ArchProCoding
RURAL & COMMUNITY HEALTH

# Rural & Community Health Documentation, Coding, and Billing Bootcamp

LPCA
LOUISIANA PRIMARY CARE ASSOCIATION
Louisiana's Community Health Centers


Instructor

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# Other ArchProCoding Live and Online Certification Programs

## 1 Critical Access Hospital & Small Rural Hospital Coding and Billing Specialist (CAH-CBS)

This Bootcamp provides CAH staff with what they need to know about their documentation, coding, and billing needs.

## 2 Rural & Community Health Credentialing Specialist Certifications (RH-CS or CH-CS)

These certifications are designed to increase your knowledge and competence in the credentialing and enrollment process.

## 3 Department Lead Specialist Certification (DLS)

This course will help anyone developing their skills to perform a department lead/middle management/office manager role.

# General Section Breakdown

Introduction and Class Orientation

What Makes RHCs and FQHCs Different?

Documenting Patient Encounters

Coding Diagnostic & Therapeutic Services

Proper Billing and Validate Payments

Self-Study & Exercises

Action Items & After Class

# Main Sections Summary

## 1. What Makes RHC/FQHC Different?

**Medicare and maybe Medicaid see us as a RHC or FQHC** but most private/commercial payers see us as a regular Part B doctor's office.  Billing will differ by payer.

## 2. Documenting Patient Encounters

**Clinical providers need routine exposure** to the AMA CPT, CMS Medicare/Medicaid HCPCS-II explanations, and ICD-10-CM guidelines to properly document their preventive, diagnostic, and therapeutic E/M services.

## 3. Coding Diagnostic & Therapeutic Services

**From office-based skin procedures to surgical injections, minor procedures, behavioral health** and more, there are many documentation details found within the AMA's CPT that will enhance revenue capture.

## 4. Proper Billing and Validate Payments

**RHCs and FQHCs will use BOTH the CMS1450/1500 forms** to report their services to various payers which requires careful attention to claims formatting, bundling, modifiers, quality reporting, and denials management.

Proper Billing and Validate Payments

Coding Diagnostic & Therapeutic Services

Documenting Patient Encounters

What Makes RHCs and FQHCs Different?

# INTRODUCTION AND CLASS ORIENTATION

**Build a common coding/billing language and grow shared knowledge to stay organizationally aligned across your team.**

# Bootcamp Disclaimers

**Educational Intent**

All information presented by ArchProCoding is based on research, experience, and training and includes professional opinions that do not replace any legal or consulting guidance you may need.

**Research your Contracts**

ArchProCoding accepts no liability for errors, omissions, misuse, or misinterpretation of our educational content. You maintain responsibility for your facility's compliance with all relevant rules.

**Check Often for Updates**

We encourage you to always double-check for potential updates to hyperlinks, reference sources, payer billing rules, and compliance changes. Please don't distribute our content outside of your facility.

# ArchProCoding RHC/FQHC
# Bootcamp Facility Types


## 1 Rural Health Clinics (RHC)

**Independent and Provider-Based RHCs** should also refer to National Association for Rural Health Clinics (NARHC), the National Rural Health Association (NRHA), and state rural health associations for valuable resources, webinars, and periodic legislative updates.


## 2 Federally Qualified Health Centers (FQHC)

**We will use the terms Community Health Center** and FQHCs interchangeably as most refer to themselves as “health centers” as well as by the leading national advocacy organization for community health, the National Association of Community Health Centers (NACHC) and most state primary care associations.

# This Bootcamp Includes an Optional Certification Exam For Career Development

As a Bootcamp, it is assumed that you **already have basic/intermediate knowledge** about documentation, coding, and billing.

This course is designed to prepare you to become a **Rural/Community Health - Coding & Billing Specialist** (RH-CBS and CH-CBS).

We will provide opportunities in class and after class to **practice your skills** regardless of whether you choose to take the optional certification exam.

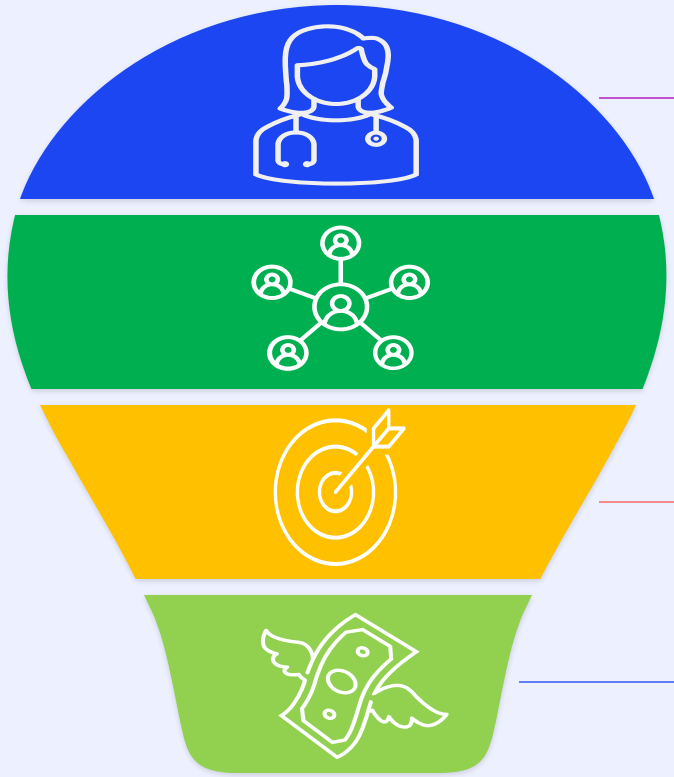
The optional online exam is **100 questions over 24 hours,** and you must pass **with a 70% score** on the initial exam or free re-test in the same 90-day period after beginning the self-study videos.

**Pass and you are certified for 1 year.** Each year after you will owe a $125 membership fee and 8 CEUs relevant to coding/billing/RHC/FQHC to maintain your credential.

# Target Bootcamp
## Audiences & Goals

Build and maintain a shared platform of knowledge across the 4 target audiences to ensure organizational alignment, optimize revenue capture, and maximize quality reporting.

Empower you and your team to efficiently research, access, and effectively apply the latest regulatory changes and billing updates.



01 **Clinical Providers**

02 **Facility Leadership**

03 **Professional Coders**

04 **Medical Billers**

**AMA's CPT**

**HCPCS-II**

**ICD-10-CM**

# Key Themes for Consideration

## Compliant Billing

**Are coding and billing different job skills with different goals?**

Those certified as coders likely had 0 questions about generating proper revenue – only coding.

## Professional Coding

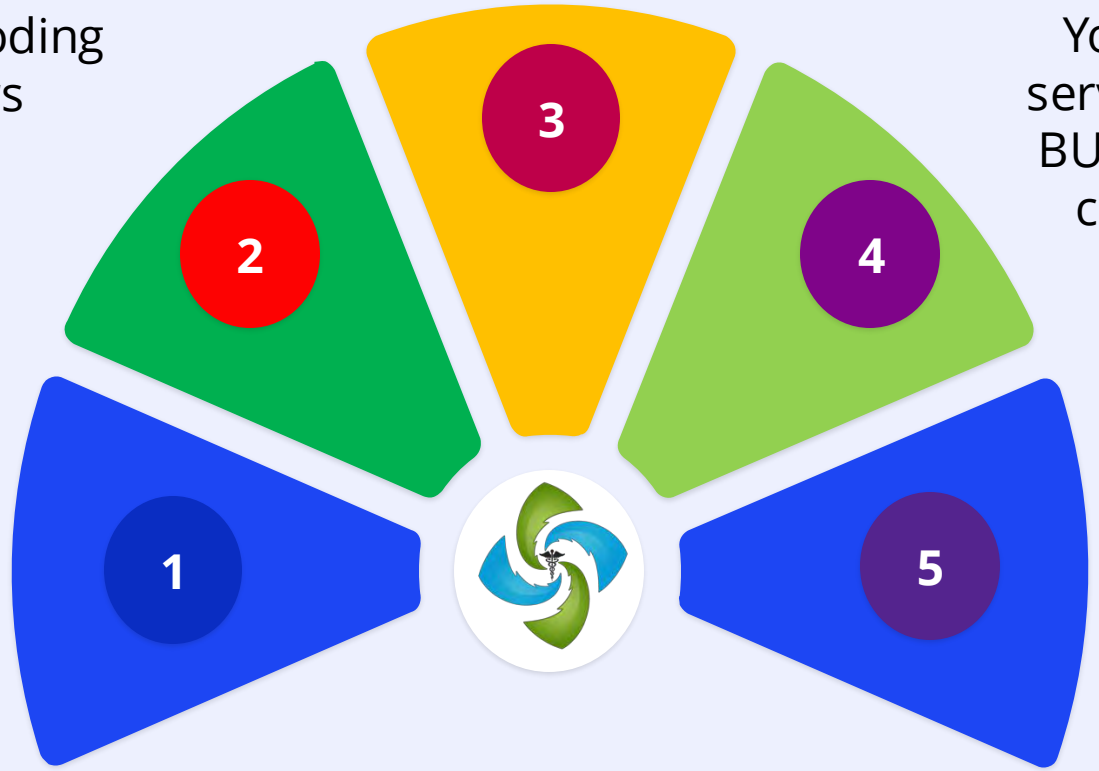
**Let providers document and let professional coders code?**

What level of "professional" coding is given to clinical providers vs. revenue cycle staff?

## Quality Reporting

**Does Managed Care often ask for non-payable codes?**

You likely already perform these services or can report existing data, BUT others are "discretionary" and can generate incentive monies.




## Documentation

**"If you didn't document it – it didn't happen"?**

Disagree. It happened, we just can't code it and keep the revenue if not supported.

## Our Shared Focus

**Where are the knowledge gaps and who are they with?**

Do our IT/EHR/billing systems get in the way, or do they help?

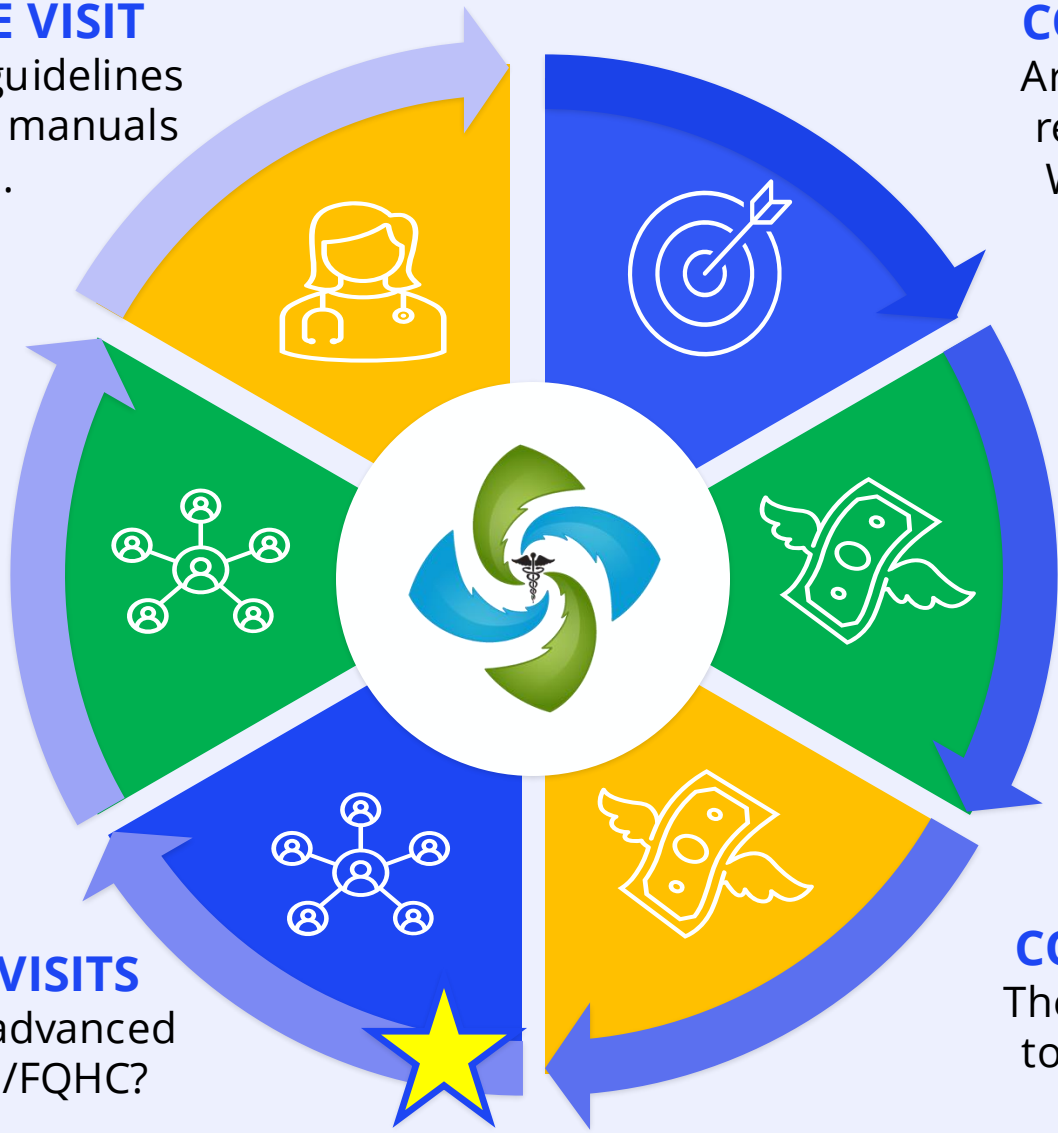
# Our Shared Path

## TREAT AND DOCUMENT THE VISIT

Train staff on the documentation guidelines found in CPT/HCPCS-II, ICD-10-CM manuals rather than EHR shortcuts.

## CODE THE FULL ENCOUNTER

Are provider, managers, or coders responsible for coding accuracy? What about the cost report and quality reporting?



## GREET THE PATIENT

How does insurance type impact which claim form we use, patient cost sharing, and revenue?

## REPORT BILLABLE SERVICES AND VALIDATE PAYMENTS

Are you getting paid everything deserved but no more than allowed?

## PREPARE FOR PATIENT VISITS

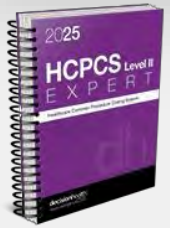
Are you ready to handle the advanced issues of operating in a RHC/FQHC?

## COST/QUALITY REPORTING

There are many services we need to capture or report that do not necessarily generate direct revenue.

# Key resources and references vital to ongoing success and necessary for class and self-study/exercises

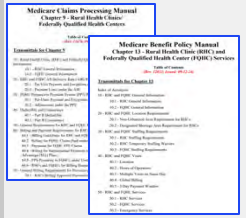

**AMA's CPT (Professional Edition)**




**CMS' HCPCS-II Code Set**


**ICD-10-CM Code Set**

Indicates Self-Study/Exercise Opportunity



**CMS Benefit Policy and Claims Manuals**


**Access to Various CMS/Medicare Learning Updates+ NCD/LCD**

**Awareness of Commercial & Medicaid Billing Contract Details**

# Disclaimer and Important Info
## Do you have electronic or printed access?

### American Medical Association's (AMA)
### Current Procedural Terminology (CPT)®


CPT® is a registered trademark of the American Medical Association. Use of the CPT codes and descriptions during this program is for educational fair use purposes only. Check for occasional updates at the ***AMA's Errata and Technical Corrections – CPT 2025***.

Most encoder software programs, EHR code descriptions for providers, and ***all*** non-AMA printed CPTs ***DO NOT*** contain the valuable documentation guidelines necessary to build knowledge and maintain coding compliance.

# Are you familiar with the 3 categories of CPT codes? (aka HCPCS Level I)


- **CPT Category I** codes identify preventive, diagnostic, and therapeutic services and are 5-digit numeric codes (*ex. 99214 for an established OV*) or 2-digit modifiers (*ex. -59 for a distinct procedural service*).
- **CPT Category II codes** are performance measurement codes (*ex. 0001F for assessing heart failure*) and are often required by Medicare/Medicaid managed care companies for required or voluntary "quality reporting."
- **All Category III codes** for emerging technology (*ex.0591T-0593T for "health and well-being coaching services"* ) that may one day become CPT I code and are not typically associated with RHC/FQHC.
- **Per the CPT Introduction section** - Just because there is a code in the CPT "*does not imply any health insurance coverage or reimbursement policy.*" You may need to change a code to a HCPCS-II code depending on who you are billing.

# Symbols of the AMA's CPT are easy to overlook

- ● **New code (Appendix B) –** Fee schedule impact?
- ▲ **Revised code/definition changed (Appendix B) –** Fee schedule impact?
- ; **Separates "base definition" from subset –** Be aware of "bundling."
- ▶◀ **New or revised text –** Documentation guidelines changes, not code changes!
- \+ **Add-On Codes (Appendix D) –** Should never cause a payment reduction.
- ⃠ **Modifier "–51" exempt (Appendix E) –** FFS impact for multiple procedures.
- ↯ **FDA approval pending (Appendix K)**
- \# **Re-sequenced codes (Appendix N) –** Not all codes are in numerical order!
- ○ **Recycled or Reinstated code**
- ★ **Telemedicine –** Does not assure payment based on payer rules.
- 🔈 **Audio-only –** Does not assure payment based on payer rules.

# CPT Category I Codes

**Introduction**

**Evaluation and Management 99xxx + 98xxxx**
- *Know the rules and new E/M codes!*

**Anesthesia (0xxxx)**

**Surgery (1xxxx – 6xxxx)**
- *Varying payer surgical package definitions change billing significantly!*
- *Be prepared to review Ch.13 CMS Benefit Policy Manual, Section 40.4 for details.*

**Radiology (7xxxx)**

**Pathology and Laboratory (8xxxx)**

**Medicine (9xxxx) –** Assorted code types including vaccines, psych, eye, EKGs, injections/infusions, etc.

**Appendix A = Modifiers**
**Appendix B = 2025 changes and definition updates**
**There are several more appendices!**

# CPT Category II Codes


**Modifiers – 1P, 2P, 3P, 8P**

**Composite Measures 0001F – 0015F**

**Patient Management 0500F – 0575F**

**Patient History 1000F – 1220F**

**Physical Examination 2000F – 2050F**

**Diagnostic/Screening Processes/ Results 3006F – 3573F**

**Therapeutic, Preventive, or Other Interventions 4000F – 4306F**

**Follow-Up or Other Outcomes 5005F – 5100F**

**Patient Safety 6005F – 6045F**

**Structural Measures 7010F – 7025F**

# Review your insurance contracts to see who may “require” or “encourage” CPT Category II codes


- **Patient History 1000F** = Tobacco use assessed (CAD, CAP, COPD, PV)[1] (DM)[4]
- **Patient History 1031F** = Smoking status and exposure to 2nd hand smoke in the home assessed (Asthma)[1] – see also 1032F-1039F
- **Patient History 1040F** = DSM-5 criteria for major depressive disorder documented at the initial evaluation. (MDD, MDD ADOL)[1]
- **Patient History 1125F and 1126F** = Pain severity quantified: (pain present vs. not present) (COA)[2] (ONC)[1]

# Think of the CPT and HCPCS-II books as the "HCPCS Family of Codes"


**Center for Medicare and Medicaid Services (CMS)**
**Healthcare's Common Procedural Coding System (HCPCS-II) or "HCPCS Level II"**

These codes do not have any documentation guidelines printed in the manual or in electronic format. You must do significant research on documentation and billing rules including ***CMS' Local/National Coverage Decisions (LCD/NCD)***

Created and maintained by the Centers for Medicare and Medicaid (CMS) on an annual basis but updates can occur ***on a quarterly schedule***, or as needed.

Be aware that many CPT and HCPCS-II codes have similar/same definitions or even the same! There are also many ***RHC/FQHC-Medicare specific G-codes, Medicaid reserved H-codes for mental/behavioral health and Medicaid reserved T-codes*** to be aware of proper for billing.

# CPT Medical options

**93000-93010 –** EKG global or technical ("tracing only")/ professional component only

**98000-98015 –NEW** Telemedicine E/M Services

**98016 – NEW** Brief virtual check-in E/M, 5-10 minutes….unrelated to an E/M…7 days…

**96372 –** Subcutaneous or intramuscular injection given

**99202-99215 –** Evaluation and management (E/M) office visit codes

**99381-99397 –** Preventive Medicine Services
**99408-99409 –** Alcohol/substance screening and intervention, 15-30 or >30 minutes

# HCPCS-II Medical options

**G0403-G0405 –** Screening EKG global or technical/ professional only with a "Welcome to Medicare"/IPPE visit

**G2025 –** RHC/FQHC-only medical telehealth service
**G0071 –** RHC/FQHC-only virtual check-in ***or*** remote evaluation of recorded video/images, 5+ minutes

**J3420 –** Injectable drug, vitamin B-12, up to 1000mcg
(*Be careful with # of units vs. another code with a higher dosage*)

**G0466-G0470 –** FQHC-only PPS billing "valid encounter" codes to be followed by a CPT/HCPCS-II code on the Qualifying Visit List (QVL) to Medicare only?

**G0101, G0402, G0438-G0439 –** CMS pelvic and breast exam, Initial Preventive Physical Exam (IPPE) and initial/subsequent Annual Wellness Visits (AWV)

# CPT Behavioral Health options

**+ 90785 –** Interactive Complexity add-on code for more revenue when dealing with barriers to communication

**90791-90792 –** Psychiatric Diagnostic Evaluations

**90832-99838** – Psychotherapy with or without prescription management of 30/45/60 minutes
**99839 –** Psychotherapy pt. in crisis

**96156-96161 –** Newly covered by Medicare in 2024 for Health Behavior Assessments/Interventions when the diagnosis is *physical* in nature.

**99492-99494 –** Psychiatric Collaborative Care Model (Psych CoCM)
**99484 –** Care Management for Behavioral Health Integration (ex. BHI)

# HCPCS-II Behavioral Health options

**G0140 -** for non-Medicare claims for Principal Illness Navigation (PIN) by certified peer specialists.
**G0023-G0024** PIN for Medicare and maybe Medicaid

**G0511 –** General Care Management (including BHI)
**G0512 –** Psychiatric Collaborative Care Model (*RHC/FQHC-specific codes reported by medical provider*)

**G2011-** Alcohol/substance (other than tobacco) misuse assessment…brief intervention, 5-14 minutes.

**G0396-G0397 -** …assessments/intervention, 15+ minutes

**H0001 –** Alcohol and/or drug assessment

**H0038 –** Self-help peer services , per 15 minutes, for Medicaid only

# Finding an ICD-10-CM Code isn't enough
# Can you Access Key Instructional Notations also?

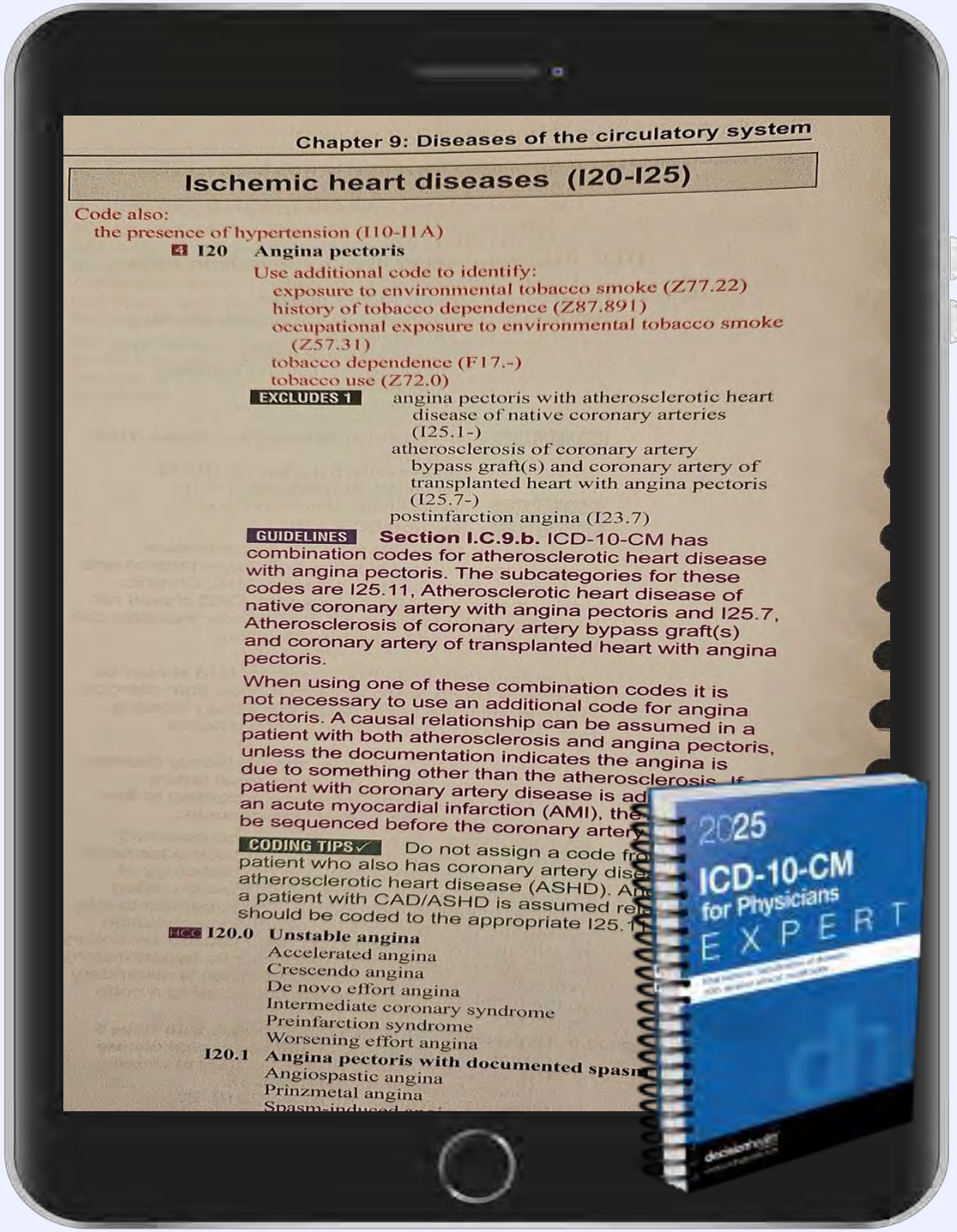
## International Classification of Diseases – Clinical Modification, 10th Revision (ICD-10-CM)


Ensure that clinical providers and coders/billers can also go beyond the code definitions to view key instructional notations crucial to establishing ***"medical necessity"*** and getting credit for mandatory and voluntary quality reporting.

The ***"ICD-10-CM Official Guidelines for Coding and Reporting FY 2025 October 1, 2024 – September 30, 2025"*** provides the foundation for all diagnosis code knowledge. It is vital that providers are aware of these guidelines before learning how to operate various EHR/IT systems where they document and/or select ICD-10-CM codes.

# How much detail can your clinical providers see when assigning ICD-10-CM codes?

1. Punctuation – (xxxxxxx) is different than [xxxxxx]
2. Definition of the word(s) "**and**", "**code also**", "**code first**", "**use additional code**",
3. **Excludes 1** vs. **Excludes 2** – what is the difference?
4. For injuries, poisonings, and trauma – how do we define **Initial** vs. **Subsequent** vs. **Sequela** episodes of care?
5. When should "**unspecified**" codes be properly used?
6. What about **signs or symptoms** vs. conditions that are/are not **integral** to disease processes?



# ICD-10-CM Considerations

Clinical

**What level of training have your providers received on the "Official Guidelines for Coding and Reporting"?** How do providers "link" the diagnoses to each procedure/service so coding/billing knows which diagnoses should be paired with which procedures, if required?

IT/EHR Research

**Do your EHR vendors allow providers to see the full code definitions or just summary definitions?** Do you have policies that allow coders/billers to adjust codes based on existing clinical documentation?

Coding/Reporting

**Do you see diagnoses listed on your "electronic superbill" that are not documented in the actual closed encounter note?** Have managed care organizations told your providers to list every active diagnosis the patient has for each visit and if so, what problems can that cause?

Billing

**Do you know if a National/Local Coverage Decisions (NCD/LCD) impacts the claim's expected success?** Has a professional coding review been performed BEFORE billing to validate that the medical record contains supporting documentation? Do you need to adjust the codes based on payer contracts?

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

# INTRODUCTION AND CLASS ORIENTATION

## Self-Study & Exercises

1. Secure access to all CPT/HCPCS-II/ICD-10-CM source materials and/or manuals.
2. Determine if your clinical providers and coders can access the AMA's CPT guidelines rather than only seeing the code numbers and definitions and research the issues presented related to CPT code symbols and their revenue impact.
3. Review key HCPCS-II code sections to highlight possible alternate billing options with a focus on approved Medicaid billing codes for each of your enrolled provider types.
4. Determine if your clinical providers, professional coders, and medical billers have access to the same ICD-10-CM instructional notations rather than only the code number(s) and definition(s)?

