



# Arch Pro Coding's



## Educating Providers and Managers on Revenue & Documentation for RHCs

September 23, 2020



Association for Rural & Community Health Professional Coding  
Metro-Atlanta, GA

EDUCATION :: CERTIFICATION :: AUDIT SUPPORT ::  
EARN CME/CEU

In conjunction with:





*Speaker*

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# Arch Pro Coding

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## WHO WE HELP



**RURAL HEALTH CLINIC**



**Community Health Center/  
FQHC**



**Critical Access Hospitals (CAH)  
and Small Rural Hospitals**

### Rural Health Clinics (RHC)

Independent vs. Provider-based changes a lot of CMS billing rules.

### Federally Qualified Health Centers (FQHC)

Can be in either a rural OR urban Health Professional Shortage Area (HPSA).

We now offer a separate live or online self-study option for those in small rural PPS or CAH facilities – get certified!

**Get certified as Rural, Community, CAH – Coding & Billing Specialist (RH-CBS/CH-CBS/CAH-CBS)**



# Arch Pro Coding's

## TARGET AUDIENCE



### Clinical Providers

Do you document 100% of what is done (CPT/HCPCS-II) and why (ICD-10-CM) according to the official guidelines?



### Facility Leadership

Do you ensure that your facility codes/captures 100% of the services you perform for your cost report and patients?



### Coding/Billing/Quality

Do you get paid 100% of what you should (*and no more than allowed*) and understand differing payer rules?

# Welcome Managers & Clinical Providers

You have primary responsibility  
(*among many others*) to document,  
track, report, and get paid correctly  
for the valuable services you provide.

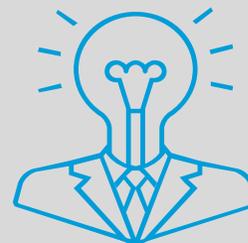
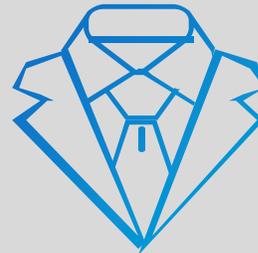
Are you:

... responsible for the financial health of your facility that are based on rules you need more knowledge about? Is your cost report accurate?

... an employed provider who just wants to know the rules so you can place your focus on clinical care?

... signing participation contracts with insurance companies with little understanding of their impact on your mission and financial goals?

... dealing daily with EHR/IT systems that were supposed to make life easier but have proven to make things more challenging?





# Are you “new” to RHCs? How are we different?

Is there one centralized place where all of these resources can be found?



Different Claim Forms  
are Used



“Split Billing” for  
Diagnostic tests



Coinsurance not 20% of  
“Allowed”



Fixed Encounter Rates  
not just FFS



Deductible may not  
Apply



More Flexibility with  
Non-Physicians



Provider-based vs.  
Independent



Cost Reports

# What path do we all share?

This Arch Pro Coding Bootcamp will give you chances to practice and research common issues that you may run into each day!

## GREET:

Staff/nurses gather start the process

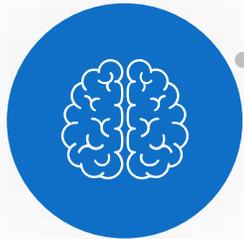
- Are we an “office” or a RHC/FQHC for this visit?
- “Sick” or preventive visit (*or both*)?
- Inform patient of coinsurance responsibility?



## CODE:

Work together to code each encounter fully

- Superbill vs. Patient Receipts vs. EOBs?
- Cost reporting needs met?
- Provider or managers responsibility for full encounter coding?



## PREPARE:

Are you truly ready?

- Know your code manuals?
- Is the superbill updated?
- Have you researched past issues fully?
- Have we established a shared foundation of knowledge?



## TREAT:

Primary provider documents + “superbill”

- Is the note timely, complete, and accurate?
- Were procedures performed?
- Linking diagnoses to services?
- Access to CPT/ICD-10-CM guidelines?



## BILL & REPORT QUALITY:

Getting paid everything you deserve

- Using varying billing rules to adjust bill type and applying modifiers?
- Understand different bundling & global billing rules?
- Appealing denied claims?

# Where are you?



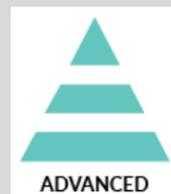
## Documentation

What information must be present in the medical record?



