Separating Clinical Documentation, Coding, and Billing in Rural Health

What Clinicians & Managers Need to Know About Clinical Documentation, Coding, and Billing

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Before We Get Started…

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- ARHPC is not responsible for providing billing or legal advice. You and your organization are responsible for all code selections and billing as required by applicable payers

- CPT® nomenclature belongs to the AMA.

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THIS IS A FAST-PACED HIGH-LEVEL REVIEW OF KEY TOPIC AREAS.

Additional in-depth training and research is the recommended next step!

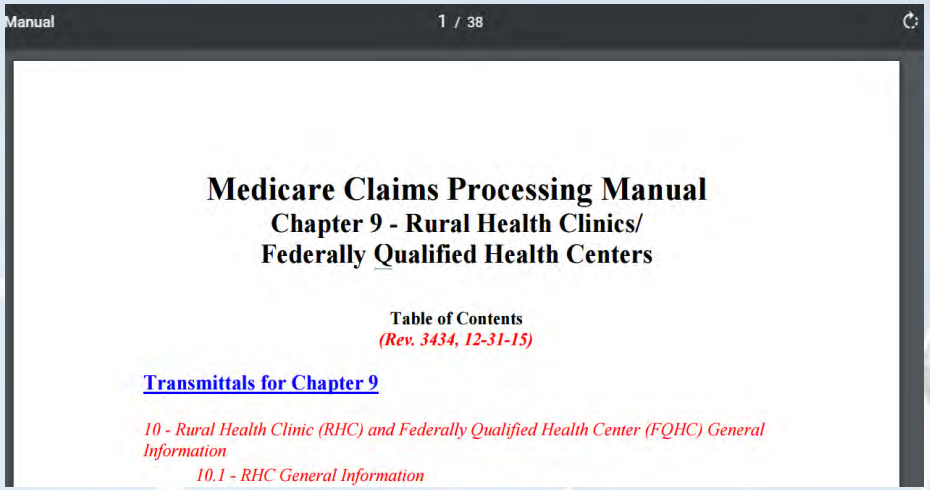
Overview of the Need

- Even though you are paid under the **All Inclusive Rate (AIR) in a Rural Health Center** – your Medicare payments may stay the same because they are typically per diem (i.e. daily flat rates) **BUT…**
  - ✓Your patient coinsurance amounts may go up with the new rules for HCPCS code detail that CMS now requires for RHCs.
  - ✓Commercial insurers and Medicaid often pay for things that Medicare does not.
  - ✓Are we accurately capturing items that will go on the Cost Report which affects my future rates?
  - ✓"Full coding" can help properly budget and can help you develop and maintain production-based (i.e. RVUs) physician compensation models.
  - ✓ Are you being asked to report Quality Measurers yet?

Be sure to carefully research your commercial payer contracts and provider manuals!

1 - Remember that Medicaid is *different from state-to-state* and the rules of coverage are likely even different within each type of Medicaid option available in your state!

2 - Commercial insurance may have completely different core definitions and rarely pay via a per diem (eg. AIR/PPS) rate and *often follow many "regular" Medicare Part B professional service billing rules but not all!*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Medicare Claims Processing Manual
Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers

