NCCHCA Finance Essentials

Coding and Documentation – The CFO's Favorite Subject!

September 10, 2019
Meri Harrington, CPC, CEMC
Brown Consulting Associates, Inc.

Today's Agenda

Unique Revenue Concerns

- Service Coding
  - Upcoming Changes and E/M Visit Codes
  - FQHC Guidelines
  - Approach and Outcomes
  - Stories Told by Your Data
- Diagnosis Coding and Reporting
  - Risk Adjustment Programs
    - Overview of Various Models
    - Anatomy of a risk score
  - Roles & Responsibilities
- Integrated Behavioral Health – *The Finest New Frontier*
  - Care Models
  - Evidence-Based Medicine
  - Integrated Behavioral Health

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Bonnie R. Hoag, RN, CCS-P, is the founder and a principal owner of Brown Consulting Associates, Inc., (BCA) which was established in 1989. Bonnie has served as a national physician office consultant and seminar speaker for a variety of firms, including St. Anthony Publishing and Consulting in Alexandria, Virginia and Medical Learning Inc. in Minneapolis, Minnesota. Bonnie has presented seminars to groups including, Montana Medical Association, Idaho Medical Association, Iowa Medical Society, and National Association of Community Health Centers and others.

Since 1990 she and other BCA consultants have provided unique training to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) throughout the U.S. Nearly 50 percent of BCA's clinic client-base is FQHC facilities. She has provided FQHC/RHC seminars for HRSA, National Health Service Corp and various Regional Primary Care Associations. Bonnie is honored to serve on the board of directors of a large community health center in her community. With her guidance, Brown Consulting Associates, Inc. has developed and presents live, web-based certification training.

As a senior consultant Bonnie's work on the BCA auditing team involves E/M and procedure coding and documentation audits. This includes onsite and live web-based training with clinicians where their medical records are used during training with a goal to improve the quality of the medical records and coding compliance. She has a special interest in Chronic Care Management projects and new Behavioral Health Consultant (BHC) services. Bonnie and other BCA consultants serve as a coding instructor for BCA's six-month, live web-based *CCEP* program, which is designed for coders and billers who wish to become certified.

Historically, Bonnie spent twelve years as director and instructor for the coding program at the College of Southern Idaho. She has served on the AHIMA National Physician Practice Council Group. In the "early days" of state-based managed care, Bonnie worked with the State of Idaho Department of Health as a "Physician Representative."

On occasion Bonnie is called upon to work with health care legal defense attorneys to assist physicians in resolving third-party-payer coding actions. Bonnie has provided physician/clinician training and coder/biller training in nearly one hundred different health centers nationwide.

Sixteen years of clinical experience combined with twenty-six years of coding consulting and training provides an exceptional skill base for application to the challenging and changing medical coding environment.

Bonnie graduated from Los Angeles County-USC Medical Center School of Nursing in 1973. Her nursing experience includes office and hospital nursing in the areas of surgery, ER, ICU, and home health. She served as an Air Force Flight Nurse.

Bonnie worked in physician office nursing and management, dealing directly with reimbursement issues in Las Vegas, Nevada; Salt Lake City, Utah; and Twin Falls, Idaho. She has been teaching and consulting since 1988 and has worked in 41 states. As a physician reimbursement consultant, Bonnie visits physician offices, clinics and ERs to assess the issues that directly and indirectly affect reimbursement and CMS compliance.

Shawn R. Hafer, CCS-P, CPC, is a senior consultant and co-owner of Brown Consulting. She has enjoyed more than 20 years of physician coding and reimbursement experience in a variety of specialties. She holds coding certifications from both the American Health Information Management Association (AHIMA) and the American Academy of Professional Coders (AAPC) and is a member of both organizations. Her background provides an excellent foundation for the demanding medical coding environment.

Shawn has been with Brown Consulting since 1999, and is uniquely qualified due to her diverse management skills, experience, and coding and billing expertise. Shawn also serves as a senior auditor conducting hundreds of medical record audits each year providing both clinician and coder training in all facets of coding and documentation.

Shawn's creative skills and experience have led to the development of many coding tools and published training material used by Brown Consulting clients and Brown Consulting students. Shawn developed Brown's popular *New Doctor Training Program*. She also developed the *Brown Girls Favorite ICD-10-CM Diagnosis Code Booklet.* Shawn spends much of her training time at clinic locations ranging from small rural health clinics served only by visiting providers to large inner-city clinics with more than 100 clinicians.

Shawn is the architect of our long-standing *Brown Consulting Webinar Program* offering both clinician and coder webinars and classes. Our fee-based webinars typically involve two-hour training sessions paired with post-training assessments; most are certified with CEUs. Topics include E/M Coding, Level I-III; Diagnosis Coding, (14 separate sessions) including Beginning and Intermediate Diagnosis Coding, as well as ICD-10-CM chapter-based webinars; Preventive Service Webinars; FQHC Specific Webinars; Use of Modifiers I & II; Minor Surgery Coding; Coding from an Op Report; Behavioral Health for Non-prescribers; Behavioral Health/Psychiatry for Prescribers. We also offer various specialty-based webinars and FQHC-specific webinars. Shawn is also responsible for the *Brown Consulting Chart Auditing Training Series*, which includes six sessions.

Historically, Shawn has worked with healthcare defense attorneys on behalf of physicians involved in third-party payer audits. Shawn authors and presents coding seminars and webinars for our many workshop/seminar partners including the Idaho Medical Association, Montana Medical Association, Iowa Medical Society, West Virginia Primary Care Association and other regional and national groups.

For ten years, Shawn served as a coding instructor at the College of Southern Idaho and for Northwest Regional Primary Care Association, and was a long-term member of the Advisory Committee for Coding Education at the College of Southern Idaho. Shawn attended the College of Southern Idaho and at Pima College in Tucson, AZ.

Meri Harrington, CPC, CEMC, began her healthcare career with 12 years of coding and auditing experience in a multispecialty rural health clinic that led the way in the rural residency training program. She was responsible for writing the E&M coding policy for the organization, as well as conducting multiple clinician and peer audits and education sessions. She has also assisted with internal audits to assure Meaningful Use implementation and attestations.

Meri and the BCA team perform documentation quality and coding compliance audits and develop customized clinician and coder training. She has spent multiple hours working alongside clinicians and peers on projects aimed at improving the user-friendliness of electronic medical record programs.

Meri has a special interest in data analysis and training related to the intricacies of appropriate ICD-10-CM diagnosis codes and chronic care coding with expertise related to HCCs. She has had the opportunity to work along side third-party payers with a focus on appropriate diagnosis coding as a risk-based measurement instrument.

Meri's knowledge and study of contemporary "quality" healthcare concerns coupled with her understanding of MACRA, MIPs and other quality-based federal reimbursement plans, has positioned Meri to guide BCA in such a manner that we are able to incorporate emerging physician documentation requirements in current coding and documentation training.

For several years, Meri has served as the director of BCA's six-month *Comprehensive Coding Education Program* which is designed to prepare coders and billers for professional national certification.

Meri also enjoys unique auditing and training services with clinics that provide focused services such as Contraceptive Management/Family Planning, and HIV services. Meri spends a great deal of her time working with Family Practice, Pediatrics, Geriatrics and OB-GYN. She is an expert with surgical coding. Now in her 18th year in the healthcare industry, Meri is pleased and excited to see Behavioral Health, for which she is considered a subject matter expert, receiving the recognition it deserves as a medically necessary aspect of the whole-body health of patients.

Historically, Meri's education includes several years volunteering as an EMT in her local community. Meri attended the Community Colleges of Spokane – Colville IEL. Meri has developed multiple educational programs including the *BCA Transition Mission* training series, which was extensively utilized by clinics throughout the US as a tool for ICD-10-CM Implementation.

Jennifer Bartlett, CPC, CCS-P, joined the Brown Consulting team in 2018 and brings with her 15 years of experience in medical coding and billing. She began her career performing administrative duties, including billing for a small orthotic and prosthetic facility. She obtained her coding certification in 2011 and transitioned to a large health system holding various Charge Capture positions within Revenue Cycle. Jennifer was part of a team that successfully implemented a Charge Capture department for one of the larger facilities within the health system. She and her team ensured the integrity and charging accuracy of a high volume of inpatient charges including bedside procedures, infusions and injections, outpatient rehabilitation and observation charges to name a few.

In 2016, Jennifer was involved in the system-wide Epic EMR implementation at this facility. She played a role in educating hospital managers and directors on the responsibility shift that Epic would bring to their day-to-day responsibilities. With the transition to the Epic EMR, she also supervised a team of surgical service coders that took over the responsibility of outpatient surgical coding for the entire health system. This team was able to successfully decrease charge lag for surgical coding from 20 days to less than 4 days.

Jennifer attended the College of Southern Idaho in Twin Falls, ID. She also successfully completed the HCPro Coding Certification program which laid the foundation for her career as a certified coder.

Brown's Commitment Brown Consulting Associates, Inc. has provided national physician training services since 1989. BCA recognizes the increasing and constantly changing demands placed on the physician office by federal and state government, CMS, PCMH programs, value-based reimbursement projects and private insurance carriers. In addition to serving physician offices, Brown Consulting Associates provides specialized training for various third party payers, outpatient hospital-based clinics, and Federally Qualified Health Centers and Rural Health Clinics. Brown Consulting Associates offers physician and staff education designed and customized to enhance quality, operations and federal compliance.

Learning Objectives

Participant will:

1. **recognize** FQHC service coding opportunities and pitfalls
2. **describe** two methods of code assignment for E/M services
3. **examine** diagnosis coding guidelines and risk value indicators
4. **endorse** the value of investing in coder education and tools
5. **be familiar with** a variety of behavioral health services and documentation requirements

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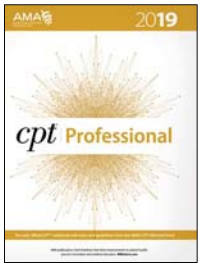
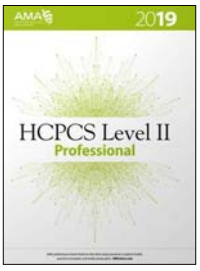
Service Coding for Physicians and Clinicians

All Stakeholders – Know Your Resources



AMA & HCPCS CPT Code Book



AMA HCPCS Code Book

CMS Medicare & FQHC

State Medicaid Manuals

https://medicaid.ncdhhs.gov/providers/programs-services/medical/federally-qualified-health-centers

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Biggest E/M Code Changes since 1992

*CMS Newsroom Release July 29, 2019 related to January 1, **2021***

1. RVUs will continue to be valued individually.
2. CMS & AMA agree on guidelines changes.
   - Code selection based on MDM or encounter time
   - Overhaul MDM doc. guidelines to emphasize complexity of conditions
3. AMA's CPT will remove the lowest level New Patient code, 99201.

"We are announcing proposals so that the government doesn't stand in the way of patient care, by giving clinicians the support they need to spend valuable time coordinating the care of these patients to ensure their diseases are well-managed and their quality of life is preserved." Seema Verma, CMS Administrator

July 29th Press Release https://www.cms.gov/newsroom/press-releases/trump-administrations-patients-over-paperwork-delivers-doctors

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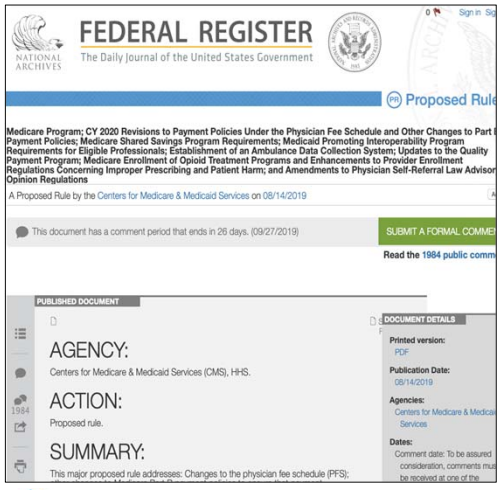
What is Expected from CMS/Medicare in 4 Months?

*For changes effective **January 1, of 2020***



Federal Register – August 14, 2019

https://www.federalregister.gov/documents/2019/08/14/2019-16041/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other

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FQHC Medicare ~ Something Special!

A Dozen "Must Know" Things

1. A reimbursable FQHC encounter is defined as a "medically necessary" visit between a ***qualifying clinician and a patient***.
2. A patient is considered "new" only if they have not been seen by ***any of your clinicians*** within the past three years.
3. A ***nurse-only visit*** is/and should be "counted", but ***is not paid***.
4. ***Minor surgeries*** may never be billed to Part B, they are a clinician professional service included in a qualifying encounter.
5. A ***"surgery only"*** visit, (one without an E/M) is ***not reimbursed***.
6. ***Hospital inpatient*** services are ***coded/billed to Medicare Part B***.
7. ***Skilled Nsg. visits*** are billed w/G code & ***reimbursed as an encounter***.

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FQHC Medicare ~ Something Special!

A Dozen "Must Know" Things

8. ***Labs done in clinic*** are reimbursed separately by ***Part B Medicare***.
9. The technical portion of an ***x-ray*** *(modifier TC)* taken in the clinic, is ***billed Part B***. The reading is part of professional encounter rate.
10. The ***technical portion*** of an ***EKG (93005)*** is billed to ***Part B Medicare***.
11. FQHC payment for ***Medicare Welcome/AWV*** is increased by ***34%***.
12. Services listed ***below*** are ***reimbursed outside the rate,*** however, they are not billed to Part B. Billers, include in "UB" Medicare billing and, as always, monitor for appropriate reimbursement.
    - Chronic Care Management or Behavioral Health Integration G0511
    - Advanced Care Planning 99497 & 99498
    - Virtual Communication G0071

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The Medicare Physician Fee Schedule

A free tool for you

2019 National Physician Fee Schedule Relative Value File Ju

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Dental codes (D codes) are copyright 2018/19 American Dental Association. All Rights Res

Activity 1: Download the Excel Version of the Current Medi

Google Medicare Phy

RELEASED 05/03/2019

HCPCS	MOD	DESCRIPTION	STATUS CODE	1 WORK RVU	NON-FAC 2 PE RVU	NON-FAC NA IND
99201		Office/outpatient visit new	A	0.48	0.76	
99202			A	0.93	1.14	
99203		Office/outpatient visit new	A	1.42	1.49	
99204		Office/outpatient visit new	A	2.43	1.99	
99205		Office/outpatient visit new	A	3.17	2.38	
99211		Office/outpatient visit est	A	0.18	0.45	
99212		Office/outpatient visit est	A	0.48	0.75	
99213		Office/outpatient visit est	A	0.97	1.05	
99214		Office/outpatient visit est	A	1.50	1.46	
99215		Office/outpatient visit est	A	2.11	1.84	

Activity 2: Use Excel Medicare Fee Schedule to determine your new charges

Google Medicare Physician Fee Schedule 2019

Activity 3 Use Excel Medicare Fee Schedule to evaluate a third-party list of proposed payments (new contract)

Google Medicare Physician Fee Schedule 2019

HCPCS or CPT CODE	Abbreviated Description - Must see CPT	WORK RVU	PRACTICE EXPENSE RVU	MAL-PRACTICE RVU	CLINIC TOTAL RVU	Enter 3rd Pty Fee (RVU X CF)	3rd Party Con. Factor: (divide fee by RVU)
99201	Office/outpatient visit **new** - Stfor 10 min	0.48	0.76	0.05	1.29	$ 60.00	$ 46.51
99202	Office/outpatient visit **new** - Stfor 20 min	0.93	1.14	0.08	2.15	$ 88.00	$ 40.93
99203	Office/outpatient visit **new** - Low 30 min	1.42	1.49	0.14	3.05	$ 125.00	$ 40.98
99204	Office/outpatient visit **new** - Mod 45 min	2.43	1.99	0.21	4.63	$ 159.00	$ 34.34
99205	Office/outpatient visit **new** - High 60 min	3.17	2.38	0.27	5.82	$ 183.00	$ 31.44
99211	Office/outpt. **established** - [nurshish] 5 min	0.18	0.45	0.01	0.64	$ 25.00	$ 39.06
99212	Office/outpt. **established** - stfor 10 min	0.48	0.75	0.04	1.27	$ 50.00	$ 39.37
99213	Office/outpt. **established** - low 15 min	0.97	1.05	0.07	2.09	$ 69.00	$ 33.01
99214	Office/outpt. **established** - mod 25 min	1.50	1.46	0.10	3.06	$ 94.00	$ 30.72
99215	Office/outpt. **established** - high 40 min	2.11	1.84	0.15	4.10	$ 150.00	$ 36.59

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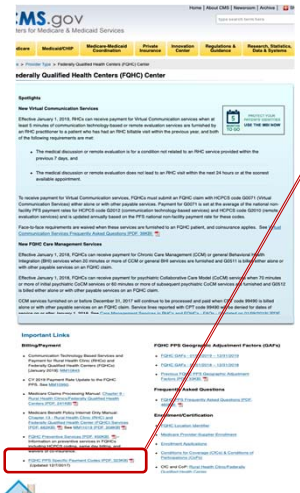
The FQHC "Encounter" Payment List (abbreviated)

Google *"FQHC Payment List"*



Specific Payment Codes for the Federally Qualified Health Center Prospective Payment System (FQHC PPS)

(Rev. 12-06-17)

A FQHC visit is a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between a FQHC patient and a FQHC practitioner during which time one or more FQHC services are furnished. A FQHC practitioner is a physician, nurse practitioner (NP), physician assistant (PA), certified nurse midwife (CNM), clinical psychologist (CP), clinical social worker (CSW)...

