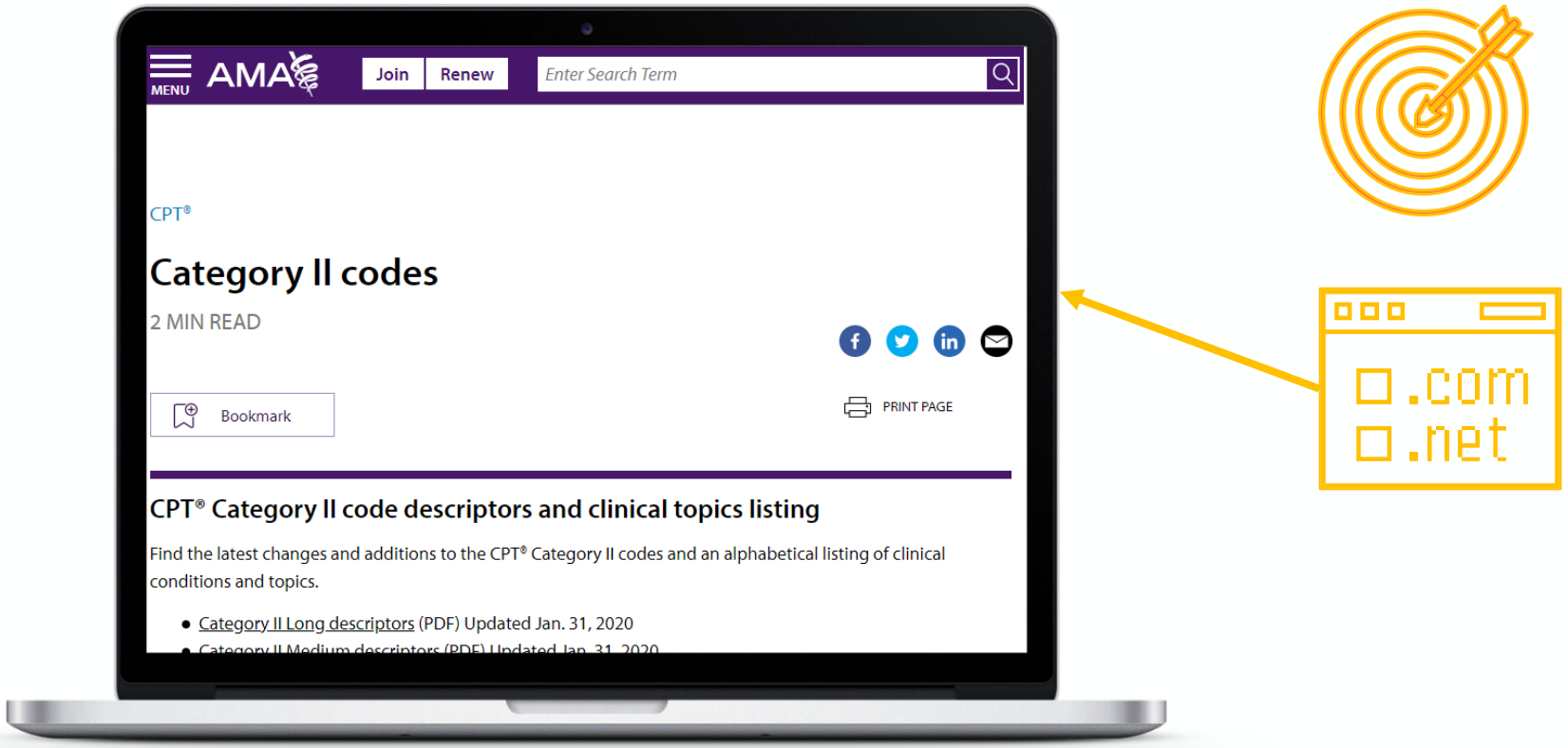
Disease-specific?
Reported if patients have the abbreviated diagnoses appearing in parentheses.

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!

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%*

HIPAA Required Code Sets
Using the manuals vs. software

Healthcare's Common Procedural Coding System Level II code set (*aka HCPCS-II*)

- HCPCS-II codes are 5-digit alphanumeric codes (ex. G0511) or 2-digit modifiers (ex. –GA) maintained by CMS as an alternative to CPT codes requiring careful research to verify when codes need to be change to meet varying payer rules, especially Medicare!
- There are zero documentation guidelines inside the manual and code set itself, you MUST research CMS and payer rules surrounding their use. Check for quarterly updates here.
- Use caution as *many CPT and HCPCS-II codes have definitions that are similar/same*! NOTE - there are many RHC/FQHC-Medicare specific G-codes and/or Medicaid specific H- and T-codes that you need to be aware of proper billing.

Compare
Sample Medical 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

99024 – Post-op follow up visit for a reason related…

99070 – Supplies and materials…over and above…drugs etc.

99202-99215 – RHC/FQHC E/M Services

99211 – "Nurse visit"

99381-99397 – Preventive Medicine Services

99401-99411 – Counseling Risk Factor Reduction and Behavior Change Intervention for persons without a specific illness…who have behavior(s) often considered an illness itself, such as…addiction, substance abuse, or obesity.

99424, 99487-99490 – Principal/Chronic Care Management

99460, 90461, and 90471-90474 – Vaccine Administration

Contrast
Sample Medical HCPCS-II Codes

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

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

J3420 – Injection, vitamin B-12, up to 1000mcg

G0466-G0470 –FQHC-only PPS Visit Codes to be followed by a code on the qualifying visit list (QVL) to Medicare

G0101, G0402, G0438-G0439 – CMS pelvic and breast exam, Initial Preventive Physical and Initial/Subsequent Annual Wellness Visits (AWV)

G0511 – RHC/FQHC-only billing code that captures monthly Principal/Chronic Care Management, Behavioral Health Integration, Chronic Pain Management, Remote Physiological Monitoring, Remote Therapeutic Monitoring, etc.

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

Compare Sample Behavioral Health CPT Codes

+ 90785 – Interactive Complexity add-on code for more revenue when dealing with barriers to communication

90791-90792 – Psychiatric Diagnostic Evaluations

90832-99838 – Psychotherapy with or without drug management 30/45/60 minutes

96127 – Brief emotional/behavioral assessment with scoring and documentation, per instrument likely used with diagnosis code Z13.3x

96156-96161 – Newly covered by Medicare in 2024 for Health Behavior Assessments when the diagnosis is *physical* in nature.

99492-99494 – Psychiatric Collaborative Care Model

99484 – Care Management for Behavioral Health Conditions (ex. BHI)

Contrast Sample Behavioral Health HCPCS-II Codes

G0210/G2250 + G0212/G2251-2 – Virtual check-ins and "store and forward" virtual check-ins for commercial/Medicaid claims

G0512 – Psychiatric Collaborative Care Model (*RHC/FQHC-specific reported by the medical side, not psych*)

H0038 – Self-help peer services , per 15 minutes for Medicaid only but check out the new 2024 codes G0023-G0024 for Principal Illness Navigation (PIN) for Medicare and others + G0140 for non-Medicare for PIN by certified peer specialists as of 2024

H2011-H2013, H2018-H2022 – Crisis interventions, behavioral/psychiatric health day treatments, psychosocial rehab, community-based wrap-around services (*time-based*)

H2034-H2036 – Alcohol and/or drug abuse halfway house

HIPAA Required Code Sets
Using the manuals vs. software

ICD-10-CM diagnostic code set – which is different from ICD-10-PCS used on hospital facility claims

- All providers, coders, and billers should learn the "*Official Guidelines for Coding and Reporting*" Section I, Subsections A-C for general and specialty-specific info.
- Instead of just using an EHR's alphabetic index search (i.e., Volume 2) as a shortcut – it is vital for clinical providers/coders to access the "instructional notations" found in Volume 1's Tabular code listing for proper diagnostic coding and billing.

Proper ICD-10-CM coding balances optimal clinical care, care coordination, revenue cycle, and patient education

Medical Necessity: OAC 5160-1-01

- The fact that a physician, dentist or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself make the procedure, item, or service medically necessary and does not guarantee payment for it.
- The definition and conditions of medical necessity articulated in this rule apply throughout the entire medicaid program. More specific criteria regarding the conditions of medical necessity for particular categories of service may be set forth within ODM coverage policies or rules.

ICD-10-CM Considerations

Clinical Providers

What level of training have your providers received on the Official Guidelines for Coding and Reporting? Can they locate "base code notes"? How do providers "link" the diagnoses to each procedure/service so coding/billing knows which diagnoses should be paired with which procedures? Which diagnoses should NOT be reported on each visit?

Managers

Do your EHR vendors allow providers to see the full code definitions or just summary definitions? Does your "encounter form" or billing tab in your EHR allow providers to "link" diagnoses or do coders/billers have to make an educated guess? Do you have policies that allow coders/billers to adjust codes based on existing clinical documentation?

Coders

Do you see diagnoses listed on your "electronic superbill" that are not documented on the actual closed encounter note? Have managed care organizations told your providers to list every active diagnosis the patient has for each visit and if so, what problems can that cause? Which diagnoses can impact your PMPM payments and/or are being tracked for quality reporting requirements?

Billers

Which claim form requires you to "link" diagnoses and which claim form does not? Do you know if a National/Local Coverage Decisions (NCD/LCD) impacts the claim's expected success? Has a professional coding review been performed BEFORE billing in order to validate that the medical record contains supporting documentation?

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

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.

ICD-10-CM Self-Study – Research in the ICD-10-CM's Volume 1 and "Official Guidelines"

A18.0

"Tuberculosis of bones and joints"

There are no codes for tuberculosis in just the bones or in just the joints – how would you code that?

F10-F19

Code for substance-specific use, abuse, or dependence.

How do you code these when most providers document "mild, moderate, or severe use disorders"?

E11.9

When using "Type II diabetes (*or other chronic condition*), without complications" and then listing other ICD-10-CM codes for related complications what problems can this cause and what type of codes found in section I, subsection B would help?

Z00.xx and Z01.xx

In what order should codes for "general adult and child medical examinations" be on a claim compared to any acute/chronic conditions?

Z55-Z65

Social Determinants of Health (SDOH) codes identify social/economic issues that affect care.

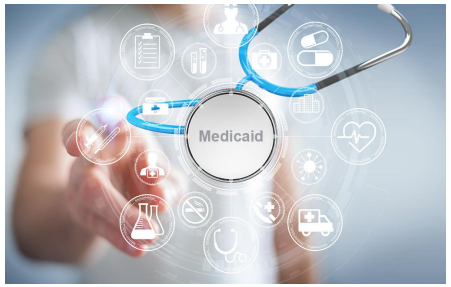
How can they impact your E/M code choice?

How RHCs/FQHCs are Different,

Key CMS Resources to Monitor

Examples of Varying Insurance Types

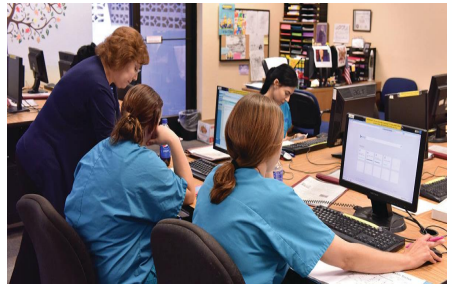
Medicaid



Automobile & Worker's Comp

Medicare
Parts A, B, C, and D

Commercial Insurers



Self-Pay/No Insurance
"Pure Coding"

There are Several Medicare Coverage Options

Part A

In general, Part A covers hospital care, skilled nursing facility, nursing home care, etc. Sometimes called "facility services". RHC/FQHC are Part B providers who usually get paid for encounter rates via Part A claims.

Part B

RHC & FQHC are Part B providers even though we primarily use a claim form associated with Part A.

RHCs/FQHCs bill Part B also for many services!

Part C

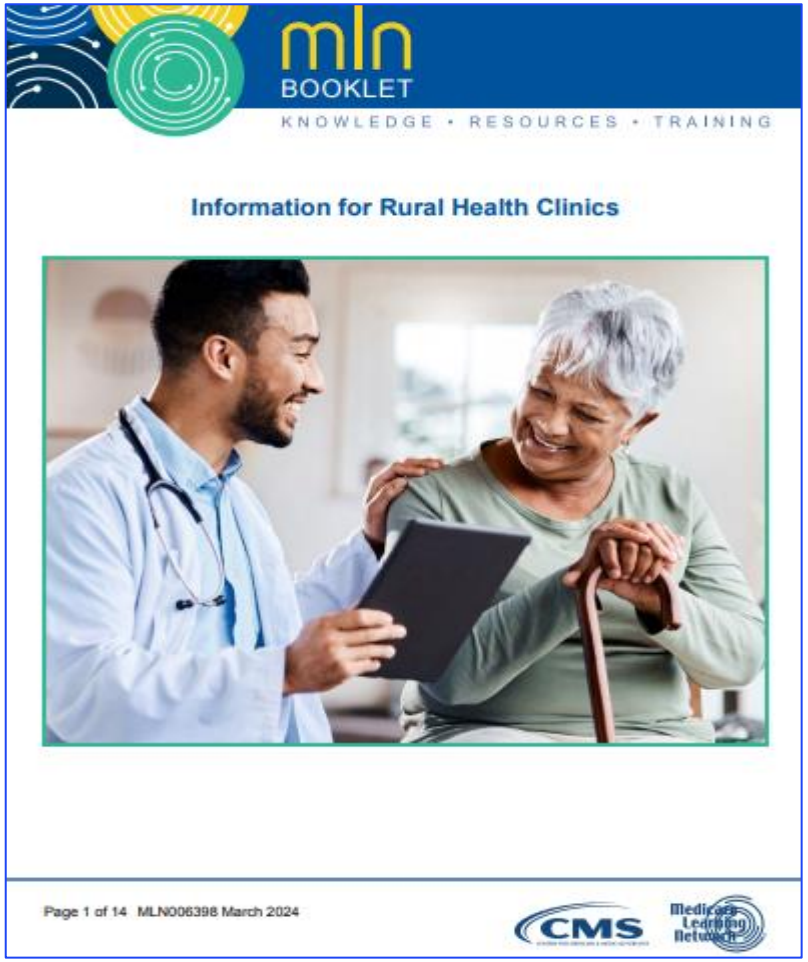
Combines Parts A & B (and maybe Part D) into one plan and is generically likely referred to as a Medicare Managed Care Organization (MCO) and is run by a private insurance company.

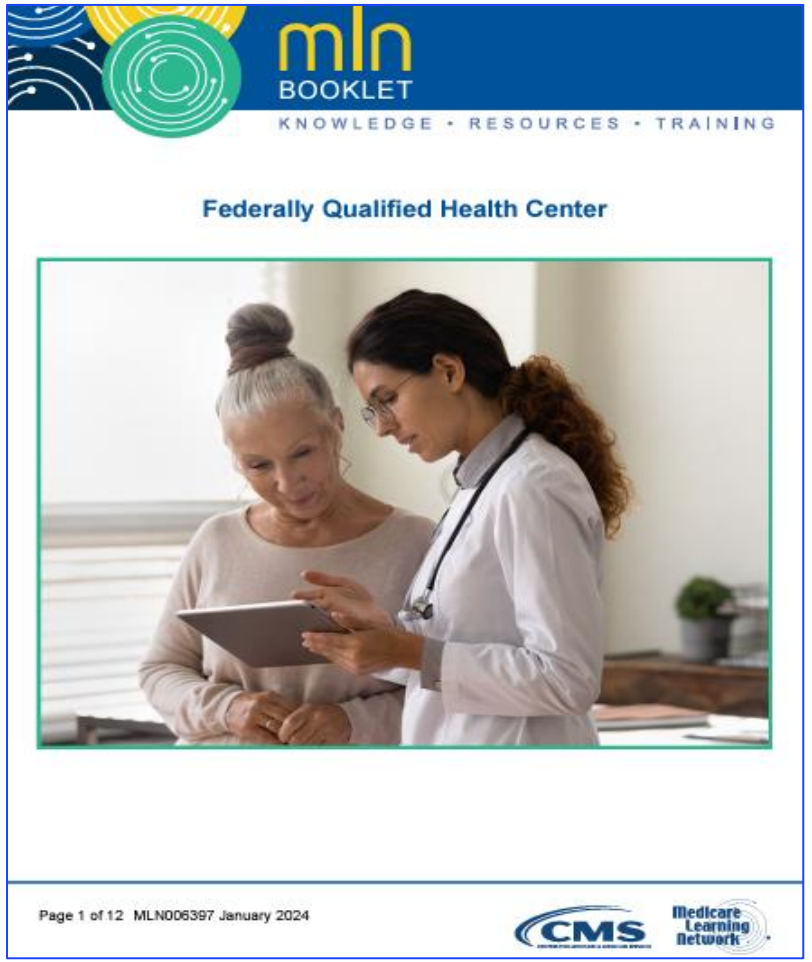
Don't assume that all traditional Medicare billing rules apply!

Part D

A broad term for Medicare Prescription Drug coverage. There are various Part D plans. When combined with a Medicare MCO it may be called a Medicare Advantage – Prescription Drug (MA-PD) plan.

What Makes RHCs and FQHCs Different?





Also - go to www.CMS.gov > Medicare> Provider Type> scroll down to RHC or FQHC and bookmark it for periodic updates and access to wonderful resources all in one place!

Last known update – March 2024

Last known update – January 2024

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

Table of Contents
(Rev. 12070, 06-07-23)

Transmittals for Chapter 9

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Table of Contents
(Rev. 12070, 06-07-23)

Chapter 13 - CMS Benefits Policy Manual

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

Table of Contents
(Rev. 11803, 01-26-23)

Transmittals for Chapter 13

Table of Contents
(Rev. 11803, 01-26-23)

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

How are RHCs and FQHCs different than traditional doctor's offices for Medicare?

- Received authorization from HHS and are operating in either a rural or urban Health Professional Shortage Area (HPSA) and can perform a small set of select lab services onsite.

- Over 50% of the services each year during your posted hours of operation are "primary care" in nature. What about mental health or other specialty services?

- RHC/FQHC have tremendous flexibility with "other qualified health professionals" and get full payment from Medicare for the services of PA, NP, CNM, CP, and CSW when performed as a "valid encounter" with no indication on most claims of who provided the services.
    - New for RHC/FQHC 2024 – Mental Health Counselors (MHC) and Marriage and Family Therapist (MFT) became authorized billing providers for Medicare. CMS is considering expansion to include substance/opioid abuse counselors pending credentialing clarifications.

How are RHCs and FQHCs different than traditional doctor's offices for Medicare? (cont'd)

- Most services are billed on a UB/CMS1450/837i form with completely different claims rules than you use for most other carriers expecting to use a "HCFA"/CMS1500/837p, form including Type of Bill, Revenue Codes, and different rules for NPI usage.
- RHC and FQHC must submit an annual cost report impacting your future AIR/PPS, annual reconciliation and/or FQHC wrap-around payments, vaccine billing, and should show your true costs.
- Medicare does not pay for certain services at all, or in the same way, as they pay regular Part B provider offices (ex. 99211).
- RHC and FQHC should bill for the technical component of diagnostic tests separate from any claim with AIR/PPS payments via "split billing" to get fee-for-service for the equipment they own.

Rural Health Clinic Medicare Basics

Independent RHCs are *self-owned* LLC, corporations, etc. and Provider-based RHCs are *owned by another entity* such as a CAH/hospital system that owns one or more RHCs.

- Instead of getting paid fee-for-service (FFS) Medicare pays you ~80% of an All-Inclusive Rate (AIR) for "valid encounters."
    - Patient coinsurance ***is not*** 20% of the AIR or 20% of Medicare's FFS rate!
- ***Being independent vs. provider-based*** changes how you will bill for the technical components of Medicare-covered diagnostic tests (i.e., x-ray, EKG, ultrasound) via "split billing", lab services paid via the clinical lab fee schedule, and pre-/intra-/post-op surgical procedures performed outside of your RHC.
- Billing for ***procedure-only visits*** is acceptable if the service is covered by Medicare in a RHC. If performing ***BOTH*** and E/M and a procedure no modifier -25 is needed on the E/M since the CMS global surgical package does not apply.

Rural Health Clinic Medicare Basics (cont'd)

- Medicare ***does not*** *have a RHC "qualifying visit list"* officially active that identifies ***all*** possible services that are allowable to be billed in a RHC to get your AIR. Several versions were released throughout 2016, but effective October 2016 the newest version indicates the following:

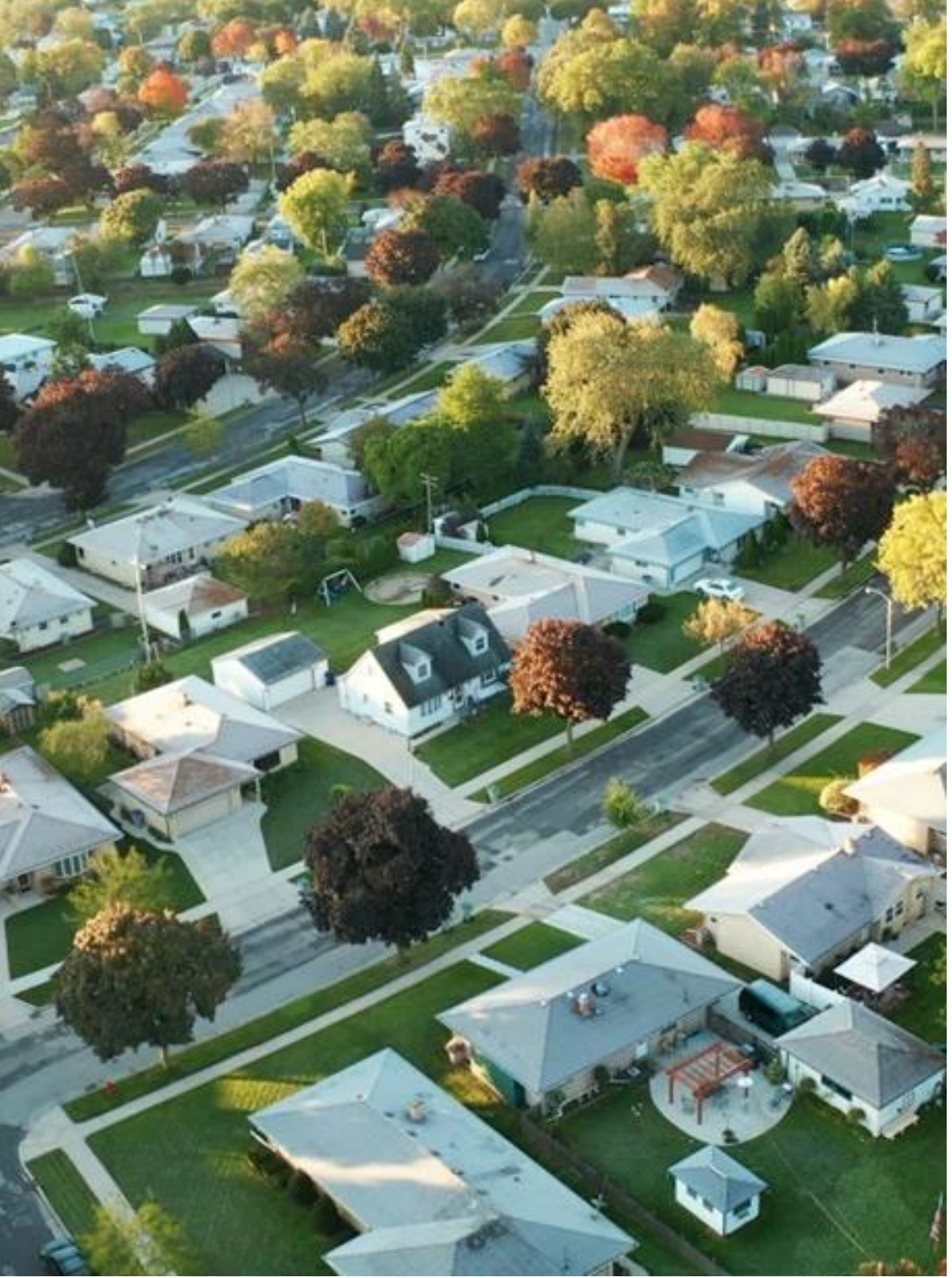
Rural Health Clinic Qualifying Visit List (RHC QVL)
(8-01-16)

payment *with the CG modifier (explained below)*. For dates of service on or after October 1, 2016, a medically-necessary service not on the current QVL can be billed as a stand-alone billable visit if the service meets Medicare coverage requirements, is within the scope of the RHC benefit, and is not furnished incident to a physician's service.

NOTE: The use of a HCPCS code from the below QVL does not guarantee payment of the claim. All of the conditions for coverage and payment must be met for payment to be made. RHCs must retain adequate documentation of a patient's condition and the services furnished as part of the patient's medical record, which, along with the claim, may be subject to review by CMS, its contractors, or other oversight authorities.

