Association for Rural & Community Health Professional Coding

(Arch Pro Coding)

2019 Kentucky Office of Rural Health Summit

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EDUCATION :: CERTIFICATION :: AUDIT SUPPORT

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Instructor

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EDUCATION • CERTIFICATION • AUDIT SUPPORT

Vice President of Education

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Who is this session designed for?

Clinical Providers

We will use this traditional symbol for MD, DO, NP, PA, CP, RN, CNM, and others licensed and operating under their state's scope of care.

Our certification exam is optional, but not required.

CE/CMEs may be available

KEY: Clinical Documentation

Management

We will use this symbol of a sun for those who manage clinical and revenue staff and make policy, hiring, and IT decisions.

Our certification exam is encouraged but not required.

CEUs are available
(ArchProCoding/AAPC)

KEY: Professional Coding

Coders/Billers

We will use this symbol of a windmill for those who use clinical documentation to compliantly code and bill for a RHC/FQHC.

Our certification exam is highly encouraged for your long-term career growth.

CEUs are available
(ArchProCoding/AAPC)

KEY: Coding & Billing

Develop a shared foundation of knowledge and get results!

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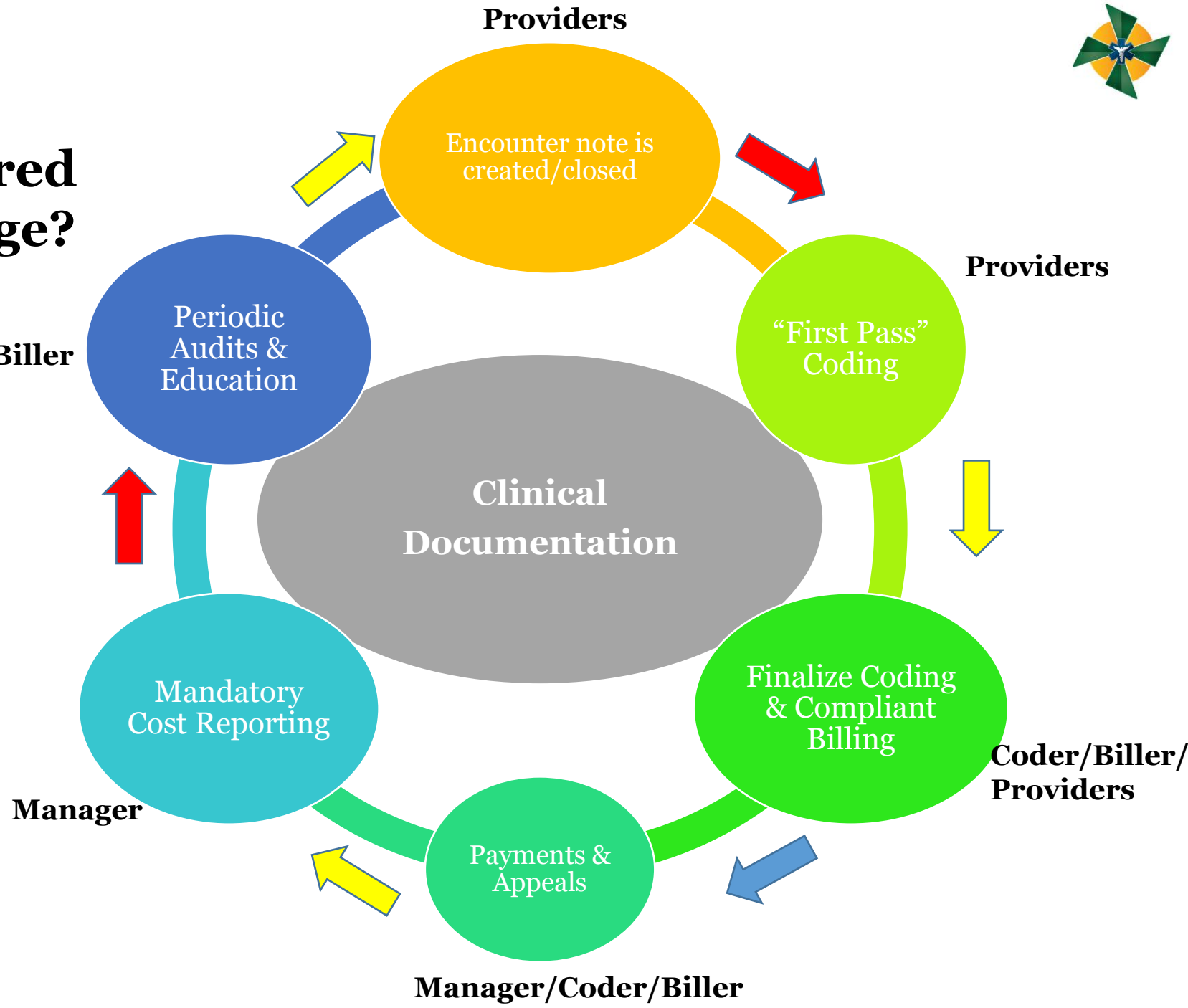
Have you Created a Shared Foundation of Knowledge?



