

Arch Pro Coding's

Quality Reporting for Rural Health Clinics

September 2020

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

EDUCATION :: CERTIFICATION :: AUDIT SUPPORT ::
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In conjunction with:





Speaker

Gary Lucas, MSHI

Vice President - Education

University of Georgia – Bachelor of Business, Marketing (1994)

University of Illinois-Chicago – Master of Science, Health Informatics (2014)

Metro-Atlanta, GA

Gary@ArchProCoding.com

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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?



Arch Pro Coding



WHO WE HELP



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).

Critical Access Hospitals (CAH) and Small Rural Hospitals

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 or Community Health – Coding & Billing Specialist (RH-CBS/CH-CBS) or CAH-CBS



What path do we all share?

This course will give you chances to see who is involved in the process of reporting quality & care management.

GREET:

Staff/nurses gather start the process

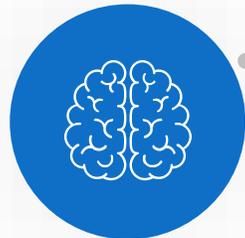
- Are we an "office" or a RHC for this visit?
- "Sick" or preventive visit (or both)?
- Inform patient of coinsurance responsibility?



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?

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.

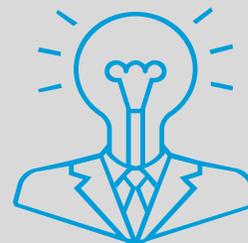
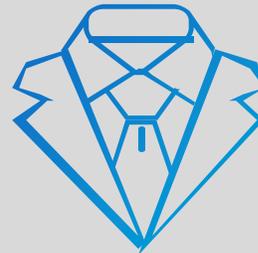
Are you:

... 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?



Welcome Coders/Billers/ Quality Staff

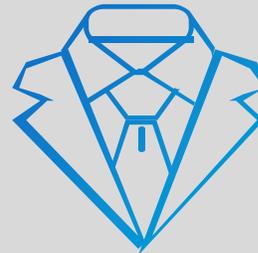
You have primary responsibility to ensure that PRIOR to submitting a bill or quality measure that you have a fully *completed and timely* medical record of each clinical encounter that:

... documents the full scope of diagnostic and therapeutic services provided and the supplies used?

... helps us give the patient a “receipt” of everything that was done (*i.e. CPT/HCPCS-II codes*) and why (*i.e. ICD-10-CM codes*)?

... helps nurses and quality staff capture and report “quality” at the time of visits – but nobody ever explained proper coding guidelines to your nursing staff?

... ensures that we aren’t leaving money on the table in the new world of Value-Based Care?



Which payers does “quality” apply to in a RHC?

December 27, 2017

NOTE TO: Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties

SUBJECT: Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for the Medicare Advantage (MA) CMS-HCC Risk Adjustment Model

Medicare Advantage has been successful in providing Medicare beneficiaries with options so that they can choose the healthcare that best fits their individual health needs. The Medicare Advantage program demonstrates the value of private sector innovation and creativity and CMS is committed to continuing to strengthen Medicare Advantage by promoting greater innovation, transparency, flexibility, and program simplification.

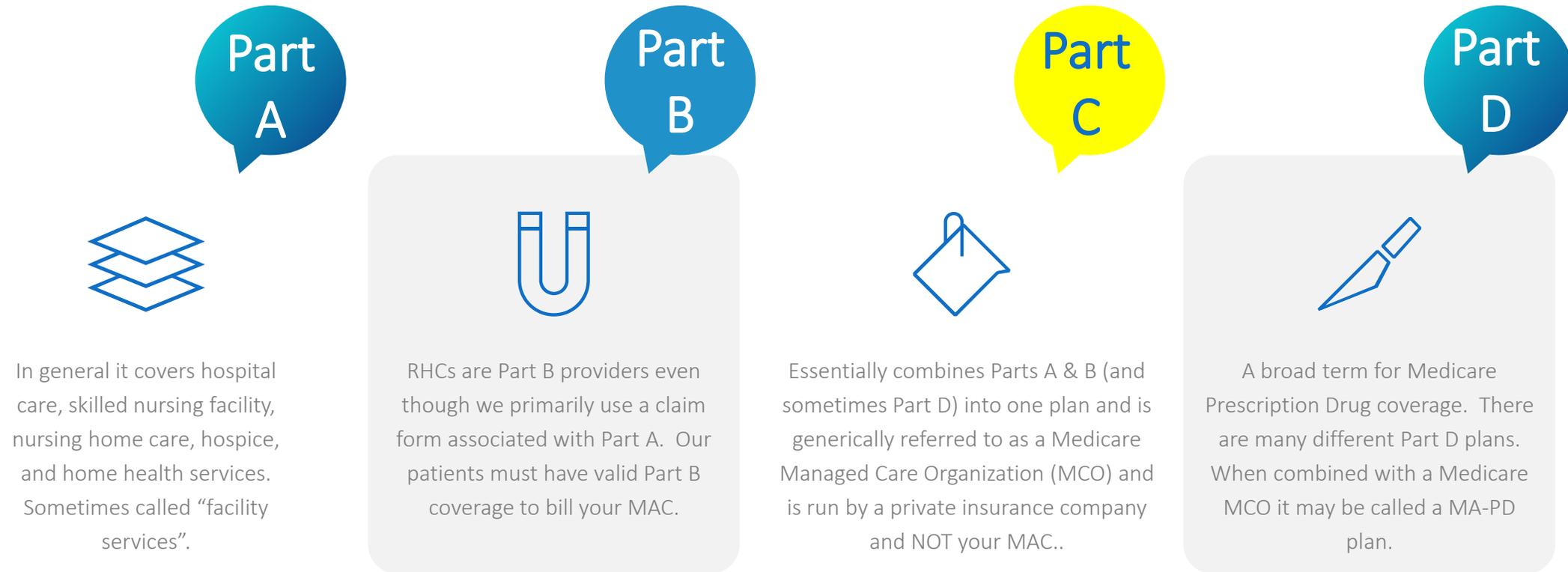
A key element in the success of Medicare Advantage is ensuring that payments to plans reflect the relative risk of the people who enroll. A critical tool that CMS uses to accomplish that goal is the use of risk adjustment models which adjust payments based on the characteristics and health conditions of each plan’s enrollees.