# WHAT MAKES RHCs AND FQHCs DIFFERENT?

**What everyone needs to know about the unique nuances of being a RHC or FQHC and how does it change what we do?**

# Section Topics

1. Build a RHC and FQHC educational foundation via CMS' Medicare Learning Network and more
2. Overview the AIR and PPS payment methods and patient cost sharing
3. CMS "Valid Encounters" defined
4. Role of the Qualifying Visit List in RHC vs. FQHC
5. Comparison of the CMS 1450/1500 forms and medical and mental health claim examples
6. 2025 CMS updates to the Physician Fee Schedule related to RHC and FQHC

## What Makes RHCs and FQHCs Different?

# Be aware of the different usages of the word "Medicare" between patients and your staff

**Part A**

Part A is an automatic benefit if you meet eligibility criteria. Even though RHCs/FQHCs submit the majority, but not all, of our Medicare claims on a Part A "UB" claim form, we are Part B providers.

**Part B**

Part B is an option for patients to choose each year. RHC/FQHC are Part B providers, and our patients must have Part B for us to bill as a RHC/FQHC unless the patient is in a managed care plan.

**Part C**

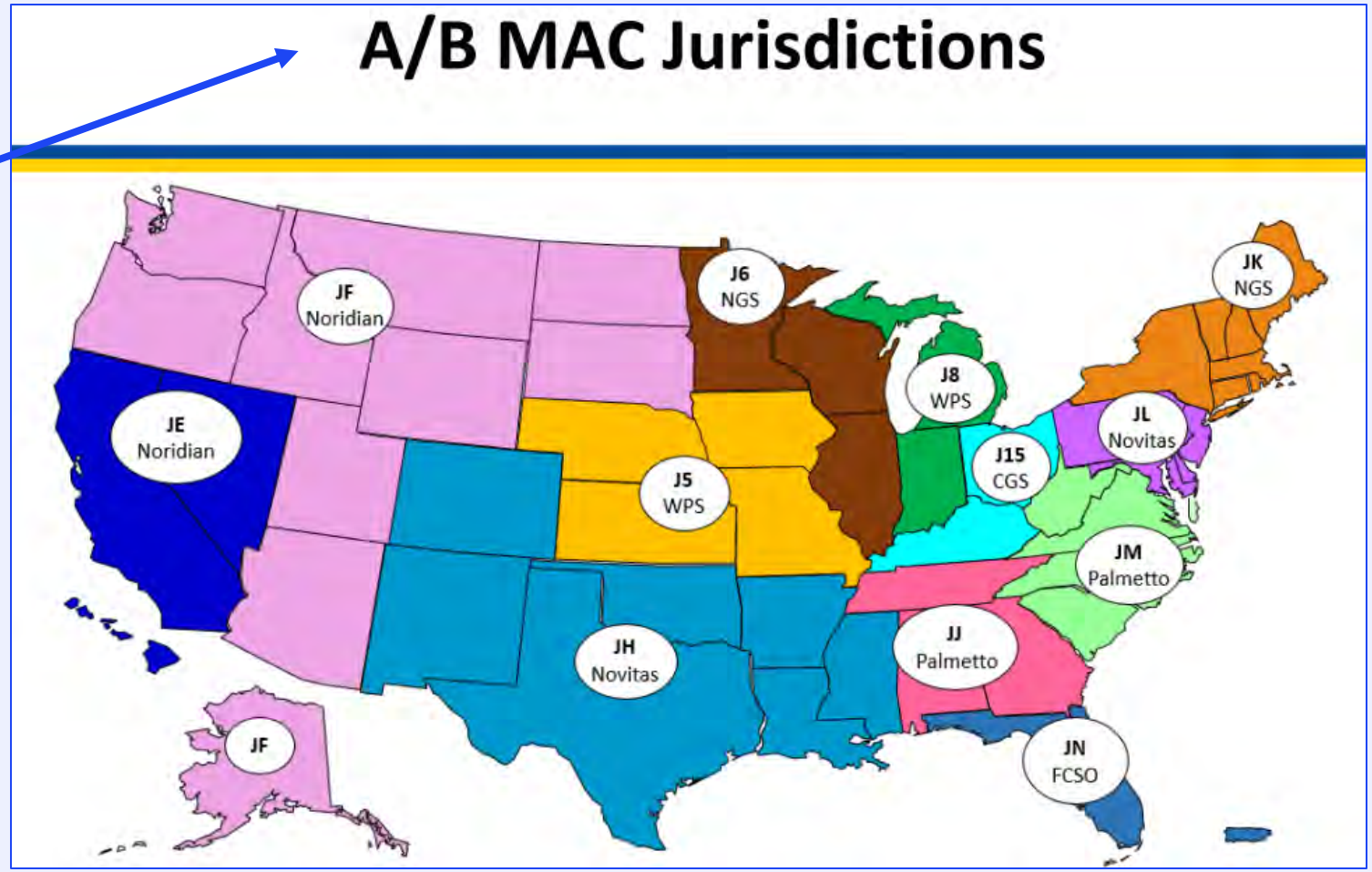
Patients who combine Part A & B coverage into a Medicare Managed Care Organization (MCO) which is run by a commercial insurance company.

Patients shouldn't lose any Part A/B benefits but MCOs often offer coverage for additional services.

**Part D**

A broad term for various Medicare Prescription Drug coverage. When combined with a Medicare MCO it may be called a Medicare Advantage – Prescription Drug (MA-PD) plan.

# Our Part B claims are processed by private Medicare Administrative Contractors (MAC) who must learn Medicare RHC/FQHC just like us!




**For Medicaid, some states have specific RHC/FQHC options with AIR/PPS options, while others see you as a traditional doctor's office and pay FFS.**

**Some states have only 1 Medicaid payer and others have many!**

# Check for updates to CMS' general educational materials via CMS' Medicare Learning Network (MLN)

## The Medicare Learning Network®

mln
KNOWLEDGE • RESOURCES • TRAINING

Free educational materials for health care providers on CMS programs, policies, and initiatives.

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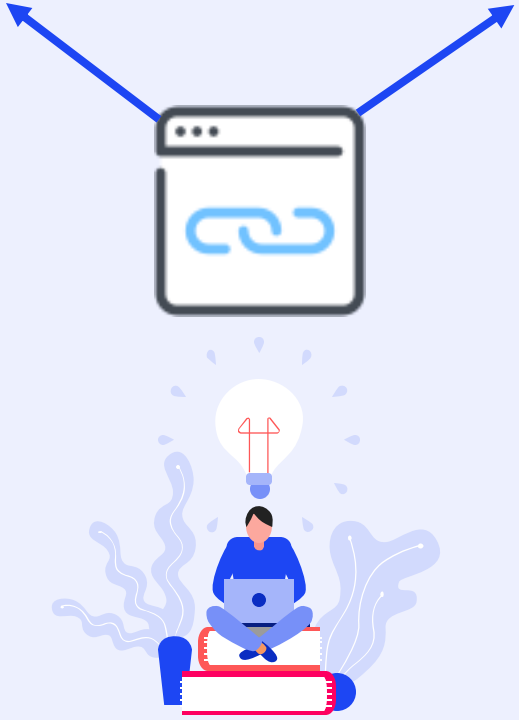


## MLN Publications & Multimedia

Filter on title or topic to get free educational resources for health care providers.

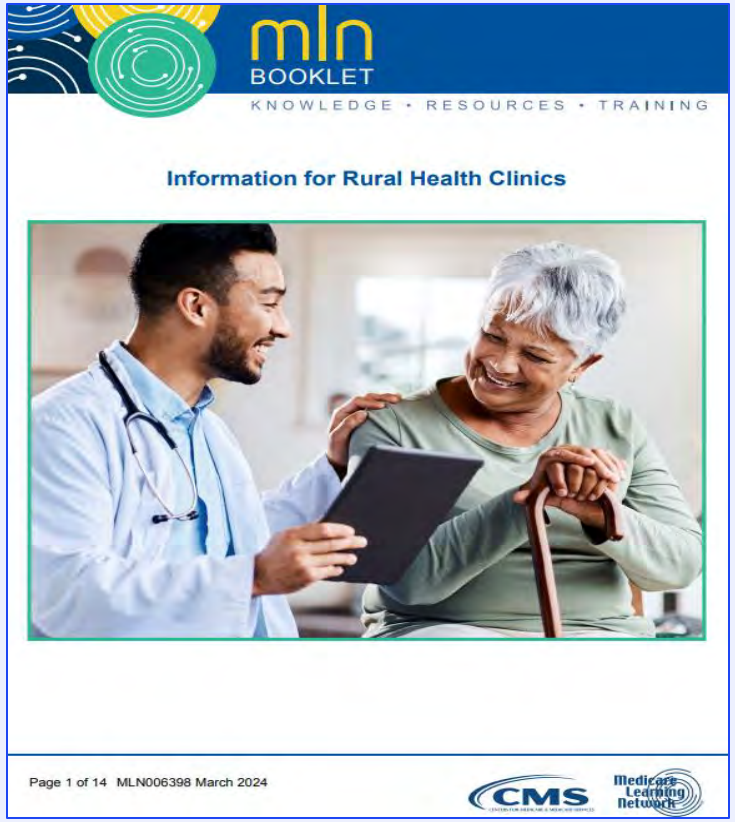
Showing 1–10 of 105 entries

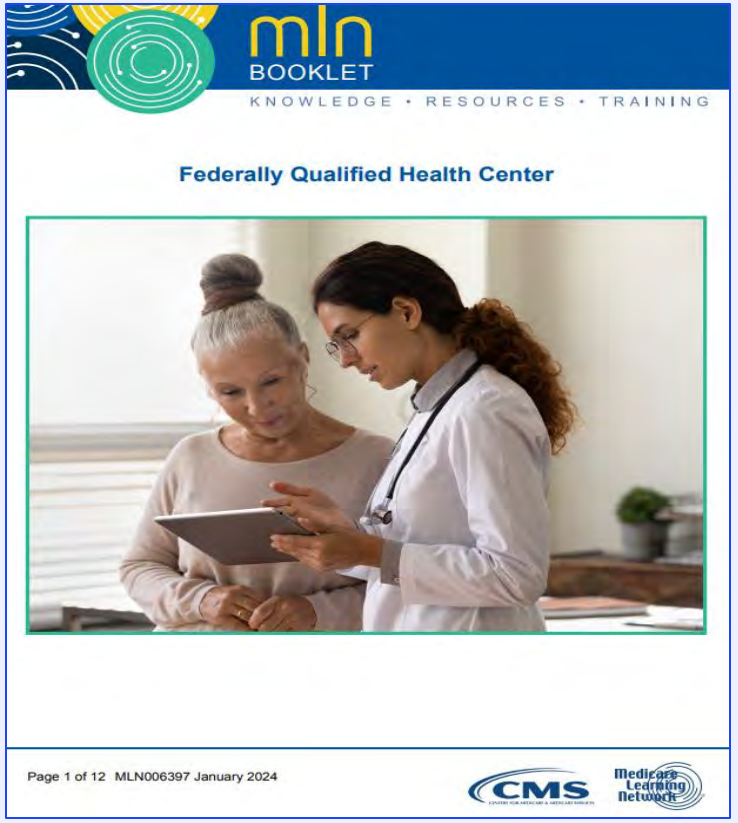
Show Entries: 10 per page

Filter On:

| Date | Topic | Title | Format |
|---|---|---|---|
| 2024-12 | Preventive Services | Medicare Preventive Services | Educational Tool |
| 2024-12 | Rural Health | Information for Critical Access Hospitals | Booklet |
| 2024-12 | Provider-Supplier Enrollment | Medicare Provider Enrollment | Educational Tool |
| 2024-12 | Provider-Specific | Intravenous Immune Globulin Items & Services | Fact Sheet |
| 2024-12 | Payment Policy | Medicare Payment Systems | Educational Tool |
| 2024-11 | Payment Policy | Medicare Part B Inflation Rebate Guidance: Use of the 340B Modifier | Fact Sheet |
| 2024-11 | Rural Health | Rural Emergency Hospitals | Fact Sheet |
| 2024-11 | Provider-Specific | Global Surgery | Booklet |
| 2024-11 | Preventive Services | Medicare Wellness Visits | Educational Tool |

# For the basics on RHCs and FQHCs
# CMS maintains these 2 reference materials




Also visit the following website and bookmark it to check for periodic updates!

www.CMS.gov >Training & Education> Find Your Provider Type> Facilities > Outpatient Facilities > RHC/FQHC

# RHCs and FQHCs
# Are Medicare Institutional Facilities

***RHCs are in a HHS-designated rural*** health professional shortage area while ***FQHCs can be in either a HHS-designated rural OR urban*** health professional shortage area.

Most, if not all, ***traditional private insurance companies*** see you as a regular doctor's office and ***pay you Fee-for-Service (FFS)***. Please do not assume that each state's Medicaid options use the same RHC/FQHC rules as state laws and managed care plans determine coverage.

Independent RHCs and freestanding FQHCs must submit an ***annual cost report*** impacting your future AIR/PPS rates, and ***FQHCs can receive an annual reconciliation*** if the Medicare Managed Care Plan payments are less than regular Medicare PPS payments.

# RHCs and FQHCs
# General Info

We have tremendous reimbursement flexibility related to the term ***"other qualified health professionals"*** when PA, NP, CNM, CP, CSW, Mental Health Counselors, and Licensed Marriage and Family Therapists perform a ***"valid encounter"***.

***Over 50%*** of the services each year should be ***"primary care" in nature***. You may have any specialty at your facility, including mental/behavioral health, but still must show you have a primary care/preventive focus.

Medicare does not pay us for certain services in the same way they pay regular Part B provider offices. For example – ***incident-to-only visits without the patient seeing an authorized provider and "split billing"*** for technical component of diagnostic tests.

# Check often for updates to CMS' RHC and FQHC Claims (Ch.9) and Benefits Policy (Ch. 13) Manuals

**Medicare Claims Processing Manual**
**Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers**

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*(Rev. 12070, 06-07-23)*

**Transmittals for Chapter 9**



**Although CMS groups RHC and FQHC in these 2 documents, be aware that the rules are not always the same.**

**Ch. 9** discusses the All-Inclusive Rate (AIR) and Prospective Payment System (PPS) billing systems.

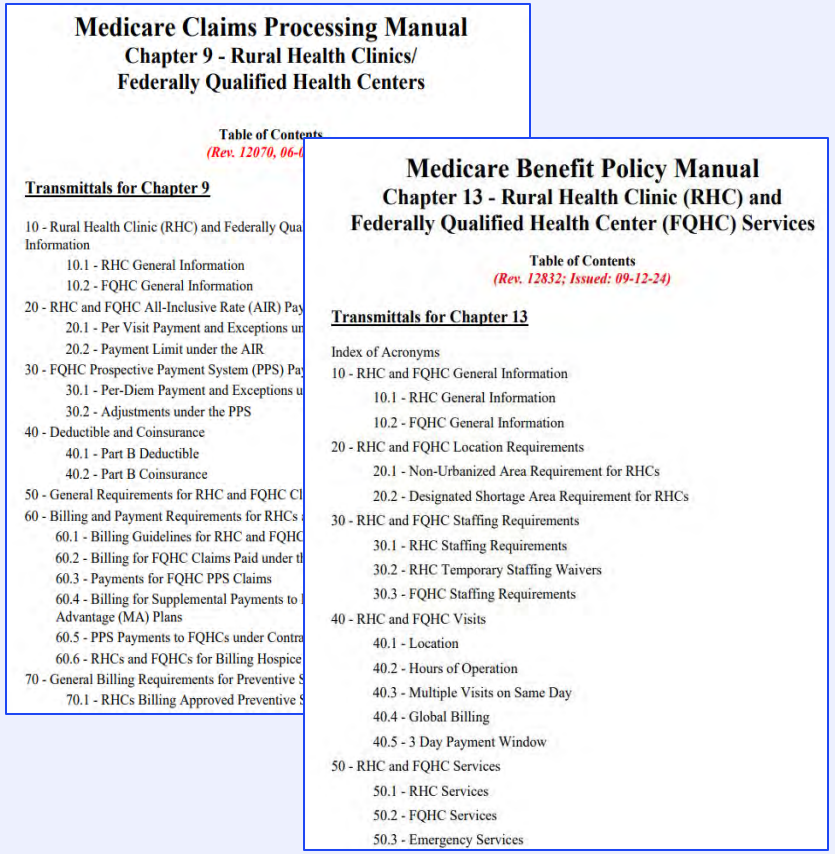
**Ch. 13** discusses staffing requirements, same day multiple visits, and global billing.

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

**Table of Contents**
*(Rev. 12832; Issued: 09-12-24)*

**Transmittals for Chapter 13**

# Review these key sections from Claims and Benefit Policy Manuals



**Medicare Claims Processing Manual**
**Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers**

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

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(Rev. 12832; Issued: 09-12-24)

Transmittals for Chapter 13

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**Claims Manual Sections 20/60/70**
CAUTION: Any reference to a FQHC getting an AIR expired in 2016 and the claims examples have errors.

**Claims Manual Section 30.2**
Explains how a FQHC's PPS rate is determined and when it may be adjusted up by 34.16%

**Claims Manual Section 40**
Clarification of RHC vs. FQHC deductible and coinsurance and how they are different.

**Benefit Policy Manual Section 30**
Staffing requirements, employment rules, and provider coverage arrangements are described.

**Benefit Policy Manual Section 40**
Defining visits, location rules, hours of operation, same day multiple visits, and global billing.

**Benefit Policy Manual Section 60.1**
Non-RHC/FQHC services are discussed.

**Benefit Policy Manual Section 120**
"Incident-to" **only** visits should not $ AIR/PPS.

# CMS Valid Encounters Defined to get the AIR/PPS

**01**

## Face-to-Face Visit?

Exceptions?

**02**

## Authorized Provider?

Are there differences for DSMT and medical nutrition therapy staff for RHC vs. FQHC?

**03**

## Is it "Medically Necessary"?

Are you familiar with NCDs vs. LCDs and the Medicare Coverage Database?

**04**

## Approved Location?

Also includes services at Skilled Nursing Facilities and where else?

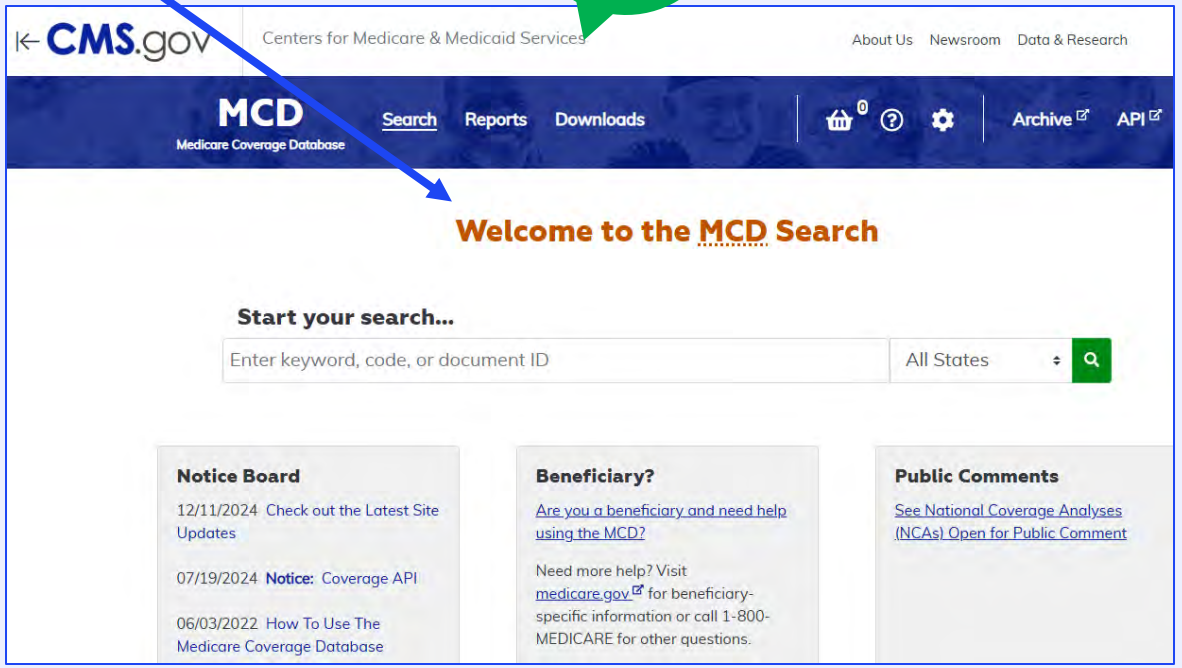
***"An RHC or FQHC visit is a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, CSW, MFT or MHC during which time one or more RHC or FQHC services are rendered."***

**CMS Benefit Policy Manual, Chapter 13, Section 40**

# Get webinar training on, and then access to, the Medicare Coverage Database

Step 1

Step 2

# Sample from Chapter 13 section 40.3 for Multiple Visits on Same Day

## 40.3 - Multiple Visits on Same Day

*(Rev. 12832; Issued: 09-12-24; Effective:01-01-24; Implementation:10-14-24)*

Except as noted below, encounters with more than one RHC or FQHC practitioner on the same day, or multiple encounters with the same RHC or FQHC practitioner on the same day, constitute a single RHC or FQHC visit and is payable as one visit. This policy applies regardless of the length or complexity of the visit, the number or type of practitioners seen, whether the second visit is a scheduled or unscheduled appointment, or whether the first visit is related or unrelated to the subsequent visit. This would include situations where an RHC or FQHC patient has a medically-necessary face-to-face visit with an RHC or FQHC practitioner, and is then seen by another RHC or FQHC practitioner, including a specialist, for further evaluation of the same condition on the same day, or is then seen by another RHC or FQHC practitioner, including a specialist, for evaluation of a different condition on the same day.

# Exceptions to the single AIR/PPS per day guidance

Exceptions are for the following circumstances only:

- The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has afall and returns to the RHC or FQHC). In this situation only, the FQHC would use modifier 59 on the claim and the RHC would use modifier 59 or 25 to attest that the conditions being treated qualify as 2 billable visits;
- The patient has a medical visit and a mental health visit on the same day (2 billable visits);
- For RHCs only, the patient has an initial preventive physical exam (IPPE) and a separate medical and/or mental health visit on the same day (2 or 3 billable visits); *or*
- *An IOP service and medical visit on the same day.*

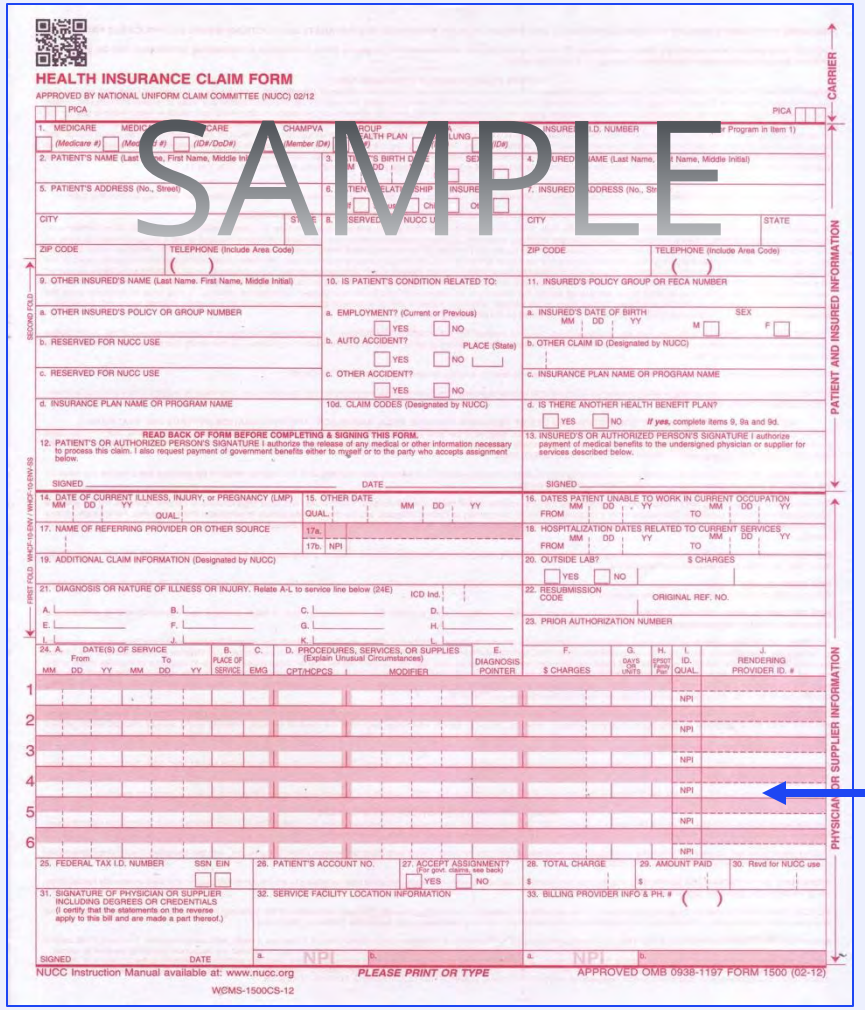
*Note: A mental health visit and IOP service may occur on the same day; however, if a mental health visit is furnished on the same day as IOP services, payment will only be made at the IOP rate, and the mental health visit will be considered packaged.*

**NOTE:** These exceptions do not apply to grandfathered tribal FQHCs.

Note how RHC vs. FQHC have different ways to identify this exception to on AIR/PPS claims.

Check with all payers who pay you via encounter rates if they have the same exceptions and how to show the exception(s)?

