Rural Health Clinic Coding & Billing Boot Camp

Agenda – Day 1

• Overview of Medicare Part A and Part B
  – Overview of RHC Medicare Billing
• Overview of RHC billing for Idaho Medicaid
• Coding Overview
  – Evaluation and Management (E/M) Documentation Guidelines
  – CPT and HCPCS-2 Modifiers
  – Surgical and Global Package
  – Same Day Visits
  – Incident-to Overview
  – Visiting Nurse Services
  – Injections, Vaccines, Immunization and Medications
  – Preventative care - Annual Wellness visits and the IPPE
  – Advanced Care Planning
  – Transitional Care Management (TCM)
• Telehealth
Agenda – Day 2

• Coding Overview
  – Chronic Care Management (CCM)
  – Behavioral Health Integration (BHI)
  – Psychiatric Collaborative Care Management (CoCM)
  – ICD-10-CM
  – Hierarchical Conditional Category Coding (HCC)

• Survey and CEUs

Overview of Government Payers
What is Medicare?

Medicare is the federal health insurance program for:
- People who are 65 or older
- Certain younger people with disabilities
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD)

Medicare Part A

- Considered “hospital insurance”
- Part A covered stays in inpatient hospital stay, stays in a skilled nursing facility, hospice care, and some home health care.
- Claims administered and paid by the Medicare Administrative Contractor (MAC) (formerly a Fiscal Intermediary)
- Claim form is the 837I* (UB-04)
- Typically, no premium is paid
  - Episode deductible $1340

*All claims should be submitted electronically
Medicare Part B

- Considered “medical insurance”
- Part B covers doctors' services, outpatient care, medical supplies, and preventive services.
- Claims administered by MAC,(formerly a Carrier)
- Claim form is the 837P (CMS-1500)
- Premium is paid monthly
- Deductible = $183
- Copay = 20%

What is Medicare Advantage?

- Medicare Advantage, also known as Medicare Part C, is an alternative way to obtain Original Medicare, Part A and Part B, coverage.
What is Medicaid?

- **Medicaid** is a state and Federal partnership that provides health coverage for selected categories of people in **Minnesota** with low incomes. Its purpose is to improve the health of people who might otherwise go without medical care for themselves and their children.
Medicare Rural Health Clinic

Background

Rural Health Clinics (RHCs) were established by the Rural Health Clinic Service Act of 1977 to address an inadequate supply of physicians serving Medicare beneficiaries in underserved rural areas, and to increase the utilization of nurse practitioners (NP) and physician assistants (PA) in these areas.

RHCs have been eligible to participate in the Medicare program since March 1, 1978, and are paid an all-inclusive rate (AIR) for medically-necessary primary health services, and qualified preventive health services, furnished by an RHC practitioner.

RHC Location Requirements

- To be eligible for RHC certification, a clinic must be located in an area that has one of the following types of shortage area designations;
  - Geographic Primary Care Health Professional Shortage Area (HPSA);
  - Population-group Primary Care HPSA;
  - Medically Underserved Area (MUA) (this does not include the population group Medically Underserved Population (MUP) designation); or
  - Governor-Designated and Secretary-Certified Shortage Area (this does not include a Governor’s Medically Underserved Population designation)

The designation cannot be more than 4 years old in order to meet the requirement of being in a currently designated area.
**RHC Location Requirements**

- Must meet *both* the rural & underserved location requirements
- *Mobile clinics* must have a fixed schedule that specifies date & location of services; each location must meet the location requirements
- Existing RHCs are not currently required to continue to meet the location requirements
- RHCs that plan to relocate or expand should contact their Regional Office (RO) to determine their location requirements

**RHC Location Requirements**

RHC visits **may** take place in:
- the RHC
- the patient’s residence (including an assisted living facility)
- a Medicare-covered Part A SNF
- the scene of an accident

RHC visits **may not** take place in:
- an inpatient or outpatient department of a hospital, including a CAH, or
- a facility which has specific requirements that preclude RHC visits (e.g., a Medicare comprehensive outpatient rehabilitation facility, a hospice facility, etc.)
Provider Types

- Physician
- NP
- PA
- Certified Nurse Midwife (CNM)
- Clinical Psychologist (CP)
- Clinical Social Worker (CSW)
- Register nurse (RN) (homebound services)
- Licensed nurse (LPN) (homebound services)

*A NP, PA or CNM must work in the clinic at least 50% of the time the RHC is open. One practitioner must be present in the RHC and available at all times to furnish patient care.*

Provider Types

- Dentists, podiatrists, optometrists, and chiropractors are all considered physicians by Medicare statute.
  - Services must be within scope of licensure and covered by Medicare.

- These provider types are not considered primary care and therefore, can’t function as medical directors and are not considered as practitioners for meeting the need of a practitioner always present.
Types of RHCs

RHCs can be independent or provider-based

- Independent RHCs bill RHC services to the Medicare MAC (formerly Fiscal Intermediaries)

- Provider-based RHCs bill RHC services to Medicare MACs of the host provider (usually a hospital).

Independent RHCs

- Stand-alone or freestanding clinics
- Submit 837-I to Medicare MAC
- Assigned a CMS Certification Number (CCN) ranging from 3800-3974 or 8900-8999
Provider-Based RHCs

Integral & subordinate part of a

- Hospital - including critical access hospital (CAH), skilled nursing facility (SNF), or a home health agency (HHA)
- Submit 837-I to Medicare MAC
- Assigned a CMS Certification Number (CCN) ranging from 3400-3499, 3975-3999 or 8500-8899

RHC Additional Requirements

- Directly furnish routine diagnostic & laboratory services including onsite provision of the following 6 tests;
  - Chemical examination of urine by stick or tablet method or both;
  - Hemoglobin or hematocrit;
  - Blood sugar;
  - Examination of stool specimens for occult blood;
  - Pregnancy tests; and
  - Primary culturing for transmittal to a certified laboratory
- Have arrangements with one or more hospitals to furnish medically necessary services that are not available at the RHC
- Have available drugs and biologicals necessary for the treatment of emergencies
- Meet all health and safety requirements
- Not be a rehabilitation agency or a facility that is primarily for mental health treatment
Medicare RHC Visits & Services

Medicare RHC Visits

- A RHC visit is a medically-necessary, face-to-face medical or mental health visit, or a qualified preventive health visit, with a RHC practitioner during which time one or more RHC services are rendered.
  - Typically furnished in an outpatient setting
Medicare Covered RHC Services

- Physician services
- Services of non-physician practitioners (NPP), which include physician assistants (PA), nurse practitioners (NP), and certified nurse midwives (CNM)
  - Does not include clinical nurse specialists (CNS)
  - Services and supplies “incident to” Physicians and NPPs
- Clinical psychologist (CP) and clinical social worker (CSW) services
  - Services and supplies incident to clinical psychologist and clinical social workers
- Visiting nurse services to the homebound
- Physician services for beneficiaries in Part A stay in SNF (including hospital swing bed)

Physician Services

- Physician services can include:
  - Therapy, surgery, consultation, and interpretation of tests (EKG, x-rays)
- Services performed at the clinic are payable only to the RHC and can include those services delivered in a:
  - RHC
  - Patient’s place of residence or implied place of residence (SNF, NF, or swing bed)
- Payment is made under the all-inclusive rate (AIR)
NP, PA and CNM Services

- NP, PA, and CNM services follow the same guidelines as physician services
  - Must still consider state scope of practice regulations
- There is no reduction in the Medicare reimbursement
  - Paid at physician rate
- Payment is made under the all-inclusive rate (AIR)

Visiting Nurse Services

- A visiting nurse service must be a *skilled* nursing service
  - Must be in a HH shortage area
  - Patient must be home bound
- Furnished by RN, LPN, or LVN
  - Nurse must be an employee of RHC
- Furnished as part of a written plan of treatment with is reviewed once every 60 days by supervising physician of RHC
Non RHC Services

- Durable Medical Equipment (DME)
- Ambulance services
- Diagnostic tests such as X-ray and EKGs
- Lab tests (requirement to perform 6 CLIA waived tests, still non RHC services)
  - Exception is venipuncture, which is included in AIR
- Screening mammography services
- Prosthetic devices
- Services provided to hospital patients (except those in a swing bed)

Non RHC Services are billed to Medicare Part B

Lab Details

- Independent RHC
  - Bill all lab services (including the six basic required tests) to Part B on CMS 1500/837-P
- Provider-based RHC operated by a CAH
  - For CAH lab services with dates of service beginning July 1, 2009, use 85X bill (837-I) type to receive cost based reimbursement for lab services
- Provider-based RHC operated by a PPS hospital
  - Bill all lab services (including the six basic required tests) as reference lab to FI on UB-04/837-I using hospital billing number (not RHC number)
  - Bill type 143X, Revenue Code 030X
  - CPT codes requires, reimbursed from fee schedule
Medicare Billing & Payments

RHC Medicare Payment

RHCs are paid a flat, all inclusive rate (AIR) for each face-to-face, medically necessary encounter with an RHC practitioner based on the anticipated average cost for direct and supporting services (including allocated costs), with a reconciliation of costs (i.e., cost report) occurring at the end of the fiscal year.
The All Inclusive Rate (AIR)

- The all-inclusive rate is subject to a maximum payment per visit, which is:
  - Established by Congress
  - *Updated annually* based on the percentage change in the Medicare Economic Index
  - Subject to annual reconciliation

- The per-visit limit *does not apply* to RHCs determined to be an integral & subordinate part of a hospital with fewer than 50 beds

- Laboratory tests (excluding venipuncture) & technical components of RHC services are paid separately.

- The RHC payment limit per visit for Calendar Year (CY) 2018 is $83.45, unless you have an exception.

Copay and Deductible

- **Part B Deductible**
  - The 2018 Part B deductible is $183 and applies to services covered under the RHC benefit

- **Part B Coinsurance**
  - If the item or service is covered under the RHC benefit, the beneficiary is responsible for 20% of the *customary charge*
  - If the service is a non-covered RHC benefit, but is covered under Part B, the beneficiary is responsible for 20% of Medicare *allowed amount*, which is based on the Physician Fee Schedule (PFS)
Medicare AIR

- In general only one medically-necessary face-to-face visit with a RHC practitioner is paid (AIR) per day, regardless of number of services provided. The limited exceptions include:
  - The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC);
  - The patient has a medical visit and a mental health visit on the same day;
  - The patient has an Initial Preventive Physical Examination (IPPE) and a separate qualified medical and/or mental health visit on the same day

Medicare AIR

- Medicare pays 80 percent (application of copay and deductible) of the RHC’s AIR, subject to the payment limit, except for RHCs that have an exception to the payment limit.
  - 2018 Example: 80% of $83.45
    - Exception: Certain Preventive Services, which are reimbursed at 100% of cost
  - Non-covered expenses do not count toward the deductible.

- An interim rate for newly certified RHCs is established based on the RHCs anticipated average cost for direct and supporting services.

- At the end of the reporting period, the A/B MAC determines the total payment due and reconciles payments made during the period with the total payments due.
Provider-Based RHC Exceptions

- A provider-based RHC that is an integral and subordinate part of a hospital (including a CAH), can receive an exception to the per-visit payment limit if:
  - The hospital has fewer than 50 beds
  - The hospital’s average daily patient census count of those beds does not exceed 40 and the hospital meets both of the following:
    ◊ It is a sole community hospital or an essential access community hospital
    ◊ It is located in a level 9 or level 10 Rural-Urban Commuting Area (RUCA)
- The exception to the payment limit applies only during the time that the RHC meets the requirements for the exception.

AIR Calculation

- The AIR for an RHC is calculated by dividing the total allowable costs by the total number of visits for all patients.
- Productivity, payment limits, and other factors are also considered in the calculation.
- Allowable costs must be reasonable and necessary and include practitioner compensation, overhead, equipment, space, supplies, personnel, and other costs incident to the delivery of RHC services.
Type of Bills

RHC Type of Bill (TOB) = 71x

The third digit, called a frequency code, is used on RHC claims in the following way:

710 = Non-payment/zero claim
    – A claim with only non-covered charges

711 = **Admit through discharge (original claim)**
    – Most commonly used

717 = Replacement of prior claim (adjustment)

718 = Void/cancel prior claim (cancellation)

Submitting a Claim

- Billed on a 837-I/UB-04
- TOB 711 for initial claims
- RHCs should submit **actual charges, not** the RHC encounter rate.
- Co-insurance and deductible amounts are applied based on **charges**.
- A medically-necessary diagnosis is required.
- Only one encounter per day is reimbursed, with limited exception.
- For services that do not qualify as a billable visit, the usual charges for the services are added to those of the qualified visit (see examples).
Revenue Codes

0521 - Clinic Visit at RHC;
0522 - Home visit by RHC provider;
0524 - Visit by RHC provider to a Part A SNF bed;
0525 - Visit by RHC provider to a non-SNF bed, NF or other residential facility (non-Part A);
0527 - Visiting Nurse service in home health shortage area;
0528 - Visit by RHC provider to other non-RHC site (i.e., scene of an accident).

0250 – Pharmacy (Does not need a HCPCS)
0300 – Venipuncture
0636 – Injection/Immunization
0780 – Telehealth
0900 – Mental Health Treatment

RHC’s are required to report a HCPCS code for each service line and a line item date of service.

Summary of RHC Billing

<table>
<thead>
<tr>
<th>RHC Type</th>
<th>Encounter Form</th>
<th>CLIA Lab</th>
<th>Other Lab/Ancillary</th>
<th>Outside RHC Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>Part A 837-I</td>
<td>Part B* 837-P</td>
<td>Part B* 837-P</td>
<td>Part B* 837-P</td>
</tr>
</tbody>
</table>
| Provider Based    | Part A 837-I   | Billed by Parent hospital | Billed by Parent hospital | Billed either to Part B MAC or as hospital charge, if appropriate.

