NARHC Webinar
Tuesday March 9, 2021
Moderator: Nathan Baugh
Speakers: Patty Harper, inQuiseek
Shannon Chambers, South Carolina Office of Rural Health

2021 RHC Billing and Coding Update

Nathan Baugh

0:17

Good afternoon, everyone. Thank you for joining our webinar today. My name is Nathan Baugh, the Director of Government Affairs for the National Association of Rural Health Clinics, and I'm the moderator for today's call. Today's topic is the 2021 RHC Coding Billing & Coding Update and this webinar series is sponsored by HRSAs Federal Office of Rural Health Policy and it's done in conjunction with the National Association of Rural Health Clinics. We are supported by a co-operative agreement, as you can see on your screen now, through the Federal Office of Rural Health Policy. So, we want to thank them for sponsoring this. And that allows us to bring the RHC Community these calls free of charge. The purpose of the series is to provide IT staff with valuable technical assistance and RHC specific information. Please help us spread the word about these free webinars by encouraging anyone who may benefit from this information to sign up to receive announcements regarding data topics and speakers at either the RSI Hub website or the ... website. Although, I think they might have taken the link at the RH, I have website down, definitely the AIC website. When we get to the Q and A portion of today's presentation, we're going to open up a chat box that will allow you all to ask questions. And as with all webinars, we are at the Mercy of Good bandwidth for all parties and we all know that connectivity can go up and down. So if you have any audio or visual freezes, we suggest refreshing the page. Or reloading the goto Webinar that usually fixes the issue. If you continue to have issues, don't worry because a recording of today's presentation will be posted on the narhc.org website and be freely available, including the slides and the transcript. With that out of the way, I have the privilege of introducing our two distinguished speakers today. Patty Harper is the CEO of inQuiseek, I always have to pause before I say that, Pattie, I'm sorry, Consulting. She has over 22 years of health care experience in the areas of health care, finance and reimbursement, health information management, compliance, and practice management. She began her healthcare career as a hospital controller and reimbursement analyst. She is credentialed as I'm not even going to read all these Patty, but she's very well credentialed, is the point. And she currently serves on both our board, an RHC, but also the board of L R H a, which is Louisiana. Rural, is a Health or Hospital Patty Health Association. So, Patti is gonna kick us off and then we're gonna switch over to Shannon Chambers, who is also on the RHC Board.

3:23

Shannon Chambers serves as the Director of Provider Solutions for the South Carolina Office of Rural Health. In this role, Shannon assist private physician offices who desire to convert to rural health clinics.She provides technical assistance, sorry, sees, and compliance activities, billing, and coding, EHR implementation, and practice management during covid 19. Shannon has worked tirelessly with NOSORH, The National Organization of State Offices of Rural Health, and us, an RHC, to help with the RHC coven 19 testing Reporting Program, and the testing program, in general. And then she's also done a lot on the vaccine distribution. Shannon is a certified professional coder with the American Academy of Professional Coders and an AHIMA, approved ICD 10 trainer, Certified Revenue Cyclists' Cycle Associate, and a notary, a public notary. So with that, we have, these are just two of the biggest names in rural health care, rural health clinics. And we're excited to have them talk about all the latest and greatest on billing and coding, and we'll have plenty of time for questions at the end. So with that, I'm gonna turn it over to you, Patty.

Patty Harper

4:49

Thank you, Nathan. We want to thank all of you for joining us today. We know your day is very busy. Your time is very limited, and so we feel privileged that you want to spend this hour or so with us. So this afternoon, these are the things that we're going to go over in this webinar. We're going to discuss the new evaluation and management

service codes, and the guidelines for assigning those codes. I'm going to talk you through that. Shannon's gonna jump in, We're going to tag team. She's going to talk about Covid 19 immunizations, and also the antibody infusions. Then, we're gonna I'm gonna jump back and talk a little bit about a telehealth update and some diagnosis coding. And then we're going around the whole webinar out with Shannon, talking to you about lab billing, and the RHC reporting that is going on that's necessary. So, again, we welcome your questions. We want this to be something that you get to take away from. So, we will try to leave time for plenty of questions at the end. You can put those in the chat box. Here are pretty faces. Nathan already told you a little bit about us. So, so, glad to be with you again. All right. So if you haven't heard, there are new 2021 changes to the way that we assign evaluation and management levels of service for office and outpatient settings. And so this change actually was effective at that first of the year. We're still getting a lot of questions and comments about the changes, and so we wanted to cover that a little bit with you today.

6:42
So these changes apply only to the ... codes as they relate to office services, which would be our rural health clinics, and other outpatient settings. So, these are our 99202399215 E and M codes that have changed. So other evaluation and management guidelines have not change. So, inpatient, rounding, some of those other care facility evaluation and management services have not changed as part of the change. We have the both revised codes, Revised Code descriptions. We also have revised guidelines for assigning those codes, and we also have some changes, some additions, to, to prolonged service codes that really won't apply to our rural health clinic services, but something that you need to know for your other payers. So, that's kind of the high points of the changes. So, the changes, actually, have been in effect for over two months, But we are still getting a lot of questions, so we wanted to cover this. What has not changed? and we still get a lot of questions about, is, new patient versus established patient? And we get a lot of questions about these, particularly in the rural health clinics, when we may have a number of providers that are, are, are in our clinic, providing different services. So, we need to know, is that patient a new patient, or an established patient? And so, these have not changed. But I want to go back over them. A new patient is one who has not received any professional service from a physician or another qualified healthcare professional of the exact same specialty R sub specialty that belongs to the same group practice. And that is not been seen within three years. So, even though our rural health clinics are facilities, for the purpose of discussion, as same group practice, we're going to be talking about tax ID number.On the other hand, an established patient is a patient who has received a service from a healthcare professional of the same specialty within the last three years. So, we're gonna go through a few scenarios. I'm not going to read all of them, but I'm going to tell to have a chart for you. Just kind of a self quiz that you can download the handout and go over later. So, if we have, we have a patient in our first example, and she is, she's always received care from the same physician at the same clinic, but it's been three years since she has seen doctor Thomas, who is her normal health care provider, and she has never seen anybody else in the clinic during that time period. So, even though she has an established relationship with doctor Thomas, she is a new patient, because more than three years have passed since the last time that she received a service from doctor Thomas. So that is a new patient.

10:07
So also, if we have our second patient, and he sees. He sees a doctor in his same group, but from a different specialty. Is he a new patient to that new provider who is providing him specialty care? And the answer is yes, because that specialist, doctor Jones, does not have the same taxonomy code, as doctor Stephens, who is his family practice provided. And then, so we have our third patient. She has always seen the same family medicine provider, but that providers on vacation and she needs some follow-up care, while that doctor is out. And, so, she's going to see another family medicine provider within that same tax ID number. So, she is not a new patient, Although she has never seen that individual provider before. And if we look at the same type of scenarios in an established patient, they're just kind of the reverse of what we just talked about. And so, if we have a patient who has been seeing one provider at a new clinic, and now they're seeing another provider in that clinic of the same specialty, that you're an established patient, even if they have not seen the second provider personally.