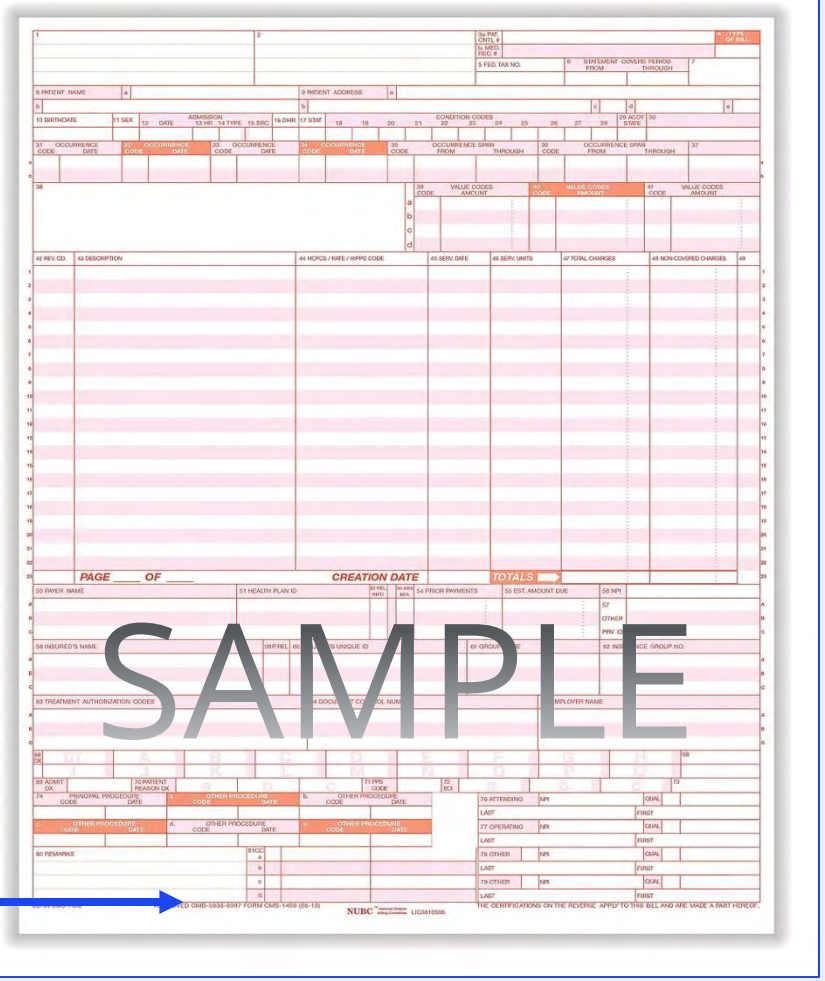
# There are many functional differences between the CMS-1500 and CMS-1450 forms




**Depending on who you are billing, CPT/HCPCS-II codes may need to be changed, and ICD-10-CM codes may need to be linked to each CPT/HCPCS-II code.**

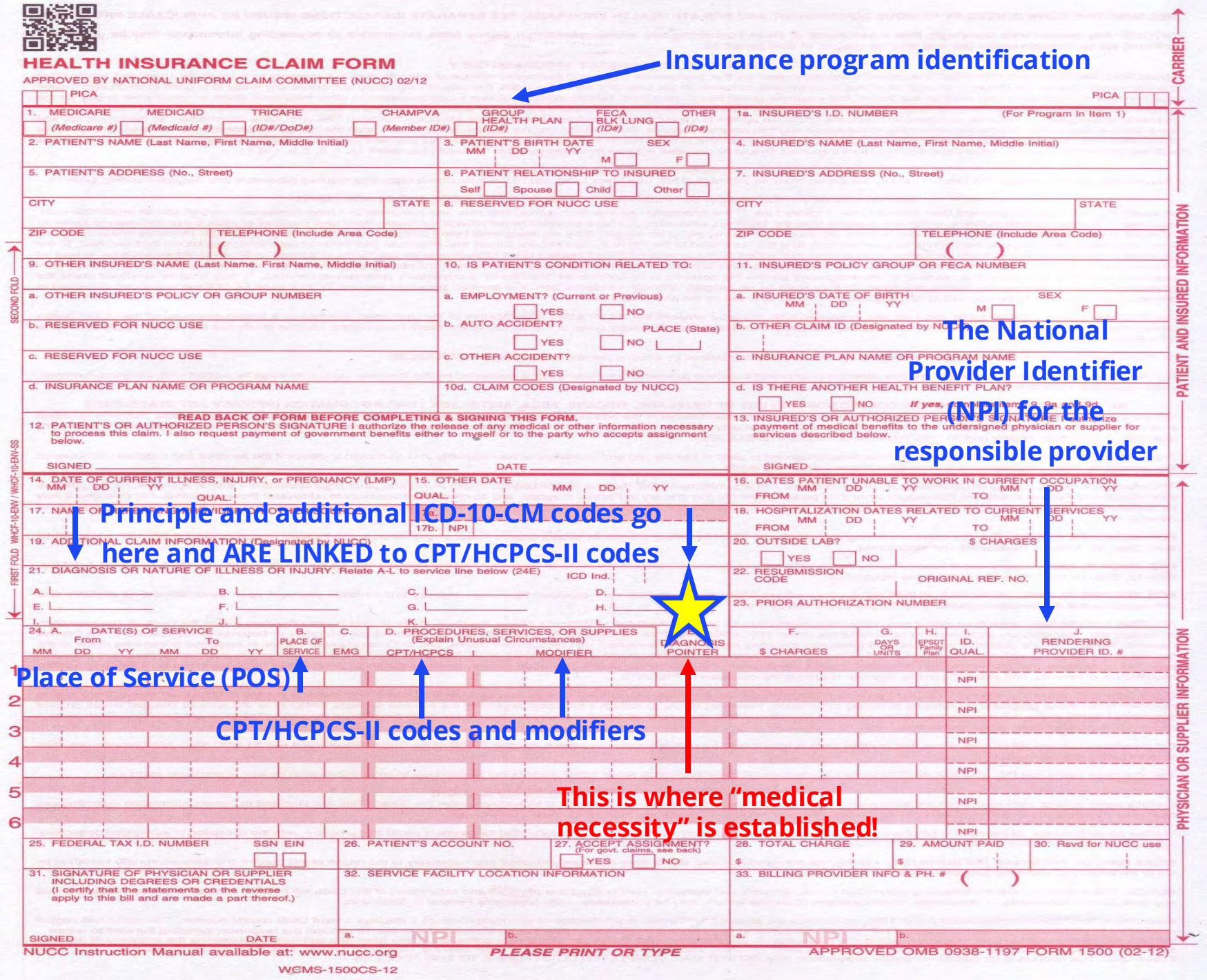
**One claim per provider**

**One claim per institution**



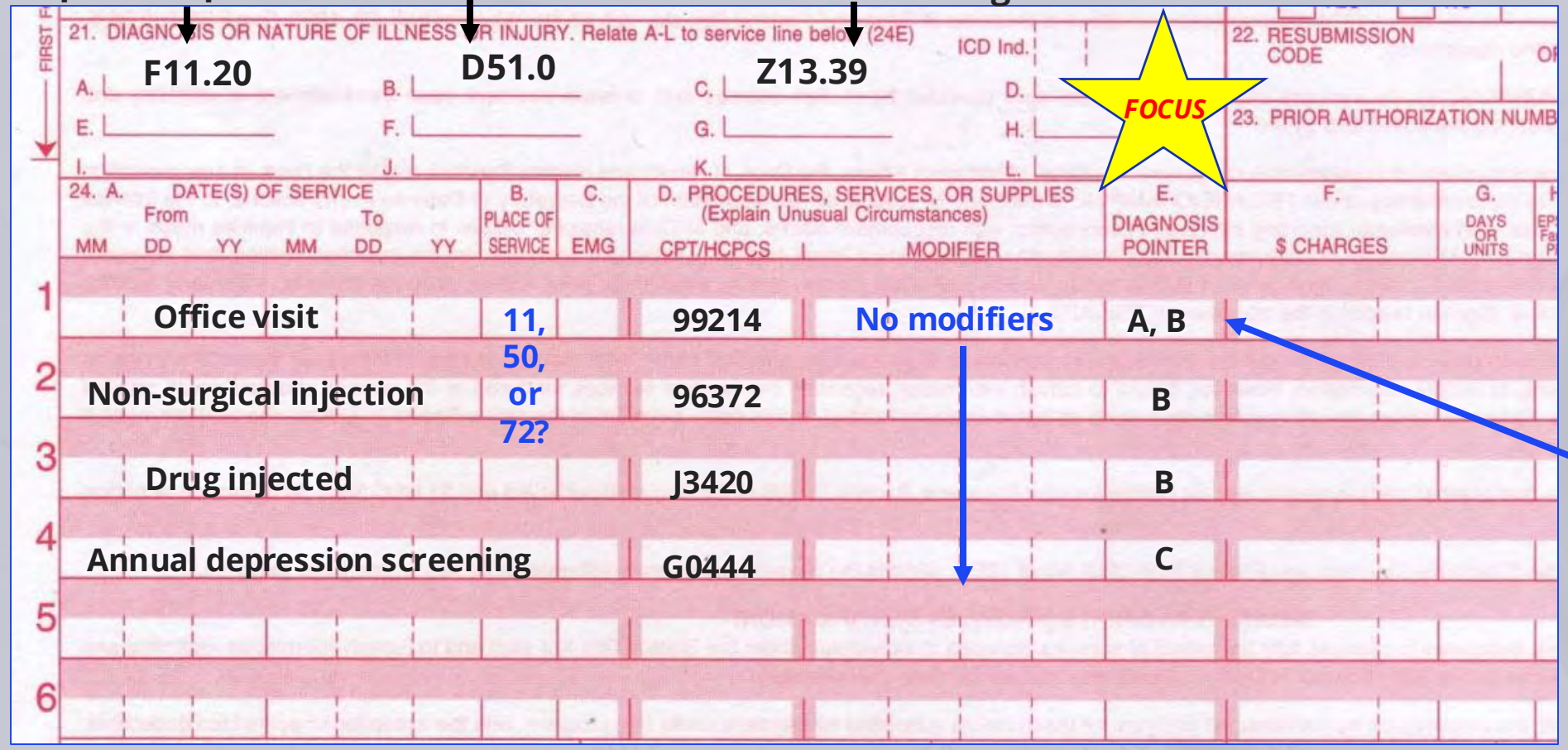
# The electronic version of the CMS-1500 is called the 837p (provider) form

This is the primary claim form used when billing commercial insurance companies expecting to pay you via ***Fee-for-Service (FFS)*** as well as Medicare FFS payments for services such as ***labs, hospital services surgery/delivery centers, and the technical components of diagnostic tests*** done at your RHC/FQHC.



# Sample FFS 837p claim for a **medical provider** providing various services

**Opioid Dependence** **Pernicious Anemia** **Screening for Mental/Behavioral Disorder**

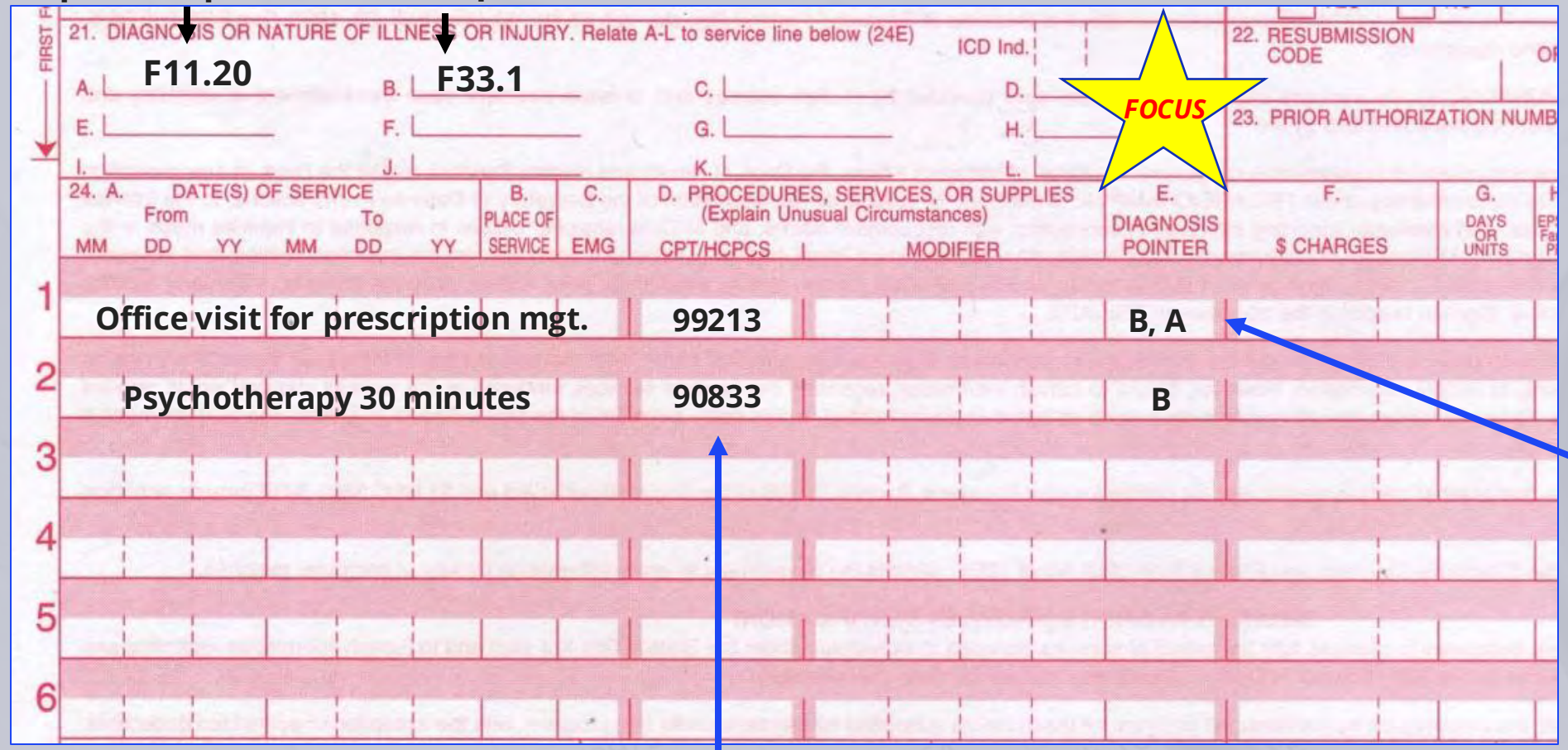



**What would happen if we just entered "A,B,C" for all lines?**

# Sample FFS 837p claim for a **mental health** office visit and therapy

Opioid Dependence

Depression

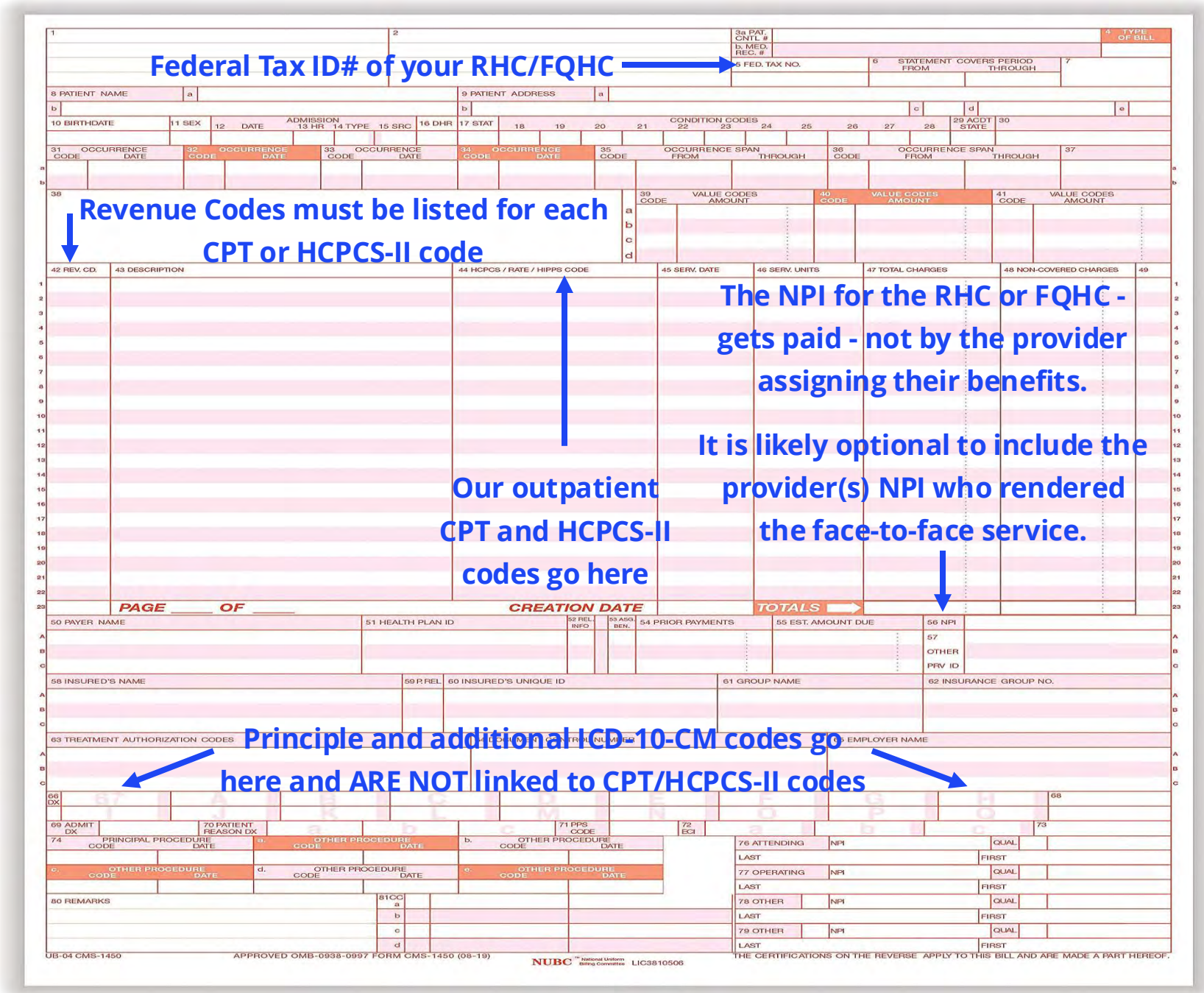



What would happen if we just entered "A,B" for both lines?

Why isn't this code 90832?

# The electronic version of the CMS-1450 is called the 837i (institutional) form

This is the primary claim form used when billing Medicare for "valid encounters" and getting paid via a ***RHC's All-Inclusive Rate (AIR) or a FQHC's Prospective Payment System (PPS)*** or by a special payment rate (i.e. CCM using code G0511).



# The 2 Types Rural Heath Clinics and All-Inclusive Rate (AIR) Basics

**Independent RHCs are *self-owned* LLC, corporations, etc. and Provider-based RHCs are *owned by another entity* such as a CAH/hospital system that owns one or more RHCs.**

- Instead of getting paid fee-for-service (FFS) Medicare pays you ~80% of a preset All-Inclusive Rate (AIR) for "valid encounters." Some services like Care Management using code G0511 *(until it is deleted July 1, 2025)* and medical telehealth may currently pay via special payment rules and labs are likely paid via the Clinical Lab Fee Schedule on a CMS1500 form.

- ***Independent and provider-based RHCs owned by a hospital with 50 or more beds*** the AIR upper limit is capped at $152 for 2025 with ~ $13 annual increases up to $190 in 2028.

- If you are a ***provider-based RHC owned by a hospital with less than 50 beds***, you likely get paid a preset AIR based on your recent cost report rather than at "cost" as in the past.
  - Critical Access Hospitals (CAH) and small rural hospitals that own provider-based RHCs can have ***significantly higher AIR reimbursement,*** in some cases, compared to independent RHCs or provider-based RHCs owned by larger hospital systems.

# Rural Health Clinics
# do not use a Qualifying Visit List

- Medicare ***does not maintain an active RHC "qualifying visit list"*** that identifies ***all*** possible services that are allowable to be billed in a RHC to get your AIR.
- Several versions were released throughout 2016, but effective October 2016 it went away.
- Always follow the **National/Local Coverage Decisions (NCD/LCD)** of your Part B MAC and reference the ***Medicare Coverage Database***?

**Rural Health Clinic Qualifying Visit List (RHC QVL)**
*(8-01-16)*

payment *with the CG modifier (explained below).* For dates of service on or after October 1, 2016, a medically-necessary service not on the current QVL can be billed as a stand-alone billable visit if the service meets Medicare coverage requirements, is within the scope of the RHC benefit, and is not furnished incident to a physician's service.

NOTE: The use of a HCPCS code from the below QVL does not guarantee payment of the claim. All of the conditions for coverage and payment must be met for payment to be made. RHCs must retain adequate documentation of a patient's condition and the services furnished as part of the patient's medical record, which, along with the claim, may be subject to review by CMS, its contractors, or other oversight authorities.

# RHC patient deductible and coinsurance is impacted heavily by proper coding!

- The 2025 RHC Part B patient deductible ($257) is the same as in traditional doctor's offices .

- The patient's coinsurance is based on ***20% of your charges*** for each medically necessary CPT/HCPCS-II code; therefore, it is imperative to ***document, code, and bill for all services provided*** on a line-by-line basis. Patient coinsurance is not 20% of the AIR nor 20% of Medicare's FFS rate(s) regardless of if you are getting your AIR.

- ***Being independent vs. provider-based*** also changes how you will bill for the technical components of Medicare-covered diagnostic tests (i.e., x-ray, EKG, ultrasound) via "split billing", lab services paid via the clinical lab fee schedule, and pre-/intra-/post-op surgical procedures performed outside of your RHC.

# RHC patient coinsurance is based on line-by-line CPT/HCPCS-II charges

- The first line on the CMS1450 claim form should identify the primary service provided or main reason for the visit. The charge for this first listed code ***will also include the charges*** for each line item below it all ***"rolled up" to give a number that identifies the total charge(s)*** that the patient owes 20% of for approved services.
  - Medicare pays 80% of the AIR rate which includes payment ***for all CMS-covered services listed***, not just the first listed code.
  - Medicare wants RHCs to ***add a modifier –CG*** ("policy criteria applied") on that first line item as well as on ***any other code*** that may represent a request ***for an additional AIR*** on the same day, if key exceptions are met via the ***Benefit Policy Manual Section 40.3 on "Multiple Visits on Same Day"*** that we will review soon.
  - Most covered preventive medicine services have $0 coinsurance or deductible.

# Sample RHC 837i claim for same day medical and mental health therapy visits

One claim goes out for all services on the same claim form for 2 AIR payments

| 42 REV CD | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV DATE | 46 SERV UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|
| | Medical office visit | 99214 - CG | | | TOTAL | | |
| | Non-surgical injection | 96372 | | | $.01 | | |
| | Drug injected | J3420 | | | $.01 | | |
| | Annual depression screening | G0444 | | | $.01 | | |
| | Psychotherapy 30 minutes | 90832 -CG | | | $.01 | | |

Total charges for all services rolled up to the first line item – patient owes 20%

All diagnoses from all providers are included and NOT linked

| | | | | |
|---|---|---|---|---|
| F11.20 | D51.0 | Z13.39 | F33.1 | |

# FQHC/Community Health
# Prospective Payment System (PPS) Basics

- Geographic differences adjust the national 2025 PPS base rate depending on how your state adjusts payments based on your location.
  - 2025 Base Rate of $202.65 (x) Your Geographic Adjustment = **Your local PPS rate**

- You will establish a charge for each of the ***5 FQHC-only "magic billing" G-codes (i.e. G0466-G0469)*** that identifies your charge for a "**typical bundle of Medicare-covered services**."

- Medicare ***will compare the charge amounts*** for the 5 billing G-code(s) reported to your preset localized PPS rate and the MAC will pay 80% using the **"lesser of"** the 2 compared charges.

# FQHC/Community Health
# Prospective Payment System (PPS) Basics (cont'd)

- Instead of getting paid FFS, Medicare likely pays you 80% of a **Prospective Payment System (PPS)** rate for "valid encounters." Some services like Care Management using G0511 and medical telehealth may currently pay via special payment rules and labs are paid via the Clinical Lab Fee Schedule on a CMS1500 form.
- You are required to perform, document, and bill a code on the ***Qualifying Visit List (QVL) preceded*** by at least one of ***5 FQHC-only "magic" billing G-codes*** G0466-G0470 that must be listed first on the CMS1450/837i claim form.
  - **G0466-G0467** – New vs. established (medical) face-to-face service(s) with an authorized provider
  - **G0468** – A visit ***that includes*** either the Initial Preventive Physical Exam (IPPE) or an Initial/Subsequent Annual Wellness Visit (AWV)
  - **G0469-G0470** – New vs. Established mental health face-to-face/telehealth visit

# FQHC/Community Health
# Impact of the Qualifying Visit List (QVL)

- "Detailed Healthcare Common Procedure Coding System (HCPCS) coding with the associated line-item charges ***listing the visit that qualifies the service for an encounter-based payment and all other FQHC services furnished*** during the encounter are also required."

- Use caution, as this guidance document has ***codes on the current list that were deleted*** from the CPT manual many years ago such as 99201 and 99324-99328 (domiciliary/rest home codes) as well as outdated services such as Psychoanalysis (90845).

- It is not clear at this time if there are other CMS covered services that may generate valid PPS payments since ***the list has not been updated since 2017***. Examples include, performing structured screenings for alcohol and substance abuse (99408-99409) and the Social Determinant of Health risk assessment (G0136) as stand-alone services.

# FQHC /Community Health
## Patient Deductible and Coinsurance

- The Part B deductible ***does not apply*** to FQHC Part B patients, but it does to RHC.

- Once your MAC determines that you have a valid encounter(s) and that your G-code charge is higher that your localized PPS rate, ***your patients owes 20% of the PPS rate*** for all CMS-covered services associated with that encounter.
  - If you meet the exceptions found in the ***Benefit Policy Manual Section 40.3*** related to ***"Multiple Visits on Same Day"*** – the patient may owe an additional 20% of the PPS rate for additional valid encounters.

- Medicare should increase your PPS rate by 34.16% for new patient visits or the IPPE or AWV. Note that ***Medicare does NOT use the traditional CPT definition*** of new vs. established patients in FQHCs.

- Most covered preventive medicine services have $0 coinsurance or deductible.

# Sample FQHC 837i claim for same day medical and mental health visits

These codes are the FQHC-only "magic" billing codes that should generate 2 PPS payments

| 42 REV CD | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV DATE | 46 SERV UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|
| | Est. Pt. – 1+ Medical Services | G0467 | | | | | |
| | Medical office visit | 99214 | | | | | |
| | Non-surgical injection | 96372 | | | | | |
| | Drug injected | J3420 | | | | | |
| | Est. Pt. – Mental Health | G0470 | | | | | |
| | Psychotherapy 30 minutes | 90832 | | | | | |

Followed by code(s) on the QVL.

List "…all other services provided…"

| | | | |
|---|---|---|---|
| F11.20 | D51.0 | Z13.39 | F33.1 |

# CY2025 Physician Fee Schedule Final Rules for RHC and FQHC Billing - Quick Glance



**Perform a more detailed review of the proposed rules, public comments, and final rule decisions from the CY2025 CMS Physician Fee Schedule from a few different sources including your MACs and follow these sites for expected updates!**

# CY2025 Physician Fee Schedule Final Rules for RHC and FQHC Billing - Quick Glance

- Finalized the eventual requirement date for ***reporting individual CPT/HCPCS-II codes for care management*** rather than using G0511 for over 30+ General Care Management Services along with the creation of new Advanced Primary Care Management HCPCS-II options.
- Increased the number of allowable billable services for providing an ***Intensive Outpatient Program in a RHC/FQHC to a maximum of 4 services per day*** ($~408) instead of 3 (~$270).
- Clarified the policy allowing payment for certain ***dental services*** via modifier – KX ("specific required documentation on file") ***deemed inextricably linked to certain medical services*** being payable on the same days other medical services.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Billing Requirements for Intensive Outpatient Program Services with New Condition Code 92

Related CR Release Date: December 21, 2023 MLN Matters Number: MM13496

Effective Date: January 1, 2024 Related Change Request (CR) Number: CR 13496

Implementation Date: January 2, 2024 Related CR Transmittal Number: R12425BP and R12425GI

Related CR Title: Enforcing Billing Requirements for Intensive Outpatient Program (IOP) Services with New Condition Code 92

Affected Providers

- Hospital outpatient departments
- Critical access hospitals (CAHs)
- Community mental health centers (CMHCs)
- Other providers billing Medicare Administrative Contractors (MACs) for IOP services they provide to Medicare patients

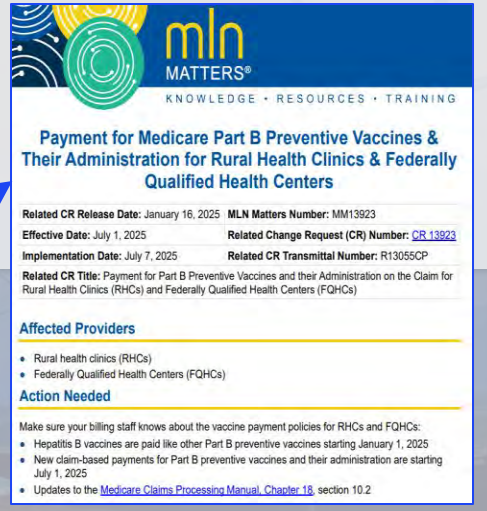
# CY2025 Physician Fee Schedule Final Rules for RHC and FQHC Billing - Quick Glance (cont'd)

- Effective January 1, 2025, CMS added payments for ***Hepatitis B vaccinations/administrations*** as Part B covered preventive vaccinations to mirror the way we currently get paid for Part B covered COVID, flu, and pneumococcal vaccines ***via 100% of the reasonable cost***, typically through the annual cost report until July 1, 2025.
- Effective July 1, 2025, RHC and FQHC can bill and ***be paid for Part B preventive vaccines and their administrations at the time of service*** via 95% of the Average Wholesale Price and additional payment reconciliations needed will still likely take place at cost report time.
- Via Congress in December 2024 and March 14, 2025 – provided a temporary ***extension of reporting medical and mental health telehealth the same as we did in 2024*** **until September 30, 2025.** Congress and CMS should pass additional permanent extensions in the new year prior to the deadline.