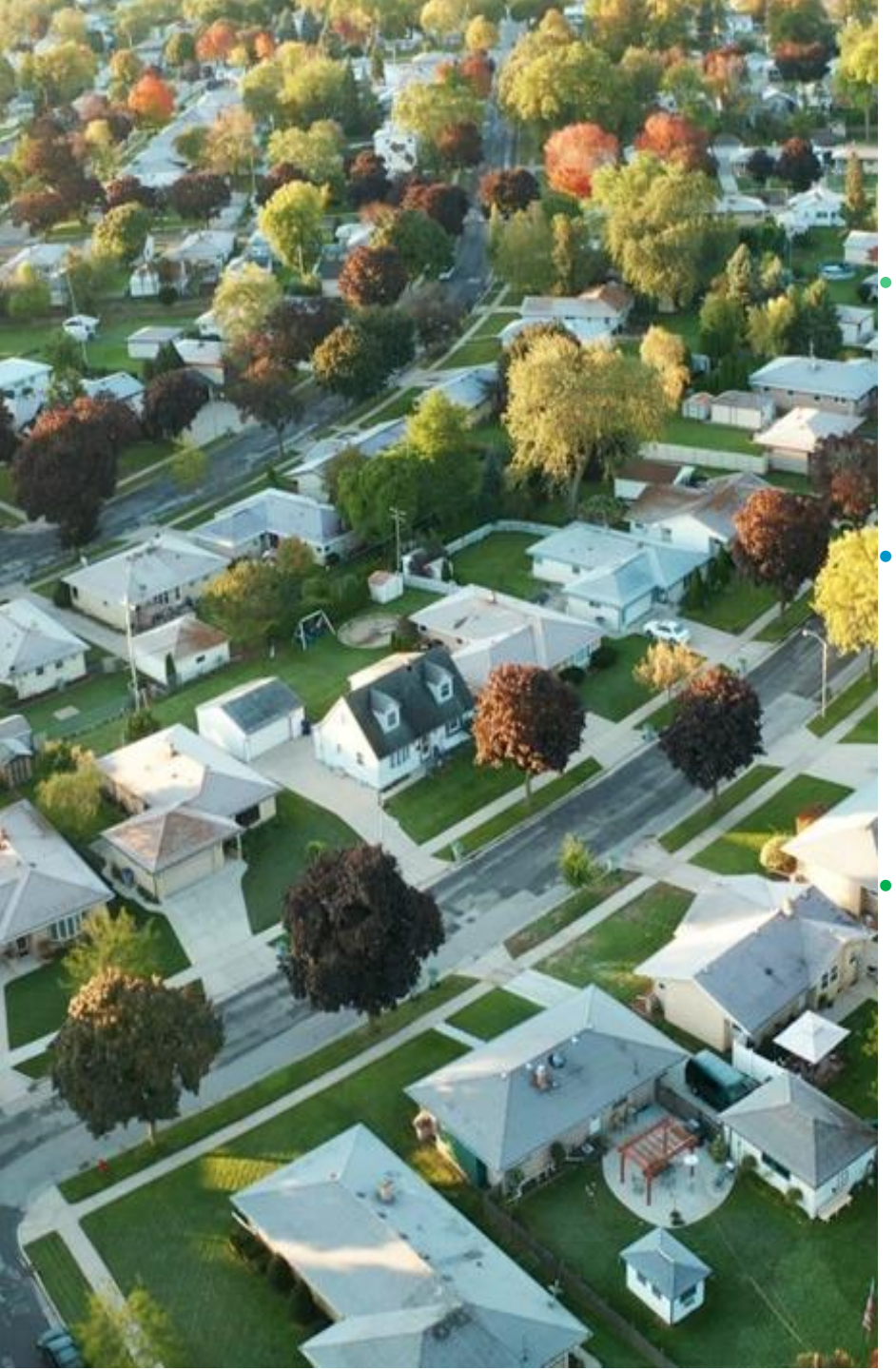
SOURCE:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Qualifying-Visit-List.pdf

- Always follow the ***NCDs/LCDs*** of your Part B MAC.
  - Are you familiar with the ***Medicare Coverage Database***?



Federally Qualified Health Center Medicare Basics

- Instead of getting paid fee-for-service (FFS) Medicare ,and possibly Medicaid, pays you ~80% of a Prospective Payment System (PPS) rate for “valid encounters.”
- To receive Medicare payment, you are required to perform, document, and bill a code on their **Qualifying Visit List (QVL)** preceded by one of 5 FQHC-only “magic” billing G-codes G0466-G0470.
- Your FQHC will determine a fee for each of the FQHC-only G-codes that identifies your charge for a “**typical bundle of Medicare-covered services**.”



Federally Qualified Health Center Medicare Basics (cont'd)

- Medicare will compare your charges for one of the 5 billing G-codes to your established localized PPS rate and will pay 80% using the **"lesser of"** the compared charges.

- Geographic differences adjust the national 2024 PPS base rate depending on how your state adjusts payments based on your location.
  - ✓ Base Rate $195.99 (x) Possible Geographic Adjustment = **Your locally adjusted PPS rate**

- Billing ***procedure-only visits*** in a FQHC without a medically necessary E/M being documented first ***will NOT generate a PPS rate*** since the qualifying visit list is mainly encounter-based (*i.e. E/M*).
  - If reporting an E/M (*or other service on the QVL*) and a procedure, modifier -25 is NOT needed on the E/M since the CMS global package rules do not apply.

RHC and FQHC
Medicare Billing Requirements

Rural Health Clinics (RHCs) Reporting Requirements Frequently Asked Questions (FAQs)

(Revised 10-14-16)

Effective April 1, 2016, RHCs are required to report a HCPCS code for each service furnished along with an appropriate revenue code. For claims with dates of service on or after April 1, 2016, RHCs should follow the reporting requirements for modifier CG found in MLN Matters Article SE1611. A compilation of FAQs about reporting modifier CG and CMS responses are provided below.

RHC Reference: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Reporting-FAQs.pdf

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

CMS RHC/FQHC Valid Encounters,

FQHC Qualifying Visit List,

CMS Patient Cost Sharing, and

Cost Reporting

CMS Valid Encounters Defined for RHC/FQHC

01

Face-to-Face Visit?

Exceptions?

02

Authorized Qualified Health Professional (QHP)?

Slight differences for RHC vs. FQHC with DSMT and medical nutrition therapy.

Added Mental Health Counselor and Marriage and Family Therapist in '24

03

"Medically Necessary"?

Familiar with NCDs vs. LCDs and where to get them?

Try this hyperlink

04

Authorized location?

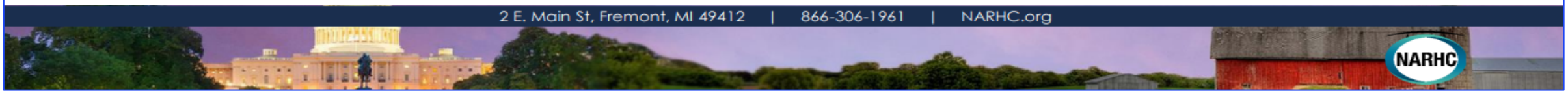
Office, Part A SNF, patient's residence, where else?

"An RHC or FQHC visit is a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, or a CSW during which time one or more RHC or FQHC services are rendered." – CMS Benefits Policy Manual, Chapter 13, Section 40

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

- 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)

CMS exceptions to the one encounter per day rule from Ch. 13

- *What are the 3 exceptions?*
- *What modifier(s) should I add to identify an exception?*

40.3 - Multiple Visits on Same Day

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

Except as noted below, encounters with more than one RHC or FQHC practitioner on the same day, or multiple encounters with the same RHC or FQHC practitioner on the same day, constitute a single RHC or FQHC visit and is payable as one visit. This policy applies regardless of the length or complexity of the visit, the number or type of practitioners seen, whether the second visit is a scheduled or unscheduled appointment, or whether the first visit is related or unrelated to the subsequent visit. This would include situations where *an* RHC or FQHC patient has a medically-necessary face-to-face visit with *an* RHC or FQHC practitioner, and is then seen by another RHC or FQHC practitioner, including a specialist, for further evaluation of the same condition on the same day, or is then seen by another RHC or FQHC practitioner, including a specialist, for evaluation of a different condition on the same day.

Sample information from Chapter 13 for RHC/FQHC Visits

The March 2024 update to MLN006398 "Information for Rural Health Clinics" **ADDS another exception:**

- *"Has IOP services on the same day with a medical visit."*

Check with all payers who pay via encounter rates if they have the same exceptions and how to show the exception(s) on BOTH claim forms?

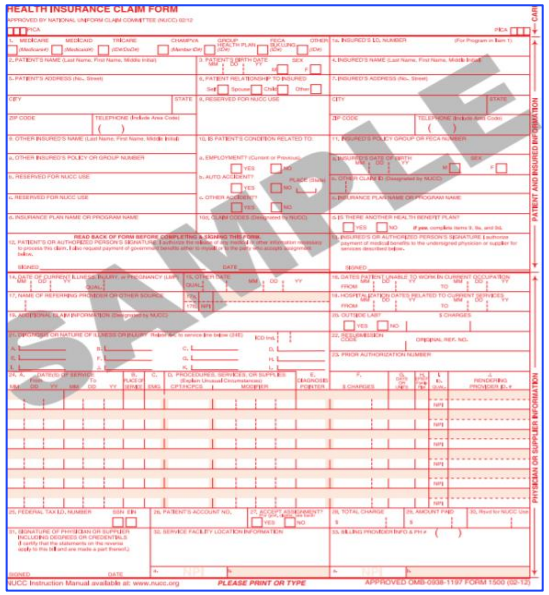
Exceptions are for the following circumstances only:

- The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC or FQHC). In this situation only, the FQHC would use modifier 59 on the claim and the RHC would use modifier 59 or 25 to attest that the conditions being treated qualify as 2 billable visits;
- The patient has a medical visit and a mental health visit on the same day (2 billable visits); or
- For RHCs only, the patient has an initial preventive physical exam (IPPE) and a separate medical and/or mental health visit on the same day (2 or 3 billable visits).

NOTE: These exceptions do not apply to grandfathered tribal FQHCs.

Be prepared to use both claim forms for some carriers

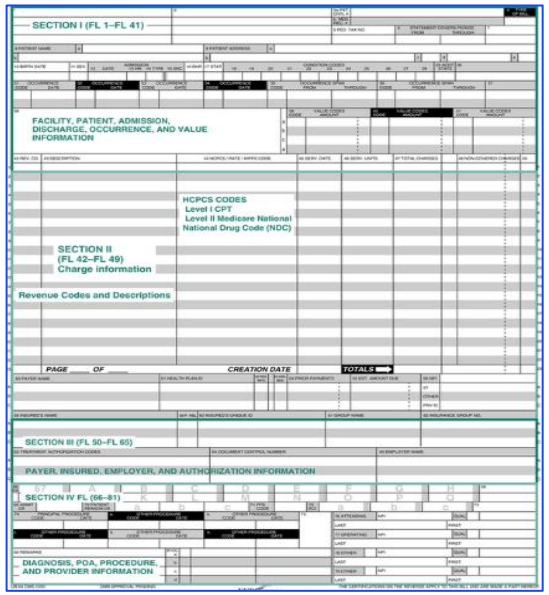
CMS 1500/837p Form



Used by RHC/FQHC to most all commercial and non-Medicare carriers **expecting to receive Fee-for-Service (FFS) payments and/or reporting non-RHC/FQHC services** such as labs, hospital visits, and technical component of diagnostic tests, for example, on Medicare Part B patients that also require POS codes from the beginning of the CPT.

vs.

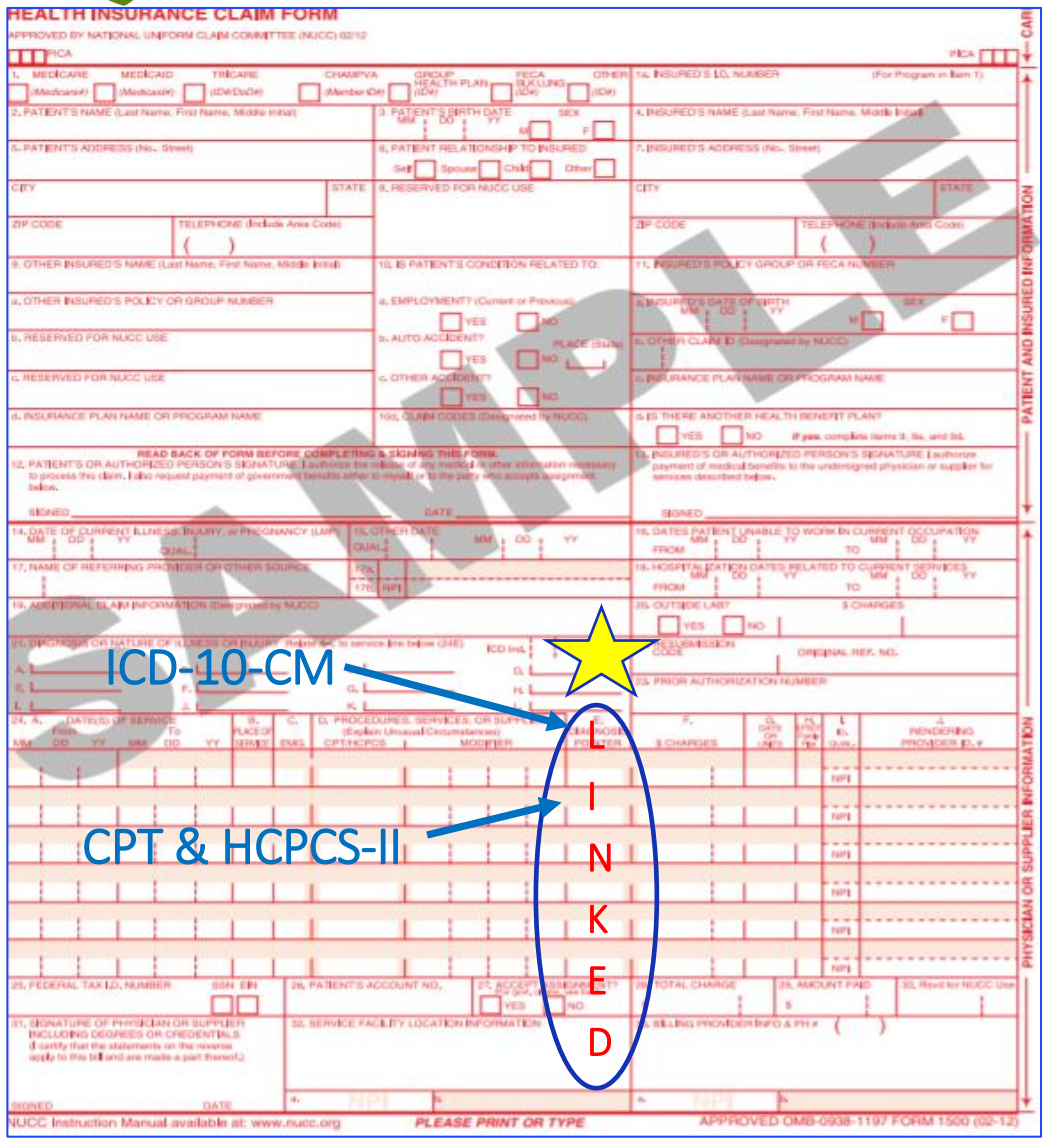
CMS 1450/837i Form



Used by RHC/FQHC submitting claims to Medicare (*and some Medicaid carriers*) for "valid encounters" when **expecting the AIR/PPS rate.**

Unlike the CMS1500, the CMS1450 also requires Type of Bill (TOB) and Revenue Codes.

Compare CMS 1500 form (aka "HCFA" or 837p)



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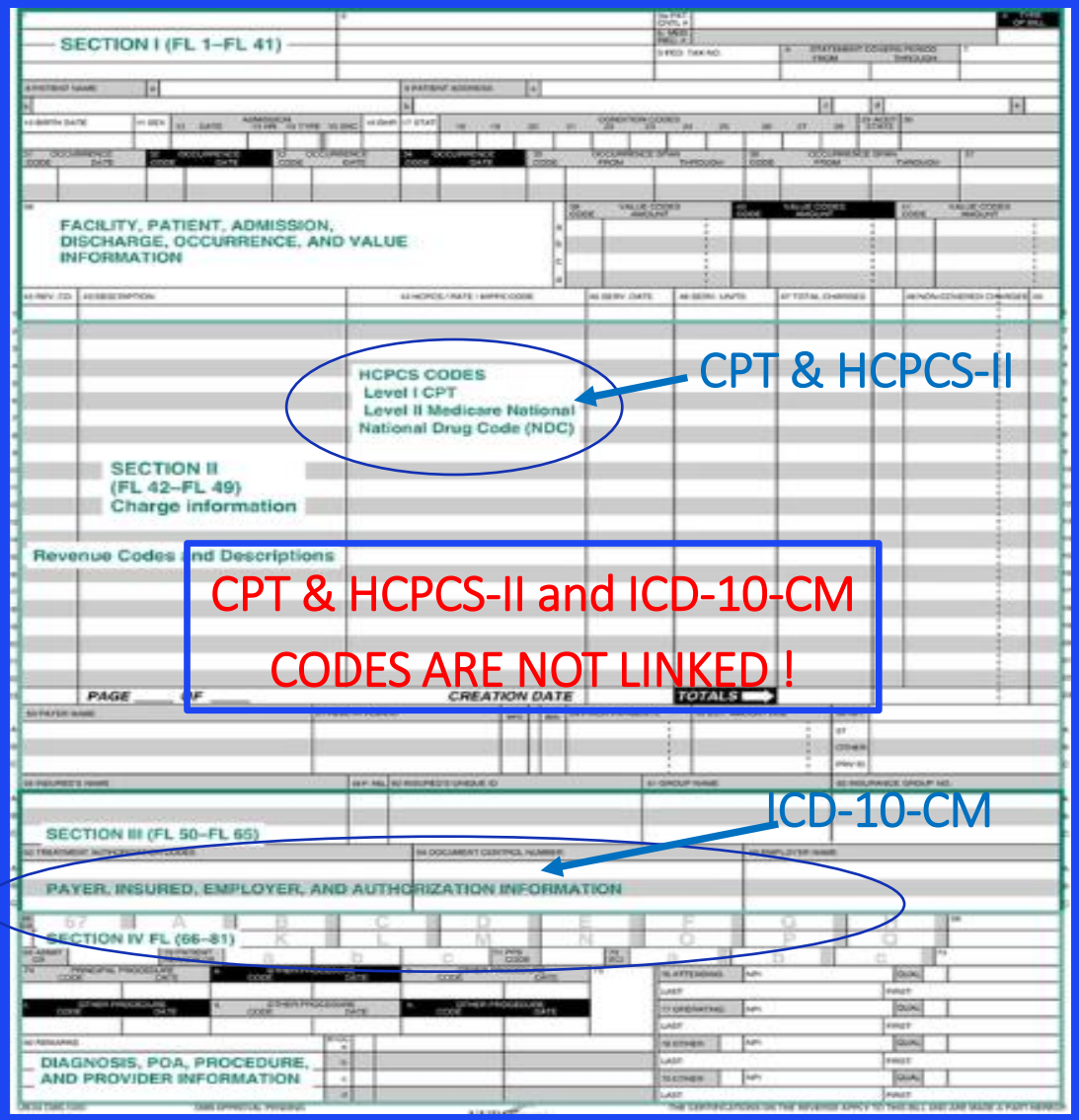
HYPERLINKS
Claim
Instructions

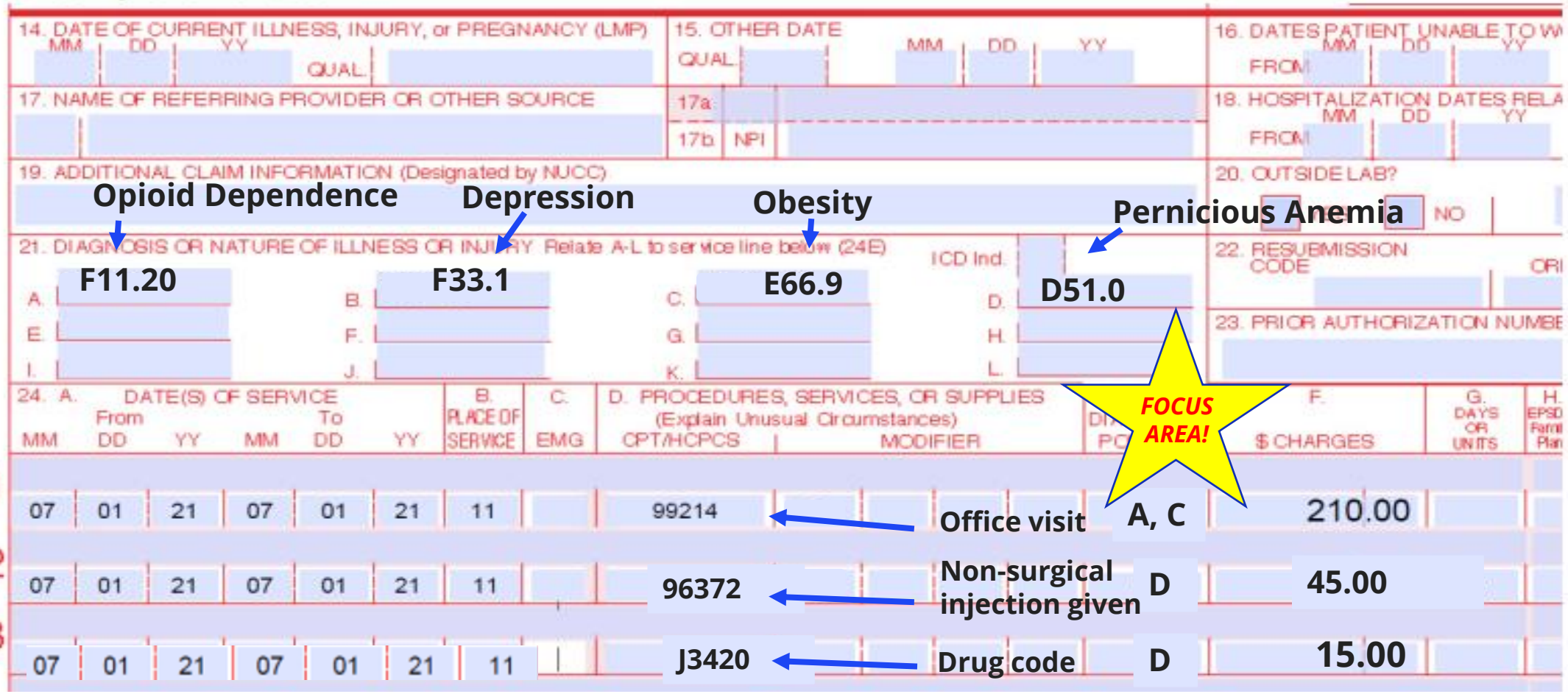
Contrast CMS 1450 (aka "UB" or 837i)



Sample FFS claim for a medical provider giving an unrelated injection

(if a same day mental health service is also provided – each claim can be sent out separately)

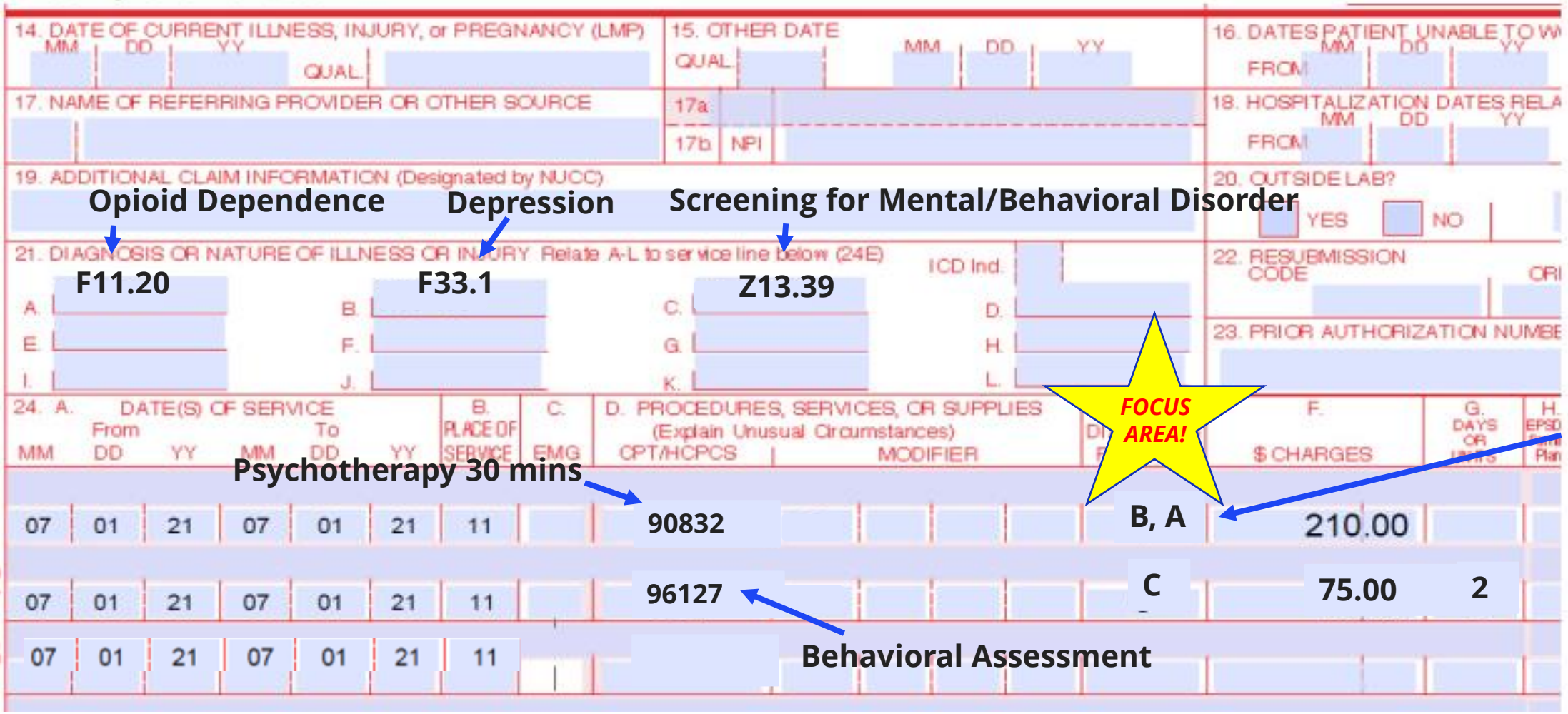
Sample CMS 1500



Sample FFS claim for a mental health provider providing therapy and additional assessments

(if a same day medical service is also provided – each claim can be sent out separately)

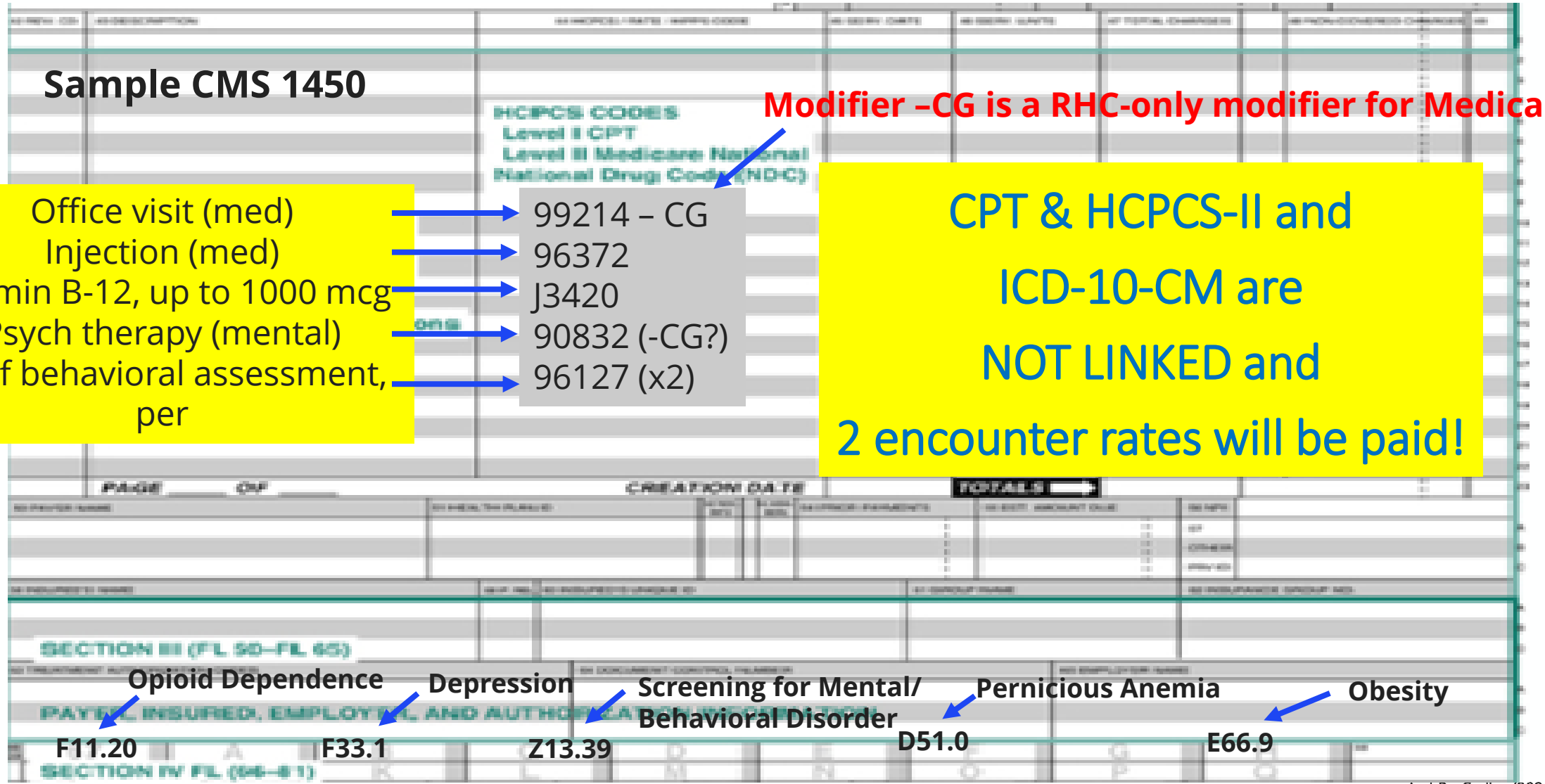
Sample CMS 1500



Are you allowed to not have "A" first? MACs vary!

