

Vital Conversations with the Patient BEFORE they see your Core Provider

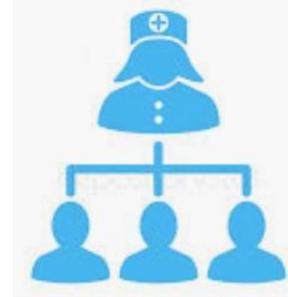
ALL VISITS :: Is the reason you made your appointment for the same reason you are here today?

SCHEDULED PREVENTIVE VISIT :: Is there anything else that you need to see the provider for today?

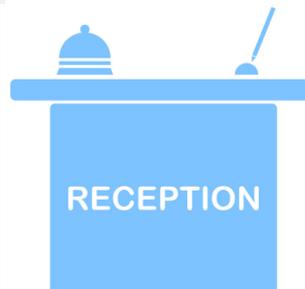
SCHEDULED ACUTE "SICK" VISIT :: Are you aware of the preventive medicine options that your insurance company/we offer?

SCHEDULED CHRONIC CARE VISIT :: Are we currently your Care Plan Manager? Have you had any recent hospitalizations?

When can we report and GET PAID for performing BOTH a sick & a well visit? What about vaccines and labs?



Scheduling and exam room management is tough, especially when we often don't really know what patients are there for.



Oh....**BY THE WAY**.....
I forgot tell the nice folks up front – I also need you to *(fill-in-the-blank)* by the end of tomorrow or else.... and did I mention that my *(fill-in-the blank)* has been hurting a lot lately? I hadn't mentioned it to anybody until I saw you...we do it today while I'm here?





Sample RHC “sometimes covered” Preventive Services

Check these first before considering the CPT codes 99381-99397!



Initial Preventive
Physical Exam (IPPE) and
Screening EKG

G0402-G0405



Annual Wellness Visits
(initial and subseq.)

G0438-G0439



Screening Pelvic/Breast
& Screening Pap
Handling

G0101/Q0091



Smoking/Tobacco
Cessation Counseling

99406-99407



Prostate Cancer
Screening

G0102



Glaucoma Screening

G0117-G0118



Alcohol and/or
Depression Screening or
Counseling

G0442-G0444



Screening for STD/High
Intensity Behavioral
Counseling

G0445-G0447

CMS' RHC Preventive Service Chart

| 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' IPPE Fact Sheet



INITIAL PREVENTIVE PHYSICAL EXAMINATION



Target Audience:
Medicare Fee-For-Service Providers

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.



| Medicare Coverage of Physical Exams—Know the Differences | | |
|--|--|--|
| <p>Initial Preventive Physical Examination (IPPE)</p> <p>Review of medical and social health history, and preventive services education</p> <ul style="list-style-type: none"> ✓ Covered only once, within 12 months of Part B enrollment ✓ Patient pays nothing (if provider accepts assignment) | <p>Annual Wellness Visit (AWV)</p> <p>Visit to develop or update a personalized prevention plan, and perform a health risk assessment</p> <ul style="list-style-type: none"> ✓ Covered once every 12 months ✓ Patient pays nothing (if provider accepts assignment) | <p>Routine Physical Examination (See Section 90)</p> <p>Exam performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury</p> <ul style="list-style-type: none"> ✗ Not covered by Medicare; prohibited by statute ✗ Patient pays 100% out-of-pocket |

CMS' AWW Fact Sheet



ANNUAL WELLNESS VISIT



Target Audience:
Medicare Fee-For-Service Providers

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Compare/Contrast AMA vs. CMS Global Packages

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

Review the CPT definition of the Surgical Package that is on the green pages just before the first CPT surgical codes and after the anesthesia Section. Later in the Advanced BILLING & QUALITY REPORTING section we will dive deeper into how to apply this information to generate revenue

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

Key revenue opportunity :: Which definition of the global package do your commercial carriers follow?



Do global billing rules apply to RHC/FQHC for Medicare?

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

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

40.4 - Global Billing

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

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

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





CMS Surgical Package Definition – use for FFS 3rd party carriers NOT Medicare!

Pre-operative

\$

Minor – E/M day of surgery included

Major – E/M day of and day before surgery

Intra-operative

\$



Post-operative

\$

Minor adds either 0 or 10 days of follow-up

Major adds 90 days of follow-up

BE CAREFUL!!!