# Starting July 1, 2025, you can get paid at the time of service for preventive influenza, pneumococcal, COVID, and Hep B vaccines and their administration

**Prior to this change, we had delayed reimbursement, basically at the end of the year via the cost report, for key vaccines and their administrations causing cash flow challenges and administrative burdens**

- These claims will initially pay 95% of the Average Wholesale Price for the vaccine product itself. We still expect annual reconciliation on an annual basis to make up the difference.
- Several vaccine administrations will be paid via a special payment rule and the following codes rather than traditional CPT vaccine admin codes:
  - G0008 (flu) = ~$33.71
  - G0009 (pneumo) = ~$33.71
  - G0010 (Hep B) = ~$33.71
  - 90480 (COVID-19) = ~$44.95



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**Payment for Medicare Part B Preventive Vaccines & Their Administration for Rural Health Clinics & Federally Qualified Health Centers**

**Related CR Release Date:** January 16, 2025 **MLN Matters Number:** MM13923
**Effective Date:** July 1, 2025 **Related Change Request (CR) Number:** CR 13923
**Implementation Date:** July 7, 2025 **Related CR Transmittal Number:** R13055CP
**Related CR Title:** Payment for Part B Preventive Vaccines and their Administration on the Claim for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

**Affected Providers**

- Rural health clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

**Action Needed**

Make sure your billing staff knows about the vaccine payment policies for RHCs and FQHCs:

- Hepatitis B vaccines are paid like other Part B preventive vaccines starting January 1, 2025
- New claim-based payments for Part B preventive vaccines and their administration are starting July 1, 2025
- Updates to the Medicare Claims Processing Manual, Chapter 18, section 10.2

# Dental services are expanding in rural/community health but CMS reimbursement issues have made it difficult

**Medicare is not allowed, by statute, to pay for many dental services, especially routine treatments and cleanings deemed not medically necessary.**

**Examples include reporting CDT code D7140 (*tooth extraction*) + K03.2 (*erosion of teeth*)**

- The list of services that are "inextricably linked" has been expanded to include a "dental or oral examination performed as a part of a comprehensive work-up prior to any medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with":
  - Bone marrow, hematopoietic stem cell, and organ transplants,
  - chimeric antigen receptor T-cell therapy when treating cancer,
  - cardiac valve replacements,
  - valvuloplasty procedures,
  - chemotherapy when used in the treatment for cancer,
  - antiresorptive therapy when treating cancer,
  - **Patients preparing to receive dialysis for ESRD (ADDED in 2025!)**

# Dental Action Items
## Based on 2025 changes for RHC/FQHC

1. **Reach out to your clinical providers to identify which dental services that are linked to covered medical services can be billed separately by community health centers in 2025 *IN ADDITION* to a medical/mental health visit using *HCPCS-II modifier –KX defined as "Specific required documentation on file."***

2. **See how/if this impacts commercial insurance and/or Medicaid coverage of similar services and/or if the –KX modifier is necessary.**

3. **Look for confirmation in a potential 2025 update to the CMS Benefit Policy Manual Chapter 13 Section 40.3.**

# 2025 continues to allow for using technology to meet the definition of “direct supervision.”

“b. RHCs and FQHCs
In section III.B. of this final rule, we finalized the policy ***to adopt the definition “immediate availability” as including real-time audio and visual interactive telecommunications for the direct supervision*** of services and supplies furnished incident to a physician’s service through December 31, 2024 for RHCs and FQHCs.

We also finalized the policy change (*related to*) the required level of supervision for behavioral health services furnished “incident to” a physician or non-physician practitioner’s services at RHCs and FQHCs to allow general supervision, rather than direct supervision, consistent with the policies finalized under the PFS for CY 2023.”

**Source: Page 1939 of the 2024 Federal Register - https://public-inspection.federalregister.gov/2023-24184.pdf**

# WHAT MAKES RHCs AND FQHCs DIFFERENT?

## Self-Study & Exercises

1. **Bookmark key CMS websites and interact often with the free CMS Medicare Learning Network® (MLN) educational opportunities including MLN Matters Articles, MLN Web-based Training, and MLN Publications & Multimedia, and those available via your MAC.**
2. **Perform a detailed review CMS' RHC/FQHC Claims and Benefit Policy Manuals with a focus on key sections noting opportunities, conflicts, and areas that may need updates.**
3. **Seek out different sources who covered the 2025 proposed rules, public comments, and final rule decisions from the CY2025 CMS Physician Fee Schedule including your MACs!**

# DOCUMENTING PATIENT ENCOUNTERS

**What needs to be in the medical record so we can properly and accurately report our preventive, problem-oriented, care management, and telehealth visits?**

# Section Topics

1. Review the past, present, and future of the AMA CPT Evaluation & Management (E/M) Services Guidelines
2. Overview of how to select level of E/M services via Time vs. Medical Decision Making
3. Other E/M services not performed in your RHC/FQHC
4. Documenting CPT Preventive Medicine Services vs. CMS Covered Preventive Medicine Services
5. Documenting Care Management Services

## Documenting Patient Encounters

# Common Provider Documentation Issues

**Establish routine communications** between your clinical staff and revenue cycle staff on common denials and how to ensure that documentation is present in the medical record BEFORE sending the claim.

**Work with your EHR and billing system vendors** to determine if you can upload custom templates and build in compliance/coding safeguards to ensure billing compliance.

Only sees abbreviated code definitions and does not have access/knowledge of the actual CPT/HCPCS-II and ICD-10-CM guidelines.

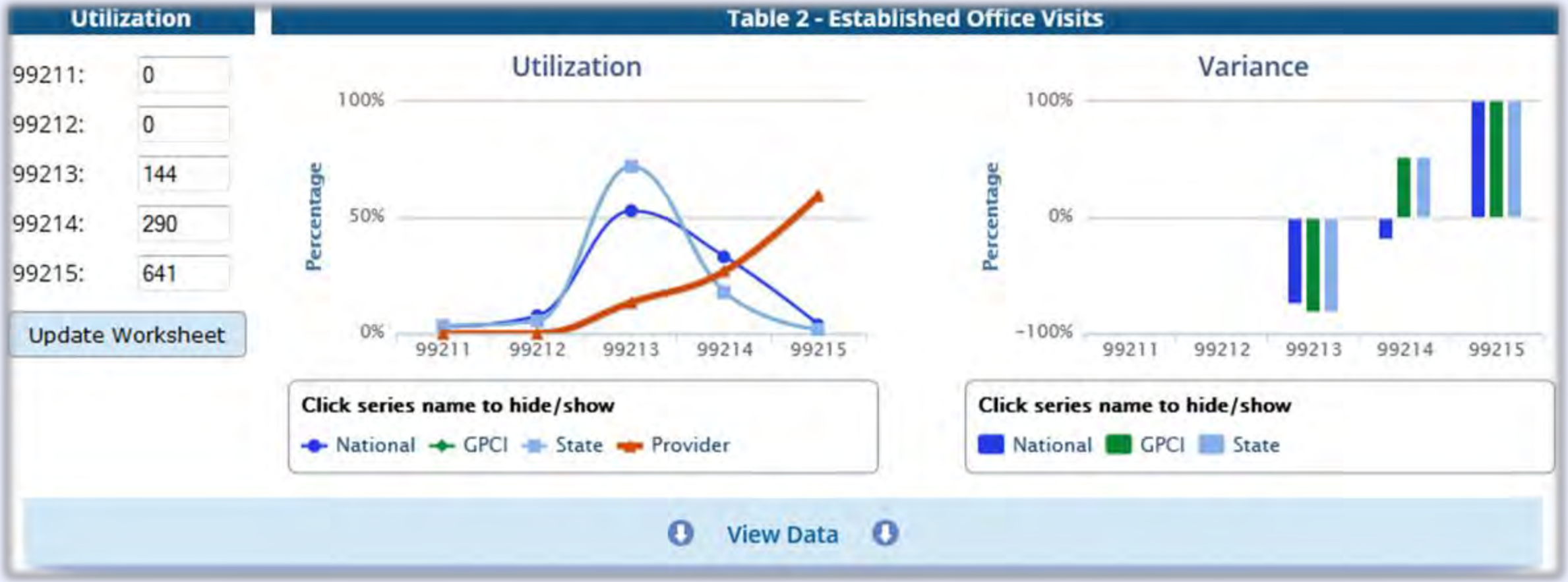
Not knowing when TIME impacts code selection. It is different for time-based codes vs. medical E/M services vs. psychotherapy.

Using outdated templates that are not tailored towards specific services such as updated E/M guidelines, IPPE, and Annual Wellness Visits.

Not enforcing the timely closing of encounters. Do your claims go out before the note is completed or a coding review takes place?

Not establishing medical necessity on each date of service. Each day's documentation must be able to support all services reported.

# Analyze your prescribing provider's E/M patterns broken down by specialty and location




## What are some observations you have about this provider?

# It all starts with the Chief Complaint

How can these be improved to support a problem-oriented visit?


There may be a difference between a patient coming in with a symptom/sign for an ***acute illness/injury compared to the management of ongoing chronic conditions***.

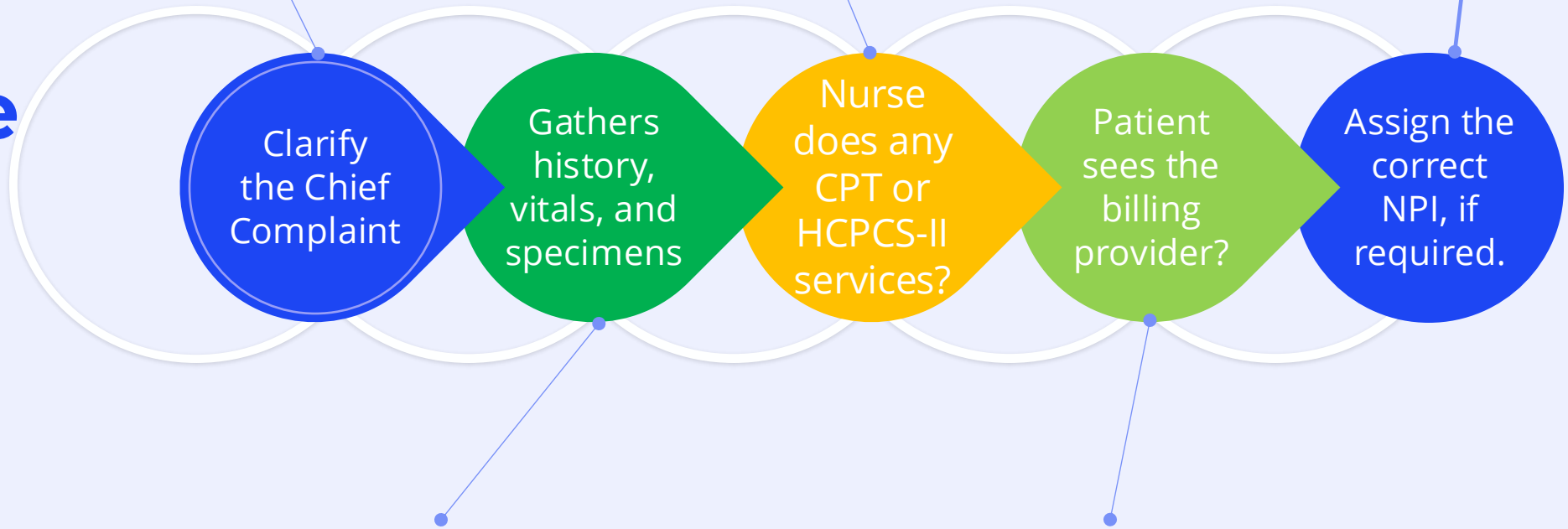
Try to include the status of the existing condition(s), side effects, "worsening," or "failing to improve," to feed Medical Decision Making.

# Nurse's Role Starting a visit in the EHR

**Problem-oriented and/or Preventive services?**

**Code for injections (ex. 96372), vaccines (ex. 99480), or minor procedures (ex. 69209) and/or only a 99211.**

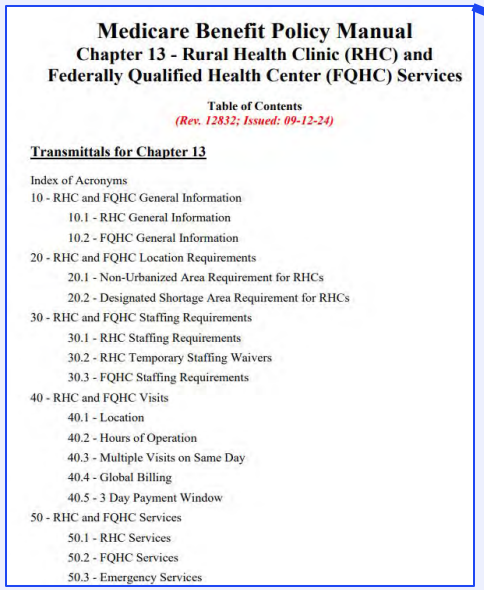
**"Incident-to"** is typically a Medicare-only term.




**Apply CPT-II codes on blood pressure, A1C or cholesterol levels, if required etc.**

**RHC/FQHC** can't get their AIR/PPS for incident-to ***only*** visits using 99211!

# Incident-to services on a Medicare RHC/FQHC patient requires that they have see an authorized provider face-to-face



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

**Table of Contents**
*(Rev. 12832; Issued: 09-12-24)*

**Transmittals for Chapter 13**



**120.1 - Provision of Incident to Services and Supplies**
**(Rev. 263, Issued: Effective: 01-01-20, Implementation: 01-23-20)**

When services and supplies are furnished incident to an RHC or FQHC visit, payment for the services are included in the RHC AIR or the FQHC PPS rate. An encounter that includes only an incident to service(s) is not a stand-alone billable visit for RHCs or FQHCs.

***Some non-Medicare payers may allow*** a non-authorized provider (*ex. RN, MA, peer support, community health worker*) to see a patient by themselves and ***report a 99211*** if an authorized provider is giving direct supervision, in other words "*immediately available in the office suite*", and may not require a face-to-face service **using the MD/PA/NP/CP/CSW's billing NPI#**.

# DOCUMENTING PROBLEM-ORIENTED ENCOUNTERS

1. New E/M Telemedicine options
2. Office and telehealth visits
3. Observation/hospital
4. Inpatient/outpatient consultations
5. Nursing facility
6. Home or residence services

# New 2025 CPT Telemedicine E/M
## Synchronous Audio-only and Audio/Video visits


**Not for Medicare Billing for RHC/FQHC**

There are 17 new E/M codes for telemedicine and virtual check-ins.

Previous telephone E/M codes ***99421-3 were deleted for 2025***.

***You will need to determine*** if these new codes are on your ***2025 fee schedules for non-Medicare plans*** or if should you continue to use modifiers-93/-95, G2250 - G2252, or T1014.

**NEW telemedicine with synchronous *audio and video***

98000-98003 (new)

98004-98007 (est.)

+

**NEW telemedicine with synchronous *audio-only***

98008-98011 (new)

98012-98014 (est.)

**Brief patient initiated "virtual check-in"**

Bill 98016 (*5-10 minutes, not related to an E/M w/in 7 days, doesn't result in an immediate visit*)

**As of today, RHC/FQHC report VCS via G0071.**

# Clinical provider's historical complaints with complicated documentation rules has been heard!

- In 2020, the **Patient's Over Paperwork** initiative "*CMS' internal process to evaluate and streamline regulations*" winds up and sweeping changes took effect January 2021 for office/outpatient E&M codes and in January 2023 for hospital, observation, nursing facility and home visits.
  - ✓ Reduce documentation burden for qualified providers **– check!**
  - ✓ Eliminate "note bloat" and need to "re-document" certain aspects of the record **– check!**
  - ✓ Reduce professional dissatisfaction and provider "burnout" **– hopefully!**
  - ✓ Encourage more time with patients and less time with unnecessary paperwork **– it is literally in the definition now!**

# 3 E/M "Key Components"
# PAST (1992-2020)


**History**
Problem/Expanded problem-focused, Detailed, or Comprehensive

**Exam**
Problem/Expanded problem-focused, Detailed, or Comprehensive

**Medical Decision Making (MDM)**

**Nature of Presenting Problem**

**Counseling**

**Coordination of Care**

**Time**
Only used if Counseling and/or Coordination of Care was over 50% of the encounter

What are your provider's most significant issues with the format of their EHR templates?

# Medical Decision Making or Time, whichever gets you to the highest level PRESENT (2021-today)


**History**

"medically appropriate"

**Exam**

"medically appropriate"

**Medical Decision Making (MDM)**

**OR**

**Time**

**Nature of Presenting Problem**

**Counseling**

**Coordination of Care**

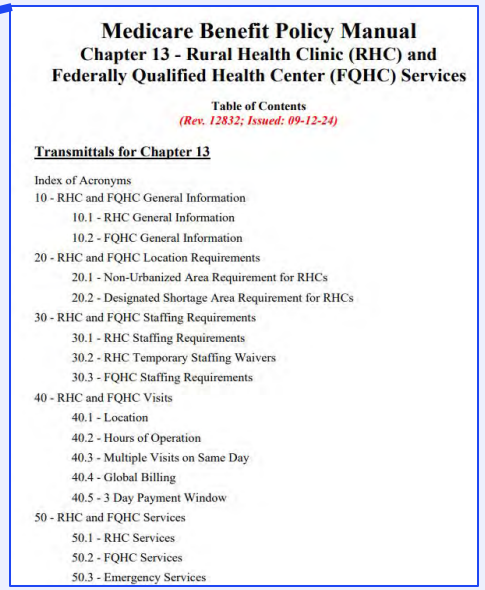
You will need to learn and apply both options!

# Grab your physical CPT Manual and follow along!


- **Reference Source:  AMA 2025 CPT Professional Edition**, Evaluation and Management (E/M) Services Guidelines found on pages 4-14 provide general rules for the entire E/M section.
- Pay careful attention to the significant educational guidance that precedes each E/M code section (observation, hospital, nursing facility, home/residence care, and prolonged services) and be prepared to make key self-study highlights.
- Remember, any non-AMA CPT manual (*and most EHR/coding software*) will only contain interpretations of the core source guidelines since the AMA doesn't typically license the guidelines to other book publishers and usually only licenses its code numbers and definitions.
- Be cautious of any EHR "short cut" that gives a recommended E/M level unless you have 100% certainty it is only based on the AMA's guidance in this year's CPT.

# Notice that FQHC do not use the same definition of new vs. established patients

New Patient Adjustment: The PPS payment rate is adjusted by a factor of 1.3416 when an FQHC furnishes care to a patient who is new to the FQHC. A new patient is someone who has not received any Medicare-covered professional health service (medical or mental health) from any site within the FQHC organization, or from any practitioner within the FQHC organization, within the past 3 years from the date of service.



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

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**Transmittals for Chapter 13**



Review ***section 70.3 in the Benefit Policy Manual*** for the FQHC definition of new vs. established and ***compare it to*** the decision tree found in the ***2025 CPT Professional Edition on page 6*** to see when you can get a ***34.16% INCREASE*** in your PPS rate!

Does this apply to others that pay you for valid encounters?

# When determining E/M by time know when the “clock is ticking” and do not round up


| 99202 | 99203 | 99204 | 99205 |
|---|---|---|---|
| 15 minutes | 30 minutes | 45 minutes | 60 minutes |

| 99212 | 99213 | 99214 | 99215 |
|---|---|---|---|
| 10 minutes | 20 minutes | 30 minutes | 40 minutes |

***Review pages 13-14 of the 2025 AMA’s Professional Edition*** *for details on what non-face-to-face time may be included when determining total time!*

# For prescribers spending time on the below items track time if done on the date of service


- preparing to see the patient (*e.g., review of tests*)
- obtaining and or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (*when not separately reported*)
- **documenting clinical information in the electronic or other health record**
- independently interpreting results (*not separately reported*) and communicating results to the patient/family/caregiver
- care coordination (*not separately reported*)

Which items does the AMA CPT say is NOT included in tracking time?

# Updated Terms
# Medical Decision Making (MDM) Elements

**Study Medical Decision Making!**

Please review and ***study pages 8-13 of your AMA Professional Edition CPT*** manual to find helpful updates and information that clinical providers should be familiar with when documenting in the medical record.

**You will use the *highest 2 of the 3 elements* to determine straightforward, low, moderate, or high complexity of MDM.**


**Number and Complexity of Problems Addressed at the Encounter**

**Amount and/or Complexity of Data to be Reviewed and Analyzed**

**Risk of Complications and/or Morbidity or Mortality of Patient Management**

# Table 2 – CPT E/M Office Revisions
# Level of Medical Decision Making (MDM)

**Revisions effective January 1, 2021:**

*Note: this content will not be included in the CPT 2020 code set release*

***Some items were added in 2023 and are shown in red.***

*This is key!*

| Code | Level of MDM (Based on 2 out of 3 Elements of MDM) | Elements of Medical Decision Making: Number and Complexity of Problems Addressed | Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.* | Elements of Medical Decision Making: Risk of Complications and/or Morbidity or Mortality of Patient Management |
|---|---|---|---|---|
| 99211 | N/A | N/A | N/A | N/A |
| 99202<br>99212 | Straightforward | **Minimal**<br>• **1** self-limited or minor problem | **Minimal or none** | **Minimal risk of morbidity from additional diagnostic testing or treatment** |
| 99203<br>99213 | Low | **Low**<br>• **2** or more self-limited or minor problems;<br>**or**<br>• **1** stable chronic illness;<br>**or**<br>• **1** acute, uncomplicated illness or injury<br>**or 1 stable acute illness acute**<br>**or uncomplicated illness or injury requiring hospital inpatient/observation care** | **Limited**<br>*(Must meet the requirements of at least 1 of the 2 categories)*<br>**Category 1: Tests and documents**<br>• **Any combination of 2 from the following:**<br>  • Review of prior external note(s) from each unique source*;<br>  • review of the result(s) of each unique test*;<br>  • ordering of each unique test*<br>**or**<br>**Category 2: Assessment requiring an independent historian(s)**<br>*(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)* | **Low risk of morbidity from additional diagnostic testing or treatment** |
| 99204<br>99214 | Moderate | **Moderate**<br>• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;<br>**or**<br>• **2** or more stable chronic illnesses;<br>**or**<br>• **1** undiagnosed new problem with uncertain prognosis;<br>**or**<br>• **1** acute illness with systemic symptoms;<br>**or**<br>• **1** acute complicated injury | **Moderate**<br>*(Must meet the requirements of at least 1 out of 3 categories)*<br>**Category 1: Tests, documents, or independent historian(s)**<br>• **Any combination of 3 from the following**:<br>  • Review of prior external note(s) from each unique source*;<br>  • Review of the result(s) of each unique test*;<br>  • Ordering of each unique test*;<br>  • Assessment requiring an independent historian(s)<br>**or**<br>**Category 2: Independent interpretation of tests**<br>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);<br>**or**<br>**Category 3: Discussion of management or test interpretation**<br>• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported) | **Moderate risk of morbidity from additional diagnostic testing or treatment**<br>*Examples only:*<br>• Prescription drug management<br>• Decision regarding minor surgery with identified patient or procedure risk factors<br>• Decision regarding elective major surgery without identified patient or procedure risk factors<br>• Diagnosis or treatment significantly limited by social determinants of health |
| 99205<br>99215 | High | **High**<br>• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;<br>**or**<br>• **1** acute or chronic illness or injury that poses a threat to life or bodily function | **Extensive**<br>*(Must meet the requirements of at least 2 out of 3 categories)*<br>**Category 1: Tests, documents, or independent historian(s)**<br>• **Any combination of 3 from the following**:<br>  • Review of prior external note(s) from each unique source*;<br>  • Review of the result(s) of each unique test*;<br>  • Ordering of each unique test*;<br>  • Assessment requiring an independent historian(s)<br>**or**<br>**Category 2: Independent interpretation of tests**<br>• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**<br>**or**<br>**Category 3: Discussion of management or test interpretation**<br>• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) | **High risk of morbidity from additional diagnostic testing or treatment**<br>*Examples only:*<br>• Drug therapy requiring intensive monitoring for toxicity<br>• Decision regarding elective major surgery with identified patient or procedure risk factors<br>• Decision regarding emergency major surgery<br>• Decision regarding hospitalization **or escalation of hospital-level of care**<br>• Decision not to resuscitate or to de-escalate care because of poor prognosis<br>• **Parenteral controlled substances** |

| Evaluation and Management Code (E&M Level) | Number and Complexity of Problems Addressed at the Encounter | Complexity/Level of Medical Decision Making (MDM) |
|---|---|---|
| **99202**<br>**99212** | • 1 self-limited or<br>• 1 minor problem | **Straightforward** |
| **99203**<br>**99213** | • 2+ self-limited or minor problems<br>• 1 **stable chronic** illness<br>• 1 **stable acute** illness<br>• 1 **acute uncomplicated** illness/injury requiring hospital inpatient or observation level of care | **Low** |
| **99204**<br>**99214** | • 1 or more **chronic** issues with exacerbation, progression, or side effects of treatment<br>• 2+ stable **chronic** illnesses<br>• 1 Undiagnosed problem with uncertain prognosis<br>• 1 **Acute** illness with systemic symptoms<br>• 1 **Acute** complicated illness | **Moderate** |
| **99205**<br>**99215** | • 1+ **chronic** illnesses with severe exacerbation/progression or side effect of treatment<br>• 1 **acute or chronic illness** or injury posing a threat to life or bodily function | **High** |

| Evaluation and Management Code (E&M Level) | Amount and/or Complexity of Data to be Reviewed and Analyzed<br>*(Each unique test, order, or document contributes to the combination of 2/3 in categories mentioned below!)* | Complexity/Level of Medical Decision Making (MDM) |
|---|---|---|
| 99202<br>99212 | **Minimal or none**<br>Each lab test counts toward the combination requirement below. | Straightforward |
| 99203<br>99213 | **Limited (Must meet at least 1 of the following 2 categories)**<br>• **Category 1: Tests and Documents***<br>• Any combination of 2 from the following:<br>• **1.** review prior external notes, **2.** review results of EACH unique test, **3.** order of EACH unique test<br>• **Category 2: Assessment requiring "Independent Historian(s)"** | Low |
| 99204<br>99214 | **Moderate (Must meet at least 1 of the following 3 categories)**<br>• **Category 1: Tests, Documents and Independent Historian(s)**<br>• Any combination of 3 of the following:<br>• **1.** review of prior external note(s) from each unique source, **2.** Review results of each unique test, **3.** order of each unique test, **4.** Assessment requiring independent historian(s)<br>• **Category 2: Independent interpretation of test performed by another provider (not billed)**<br>• **Category 3: Discussion of Management or test interpretation with outside provider (not billed)** | Moderate |
| 99205<br>99215 | **Extensive (Must meet at least 2 of the following 3 categories)**<br>• **Category 1**: **Tests, documents, or independent historian(s)** • **Any combination of 3 from the following**: **1.** Review of prior external note(s) from each unique source*; **2.** Review of the result(s) of each unique test*; **3.** Ordering of each unique test*; **4.** Assessment requiring an independent historian(s) ***or***<br>• **Category 2: Independent interpretation of tests** **1.** Independent interpretation of a test performed by another physician/other qualified health care professional (*not separately reported*); ***or***<br>• **Category 3**: **Discussion of management or test interpretation** **1.** Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (*not separately reported*) | High |

| Evaluation and Management Code (E&M Level) | Risk of Complications and/or Morbidity or Mortality of Patient Management *(Based on risks associated with diagnostic/therapeutic procedures)* | Complexity/Level of Medical Decision Making (MDM) |
|---|---|---|
| **99202**<br>**99212** | **Minimal risk of morbidity from additional diagnostic testing or treatment**<br>• Ex. Rest, gargles and bandages | **Straightforward** |
| **99203**<br>**99213** | **Low risk of morbidity from additional diagnostic testing or treatment**<br>• Ex. OTC | **Low** |
| **99204**<br>**99214** | **Moderate risk of morbidity from additional diagnostic testing or treatment**<br>• ***Prescription drug management (rx)***<br>• Decision for minor surgery with identified patient or procedure risk factors (0, 10 days)<br>• Decision for elective major surgery without identified patient or procedure risk factors (90 days)<br>• ***Diagnosis or treatment significantly limited by social determinants of health (SDoH)*** | **Moderate** |
| **99205**<br>**99215** | **High risk of morbidity from additional diagnostic testing or treatment**<br>• ***Drug therapy requiring intensive monitoring for toxicity (e.g., warfarin/chemo agents, etc.)***<br>• Decision regarding elective major surgery with identified patient or procedure risk factors<br>• Decision regarding emergency major surgery<br>• Decision regarding hospitalization or escalation of hospital level of care<br>• Decision not to resuscitate or to de-escalate care because of poor prognosis<br>• ***Parenteral controlled substances*** | **High** |

# Grab your CPT Manual and follow along!


- Let's ***get hands-on with the documentation guidelines*** in the remainder of the CPT E/M section starting with Hospital Inpatient and Observation Services, Consultations, Nursing Facility, Rest Home, Preventive Medicine Services, Care Management, and more.

- ***Grab a highlighter and be ready to perform self-study exercises that can only be done from the AMA CPT!*** This is the MOST educationally valuable time you can spend reviewing the guidance that is not included in any EHR or coding product used by providers, coders, and billers.

# DOCUMENTING PREVENTIVE MEDICINE VISITS

1. Initial/periodic comprehensive preventive medicine codes 99381-99397 documentation review.
2. When can you code for BOTH a preventive visit and a problem-oriented E/M?
3. Compare 99381-99397 to the Initial Preventive Physical Exam (IPPE), Initial/Subsequent Annual Wellness Visits, screening pelvic/breast exam, and many others.
4. Counseling/risk factor reduction and behavior change interventions (ex. smoking, alcohol, and substance abuse screenings).