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11:39
So, what if we have, like, on our top example, doctor Smith used to be down the street at another clinic, and now he's practicing at Oak Hill Clinic, but all in his former patients are following him to his new location. So, all of these patients have a relationship with doctor Smith, within the last three years, even though he is not in the same group. So, those patients are still established patients for this individual provider. Our middle example, again, is more than three years have elapsed since this patient saw their nurse practitioner, so, they are not an established patient. They flip back to a new patient. There's a lot of history and a lot of time that's passed that that provider's gonna have to come up to speed on what's going on with that patient and then the bottom one is probably the situation. We get the most with rural health clinics, is we have a new provider in our rural health clinic and she's never seen any of these patients, but she is the same specialty family practice as the other providers in the clinic. So, they are established patients to our, to Sally, our new nurse practitioner, even if she's never seen any of these patients before. So, this might be a good thing for you to use these last two slides, kinda, to do a little quick in service with your registration staff or with your providers. So they know the difference between new and established patient. All right, we're we're gonna start transitioning into what has changed about Ian Encodings for 2021 and I want us to look at what the elements of clinical documentation typically can be, when we when we're talking about documenting or an RHC encounter. So, we know that historically, well, historically, we have history. That's, that's, that's kind of funny, isn't it? So we had the history section of our note, We have the exam section of our note, and we have the medical decision making part of our note. And so in our history section of our note, is going to be the reason for the visit, it's going to be our chief complaint, It's going to be the history of the present illness. When did this patient start feeling ill? What makes it better and worse? What else is going on with you, and recapping your personal, social, and family history. And then the exam, of course, is whatever components of a physical exam that our provider is going to perform. The medical decision making is the number and complexity of the problems that the provider has to address. The amount of clinical data reviewed, How much risk is our patient at? Is he at risk, our is our patient, based on the decision? It's for treatment. How much risk is our patient at for developing complications, morbidity, mortality, right? So we've had a lot of people say, OK, well, I don't have to document any of this with the new guidelines and I don't want us to be misled. We still need a strong clinical documentation of the visit.

15:03
So although we aren't going to use all of these elements into signing and signing the level of the evaluation and management service, that doesn't mean we don't still need to have that clinical documentation. We need to be able to support What it is that we've done, the medical necessity of it. We need to be able to have a note that another provider can follow, that will provide continuity of care. So these elements are not going away. We just may not need the same amount of emphasis on some of them as far as that being the criteria for assigning the Iam level. Because it brings us to this slide. Because now, in 20 21, we only use either medical decision making or the provider time to assign the level. So, clicking away all of the elements of the physical exam may be very pertinent and medically necessary for that clinical documentation, but physical exam or history, are no longer going to drive the level of service. We have a choice between medical decision making or that provider's time, OK, so medical decision making. How sick is our patient? How hard is our provider having to work to come up with, assessing and treating that patient? How difficult of a decision do we have to make? How sick as our patient? This is really what the level of ... service has always been about if you ask someone who's been an auditor. It's always been about how hard is the provider having to work, how sick is the patient, Now, we can choose between medical decision making and the total provider time spent on that date of service. And so, this is a very big departure from how we have have assigned these levels in the past. We have two slides that also might be just really easy, little things for you to distribute among your medical staff. So, we're still going to document history in exam, to the amount, to the extent that it is clinically appropriate for that patient and for that visit. But we are going to either go on medical decision making our time, as far as assigning the actual E and M level. And I want you to look at the turn values in the very bottom row of this chart, that are assigned to the specific, the different levels for a higher level of service. if we are going to be using time as our determinant.

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18:04
We have got a lot of provider time allocated to, to these particular visits. We have the same chart for established patients. Remember, we went through our definitions of new and established patients. So, again, we're gonna want a sound, a clinical note, that documents the reason for the visit, and what it was our provider actually performed, but our assignment of the level is going to come down to either medical decision making, or time. There are an awful lot of new definitions that go with the different levels of medical decision making in your handouts. You'll have available to download the actual AMA Code Guidelines, which is going to give you a lot more of that definition. So we find, in the past, most of our physicians or nurse practitioners are PA's, depending on how they were trained. They just have a seat of your pants feel, for what is a Level three? What is a Level two? You know, I've always heard provider say, Oh, well. I'll follow up. Is always a two, or No, so such and such as always a four. And so, you really want to take time to digest the, the new guidelines, and we've made those available in the handout for you. And we are also going to cover the 2021 E and M Coding Guidelines more extensively as part of the ... Spring Conference. So, that may be a suit, a session that you want to pay attention to. Today, we'll just kind of giving you the high points of it. We also have two new prolongs service codes that have been added. one has been added by the AMA to the actual CPT manual. And it is for Prolonged Prolonged Office Services beyond the time spent on a level five new or established patient visit. So, we're going to find these being used on our non RHC claims. And you will want to check with your payor to see if they are going to honor these prolongs service codes. Just because we have a new code, we do have a valid code that's been added, doesn't necessarily mean that all payers are going to two to separately pay for a CPT code. The same is true. For a CMS has also created a new prolonged service code, G 20 to 12. Again, we do not expect to be seeing these on RHC claims because we won't be paid separately for these add-on codes. And also, when we add on a service for our patient, all we really end up doing is increasing that cost share or that co-insurance amount for our RHC, Medicare Patient. But I did want you to be aware of those two new service codes. If your EHR vendor has not reached out to you to make you aware of revisions or modifications that they have made to your product, you need to get them on the phone, because their old wizard function of assigning their evaluation and management level are helping guide you in that. Is not going to be compatible with the new guidelines. So, we know that now we have to document time. And so, you need to reach out to your vendor. You need to know if they've modified their product, is this going, is time going to be something that's a free text function? Are you going to have a radio button that you can click to assign a range of minutes that the provider has spent on solving that case on the date of service? So, if you have not heard from your EHR vendor, you probably need to reach out to them. If they have modified their product, you're going to want to spend some time with your providers, and your coding and billing staff. So there knowledgeable of these new features. I'm also, the work are the use associated with the new codes have slightly changed because we have deleted 9, 9, 2, 0, 1 new patient level one visit that has been deleted. So all of those work are they use have shifted just a little tiny bit. Here are the resources from the slides on this section of the webinar. Again, that AMA handout is going to be in your handout resources for the webinar, and these links are also where you can find that information. OK, I'm going to switch back over to Shannon. We're going to talk about coburg 19 Vaccine Administration.

Shannon Chambers
23:10
All right. Good afternoon. So we're going to talk a little bit about how, as rural health clinics, we're going to need to report this information. So, going through today, patee, next slide. So, for our Medicare kovac Vaccine Administration, Rural Health Clinics, both independent and provider based, are not going to include this information on your claims. There will be updates to the cost reporting forms and formulas to allow for vaccine administration and the antibody treatments that are performed in rural health clinics to be added to your cost report. You should still document all of your vaccines. We have a log here that we can provide for you, as well. It made it very simple. It's the same thing as we're doing for our flu and pneumonia shots already. We're already used to this. There are one. So, for example, on this one, you'll see astra zeneca, which is, of course, not yet approved in the United States.