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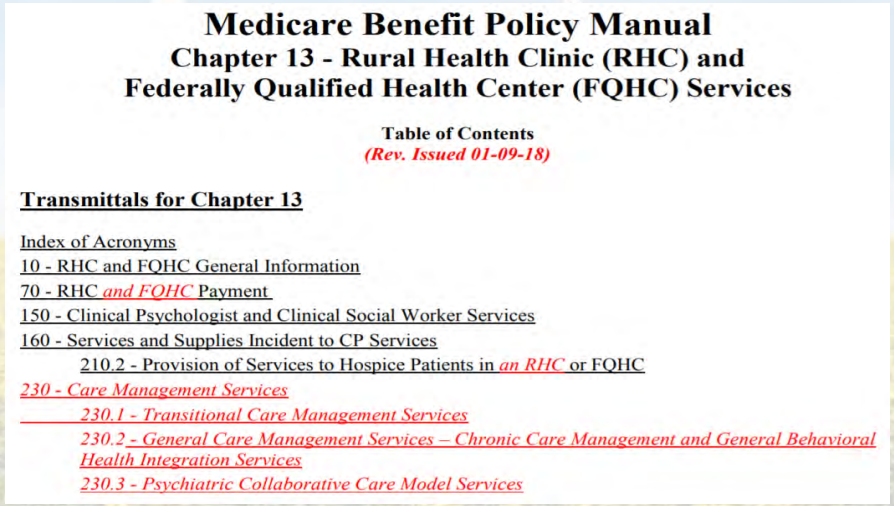
Medicare Benefit Policy Manual
Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

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Ever heard this?
"Just do whatever you have to do to get the bill paid!"

- **Question** – is the clinical documentation fully completed and signed before the patient leaves?
  - How about when their coinsurance is calculated at check-out?
  - Once completed - does somebody perform checks to make sure that the clinical documentation matches exactly what has been coded and then billed?
- **Question** – How much information should the patient receive on what services you provided to them (i.e. CPT/HCPCS-2) and why (ICD-10-CM) and when should they receive it?

Clinicians: Questions/ Concerns/Priorities

"We Provide Care + Document in the EHR"

- Have you received routine & adequate training on how to document the *full scope of the care* you and your team provide?

- What type of training do you prefer? *For example* – Do you prefer *self-paced online training, in-person training*, or a mixed approach?

- What level of trust do you have in your EHR's "auto-code" feature(s)? *When do clinical documentation, coding, and billing rules change* based on the patient's insurance coverage – or do the rules ever change?

Clinicians: Questions/ Concerns/Priorities

"We Provide Care + Document in the EHR"

- Can I assign a code on a patient's claim even though I didn't document it in the medical record, and if so – *how does that affect my clinical liability* and the patient's awareness of the care they receive?
- Have you ever read the "ICD-10-CM Guidelines for Coding & Reporting" or Medicare's Evaluation & Management Documentation Guidelines from 1995/1997?
- Does my EHR give me access to the American Medical Association's documentation rules contained in the CPT? *The quick answer is NO – none of them do*!
- Do my documentation practices impact coordination of care and the patient's understanding of the care they receive?

Management: Questions/ Concerns/Priorities

"We Hire, Manage, and Make Policy Decisions"

- Facility leadership and management professionals are the direct link between *those who provide care* (*MD/DO/PA/NP/etc*) & *those that get help get us paid (coders/billers)*.

- You have management responsibility for making sure that we:
  - **Document** 100% of the care provided in a consistent manner regardless of insurance,
  - **Capture** 100% of what we do (CPT/HCPCS-2) and why (ICD-10-CM),
  - **Receive** 100% of all of the revenue we are entitled to but not more than we are allowed.

- How much do you really understand clinical documentation creation/coding/billing at a level that *allows you to make informed decisions* on financial policies, EHR settings, hiring decisions, denials management, and accounts receivable?

Management: Questions/ Concerns/Priorities

"We Hire, Manage, and Make Policy Decisions"

- How many existing policies are based on *"how we have always done things"* rather than having adapted to the unique nature of RHC and FQHC/Community Health rules.
  - Do you work in a hospital that just bought RHC or Community Health Centers – ***is it a tad different?***

- Do providers and coders/billers have an effective relationship that *balances patient care with the financial needs* of the practice?

- If you previous jobs were not in rural or community health – have you *noticed any significant differences in billing rules* between Medicare, Medicaid, and commercial 3rd party payers?

- Does your coders certification have anything to do with billing or does their certification have anything to do with the reality of a *Rural (RHC) or Community Health (FQHC) facility*?