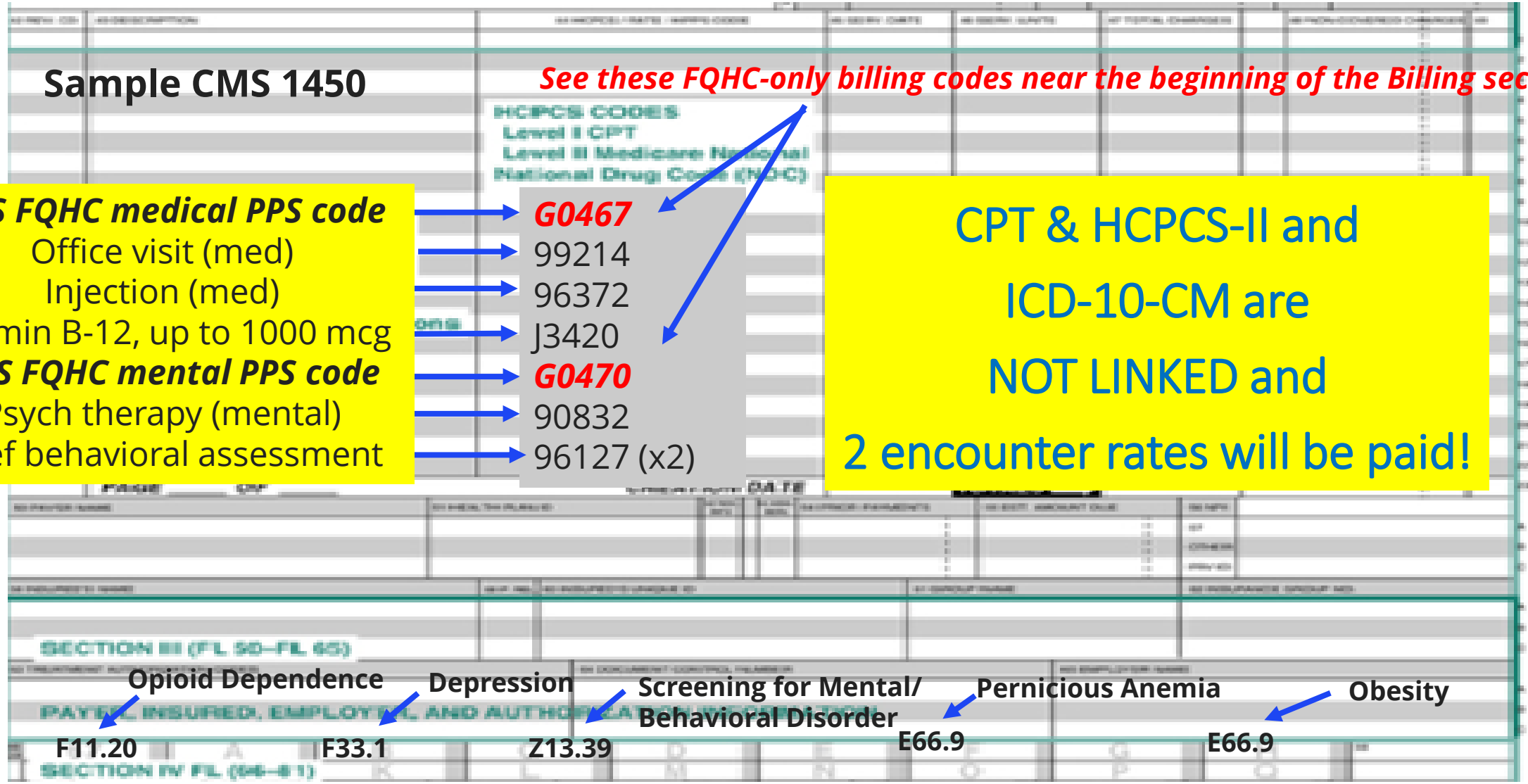
RHC same day injection from medical & psychotherapy by mental health provider to Medicare

(BOTH encounters should go out on the same claim on the same date!)



FQHC same day injection from medical & psychotherapy by mental health provider to Medicare

(BOTH encounters should go out on the same claim on the same date!)



Required information on RHC/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)

Managers – Does your EHR/IT billing environment support RHC/FQHC-specific rules?
Who can bypass claim scrubber edits and change codes in your systems?

Qualifying Visit List For RHC

Intended as a general guide for RHCs reporting HCPCS Level I and II codes.

It is not an all-inclusive list. You can report services not on this list if they meet medical necessity (ex. NCDs/LCDs) and were provided after 10-1-16.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Qualifying-Visit-List.pdf

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

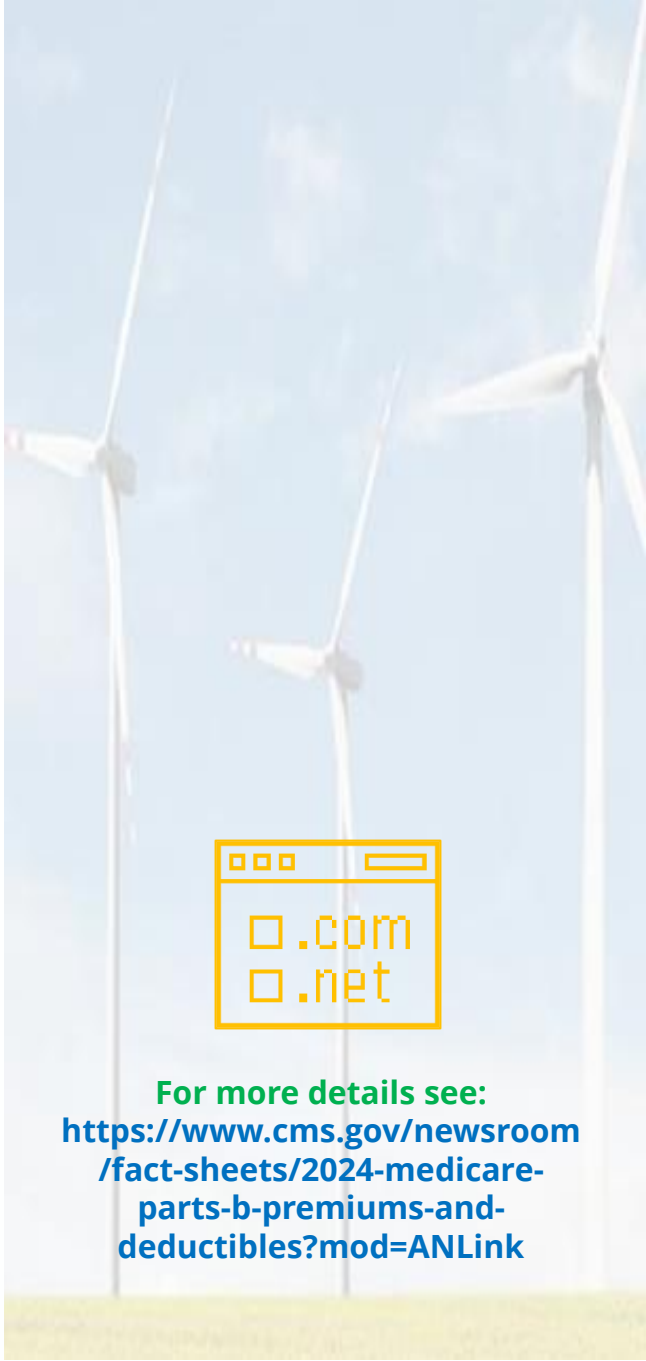
Rural Health Clinic Patient Cost Sharing

- The 2024 RHC Part B patient deductible ($240) is the same as they have in traditional doctor's offices.

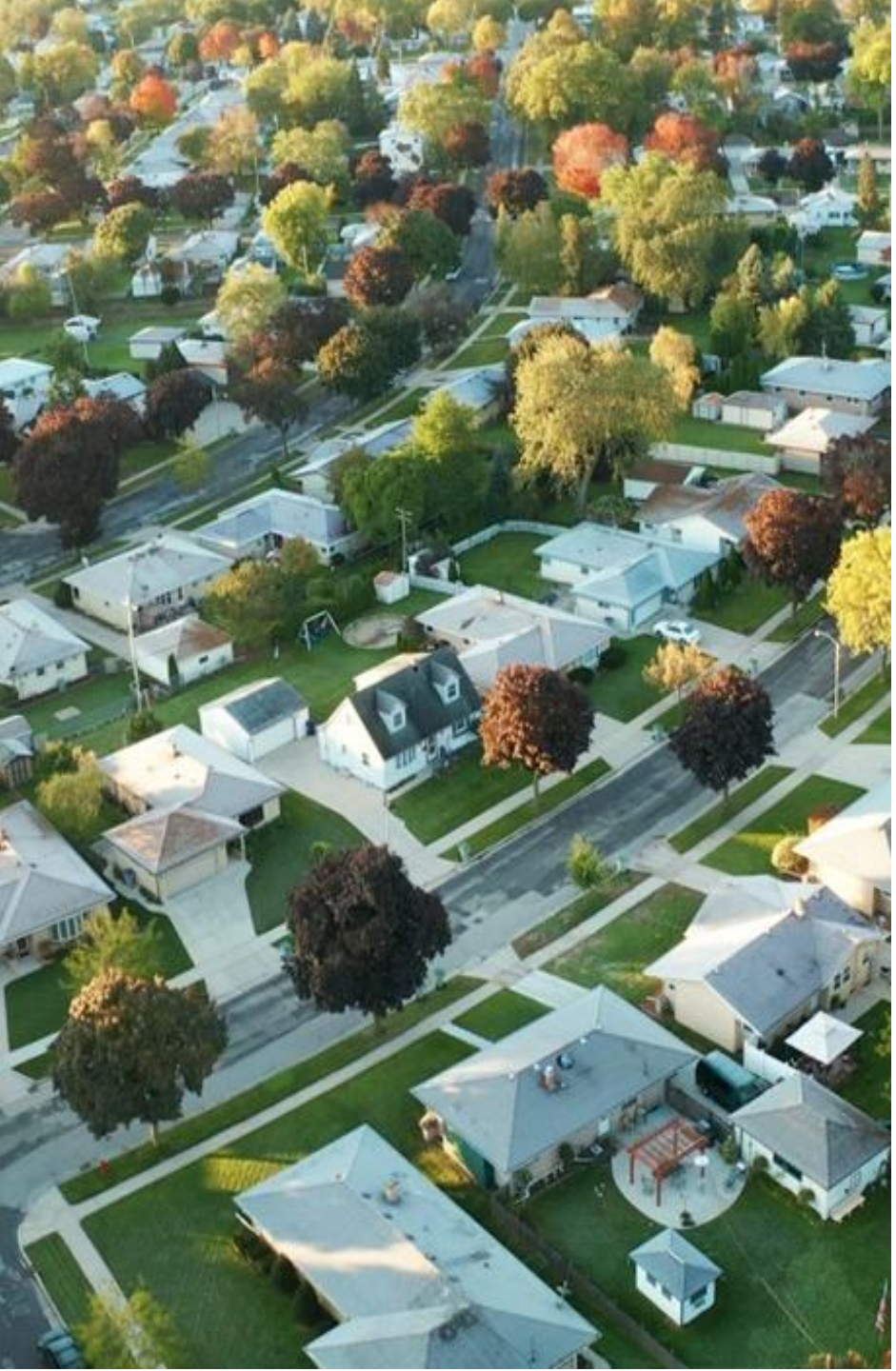
- For valid AIR encounters the RHC patient coinsurance is **20% of your TOTAL ALLOWABLE CHARGES** from the first line on the CMS1450 form that carries modifier –CG.
  - ✓ Line #1 on the UB claim also should include your charges for that code as well as the allowable charges for all allowable codes below it - all totaled on the Line #1's code carrying –CG.

- Independent and provider-based RHCs in a hospital with 50 or more beds **the AIR upper limit is capped at $139** for 2024 with ~ $13 annual increases to up to $190 in 2028 as per the RHC Modernization Act of 2021.
  - ✓ If you are a provider-based RHC owned by a hospital with less than 50 beds, you likely get paid an AIR based on your recent cost report rather than at "cost" as in the past.
  - ✓ "Grandfathered" RHCs adds 4.6% to the upper limit or $139 whichever is greater.

- Most covered preventive medicine services have $0 coinsurance or deductible.



For more details see: https://www.cms.gov/newsroom/fact-sheets/2024-medicare-parts-b-premiums-and-deductibles?mod=ANLink

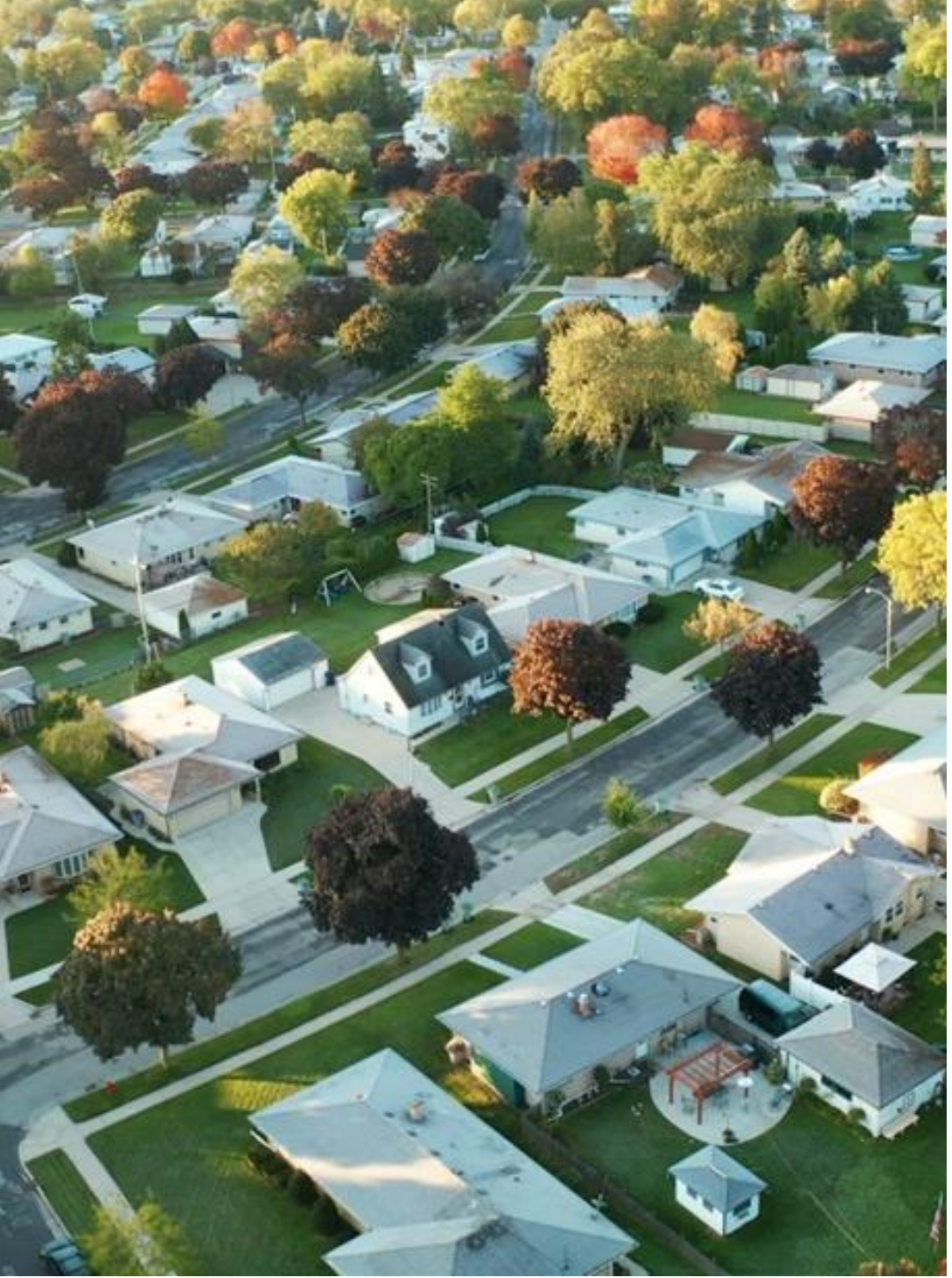


Federally Qualified Health Center Patient Cost Sharing

- 2024 FQHC patient deductible for Part B patients **is $0 except for distant site telehealth services**.

- A Part B FQHC patient's coinsurance is **determined according to the "lesser of" policy** by comparing your charge for the FQHC billing codes G0466-G0470's to your locally adjusted PPS rate.
  - ✓ Your MAC should pay 80% of the lower of the 2 charges.
  - ✓ Your patients owe 20% of the lower of the 2 charges.

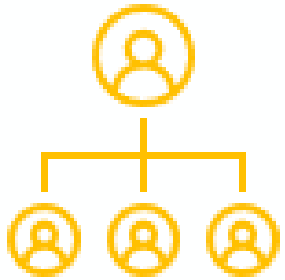
- Most covered preventive medicine services have $0 coinsurance or deductible.



Federally Qualified Health Center Patient Cost Sharing

- Medicare should pay a **34.16% increase to your PPS rate** for new patient medical or mental health visits **OR** the performance of an IPPE *(aka "the Welcome to Medicare Physical")* code G0402 or Initial/Subsequent Annual Wellness Visit (AWV) codes G0438-G0439.
- For Medicare FQHCs **DO NOT** use the established CPT definition of New vs. established!!!

How do Managers and Professional Coders Balance Billing vs. Cost Reporting?



Total Allowable Costs via CPT/HCPCS-II

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Allowable Visits

= **Your "Cost"**

- Are you reporting all CPT/HCPCS-II codes?
- What about Quality Reporting $$$ incentives?
- Any impacts on non-Medicare insurance $$$ using FFS?
- RHC impacts of cost reporting vs. FQHCs using a "market basket"

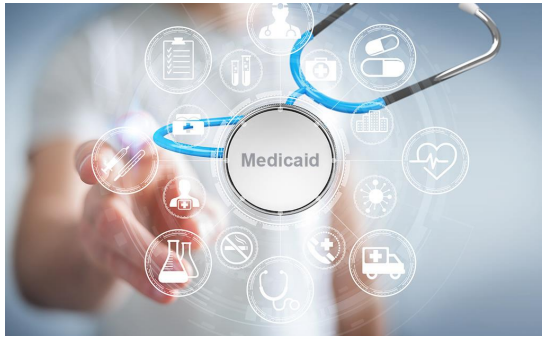
EVERYTHING about cost reports is centered on how well you are truly capturing all the services you provide based on CPT/HCPCS-II coding whether the services generate payment or not!

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)

Expected Variations with Non-Medicare Payers,

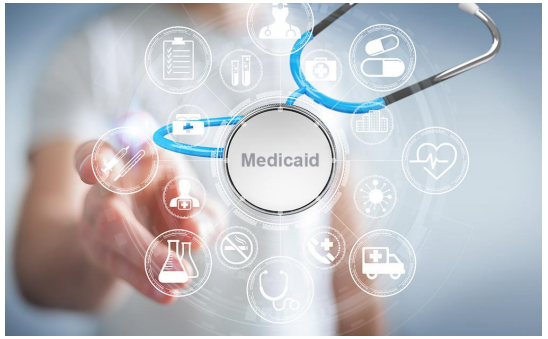
Non-Medicare Payer Contracting Considerations

Medicaid and Commercial carriers likely have different billing rules



- Some states have a single Medicaid option and others have assorted plans administered by assorted carriers who likely have different billing rules for different provider types that are billed on different claim forms using different billing codes and modifiers.
- Some carriers post their “approved” codes on their website (*or in your participation contracts*) and break down what services each provider type (i.e., MD, NP, PA, LPC, Peer Support Specialists, etc.) can get paid for.
  - ✓ What are their “incident-to” rules and their definition of New vs Established patients?
  - ✓ Which definition of the “global surgical package” do they use?
  - ✓ Do any Medicaid plans require H- or T- codes and/or unique modifiers?
  - ✓ Do they have a Qualifying Visit List?
  - ✓ What else could change?

Medicaid and Commercial carriers likely have different billing rules



- Do your managed care plans, Medicaid plans, and commercial carriers want you to use Place of Service (POS) code 11 for a traditional doctor's office OR are you enrolled as a participating provider using POS 50 for a FQHC or 72 for a RHC? CMS1450 versus CMS1500?

- There may be significant advantages to receiving AIR/PPS rates rather than traditional FFS payments via a contracted fee schedule or via xxx% of Medicare's FFS amounts.

Documenting Patient Visits

ArchProCoding
RURAL & COMMUNITY HEALTH

Section Overview
Documenting Patient Visits

Nursing's Role in Clinical Documentation

We will review the RN/MA/LPNs, for example, initiating regular office visits, performing "incident-to" E/M visits on their own, and performing minor procedures, vaccinations, and/or injections on their own

Core Principles of Documenting Visits

Role of the chief complaint, "stand-alone" documentation requirements, monitoring coding patterns, and using EHR templates.

Overview of 2024 E/M Guidelines

Do your clinical providers document according to the AMA E/M guidelines?

Does you EHR have templates that reflect recent E/M changes?

Hands-on with the E/M Section

We will go into the AMA's CPT manual to review key documentation guidelines for office and other locations with a focus on the updated CPT text.

Section Overview
Documenting Patient Visits

Documenting Preventive Medicine Services

There is a vital difference between the CPT's Preventive Service codes 99381-99397 and ~30 "sometimes covered" CMS-created G-codes.

Documenting Care Management Services

Care management codes include Principal/Chronic Care Management (PCM/CCM), Transitional Care Management (TCM), new monthly Chronic Pain Management, Behavioral Health Integration (BHI), and the Psychiatric Collaborative Care Model (Psych CoCM).

Telehealth vs. Virtual Communication Services

We will compare/contrast how to report prescheduled medical and mental health telehealth visits as well as patient-initiated virtual check-ins to various payers.

Nursing’s Role in Clinical Documentation

Documenting incident-to services when nurses perform key portions of visits

- Below are examples of common nurse/medical assistant services performed under ***direct supervision***, rather than general or personal, without an authorized provider performing a face-to-face service that will likely be billed using the supervising provider's NPI# for FFS payment.
  - Non-surgical injection-only visits (ex. B-12) **use codes 96372 and J3420** under the supervising provider. Similarly, allergy injections will likely be reported via **95115** and **95117**, for example.
  - Vaccine-only visits use a vaccine administration code such as **90471** and a code for the vaccine product itself such as **90700** for DTaP.
    - Use **G0008-G0009** for flu and pneumo and various Covid administration codes. These are not directly reimbursed, rather they go to the Cost Report.
  - Visits for lab draws only nurses can code **36415**, for example, and the code for the lab itself such as **80050** for a general health panel.
  - Dressing changes, suture-only visits, prescription refill visits and similar services should use **99211** if there is no code that specifically identifies what was done.

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 (*related to*) 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

Billing incident-to services when nurses perform Medicare visits on their own in a RHC/FQHC

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

120.1 - Provision of Incident to Services and Supplies
(Rev. 263, Issued: Effective: 01-01-20, Implementation: 01-23-20)

When services and supplies are furnished incident to an RHC or FQHC visit, payment for the services are included in the RHC AIR or the FQHC PPS rate. An encounter that includes only an incident to service(s) is not a stand-alone billable visit for RHCs or FQHCs.

If any of the services on the previous slide occur without a CMS-authorized RHC/FQHC provider seeing the Medicare patient face-to-face, the services should be documented, coded, and stored in your EHR/IT environment but ***should not go on a claim form for AIR/PPS payments***.

Once the patient returns in a medically reasonable timeframe (*ex. 30 days*), you should list the incident-to services performed in the past on the next claim form.

Core Principles of Documenting Visits,

Overview of 2024 E/M Guidelines

Common Provider Medical Record Documentation Issues

Not knowing current CPT/ICD-10-CM guidelines and only seeing abbreviated/truncated code definitions.

Incomplete or Missing Documentation

Not knowing when time impacts code selection.

How is it different for medical vs. psychotherapy?

"Upcoding"

vs.

"Downcoding"

Absence of a consistently enforced office policy on submitting timely notes

Not separating problem-oriented and preventive services notes based on EHR settings

Lack of "medical necessity" explanation and/or specificity of ICD-10-CM codes

What are your common issues?

