

Phillip Stringfield (00:00:04):

All right. Thank you so much, Olivia. Good morning and good afternoon everyone. My name is Phillip Stringfield. I serve as the Manager of Health Center Operations Training. I'm also joined by my colleague, Ama Johnson, who serves as the Manager of Health Center Finance Training here with the NACHC Training and Technical Assistance Division, and we are so excited to be here with you all today. As we get started, I just have a couple of quick reminders and announcements for you all. So first things first, I just wanted to give you all a heads-up, the 2023 Policy and Issues Forum happening in Washington DC this March six through 11th. It will be a hybrid offering as well. We definitely look forward to seeing you there.

(00:00:46):

Next, I wanted to go ahead and give you just a heads-up about this series here that you see in our attending part one, but just wanted to remind you that this is a two-part webinar series and you do have the opportunity of earning up to three CEUs by attending both webinars. So we definitely want to make sure that you are there next week as well, at the same time, same place. And we'll go ahead and put a link in the chat so that way you're able to register for that if you're interested in doing so. All right, and then just moving on to our last couple of announcements and wrapping up, just wanted to go ahead and introduce today's presenter, Gary Lucas, who serves with the Association for Rural and Community Health Professional Coding, one of NACHC's longstanding partners. When it comes to this type of information that you want to get. We typically start the year off with Gary and his team with these updates, and we're excited to have them here to discuss the Top Five Documentation and Revenue Tips in Community Health.

(00:01:45):

So without further ado, I'll go ahead and pass things over to Gary. I do want to just remind you all there is over 500 folks on the line right now. You will have to stay for the entire duration of today's call in order to get that index number. It will be released at the end of the call, so we will not be sharing it via email. You'll have to make sure you attend, make sure to just get a quick strategy, message someone so that way you have some presence here. That will be the only way that we will be issuing it. So I just wanted to get that final reminder. I will be putting out gentle reminders in the chat, but definitely enjoy today's session. And Gary, I'll go ahead and pass it to you.

Gary Lucas (00:02:26):

All right, Philip and Ama and Olivia, I thank each of you for the chance to help everybody out and go over what we're referring to as the Top Five Documentation and Revenue Tips in Community Health. I wanted to welcome each and every one of you. I know we have a good morning and a good afternoon. We probably have folks represented from all 50 states and Hawaii and all the way out into the far Pacific Ocean, and I am honored to represent ArchProCoding, again, the Association for Rural and Community Health Professional Coding there. In doing both today's session as well as next week's. Should there be questions that we don't get the opportunity to get to today or maybe the discussions we have, generate some good internal discussions with you and your colleagues. Please feel comfortable reaching out to me after the session. You see here Masters of Science and Health Informatics and I serve as Vice President of research and development and have a little bit of experience going out to see each and every one of you there across the country.

(00:03:36):

For now, actually over the past 29 years with a particular focus, the last eight or nine, on community health centers as well as rural health clinics today. But obviously our focus remains on laser focus with

community health. So at the very end of the session, I'll put that same slide up here in a little bit. But since we're bringing up a lot of coding and documentation issues, we do need to remind you, as a couple quick little disclaimers, that anytime we reference a CPT code that that is owned by the American Medical Association. And if you're only using coding software or you're using non AMA CPTs, respectfully, you do not have access to the educationally valuable knowledge that is only printed in the AMA's version of the CPT. So please make sure you're using the solid foundation in terms of what your revenue sources are and reimbursement sources are, and use software to supplement that knowledge. But when we refer to the CPT, of course we are very, very encouraging of you to have access to the book.

[\(00:04:44\)](#):

If you don't have it today, no problem, but make sure that you're not just using software. I promise that I will not be overwhelming you with a bunch of bullets on a bunch of slides, and I'm not going to read each one necessarily to you. But in addition to hopefully factual information backed up by resources, don't be surprised that I'm going to be giving, of course, a couple professional opinions as well where the topics or the issues we discussed might be a bit different for you. For example, based on your EHR or your IT landscape, based on individual contracts that you have with commercial carriers. Medicaid of course, is different in every state and even within each state there are often different plans, and of course the scope of services that many of you provide might be a tad different. So I use the Q&A box, I'll do my best to go to them, but for example, I do see a question, what are the billable codes for MFT services?

[\(00:05:46\)](#):

I do need an obligation to the 575 folks on here that if at all possible, I realize you may have good questions that might go beyond our scope, but I'm going to try to focus on those that are relevant to the content that we're discussing at that time. But making sure to provide you with access to me following today's session. So of course, your organization is responsible for ensuring compliance. Please don't take any actions based on the general content that we provide today to each individual carrier. Of course, I have double-checked the hyperlinks that I'm providing you and the reference sources, but as they do and often change, please give me a buzz if one of the hyperlinks is broken or if you found any more updated information. Of course, because the moment we get all of this down, it's going to change and we need to be prepared for that.

[\(00:06:42\)](#):

And on behalf of ArchProCoding, let's go ahead and get started. Without seeing the full list of everybody that's attending because it's such wonderful attendance, folks. 588 folks at the moment, we assume that we have some clinical providers here. Managers of the health clinic, coders, billers, and those of you that help manage and monitor your EHR, your billing systems and your IT infrastructure. So rather than just give five total tips for this session, rather, I'm going to actually go through here and we're going to give five tips for clinical providers and we'll review those together. Now, clinic and health center managers, of course, if you are a CFO, CEO, revenue cycle manager, front desk manager or data coordinator, et cetera, all of the information's going to apply for you, of course, because you are the entity that is coordinating the balancing of both your clinical goals as well as your revenue goals out there.

[\(00:07:44\)](#):

That will then go through and give five tips for coders, relevant to leaning back to the providers to make sure that they have completed their documentation according to the guidelines, and then they're trying to extract all of the data from that claim. Billing obviously, is a very different subject and we want to

almost just visualize a pretty important wall there between coding and billing. Some folks are both coders and billers and they are completely different job skills, completely different goals, although shared across your entire health center. And then we'll give some top five billing tips. Now, depending upon where we get with time for those three check marks out there, recognizing that those on the EHR and IT side as well as managers are going to need all of this information. What I've done is finished the last, let's call it, 20 slides of the session with the reference information that goes into more detail that we're providing over the top five tips, and then depending upon how time works, I'll get through many of, probably not all of the, what I'm calling the bonus section for post class research.

[\(00:09:01\)](#):

But we'll make sure for the last 15 minutes of the session that we have a process where we can go through the Q&A box as best we can and try to deal with questions that might have the most broad scope for everybody. I have a little timer over here going, so if you randomly hear a beep, that's just going to be an indication to me that we have about five minutes left. But the top five general tips on building knowledge of FQHC basics for everyone is where I want to start. Please remember, these slides will be made available to you via a couple different options that Olivia and Philip have outlined here at the beginning or at the end of the session. But as you're taking notes, of course, the recording will be available with the slides in PDF format as well. And I encourage you to use them internally, should you need to get this information to other folks. Because the wonderful world of a community health center is clinically, similar to a traditional doctor's office.