Coders/Billers: Questions/ Concerns/Priorities

"We Try to Turn Documentation into Compliant Revenue"

- Would having a *rural/FQHC credential* help you have a career in healthcare and not just a job?
- Do other coding certifications include billing for RHC/FQHC or did they include services that will never be done in a RHC or FQHC? Where can I find *RHC and/or FQHC-specific education*?
- Do I have *regular and effective communications with my clinical providers* coupled with informed management buy-in on ways *to increase revenue* or to identify items that may put us at compliance risk?
- Do the providers in my clinic have a firm understanding on the differences between **professional coding principles** and how they may differ from **proper medical billing processes**?

You may not be paid "directly" for everything you do via the AIR or PPS rates

- It is possible that you will change codes from its traditional CPT definition based on payer rules. For example, you may have performed a Consultation (99241-99245) on a Medicare patient – but Medicare hasn't paid consults since around 2010 – so you would have to ***convert it*** to a "regular" office/outpatient service.

- Some items may not get paid as valid RHC or FQHC encounters from Medicare (*e.g. some vaccinations*) – but may be captured via coding and included on your required ***annual Cost Report***. This highly accounting-based process essentially determines the total cost of your services divided by the number of encounters and determines your future AIR/PPS rates.

You may not be paid "directly" for everything you do via the AIR or PPS rates

- If you are seeing a patient in a typical inpatient setting – these services **may** not qualify as RHC and FQHC visits since they were not located in the clinic, so they may need to be reported to Medicare on a traditional part B claim form and we would get the standard FFS rate based on the provider fee schedule.
  - HINT – there are exceptions to these rules. Do you know them?

You may not be paid "directly" for everything you do via the AIR or PPS rates

- You will need to use different claim forms to report the same services to different insurers – the CMS-1450 and the CMS-1500 forms.

- **Split Billing** = Medicare does not consider the AIR nor the PPS to include any payment to you for the *technical component of traditional diagnostic tests (e.g. EKGs and x-rays).*
  - You would be able to include codes for the professional component in addition to the other services you provided in your RHC/FQHC on your claim form (i.e. CMS-1450), but the coding piece representing the technical component would be reported on a traditional part B claim form (i.e. CMS-1500) and we would get the standard FFS rate based on the provider fee schedule.
  - If you are an independent versus a provider-based Rural Health Clinic you would bill under the owning entity's provider number on the appropriate claim form to the Part B MAC.
    - *For more information in this see our discussion on EKGs (93000-93010 and G0403-G0405)*

“Billing” patients the same way vs. “charging” the same

- Medicare sets the foundation for how other payers process and pay claims but they don’t have jurisdiction over commercial claims.
- That said – if you are billing all payers the same way – your are losing revenue that you are entitled to, especially from 3rd party commercial insurance companies (*e.g. BCBS, Humana, Aetna, etc*)!
- Do you have one set fee schedule with set amounts for each service? If so, you are “charging” everybody the same.
  - Unless it is in a Medicaid or commercial insurance contract – you don’t expect to “bill” everybody the same way because all insurance is different.

SUMMARY

Team-based Training is the Best Way to Establish Optimum Workflows

Does each staff member truly understand the priorities and rules around people's jobs OTHER than their own?

Coding and Billing Are Not The Same

- Coding turns medical documentation into useable data regardless of whether it generates $$
  - Vaccines for example may not be separately “billable” if the vaccine is provided by a State program however the code(s) still need to be reported
- Just because you bill it does not mean you’ll be paid
- Just because you get paid doesn't mean you did it right
- Just because you didn’t get paid doesn’t mean you did it wrong
- Just because you got paid doesn’t mean you get to keep the $$
  - This is highly trust-based…have documentation in case you to need to prove it

HCPCS II Codes with Similar Level I Options

* G0008 - Administration of influenza vaccines
* G0009 - Administration of pneumococcal vaccine