# Avoid calling these services physicals, general health exams, well-checks, and annuals visits

**“Initial”/new** = 9938x-9938x

**“Periodic”/est.** = 9939x-9939x

| CPT code’s 5th character | Patient’s age at time of service |
|---|---|
| 1 | < 1 |
| 2 | 1-4 |
| 3 | 5-11 |
| 4 | 12-17 |
| 5 | 18-39 |
| 6 | 40-64 |
| 7 | 65+ |

* Also be sure to report vaccines, immunizations, labs, and/or screening tests.
* Check with your FFS payers to see if they also cover the G0513-G0514 Prolonged Preventive Service(s) codes.

# When can you code BOTH a problem-focused E/M in addition to a Preventive Medicine service?


**Per page 39 of the AMA's 2025 CPT Professional Edition:**

**9939x + 9921x (-25)**

"If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, ***and if the problem or abnormality is significant enough to require additional work*** to perform the key components of a problem-oriented evaluation and management service, then the appropriate office/outpatient code…***should also be reported***…(with) modifier 25 (on the office visit code).

**OR**

**9939x only**

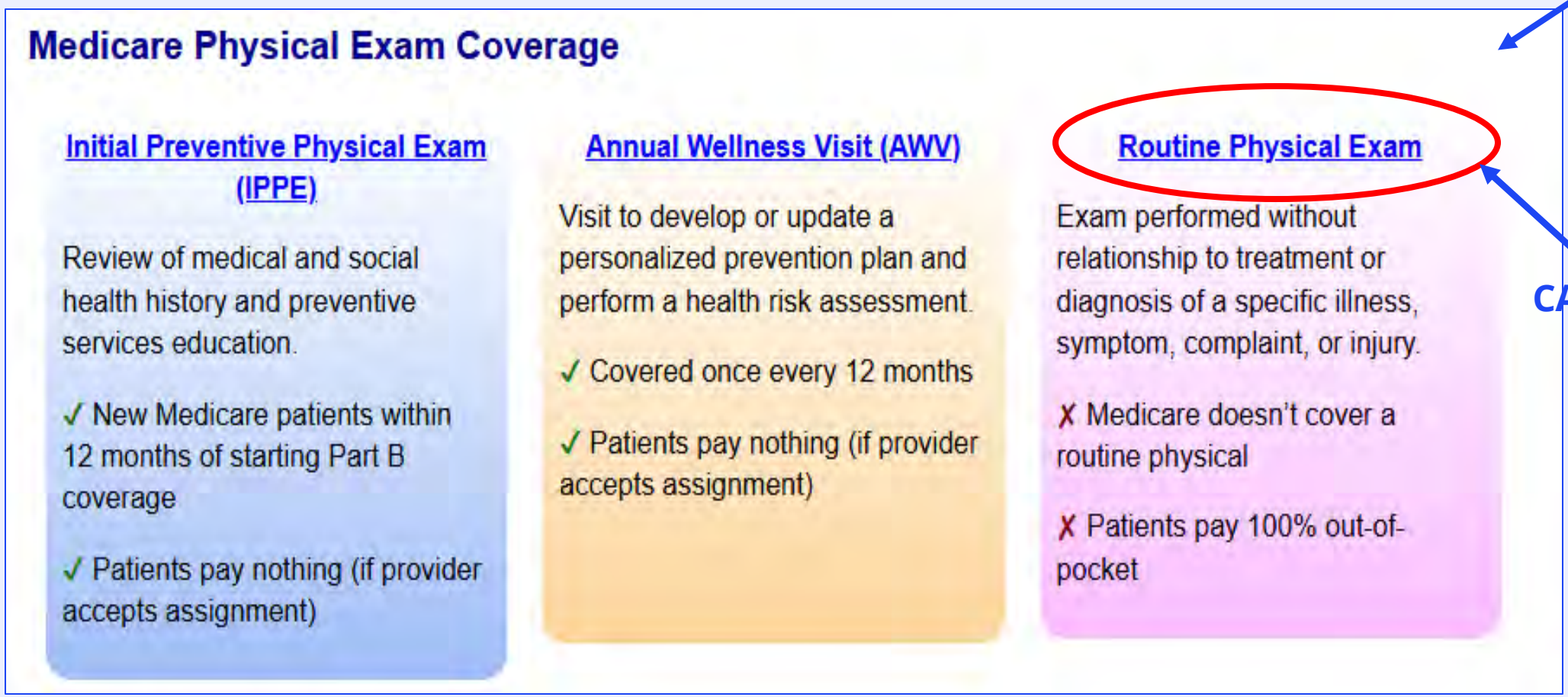
An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and ***which does not require additional work*** and the performance of the key components of a problem-oriented E/M service ***should not be reported***."

# Is the patient actually there for a CMS-covered preventive medicine service, such as...?

| | | | |
|---|---|---|---|
| **Initial Preventive Physical Exam (IPPE) and Screening EKG**<br>**G0402-G0405** | **Annual Wellness Visits (initial and subseq.)**<br>**G0438-G0439** | **Screening Pelvic/Breast & Screening Pap Handling**<br>**G0101/Q0091** | **Smoking/Tobacco Cessation Counseling**<br>**99406-99407** |
| **Prostate Cancer Screening**<br>**G0102** | **Glaucoma Screening**<br>**G0117-G0018** | **Alcohol and/or Depression Screening or Counseling services**<br>**G0442-G0444** | **Screening for High Intensity Behavioral Counseling for STD**<br>**G0445-G0447** |

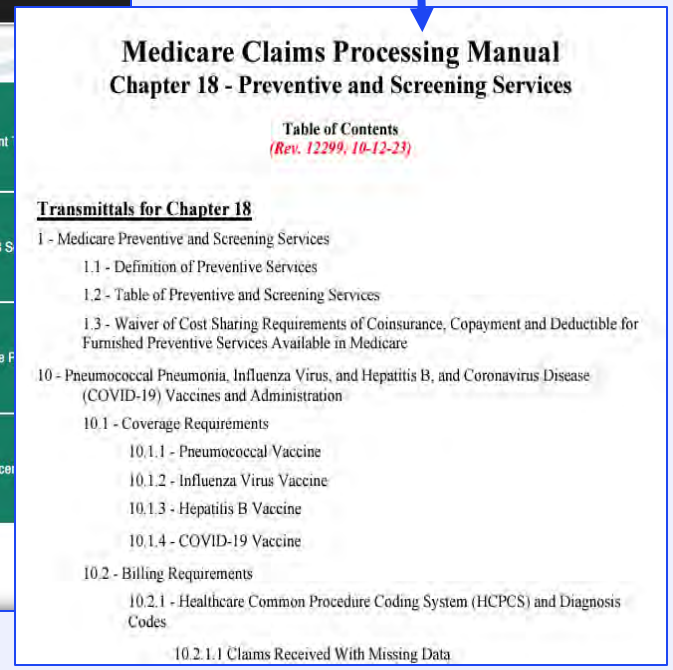
**Most CMS-covered preventive services are structured services with specific documentation guidelines and less clinical flexibility. However, CPT E/M codes 99381-99397 are far less structured giving the provider maximum flexibility.**

# This CMS document makes the issue more difficult since there aren't any "Routine Physical Exam" codes!




CAREFUL!

# Access the CMS interactive website for awesome summaries of covered Medicare Preventive Services

**Medicare Claims Processing Manual**
**Chapter 18 - Preventive and Screening Services**

Table of Contents
*(Rev. 12299, 10-12-23)*

**Transmittals for Chapter 18**



Access more detailed information in the ***Medicare Claims Processing Manual Chapter 18 – Preventive and Screening Services*** manual but use caution as this document ***is not written specifically for RHC or FQHC billing***.

# Preventive Service Chart for RHC

| Service | HCPCS Code | Short Descriptor | Paid at the AIR | Eligible for Same Day Billing | Coinsurance /Deductible | CMS Pub 100-04 |
|---|---|---|---|---|---|---|
| AWV | G0438 | Ppps, initial visit | Yes | No | Waived | Ch. 18 §140 |
| | G0439 | Ppps, subseq visit | Yes | No | Waived | |
| Screening Pelvic Exam | G0101 | Ca screen; pelvic/breast exam | Yes | No | Waived | Ch. 18 §40 |
| Prostate Cancer Screening | G0102 | Prostate ca screening; dre | Yes | No | Not Waived | Ch. 18 §50 |
| Glaucoma Screening | G0117 | Glaucoma scrn hgh risk direc | Yes | No | Not Waived | Ch. 18 §70 |
| | G0118 | Glaucoma scrn hgh risk direc | Yes | No | Not Waived | |
| Screening Pap Test | Q0091 | Obtaining screen pap smear | Yes | No | Waived | Ch. 18 §30 |
| Alcohol Screening and Behavioral Counseling | G0442 | Annual alcohol screen 15 min | Yes | No | Waived | Ch. 18 §180 |
| | G0443 | Brief alcohol misuse counsel | Yes | No | Waived | |
| Screening for Depression | G0444 | Depression screen annual | Yes | No | Waived | Ch. 18 §190 |

# Preventive Service Chart for FQHC

| Service | HCPCS Code | Short Descriptor | Paid under the PPS methodology | Increase in the PPS rate by 34%[1] | Coinsurance | CMS Pub 100-04 |
|---|---|---|---|---|---|---|
| Diabetes Self-Management Training (DSMT) | G0108 | Diab manage trn per indiv | Yes | No | Not Waived | Ch. 9 §181<br>Ch. 18 §120 |
| Medical Nutrition Therapy (MNT) | 97802 | Medical nutrition indiv in | Yes | No | Waived | Ch. 9 §182 |
| | 97803 | Med nutrition indiv subseq | Yes | No | Waived | |
| | G0270 | Mnt subs tx for change dx | Yes | No | Waived | |
| AWV | G0438 | Ppps, initial visit | Yes | Yes | Waived | Ch. 18 §140 |
| | G0439 | Ppps, subseq visit | Yes | Yes | Waived | |
| Screening Pelvic Exam | G0101 | Ca screen; pelvic/breast exam | Yes | No | Waived | Ch. 18 §40 |
| Prostate Cancer Screening | G0102 | Prostate ca screening; dre | Yes | No | Not Waived | Ch. 18 §50 |
| Glaucoma Screening | G0117 | Glaucoma scrn hgh risk direc | Yes | No | Not Waived | Ch. 18 §70 |
| | G0118 | Glaucoma scrn hgh risk direc | Yes | No | Not Waived | |

# DOCUMENTING PREVENTIVE MEDICINE VISITS

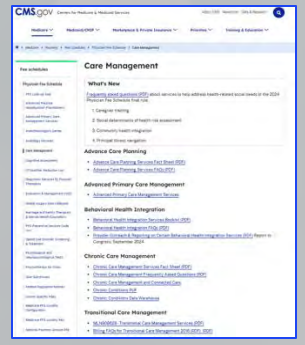
## Self-Study & Exercises

1. Review Ch. 18's Preventive Services manual and navigate around the CMS interactive Medicare Preventive Services website.
2. Select 10 charts where BOTH a problem-oriented visit like 99214 and a 9938x-9939x initial/periodic CPT preventive service were billed and determine if it fits the guidance in the CPT.
3. Set up training for clinical providers who may not be familiar with these guidelines and reach out to your vendors to develop and implement structured templates for your most common CMS-covered preventive medicine services.

# DOCUMENTING CARE MANAGEMENT SERVICES

1. There were ***no updates*** to codes or documentation guidance in the ***2025 AMA CPT Care Management Services*** section, but ***significant RHC/FQHC billing updates*** will require you to decide on how to bill for ***General Care Management from January-July 2025***.

2. We will review your ***potential use of new 2025 Advanced Primary Care Management*** HCPCS-II codes ***as a substitute to traditional monthly time-based codes*** for principal/chronic care, behavioral health integration, remote patient monitoring, community health integration, and more.




**Visit CMS' main Care Management website – use caution for RHC/FQHC billing advice though!**

# Care Management Services
# Documentation for Clinical Providers


**The 2025 AMA Professional Edition (pg. 54) has *2+ pages of text on care management* documentation guidelines. *Providers must be familiar with these guidelines* rather than how we get paid!**

**AMA CPT Guidelines**

"management and support services provided ***by clinical staff***, under the direction of a physician or other qualified health care professional....(that) include"

**"Establishing, implementing, revising, or monitoring the care plan**

**Coordinating the care of other professionals and agencies**

**Educating the patient or caregiver about the patient's condition, care plan, and prognosis"**

# “General Care Management”
# Coding for Providers Managing Care Plans


**TIPS: Develop templates in your EHR, track monthly time, document care plan updates and *get credit for the clinical work you do in between patient visits*. Consider external care managers to help with the workload.**

**Get patient verbal/written consent to be their ONLY care manager**

**Perform an “Initiating Visit”** within 1 year prior to first billing General Care Management.

**Chronic Care Management**

99487-99491, +99439

**+**

**Principal Care Management**

99424-99427

**Behavioral Health Integration (BHI)**
99484

**OR**

**Psychiatric Collaborative Care Model (Psych CoCM)**

99492-99494

**Monthly Chronic Pain Management**

See G3002 and +G3003 for consideration with commercial and non-Medicare payers.

**Many more related monthly General Care Management options for RHC/FQHC were added by CMS in 2024!**

# All of these Care Management codes can be reported with G0511 to Medicare by RHC/FQHC until 7-1-25

| Physician Fee Schedule Code | Description |
|---|---|
| G0323 | General Behavioral Health Integration (BHI) |
| 99487 | Complex CCM (over 60 minutes of care management per month) |
| 99490 | Basic CCM (20 minutes of care management) |
| 99491 | 30 minutes or more of CCM furnished by a physician or other qualified health professional |
| 99424 | 30 minutes or more of Principal Care Management furnished by physicians or non-physician practitioners |
| 99426 | 30 minutes or more of PCM services furnished by clinical staff under the supervision of a physician or non-physician practitioner |
| G3002 | Chronic pain management first 30 minutes |
| G3003 | Chronic Pain Management (each additional 15 minutes) |
| **99453** | **Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial: set-up and patient education on use of equipment** |
| **99454** | **Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial: device(s) supply with daily recording(s) or programmed alert** |
| **99457** | **Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes** |
| **99458** | **Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes** |
| **99091** | **Collection and interpretation of physiologic data (e.g. Blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or oth (when applicable) requiring a minimum of 30 minutes of time, each 30 days** |
| **98975** | **Remote therapeutic monitoring (eg, therapy adherence, therapy response); initial set-up and patient education on use of equipment** |
| **98976** | **Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respira** |
| **98977** | **Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor muscul** |
| **98980** | **Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes** |
| **98981** | **Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive comm 20 minutes** |
| **G0019** | **Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit** |
| **G0022** | **Community health integration services, each additional 30 minutes per calendar month** |
| **G0023** | **Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month,** |
| **G0024** | **Principal Illness Navigation services, additional 30 minutes per calendar month** |

Care management for BHI led by a CP, CSW, MHC, LMFT w/ a prescriber

General Care Management

Remote Physiologic Monitoring (RPM)

Remote Treatment Management (RTM)

Remote Therapeutic Monitoring (RTM)

Community Health Integration

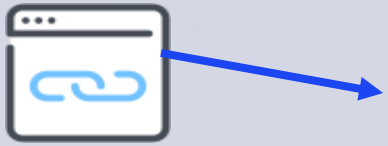
Principle Illness Navigation

# You may use either code G0511/2 or the actual CPT/HCPCS-II codes from now until the end of June 2025 to Medicare

- ***If you already bill*** commercial and/or Medicaid carriers for Care Management services ***using the service-specific CPT/HCPCS-II codes*** – it seems as though that would be a logical option on January 1, 2025 and beyond to bill Medicare in the same way.

- This would allow you to **also report the *"…additional (XX) minutes"*** codes to be paid and patients know what they are being charged for.
  - Be very careful to charge the patient's coinsurance correctly based on your choice!

- The reimbursement from Medicare if using the actual CPT/HCPCS-II code(s) will be ***paid at the non-facility physician fee schedule*** (i.e. fee-for-service) for each code range via a special payment rate ***rather*** than the PPS rate.



**Or consider the OPTION to use the new 2025 Advanced Primary Care Management (APCM) codes.**

# Other Monthly E/M Care Management Codes
# Remote Physiologic Management (RPM)

Monitoring weight, blood pressure, glucose, pulse ox, respiratory flow rate, etc. over a 30-day period using an FDA-approved medical device.

**Includes:** accessing, reviewing, and interpreting the data, modification of care plan, communications with the patient, and time documenting.

Use **99453** for the Initial Set-up and patient education on use of the equipment.

Use **99454** to report daily recording(s) or programmed alerts transmission

According to the AMA's CPT – "*An episode of care is defined as* ***beginning*** *when the remote monitoring physiological services is initiated and* ***ends*** *with the attainment of* ***targeted treatment goals***."

# Other Monthly E/M Care Management Codes
# Remote Physiological Treatment Management (RTM)

When clinical staff ***"use the results of RPM to manage a patient under a specific treatment plan"*** requiring a ***live interactive communication***

Use **99457** to report the first 20 minutes of clinical provider time in a calendar month.

Use **99458** to report each additional 20 minutes ***in addition*** to 99457.

According to the AMA's CPT – ***Do not count any time performing RTM*** on a day when an E/M service is provided!

# Other Monthly Care Management Codes
## Remote Therapeutic Monitoring Treatment Management - *in the Medicine section of the CPT*

When clinical staff "***use the results of RPM*** *to manage a patient under a specific treatment plan*" requiring a "***at least one live interactive communication with the patient***"

Use **98980** to report the first 20 minutes of clinical provider time in a calendar month.

Use **98981** to report each additional 20 minutes ***in addition to 99457***.

According to the AMA's CPT – ***Do not count any time performing RTM*** on a day when an E/M service is provided!

# Documentation Basics for Transitional Care Management (TCM)


TCM is intended to ***lower preventable hospital readmissions*** by establishing a smooth transition from inpatient providers ***to the patient's designated sole Care Manager***.

Establish ***direct patient contact with the patient within 2 days of the discharge*** to determine what happened in the inpatient stay.

TCM ***also consists non-face-to-face services*** by clinical staff including reviewing discharge info, medication reconciliation, and coordinating with external agencies and referred services.

***If the patient is re-admitted*** during the 30-day post-discharge period for the same/similar conditions some carriers may think that the TCM ***money may need to be returned***.

# Coding for
# Transitional Care Management (TCM)

**NOTE:** The same provider who discharged the patient may report TCM services, but ***the required face-to-face visit cannot take place on the same day*** as the actual discharge day management services.

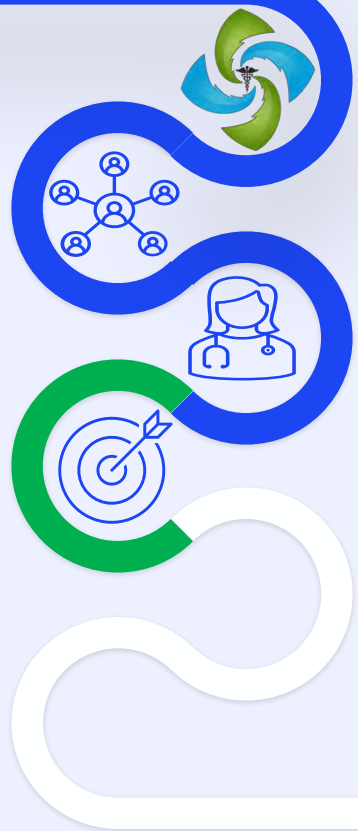
***Determine Medical Decision Making*** from the 2-day contact and then ***schedule 7 or 14 days from discharge***.

**99495**
Medical Decision Making of at least **moderate complexity** with a ***face-to-face visit within 14 calendar days*** of discharge.

**99496**
Medical Decision Making of at least ***high complexity*** with a ***face-to-face visit within 7 calendar days*** of discharge

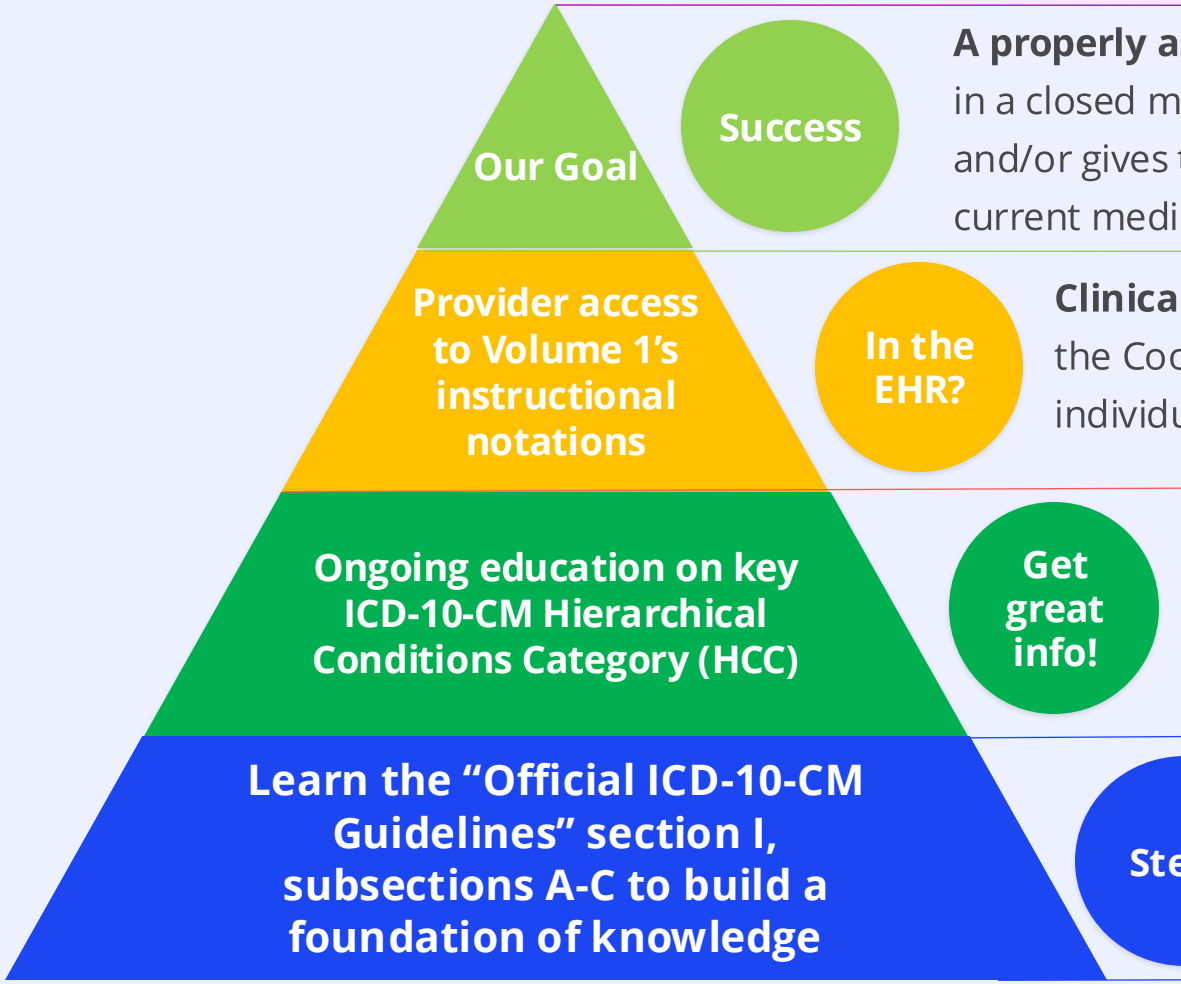
# Section Topics

1. ICD-10-CM's impact on Value-based Care and quality reporting **(ex. HEDIS, UDS, HCC, Shared Savings, and Risk Based Coding)**
2. Overview of the ICD-10-CM "**Official Guidelines**"
3. Comparison of the traditional **CPT vs. CMS Global Surgical Package** definitions
4. **Coding self-study exercises** related to common office-based procedures performed in RHCs/FQHCs
5. Documentation and coding for **diagnostic tests (ex. eye, x-ray, ultrasound, EKG), labs, vaccinations, and behavioral/mental health**



## Coding Diagnostic & Therapeutic Services

# Build and maintain your ICD-10-CM educational pyramid




**Success**

**A properly assigned ICD-10-CM code(s)** that is supported by valid documentation in a closed medical encounter whether it generates revenue via "medical necessity" and/or gives the patient (and their insurer) knowledge about the patient's past or current medical condition(s).

**In the EHR?**

**Clinical providers, coders, and billers must** share access to and knowledge of the Cooperating Parties (CMS, NCHS, AHA, AHIMA) guidelines specific to individual codes and code groups key to compliance.

**Get great info!**

**The AMA's Risk Adjustment Documentation & Coding** is a well-respected book that explains how ICD-10-CM codes impact ACO/managed care budgets and payments, and value-based care.

**Step 1**

**Start by learning the rules of the road** maintained by Centers for Medicare & Medicaid Services, the National Center for Health Statistics, the American Hospital Association, and the American Health Information Management Association.

# Basic Tenets of Diagnostic Coding

**Diagnostic coding has gone far beyond establishing "medical necessity"** to get claims paid. Value-based care is a federal and/state mandate that involved the tracking of health via your ICD-10-CM code usage.

**Managed care organizations may use your "*very important*" ICD-10-CM codes** to establish how ***they*** get monies from the state/federal health authorities if they are reported ***at least once per year***. Your facility can also use this concept to get incentive payments referred to as ***Shared Savings***.

Code the reason for the primary service and/or your primary assessed condition first if identified as being ***"chiefly responsible".***

Code other coexisting and/ chronic diseases if the patient receives active treatment (*or "MEAT" is met*) for them or ***if it is documented as affecting*** the primary/secondary diagnoses.

***Do NOT code*** "probable, suspected, questionable or rule out" diagnoses as if they are established diagnoses.

***Do NOT code*** diagnoses that are not documented on that day's note as impacting care. Remember, value-based care HCC codes need to be captured only once per year.

And finally, identify which diagnoses should be ***"linked"*** to each diagnostic or therapeutic service, in order of importance, for proper billing!

# Sample impact of HCC coding on budgets for ACOs and/or managed care payers

**EXAMPLE**

Martin McNally is an MA patient whose comorbidities are tallied into a RAF score for HCCs. He does not subscribe to Part D (prescription coverage).

| RISK/PAYMENT FACTOR | HCC | RAF |
|---|---|---|
| 66-year-old male | (community, nondual, aged) | 0.300 |
| Congestive heart failure (CHF) | 85 | 0.323 |
| Prostate cancer | 12 | 0.146 |
| Diabetes mellitus (DM), complicated | 18 | 0.318 |
| Peripheral vascular disease | 108 | 0.298 |
| Below-knee amputation | 189 | 0.588 |
| Morbid obesity | 22 | 0.273 |
| Interaction CHF & DM | NA | 0.154 |
| **Total RAF** | | **2.400** |

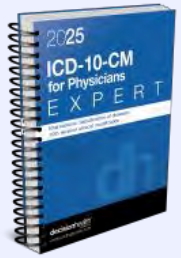
**Nondual**
A term used to describe Medicare beneficiaries who are not enrolled in Medicaid or Medicaid beneficiaries who are not enrolled in Medicare.

If we assume a CMS capitated rate for McNally's locality of $800 per month, the MAO would receive a payment of $9,600 per year for an enrollee without risk diagnoses. Multiply the capitated rate ($9,600) by 2.400 (McNally's RAF) to determine the CMS payment to the MAO to cover McNally's care. The total is $23,040 annually. RxHCCs would be calculated separately and added to payment, if the patient subscribed to Part D.

A patient with McNally's comorbidities would be at higher risk for resource-intensive care, including hospitalization. The MAO would pay for such care.

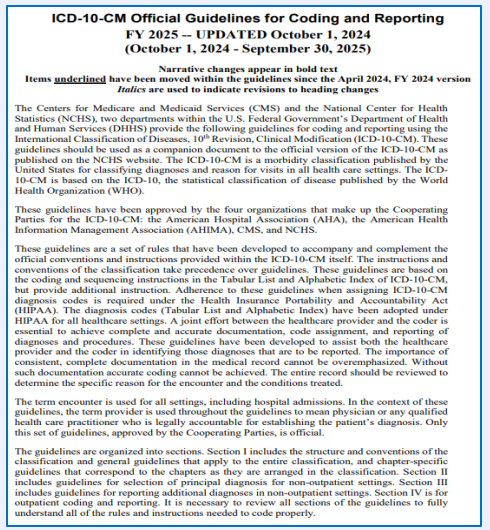

**SOURCE:** AMA Risk Adjustment Documentation and Coding by Sheri Poe Bernard (Second Edition 2020)

# 2025 ICD-10-CM Official Guidelines for Coding and Reporting




**Section I: A. Conventions of ICD-10**

- Alphabetic Indexing and Tabular Listings
- Format and Structure
- Use of Codes for Reporting Purposes
- Placeholder Character
- 7th Digit Characters
- Abbreviations (Index and Tabular)
- Punctuation
- Use of "And", "With", "See Also", "Code Also"
- "Unspecified" Codes, "Includes" and "Excludes"
- Etiology/Manifestation Conventions (e.g., *"code first", "use additional code", "in diseases classified elsewhere"*)
- Default codes and Syndromes



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**Items underlined have been moved within the guidelines since the April 2024, FY 2024 version**
***Italics* are used to indicate revisions to heading changes**

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These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.