Stable?

Improving?

Needs Attention?

Coding and Billing Aren't The Same!

- Coding turns medical documentation into useable data regardless of whether it generates $$$ or not.
- Just because you bill it does not mean you'll be paid.
- Just because you didn't get paid doesn't mean you did it wrong.
- Just because you got paid doesn't mean you get to keep the $$.
- Where Medicare goes with billing rules, which other payers tend to follow?
- This is a highly trust-based field …be ready to prove it if medical documentation is requested by a payer or patient.

Competing goals?

The goal of effective Clinical Documentation is to:

Document 100% of services you perform whether "payable" or not

The goal of effective Professional Coding is to:

Extract 100% of the codes from the medical record

The goal of effective Medical Billing is to:

Get 100% of the money you are entitled to - but no more

What level of training is needed?

Basic Training

- You are starting a job in a medical office at the front desk with little to no medical training. You have worked the front desk and have seen the billing forms but don't understand them.
- You provide coverage and/or back-up duties for someone on the revenue cycle team in case of sickness or missed work and nobody has ever explained the "why."
- You are not actively engaged on a daily basis with coding/billing but you interact with patients and/or practice operations and are considering a move for career development.
- **Manager:** "Congratulations – you are our new coder/biller! **You:** "Wait – what?"

Example - A nurse who wants to become a Quality Reporting professional and get a raise.

LEARN MORE TO EARN MORE

What level of training is needed?

Intermediate Training

- **You are a department/office leader (*ex. CMO, CFO, office manager*) who hires staff, manage people and policies, and may supervise the coding/billing staff but have little to no education about how to speak the language of coding versus the language of billing.**
- **You are responsible for an IT/EHR/Practice Management/Billing system but are new to RHC/FQHCs and their unique billing issues.**
- **You have day-to-day responsibilities over people, processes, and technology and help merge the practice's clinical and business goals and/or have responsibility for onboarding and training new staff to your processes and policies.**

I need a better understanding of RHC/FQHC details and how we get paid

LEARN MORE TO EARN MORE

What level of training is needed?

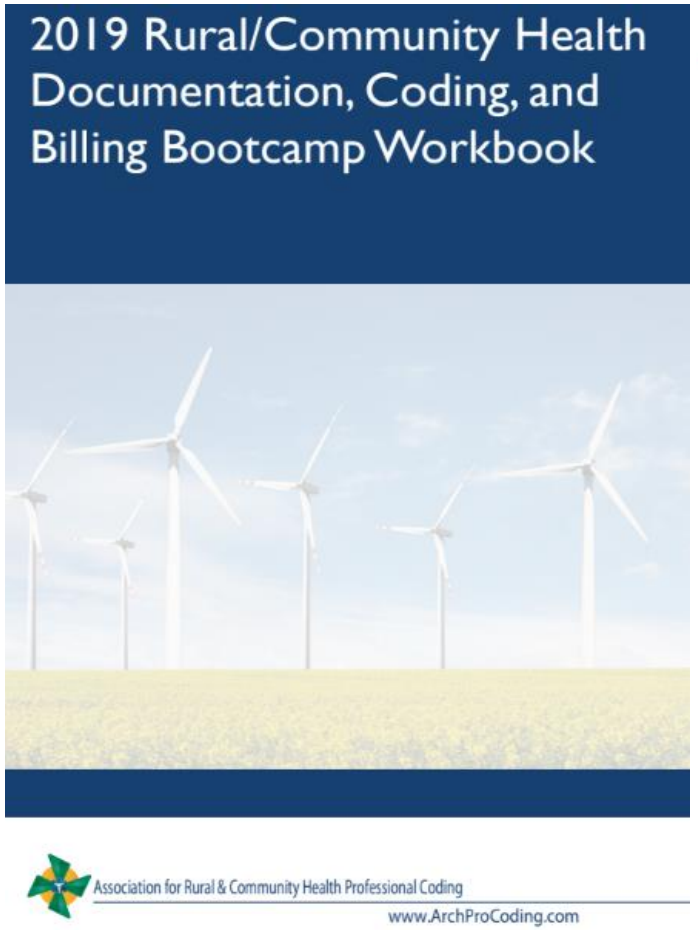
Advanced Training

- You serve in a leadership role in the revenue cycle with direct reporting responsibilities to senior management and finance.
- You are considered a Subject Matter Expert in coding or billing in your office and provide training and education to others in your office.
- You have earned certifications in coding (ex. CPC, CCS-P) that didn't cover anything to do with RHC/FQHC billing and forced you to learn concepts that you will never use in a RHC/FQHC.
- You are a clinical provider with management responsibilities + financial oversight and serve in a leadership role to fellow providers.