[\(00:10:06\)](#):

But as many folks have learned both on the clinical team and the revenue team and the office-based staff, you get into the world of an FQHC you've been in a traditional office for five, 10, 20 years and about three weeks after you're in the FQHC, you discover, and sorry to use such technical words, you discover how whackadoodle some of these guidelines are compared to the rules we need to follow in a traditional office. So I recognize there are some of you that could probably teach this course. You have a good range of experience instead of focusing on, "Okay, what are the new tips?" I hope that what I'm doing in this session is reinforcing that what you're already doing is correct and to help those experienced folks get knowledge of those basics. Obviously everything is going to come down to the HIPAA code sets. Now, understanding that there are HIPAA mandated code sets that are available that differ based on what type of facility you're in. Now, ours are pretty straightforward.

[\(00:11:13\)](#):

We know and love the CPT book. We know and love the HCPCS Level II code book and of course the ICD-10-CM manual. Remember the CM in your ICD-10 book stands for Clinical Modification. But if you just use the phrase ICD-10 to a colleague, and they may work at a hospital and they're doing the facility fees and facility charging for that hospital, not reimbursing the health center, not reimbursing their provider's individual work, they have something called the ICD-10-PCS. PCS in the context of an ICD-10 is a, quote, Procedural Coding System. So while we think of an ICD-10 as a diagnosis book hospital, folks may and some other facility folks may think of ICD-10 as those procedure codes. There are national drug codes, not likely needed on your claims for reimbursement, but Medicaid and some other folks may want you to indicate the NDC number of certain drugs and other biologicals out there, but that's not necessarily relevant to our traditional coding and billing process there.

[\(00:12:24\)](#):

If you have dental care, they often will use the ICD-10 book to report cavities, although they call them caries. But most procedures performed by dentists, they have their own HIPAA approved code set called the CDT, Current Dental Terminology, that is outside of our scope today. So understanding that there

are code sets that are available for other facilities, although HIPAA approved, are not going to necessarily fall under our purview. And we are pretty confident that many providers may not be aware, from a hands-on level, what's in that CPT book, I'll hit several of those highlights as we move forward. But even the discussion about coding and billing are two completely different processes is eye-opening to many managers and providers because they need to hire somebody sometimes to perform billing activities, but they put an ad out there for a certified coder.

[\(00:13:26\)](#):

Now having being certified as encoding is an absolutely wonderful process for showing you understand the required code sets that we have to follow, but there was not one question on most coding exams that had anything to do with billing, let alone how I might need to change codes when submitting a bill to let's say Medicare compared to a traditional commercial insurer. So building that foundation is really focusing on the documentation and coding aspects, whereas billing has its own unique issues we'll continue to focus on. Well, of course, knowing how we and FQHCs are different, and of course I'll be using FQHC and community health centers interchangeably, but when you are certified through HHS and all of those processes of becoming an FQHC, we've automatically agreed to accept primarily, encounter based reimbursement for Medicare. The question is does that, or how does that impact Medicaid?

[\(00:14:31\)](#):

Do you live in a state where you may be, quote, automatically enrolled as an FQHC thus moving from maybe a fee-for-service reimbursement mechanism over to the encounter based? I realize some people call them per diems, but there are numerous scenarios where an FQHC can receive more than one encounter rate on the same patient, on the same day, depending upon where we are. I know one of those slides at the end of the session talks about that and it's going to focus on Chapter 13 of the CMS benefits policy manual. In the ads and the preliminary workups that we gave you in terms of advertising, we mentioned we're going to come from the perspective of CMS Chapter Nine of the claims manual and Chapter 13 of the Benefits Policy Manual. So understanding what makes an FQHC different is going to require us to monitor many CMS resources often.

[\(00:15:32\)](#):

Now, the dates of those as shown by the hyperlinks, I'll give you later on in this session. One of them was updated last April, one, a little bit longer than that. But I even, this morning went through to see if they've been updated, I'll give you those links later. But as we get new benefits, for example, as mental health telehealth billing went through a big change last year. As principal care management is now included underneath our billing of code G0511 that we'll talk about later as those changes come out, those are going to be the key resources to follow. If you need to know what staffing... Let me rephrase. What clinical staff members are authorized billing providers to Medicare, for example, MDs, PAs, nurse practitioners, clinical psychologists, clinical social workers might have a different term in instead of CSW might have a LCSW.

[\(00:16:36\)](#):

So Chapter 13's going to be the one where you see the requirements as far as what Medicare wants that CSW to have in terms of education, credentialing and experience. If you need to know about office hours and multiple visits on the same day, those should be some documents you're intimately familiar with. Heads-up, though, not to denigrate the authors of those materials. They have a very complex and complicated job, but there are some things tucked into these guidelines that you... And I'm almost making this up, you need to read with a grain of salt, okay? Because we have been in FQHCs been receiving what's called a PPS payment, Perspective Payment System, since 2016. But in the documents

you'll see some references to the prior payment methodology that FQHCs get from Medicare referred to as an all-inclusive rate. There are still some places where they mention all-inclusive rate rather than PPS.

[\(00:17:39\)](#):

So I encourage you to reach out to me if you see something in those guidelines that might differ from what you're aware of or what we talk about, and we need to be prepared for some of those issues because we are having to truly separate our traditional fee-for-service encounters with Medicare's definition of what is a valid encounter. I'll have a slide, again, in that bonus section for what is a valid encounter to Medicare. Here's the fun part. We have a Qualifying Visit List, assuming that we're following the terms of those key CMS resources, assuming we're receiving a CMS valid encounter rate known as that Perspective Payment System, we're going to have to follow what you'll hear many people abbreviate as a QVL or a Qualifying Visit List, which is a very specific list of codes. It has not been updated as recently as I would like to see, but it's going to tell you if you perform these services and mean all of the other guidelines you should expect to receive your encounter rate.

[\(00:18:45\)](#):

But wait a minute, Medicaid's Qualifying Visit List may be different. Maybe they don't have a Qualifying Visit List and maybe you're receiving a per member per month payment where your ICD-10 codes can actually impact your reimbursement on a patient by patient level based on diagnosis codes, not just procedural codes. So in a perfect world, we want providers to document, a coder to code and a biller to bill. However, in a variety of different cases, those lines kind of overlap. We have a provider that completes their visit but is asked by management to submit preliminary coding information to the coders and billers so they can get started on their work. The issue there is, that's often done before the provider closes their note. Maybe they have 24 hours, 48 hours or a week to complete the note, but we're telling the billers to get the claim out of the door within one to two days of the service.

[\(00:19:52\)](#):

So what we've done is overlapped those requirements potentially causing some gaps, financial risks from a compliance perspective. Or let's be honest, the provider finishes their note a few days later, the bill's already gone out with their preliminary coding report they gave, but then in their note, they show that they performed another service that didn't get captured there. Secondly, oftentimes that information moves from the provider all the way to the biller. Maybe that code is on a Qualifying Visit List indicating we're entitled to revenue depending on the payment system and depending on the payer. But what happens is oftentimes we have to collapse and bundle codes together, but the FQHC has no formal coding process that is following those HIPAA code sets, whether those services are billable or not. So we have a cost report we have to submit every year. That's what makes us different from a traditional doctor's office.

[\(00:20:56\)](#):

So for example, Medicare does not reimburse or want to pay us our PPS rate for a 99211, that nurse visit code that did not require the presence of an otherwise authorized practitioner. So the biller says, "Well, wait a minute, that's not going to get us reimbursed." Does that code still live somewhere in your system even though it doesn't live on a bill in order for your CFO and their staff to include that in the cost of our services. Now, whether that's the 99211 or other non-reimbursable codes, that will count towards the cost report as a separate conversation about what is countable in the cost report and such. But these five items should help build a shared platform of knowledge between a variety of folks, whether they're new to the world of FQHCs or to the world of medical reimbursement and documentation themselves.