G0010 - Administration of hepatitis B vaccine

- Other payers may prefer 90460-90461 or 90471-90474

G0101 – Pelvic and breast exam, "well-woman"

- Remember Q0091 for handling/conveying pap specimen to lab

G0402 – "Welcome to Medicare Physical Exam" - IPPE

G0438 – Initial, annual wellness visit

G0439 - Subsequent, annual wellness visit

- Refer to CPT code 99381-99397 for preventive service codes

* *Per CMS - If this is the only service provided they will not go on a claim but will go on your cost report. If done with another service it goes on the claim and the cost report depending on your POS.*

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Who Needs Documentation, Coding, and Billing Education?

EVERYBODY

✓Certainly different roles need different levels of education.

✓Have you created a *shared foundation of knowledge* *or does everyone get their training from different sources that sometimes say different things*?

Remember that we code for reasons other than to just get paid

- Are patients entitled to a full listing of what was done to them (CPT and HCPCS-2 codes) and why (ICD-10-CM)?
  - This is professional coding!
- Should your facility have a complete understanding of everything that was done in the patient encounter even if it isn't payable by the insurance plan?
- Public health gathers data from what we submit, especially related to tracking and monitoring acute and chronic diseases.
- Likely future payment reforms may raise or lower your payment rates for some carriers based on clinical outcomes.

What Constitutes a RHC Visit?

- To qualify for Medicare payment, all the coverage requirements for a RHC visit must be met.
  - Refer to *42 CFR Part 405 Subpart X, including 42 CFR 405.2463* that describes what constitutes a visit.

§ 405.2463 What constitutes a visit.

(a) *Visit - General.*

(1) For RHCs, a visit is either of the following:

- **(i)** Face-to-face encounter between a RHC patient and one of the following:
  - **(A)** Physician. (*MD, DO, Chiropractor, Podiatry, Dentist, Optometry if in state scope*)
  - **(B)** Physician assistant.
  - **(C)** Nurse practitioner.
  - **(D)** Certified nurse midwife.
  - **(E)** Visiting registered professional or licensed practical nurse.
  - **(G)** Clinical psychologist.
  - **(H)** Clinical social worker.
- **(ii)** Qualified transitional care management service.

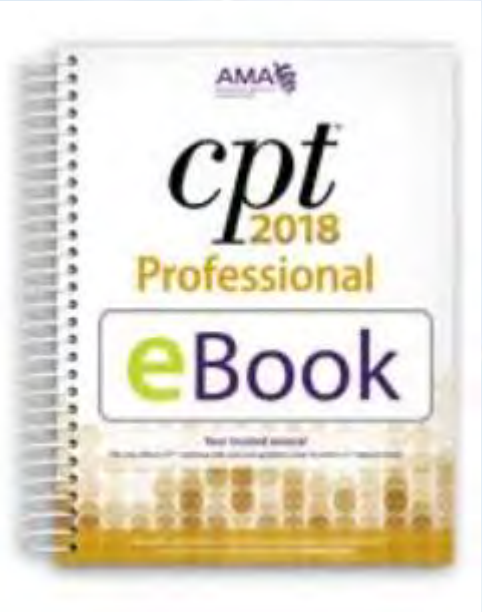
Rural Health

What Are the HIPAA Approved Code Sets?

- CPT ®
  - *What*?
  - Created by AMA (updated annually – except for vaccine product codes)
  - CPT is currently identified by the Centers for Medicare and Medicaid Services (CMS) as **Level I** of the Healthcare Common Procedure Coding System.
  - Updated January 1st each year
- HCPCS II
  - Many temporary codes (e.g. Q0091)
  - Supplies, DME, many specific CMS preventive medicine services
  - Created by CMS as a supplement to Level I CPT codes
  - HCPCS is currently identified by the Centers for Medicare and Medicaid Services (CMS) as **Level II** of the Healthcare Common Procedure Coding System.
- ICD-10-CM
  - *Why*?
  - Overseen by Cooperating Parties (AHA, AMA, CMS, NCHS)
  - Effective 10/1/2015
  - "Leniency" period expired 10/1/2016
  - New codes become effective on October 1 each year