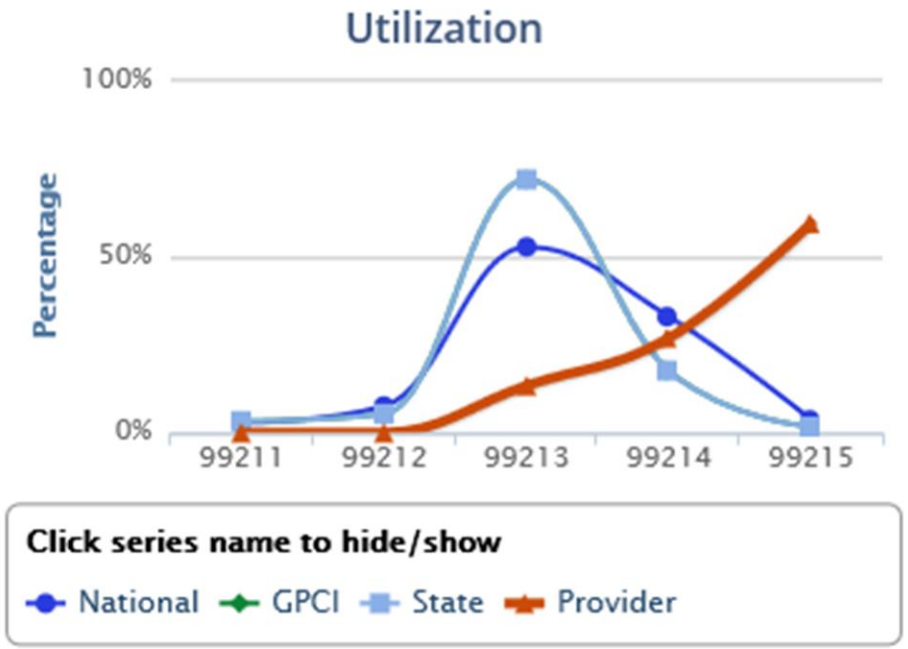
Have you analyzed your E/M code patterns for each provider, specialty, and location?

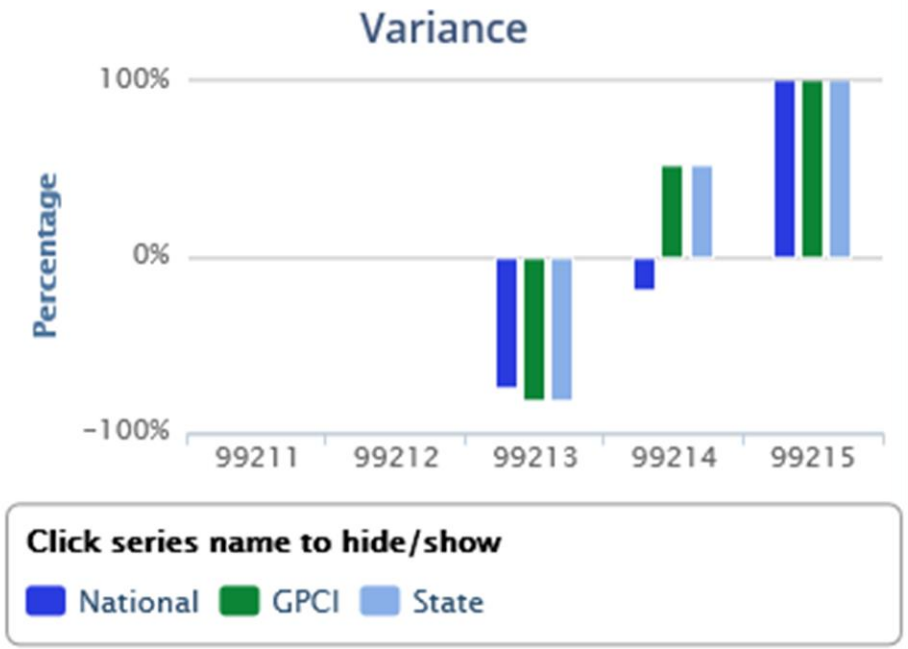
Utilization

99211:	0
99212:	0
99213:	144
99214:	290
99215:	641

Update Worksheet

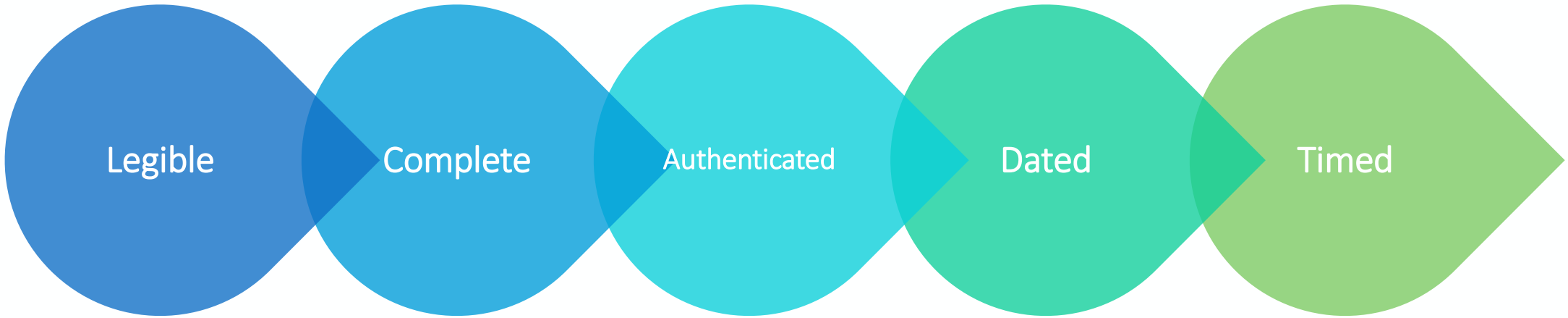
Table 2 - Established Office Visits





View Data

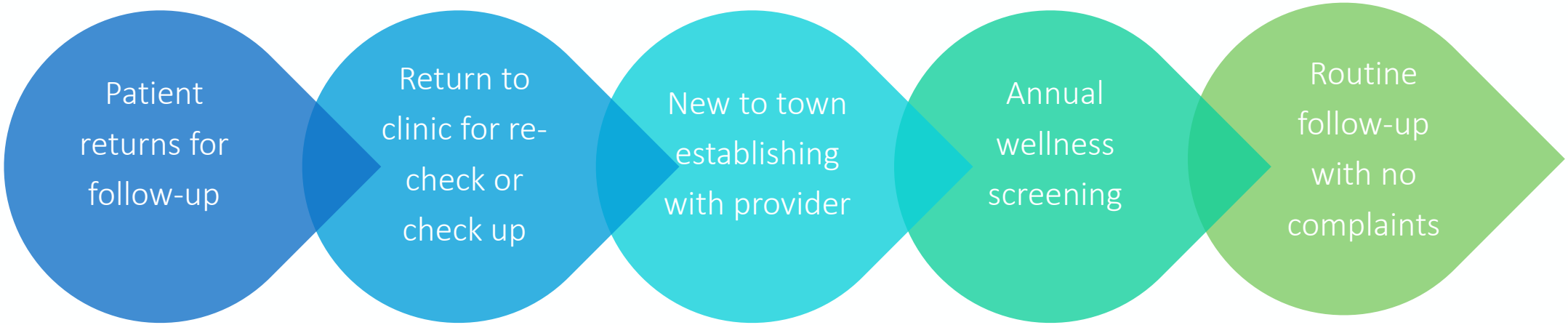
Goals for Each Note



Though the items above are found in HHS/CMS' Conditions of Participation for Hospitals **CFR Section 482.24(c)(1)** and we recommend them for all visits, treatments, and orders created in a RHC/FQHC

It all starts with the Chief Complaint

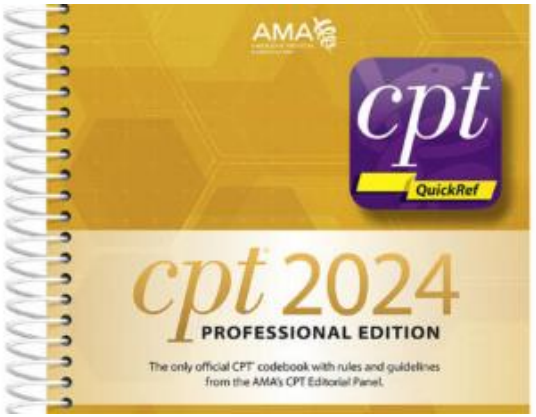
How can these be improved to show that they support a problem-oriented service rather than a preventive medicine service which could change who pays?



There may be a difference between a patient coming in with a symptom/sign for an acute illness/injury – compared to a patient getting ongoing care for the management of chronic conditions already being treated.

Note that each day's documentation must be able to "stand on its own" to meet documentation guidelines!

E/M Key Components – Past (1992-2020) vs. Present (2021-now)



HISTORY	EXAM	MEDICAL DECISION MAKING	Nature of Presenting Problem
Counseling	Coordination of Care	TIME	**What are your provider's most significant issues with the format of your EHR templates?**

Clinical provider's historical complaints with complicated documentation rules has been heard!

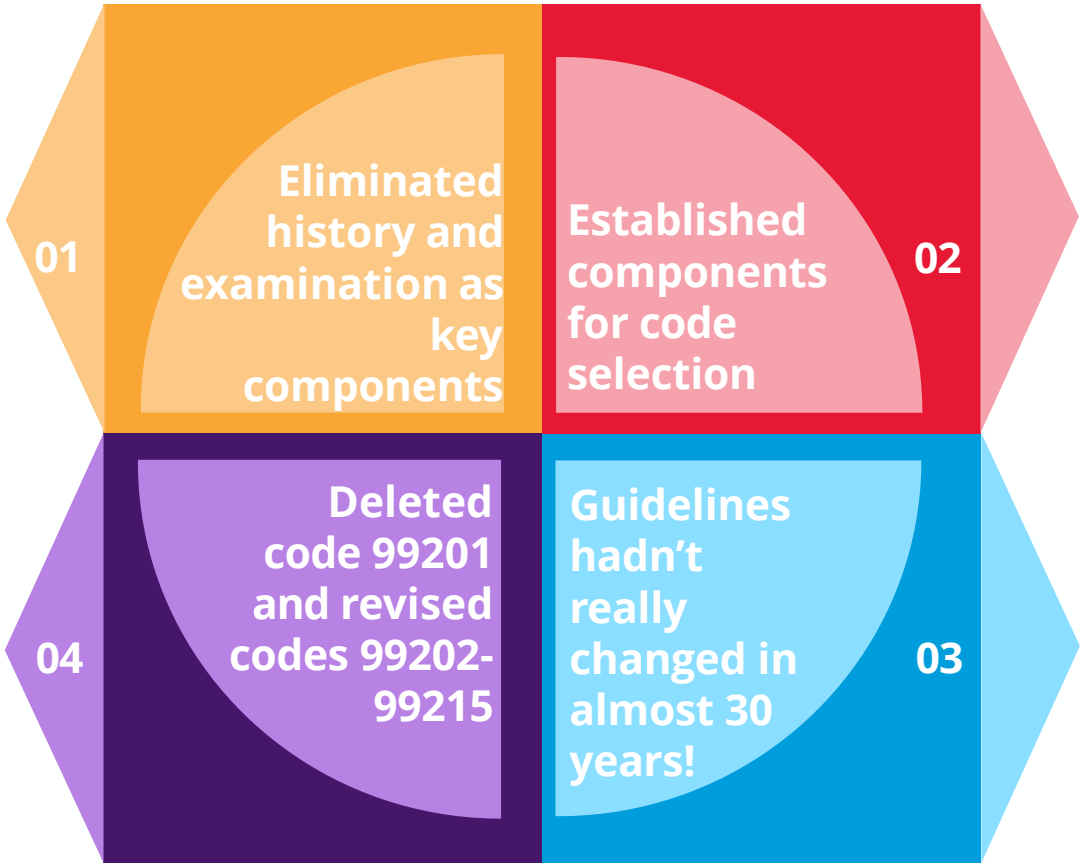
- In 2020, the **Patient's Over Paperwork** initiative "*CMS' internal process to evaluate and streamline regulations*" winds up and sweeping changes took effect January 2021 for office/outpatient E&M codes and in January 2023 for hospital, observation, nursing facility and home visits.

  - ✓ Reduce documentation burden for qualified providers **– check!**
  - ✓ Eliminate "note bloat" and need to "re-document" certain aspects of the record **– check!**
  - ✓ Reduce professional dissatisfaction and provider "burnout" **– hopefully!**
  - ✓ Encourage more time with patients and less time with unnecessary paperwork **– it is literally in the definition now!**

Summary of Major E/M Revisions from 2021-2024

AMA's CPT: Continue to provide a "*medically appropriate history* ***and/or*** *physical exam, when performed…(which)* ***is not*** *an element in selection of the level" of E/M codes."*

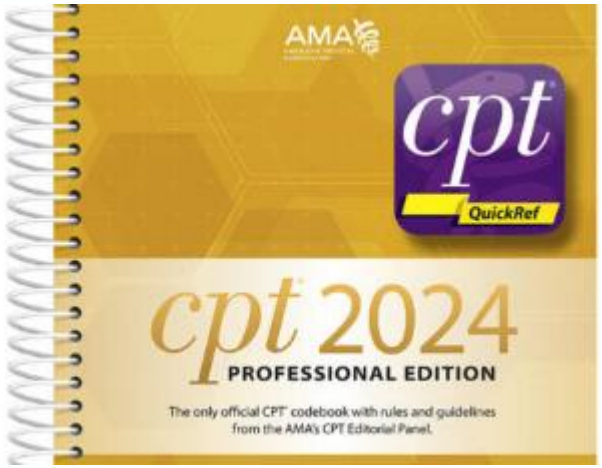
99211 and Incident-to
This code is still only used for most non-Medicare nurse services that don't already have a code (e.g. vaccine admins)



Use either **MDM** level or **Total Time** on the date of the encounter whichever gets you to the highest level of service.

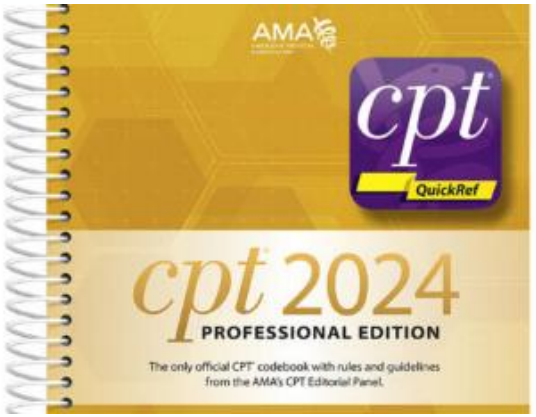
Specific only to E/M office visits in 2021 but expanded to inpatient care (and beyond) in 2023.

Grab your physical CPT Manual and follow along!



- **Reference Source:** AMA 2024 CPT Professional Edition, Evaluation and Management (E/M) Services Guidelines found on pages 4-14 provide general rules for the entire E/M section. Check out the new information on page 6 related to "Split or Shared Visits."
- Please also pay careful attention to the significant educational guidance that precedes each type of E/M code sections and be prepared to make key self-study highlights.
- Any non-AMA CPT manual (*and most EHR/coding software*) will only contain interpretations of these core source guidelines as the AMA does not typically license the actual guidelines to other publishers that it solely licenses its code numbers and definitions to.
- Be cautious of any EHR "short cut" that gives a recommended E/M level unless you have 100% certainty it is only based on the AMA's guidance in this year's CPT.

Caution – a billing nuance for FQHCs! reporting services to Medicare have a different definition of a “new patient”



- Let’s first compare the CPT’s definition of new patients (page 5) versus CMS’ definition below that is specific for FQHCs as found in Chapter 13 of the CMS Benefits Policy Manual Section 70.3.

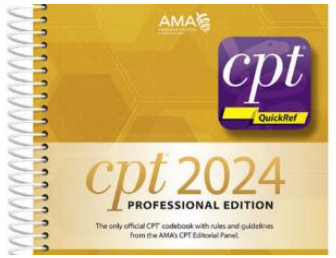
versus

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

Table of Contents
(Rev. 10729, 04-26-21)

New Patient Adjustment: The PPS payment rate is adjusted by a factor of 1.3416 when an FQHC furnishes care to a patient who is new to the FQHC. A new patient is someone who has not received any Medicare-covered professional health service (medical or mental health) from any site within the FQHC organization, or from any practitioner within the FQHC organization, within the past 3 years from the date of service.

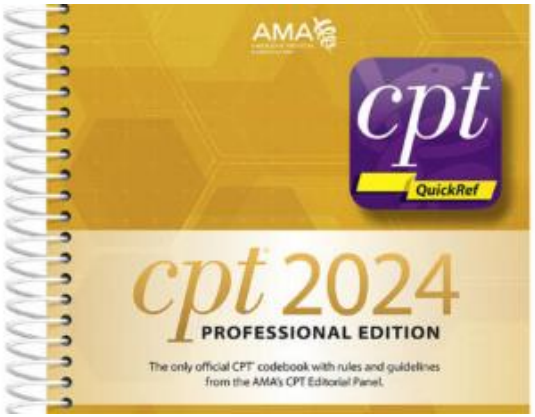
Updated for 2024 - minimum times associated with Office/Outpatient E/M codes – do not “round up”



New Patient 99202 15 minutes	**New Patient 99203** 30 minutes	**New Patient 99204** 45 minutes	**New Patient 99205** 60 minutes
Est. Patient 99212 10 minutes	**Est. Patient 99213** 20 minutes	**Est. Patient 99214** 30 minutes	**Est. Patient 99215** 40 minutes

Review pages 13-14 of the AMA’s Professional Edition for details on what non-face-to-face time may be included when determining total time!

Time spent on the below items is counted if on the date of service



- 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*)

See pg. 13-14 in the AMA's CPT Professional Edition for items NOT included in time calculations in 2024

Updated Terms
Medical Decision Making (MDM) Elements

Study the Medical Decision Making!

Please review and study pages 8-13 of your AMA Professional Edition CPT manual to find helpful updates and information that clinical providers should be familiar with when documenting in the medical record.

Providers should get together to share a common definition of this area, in particular.

- **Number and Complexity of Problems Addressed at the Encounter**
- **Amount and/or Complexity of Data to be Reviewed and Analyzed**
- **Risk of Complications and/or Morbidity or Mortality of Patient Management**

Provider *chooses* whether coding is based on MDM or Total Time for Office E/M

Page 8 of AMA's Professional Edition shows that Medical Decision Making has the same 4 levels of complexity:

- ✓ Straightforward
- ✓ Low
- ✓ Moderate
- ✓ High

Use "2 of the 3 elements" when determining overall MDM:

- ✓ Starting at the highest MDM level, use the highest two MDM elements to determine the overall level by either dropping or ignoring the lowest MDM element.

Updated AMA 2024 MDM Table

Level of Medical Decision Making (MDM) | **Revisions effective January 1, 2023 are noted in red text**

	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making: 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 or • 1 stable acute illness; or • acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**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 or escalation of hospital-level of care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

Evaluation and Management Code (E&M Level)	Number and Complexity of Problems Addressed at the Encounter	Complexity/Level of Medical Decision Making (MDM)
99202 **99212**	• 1 self-limited or • 1 minor problem	**Straightforward**
99203 **99213**	• 2+ self-limited or minor problems • 1 **stable chronic** illness • 1 **stable acute** illness • 1 **acute uncomplicated** illness/injury requiring hospital inpatient or observation level of care	**Low**
99204 **99214**	• 1 or more **chronic** issues with exacerbation, progression, or side effects of treatment • 2+ stable **chronic** illnesses • 1 Undiagnosed problem with uncertain prognosis • 1 **Acute** illness with systemic symptoms • 1 **Acute** complicated illness	**Moderate**
99205 **99215**	• 1+ **chronic** illnesses with severe exacerbation/progression or side effect of treatment • 1 **acute or chronic illness** or injury posing a threat to life or bodily function	**High**

Evaluation and Management Code (E&M Level)	Amount and/or Complexity of Data to be Reviewed and Analyzed *(Each unique test, order, or document contributes to the combination of 2 or 3 in Category 1 below!)**	Complexity/Level of Medical Decision Making (MDM)
99202 99212	**Minimal or none**	Straightforward
99203 99213	**Limited (Must meet at least 1 of the following 2 categories)** • **Category 1: Tests and Documents*** • Any combination of 2 from the following: • **1.** review prior external notes, **2.** review results of EACH unique test, **3.** order of EACH unique test • **Category 2: Assessment requiring "Independent Historian(s)"** How does your EHR "capture" that you reviewed prior labs?	Limited
99204 99214	**Moderate (Must meet at least 1 of the following 3 categories)** • **Category 1: Tests, Documents and Independent Historian(s)** • Any combination of 3 of the following: • **1.** review of prior external note(s) from each unique source, **2.** Review results of each unique test, **3.** order of each unique test, **4.** Assessment requiring independent historian(s) • **Category 2: Independent interpretation of test performed by another provider (not billed)** • **Category 3: Discussion of Management or test interpretation with outside provider (not billed)**	Moderate
99205 99215	**Extensive (Must meet at least 2 of the following 3 categories)** • **Category 1**: **Tests, documents, or independent historian(s)** • **Any combination of 3 from the following**: **1.** Review of prior external note(s) from each unique source*; **2.** Review of the result(s) of each unique test*; **3.** Ordering of each unique test*; **4.** Assessment requiring an independent historian(s) ***or*** • **Category 2: Independent interpretation of tests** **1.** 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** **1.** Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (*not separately reported*)	High

Evaluation and Management Code (E&M Level)	Risk of Complications and/or Morbidity or Mortality of Patient Management *(Based on risks associated with diagnostic/therapeutic procedures)*	Complexity/Level of Medical Decision Making (MDM)
99202 99212	**Minimal risk of morbidity from additional diagnostic testing or treatment** • Ex. Rest, gargles and bandages	Straightforward
99203 99213	**Low risk of morbidity from additional diagnostic testing or treatment** • Ex. OTC	Low
99204 99214	**Moderate risk of morbidity from additional diagnostic testing or treatment** • ***Prescription drug management (rx)*** • Decision for minor surgery with identified patient or procedure risk factors (0, 10 days) • Decision for elective major surgery without identified patient or procedure risk factors (90 days) • ***Diagnosis or treatment significantly limited by social determinants of health (SDoH)***	Moderate
99205 99215	**High risk of morbidity from additional diagnostic testing or treatment** • Drug therapy requiring intensive monitoring for toxicity (e.g., warfarin/chemo agents. etc.) • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital level of care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances	High

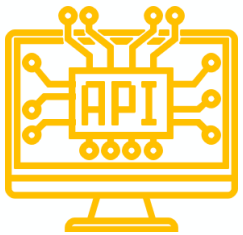
Does your EHR have templates that reflect the updated E/M guidelines?

Clinical Providers

Managers

The way that past EHR office note templates are organized likely are based on the old days where history and exam areas of EHR matched the very detailed (no longer in effect) history of present illness, review of systems, past/family/social history and detailed general- and single-system specialty exams.

- Of course, history and exam areas will still be present but is there a way for time to be easily captured and included?
- Does the billing tab used by your provider give them a little checklist or reminder of newly updated MDM items?



EHR/IT professionals/

Managers

Coders

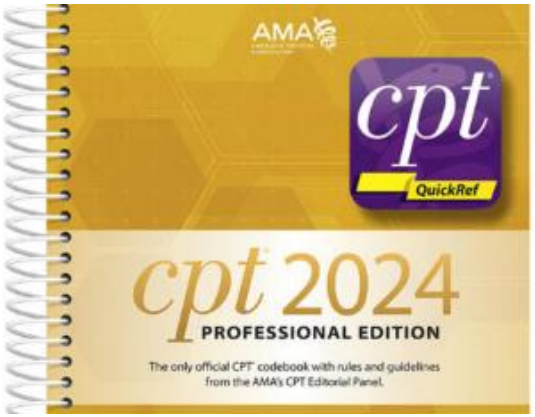
Do you code/bill before the note is closed?

- If coding based on time, providers may still be performing valuable services after the patient visit but still on the date of service.
- If you are coding based on Medical Decision Making, there may be an opportunity to include the fully completed EHR contents rather than using the provider's preliminary level of service that was likely determined while the note was still open.

What are your existing policies and procedures on how to get it right every time?

Hands-on with the E/M Section

Grab your CPT Manual and follow along!



- Let's now focus on **getting hands-on** with the documentation guidelines in the remainder of the CPT E/M section starting with Hospital Inpatient and Observation Services, Consultations, Nursing Facility, Rest Home, Preventive Medicine Services, Care Management, and more.

- **Grab a highlighter!** This is the MOST educationally valuable time you can spend reviewing the guidance that is not included in any EHR or coding product used by providers, coders, and billers.

Inpatient and Observation Care Services

High Level Summary – be aware of guideline revisions!

- Deletion of observation CPT® codes (99217-99220, 99224-99226) and merged into the existing hospital care CPT codes (99221-99223, 99231- 99233, 99238-99239).

- Editorial revisions to the code descriptors to reflect the structure of total time on the date of the encounter or level of medical decision making when selecting code level.
  - ✓ Specifically, the replacement of the three-key-components requirement with increasing level of MDM, along with changes in the time element to be used for each code when time is the basis for code selection.

- Retention of revised Observation or Inpatient Care Services (Including Admission and Discharge Services) (99234-99236).

Initial Hospital Inpatient or Observation Care

Code Descriptor Example

99221 **Initial hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making.

When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99221	40
99222	55
99223	75
Prolonged (99418)*	90 mins or longer

Subsequent Hospital Inpatient or Observation Care

Code Descriptor Example

★ **99231** **Subsequent hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making.

When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99231	25
99232	35
99233	50
Prolonged (99418)*	65 mins or longer

Hospital Inpatient or Observation Care Services (Including Admission and Discharge Services)

99234 **Hospital inpatient or observation care,** for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making.

When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99234	45
99235	70
99236	85
Prolonged (99418)*	100 mins or longer

Hospital Inpatient or Observation Discharge Services

Code Descriptor Example and Guideline Revisions

99238 **Hospital inpatient or observation discharge day management**; 30 minutes or less on the date of the encounter

99239 More than 30 minutes on the date of the encounter

(For hospital inpatient or observation care including the admission and discharge of the patient on the same date, see 99234, 99235, 99236)

Codes 99238, 99239 are to be used by the physician or other qualified health care professional who is responsible for discharge services. Services by other physicians or other qualified health care professionals that may include instructions to the patient and/or family/caregiver and coordination of post-discharge services may be reported with 99231, 99232, 99233.

Hospital Inpatient or Observation Care Services (Including Admission and Discharge Services)
Guidelines revisions

- Used to report hospital inpatient or observation care services provided to patients admitted and discharged on the same date of service.

- Codes 99234, 99235, 99236 require ***two or more encounters*** on the same date of which one of these encounters is an initial admission encounter and another encounter being a discharge encounter.
  - ✓ For a patient admitted and discharged at the same encounter (i.e., one encounter), see 99221, 99222, 99223.