[\(00:21:54\)](#):

So now those items were for everyone. Let's dive in a bit more deeply into the top five, for now, tips for clinical providers. We hope that they are with us today are or able to participate in some format on your end with going through this information at some point. Well, bottom line, the number one, after 29 years in this industry, the number one thing that I know providers can likely benefit from on the educational side of things is to not just use little favorites lists to assign a CPT code that says what they've done. To not use an EHR software vendor's feature that says, "Code me and a pop your level of office visit." Rather to review and be conscious of, for example, in this CPT manual, the first, let's call it, 12 to 13 pages in the AMA's professional edition of the CPT, where we've seen significant updates in 2021 and this year to how we document our level of office visits such as using time and medical decision-making rather than focus on history and exam.

[\(00:23:11\)](#):

We'll tie into this and give you some information briefly on that in that last section, but we saw significant changes in 2021 to how we determine our level of service that might actually have increased the level of codes your providers have been using because of what's called the patient's over paperwork initiative. That is continuing to be updated into our system so that this year our documentation of hospital visits, observation visits, home visits, et cetera, is now also based primarily on the time spent with the patient or what's called medical decision-making. But it's tucked into the CPT manual, folks, I'm even going to peak at that page. I think it's in your CPT book at the beginning in the E&M section where it describes what is included in time, if we're billing in that manner. There are things like, the time I spend as a provider preparing to see the patient, all right. By going through previous notes, looking at the master problem list, looking at labs and other reports from external providers, et cetera, the clock is ticking.

[\(00:24:30\)](#):

Obviously, the time they spend gathering a history and doing the exam is included, but folks, even during their lunch break, if they're going to order medications and tests and procedures for that patient, the clock is ticking. Even at the end of the night, the provider goes home, has dinner, puts the kids down, et cetera, and they go in. If it's on that same data service and they complete their note, that might take another 10, 15 minutes. The clock is ticking. So using the AMA's CPT guidelines to give your providers credit for what they do. Same idea here with the ICD-10 codes, not just performing an alphabetic index search and clicking on the code that may look best, but making sure the note supports that code choice. Because as you see on the bottom left-hand side, providers are often asked to give preliminary coding data to the revenue cycle staff likely before the encounter note is closed. And that tip will help increase the accuracy of the information they pass on to coding as well as the level of service.

[\(00:25:41\)](#):

Well, as the son of a combat nurse, the role of the nurse vital. Well, tip number two for providers is be able to understand the differences on how various insurance companies will or will not provide reimbursement for the services of a nurse, especially when they do the visit on their own. If they give the patient an allergy injection but they never see an otherwise authorized provider. Maybe they're doing a med check and a dressing change, et cetera, maybe they're giving a B12 injection without seeing the provider, maybe they're giving a vaccination. Some of those services may be billed as though the primary provider did the work. And in other cases you might see, for example, like Medicare that rather than generating direct reimbursement, it's going to be reimbursed through the cost report and annual reconciliation and what is called wraparound payments. So making sure that not only we're talking about nurses here, but folks like licensed professional counselors who may be absolutely vital and valuable members of the clinical team, but until a 2023 change just occurred, they were not able to be directly reimbursed by Medicare for their services.

[\(00:27:05\)](#):

Well, how does that affect us in an FQHC? What if we have a provider that's in the office who's otherwise authorized, who maybe for a commercial insurance company provides direct supervision and still maintains control of the care plan? Well, that service might be [inaudible 00:27:22] ably billed under my number as that provider, even though performed by that licensed professional counselor. Folks, what is called the incident-to rules. When I bill for their services under my number, in this case to a commercial carrier, they vary by payer. How often do I need to maintain active participation in the care plan? Can I be under what's called general supervision, meaning I don't have to be anywhere near the office? Do I have to provide direct supervision, meaning I'm available in the office suite if there's an emergency or are there certain services I have to personally perform? Now, we don't want to ever change the way we treat our patients based on their insurance plan, but we do need to recognize how those services are reimbursable, through what methodology and how the supervision or incident-to guidelines could vary and could change.

[\(00:28:24\)](#):

Tip number three, big one. These are not necessarily in any particular order when you move from tip two, three, four, and five, but those 2021 and 2023 Evaluation Management Documentation updates are absolutely massive. Folks, we no longer have to worry about the calculation of our history when figuring our level of office visits out. For 20 something years, believe me, you weren't the only one that got tired of talking about the history of present illness and the review of systems and how the definition of past family and social history changed based on whether they were new or established. We had what were called the 1995, the 1997. Some people call them 1998 Exam Guidelines. No longer do we have to focus on those, the guidelines in the CPT, thus for all carriers, meaning we met the definition of the code, is going to say bill based on time and decision-making.

[\(00:29:30\)](#):

And so as we consider those changes to the office visit, you heard me mention medical decision-making. Well, how in the world do we put a provider's thought process down in a medical record? Well, there's four, five, six wonderful pages we could spend an easy hour on just going through the updated definitions of medical decision-making. Quick hint, everybody, the definition of new versus established patient in the CPT book, are you ready? Does not apply to FQHCs when billing Medicares. Now remember, because of the variety of Medicaid payers, the variety of commercial insurance payers, of course, there's a variety of things that might be needed, but if we're going by the CPT rule, we know we're good. Where Medicare goes with billing rules, many carriers tend to follow. But even the simple idea of a definition of new versus established that's really been in the CPT manual since 1992 with only one little change, is different for an FQHC.

[\(00:30:40\)](#):

For example, unlike the coding manual says, if any provider within your FQHC network, even if that covers a large geographic area, even if that crosses state lines, if any provider has seen that patient in your network or in your tax ID number, basically. If they've provided a Medicare coverage service to that patient in the previous three years, any new provider of any specialty that sees that patient in three years, it's an established patient. So although that seems a bit restrictive, one thing to note, providers, just as a heads-up, when you bill a new patient visit to Medicare, they're supposed to increase your PPS or your encounter payment by 34.16%. So folks, we often worry about getting audited by payers. Respectfully, I'd like you to do an internal audit of the payers and whether or not they're recognizing the need to increase new patient encounters by 34.16%, but making sure we don't report too many new patient visits, thus getting too many of those 34% increases.

[\(00:31:55\)](#):

Now, when you're looking at your providers, you may have performed in the past some internal or maybe you hired a company to do chart reviews. You likely want to now, after seeing the 2021 changes for all of 2021 and all of last year, now would be the time to go perform internal or external, hiring somebody, documentation reviews. Because if there's one thing that providers love is they love data, so instead of, "Hey, we feel like you're coding too high or you're coding too low, or you're not documenting enough, or, Hey, you're documenting too much." Let's give them data. Let's perform reviews based on these guidelines. Identify any opportunities, identify any risks, and help them by using a comparison of their average coding patterns to their peers. But by the way, not trying to make your coding patterns meet your peers because they could be doing it wrong, but getting that data is very important.

[\(00:33:02\)](#):

Establishing a threshold of an expectation that you're coding blank percent correctly, identifying those gaps, providing direct education from the guidelines on those gaps and then following up will be extremely important and valuable. Now, to tie some of these, especially tips three and four together with the update in those guidelines, have your EHR companies given you more choices on how to kind of organize your templates that your providers are using in their EHR. There likely has been a pretty big focus on filling up multiple screens of history and multiple screens of exams because they were two of the three primary focuses in figuring your level of service out. Well, now the CPT and everybody in Medicare says, quote, "Perform a medically appropriate history, perform a medically appropriate exam." Does your EHR give you some options in the record or give you opportunities to have that organized based on medical decision-making or based on time?