CPT Structure and Design

- Introduction
  - The rules
- Evaluation and Management (99xxx)
  - It all starts here
- Anesthesia (0xxxx)
- Surgery (1xxxx – 6xxxx)
  - Surgical package, modifiers, NCCI, etc.
- Radiology (7xxxx)
  - TC and -26
- Pathology and Laboratory (8xxxx)
- Medicine (9xxxx)
- Category II (xxxxF)- outcomes measures
- Category III (xxxxT)- emerging technology
- Appendix A-O
  - Appendix A = Modifiers! & Appendix B - CHANGES
- Alphabetic Index



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Introduction to CPT Coding

- All CPT® References made relate to 2017 CPT® Professional Edition (AMA)
- Structure, layout and design, place of service designation, table of contents,
- CPT Introduction, symbols and appendices
- Anatomy and Medical Terminology Primer, Category I, II, III CPT codes

Evaluation and Management Services (E&M)

- "THE" Major Chapter of CPT that affects almost every medical facility in America
- Outpatient versus Inpatient, New versus Established, Initial versus Subsequent, Observation, Consultations, Critical Care, Prolonged Services, Preventive Medicine, etc…
- "KEY" components and selecting levels of E&M service

Surgical Package and Modifiers

- Modifiers
- Pre-operative and post-operative periods
- How to "break out" services rendered in the global period
- CPT definitions versus Medicare and various 3rd party payers
- "Separate procedures" and unlisted procedures
- Surgical chapter-specific coding/documentation highlights

CPT Appendices and Locating CPT Codes

Appendix A – Modifiers and full descriptions

Appendix B – Changes (About 700 changes for 2017)

~~**Appendix C – E&M Clinical Examples**~~ – This is NOT the way to learn about E/M!

Appendix D, E, F, G – These all correlate to some symbols in the CPT and may affect payment and/or write-off amounts.

Locating CPT Codes

- Anatomically:
  - Codes range from head to toe and from outside to inside
    - (e.g.., incision comes before excision in each chapter)
- Indexing:
  - The Alphabetic Index
    - Procedure or service (eg. Laparoscopy)
    - Organ or anatomic site (eg. Liver or Humerus)
    - Condition (e.g.., Abscess)
    - Eponym, synonym, abbreviations (e.g.., Morton's Neuroma)

TIP:

- NEVER CODE DIRECTLY FROM THE INDEX; ALWAYS CONSULT THE TABULAR LIST

E/M Determining Levels of Service

Component elements, extent/types of key components, and category and level of E&M service supported by documentation provided to reviewer:

History

- n/a
- Problem
- Expanded
- Detailed
- Comprehensive

HPI
- none (0)
- brief (1-3)
- extended (4/3c)

location, quality, severity, duration, timing, context, mod. factors, assoc. sn/sx, three chronic

ROS
- n/a (0)
- problem (1)
- extended (2-9)
- complete (10/NEG)

all/lm, cv, const, enmt, endo, eye, gi, gu, he/ly, msk, neur, psyc, resp, skin, NEG

PFSH
- n/a (0)
- pertinent (1)
- complete (e2+,n3)

past, family, social

All elements must meet or exceed level requirements

Exam

- n/a
- Problem
- Expanded
- Detailed
- Comprehensive

1995 multi-system	1997 elements	OR	1997 single system
none documented	none documented		none documented
1	1-5		1-5
2-7	6-11		6-11
2-7, w/ 1 detailed	12 or more		12 (except eye/psyc=9)
8 or more	18 / 9 systems		perform/doc. ALL shaded+1 unshaded