FQHC Payment List for MH/BeH "Encounters"
Clinicians = Clinical Psychologist (CP) and LCSW

A. FQHC Payment Code for New MH - G0469
B. FQHC Payment Code for Estb. MH - G0470

1. 90791 Psych diagnostic evaluation
2. 90792 Psych diagnostic eval w/med service
3. 90832 Psychotherapy pt &/family 30 min.
4. 90834 Psychotherapy pt &/family 45 min.
5. 90837 Psychotherapy pt &/family 60 min.
6. 90839 Psychotherapy crisis initial 60 min.

FQHC Payment List for Medical "Encounters"
Clinicians = MD/DO/NP/PA/CNM

A. FQHC Pmt. Code New Med. Visit = G0466
B. FQHC Pmt. Code Estb. Med. Visit = G0467

1. 99201 Office/outpatient visit new
2. 99202 Office/outpatient visit new
3. 99203 Office/outpatient visit new
4. 99204 Office/outpatient visit new
5. 99205 Office/outpatient visit new
6. 99212 Office/outpatient visit established
7. 99213 Office/outpatient visit established
8. 99214 Office/outpatient visit established
9. 99215 Office/outpatient visit established
10. 99406 Behavior change smoking 3-10 min
11. 99407 Behavior change smoking > 10 min
12. G0442 Annual alcohol screen 15 min
13. G0443 Brief alcohol misuse counsel
14. G0444 Depression screen annual

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Virtual Communication, G0071 *1*

Additional FQHC/RHC Reimbursement Since January 1, 2019

What type of technology is required for VC?

- telephone call
- integrated audio/video system or
- through a store-and-forward method such as sending a picture or video to the RHC or FQHC practitioner for evaluation/FU within 24 hours.
- FQHC/RHC practitioner may respond by telephone, audio/video, secure text messaging, email or use of a patient portal.

Behaviorist

Medical Clinician

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Virtual Communication, G0071 *2*

Patient contacts clinician & communicates for 5 or more minutes

1. Initiated by the patient Estimated payment $14.00, co-pay applies
2. For services of nurse/other? No, use by FQHC practitioner only
3. Beneficiary consent for billing is required? Yes, obtain consent first
4. Is code OK for condition monitoring by FQHC practitioner? No
5. Is there a Medicare limit on frequency of service? No limitations at this time
6. Billing: G0071 can be billed either alone or on the same claim as a billable visit.

Remember not billable if a related visit was provided within the previous 7 days or if the service leads to an appointment within the next 24 hours or soonest available.

Reference the Medicare Benefit Policy Manual, Chapter 13-FQHC, Section 24

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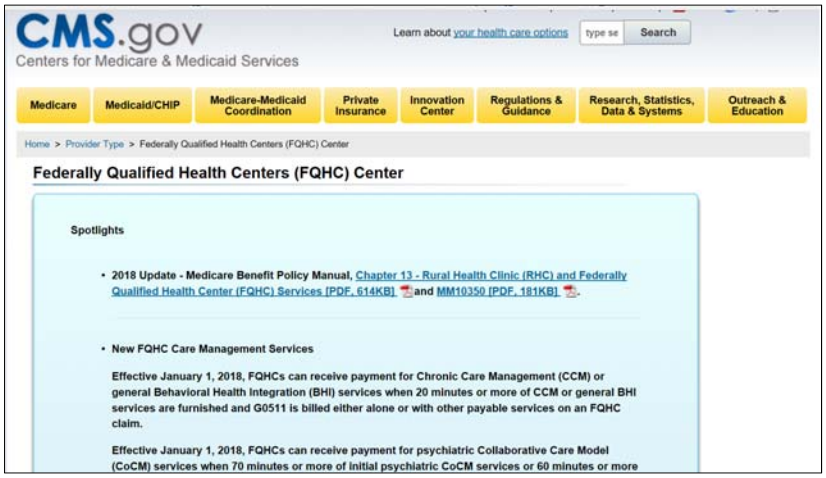
FQHC Resources



https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf

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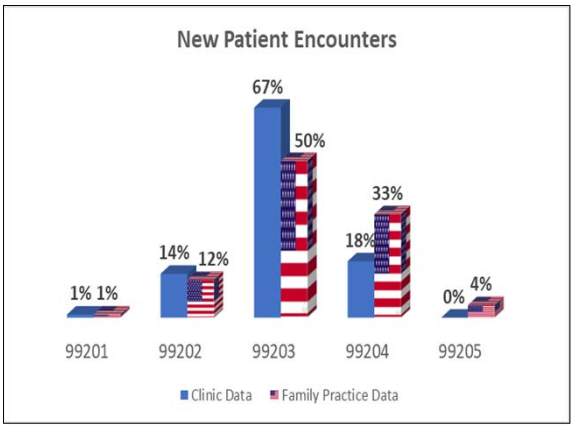
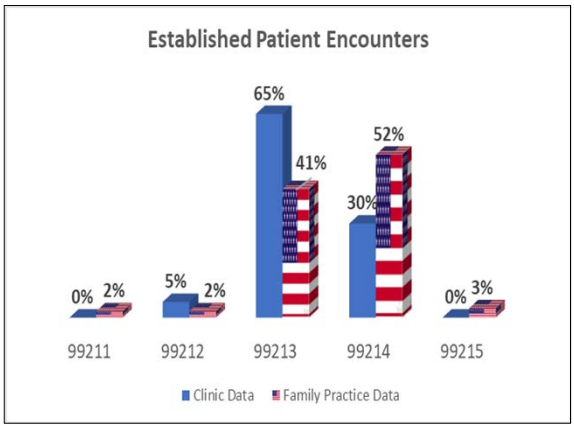
Collective Production/Coding Pattern

How do you compare?





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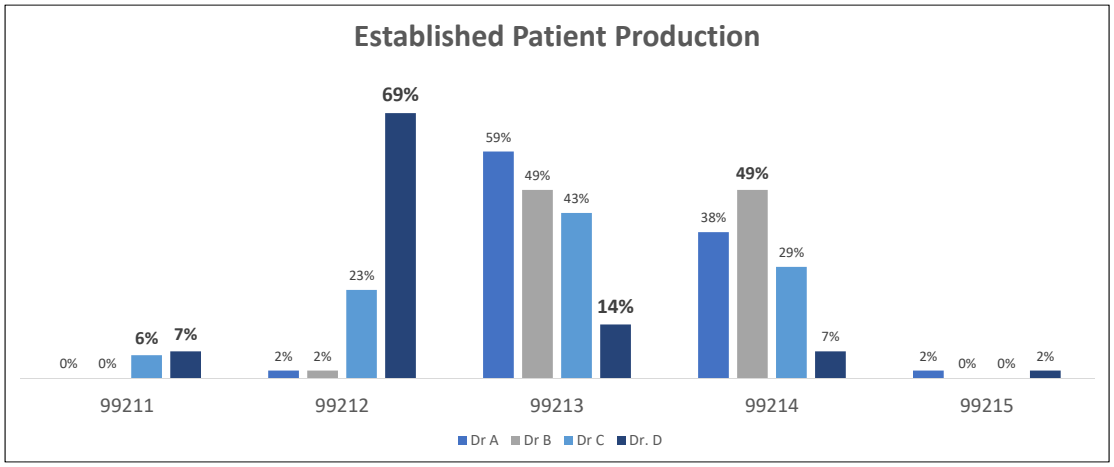
Lessons in Variability



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CPT Service Code Frequency Report *1*

Glean the hidden messages

1. 20,000 established visits, 1,800 Medicare FQHC encounters = 9%
2. Internal codes tracking OB, are all being reimbursed in the long run?
3. 14% of established pt. encounters are preventive services.
4. ZERO Medicare AWVs, pd. 134% of the encounter rate.
5. Deleted codes on production
6. Examine report for expected, but missing services... G0711, VC.

25 Medical Clinicians

Codes Organized by Frequency			Codes Organized by Code Order		
Code	Description	Units	Code	Description	Units
99213	Office/outpatient visit, est, exp p	14994	00000	Prenatal Visit	407
99214	Office/outpatient visit, est, detai	3925	00003	No Charge Provider Visit	43
36415	Collect venous blood, venipunctu	3893	00004	Chinese Herb Homeopathics	73
36416	Collect capillary blood specimen	3532	00099	Postpartum Visit	50
83036	Glycosylated hemoglobin assay	2820	0500F	Initial Prenatal Care Visit	3
G0467	Fqhc visit, estab pt	1808	10060	Incision & drainage abscess, simp	22
90471	Immunization admin, 1 vaccine	1373	10061	Incision & drainage abscess, com	2
81002	Urinalysis, non-automated, w/o s	1225	10120	Incision/removal foreign body su	2
82948	Stick assay of blood glucose	1182	11042	Debridement, skin and subcutane	2
85018	Blood count, hemoglobin	1023	11055	Pare/cut benign hyperkeratotic l	4
99212	Office/outpatient visit, est, prob	1005	11056	Pare/cut benign hyperkeratotic l	1
81025	Urine pregnancy test	840	11057	Pare cut benign hyperkeratotic le	1
T1015	CLINIC SERVICE	792	11100	Biopsy, skin/subcut/mucous mem	10
99393	Preventive checkup, est, 5-11 yrs	733	11101	Biopsy, skin subcut/mucous mem	2
99392	Preventive checkup, est, 1-4 yrs	640	11200	Removal of skin tags, any area, u	26
99203	Office/outpatient visit, new, det	602	11201	Removal of each additional 10 sk	4
87210	Smear, stain & interpret, wet	576	11300	Shave skin lesion, trunk/arm/leg,	9
99202	Office/outpatient visit, new, exp	533	11301	Shave skin lesion, trunk/arm/leg,	5
90686N	Flu Vac No Prsv 4 Val 3 Yrs+	529	11302	Shave skin lesion, trunk/arm/leg,	1
99391	Preventive checkup, est, infant	520	11305	Shave lesion, scalp/neck/hand/fc	3
90715N	Tetanus, Diphtheria Toxoids And	502	11307	Shave lesion, scalp/neck/hand/fc	1
99394	Preventive checkup, est, 12-17 yr	488	11308	Shave lesion, scalp/neck/hand/fc	1
99396	Preventive checkup, est, 40-64 yr	465	11310	Shave lesion face/lid/ear/nose/li	1
99395	Preventive checkup, est, 18-39 yr	460	11312	Shave lesion, face/lid/ear/nose/l	1

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CPT Service Code Frequency Report 2

A deeper dive, a value in coder report study

1. Missing expected "paired" coding circumstances?
   a. Vaccines & therapeutic injection with paired administration codes
   b. Steroids + Joint injection codes
   c. IUDs + IUD insertion codes
2. Evidence of unique Medicare Part B FFS billing?
   a. Technical portion of EKGs (93005)
   b. Technical portion of x-rays (modifier TC)
   c. Laboratory studies performed in the clinic
3. Skilled nursing visits (99304-99316) represent an encounter rate.
4. Expect visit billing for follow-up Medicare minor procedures.

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Minor Procedures

Relative value and follow-up days

CPT	Brief Description (Review CPT for code details)	1Work RVU	4Total RVU	MCare Pt.B Allowable	Follow-up days
17000	Destruction ONE premalignant les	0.61	1.85	$66.67	10 days
+17003	2nd-14th premalignant lesion (e	0.04	0.16	$5.77	NA
17110	Destruction 1-14 benign lesion	0.70	3.13	$112.80	10 days
12001	Simple 2.5cm lac repair ...eg, extre	0.84	2.53	$91.18	zero
12002	2.6cm - 7.5cm	1.14	3.08	$111.00	zero
12004	7.6cm - 12.5cm	1.44	3.61	$130.10	zero
12011	Simple 2.5cm lac repair ...eg, face	1.07	3.09	$111.36	zero
12031	Intermediate 2.5cm ...eg, extremit	2.00	6.98	$251.55	10 days
• 11104	Punch biopsy of skin	0.83	3.52	$126.86	zero
• 11106	Incisional biopsy of skin	1.01	4.26	$153.53	zero
11730	Avulsion part/complete nail plate	1.05	3.09	$111.36	zero
20610	Joint injection (knee)	0.79	1.71	$61.63	zero

- Often, there is a coder expectation that minor surgery includes follow-up.
- "Package" concept ***does not apply*** for FQHC Medicare (and likely FQHC Medicaid) procedures

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Overpayment Misadventures

An adventure to avoid

1. Reporting global x-ray service when only the technical portion is appropriate, or when the clinician was simply ordering an x-ray
2. Reporting procedures to Part B for separate payment
3. Reporting global EKG services when an outside entity interprets
4. Pairing non-covered services with FQHC payment codes
5. Changing diagnosis/service coding inaccurately because the payer won't cover charges as documented

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Clinic Operations - Coder Utilization

Clinic policy - 95% of claims are released within 72 hours of DOS

A. Clinician assigns code(s) at time of service. Clean claims go out.
B. Coders primarily do data entry and "payment problem" work.
C. Certain claims for certain reasons are tagged for a "coder work-bucket."
D. Coders do a quick overlook of certain items, then release the claim, example minor procedure.
E. Coders do random review of "claim types" for pre-determined reasons.
F. Coders review all Dx coding (mostly for specificity); or pre-determined diagnosis coding only.
G. Coders review all CPT and Dx coding, making changes as they see fit. Clinician may or may not be queried for approval.

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Evaluate Needs & Empower Your Coders

Certification is just the beginning

- Consider the needs of your organization (specialty care, surgical, etc.)
- Allow for coder education opportunities unique to those needs
- Validate skills with pre- and post-training evaluations
- Recognize leadership, educators, researchers, data analysts
- Sponsor effective communication training
- Create policies to ensure uniformity
- Dedicate first moments of provider meetings to coder hot topics
- Budget for continuing education for coders

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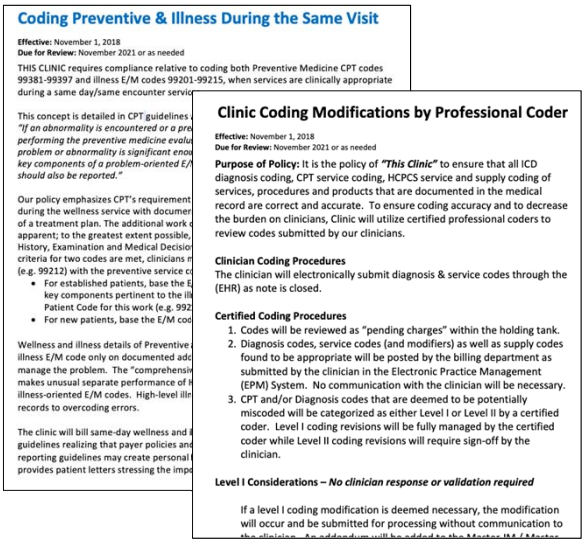
Coding/Billing Policies

1-2 page policies for consistency and confidence

- Coding Policies should be brief, relevant to all.
- Updated as needed or at least annually.