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24:09
But we all know that Johnson and Johnson or the Janssen product came out recently so, we could add that information out there as well. And on the next slide, you're going to see where all the information is actually provided for you. So, just because you're a rural health clinic and for Medicare, you're not putting that on the claim, does not mean that you shouldn't be putting that on your actual non RHC claims. So, when we say non RHC, what we really mean is Medicare and Medicaid is RHC. And everyone else is non RHC. Now, with that said, Medicaid is different across every single one of the states. I can tell you, here, in South Carolina, how we would do that information, but it's going to be different with our friends in Texas or Arizona, et cetera. So, we've provided you the latest information. Again, this includes our Johnson and Johnson or jansson, whichever one you choose to use there. Vaccine and administration charges. And what's great is all of these, including the handouts that Patty was talking about a minute ago, are already located in the handout section on the goto Webinar sidebar information. So trying to remind people, that's part of this is, you know, we also heard from a multitude of different rural health clinics that they are still struggling to get vaccines. We encourage you to highly reach out to your Department of Health and make sure that you're signed up in the federal vamps systems, and that you're going through the requirements in order for you to be a vaccine administrator. In addition, making sure that you're staying within the phases that your state has yuen, depending on, if you are in phase one, A, one, B, et cetera. And with that, I'm going to turn it back over to Patty to talk to you a little bit more about telehealth.

Patty Harper
26:02
OK, we're just jumping all around, trying to keep all of you guys on your toes, so you may have already seen on the nark forum or through some other communication that has come out, that we have had an update to, the Medlar matters, S E 20016. So, this is a document that has become near and dear to our hearts. It has been revised. I think this is the fourth time, so you want to make sure that you have the, the most current version of this and, of, of this CMS document. And we then, had the link here for you also. Said, There are high points of the change most recently is that our reimbursement four, distant site, Telehealth Services, four, that are reported under G 2025. Effective January first. That reimbursement amount is going from 92 oh 3 to 99, 45, so, if you happen to have had claims that were processed before this revision was made, your Medicare contractor should be re processing those claims for you. So we also know that the things that have not changed is there still a 20% co-insurance that applies? Unless we are using the SCS modifier. And that all of the codes are payable under G 20 25, or on this link, on this slide, to all of the approved Telehealth and telemedicine codes during the public health emergency. So, again, although we are working very hard to have a permanent fix for telehealth, we can only use G 25 G 2025. We can only provide distant site telehealth services during the public health emergency. As it stands right now that public health emergency is extending into April and, and we will see if we get another 90 day extension at that point two modifiers that you want to be aware of when reporting G 2025. So we know that G 2025 is the only code that is reported on the claim, it's a big umbrella code that covers all of the CPT codes that are on the approved telehealth list. But we have two optional modifiers. So we can use modifier 95, which indicates that this was a telehealth service. The use of this modifier is going to be more for your own internal use so that you can identify how many telehealth visits you had, and if you are able to within your system to capture the original code, and and then have it converted to G 20 25, you're also going to want that 95 modifier so that, again, you can do internal tracking on those services. A lot of confusion, still about the C S Modifier, so C S, is cost share, so anytime we append the CS modifier to to a CPT code, we are either indicating that it is a co bid related service. And we know that, under the public health emergency, there are no out of pocket patient cost for cobin related services. So, that's one, you said, the CS modifier. The other use of the CS Modifier is if we are performing a preventive service, a qualified RHC preventive service by Telehealth for which the patient normally would not have a deductible or co-insurance. So, if it's a Medicare service that that cost share is typically waived, we're also going to want that CS Modifier to be on that G 20, 25. So, two reasons that we will use the CS Modifier, a Kobo related service, or to identify a preventive service provided by telehealth that normally would not have a deductible or co-insurance for that patient. OK. and if you have questions, be sure that you put those in the chat box so that we can address

those at at the close of the webinar. I just want to really quickly show you a couple of slides about diagnosis coding for Cobin. We're still having a lot of questions come through.

30:48
Does the patient have to have a positive, cobin Test result too to be tested or to have a coded related visit? And so we just want to bring a few of these ICD 10 CM codes to your attention. And basically we have a couple of zip codes. So, if we think our patient might be exposed, we've got a zip code. If we know our patient has been exposed, we have a different zip code and again, I'm not going to read this whole chart to you or if we're screening that patient, the patient is asymptomatic. but we're just trying to make sure that they have not not contracted coded. These are our zip codes that we would use. Of course, Z codes are the reason for a service. They can be first listed. So we want to keep those in mind. And then, if we have a positive code, the diagnosis, and not a rule out, not a suspected, not a differential diagnosis, but we know we have a positive, we are going to use the covert 19 organism, the U 0 7 zero point one. So this would be the first listed, and we would not use one of the other Z codes if we, if our clinical document mentation supports a Positive coven patient. And then lastly, as if we're dealing with co bid and we have a patient who is pregnant, always, we know that the code from the obstetrics chapter that oh, code always is the first listed, followed by the code, the diagnosis, or any other manifestation codes. And if we don't end up with with any of these suspected exposures, then we can always code calm the common respiratory signs and symptoms. So you may want to share these couple of slides with your providers and with your coding and billing staff, OK, Shanon, back to you.

Shannon Chambers
33:04
Awesome. So now we're going to talk a little bit about the covert testing and reporting website. So I have spent a lot of time lately on the Kogod 19 testing and reporting website. And y'all have done a fabulous job. So, all of the clinics, all of our rural health clinics across the country received this payment. These were payments that, depending on when you received it, whether that was the first payment that was issued on roughly May 20th. If you receive those payments electronically, or by check. And then, there were other several, as we identified, additional rural health clinics, that were, for some reason, not included, in the first round of payments. We had additional payments that were issued in December and in January. And then recently, we asked anyone that hasn't had additional or hasn't received that payment at all to let us know. Again, um, on the RHC Covered Reporting website, you actually have an option to say that your clinic did not receive the funding and you thought that you should have received the funding. So, it's very important at that point, too. Make sure you let us know. We did have a lot that we're not even aware of, because, again, this recording is at the tax ID level. So the payments came at the tax ID level, meaning if you're one of our provider based friends, those payments actually went under that hospital tin if that's how you're set up. And so the clinic necessarily may not have known that payments have been received. So, we have a website here. Of course, our rural health clinic or provider reporting portal, sorry. Nope, you're good, no worries. And on here, you'll have information. There's an FAQ located up on the right hand corner. There's information all the way through here that tells you a little bit about some of the questions that have come through. So hopefully by now, you are used to this website. If not, you may or may not have gotten an e-mail from me, or you may or may not have heard from some of our friends at offices rural health across the country. They have stepped up in a big way and provided outreach to their rural health clinics in their respective states, so we're very thankful for all of their partnerships. Next slide.

Nathan Baugh
35:24
Shannon, we should just note that it is down today, though.