Decision Making

- n/a
- Straightforward
- Low
- Moderate
- High

# of problems	Amount of Data	Overall Risk
0-1	0-1	none documented
2	2	minimal
3	3	low
4 or more	4 or more	moderate
		high

At least two elements must meet or exceed level requirements

New Patient OV	99201 (10 min)	99202 (20 min)	99203 (30 min)	99204 (45 min)	99205 (60 min)
History	problem	expanded	detailed	comprehensive	comprehensive
Exam	problem	expanded	detailed	comprehensive	comprehensive
Decision Making	straightforward	straightforward	low	moderate	high

All three key components must meet or exceed level requirements

Estab Patient OV	99211 (5 min)	99212 (10 min)	99213 (15 min)	99214 (25 min)	99215 (40 min)
History	n/a	problem	expanded	detailed	comprehensive
Exam	n/a	problem	expanded	detailed	comprehensive
Decision Making	n/a	straightforward	low	moderate	high

At least two key components must meet or exceed level requirements

Outpatient Consult	99241 (15 min)	99242 (30 min)	99243 (40 min)	99244 (50 min)	99245 (80 min)
History	problem	expanded	detailed	comprehensive	comprehensive
Exam	problem	expanded	detailed	comprehensive	comprehensive
Decision Making	straightforward	straightforward	low	moderate	high

All three key components must meet or exceed level requirements

Go get a copy of 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

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

Medicare-specific Preventive Medicine Services to consider before using the CPT codes

Examples of notes like this are vital to understanding any differences with Rural/FQHCs – be on the look-out and continue to find the areas they lead you to!

There are Initial Preventive Physical Examination (IPPE) instructions that are unique to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). Refer to chapter 9, section *70.6* of this manual for a description of these instructions.

Initial Preventive Physical Examination

Ch. 9 § 150 Ch. 18 § 80

- **Rural Health Clinic (RHC)**
- CPT/HCPCS II Code(s):
  - **G0402-** Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first **12** months of Medicare enrollment
- Common ICD-10-CM Code(s):
  - Z00.00- Encounter for general adult medical examination without abnormal findings
  - Z00.01- Encounter for general adult medical examination with abnormal findings
- Frequency:
  - 1 per lifetime
  - Within 12 months of Medicare B

Annual Wellness Visits (AWV)
Ch. 18 § 140

- **Rural Health Clinic (RHC)**
- CPT/HCPCS II Code(s):
  - **G0438**- Initial AWV
  - **G0439**- Subsequent AWV
- ICD-10-CM Code(s): (similar to IPPE)
- Frequency:
  - Annually
- Documentation:
  - "Personalized prevention plan visit" (PPPS)
  - 71X TOB

140 - Annual Wellness Visit (AWV)

(Rev. 2159, Issued: 02-15-11, Effective: 01-01-11, Implementation: 04-04-11)

Pursuant to section 4103 of the Affordable Care Act of 2010, the Centers for Medicare & Medicaid Services (CMS) amended section 411.15(a)(1) and 411.15(k)(15) of 42 CFR (list of examples of routine physical examinations excluded from coverage) effective for services furnished on or after January 1, 2011. This expanded coverage is subject to certain eligibility and other limitations that allow payment for an annual wellness visit (AWV), including personalized prevention plan services (PPPS), for an individual who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period, and has not received either an initial preventive physical examination (IPPE) or an AWV within the past 12 months.

The AWV will include the establishment of, or update to, the individual's medical/family history, measurement of his/her height, weight, body-mass index (BMI) or waist circumference, and blood pressure (BP), with the goal of health promotion and disease detection and encouraging patients to obtain the screening and preventive services that may already be covered and paid for under Medicare Part B. CMS amended 42 CFR §§411.15(a)(1) and 411.15(k)(15) to allow payment on or after January 1, 2011, for an AWV (as established at 42 CFR 410.15) when performed by qualified health professionals.

