ANO REVENUE CYCLE MANAGEMENT MONTHLY NEWSLETTER

July 2023

CODING HIGHLIGHT

Description for 99495 and 99496

99495: Provider manages the period of transitional care postdischarge from an inpatient setting. He communicates with the patient or caregiver shortly after discharge and makes a face-to-face visit *within 14 days*. He performs medical decision-making of *moderate complexity*.

99496: Provider manages the period of transitional care postdischarge from an inpatient setting. She communicates with the patient or caregiver shortly after discharge and makes a face-to-face visit *within 7 days*. She performs medical decision making of *high complexity*.

Monthly humor

Q&A

Q: What are the most common concerns providers have about billing companies?
A: I have found that most providers are concerned with billing companies not working claims to the fullest capacity and not receiving the money they are owed. Also not knowing what is or is not being done as there is a lack of communication between the billing company and providers.

Q: What do you do to help alleviate or make providers feel more comfortable?
A: Words are just that, words. I can tell a provider that I work differently but they need to be able to see it. I am very transparent when it comes to the services I provide. I welcome questions and want to educate my clients on what I am doing and how it is getting done. I believe that working WITH the provider is beneficial for both parties.

Do you have a question you would like answered? Send us your questions at info@ano-rcm.com

"Success is not final; failure is not fatal: It is the courage to continue that counts." ~ Winston S Churchill

COMMON MISTAKES PROVIDERS MAKE:

Some of the most common mistakes made by providers are:

- **Lack of documentation**: If the service or procedure is not documented then, for billing and insurance purposes, it was not done. It might sound like a small item but, truly it is extremely important. Many providers bill for a service only to have the insurance company request records later and the service is not documented. The insurance can and will demand the orignal payment back.
- **Not coding or billing for a service**: Some providers do not add all their services into their note, or on their claim, to try and 'Help' the patient. In reality you are not helping the patient, or yourself. This type of ommision

Telehealth visits

can actually harm you as it can be considered abuse or fraud. Always make sure to document all the services you have provided.

- **Cloning**: With the way EMR's are set up it has become so easy for a provider to 'Cut and Paste' the previous note into the new note and just change a couple of items to make it 'New' for that date of service. This can be very dangerous if it is not done properly. If you are pulling over data from the previous visit you always want to make sure you are reading through everything first, removing any labs, diagnositic information, or referal information, and information that would have only pertained to that visit. Pulling that type of information over repeatedly is considered cloning and can cause a provider or practice money.

CODING UPDATES: TELEHEALTH SERVICES

Establishing telehealth visits for primary care services can be very beneficial. It allows you to market to patients that may typically avoid primary care visits due to not being able to travel. Telehealth visits also allow patients not to miss a lot of work as they do not need to come into the office and do not need to leave work. In-office visits can be a big obstacle, whether it is lack of daycare, not able to travel, or losing time from work. Offering telehealth expands your practice and offers more options for your patients.

There are many preventive services that are covered by Medicare and can be performed using telehealth:

- Alcohol misuse screening anc counseling
- Medical nutrition therepy
- Depression screening
- Annual Wellness Visit
- Intensive Behavioral Therapy (IBT) for Cardiovascular disease
- IBT for Obesity
- Diabetes self-management training
- Prolonged preventive services
- Lung cancer screening
- Sexually Transmitted Infection (STI) screening and High Intestity Behavioral Counseling (HIBC) to prevent STI's
- Counseling to prevent tobacco use

Medicare will continue to cover Telehealth Office Visits (99202–99215) through the end of 2024. These telehealth visits are required to be audio *and* video and must be through a HIPAA compliant platform. Use of FaceTime or Skype will no longer be compliant as of August 9, 2023. As of January 1, 2024 Incedient-to services will no longer be allowed by virtual supervision. In additiona, Medicare will continue to cover audio-only telephone services (99441-99443), this is only for established patients.