SOURCE: <https://www.cms.gov/medicare/health-plans/medicareadvtspeccratestats/downloads/advance2019part1.pdf>

MEDICARE BASICS



You are most likely NOT required to gather and submit quality data and performance measures to “regular” Medicare Part B patients. It is necessary to maintain close contacts with your MCOs, your state primary care associations, and your Medicaid carriers to find out what they want, when they want it, and how they want it reported. Expect little consistency between carriers.



RHCs are typically participating providers with Parts B & Part C plans.

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?



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

Primarily used by RHCs who are reporting claims to commercial and non-Medicare carriers expecting to receive a Fee-for-Service payment for non-RHC 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. A vertical label on the right side reads 'PATIENT AND INSURED INFORMATION' and 'PHYSICIAN OR SUPPLIER INFORMATION'. A vertical label on the far right, written in red, says 'LINKED'. Three yellow stars are placed on the form: one in section 14 (Patient's or Authorized Person's Signature), one in section 23 (Signature of Physician or Supplier), and one in section 24 (Date of Current Illness, Injury, or Pregnancy Limit). A red star is placed in section 23. Arrows point from the stars to the 'LINKED' text.



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

Used for RHCs 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 vertical label on the right side reads 'PATIENT AND INSURED INFORMATION' and 'PHYSICIAN OR SUPPLIER INFORMATION'. A vertical label on the far right, written in red, says 'LINKED'. A blue oval highlights the 'HCPCS CODES' section (Level I CPT, Level II Medicare National, National Drug Code (NDC)). Another blue oval highlights the 'SECTION IV FL (66-81)' section (DIAGNOSIS, POA, PROCEDURE, AND PROVIDER INFORMATION). A vertical label on the far right, written in red, says 'NOT LINKED'.

CPT & HCPCS-II
And ICD-10-CM

NOT LINKED

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?

In order to be prepared to fully document and report quality it is necessary to build a shared foundation of knowledge between providers, managers, and coder/billers.



Does each facility/nurses station have each of the CURRENT federally-mandated HIPAA Code Sets used by RHCs 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, 13, 15, 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?



Overview of Quality Reporting



QUALITY & CARE MANAGEMENT: What do we need?

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

Public health professionals have other goals

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/OD), Medication Assisted Therapy (MAT), and developing Peer Recovery Coach programs.



What is Value-based Care?

Value-based Care and similar reimbursement models differ significantly from the Fee-for-Service and encounter-based care (*i.e. per diems*) we are used to at RHCs.

- Instead of paying us for what we do - we may get reimbursed for ‘efficiency and effectiveness’ compared to others and to national standards used by CMS.
- CMS and more commercial payers are looking to Accountable Care Organizations (ACO) using various Medicare Shared Savings Programs and/or Patient-Centered Medical Homes (PCMH). CMS is underway with a required transition to this model!
- Clinical outcomes are measured based on things like reduced hospital readmissions, increased use of approved preventive care, and use of certified health IT systems to increase and facilitate data collection.
- **BEWARE:** There appears to be some conflicting motivations in this newer area of healthcare when you compare what “quality” means to insurers vs. providers vs. patients!