## Coding

What CPT/HCPCS-II/ICD-10-CM codes are available? Where are the documentation rules? *Will our cost report be accurate?*



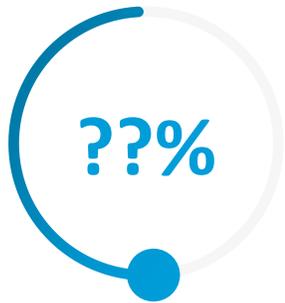
## Billing

How do different insurers want the bill formatted? Which claim form to use? How to calculate patient coinsurance?

- **Beginner** = the minimum amount of knowledge needed; basic data entry from the superbill; likely not formatting bills; no contact with carriers for appeals and questions.
- **Intermediate** = info necessary to effectively manage people or processes; involved in the annual cost report; facilitate conversations between providers and coders/billers; understands how participation contracts affect clinical operations (*i.e. quality reporting*) and revenue goals.
- **Advanced** = familiar with the ICD-10's *Official Guidelines for Coding & Reporting* and can look at medical documentation, LCDs/NCDs, and CMS regs and fully code each encounter; can correctly format a bill based on varying CMS, Medicaid, and Managed Care rules using both the CMS 1450 and CMS1500 forms; can determine patient coinsurance and different definitions of the global surgical package.

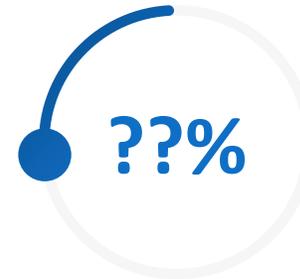
# How Well Do You?

Analyze your operations, identify which EHR/IT systems are involved, engage your vendors, and don't be afraid to change!



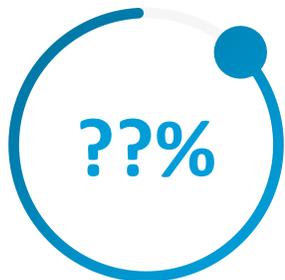
## Patient arrives for visit – are we truly ready?

Managers have a focus here to make sure you are prepared, educated, fully staffed, and have the reference materials you need. Front desk staff have a key role in coding & billing and insurance verification.



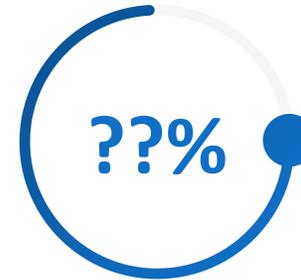
## Work together to code all encounters fully?

A lot clearly depends on when the documentation is completed compared to the visit. Does the patient ever get a complete listing of the “what was done and why”?



## Providers document according to guidelines?

EHRs can help but confusing screen designs and pop-up warnings can distract providers from focusing on reporting “quality” care and meeting revenue needs.



## Getting paid what you deserve and no more?

There is a big difference between how Medicare, Medicaid, and commercial carriers (i.e. Managed Care) pay claims. The bills will look different! Are you leaving revenue on the table available for care management?

# Before we begin - Are you fully prepared and enabled to get the job done?



Does each facility/nurses station have each of the CURRENT federally-mandated HIPAA Code Sets used by RHCs and FQHCs or are you too dependent on software?

Do you have access to and understand the contents of key Medicare Updates, Policy & Benefits Manuals such as chapters 9, 12, 13, and 18?

Do you have full awareness of how each of your participation contracts (ex. Medicaid and Managed Care) requires you to report quality, bill for services, in order to legally maximize revenue?

# KEY ONLINE RESOURCES YOU MUST KNOW



[Ch. 9 – CMS Claims Manual](#)



[Ch. 18 – CMS Claims Manual](#)



[Ch. 13 – CMS Benefits Manual](#)



2021 CMS' Evaluation  
& Management Rules  
– TBD!





# Compare/Contrast 2020 vs. 2021 KEY COMPONENTS of an E/M Service

Grab your physical AMA CPT manual and turn to the introductory pages that precede the full code section.  
Have you EHR vendors provided initial guidance on expected changes yet? What about their “Code Wizards?”

HISTORY

01



EXAM

02



MEDICAL DECISION  
MAKING



Nature of Presenting  
Problem

Counseling

Coordination of Care

TIME

Which 3 of these are  
KEY to getting paid  
correctly?