* Costs related to services reimbursed under Part B are carved out on the RHC cost report so that the encounter rate is not overstated to avoid double-dipping.
Billing for Non RHC Services

<table>
<thead>
<tr>
<th></th>
<th>Independent</th>
<th>Provider Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab</td>
<td>Part B (837-P) Use RHC #</td>
<td>Billed on 837-I Bill type (14x, 13x, or 85x)</td>
</tr>
<tr>
<td>Diagnostic/Radiology (Professional)</td>
<td>Bill with encounter if read by RHC practitioner. If read by non RHC practitioner, bill Part B.</td>
<td>May be billed with encounter. If read by hospital radiologist, bill Part B.</td>
</tr>
<tr>
<td>Diagnostic/Radiology (Technical)</td>
<td>Billed to Part B (837-P) Use RHC #</td>
<td>Billed on 837-I Bill type (13x or 85x)</td>
</tr>
<tr>
<td>Non-RHC Professional Services (i.e., inpatient, ER, outpatient)</td>
<td>Billed to Part B (837-P) Use RHC #</td>
<td>Billed to Part B using existing group number. If Method II CAH, bill to Part A for pro fees.</td>
</tr>
</tbody>
</table>

Example – Medical Encounter

An established patient is seen and 99213 for $100 is billed. The applicable coinsurance and/or deductible shall be based upon $100. Medicare will pay the encounter at 80% of the AIR. The patient will be responsible for $20.00 in co-insurance.

<table>
<thead>
<tr>
<th>FL43</th>
<th>FL44</th>
<th>FL45</th>
<th>FL46</th>
<th>FL47</th>
<th>Total Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desc</td>
<td>HCPCS/CPT</td>
<td>DOS</td>
<td>Units</td>
<td></td>
<td>$100.00</td>
</tr>
<tr>
<td>OV Est 3</td>
<td>99213 CG</td>
<td>4/2/2018</td>
<td>1</td>
<td>$100.00</td>
<td></td>
</tr>
<tr>
<td>Total Charge</td>
<td></td>
<td></td>
<td></td>
<td>$100.00</td>
<td></td>
</tr>
</tbody>
</table>
Example – Medical Encounter & Ancillary

The Toradol charge is $25.00 and is added to the $100 charge for the 99213 qualifying visit line. Medicare will use the line with the qualifying visit (QV) to determine the total charge and calculate co-insurance.

It is acceptable to add a line item charge for 0.01, if required by your EHR.

<table>
<thead>
<tr>
<th>Desc</th>
<th>HCPCS/CPT</th>
<th>DOS</th>
<th>Units</th>
<th>Total Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>OV Est 3</td>
<td>99213 CG</td>
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<td>$125.01</td>
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<tr>
<td>Toradol</td>
<td>J1885</td>
<td>5/15/2018</td>
<td>1</td>
<td>$0.01</td>
</tr>
<tr>
<td>Total Charge</td>
<td></td>
<td></td>
<td></td>
<td>$125.02</td>
</tr>
</tbody>
</table>

Example – Medical Encounter & EKG

A qualifying visit of 99213 is billed with a charge of $100. The professional and technical components of an EKG (93005/93010) are also billed for $80/$40.

<table>
<thead>
<tr>
<th>Desc</th>
<th>HCPCS/CPT</th>
<th>DOS</th>
<th>Units</th>
<th>Total Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>OV Est 3</td>
<td>99213 CG</td>
<td>6/1/2018</td>
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<tr>
<td>EKG-PC</td>
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<tr>
<td>Total Charge</td>
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<td></td>
<td></td>
<td>$140.01</td>
</tr>
</tbody>
</table>

If an Independent RHC, the TC is billed to Part B. Provider Based RHCs will bill under the hospital to Part B.
Example – Medical Encounter & Mental Health Encounter

Both encounters are separately payable, both are qualifying visits.

<table>
<thead>
<tr>
<th>FL42</th>
<th>FL43</th>
<th>FL44</th>
<th>FL45</th>
<th>FL46</th>
<th>FL47</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rev CD</td>
<td>Desc</td>
<td>HCPCS/CPT</td>
<td>DOS</td>
<td>Units</td>
<td>Total Charge</td>
</tr>
<tr>
<td>0521</td>
<td>OV Level 3</td>
<td>99213 CG</td>
<td>9/2/2018</td>
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<td>$100.00</td>
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<tr>
<td>0900</td>
<td>BH Session</td>
<td>90834 CG</td>
<td>9/2/2018</td>
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<td>$120.00</td>
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<td>0001</td>
<td>Total Charge</td>
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<td></td>
<td></td>
<td>$220.00</td>
</tr>
</tbody>
</table>

Example – Medical Encounter and Preventive Service

The charge for the preventive service (pelvic exam) should NOT be included in the 99213 charge since there is no co-insurance applied to the preventive service. The $20.00 venipuncture charge will be bundled with the 99213.

<table>
<thead>
<tr>
<th>Rev CD</th>
<th>Desc</th>
<th>HCPCS/CPT</th>
<th>DOS</th>
<th>Units</th>
<th>Total Charge</th>
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</thead>
<tbody>
<tr>
<td>0521</td>
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<td>$120.01</td>
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<tr>
<td>0521</td>
<td>Breast/Pelvic</td>
<td>G0101</td>
<td>8/5/2018</td>
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<td>$75.00</td>
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<tr>
<td>0300</td>
<td>Venipuncture</td>
<td>36415</td>
<td>8/5/2018</td>
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<td>$0.01</td>
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<tr>
<td>0001</td>
<td>Total Charge</td>
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<td></td>
<td></td>
<td>$195.02</td>
</tr>
</tbody>
</table>
**Example – IPPE Only**

No CG Modifier is required on the IPPE code. Also, remember to report preventive services on your cost report.

<table>
<thead>
<tr>
<th>Rev CD</th>
<th>Desc</th>
<th>HCPCS/CPT</th>
<th>DOS</th>
<th>Units</th>
<th>Total Charge</th>
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</thead>
<tbody>
<tr>
<td>0521</td>
<td>IPPE</td>
<td>G0402</td>
<td>4/4/2018</td>
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<td>$ 185.00</td>
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<td>0001</td>
<td>Total Charge</td>
<td></td>
<td></td>
<td></td>
<td>$ 185.00</td>
</tr>
</tbody>
</table>

**Example – Medical Visit & IPPE**

Again, modifier CG does not need to be reported with the IPPE code. When an IPPE is furnished with another medically necessary face-to-face service, modifier CG is reported with the HCPCS code for the other billable service.

<table>
<thead>
<tr>
<th>Desc</th>
<th>HCPCS/CPT</th>
<th>DOS</th>
<th>Units</th>
<th>Total Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Est Patient III</td>
<td>99213CG</td>
<td>7/13/2018</td>
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<tr>
<td>IPPE</td>
<td>G0402</td>
<td>7/13/2018</td>
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<td>$ 185.00</td>
</tr>
<tr>
<td>Total Charge</td>
<td></td>
<td></td>
<td></td>
<td>$ 285.00</td>
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</table>
Example – Office Visit with Venipuncture

**Example 1: Medical Services**

RHCs shall report one service line per encounter/visit with revenue code 052X and a qualifying medical visit from the RHC Qualifying Visit List. Payment and applicable coinsurance and/or deductible shall be based upon the qualifying medical visit line. All other RHC services furnished during the encounter are also reported with the charge for the service.

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
<th>FL 47 Total Charges</th>
<th>Payment</th>
<th>Coinsurance/ Deductible Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>052X</td>
<td>99213¹</td>
<td>04/01/2016</td>
<td>1</td>
<td>$76.40²</td>
<td>AIR</td>
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<td>0300</td>
<td>36415</td>
<td>04/1/2016</td>
<td>1</td>
<td>$3.00³</td>
<td>Included in the AIR</td>
<td>No</td>
</tr>
</tbody>
</table>
Example – Problem & Prevent

Example 2: Medical Services and Preventive Services
If an approved preventive service is furnished with a medical visit, the RHC shall report the preventive service on an additional 052X service line with the associated charges. The qualifying medical visit line should include the total charges for the visit and payment and coinsurance will be based upon this line. All other RHC services furnished during the encounter are also reported with the charge for the service. Preventive services furnished with a medical visit are ineligible to receive an additional encounter payment at the AIR, except for the IPPE.

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
<th>FL 47 Total Charges</th>
<th>Payment</th>
<th>Coinsurance/Deductible Applied</th>
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<tbody>
<tr>
<td>052X</td>
<td>99213¹</td>
<td>04/01/2016</td>
<td>1</td>
<td>$76.40²</td>
<td>AIR</td>
<td>Yes</td>
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<td>$38.67³</td>
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<td>0300</td>
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<td>04/01/2016</td>
<td>1</td>
<td>$3.00³</td>
<td>Included in the AIR</td>
<td>No</td>
</tr>
</tbody>
</table>

Example – Preventive Only

Example 3: Preventive Service Only Encounter
When a preventive health service is the only qualifying visit reported for the encounter, the payment and applicable coinsurance and/or deductible will be based upon the associated charges for this service line. Frequency edits will apply.

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
<th>FL 47 Total Charges</th>
<th>Payment</th>
<th>Coinsurance/Deductible Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>052X</td>
<td>G0101¹</td>
<td>04/01/2016</td>
<td>1</td>
<td>$38.67²</td>
<td>AIR</td>
<td>No³</td>
</tr>
</tbody>
</table>

¹Preventive service HCPCS code from the RHC Qualifying Visit List
²Total charges for encounter
³Coinsurance and deductible are waived when appropriate
Example - Mental Health

**Example 4: Mental Health Services**

RHCs shall report one service line per mental health encounter/visit with revenue code 0900 and a qualifying mental health visit from the *RHC Qualifying Visit List*. The qualifying mental health visit line should include the total charges for the visit and payment and coinsurance will be based upon this line. All other RHC services furnished during the encounter are also reported with the charge for the service.

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
<th>FL 47 Total Charges</th>
<th>Payment</th>
<th>Coinsurance/Deductible Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>0900</td>
<td>90834(^1)</td>
<td>04/01/2016</td>
<td>1</td>
<td>$110.63(^2)</td>
<td>AIR</td>
<td>Yes</td>
</tr>
<tr>
<td>0900</td>
<td>90863</td>
<td>04/01/2016</td>
<td>1</td>
<td>$25.42(^3)</td>
<td>Included in the AIR</td>
<td>No</td>
</tr>
</tbody>
</table>

\(^1\)HCPCS code from the *RHC Qualifying Visit List*

\(^2\)Total charge for the encounter

\(^3\)Charge for the service

---

Example – Multiple Medical Services

**Example 5: Multiple Medical Services**

RHCs shall report one service line per encounter/visit with revenue code 052X and a qualifying medical visit from the *RHC Qualifying Visit List*. Each additional medical service furnished should be reported with revenue code 052X. The qualifying medical visit line should include the total charges for the visit and payment and coinsurance will be based upon this line.

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
<th>FL 47 Total Charges</th>
<th>Payment</th>
<th>Coinsurance/Deductible Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>052X</td>
<td>99213(^1)</td>
<td>04/01/2016</td>
<td>1</td>
<td>$183.32(^2)</td>
<td>AIR</td>
<td>Yes</td>
</tr>
<tr>
<td>052X</td>
<td>12002</td>
<td>04/01/2016</td>
<td>1</td>
<td>$109.92(^3)</td>
<td>Included in the AIR</td>
<td>No</td>
</tr>
</tbody>
</table>

\(^1\)HCPCS code from the *RHC Qualifying Visit List*

\(^2\)Total charges for the encounter

\(^3\)Charge for the service
Example – Incident to Services

Example 6: Medical Services and Incident to Services

Services and supplies furnished incident to a RHC visit are considered RHC services. They are included in the payment of a qualifying visit and are not separately payable as stand-alone services. The qualifying visit line must include the total charges for all the services provided during the encounter/visit. RHCs can report incident to services using all valid revenue codes except 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096x-310x. RHCs should report the most appropriate revenue code for the services being performed.

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
<th>FL 47 Total Charges</th>
<th>Payment</th>
<th>Coinsurance/Deductible Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>052X</td>
<td>99213¹</td>
<td>04/01/2016</td>
<td>1</td>
<td>$139.11²</td>
<td>AIR</td>
<td>Yes</td>
</tr>
<tr>
<td>0300</td>
<td>36415</td>
<td>04/01/2016</td>
<td>1</td>
<td>$3.00²</td>
<td>Included in the AIR</td>
<td>No</td>
</tr>
<tr>
<td>0636</td>
<td>90746</td>
<td>04/01/2016</td>
<td>1</td>
<td>$59.71³</td>
<td>Included in the AIR</td>
<td>No</td>
</tr>
<tr>
<td>0771</td>
<td>G0010</td>
<td>04/01/2016</td>
<td>1</td>
<td>$5.00³</td>
<td>Included in the AIR</td>
<td>No</td>
</tr>
</tbody>
</table>

¹HCPCS code from the RHC Qualifying Visit List
²Total charge for the encounter
³Charge for the service

Medicare Denials

- For any service line included in the AIR payment, the following remittance codes will be received:
- CO- Contractual obligation;
  - CARC 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated; and
  - RARC M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
Cost Report Annual Reconciliation

Cost Report Forms

- **Independent RHCs**

- **Hospital-Based RHCs**
  - Worksheet M of Form CMS-2552-10, Hospital and Hospital Health Care Complex Cost Report.