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Shannon Chambers

35:29

Yeah. So, the portal, as Nathan just said, the actual portal is down today. They are working on getting some updates out on that. We hope to have that up. I probably crashed it. It's probably my fault. Y'all can all blame me. It's fine. But we are working on getting that back up. At the end, I'm going to talk to you a little bit about the details off of some of the reports that I've pulled on Monday. So, we do want to remind you that the RHC covered reporting is not Provider Relief funds. The Provider Relief Funds originally had that you needed to register by February 15th, or by January 15th, excuse me, and that you needed to start reporting by February 15th. If you were to go to the Provider Relief Funds. and the other way to remember, this is the first round of Provider Relief Funds paid around May seventh. The RHC covered payments did not pay until the end of May. This website, we are hoping to hear that it is updated and ready for you to start entering how you spent that Provider Relief Fund money. But, as of now, it is not up and not ready. You can go ahead and register to be prepared. So I kinda wanna remind you is we attested to the fun. So, whether we got provider relief funds or we received the RHC, covered 19 specific funds we attested for both of those. The RHC Covered Reporting website is telling per-se how you spent those funds. This website, the Provider Relief Fund, is telling them how you spend those funds, which is why there's two separate ways regardless of how you attested to them. We still have to report that information. Next slide. In addition, this is not lab data reporting. So if you are reporting information for your state, maybe you're doing some. So one of our friends in Nebraska let us know that they're doing some testing for their state. And they're having to report that data to test Nebraska. The the reporting numbers that you're entering on the RHC coven page, where you're telling us, the amount us tests that you did per month. And the amount of positives that you had per month, is not duplicating the results. That information is huge, just to determine how you spent the funds and the impact that we had across the country as rural health clinics. So why do we even care? Honestly, this is the first time that federal funds have come down to RHCS for us to be able to perform. This coven 19 testing. It's important, as part of it, to make sure that we're telling our story. You'll hear me say that a lot throughout any of my presentations. It really is about telling your story. How do we tell them that we did a great job? And that, we were able to use the code of 1900 funds to, not only whether that was have conversations about testing with our staff, and making sure that they had the right supplies or, you know, we retrofitted some of our organizations to be able to do testing, et cetera. So, this information, we wanted to make sure that you had as part of the lab data reporting. And, again, the reporting that you're doing for the RHC Covered Reporting website or portal does not affect the reporting requirements that your state may have in place. Next slide. All right, So we're going to talk a little bit about some of the FAQs, so if you are doing the antibiotic testing in your RHC, that isn't allowed expense. As long as you are not double dipping, what does that really mean? So, double dipping means that if you're able to get that reimbursed through insurance, then you shouldn't be using the RHC Koga Testing Fund money to also reimburse for those test. Does coven 19 testing? The Portal, does it include specimen collection? Yes. So, the collection of specimens is an allowable testing cost. Remember, again, that we cannot double depth, so, if you are using uninsured reimbursement program for the testing, are for including your specimen collection. No, we can't use those same. We can't use the funds for the RHC coven 1900 funds that we received. For that, as well.

40:01

And then, the other question I try to pull some of the ones that Nathan are getting a lot of throughout this process is does your RHC need to conduct full testing process to be eligible. You do not have to conduct the full testing to use the funds. If you do, then the RHC would need to, of course, have those capabilities. Next slide. All right, so, this goes back to a few of the things I said a minute ago. RHCS required to seek reimbursement from insurance for cov at 19 testing. Yes. So, again, for us, for rural health clinics, for the testing you should be sending that information in. If you have the patient that is uninsured and you're signed up through Optum, then you would need to seek reimbursement through Optum for the uninsured program. It's pretty simple to do and walks you through. We can find all of that information on the Frequently Asked question. You should be keeping up and

maintaining those records of your testing and your amount positives, et cetera, throughout the process, as part of the testing requirements.

41:14
So, how long do we actually need to record it? Well, as you can see, you're getting this information within three weeks. So, the FAQs were updated on February 22nd. That says, RHC coven 19 Testing Program Reporting is anticipated to continue until July 31st of 2020. As you will note here, the asterix HRSA may revise that date, But what does that really mean? So, July 31st of 2021 would mean the last time that the information of you would need to report is four June of 2021. Today is March ninth. So, we should already have our January numbers in. Of course, if you try to go in today and update us, the website is down. So, please try to go back end later on this week and update that information. That will continue to provide information out. HRSA has been sending in e-mails out to remind you that this is mandatory reporting and that information is due monthly in the portal. Next slide. All right. So, can 10 organizations use the RHC cover 19 Testing funds for Vaccine Administration? No. The funds for the covert 19 Testing Program are for covert 19 testing, only, Has nothing to do with vaccine administration. Hopefully, the information, as we're starting to see a lot of bills passed and things like that. The point of telling our story really well this time and making sure that we have shown to HRSA, that we are able to provide ways that we've spent this money, show our data. Hopefully, that will allow us to receive more funding in the future. With that, we'll go onto the next slide for me. So, I'm going to give you, here's a few resources. So, the step by step instructions, Um, we developed, so that you literally knew what you were actually having to put into the portal. There is nothing worse than having to go into a portal, sign up, and you have no idea what information you actually have to report. Here's the information for the FAQs. Then, of course, their provider, or, excuse me, the rural testing early funds, in terms, then the HRSA frequently asked questions. I'm going to stop on this slide for a second, and I'm gonna give you a little bit of updates. So one of the great things, as part of this information, is rural health clinics should be very, very proud. I'm super proud of all of you. We did eight point seven million tests of curve at 19, with one point one million of positive results. So how about telling our story right there, and how many of our patients came to us, for us to take care of them. In addition, with most of you, 88% of people actually use the funds to get supplies. Whether that was PPE, whether that was hand sanitizer, whether that was your cabbie wipes, or whatever you use. Um, then, 82% used it for staff and salary for actually doing the testing. Remember, of course, we can't double dip. So if you did receive your PPP loans, we would want to make sure that you are not utilizing these same funds to cover that staff if they were covered under a PPP loan. 72% of you did it for training for your providers and staff. Every single month starting in March, I guarantee you, we have talked about covert 19. We're almost here into this at this point. We've done a lot of education, whether that's providing the right way to Don PPE and to take it off, whether that's to talk about wiping down our exam rooms, whether that's wiping down our waiting rooms, or even clipboards that patients come in and sign, or even pins. The interesting part of this is 10% so far have said that they have not used their funds. So, if you're one of those that have currently put in that you have not used your funds, and you're reporting your data, and realize, Oh, well, now we have updated, and we are actually doing that for supplies, or, we're doing that for salary time. Please make sure that you go in, uncheck the box of you've not used your funds, and put in however you're actually using your funds in that testing information. Next slide. I'm going to go back. All right. So, with that, Nathan, my part of the presentation is finished Pattie. Any additional thoughts before we jump into questions?

Patty Harper
45:58
No.

45:58
Not that I can think of, but I'm sure we'll get questions that will trigger my memory.