All stakeholders buy in and sign-off - everyone from the front desk to the CEO!



Coding Preventive & Illness During the Same Visit

Effective: November 1, 2018
Due for Review: November 2021 or as needed

THIS CLINIC requires compliance relative to coding both Preventive Medicine CPT codes 99381-99397 and illness E/M codes 99201-99215, when services are clinically appropriate during a same day/same encounter servic

This concept is detailed in CPT guidelines
"If an abnormality is encountered or a pre
performing the preventive medicine evalu
problem or abnormality is significant enou
key components of a problem-oriented E/
should also be reported."

Our policy emphasizes CPT's requirement
during the wellness service with documer
of a treatment plan. The additional work
apparent; to the greatest extent possible,
History, Examination and Medical Decisio
criteria for two codes are met, clinicians
(e.g. 99212) with the preventive service c

- For established patients, base the E key components pertinent to the ill Patient Code for this work (e.g. 992
- For new patients, base the E/M coc

Wellness and illness details of Preventive illness E/M code only on documented adc manage the problem. The "comprehensi makes unusual separate performance of illness-oriented E/M codes. High-level ill records to overcoding errors.

The clinic will bill same-day wellness and guidelines realizing that payer policies an reporting guidelines may create personal provides patient letters stressing the imp

Clinic Coding Modifications by Professional Coder

Effective: November 1, 2018
Due for Review: November 2021 or as needed

Purpose of Policy: It is the policy of ***"This Clinic"*** to ensure that all ICD diagnosis coding, CPT service coding, HCPCS service and supply coding of services, procedures and products that are documented in the medical record are correct and accurate. To ensure coding accuracy and to decrease the burden on clinicians, Clinic will utilize certified professional coders to review codes submitted by our clinicians.

Clinician Coding Procedures
The clinician will electronically submit diagnosis & service codes through the (EHR) as note is closed.

Certified Coding Procedures

1. Codes will be reviewed as "pending charges" within the holding tank.
2. Diagnosis codes, service codes (and modifiers) as well as supply codes found to be appropriate will be posted by the billing department as submitted by the clinician in the Electronic Practice Management (EPM) System. No communication with the clinician will be necessary.
3. CPT and/or Diagnosis codes that are deemed to be potentially miscoded will be categorized as either Level I or Level II by a certified coder. Level I coding revisions will be fully managed by the certified coder while Level II coding revisions will require sign-off by the clinician.

Level I Considerations – *No clinician response or validation required*

If a level I coding modification is deemed necessary, the modification will occur and be submitted for processing without communication to

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EMR Documentation Integrity Concerns

1. The **EMR has not delivered** on promises of "easier", "quicker" or "better quality documentation."
2. Clinicians are **frustrated** by time consumed in search process - without helpful findings.
3. Unidentified **"cut and paste"** entries create confusion.
4. The EMR's **Problem List** can be a problem!
5. **Coders have difficulty** helping because they are not familiar with clinician process in the EMR or clinician EMR screens.
6. **Clinicians are not familiar** with coding rules/guidelines for appropriate diagnosis code reporting.

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Evaluation and Management (E/M) Codes

90% of Clinic Time = E/M Codes

BCA E/M Recipe Card *(Use the back first)*

Established Patient Medical Dec. Making (MDM)	HISTORY (OR)	EXAM	E/M Code	Time Guideline
Straightforward MDM	Chief Complaint & HPI x 1-3 qualifiers - *See yellow box*	1 system/area	99212	10 min
Low Complexity MDM	CC, HPI x 1-3 qualifiers (e.g., 1. Location, 2. Dur., 3. Sev., 4. Modifying factors, 5. Assoc S/S, etc.) **& ROS x1 system**	2-4 systems/areas	99213	15 min
Moderate Complexity Medical Decision Making	CC, HPI x 4 *or - HPI as status of 3 chronics*; **and ROS x 2-9 sys and** pertinent Med or Fam or Soc Hx.	5-7 sys/areas 1 system must be detailed	99214	25 min
High Complexity MDM	CC, HPI x 4/status 3 chronics, **ROS x 10** & 2 histories	8 or > organ systems	99215	40 min
Nurse Visit	Nurse or MA. Medicare and some other payers require clinician to be in office.		99211	5 min or >
New Patient Medical Dec. Making (MDM)	**HISTORY (AND)**	**EXAM**	**E/M Code**	**Time Guideline**
Straightforward MDM	Chief Complaint & HPI x 1-3 qualifiers - *See yellow box*	1 system/area	99201	10 min
Straightforward MDM	CC, HPI x 1-3 qualifiers (yellow box) **AND ROS x 1** sys	2-4 systems/areas	99202	20 min
Low Complexity MDM	CC, HPI x 4 or HPI as status of 3 chronics; **and ROS x 2-9 sys.** and pertinent Med or Fam or Soc Hx.	5-7 sys/areas 1 system must be detailed	99203	30 min
Moderate Complex MDM	CC, HPI x 4 qualifiers or HPI as status of 3 chronics;	Comprehen ex of 8 or > organ systems	99204	45 min
High Complexity MDM	**ROS x 10 sys. & all of** Med. & Fam. & Soc. History		99205	60 min

HPI Qualifiers

1 Location
2 Duration
3 Severity
4 Quality
5 Context
6 Timing

of chief complaint

7 Factors that modify chief complaint
8 Associated S&S

E/M codes requiring four HPI qualifiers may instead be documented with the [incoming] ***status of 3 or more chronic problems.***

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Two Ways to Choose the Visit Code

Choose Based on "Components" or "Counseling Time"

E/M visit codes may be assigned based on

1. **Counseling time** may be considered as an alternate code selection technique when more than 50% of clinician-patient face-to-face time was devoted to counseling. *Three documentation elements are required.*

OR

2. **Components:** Documentation of "medically necessary" *History*, *Exam*, and *MDM* (medical decision making).

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Time Based E/M Coding

The "Greater Than 50%" Rule

"When greater than 50% of the face-to-face encounter is devoted to counseling or coordination of care, you may default to the documented time to assign the E/M code." *Review in CPT 2019*

Counseling = discussion with a patient concerning:

- Diagnostic results, impressions, recommended studies
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management and/or follow-up
- Importance of compliance with management options
- Risk factor reduction and/or Patient education

Documentation Based on Time:

1. Document & code ***your*** total visit time.
2. Document >50% of visit was counseling.
3. **Document detailed content of your counseling, discussion, expectations...**

Today's Assessment & Plan

"Labs confirm DM2, the majority of this 25 minute visit devoted to counseling, multiple treatment options, diet, meds...exercise" Scheduled with DM trainer, started log, He will monitor his BS. Rtn 4 weeks."

(Back of Recipe Card)

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Time Based E/M Coding

Documentation must include three distinct elements:

1. Total encounter time in minutes
2. Time devoted to counseling/coordination of care
   (documented confirmation counseling was > half total time)
3. Content with detail of the counseling

E/M Code	Time Guideline
99212	10 min
99213	15 min
99214	25 min
99215	40 min
99211	5 min or

E/M Code	Time Guideline
99201	10 min
99202	20 min
99203	30 min
99204	45 min
99205	60 min

Example for selection of 99214:

"Greater than 50% of this 25-minute face-to-face visit with this established patient was spent counselling on End stage COPD, end of life decisions and goals of care discussion and coordinating care..."

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Time Scenario

Assessment/Plan

1. Asthma, mild & persistent, uncomplicated (J45.30) 5-year-old is doing well, but Mom smokes cigarettes at home and in the car.

2. Second-hand tobacco smoke exposure (Z77.22)

"The majority of this 20 minute visit was focused on counseling about the medication plan. Details and a chart outlining use of inhaler, and oral medications explained. Risks and side effects reviewed. Also asked Mom to only smoke outside and never when directly with child. She does seem to understand."

99213

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Time Scenario

Assessment/Plan

1. **ADHD, inattentive type (F90.0)**
2. **Other noncompliance with medication regimen (Z91.14)**
3. **Underachievement in school (Z55.3)**

The majority of this 25-minute encounter was spent in counseling this 14 yo patient and his mother regarding importance of taking the medication as prescribed; he has repeatedly discontinued the medication. We discussed various coping mechanisms with and without medication. I explained that I will not be able to help him if he does not stay compliant with chosen treatment plan. He indicated an understanding. Pt states he would like to restart medication now due to poor school performance.

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99214

What if….?

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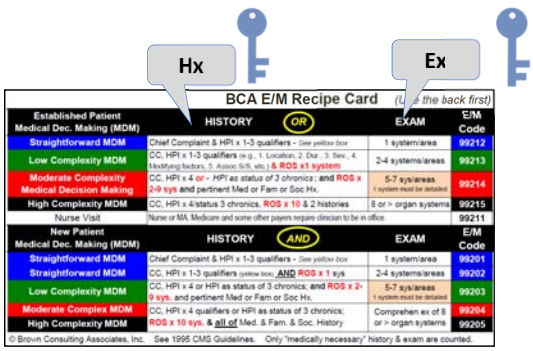
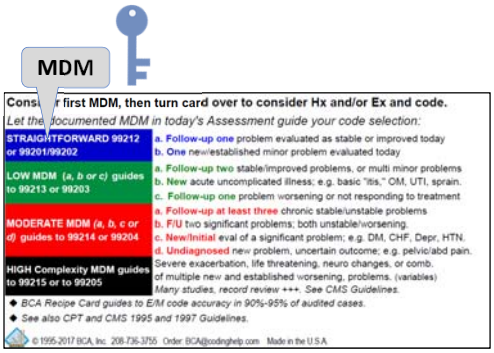
E/M Visit Code Selection

Three "Key Components" History, Exam & Medical Decision Making





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Documenting HPI – Two Techniques

Typical *Acute* Version HPI (History of Present Illness)
9 year old presents with a five day history of runny nose, sore throat and cough. Mom has been having him gargle with salt water, but is concerned because he is not better. No fever, no nausea, denies headache.

***3 Chronics* Version HPI** Six month planned follow-up: **HTN** is stable on medication, he does check BP occasionally. **PRE-DM**: Last A1C 6.4 in January 2019. Taking metformin as ordered, continues to work on diet compliance. **GERD** is helped w/Omeprazole and careful diet choices. **MDD** is stable on meds and occasional visit with w/BMed.

HPI Qualifiers

1 Location
2 Duration
3 Severity
4 Quality
5 Context
6 Timing
of chief complaint

7 Factors that modify chief complaint
8 Associated S&S

E/M codes requiring four HPI qualifiers may instead be documented with the [incoming] ***status of 3 or more chronic problems.***

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CC and HPI Hot Button Issues

- Vague Chief Complaint
  - "Med Refills" "Follow-up" "Here to establish care"
  - Unclear whether problem is new or established to the chart
- Contradictions between CC, HPI and/or ROS:
  - HPI: "Patient complains of dysuria that started two days ago."
  - ROS: "Denies dysuria and urinary frequency"
- Cut & Paste documentation

"Cut and Paste" Best Practice Considerations

"Cut and paste," moving documentation from anywhere into today's current medical record must be purposeful. It must be clearly identified as *historic information* . ***Be cautious with "cut and paste" information as it may potentially create confusion in today's record which could lead to clinical errors.***

1 Only move documentation into today's medical record if there is a clinical indication.
2 Include the pasted information in **quotation marks.**
3 Identify, in today's note the **original source** of pasted information.
4 Identify, in today's note the **original date** of pasted information.
5 Identify, in today's note the **original author** of pasted information.

"This P. Jones MD consult on 6/1/18 - copied here from Consult Section on 6/5/18"

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Exam – 2nd Key Component

- 1995 CMS Documentation Guidelines
  - Body systems or areas.
  - Comprehensive exam = body systems only.
- 1997 CMS Documentation Guidelines
  - Identified exam elements.

BCA E/M Recipe Card *(Use the back first)*

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New Patient Medical Dec. Making (MDM)	HISTORY (AND)	EXAM	E/M Code	Time Guideline
Straightforward MDM	Chief Complaint & HPI x 1-3 qualifiers - *See yellow box*	1 system/area	99201	10 min
Straightforward MDM	CC, HPI x 1-3 qualifiers (yellow box) AND ROS x 1 sys	2-4 systems/areas	99202	20 min
Low Complexity MDM	CC, HPI x 4 or HPI as status of 3 chronics; and ROS x 2-9 sys, and pertinent Med or Fam or Soc Hx.	5-7 sys/areas (1 system must be detailed)	99203	30 min
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High Complexity MDM			99205	60 min

HPI Qualifiers (of chief complaint)
1 Location
2 Duration
3 Severity
4 Quality
5 Context
6 Timing
7 Factors that modify chief complaint
8 Associated S&S

E/M codes requiring four HPI qualifiers may instead be documented with the [incoming] *status of 3 or more chronic problems.*

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Medical Decision Making (MDM) – 3rd Component

1. Most useful key for proving coding version of "medical necessity"
2. MDM is scored; e.g. 1 stable problem = 1 point, 2 stables = 2 points, new significant problem today, 3 points...
3. Process is the same for all E/M coding based on components

Consider first MDM, then turn card over to consider Hx and/or Ex and code.

Let the documented MDM in today's Assessment guide your code selection:

STRAIGHTFORWARD 99212 or 99201/99202	a. **Follow-up one** problem evaluated as stable or improved today b. **One** new/established minor problem evaluated today
LOW MDM (*a, b or c*) guides to 99213 or 99203	a. **Follow-up two** stable/improved problems, or multi minor problems b. **New** acute uncomplicated illness; e.g. basic "itis," OM, UTI, sprain. c. **Follow-up one** problem worsening or not responding to treatment
MODERATE MDM (*a, b, c or d*) guides to 99214 or 99204	a. **Follow-up at least three** chronic stable/unstable problems b. **F/U** two significant problems; both unstable/worsening. c. **New/Initial** eval of a significant problem; e.g. DM, CHF, Depr, HTN. d. **Undiagnosed** new problem, uncertain outcome; e.g. pelvic/abd pain.
HIGH Complexity MDM guides to 99215 or to 99205	Severe exacerbation, life threatening, neuro changes, or comb. of multiple new and established worsening, problems. (variables) *Many studies, record review +++. See CMS Guidelines.*

◆ *BCA Recipe Card guides to E/M code accuracy in 90%-95% of audited cases.*
◆ *See also CPT and CMS 1995 and 1997 Guidelines.*

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Determine the Level of MDM (Blue, Green or Red)

Which code does this level of MDM lead you to?

HPI: 62 year old was seen three weeks ago for 3-month check of her chronic conditions, at that time her diagnostic blood pressure was significantly elevated, I asked to come back for a recheck.

Assessment and Plan

1. HTN, now stable

She has been checking at the senior center and now reports normal range on her BP Card. Today BP checked in 2 positions and 132/78. She is working on diet and is walking every day. Return for her follow-up of DM2, Obesity, HTN and COPD in three months.

Straightforward MDM: 99212

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Determine the Level of MDM (Blue, Green or Red)

Which code does this level of MDM lead you to?

HPI: 12-year-old comes in today with a two day history of upper respiratory congestion, cough, body aches and low grade fever & fatigue.

Assessment and Plan

1. Viral URI – supportive measures, hydration, OTC antihistamine and rest, should resolve over next several days.

Low MDM: 99213

HPI: 24-month-old male with asthma exacerbation secondary to viral infection. Initial resp exam revealed moderate belly breathing and suprasternal retractions, tight and frequent cough, very tight throughout with faint wheeze in base. Pt given duoneb x3 in clinic with improvement. Rx Prednisolone, discussed importance of giving albuterol txs at home. Follow-up tomorrow. If cough worsens, trouble breathing go to ER…

Assessment and Plan

1. Asthma exacerbation
2. Viral infection

Moderate MDM: 99214

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E/M Suggestions – New Patients

New patients: In Family Medicine think 99202 or 99203

- Three of three key components (or time) required
- Think about your work routine for new patients
  - Consider 99203 for New Patients; if you do less work, code lower.
  - 99204 requires a Comprehensive History & Comprehensive Exam.