- **Skilled Nursing Facility-Based**
  - Worksheet I series of form CMS-2540-10 “Skilled Nursing Facility and Skilled Nursing Facility Care Complex Cost Report”

- **Home Health Agency-Based**
  - Worksheet RF series of Form CMS-1728-94 “Home Health Agency Cost Report”

- Other provider-based RHCs must complete the appropriate set of RHC worksheets on the cost report filed by the parent provider.
Cost Reports

- RHCs must file a cost report annually to determine their payment rate & reconcile interim payments, including adjustments for graduate medical education (GME) payments, bad debt, and influenza & pneumococcal vaccines and their administration.
- RHCs must maintain & provide adequate cost data based on financial and statistical records, that can be verified by qualified auditors.
- RHCs are allowed to claim bad debts, such as unpaid co-insurance and deductibles.
  - Must be able to prove reasonable efforts were made to collect these amounts.
  - Amounts waived due to statutory waiver or a sliding fee scale, may not be claimed.

Cost Reports – Vaccination Carve Out

<table>
<thead>
<tr>
<th>Title</th>
<th>RHC 1</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pneumococcal</td>
<td>Influenza</td>
</tr>
<tr>
<td>1.00</td>
<td>1,805,154</td>
<td>1,805,154</td>
</tr>
<tr>
<td>2.00</td>
<td>0.00204</td>
<td>0.00204</td>
</tr>
<tr>
<td>3.00</td>
<td>3.67</td>
<td>0.236</td>
</tr>
<tr>
<td>4.00</td>
<td>10.244</td>
<td>4.00</td>
</tr>
<tr>
<td>5.00</td>
<td>14.500</td>
<td>5.00</td>
</tr>
<tr>
<td>6.00</td>
<td>1,967,055</td>
<td>1,967,055</td>
</tr>
<tr>
<td>7.00</td>
<td>945,462</td>
<td>945,462</td>
</tr>
<tr>
<td>8.00</td>
<td>0.0007735</td>
<td>0.0007735</td>
</tr>
<tr>
<td>9.00</td>
<td>31,365</td>
<td>6,973</td>
</tr>
<tr>
<td>10.00</td>
<td>102,793</td>
<td>21,143</td>
</tr>
<tr>
<td>11.00</td>
<td>414</td>
<td>14.00</td>
</tr>
<tr>
<td>12.00</td>
<td>226.04</td>
<td>30.20</td>
</tr>
<tr>
<td>13.00</td>
<td>209</td>
<td>13.00</td>
</tr>
<tr>
<td>14.00</td>
<td>31,289</td>
<td>14.00</td>
</tr>
<tr>
<td>15.00</td>
<td>124,264</td>
<td>15.00</td>
</tr>
<tr>
<td>16.00</td>
<td>70,453</td>
<td>16.00</td>
</tr>
</tbody>
</table>

The total cost of pneumococcal and influenza vaccines are not paid under the all inclusive rate per visit. These costs are calculated based on staff time studies and the invoice cost of the vaccines.
Consolidated Cost Reports

• RHC with more than one site may file consolidated cost reports if approved by the A/B MAC in advance of the reporting period for which the consolidated report is to be used.

• Once having elected to use a consolidated cost report, the RHC may not revert to individual reporting without the prior approval of the A/B MAC.

Consolidated Cost Reports

• Rather than completing separate forms as shown in the previous examples for each site, the forms are combined into one location.

• Potential advantages can include:
  – Elimination of minimum visit productivity limit for one or more locations
  – Shifting of a higher cost per visit in a lower Medicare/Medicaid utilized clinic to a clinic with a lower cost per visit and higher Medicare/Medicaid Utilization
RHCs and Idaho Medicaid

RHCs – Idaho Medicaid

- To qualify as a Rural Health Clinic (RHC), the clinic must be located in a non-urbanized area and a designated medically underserved area (MUA) or designated population group or geographic health professional shortage area (HPSA).
- RHCs provide routine diagnostic and laboratory services and employ mid-level practitioners 50 percent of the time the clinic is open.

https://healthandwelfare.idaho.gov/Health/RuralHealthandPrimaryCare/RuralHealthClinicCertification/tabid/408/Default.aspx
Claim Form Billing Requirements

- Submitted on 837-P or CMS-1500
- RHCs must use procedure code T1015 for all encounters
  - In addition to the required encounter code also include all appropriate CPT/HCPCS codes for services provided during the encounter
- Place of service = 72
- Bill encounter with appropriate rate charge on the 1st detail line, then list all the appropriate CPT/HCPCS services provided during the encounter priced at $0 on subsequent lines.

*Charge Consideration:* If the total charges for T1015 does not equal or exceed the clinic’s Medicaid rate, the clinic will not receive its full RHC rate.

Billing Example

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS</th>
<th>Diagnosis</th>
<th>Description</th>
<th>Modifier</th>
<th>Place of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic/Center - Rural Health Clinics</td>
<td>T1015</td>
<td>Use appropriate diagnosis code for services rendered. (i.e., Well Child Exam, Family Planning)</td>
<td>All rural health clinics must use procedure code T1015 for medical services.</td>
<td>76 (same day/same provider) 77 (same day/different provider)</td>
<td>72</td>
</tr>
</tbody>
</table>
Crossover Claims

Patients may be dually eligible for Medicare and Medicaid.

- The RHC must first bill Medicare for rendered services.
- A copy of the Medicare Remittance Notice (MRN) must be included with the Medicaid claim when billing on paper.
- If billing electronically, the information from Medicare must be entered on the appropriate screens.
- If a person is eligible for both Medicare and Medicaid, Medicaid’s payment for services will not exceed the amount allowed by Medicaid minus Medicare’s payment for those services.

- Crossover claims may require rebilling to Medicaid with appropriate Medicaid approved coding for consideration.


Coding in a RHC
Evaluation and Management Coding (E/M)

Evaluation and Management Coding Key Components

- History
- Examination
- Medical Decision-Making
History Elements

- Chief Complaint (CC)
- History of Present Illness (HPI)
- Review of Systems (ROS)
- Past, Family, & Social History (PFSH)

History

- Ancillary staff may document Review of Systems and Past, Family, & Social History
- Provider must personally document History of Present Illness (HPI)
- Chief Complaint (CC) may be inferred
- May use patient-completed history form, but provider must date and initial form and refer to it in documentation
  - If electronic, provider must state where it is in the chart
HPI Interpretation of Elements

- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying Factors
- Associated Signs and Symptoms

HPI – 1997 Guidelines

In lieu of elements of HPI, provider may document the status of 3 chronic conditions
- Cannot simply state that the patient has the condition, must also give the status.
  - DM type 2 well controlled with diet
  - HTN controlled with Toprol
  - Hyperlipidemia – pt is attempting to control with dietary changes, however levels still elevated

CMS has clarified that this concept can also be used with the 1995 Guidelines
**Review of Systems -**

the patient’s answers to specific questions relating to organ systems

- Constitutional
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Nervous
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

**Review of Systems**

- The history element that is most often lacking
- May indicate “All other systems negative” after documentation of related system
  - But must list at least one system specifically
- “ROS – Negative” is insufficient documentation for complete Review of Systems
Past, Family, & Social History

Past – illnesses; surgeries; current medications; allergies
Family – hereditary diseases; health status of parents, siblings, children
Social – smoking, alcohol, drug use; marital status; living arrangements; employment; education; day care (for children)

New patients visits require all three areas to support a comprehensive history
Established patients:
– 2 of 3 for comprehensive
– 1 of 3 for problem pertinent

History Caveat

1995 Documentation Guidelines –
If the physician is unable to obtain a history from the patient or other source, the record should describe the patient’s condition or other circumstance which precludes obtaining a history.

If the patient is comatose, poor historian, can’t give their history, the provider stating any details they can provide and the reason the rest can’t be obtained supports a comprehensive history.
1995 Exam Elements – Body Areas

For purposes of examination, the following body areas are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

1995 Exam Elements – Organ Systems

For purposes of examination, the following organ systems are recognized:

- Constitutional (e.g., vital signs, general appearance)
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic
1995 Exam Guidelines from CMS

• The extent of examinations performed and documented is dependent upon clinical judgment and the nature of the presenting problem(s). They range from limited examinations of single body areas to general multi-system or complete single organ system examinations.
  – **DG**: Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of "abnormal" without elaboration is insufficient.
  – **DG**: Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) should be described.
  – **DG**: A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).
  – **DG**: The medical record for a general multi-system examination should include findings about 8 or more of the 12 organ systems.

1997 Exam Guidelines

These types of examinations have been defined for general multi-system and the following single organ systems:

• Cardiovascular
• Ears, Nose, Mouth, and Throat
• Eyes
• Genitourinary (Female)
• Genitourinary (Male)
• Hematologic/Lymphatic/Immunologic
• Musculoskeletal
• Neurological
• Psychiatric
• Respiratory
• Skin
### Medical Decision-Making

- **Number of Diagnosis and Management Options**
- **Amount and Complexity of Data**
- **Table of Risk**
Number of Diagnoses and Management Options

- Self-limited or minor problem
- Established problem – improving
- Established problem – worsening or failing to change as expected
- New problem – no additional workup
- New problem – with additional workup

Amount and Complexity of Data

- Review and/or order of clinical lab tests
- Review and/or order of radiology tests
- Review and/or order of tests in medicine section of CPT
- Discuss test results with performing MD
- Independent review of image, tracing or specimen
- Decision to obtain old records and/or obtain history from others
- Review and summarize old records
# Table of Risk

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimal</strong></td>
<td>• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis&lt;br&gt;• One stable chronic illness, e.g., well controlled hypertension, non-insulin dependent diabetes, cataract, BPH&lt;br&gt;• Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain</td>
<td>• Laboratory tests requiring venipuncture&lt;br&gt;• Chest x-rays&lt;br&gt;• EKG/EEG&lt;br&gt;• Urinalysis&lt;br&gt;• Ultrasound, e.g., echocardiography&lt;br&gt;• KOH prep</td>
<td>• Rest&lt;br&gt;• Gargles&lt;br&gt;• Elastic bandages&lt;br&gt;• Superficial dressings</td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>• Two or more self-limited or minor problems&lt;br&gt;• One stable chronic illness, e.g., well controlled hypertension, non-insulin dependent diabetes, cataract, BPH&lt;br&gt;• Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain</td>
<td>• Physiologic tests not under stress, e.g., pulmonary function tests&lt;br&gt;• Non-cardiovascular imaging studies with contrast, e.g., barium enema&lt;br&gt;• Superficial needle biopsies&lt;br&gt;• Clinical laboratory tests requiring arterial puncture&lt;br&gt;• Skin biopsies</td>
<td>• Over-the-counter drugs&lt;br&gt;• Minor surgery with no identified risk factors&lt;br&gt;• Physical therapy&lt;br&gt;• Occupational therapy&lt;br&gt;• IV fluids without additives</td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment&lt;br&gt;• Two or more stable chronic illnesses&lt;br&gt;• Undiagnosed new problem with uncertain prognosis, e.g., lump in breast&lt;br&gt;• Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis&lt;br&gt;• Acute complicated injury, e.g., head injury with brief loss of consciousness</td>
<td>• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test&lt;br&gt;• Diagnostic endoscopies with no identified risk factors&lt;br&gt;• Deep needle or incisional biopsy&lt;br&gt;• Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram, cardiac catheterization&lt;br&gt;• Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis</td>
<td>• Minor surgery with identified risk factors&lt;br&gt;• Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors&lt;br&gt;• Prescription drug management&lt;br&gt;• Therapeutic nuclear medicine&lt;br&gt;• IV fluids with additives&lt;br&gt;• Closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td><strong>High</strong></td>
<td>• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment&lt;br&gt;• Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure&lt;br&gt;• An abrupt change in neurologic status, e.g., seizure, TIA, weakness, sensory loss</td>
<td>• Cardiovascular imaging studies with contrast with identified risk factors&lt;br&gt;• Cardiac electrophysiological tests&lt;br&gt;• Diagnostic Endoscopies with identified risk factors&lt;br&gt;• Discography</td>
<td>• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors&lt;br&gt;• Emergency major surgery (open, percutaneous or endoscopic)&lt;br&gt;• Parenteral controlled substances&lt;br&gt;• Drug therapy requiring intensive monitoring for toxicity&lt;br&gt;• Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>
Time

- Provider can bill based upon time if they spend greater than 50% of encounter counseling and/or coordinating the care of the patient
- The provider must document the total time of the visit and how much time was spent counseling the patient and include the details of what the patient was counseled about
- Code can then be selected based off of time as the key component
CPT and HCPCS Level II Modifiers

Limited modifier use on RHC claims

- Modifier CG – used to identify a *qualifying visit* that may be entitled to payment under the AIR
  - See QV list

- When a patient returns on the same day for a separate visit under an RHC exception, modifier 25 or 59 may be used
  - Prior to October 1, 2016 modifier 59 was used to report multiple encounters in the RHC on the same day
Modifiers 25 & 59

**Modifier 25:** significant, *separately identifiable* E/M service by the *same* physician (RHC) on the *same* day of the procedure or other service

**Modifier 59:** Distinct procedural service

---

**Global Billing and Surgical Package**
Global Billing and Surgical Package

- Surgical procedures performed and billed in an RHC by an RHC Practitioner are considered RHC services
  - Payment for procedures is bundled in the AIR when done in RHC
- Medicare global billing requirements do not apply to RHC billing or payment
    ◊ Section 40.4 Global Billing

Global Billing and Surgical Package

- If surgical procedures are furnished at locations other than RHCs, the procedures may be subject to Medicare global billing requirements

- If an RHC furnishes services to a patient who has had surgery elsewhere and is still in the global billing period, the RHC must determine if these services have been included in the surgical global billing
  - Ask the patient who performed surgical procedure, follow up with other providers office to have them adjust their claim otherwise, RHC claim may be denied
Global Billing and Surgical Package

- RHCs may bill for a visit during a global surgical period if the visit or service is not included in the global billing package
  - If the service furnished by the RHC was included in the global payment for the surgery, the RHC may not bill for the service

Global Billing and Surgical Package

Services not included in Global Surgical Package:

- **Initial consultation** by the surgeon to determine the need for major surgery
- Visits unrelated to the diagnosis necessitating the surgical procedure (unless the visit occurs due to complications of the surgery)
- **Treatment for the underlying condition or an added course of treatment** which is not part of normal recovery from surgery; etc.
Two Visits on the Same Day

• Encounters with more than one RHC practitioner on the same day, or multiple encounters with the same RHC practitioner on the same day, constitute a single RHC visit, and is payable as one visit – regardless:
  – of the length or complexity of the visit
  – of the number or type of practitioners seen
  – whether the second visit is a scheduled or unscheduled appointment
  – whether the first visit is related or unrelated to the subsequent visit*

* See exceptions on slide 102
Two Visits on Same Day

- This includes situations where an RHC patient has a medically-necessary visit with an RHC practitioner, and is then seen by another RHC practitioner, including a specialist, for further evaluation of the same/different condition on the same day.