- CMS Proposes to accept term “calendar date” as the same as “per day”, with retention of special rules for these code
  - ✓ If less than 8-hour stay only use 99221-99223, not 99234-99236
  - ✓ If 8 or more, but less than 24 hours, even if two dates, use only 99234-99236

Office or Other Outpatient Consultations

Code Descriptor Example

★ **99242** **Office or other outpatient consultation** for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99242	20
99243	30
99244	40
99245	55
Prolonged (99417)	70 mins or longer

Inpatient or Observation Consultations

Code Descriptor Example

★ **99252** **Inpatient or observation consultation** for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99252	35
99253	45
99254	60
99255	80
Prolonged (99418)	95 mins or longer

Check out codes G0406-G0408 for CMS payable "Follow-up inpatient consultation via telehealth!

Initial Nursing Facility Care

Code Descriptor Example

99304 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making.

When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99304	25
99305	35
99306	45
Prolonged (99418)*	60 mins or longer

Subsequent Nursing Facility Care

Code Descriptor Example

★ **99307** Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99307	10
99308	15
99309	30
99310	45
Prolonged (99418)*	60 mins or longer

Nursing Facility Discharge Services

Code Descriptor Example

The nursing facility discharge management codes are to be used to report the total duration of time spent by a physician or other QHP for the final nursing facility discharge of a patient.

- The codes include, as appropriate, time spent in final examination of the patient, discussion of the nursing facility stay, and instructions are given for continuing care to all relevant caregivers, preparation of discharge records, prescriptions, and referral forms. Time for this service includes the total time spent on that date even if it is not continuous.
- These services require a face-to-face encounter with the patient and/or family/caregiver that may be performed on a date prior to the date the patient leaves the facility.
- Code selection is based on the total time on the **date of the discharge management face-to-face encounter.**

99315	Nursing facility discharge management; 30 minutes or less total time on the date of the encounter
99316	More than 30 minutes total time on the date of the encounter

Home or Residence Services

Code Descriptor Example

99341 **Home or residence visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99341	15
99342	30
99344	60
99345	75
Prolonged (99417)*	90 mins or longer

Home or Residence Services

Code Descriptor Example

99347 **Home or residence visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

CPT®	Time (in minutes) *(Must be met or exceeded)*
99347	20
99348	30
99349	40
99350	60
Prolonged (99417)*	75 mins or longer

Prolonged E/M Service Codes to use in place of 99418 per CMS

- **+ G0316** Prolonged **hospital inpatient or observation care** evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services).

- **+ G0317** Prolonged **nursing facility** evaluation and management service(s); each additional 15 minutes

- **+ G0318** Prolonged **home or residence** evaluation and management service(s); each additional 15 minutes

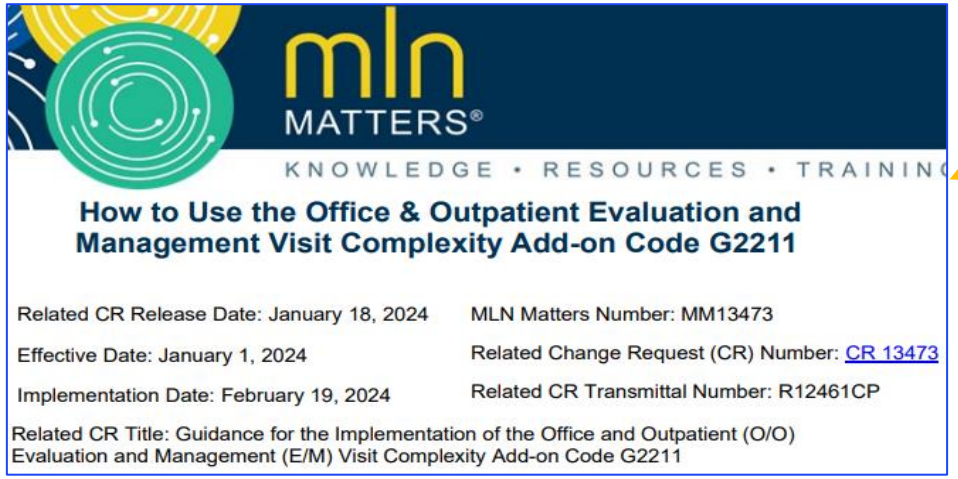
NEW Evaluation & Management Codes for 2024!

New CPT code #+ 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)
- FYI - This should not be listed along with a documented G0101 since it duplicates the pelvic exam.

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 MEDICAL telehealth services using G2025 as a potential for 2x payment of telehealth (*we are awaiting future guidance on this issue*).


mln MATTERS®

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How to Use the Office & Outpatient Evaluation and Management Visit Complexity Add-on Code G2211

Related CR Release Date: January 18, 2024
MLN Matters Number: MM13473
Effective Date: January 1, 2024
Related Change Request (CR) Number: CR 13473
Implementation Date: February 19, 2024
Related CR Transmittal Number: R12461CP
Related CR Title: Guidance for the Implementation of the Office and Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-on Code G2211

Sample billing code options for screening for SUD/OUD

G2011: Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g. audit, dast) and ***brief*** intervention, 5 to 14 minutes.

99408/G0396: Alcohol and/or substance misuse (other than tobacco) structured assessment and ***brief*** intervention; 15 to 30 minutes

99409/G0397: Alcohol and/or substance abuse structured screening and intervention services; greater than 30 minutes

H0049: for Alcohol and/or drug screening **+ H0050:** for Alcohol and/or drug screening, brief intervention, per 15 minutes

G0442: Annual alcohol misuse screening, 5-15 minutes

G0443: Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

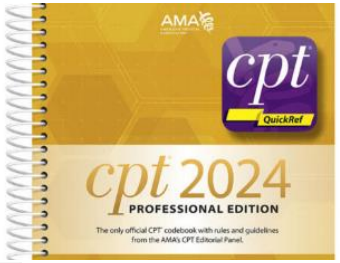
G0444: Annual depression screening, 5-15 minutes

Documenting Preventive Visits,

Documenting Care Management Services

Avoid calling these services “physicals, general health exams, well-checks, and annuals visits”

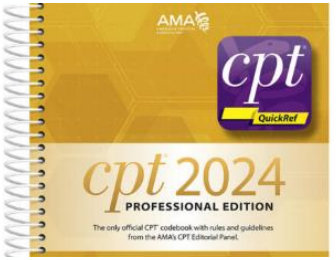
CPT codes 9938x-9938x (new)
CPT code 9939x-9939x (established)
Let’s CAREFULLY REVIEW the notes in the AMA’s CPT before these codes are found!



CPT code’s 5th character	Patient’s age at time of service
1	< 1
2	1-4
3	5-11
4	12-17
5	18-39
6	40-64
7	65+

Check with your FFS payers to see if they cover the G0513-G0514 Prolonged Preventive Service(s) codes

Review the notes found in the CPT on when you may or may not also code a problem-focused E/M visit in addition to a Preventive Medicine Service.



Per page 35 of the AMA's 2024 CPT Professional Edition:

"If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and ***if the problem or abnormality is significant enough to require additional work*** to perform the key components of a problem-oriented evaluation and management service, then the appropriate office/outpatient code…***should be reported***…(with) modifier 25 (on the office visit code).

+

An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service ***and which does not require additional work*** and the performance of the key components of a problem-oriented E/M service ***should not be reported***."

Access the CMS Interactive website on Initial/Periodic Comprehensive Preventive Medicine Services vs. IPPE/AWV

Medicare Physical Exams Coverage

Initial Preventive Physical Exam (IPPE)

Review of medical and social health history and preventive services education.

✓ New Medicare patients within 12 months of first Part B coverage period

✓ Patients pay nothing (if provider accepts assignment)

Annual Wellness Visit (AWV)

Visit to develop or update a Personalized Prevention Plan (PPP) and perform a Health Risk Assessment (HRA).

✓ Covered once every 12 months

✓ Patients pay nothing (if provider accepts assignment)

Routine Physical Exam

Exam performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

✗ Medicare doesn't cover a routine physical (it's prohibited by statute), but the IPPE, AWV, or other Medicare benefits cover certain routine physical elements

✗ Patients pay 100% out-of-pocket

CAREFUL!

Check first if you are performing one of these sample sometimes-covered CMS services

For more details read this 2-15-24 update: https://www.cms.gov/medicare/coverage/preventive-services-coverage

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 services (see new '23 definitions)

G0442-G0444

Screening for High Intensity Behavioral Counseling for STD

G0445-G0447

Please review the key details around each CMS sometimes-covered G-code in Chapter 18 and via a new interactive CMS tool

Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

Table of Contents
(Rev. 12299, 10-12-23)

Transmittals for Chapter 18

Use caution as this document is not written specifically for RHC or FQHC. It will, however, contain the key documentation guidelines for providers as well as helpful coverage information for coders/billers.

Counseling Risk Factor Reduction and Behavior Change Interventions (99401-99412) are not currently covered by Medicare – but check other payers!

Promoting Health and Preventing Illness or Injury

Per AMA's 2024 CPT Professional Edition page 37: *"these services are used for persons **without a specific illness** for which the counseling might otherwise be used as a part of treatment."*

Preventive Medicine Counseling

"should address issues as family problems, diet and exercise, substance use, sexual practices, injury prevention, dental health…"

Behavior Change Interventions

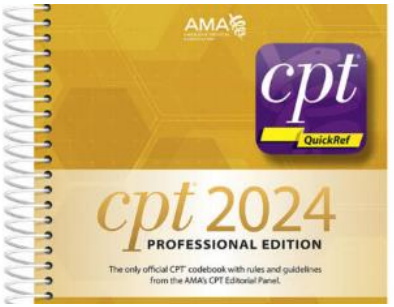
"for persons who have behavior that is often considered an illness itself, such as tobacco use and addiction, substance abuse/misuse, or obesity."

Bundling Billing Rules per CPT

"E&M services reported on the same day must be distinct and reported with modifier 25."

"Health behavior assessment and intervention services should not be reported on the same day as these."

Care Management Documentation for Clinical Providers



- Info on the main Care Management services are located at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management

TIPS: Develop templates in your EHR, track monthly time, document care plan updates and *get credit for the clinical work you do in between patient visits*. Consider external care managers to help with the workload.

AMA CPT Guidelines

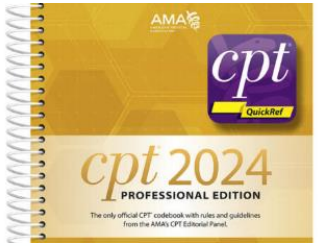
According to the CPT these are "management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional….(that) include"

"Establishing, implementing, revising, or monitoring the care plan

Coordinating the care of other professionals and agencies

Educating the patient or caregiver about the patient's condition, care plan, and prognosis"

“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!

BHI and Psych CoCM Additional info for RHC/FQHC

When a **medical provider supervises and directs the care plan for patients with a mental, behavioral, or psychiatric conditions** (including substance use disorders).

- To distinguish general BHI services from the Psych CoCM please visit this link CMS Fact Sheet for Behavioral Health Integration Services for details on the CoCM model and how it differs from general BHI.

BHI ***optionally*** includes a Behavioral Heath Manager and a Psychiatric Consultant, whereas the Psych CoCM ***requires*** their active participation.

- Check out code **G0323** for *Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist or clinical social worker time, per calendar month* for possible use with **non-Medicare payers**.
  - ***You may use G0511 to report this service to Medicare for MFT/MHC services as well.***

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, various remote monitoring services, CHI, PIN, and the Psych CoCM

G0511 = Rural Health Clinic or Federally Qualified Health Center only, ***general care management*** 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.

- "**General care management" =** principal/chronic care management, monthly chronic pain management, assorted remote monitoring services, community health integration, principal illness navigation, OR behavioral health integration.

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.

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

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."

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,**
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 p per calen 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

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

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

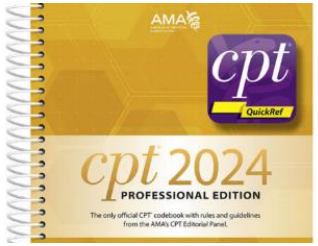
Community Health Integration services are to address unmet SDOH needs that affect the diagnosis and treatment of the patient's medical problems, 60 minutes per month and each additional 30 minutes.

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

Other Monthly Care Management Codes
Remote Physiologic Management (RPM) *– in the E/M section*



Monitoring weight, blood pressure, glucose, pulse ox, respiratory flow rate, etc. over a 30-day period using an FDA-approved medical device.

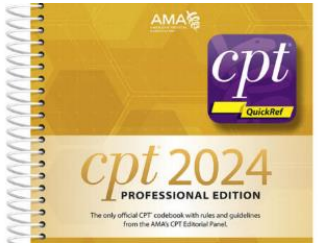
Includes: accessing/reviewing/interpreting the data, modification of care plan, including communications with the patient, and documenting.

Use 99453 for the Initial Set-up and patient education on use of the equipment.

Use 99454 to report daily recording(s) or programmed alerts transmission

According to the AMA's CPT - *"An episode of care is defined as **beginning** when the remote monitoring physiological services is initiated and **ends** with the attainment of targeted treatment goals."*

Other Monthly Care Management Codes
Remote Physiological Treatment Management (RTM) – *in the E/M section*



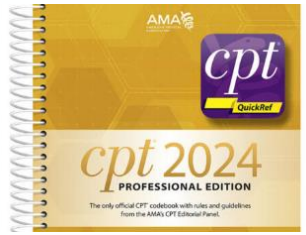
When clinical staff "***use the results of RPM*** *to manage a patient under a specific treatment plan*" requiring a "***live interactive communication***"

To non-Medicare payers you may report these codes during the same month as General Care Management Services as long as you are not "double-dipping" times.

Use **99457** to report the first 20 minutes of clinical provider time in a calendar month.

Use **99458** to report each additional 20 minutes ***in addition*** to 99980.

According to the AMA's CPT – Do not count any time performing RTM on a day when an E/M service is provided!



Other Monthly Care Management Codes
Remote Therapeutic Monitoring Treatment Management *- in the Medicine section*

When clinical staff "***use the results of RPM*** *to manage a patient under a specific treatment plan*" requiring a "***at least one live interactive communication with the patient***"

To non-Medicare payers you may report these codes during the same month as General Care Management Services as long as you are not "double-dipping" times.

Use **98980** to report the first 20 minutes of clinical provider time in a calendar month.

Use **98981** to report each additional 20 minutes ***in addition*** to 99457.

According to the AMA's CPT – Do not count any time performing RTM on a day when an E/M service is provided!

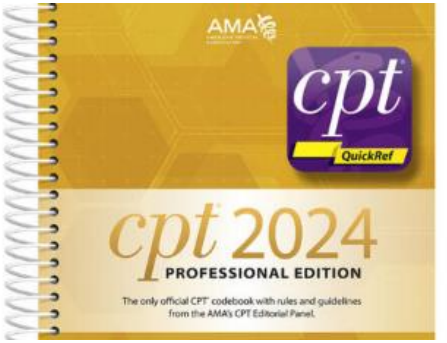
Research other Care Management Services Additional info from CMS

Access current general information on various principal/chronic care management, BHI, Psych CoCM, and other Care Management services called **Transitional Care Management and Advanced Care Planning** on the CMS Care Management website.

For more details on RHC/FQHC updated payment info related to **Advanced Care Planning for end-of-life issues (**99497-99498) review the CMS Fact Sheet.

- See the updated documentation requirements and when it may be reported ***as a part of an AWV service*** and the possible impact of modifier -33 and when coinsurance might be waived.

Documentation Basics of Transitional Care Management (TCM)



AMA CPT Guidelines

The goal of TCM is to lower preventable hospital readmissions by establishing the smooth transition from an inpatient stay between a patient's various care providers and their designated primary care manager.

Establish direct patient contact with the patient within 2 days of the discharge to determine what happened in the inpatient stay.

Based on those findings (i.e., med reconciliation and treatment referrals) schedule a face-to-face visit within either 7 or 14 days.

If the patient is readmitted by anyone for that same condition in the 30 days following the discharges, TCM should likely not be paid/reported.

Coding for Transitional Care Management (TCM)

See the AMA CPT documentation guidelines for codes 99495 and 99496

99495

Medical Decision Making of at least **moderate complexity**

Face-to-face visit within 14 calendar days of discharge

99496

Medical Decision Making of at least **high complexity**

Face-to-face visit within 7 calendar days of discharge

NOTE: 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.

Telehealth vs. Virtual Communication Services

Telehealth vs. Virtual Communication Services (VCS)

- ***Telehealth services are usually pre-scheduled*** and can be audio only under certain circumstances, such as many mental health visits.
  - What is the difference between “distant” and “originating” site telehealth
  - Medicare clarifies that in 2024 RHC/FQHC telehealth services must be performed during your posted hours of operation!

- ***VCS are “virtual check-in services” and/or “store-forwarding of audio/video” that are usually patient-initiated*** and can include phone or other electronic means, such as an online patient portal where patients are reaching out to see if they need to come in for an immediate visit or can be taken care of virtually.

2024 Telehealth Updates from Medicare impacting RHC/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 **real-time audio/visual** telecommunications when supervising residents and "direct supervision" for incident-to services through the end of 2024.

Provider Telehealth
Key Thoughts for Coding/Billing

- Expect payer variations in which services can be reimbursed using telehealth using this link for Medicare (*last update November 13, 2023*) https://www.cms.gov/Medicare/Medicare-general-information/telehealth/telehealth-codes

- Use Q3014 with revenue code 0780 ($29.96 flat fee) for originating site facility fee if other providers elsewhere are doing telehealth but you are using your office's room and audio/video resources and maybe a nurse.

- Ensure that your EHR can clearly distinguish these as not being provided in person. Though a free-form text area may suffice, be sure that coders/billers are aware of how the service was performed.

- Be aware of non-Medicare billing including codes G2061-G2063 and/or 98966-98972 for non-physician telehealth.

RHC/FQHC Telehealth Key Thoughts for Billing

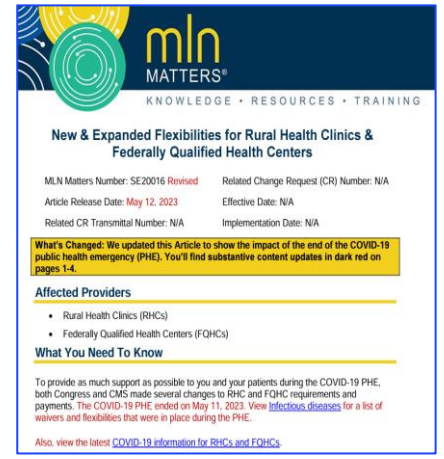
- **PRIVATE INSURANCE** – For non-Medicare carriers it is likely that the payer just wants the CPT/HCPCS-II code performed (99213 or 90832) plus a modifier -93/-95/-FQ/-FR and/or Place Of Service code 02 or 10 on the CMS1500 claim.

- **RHC/FQHC MEDICAL SERVICES** – For Medicare patients, RHC/FQHC are instructed to use code G2025 for in order to receive the flat fee of $95.37 (split 80/20%) if the code is on the CMS approved services list.

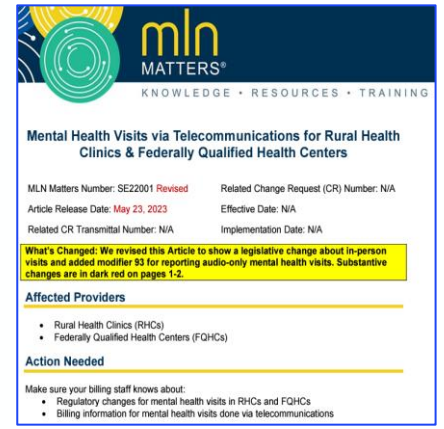
- **RHC/FQHC MENTAL HEALTH SERVICES** – For Medicare patients, RHC/FQHC are instructed to report a code on the CMS approved services list as if performed in-person and billing should add a modifier -93/-95 in order to receive your AIR/PPS payments.

CMS resources for RHC/FQHC Telehealth

- Get the CMS Med Learn Matters #SE20016 for **RHC/FQHC-specific telehealth info** (*last updated 5-12-23*) for updates, revenue codes, modifiers, and other great billing info.



- For updates on reporting **mental health telehealth in RHC/FQHC** please this Med Learn Matters SE#22001 document *(updated 5-23-23)*



- For the general CMS Telehealth Fact Sheet which **is not focused on RHC/FQHC** check out this document *(last update February 2024).*

RHC/FQHC Details
Telehealth and Virtual Communication Services

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)

+

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)

Virtual Communication Services (VCS) Details

Purpose:

1 - **"Virtual check-ins"** via phone lasting for over 5 minutes **OR**

2 - **"Store and forward"** scenario wherein a patient posts a message/audio/video/pictures via a patient portal and the clinical provider interprets and reviews the data within 24 hours of submission

Under the following conditions:

1 **-** *For condition(s) unrelated to recent visits in the last 7 days* ***AND***

2 - That do not result in an immediate visit.

Additional FAQs:

CMS prepared an 8-page set of frequently asked questions (FAQ) that is specific for FQHC/RHC providers. Get it at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf (December 2018)

RHC/FQHC Details on Virtual Communication Services

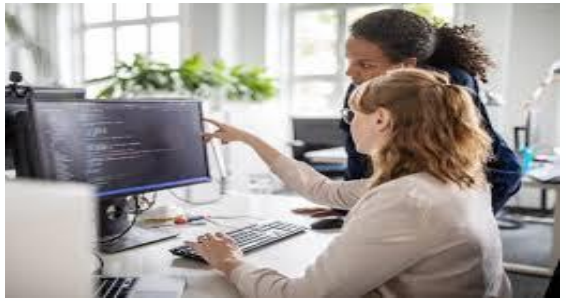
- **Virtual Check-in -** Via telephone or other electronic means using HCPCS-II code G2251-G2252 for non-Medicare and **RHC/FQHC should use G0071** to Medicare (~$13)

- **"Store and Forward" Audio/Video -** Via video/images uploaded by a patient via a patient EHR portal and reviewed by a provider using HCPCS II code G2250 and **RHC/FQHC should use G0071** to Medicare (~$13).

- **REMOVED IN 2024 for RHC/FQHC: Telephone/Online Digital E/M Services -** Online digital E/M visits reported once per 7 days using CPT codes 99421-99423/99441-99443 can still be used for non-Medicare payers.

Coding the Full Encounter

ArchProCoding
RURAL & COMMUNITY HEALTH



Section Overview
Coding the Full Encounter

ICD-10-CM's Impact on Quality Reporting

In the world of Value-based Care, ICD-10-CM codes have a larger impact than just determining if a service is "medically necessary" including the assorted requirements of many UDS and HEDIS measures.

Key areas include Shared Savings and Risk Adjusted Coding via Hierarchal Conditions Categories.

2024 ICD-10-CM Official Guidelines for Coding and Reporting

Are your clinical providers are aware of the broad contents of Section I, Subsections A, B, and C of the guidelines in order to determine diagnosis code(s) used for care coordination, quality reporting, and revenue?

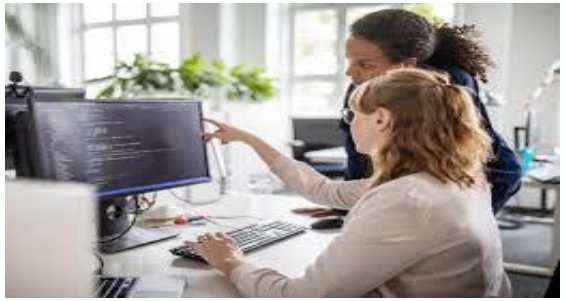
Sample Diagnostic Coding and Self-Study Reference Materials

We will identify a great resource and self-study tool from the AMA to help guide the proper coding of ICD-10-CM services.

These can also be used for provider documentation training purposes!

Social Determinants of Health (SDoH)

This subset of ICD-10-CM codes is gaining in importance in public health and outcomes measurement based on social/economic issues that affect patient care.



Section Overview
Coding the Full Encounter

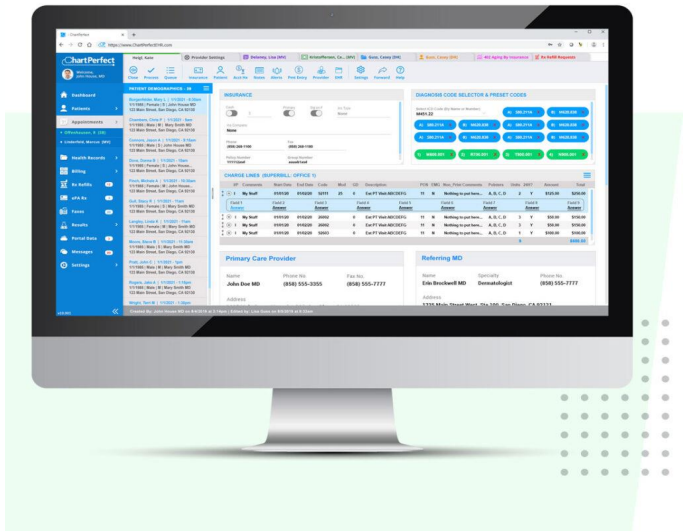
Self-study on Surgical Documentation and Coding

This section will focus on the details associated with coding for procedures commonly performed in a RHC and FQHC. The most valuable information comes from the CPT guidelines rather than the code definitions.

Diagnostic Tests, Labs, and Vaccinations

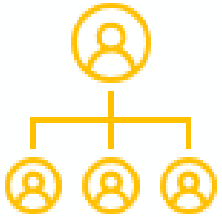
Behavioral and Mental Health Services

Showing the value of a professional coding review



- What is your process for providers who can’t locate a CPT, HCPCS-II, or ICD-10-CM code? Who is authorized to make necessary changes to this information and are changes tracked and monitored?
- Is this the information billing services are using to generate claims or are they able to access the completed medical record?
- Do clinical providers have access to the full code CPT guidelines and definitions as well as ICD-10-CM Base Code information or are they simply seeing high-level summaries of codes?

How are your providers moving preliminary coding info to coders/billers?