New Patient Medical Dec. Making (MDM)	HISTORY (AND)	EXAM	E/M Code	Time Guideline
Straightforward MDM	Chief Complaint & HPI x 1-3 qualifiers - *See yellow box*	1 system/area	99201	10 min
Straightforward MDM	CC, HPI x 1-3 qualifiers (yellow box) **AND** ROS x 1 sys	2-4 systems/areas	99202	20 min
Low Complexity MDM	CC, HPI x 4 or HPI as status of 3 chronics; **and** ROS x 2-9 sys. and pertinent Med or Fam or Soc Hx.	5-7 sys/areas 1 system must be detailed	99203	30 min
Moderate Complex MDM	CC, HPI x 4 qualifiers or HPI as status of 3 chronics;	Comprehen ex of 8	99204	45 min
High Complexity MDM	ROS x 10 sys. & **all of** Med. & Fam. & Soc. History	or > organ systems	99205	60 min

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E/M Suggestions – Established Patients

Established patients: In Family Medicine think 99213 or 99214

- Two of three 3 key components (or time) required
- 99214 hx and exam = 99203 hx and exam
- Think about your history and exam routines

Established Patient Medical Dec. Making (MDM)	HISTORY (OR)	EXAM	E/M Code	Time Guideline
Straightforward MDM	Chief Complaint & HPI x 1-3 qualifiers - *See yellow box*	1 system/area	99212	10 min
Low Complexity MDM	CC, HPI x 1-3 qualifiers (e.g., 1. Location, 2. Dur., 3. Sev., 4. Modifying factors, 5. Assoc S/S, etc.) **& ROS x1 system**	2-4 systems/areas	99213	15 min
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High Complexity MDM	CC, HPI x 4/status 3 chronics, ROS x 10 & 2 histories	8 or > organ systems	99215	40 min

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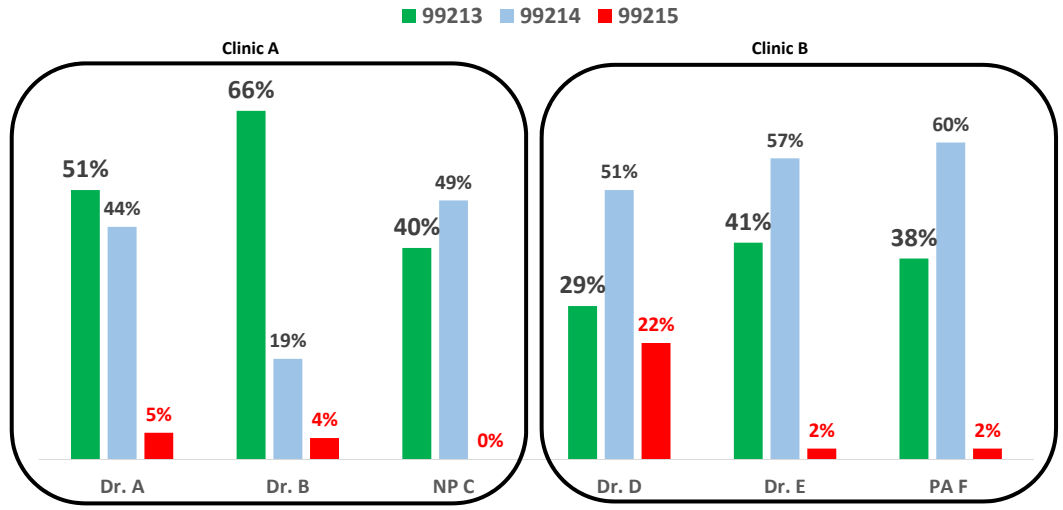
Similar Clinics

One with approx. 4 visits per year, the other with approx. 6.5 visit per year. Why?



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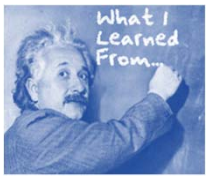
Evaluation & Management (E/M) Take Homes



1. **Clear Chief Complaint** (new vs FU problem).
2. **HPI details** should be included for each condition managed today. Remember the **HPI 'incoming' status rule**.
3. **Well-detailed Assessment and Plan for each condition**.
4. **BCA Recipe Card** to improve understanding of MDM with required history and exam for each code.
5. **Study** your own data. **Share/compare** with other FQHCs.
6. Ensure **timely signatures** (FTCA indicates 72 hrs).
7. **Audit records,** *be willing to not be an expert, you will improve!*
8. **Teach your clinician** - *then, audit again, teach again, repeat...repeat.*

Use the **BCA Recipe Card.*

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Medical Decision Making (MDM)

Documentation Take Homes

1. Be clear if **problem is new**
2. Who was **historian**?
3. If f/u, include HPI incoming status details
4. Identify any reports reviewed
5. Document work-up, labs/images/studies & why
6. Any **discussions** with others?
7. Identify your interpretation of studies
8. If you request **"old records"**
9. In Assessment, include ***status*** *(stable, improving, worsening etc.)*
10. Your **conclusions/concerns & planned follow-up**

Management's Take-home

In early 2020...
1. Do data E/M data study
2. Perform Ed. E/M audits
3. Empower your coders

Remember, MDM & Time will rule in 2021.

It will never be easier than it is today!

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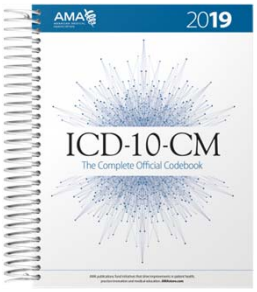
ICD-10-CM Coding and Reporting

All stakeholders – Know your resources



cdc.gov/nchs/icd/icd10cm

CMS.gov
Centers for Medicare & Medicaid Services

Medicare Managed Care Manual 100-16
Chapter 7: Risk Adjustment

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c07.pdf

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BCA's Favorite Diagnosis Coding Guidelines

HIPPA Mandated for Physician Services, No Matter Where they Work

1. The 1st listed dx identifies condition requiring the greatest work-effort as determined by the clinician & supported in the record.
2. Document all conditions that require/affect care.
3. Document reasons for all studies.
4. Code to the highest level of specificity known.
5. Do not assign "rule out" or unconfirmed diagnoses; instead report known signs and symptoms.

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Risk-Adjustment & HCCs

Value-based Reimbursement

- Various risk-based reimbursement models are utilized to predict medical expenditures
  - CMS HCC Model *(Hierarchical Condition Categories)*
  - Medicaid CDPS Model *(Chronic Disease & Illness Payment System)*
  - Various hybrid models
- Categories describe a broad set of similar diseases (ICD-10-CM codes)
  - Risk variation between different models focused on certain patient populations
  - Broken down into hierarchical categories based on severity
- Well diagnosed conditions may result in added "value."
- Reporting all conditions that affect care may also result in added value

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Understanding Risk Adjustment and HCCs

- Each year the CMS model resets the list of HCCs and RAF for each patient.
- Annual health assessment is a must!
- CMS relies on ICD-10 coding that is supported in the medical record.
- If the documentation and coding are not done well, it may indicate the clinician did much less work than was actually provided.

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Understanding Risk Adjustment Factors

- **Risk Adjustment Factors (RAF)** are based on demographics and health status to calculate a risk score for each member.
  - Where the patient resides; community or institutional
  - Age, gender, reason for Medicare entitlement and Medicaid eligibility
  - New enrollee? Uses demographics only; age, gender, disability status since enrollee has less than 12 months of medical history.
  - Disability status
- **Health status measured by HCCs.** Expected costs adjusted for outliers based on the member's risk score and whether the patient has ESRD.

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HCCs & Risk-Adjustment

Hierarchical Condition Categories

1. Diabetes
2. Hypertensive heart & renal disease
3. Major depressive disorder
4. Substance dependence
5. Angina/Ischemic codes
6. Many arrhythmias
7. Morbid obesity
8. Many COPD codes
9. Some chronic hepatitis diagnoses
10. Rheumatoid Arthritis
11. Coagulation Defects
12. CKD, Stage 4 & Stage 5
13. Dialysis status
14. Pneumonia
15. Metastatic disease
16. HIV/AIDS
17. Hip fracture/dislocation
18. Vertebral fractures
19. Pressure ulcers
20. Traumatic amputations & amp. *status*
21. Status - Artificial opening for feeding/elimination & tracheostomy

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HCC Comparison

68-year-old, last seen 8 mos. ago	68 yo (2 missed appointments)
• Relatively healthy • I10: Stable HTN (No added risk) • $700 per member/month for care	• 3 stable chronic illnesses: Condition — Added Risk E11.9 Type 2 DM — 0.104 E66.01 Morbid Obesity — 0.273 I11.0 HTN w/I50.9 CHF — 0.323 Total Added Risk — 0.700 + *Interaction DM/CHF* — 0.182 • Approximately $1900/month set aside

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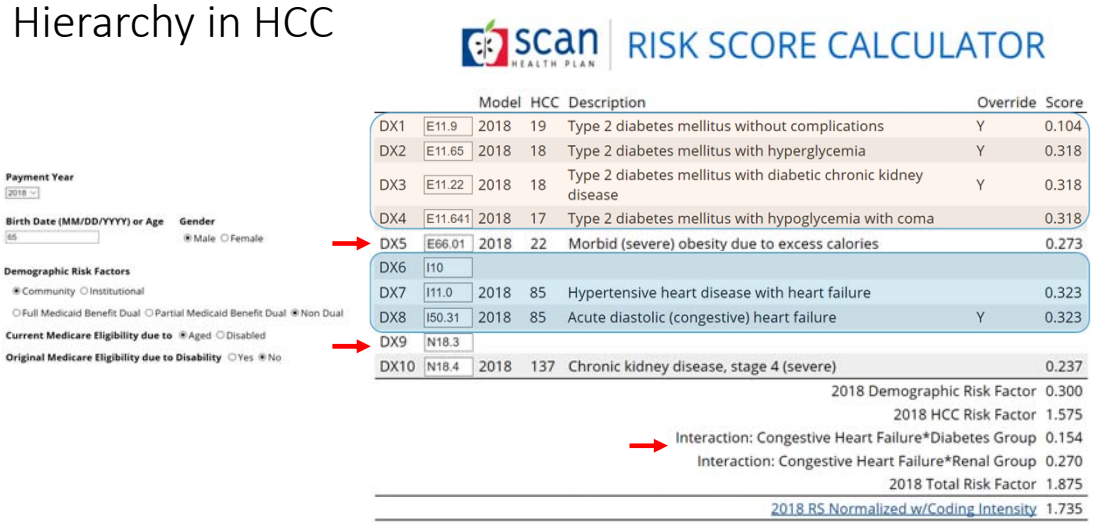
Hierarchy in HCC



http://www.hccuniversity.com/risk-score-calculator/

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Understanding CDPS

Chronic Disease & Illness Payment System

1. Maps Dx to 56 categories of major body systems/chronic diseases
2. Similar to HCC models, but greater emphasis on chronic conditions more prevalent among disabled Medicaid members
3. Divided into four levels:
   - Very high
   - Moderate
   - Low
   - Extremely low
   - Only the most severe within a category 'counts'
   - Conditions from separate categories will 'count' individually

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Understanding RxHCCs

1. Reimbursed to Medicare Part D and Medicare Advantage programs
2. Approximately 75 RxHCCs
3. Many similar categories to HCCs
4. Includes condition categories likely to incur prescription costs (e.g., hypertension and hypothyroidism)

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Understanding Adjusted Clinical Groups (ACGs)

1. Population/patient case-mix adj. system based on morbidity burden
2. Creates individual risk score based on expected or actual consumption of health services
3. Originally 32 groups of diagnosis codes based on:
   1) Duration
   2) Severity
   3) Diagnostic certainty
   4) Etiology
   5) Specialty care involvement
4. Number of actual categories depends on model adopted

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Challenges Faced By Risk-Adjustment Programs

The number one issue - Equitable Data

1. Minimal reinforcement of ICD-10-CM Guidelines thus far, as payment has been historically based on CPT/HCPCS coding
2. Most clinicians do not know, or even know about, ICD-10-CM Guidelines
3. Coders often struggle with ICD-10-CM Guideline application
4. Multiple EMR descriptions of individual ICD-10-CM codes make accuracy significantly challenging
5. 'Favorites' lists limit Dx choices when used primarily or exclusively
6. Problem lists are problematic

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The Role of the Clinician

- Safely and effectively treat your patient's conditions and concerns.
- Create documentation that proves complexity of your work efforts:
  - What conditions required care?
  - What complications/manifestations are present?
  - What other conditions affect care/management options?
  - Tell us what we don't know:
    - Ankle sprain treatment is different in a diabetic (especially with PVD or neuro issues).
    - Underlying kidney disease causes you to carefully consider medication choices for the current condition.
- Provide the current status of conditions at each follow-up encounter

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The Role of the Coder

- Evaluate accuracy of diagnosis code assignment based on documentation.
- Consider whether condition is current or personal history (neoplasms).
- Apply ICD-10-CM Official Guidelines for reporting outpatient services.
- Utilize manuals. Consult tabular list for final code assignment.
- Study your data! Compare to national/state disease prevalence data.
- Evaluate your understanding of common disease processes - research what you do not know.
- Educate peers/admin/clinicians regarding coding changes, trends, etc.

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The Role of the Medicare Advantage Organization

- Ensure accuracy & integrity of risk adjustment data submitted to CMS
  - Must be a result of a face-to-face visit
  - Must be coded according to ICD-10-CM Guidelines for Coding and Reporting
- Implement procedures to ensure dxs are from acceptable sources
- Submit the required data elements from acceptable data sources according to ICD-10-CM coding guidelines
- Submit all required dx codes for each beneficiary and submit unique diagnoses at least once during the data-reporting period

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The Role of the Medicare Advantage Organization

- Receive and reconcile CMS Risk Adjustment Reports in a timely manner, including tracking their submission and deletion of dx codes on an ongoing basis
- Request a recalculation if indicated by discovering the submission of inaccurate diagnosis codes (must inform CMS immediately upon such a finding)

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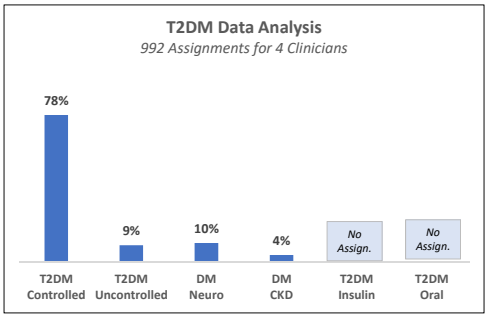
Diabetes Data

Codes Organized by Frequency		
Code	Description	Units
I10	Essential (primary) hypertension	1864
E78.5	Hyperlipidemia, unspecified	1164
E11.9	Type 2 diabetes mellitus without complic	770
Z13.9	Encounter for screening, unspecified	602
Z28.3	Underimmunization status	566
E03.9	Hypothyroidism, unspecified	561
F11.20	Opioid dependence, uncomplicated	488
Z23	Encounter for immunization	479
J44.9	Chronic obstructive pulmonary disease, u	425
Z00.00	Encounter for general adult medical exam	404
K21.9	Gastro-esophageal reflux disease without	335
F32.9	Major depressive disorder, single episode	324
G47.00	Insomnia, unspecified	313
F17.200	Nicotine dependence, unspecified, uncor	296
N39.0	Urinary tract infection, site not specified	240
Z12.11	Encounter for screening for malignant nec	233
Z13.0	Encounter for screening for diseases of th	225

Code	Description	Units
E11.9	Type 2 diabetes mellitus without complic	770
E11.65	Type 2 diabetes mellitus with hyperglycer	86
E11.40	Type 2 diabetes mellitus with diabetic ne	76
E11.51	Type 2 diabetes mellitus with diabetic pe	52
E11.22	Type 2 diabetes mellitus with diabetic chr	31
E11.621	Type 2 diabetes mellitus with foot ulcer	25
E11.49	Type 2 diabetes mellitus with other diabe	23
E11.319	Type 2 diabetes mellitus with unspecified	19
E11.29	Type 2 diabetes mellitus with other diabe	5
E11.311	Type 2 diabetes mellitus with unspecified	3
E11.641	Type 2 diabetes mellitus with hypoglycem	1



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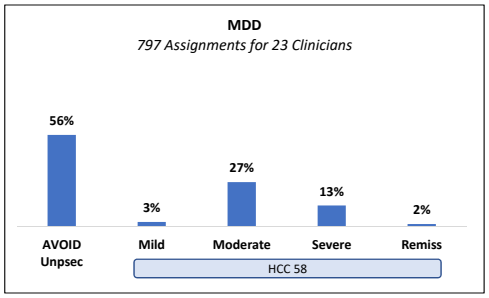
Major Depressive Disorder