Exceptions to 2 Encounters Billed on Same Day

- Exceptions:
  - The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day
    - Example: If a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC for treatment.
    - In this situation only, the RHC would use modifiers 25 or 59 and CG to attest that the conditions being treated qualify as 2 separately billable visits
  - The patient has a qualified medical visit and a qualified mental health visit on the same day (2 separately billable visits)
  - The patient has an initial preventative physical exam (IPPE) and a separate medical and/or mental health visit on the same day
    - This could result in up to 3 separately billable visits
3-Day Payment Window

- Medicare has a 3 day payment rule that applies to OP services performed in a PPS hospital
  - Hospital services within the preceding 3 days (the technical component only) need to be bundled into the inpatient stay
    - Sometimes referred to as the “72 hour rule”
- However, RHCs ARE NOT subject to this rule!
Billing Incident To in a RHC

Defining Coverage:

- Physicians' services, including services and supplies incidental to a physician services:
- NPs, PAs, and CNMs, including services and supplies incidental to the NPs, PA and CNMs services
- CP and CSW services, including services and supplies incidental to the CPs and CSWs services
- Physical and Occupational Therapy Services

Incident-To Rules

Services incident to a RHC professional service are included in the per-visit payment (AIR)

- Services and supplies provided by auxiliary personnel
- Must result from the patient’s encounter with the physician and be furnished in a medically appropriate timeframe
- More than one incident-to service or supply can be provided as a result of a single physician visit
- Should be included on the RHC cost report

Incident to by NP, PA, or CNM

- Furnished under the general medical supervision of a physician;
- Furnished in accordance with RHC policies and any physician medical orders for the care and treatment of a patient;
- A type of service which the NP, PA, or CNM who furnished the service is legally permitted to furnish by the state in which the service is rendered;
- Furnished in accordance with state restrictions as to setting and supervision;
- Furnished in accordance with written RHC policies that specify what services these practitioners may furnish to patients; and
- A type of service which would be covered under Medicare if furnished by a physician.
Incident To Provision of Supplies & Services

Drugs and biologicals that are not usually self-administered, and Medicare-covered preventive injectable drugs are considered incident-to supplies:

- Venipuncture
- Bandages, gauze, oxygen and other supplies
- Physical Therapy, Occupational Therapy
  - Furnished by a RHC practitioner acting within their state scope of practice
- Assistance by auxiliary personnel such as a nurse, medical assistant, or anyone acting under supervision of physician, NP, PA, or CNM

Incident to services provided on a different day as the billable visit may be included in the charges for the visit if furnished in a medically appropriate timeframe.

Incident To Services

- Services that are not considered incident to include the services of an independently practicing therapist who forwards his/her bill to the RHC for inclusion in the entity’s statement of services, services provided by an independent laboratory or a hospital outpatient department, etc.
Payment for the Incident To Services

- When services and supplies are furnished incident to *an RHC* visit, payment for the services are included in the *RHC AIR*
- An encounter that includes only an incident to service(s) is not a stand-alone billable visit for RHCs
  - Submitted but not paid
  - These visits should still be reported for purposes of costing

Direct Supervision

- Direct Supervision requires a **physician, NP, PA or CNM** available in person “supervising” the services
- Direct supervision *does not require* the supervising practitioner to be present in the same room. However, they must be in the RHC & immediately available to provide assistance and direction throughout the time the *incident to service or supply is being furnished.*
- The direct supervision requirement is met in the case of an NP, PA, or CNM who supervises the furnishing of the service only if such a person is permitted to exercise such supervision under the written policies governing the RHC.

Physician Supervision

- RHCs which are not physician-directed must have an arrangement with a physician that provides for the supervision and guidance of NPs, PAs, and CNMs.
- The arrangement must be consistent with state law.


Payments to Physician Assistants

- The only time that a PA may be paid directly by Medicare is when the PA is the owner of a RHC for a continuous period beginning before the date of the enactment of the BBA, and ending on the date the Secretary determines the RHC no longer meets the requirements of Section 1861(aa)(2) of the Act.
  - Per Section 4205(d)(3)(B) of the Balanced Budget Act (BBA), which amended Section 1842(b)(6)(C) of the Act
Mental Health Visits

- A mental health visit is a medically-necessary face-to-face encounter between an RHC patient and an RHC practitioner during which time one or more RHC or mental health services are rendered.

- Medicare-covered mental health services furnished incident to an RHC visit are included in the payment for a medically necessary mental health visit when an RHC practitioner furnishes a mental health visit.
  - Group mental health services do not meet the criteria for a one-one-one, face-to-face encounter in an RHC.
  - Medication management, or a psychotherapy “add on” service, is not a separately billable service in an RHC and is included in the payment of an RHC medical visit.

Clinical Psychologist (CP) and Clinical Social Worker (CSW) Services

A CP is an individual who:
- Holds a doctoral degree in psychology, and
- Is licensed or certified, on the basis of the doctoral degree in psychology, by the state in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

A CSW is an individual who:
- Possesses a master’s or doctor’s degree in social work;
- After obtaining the degree, has performed at least 2 years of supervised clinical social work; and
- Is licensed or certified as a clinical social worker by the state in which the services are performed; or, in the case of an individual in a state that does not provide for licensure or certification, meets the requirements listed in CFR 410.73(a)(3)(i) and (ii).
CP and CSW Services

Services may include diagnosis, treatment, and consultation

- The CP or CSW must directly examine the patient, or directly review the patient’s medical information. *Except for services that meet the criteria for authorized care management services*, telephone or electronic communication between a CP or CSW and a patient, or between such practitioner and someone on behalf of a patient, are considered CP or CSW services and are included in an otherwise billable visit.

CP and CSW Services

Services performed by CPs and CSWs must be:

- Furnished in accordance with RHC policies and any physician medical orders for the care and treatment of a patient;
- A type of service which the CP or CSW who furnished the service is legally permitted to furnish by the state in which the service is rendered; and
- Furnished in accordance with state restrictions as to setting and supervision, including any physician supervision requirements.
Incident to CP and CSW Services

**NOTE:** The direct supervision requirement is met in the case of a CP who supervises the furnishing of the service only if such a person is permitted to exercise such supervision under the written policies governing the RHC.

- Services and supplies covered under this provision are generally the same as incident to a physician’s services and include services and supplies incident to the services of a CP. The Part B benefit for CSWs does not authorize CSWs to have services furnished incident to their own professional services.

Physical Therapy, Occupational Therapy, & Speech Language Pathology Services

- Physical Therapy (PT), Occupational Therapy (OT), and Speech Language Pathology (SLP) services may be provided in the RHC directly by a physician, NP, or PA, if included in the practitioner’s scope of practice.

- A physician, NP, or PA may also supervise the provision of PT, OT, and SLP services provided incident to their professional services in the RHC by a PT, OT, or SLP therapist.
  - PT, OT, and SLP therapists who provide services incident to a physician, NP, or PA visit may be an employee of the RHC or contracted to the RHC.
Visiting Nurse Services - Criteria

- Must be a **skilled** nursing services
  - Performed by an RN, LPN or LVN
  - Based on the patients condition and the complexity of the service
    - IV or IM injections or catheter insertions
- Requires nurse for safety and efficacy, and adherence to acceptable nursing standards
Visiting Nursing Services - Criteria

• Patient has to be considered “homebound”
• RHC is located in a home health agency shortage area
• Services and supplies are provided under a written treatment plan
• Nursing services are furnished on part-time or intermittent basis only
• Drugs and biologicals are not provided

Visiting Nursing Services - Criteria

• RHCs located in an area that has not been determined to have a current HHA shortage which are seeking to provide visiting nursing services must make a request to the CMS RO along with written justification outlining the area they serve meets the required conditions
Treatment Plans for Visiting Nursing

- Treatment plans must be written and reviewed by supervising physician, NP, PA, CNM, CP as appropriate, at least every 60 days
- If not reviewed every 60 days the treatment plan will be terminated unless:
  - Supervising physician has reviewed the plan of treatment and made a recertification within the 60 day period which indicates that the lapse of visits is part of the physician’s regimen for the patient
  - Nursing visits are required at intervals less frequently than once every 60 days, but intervals are predictable
  - Home nursing visits furnished before the plan is put into writing are covered if authorized in writing by supervising physician

Visiting Nurse Services - Billing

- Claims should include the following:
  - Line item date of service with the type of bill 071X
  - HCPCS code G0490 and revenue code 052X, including the Modifier CG
  - These services are included in the AIR payment
Injections, Vaccines, Immunizations and Medications

- When performed during normal clinic hours, injections are incident to another clinic encounter
  - Incident to services provided on a different day as the billable visit may be included in the charges for the visit if furnished in a medically appropriate timeframe

- **Influenza and pneumococcal** vaccines and their administration are paid through the cost report.

- Payment for a **hepatitis B** vaccine and its administration is included in an otherwise qualifying visit.

- If a Medicare-covered Part B drug is furnished by an RHC practitioner to a Medicare patient as part of a billable visit, the cost of the drug and its administration is included in the AIR payment
Influenza and Pneumococcal Vaccine Administration and Payment

The costs of the influenza and pneumococcal vaccines and their administration are separately reimbursed during the annual cost settlement.

- Influenza and pneumococcal vaccines and their administration are paid at 100% of reasonable cost through the cost report.
- No visit is billed, and these costs should not be included on the claim.
- There is a separate worksheet on the cost report to report the cost of these vaccines and their administration.
- The patient pays no Part B deductible or coinsurance for these services as they are waived.

When an RHC practitioner sees a patient for the sole purpose of administering these vaccinations, the RHC may not bill for a visit.
Preventative Medicine in a RHC

- Most preventative services are paid through the AIR
  - Must pay attention to copayment and deductible
  - If waived due to USPSTF, nothing to collect from patient.
    ◊ Some preventive services still have beneficiary responsibility.

Diabetes Counseling and Medical Nutrition Therapy

- Diabetes counseling and medical nutrition services provided by a registered dietician or nutritional professional may be considered incident to a visit provided all applicable conditions are met

- Includes both
  - Diabetic Self Management Training (DSMT) (G0108) and Medical Nutrition Therapy (MNT) (G0270)
Medicare Well-Woman Exam (G0101)

- If this is the only service performed during an encounter it is separately billable
  - If not, payment is included in the AIR
  - Covered once every two years unless high risk, than annually

- G0101 includes examination of any seven of these components:
  - clinical breast exam, digital rectal exam, external genitalia, urethral meatus, urethra, bladder, vagina, cervix, uterus, adnexa, anus and perineum
  - Diagnosis codes: Z01.411/Z01.419

- May also bill Q0091 for obtaining the pap smear
  - Diagnosis: Z12.4

Well-Woman

- High Risk patient screenings are paid every year
  - Billed with dx code Z91.89 plus a code to indicate high risk condition
  - Z72.51 – 5 or more lifetime sexual partners
  - Z72.51 – onset of sexual activity prior to age 16
  - Z86.19 – history of STD
  - R87.619 – absence of 3 consecutive negative pap smears
  - Z21 or B20 – history of HIV
  - P04.8 – prenatal exposure to DES
  - Send documentation – no pap smears in previous seven years

- If the patient has had a well-woman exam in the last two years, it will be patient responsibility
Glaucoma Screening (G0117 & G0118)

- Can be billed as an encounter if it is the only medical service provided, otherwise included in the AIR
  - Coinsurance and deductible apply and will be based on the charges reported on the revenue code 052x service line with modifier CG

Prostate Cancer Screening (G0102)

- Can be billed as the encounter if it is the only medical service provided, otherwise included in the AIR
  - Coinsurance and deductible apply and will be based on the charges reported on the revenue code 052x service line with modifier CG
Lung Cancer Screening Using Low Dose CT (G0296)

- Can be billed as the encounter if it is the only medical service provided, otherwise included in the AIR
  - Coinsurance and deductible waived