I want to have a long-term career in healthcare – not just a job.

Key Resources

- AMA's CPT, HCPCS-II, and ICD-10-CM physical manuals,
- Chapter 9 Medicare Claims Processing Manual,
- Chapter 13 Medicare Benefit Policy Manual
- 2019 ICD-10-CM Official Guidelines for Coding & Reporting
- Tons of websites and hyperlinks: CMS FAQs, MAC regulatory clarifications, Med Learn Matters, etc.



Our HIPAA Code Sets for Coding/Billing

CPT ® - *What did you do?*

- CPT is currently identified as Level 1 of the Healthcare's Common Procedural Coding System (HCPCS) and is split into 3 categories.
- Created and maintained by the American Medical Association whose documentation rules aren't licensed to others who also publish manuals!
- Most codes are updated January 1st each year–but vaccine product codes can be updated twice a year.

HCPCS II - *What did you do and/or what supplies were used?*

- Created by CMS as a supplement to Level I CPT codes for its needs, for example, to create FQHC valid encounter codes to generate your PPS encounter rate ex. G0466.
- "Temporary" codes (e.g. Q0091) and permanent codes have different update schedules, some codes (ex. J----) need units!
- Supplies, DME, and many specific CMS preventive medicine services are found here.

ICD-10-CM - *Why did you perform a service?*

- Overseen by the Cooperating Parties (AHA, AMA, CMS, NCHS).
- New codes effective on Oct. 1 each year – check to see which guidelines you have.
- Often, but not always, are needed to be "linked" to your procedure codes to get paid

RHC Revenue Foundations

Clinical Providers, Management, Coders/Billers

- How are RHCs different related to revenue?
- Location and provider requirements
- Definition of AIR vs. FFS
- Identification of primary reference materials from CMS (Ch. 9,13, 18)
- Insurance types, QVL, 1450/1500 form
- Line-by-line CPT/HCPCS-II coding
- Hot topics (e.x. reporting “Quality”)

Areas for Research

Commercial insurance participation contracts

People-Process-Technology (EHR/Coding/Billing)

Internal auditing of revenue items?

Determine educational needs of each job role

Resources

CMS Benefits (Ch.13) & Claims Manual (Ch. 9)