Major Depressive Disorders (MDD)		Code
MDD, single episode code choices		
"Single episode" is the first-ever episode. DSM-5, pg 162: Dx code for MDD based on sing vs recurrent and severity.		
MDD, single episode; *(The patient's 1st Dx of MDD - may last months/years)*		
MDD, single episode; **mild severity**	HCC	F32.0
MDD, single episode, **moderate severity**	HCC	F32.1
MDD, single episode; **severe, *WITHOUT*** **psychotic symptoms**	HCC	F32.2
MDD, single episode; **severe, *WITH*** **psychotic symptoms**	HCC	F32.3
MDD, single episode; **in PARTIAL remission**	HCC	F32.4
MDD, single episode; **in FULL remission**	HCC	F32.5
MDD, **single** episode; *severity cannot be specified* *avoid*	No	F32.9
MDD, recurrent episode code choices ***(more common than single episode)***		
An "episode" likely to last many mos/years. DSM-5, pg 162: "recurrent" = interval of ≥ 2 consecutive months between separate episodes in which criteria for MDD are not met.		
MDD, recurrent episode; **mild** *subsequent re-dx after remission*	HCC	F33.0
MDD, recurrent episode; **& moderate severity**	HCC	F33.1
MDD, recurrent; & severe, *WITHOUT* **psychotic symptoms**	HCC	F33.2
MDD, recurrent; & severe, *WITH* **psychotic symptoms**	HCC	F33.3
MDD, recurrent episode **in *PARTIAL*** **remission**	HCC	F33.41
MDD, recurrent episode **in *FULL*** **remission**	HCC	F33.42
MDD, Other reccurrent depressive disorder *(specified in record)*	HCC	F33.8
MDD, recurrent episode, *severity cannot be specified* *avoid*	HCC	F33.9
Other Depressive Episodes *(Added 2016)*		
• Premenstrual dysphoric disorder		F32.81
• Other specified depressive episode *(specified in record)*		F32.89

See pg. 18



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Major Depressive Disorder

Two Code Selection Specifiers

1 The first specifier identifies whether the clinical presentation today represents a ***single or recurrent episode of MDD*.**

Single Episode A *"single episode"* identifies circumstances where MDD is first diagnosed. Some people will continue to struggle with MDD for their entire life, or may go into remission. ***See Details in DSM-5, written by APA; page 188***

Recurrent Episode A *"recurrent episode"* indicates that the patient had at least a two month break in symptoms, then had a recurrence. Remission may occur, but any future recurrence will again be a "recurrent episode." ***See Details in DSM-5, written by APA; page 188***

2 The second code selection specifier identifies the current severity of MDD symptoms as ***mild, moderate or severe*.**

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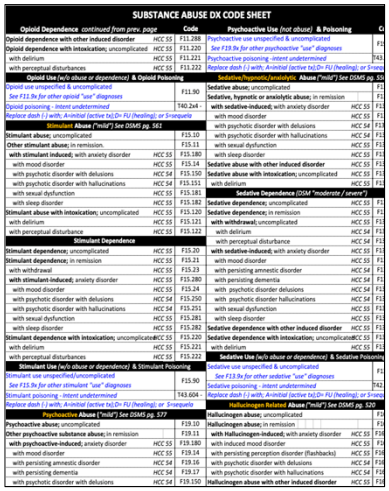
Substance Use, Abuse, & Dependence

Terminology Comparison

DSM-5		***ICD-10-CM***
• *mild*	code as →	**abuse**
• *moderate*	code as →	**dependence**
• *severe*	code as →	**dependence**

DSM-5 *"Report code for each substance when polysubstance abuse/dependence/use is documented." DSM-5*



SUBSTANCE ABUSE DX CODE SHEET

Opioid Dependence *continued from prev. page*	Code
Opioid dependence with other induced disorder HCC 55	F11.288
Opioid dependence with intoxication; uncomplicated HCC 55	F11.220
with delirium HCC 55	F11.221
with perceptual disturbances HCC 55	F11.222
Opioid Use *(w/o abuse or dependence)* **& Opioid Poisoning**	
Opioid use unspecified & uncomplicated *See F11.9x for other opioid "use" diagnoses*	F11.90
Opioid poisoning - *intent undetermined*	T40.2x4 -
Replace dash (-) with: A=initial (active tx);D= FU (healing); or S=sequela	
Stimulant Abuse *("mild") See DSM5 pg. 561*	
Stimulant abuse; uncomplicated	F15.10
Other stimulant abuse; in remission.	F15.11
with stimulant induced; with anxiety disorder HCC 55	F15.180
with mood disorder HCC 55	F15.14
with psychotic disorder with delusions HCC 54	F15.150
with psychotic disorder with hallucinations HCC 54	F15.151
with sexual dysfunction HCC 55	F15.181
with sleep disorder HCC 55	F15.182
Stimulant abuse with intoxication; uncomplicated HCC 55	F15.120
with delirium HCC 55	F15.121
with perceptual disturbance HCC 55	F15.122
Stimulant Dependence	
Stimulant dependence; uncomplicated HCC 55	F15.20
Stimulant dependence; in remission HCC 55	F15.21
with withdrawal HCC 55	F15.23
with stimulant-induced; anxiety disorder HCC 55	F15.280
with mood disorder HCC 55	F15.24
with psychotic disorder with delusions HCC 54	F15.250
with psychotic disorder with hallucinations HCC 54	F15.251
with sexual dysfunction HCC 55	F15.281
with sleep disorder HCC 55	F15.282
Stimulant dependence with intoxication; uncomplicated HCC 55	F15.220
with delirium HCC 55	F15.221
with perceptual disturbances HCC 55	F15.222
Stimulant Use *(w/o abuse or dependence)* **& Stimulant Poisoning**	
Stimulant use unspecified/uncomplicated *See F15.9x for other stimulant "use" diagnoses*	F15.90
Stimulant poisoning - *intent undetermined*	T43.604 -
Replace dash (-) with: A=initial (active tx);D= FU (healing); or S=sequela	
Psychoactive Abuse *("mild") See DSM5 pg. 577*	
Psychoactive abuse; uncomplicated	F19.10
Other psychoactive substance abuse; in remission	F19.11
with psychoactive-induced; anxiety disorder HCC 55	F19.180
with mood disorder HCC 55	F19.14
with persisting amnestic disorder HCC 54	F19.16
with persisting dementia HCC 54	F19.17
with psychotic disorder with delusions HCC 54	F19.150

Psychoactive Use *(not abuse)* **& Poisoning**	Co
Psychoactive use unspecified & uncomplicated *See F19.9x for other psychoactive "use" diagnoses*	F1
Psychoactive poisoning -*intent undetermined*	T43
Replace dash (-) with: A=initial (active tx);D= FU (healing); or S=sequ	
Sedative/hypnotic/anxiolytic Abuse *("mild") See DSM5 pg. 55*	
Sedative abuse; uncomplicated	F1
Sedative, hypnotic or anxiolytic abuse; in remission	F1
with sedative-induced; with anxiety disorder HCC 55	F13
with mood disorder HCC 55	F1
with psychotic disorder with delusions HCC 54	F13
with psychotic disorder with hallucinations HCC 54	F13
with sexual dysfunction HCC 55	F1
with sleep disorder HCC 55	F1
Sedative abuse with other induced disorder HCC 55	F1
Sedative abuse with intoxication; uncomplicated HCC 55	F1
with delirium HCC 55	F1
Sedative Dependence *(DSM "moderate / severe")*	
Sedative dependence; uncomplicated HCC 55	F1
Sedative dependence; in remission HCC 55	F1
with withdrawal; uncomplicated HCC 55	F1
with delirium HCC 54	F1
with perceptual disturbance HCC 54	F1
with sedative-induced; with anxiety disorder HCC 55	F1
with mood disorder HCC 55	F1
with persisting amnestic disorder HCC 54	F1
with persisting dementia HCC 54	F1
with psychotic disorder delusions HCC 54	F1
with psychotic disorder hallucinations HCC 54	F1
with sexual dysfunction HCC 55	F1
with sleep disorder HCC 55	F1
Sedative dependence with other induced disorder HCC 55	F1
Sedative dependence with intoxication; uncomplicated HCC 55	F1
with delirium HCC 55	F1
Sedative Use *(w/o abuse or dependence)* **& Sedative Poisoning**	
Sedative use unspecified & uncomplicated *See F13.9x for other sedative "use" diagnoses*	F1
Sedative poisoning - *intent undetermined*	T42
Replace dash (-) with: A=initial (active tx);D= FU (healing); or S=sequ	
Hallucinogen Related Abuse *("mild") See DSM5 pg. 520*	
Hallucinogen abuse; uncomplicated	F1
Hallucinogen abuse; in remission	F1
with Hallucinogen-induced; with anxiety disorder HCC 55	F1
with induced mood disorder HCC 55	F1
with persisting perception disorder (flashbacks) HCC 55	F1
with psychotic disorder with delusions HCC 54	F1
with psychotic disorder with hallucinations HCC 54	F1
Hallucinogen abuse with other induced disorder HCC 55	F1

BCA's Favorite Dx Coding Booklet pg. 22

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Substance Related "Disorders" by DSM

Substance-related Disorders (DO) are divided into **two groups**:

1. Substance **Use** Disorders (SUDs)
2. Substance-**induced** Disorders
   The *Substance-induced* disorders are
   a) Intoxication
   b) Withdrawal
   c) Other substance/medication-induced
      psychotic, bipolar, depressive, anxiety, obsessive-compulsive, sleep, sexual dysfunction, delirium and neurocognitive disorders

Alcohol Dependence *(DSM "moderate / severe")*		
Alcohol dependence; uncomplicated	HCC	F10.20
Alcohol dependence; in remission	HCC	F10.21
with withdrawal; uncomplicated	HCC	F10.230
with delirium	HCC	F10.231
with perceptual disturbance	HCC	F10.232
with alcohol-induced; anxiety disorder	HCC	F10.280
with mood disorder	HCC	F10.24
with persisting amnesic disorder	HCC	F10.26
with persisting dementia	HCC	F10.27
with psychotic disorder delusions	HCC	F10.250
with psychotic disorder hallucinations	HCC	F10.251
with sexual dysfunction	HCC	F10.281
with sleep disorder	HCC	F10.282
Alcohol dependence with intoxication; uncomplicated	HCC	F10.220
with delirium	HCC	F10.221

A mental condition may co-exist with substance abuse and not be induced by the substance. When coding, do not assign as substance or medication induced unless documentation is crystal clear. When in doubt, ask.

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Don't Overvalue These Diagnosis

Too Risky…

- Current cancers when truly a PMH of cancer with no further treatment directed at the site.
- Diabetes with other specified/unspecified complications with no documentation of a complication
- Reporting of concurrent comorbidities that do not require or affect care today

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UDS Data

A data quality check

- Know your own
- Compare with others
- Know what your payers are doing with the information
- Top performer = $$$
- Significant improvement = $$$

https://bphc.hrsa.gov/uds/datacenter.aspx?state=NC

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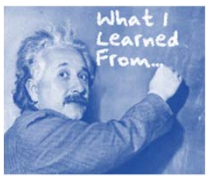
Diagnostic Data Take Homes



- Create equitable data that tells your story well
- Compare to regional data/peers
- Compare to national prevalence rates
- Build your team wisely
- Empower and educate coders
- Learn from your coders
- Learn from your clinicians

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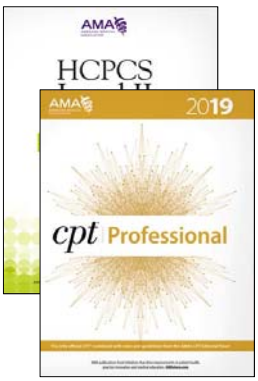
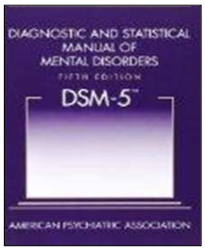
Behavioral Health Service Coding

An Introduction to Integration



AMA & HCPCS CPT Code Book

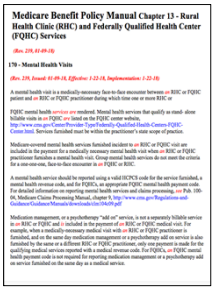
BCA Recipe Card



Designed as clinician resource

A "companion" reference for coders

NC Medicaid



CMS Medicare & FQHC

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BHI Relevance

The evidence says...

- Evidence suggests 70% of primary health patients have a mild to severe behavioral health component.
- Greater than 50%-70% of family medicine patients have various levels of psychosocial disorders or significant health barriers.
- 50% of patients "referred" to "traditional" behavioral health care models are never seen.
- An estimated 44% of successful suicide patients had seen Family Medicine clinicians five or fewer days before death.

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These are the Early Days

The coding/documentation for BHI services will never be easier than it is today

- You are one of the pioneers - Embrace what may be the most relevant evidence-based primary care delivery change in decades.
- Clinicians do what needs done and documents to support & share.
- Code what is done, whether you get paid or not.
- Behaviorists and coders teach each other.
- Train everyone including your payers, be in a position to speak to payers' clinical value – your training will make a difference.

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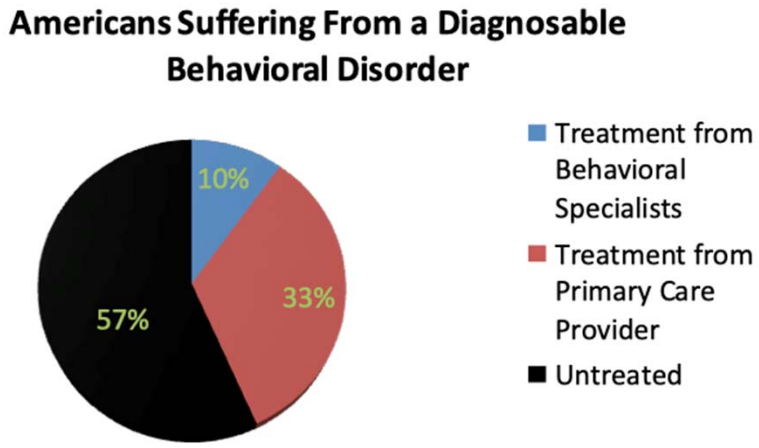
Who is Managing Behavioral Health Conditions?