### Preventive Services

<table>
<thead>
<tr>
<th>Services</th>
<th>CPT/HCPCS codes</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Screening and behavioral counseling</td>
<td>G0442</td>
<td>Annual Alcohol Screen 15 min (must be &gt;8 min) And Brief Alcohol misuse counsel</td>
</tr>
<tr>
<td></td>
<td>G0443</td>
<td></td>
</tr>
<tr>
<td>Screening for Depression</td>
<td>G0444</td>
<td>Annual Depression Screening</td>
</tr>
<tr>
<td>Screening for Sexually Transmitted Infections and High Intensity Behavioral Counseling</td>
<td>G0445</td>
<td>High intensity behavioral counseling to prevent sexually transmitted infection; face to face, individual</td>
</tr>
</tbody>
</table>
Preventive Services

<table>
<thead>
<tr>
<th>Services</th>
<th>CPT/HCPCS codes</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive Behavioral Therapy for Cardiovascular Disease</td>
<td>G0446</td>
<td>Face-to-face behavioral counseling for obesity, 15 minutes ( must be &gt;8 min)</td>
</tr>
<tr>
<td>Smoking and Tobacco Cessation Counseling</td>
<td>99406</td>
<td>Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes</td>
</tr>
<tr>
<td>Smoking and Tobacco Cessation Counseling</td>
<td>99407</td>
<td>greater than 10 minutes</td>
</tr>
</tbody>
</table>

Screening – ICD-10-CM Guidelines

- **Screening** is the testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease (e.g., screening mammogram).
- The testing of a person to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening. In these cases, the sign or symptom is used to explain the reason for the test.
Medicare’s Annual Wellness Visit (AWV) and Initial Preventive Physical Examination (IPPE)

The Medicare Wellness Continuum

- Welcome to Medicare Physical (G0402)
  - First year of Medicare only.
  - Also called Initial Preventive Physical Examination

- Annual Wellness Visit, Initial (G0438)
  - Second year of Medicare

- Annual Wellness Visit, Subsequent (G0439)
  - Annually for Medicare
Initial Preventative Physical Exam (IPPE)

The Welcome to Medicare Physical

“The IPPE is an introduction to Medicare and covered preventative benefits and focuses on health promotion and disease prevention and detection to help beneficiaries stay well. Medicare does not cover routine physical examinations.”

Medicare Initial Preventive Physical Examination

IPPE or “Welcome to Medicare” visit

– HCPCS G0402
– Covered screening services may be billed separately
  ◊ May be included in the AIR as previously noted
– May be performed by MD, DO, or APP
– Medicare patients are eligible one time, their first year of Part B benefits
IPPE

- Seven Elements required for IPPE
  - Review of medical and social history with attention to risk factors
  - Review of risk factors for depression
  - Review of functional ability and level of safety
  - Examination – must include visual acuity screen and BMI
  - Performance and interpretation of EKG, if desired
  - Education, counseling, and referral as appropriate
  - Brief written plan for other appropriate screening services

- Problem-oriented or mental health visit may be billed separately
  ◊ Coinsurance and deductible waived for IPPE only

- EKG performed at discretion of physician, and is billed separately
  ◊ G0402 for EKG – (payment based on 93005) with the 052X Rev Code
  ◊ G0405 for interpretation only – (payment considered to be part of the RHC visit)
  ◊ For both the professional & tech components, neither deductible or co-insurance waived
**IPPE AAA Screening**

**Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)** is an optional service that may be ordered/performed as a results of a referral. Patients must meet the following criteria to have this screening ordered.

- Beneficiaries at risk that have a family history of AAA
- Men age 65 to 75 who have smoked at least 100 cigarettes in their lifetime
  - G0389 is covered **once in a lifetime**

**Co-ins & deductible do NOT apply**

---

**Annual Wellness Visits (AWV)**

**Eligible Providers**

- MD, DO, NP, PA, CNS; and
- A medical professional (including a health educator, registered dietitian or nurse, or nutrition professional or other licensed practitioner) or a team of such medical professionals, **working under the direct supervision of a MD, DO, NP, PA or CNM**
- Direct Supervision means physically available to assist, but need not be present during the face-to-face encounter

**Bottom Line:** *Nurses and MAs can provide the AWV & ACP! They can NOT provide the IPPE!*
AWV

- Considerations
  - IPPE & AWV are not intended to be a “routine physicals”
    - Medicare does not cover routine physicals
  - There is no specific diagnosis requirement
  - All elements of the AWV must be performed to bill for the service, it includes a health risk assessment
  - Patients are eligible 12 months after effective date of Medicare, and if they not received an IPPE (“Welcome to Medicare”) in past 12 months
  - Included in the AIR when billed with another service on the same day

Initial Elements Include

- Health Risk Assessment (Approx. 20 minutes)
  - Can be completed by the patient prior to the encounter
- Establish list of current providers
- Establish medical/family history
- Use appropriate screening tool for patients without a current dx of depression to assess risk factors
- Based on direct observation, review functional ability and level of safety (fall risk, ADLs, hearing, home safety)
- Obtain height, weight, BMI and BP
- Based on direct observation assess cognitive function including consideration of reports and concerns raised by family, caregivers, friends and others
Health Risk Assessment

Addresses, at a minimum:

- Demographic data, including but not limited to age, gender, race, and ethnicity.
- Self assessment of health status, frailty, and physical functioning.
- Psychosocial risks, including but not limited to depression/life satisfaction, stress, anger, loneliness/social isolation, pain, or fatigue.
- Behavioral risks, including but not limited to tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual practices, motor vehicle safety (seat belt use), and home safety.

- Activities of daily living (ADLs), including but not limited to dressing, feeding, toileting, grooming, physical ambulation (including balance/risk of falls), and bathing.
- Instrumental activities of daily living (IADLs), including but not limited to shopping, food preparation, using the telephone, housekeeping, laundry, mode of transportation, responsibility for own medications, and ability to handle finances.
AWV

- Initial/Subsequent Counseling Elements
  - Establish/Update a written screening schedule for 5-10 years
  - Establish/Update a list of risk factors and conditions for which interventions are recommended or planned
  - Provide personalized prevention plan
    ◊ including referrals to appropriate health education and preventive services (community based lifestyle interventions, fall prevention, nutrition, physical activity, tobacco-use cessation and weight loss)

Medicare Covered Preventive Services

<table>
<thead>
<tr>
<th>Alcohol Misuse Screening &amp; Counseling</th>
<th>Intensive Behavioral Therapy (IBT) for CVD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone Mass Measurement</td>
<td>IBT for Obesity</td>
</tr>
<tr>
<td>Lung Cancer Screening Counseling &amp; LDCT</td>
<td>Medical Nutrition Therapy</td>
</tr>
<tr>
<td>Cardiovascular Disease Screening</td>
<td>Prostate Cancer Screening</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>STI Screening and IBT for STIs</td>
</tr>
<tr>
<td>Counseling to Prevent Tobacco Use</td>
<td>Screening Mammography</td>
</tr>
<tr>
<td>Depression Screening</td>
<td>Screening Pap</td>
</tr>
<tr>
<td>Diabetes Screening</td>
<td>Screening Pelvic Exam and Breast Exam</td>
</tr>
<tr>
<td>Diabetes Self Mgmt Training</td>
<td>Ultrasound for AAA</td>
</tr>
<tr>
<td>Glaucoma Screening</td>
<td>Hep C Screening</td>
</tr>
<tr>
<td>Flu, Pneumo and Hep V Vaccines</td>
<td>Advance Care Planning</td>
</tr>
</tbody>
</table>
Advance Care Planning (ACP)

Advance Care Planning - Time

99497: Advance Care Planning including the explanation and discussion of advance directives such as standard forms (including the completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family members and/or surrogate

Minimum of 16 minutes spent and documented

Engage in the Conversation

+99498: Each additional 30 minutes

Minimum of 46 minutes spent and documented
Some Conversations Take Longer

- **Up to 15 minutes:** included in E/M code, other services and are not billable
- **16-45 minutes:** 99497
- **46-75 minutes:** 99497 + 99498
- **76-105 minutes:** 99497 + 99498 x 2
- **106 – 135 minutes:** 99497 + 99498 x 3, etc.

Best Practice ACP Documentation Tips

- **Document a brief summary of the voluntary conversation**
  - Detail should vary based on length/complexity of the conversation, which would also justify time duration
- **Document the time and who was present**
  - Either by start/stop time or total time in minutes
- **Form completion may or may not occur**
  - If forms are completed, document which forms were completed and maintain a copy in the record (Advance Directive, MOLST, etc.)
- **No diagnosis requirements**
  - If a serious illness is a driver to the conversation, it is expected that such diagnosis will be reflected on the claim
More Best Practice Documentation Tips

- Denote the person designated to make decisions for the patient if the patient cannot speak for him or herself
- Capture the preferred types of medical care and comfort level
- Note patient consent for ACP performed as part of an annual wellness visit (Medicare only)
- Consider how the patient prefers to be treated by others and what the patient wishes others to know

ACP – same day as AWV

Example Documentation –

“Aside from the time spent in performing Annual Wellness Visit, I spent 30 minutes discussing the patient’s wishes regarding end-of-life care. Forms for advanced directive were discussed, and she will complete them after discussing with her children.”
ACP – same day as AWV

- HCPCS G0438 AWV
  - Typical dx code Z00.00
- 99497 ACP
  - Recommended dx code Z71.89 - other specified counseling
  - Patient has no financial responsibility if performed on same day as AWV
- May be included as part of Chronic Care Management care plan

Transitional Care Management (TCM)
Transitional Care Management (TCM)

Managing transition services provided through 30 days post discharge from one of the following facilities

<table>
<thead>
<tr>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Acute Care Hospital</td>
</tr>
<tr>
<td>Inpatient Psychiatric Hospital</td>
</tr>
<tr>
<td>Long Term Care Hospital</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Facility</td>
</tr>
<tr>
<td>Hospital observation or partial hospitalization; and</td>
</tr>
<tr>
<td>Partial hospitalization at a Community Mental Health Center</td>
</tr>
</tbody>
</table>

Transitional Care Management

99495 – Visit in 14 days

- **Interactive communication** (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of at least moderate complexity during the service period
- Face-to-face visit within 14 calendar days of discharge
  - Medication Reconciliation

99496 – Visit in 7 days

- **Interactive communication** (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of high complexity during the service period
- Face-to-face visit within 7 calendar days of discharge
  - Medication Reconciliation
Who May Bill for TCM?

- Physicians: MD, DO
- Mid-level Providers: NPs, PAs, CNMs, CNSs
  - Licensed Clinical Staff may perform applicable non face to face service requirements under General Supervision
  - TCM is included in the AIR

Non Face-to-Face TCM Services

Provider-Directed Licensed Clinical Staff;
(if medically indicated)
- Communicate with agencies and community services used by the beneficiary;
- Provide education to the beneficiary, family, guardian and/or caretaker to support self-management, independent living and activities of daily living;
- Assess and support treatment regimen adherence and medication management;
- Identify available community and health resources; and
- Assist the beneficiary and/or family in accessing needed care and services
Non Face-to-Face TCM Services

Performed by **Physician or NPP**

*(if medically indicated)*

- Obtain and review discharge information
- Review need for follow-up on pending diagnostic tests and treatment
- Interaction with specialists assuming care for specific problems
- Provide education to patient, family, guardian and/or caregiver
- Establish referrals for needed community resources
- Assist in scheduling follow-up with community service providers

TCM Billing Summary

Face-to-Face visit
- Within either 7 or 14 days, depending on acuity and subsequent decision making required

Billing Considerations
- Billed by only one health care professional, per discharge
- Bill once per beneficiary, per 30 days transitional period
- Reasonable and necessary E/M services can be billed in addition to TCM during the 30 day period
- Cannot be billed in a post-operative global period for procedure by same provider
TCM Minimum Documentation Requirements

- Date of discharge
- Date of the interactive contact
- Date of face-to-face visit
- The complexity of medical decision making
  - Either moderate or high, based on the ‘95 or ’97 E/M Documentation Guidelines

Telehealth Services
What is Telehealth?

Telehealth and Telemedicine:

Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve patients' health status.

Closely associated with telemedicine is the term telehealth, which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services. Videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs, continuing medical education and nursing call centers are all considered part of telemedicine and telehealth.

The two terms have become synonymous.

– Additional terms include; digital health, mHealth, virtual health, and e-visit

– Source: American Telehealth Association

Medicare & Telehealth
**Medicare “Telehealth” Regulations:**

Telehealth reimbursement began as a means to expand access in rural areas and was driven by Medicare. Under Medicare, only specific services performed by specific providers at specific locations are covered.