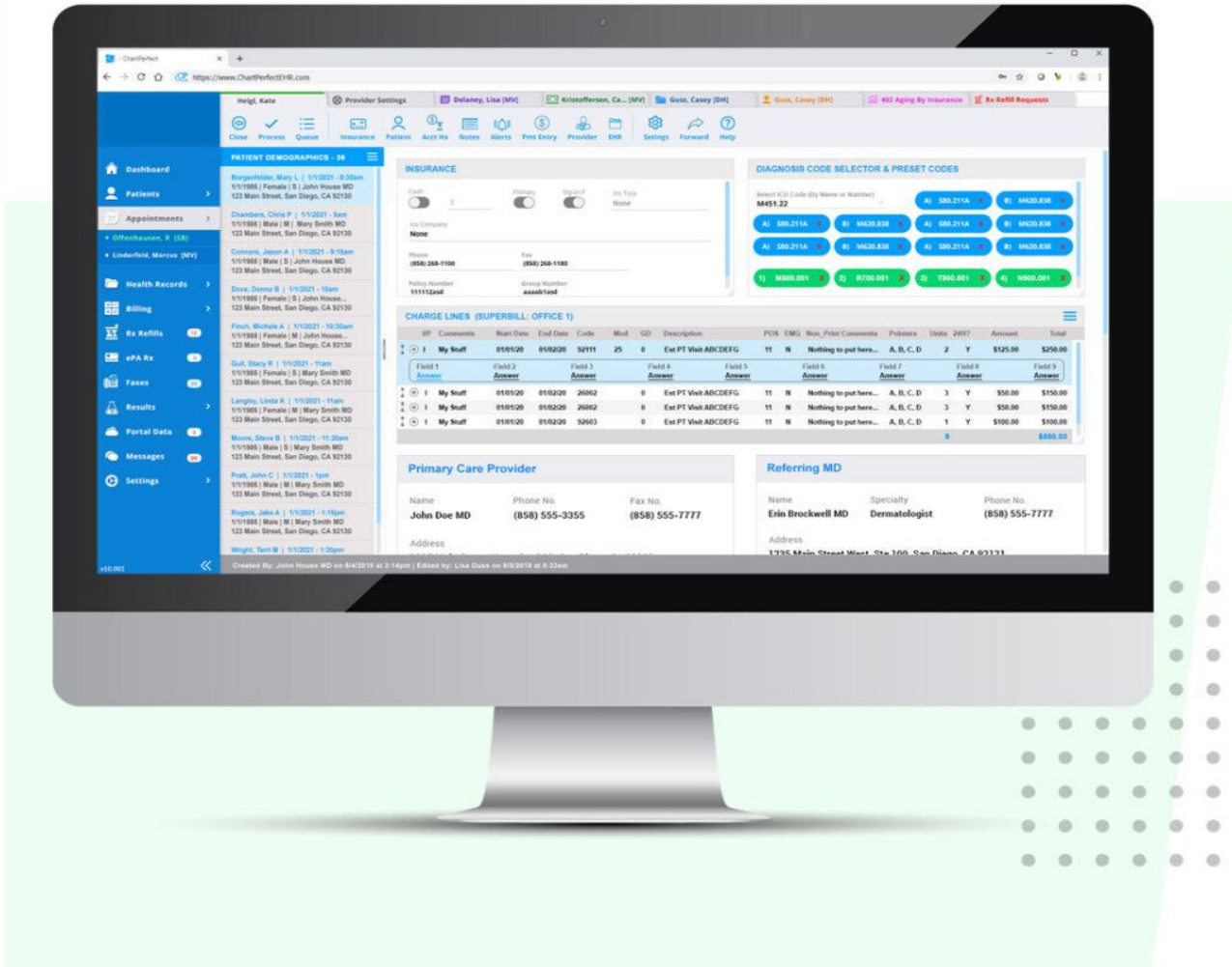


Is this information a part of the actual medical record or just internal billing data?

Is this info only used internally for a professional coding review?

Contains enough info for patients to self-file insurance, if needed, or just as a receipt?

Does each service/procedure have at least one ICD-10-CM code identified as being primarily responsible for each CPT/HCPCS-II code?



ICD-10-CM's Impact on Quality Reporting

Coding data serves as primary source for public health and determining managed care effectiveness

Monitoring clinical outcomes for chronic diseases to save more lives and make sure people get the care and support they need,

- ✓ Monitoring pre-hypertension and pre-diabetes patients to “prevent” chronic diseases often by reporting HEDIS measures and HCC codes.

Making sure that patient “risk pools” are spread out fairly amongst Medicaid and commercial insurers to meet federal and state insurance rules,

- ✓ Risk Adjusted coding + Hierarchical Conditions Categories (HCC)

Determining the effectiveness and optimum use of referrals for various state/federal initiatives designed to “close the loop” on social services and to determine patient eligibility for available social programs.

- ✓ See also – Substance/Opioid Use Disorders (SUD/OUD), Medication Assisted Treatment (MAT), and developing Peer Recovery Coach programs.

Proper ICD-10-CM use can generate revenue for capitated (i.e., PMPM) payments

Risk Adjusted Coding (RAC) is becoming more and more common with Medicare/Medicaid Managed Care Organizations (MCO). They have stressed in many of their recent trainings how important diagnosis coding is. Have you seen this?

If you and/or your payers are receiving any capitated (ex. PMPM) payments – ICD-10-CM codes can increase payments on a patient-by-patient level!

A subset of ICD-10-CM codes (~9500) called Hierarchical Conditions Categories (HCC) and proper diagnostic coding can significantly impact "Risk Adjusted Coding" as well as you maybe receiving annual "Shared Savings" such as when you are in an Accountable Care Organization.

Managed care companies are also very dependent on us to provide them with accurate data, (*especially via ICD-10-CM and CPT-II codes*) to help them show state/federal stakeholders that they are meeting their population health initiatives such as teen smoking, obesity, and diabetes control.

Quality Reporting Basic Definitions

Value-based Care – Moving away from FFS/Per Diem payments towards paying based on clinical outcomes and disease prevention.

Accountable Care Organizations (ACO) and Shared Savings – By being a "member" of an ACO you can get money for assuming some of the financial risk and staying under a "benchmark" of expected costs.

HCCs and Risk Adjusted Coding – Ensuring that your diagnosis codes fully reflect the complexity of patients in order to "risk adjust" for those patients requiring more care than normal in a "risk pool."

- For those paid a Per-Member-Per-Month amount – these key HCC ICD-10-CM codes can change payments at the individual patient level via a Risk Adjustment Factor (RAF).

UDS/HEDIS measures – Used by HRSA/carriers to determine if you have performed certain pre-defined diagnostic/therapeutic services to "close gaps" for eligible patients to promote overall health and to help carriers show the state/federal governments that they are providing "quality" care.

Sample impact of HCC coding on payments to RHC/FQHC and/or managed care payers

EXAMPLE

Martin McNally is an MA patient whose comorbidities are tallied into a RAF score for HCCs. He does not subscribe to Part D (prescription coverage).

RISK/PAYMENT FACTOR	HCC	RAF
66-year-old male	(community, nondual, aged)	0.300
Congestive heart failure (CHF)	85	0.323
Prostate cancer	12	0.146
Diabetes mellitus (DM), complicated	18	0.318
Peripheral vascular disease	108	0.298
Below-knee amputation	189	0.588
Morbid obesity	22	0.273
Interaction CHF & DM	NA	0.154
Total RAF		**2.400**

Nondual
A term used to describe Medicare beneficiaries who are not enrolled in Medicaid or Medicaid beneficiaries who are not enrolled in Medicare.

If we assume a CMS capitated rate for McNally's locality of $800 per month, the MAO would receive a payment of $9,600 per year for an enrollee without risk diagnoses. Multiply the capitated rate ($9,600) by 2.400 (McNally's RAF) to determine the CMS payment to the MAO to cover McNally's care. The total is $23,040 annually. RxHCCs would be calculated separately and added to payment, if the patient subscribed to Part D.

A patient with McNally's comorbidities would be at higher risk for resource-intensive care, including hospitalization. The MAO would pay for such care.

SOURCE: AMA Risk Adjustment Documentation and Coding – by Sheri Poe Bernard (Second Edition 2020)

Quality/Care Management Category	Use CPT	Use HCPCS-II	Use ICD-10-CM	Impact on RHC/FQHC Revenue
Care Management Services	✓	✓	✓	HIGH
CPT Category II Performance Measures	✓		✓	LOW
Preventive Medicine Services	✓	✓	✓	HIGH
Hierarchical 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

ICD-10-CM Official Guidelines

Basic Tenets of Reporting Diagnostic Codes via the ICD-10-CM

Don't code "probable, suspected, questionable or rule out" diagnoses.

Code the reason for the primary service and/or your primary assessed condition first.

Code other chronic diseases if the patient receives active treatment for them or if it directly affects the primary/secondary diagnoses.

Be sure to code any coexisting conditions affecting patient care at the time of the visit.

Do not list diagnoses that are not documented on that day's note as impacting care.

Be sure providers can locate their instructional notations rather than just performing an alphabetical index search.

And finally, identify which diagnoses should be "linked" to each diagnostic or therapeutic service, in order of importance for proper billing!

What are your common diagnostic coding issues?

2024 ICD-10-CM Official Guidelines for Coding and Reporting

Section I: A. Conventions of ICD-10

- 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

2024 ICD-10-CM Official Guidelines for Coding and Reporting

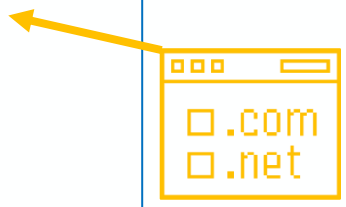
Section I: B. General Coding Guidelines

- 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

2024 ICD-10-CM Official Guidelines for Coding and Reporting

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 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)
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)



2024 ICD-10-CM Official Guidelines for Coding and Reporting

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

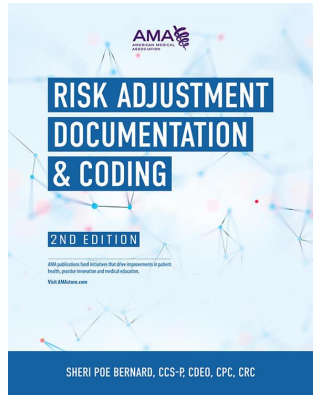
Use the "MEAT" concept to help when deciding which of the patient's conditions from the master problem list should be coded

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.

AMA



Sample Diagnostic Coding Materials,

Social Determinant of Health (SDoH)

BEST PRACTICES

Coder Abstraction Tips

Proper code look-up affects code selection, which can affect the physician's compliance and reimbursement. The patients are affected too, as the codes assigned become part of their permanent health record.

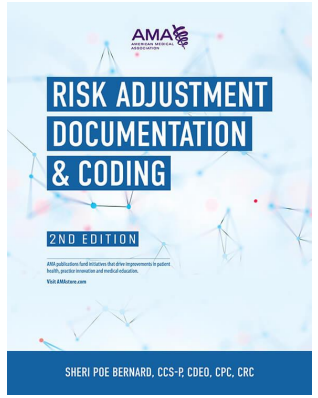
- **Follow the instructions** in the Alphabetic Index, Tabular Section, official guidelines, and AHA's *Coding Clinic*. When there is conflict in these instructions, the Alphabetic Index and Tabular Section supersede the official guidelines and AHA's *Coding Clinic*, and the official guidelines supersede AHA's *Coding Clinic*.
- **Don't stop at the Alphabetic Index when looking up a code.** The Index points to the correct direction, but it does not always give the exact code. Look up the code in the Tabular Section after finding it in the Index.
- **Never rely solely on the ICD-10-CM Tabular Section when looking up a code;** always consult the Alphabetic Index first.
- **Pay attention to who is "talking."** Do not code patients' self-diagnoses. Do not code diagnoses written by medical assistant or nurse. Code only diagnoses documented by the physician or other acceptable provider.
- **Watch out for "cloning."** Be aware of what is unique to the current encounter and what is copied from previous encounters. Some electronic health records (EHRs) pull information forward automatically. Do not code from information that has not been referenced or updated by the physician during the current encounter.
- **Check physician coding.** If a physician assigns codes in documentation or in the billing software, check them prior to bill submission. The physician is the expert clinician, while coders are the experts at coding. The physician's words matter more than the codes they select or document. Documented codes without language describing the diagnosis cannot be abstracted.
- **Never make assumptions** about what the note means. A blood glucose reading of 900 mg/dl cannot be reported as hyperglycemia, unless the physician documents it as such.

Uncertain or Differential Diagnoses

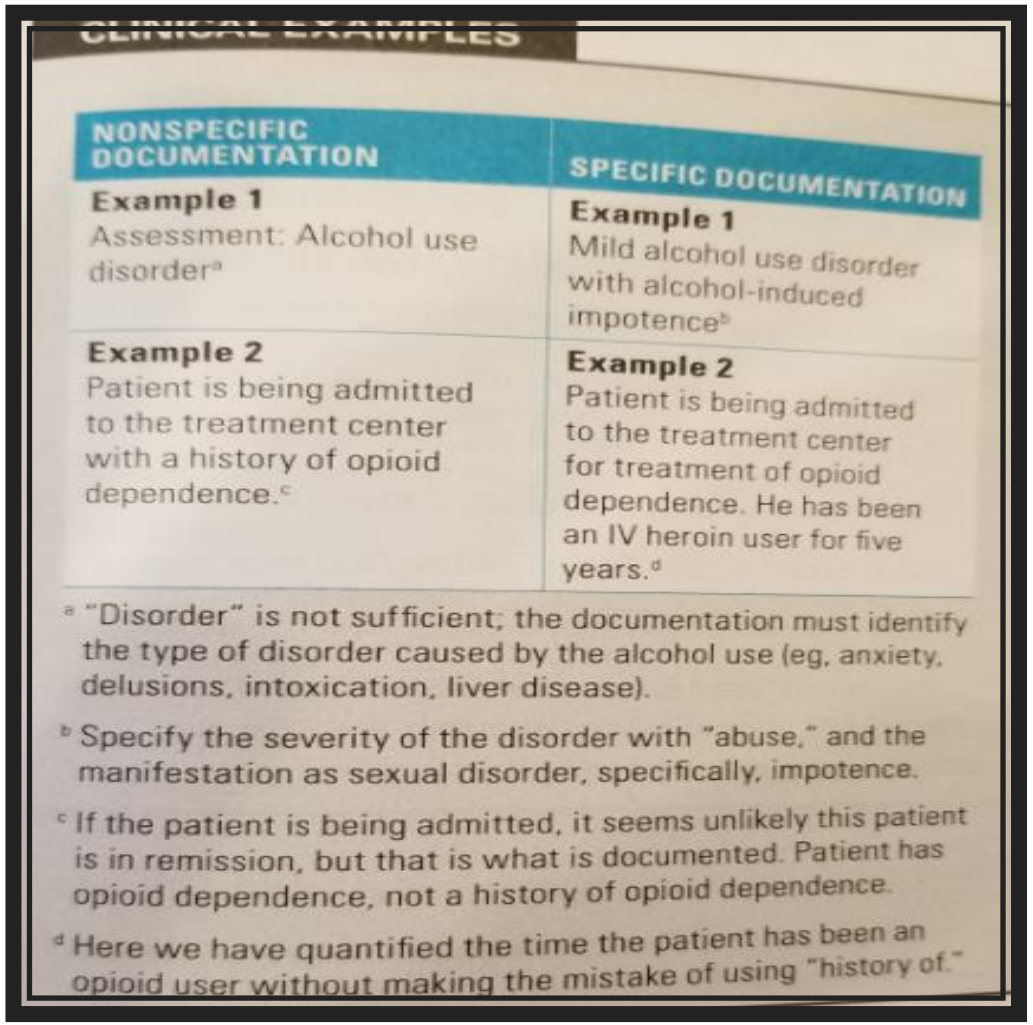
In the outpatient environment, do not code diagnoses documented as "probable," "suspected," "questionable," "rule-out," "compatible with," "consistent with," or "working" diagnoses. Do not code "differential" diagnoses.

- **Link related conditions** when they are documented as related. Use the Alphabetic Index to determine which conditions are automatically linked by the "with" or "in" convention in the ICD-10-CM guidelines.
- **Search and research the Internet** often to understand medications and conditions referenced in documentation. Medscape, National Institutes of Health, and MedlinePlus are dependable resources. Query physicians if the documentation does not match research.
- **Use language** found in the documentation when searching the Alphabetic Index.
- **Read the entire note.** Often, diagnoses are buried within the operative or physical examination notes. Do not rely solely on the assessment.
- **Do not depend completely on software code-lookup programs.** These are not always accurate.
- **Always code these status conditions** when present: ostomy, dialysis, HIV positive, transplant, amputation, dependence on respirator.
- **Update codebooks,** resources, and software for ICD-10-CM effective October 1 of each year.
- **A rule of thumb for coding:** If a patient is on medication for a documented condition, and the condition would return if medication were stopped, code the condition.
- **Never code from superbills.** Use only provider documentation.

Check out this sample from the AMA's "Risk Adjustment Documentation and Coding" (2nd ed.)



Get more documentation samples from this great reference!



CLINICAL EXAMPLES

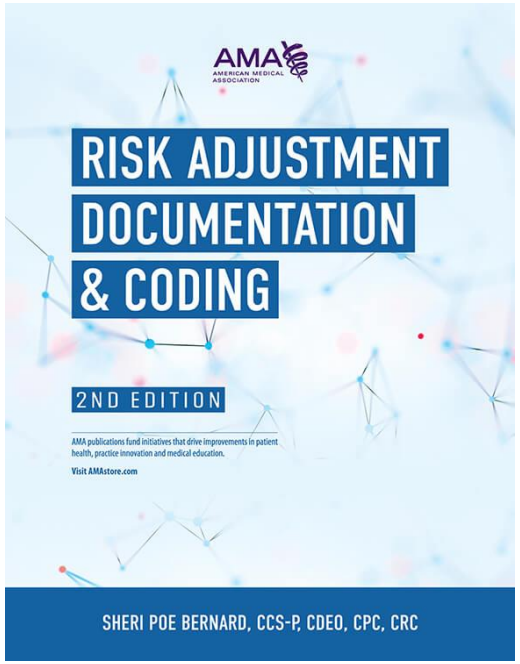
NONSPECIFIC DOCUMENTATION	SPECIFIC DOCUMENTATION
Example 1 Assessment: Alcohol use disorder[a]	**Example 1** Mild alcohol use disorder with alcohol-induced impotence[b]
Example 2 Patient is being admitted to the treatment center with a history of opioid dependence.[c]	**Example 2** Patient is being admitted to the treatment center for treatment of opioid dependence. He has been an IV heroin user for five years.[d]

[a] "Disorder" is not sufficient; the documentation must identify the type of disorder caused by the alcohol use (eg, anxiety, delusions, intoxication, liver disease).

[b] Specify the severity of the disorder with "abuse," and the manifestation as sexual disorder, specifically, impotence.

[c] If the patient is being admitted, it seems unlikely this patient is in remission, but that is what is documented. Patient has opioid dependence, not a history of opioid dependence.

[d] Here we have quantified the time the patient has been an opioid user without making the mistake of using "history of."



Source:

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

Get more coding documentation samples from this great reference!

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.

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

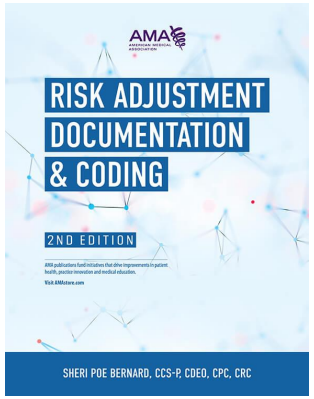
Because type 1 DM requires insulin injections multiple times daily, there is no need to code Z79.4 with type 1 diabetes.

- **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

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.

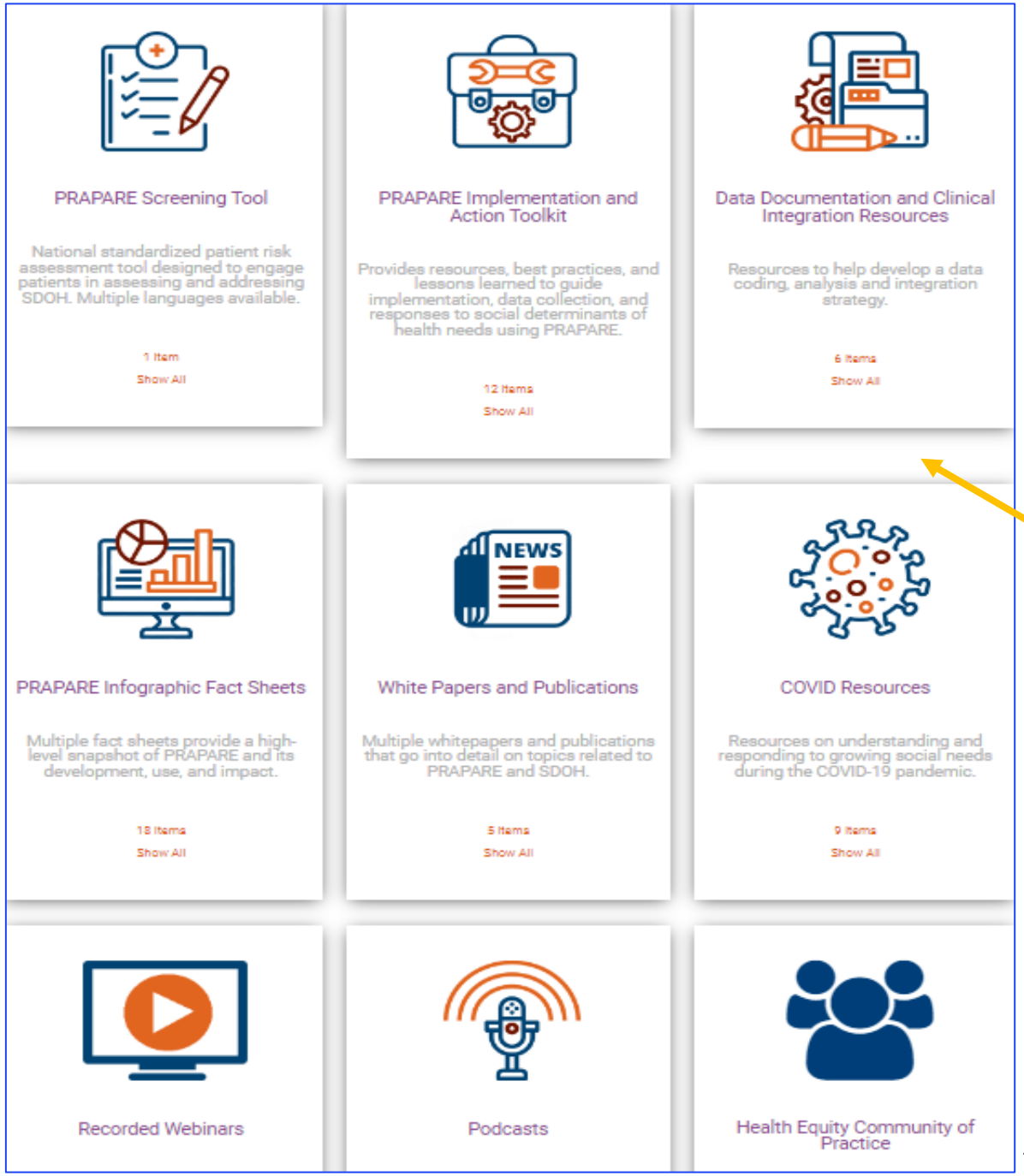
- Consider SDoH's possible impact on documentation of Medical Decision Making and E/M coding. How often do they need to be reviewed and documented in order to make it on a claim form?

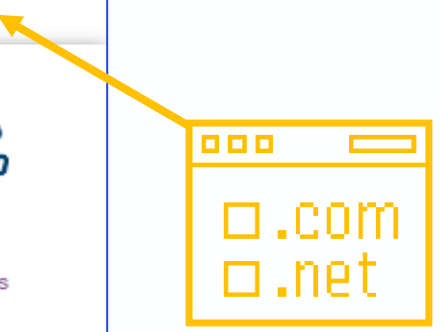
- Research the "PRAPARE" tool for a ton of valuable SDoH information from national leaders including webinars, templates, and additional resources to capture key data by clinical staff for inclusion on claims at: https://prapare.org/

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

PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences





Performing Social Determinants of Health (SDOH) Assessments by medical and behavioral health

"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 6 months***

CMS has indicated that this service may be reported as an optional element in Initial/Subsequent Annual Wellness Visits (AWV) like Advanced Care Planning and ***is also on the updated CMS approved telehealth list*** and may need modifier -33 to eliminate patient coinsurance.

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KNOWLEDGE • RESOURCES • TRAINING

Annual Wellness Visit: Social Determinants of Health Risk Assessment

Related CR Release Date: May 2, 2024 | MLN Matters Number: MM13486

Effective Date: January 1, 2024 | Related Change Request (CR) Number: CR 13486

Implementation Date: October 7, 2024 | Related CR Transmittal Numbers: R12599BP & R12599CP

Related CR Title: A Social Determinants of Health Risk Assessment in the Annual Wellness Visit Policy Update in the Calendar Year 2024 Physician Fee Schedule Final Rule

Affected Providers

- Hospitals
- Physicians
- Other providers billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients

Action Needed

Make sure your billing staff knows:

- A social determinants of health (SDOH) risk assessment is now an optional annual wellness visit (AWV) element
- The eligibility and billing requirements for doing the SDOH as part of the AWV

Background

The AWV includes the establishment, or update, of:

- The patient's medical and family history
- A health risk assessment
- A personalized prevention plan

The AWV includes the initial visit (HCPCS code G0438) and the subsequent visit (HCPCS code G0439). The AWV also includes the frequency limitations that require that eligible patients:

- Are no longer within 12 months of the effective date of their first Medicare Part B coverage period

Page 1 of 3

CMS Medicare Learning Network

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

ICD-10-CM Self-Study – Research in the ICD-10-CM's Volume 1 and "Official Guidelines"

A18.0

"Tuberculosis of bones and joints"

There are no codes for tuberculosis in just the bones or in just the joints – how would you code that?

F10-F19

Code for substance-specific use, abuse, or dependence.

How do you code these when most providers document "mild, moderate, or severe use disorders"?

E11.9

When using "Type II diabetes (*or other chronic condition*), without complications" and then listing other ICD-10-CM codes for related complications what problems can this cause and what type of codes found in section I, subsection B would help?

Z00.xx and Z01.xx

In what order should codes for "general adult and child medical examinations" be on a claim compared to any acute/chronic conditions?

Z55-Z65

Social Determinants of Health (SDOH) codes identify social/economic issues that affect care.

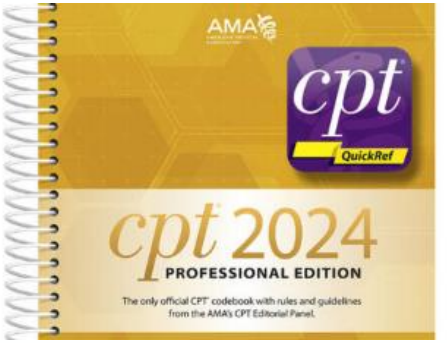
How can they impact your E/M code choice?