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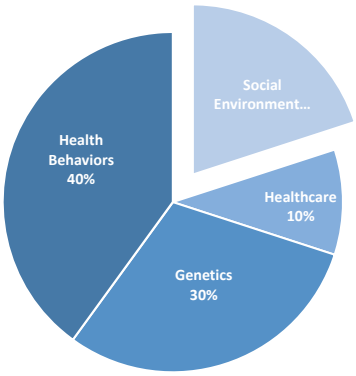
Health Barriers In Our Patient Population



New England Journal of Medicine, Sept. 20, 2017

Social Circumstances

1. Social isolation
2. Vulnerability
3. Violence
4. Unemployment
5. Poverty
6. No access to care
7. Separate silos of care
8. BeH not treated or undertreated

Health Behaviors

1. Drugs *(polypharmacy)*
2. Alcohol
3. Smoking
4. Obesity
5. Underweight
6. Diet

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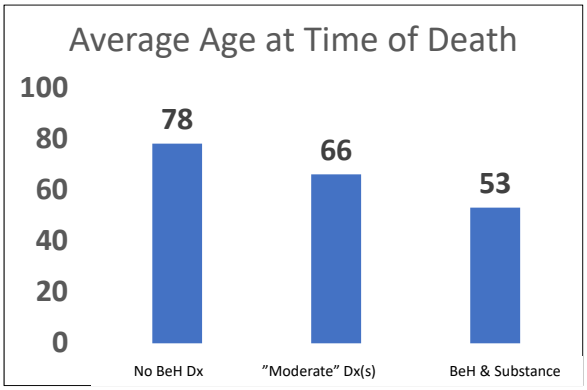
Death Decades Early

Primary care is the first line of defense in identifying the need for behavioral health services

Integrated care settings:

- create ease of connection to resources
- reduce time between recognition of need and appropriate interventions
- Increase probability that patient will engage in resource utilization



SAMHSA HRSA July 2016 integration.samhsa.gov
Druss study June, 2011 and Daumit, Aug 2010

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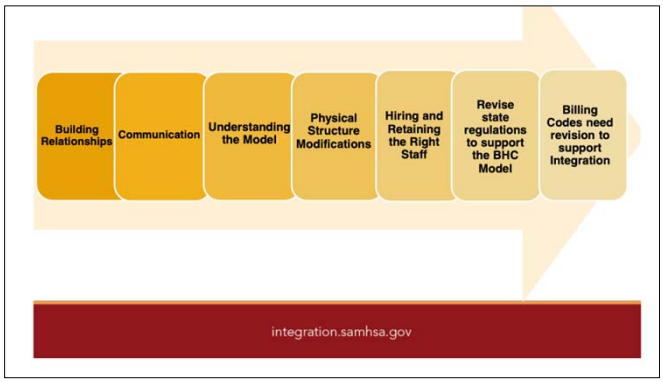
Recurrent Themes on the Path to Successful Integration



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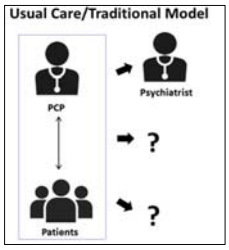
The Traditional Model

Yesterday and Today

Traditional BeH Model *Specialty Care:* long-standing, independent, appointment-based service provided in the office of a qualifying BeH professional



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Integrated Behavioral Health Care

Three 'models' for today's contemporary health delivery

1. **Co-located Model:** Behaviorist providing *Specialty Care* services in an office which is located in a medical clinic.
2. **Primary Care Model:** *Behavioral Health clinician* embedded in medical clinic as 'care-team member'
   - BeH serves as consultant and trainer to the PCP & clinic medical staff
   - BeH provides brief (15-30 min.) therapeutics during PCP visit, in the exam room for patients with behavioral health concerns and/or chronic medical concerns
   - Over a "short run", patient may continue to be seen in medical clinical visit by BeH or may, as clinically indicated, be moved to a *specialty care* environment.
   - The model involves a focus on population health

2a. Various "Hybrid" Models (developed by clinics)...

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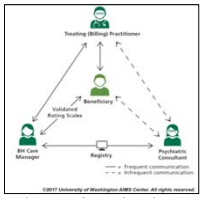
Integrated Behavioral Health Care 2

Three 'models' for today's contemporary health delivery

3. Psychiatric Collaborative Care Model (CoCM)



BCA/copy permission for training from UW/AIMs 2018

CMS reimburses specific services through the Medicare program; CoCM Model enhances usual primary care by two added key services:

1. Care Management patient support
2. Regular inter-specialty consultation to the PCP & primary medical care team, particularly regarding patients whose conditions are not improving
3. Both CPT services and HCPCS services codes are available for assignment of CoCM.

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Thinking about Unique "Models of Service"

BHI service ties directly to PCMH

- Based on many factors, clinics customize service for their population
- What size are the "case loads"
  - By contrast, some data suggests Traditional/Specialty case load of approximately 75 patients
  - Patients may be seen weekly, biweekly or monthly
- Some studies say BHI patients are seen, on average 1-4 times
  - Some are moved to Traditional/Specialty Care
- In some settings, a BeH may split time between BHI & T/Specialty Svc.
  - Some data suggests in split service between 25-50% might be BHI

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BeH in Medicine Environment

Not your mother's service model!

1. For Behaviorists, likely not what they were trained to do
2. Working in the medical clinic - not physically set up as is traditional
3. Not staffed (or unstaffed) when compared to traditional/specialty
4. Working within the medical setting may initially be intimidating
5. Majority of "service codes" for reporting and billing were written for traditional/specialty models... Not the integrated model
6. Funding streams are non-existent or at best blurry
7. Medical /MH /SUD Medicare...Medicaid...State Law

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Resource Utilization Scenario

Making sense of the expense

Suicidal patient in traditional care setting refuses tertiary care, but wants to talk:

- Medical clinician spends 4 hours with patient, rescheduling other encounters.
- One Medicaid encounter reported, garnering $200 for this extended service.

Same suicidal patient in Integrated setting:

- Medical clinician provides initial contact, identifies need for intervention, introduces BHC
- Medical clinician sees 2 pts/hr, reports a total of 8 encounters over same 4 hours = $1600
- BHC, if qualified, also reports psychotherapy for crisis

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New Clinical Approach to Problems (Diagnoses)

BHC meeting the patient "where they are..." (Literally & Emotionally)

- Zero to minimal preparation
- Enter the bright exam room, patient sitting on a paper sheet

  First eye contact - patient with anxiety/dread/apathy in their eyes
- Limited time to serve requires *insta-rapport* techniques
  - I am honored to meet you, I am Cindy and come to you with training and experience in working with people... based on the understanding that physical health is directly tied to all the features of life...
  - Next opening
  - Next opening
- Today, do what is necessary for the patient
- Today, document in a style to help both the patient and the team
- Today, code your encounter to represent your today's service

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Evidence-Based Coding!

BHI service ties directly to PCMH

- What does your coding and data "evidence" say?
  - Understand model & services: What is actually done for patients?
  - Coder and behaviorist: Share concerns and develop solutions!
  - Does the documentation support the code assignment?
  - Is the coding staff familiar with third-party contract information?
  - What is the success of your coding?
    - Payment rates by payer-type? Denial rates by payer-type?
    - How are the third-party appeals going?
- **Quiz Question:** What is the most potentially damaging ***one-liner*** said to behaviorists/management?

" They don't pay for that."

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BHI Services – Some Codes You May Be Using

The Warm Hand Off, Meet & Greet, Room Consult

Traditional *Eval & Therapy*	***HBAI*** *Health & Behavior*	***Nicotine***	***Screening*** *"Instrument" Work*	***Prevention***
Psych. Dx. Eval Psychotherapy Prolonged Fam. & Group Crisis visits Complex visits Virtual Com. $-Low Risk	Asmt 15 min ReAmt 15 min Ind. 15 min Grp. 15 min Fam 15 min $-Risk (Credential)	99406 99407 $-Risk (Credential)	Dev. Screen Audit/Dast Depression GAD PTSD Others $-Risk (Credential)	Individual Group (15 min units) $-Risk (E/M)

Alcohol/Sub
- G2011
- G0442
- G0443
- 99408
- 99408

$-Risk (Credential)

HCPCS
Unlisted
Unspecified
MH Assmt
BeH Counsel
Psychoed
MH Plan
$-Risk (no RVUs)

BHI
The "20 Min Code"

FQ/R	CPT
G0511	99484

CoCM/PCCM
"60-70 Min Codes"

FQ/R	CPT
G0512	99492
G0512	99493
G0512	99494

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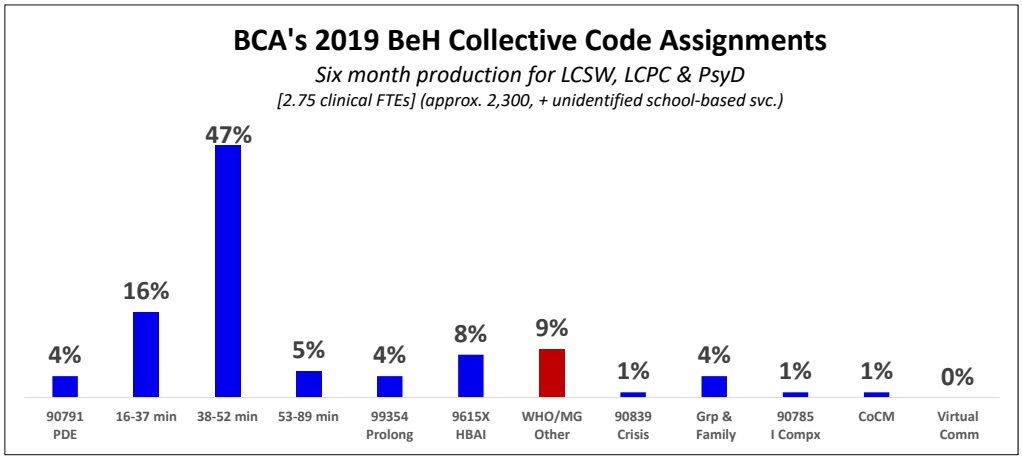
BCA Audit Results

Numbers matter to evidence-based coders!



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Selected HCPCS Codes

Review HCPCS Book, Medicaid Information

When in discussion w/third-party payers, these codes may be helpful:

H0031 Mental health assessment, by non-physician	No RVUs
H0004 Behav. health counseling & therapy per 15 min	No RVUs
H2027 Psychoeducational service, per 15 min	No RVUs
H0046 Mental health service, not otherwise specified	No RVUs
H0032 Mental health service plan by non-physician	No RVUs
90899 Unlisted psychiatric service/procedure	No RVUs

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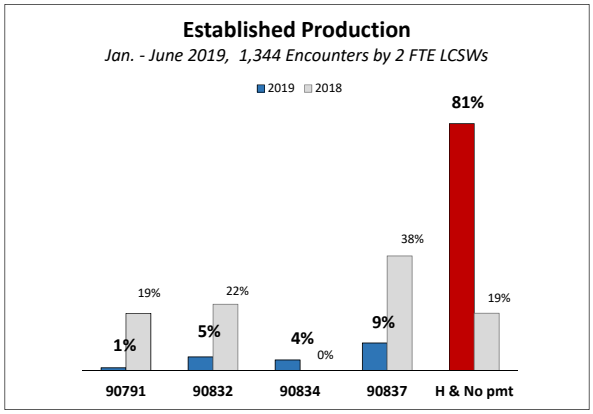
A FQHC's 15 Month Data of Easing into BHI...

19% billable

First Six Months of 2019

- 2 LCSW FTE
- 104 billable encounters
- 81% of documented encounters were not billable
- Minimal "grant" funding...



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Two BHI Codes, Apples & Oranges? *OR…*

Comparing Red Apples with Green Apples

G0511 Rural Health Clinic or Federally Qualified Health Center (FQHC/RHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (MD/DO/NP/PA/CNM), per calendar month	**99484** Care management services for behavioral health conditions, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated 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.

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BHI MBPM, Chapter 13, (RHC/FQHC)

Section 230.2 General BHI

"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. Effective January 1, 2018, RHCs and FQHCs are paid for general BHI services when a minimum of 20 minutes of qualifying general BHI services during a calendar month is furnished to patients with one or more new or pre-existing behavioral health or psychiatric conditions being treated by the RHC or FQHC primary care practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC primary care practitioner, warrants BHI services."

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Medicare's G0511 BHI [FQHCs/RHCs only]...General care management, 20 minutes or > clinical staff time for CCM services or behavioral health integration services directed by a RHC/FQHC practitioner (MD/DO/NP/PA CNM), per calendar month.

A PCP/other initiates & bills service *(Incident to/gen. supervision) & has had E/M within the past year*

B Consent - Patient verbal/written consent for service (documented)

a) Zero to 20% of Medicare allowable – *possible cost-share, consider sliding fee scale*
b) Includes permission for care givers to consult with relevant *specialists*
c) Patient may *terminate* service

1 Initial assessment & ongoing monitoring using validated clinical rating scales

2 BeH care planning in relation to BeH/Psych/Substance health problems

a) Including revisions for lack of progress or worsening status
b) BCA suggests an Excel spreadsheet "registry/roster" file *(not a requirement)*

3 Facilitating/coordinating *P. Therapy, Pharm., Counseling &/or Psychiatric Consultation*

4 Continuity of care with designated care team member *(likely 'Care Manager')*

Service Content

$ Medicare's G0511 Billing Detail

C Bill any time during a service month, bill on UB w/wo other payable services

D Secondary or patient responsible for 20% copay, consider sliding fee scale

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CPT 99484 BHI Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

A Supervising physician or [NP, PA, CNM] bill services *(under general supervision)*

a) Billing professional must have an ongoing relation w/pt & clinical staff care manager
b) Clinical staff must be available for face-to-face service

1. Initial assessment or FU monitoring using validated clinical rating scales
2. Treatment plan in relation to BeH/Psych/Substance health problems
   a) Including revisions for lack of progress or worsening status
   b) BCA suggests an Excel spreadsheet "registry/roster" file *(not a requirement)*
3. Facilitating/coordinating Treatment such as Psychotherapy, Pharmacotherapy, Counseling and/or Psychiatric Consultation
4. Continuity of care with designated care team member *(likely 'Care Manager')*

Service Content

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Medicare's "Incident to..." Basics

Medicare "Rules" written in federal terms have layers of detail

- **Medicare's "Incident to..." involves Payment & Practice**
  - Service billed as though 'supervising clinician did the work'
  - Established Dx under treatment by supervising clinician [*MD/DO/NP*]
  - Service is billed & paid as though done by billing clinician
  - Requires compliance with CMS "Supervision Guidelines" *(next slide)*
  - Some, *not all* payers have adopted Medicare's "Incident to" concept

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Medicare's "Supervision" Basics 2

Medicare "Rules" written in federal terms have layers of detail

Medicare's "Supervision" Defined by Categories

Medicare's supervision categories listed below define the "extent and details of supervision required in order to be able to bill certain CPT/HCPCS services".

- **Personal** - Supervising clinician (SC) *or proxy* is ***SC in consult room***
- **Direct – *SC in clinic***, but not in session - *may be a covering clinician*
- **General – *SC available, but not present*** in clinic, but available

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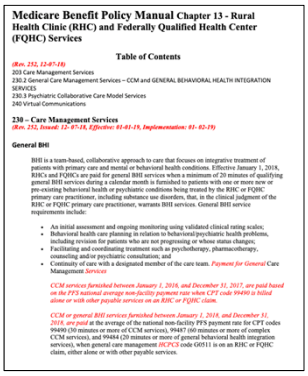
Best Official Resources for G0511

Remember, HCPCS code G0511 (BHI) was invented by Medicare



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

Table of Contents

(Rev. 252, 12-07-18)

203 Care Management Services

230.2 General Care Management Services – CCM and GENERAL BEHAVIORAL HEALTH INTEGRATION SERVICES

230.3 Psychiatric Collaborative Care Model Services

240 Virtual Communications

230 – Care Management Services

(Rev. 252, Issued: 12- 07-18, Effective: 01-01-19, Implementation: 01- 02-19)

General BHI

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. Effective January 1, 2018, RHCs and FQHCs are paid for general BHI services when a minimum of 20 minutes of qualifying general BHI services during a calendar month is furnished to patients with one or more new or pre-existing behavioral health or psychiatric conditions being treated by the RHC or FQHC primary care practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC primary care practitioner, warrants BHI services. General BHI service requirements include:

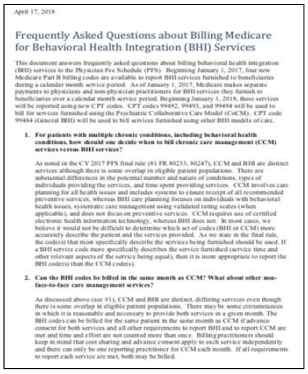
- An initial assessment and ongoing monitoring using validated clinical rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such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

CCM services furnished between January 1, 2018, and December 31, 2017, are paid based on the PFS national average non-facility payment rate when CPT code 99490 is billed alone or with other payable services on an RHC or FQHC claim.

CCM or general BHI services furnished between January 1, 2018, and December 31, 2018, are paid at the average of the national non-facility PFS payment rate for CPT codes 99490 (20 minutes or more of CCM services), 99487 (60 minutes or more of complex CCM services), and 99484 (20 minutes or more of general behavioral health integration services), when general care management *HCPCS* code G0511 is on an RHC or FQHC claim, either alone or with other payable services.

Google: MBPM Chapter 13

You have this as separate handout



April 17, 2018

Frequently Asked Questions about Billing Medicare for Behavioral Health Integration (BHI) Services

This document answers frequently asked questions about billing behavioral health integration (BHI) services to the Physician Fee Schedule (PFS). Beginning January 1, 2017, four new Medicare Part B billing codes are available to report BHI services furnished to beneficiaries during a calendar month service period. 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. Beginning January 1, 2018, these services will be reported using new CPT codes. CPT codes 99492, 99493, and 99494 will be used to bill for services furnished using the Psychiatric Collaborative Care Model (CoCM). CPT code 99484 (General BHI) will be used to bill services furnished using other BHI models of care.