- “Originating site” requirements (where patient is located for services)
  - An acceptable site where tele-capability exists and in rural area:
    ◊ A county outside of a Metropolitan Statistical Area (MSA) or
    ◊ A rural Health Professional Shortage Area (HPSA) located in a rural census tract
- “Distant site” requirement
  - Where the **practitioner** is who will provide the service/bill for the service
  - Only certain providers are acceptable under distant site requirements
- Store & Forward **not** covered, must be real-time (synchronous) technology. (except for Hawaii, Alaska)

**Qualifying Originating Sites**

- Offices of physicians or practitioners
- Hospitals, Critical Access Hospitals (CAHs)
- **Rural Health Clinics**
- Federally Qualified Health Centers (FQHCs)
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
- Skilled Nursing Facilities (SNFs) and
- Community Mental Health Centers (CMHCs)

Are you located in a rural area that qualifies?

https://datawarehouse.hrsa.gov/tools/analyzers/geo/Telehealth.aspx
Qualifying Distant Site Practitioner

- Physicians
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Nurse-midwives
- Clinical nurse specialists (CNSs)
- Certified registered nurse anesthetists
- Clinical psychologists (CPs) and clinical social workers (CSWs).
  - CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services.
- Registered dietitians or nutrition professionals

(all subject to respective State law)

Reimbursable Services

Medicare reimburses for a specific list of services/codes. While CMS continues to expand this list every year, services generally fall into the following areas:

- Behavioral health
- Chronic disease management
- Professional consultations
- End stage renal disease
- Wellness services
## Medicare Telehealth Reimbursement Examples

<table>
<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Description</th>
<th>2018 Allowed Amount(s) Non-Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0425–G0427</td>
<td>Telehealth consultations, emergency department or initial inpatient (30, 50 and 70 minutes)</td>
<td>$101.52 $137.52 $205.20</td>
</tr>
<tr>
<td>G0406–G0408</td>
<td>Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs (15, 25, and 35 minutes)</td>
<td>$39.24 $73.44 $105.48</td>
</tr>
<tr>
<td>G0459</td>
<td>Telehealth Pharmacologic Management</td>
<td>$41.76</td>
</tr>
<tr>
<td>G0396 &amp; G0397</td>
<td>Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services</td>
<td>$36.36* $69.84*</td>
</tr>
<tr>
<td>G0438</td>
<td>Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit</td>
<td>$175.32</td>
</tr>
<tr>
<td>G0508</td>
<td>Telehealth Consultation, Critical Care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth</td>
<td>$204.12</td>
</tr>
<tr>
<td>Q3014</td>
<td>Telehealth originating site facility fee</td>
<td>$25.76</td>
</tr>
</tbody>
</table>

* Non-facility varies from facility fee.

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## Telehealth Billing

- RHCs may bill the Telehealth originating site facility fee under revenue code 0780 using HCPCS code Q3014
Virtual Care Across the States

Telehealth Across the States

Where each state stands on telehealth

Source: Advisory Board research
**Interstate Medical Licensure Compacts (IMLC)**
- Voluntary expedited pathway to licensure for qualified physicians who wish to practice in multiple states
- Designed to increase access in underserved or rural areas, particularly through use of telemedicine technologies
- Designed to make it easier for physicians to obtain licenses to practice in multiple states (while still protecting patients)
- 24 states are currently a part of the compact (teal/darker blue states)

Source: https://imlcc.org/

**Enhanced Nurse Licensure Compact (eNLC)**
- Allows “nurses to practice in person or provide telehealth nursing services to patients located across the country without having to obtain additional licenses.”
- 29 Compact States: Arizona, Arkansas, Colorado, Delaware, Florida, Georgia, Idaho, Iowa, Kentucky, Maine, Maryland, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin and Wyoming.

- The eNLC allows for registered nurses (RNs) and licensed practical/vocational nurses (LPN/LVN) to have one multistate license, with the ability to practice in person or via telehealth in both their home state and other eNLC states. Licensing standards are aligned, which include a federal and state criminal background check.

- eNLC also enables nurses to provide telehealth nursing services to patients located across the country without having to obtain additional licenses.

Source: https://www.ncsbn.org/11945.htm
The Impact of a Compact

• Aids in increasing access
• Reduces the time for licensing a new provider
• Eases the burden of providers that work across state lines, particularly those on border states
• Is a fundamental element in the expansion of virtual care delivery across the country

Barriers
General Barriers

- Where and when to start
- How to make the financials work
- IT and infrastructure costs
- Vendor and device selections
- Staff time and workflow changes
- Connectivity/broadband
- Maze of requirements/regulations

Expanding Telehealth in Medicare

Two of the barriers which continue to impact Medicare’s rapid expansion include:

1. *CMS is constrained with how much it can do through its regulatory authority. Congress will need to continue to pass laws reducing burden and allowing broader reimbursement across the continuum.*

2. *Congress has been constrained in how much it is willing to expand telehealth because, depending on the approach/policy, CBO has indicated it will increase costs to the federal budget.*
2019 Physician Fee Schedule Finalizes Medicare Virtual Care Expansion

“CMS is committed to modernizing the Medicare program by leveraging technologies, such as audio/video applications or patient-facing health portals, that will help beneficiaries access high-quality services in a convenient manner.”

- CMS Administrator Seema Verma

1. CMS finalized two non “telehealth” communication technology-based reimbursable services
2. CMS expanding “telehealth” services in the office & outpatient setting

CMS finalizes a policy to allows RHCs and FQHCs to receive an additional payment for the costs of communication technology-based services or remote evaluation services that are not already captured in the RHC AIR or the FQHC PPS payment when the requirements for these services are met.

Effective January 1, 2019

2019 Final Physician Fee Schedule Rule
Medicare Virtual Care: FQHCs, RHCs

- RHCs/FQHCs paid for HCPCS code G0071 (Virtual Communication Services) when HCPCS code G0071 is on an RHC or FQHC claim, either alone or with other payable services, and at least 5 minutes of communication technology based or remote evaluation services are furnished by an RHC/FQHC practitioner to a patient who has had an RHC or FQHC billable visit within the previous year, cannot be related to a medical discussion or remote evaluation for a condition the RHC/FQHC provided in past 7 days, and does not lead to an RHC/FQHC visit within next 24 hours or at the soonest available appointment
- HCPCS code G0071 is set at the average of the national non-facility PFS payment rates for HCPCS code G2012 (communication technology-based services) and HCPCS code G2010 (remote evaluation services) and is updated annually based on the PFS national nonfacility payment rate for these codes.
- RHC/FQHC face-to-face requirements are waived when services furnished to RHC/FQHC patient
2019 Final Physician Fee Schedule Rule

Medicare Telehealth

• CMS finalizes two add-on codes
• Payment for prolonged preventive services ⇒ yes, “telehealth.”
  • HCPCS code G0513 (Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service).
  • HCPCS code G0514 (Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code G0513 for additional 30 minutes of preventive service).
• Facility Fee set for 2019 at $26.15

Chronic Care Management (CCM)
What is CCM?

Chronic Care Management (CCM) is defined as the non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more), significant chronic conditions.

In addition to office visits and other face-to-face encounters (billed separately), these services include communication with the patient and other treating health professionals for care coordination (both electronically and by phone), medication management, and being accessible 24 hours a day to patients and any care providers (physicians or other clinical staff).

The creation and revision of electronic care plans is also a key component of CCM.

### Chronic or Complex Chronic

**Chronic Care Mgmt:**

- G0511

**Complex Chronic Care Mgmt:**

- (99487)

  *Cannot be billed by RHC*

- moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

- multiple (two or more) chronic conditions expected to last at least 12 months which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

- establishment or substantial revision of a comprehensive care plan

- at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

- multiple (two or more) chronic conditions expected to last at least 12 months which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

- comprehensive care plan established, implemented, revised, or monitored
CCM is Contact-based Care

**Contact-based care** – To count the time towards the 20-minutes of non-face-to-face time, the care must be “contact initiated.”

This could be patient-doctor, patient-nurse, doctor-doctor, pharmacy-doctor, lab-doctor, or other contact regarding or by the patient via phone or electronic communication.

General planning time or care coordination doesn’t count unless it is initiated based on a contact and/or results in a patient or patient-related contact.

- For example, if the pharmacist calls the office because the patient reported a rash, then the time counts. If the office spends time running a report of all participants due for a flu shot or an A1C check, that time doesn’t count. When they call and speak to the patient and then coordinate care, then that time would count.

CCM Documentation and Billing Tips

- **CCM** may be billed *once per month*, **not** included in AIR
  - Can’t be billed during the same month as Transitional Care Management (TCM)
  - Patient consent should be documented and obtained at the initiating visit (can be AWV, IPPE, TCM or medical visit)

- **Documentation and Care Requirements:**
  - Documentation requires the time spent by the provider or nursing staff on patient phone calls or caring for the patient (Not face to face)
  - Structured Recording of Patient Information Using a Certified EHR
    - Currently 2014 or 2015 certified
  - Provide 24/7 access
  - Continuity of care
Additional CCM Requirements

- Home and Community-Based Care Coordination
  - Coordination with home and community based clinical service providers.
  - Communication to and from home and community-based providers regarding the patient’s psychosocial needs and functional deficits must be documented in the patient’s medical record.
  - Enhanced Communication Opportunities: Enhanced opportunities for the beneficiary and any caregiver to communicate with the practitioner regarding the beneficiary’s care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.

Behavioral Health Integration (BHI) and Psychiatric Collaborative Care Management (CoCM)
Behavioral Health Integration

Integrating behavioral health care with primary care (“behavioral health integration” or “BHI”) is now widely considered an effective strategy for improving outcomes for the millions of Americans with mental or behavioral health conditions. As of January 1, 2017, Medicare makes separate payments to physicians and non-physician practitioners for BHI services they furnish to beneficiaries over a calendar month service period.

Health Care Team Providers

- **Treating (Billing) Practitioner** – A physician and/or non-physician practitioner (PA, NP, CNM); typically primary care, but may be of another specialty (e.g., cardiology, oncology)

- **Potentially Clinical Staff** – The service may be provided in full by the billing practitioner. Alternatively, the billing practitioner may use qualified clinical staff to provide certain services using a team-based approach. These clinical staff may- but are not required to-include a designated behavioral health care manager or psychiatric consultant.
General BHI

• General BHI is a team-based, collaborative approach to care that focuses on integrative treatment of patients with primary care and mental or behavioral health conditions.

• Patients are eligible to receive BHI services if they have one or more new or pre-existing behavioral health or psychiatric conditions being treated by the RHC, including substance use disorders, that, in the clinical judgment of the primary care practitioner, warrants BHI services.

Beneficiary Communication Requirements

• Given permission to consult with relevant specialists as needed;
• Been informed that there may be cost-sharing for both in-person and non-face-to-face services that are provided;
• Been informed that only one practitioner/facility can furnish and be paid for these services during a calendar month; and
• Been informed that they can stop care management services at any time, effective at the end of the calendar month.
General BHI Service Requirements

- An initial assessment and ongoing monitoring using validated clinical rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team

General BHI Requirements & Payment

- A separately billable initiating visit with an RHC practitioner is required before BHI care management services can be furnished. This visit can be an E/M, AWV, or IPPE visit, and must occur no more than one-year prior to commencing care management services.
- Billed with G0511 and payment is set at the average of the national non-facility PFS payment rate of 9940, 99487 and 99484.
  - Minimum of 20 minutes per month
  - RHCs can bill G0511 when the requirements for either CPT codes 99490, 99487, or 99484 are met. G0511 can be billed alone or in addition to other services furnished during an RHC visit.
  - Copay and deductible apply
What is CoCM?

A model of behavioral health integration that enhances “usual” primary care by adding two key services:

1. Care management support for patients receiving behavioral health treatment; and
2. Regular psychiatric inter-specialty consultation to the primary care team, particularly regarding patients whose conditions are not improving

Health Care Team Providers

- **Treating (Billing) Practitioner** – A physician and/or non-physician practitioner (PA, NP, CNM); typically primary care, but may be of another specialty (e.g., cardiology, oncology)

- **Psychiatric Consultant** – A medical professional trained in psychiatry and qualified to prescribe the full range of medications

- **Behavioral Health Care Manager** – A designated individual with formal education or specialized training in behavioral health (including social work, nursing, or psychology), working under the oversight and direction of the billing practitioner
**RHC Practitioner Requirements**

- The RHC practitioner is a primary care physician, NP, PA, or CNM who:
  - Directs the behavioral health care manager and any other clinical staff;
  - Oversees the beneficiary’s care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed; and
  - Remains involved through ongoing oversight, management, collaboration and reassessment.

**Behavioral Health Care Manager Requirements**

The behavioral health care manager is a designated individual with formal education or specialized training in behavioral health, including social work, nursing, or psychology, and has a minimum of a bachelor’s degree in a behavioral health field (such as in clinical social work or psychology), or is a clinician with behavioral health training, including RNs and LPNs.

- The behavioral health care manager furnishes both face-to-face and non-face-to-face services under the general supervision of the RHC practitioner and may be employed by or working under contract to the RHC.
The BH Manager Responsibilities

- Provides assessment and care management services, including the administration of validated rating scales;
- Provides behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Provides brief psychosocial interventions;
- Maintains ongoing collaboration with the RHC practitioner;
- Maintains a registry that tracks patient follow-up and progress;
- Acts in consultation with the psychiatric consultant;
- Is available to provide services face-to-face with the beneficiary; and
- Has a continuous relationship with the patient and a collaborative, integrated relationship with the rest of the care team.

Psychiatric Consultant Requirements

The psychiatric consultant is a medical professional trained in psychiatry and qualified to prescribe the full range of medications. The psychiatric consultant is not required to be on site or to have direct contact with the patient and does not prescribe medications or furnish treatment to the beneficiary directly.
Psychiatric Consultant Responsibilities

- Participates in regular reviews of the clinical status of patients receiving psychiatric CoCM services;
- Advises the RHC practitioner regarding diagnosis and options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment; making adjustments to behavioral health treatment for beneficiaries who are not progressing; managing any negative interactions between beneficiaries’ behavioral health and medical treatments; and
- Facilitates referral for direct provision of psychiatric care when clinically indicated.

CoCM Requirements & Payment

- A separately billable initiating visit with an RHC practitioner is required before BHI care management services can be furnished. This visit can be an E/M, AWV, or IPPE visit, and must occur no more than one-year prior to commencing care management services.
- Billed with **G0512** and payment is set at the average of the national non-facility PFS payment rate for CPT code 99492 CPT code 99493
  - 70 minutes of behavioral health care manager time the first month
  - 60 minutes subsequent months
Eligible Diagnoses for BHI Services

Any mental, behavioral health, or psychiatric condition being treated by the billing practitioner, including substance use disorders, that, in the clinical judgment of the billing practitioner, warrants BHI services.