Quality Reporting for RHCs :: An overview of where to find the codes

- Hierarchical Conditions Categories (HCC) concepts also known as “Risk Adjusted Coding” (*solely ICD-10-CM*)
- Healthcare Effectiveness Data & Information Set (HEDIS) measures (*combines CPT, HCPCS-II, and ICD-10-CM*)
- “Performance Measures” come from the back of the AMA’s CPT and are used in addition to regular CPT/HCPCS-II codes (*CPT Cat. II codes*)
- Social Determinants of Care/Population Health such as impact on lack of transportation, access to nutritional food, and housing instability being gathered to aid public health getting the right resources to the right patients (*solely ICD-10-CM*)



Quality Reporting Basic Definitions

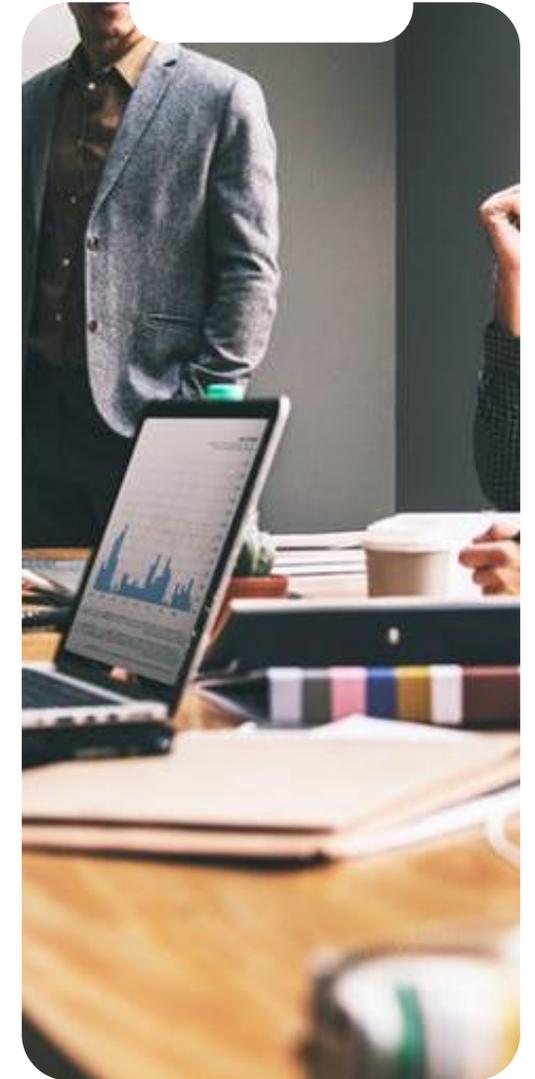
Value-based Care – Moving away from FFS/Per Diem payments towards paying based on clinical outcomes and disease prevention.

ACOs 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 – 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).

HEDIS measures – Used by 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.

Risk Adjusted Coding – How Medicare/Medicaid managed care plans can bill CMS for more money for complex patients that require more care than the “average” patient.



Sample impact of HCC coding on payments to MCO/MAO

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).

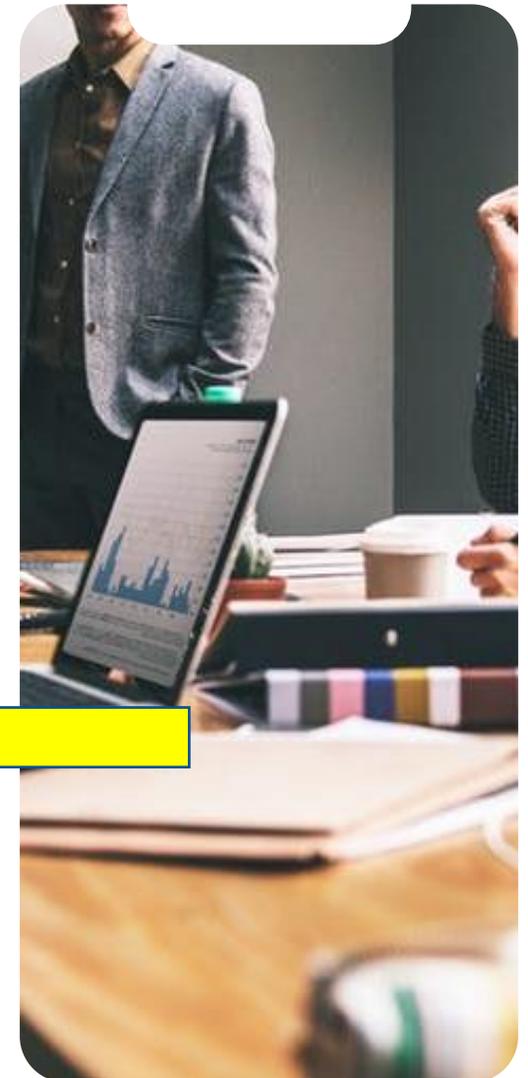
RISK/PAYMENT FACTOR	HCC	RAF
66-year-old male	(community, <u>nondual</u> , aged)	0.300
Congestive heart failure (CHF)	85	0.323
Prostate cancer	12	0.146
Diabetes mellitus (DM), complicated	18	0.318
Peripheral vascular disease	108	0.298
Below-knee amputation	189	0.588
Morbid obesity	22	0.273
Interaction 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 (2018)