State Operations Manual

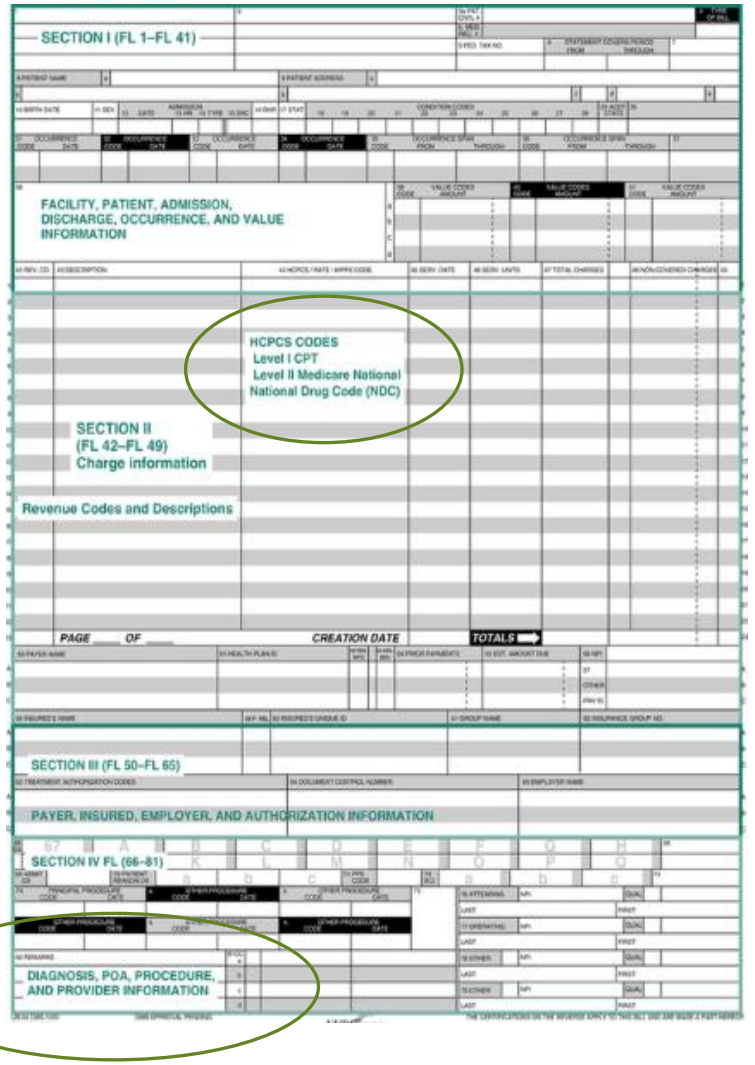
ICD-10-CM Guidelines

CMS E/M documentation rules

Learn More to Earn More

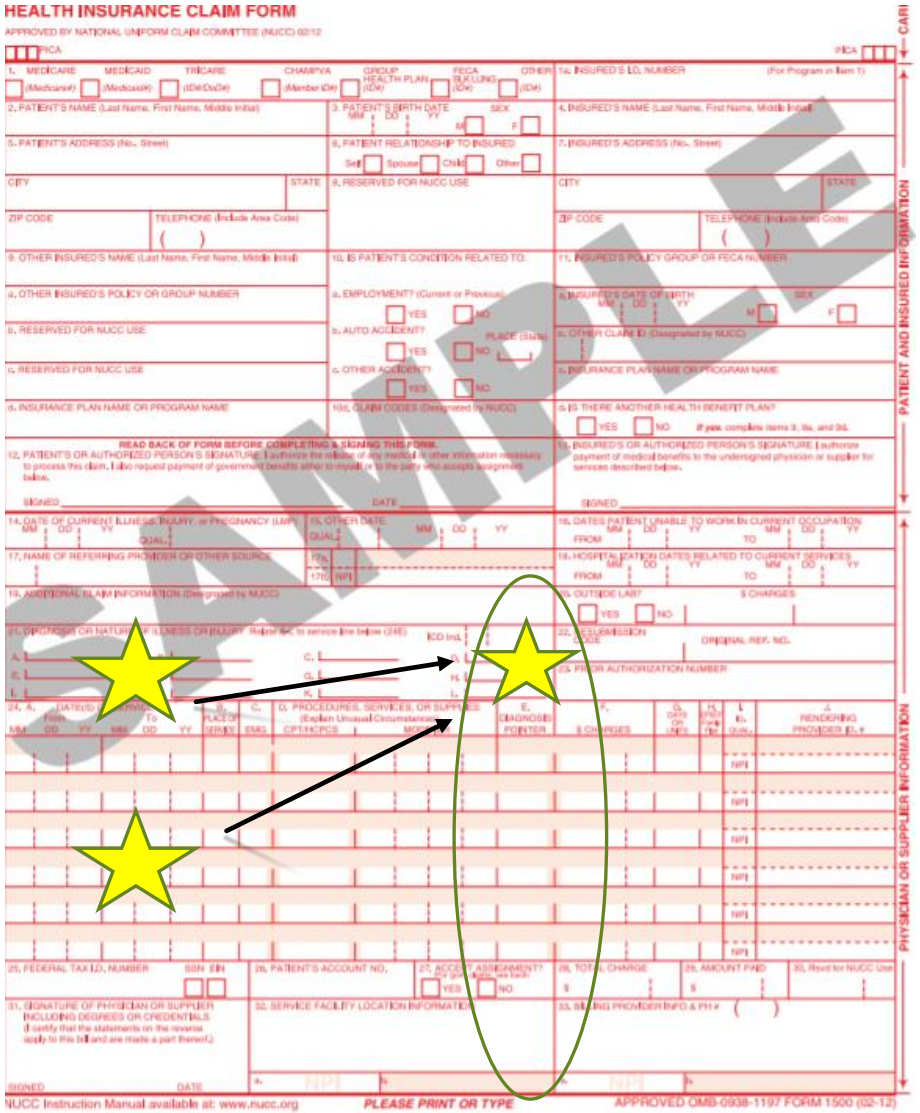
CMS-1450 Form

- Instructions on completing the CMS-1450 form (also known as the "UB-04") can be found here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1104CP.pdf
- This form is used for most "__covered__" Medicare services, especially those provided in a RHC/FQHC including office visits, procedures, preventive medicine, etc.
- Need to include Type of Bill and Revenue Codes not needed on the CMS1500 form.
- **Requirement to "link" diagnosis codes?**



CMS-1500 Form

- Instructions on completing the CMS-1500 form can be found here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
- This form is used for reporting non-RHC/FQHC and "some" Medicare covered services such as hospital visits and the technical portion of some diagnostic tests.
- **Diagnosis codes must be "linked" to services/procedures in box 24e.**



Overview: Clinical Documentation

Clinical Providers

Highest Impact

Sick vs. "Well"

Recent training coding/billing?