The diagnosis or diagnoses could be either pre-existing or made by the billing practitioner and may be refined over time.

Beneficiaries may, but are not required to have, comorbid, chronic, or other medical condition(s) that are being managed by the billing practitioner.

Neither BHI or CoCM are included in the AIR.

<table>
<thead>
<tr>
<th>BHI Code</th>
<th>BEHAVIORAL HEALTH CARE MANAGER OR CLINICAL STAFF THRESHOLD TIME</th>
<th>ASSUMED BILLING PRACTITIONER TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>CoCM First Month (G0512)</td>
<td>70 minutes per calendar month</td>
<td>30 min</td>
</tr>
<tr>
<td>CoCM Subsequent Months (G0512)</td>
<td>60 minutes per calendar month</td>
<td>26 min</td>
</tr>
<tr>
<td>General BHI (G0511)</td>
<td>At least 20 minutes per calendar month</td>
<td>15 min</td>
</tr>
<tr>
<td>BHI Initiating Visit (AWV, IPPE, TCM or other qualifying E/M)</td>
<td>N/A</td>
<td>Usual work for the visit code</td>
</tr>
</tbody>
</table>
ICD-10-CM Coding

ICD-10-CM

  – Developed by the World Health Organization (WHO)

• Cooperating Parties:
  – Centers for Medicare and Medicaid Services (CMS)
  – American Hospital Association (AHA)
  – National Center for Health Statistics
  – American Health Information Management Association (AHIMA)
ICD-10-CM

- Officially implemented in 2015, yearly updates in October
- AHA Coding Clinic
- ICD-10-CM Official Guidelines

ICD-10-CM

- Physician offices, including RHCs, must comply with the coding guidelines even if providers see patients as Inpatients, using Outpatient guidelines
  - Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services
ICD-10-CM Breakdown

- Codes range from 3 to 7 characters
- Alphanumeric
- Placeholders of “X” are used when the code expands to 7 characters
- As of 10-1-2018, ICD-10-CM has over 71,000 diagnosis codes compared to 13,000 in ICD-9-CM

ICD-10-CM Common Mistakes

- Not coding all characters, leaving off the last character or the placeholders
- Coding as definitive diagnosis when provider is still working patient up
  - Must code signs and symptoms per ICD-10-CM OP guidelines if not certain of dx
- Forgetting or neglecting to code co-morbidities or complicating diagnoses
  - Guidelines specifically address coding all conditions that are being considered or treated
ICD-10-CM Common Mistakes

- Not reading and/or following the ICD-10-CM Guidelines (in the front of your ICD-10-CM book or online)

- Some coding scenarios will require multiple codes
  Example: Diabetes and complications

Hierarchical Condition Category Coding (HCC)
Background

Physicians traditionally have relied on FFS or AIR payment
- Providers bill services based on E/M and CPT procedure codes
- Payment is based on complexity of the
- Payment is not affected by the complexity of the patient
- ICD-10 diagnosis codes used to demonstrate medical necessity

CMS now assigns some payments for patients based on risk
- Higher specificity ICD-10 diagnosis codes better define expected cost of a attributed population
- Introduces financial incentives to reflect acuity of each patient

Hierarchical Condition Categories – HCC’s
- Created by CMS in 2004 to risk adjust capitated payments for Medicare Advantage plans based on risk, use has now expanded to Merit-based Incentive Payment System or MIPS, and many other value based payment models
- The purpose of HCCs is to capture the disease burden of a particular patient to predict the payment rate
Types of HCC’s

- **CMS HCC’s**
  - Traditionally used for Medicare Advantage Plans
  - Capture acuity of medical care for Part A and Part B
- **HHS-HCC**
  - Used for Federal Exchanges
- **Rx-HCC’s**
  - Used with Medicare HCC’s
  - Capture outpatient pharmacy costs associated with Medicare Part D
- **ACG’s (Adjusted Clinical Groups)**
  - Used by commercial payers

From ICD-10 Diagnosis to HCC

- ~71,000 ICD-10 Diagnosis Codes
- ~9,500 ICD-10 codes Map to HCCs
- 27 Condition Categories
- 79 HCCs
## 27 Condition Categories

<table>
<thead>
<tr>
<th>Infection</th>
<th>Blood</th>
<th>Cerebrovascular Disease</th>
<th>Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neoplasm</td>
<td>Substance Abuse</td>
<td>Vascular</td>
<td>Transplant</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Psychiatric</td>
<td>Lung</td>
<td>Openings</td>
</tr>
<tr>
<td>Metabolic</td>
<td>Spinal</td>
<td>Eye</td>
<td>Amputation</td>
</tr>
<tr>
<td>Liver</td>
<td>Neurological</td>
<td>Kidney</td>
<td>Disease Interactions</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Arrest</td>
<td>Skin</td>
<td>Disability Status</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Heart</td>
<td>Injury</td>
<td></td>
</tr>
</tbody>
</table>

### HCC Categories for 2018

<table>
<thead>
<tr>
<th>HCC</th>
<th>HCC Description</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HIV/AIDS</td>
<td>0.312</td>
</tr>
<tr>
<td>2</td>
<td>Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Septic Shock</td>
<td>0.455</td>
</tr>
<tr>
<td>6</td>
<td>Opportunistic Infections</td>
<td>0.435</td>
</tr>
<tr>
<td>8</td>
<td>Metastatic Cancer and Acute Leukemia</td>
<td>2.625</td>
</tr>
<tr>
<td>9</td>
<td>Lung and Other Severe Cancers</td>
<td>0.070</td>
</tr>
<tr>
<td>10</td>
<td>Lymphoma and Other Cancers</td>
<td>0.677</td>
</tr>
<tr>
<td>11</td>
<td>Colorectal, Bladder, and Other Cancers</td>
<td>0.301</td>
</tr>
<tr>
<td>12</td>
<td>Breast, Prostate, and Other Cancers and Tumors</td>
<td>0.146</td>
</tr>
<tr>
<td>17</td>
<td>Diabetes with Acute Complications</td>
<td>0.318</td>
</tr>
<tr>
<td>18</td>
<td>Diabetes with Chronic Complications</td>
<td>0.318</td>
</tr>
<tr>
<td>19</td>
<td>Diabetes without Complication</td>
<td>0.104</td>
</tr>
<tr>
<td>21</td>
<td>Protein-Calorie Malnutrition</td>
<td>0.545</td>
</tr>
<tr>
<td>22</td>
<td>Morbid Obesity</td>
<td>0.273</td>
</tr>
<tr>
<td>23</td>
<td>Other Significant Endocrine and Metabolic Disorders</td>
<td>0.228</td>
</tr>
<tr>
<td>27</td>
<td>End-Stage Liver Disease</td>
<td>0.962</td>
</tr>
<tr>
<td>28</td>
<td>Cirrhosis of Liver</td>
<td>0.390</td>
</tr>
<tr>
<td>29</td>
<td>Chronic Hepatitis</td>
<td>0.185</td>
</tr>
<tr>
<td>33</td>
<td>Intestinal Obstruction/Perforation</td>
<td>0.246</td>
</tr>
<tr>
<td>34</td>
<td>Chronic Pancreatitis</td>
<td>0.276</td>
</tr>
<tr>
<td>35</td>
<td>Inflammatory Bowel Disease</td>
<td>0.294</td>
</tr>
<tr>
<td>39</td>
<td>Bone/Joint/Muscle Infections/Necrosis</td>
<td>0.425</td>
</tr>
<tr>
<td>40</td>
<td>Rheumatoid Arthritis and Inflammatory Connective Tissue Disease</td>
<td>0.423</td>
</tr>
<tr>
<td>46</td>
<td>Severe Hematological Disorders</td>
<td>1.386</td>
</tr>
<tr>
<td>47</td>
<td>Disorders of Immunity</td>
<td>0.625</td>
</tr>
<tr>
<td>48</td>
<td>Coagulation Defects and Other Specified Hematological Disorders*</td>
<td>0.221</td>
</tr>
<tr>
<td>54</td>
<td>Drug/Alcohol Psychosis</td>
<td>0.383</td>
</tr>
<tr>
<td>55</td>
<td>Drug/Alcohol Dependence</td>
<td>0.383</td>
</tr>
<tr>
<td>57</td>
<td>Schizophrenia</td>
<td>0.608</td>
</tr>
<tr>
<td>58</td>
<td>Major Depressive, Bipolar, and Paranoid Disorders</td>
<td>0.395</td>
</tr>
<tr>
<td>70</td>
<td>Quaertrigenia</td>
<td>1.314</td>
</tr>
<tr>
<td>71</td>
<td>Paraplegia</td>
<td>1.007</td>
</tr>
<tr>
<td>72</td>
<td>Spinal Cord Disorders/Injuries</td>
<td>0.528</td>
</tr>
</tbody>
</table>
HCC Example: Diabetes

*The Condition Category*: Diabetes

Has 3 HCCs that ICD-10 codes are mapped to:

- Diabetes with acute complications (HCC 17)
- Diabetes with chronic complications (HCC 18)
- Diabetes without complication (HCC 19)
  - If HCC 18 is reported, then HCC 19 will be dropped if both are reported in the same calendar year
  - List complications as due to the diabetes, neuropathy, CKD or retinopathy otherwise they will not compound

What is Risk Adjustment?

- Risk adjustment is the statistical process by which reimbursement is determined based on underlying health status and demographics of the patient
- Ensures adequate resources to care for our high-risk patients
  - Higher reimbursement for patients with more chronic disease
- Allows health plans and providers to be paid for the actual risk of their patients
  - Prevents cherry-picking only healthy patients and lemon dropping patients with multiple co-morbidities
Risk Adjustment Across Payers/Models

HCC Risk Adjustment

Sources: CMS takes diagnoses from IP/OP hospital and physician data

Prospective: Slate wiped clean each year with no memory. Predicts cost for next year

Disease Interactions: Scaling factors applied when chronic diseases enhance complexity (e.g. DM and HF)

Demographics: Age, Sex and Medicare Entitlement status
HCC’s to RAF

Risk adjustment predicts (or explains) the future healthcare expenditures of individuals based on demographics and disease data.

What is a Risk Adjustment Factor Score (RAF)?

- Each HCC category is assigned a coefficient or ‘weight’ that is additive into the Risk Score
- The calculation is by condition category – if multiple ICD-10 diagnosis codes map to the same HCC category reported, the category is still only counted once toward the RAF Score
- “Average” RAF Score is 1.0
  
  Higher score = sicker than average patient likely to incur higher cost
  Lower score = healthier than average patient likely to incur less cost
CMS HCC’s: Disease Interaction Plays a Role

- Provides additional “weight” for certain disease interactions/comorbidities that have impact on complexity and cost
- Disease interaction weight is calculated in addition to the weights from both disease categories

Examples:
- Immune disorders + Cancer
- Congestive Heart Failure + Diabetes
- Congestive Heart Failure + COPD
- Congestive Heart Failure + Renal Disease
- Congestive Heart Failure + Specified Heart Arrhythmias

RAF-HCC Example

Example:
A 1.0 risk score represents average annual Medicare costs for an individual

Let’s use $10,000 as an average cost, for illustration purposes
- Greater than 1.0 means the individual is likely to incur costs higher than $10,000
- Less than 1.0 means the individual will likely incur costs less than $10,000
- If the risk score was 1.5, the expected costs = $15,000 (1.5 X the average score of $10,000)

A low RAF score can mean 1 of 2 things:

1. Low RAF = Healthier Population
2. Low RAF = Administrative Error
   - Inadequate chart documentation
   - Inadequate/Incomplete coding
   - The patient has not been seen
Sample CMS-HCC RAF

### 2016 RAF Score Example – Medicare Advantage Reimbursement Model

<table>
<thead>
<tr>
<th>Condition</th>
<th>Coefficient</th>
<th>PMPM Payment to MA Plan</th>
<th>Annual Payment to MA Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base rate: 75-79 y.o. male Full Benefit Dual Aged</td>
<td>.458</td>
<td>$352</td>
<td>$4,218</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition</th>
<th>Coefficient</th>
<th>PMPM Payment to MA Plan</th>
<th>Annual Payment to MA Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 2 Diabetes w/ diabetic chronic kidney disease (ICD E11.22)</td>
<td>.378</td>
<td>$290</td>
<td>$3,481</td>
</tr>
<tr>
<td>Chronic Kidney Disease Stage 4 (ICD N18.4)</td>
<td>.230</td>
<td>$177</td>
<td>$2,118</td>
</tr>
<tr>
<td>Chronic Diastolic CHF (ICD I150.32)</td>
<td>.355</td>
<td>$285</td>
<td>$1,978</td>
</tr>
<tr>
<td>Disease Interaction – Diabetes and CHF</td>
<td>.205</td>
<td>$165</td>
<td>$1,980</td>
</tr>
<tr>
<td><strong>Total RAF</strong></td>
<td><strong>1.626</strong></td>
<td><strong>$1,269</strong></td>
<td><strong>$13,775</strong></td>
</tr>
</tbody>
</table>

1 Includes FFS Normalization and Coding Intensity multiplier calculations. MI Regional Base Rate 2016 = $804.86; less 2% Sequestration, each county paid at slightly different rate