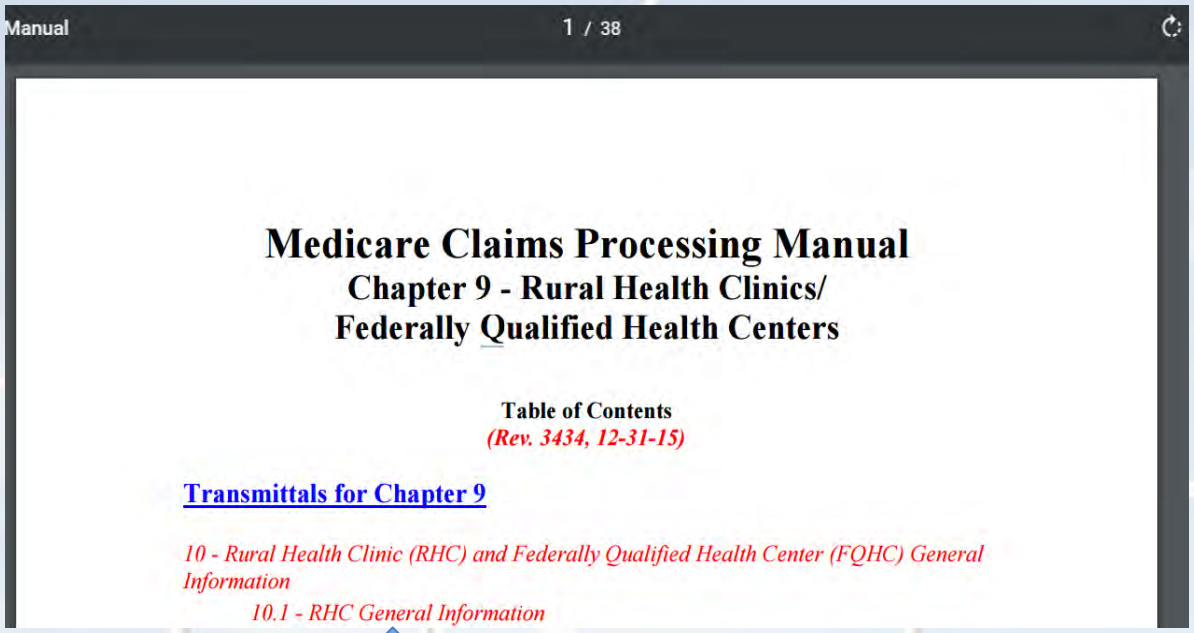
What I Learned from the ICD-10 Implementation

- Coding is a process that requires high-level critical analysis skills
- Team-based Training works the best – especially considering workflow changes brought by EHRs
- Many believe that there is an IT solution to documentation>coding>billing – it is simply not true
- I had the chance to see several EHR systems, encoders, and other applications that NEVER gave the same detailed information as an actual ICD-10-CM manual
- The *Official Guidelines for Coding and Reporting* provided the best educational moments. These are NOT found in your software!
- There is no way to memorize your most relevant ICD-10 codes, nor will the traditional concept of a superbill/encounter form capture the variety of diagnoses we see.

What Did Not Change With ICD-10-CM

- Code reason for visit first
- Code to the highest level of known specificity
- Don't code "probable, suspected, questionable or rule out"
- Code chronic diseases as often and as long as the patient receives treatment for them
- Code coexisting conditions affecting patient care at the time of the visit

Once you know documentation and coding, then move to reporting your services to Medicare using these key documents as the main source.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10.1 - RHC General Information

38 pages of CMS regulations

This document has a NEW EFFECTIVE DATE of 1-22-18

Make sure you have the most up-to-date version and are aware of all of the changes!