Change your clinical approach due to revenue or quality?

Management

Clinical & revenue balance

Billing & Mgt. systems "talk"?

Too reliant on "certified" staff?

The TaxID is "responsible" for compliance

Coders/Billers

Dependence on documentation

Give providers direct access to documentation guidelines!

Perform internal audits

Provider communication!

Areas for Research

Encounter Form Functionality

E/M & ICD-10 documentation

Research Medicare Preventive Templates

Quality reporting needs

Training/Audits

AMA vs CMS definitions of E/M guidelines

CPT minor procedures

Coding vs. Billing on Encounter Forms

GET RESULTS: Document 100% of services you perform whether "payable" or not

Section 2: Documentation Basics

- What must be documented by provider (e.g., CC, HPI, ROS, PFSH)?
- Ancillary staff documentation is OK? Role of “scribes”?
- Familiar with CMS signature requirements? Commercials have policies and track? Do you have an internal policy that is enforced?
- Focus on the need to manage who can enter in the reasons for the patient’s visits into the EHR:
  - Does cc: get pulled in from your scheduling system?
  - Who has access to those EHR fields?
  - Does your system combine the CC and HPI?
  - Who performs HPI/ROS/PFSH
  - What about previously documented history?

CMS Signature Requirements

- CMS suggests that a "timely" record entry as one that occurs within 24-48 hours. Occasionally, up to 72 hours is acceptable. Many payers require this as a CoP.

What should I do if I have not signed an order or medical record?	You may not add late signatures to medical records (beyond the short delay that occurs during the transcription process). Medicare does not accept retroactive orders. If the practitioner's signature is missing from the medical record, submit an attestation statement from the author of the medical record. Your contractor may offer specific guidance regarding addenda to medical records.

"Complying with Medicare Signature Requirements"
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf

Clinical Documentation Pitfalls

- "Missing" documentation
- Lack of "*medical necessity*"
- Not knowing when "*time*" impacts coding
- Lacking "*key component*" documentation
- Lacking (or untimely) signatures
- Billing under the wrong provider on team visits
- Not separating preventive service documentation from problem-oriented visits – it depends on the EHR!
- Unaware of CPT Guidelines
- "One-coding" and "block billing"
  - Ever look at your provider's billing 'patterns'?

Action Items & How to Get Results

Action Items

- Review the full E/M documentation guidelines from AMA and CMS.
- Update the encounter form a minimum of twice a year.
- Have providers review key areas of the ICD-10-CM Official Guidelines for Coding & Reporting.
- Identify codes that have both CPT and HCPCS-II options

Get Results

- Make your electric superbill a fully functional and usable document rather than a list of favorite codes.
- Establish a process for providers to report codes not on the superbill.
- Report diagnoses in order of importance and link diagnoses for all patients.
- Focus on chief complaints and “stand-alone” documentation.

Overview: Professional Coding

Clinical Providers

Complete the encounter form

When is the note "complete"?

Dependent on EHR/software?

Legal issues re: documentation accuracy

Management

Highest Impact

Determine your true "costs"

Speak clinical & revenue "languages"?

Policies, and workflows

Coders/Billers

Coding vs. billing training?

Easy access to a "completed" medical record?

Create an educational loop using real notes

Insurance type?

Areas for Research

Annual Cost Reporting

Medicaid and quality needs impact

HEDIS and HCC

EHR/mgt/billing integrations

Training/Audits

Levels of Service impact on patient coinsurance

Bundling/Claim Scrubbers/CCI

Modifiers

Preventive vs. Problem-oriented

GET RESULTS: Extract 100% of the codes from the medical record

Measuring “quality” is complicated and evolving

- How much does this transition change the focus on completely and accurately documenting your care in your medical record?
- Which staff should participate in the additional coding/reporting responsibilities necessary for quality reporting?
- Is it necessary for us to adjust how we train our clinical providers and coders/billers?
- Have you experienced any push-back from your providers over the additional coding responsibilities they have been given over the last few years?
- We obviously want to continue to make our patients the primary focus of our work day, but are there any new reforms that are taking your time away from YOUR primary focus?