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Shannon Chambers, South Carolina Office of Rural Health

Shannon Chambers
46:05
So I know that we received one question yesterday. So we did receive a question that was e-mailed to Nathan. That question was regarding dorma bond. So Patti, I'll start, and then jump in, of course. Did receive a question yesterday regarding billing for Dharma Bond. There is a G code out there, for billing for dermot bond. But when you read it, it actually is talking about apart a service, which is the hospitals, not rural health clinics. So for dermot bond, you would continue to provide that under the actual CPT code, where you're closing that wound by adhesive And actually billing for the CPT code that way versus using the ... G0168 code that came in. Did I miss anything, Patty?

Patty Harper
I don't think so. I know it's confusing because, you know, often it kind of goes back to what we said before just because there is a valid CPT or hex fixed code for a service or a product doesn't necessarily mean that it's always appropriate to use that. So it can also be confusing But Shannon and I did some research on this and compared Notes and we feel like the coding guidance. That's out there would suggest that you use, the normal laceration are wound repair code that reflects the service that was done.

Nathan Baugh
47:32
All right, great. So, the question box is now open, and so folks can type their questions in, and, and we'll get through as many of those as we can, but we'll do the best we can there, and while folks are typing in questions, I do. I did get another question that was just e-mailed to me. Patty and Shannon, this is from Shelby Salchow car, she says that, I've heard that if a provider is billing a lab and N E N M office visit, and she clarifies that the charges are on the same claim form, you cannot count the lab under the data reviewed element. Can the speakers address this? I've not been able to find a resource, but I've heard this once.

Shannon Chambers
48:29
Now, data reviewed is actually something that you can count. I understand that you're talking about on the claim form that the office visit, especially if it's an RHC claim, so Medicare, Medicaid, is not on the same claim form. But in the AMA guidelines and other templates that we have when you actually review the lab work, that is a data review. So that, in a sense, I don't want to say gives you a point, but that's kinda, how, if you're looking at the point system, that's kinda how it is done. You're gonna find some of that information in the AMA. And, if not, I've got some templates that I will get out, and we can try to get, get that information to you, as well. So, Nathan, if you afford me her e-mail, I'll reach out directly.

Patty Harper
49:16
So, yeah, so, just just to add to that, in the AMA document that is also included in your handouts. There's going to be, it's a chart format of the medical decision making, the complexity of medical decision making, and the different types of data review, and which types of data review are used to, or which elements correlate with the complexity of medical decision making. So it can be a test that that your provider, you know ordered. It can be an independent review of lab data that an outside provider performed. So I think you'll get more detail if you can look at that guidance, and reach out to us for additional resources if you need them.

Nathan Baugh
50:11
OK, probably can do me a favor and go one more slide. Sure. I think that is the CRHCP code. So we didn't want to give it away too soon, sorry, yeah, but I just put it up now brief. Paying attention, you can get it. CRH CP code for today's presentation is Y W P X G. All right, we'll repeat that at the end.

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50:41
But Patty, you can bring it back to the resources or your contact information And we're going to start knocking out these sessions are first question is from Andrea Baros. She says that she thought the Z 1 1, that 5 9, was no longer appropriate to use for screening as of December this year, is that correct?

Patty Harper
51:09
No, I'm just going to have to be really honest and let you know that those are some slides we had taken from an earlier presentation, and I did not fact check those. So we will look into that and make a clarification on the forum, Nathan.

Nathan Baugh
51:26
OK, yeah, we can make that I feel like I've gotten a few questions on this. But yeah, we'll get to the bottom of it. And yeah, Next question is from Marilyn Blazed owl. Who, as I was instructed that modifier, 95, should not be used with G 2025, is that true?

Shannon Chambers
51:50
So G 2025: If you read the SC 20016, it does say that 95 modifier, that you can report it. It is not required. You do want to make sure if you're billing telehealth to your other payers, my suggestion is, what we've explained is, build you a little cheat sheet. Take that information and say, Blue Cross Blue Shield requires this, with this CPT code and this modifier, Cigna, Aetna, United, doesn't matter. Medicare requires us to bill as G 2025, and then pull in your information for your Medicaid. So 95 is not required, but you can report it per the SE 20016

Nathan Baugh
Perfect, OK, Next question is from, thank you, Shannon. Next question is from Spring Cook. She asks if a patient comes in for a sore throat or fever and has tested for strep influenza and covert. Would that have to see cs modifier, but that visit or that test with those services?

Patty Harper
53:01
I mean, it is it is screening the patient for covert for symptoms that are compatible with the covid presentation. I feel like that that would be appropriate.

Nathan Baugh
53:14
Yes, I agree

Patty Harper
Shannon. And is there anything I'm forgetting?

Shannon Chambers
53:17
Fully agree. It's what's your patient presented? And then what you do to determine what is wrong with your patient, You believe that patient has covered, and I agree with that as well.

Patty Harper
53:27
Right. So there was a lot of information at the very first that, that lead people to believe that there had to be a positive test result. And I've even had a Rural Health Clinic reach out to me and say, they weren't billing for any coven Lab test that weren't a positive result. So, you know, this has been a very fluid situation. It's the last 12

months, but, you know, I feel like if that patient is coming because they fear, they might have covert or the provider thinks that it's appropriate to test for ..., then there should be no cost share for that patient.

Nathan Baugh
54:04
Next question is from Katie Gros, who asks those covid testing codes go on our RHC claims or what those go to Part B, like our strap flew, et cetera.

Shannon Chambers
54:17
All right. so, that is going to be whatever, if you are an independent clinic and you are doing the curve at 19 testing, that is going to go on your Part B claims. If you're one of our provider-based friends, that is going to follow the same way that you do your other labs for those covid 19 testing.

Patty Harper
54:37
Right, so, we don't so know labs at all. Point of care are the kogod lab testing no labs go on our regular Medicare RHC UB claim.

Nathan Baugh
54:49
Right? But, you can't, you can't just build them on the 1500, though. If you want. Right? Like, you can't switch back and forth between the two.

Shannon Chambers
55:07
Sorry, if this is covert 19 testing. Yeah, and you're going to build that as a CPT code.If it's a vaccine, then you're going to need to put that on the cost report. So, I think we have to be, I'd have to reread that question, but if it's Testing, and you're actually doing a lab test, you are going to bill for that service. Whether you're gonna build that on Part B, if you're an independent clinic, or you're gonna build that under your hospital numbers. Just like the patient walked into the hospital if you're one of our provider based friends, if it's a vaccine. You are going to bill that information. You're going to put that on a log and that is going to be submitted as part of your cost report.

Nathan Baugh
55:49
OK, but if you're doing the covert testing, do you have to pull out those costs on your cost report? When you're doing those services? Well, if you've got, if you're going to bill it, too, a part B,

Patty Harper
it's going to all go back to that double dipping issue. So, you know, we're not going to bill for that and counted on our, on our testing. Against our testing money,

Nathan Baugh
OK, but it also would not be on the cost report, right?

Patty Harper
56:23
Right, yeah. Because our Part B labs do get pulled out for the cost report, correct?

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Nathan Baugh
56:28
OK, All right, next question is from Ashley. Stanford, she asks, Is there actually I skipped Diane, Diane, I'm sorry, Diane content and asks, regarding new patient, is the taxonomy. Is it the taxonomy or the tax ID number that applies to the definition, Patty mentioned both.