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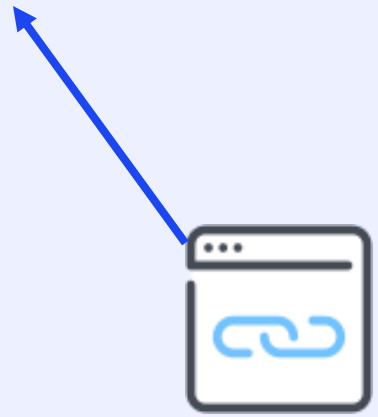

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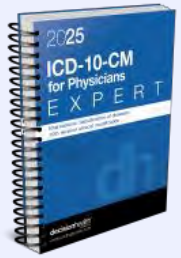
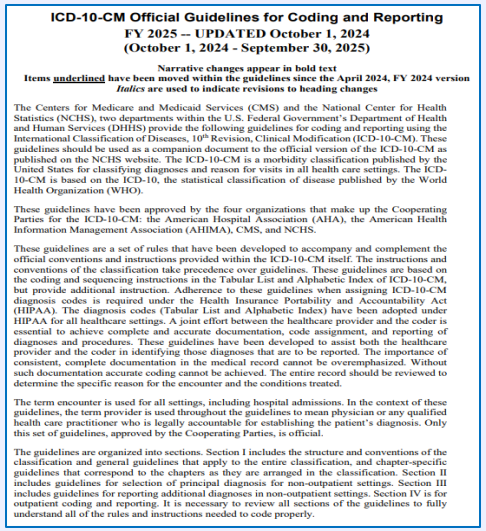



## Section I: B. General Coding Guidelines

- Locating ICD-10 codes, levels of detail in coding
- Codes A00.0-T88.9, Z00-Z99.8
- Signs and Symptoms
- Conditions that are integral part of disease process
- Conditions that are not integral part of disease process
- Multiple coding for a single condition
- Acute and Chronic conditions
- Combination codes
- Late effects (sequela)
- Impending or threatened conditions
- Reporting same diagnostic code more than once
- Laterality
- Documentation for BMI and Pressure Ulcer stages



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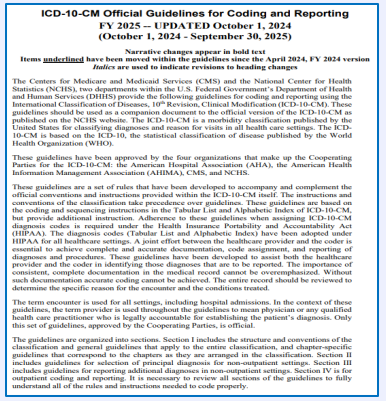
# 2025 ICD-10-CM Official Guidelines for Coding and Reporting


## Section I: C. Chapter Specific Coding Guidelines



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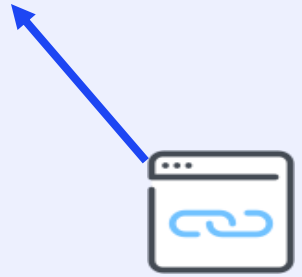

- Chapter 1: Infectious and Parasitic Disease (A00-B99)
- Chapter 2: Neoplasms (C00-D49)
- Chapter 3: Diseases of Blood and Blood Forming Organs (D50-D89)
- Chapter 4: Endocrine, Nutritional and Metabolic Diseases (E00-E89)
  - Diabetes is in this Section (E08-E13)
- Chapter 5: Mental and Behavioral Disorders (F01-F99)
- Chapter 6: Diseases of the Nervous System and Sense Organs (G00-G99)
- Chapter 7: Diseases of the Eye and Adnexa (H00-H59)
- Chapter 8: Diseases of the Ear and Mastoid Process (H60-H95)
- Chapter 9: Disease of the Circulatory System (I00-I99)
- Chapter 10: Diseases of the Respiratory System (J00-J99)
- Chapter 11: Diseases of the Digestive System (K00-K94)
- Chapter 12: Diseases of Skin and Subcutaneous Tissue (L00-L99)
- Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)

# 2025 ICD-10-CM Official Guidelines for Coding and Reporting

## Section I: C. Chapter Specific Coding Guidelines (cont'd)

Chapter 14: Diseases of the Genitourinary System (N00-N99)

Chapter 15: Pregnancy, Childbirth, Pueperium (O00-O9A) OB, Delivery and Postpartum Services

Chapter 16: Newborn (Perinatal) Guidelines (P00-P96) Newborn services and reporting stillborns

Chapter 17: Congenital Malformations, Deformations, and Chromosomal Abnormalities (Q00-Q99)

Chapter 18: Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00-R99)

Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00-T88)

Chapter 20: External Causes of Morbidity (V01-Y99)

**Chapter 21: Factors Influencing Health Status and Contact With Health Services (Z00-Z99)**

Chapter 22:  Codes for Special Purposes


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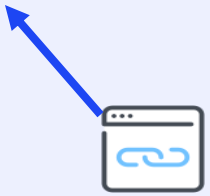


# Use “MEAT” to help when deciding which of the patient’s conditions from a master problem list should be reported on a claim

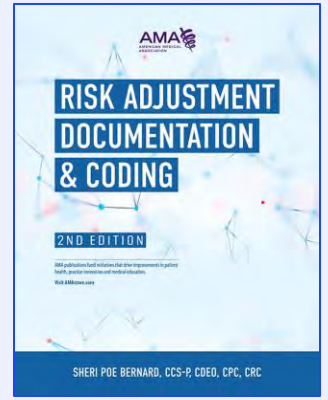
**TABLE 3.1** Examples of Support as Described by MEAT

| MEAT ELEMENT | PROBLEM | SUPPORT |
|---|---|---|
| Measured, monitored | Morbid obesity | George is still unwilling to consider bariatric surgery, even though it would help his knees considerably |
| | Diabetes mellitus | A1C today is 6.7 |
| Evaluated | CHF | +3 LE edema |
| | Pneumonia | Film shows R lung is clearing |
| Assessed, addressed | HTN | Blood pressure is controlled |
| | Moderate reactive asthma | Continue low sodium diet |
| | | Breathing improved with weather change |
| Treated | Assessment: Hypothyroidism | New Rx for levothyroxine 125 mcg daily |
| | New diagnosis of Stage 3 CKD | Referred to nephrology clinic |

Abbreviations: CHF indicates congestive heart failure; CKD = chronic kidney disease; HTN = hypertension; LE = lower extremity; and Rx = prescription.



AMA



# Review Z-code categories and align clinical staff and coding/billing staff

- Z55 Problems related to education and literacy
- Z56 Problems related to employment and unemployment
- Z57 Occupational exposure to risk factors
- Z58 Problems related to physical environment
- Z59 Problems related to housing and economic circumstances
- Z60 Problems related to social environment
- Z62 Problems related to upbringing
- Z63 Other problems related to primary support group, including family circumstances
- Z64 Problems related to certain psychosocial circumstances
- Z65 Problems related to other psychosocial circumstances

# Social Determinants of Health (SDoH) should never be the primary diagnosis

- Those were only the main categories of codes – each section on the previous slide contains anywhere from 6-12 specific codes that may be needed for state/federal grant projects, limited Medicaid coverage restrictions, or any other administrative reason to identify how a patient's social factors can influence their overall health.

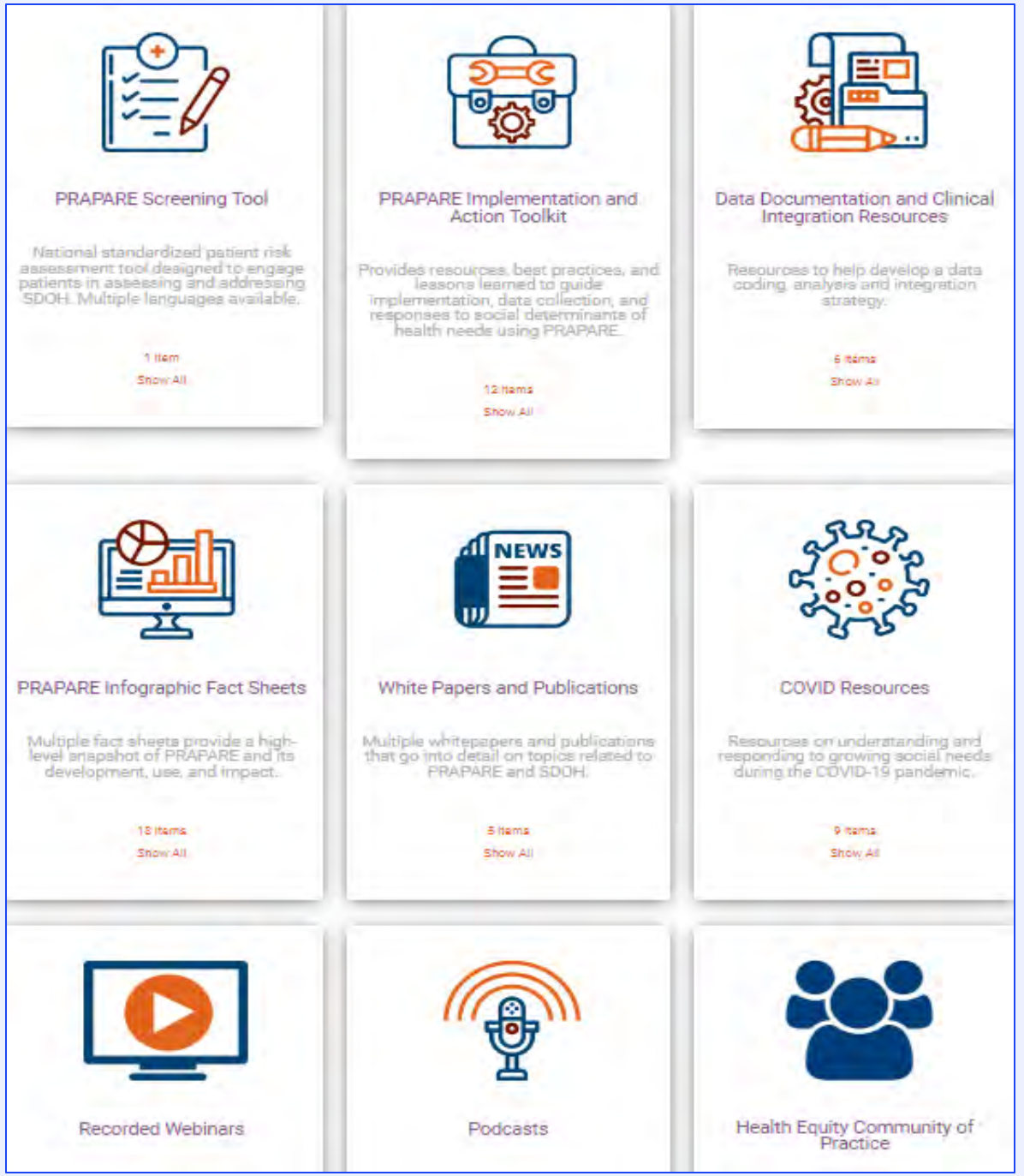
- Consider SDoH's possible ***impact on documentation of Medical Decision Making*** and E/M coding. How often do they need to be reviewed and documented in order to make it on a claim form?

- When gathering/using SDOH information you need to use a structured tool. Consider ***research on the "PRAPARE" tool*** for a ton of valuable SDoH information from national leaders including webinars, templates, and additional resources to capture key data by clinical staff for inclusion on claims at: https://prapare.org/

# Research the PRAPARE tool for excellent information and patient tools for SDOH and their *"social drivers of health"*

PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences



# Social Determinants of Health (SDOH) Assessments by medical and behavioral health

"SDOH risk assessment refers to the ***review of*** the individual's SDOH or identified ***social risk factors that influence the diagnosis and treatment*** of medical conditions and recognizes the time and resources spent by practitioners when assessing SDOH."

**Source: 2024 Physician Fee Schedule Final Rule Released – APA Services, Inc.**

Use **G0136** to report the administration of a standardized, evidence-based risk assessment, 5 to 15 minutes, ***not more often than every 6 months.***

CMS has indicated that this service ***may be reported as an optional element in Initial/Subsequent Annual Wellness Visits*** (AWV) like Advanced Care Planning and ***is also on the updated CMS approved telehealth list*** and may need modifier -33 to eliminate patient coinsurance.


**To see how to integrate the SDOH assessment into the AWV visits, check out this CMS MLN Matters.**

# CODING PROCEDURES DONE IN YOUR RHC/FQHC


- This section will focus on how to properly turn completed clinical provider documentation into the proper CPT codes from the Surgery section of the ***CPT page 80 of the AMA Professional Edition*** which covers guidelines for all codes that begin with a #1-6 as well as several procedural codes found in the Medicine section.

- It is vital to look at this section from a ***"pure coding"*** perspective rather than billing as different insurance companies pay using different definitions of the "global surgical package."

- This section will not discuss how different carriers want services billed, on which claim forms, and how often. ***Review the Billing section for details on likely varying Medicare and commercial payer reimbursement issues***, such as whether an E/M visit is included and how much, if any, post-procedure time is being paid or can be billed separately and the proper application of CPT and HCPCS-II modifiers.

# Sample Self-Study Items on CPT Surgery Coding
## Integumentary System

### Excision of benign or malignant lesions

Do we also code 96372/J-code for local anesthesia?

How do we measure?

Group or code separately?

Also includes/excludes what other CPT codes?

What can be coded in addition to the excision?

### Paring or cutting of lesions + trimming, debridement, and avulsions of nails

These codes often get rejected for payment for being "medically necessary" – consider modifiers ***–Q7, Q8, or Q9*** to use to show when the patient has other conditions that could generate coverage.

### Skin repairs (Closures)

When should this be included in an E/M?

What are the 3 types?

What about code G0168?

When to use modifier -59?

Group or code separately?

When do we add the lengths of various skin repairs?

### Destruction of lesions

Difference between each code sections from 17000-17286?

Does your EHR include enough detail to correctly code the number units provided?

# Sample Self-Study Items on CPT Surgery Coding
# Musculoskeletal System

## Introduction or Removal section

Difference between code **20526** "injection, therapeutic (ex. local anesthetic, corticosteroid), carpal tunnel and code **96372** "therapeutic, prophylactic, or diagnostic injection…subcutaneous or intramuscular"?

What else would be coded when using either code?

## Trigger point and joint injections

Do we code on the number of muscles, injections, or number of trigger points?

Does your EHR give providers an option to **identify the correct number of units**?

Where are spinal injection codes found?

## Fractures and/or dislocations

What is included as far as pre- and/or post-procedure coding and when will it differ by payer?

Need to use CPT modifiers -54, -55, and/or -56?

When to use the **"Application of Casts or Strapping"** codes 29000-29584 vs. **"Removal or Repair"** codes 29700-29750?

## Biopsies

When should you use the codes from the integumentary section (11102-11106) versus the biopsy codes found in the musculoskeletal section?

Does your EHR include enough detail to **correctly code the number units provided**?

# Sample Self-Study Items on CPT Surgery Coding
## Other surgical code chapters

### Respiratory System

Use the CPT notes found below the definition of code 30110 for "Excision, nasal polyps, simple" to cross-reference with your EHR and coding software to see if you have access to the same valuable coding information!

What **valuable coding information** is found before the codes 31233-31298?

### Cardiovascular System

Which venous access codes 36400-36416 are performed and how does the billing department **determine if they are covered** in addition to the main procedure performed?

### Digestive System

Which procedures are **performed in your office versus performed at an outside location** such as a surgery center or hospital?

How does that change coding and billing processes?

### Urinary System

When performing urodynamics studies, **when is modifier -51 needed**, who adds it, and how could it change payments from various insurers?

# Sample Self-Study Items on CPT Coding
# Radiology, Path and Lab, Medicine chapters

## Radiology

What is the proper application of **modifier –TC and -26** and how will billing differ when performed in your clinic or health center when billing Medicare compared to traditional commercial insurers via **"split billing"?**

Can Medicare's RBRVS help with coding technical and professional components?

## Pathology and Lab Services

When would **modifiers –QW, -90, -91, and -92** be needed?

Additional info at CMS Ch. 13 section 60.1 as well as this **December 2023 CMS Fact Sheet on Clinical Lab Fee Schedule**

## Medicine Section – Vaccines and Administrations

Which two main types of vaccine codes are likely required, and **what makes them different from each other**?

How does coding/billing change if I purchase the vaccines vs. getting them for free from the manufacturer or the CDC's Vaccines for Children program?

## Medicine Section – Cardiography/EKGs

When reviewing codes 93000-93042 what changes the coding and **when will modifiers –TC and/or -26 be necessary**?

How do we work with our billing department if someone else **only performs the test itself or only does the professional interpretation**?

# Sample Self-Study on CPT Coding Medicine chapter
# Psychiatry section

### Interactive Complexity

What is an add-on code?

What other codes can this code be added to?

What needs to be in the medical record to support the coding of +90785?

### Psychiatric Diagnostic Evaluations

What is the difference between the 2 main codes and which types of providers can perform which?

What else is included in this assessment per the notes before the codes?

What if done on somebody other than the patient?

### Psychotherapy

Which provider types can code 90832, 90834, and 90837 **versus** codes +90833, +90836, and +90838?

What if the patient gets an **"urgent assessment and history of crisis state, a mental status exam, and a disposition"?**

What if the time units aren't met exactly?

### Assorted Psychiatric Codes

Check out codes for family/group therapy and expect carrier variations in payment.

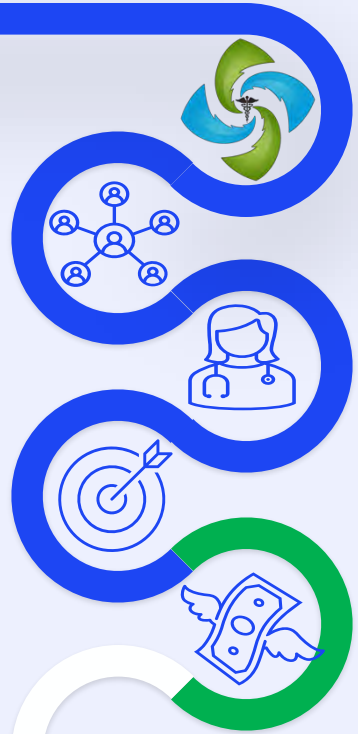
Review codes +90863 for pharmacological management and 90885-90989 for assorted review of medical records to provide advice or recommendations.

# PROPER BILLING & VALIDATE PAYMENTS

**Just because you get paid does not mean you get to keep the money. Just because you got denied does not mean that you did anything wrong. We are required to charge the same for each service, but we will not bill the same based on carrier variations.**

# Section Topics

1. Type of bill codes, revenue codes, place of service codes, RHC/FQHC “split billing” for diagnostic tests, and billing non-RHC/FQHC services.
2. Telehealth vs. Virtual Communication Services
3. General Care Management & Psych CoCM RHC/FQHC billing
4. FQHC billing G-codes required for Medicare PPS payments and the CMS FQHC Qualifying Visit List
5. Billing minor/major procedures using varying definitions of the Global Surgical Package
6. CPT/HCPCS-II modifiers' role in successful claims recovery



## Proper Billing and Validate Payment

# Sample Differences between RHC/FQHC Medicare billing

**Remember that most non-Medicare plans** see you the same way they do regular provider offices and billing issues may not mirror CMS' RHC/FQHC for AIR or PPS rates via "valid encounters."

**Medicare/Medicaid managed care organizations may see you as a RHC/FQHC or a regular provider office** but that does not directly tell you if they are going to pay you FFS or via AIR/PPS rates. Even if they pay AIR/PPS rates, the billing rules may differ in terms of authorized providers, covered services, frequency requirements, and much more.

Deductible/coinsurance is calculated very differently in a RHC vs. FQHC.

FQHCs must use one of their 5 billing G-codes followed by a code on the qualifying visit list (QVL) for PPS visits. RHCs have no QVL.

RHCs are required to use modifier –CG (*at least on the first line item*) on all eligible AIR expected payment claims.

Medicare should add a 34.16 % increase in the PPS rate for new patient visits, IPPE, and AWVs in FQHC, but not RHCs.

IPPE & an approved medical/mental health visit qualifies for AIR 2/3 encounter rate payments in a RHC, but not in a FQHC.

Eligible authorized providers are slightly different in FQHCs, for example, nutritionists and dieticians reporting DSMT and MNT.

# Medicare may pay via "*special payment rules*" in addition to AIR/PPS payments

- ***Lab services are paid on the lab fee schedule*** and aren't on the AIR/PPS claim, rather they are likely billed on a CMS1500/837p.
- ***Hospital services and surgeries*** performed outside of your RHC/FQHC are ***paid via fee-for-service (FFS) based on RBRVS and the Medicare Physician Fee Schedule*** just like other Part B providers.
- If you choose to report Care Management codes G0511/G0512 until 6-30-25, they are ***paid at 80/20% of the average Medicare pays FFS*** for all the codes that are bundled into them (ex. Principal/chronic care, chronic pain management, RPM, RTM, CHI, PIN, BHI, and Psych CoCM).
  - **New 2025 rate for G0511 = $54.67** down from $71.69 in 2024
  - **New 2025 rate for G0512 = $139.41** down from $144.07 in 2024
- Originating site telehealth using Q3014 is ***paid via a new 2025 flat fee ~$31***
- As of 2025, Intensive Outpatient services ***(IOP=9-19 hours per week of approved mental health services)*** will pay a RHC/FQHC for ***3 approved services at $269.19 per day or for 4 at $408.55***.
- Distant site ***medical*** telehealth using G2025 (until 9-30-25 updates) is ***paid via at the new 2025 rate of $96.87*****.**
- Some ***preventive vaccines get "paid" via your cost report*** (*e.g. COVID, influenza, HepB, pneumo*) and/or via periodic "roster billing" until ***July 1, 2025, when they begin getting paid at 95% AWP at the time of service***.

# Sample RHC TOB
## UB options

710 – Claim for Denial/Non-payment/zero claim

711 – Original RHC Claim

717 – Adjustment Claim

718 – Cancelled Claim

Be sure to view your MAC's website for the full list and/or their definitions and guidance.

# Sample FQHC TOB
## UB options

519 – Supplemental FQHC Payments on Medicare Advantage Claims Only (*See CMS Ch. 9 Section 60.4*)

771 – Original FQHC Claim

777 – Adjustment Claim

778 – Cancelled Claim

770 – Non-payment/zero claim

77Q – Reopened Claim

# Sample Revenue Codes for the CMS1450/837i

A revenue code needs to be applied to each line item(s) on claims submitted on the "UB" claim form. It is vital that they match in terms of the type of service or where it was provided. Check with your EHR/IT/Billing system to see if these are automatically added or must be added by billing staff using your MAC's guidance.

| | |
|---|---|
| 0521 | • Clinic visit by beneficiary to the RHC/FQHC |
| 0522 | • Home visit by the RHC/FQHC practitioner |
| 0524 | • Visit by RHC/FQHC practitioner to beneficiary in covered Part A stay at a Skilled Nursing Facility (SNF) |
| 0525 | • Visit by RHC/FQHC practitioner to beneficiary in a SNF (not covered Part A), NF, ICF/MR or other residential facility |
| 0527 | • RHC/FQHC Visiting Nurse Service to a member's home when in a home health shortage area |
| 0528 | • Visit by RHC/FQHC practitioner to other non-RHC/FQHC site |
| 0519 | • Visit by a beneficiary in a Medicare Advantage Plan |
| 0300 | • Visit for general labs |
| 0636 | • Drugs requiring detailed coding |
| 0780 | • Visits held through telephone - Telehealth visits |
| 0900 | • Behavioral Health Treatment Services |

**Check out 2 sample websites for further details**

[Noridian MAC]

+

[National Uniform Billing Committee]

# Split billing for diagnostic tests (ex. EKG, ultrasound, x-ray) to "Medicare only"

- ***When you perform a diagnostic test*** that can be split between a technical (*i.e., who owns the equipment*) and professional component (*i.e., who documents the final interpretation and report*) in addition to a face-to-face visit – ***you may only include the professional component on the CMS1450/837i Medicare claim*** and it will be included in your AIR/PPS payments.

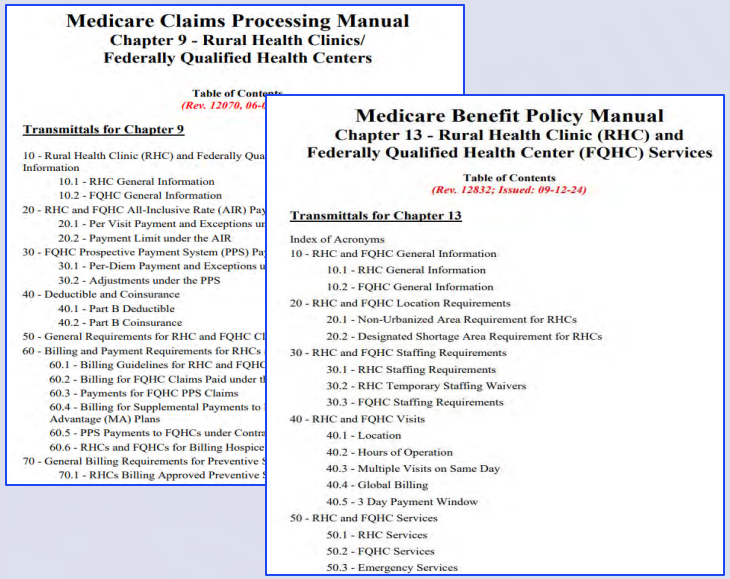
- Most codes can ***split the service between its technical/professional component using modifier –TC/-26*** whereas ***EKGs will never carry those modifiers*** as the code ranges 93000-93010 has individual codes to report either the entire service, "tracing only" (i.e. technical component 93005), or an interpretation and report only (93010) if it is necessary to split the service up to.

- Therefore, whoever owns the equipment should ***separately report the technical component*** on the appropriate claim form ***(i.e. CMS1500 for independent RHC and FQHC)*** to get reimbursed FFS separately for the technical component.
  - ***Provider-based RHCs may bill on either form*** depending on how the RHC owners normally bill such services if performed at their outpatient location. That could be on an 837i or 837p claim form and may be paid "at cost" or other existing billing methodology.

# Billing for non-RHC/FQHC Services

**"Certain services are not considered RHC or FQHC services because they 1- are not included in the RHC or FQHC benefit, or 2- are not a Medicare benefit."**

***See Ch. 9 Section 90 and Ch. 13 Section 60***



**Medicare Claims Processing Manual**
**Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers**

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*(Rev. 12070, 06-0*

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

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*(Rev. 12832; Issued: 09-12-24)*

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30 - RHC and FQHC Staffing Requirements
30.1 - RHC Staffing Requirements
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40.3 - Multiple Visits on Same Day
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50 - RHC and FQHC Services
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50.2 - FQHC Services
50.3 - Emergency Services

- Medicare excluded services
- Technical components of diagnostic tests
- Laboratory Services
- Hospital Professional Services (E/M and procedures)
- Durable Medical Equipment
- Ambulance/Prosthetics/Body Braces
- Group Services/Therapy/Training

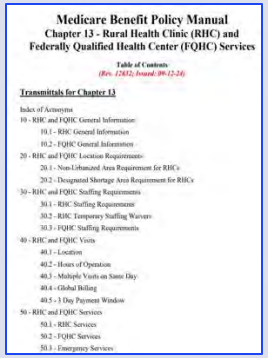
**To access a more comprehensive CMS document, check out Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services by clicking here.**

# Billing for non-RHC/FQHC Services
# Commingling

**Commingling refers to the sharing of RHC or FQHC space, staff…and is prohibited to prevent…**

- ***Duplicate*** Medicare or Medicaid ***reimbursement***
- Selectively ***choosing a higher or lower reimbursement rate*** for the services
- RHC and FQHC practitioners ***may not furnish or separately bill*** for RHC or FQHC-covered professional services ***as a Part B FFS provider*** in the RHC or FQHC…***during RHC or FQHC hours of operation***
- If an RHC or FQHC practitioner ***furnishes an RHC or FQHC service during office hours***, the service must be billed as a RHC or FQHC service. The ***service cannot be*** carved out of the cost report and ***billed to Part B***.

***See Ch. 13 Section 100 - Commingling*** →



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50.1 - RHC Services
50.2 - FQHC Services
50.3 - Emergency Services

# Telehealth vs.
# Virtual Communication Services (VCS)

***Telehealth services are usually pre-scheduled*** and can be audio only under certain circumstances, such as many mental health visits.