[\(00:34:14\)](#):

And so monitoring the performance through these updates is vital. All right, got a pretty fair set of questions over there, folks. We'll do our best at the end to get to those. However, in the interest of getting through the top five ideas here, tip number five, ensure that not only does your documentation support the appropriate reporting and billing issues there. But when we're focused on documentation, we're not looking for adherence to the guidelines just for those insurance companies. The notes that you provide, the more standardized they are as far as the guidelines are, the more easy and unified care coordination, not only between your providers will improve, but with other external providers that might be using your notes. We want to make sure that they don't have to redo or re-perform diagnostic tests based on unspecific diagnoses, for example, when in fact there was a more specific diagnosis already established.

[\(00:35:18\)](#):

But what about quality reporting? We say we don't want to change the way we treat our patients based on their insurance, but some particularly Medicare, Medicaid advantage organizations want you to report what are called CPT Category Two codes or Performance Management codes. They might want you to evaluate whether you assessed smoking or not, or maybe they want you to report the patient's A1C levels on a periodic basis. Heck, maybe they'll even pay you and incentivize you for those. So how have we worked together with the business staff to clearly upfront, in a proactive manner, identify which insurance companies require which quality reporting guidelines, are they required? Are they incentivized or are they maybe needed to support grant activities or to help get the patient transportation to the office or become a member of a food bank through what's called the Social Determinants of Health Diagnosis codes.

[\(00:36:25\)](#):

So we don't document just to get paid, we document so the patients have an understanding of what happened. And that's really where we make the transition to professional coders. Now, please again, make sure you're separating coding responsibilities from billing responsibilities. When we're saying coding, we're really not necessarily wanting to think about what are we getting paid for. We think that every clinical encounter should receive a complete professional coding review that will not involve those CMS billing manuals. That really won't matter or depend upon whether we're getting paid fee-for-service or based on an encounter rate or based on per member per month payments. No, no. We want to be able to understand, for example, that coding in essence is giving the patient the ability to see what happened at that visit, whether they have insurance or not, whether the services are covered or not.

[\(00:37:25\)](#):

We need to have that patient just like when you go to the grocery store or you get your vehicle fixed, understand what happened and why did it happen. Not just, "Here's what we're billing for. Here's what you will or will not have to pay for." Obviously, the more thorough a professional coding approach has already been performed is going to absolutely give the billing staff the best heads-up of what might need to change when we move to the bill. So there's this idea that, "Okay, documentation remains consistent across all patients and all payers." Done. Coding is coding, is coding. Coding is based on these guidelines, based on where you provided the service. There is not one single solitary word in the CPT book that tells you what you need to do to get paid. It is literally a coding manual, but you're going to have to change codes when you get to the next step.

[\(00:38:23\)](#):

The CPT book has chronic care management codes, principle care management codes, but Medicare has their own billing G code they want us to use. So this idea, which is totally understandable, and that is, "Well, wait a minute. I thought we had to, quote, bill everybody the same." That is factually incorrect. What we have to do is provide the same care to everybody regardless of payment. Code each patient the same way, but different carriers have different payment methodologies. We use different claim forms for different insurance companies. Heck, for Medicare, we use a Part A claim form to get paid for most of our work, even though we're a Part B provider. So we use the UB form for most of what we do, but your provider leaves, goes to the hospital. Now we're using a 1500 form. So ensuring that we not only have thorough documentation, that we've done a full coding review, but the billing staff might note, "Hey, wait a minute, even though you did this service, we're not going to include it on the bill."

[\(00:39:27\)](#):

But how do I keep it in my system and available for review by the cost report team each year? Because that might help positively influence, or if we're not doing it thoroughly, negatively influence what our future PPPs rates might be or change some of those annual reconciliation or wraparound payments that we get. You'll often find that nurses are asked towards the end of your UDS reporting period or what are called HEDIS codes, HEDIS reporting period, other quality reporting initiatives. The nurses maybe 60 days before everything is due, they go back, oftentimes, without professional coding knowledge and they're going to find out, "Hey, do we need to close the gaps of care?" And we struggle for the next two months to get all of these measures performed and documented, whereas the nurses, the managers, and coders can work together, if possible, in all of your free time. I'm kidding, but to make sure we're capturing those quality and those data reporting requirements at the time of service, again, at the bottom, even though it may not live on a claim form.

[\(00:40:43\)](#):

So the issues here, for example, tip number two, you're going to see that's obviously on the previous slide for providers, but additionally, all right? The coders need to be aware that, again, software literally

does not give the documentation guidelines that are in the AMA CPT book. Heck, sometimes coders and sometimes providers are being asked to perform coding activities or documentation activities, and they don't even see the full definition of the code. They heavily truncated definition or abbreviated definition of the code and the need to see the full code and the full definition cannot be understated. But it should be noted, the AMA licenses every code number and every code definition to a bunch of different software vendors, but the first 10 to 12 pages of the CPT outlining the updates on how we pick our level of visit, they're not published anywhere else except in the CPT.

[\(00:41:47\)](#):

There might be some paragraphs tucked into the CPT manual in between code definitions such as, don't report this code unless it's a Tuesday and you're a Libra that had a Turkey sandwich that week. I'm obviously kidding, but those notes will never be seen in an EHR, likely will not be seen in an encoder because they're not licensed there. So it doesn't just apply, excuse me, to E&M. It applies to changes in how we code for the excision of malignant benign lesions and skin repair and joint injections and impacted cerumen removals, et cetera. Use that. Here's the key. You'll see how some of these themes are going to overlap each other here. The key is, please... Well, I would not recommend initiating a professional coding review until that office note is closed. Now we have 657 people in the session at this moment.

[\(00:42:46\)](#):

I can tell you from my almost 30 years of doing this, when I say, "Okay, how many of you have a policy that requires providers to complete their medical records in a certain amount of time, whatever that time might be?" I get about 80 to 85, almost 90% yeses, and then I say, "Okay, let me ask this question. Respectfully, how many of you actually enforce that policy?" The numbers go significantly down, sometimes around 20 to 30%. That is a massive issue or opportunity or risk of performing, let alone a billing review and submitting the bill before the notes close, but again, missing information on a full review. So whether that's giving your providers more time to complete their notes, assuming you're wonderfully and fully staffed, one or two less patients a day, but still having that patient get care from somebody. More office hours, recognizing that work you do even after the visit's over and you're closed, still could be used in some cases to make sure that is only performed on a closed medical record.

[\(00:43:59\)](#):

Now, that's going to go back to your EHR and your IT system. Depending upon whether you're a coder or a biller, if you're making that distinction, one may and the other may not even have access to even see the medical record until the note is closed. Now, if your EHR is from company A, your billing system is from company B, maybe they don't really communicate that well or some manual processes involved, you might be able to actually submit a claim without the note being closed because they're not talking to each other. Now, if you have a unified system and they're very well integrated, hopefully, they're built in checks to prevent that from happening. But if the note has been started, I can see an argument of, "Hey, professional coders can still access that but can't make any changes. It's a read only, and if anything is updated or added later, they are triggered or notified that there have been changes and that when that note is closed, they can do it.