Self-study on Surgical Documentation and Coding,

Diagnostic Tests, Labs, and Vaccinations,

Behavioral and Mental Health

Grab your CPT Manual and review the Surgery Guidelines' Surgical Package Definition

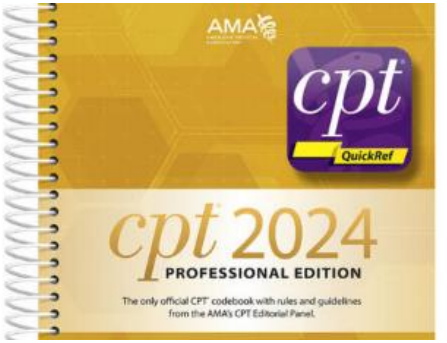


- This section will focus on how to properly turn completed clinical provider documentation into the proper CPT codes from the Surgery section of the CPT page 76 (AMA Professional Edition) which covers all codes that begin with a #1-6 as well as several procedural codes found in the Medicine section.

- Most of your attention should go towards researching the detailed key documentation guidelines found in each body area/organ system's subheadings text that are not found in the code definition nor in any EHR or non-AMA CPT manual!

- Should you choose to take ArchProCoding's optional certification exam to become a Rural/Community Health – Coding & Billing Specialist (RH-CBS or CH-CBS) you will need to be prepared to access such details during the examination as well as in real-life to stay compliant with your clinic or health center's coding/billing obligations.

Grab your CPT Manual and review key Surgery guidelines



- Be sure to supplement your work for this class with a review of key codes found in your clinic's or health center's "Production Report" to identify possible compliance issues or revenue options to pass on to your colleagues.

- It is vital to look at this section from a "pure coding" perspective rather than billing as different insurance companies pay using different definitions of the "global surgical package."

  - ✓ Please refer to the next Billing section for details on likely varying Medicare and commercial payer reimbursement issues, such as whether an E/M visit is included and how much, if any, post-procedure time is being paid or can be billed separately and the proper application of CPT and HCPCS-II modifiers.

Sample Self-Study Items on CPT Surgery Coding Integumentary System

Excision of benign or malignant lesions

Do we also code 96372/J-code for local anesthesia?

How do we measure?

Group or code separately?

Also includes/excludes what other CPT codes?

What can be coded in addition to the excision?

Paring or cutting of lesions + trimming, debridement, and avulsions of nails

These codes often get rejected for payment for being “medically necessary” – consider modifiers –Q7, Q8, or Q9 to use to show when the patient has other conditions that could generate coverage.

Skin repairs (Closures)

When should this be included in an E/M?

What are the 3 types?

What about code G0168?

When to use modifier -59?

Group or code separately?

When do we add the lengths of various skin repairs?

Destruction of lesions

Difference between each code sections from 17000-17286?

Does your EHR include enough detail to correctly code the number units provided?

Sample Self-Study Items on CPT Surgery Coding Musculoskeletal System

Introduction or Removal section

Difference between code **20526** "injection, therapeutic (ex. local anesthetic, corticosteroid), carpal tunnel and code **96372** "therapeutic, prophylactic, or diagnostic injection…subcutaneous or intramuscular"?

What else would be coded when using either code?

Trigger point and joint injections

Do we code on the number of muscles, injections, or number of trigger points?

Does your EHR give providers an option to **identify the correct number of units**?

Where are spinal injection codes found?

Fractures and/or dislocations

What is included as far as pre- and/or post-procedure coding and when will it differ by payer?

Need to use CPT modifiers -54, -55, and/or -56?

When to use the **"Application of Casts or Strapping"** codes 29000-29584 vs. **"Removal or Repair"** codes 29700-29750?

Biopsies

When should you use the codes from the integumentary section (11102-11106) versus the biopsy codes found in the musculoskeletal section?

Does your EHR include enough detail to **correctly code the number units provided**?

Sample Self-Study Items on CPT Surgery Coding Other surgical code chapters

Respiratory System

Use the CPT notes found below the definition of code 30110 for “Excision, nasal polyps, simple” to cross-reference with your EHR and coding software to see if you have access to the same valuable coding information!

What **valuable coding information** is found before the codes 31233-31298?

Cardiovascular System

Which venous access codes 36400-36416 are performed and how does the billing department **determine if they are covered** in addition to the main procedure performed?

Digestive System

Which procedures are **performed in your office versus performed at an outside location** such as a surgery center or hospital?

How does that change coding and billing processes?

Urinary System

When performing urodynamics studies, **when is modifier -51 needed**, who adds it, and how could it change payments from various insurers?

Sample Self-Study Items on CPT Coding Radiology, Path and Lab, Medicine chapters

Radiology

What is the proper application of **modifier –TC and -26** and how will billing differ when performed in your clinic or health center when billing Medicare compared to traditional commercial insurers via **"split billing"?**

Can Medicare's RBRVS help with coding technical and professional components?

Pathology and Lab Services

When would **modifiers -90, -91, and -92** be needed?

Additional info at CMS Ch. 13 section 60.1 as well as this **December 2023 CMS Fact Sheet on Clinical Lab Fee Schedule**

Medicine Section – Vaccines and Administrations

Which two main types of vaccine codes are likely required, and **what makes them different from each other**?

How does coding/billing change if I purchase the vaccines vs. getting them for free from the manufacturer or the CDC's Vaccines for Children program?

Medicine Section – Cardiography/EKGs

When reviewing codes 93000-93042 what changes the coding and **when will modifiers –TC and/or -26 be necessary**?

How do we work with our billing department if someone else **only performs the test itself or only does the professional interpretation**?

Sample Self-Study on CPT Coding Medicine chapter Psychiatry section

Interactive Complexity

What is an add-on code?

What other codes can this code be added to?

What needs to be in the medical record to support the coding of +90785?

Psychiatric Diagnostic Evaluations

What is the difference between the 2 main codes and which types of providers can perform which?

What else is included in this assessment per the notes before the codes?

What if done on somebody other than the patient?

Psychotherapy

Which provider types can code 90832, 90834, and 90838 **versus** codes +90833, +90836, and +90838?

What if the patient gets an **"urgent assessment and history of crisis state, a mental status exam, and a disposition"?**

What if the time units aren't met exactly?

Assorted Psychiatric Codes

Check out codes for family/group therapy and expect carrier variations in payment.

Review codes +90863 for pharmacological management and 90885-90989 for assorted review of medical records to provide advice or recommendations.

Health Behavior Assessment and Intervention Coding Medicine/Psychiatry section (96156-96161) Covered for 2024 by RHC and FQHC!

Behavioral factors to assess, treat, or manage PHYSICAL health problems

*"the patient's primary diagnosis is **physical** in nature and the focus of the assessment and intervention is on factors complicating medical conditions and treatments. Designed to **improve the patient's health and well-being utilizing psychological intervention**."*

Health Behavior Assessments

"includes evaluation of the patient's responses to disease, illness or injury, outlook, coping strategies, motivation, and adherence to medical treatment."

Health Behavior Interventions

"it includes promotion of functional improvement, minimizing psychological and or psychosocial barriers to recovery, and management of and improved coping with medical conditions."

Bundling Billing Rules per CPT

"For patients that requires psychiatric services as well as health behavior assessments and interventions, report the predominant service performed."

Do not report these codes in addition to traditional diagnostic/therapeutic services on the same day.

RHC/FQHC eligibility to report Intensive Outpatient Programs (IOP) for SUD/OUD/MAT patients

Get the list of approved codes on a separate link in the document above and/or use this link: https://www.cms.gov/files/document/r12460otn.pdf#page=11

Billing for Optimal Reimbursement

ArchProCoding
RURAL & COMMUNITY HEALTH

Possible H-code Billing Options Reserved for Possible Medicaid Use

It is necessary for your full team to review the definitions of every single H-code in the HCPCS-II manual. We can't list them all below and many may not ever be needed depending on carrier variations BUT, check out these highlights for now...

H0001-H0007

Alcohol and/or drug assessments, behavioral health counseling and therapy, case management, crisis interventions.

H0015

Alcohol/drug intensive outpatient treatment at least 3 hours a day, 3 days per week, includes assessment, crisis eval, activity therapy, etc.

H0038

Self-help/peer services, per 15 minutes. Consider using for Peer Support Services.

H0033, H0034

Oral medication administration with direct observation, medication training and support.

H0047-H0050

Examples include alcohol/drug services NOS, drug testing collection & handling non-blood specimens, screening, brief interventions.

H2010- H2037 – Time and Per Diem Codes

Medication services, day treatments, community services, wrap-around services.

Possible HCPCS-II T-codes RESERVED FOR MEDICAID

T1001

Nursing Assessment and/or Evaluation

T1002 - T1003

RN or LPN/LVN services, up to 15 minutes

T1006 - T1007

Alcohol and or substance abuse services including family/couple counseling and assorted treatment plan development and or modification

T1014

Telehealth transmission, per minute, professional services billed separately

T1015

Clinic visit/encounter, all inclusive

Sample from the CMS FQHC Qualifying Visit List (QVL)

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!

HYPERLINK to full FQHC QVL

…there are more codes…

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

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.

CMS Preventive Service Chart for RHC

Service	HCPCS Code	Short Descriptor	Paid at the AIR	Eligible for Same Day Billing	Coinsurance /Deductible	CMS Pub 100-04
AWV	G0438	Ppps, initial visit	Yes	No	Waived	Ch. 18 §140
	G0439	Ppps, subseq visit	Yes	No	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 Waived	Ch. 18 §70
	G0118	Glaucoma scrn hgh risk direc	Yes	No	Not Waived	
Screening Pap Test	Q0091	Obtaining screen pap smear	Yes	No	Waived	Ch. 18 §30
Alcohol Screening and Behavioral Counseling	G0442	Annual alcohol screen 15 min	Yes	No	Waived	Ch. 18 §180
	G0443	Brief alcohol misuse counsel	Yes	No	Waived	
Screening for Depression	G0444	Depression screen annual	Yes	No	Waived	Ch. 18 §190

CMS Preventive Service Chart for FQHC

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 Waived	Ch. 18 §70
	G0118	Glaucoma scrn hgh risk direc	Yes	No	Not Waived	

For RHC/FQHC details around the reporting of approved preventive services for CMS

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

70.1 - RHCs Billing Approved Preventive Services
(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

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

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

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

Section Overview
Billing and Reporting

Type of Bill (TOB) and Revenue Codes that are required on the CMS1450/837i for RHC/FQHC

Sample Differences in RHC/FQHC CMS billing

+

Medicare does not pay via only AIR/PPS payments

Billing for Non-RHC/FQHC Services

RHC/FQHC Split Billing for Diagnostic Tests

+

Vaccine Billing Tips for RHC and FQHC

Free Online Revenue Tools from CMS

Many software programs may include the **NCCI's bundling rules and RBRVS' billing information**, but we would like you to be able to get them on-demand and for free.

Section Overview
Billing and Reporting

Surgical Package for Onsite vs. Offsite Surgeries

Depending on where you provide a minor/major surgery and which carrier you are billing it is imperative to know not what amount you are getting paid, but what are you getting paid for?

Bonus Section on CMS-covered Preventive Services

We have given you 20+ slides that identify the main documentation, coding, and billing issues related to most of the “sometimes-covered” CMS Preventive Medicine codes .

What to Do After Class?

How can you increase the effectiveness of this class, regardless of whether you choose to seek RH-CBS or CH-CBS certification?

Type of Bill (TOB) and Revenue Codes,

Medicare does not only pay via AIR/PPS,

Billing for non-RHC/FQHC Services

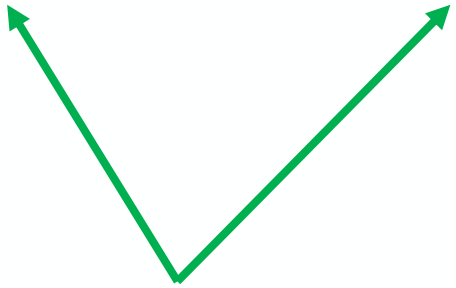
Sample RHC Bill Types for the CMS1450/837i

710 – Claim for Denial/Non-payment/zero claim

711 – Original RHC Claim

717 – Adjustment Claim

718 – Cancelled Claim



Be sure to view your MAC's website for the full list and/or their definitions and guidance.

Sample FQHC Bill Types for the CMS1450/837i

519 – Supplemental FQHC Payments on Medicare Advantage Claims Only (*See CMS Ch. 9 Section 60.4*)

771 – Original FQHC Claim

777 – Adjustment Claim

778 – Cancelled Claim

770 – Non-payment/zero claim

77Q – Reopened Claim

Sample Revenue Codes for the CMS1450/837i

A revenue code needs to be applied to each line item(s) on claims submitted on the "UB" claim form. It is vital that they match in terms of the type of service or where it was provided. Check with your EHR/IT/Billing system to see if these are automatically added or must be added by billing staff.

0521	• Clinic visit by beneficiary to the RHC/FQHC
0522	• Home visit by the RHC/FQHC practitioner
0524	• Visit by RHC/FQHC practitioner to beneficiary in covered Part A stay at a Skilled Nursing Facility (SNF)
0525	• Visit by RHC/FQHC practitioner to beneficiary in a SNF (not covered Part A), NF, ICF/MR or other residential facility
0527	• RHC/FQHC Visiting Nurse Service to a member's home when in a home health shortage area
0528	• Visit by RHC/FQHC practitioner to other non-RHC/FQHC site
0519	• Visit by a beneficiary in a Medicare Advantage Plan
0300	• Visit for general labs
0636	• Drugs requiring detailed coding
0780	• Visits held through telephone - Telehealth visits
0900	• Behavioral Health Treatment Services

2 sample websites for further detail

Noridian MAC

+

National Uniform Billing Committee

Sample differences in RHC vs. FQHC Medicare Billing

Coinsurance is calculated very differently in a RHC vs. FQHC *(for AIR/PPS encounters)*

The Medicare Part B deductible **does not apply** in a FQHC, but does in a RHC

IPPE & an approved medical/mental health visit qualifies for **2/3 encounter rate payments** in a RHC, but not in a FQHC

Medicare should add a **34.16 % increase** in the PPS rate for new patient visits, IPPE, and AWVs in FQHC, but not RHCs

FQHCs must use one of their 5 billing G-codes followed by a code on the qualifying visit list (QVL) for PPS visits. RHCs have no QVL.

RHCs are required to use modifier –CG (*at least on the first line item*) on all eligible AIR expected payment claims.

Eligible authorized providers are slightly different in FQHCs.

For example, registered nutritionists and dieticians reporting…

Diabetes Self-Management Training (G0108) and Medical Nutrition Therapy (G0270, 97802-3) **are covered services in FQHCs**, but not RHCs

Medicare does not just pay RHC/FQHC via AIR/PPS payments

- Lab services are **paid on the lab fee schedule** and aren't on the AIR/PPS claim, rather they are likely billed on a CMS1500/837p.
- ***Hospital services and surgeries*** performed outside of your RHC/FQHC are **paid via fee-for-service (FFS) *based on RBRVS and the Medicare Physician Fee Schedule*** just like other Part B providers since you are not in your RHC/FQHC.
- Care Management codes G0511/G0512 are **paid at 80/20% of the average Medicare pays FFS** for all the codes that are bundled into them (ex. Principal/chronic care, chronic pain management, RPM, RTM, CHI, PIN, BHI, and Psych CoCM)
  - **New 2024 rate for G0511 = $71.69**
  - **New 2024 rate for G0512 = $144.07**
- Originating site telehealth using Q3014 is **paid via a new 2024 flat fee around $29.96**
- As of 2024 – IOP services will pay as though they were provided in a hospital setting - - **$284.00 per day**
- Distant site ***medical*** telehealth using G2025 is **paid via at the new 2024 rate of $95.37** split 80/20%.
- Some vaccines get **"paid" via your cost report** (*e.g. influenza, HepB, pneumo codes G0008-G0010*) and/or via periodic "roster billing".
- And more…

Billing for non-RHC/FQHC Services

Per Ch. 9 Section 90

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

Table of Contents
(Rev. 11200, 01-12-22)

Transmittals for Chapter 9

Medicare excluded services

Technical components of diagnostic tests

Laboratory Services

Hospital Professional Services (E/M and procedures)

Durable Medical Equipment

Ambulance/Prosthetics/Body Braces

Group Services/Therapy/Training (some may be billable via telehealth)

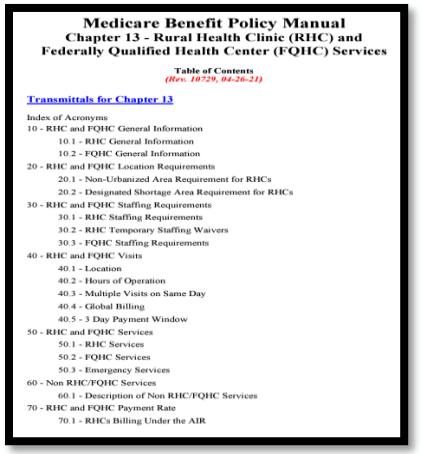
RHC/FQHC Split Billing for Diagnostic Tests,

Vaccine Billing Tips for RHC and FQHC,

Free Online Revenue Tools from CMS

Split billing for diagnostic tests (ex. EKG, ultrasound, x-ray) to Medicare "only"

Per Ch. 13 Sections 40.5 and 60.1



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

Table of Contents
(Rev. 10729, 04-26-21)

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
70 - RHC and FQHC Payment Rate
70.1 - RHCs Billing Under the AIR

- Most codes like x-rays and ultrasound can split the code between its technical/professional component, according to RBRVS, using modifier –TC/-26 whereas EKGs will never carry those modifiers as the code ranges 93000-93010, for example, use different CPT codes to split the service, if needed.
  - ✓ What about codes G0403-G0405 when performing an IPPE? Look in your HCPCS-II manual!

- When you perform a diagnostic test that can be split between a technical (*i.e., who owns the equipment*) and professional component (*i.e., who documents the final interpretation and report*) in addition to a face-to-face visit – you may only include the professional component on the CMS1450/837i bill and it will be included in your AIR/PPS payments.

- Therefore, whoever owns the equipment should **separately report the technical component** on the appropriate claim form to get reimbursed however they normally bill.
  - ✓ Independent RHCs and FQHCs will send their own claim on a CMS1500/837p and should expect a FFS payment.
  - ✓ Provider-based RHCs may bill on either form depending on how they normally bill such services, and it could be on an 837i or 837p claim form and may be paid "at cost", through the existing AIR, or other existing billing methodology.

Vaccine Billing Tips for RHCs

Make a bookmark for this wonderful resource that has a couple tips for vaccines plus a ton of general info for RHCs. See pages 9-10 of the **CMS RHC Fact Sheet**.

Flu & Pneumococcal Shots

We pay for flu and pneumococcal shots and their administration at 100% of reasonable cost. RHCs report these services on a separate cost report worksheet. RHCs shouldn't report these services on their RHC billing claims.

COVID-19 Monoclonal Antibody Therapies & Vaccines

For COVID-19 monoclonal antibodies used for post-exposure prophylaxis or treatment of COVID-19, we'll continue to pay at 100% of reasonable cost through the cost report through the end of the CY in which the Emergency Use Authorization (EUA) declaration for COVID-19 drugs and biologicals ends. The EUA declaration is distinct from, and not dependent on, the COVID-19 public health emergency (PHE).

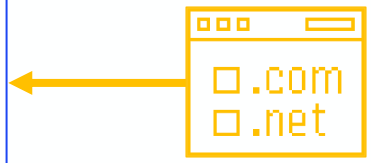
Starting January 1 of the year after the EUA declaration ends:

- We'll pay you for monoclonal antibody products used for **post-exposure prophylaxis or treatment** of COVID-19 in the same way we pay for other Part B drugs and biological products through the RHC AIR
- We'll continue to pay for covered monoclonal antibody products and their administration when used as **pre-exposure prophylaxis for prevention** of COVID-19 at 100% of reasonable cost through the cost report

An RHC can't bill a visit when the practitioner only sees a patient to administer a vaccine. Instead, the RHC includes vaccines and their administration on the annual cost report, and we reimburse them at cost settlement. Patients pay no Part B deductibles and coinsurance for these services.

Hepatitis B Shot Administration & Payment

The bundled payment, or AIR, for an RHC visit includes the hepatitis B shot and its administration costs. This means you can't bill the shot or its administration separately from the visit, and you can't bill for a visit if shot administration is the only service you provided. However, you can include it on a separate line item when you submit the visit's bill, which ensures the patient pays no Part B deductible and coinsurance. If the shot was the only service you provided, you can add it on a separate line item for the next visit.



Vaccine Billing Tips for FQHCs

Make a bookmark for this wonderful resource that has a couple tips for vaccines plus a ton of general info for FQHCs. See pages 9-10 of the **CMS FQHC Fact Sheet**.

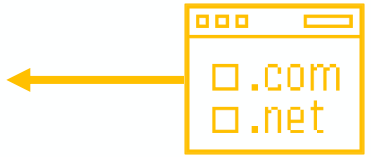
Flu & Pneumococcal Shots

We pay for flu and pneumococcal shots and their administration at 100% of reasonable cost. We include the cost in the cost report so you don't bill a visit. You must include these charges on the claim if they're part of a visit. If you only provide the shot administration on that day, waive the patient coinsurance, and don't file a claim.

COVID-19 Vaccines & COVID-19 Monoclonal Antibody Therapies

For **Original Medicare patients**, we pay for administering COVID-19 vaccines and COVID-19 monoclonal antibody products at 100% of reasonable cost through the cost report.

Note: We updated the FQHC cost report to show costs related to COVID-19 shots, COVID-19 monoclonal antibody products, and how you administer them.



For COVID-19 monoclonal antibodies used for post-exposure prophylaxis or treatment of COVID-19, we'll continue to pay at 100% of reasonable cost through the cost report through the end of the CY in which the Emergency Use Authorization (EUA) declaration for COVID-19 drugs and biologicals ends. The EUA declaration is distinct from, and not dependent on, the COVID-19 PHE.

Starting January 1 of the year after the EUA declaration ends:

- We'll pay you for monoclonal antibody products used for **post-exposure prophylaxis or treatment** of COVID-19 in the same way we pay for other Part B drugs and biological products (through the FQHC PPS)

Hepatitis B Shot Administration & Payment

We include the hepatitis B shot and its administration in the FQHC visit. They aren't separately billable. If you provide a qualifying FQHC visit on the same day as the hepatitis B shot, report the charges for the shot and related administration as a separate line item to ensure we don't apply coinsurance. You can't bill a visit if shot administration is the only service you provided.

Access RBRVS code status, global days, and modifier information

Access the hyperlink, access instructions of how to use the tool, and utilize the info depending on who you are billing and where. You can also access RVU info!

Physician Fee Schedule Search

Search Results [1 Record(s)]

Selected Criteria:

Year:	2024	HCPCS:	11400
Type of Info.:	Payment Policy Indicators	Modifier:	All Modifiers
HCPCS Criteria:	Single HCPCS Code		

Update Results

Single HCPCS Code

Code	Description
11400	Exc tr-ext b9+marg 0.5 cm<

Print Results | Download Results | Email Results

For your convenience, search results can be printed, downloaded or emailed.

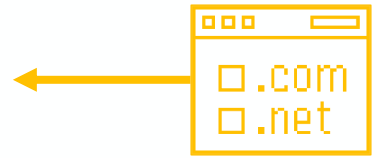
1

View Items Per Page: 10 Go

MODIFIER	PROC STAT	PCTC	GLOBAL	MULT SURG	BILT SURG	ASST SURG	CO SURG	TEAM SURG	PHYS SUPV	DIAG IMAGING FAMILY IND
	A	0	010	2	0	1	0	0	09	99

1

View Items Per Page: 10 Go



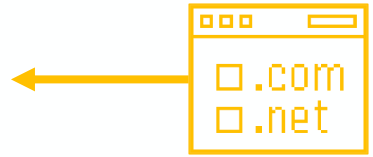
Medicare's bundling information (i.e., NCCI) determines possible modifiers and can reduce claim denials

1	2	3	4	5	6	7
A	B	C	D	E	F	G H I J

Column1/Column 2 Edits

Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale
99215	G0101		19980401	19980401	9	More extensive procedure *
99215	G0102		20000605	*	0	Standards of medical / surgical practice *
99215	G0104		19980401	19980401	9	More extensive procedure *
99215	G0105		19980401	19980401	9	More extensive procedure *
99215	G0106		19980401	19980401	9	More extensive procedure *
99215	G0107		19980401	19980401	9	More extensive procedure *
99215	G0117		20020101	*	0	Standards of medical / surgical practice *
99215	G0118		20020101	*	0	Standards of medical / surgical practice *
99215	G0120		19980401	19980401	9	More extensive procedure *
99215	G0245		20020701	*	0	Standards of medical / surgical practice *

Figure 2: Column 1/Column 2 table with 99215 in Column 1



How do you know when an appropriate modifier may be used?

Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass a PTP code pair edit if the clinical circumstances do not justify its use. If the Medicare Program imposes restrictions on the use of a modifier, the modifier may only be used to bypass a PTP code pair edit if the Medicare restrictions are fulfilled.

In the modifier indicator column, the indicator 0, 1, or 9 shows whether an PTP-associated modifier allows the PTP code pair to bypass the edit. The following Modifier Identifier Table provides a definition of each of these indicators.

Modifier Indicator Table

MODIFIER INDICATOR	DEFINITION
0 (Not Allowed)	There are no modifiers associated with NCCI that are allowed to be used with this PTP code pair; there are no circumstances in which both procedures of the PTP code pair should be paid for the same beneficiary on the same day by the same provider.
1 (Allowed)	The modifiers associated with NCCI are allowed with this PTP code pair when appropriate.
9 (Not Applicable)	This indicator means that an NCCI edit does not apply to this PTP code pair. The edit for this PTP code pair was deleted retroactively.

Are you using a Medicare claim scrubber on commercial plans? What policies do you have on using modifiers to overturn a likely denial, for example, using modifier -59.

Modifier -59 Basics
Overused and Misunderstood

Medicare's NCCI can be different than non-Medicare bundling rules!

How do you know when an appropriate modifier may be used?