Patty Harper
56:49
OK, so, I may have been so, when it comes to determining the provider specialty or subspecialty, that is going to be the individual taxonomy code that that individual provider has reported with the individual NPI. So, the tax ID is just, what big umbrella are they all falling under? But the specialty or subspecialty on the provider will depend on the individual providers, NPI registration.

Nathan Baugh
57:23
OK, perfect. Next question is from Ashley Stanford. Is there a link or a website that will give more information on RHCS for the Revenue Code to be used with G 2025?

Shannon Chambers
57:39
So, for the G 2025, that revenue code is the 0521. Just is that patient, just like you would bill for your regular visits. This is where we have to be really careful. There are there is a telehealth revenue code out there. But that was for actually when our patient is sitting in our rural health clinic and talking to another type of provider that is not in an RHC or FQHC. So for the revenue code, it's 0521 and that is tied to your G 2025 CPT code.

Patty Harper
58:19
It would is another way to say it might be It's where the patient normally would be to receive that service because it's also possible that we could have a telehealth visit in a nursing facility, our swing bed. So, yes, but I totally agree that the other revenue code for Telehealth applies to the originating site only.

Shannon Chambers
58:42
Great way to word that, Patty. Thank You.

Nathan Baugh
58:46

OK, great. Next question is from Renee Ray. What code would you use for Incident two charges?

Shannon Chambers
58:57
Am kind of giggle. And a little bit, because Patty and I talked about incident to billing this morning. We do glad I wasn't the only one that was kinda giggling. I was like Incident two guidelines, We have to make sure that we're following the full incident to guidelines. Meaning, if I have a nurse practitioner that is seeing a patient, that we are following the guidelines of the provider that you're billing under, is available for consult with that nurse practitioner. So, for the Incident two guidelines, the main thing is, is making sure that it's not always the supervising physician that you're billing under for the nurse practitioner. Meaning, if I'm the nurse practitioner, and Nathan is the provider, and he is not in the office, and maybe he's out on vacation, and Patty is the provider in the office, the actual MD or a DO that if my services are being billed under the actual provider, then we would build those under Patty that day, because she is the one within the building, or with able to be able to reach them within a 50 mile radius. Incident 2 is one of those really weird things. So, the billing guidelines don't necessarily

change for E & M, for calculating the E&M visit, but it really is more on the billing side and how those things are are done.

Patty Harper
1:00:29
Right, so, I would just add, that, if we are billing a non-physician provider as incident to a physician, that also has to be an established patient, with an established problem, and that that non physician provider, is providing subsequent care to the physician's initial service. And so, and so, you know, we get a lot of questions about, Can I know, I haven't credentialed Somebody yet, can I just build them under the medical director? And the answer is, probably not, unless they're meeting all those incident to requirements. We also have another kind of incident to service, and those are also services that take place subsequent to an initial RHC encounter, and that may the bandage change or a second drug administration. It could be supplies used for procedure, although most supplies that are integral to a procedure, are included in that procedure CPT code. And so, I'm not sure if the question was about incident to billing, under a physician or incident to services that happen in another, another subsequent service. So, if, if we need to clarify that, let us know.

Nathan Baugh
1:01:53
All right, thank you, Patty. So, just a note on logistics, we're obviously past 3. As I think, most of you know, if you've been on any of these calls before, we usually go over. and I think we'll have a hard stop at 3 30. So, we're just going to try to answer as many questions as we can till 330. And so, with that, I'll get right back to it. There it is, yeah, OK. The code is Y W P X G, Y WP X G. You better hopefully you're paying attention now if you need this code All right, Patty, can you go to slide 38 and 39? Because the next question is on those slides We've been getting F this is from Deb Bartell. She says we've been getting free rapid covert tests from our county, So we haven't been billing know,

Patty Harper
I don't think I have the slides numbered, so can somebody help me where my go in the right place.

Shannon Chambers
OK, Should be the FAQ questions.

Nathan Baugh
1:02:59
OK, so, they've been getting free covered tests, right, so they so, she says we haven't been billing for any covert testing based on slides 38 and 39 can we build for the test? And swab or just swab? There's something that is worrying me about this, but Shannon, do you want to start?

Shannon Chambers
1:03:23
Sure, so if you've been given those test free, then we can't double dip and use the covid 19 funding as well. So, Nathan, tell me a little bit about your thoughts here.

Nathan Baugh
1:03:37
OK, so my thoughts are, one aye. Yes. Shannon's, right? If you've gotten it for free, you can't use this funding, the Cove in 19 funding to pay for this. So, essentially it one way to think of it is that you need to allocate $49,400 per clinic appropriately to cover 19 expenses that weren't reimbursed. Obviously, if you're getting something for free, it's not an expense. So that's one, number two. And I'm not sure if it's in the FAQs on this slides, but I know it's on the HRSA FAQs, is you are not allowed to not seek reimbursement. Let me say that without a double negative, you have to seek reimbursement for coven testing If the patient has any form of insurance, the question came along is,

like, well, can we just not seek reimbursement until we've incurred $49,500 of cost? And the answer is, no. You have to seek reimbursement for services provided if that patient has a payer, that is obligated to pay for, coven 19 testing.

Shannon Chambers
So, maybe the next slide, Patty?

Nathan Baugh
1:05:09
You have to have to bill for text, there. It is, OK. Yeah. And this is one of the ones you'll see, it was clarified when in February, right? So this is a newer clarification that has just come out. So I don't know if we her question.

Patty Harper
stands to reason that if there is another third party responsible to reimburse for that service, then a government payer would not be, our government program would not be responsible for that. So there, that's, there's a lot of logic in that.

Nathan Baugh
1:05:50
So you need to bill for what you are doing. So if it's just the swab, you can just bill for the swab if it's the lab portion and the swabbing need to bill for all of it.

Patty Harper
1:06:05
So we don't have a code for just the swab collection, for the four the covid test, right? Specimen collection codes are handling and collection codes. I don't know if all those definitions apply. But what I was gonna say, I think Shannon had touched on it, we could allocate, I think she said 80% of the clinics had allocated labor for additional staff to perform the test. Am I saying that correctly, Shannon?

Shannon Chambers
1:06:49
Yes, Based on the numbers that we pulled earlier, that was actual staffing, so, and it may be that that's a one-off that we may want to. So, I'm gonna provide my e-mail address, so for those of you that are on the line, if you have a specific question that we did not get to, or something that's so particular to your clinic.

You can e-mail me at chambers@scorh.net. South Carolina, Office Rural Health.

Nathan Baugh
1:07:33
Sure, you can use the chat function.

Patty Harper
add my e-mail there as well if there's another question?

Nathan Baugh
1:07:50
Well, I don't want to commit you guys to this but we do we we will have a record of all these questions and you know who asks them. So we can send you that Excel sheet afterwards Patty and Shannon, and you can You can see all the questions that were asked and respond, if you wish. Next question that we're gonna get to right now is from Casey Parks. We are currently building out all Medicare telehealth visits as G 2025, which I have found has the zero RVU attribute attributed to that? Is that correct? I think you addresses Paddy.