[\(00:45:06\)](#):

But you really got to close the door on billing folks, until you've done a coding review. Tip four, assist the billing department in identifying alternate codes that may be needed by payer policies for proper billing. Now, one of the slides that I've put into the bonus section for post-class research is going to be kind of a blue... Or white and blue 50/50 page. It's going to say, compare these CPT codes to these what are called HCPCS Level II codes created by Medicare. Where there are often FQHC specific codes, only for

use with Medicare may be for Medicaid. You see where the tricks are occurring there. The example of already given is a chronic care management code 99490, might go to a commercial payer and generate payment. But Medicare wants G0511. So you see, we can't possibly bill people the same, but from a coding perspective, you got to decide, "I'm going to capture that 99490. That is my professional coding review."

[\(00:46:13\)](#):

What's going to happen to that data when a biller, correctly and illegally, adjusts that code to the G code for Medicare, making sure the charges are similar. So how does that process exist? Because I don't think I've ever heard of an insurance company coming back to a biller and saying, "Hey, you used the wrong code. That's why we denied the claim. But by the way, if you would've used this code, we would've paid you." They don't do that, folks. That's up to us to be able to identify potential options that might exist in various manuals. One of the most important issues that I have a couple slides for again in the bonus section is to establish a shared vocabulary with providers, especially between providers and coders of what it means, "Hey, the patient's coming in for an annual visit, they're coming in for a physical, they're coming in for a checkup, they're coming in for a well visit."

[\(00:47:15\)](#):

All right. None of those words... Yeah, annual peaks up in one code there, but basically those words do not carefully and correctly and appropriately align with actual codes. Many folks mean different things by those words. Yeah, we have a welcome to Medicare Physical called the Initial Preventive Physical Exam, IPPE. Clearly that has a physical exam component, but then each year after that, that service had to be done within basically a year of the patient's enrollment in Part B. Then they get an initial annual wellness visit, and then each year after that... That's an initial annual wellness visit, then a subsequent annual wellness visit. Well, folks, that annual wellness visit does not contain an exam element. When you go to chapter 18 of the Preventive Service manual, I've given you a link to when you get these slides, you'll see that the only exam required for that initial or subsequent annual wellness visit, I think it's just height, weight, and blood pressure.

[\(00:48:22\)](#):

So what one person means by an annual might be different. So we'll do in the bonus section is give you data about the CPT initial and periodic comprehensive preventive medicine services, which Medicare does not pay, but many insurances do. Medicaid or a secondary payer might pay for it, or your insurance company might pay for it once a year versus about, I'm going to say 16 or 18 different sometimes covered G codes or annual codes for Medicare. And I've given you some good information at the end to ensure that we're all meaning the same thing and that we're calling codes by their proper name rather than kind of historically accepted jargon, for lack of a better way of saying it, big time revenue issue. And we also want to make sure our patients are maximizing their insurance. "Hey, there are 12 other services that your insurance company may pay for this year, possibly without any co-insurance or deductible. Which one of these can we schedule for you so that you can maximize your insurance benefits?"

[\(00:49:36\)](#):

And then how that ties into billing cannot be understated. All right, I'm going to have to hold off on the Q&A for a brief moment. I'll do my darnedest as soon as we come back. As we move forward, folks, and we are still adding people. This is wonderful. We're at 660 people. Moving on to the top five tips for Medical Billers and Quality Reporting. Yes, you're going to see some overlap and some carry over from those previous discussions because billers are that kind of the last part of the line here. Once we hopefully deposit the check or process a claim and appeal it and get it paid, and then of course

everything follows through. Again, if I were in a room full of coders and billers, boy, this one always goes really well.

[\(00:50:25\)](#):

It's going to be a little difficult in a virtual session to do this, but folks, if you're trying to hire a biller, let's see if they have a billing certification, not just a coding certification, all right? So if you are able to locate a certification that happens to combine coding and billing, that might be an individual that rises to the top of being hired or advanced to management of some sort, let alone what if there was a certification out there that not only combined coding and billing but was specific to the services of an FQHC. By the way that certification exists, let me know if you need information in order to get that. Because what goes over really well in the classroom is I say, "Okay, how many of you do coding?" People raise their hands. "How many of you do billing?" They raise their hands.

[\(00:51:16\)](#):

I say, "How many of you do coding and billing in terms of being distinct processes?" I do get some hands, and I jokingly say, "Okay, good. I hope you're getting double salary, because performing both responsibilities." Folks, coders have a different mindset than billers. Coders are kind of data oriented. What is in the guidelines? What is the code definition? Is that documentation present or not? You got to be pretty science based on a coding perspective. If you're going on the billing side, all right? On the billing side, you need some people with some creativity skills to understand if it's going out on a different claim form and a code might need to change. So it's not easy to do both coding and billing because it's kind of involving different types of soft and hard skills. But if the same staff member is performing both coding and billing responsibilities, make sure that the coding portion's done before billing, making sure to identify which services might not get paid via traditional claims, but maybe through that cost report, et cetera.

[\(00:52:29\)](#):

You've seen, we've talked about many of these. Waiting until the results of a professional coding review has been completed to identify not only the revenue options, but what quality reporting initiatives are being met is hugely important. Do those need to be submitted with the claim or are they submitted separate from the claim? You'll probably see both. Some might go want them on a 1500 form, some might want it on a UB form with a type of bill like 770 for nonpayment claim, informational only, right? If we look here, that's tying this together, but maintaining the awareness of the reporting requirements for various types of UDS, Uniform Data System, HEDIS and CPT measures. Here's the key. By working very closely with senior management to identify which Medicare and/or Medicaid advantage company requires or incentivizes certain services like those CPT performance measurements, maybe it turns out you only have four insurance companies that require us to capture or even get that information out to them.

[\(00:53:45\)](#):

Well, maybe when a patient comes to the front desk and checks in based on seeing what diagnoses they have and what procedures we've worked with the nurses on, "Hey, this patient has coronary artery disease, so their carrier requires us in addition to the services we're performing to report blank." Maybe they just give a little index card color coded by that insurance company and I hand it to the patient. I say, "Hey, when you get back to see the nurse, just hand that to them." And they're reading it says, "Hey, your insurance company might ask us to perform certain things for you that may not seem that they're related to what you're here for. However, your insurance company requires us, for example, to ask questions about substance and or opioid use disorders. I know you're here because your toe hurts or you're having heart issues. Please understand that we're doing this for them."

[\(00:54:37\)](#):

Boom, the nurse gets that from the patient and they either perform that care capturing those codes now, or they tell the provider, "Hey, by the way, don't forget, here's what we have to do." Now, there can be more advanced technological ways of doing what I just mentioned, but I can do that what I just described for five bucks by buying five, four different colored, three by five note cards. But understanding when and how they're required, getting that information. But here's the key monitoring, of course, what are our common denials? Monitoring those explanation of benefits, having... I'm just going to say, a better knowledge of the rules than your payers. They often need to be educated in some cases of the guidelines and of the rules, and to show that you're aware of those guidelines and that you're providing internal training back to the coders, back to the providers, back through the managers to overcome those common denials and set up proactive measures that might require us using a modifier that we wouldn't otherwise use.