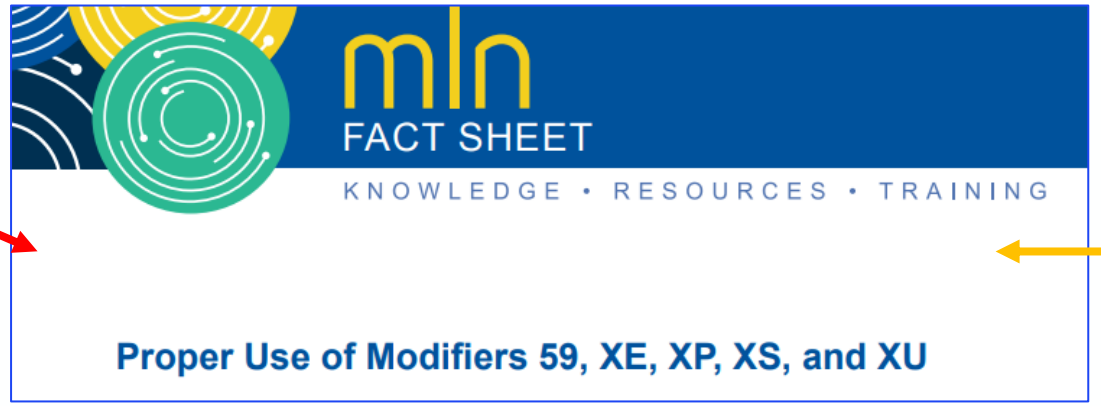
Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass a PTP code pair edit if the clinical circumstances do not justify its use. If the Medicare Program imposes restrictions on the use of a modifier, the modifier may only be used to bypass a PTP code pair edit if the Medicare restrictions are fulfilled.

In the modifier indicator column, the indicator 0, 1, or 9 shows whether an PTP-associated modifier allows the PTP code pair to bypass the edit. The following Modifier Identifier Table provides a definition of each of these indicators.

Modifier Indicator Table

MODIFIER INDICATOR	DEFINITION
0 (Not Allowed)	There are no modifiers associated with NCCI that are allowed to be used with this PTP code pair; there are no circumstances in which both procedures of the PTP code pair should be paid for the same beneficiary on the same day by the same provider.
1 (Allowed)	The modifiers associated with NCCI are allowed with this PTP code pair when appropriate.
9 (Not Applicable)	This indicator means that an NCCI edit does not apply to this PTP code pair. The edit for this PTP code pair was deleted retroactively.

- Refer to the NCCI (*or other carrier's bundling system*) and reference the Modifier Indicator to determine if a modifier can overcome the billing edit.
- This is a "*modifier of last resort*" and should be used carefully based on available documentation, not just to get that item paid!
- Be aware of possible best uses of the similar modifiers –XE, XS, -XP, and –XU. Check out this CMS document!



Surgical Package for Onsite and Offsite Surgeries,

Self-study on CPT and HCPCS-II Modifiers

Medicare global billing rules do not apply to RHC/FQHC services

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.

How does this issue impact the possible need for an E/M to require a modifier -25 to get reimbursed for a visit and a procedure in a RHC/FQHC?

CMS' Surgical Package definition to use for a Medicare patient if the procedure is performed outside of your RHC/FQHC

Pre-operative

Intra-operative

Post-operative

$ ⟷ $ ⟷ $

Minor
E/M day of surgery included
(use modifier -25?)

Major
E/M day of and day before surgery is included *(use modifier -57?)*

Minor
Adds either 0 or 10 days of follow-up

Major
Adds 90 days of follow-up

(Use modifiers -24 or -79 for unrelated services?)

BE CAREFUL! 1 day of pre-op + the day of the procedure + 90 days of post-op
= **92 TOTAL global days**

ALSO! If a code in RBRVS shows as having "XXX" global days – there is NO surgical package!

Most non-Medicare payers use a similar (*or maybe the same*) definition of how to report onsite and offsite procedures in a medical office with E/M and unrelated services

Intra-operative

Pre-operative ⟷  ⟷ Post-operative

- ✓ **BE CAREFUL!** Non-Medicare payers can include 3-days of pre-op care in the procedure or maybe even 30/45/60/90/120 days of post-op care in the original reimbursement for the procedure.
- ✓ Find out during pre-authorization and/or your participation contract as it affects when you can bill again.

How could a non-Medicare carrier's different global rules change how we bill for procedures?

Does the surgical fee also include the Evaluation & Management service?

?

Most CPT Surgical Codes that begin with a 1-6

?

Did our payment for the surgical procedure include any post-procedure visits?

An E/M "may" be included in your payment for surgery.

Which payers recognize modifiers -25/-57?

Does the procedure fee include just the E/M on the day of the procedure, or could it be 24-72 hours prior?

Do they use Medicare's NCCI, or do they have their own "bundling" rules when billing for multiple procedures?

Does your "claim scrubber" allow modifier -59 to be added too easily to bypass edits?

Are there different payment amounts for multiple procedures via modifier -51?

E/M modifier -24 may be needed for non-Medicare unrelated E/M visits. What about 99024?

When can you start billing routine follow-up visits versus using code 99024 or E/M codes with a -24 modifier or unrelated procedures via modifier -79?

The perfect time to ask is if the carrier requires prior authorizations or pre-approval. Be sure to ask when you sign contracts also!

Modifier use will change based on the definition of the surgical package used

Pre-operative	Day of the procedure	Post-operative
Minor Procedure + related or separately identifiable E/M modifier **-**25?	**"Please pay this though you normally don't"** ✓ -32, -59, -76/-77, -91	**Unrelated E/M** modifier -24?
Major Procedure + with a decision for surgery E/M modifier -57?	**Changes payment amount:** ✓ -22/-52 (pay me more or less than normal) ✓ -50, -51 (payment reductions for bilateral/multiple procedures on same day) ✓ -53/-73*/-74*(incomplete services) ✓ -62, -66, -80, -81, -82 (surgical teams)	**Other Procedures** modifiers -58, -78, -79?
Pre-op only modifier -56	**Surgical care only** ✓ modifier -54	**Post-op only** modifier -55

Grab your CPT and HCPCS-II manuals and review the definitions of these, and locate the answers

- Do you have to have different diagnoses when using -25 on an E/M and when doing a minor procedure?
- Do EKG codes ever carry the –TC/-26 modifiers? What about x-rays?
- When would you never use modifier -51? What is the impact on revenue?
- Are there "*more descriptive modifiers available to use rather than modifier -59*"?
  - ✓Where are they found?

-AI (principal physician of record for admissions)
-CG and –GV
-CS (remove cost sharing?)
-E1-E4
-EP
-F1-FA
-FQ and -FR
-GA
-GG and –GH
-GT
-GY and –GZ

-HF and -HG
-JW
-M2
-Q5 and -Q6
-Q7 through Q9
-QW
-LT and-RT
-TC,
-XE through -XU

Modifier -25 on E/M for a related service carrying a global package

“Significant…E/M”

9921(?) -25

Add -25 if the primary diagnoses are similar or the same and if the **E/M level meets the definition of ‘significant’** such as 99214/99215.

20610

Note this example assumes this code carries a pre-op surgical package of “0” days.

Jxxxx

Also report the J-code with the proper # of units based on dosage since this was a “surgical injection” rather than just a shot!

Modifier -25 on E/M for an unrelated service carrying a global package

“…Separately identifiable E/M”

9921(x)-25

Add modifier-25 here if the primary diagnoses for the visit and the procedure code **have nothing to do with each other** regardless of level of service (*never use -25 on a 99211*).

69210

In this example assumes this code carries a ‘surgical package’ of “0” days.

Modifier –CG is a must on RHC claims to Medicare and maybe Medicaid

Rural Health Clinics (RHCs) Reporting Requirements Frequently Asked Questions (FAQs)

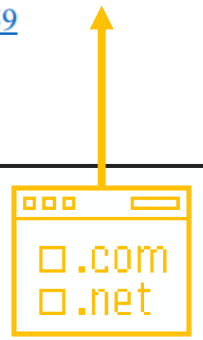
(Revised 10-14-16)

Effective April 1, 2016, RHCs are required to report a HCPCS code for each service furnished along with an appropriate revenue code. For claims with dates of service on or after April 1, 2016, RHCs should follow the reporting requirements for modifier CG found in MLN Matters Article SE1611. A compilation of FAQs about reporting modifier CG and CMS responses are provided below.

Sections

- Reporting Modifier CG
  - Reporting Modifier CG with Preventive Services
  - Reporting Modifier CG with Medical and/or Mental Health Services
  - Other Modifier CG Questions
- Reporting Modifier 25 or Modifier 59
- Other Questions

Click a section title to jump ahead



- RHCs must report modifier -CG on at least one CPT/HCPCS-II code per day if expecting the AIR.
- If performing a qualifying medical visit and a mental health visit, -CG would go on both services lines.
- Charges for the additional service lines (i.e., CPT/HCPCS-II codes) are packaged/bundled, “rolled up” in the qualifying visit service line and include the authorized charges for all lines of the claim where coinsurance/deductible apply.

BONUS Self-Study Section on CMS-covered Preventive Services

Who Can Perform IPPE and AWV Services?

IPPE must be performed by physician or practitioner as defined in section 1861 of SSA to qualify for a stand-alone encounter by RHC/FQHC.

- Doctor of medicine or osteopathy (MD, DO)
- Qualified non-physician practitioner (NP, PA, CNS)

The AWV can be performed by those mentioned above or by a health educator, registered dietician/nutrition professional or other licensed practitioner (ex. Pharmacist)… *but still requires a "face-to-face" component* to be given by an authorized provider for a stand-alone encounter to be paid.

IPPE can not be combined with AWV (mutually exclusive)

Medicare does not provide coverage for the misnamed 'routine annual physicals'

The IPPE is the only 'physical' Medicare covers and AWV is does not have a physical exam component.

Initial Preventive Physical Examination "*Welcome to Medicare*" physical

HCPCS II code G0402

- *Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare Part B enrollment*

Provides a written plan of care to the patient detailing any follow-up screening or preventive services necessary.

Deductible and co-pay are waived for the IPPE, but not for the screening EKG

In the RHC setting, the IPPE may qualify for the AIR on the same date as another covered medical or mental health visit but not in FQHCs

TOB 71X (RHC) and 77X (FQHC), Revenue Code 052X

Before billing an IPPE did you document the following?

Past medical and history

Current medications and supplements

Family history

History related to alcohol, tobacco, illicit drugs

Diet and physical activities

Risk for depression and mood disorders

Use a screening instrument to assess potential for depression (e.g., PHQ-9)

Review functional ability and level of safety

Hearing, ADLs, fall risk and home safety

Examination

Height, weight, body mass index, and blood pressure;

Visual acuity screen; and

Other factors deemed appropriate based on the beneficiary's medical and social history and current clinical standards.

End of life planning

Verbal or written and provided to the patient

Advance directive in case the beneficiary can't make health care decisions

Education, counseling and referrals

Include written preventions plan ('checklist') for patient including (as deemed appropriate) a once in a lifetime screening EKG (G0403-G0405)

Reporting Annual Wellness Visits (AWV)

HCPCS II code G0438 (Annual wellness visit; includes a personalized prevention plan of service (PPS), **initial** visit) – should only be reported if IPPE has not been reported in last 12 months!

HCPCS II code G0439 (Annual wellness visit, includes a personalized prevention plan of service (PPS), **subsequent** visit) should only be reported if IPPE/AWV not reported in last 12 months!

- Includes patient's history; compiling a list of current providers; height and weight; reviewing the patient's risk factor for depression; identifying any cognitive impairment; reviewing the patient's functional ability and level of safety (based on observation or screening questions); setting up a written patient screening schedule; compiling a list of risk factors, and furnishing personalized health services and referrals, as necessary.

Be sure to add Advanced Care Planning (99497-99498) and/or the new for 2024 code G0136 for completing the SDOH risk assessment if performed in addition to the AWV.

IPPE/AWV in a RHC

G0402: The IPPE can be billed as a stand-alone visit if it is the only medical service provided on that day with a RHC practitioner. If an IPPE visit is furnished on the same day as another billable visit, two visits may be billed. The beneficiary coinsurance and deductible are waived for the IPPE.

G0438-G0439: The AWV can be billed as a stand-alone visit if it is the only medical service provided on that day with a RHC practitioner. If the AWV is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

IPPE/AWV in a FQHC

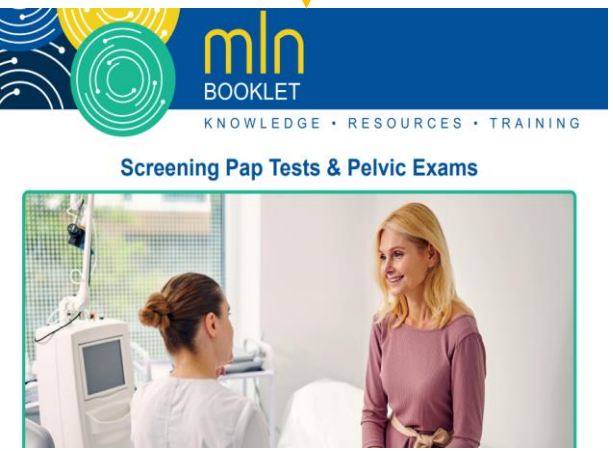
G0468/G0402: The IPPE can be billed as a stand-alone visit if it is the only medical service provided on that day with a FQHC practitioner. If an IPPE visit is furnished on the same day as another billable visit, FQHCs may not bill for a separate visit. These FQHCs will have an adjustment of 1.3416 to their PPS rate.

G0468/G0438-G0439: The AWV can be billed as a stand-alone visit if it is the only medical service provided on that day with a FQHC practitioner. If the AWV is furnished on the same day as another medical visit, it is not a separately billable visit. FQHCs that are authorized to bill under the FQHC PPS will have an adjustment of 1.3416 to their PPS rate.

Coverage of HCPCS II Code G0101 + Q0091-PAP

Cervical or vaginal cancer screening; pelvic and clinical breast exam

An April 2023 update added 3 new covered diagnoses!



Covered under Medicare Part B when one of the following conditions are met:

Has not had such a test during the preceding two years or is a woman of childbearing age,

Evidence of high risk of developing cervical cancer and her physician (or practitioner) recommends more frequently than every two years.

High risk factors for cervical and vaginal cancer are:

- Early onset of sexual activity (under 16 years of age)
- Multiple sexual partners (five or more in a lifetime)
- History of sexually transmitted disease (including HIV infection)
- Fewer than three negative or any pap smears within the previous seven years; and
- DES (diethylstilbestrol) - exposed daughters of women who took DES during pregnancy

Screening Pelvic Exam - Ch. 18 §40

Rural Health Clinic and Federally Qualified Health Centers

- Screening pelvic and clinical breast examination can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner.
- If it is furnished on the same day as another medical visit, it is not a separately billable visit.
- The beneficiary coinsurance and deductible are waived.
- No increase of PPS for stand-alone pelvic exam in FQHC
- What are the clinical documentation requirements?
- What diagnoses justify payment?

Only report a G0101 if 7 or more of the 11 items below are documented

1. Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge.
2. Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses. Pelvic examination (with or without specimen collection for smears and cultures) including:
3. External genitalia (for example, general appearance, hair distribution, or lesions).
4. Urethral meatus (for example, size, location, lesions, or prolapse).
5. Urethra (for example, masses, tenderness, or scarring).
6. Bladder (for example, fullness, masses, or tenderness).
7. Vagina (for example, general appearance, estrogen effect, discharge lesions, pelvic support, cystocele, or rectocele).
8. Cervix (for example, general appearance, lesions, or discharge).
9. Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support).
10. Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity).
11. Anus and perineum.

G0101 ICD-10-CM codes and TOB/Rev Codes

Risk Level	ICD-10-CM Diagnosis Code	Code Descriptor
Low	Z01.411	Encounter for gynecological examination (general) (routine) with abnormal findings [Use additional code(s) to identify abnormal findings]
Low	Z01.419	Encounter for gynecological examination (general) (routine) without abnormal findings
Low	Z12.4	Encounter for screening for malignant neoplasm of cervix
Low	Z12.72	Encounter for screening for malignant neoplasm of vagina
Low	Z12.79	Encounter for screening for malignant neoplasm of other genitourinary organs
Low	Z12.89	Encounter for screening for malignant neoplasm of other sites
High	Z72.51	High risk heterosexual behavior
High	Z72.52	High risk homosexual behavior
High	Z72.53	High risk bisexual behavior
High	Z77.21	Contact with and (suspected) exposure to potentially hazardous body fluids
High	Z77.29	Contact with and (suspected) exposure to other hazardous substances
High	Z77.9	Other contact with and (suspected) exposures hazardous to health
High	Z91.89	Other specified personal risk factors, not elsewhere classified
High	Z92.89	Personal history of other medical treatment

Rural Health Clinic (RHC)	71X	052X	052X

Page 8 of 13 ICN 909032 January 2018

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Screening Pap Tests and Pelvic Examinations MLN Booklet

Table 7. Facility Types, TOBs, and Revenue Codes for Screening Pap Tests and Pelvic Examinations (cont.)

Facility Type	TOB	Pap Test Revenue Code	Pelvic Examination Revenue Code
Federally Qualified Health Center (FQHC)	77X	052X	052X
CAH	85X, 096X, 097X, or 098X	0311	0770

NOTE: The April 2022 update added these 3 new covered diagnoses: Z92.850, Z92.858, and Z92.86 on page 8 of the document.

Screening Pap Test Q0091
Ch. 18 §30

Frequency	Covered For	Additional Information
Every 24 months (that is, at least 23 months after the most recent screening Pap test or pelvic examination)	**Any** asymptomatic female beneficiary	N/A
Annually (that is, at least 11 months after the most recent screening Pap test or pelvic examination)	A female beneficiary who meets **one** of the following criteria: • Evidence (on the basis of her medical history or other findings) that she is at high risk for developing cervical or vaginal cancer **and** her physician (or authorized practitioner) recommends that she have the test more frequently than every 2 years • A woman of childbearing age* who has had a screening pelvic examination or Pap test during any of the preceding 3 years that indicated the presence of cervical or vaginal cancer or other abnormality	**High risk** factors for cervical and vaginal cancer include: • Early onset of sexual activity (under 16 years of age) • Multiple sexual partners (five or more in a lifetime) • History of STI (including human immunodeficiency virus [HIV] infection) • Fewer than three negative Pap tests or no Pap tests within the previous 7 years • DES (diethylstilbestrol) exposed daughters of women who took DES during pregnancy

Can be a “stand alone” visit or reported with another encounter.

TOB: 71x (RHC) 77x (FQHC)

Revenue code: 052x

Prostate Cancer Screening in RHCs and FQHCs
Ch. 18 §50

HCPCS-II Code(s):

G0102- Prostate cancer screening; digital rectal examination

Rural Health Clinic (RHC)

- Can be stand alone visit or included in AIR for other covered service
- Coinsurance/deductible applies (NOT waived)

Federally Qualified Health Center (FQHC)

- Can stand alone to qualify for PPS
- Coinsurance applies (NOT waived)

Medicare covers an annual preventive prostate cancer screening PSA test and DRE once every 12 months for men 50+

- According to CMS, coverage begins the day after the beneficiary's 50th birthday!

Glaucoma Screening
Ch. 18 §70

Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)

HCPCS II Code(s):

- G0117- Glaucoma screening for high risk patients (by optometrist or ophthalmologist)
- G0118- Glaucoma screening for high risk patient under the direct supervision
- Revenue Code: 770

ICD-10-CM Considerations:

- Federally Qualified Health Center (FQHC)
- Per CMS, covered for (1) individuals with diabetes mellitus, (2) individuals with a family history of glaucoma, or (3) African-Americans age 50+, (4) Hispanics 50+

Frequency: once per year (11 months must pass)

Documentation: dilated eye examination with an IOP; and direct ophthalmoscopy or slit-lamp

Alcohol Screening /Behavioral Counseling Ch. 18 §180

Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)

HCPCS II Code(s): ***Updated definition for 2023 set a 5-minute minimum for G0442***

G0442- annual alcohol misuse screening (5-15 min)

G0443- brief behavioral counseling for alcohol misuse (15 minutes)

ICD-10-CM Code(s): NCD information may be currently under review/revision – check with your MACs.

Frequency: Annually for G0442 and 4 times per year for G0443

Screening for Depression
Ch. 18 §190

Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)

HCPCS-II Code(s): ***2023 updated definition set a minimum of 5 minutes***

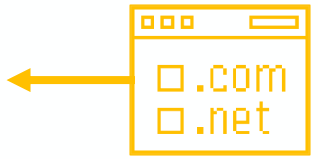
G0444 - Annual depression screening, **5-15 minutes**

Frequency:

Annually…eleven (11) months must pass from last annual depression screening
Medicare coinsurance and Part B deductible are waived

Coverage:

- Limited to screening services only. Not for patients known for having depression
- Per CMS, "*RHCs and FQHCs, annual screening for depression in adults is not separately payable with another face-to-face encounter on the same day*"
- An industry recognized tool (e.g., PHQ-9) must be administered - https://www.uspreventiveservicestaskforce.org/Home/GetFileByID/218
- Refer to Z13.89- Encounter for screening for other disorder



Smoking Cessation Services

Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)

99406 (Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, **greater than 3 minutes, up to 10 minutes**) and

99407 (Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, **greater than 10 minutes**)

Medicare allows 2 individual tobacco cessation attempts per year. Each attempt can include up to four intermediate or intensive sessions (up to 8 sessions per year)

- F17.200, nicotine dependence, unspecified, uncomplicated,
- F17.201, nicotine dependence, unspecified, in remission,
- F17.210, nicotine dependence, cigarettes, uncomplicated,
- F17.211, nicotine dependence, cigarettes, in remission,
- F17.220, nicotine dependence, chewing tobacco, uncomplicated,
- F17.221, nicotine dependence, chewing tobacco, in remission,
- F17.290, nicotine dependence, other tobacco product, uncomplicated,
- F17.291, nicotine dependence, other tobacco product, in remission, or
- Z87.891, personal history of nicotine dependence, unspecified, uncomplicated

Screening for Sexually Transmitted Disease Ch. 18 §170

Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)

HCPCS-II Code(s): G0445- Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training & guidance on how to change sexual behavior

ICD-10-CM Code(s):

Z72.51- High risk heterosexual behavior
Z72.52- High risk homosexual behavior
Z72.53- High risk bisexual behavior

Frequency:

Semi-annually (every 6 months)

Intensive Behavioral Therapy for Cardiovascular Disease (IBT for CVD) Ch. 18 §160

Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)

HCPCS-II Code(s): G0446- Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes (also known as "*CVD risk reduction visit*")

ICD-10-CM Code(s):

Frequency: Annually

Documentation:

- Encouraging aspirin use for the primary prevention of CVD when the benefits outweigh the risks for men age 45-79 years and women 55-79 years
- Screening for high blood pressure in adults age 18 years and older
- Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular and diet-related chronic disease.

Lung Cancer Screening w/ Low Dose CT Ch. 18 §220

Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)

HCPCS-II Code(s): G0296- Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT)

Frequency: Annually

Documentation:

- Determination of beneficiary eligibility including age, absence of signs or symptoms of lung cancer, a specific calculation of cigarette smoking pack-years; and if a former smoker, the number of years since quitting;
- Shared decision making, including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure;
- Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of comorbidities and ability or willingness to undergo diagnosis and treatment;
- Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions; and
- If appropriate, the furnishing of a written order for lung cancer screening with LDCT

Diabetes Self-Management Training (DSMT)
Ch. 9 §181 + Ch. 18 §120

ONLY FOR Federally Qualified Health Centers (FQHC) – may be performed in a Rural Health Clinic (RHC) but it would be captured via coding for the cost report.

When DSMT/MNT is furnished on the same day as another medical visit, only one visit can be billed

- Coinsurance not waived
- No increase in PPS

CPT/HCPCS II Code: G0108- Diabetes outpatient self-management training services, individual, per 30 minutes

ICD-10-CM Code(s): Must have diabetes diagnosis

Frequency:

- 10 hours in the initial year and 2 hours in subsequent years

Medical Nutrition Therapy (MNT)
Ch. 9 §182

ONLY FOR Federally Qualified Health Centers (FQHC)

Not a “covered” RHC service to CMS but may be claimed on the cost report.

Must be performed by registered dietitians or nutrition professionals

Coinsurance is waived and no increase in PPS

CPT/HCPCS II Code(s):

97802- Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each **15** minutes

97803- Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each **15** minutes

G0270- Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each **15** minutes

Intensive Behavioral Therapy for Obesity (Ch. 18 §200)

Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)

IBT for obesity should be consistent with the "*5-A framework*" (per USPSTF)

- ***A**ssess, **A**dvise, **A**gree, **A**ssist, **A**rrange*

CPT/HCPCS II Code(s): G0447- Face-to-face behavioral counseling for obesity, 15 minutes

ICD-10-CM Code(s): ICD-10-CM code for obesity are found in code family E66.-

Coverage: Medicare beneficiaries with obesity who are "*competent and alert*"

- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2-6;
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg weight loss requirement during the first six months

Answers: Self-Study on ICD-10-CM

A18.0

According to the Official Guidelines Section I. Subsection A, Paragraph 14 – the word "and" should be read as "and/or."

Check out #7 in the same section for the difference between parentheses and brackets.

F10-F19

Although the DSM-5-TR no longer differentiates between substance abuse vs. dependence the ICD-10-CM certainly does. It uses "use, abuse, and dependence."

Instructional notes should point you to code mild use as abuse, and moderate/severe use as dependence.

E11.9

Listing a diagnosis as "uncomplicated" but then adding related complications as subsequent codes will impact revenue, prior approvals, and especially your ability to "get credit" for the true complexity of a patient's condition when it comes to value-based diagnosis coding that can also impact PMPM payments.

See Section I. Subsection B, Paragraph 9 for combination codes

Z00.xx and Z01.xx

Section I.C.2.13 identifies key guidelines related to asymptomatic reasons you see patients.

Z-codes go first but also list relevant acute/chronic conditions to get quality reporting credit.

Z55-Z65

Section I.C.21.17 requires any SDOH to be documented in that day's record.

According to the AMA's E/M guidelines, the presence of a relevant SDOH may be used to show a moderate level of "risk" when determining overall MDM.

What to do After Class

Thoughts for after class

Do you now have access to key RHC/FQHC references and know how to keep track of changes?

Are you aware of how Medicare and non-Medicare payers may want things reported differently?

Can you think of anyone else from your clinic or health center that could benefit from this training?

Ask about our online self-study Bootcamp options!

Did you identify questions and issues for discussion with your EHR/IT/billing system vendors?

Are your existing policies and procedures detailed enough to allow for full clinical flexibility while maintaining coding/billing compliance?

Optional Certification Exam Details

Be sure we have your **individual email address** to send you your CEU certificate and brief survey.

Access to the **20 question Practice Exam** will also be included in the post-class email. Be sure to designate RHC or FQHC.

Once the post-class email arrives you have **180 days to complete** the optional Practice Exam, and/or the actual RH-CBS or CH-CBS certification exam.

The online exam is **100 questions (24 hours), and you must pass with a 70% score** on the initial exam or free re-test in the same 60 days post-class.

Pass and you are certified for 1 year. A year from passing you will owe a membership fee and 8 CEUs relevant to coding/billing/RHC/FQHC per year

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