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Patty Harper
1:08:35
I did, but I don't, We there is actually a work Garvey you attributed to G 2025, right?

Nathan Baugh
1:08:43
I think she's referring to the air. Remember, you, Patty. I caught this error. Yes. There was, for a moment, there was a file release that didn't have a practice expense RVO associated with G 2025. And so payment looks like it was $50. It has since been updated, and now the practice expense, our view, is in there, which gets us to our $99 rate. So if you've seen any of those claims come back incorrectly in the $50 range. Those are supposed to be reprocessed.

Patty Harper
1:09:21
I'm sorry. I had a, I had a senior moment on that, I shouldn't touch, but that was the one that raised the flag on that. So, yes, there was an era in the addendum B in the in the RD you follow that was released for the first quarter.

Shannon Chambers
1:09:39

In addition, she also may want to check within her EMR if that's how they're calculating, to be sure that it's added on the backside there. If the RV use are calculated on the back side for her, she wants to make sure that it's been added there.

Patty Harper
1:09:53
Oh, good. That's a good point.

Nathan Baugh
1:09:57
Awesome. Alright, next question is from Karen. She asked our Medicare and Medicaid replacement plans billed as RHC or non RHC.

1:10:06
Shannon Chambers
Oh, this is probably one of my favorite questions. So, that is, it honestly depends on the type of contract that you have. If you are contracted with the Medicare Advantage Plan. I'm going to top Medicare first. If you're contracted with the Medicare Advantage Plan, then you have to follow the billing rules that they have in place. If you are a non-contracted provider, they still have to follow your RHC, all-inclusive rate reimbursement. But a lot of times, there is confusion because, again, if you're not enrolled with them, you may have to provide their information. Know, your all-inclusive information to them. Medicaid is state by state. So, for example, in South Carolina, we have five different Medicaid MCO plans, and none of them are the same way. Um, I suggest, again, adding a, um, you'll hear me say cheat sheets all the time, and come up with, and reach out, and contact each one of those. I've got a great one that you can start and use for your state, that I can provide as well.

Patty Harper
So it's going to depend on how the states plan that they submitted to CMS, how it's worded. We find a lot of the states for Medicaid, they are supposed to pay an honor at whatever rate setting methodology, you're your legacy Medicaid provider or our state Medicare provider uses. And so, Shannon's absolutely correct. It's, it's just, it's, you know, that's the thing, I think that frustrates us the most as educators and consultants, is sometimes we have 49 different answers to this same question, because on a state level, there's so much that is not consistent.

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Nathan Baugh
1:12:07
Excellent. Thank you, Patty. Thank you, Shannon. All right. Next question is from Stephanie Busser she wants to know, can you put the cs Modifier in lab charges?

Patty Harper
1:12:22
The cs modifier, there is no co-insurance on a lab charge for Medicare. So I believe the SES Modifier only goes on the evaluation and management code, or the approved telehealth service, or the qualified preventive service.

Nathan Baugh
1:12:42
Alright. Perfect. Stephanie has a long comment here. She says, I think she's noting that the ICD 10 codes were updated in the beginning of 2021 OK, my apologies. So, thank you, Stephanie, for the comment. She's saying that it is a different z code. I think, I don't know if other folks can read it, but she's saying that it's the 1, 1, 5, 2. I think we'll send an e-mail to everyone, just clarifying on the ICD 10 issue on that ad and we'll skip those questions for now. Alright, next question is from Robin, too, qubo, what is the proper way to bill a TB test? Can we bill for the tuberculin, or just the 86580?

Shannon Chambers
8 6 5, 8 0 normally is inclusive of that. The reading is when, you know, if the patient comes back. I provide the PPD or provide the medication, injected that day, and then the patients coming back to review those results in three days, or whatever. I think it's three days off the top of my head today. But it's normally the medication for that one is included in the code.

Patty Harper
1:14:10
Agreed.

Nathan Baugh
1:14:11
Awesome. That one was easy. All right, Next question is from Tabitha wince. This one won't be easy. Pattie, do you have a workaround on telehealth or for telehealth, how are providers getting credit for annual wellness visit?

Patty Harper
1:14:29
Well, that's something we've all had heartburn over, right? Because we really if we do the G 20 25 code then that preventive services not getting on that patients common working file and our provider if they need attribution for that for some type of quality reporting or ACO participation they're not getting credit for that either. So I think that's been one of the things that we have regretted. I do not have a workaround for that, other than and, and correct me if I'm speaking incorrectly, but we do have some systems where people are reporting that, the actual service that they did, if their system will let them suppress that code and only report the G2025 on the claim because we can only have the one code on the claim. So if internally there was a way for you to track it, in case we are asked to report on that later just for internal tracking, Shannon, is there something I'm overlooking?

Shannon Chambers
1:15:42
I 100% agree is that you know, it does an update on the common working file. So, even if you go and look to see when the patient had their last one. I do agree that we're going to have some issues with ACCO with patients being attributed to providers that may or may not look like they met the quality measure, but they did. There's going to

have to be a way that they figure out a workaround, whether that you providing the number that were done by telehealth for those annual wellness are. Unfortunately, we don't have that answer today.

Nathan Baugh
1:16:23
We can't do advocacy on this call, but I'll just say that. This is one of the issues with the current tenure system, that's that is temporary. And, of course, we're trying to make it work better, if it becomes permanent. And so, this is just one of the issues, and we are aware of that. So, But there's basically no good solution right now. Next question up she's left. Next question is from Jeanette Oshiro. She says, Can you please review the prolonged visits again. What do you mean about non RHC billing?

Shannon Chambers
1:17:04
While Patty gets back to that slide, I'll start. So, you have to remember for non RHC, meaning, Blue Cross, Aetna, Cigna, United Health Care or any other provider that is not Medicare and not Medicaid, you may be able to use these services or those that are Medicare and Medicaid. They are considered non RHC. Pattie, I'll stop there.

Patty Harper
1:17:35
So, yeah, and know that this is an add on code if you are allowed to bill for it from a commercial payer. It is an add-on code to a Level five new or established patient visit. It has to be a full 15 minutes, both the AMA code and the CMS code, RF, for 15 minutes, in addition. So, no rounding like, not eight minutes doesn't round up to this Add-on code. It has to be a full time. So, we're also talking about a lot of time that the provider has spent with that patient. And the only other thing I would say is, just because we have new approved AMA codes, we have new approved CPT codes. Does not mean that a particular payer is obligated to have to reimburse for that code. We have all kinds of codes in that book that are valid codes, but they may not be reimbursable by a particular payer. And so, the AMA code add on is this. So, I would reach out to your provider reps for your different plans, or check quarterly updates on provider updates to see how particular providers are going to, to view these codes.

Nathan Baugh
1:18:56
Yeah, I think another way to say non RHC billing the way you mean it. Shannon, is commercial payers, private payers. Privately insured individuals, those, that's, that's the universe we're talking about here. Patty is this the code that Medicare decided to not take up in the final rule or is the right thinking of a different ad on code, OK, are you tapped into this?