[\(00:55:48\)](#):

And so that feedback loop is what I'm really looking at here, because quite often if you as a biller are going to go ask a manager or ask a provider a question and you see them down the hallway and you have your coding book in your hand and they see you coming down the hallway, boy, they might take off down that hall and out that back door. So what, managers, is your process for a feedback loop on why we're getting denied and what we can do to work together to hopefully get paid the first time. Not just having somebody that can correctly fix and adjust a claim to get it paid the second time, but how do we do it correctly the first time, all right? And the same idea here, capturing some of that data that might not be reimbursed under our PPP system for annual cost reports. Not to understate it, but that has been a theme that carries through to each and every one of those folks.

[\(00:56:44\)](#):

So what we've done now is given the top five tips for everyone, top five tips for providers, top five tips for coders, top five tips for billers and quality reporting, seeing some understandable carryover. What I'd like to do for the next 15 minutes is just review with you. And folks, I'm going to do this at a high level. I'm not going to read each slide, but I'd like to outline for you what you will see in these slides and in PDF format, and you can go follow some of these hyperlinks that are going to involve your providers, the coders, the billers, and the quality staff all together. And then we'll go through and see how we're going to do the Q&A here.

[\(00:57:33\)](#):

So again, not reading each item here, some of these. These are based on the tips that we provided in the first portion of this session, all right? We talked about the Qualifying Visit List that we have. Medicare has what they call their... I call, their magic billing codes. That must be the first code on a Medicare claim in order to get reimbursed our PPS rate if the next line on the claim is on the Qualifying Visit List, right? So a little of information here on each of these slides that's going to kind of summarize what makes us different in an FQHC confirming that potential 34.16 increase. Not only for new patient medical or mental health visits, but also when we perform that initial preventive physical exam or the initial or subsequent annual wellness visits that increasing your PPS rate and thus your patients co-insurance, by the way, it's going to go up for new visits, is a Part And parcel with what makes us different.

[\(00:58:43\)](#):

Now, often, not often, almost every time you look at a Medicare document from CMS, it's going to combine information not only about us, but it's going to combine information about rural health clinics. So recognize that sometimes we both abide by the same rule, but oftentimes Medicare creates some distinctions and differences between us and our colleagues in rural health. Keeping in mind that an

FQHC can be in either a rural or an urban health professional shortage area. But we in FQHCs are allowed to perform medical nutrition therapy or diabetes self-management training. Now, I got to be a little careful with how I said that, and I hadn't thought about it. RHCs can perform medical nutrition therapy. They can perform diabetes self-management training. It doesn't, however, for rural health clinics, generate their encounter rate like it would for us. That would be an example of a code, medical nutrition therapy and DSMT that would get reimbursed by RHCs in the cost report.

[\(00:59:46\)](#):

But for us, they also identifies that our authorized providers are slightly different than our friends in rural health. We might have a registered nutritionist or dietician performing these services, if you've otherwise met all of the program requirements. So just be aware of some of the changes that we have between our friends in rural health because most of the guidelines from CMS include us both. When we were talking earlier about what is a CMS valid encounter. To me, these are the four pillars based on, and I'm not sure if we can see the highlight here because I'm highlighting in yellow at the bottom. There we go. Section 40 of Chapter 13 of the CMS Benefits Manual. Essentially to summarize, says, if I do a face-to-face visit with an authorized provider that meets medical necessity guidelines and it was performed in an authorized location, we should be able to generate our appropriate rate.

[\(01:00:45\)](#):

But we've mentioned in the past some exceptions to the face-to-face visit. Well, folks, I am able to generate a PPS rate now, as of last year, about April. Should have gone for the whole year, but usually around April's when I saw it really kind of become more distributed. But if you are doing a mental health telehealth visit, you're essentially reporting that as though you did it face-to-face. You're going to use a little modifier, maybe 93, maybe it's 95, maybe it's Modifier FR, et cetera, to indicate that it was done via telehealth. But a very positive change out there would say that you would get your PPS rate, even though that was done via telehealth. Now, mind you, if that was a medical service rather than a mental health service, we report that code regardless of what was done with G2025, and I think that's about a \$98 total payment.

[\(01:01:50\)](#):

I think it's \$98 and 24 cents this year. But if it was a mental health visit on telehealth, if that service is on the CMS covered telehealth list, you use the modifier, you get your PPS rate. That is a recent change. I just went through the slight differences in who authorized providers are, but if you want to check to see if the service meets medical necessity guidelines, I'm going to encourage you to use the hyperlink. Notice when I hover over that, it's going to give you a link to what's called the Medicare Coverage database to get national coverage decisions, local coverage decisions. For example, what are the frequency requirements? How often does Medicare want to pay for this? What is the list of covered diagnoses for a B12 injection, for example? You can break that down by location between Part A and Part B, very, somewhat complicated, but a very useful tool that I hope benefits you.

[\(01:02:53\)](#):

Of course, authorized locations for us can include not just our office, but a nursing facility. In some cases, a patient's residence. Heck, even at the scene of an accident. Here's a visual as, again, I'm just going to highlight for you quickly that I'm giving you a link to the FQHCs Qualifying Visit List. There's more codes than we could fit on this for our five magic billing codes. But I do need you to notice sometimes, and in this particular case, there's a code on our Qualifying Visit List that was deleted from the CPT in 2021. Some of you may have chiropractors. They are a physician, they count as a physician. They are authorized providers to Medicare, but there are no chiropractic codes on the Qualifying Visit List. These are issues that State national association such as NAC and your state's association, as I

understand, are discussions underway. But if I report one of my magic G codes, the next code on the claim better be on that Qualifying Visit List.

[\(01:04:03\)](#):

Now, I promised also to give you a sample comparison when you get your slides of some CPT codes. Let's just think about that from a kind of, for the most part, a fewer coding perspective, all right? Whereas the right-hand side might show some sample HCPCS codes that need to be... Or changes from the CPT. Maybe I'm doing a 12 lead EKG and I'm using this code range, whether this is Medicare or commercial carrier depends. But hey, wait a minute, what if I'm doing that 12 lead EKG as a part of an Initial Preventive Physical Exam? The welcome to Medicare Physical. Now I likely need to go to G0403 to G0405. A lot of payers including Medicare, they don't pay for 99000 there, handling and/or conveyance of a specimen for transfer to a lab. But we do need to know the Q code that should be reimbursable.

[\(01:05:01\)](#):

It is on the Qualifying Visit List even for Medicare, if you're handling a screening pap smear. Whether it's a nurse visit, E&M services, chronic care management, the example I used earlier, so that way you have access to some of the examples I've used. The difference between preventive medicine services and some of those otherwise cover G codes. Same idea here when we're comparing sample behavioral health codes with sample behavioral health HCPCS codes... Excuse me, CPT codes to HCPCS codes. One thing you notice immediately sometimes is that the code, like let's say this H0038, there are some codes out there that are only for use with Medicaid, all right? The HCPCS Level II code book. We know what codes in the HCPCS Level II code book because it begins with a letter, whereas all CPT codes begin with a number. But H codes folks and/or T codes are specifically reserved for Medicaid.

[\(01:06:14\)](#):

That doesn't mean they are guaranteed to want them, but they might. So, welcome to the wonderful wacky world of billing, folks. We're going to have different codes for different payers. I've given you a sample of some of those T codes rather than the way we report some all inclusive or PPS visits maybe to Medicaid, it's going to be via code T1015. Although Medicare does not maybe want the nurse visit with 99211, maybe Medicaid wants one of these T codes rather than the way we bill for telehealth with some, maybe they want T1014, all right? So being aware of the complexity of that biller's job is very, very vital. We mentioned making sure your providers aren't just doing an index search to locate the right code. The question is are they able to see, for example, what are called the base code notes?