# What's Coming In 2021 in Terms of MDM?

## **“Number of Diagnoses and Management Options”**

- Will be revised to read “Number and Complexity of Problems Addressed”

## **“Amount and/or Complexity of Data to be Reviewed”**

- Will be revised to read “Amount and/or Complexity of Data to be Reviewed and Analyzed”

## **“Overall Risk of Complications and/or Morbidity or Mortality”**

- Will be revised to read “Risk of Complications and/or Morbidity or Mortality of Patient Management



# Key Areas of Possible Revenue Growth

## LEARN MORE TO EARN MORE



Are you actively investigating becoming your Medicare/Medicaid patient's Care Manager in order to realize revenue for your clinical work in between visits? What about Virtual Communication Services (VCS)? *What about the expanded CMS distant site telehealth list that goes until near the end of October and EXPANDS the services you can get paid for!*



Do your facility managers and clinical leaders have enough information needed to research CMS and managed care updates in order to adjust/ workflows that will meet state/federal scrutiny?



Understand the impact on billing on global/surgical package differences and modifier usage.



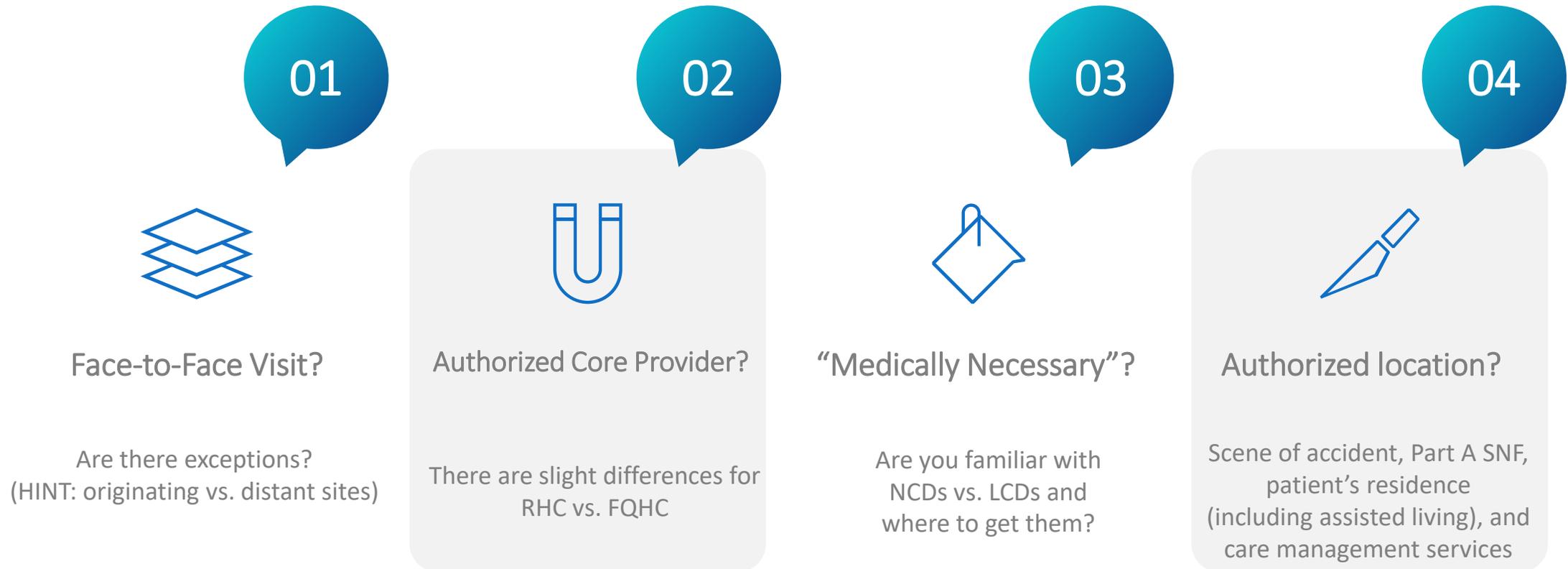
Research revenue opportunities for CPT Category II codes with non-Medicare managed care plans  
*Ex. – A major Southeastern Medicaid carrier pays for A1C levels 4 times a year at \$10 per report (see 3044F-3046F) and a flat fee (~\$20) to the patient to get preventive medicine!*

Help patient maximize their insurance benefits by understanding coverage guidelines for CPT codes + HCPCS-II codes and how Medicare differs from Medicaid and others.

# CMS VALID ENCOUNTERS :: An Overview

Rather than refer to the AIR and PPS Medicare payment systems using the traditional “per diem” or “daily rate” – let’s call them “encounters.”

After all, there are quite a few situations where even Medicare will pay more than on AIR/PPS rate on the same day on the same patient!