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

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Transmittals for Chapter 13

Sample Action Items for Managers & Clinicians

- Gather physical copies of this current year's coding manuals along with a printed copy of your "superbill" or "encounter form".
- Determine the level of education that each provider has had on clinical documentation requirements and ask them which areas they could use help with.
- Print a copy of your Production Report that shows the CPT/HCPCS-2, ICD-10-CM codes that you have reported most often. Note whether or not this list is what was coded internally or is it what was billed out or both. If possible, separate it by provider and/or by location.

Sample Action Items for Managers & Clinicians

- Define the percentage of each payer type for the last 3 years (e.g. Medicare, Medicaid, commercial, etc.).
- Gather all relevant written policies that impact the clinical documentation, coding, and billing areas and be ready to compare to “Best Practices”.
- Review agreements with your EHR vendor and/or billing company to identify when and how often they provide training to providers and identify the process to make updates to screen designs and/or the “superbill”.
- With the permission and assistance of facility management, locate any sections of your participation contracts with commercial insurance dealing with documentation, coding, and billing. *Place a particular emphasis on Medicaid/Medicaid Managed Care provider manuals that lay out their specific guidance in these areas.*

Sample Action Items for Managers & Clinicians

- Read the Introduction section to your AMA CPT manual. Highlight 3-5 items that you think your clinical providers would be interested in or that you already knew but hadn't ever seen it in writing!

- Review the Table of Content for your desired HCPCS-2 manual highlighting where modifiers are located, flip through the G-code and J-code sections and see if you have a G-code Crosswalk.

- Download the 2 main CMS billing documents for RHC/FQHC–
  - Chapter 9 from the Medicare Claims Manual at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf
  - Chapter 13 from the Medicare Benefits Manual at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf

Sample Action Items for Managers & Clinicians

- Print the ARHPC Evaluation & Management (E/M) Audit Tool and compare its layout of the key components required for each level of office/outpatient visit. Are "3 of 3" key components required or just "2 of 3"?

- Print/download the "CMS Evaluation & Management Services". Be sure to check the CMS website to see if they have been updated. ***HEADS-UP – this is a large document!*** Review the CMS guidelines and notice where they expand upon the CPT definitions of history, exams, and medical decision making.

- Locate any 1997/1998 Single System Specialty examination template your specialty providers may need (*e.g. Behavioral Health physicians need to locate the CMS Psychiatric exam*).

- Identify what the settings are on any "E/M Code Wizards" that may give your providers a recommended E/M code.

Sample Action Items for Managers & Clinicians

- Download/Print and review the Medicare Rural or Community Health Preventive Service Chart (*these are 2 different documents*)
  - RHC Preventive Service Chart - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Preventive-Services.pdf
  - FQHC Preventive Service Chart - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-Preventive-Services.pdf

- Download/Print and review the outline and organization of the "Medicare Claims Processing Manual – Chapter 18 – Preventive and Screening Services" at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf
  - This is a very long document written primarily from the perspective of the FFS traditional doctor's office. Guidance for RHC and FQHC is scattered throughout and is not often easy to locate – so use caution. BUT it is chock full of great information regarding documentation rules, "covered" diagnoses, frequency limitations, and more.

Benefits of this Session

- In order to have a full grasp on documentation requirements, all staff should have knowledge of which rules apply, where they are written, how often they could be updated, and why different carriers may have different interpretations.
- Managers can have more detailed knowledge of what everybody is doing in order to make better key hiring decisions, IT purchases, policy creation and updates, and reach their facility's mission and financial goals.

Summary

- In order to have a full grasp on documentation requirements, all staff should have knowledge of which rules apply, where they are written, how often they could be updated, and why different carriers may have different interpretations.
- Managers can have more detailed knowledge of what everybody is doing in order to make better key hiring decisions, IT purchases, policy creation and updates, and reach their facility's mission and financial goals.
- A ***TEAM*** working together from a shared foundation of knowledge will have a better chance of meeting their goals.

Separating Clinical Documentation, Coding, and Billing in Rural Health

What Clinicians & Managers Need to Know About Clinical Documentation, Coding, and Billing

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