1. Telehealth visits may not be pre-scheduled if a VCS service transitions to a full and immediate telehealth visit - in which case the VCS is not billed.

***VCS are usually patient-initiated*** where patients are reaching out to see if they need to come in for an immediate visit or can they be taken care of virtually as long as they are unrelated to a visit in the last 7 days and does not result in an immediate appointment.

1. ***Virtual check-in*** services via technology-based interactive services ***OR***
2. ***Remote assessment of recorded video and/or images*** not originating from a visit in the last 7 days.

# 2025 RHC/FQHC Medicare Billing Thoughts for 2025

## Until 9-30-25 pending future updates

### Medicare Billing 2025 Updates

On March 15, 2025, Congress ***extended the COVID-era Medicare telehealth flexibilities until 9-30-25*** that expanded the geographic requirements and eligible practitioners for RHC/FQHC services that were due to expire 3-31-25.

Expect upcoming clarifications in the new 2025 Congress and CMS educational materials.

### RHC/FQHC Medical Telehealth

Report code **G2025** ***for all non-mental health telehealth services*** if on the most recent CMS-approved list to get paid via special payment rule ***flat fee ~$96 split 80/20***.

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### RHC/FQHC Mental/Behavioral Telehealth

List the ***CPT/HCPCS-II codes performed and add a modifier*** (ex. -93/-95) identifying audio-only or audio/video, etc. generating your AIR/PPS rate and applicable coinsurance.

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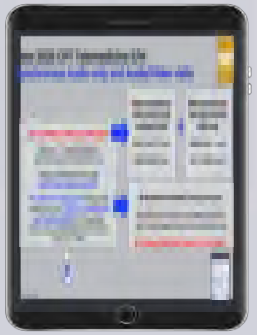
### Brief *patient initiated* "virtual check-in"

Expect to continue using the ***RHC/FQHC-specific code G0071***.



# Which RHC/FQHC telehealth services are covered by Medicare in 2025?

- Expect payer variations in which services can be reimbursed using telehealth using this CMS link
- Use ***Q3014*** with revenue code 0780 ***(flat fee of $31.01 for originating site facility fee)*** if other providers elsewhere are doing telehealth but you are ***using YOUR office's exam room*** and audio/video resources and maybe a nurse.

# Non-Medicare payers may have different ways to for you to bill telehealth compared to Medicare

- Other non-Medicare telehealth options include the set of ***new 2025 CPT E/M telehealth codes 98000-98016*** that will likely get assigned FFS payment rates that could differ by payer.

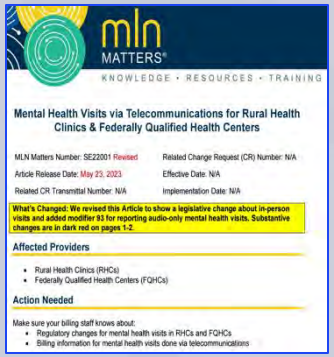
- Some carriers ***may instead pay*** you the same for ***telehealth as if performed in person*** (ex. 99213 or 90832). Billing rules could ask you to ***add a modifier -93/-95*** (*or other*) to the service to indicate that the service was ***done via audio/video or audio-only***.

- Other commercial non-Medicare coding options include telephone assessments performed ***by non-physician Qualified Healthcare Professionals using codes 99866-98968***.

- ***Medicaid payers may want code T1014*** to be reported by the number of minutes the service(s) lasted in the units claim box.

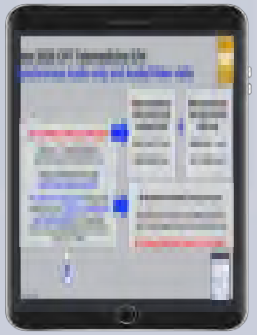
# CMS resources for RHC/FQHC Telehealth


mln MATTERS®
KNOWLEDGE • RESOURCES • TRAINING
New & Expanded Flexibilities for Rural Health Clinics & Federally Qualified Health Centers
MLN Matters Number: SE20016 Revised | Related Change Request (CR) Number: N/A
Article Release Date: May 12, 2023 | Effective Date: N/A
Related CR Transmittal Number: N/A | Implementation Date: N/A
What's Changed: We updated this Article to show the impact of the end of the COVID-19 public health emergency (PHE). You'll find substantive content updates in dark red on pages 1-4.
Affected Providers
Rural Health Clinics (RHCs)
Federally Qualified Health Centers (FQHCs)
What You Need To Know
To provide as much support as possible to you and your patients during the COVID-19 PHE, both Congress and CMS made several changes to RHC and FQHC requirements and payments. The COVID-19 PHE ended on May 11, 2023. View Infectious diseases for a list of waivers and flexibilities that were in place during the PHE.
Also, view the latest COVID-19 information for RHCs and FQHCs.


mln MATTERS®
KNOWLEDGE • RESOURCES • TRAINING
Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers
MLN Matters Number: SE22001 Revised | Related Change Request (CR) Number: N/A
Article Release Date: May 23, 2023 | Effective Date: N/A
Related CR Transmittal Number: N/A | Implementation Date: N/A
What's Changed: We revised this Article to show a legislative change about in-person visits and added modifier 93 for reporting audio-only mental health visits. Substantive changes are in dark red on pages 1-2.
Affected Providers
Rural Health Clinics (RHCs)
Federally Qualified Health Centers (FQHCs)
Action Needed
Make sure your billing staff knows about:
Regulatory changes for mental health visits in RHCs and FQHCs
Billing information for mental health visits done via telecommunications


mln FACT SHEET
KNOWLEDGE • RESOURCES • TRAINING
Telehealth Services
What's Changed?
Substantive content changes are in dark red.
Page 1 of 6 MLN901705 February 2024
CMS

- Get the **CMS Med Learn Matters #SE20016** for ***RHC/FQHC-specific telehealth info*** (*last updated May 2023*) for updates, revenue codes, modifiers, and other great billing info.
- For updates on reporting ***mental health telehealth in RHC/FQHC*** please this **Med Learn Matters SE#22001** document *(updated May 2023)*
- For the general **CMS Telehealth Fact Sheet** which ***is not focused on RHC/FQHC*** check out this document *(last update January 2025).*



# For Medicare, G0511 can continue to be used 1 or more times for general care management but must end 6-30-25

**NOTE that term "*general care management*" is used in the definition of G0511 rather than naming each of the 20+ options.**

Transitional Care Management and the Psychiatric Collaborative Care Model are NOT included though they are in the CPT Care Management section.

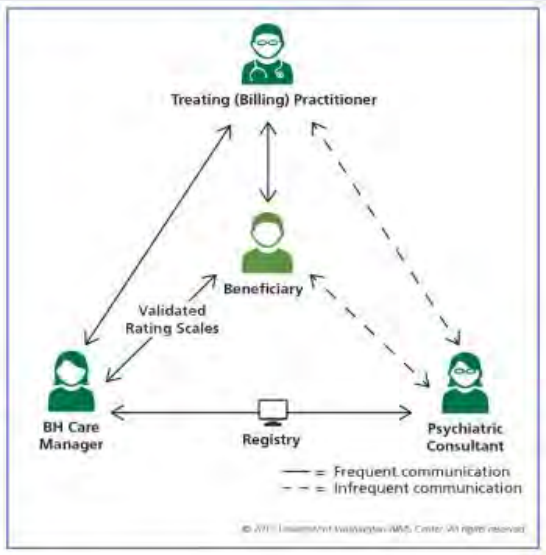
**G0511** = Rural Health Clinic or Federally Qualified Health Center only, ***general care management services 20 minutes*** or more of clinical staff time for chronic care management services directed by RHC or FQHC practitioner (MD, NP, PA, or CNM), per calendar month.

- "**General care management" =** principal/chronic care management, monthly chronic pain management, assorted remote monitoring services, community health integration, principal illness navigation, various time-based add-on codes, OR behavioral health integration.
- Payment is made via a special payment rate rather than the PPS rate at the average of what CMS pays FFS providers for all general care management services until 6-30-25 until July 1, 2025 at **~$54.67.**

Click here for CMS' individual FFS 2025 rates for care management services.

# You may use either code G0512 or 99492-99494 from January until the end of June 2025 to Medicare

**The code G0512 will also be deleted effective July 1, 2025**




**G0512** = Rural Health Clinic or Federally Qualified Health Center only, ***Psychiatric Collaborative Care Model, 60 minutes or more of clinical staff time*** for psychiatric CoCM services directed by a RHC/FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month.

- In 2024 it pays $144.07 (*down from 2023's $146.73*) split 80/20% between Medicare and the patient.

# You may use either code G0511/2 or the actual CPT/HCPCS-II codes from now until the end of June 2025 to Medicare

- ***If you already bill*** commercial and/or Medicaid carriers for Care Management services ***using the CPT/HCPCS-II codes*** – it seems as though that would be a logical option on January 1, 2025.

- This would allow you to **also report the *"…additional (XX) minutes"*** codes to be paid and patients know what they are being charged for.
  - Be very careful to charge the patient's coinsurance correctly based on your choice!

- The reimbursement from Medicare if using the actual CPT/HCPCS-II code(s) will be ***paid at the non-facility physician fee schedule*** (i.e. fee-for-service) for each code range via a special payment rate ***rather*** than the AIR/PPS rate.

**Or consider the OPTION to use the new 2025 Advanced Primary Care Management (APCM) Services**

# Advanced Primary Care Management (APCM)
## Monthly Service Options

### 2025 NEW APCM codes

**Per CMS – "…*incorporates elements of several*** existing care management and communication technology-based services ***into a bundle*** that reflects the essential elements of the delivery of ***advanced primary care*** including principal care management, transitional care management, and chronic care management."

Conditions must significantly increase risk of death, acute exacerbation/decompensation, or functional decline.

**G0556 ~$15**

Persons with one chronic condition.

**G0557 ~$50**

Persons with two or more chronic conditions.

**G0558 ~$110**

Persons with two chronic conditions **AND** a status as a dual eligible Medicare and Medicaid patient.

# FQHC/Community Health
# Qualifying Visit List (QVL) Sample

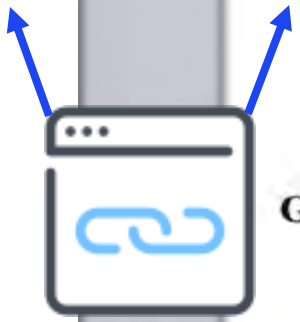
**Qualifying Visits**
The qualifying visits that correspond to the specific payment codes are as follows:

**G0466 - FQHC visit, new patient**

| HCPCS | Qualifying Visits for G0466 | Effective Date |
|---|---|---|
| 92002 | Eye exam new patient | |
| 92004 | Eye exam new patient | |
| 97802 | Medical nutrition indiv in | |
| ~~99201~~ | ~~Office/outpatient visit new~~ | |
| 99202 | Office/outpatient visit new | |
| 99203 | Office/outpatient visit new | |
| 99204 | Office/outpatient visit new | |
| 99205 | Office/outpatient visit new | |
| 99304 | Nursing facility care init | October 1, 2016 |
| 99305 | Nursing facility care init | October 1, 2016 |
| 99306 | Nursing facility care init | October 1, 2016 |
| 99324 | Domicil/r-home visit new pat | |
| 99325 | Domicil/r-home visit new pat | |
| 99326 | Domicil/r-home visit new pat | |
| 99327 | Domicil/r-home visit new pat | |
| 99328 | Domicil/r-home visit new pat | |
| 99341 | Home visit new patient | |
| 99342 | Home visit new patient | |
| 99343 | Home visit new patient | |
| 99344 | Home visit new patient | |
| 99345 | Home visit new patient | |
| 99406[2] | Behav chng smoking 3-10 min | October 1, 2016 |
| 99407[2] | Behav chng smoking > 10 min | October 1, 2016 |

Heads-up, this code was deleted in the 2021 CPT…

See the full list…

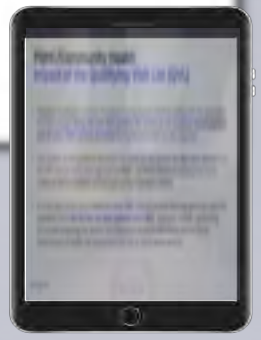


**G0469 – FQHC visit, mental health, new patient:**

| HCPCS | Qualifying Visits for G0469 |
|---|---|
| 90791 | Psych diagnostic evaluation |
| 90792 | Psych diag eval w/med srvcs |
| 90832 | Psytx pt &/family 30 minutes |
| 90834 | Psytx pt &/family 45 minutes |
| 90837 | Psytx pt &/family 60 minutes |
| 90839 | Psytx crisis initial 60 min |
| 90845 | Psychoanalysis |

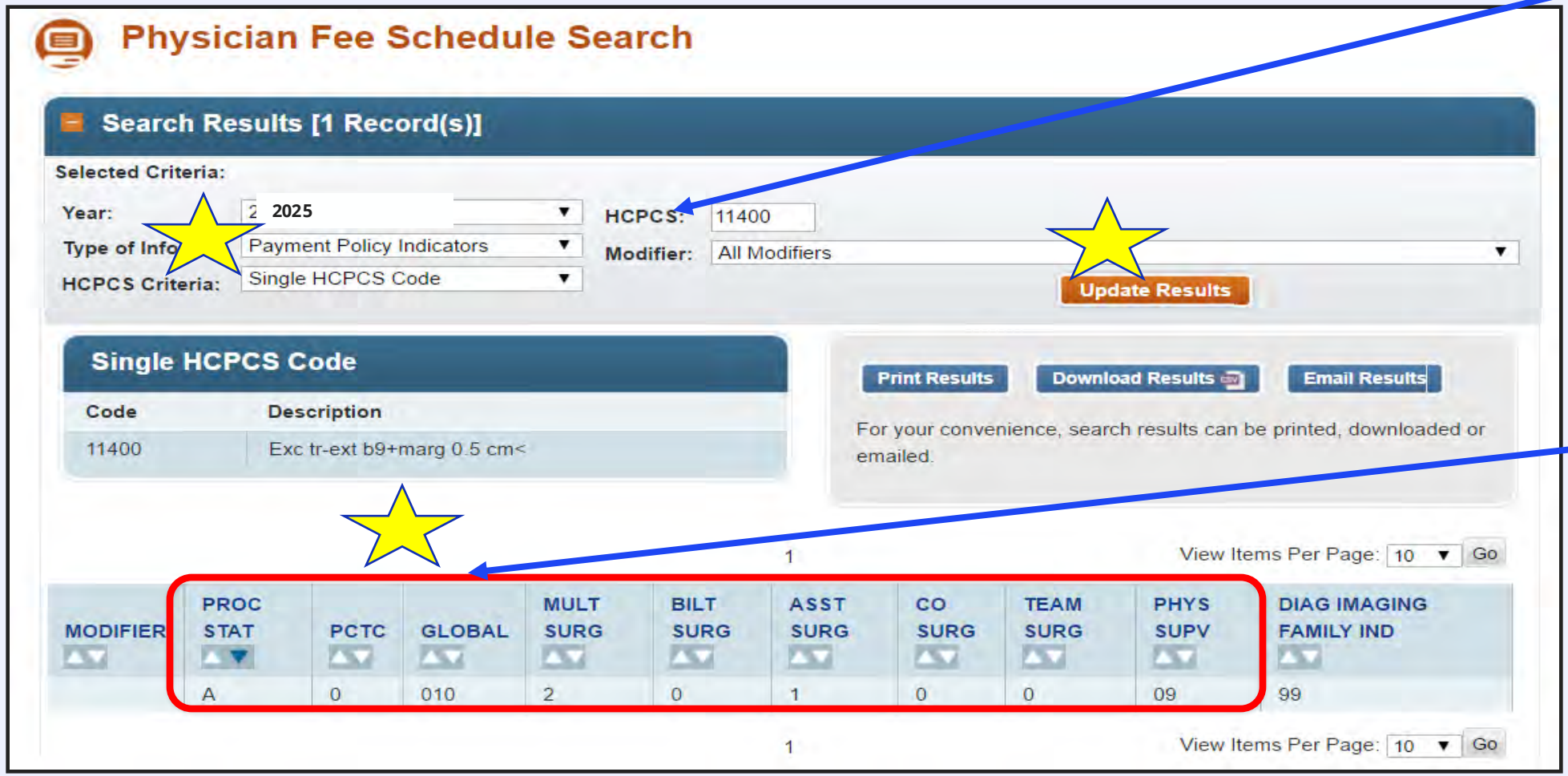
**G0470 – FQHC visit, mental health, established patient:**

| HCPCS | Qualifying Visits for G0470 |
|---|---|
| 90791 | Psych diagnostic evaluation |
| 90792 | Psych diag eval w/med srvcs |
| 90832 | Psytx pt &/family 30 minutes |
| 90834 | Psytx pt &/family 45 minutes |
| 90837 | Psytx pt &/family 60 minutes |
| 90839 | Psytx crisis initial 60 min |
| 90845 | Psychoanalysis |



# Access RBRVS code status, global days, and modifier information

Access the hyperlink, access instructions of how to use the tool, and utilize the info depending on who you are billing and where. You can also access RVU info!




To get the definitions of the "status indicators" for each column – CLICK HERE!

# Medicare global billing rules
# do not apply to RHC/FQHC services


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

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

### 40.4 - Global Billing
**(Rev. 220, Issued: 01-15-16, Effective: 02-01-16, Implementation: 02-01-16)**

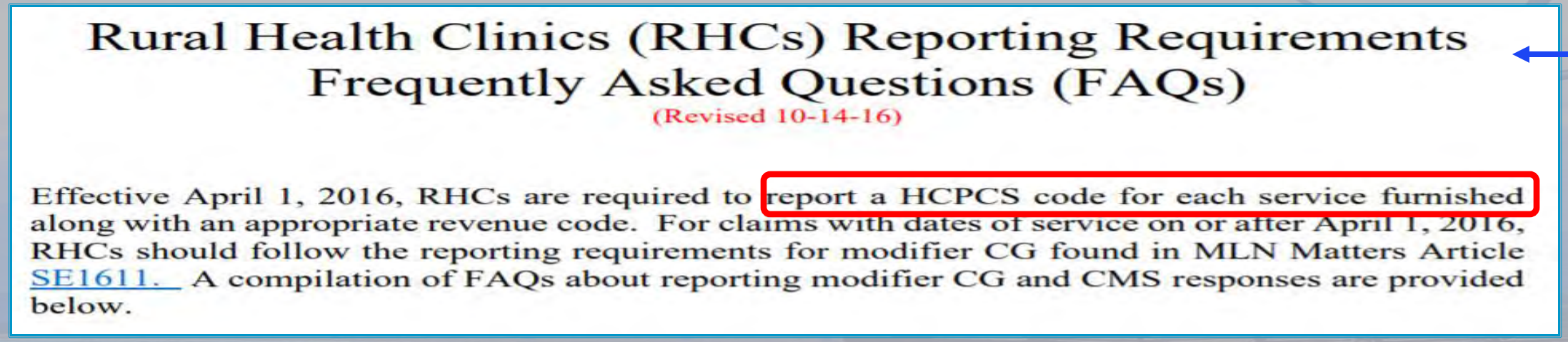
Surgical procedures furnished in a RHC or FQHC by a RHC or FQHC practitioner are considered RHC or FQHC services. Procedures are included in the payment of an otherwise qualified visit and are not separately billable. If a procedure is associated with a qualified visit, the charges for the procedure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

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

**How does this issue impact the possible need for an E/M to require a modifier -25 to get reimbursed for a visit and a procedure in a RHC/FQHC?**

# Rural Heath Clinics
## Procedure-only RHC billing

- Billing for ***procedure-only visits without an E/M code*** is acceptable to receive your AIR payment if the service is covered and considered medically necessary by Medicare in a RHC.
- If ***documenting BOTH an E/M and a procedure*** no modifier -25 is needed on the E/M since the CMS global surgical package does not apply to RHC services per section 40.4 of the CMS RHC Benefit Policy Manual.



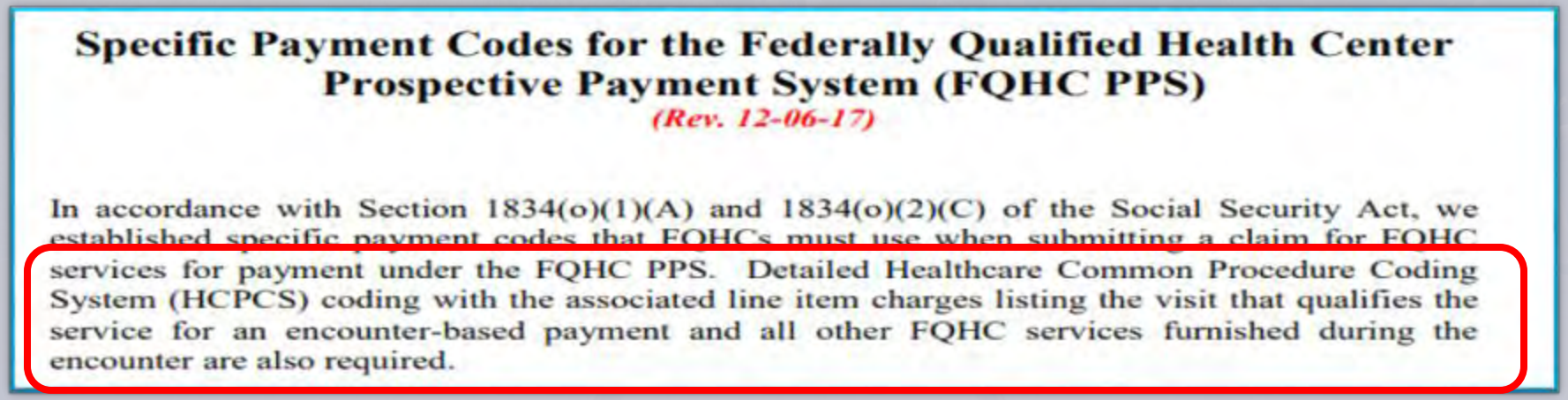
Rural Health Clinics (RHCs) Reporting Requirements
Frequently Asked Questions (FAQs)
(Revised 10-14-16)

Effective April 1, 2016, RHCs are required to report a HCPCS code for each service furnished along with an appropriate revenue code. For claims with dates of service on or after April 1, 2016, RHCs should follow the reporting requirements for modifier CG found in MLN Matters Article SE1611. A compilation of FAQs about reporting modifier CG and CMS responses are provided below.

# FQHC/Community Health
# Procedure-only FQHC visit billing

- Billing ***procedure-only visits*** in a FQHC ***without a medically necessary E/M*** being documented first ***will NOT generate a PPS rate*** since the qualifying visit list are mainly encounter-based (*i.e. E/M*) and do not contain most diagnostic or therapeutic services.

- If reporting an E/M (*or other service on the QVL*) it is listed immediately after the "magic billing codes" G0466-G0470, then list the procedure, and **modifier -25 is NOT needed on the E/M** since the CMS global package rules do not apply per section 40.4 of the CMS RHC Benefit Policy Manual.



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

*(Rev. 12-06-17)*

In accordance with Section 1834(o)(1)(A) and 1834(o)(2)(C) of the Social Security Act, we established specific payment codes that FQHCs must use when submitting a claim for FQHC services for payment under the FQHC PPS. Detailed Healthcare Common Procedure Coding System (HCPCS) coding with the associated line item charges listing the visit that qualifies the service for an encounter-based payment and all other FQHC services furnished during the encounter are also required.

# Major surgeries on Medicare patients OUTSIDE your office by RHC/FQHC provider

**Pre-operative**

**Your provider determines the need for the surgery**

***Report the E/M*** documented if done in the RHC/FQHC (modifiers -25/-57 are not needed)

**Intra-operative**

**Your provider does surgery outside of your RHC/FQHC**

Report the ***procedure code with a modifier -54*** to get FFS payment *that removes the payment for any office-based post-operative care*.

**Post-operative**

**Your provider does RHC/FQHC-based f/u care on a procedure they performed that "typically" adds +10 or +90 days of post-op**

***Report each necessary visit as an E/M*** with a supporting aftercare (Zxx.xx) ICD-10-CM code.

Check out the possibility of needing new 2025 HCPCS-II code G0559

# Major surgeries on Medicare patients OUTSIDE your office by a NON-RHC/FQHC provider

**How do RHC/FQHC get paid for post-op follow-up?**

## Pre-operative

**Outside provider determines need for surgery and performs the procedure**

***When they bill the procedure code, it likely includes their E/M*** *done the day of or the day before* the "major" surgery depending on the number of post-op days found via RBRVS or they may need to use modifier -56 on the surgery.

## Intra-operative

**Outside provider does surgery**

***If the surgeon is planning to have the patient get post-op care from us THEY should add modifier -54*** (*and -56?)* to identify they are doing the surgical case only. This should remove the post-op care from THEIR payment.

## Post-operative

**RHC/FQHC to provide post-op care**

***Report each necessary visit as an E/M*** with a supporting aftercare (Zxx.xx) ICD-10-CM code. If they improperly reported the services without the -54 modifier ***then they have already been paid*** for the follow-up care.

Be sure to ***have a transfer of care plan in place with the surgeon*** and ask how they billed the procedure before billing for post-op care!

# Billing global surgeries on NON-Medicare patients whose payers use a form of the CMS traditional Global Package

**Pre-operative**

**Your provider determines the need for the surgery**

***Only report the E/M*** on the day of if and only if, modifiers -25/-57 apply.

**Intra-operative**

**Your provider does surgery outside of your RHC/FQHC**

If performing ALL services, report the service as is and you should be paid for pre- and post-op services in the payment for the procedure(s) itself!

**Post-operative**

**Your provider does all follow-up care for a procedure that "typically" adds +10 or +90 days of $0 post-op care**

***You have already been paid for post-op care.*** Look to modifiers -24/-79 if performing ***unrelated*** E/M or procedural services for however long the post-op period lasts.

# Billing RHC/FQHC follow-up on NON-Medicare patients whose payers use a form of the CMS traditional Global Package

**Pre-operative**

***Another provider*** **determines the need for the "major" surgery**

If they bill correctly, they will get paid for the pre-op workup.

**Intra-operative**

***Another provider*** **does the "major" surgery**

If they bill correctly with modifier(s) -54 *(maybe adds -56 also)* your post-op reimbursement should still be available.

**Post-operative**

***RHC/FQHC provider*** **does all follow-up care for a procedure that "typically" adds +10 or +90 days of post-op care**

It is likely that you should report the same surgical code(s) as the surgeon and add modifier -55 to get the proper FFS payment for the entire post-op period. It may be a different number of days rather than +10 or +90.

# Global Surgery
## Self-Study & Exercises


mln BOOKLET
KNOWLEDGE • RESOURCES • TRAINING

Global Surgery





CMS Medicare Learning Network

Review the recent updates made to the CMS Global Surgery MLN document but realize it does NOT discuss our unique RHC/FQHC nuances described in the Benefit Policy Manual section 40.4.

This document will help give you guidance for those non-Medicare payers who follow CMS' Global Surgical rules although they could use a different number of days for pre-/post-op care (ex. 15/30/60 days).

# Modifier use will change based on the definition of the surgical package used

**Pre-operative**

**Minor Procedure + related or separately identifiable E/M** modifier **-**25?

**Major Procedure + with a decision for surgery E/M** modifier -57?

**Pre-op only** modifier -56

**Day of the procedure**

**"Please pay this though you normally don't"**
✓ -32, -59, -76/-77, -91

**Changes payment amount:**
✓ -22/-52 (pay me more or less than normal)
✓ -50, -51 (payment reductions for bilateral/multiple procedures on same day)
✓ -53/-73*/-74*(incomplete services)
✓ -62, -66, -80, -81, -82 (surgical teams)

**Surgical care only**
✓ modifier -54

**Post-operative**

**Unrelated E/M** modifier -24?

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

**Post-op only** modifier -55

# Grab your CPT and HCPCS-II manuals and review the definitions of these, and locate the answers

- Do you have to have different diagnoses when using -25 on an E/M and when doing a minor procedure?
- Do EKG codes ever carry the –TC/-26 modifiers?  What about x-rays?
- When would you never use modifier -51?  What is the impact on revenue?
- Are there "*more descriptive modifiers available to use rather than modifier -59*"?
  - ✓Where are they found?

-AI *(principal physician of record for admissions)*
-CG and –GV
-CS *(remove cost sharing?)*
-E1-E4
-EP
-FA-F9
-FQ and -FR
-GA
-GG and –GH
-GT
-GY and –GZ

-HF and -HG
-JW
-M2
-Q5 and -Q6
-Q7 through Q9
-QW
-LT and-RT
TA-T9,
-TC,
-XE through -XU

# Modifier -25 on E/M for a related service

Not on RHC/FQHC Medicare claims related to global surgeries!