[\(01:07:15\)](#):

That's kind of a phrase, that's not an official term, but they appear in the printed manual, but I'm assuming your providers aren't using a printed CPT manual, but every code here that begins with M02, there could be 200 codes. Look at this, code first the underlying disease. If we try to bill it without coding first, the underlying disease almost assuredly a denial. But don't worry about it, somebody in the billing department will appeal it, go look at it and realize, "Okay." And they'll fix it. Whereas what we're encouraging is that be done and seen upfront because that's actually determining the order of the diagnosis codes as they may appear depending upon whether they're linked or not to various payers. If you want to understand and get basic information at the high level, go get Medicare's fact sheets. I'm giving you access to those links or giving you access to that link.

[\(01:08:12\)](#):

As well as bookmarking, go to [cms.gov](https://www.cms.gov), click on Medicare, click on provider type. Scroll down to FQHC, and I want to check that website, check that page minimum of every two weeks. Maybe I put a calendar invite, "Hey, go check [cms.gov](https://www.cms.gov) FQHC site." Where you'll see the most recent updates and changes

before maybe, you get it from your carrier, before you hear it in a webinar or from a colleague. I promised you earlier to give you access to Chapters Nine and 13. So if you hover over these pictures just as, again, a reminder, anytime you see the... What we got there? Let me see if I can get my cursor. There we go. Hover on the left side, hover on the right side, you'll get those links. Anytime you see this included in their slide, the pictures or whatever you see next to it are likely hyperlinked, and these are your core foundational documents to be aware of.

[\(01:09:19\)](#):

If you have questions about that issue related to multiple visits on the same day, there are three or four exceptions. One exception is if you do both a medical and a mental health service on the Qualifying Visit List on the same Medicare patient, on the same day, you should get two PPS rates. There are examples of when you would need a modifier on a possible second visit. Maybe the patient came to see a provider about diabetes in the morning. Here's the key. They left the office, they came back because they fell and hurt their knee. Modifier 59 is going to go on that second visit. That should generate another PPS rate. That doesn't mean just add Modifier 59 for multiple encounters. The key is that you followed section 40.3, way there at the bottom, where it indicates the patient left and came back.

[\(01:10:14\)](#):

Now here's the fun part for my coders. When you look at Modifier 59's definition in the CPT book, it says, "Never ever, ever put it on an E&M code." Well, folks, that's a coding rule. For billing, if it's in the guidelines, even if it doesn't match traditional coding guidelines, it would still apply. So when you get a chance, look at this document, scroll down to the bottom of that section to get those exceptions. I made a little mistake there because I crossed those words out, but we talked incident-to services at the bottom from section one 20.1, an encounter that includes only an incident-to services, not a standalone billable visit, but might go to the cost report, et cetera. So I hope what this bonus section does is gives you the section number and the locations of these rules as opposed to, "Hey, this Gary Guy was on a webinar and he put it in PowerPoint, so it must be true."

[\(01:11:12\)](#):

Hopefully these provide you with assistance. What are we going to do when we talked about analyzing your E&M code patterns? Well, not only is this provider maybe billing more level five visits than their peers, maybe they're doing it correctly. How do we know unless we perform our own internal reviews? Why isn't this provider ever reporting nurse visits under their supervision, let alone level two visits? You're going to get a lot of good data. Group this by specialty, group this by location, et cetera. A summary of those E&M provisions is on slide 24 for you. Basically, already said each of these items, but a very key rule as it continues to apply a discussion that I've already have maybe to generate and kickstart a conversation between your providers and managers about seeing if our EHR templates can be updated to reflect the new guidelines.

[\(01:12:15\)](#):

Nothing new in this bonus section. Just showing you what we have here. A guideline though written for fee-for-service providers that distinguishes the annual wellness visit from the IPPE and then unfortunately in this particular case, darn Medicare calls them a routine physical exam, when there aren't even codes that say routine physical exam. They should have said initial or periodic comprehensive preventive medicine service, that we know and love for the CPT. But that can be a helpful tool to compare those CPT comprehensive preventive medicine codes from those G codes that likely appear in this 250-page document. And although it's not just written for us, you're going to locate some specific issues for those sometimes covered 16 or 18 visits. You need information on the updates I talked about for telehealth and virtual communication services, Chapter Nine, section 70.7 and Chapter

13, sections 200 and 240 can be reviewed so that if you're making changes, you're making it based on the regs, not just general guidelines.

(01:13:32):

ICD-10 guidelines here, let's get to the questions here. I've given you links to those. How are you moving information or from the providers to the coders? Is it a paper form? Is it electronic? Some food for thought there, folks. We talked briefly about those category two codes, so I'll provide you with some discussion items on what those are and how you should review payer contracts to see where they are. Folks, I am Gary Lucas, I am in Metro-Atlanta here, Vice President of Research and Development for ArchProCoding. At this point, Ama, Olivia and/or Philip. There are 58 questions in the chat box, but I would like to invite you back, please to help coordinate how we want to move forward on those questions.

Phillip Stringfield (01:14:31):

Awesome, thank you so much Gary. And will we be releasing the index number ad We're directly at 3:30. Is that a good key or note?

Gary Lucas (01:14:42):

Oh, I have that ready to put up, whenever you're ready, sir. I'm just trying to undo my-

Phillip Stringfield (01:14:46):

All right, so we can-

Gary Lucas (01:14:47):

[inaudible 01:14:47] I'm just trying to undo my camera here so that they can see you as well.

Phillip Stringfield (01:14:52):

No worries. So we do have about 59 questions in here and I can tell you about half of those questions were in regards to the FQHC certification program that you mentioned. So if there's any more information you can provide on that, we can probably clear those out and we'll go right next to the remaining questions that we have.

Gary Lucas (01:15:13):

Well, I thought I was being pretty slick here because guess which company does that? That's us. I wasn't trying to necessarily plug that. But myself, my colleague, John Burns and ArchProCoding, we just deal with rural community health. We do have the nation's only certification that is specific to community health coding and billing. Reach out to me, let me know if there's anything I can do. You can go to our website. I know we've got a class coming up in February and we are honored to work with NAC to help get this kind of information out. Check with your state primary care associations. They often, I don't know, 20, 30 of them at least if not more, over the several years have engaged us. Sometimes they pay for it and you don't even have to pay, so there's a variety of approaches that are out there. But that is our certification, and you could become what's called a Community Health Coding and Billing Specialist. Sorry about my handwriting there, but I do teach that class. It's between a nine and 11 hour class with an online exam.

Phillip Stringfield (01:16:25):

Awesome, thank you so much for that. And folks, just so you all know, those who are holding on the line, we will release the index number right after the Q&A. I'll make sure to stop us right at 3:29 so that way-

Gary Lucas ([01:16:36](#)):

Okay.

Phillip Stringfield ([01:16:36](#)):

We can get the index number shared and we'll make sure to verbalize that for those that might be on the phone. So I did go ahead and take out most of those questions. As you can see, we're now down to 44, but the first question comes from Maria, if you want to just start from there, we can take it on down.