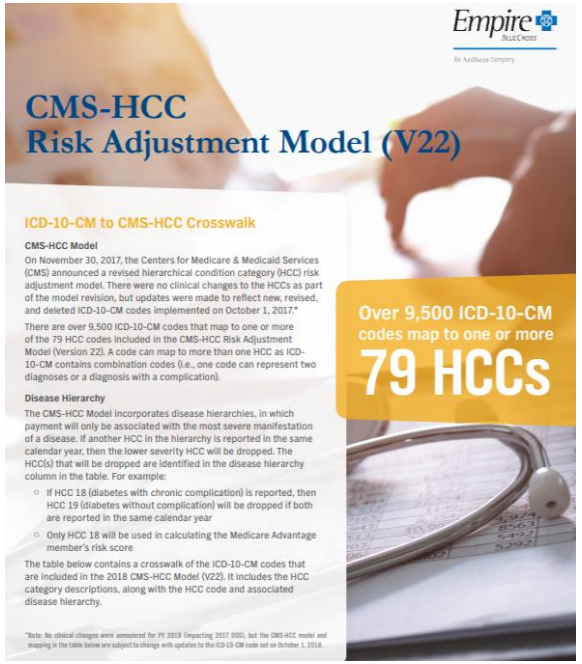
Hot Topics: Training for Quality Reporting?

- What needs to be a focus when dealing with these issues?
  - **HEDIS**- Should have a clinical background, be a EHR "super-user", understand CPT/HCPCS-II, ICD-10-CM and have direct access to CMO who may "adjust" the clinical approach based on the patient's insurance requirements.
  - **HCC**- Heavy ICD-10-CM implications and in-depth knowledge of their "Official Guidelines for Coding and Reporting".
    - Find out which categories your managed care companies are focusing on for that year – usually 5-8 areas like diabetes, pain management, heart disease, etc.
  - **Risk Adjustment and Shared Savings** - Work with your managed care plans and ACOs to "close gaps" typically by ensuring that you are painting a complete clinical picture of your patients on an annual basis, especially during your IPPE/AWV encounters.

HCC Overview

- Should be considered as the primary method to capture the Risk Adjustment needs of primarily Medicare/Medicaid managed care plans via ICD-10-CM codes using historical claims data and "hybrid" methods that may include onsite or virtual audits by payers.
- Hierarchal Conditions Categories (HCC) for 2018 ties together around 9500 ICD-10-CM codes into around 79 different categories.
- These HCCs are assigned a value that when combined with all diagnoses helps a carrier assign a "risk score" to each individual patient being evaluated by the plan.
- These scores are updated annually and requires everyone associated with the clinical documentation and coding processes to learn, understand, and apply the ICD-10-CM's "Official Guidelines for Coding & Reporting" to help (*typically*) Medicaid Managed Care organizations "close gaps".

Matching ICD-10-CM codes to HCCs risk scores



Source:
https://www11.empireblue.com/provider/noapplication/f2/s2/t4/pw_g312847.pdf?refer=ehpprovider