---

Sample CMS-HCC RAF

### No Chronic Conditions Coded

<table>
<thead>
<tr>
<th>Condition</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 year old female</td>
<td>0.437</td>
</tr>
<tr>
<td>Medicaid eligible</td>
<td>0.151</td>
</tr>
<tr>
<td>Acute UTI [N39.0, no HCC]</td>
<td>0.0</td>
</tr>
<tr>
<td>DM not Coded [no HCC]</td>
<td>0.0</td>
</tr>
<tr>
<td>CHF not coded [no HCC]</td>
<td>0.0</td>
</tr>
<tr>
<td>No Interaction</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Raw RAF Score</strong></td>
<td><strong>0.588</strong></td>
</tr>
</tbody>
</table>

### Some Chronic Conditions Coded

<table>
<thead>
<tr>
<th>Condition</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 year old female</td>
<td>0.437</td>
</tr>
<tr>
<td>Medicaid eligible</td>
<td>0.151</td>
</tr>
<tr>
<td>Acute UTI [N39.0, no HCC]</td>
<td>0.0</td>
</tr>
<tr>
<td>DM [E11.9, HCC19]</td>
<td>0.118</td>
</tr>
<tr>
<td>CHF [I50.9, HCC85]</td>
<td>0.368</td>
</tr>
<tr>
<td>Interaction [DM + CHF]</td>
<td>0.182</td>
</tr>
<tr>
<td><strong>Raw RAF Score</strong></td>
<td><strong>1.256</strong></td>
</tr>
</tbody>
</table>

### All Chronic Conditions Coded

<table>
<thead>
<tr>
<th>Condition</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 year old female</td>
<td>0.437</td>
</tr>
<tr>
<td>Medicaid eligible</td>
<td>0.151</td>
</tr>
<tr>
<td>Acute UTI [N39.0, no HCC]</td>
<td>0.0</td>
</tr>
<tr>
<td>DM w/ PVD [E11.51, HCC18]</td>
<td>0.368</td>
</tr>
<tr>
<td>CHF [I50.9, HCC85]</td>
<td>0.368</td>
</tr>
<tr>
<td>Interaction [DM + CHF]</td>
<td>0.182</td>
</tr>
<tr>
<td><strong>Raw RAF Score</strong></td>
<td><strong>1.506</strong></td>
</tr>
</tbody>
</table>

*Estimated scores are for illustration purposes only and are based on 2016 CMS-HCC relative factors for community and institutionalized beneficiaries.
<table>
<thead>
<tr>
<th>Condition</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>66 yo female</td>
<td></td>
<td></td>
<td>0.288</td>
</tr>
<tr>
<td>Diabetes, uncomp</td>
<td>Z13.9</td>
<td>19</td>
<td>0.118</td>
</tr>
<tr>
<td>Neuropathy</td>
<td>G62.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Depression</td>
<td>F32.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obesity</td>
<td>E66.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Great Toe Amputation</td>
<td>Z89.419</td>
<td>189</td>
<td>0.779</td>
</tr>
<tr>
<td><strong>Total HCC</strong></td>
<td></td>
<td></td>
<td><strong>1.19</strong></td>
</tr>
<tr>
<td><strong>Total Projected Annual Cost</strong></td>
<td></td>
<td></td>
<td><strong>$10,710</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>66 yo female</td>
<td></td>
<td></td>
<td>0.288</td>
</tr>
<tr>
<td>Diabetic Neuropathy</td>
<td>E11.40</td>
<td>18</td>
<td>0.368</td>
</tr>
<tr>
<td>Major depression, mild</td>
<td>F32.0</td>
<td>52</td>
<td>0.330</td>
</tr>
<tr>
<td>Morbid Obesity</td>
<td>E66.01</td>
<td>22</td>
<td>0.365</td>
</tr>
<tr>
<td>Left great toe amputation</td>
<td>Z89.412</td>
<td>189</td>
<td>0.779</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>I50.9</td>
<td>85</td>
<td>0.323</td>
</tr>
<tr>
<td>Disease interaction factor</td>
<td>DM &amp; CHF</td>
<td></td>
<td>0.154</td>
</tr>
<tr>
<td><strong>Total HCC</strong></td>
<td></td>
<td></td>
<td><strong>2.61</strong></td>
</tr>
<tr>
<td><strong>Total Projected Annual Cost</strong></td>
<td></td>
<td></td>
<td><strong>$24,120</strong></td>
</tr>
</tbody>
</table>

**Capturing HCC Information Requirements**

- HCC diagnoses must be reported **once per calendar year** via claim submission
- Must be documented in the medical record by CMS approved provider
- Must be documented during a **face-to-face** visit by an acceptable physician specialty type
- Record must show that condition was Monitored, Evaluated, Assessed, or Treated (MEAT)
- Record must be legible, include date of service and patient info, signed and dated w/provider credentials
Data Submission Sources

Acceptable
- Inpatient hospitalization
- Some Hospital Outpatient
- Physician Services

Excluded
- SNF, Nursing Home, Hospice, Lab, DME, ASCs, Pathology
- Problem List

Face to Face Visit Sources

Acceptable
- MD/DO
- NP/PA

Excluded
- RN, MA, Dietician

HCC requires an acceptable data source from an acceptable provider type
CMS-HCC “MEAT” Requirements

Documentation must reflect one element of MEAT:

- **Monitored:** B/P reading 120/82, HgbA1c 7.3, lipids within normal limits
- **Evaluated:** Tracheostomy site w/o infection, appears clean & dry
- **Assessed:** DM stable and well controlled
- **Treated:** Continue insulin; taking Fosamax for osteoporosis

HCC vs. E&M

To count toward MDM and E&M level, condition must be assessed and treated during the visit.

Condition does not need to be directly treated toward the visit. The medical record must reflect one element of MEAT.
Why Documentation Gets Missed

- Many common conditions don’t get billed year over year
- Assumption that conditions are all being managed
- Many of these “managed conditions” have high impact on HCC/RAF
- Lack of specificity and causality
- Copying and Pasting
- Reliance on EHR drop-down list
- Be CAUTIOUS of problem lists that aren’t up to date

Focus Efforts

Top 10 Under Documented HCC’s
- Amputations
- Artificial Openings
- Asthma & Pulmonary Disease
- Chronic Skin Ulcers
- CHF
- Drug Dependency
- Metastatic Cancers
- Morbid Obesity
- Rheumatoid Arthritis
- Specific Types of Major Depressive Orders

Top 10 Over Documented HCC’s
- Conditions that have been surgically corrected (e.g., AAA)
- Diabetes with complications
- Malnutrition
- Nephritis
- Pathological Fx’s (e.g., old fractures reported as current)
- Pneumococcal pneumonia (e.g., unspecified pneumonia reported as pneumococcal)
- Polyneuropathy (no MEAT is documented)
- Primary site cancers
- Strokes (acute vs. late effects)
- Vascular disease (no MEAT documented)

Source: 3M Claims Data, HFMA Payment Trends, October 2017
Where to Focus as you Begin

High impact, common diagnoses:

- DM and complications
- Vascular disease
- COPD
- CHF
- Depression
- CKD (level 4 & 5)

Getting Specific with Diagnosis Documentation

<table>
<thead>
<tr>
<th>If the Patient has....</th>
<th>Document the Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronchitis</td>
<td>Acute or Chronic</td>
</tr>
<tr>
<td>Asthma</td>
<td>Chronic obstructive asthma</td>
</tr>
<tr>
<td>Vertebral fracture</td>
<td>Vertebral fracture, pathological</td>
</tr>
<tr>
<td>Obesity</td>
<td>Morbid obesity with BMI of 42.5</td>
</tr>
<tr>
<td>CVA with weakness</td>
<td>History of CVA with residual non-dominant side hemiplegia</td>
</tr>
</tbody>
</table>
Accurately Capturing Diabetes

- E11.2 Type 2 diabetes mellitus with kidney complications
  - Coded by the stage of chronic kidney disease (N18.1-N18.6)
- E11.3 Type 2 diabetes mellitus with ophthalmic complications
- E11.4 Type 2 diabetes mellitus with neurological complications
  - Code with gastroparesis (K31.84) if appropriate
- E11.5 Type 2 diabetes mellitus with circulatory complications
- E11.6 Type 2 diabetes mellitus with other specified complications
  - Skin ulcers should also be coded (L97.1-L97.9, L98.41-L98.49)
- E11.8 Type 2 diabetes mellitus with unspecified complications
- E11.9 Type 2 diabetes mellitus without complications

Accurately Capturing Major Depression

Only ”Major Depression” will link to a HCC

- Major Depression (Defined by one or more of the following symptoms that are present for at least 2 weeks and are not due to substance abuse):
  - Depressed mood most of the day and nearly every day for at least 2 weeks
  - Diminished interest or pleasure in activities, plus 3-4 of the following:
    1. Significant change in appetite
    2. Sleep disturbance
    3. Lack of energy
    4. Psychomotor retardation or agitation
    5. Difficulty concentrating
    6. Feelings of guilt or worthlessness
    7. Suicidal ideation

F32.0-4 Single episode and severity
F33.8-9 Recurrent episode and severity
**Staging CKD is Important!**

<table>
<thead>
<tr>
<th>STAGE GFR</th>
<th>Definition</th>
<th>ICD-10 code</th>
<th>HCC Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>&gt;90ml/min</td>
<td>N18.1</td>
<td>N/A</td>
</tr>
<tr>
<td>Stage 2</td>
<td>60-89 ml/min</td>
<td>N18.2</td>
<td>N/A</td>
</tr>
<tr>
<td>Stage 3</td>
<td>30-59 ml/min</td>
<td>N18.3</td>
<td>N/A</td>
</tr>
<tr>
<td>Stage 4</td>
<td>15-29 ml/min</td>
<td>N18.4</td>
<td>0.237</td>
</tr>
<tr>
<td>Stage 5</td>
<td>&lt;15 ml/min</td>
<td>N18.5</td>
<td>0.237</td>
</tr>
<tr>
<td>End Stage Renal</td>
<td>Requiring chronic dialysis or</td>
<td>N18.6</td>
<td>0.422</td>
</tr>
<tr>
<td>Disease</td>
<td>transplant</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Uncommon, but Important!**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Code</th>
<th>HCC Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amputation, lower limb</td>
<td>S88-S88.92</td>
<td>0.588</td>
</tr>
<tr>
<td>Protein-Calorie Malnutrition</td>
<td>E43, E44.0, E44.1, E46</td>
<td>0.545</td>
</tr>
<tr>
<td>Morbid Obesity</td>
<td>E66.01</td>
<td>0.273</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition</th>
<th>Code</th>
<th>HCC factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tracheostomy/Respiratory</td>
<td>Z93.0</td>
<td>1.055</td>
</tr>
<tr>
<td>dependence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrostomy</td>
<td>Z93.1</td>
<td>0.571</td>
</tr>
<tr>
<td>Ileostomy</td>
<td>Z93.2</td>
<td>0.571</td>
</tr>
<tr>
<td>Colostomy</td>
<td>Z93.3</td>
<td>0.571</td>
</tr>
<tr>
<td>Cystostomy</td>
<td>Z93.5</td>
<td>0.571</td>
</tr>
</tbody>
</table>
Role of the Coder

- Increased importance of ICD-10 capture across all settings
- Additional documentation requirements for “MEAT”
- Is anyone a certified Risk Adjustment Coder?

Other Considerations

- Are there certain workflows, policies, or technology constraints that prevent you from including all documented diagnoses on charges/claims?
- Are there charge/claim rules in place that may inadvertently remove or change diagnoses?
- Are there particular areas in which provider documentation to support ICD-10 diagnoses is lacking?
- How is education and feedback on HCC documentation and coding and RAF scores given to your providers?

Best Practice Considerations

See Medicare Patients At Least Once a Year

- Diagnoses from a prior year do not “carry over” for CMS
- Annual Wellness Visits and Chronic Care Management visits are an excellent opportunity to capture and document all chronic disease codes
- HCC Face Sheet can be used at each visit to document and code for missing diagnoses if you know your risk population

Evaluate and Document all Chronic Conditions

- All conditions that constitute the “composite health picture” of the patient should be evaluated and documented clearly and legibly in the progress note of the medical record
- This is not limited to what brought the patient to the doctor today. Ask yourself, “What other conditions is the patient dealing with every day?”
Best Practice Considerations

Make Sure the Data is Captured

- How many diagnosis codes does your EHR allow?
- Is there potential for any codes to be dropped?
- Do you need to contact your vendor to increase the amount of diagnosis codes available?

Best Practice Considerations

The Claim or Encounter Format Must Contain All the Data

- When the data is extracted for claims or encounter reporting, are all diagnosis codes extracted to be sent to the health plan?
- Does the claim process limit the number of diagnoses that can be submitted?
- Is the practice in the habit of only sending one or two diagnosis codes to support the CPT code on the claim?

Ensure that Clearinghouse Can Send and Receive All Recorded Codes

- How many codes can the vendor support for data submission?
- Are valid codes being dropped?
- Many claims systems and practice management systems are being enhanced to capture more data due to HIPAA data requirements.
End of Day 2!
Congrats ~ You did it!

Thank You!

Thank you!

Sandy Giangreco Brown, RHIT, CCS, CCS-P, CHC, CPC, COC, COBGC, PCS ~ Director of Coding & Revenue Integrity
Sandy.giangreco.brown@claconnect.com

Penny Osmon Bahr, CHC, CPC, CPC-I ~ Health Care Principal
Penny.Osmonbahr@claconnect.com
Resources

- RHC Billing Guide – Noridian
- CMS Billing Information for Rural Providers and Suppliers
- Behavioral Health
- National Rural Health Resource Center
  - http://www.ruralcenter.org/
- CMS Chapter 13 – RHC Services updated 01-09-18
- Medicare Preventive Services
  - https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html
- US Preventive Services Task Force
  - https://www.uspreventivestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/