*“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 of more RHC or FQHC services are rendered.” – CMS Benefits Manual, Chapter 13, Section 40*

# COMPARE :: CMS 1500 (aka the "HCFA")

Primarily used by RHC/FQHC who are reporting claims to commercial and non-Medicare carriers expecting to receive a Fee-for-Service payment for non-RHC/FQHC services such as the technical component of diagnostic tests.

The image shows the CMS 1500 Health Insurance Claim Form. It is a complex form with multiple sections. A large watermark 'ARCH PRO CODING' is visible across the center. Three yellow stars are placed on the form: one in section 15 (ICD-9-CM diagnosis code), one in section 21 (ICD-9-CM procedure code), and one in section 23 (CPT code). A red star is placed in section 24 (HCPCS code). A vertical oval labeled 'LINKED' is drawn around sections 23 and 24. The form is divided into three main vertical sections: 'PATIENT AND INSURED INFORMATION' (top), 'PHYSICIAN OR SUPPLIER INFORMATION' (middle), and 'DIAGNOSIS, POA, PROCEDURE, AND PROVIDER INFORMATION' (bottom).



# CONTRAST :: CMS 1450 (aka the "UB")

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

The image shows the CMS 1450 UB Form. It is a complex form with multiple sections. A large watermark 'ARCH PRO CODING' is visible across the center. A blue oval highlights the 'HCPCS CODES' section (Level I CPT, Level II Medicare National, National Drug Code (NDC)). Another blue oval highlights the 'REVENUE CODES AND DESCRIPTIONS' section. A vertical oval labeled 'NOT LINKED' is drawn on the right side of the form. The form is divided into four main horizontal sections: 'SECTION I (FL 1-FL 41)', 'SECTION II (FL 42-FL 49)', 'SECTION III (FL 50-FL 65)', and 'SECTION IV FL (66-81)'. The form is primarily green and white.

CPT & HCPCS-II  
And ICD-10-CM

NOT  
LINKED

# SUPERBILL: Revenue or Compliance?



It is likely that you have recently moved from a paper superbill (i.e. encounter form) to an electronic version. Was it just a scan of the old paper form that has codes that have changed? Do our providers lean too heavily on favorites lists?

**PATIENTS:** Does it serve as the patient's receipt? Do they get something that has everything that was done (CPT/HCPCS-II) and why (ICD-10-CM) or trying to understand their EOB from their insurer?

**PROVIDERS:** Are your providers "coding" on the superbill or "billing"?

**CFOs & MANAGERS:** How possible is it that your facility is not capturing everything from a "coding" perspective and are under-reporting your TRUE COSTS (CPT/HCPCS-II) and the actual complexity of your patient population (ICD-10-CM). Are you maximizing opportunities to get revenue from quality reporting & care management services?

**CODING/BILLING/QUALITY:** Is the clinical note closed and signed before codes are entered into your billing systems? Does anyone review the completed note before the bill is created? Are you confident that providers are aware of the full code definition of CPT/HCPCS-II, or ICD-10-CM codes or that their superbill may not give them the info they need?



Questions

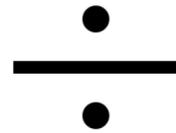
# COST REPORT: Revenue or Compliance?



Facility management is responsible each year to complete and submit an Annual Cost Report if they run a RHC/FQHC. This affects future reimbursement and helps you “get paid” at the end of the year for vaccines, incident-to visits, and more!

 Very rough definition!

(TOTAL ALLOWABLE COSTS TO PROVIDE RHC/FQHC SERVICES)



= **Your “Cost”**

(NUMBER OF VISITS MEETING REGS)



**CODING vs. BILLING!**

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

After all – you need to “capture” the service on your [superbill for ALL ENCOUNTERS](#), enter it into your system if you validate it is correctly documented in the chart, but each code(s) MAY NOT ever go out on a claim form considering that payers have varying billing rules!



# MEDICARE doesn't just pay via AIR or PPS!

o o o

Lab services are paid on the lab fee schedule.

Hospital services are paid via FFS (via "RBRVS").

Chronic Care Management is paid at 80/20% of the nat'l MC average for all Medicare providers for most CPT CCM codes.

Originating site (Q3014) versus distant site telehealth (G2025) is paid via a flat fee (originating site ~\$ 30-33 vs. distant ~\$93).

Some vaccines get "paid" via your annual cost report (e.g. influenza, HepB, pneumo) and/or via periodic "roster billing".