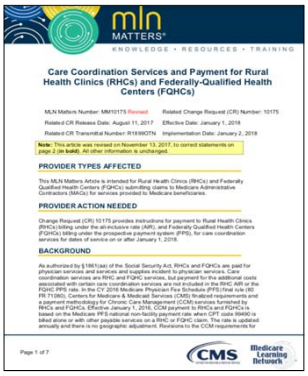
1. **For patients with multiple chronic conditions, including behavioral health conditions, how should one decide when to bill chronic care management (CCM) services versus BHI services?**

As noted in the CY 2017 PFS final rule (81 FR 80233, 80247), CCM and BHI are distinct services although there is some overlap in eligible patient populations. There are substantial differences in the potential number and nature of conditions, types of individuals providing the services, and time spent providing services. CCM involves care planning for all health issues and includes systems to ensure receipt of all recommended preventive services, whereas BHI care planning focuses on individuals with behavioral health issues, systematic care management using validated rating scales (when applicable), and does not focus on preventive services. CCM requires use of certified electronic health information technology, whereas BHI does not. In most cases, we believe it would not be difficult to determine which set of codes (BHI or CCM) more accurately describe the patient and the services provided. As we state in the final rule, the code(s) that most specifically describe the services being furnished should be used. If a BHI service code more specifically describes the service furnished (service time and other relevant aspects of the service being equal), then it is more appropriate to report the BHI code(s) than the CCM code(s).

2. **Can the BHI codes be billed in the same month as CCM? What about other non-face-to-face care management services?**

As discussed above (see #1), CCM and BHI are distinct, differing services even though there is some overlap in eligible patient populations. There may be some circumstances in which it is reasonable and necessary to provide both services in a given month. The BHI codes can be billed for the same patient in the same month as CCM if advance consent for both services and all other requirements to report BHI and to report CCM are met and time and effort are not counted more than once. Billing practitioners should keep in mind that cost-sharing and advance consent apply to each service independently and there can only be one reporting practitioner for CCM each month. If all requirements to report each service are met, both may be billed.

Google: CMS BHI FAQs



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Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs)

MLN Matters Number: MM10175 Revised | Related Change Request (CR) Number: 10175

Related CR Release Date: August 11, 2017 | Effective Date: January 1, 2018

Related CR Transmittal Number: R1919OTN | Implementation Date: January 2, 2018

Note: This article was revised on November 13, 2017, to correct statements on page 2 (in bold). All other information is unchanged.

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10175 provides instructions for payment to Rural Health Clinics (RHCs) billing under the all-inclusive rate (AIR), and Federally Qualified Health Centers (FQHCs) billing under the prospective payment system (PPS), for care coordination services for dates of service on or after January 1, 2018.

BACKGROUND

As authorized by §1861(aa) of the Social Security Act, RHCs and FQHCs are paid for physician services and services and supplies incident to physician services. Care coordination services are RHC and FQHC services, but payment for the additional costs of furnishing these services is not explicitly provided for under the AIR for RHCs or the FQHC PPS rate. In the CY 2016 Medicare Physician Fee Schedule (PFS) final rule (81 FR 71080), Centers for Medicare & Medicaid Services (CMS) finalized requirements and a payment methodology for Chronic Care Management (CCM) services furnished by RHCs and FQHCs. Effective January 1, 2016, CCM payment to RHCs and FQHCs is based on the Medicare PFS national non-facility payment rate when CPT code 99490 is billed alone or with other payable services on a RHC or FQHC claim. The rate is updated annually and there is no geographic adjustment. Revisions to the CCM requirements for

Page 1 of 7

CMS Medicare Learning Network

Google: MLM MM10175

Of course, study CPT codes in your current CPT book

Medicare Part B (FFS) coders/billers - Google: CMS MLN Behavioral Health Integration Fact Sheet (January 2018)

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

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Documentation

Documentation is necessary to serve the client and the team

Document the basics... (the usual template - likely not helpful)

1. Why is the patient here today?
2. How are they doing with the "problem(s)"
3. Your activity today?
4. Diagnoses and STATUS, (improving, or not)?
5. What is plan as of today?

A: A "roster/registry" Excel spread sheet

B: Brief EMR note

C: Maybe both at first? Ultimately you want "roster/registry" to communicate within EMR.

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Registry/Roster – G0511

Quick sample...yours will be so much better!

Don't forget – store in a HIPAA compliant format!

Patient Registery for BHI Patients & Team *(Style 2)*

CM	*Copy blank row and enter newest service on top*				Family/Other	Diagnoses	Contacted	Collab Today	INTERVENT	*Status since last contact*	Plan	Started 7-22 2019	billing
Mon.	MIN	Name	Age	MR	Address: 681 2nd Av N, City			P1 XXX-XXX-XXXX	P2 XXX-XXX-XXXX				
Aug 15		Hendersoon, Maria	44	12345678									
Aug 9 2019	7	Hendersoon, Maria	44	12345678	Lives with husband (Robert) Daugther (Anna, (XXX-XXXX) 2 miles away, wks 2d/wk High School.	1. Bipolar - Dr. Mendoza (PCP) meds. 2 Anxiety & Hx self harm 3. DM2 & CHF	by phone, A&O, engaging	Summary to PCP (med x3, PU 4th, as directed. LCSW "went to Alanon"	Did pu meds and started XXX, has gone to sewing class, working on diet, Therapy w/ LCSW XXXX 12th	stable	FU by phone 15th BHoag, CM		
Start 7-22	12				Lives with husband (Robert) Daugther (Anna, (XXX-XXXX) 2	1. Bipolar - Dr. Mendoza (PCP) manage meds	clinic, A&O, consent	Svc ordered Dr.M because.....	Reviewed w/Dr	started CM	FU by phone on 8-9 BHoag, CM		

A "registry" is not required for use of G0511 (BHI) but is a good idea. Registry is required when you move to G0512 (CoCM).

Enjoy the form, learn a few tricks in Excel!

The Excel file is available for your revision and for your use - **email** kerri@codinghelp.com ask her for "Registry, Simple Styles"

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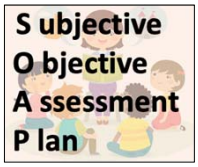
Tell Your Story

Every visit record/note tells a story...



- The beginning of the story...
  - ✓CC (Chief Complaint) & HPI (Hx of present illness)
  - ✓How is patient doing with problem(s) since you last saw them?
- What did you see?
  - ✓(Exam/Observation)
- What did you do about what you heard and what you saw?
  - ✓Today's therapeutic intervention, e.g., psychotherapy?
- How do you define what you saw?
  - ✓The Assessment (diagnoses) with your intriguing comments
  - ✓The status of treated problem(s) e.g., *MDD, moderate, "stable & improving"*
  - ✓Collaborative *next steps. "*Will discuss med concern of... with PMHNP Jones on the 12th."
- When will you get them back for the next chapter?
  - ✓Your Plan & Goals, always with the patient's goal & view of progress

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How Services Are Paid and How You Determine Charges

Relative Value Unit (RVU) is a weighted value whereby the "value" of a code is calculated based on clinican work, overhead &malpracitce. Example: Medicare bases payment allowable on $36.04 per RVU. Roughly, 90832 = $68.47. Determine your own conversion factor, then multiple your conversion factor by the RVU to establish your charges.

Add on Code	CPT Code	BCA's Non-Prescriber Clinician Psychiatric Section Fee Schedule & RVUs CPT/HCPCS Code Description April 2019	Prescriber	Nonprescriber	2019 RVU "Total" Value		Your Current Charge	Divide current charge by RVU to determine your *current* Con Fac.	Decide upon your new consistent Conversion Factor	Multiply new CF by RVU fo your NEW charge consideratio
Psychiatric Diagnostic Evaluation								*Example* Note: 2019 Medicare CV = 36.0391		
	90791	Psychiatric diagnostic eval. ***[not for MD/DO/NP/PA, see instead 90792]***	X	X	3.89	NA	$ 200.00	51.41	$60.00	$233.40
Psychotherapy										
	90832	**Psychotherapy**, [16-37 min. with patient] **($68.47)**	X	X	1.90	16-37 minutes				
	90834	Psychotherapy, [38-52 minutes with patient]	X	X	2.53	38-52 minutes				
	90837	Psychotherapy, 60 min w/patient *Note - may assign also code 99354-Prolonged Service, for well documented qualifying additional time.*	X	X	3.69	53+ minutes				
Prolonged Service Add-on Codes *(Use w/ Psychotherapy 90837 when qualifying document is provided)*										
+	99354	Prolonged evaluation E/M **or psychotherapy service(s)** (beyond the typical service time of the primary service); [first 30-74 min.]	X	X	3.80	with **90837** +30-74 minutes				
+	99355	each addl. 30 min. - *30 additional minutes after the already additional 74 minutes represented by 99354 &, after the already published 53 min. represented by 90837. Review CPT for detail.*	X	X	2.80	with **99354** +75-104 minutes				
Health and Behavior Assessment/Intervention										
	96150	Health and behavior assessment; initial assessment	No	X	0.65	each 15 minutes				

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BCA's Coder Worksheet in Excel

BCA's Behavioral Health Substance Treatment - Coder Worksheet - Always a Work-in-progress *Draft 1 8/5/19*

1 Psychiatric Diagnostic Evaluation and Psychotherapy Services by PhD, LCSW and other qualifying masters-prepared credentials - Review CPT & payer guidelines

Codes	Codes Assigned Only By Behaviorists such as CP and LCSWs	Minutes	Tot. RVU	Coding/Billing Reminders	Credential Notes	Mcare Comments, Denials & Action	MCAID Comments, Denials & Action	Next Payer #1	Our Chg.
90791	Psychiatric Dx Evaluation (PC, LCSW or oth Qual.)	NA	3.89	FQHC/RHC Enc Rate	*Payers vary re. billable credentials*				
90792	Psychiatric Dx Evaluation (MD/DO/NP/PA)	NA	4.37						
90832	Psychotherapy (30 minutes)	16-37	1.90	FQHC/RHC Enc Rate					
90834	Psychotherapy (45 minutes)	38-52	2.53						

3 HCPCS behavioral health services. Most often, no reimbursement (Medicaid $? - dependent on code and state.) Excellent for tracking & reporting.

Codes	Code Description	Minutes	Tot. RVU	Coding/Billing Reminders	Credential Notes	Mcare Comments, Denials & Action	MCAID Comments, Denials & Action	Next Payer #1	Our Chg.
H0031	Mental health assessment by non-physician	NA	iv 1.00						
H0004	Behavioral health counseling/therapy	per 15	iv 1.00						
•G0017	FQHC/RHC Virtual communication, patient contacts/communicates w/clinician-Review rules	=/> 5	$14.00	Bill on UB, addl pmt	*FQHC/RHC only Med, CP, LCSW*				

4 Alcohol and Substance Assessments and/or Intervention Services Payers vary related to who may provide and in what circumstances.

Codes	Code Description	Minutes	Tot. RVU	Coding/Billing Reminders	Credential Notes	Mcare Comments, Denials & Action	MCAID Comments, Denials & Action	Next Payer #1	Our Chg.
•G2011	Alcohol/substance **assmt.** (AUDIT/DAST) **& brief intervention** [not for tobacco]	5-14	0.47	Interp/Interv/Time	*Varied Med, CDPs?*	McareB bundle"1" w/EM McareB: providers = MD/DO/NP/PA/CNM/LCSW	Your state BeH GL? Your state CDP GL?		$XX.
Mcare G0396	Alcohol and/or sub [not tobacco] abuse **assmt.** (AUDIT/DAST) **& brief interven.**	15-30	1.01				*Some CDPs - check state law and*		$XX.

7 Behavioral Health Integration in clinic with defined "Model" BHI Services, These are billed "Incident to..." the PCP in same clinic - Review codes & payer rules.

Codes	Special Code Assignment Considerations	Minutes	Tot. RVU	Coding/Billing Reminders	Credential Notes	Mcare Comments, Denials & Action	MCAID Comments, Denials & Action	Next Payer #1	Our Chg.
G0511	FQHC/RHC **BHI** service =/> 20 min/month	20 min	1.86	$67 BHI Model... (read)					
99484	CPT **BHI** service =/> 20 min/month	per mo	1.35	$146					
Below Services require significant study and preparation before use.									
G0512	FQHC/RHC **CoCM** service =/> 70 or 60 min/mon	70-60	4.05	$146 Preservice study	X				
99492	1st **PCCM** (CoCM) no casual use [study, prep & plan]	70	4.50	Commercial	CPT/Academic, re	MCareB billers, not FQHCs			

1. Some payers require PDE before therapy.
2. Know allowable credentials for each service.
3. BeH or medical benefit?
4. Diagnosis requirements?
5. Denial trends?

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Integrated Behavioral Health Services

Take Home Notes

- Evidence-based, whole-person care
- Utilize available resources – don't reinvent the wheel
- Collaborate – learn from others' experience
- Find a mentor site. Then, BE a mentor site!
- Learning curve for everyone, from front desk to executives

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Any question, any time!

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- Third-party payment guidelines vary. Confirm payment guidelines with your payers of interest.

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NOTES

BCA's Behavioral Health Substance Treatment - Coder Worksheet - *Always a Work-in-progress* *Draft 1 8/20/19*

1 Psychiatric Diagnostic Evaluation and Psychotherapy Services by PhD, LCSW and other qualifying masters-prepared credentials - Review CPT & payer guidelines									
Codes	**Codes Assigned Only By Behaviorists such as CP and LCSWs**	**Minutes**	**Tot. RVU**	**Coding/Billing Reminders**	**Credential Notes**	**Mcare Comments, Denials & Action**	**MCAID Comments, Denials & Action**	**Next Payer #1**	**Our Chg.**
90791	Psychiatric Dx Evaluation (PC, LCSW or oth Qual.)	**NA**	3.89	FQHC/RHC Enc Rate	*Payers vary re. billable credentials*				
90792	Psychiatric Dx Evaluation (MD/DO/NP/PA)	**NA**	4.37						
90832	Psychotherapy (30 minutes)	**16-37**	1.90	FQHC/RHC Enc Rate					
90834	Psychotherapy (45 minutes)	**38-52**	2.53						
90837	Psychotherapy (60 minutes)	**53-89**	3.80						
99354	Prolonged (extra FTF time) beyond 90837	**30-74**	3.67						
90839	Psychotherapy for Crisis, 1st 60 minutes	**31-60**	3.96						
+90785	Interactive complexity *(read code rules)*	**NA**	0.42						
2 Health and Behavioral Assessment and Intervention codes by non-physicians (PhD, LCSW and other qualifying masters-prepared credentials)									
96150	**HBAI,** Initial Assessment	**ea. 15**	0.65		*Not for medical clinicians, Assign for qualifying BeH clinicians (Mcare, CP & LCSWs)*	*No for FQHC MCare*			
96151	Reassessment	**ea. 15**	0.64						
96152	visit for intervention	**ea. 15**	0.59						
96153	**HBAI, Group** Intervention	**ea. 15**	0.14						
96154	**HBAI, Family** Intervention w/patient	**ea. 15**	0.58						
3 HCPCS behavioral health services. Most often, no reimbursement (Medicaid $? - dependent on code and state.) Excellent for tracking & reporting.									
Codes	**Code Description**	**Minutes**	**Tot. RVU 2019**	**Coding/Billing Reminders**	**Credential Notes**	**Mcare Comments, Denials & Action**	**MCAID Comments, Denials & Action**	**Next Payer #1**	**Our Chg.**
H0031	Mental health assessment by non-physician	NA	iv 1.00						
H0004	Behavioral health counseling/therapy	per 15	iv 1.00						
H2027	Psychoeducation service	per 15	iv 1.00						
H0046	Mental health service, not specified	NA	iv 1.00						
H0032	Mental health service plan development	NA	iv 1.00						
90899	CPT Unlisted psychiatric service (determine chg)	NA	determine						
•G0017	FQHC/RHC virtual communication, patient contacts/communicates w/clinician-Review rules	**=/> 5**	$14.00	Bill on UB, addl pmt	*FQHC/RHC only Med, CP, LCSW*				

BCA's Behavioral Health Substance Treatment - Coder Worksheet - *Always a Work-in-progress* *Draft 1 8/20/19*

4 Alcohol and Substance Assessments and/or Intervention Services Payers vary related to who may provide and in what circumstances.