Patty Harper
1:19:25
Um, yeah. I know there are we did add a CMS, CMS did add a code but maybe it was a proposed rule code, right, getting busted all the way around today.

Nathan Baugh
Total tangent, well, yeah. That's I go there. There is, there was a code that wasn't an add-on code to the evaluation and management codes, that was in the proposed rule that was taken out for the final rule. Don't ask me which of the codes it was, but in they, delayed implementation of it for, I think, three years. And essentially, what that did, is it allowed the rest of the physician fee schedule to be paid more, because the RVUs didn't have to balance out for this add-on code. So, there is that there is a code out there. It's delayed for two years. This is all fee schedule billing on the Medicare side, so not completely relevant for RHCS, but just wanted to put that out there because it was in the E&M. E&M was getting paid more, but everything else was getting cut as a result of it and it was a big political thing here in DC. Alright? I've totally sidetracked us.

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Moderator: Nathan Baugh
Speakers: Patty Harper, inQuiseek
Shannon Chambers, South Carolina Office of Rural Health

Patty Harper
That's fine. We will well We'll validate that information and send it out with the other correction to the diagnosis codes.

Shannon Chambers
1:20:55
OK, 99417 is showing as an active code for 112021 as well as the 2212 So Nathan it must be a different code.

Nathan Baugh
1:21:05
Must have been there for one, OK, Alright, um, Let's see. Yvonne, as this is the needs and one if an annual wellness visit is done through Telehealth Do we use G 2025 and see us as we just discussed? Yes, but, you're not going to technically, it's not easy to get credit for that annual wellness visit, but that is exactly how you're supposed to bill it to Medicare.

Patty Harper
1:21:35
In, in the revised SC 20016, there is a preventive service example to, towards the end of that document that people might want to refer to.

Nathan Baugh
1:21:51
Yeah. All right, Next question is from Deb, and she makes a good point, and I'll take this one. We didn't realize we should be billing for any of this, since we got the free RHC money. So, yes, that clarification was added in February that you must seek reimbursement. With that is something that we'll take back to HRSA and see if, you know, it's going to be an issue because you were just providing free covid tests. I think as a general rule of thumb, we're not going to, if you're trying to do the right thing, the government will also try to do the right thing eventually. It might take us a long time to get there, but the government will try to do the right thing and not penalize you for doing the right things. So I wouldn't worry too much, but certainly going forward, don't just do covid testing without seeking reimbursement, OK? All right. Next question is from Renee Stamp. He says, and we'll do a couple of more than six minutes, but, like I said, we will try to answer some of these questions via e-mail after in the days to come. Renee Stamp, how do RHCS, Bill 99484 for B H II Services to Medicaid?

Shannon Chambers
1:23:29
That is going to be specific to the individual Medicaid and to the state that you're actually in. Um, Nathan, there's not gonna be a way I can answer that without knowing what state she is and doing the research.

Nathan Baugh
So, sorry, Renee, that's a state specific question. Chris Morgan asks, could you address the medical decision making level fork over one thousand test? Let's say there was possible exposure, but no symptoms. Patty, you want to take that one?

Patty Harper
1:24:02
Yeah, could you read it again, Nathan, so, the medical decision making is going to be on the on the RHC provider to decide if that patient needs to be tested. So, we do know and Shannon, jump in here, if I'm missing something, I mean, we do know that there are patients that present asymptomatic Lee. So a provider may decide to test based on what they're seeing in the community as far as positivity rates and trends in their area. So the provider would just need to somehow, you know, document our, you know, show that, in their judgement. It was medically necessary to, to, to do the screening.

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Shannon Chambers
1:24:50
And, in addition, I agree with all of that. And in addition, what comorbidities does that patient have? You know, I'm talking about a patient that has asthma, if you're talking about a patient that has COPD, et cetera, then he yes, there may be ways that we want to go ahead and test that patient. And what is the medical decision making on that? Is it medium? Is it low? Is it high? It just also depends on the comorbidities of that individual patient.

Patty Harper
1:25:16
Now, that's an excellent point. If that patient is going to be at higher risk for comorbidities or complications based on their chronic conditions, then early detection of the virus would be imperative.

Nathan Baugh
1:25:34
OK, perfect. Few more questions. This person has left but I think it's a good question. I know it's one that you guys are on top of any advice on billing for infusion of services and RHC. What revenue code should be used?

Patty Harper
1:25:53
So, are we talking about the monoclonal antibody infusions or just infusions in general?

Nathan Baugh
1:26:01
I presume it’s the covid one.

Patty Harper
1:26:03
So what, what I have heard, or what we were told, at least from Novitas, was that, that is considered a type of immunotherapy for covid. And that is also going to be reported on the cost report. The, the, the the bayamon fusions, and the So I don't ...

Nathan Baugh
1:26:25
yes, not billing for for Medicare. You'll get reimbursed for it when you file your cost report. Next question is, for Lisa away, she puts or is from Lisa White. She says, When billing by time Does the amount of time need to be documented in the note?

Patty Harper
1:26:52
Yeah, I believe it does. But we have not been given specific documentation guidelines on recording the time. Is the time that the providers spends In working on that case, are coming up with that treatment plan on the date of service. So, it's not just face-to-face time which seems kind of it seems wrong to us. It seems counter-intuitive to our RHC face-to-face description. So, I've seen two different EHRs. that one has a radio button in the template where the provider selects it a range of time. I've seen another EHR where it's a free text field for the provider to document time, as far as what payers and auditors are going to be looking for on that time documentation. I don’t think we've gotten enough specific guidance yet. I think we'll see that as we move forward. But, yes, I would want that time documented. If, if the only thing that we can document is either medical decision making or time will go, the burden is going to be on us to for our clinical documentation to support the level that we reported.

Nathan Baugh
1:28:15

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Alright. Perfect, thank you, Patty. So, we're coming up on 330. And I know Patty and, Shannon, I could do this all day. We'll try it again, But we do want to conclude the, the remarks here and, like I said, well, we'll see about maybe e-mailing out answers to the questions to folks.

Patty Harper
And we will clarify the diagnosis codes. I apologize again for that slide not being updated.

Nathan Baugh
1:28:41
Yeah, we've gotten a couple of questions on that, so we'll make sure the updated sides are the ones that are posted and and be sure to send a clarification. So, I'd like to thank everyone for attending. We had a great attendance that, especially like to thank Patty Harper and Shannon Chambers for their presentation. As well as the Federal Office of Rural Health Policy Of course response during this webinar series. Again, please encourage others who may be interested to register for the series in the RHC dot org. In addition, we welcome you to e-mail us with your thoughts and suggestions for future call topics at nathan ... dot org. Just as an FYI, when the Provider Relief Fund portal comes out, will absolutely be doing a webinar on that. When that is fully available and ready to go right now, it's just in the registration stage. So that's something to be on the lookout for. Do we have the code up on the screen? Yes, we do. For the CR HCP is the last time, I'll say, the CEU code is Y, W, P X, G. And when we schedule the next webinar, a notice will be sent by e-mail to those who have registered with the details.

1:30:03
Thank you for your participation. And that concludes today's webinar. Thank you, all.