ICD-10-CM Codes	HCC Category Description	HCC	Disease Hierarchy
B20, B97.35, Z21	HIV/AIDS	1	
A02.1, A20.7, A22.7, A26.7, A32.7, A39.2-A39.4, A40.-, A41.-, A42.7, A48.3, A54.86, B00.7, B37.7, P36.-, R57.1, R57.8, R65.1-, R65.2-, T81.12XA	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/ Shock	2	
A07.2, A31.0, A31.2, B25.-, B37.1, B37.7, B37.81, B44.0-B44.7, B44.89, B44.9, B45.-, B46.-, B48.4, B48.8, B58.2, B58.3, B59	Opportunistic Infections	6	
C77.1-C77.2, C77.4-C77.8, C78.-, C79.00-C79.72, C79.89, C79.9, C7B.-, C80.0, C91.0-, C92.00-C92.02, C92.40-C92.A2, C93.0-, C94.00-C94.22, C94.40-C94.42, C95.0-	Metastatic Cancer and Acute Leukemia	8	9, 10, 11, 12
C15.-, C16.-, C17.-, C22. -, C23, C24.-, C25.-, C33, C34.-, C38.4, C45.-, C48.-, C90.00-C90.22, C92.10-C92.32, C92.Z0-C92.92, C93.10-C93.92, C94.30-C94.32, C94.80-C94.82	Lung and Other Severe Cancers	9	10, 11, 12
C40.-, C41.-, C46.-, C47.-, C49.-, C56.-, C57.00-C57.4, C58, C70.-, C71.-, C72.-, C74.-, C75.1-C75.3, C77.3, C77.9, C79.2, C79.81, C79.82, C81.-, C82.-, C83.-, C84.-, C85.-, C86.-, C88.2-C88.9, C90.3-, C91.-, C95.10-C95.92, C96.-	Lymphoma and Other Cancers	10	11, 12
C01, C02.-, C03.-, C04.-, C05.-, C06.-, C07, C08.-, C09.-, C10.-, C11.-, C12, C13.-, C14.-, C18.-, C19, C20, C21.-, C26.-, C30.-, C31.-, C32.-, C37, C38.0-C38.3, C38.8, C39.-, C51.-, C52, C53.-, C57.7-C57.9, C64.-, C65.-, C66.-, C67.-, C68.-	Colorectal, Bladder, and Other Cancers	11	12
C43.-, C4A.-, C50.-, C54.-, C55, C60.-, C61, C62.-, C63.-, C69.-, C73, C75.0, C75.4-C75.9, C76.-, C7A.-, C80.1, C80.2, D03.-, D18.02, D32.-, D33.-, D35.2-D35.4, D42.-, D43.-, D44.3-D44.7, D49.6, E34.0, Q85.-	Breast, Prostate, and Other Cancers and Tumors	12	
E08.0-, E08.1-, E08.641, E09.0-, E09.1-, E09.641, E10.1-, E10.641, E11.0-, E11.1- , E11.641, E13.0-, E13.1-, E13.641	Diabetes with Acute Complications	17	18, 19
E08.21-E08.638, E08.649-E08.8, E09.21-E09.638, E09.649-E09.8, E10.21-E10.638, E10.649-E10.8, E11.21-E11.638, E11.649-E11.8, E13.21-E13.638, E13.649-E13.8	Diabetes with Chronic Complications	18	19
E08.9, E09.9, E10.9, E11.9, E13.9, Z79.4	Diabetes without Complication	19	
E40, E41, E42, E43, E44.0, E44.1, E45, E46, E64.0, R64	Protein-Calorie Malnutrition	21	
E66.01, E66.2, Z68.41, Z68.42, Z68.43, Z68.44, Z68.45	Morbid Obesity	22	
A39.1, C88.0, D84.1, D89.1, E03.5, E15, E20.0, E20.8, E20.9, E21.-, E22.-, E23.-, E24.-, E25.-, E26.-, E27.-, E31.-, E32.-, E34.4, E70.-, E71.-, E72.-, E74.00-E74.09, E74.20-E74.29, E74.4-E74.9, E75.21, E75.22, E75.240-E75.249, E75.3, E76.-, E77.-, E79.1-E79.9, 80.0-E80.3, E83.110, E85.-, E88.01, E88.4-, E88.89, E89.2, E89.3, E89.6, H49.811-H49.819, N25.1, N25.81	Other Significant Endocrine and Metabolic Disorders	23	
I85.-, K70.41, K71.11, K72.01-K72.91, K76.6, K76.7, K76.81	End-Stage Liver Disease	27	28, 29, 80
K70.30-K70.9, K74.3-K74.69	Cirrhosis of Liver	28	29
B18.-, K73.-, K75.4	Chronic Hepatitis	29	
A54.85, K25.1, K25.2, K25.5, K25.6, K26.1, K26.2, K26.5, K26.6, K27.1, K27.2, K27.5, K27.6, K28.1, K28.2, K28.5, K28.6, K50.012, K50.112, K50.812, K50.912, K51.012, K51.212, K51.312, K51.412, K51.512, K51.812, K51.912, K56.-, K63.1, K65.-, K67, K68.12, K68.19	Intestinal Obstruction/ Perforation	33	
K86.0, K86.1	Chronic Pancreatitis	34	
K50.-, K51.-	Inflammatory Bowel Disease	35	
A01.04, A01.05, A02.23, A02.24, A39.83, A39.84, A50.55, A54.4-, A66.6, A69.23, B06.82, B26.85, B42.82, M00.-, M01.-, M02.1-, M02.8-, M02.9, M46.2-, M46.3-, M72.6, M86.-, M87.-, M89.6-, M90.5-	Bone/Joint/Muscle Infections/Necrosis	39	
L40.5-, M02.3-, M05.-, M06.-, M08.-, M12.0-, M30.-, M31.0-M31.7, M32.-, M33.-, M34.-, M35.00-M35.3, M35.5, M35.8, M35.9, M36.0, M36.8, M45.-, M46.00-M46.1, M46.50-M46.99, M48.8X-, M49.8-	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	40	
D46.-, D46.A, D46.B, D46.C, D46.Z, D47.4, D57.0-, D57.1, D57.2-, D57.4-, D57.8-, D59.-, D60.-, D61.0-, D61.1, D61.2, D61.3, D61.82, D61.9, D66, D67, D75.81	Severe Hematological Disorders	46	48

Section 3: "Free" Coding Tools

- RBRVS - Resource-Based Relative Value System
  - Medicare's Fee Schedule for FFS payments with tons of valuable info!