Codes	Code Description	Minutes	Tot. RVU 2019	Coding/Billing Reminders	Credential Notes	Mcare Comments, Denials & Action	MCAID Comments, Denials & Action	Next Payer #1	Our Chg.
•G2011	Alcohol/substance **assmt.** (AUDIT/DAST) **& brief intervention** [not for tobacco]	**5-14**	0.47	Interp/Interv/Time	*Varied Med, CDPs?*	McareB bundle"1" w/EM McareB: providers = MD/DO/NP/PA/CNM/LCSW FQHC - no on PMT list	Your state BeH GL?		$XX.
Mcare G0396	Alcohol and/or sub [not tobacco] abuse **assmt.** (AUDIT/DAST) **& brief interven.**	**15-30**	1.01				*Some CDPs - check state law*		$XX.
Mcare G0397	greater than 30 minutes	**31 or +**	1.89						$XX.
99408	Alcohol ***+/or*** sub [no tob.] abuse **screen** (AUDIT/DAST) **& brief intervention**	**15-30**	1.01	Separate paragraph interp/interv/time			*CDPs? -check state law & MCAID doc.*		
99409	greater than 30 minutes	**31 or +**	1.95						
Mcare G0442	***Annual*** alcohol misuse ***screening***	**15**	0.51						
Mcare G0443	Brief FTF BeH **counseling** alcohol **misuse**	**15**	0.74						

5 HCPCS alcohol and substance service codes. Most often, no reimbursement (Medicaid $? - dependent on code and state.) Excellent for tracking & reporting.

Codes	Code Description	Minutes	Tot. RVU 2019	Coding/Billing Reminders	Credential Notes	Mcare Comments, Denials & Action	MCAID Comments, Denials & Action	Next Payer #1	Our Chg.
	Alcohol and/or drug;... (see code choices below)								
H0049	**...screening**	**NA**	iv 1.00						
H0001	**...assessment**	**NA**	iv 1.00						
H0050	**...services, brief intervention**	**per 15**	iv 1.00						
H0006	**...case management**	**NA**	iv 1.00						
H0007	**...crisis intervention** *(also see H2011 per 15)*	**NA**	iv 1.00						
H0047	Alc +/or drug other drug abuse svc, NOS	**NA**	iv 1.00						
Medication Related Service HCPCS Codes									
H0020	Alcohol +/or drug services; methadone administration +/or svc by Lic. Program	**NA**	iv 1.00						
H0033	Oral med administration, direct observation	**NA**	iv 1.00						
H0034	Med training and support	**per 15**	iv 1.00						

6 Smoking/Tobacco/Nicotine Cessation Counseling by clinician

Codes	Code Description	Minutes	Tot. RVU 2019	Coding/Billing Reminders	Credential Notes	Mcare Comments, Denials & Action	MCAID Comments, Denials & Action	Next Payer #1	Our Chg.
99406	Smoking/tobacco use cessation counseling visit; b/n 4-10 min w/intervention	**4-10**	0.42	Clinician, doc. assmt. & intervention *Not technically for vape.*					
99407	... intensive, greater than 10 minutes	**11 or>**	0.80						

BCA's Behavioral Health Substance Treatment - Coder Worksheet - *Always a Work-in-progress* *Draft 1 8/20/19*

7 Behavioral Health Integration in clinic with defined "Model" BHI Services, These are billed "Incident to..." the PCP in same clinic - Review codes & payer rules.									
Codes	**Special Code Assignment Considerations**	**Minutes**	**Tot. RVU 2019**	**Coding/Billing Reminders**	**Credential Notes**	**Mcare Comments, Denials & Action**	**MCAID Comments, Denials & Action**	**Next Payer #1**	**Our Chg.**
G0511	FQHC/RHC **BHI** service =/> 20 min/month	**20 min per mo**	1.86	$67 BHI Model... (read)		FQHC/RHC billers			
99484	CPT **BHI** service =/> 20 min/month		1.35	$49		MCareB billers & Commercial			
Below services require significant study and preparation before use.									
G0512	FQHC/RHC **CoCM** service =/> 70 or 60 min/mon	**70-60**	4.05	$146 Preservice study	*X*	FQHC/RHC billers			
99492	1st **PCCM** (CoCM) no casual use [study, prep & plan	**70**	4.50	Commercial	CPT/Academic, rec	MCareB billers & Commercial			
99493	FU **PCCM** (CoCM) no casual use...	**60**	3.59	Commercial	CPT/Academic, rec	MCareB billers & Commercial			
+99494	Additional per month time w/99492 & 99493	**+30**	1.86	Commercial	CPT/Academic, rec	MCareB billers & Commercial			

8 Care Management Considerations maybe add Case Management, maybe state specific codes ??									
Codes	**Code Description**	**Minutes**	**Tot. RVU 2019**	**Coding/Billing Reminders**	**Credential Notes**	**Mcare Comments, Denials & Action**	**MCAID Comments, Denials & Action**	**Next Payer #1**	**Our Chg.**
G0511	CCM ***or*** BHI ***20 min/mon.*** CM or Clinician	**20 or>**	1.86	$67.00 Mcare FQHC (r	*Clinical staff*	FQHC/RHC billers			
99490	CCM at least 20 *(read code rules)*	**20 or>**	1.17	FQHC use G0511	*Clinical staff*				
•99491	CCM by MD/DO/NP/PA *(read code rules)*	**30>**	2.33		*Clinician only*				
99487	Complex CCM, mod/high, 60 min staff	**60**	2.58		*Clinical staff*				
99489	each additional 30 minutes of 99487	**+ 30**	1.29		*Clinical staff*				
Proposed for 2020 - not confirmed GCCC1- GCCC4 & GPPP1-GPPP2 roughly same payment as CPT CCM - we shall see in December 2019 for 2020 services. FQHCs????									

NOTES

Two Versions for a patient Registry suggestions - use with G0511/99484 only. Make your own, it will be better! Work with IT.

Patient Registry for BHI Patients & Team *(Style 1)*

Copy documentation section, keep newest service on top

Aug 2019, 2nd Month On Service					Pt Name/ID				Billing		Note		Note
	Date	Min.	Staff	MR#	Demographics	Diagnoses	Contacted	Collab Today	INTERVENT	*Status since last contact*	Plan		
3	Month, day, year	Min	Your name, credential	1234567	Name/age								
					TEAM:								
					TEAM:								
					Resides								
					School/wk/other								
					C giver/Other								
2	Month, day, year	Min	Your name, credential	1234567	Name/age								
					TEAM:								
					TEAM:								
					Resides								
					School/wk/other								
					C giver/Other								
1	Month, day, year	Min	Your name, credential	1234567	Name/age								
					TEAM:								
					TEAM:								
					Resides								
					School/wk/other								
					C giver/Other								

If you would like the Excel file email kerri@codinghelp.com

Patient Registry for BHI Patients & Team *(Style 2)*

CM	*Copy blank row and enter newest service on top*				Family/Other	Diagnoses	Contacted	Collab Today	INTERVENT	*Status since last contact*	Plan		billing
Mon.	Day	Name	Age	MR									
Mon.	Day	Name	Age	MR									
Mon.	Day	Name	Age	MR									
Mon.	Day	Name	Age	MR									
Mon.	Day	Name	Age	MR									

BCA's Psychiatric Collaborative Care Management SPL – 2019

Care Management Services for Behavioral Health Conditions (BHI 99484)
Psychiatric Collaborative Care Management (99492 & 99493)

CPT BHI Care Management & CPT Psychiatric Collaboration Care Management Codes
Review CPT/CMS documentation

Four CPT Codes Assigned for Non-FQHC/RHC Patient Population – *Clinician & Coder must know Medicare variations not listed here*

CPT 99484 Care Management for Behavioral Health Conditions 20 min/month RVU = 1.35 MCare $48.65

Documented 20 minutes or more of behavioral health care management in any month

1. [ ] **Directed by** and **billed by the managing/supervising PCP** (MD, DO, NP, PA, CNM) [Under "General Supervision"]
2. [ ] **Clinical staff *[CS]*** provides service, no academic degree requirement. *Face-to-Face not required, but available for FTF.*
3. [ ] **Clinical staff *[CS];*** does initial assessment or follow-up monitoring, including use of applicable validated rating scales
4. [ ] does BH care *planning* r/t BH/psychiatric health problems, including revisions for non-progress or status change
5. [ ] facilitates/coordinates treatment (PCP, care team, psychotherapy, pharmacology/psychiatric consultation)
6. [ ] Treatment Plan [brief] required. Document behavioral health *care planning*/revisions, always identify progress/status

Clinical Staff [CS] is defined in CPT 2019 Code Book on page xii"...works under supervision and allowed by law, regulation, policy to perform/assist special services..." Review details in CPT and other applicable regulation.

CPT 99492 Initial Psychiatric Collaborative Care Management 70 min/1st month RVU = 4.50 MCare $162.18

Documented first 70 minutes of PCCM services during the 1st month.

1. [ ] **Directed by** and **billed by the managing/supervising PCP** (MD, DO, NP, PA, CNM) [Under CMS "General Supervision"]
2. [ ] ***C Mgr.*** per CPT MA/MS/PhD or specialized training in BH; See also CMS: Skills = assessment, brief intervention, care planning care management & is engaged in ongoing collaboration w/PCP and psychiatric consultant. [See CPT & CMS]
3. [ ] Team approach between medical clinician, psychiatric consultant, and behavioral health care manager
4. [ ] Time tied to code = first 70 min. [CPT range 36-85 minutes] of PCCM; only during the 1st month. Face-to-face or not.
5. [ ] Outreach to and engagement in treatment of patient by directing clinician
6. [ ] Initial assessment (not PDE), including use of applicable validated rating scales and treatment plan development
7. [ ] Review with/by psychiatric consultant and (if recommended) modification of treatment plan
8. [ ] Entering patient in registry. Use registry to:
   Track patient follow-up and progress
   Participate in weekly caseload consultation with psychiatric consultant
   [ ] Provide brief interventions using evidence-based techniques (MI, behavioral activation, etc.)

99493 Subsequent Psychiatric Collaborative Care Management 60 min/FU months RVU = 3.59 MCare = $129.38

Documented 60 minutes PCCM service during the 2nd and all subsequent months.

1. [ ] **Directed by** and **billed by the managing PCP -** MD, DO, NP, PA, CNM [Under "General Supervision"]
9. [ ] ***C Mgr.*** per CPT MA/MS/PhD or specialized training in BH; See also CMS: Skills = assessment, brief intervention, care planning care management & is engaged in ongoing collaboration w/PCP and psychiatric consultant. [See CPT & CMS]
2. [ ] Team approach between medical clinician, psychiatric consultant, and behavioral health care manager
3. [ ] Code identifies the first 60 minutes [CPT range 31-75 minutes] of PCCM during any subsequent month of PCCM service.
4. [ ] Track patient follow-up and progress using registry
5. [ ] Participate in weekly caseload consultation with psychiatric consultant
6. [ ] Ongoing collaboration with and coordination of patient's mental health care with directing clinician and any other treating mental health providers
7. [ ] Review progress and recommendations (by psychiatric consultant) for changes in treatment
8. [ ] Provide brief interventions using evidence-based techniques (MI, behavioral activation, etc.)
9. [ ] Monitor patient outcomes using validated rating scales
10. [ ] Relapse prevention planning with patient as they achieve remission of symptoms and/or other treatment goals

✚ 99494 Add-on code for additional time 30 min/month RVU = 1.86 MCare = $67.03

Documented 30 minutes or more additional PCCM service time, in any month, beyond 99492 or 99493.

[ ] Report w/codes 99492 or 99493 above for each additional 30 minutes per month of PCCM tasks.
Examine the time chart in your 2019 CPT Code Book on or about page 53.

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BCA's Psychiatric Collaborative Care Management SPL – 2019

FQHC/RHC HCPCS
BHI Care Management &
CPT Psychiatric Collaboration
Review CMS documentation

Care Management Services for Behavioral Health Conditions (BHI) G0511
Psychiatric Collaborative Care Model (CoCM) G0512

Two HCPCS Codes Assigned for your FQHC/RHC Medicare Patient Population (Check your state Medicaid)

G0511 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. FQHCs/RHCs are paid when a minimum of 20 minutes of qualifying general BHI services during a calendar month is furnished to patients with one or more new or pre-existing behavioral health, psychiatric or substance use disorder which is being treated by the FQHC/RHC primary care practitioner, in whose clinical judgement, warrants BHI services.
CMS MBPM, Chp 13, 230.2

G0511 RHC/FQHC - General Care Management for BHI Services 20 min/month RVU = 1.86 MCare $67.03

1. [ ] **Directed & billed by** FQHC/RHC **PCP** who is **managing/supervising** care (MD, DO, NP, PA, CNM) [Under "General Supervision"]
2. [ ] ***Clinical Staff [CS]*** provides most G0511 service. No academic degree requirement.
   No face-to-face requirement, but [***CS]*** is to be available for face-to-face as needed.
3. [ ] ***Clinical Staff [CS}*;** does initial assessment and ongoing monitoring using validated clinical rating scales
4. [ ] does BH care planning in relation BeH Dx(s) with treatment plan revisions in cases without progress or worsening
5. [ ] facilitates/coordinates: e.g., psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation as needed
   [ ] provides continuity of care with designated member of the care team
6. [ ] Treatment Plan not addressed in federal detail but expected and will be brief and revised as necessary

Special [ ] Before service is provided, document consent and patient advised cost-sharing may apply (payer dependent)
- Include consent for permission to consult with team members and relevant specialists as needed
- Inform patient they may halt BHI care management services at any time effective at the end of the month

Clinical Staff [CS] is defined in CPT 2019 Code Book on page xii"...works under supervision and allowed by law, regulation, policy to perform/assist special services..." Review details in CPT and other applicable regulation.

G0512 Psychiatric CoCM is a specific model of care provided by a primary care team consisting of a primary care provider and a health care manager who work in collaboration with a psychiatric consultant to integrate primary health care services with care management support for patients receiving behavioral health treatment. It includes regular psychiatric inter-specialty consultation with the primary care team, particularly regarding patients whose conditions are not improving. Patients with mental health, behavioral health, or psychiatric conditions, including substance use disorders, who are being treated by an RHC or FQHC practitioner may be eligible for Psychiatric CoCM services, as determined by the RHC or FQHC primary care practitioner.
CMS MBPM, Chp 13, 230.3

G0512 RHC/FQHC - Psychiatric Collaborative Care Model (CoCM) 70 or 60 min/month RVU = 4.05 MCare $145.96

1. [ ] **Directed & billed by** FQHC/RHC **PCP** who is **managing/supervising** care (MD, DO, NP, PA, CNM) [General Supervision]
2. [ ] BH Care Manager ***[BHCM]*** at the helm of G0512 code work management. ***BHCM*** to have BA/BS degree w/BH **or** specialized training in social work/psychology or behavioral health RN/LPN. ***BHCM*** is central to the CoCM service. ***BHCM***, as 'team leader' communicates/collaborates with PCP, works **regularly** w/psychiatric consultant & others.
3. [ ] **TIME G0512/CoCM** 1st month time is at least 70 min. of CoCM service, and, at least 60 min. all other months
4. [ ] ***BHCM;*** does initial [care manager] assessment [not a PDE], validated rating scales, available for face-to-face service
5. [ ] manages BH care planning with revisions if lack of progress, worsening problems or if there is a status change
6. [ ] provides brief psychosocial interventions, coordinates services, verifies patient participation in care
7. [ ] maintains a registry that tracks patient follow-up and progress
8. [ ] ***BHCM*** has continuous relationship w/patient and a collaborative, integrated relationship with full team

Special [ ] Before service is provided, document consent and patient advised cost-sharing may apply (payer dependent)
- Include consent for permission to consult with team members and relevant specialists as needed
- Inform patient they may halt care management services at any time effective at the end of the month

Most Reliable Medicare Resources:
CMS MBPM Chapter 13 230.3 Revz 12-07-18 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf
CMS/Medicare - Med Learn Matter "mln Matters" #MM10175 Effective date: 1-1-2018, also "Care Management in RHC/FQHC FAQ Dec. 2018"

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