+1 day pre-op

+1 day of surgery

= 92 **TOTAL** global days

NOTE: Many RHC providers perform “major” surgeries that are billed Fee-for-Service – ex. OB. If you are provider-based coordinate carefully with the facility where the procedure is performed.



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

Pre-operative

**Minor Procedure
+ E/M with -25**

**Major Procedure
+ E/M with -57**

Day of the procedure

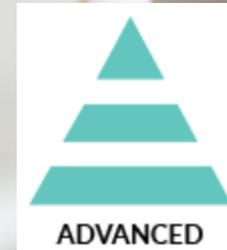
**“Please pay this though you normally don’t” =
-32, -59, -76/-77**

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

Post-operative

E/M modifier -24

**Procedures modifiers -
58, -78, -79**





EKGs to Medicare may need CPT codes on one form and HCPCS-II codes on another form

Notice the difference between 93000-93010 and G0403-G0405? Which 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 requires flexibility!

Are your providers able to see their “Base Code” Notes – or are they simply doing a key word search?



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



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.

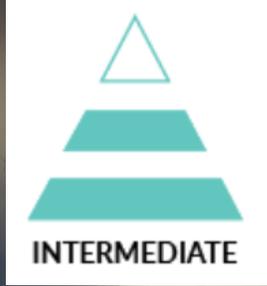
M80.0 Age-related osteoporosis with current pathological fracture

Involitional 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





QUALITY & CARE MANAGEMENT: What do we need?

| Quality/Care Management Category | Use CPT | Use HCPCS-II | Use ICD-10-CM | Impact on FQHC/RHC Revenue |
|--|---------|--------------|---------------|----------------------------|
| Care Management Services | ✓ | ✓ | | HIGH |
| CPT Category II Performance Measures | ✓ | | | MEDIUM |
| Preventive Medicine Services | ✓ | ✓ | ✓ | HIGH |
| Hierarchical Conditions Categories (HCC) | | | ✓ | LOW |
| HEDIS measures | ✓ | ✓ | ✓ | LOW |
| Population Health Prevention via Social Determinants of Care | | | ✓ | n/a |
| Primary Care & Behavioral Health Integration (ex. SUD/ODU/MAT) | ✓ | ✓ | ✓ | HIGH |

ACTION ITEMS



GET RESULTS

Determine level of training needed by job role and train together!

Review participation contracts with key carriers and seek out specific answers to specific questions.

Compare the information found in your IT shortcuts to the actual CPT/ICD-10-CM Guidelines

Confirm if you are capturing line-by-line CPT/HCPCS-II codes whether “billable” or not and work closely with your cost report staff.

Use internal audit results to train staff with a focus on compliance and profitability.

Identify educational opportunities from your state/national professional associations.

Seek out training that deals with your daily reality – not just general coding & billing training.

Educate all staff on the differences between documentation>coding>billing and ensure that all providers are “coding” on encounter forms rather than “billing.”

ACTION ITEMS



Confirm that all encounters are fully ‘coded’ before applying billing rules in order to accurately capture your “costs.”

Research Care Management (G0511/G0512) and Virtual Communication Services (VCS) options for additional revenue

Identify if you are part of the National Health Service Corp, providing SUD/ODU/MAT for substance use disorders so your providers are eligible for as many repayment options as possible.

Set regular informal/formal meetings between clinical providers and coding/billing staff.

GET RESULTS

Perform periodic audits of key areas discussed in this class with a focus on compliance and profitability.

Educate providers using their actual encounters and provide them with the source documents to gain knowledge that can be strategically applied.

Identify what services Medicaid may pay for that “regular Medicare” may not.

Educate all staff on the differences between documentation>coding>billing and ensure that all providers are “coding” on encounter forms rather than “billing.”



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How do you determine training success?

Did you find areas where you will need to discuss certain items with others who you work with?

Do you think your providers would benefit from this knowledge? How will you get it to them?

Did you identify questions and issues for discussion with your EHR/IT vendors to make sure their system does what you need?

Are your existing policies and procedures detailed enough to allow your provider full clinical flexibility over what they do while maintaining compliance with state/federal coding and billing guidelines?



NATIONAL RURAL HEALTH ASSOCIATION



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

Gary Lucas, MSHI
Arch Pro Coding :: VP Education

Gary@ArchProCoding.com