## "Significant…E/M"

### 9921(?) -25

Add -25 if the primary diagnoses are similar or the same and if the **E/M level meets the definition of 'significant'** such as 99214/99215.

### 20610

Note this example assumes this code carries a pre-op surgical package of "0" days.

### Jxxxx

Also report the J-code with the proper # of units based on dosage since this was a "surgical injection" rather than just a shot!

# Modifier -25 on E/M for an unrelated service

## "…Separately identifiable E/M"

### 9921(x)-25

Add modifier-25 here if the primary diagnoses for the visit and the procedure code **have nothing to do with each other** regardless of level of service (*never use -25 on a 99211*).

### 69210

In this example assumes this code carries a 'surgical package' of "0" days, but this still applies to +10 days global as well.

# Modifier -59 Basics
# Overused and Misunderstood

**Medicare's NCCI can be different than non-Medicare bundling rules!**

*How do you know when an appropriate modifier may be used?*

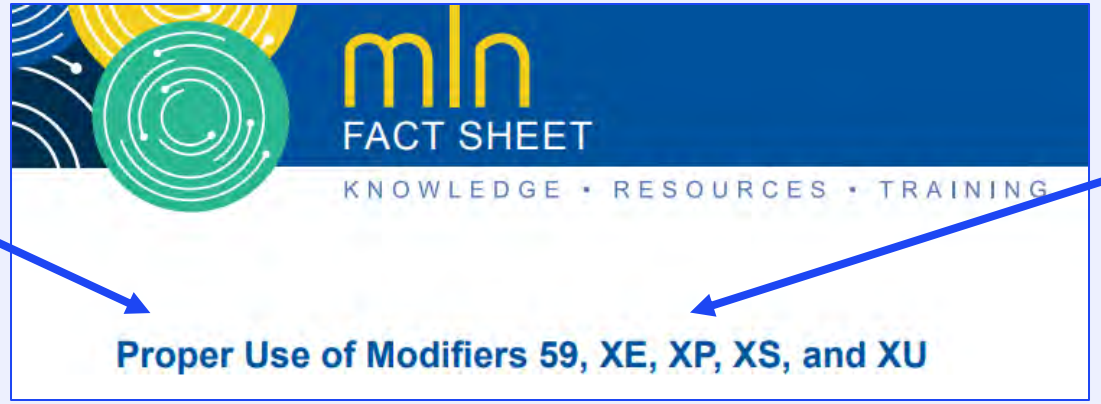
Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass a PTP code pair edit if the clinical circumstances do not justify its use. If the Medicare Program imposes restrictions on the use of a modifier, the modifier may only be used to bypass a PTP code pair edit if the Medicare restrictions are fulfilled.

In the modifier indicator column, the indicator 0, 1, or 9 shows whether an PTP-associated modifier allows the PTP code pair to bypass the edit. The following Modifier Identifier Table provides a definition of each of these indicators.

**Modifier Indicator Table**

| MODIFIER INDICATOR | DEFINITION |
|---|---|
| 0<br>(Not Allowed) | There are no modifiers associated with NCCI that are allowed to be used with this PTP code pair; there are no circumstances in which both procedures of the PTP code pair should be paid for the same beneficiary on the same day by the same provider. |
| 1<br>(Allowed) | The modifiers associated with NCCI are allowed with this PTP code pair when appropriate. |
| 9<br>(Not Applicable) | This indicator means that an NCCI edit does not apply to this PTP code pair. The edit for this PTP code pair was deleted retroactively. |

- ***Refer to the NCCI*** (*or other carrier's bundling system*) and reference the Modifier Indicator to determine if a modifier can overcome the billing edit.
- This is a "**modifier of last resort"** and should be used carefully based on available documentation, not just to get that item paid!
- ***Be aware of*** possible best uses of the similar modifiers ***–XE, XS, -XP, and –XU***. Check out this CMS document!



# Modifier –CG is a must on RHC claims to Medicare and maybe Medicaid

## Rural Health Clinics (RHCs) Reporting Requirements Frequently Asked Questions (FAQs)

(Revised 10-14-16)

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**Sections**

- Reporting Modifier CG
  - Reporting Modifier CG with Preventive Services
  - Reporting Modifier CG with Medical and/or Mental Health Services
  - Other Modifier CG Questions
- Reporting Modifier 25 or Modifier 59
- Other Questions

**Click a section title to jump ahead**

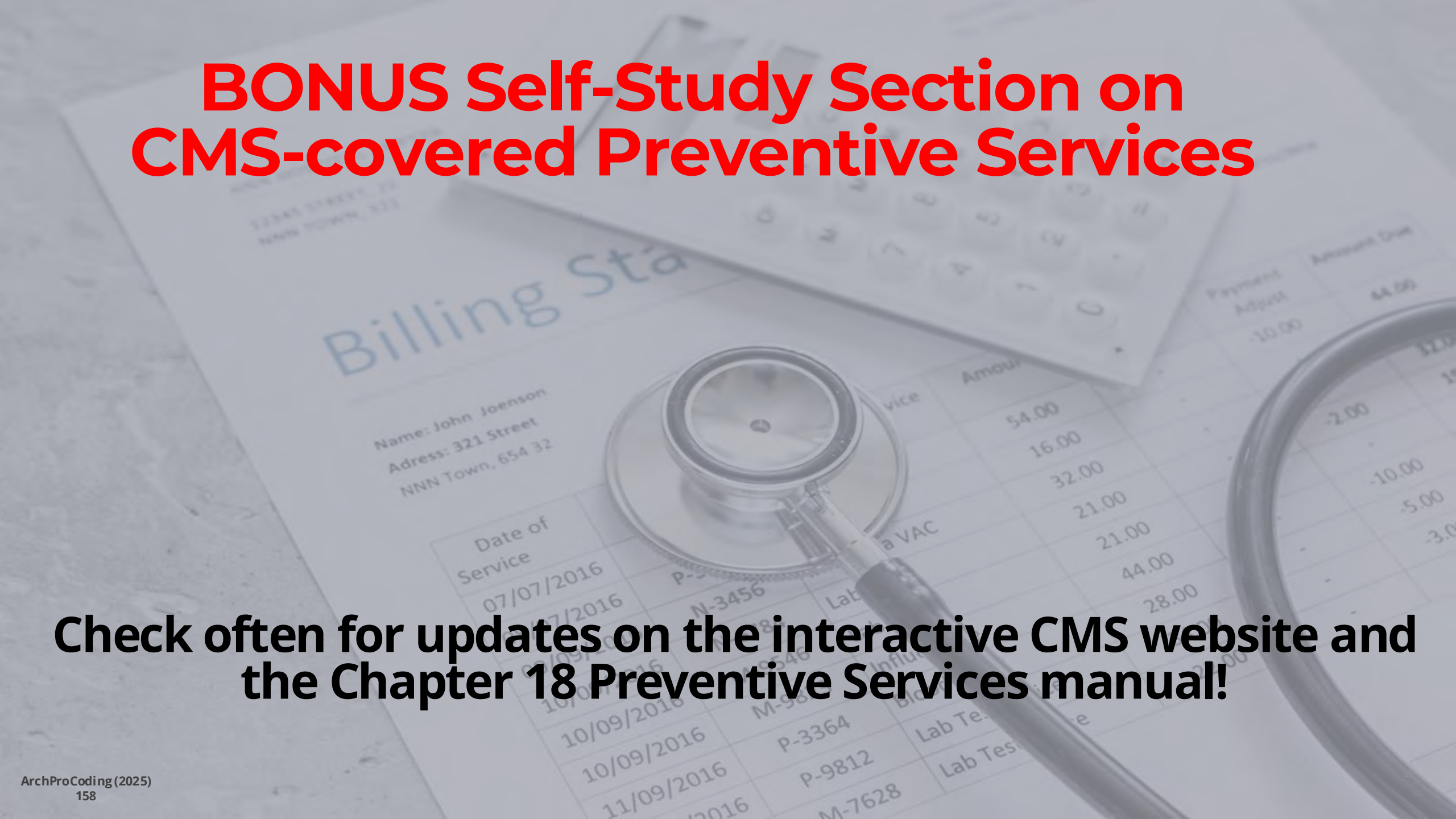
- ***RHCs must report modifier -CG on at least one*** CPT/HCPCS-II code per day if expecting the AIR.
- If performing a qualifying medical visit and a mental health visit, ***-CG would go on both*** services lines.
- ***Charges*** for the additional service lines (i.e., CPT/HCPCS-II codes) ***are packaged/bundled/"rolled up" up to the first service line*** and include the authorized charges for all lines of the claim where coinsurance/deductible apply. This is how the ***patient's 20% coinsurance is calculated***.

# PROPER BILLING and DENIALS MANAGEMENT

## Action Items & After Class

1. Read MLN#907166 on Global Surgery and carefully review the full definitions of key CPT and HCPCS-II modifiers to maximize surgical reimbursement and minimize compliance risks associated with poor transfer of care plans, especially when performing post-op care billed by others.
2. **Review your commercial and managed care contracts to determine which definition of the Global Surgical Package each major payers follows for billing *(i.e. CPT and "pure coding", the traditional Part B FFS definition, or their own?)* and engage any preauthorization/prior approval staff to find out before you perform important or expensive procedures.**

# BONUS Self-Study Section on CMS-covered Preventive Services




**Check often for updates on the interactive CMS website and the Chapter 18 Preventive Services manual!**

# Who Can Perform IPPE and AWV Services?

IPPE must be performed by physician or practitioner as defined in section 1861 of SSA to qualify for a stand-alone encounter by RHC/FQHC.

- Doctor of medicine or osteopathy (MD, DO)
- Qualified non-physician practitioner (NP, PA, CNS)

The AWV can be performed by those mentioned above or by a health educator, registered dietician/nutrition professional or other licensed practitioner (ex. Pharmacist)… *but still requires a "face-to-face" component* to be given by an authorized provider for a stand-alone encounter to be paid.

IPPE can not be combined with AWV (mutually exclusive)

Medicare does <u>not</u> provide coverage for the misnamed 'routine annual physicals'

The IPPE is the only 'physical' Medicare covers and AWV is does <u>not have a physical exam component.</u>

# Initial Preventive Physical Examination
# "*Welcome to Medicare*" physical

**HCPCS II code G0402**

- *Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare Part B enrollment*

Provides a written plan of care to the patient detailing any follow-up screening or preventive services necessary.

Deductible and co-pay are waived for the IPPE, but not for the ***screening*** EKG.

In the RHC setting, the IPPE may qualify for the AIR on the same date as another covered medical or mental health visit but not in FQHCs.

TOB 71X (RHC) and 77X (FQHC), Revenue Code 052X

# Before billing an IPPE
# did you document the following?

## Past medical and history

Current medications and supplements

Family history

History related to alcohol, tobacco, illicit drugs

Diet and physical activities

## Risk for depression and mood disorders

Use a screening instrument to assess potential for depression (e.g., PHQ-9)

## Review functional ability and level of safety

Hearing, ADLs, fall risk and home safety

## Examination

Height, weight, body mass index, and blood pressure;

Visual acuity screen; and

Other factors deemed appropriate based on the beneficiary's medical and social history and current clinical standards.

## End of life planning

Verbal or written and provided to the patient

Advance directive in case the beneficiary can't make health care decisions

## Education, counseling and referrals

Include written preventions plan ('checklist') for patient including (as deemed appropriate) a once in a lifetime screening EKG (G0403-G0405)

# Reporting Annual Wellness Visits (AWV)

**HCPCS II code G0438** (Annual wellness visit; includes a personalized prevention plan of service (PPS), **initial** visit) – should only be reported if IPPE has not been reported in last 12 months!

**HCPCS II code G0439** (Annual wellness visit, includes a personalized prevention plan of service (PPS), **subsequent** visit) should only be reported if IPPE/AWV not reported in last 12 months!

- Includes patient's history; compiling a list of current providers; height and weight; reviewing the patient's risk factor for depression; identifying any cognitive impairment; reviewing the patient's functional ability and level of safety (based on observation or screening questions); setting up a written patient screening schedule; compiling a list of risk factors, and furnishing personalized health services and referrals, as necessary.

Be sure to add Advanced Care Planning **(99497-99498)** and/or code **G0136** for completing the SDOH risk assessment, if performed, in addition to the AWV.

# IPPE/AWV in a RHC

**G0402:** The IPPE can be billed as a stand-alone visit if it is the only medical service provided on that day with a RHC practitioner. If an IPPE visit is furnished on the same day as another billable visit,  two visits may be billed. The beneficiary coinsurance and deductible are waived for the IPPE.

**G0438-G0439:** The AWV can be billed as a stand-alone visit if it is the only medical service provided on that day with a RHC practitioner. If the AWV is furnished on the same day as another medical visit, it is not a separately billable visit. The beneficiary coinsurance and deductible are waived.

# IPPE/AWV in a FQHC

**G0468/G0402:** The IPPE can be billed as a stand-alone visit if it is the only medical service provided on that day with a FQHC practitioner. If an IPPE visit is furnished on the same day as another billable visit, FQHCs may not bill for a separate visit. These FQHCs will have an adjustment of 1.3416 to their PPS rate.

**G0468/G0438-G0439:** The AWV can be billed as a stand-alone visit if it is the only medical service provided on that day with a FQHC practitioner. If the AWV is furnished on the same day as another medical visit, it is not a separately billable visit. FQHCs that are authorized to bill under the FQHC PPS will have an adjustment of 1.3416 to their PPS rate.

# Alcohol Screening /Behavioral Counseling

## Ch. 18 §180

**Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)**

**HCPCS II Code(s):**

**G0442**- annual alcohol misuse screening (5-15 min)

**G0443**- brief behavioral counseling for alcohol misuse (15 minutes)

**ICD-10-CM Code(s):** NCD information may be currently under review/revision – check with your MACs.

**Frequency:** Annually for G0442 and 4 times per year for G0443

# Diabetes Self-Management Training (DSMT)

## Ch. 9 §181 + Ch. 18 §120

### Federally Qualified Health Centers (FQHC) ONLY

DSMT may be performed in a Rural Health Clinic (RHC) ***but*** it would be captured via coding for cost report considerations.

When DSMT/MNT is furnished on the same day as another medical visit report both services ***but only one encounter will be paid***. Language in Ch 9's CMS Claims manual has references where 2 encounter rates appears allowed, ***but*** that was when FQHCs received an AIR instead of the current PPS rate!

- Coinsurance not waived
- No increase in PPS

**CPT/HCPCS II Code: G0108**- Diabetes outpatient self-management training services, individual, per 30 minutes

**ICD-10-CM Code(s):** Must have diabetes diagnosis

**Frequency:**

- 10 hours in the initial year and 2 hours in subsequent years

# Glaucoma Screening
## Ch. 18 §70
### Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)

**HCPCS II Code(s):**

- G0117- Glaucoma screening for high-risk patients (by optometrist or ophthalmologist)
- G0118- Glaucoma screening for high-risk patient under the direct supervision
- Revenue Code: 770

**ICD-10-CM Considerations:**

- Federally Qualified Health Center (FQHC)
- Per CMS, covered for (1) individuals with diabetes mellitus, (2) individuals with a family history of glaucoma, or (3) African-Americans age 50+, (4) Hispanics 50+

Frequency: once per year (11 months must pass)

Documentation: dilated eye examination with an IOP; and direct ophthalmoscopy or slit-lamp

# Intensive Behavioral Therapy for Cardiovascular Disease (IBT for CVD) Ch. 18 §160

## Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)

**HCPCS-II Code(s): G0446** - Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes (also known as "*CVD risk reduction visit*")

**ICD-10-CM Code(s):**

**Frequency:** Annually

**Documentation:**

- Encouraging aspirin use for the primary prevention of CVD when the benefits outweigh the risks for men age 45-79 years and women 55-79 years
- Screening for high blood pressure in adults age 18 years and older
- Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular and diet-related chronic disease.

# Intensive Behavioral Therapy for Obesity (Ch. 18 §200)

## Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)

IBT for obesity should be consistent with the "*5-A framework*" (per USPSTF)

- ***A**ssess, **A**dvise, **A**gree, **A**ssist, **A**rrange*

**CPT/HCPCS II Code(s): G0447**- Face-to-face behavioral counseling for obesity, 15 minutes

**ICD-10-CM Code(s):** ICD-10-CM code for obesity are found in code family E66.-

**Coverage:** Medicare beneficiaries with obesity who are "*competent and alert*"

- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2-6;
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg weight loss requirement during the first six months

# Medical Nutrition Therapy (MNT)

## Ch. 9 §182

**ONLY FOR Federally Qualified Health Centers (FQHC)**

Not a “covered” RHC service to Medicare, but report it if performed for cost report consideration.

Can be performed by registered dietitians or nutrition professionals.

Coinsurance is waived and no increase in PPS.

**CPT/HCPCS II Code(s):**

**97802**- Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each **15** minutes

**97803**- Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each **15** minutes

**G0270**- Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each **15** minutes

# Screening for Depression

## Ch. 18 §190

### Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)

**HCPCS-II Code(s):** ***2023 updated definition set a minimum of 5 minutes***

**G0444** - Annual depression screening, **5-15 minutes**

**Frequency:**

Annually…eleven (11) months must pass from last annual depression screening

Medicare coinsurance and Part B deductible are waived

**Coverage:**

- Limited to screening services only. Not for patients known for having depression. Refer to Z13.89- Encounter for screening for other disorder
- Per CMS, "*RHCs and FQHCs, annual screening for depression in adults is not separately payable with another face-to-face encounter on the same day*"
- An industry recognized tool (e.g., PHQ-9) must be administered - https://www.uspreventiveservicestaskforce.org/Home/GetFileByID/218

# Screening Pelvic Exam

## Ch. 18 §40

### Rural Health Clinic and Federally Qualified Health Centers

- Screening pelvic and clinical breast examination can be billed as a stand-alone visit if it is the only medical service provided on that day with an RHC practitioner.
- If it is furnished on the same day as another medical visit, it is not a separately billable visit.
- The beneficiary coinsurance and deductible are waived.
- No increase of PPS for stand-alone pelvic exam in FQHC
- What are the clinical documentation requirements?
- What diagnoses justify payment?

# Screening Pap Test Q0091

## Ch. 18 §30

| Frequency | Covered For | Additional Information |
|---|---|---|
| **Every 24 months** (that is, at least 23 months after the most recent screening Pap test or pelvic examination) | **Any** asymptomatic female beneficiary | N/A |
| **Annually** (that is, at least 11 months after the most recent screening Pap test or pelvic examination) | A female beneficiary who meets **one** of the following criteria:<br>• Evidence (on the basis of her medical history or other findings) that she is at high risk for developing cervical or vaginal cancer **and** her physician (or authorized practitioner) recommends that she have the test more frequently than every 2 years<br>• A woman of childbearing age* who has had a screening pelvic examination or Pap test during any of the preceding 3 years that indicated the presence of cervical or vaginal cancer or other abnormality | **High risk** factors for cervical and vaginal cancer include:<br>• Early onset of sexual activity (under 16 years of age)<br>• Multiple sexual partners (five or more in a lifetime)<br>• History of STI (including human immunodeficiency virus [HIV] infection)<br>• Fewer than three negative Pap tests or no Pap tests within the previous 7 years<br>• DES (diethylstilbestrol) exposed daughters of women who took DES during pregnancy |

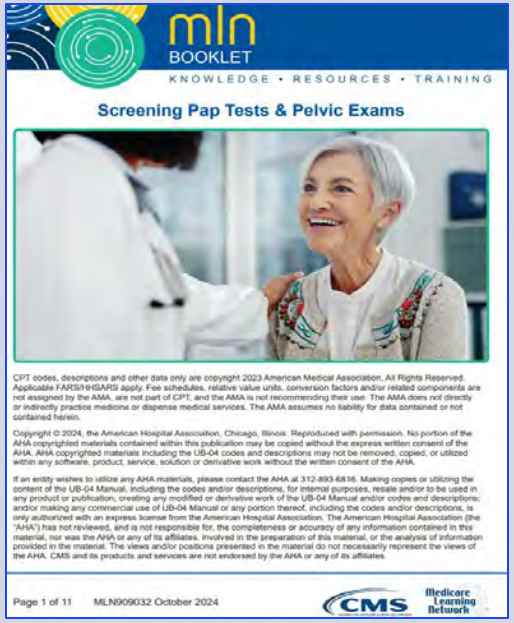
**Q0091 can be a "stand alone" visit or reported with another encounter.**

**TOB:** 71x (RHC) 77x (FQHC)

**Revenue code:** 052x

# Coverage of HCPCS II Code G0101 + Q0091-PAP

## Cervical or vaginal cancer screening; pelvic and clinical breast exam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**Covered under Medicare Part B when one of the following conditions are met:**

Has not had such a test during the preceding two years or is a woman of childbearing age,

Evidence of high risk of developing cervical cancer and her physician (or practitioner) recommends more frequently than every two years.

High risk factors for cervical and vaginal cancer are:

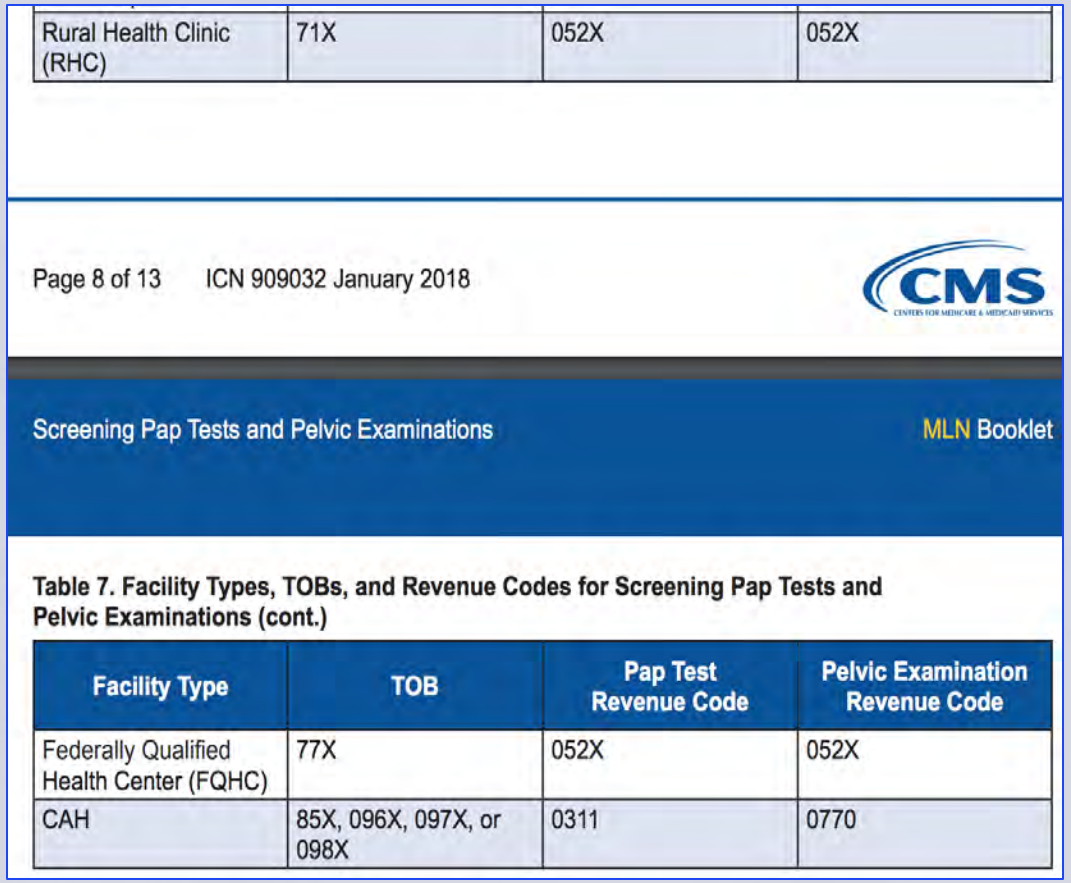
- Early onset of sexual activity (under 16 years of age)
- Multiple sexual partners (five or more in a lifetime)
- History of sexually transmitted disease (including HIV infection)
- Fewer than three negative or any pap smears within the previous seven years; and
- DES (diethylstilbestrol) - exposed daughters of women who took DES during pregnancy

# Only report a G0101 if
# 7 or more of the 11 items below are documented

1. Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge.
2. Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses. Pelvic examination (with or without specimen collection for smears and cultures) including:
3. External genitalia (for example, general appearance, hair distribution, or lesions).
4. Urethral meatus (for example, size, location, lesions, or prolapse).
5. Urethra (for example, masses, tenderness, or scarring).
6. Bladder (for example, fullness, masses, or tenderness).
7. Vagina (for example, general appearance, estrogen effect, discharge lesions, pelvic support, cystocele, or rectocele).
8. Cervix (for example, general appearance, lesions, or discharge).
9. Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support).
10. Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity).
11. Anus and perineum.

# G0101 ICD-10-CM, TOB, and Revenue Codes

| Risk Level | ICD-10-CM Diagnosis Code | Code Descriptor |
|---|---|---|
| Low | Z01.411 | Encounter for gynecological examination (general) (routine) with abnormal findings [Use additional code(s) to identify abnormal findings] |
| Low | Z01.419 | Encounter for gynecological examination (general) (routine) without abnormal findings |
| Low | Z12.4 | Encounter for screening for malignant neoplasm of cervix |
| Low | Z12.72 | Encounter for screening for malignant neoplasm of vagina |
| Low | Z12.79 | Encounter for screening for malignant neoplasm of other genitourinary organs |
| Low | Z12.89 | Encounter for screening for malignant neoplasm of other sites |
| High | Z72.51 | High risk heterosexual behavior |
| High | Z72.52 | High risk homosexual behavior |
| High | Z72.53 | High risk bisexual behavior |
| High | Z77.21 | Contact with and (suspected) exposure to potentially hazardous body fluids |
| High | Z77.29 | Contact with and (suspected) exposure to other hazardous substances |
| High | Z77.9 | Other contact with and (suspected) exposures hazardous to health |
| High | Z91.89 | Other specified personal risk factors, not elsewhere classified |
| High | Z92.89 | Personal history of other medical treatment |



| | | | |
|---|---|---|---|
| Rural Health Clinic (RHC) | 71X | 052X | 052X |

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CMS

Screening Pap Tests and Pelvic Examinations MLN Booklet

**Table 7. Facility Types, TOBs, and Revenue Codes for Screening Pap Tests and Pelvic Examinations (cont.)**

| Facility Type | TOB | Pap Test Revenue Code | Pelvic Examination Revenue Code |
|---|---|---|---|
| Federally Qualified Health Center (FQHC) | 77X | 052X | 052X |
| CAH | 85X, 096X, 097X, or 098X | 0311 | 0770 |

**NOTE:** An April 2022 update added these 3 new covered diagnoses: Z92.850, Z92.858, and Z92.86 on page 8 of the document.

# Screening for Prostate Cancer in RHCs and FQHCs

## Ch. 18 §50

### Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)

### HCPCS-II Code(s):

G0102- Prostate cancer screening; digital rectal examination

### Rural Health Clinic (RHC)

- Can be stand alone visit or included in AIR for other covered service
- Coinsurance/deductible applies (NOT waived)

### Federally Qualified Health Center (FQHC)

- Can stand alone to qualify for PPS
- Coinsurance applies (NOT waived)

Medicare covers an annual preventive prostate cancer screening PSA test and DRE once every 12 months for men 50+

- According to CMS, coverage begins the day after the beneficiary's 50th birthday!

# Screening for Sexually Transmitted Disease
## Ch. 18 §170

**Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)**

**HCPCS-II Code(s): G0445**- Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training & guidance on how to change sexual behavior

**ICD-10-CM Code(s):**

Z72.51- High risk heterosexual behavior

Z72.52- High risk homosexual behavior

Z72.53- High risk bisexual behavior

**Frequency:**

Semi-annually (every 6 months)

# Smoking Cessation Services

## Ch. 18 §190

### Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)

**99406** (Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, **greater than 3 minutes, up to 10 minutes**) and

**99407** (Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, **greater than 10 minutes**)

Medicare allows ***2 individual tobacco cessation attempts per year***. Each attempt can include up to four intermediate or intensive sessions ***(up to 8 sessions per year***)

- F17.200, nicotine dependence, unspecified, uncomplicated,
- F17.201, nicotine dependence, unspecified, in remission,
- F17.210, nicotine dependence, cigarettes, uncomplicated,
- F17.211, nicotine dependence, cigarettes, in remission,
- F17.220, nicotine dependence, chewing tobacco, uncomplicated,
- F17.221, nicotine dependence, chewing tobacco, in remission,
- F17.290, nicotine dependence, other tobacco product, uncomplicated,
- F17.291, nicotine dependence, other tobacco product, in remission, or
- Z87.891, personal history of nicotine dependence, unspecified, uncomplicated


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