Gary Lucas ([01:16:53](#)):

Yeah. Sounds good. And may I get your help, sir? Just as I answer it on, I don't want to click the wrong button, but she says, "As a family practice FQHC, we're paid for valid face-to-face encounters. Can we bill follow-up visits that occur within the 10-day global period after an office surgery we provide, such as a visit on day five to check how an incision and drainage is healing and draining?" And she says in this case she's referring to patients covered by various Medicaid programs. Maria, that's the only thing I'm going to have to do in this example is, I have to only come from a Medicare perspective because various Medicaid plans are different. I think it's Section 40.1 of Chapter 13 of the CMS Benefits Policy Manual that says, and I'm quoting, "The Medicare Global Surgical package does not apply to FQHCs."

([01:17:40](#)):

So for example, if you do an office based service when you were a traditional fee-for-service office, that would've been a visit that was included in the global payment that you received. They pay you for everything within the 10 days of follow up. You see the patient on day five, you don't bill separately. Well folks, the global package for Medicare does not apply in that case. You do the incision and drainage on day one. You have the patient come back on day five. That is a billable, if seen by the provider, reimbursable service. The trick becomes what happens if a surgeon, whether it's your provider or another provider, does a major surgery or another 10 day global period at the surgery center or at the hospital they billed as though they did everything but the patient sent back to you for follow up.

([01:18:33](#)):

You're out of luck there. They've already been paid for the follow-up for that post-op period. So we have to coordinate very carefully with that other provider or with our provider to make sure that when they bill for the surgery done offsite, they use for example, Modifier 54 and/or 56 that cuts off the post-op from their payment. Now the patient comes to us, nobody's been paid for post-op. We can bill regular visits, again, depending upon whether it's a nurse visit, which won't get reimbursed for Medicare, but if it's a provider visit, it's a, otherwise, billable visit as per normal. That's why we need to ask Medicaid, "Hey, which definition of the surgical package do we follow. Medicare's in this case which won't apply, and how could that be different?" So wonderful question there. Carolyn says, "How do you document time spent on chart after hours to back up a time-based claim if your EHR only tracks the time you were in the room?"

([01:19:33](#)):

Well, excellent question Carolyn. That's an issue with the EHR, right? If it's only tracking the time I was in the room, that doesn't come close to covering, and I appreciate the question, that doesn't come close to covering the pre-work and the post-work that's allowable. So because your provider, anytime they're

signed in, anytime they're logged in, every keystroke has been timestamped. So as long as you're confident that you're meeting the CPT guidelines at the end of the encounter, you say, "All of the services related to this service on today's date equals 32 minutes." Regardless of what the EHR is tracking, if the EHR is not able to track where the rules apply, I want to go to the EHR company or use and have the provider indicate that like in a free form text block. But the key there again, is that it was only on the date of the visit, if it was kind of at night.

[\(01:20:28\)](#):

If I don't complete my note until day two or day three, none of it's counted. Audrey says "If time..." Excuse me, "Is used as an element for the code level, can the statement be split up?" Yes. They don't need to indicate, the visit time was this many minutes, prepping the patient was this many minutes, ordering meds was this many minutes. I spent 10 minutes eating a sandwich at seven o'clock at my house documenting the record. What they have is total time, on this date meeting the guidelines is blank number of minutes. Good question. By the way, I mean could even be counseling the patient without even the counseling a family member without the patient present, which is very different than how it's been for a long time. Susan says, "So if a patient's seen by dental recently and then sees the primary doc for the first time within an FQHC network there an established patient for the primary doc." Well keep in mind when we bill Medicare or anybody else paying us a PPS type of rate, the individual's provider number's not even going on the claim form.

[\(01:21:37\)](#):

Now you might choose to add that for informational and internal purposes. Oops, I lost the question there just for quick second there. The question is, what was done in dental, by the way? If dental, for Medicare now, because I can't tell you about any Medicaid rule or any commercial carrier because of the variety, but I can tell you Medicare. So one of the things we said in there was that it had to be a Medicare covered service. So if dental was the first time a patient saw anybody in our network, but we did a cleaning, Medicare doesn't cover dental cleaning. So the first time they see primary care doc, new patient. If they did oral and maxillofacial surgery or took care of an abscess tooth or something, likely that's a Medicare covered visit. Therefore, the first time they see anybody in any other facility on our network, they're established.

[\(01:22:28\)](#):

Main thing, Diane, from the AMA as far as finding good documentation review sheets, there's a lot of them out there. I can't give you a specific link now, but welcome you to follow-up. Moving through a couple. Any tools for FQHCs in internal auditing of charts? My colleague John Burns reviews thousands of records a year, him and his team. I've not seen any good internal tools I'd recommend and I'm also not aware of NAC's full set of tools. So I'd go to NAC first with their provider resources, then maybe your state, if you're doing them on your own. The new patient rule for FQHCs is either section 70.1 or 70.3 of Chapter 13 of the Benefits or Claims Manual. Says anonymous attendee, that's funny. When were LCPCs, I'm not sure. I'm assuming you mean licensed professional counselors, allowed to bill Medicare? Effective 2023 with the updates to Medicare licensed professional counselors and... What is it?

[\(01:23:43\)](#):

Marriage and family counselors have become eligible and authorized providers for Medicare. Here's the trick. It's going to probably take a year for that rule to be finalized. It's going to probably take you many, many months to get that individual enrolled in Medicare. So you're likely, for the intervening period, going to continue to report their services via incident-to, although approved. It's going to take a bit for that to really take place. Anonymous... Okay, I'm going to skip anonymous attendee just to get to a couple other folks, again, to try to get these done in three minutes.

[\(01:24:23\)](#):

Let me scroll down here. Bear with me. Okay, Crystal asks, "Are you saying that a biller can crosswalk a CPT to a G code for MCR..." I'm assuming that's Medicare, "If the coder has already provided the CPT code?" Well, there's no rule that says, "Thou shan't use the provider's code at the expense of everything." Internally on a super bill, that's not medical records documentation. Whether you're changing it from the biller, the coder or whatever. All that's mattering here is does the documentation match what we put on the claim form. Now internally, you probably want to have some processes of A, yes, you did the CPT code, but Medicare wants this G code. That's internal discussions from a compliance perspective. Nobody's able to come in and audit your internal information. They can audit the medical record, they can audit the claim. So you have to come up with that process in that example. I'm trying to scroll down here.

Phillip Stringfield [\(01:25:27\)](#):

And this will probably be your last question, Gary, so that way we can pass along the index number.

Gary Lucas [\(01:25:32\)](#):

Well, I would like to first of all say that anonymous attendee has offered some very wonderful questions, so please if you email me, be un-anonymous there, but some good questions there. Philip, there's 46 questions. I have no clue how to pick out the best one here. So Tony says-

Phillip Stringfield [\(01:26:00\)](#):

[inaudible 01:25:59] There you go. Go ahead.

Gary Lucas [\(01:26:02\)](#):

No, I was going to say, "Do the incident-to rules apply to PAs and MPs?" In other words, if I'm reading that correctly, can a PA and an MP be a supervising provider in an FQHC? The answer is absolutely yes. Supporting information could be found in Chapter Nine and 13 to clarify that folks. So a lot of wonderful questions folks, but still remaining over 600 folks. Philip, I am going to defer to you kind sir, about how to move forward.

Phillip Stringfield [\(01:26:31\)](#):

But once, again, we want to just say a big thank you to Gary at ArchProCoding. Thank you to you all for being able to attend with us and we definitely look forward to seeing you all next week as we wrap up the series.

Gary Lucas [\(01:26:45\)](#):

Sounds good. And thank you to you for making this happen. Much appreciated, Phil. Thank you.