- NCCI/CCI - National Correct Coding Initiative for Medicare
  - Commonly referred to as "bundling" and/or "claim scrubbers"
  - Same as the one(s) commercial payers use?

- FAQs from various payers
  - e.g., Novitas has great information on E/M exam differences – for example, the "4 x 4 method" that helps with Expanded Problem Focused/Detailed exams.

Overview: Billing & Reporting

Clinical Providers

Be prepared for documentation queries

Impacts provider compensation?

Regular feedback on audit results?

Get CMO buy-in!

Management

Review participation contracts!

Understand revenue vs. quality reporting needs

Develop educational "loop" via audits

Coders/Billers

Highest impact

Insurance changes billing?

Modifiers, surgical package, and "claim scrubbers"

Patient cost sharing

Areas for Research

Participation contract details

Medicaid coverage

NCDs/LCDs

Claim scrubbers

Training/Audits

Surgical package differences

Office visit & procedures

Quality Reporting vi HCC/HEDIS

Split billing of diagnostic tests

GET RESULTS: Get 100% of the money you are entitled to - but no more

Quiz: Which payment method applies?

Medicare?		Non-Medicare?
"Split billing"	• Diagnostic tests when doing both the technical/professional?	"Pure coding"
20% MC avg. and G-code	• Chronic Care Management	Ex. 99490 FFS
Flat fee – originating only	• Q3014 for telehealth	+ distant site
Revise to "regular" E/M	• Consultation codes (99241-99255)	Have to ask!
1450/1500 form if PB	• Hospital outpatient/inpatient services	FFS normal billing
Cost report	• Influenza, HepB, pneumo vaccines	FFS normal billing
Lab fee schedule	• Lab services	Lab fee schedule

Get the CMS RHC Preventive Service Chart

Rural Health Clinic (RHC) Preventive Services Chart

(Rev. 08-10-16)

RHCs are paid an all-inclusive rate (AIR) for qualified primary and preventive health services. Except for the initial preventive physical examination (IPPE), all preventive services furnished on the same day as another medical visit constitute a single billable visit. If an IPPE visit occurs on the same day as another billable visit, two visits may be billed. All of the preventive services listed below may be billed as a stand-alone visit if no other service is furnished on the same day. The beneficiary copayment and deductible is waived by the Affordable Care Act for the IPPE and AWV, and for Medicare-covered preventive services recommended by the United States Preventive Services Task Force with a grade or A or B.

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

Source = https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Preventive-Services.pdf

Who Can Perform IPPE and AWV Services?

- IPPE must be performed by physician or practitioner as defined in section 1861 of SSA
  - 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… (still requires the “face-to-face”)
- IPPE can not be combined with AWV (mutually exclusive)
- Medicare does not provide coverage for ‘routine annual physicals’
- The IPPE is the only ‘physical’ Medicare covers and AWV is not a ‘physical’

EKGs to Medicare may need CPT codes or may require HCPCS II codes!

- Notice the difference between 93000-93010 and G0403-G0405? One is for use when reporting the Welcome to Medicare physical!
- Medicare never wants the technical portion on the RHC/FQHC "covered" encounter/visit; therefore, you would only report 93010 or G0405 when collecting your per diem rate (AIR/PPS) when done at the same time as a valid visit.
  - You would never report 93000/93005 or G0403/G0404 on the AIR/PPS claim.
- Commercial claims will likely allow a more "pure coding" approach – so remember that coding stays the same but billing correctly may require legal flexibility!

Areas for Additional Research & How to Get Results

Action Items

- Determine the global/surgical package approach for your main payers.
- Have providers review the CPT's documentation guidelines for key information about coding.
- Make your encounter forms require linking of diagnoses and/or empower coders/billers to access the full documentation prior to a code going out.

Get Results

- Learn modifiers and use them well with your commercial carriers to generate more revenue.
- Make your superbill/encounter forms dynamic and show providers the entire definition of a code.
- Create routine and effective communications between clinicians and coding/billing staff!

Create a shared foundation of knowledge and a focus on PEOPLE working TOGETHER to get REAL RESULTS

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The End?