**AAPC: Healthcare Business Monthly; July 2023 issue; *Telehealth Services after the PHE: Part 2* / **AAPC: Healthcare Business Monthly; July 2023 issue; *Which Preventive Services Can be Conducted via Telehealth?*

WANT TO INCREASE YOUR REVENUE?

Primary care providers can increase their revenue by including preventive screenings and/or counseling during a routine problem-focused visit. The key is to fully understand the requirements of the additional services and how to correctly document the work.

- **Routine Physcial Exam** – this can be performed without diagnsosis of a specific symptom, complaint or illness. This service involves ordering labs or diagnostic procedures, examination, comprehensive management, risk factor reduction and/or preventive guidance.
- **Initial Preventive Phywsical Exam (IPPE)** – this service is only allowed once in the patient's lifetime and within the first 12 of months of enrollment to Medicare, as this is a Medicare service. During this exam the provider will review the patient's safety levels and functional ability (daily living activities, fall risks, etc.) and discuss a plan for future screenings. The IPPE visit will also include end-of-life planning. (billed using G0402 for Medicare)
- **Annual Wellness Visit (AWV)** – this is billed differently for Medicare and other insurances as Medicare does not cover routine physicals. An AWV would also include ordering labs or diagnostic procedures, examination, comprehensive management, risk factor reduction and/or preventive guidance. (billed using G0438 or G0439 for Medicare and 99384-99387 for New patients and 99394-99397 for established patients)

The above mentioned physicial visits are only billable once a year, however there are several other preventive services that can be captured throughout the year.

- **Alcohol Abuse Screening (15 mins)–** can be billed annually Medicare G0442 / G0443: G0442 is annual screening, G0443 is brief face-to-face behavioral counseling for alcohol misuse, 15 minutes.
- **Depression Screening (15 mins)** – Codes 96127 / G0444: The provider administers tests to evaluate the patient for emotional and behavioral problems. This includes various standardized instruments, such as a depression inventory, attention deficit hyperactivity disorder scall, and sympotom questionnaires. The provider then scores the tests and records the results.
- **IBT for cardiovascular (15 mins)** – Codes G0446: face-to-face intensive behavioral counseling for cardiovascular disease, individual, 15 minutes.
- **IBT for obesity (15 mins)** – up to 22 times annually G0447: Screening for obesity, dietary assessment and intensive behavioral counseling and behavioral therapy. The patient must have a BMI of > 30 to be eligible.
- **Counseling to prevent STI (30 mins)** – G0445: Seminannual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training and guidance on how to change sexual behavior, performed semi-annually, 30 minutes.
- **Counseling for Smoking** – 99406 / 99407: The provider counsels the patient on steps to stop use of tobacco products. The provider uses the discussion to discover the specific barriers to cessation the patient faces and possible relapse triggers. The provider and patient then discuss practical methods for coping with those issues. The provider may write a prescription for a pharmacologic intervention. The provider also may refer the patient to a support group that matches the patient's needs. The provider documents the discussion as well as the amount of time.

Many providers are probably already providing these services but are unaware of how to capture and document all the services. A provider should review the next day's schedule to identify the potential preventive services and capture the additional revenue. Remember Document, Document, Document!

**AAPC: Healthcare Business Monthly; July 2023 issue; *PCPs: Increase Practice Revenue by 20%* / **AAPC: Healthcare Business Monthly; July 2023 issue; *Telemedicine Opportunities That Reap the Best Rewards* / AAPC Procedure Desk Reference

If you have any questions or would like a specific code highlighted in our next newsletter, please send those requests to info@ano-rcm.com.

The ANO Revenue Cycle Management Monthly Newsletter is created to assist our clients with brief topic information. The newsletter is not intended to direct any provider, client or practice on how to manage their own practice or services. The information within the ANO Revenue Cycle Management Newsletter is based on the opinion and discretion of the author and may be pieces of a larger topic / subject. Information for the newletter is found within several sources, including but not limited to the AAPC Healthcare Business Monthly, HCPCS book, CPT books, Procedure Desk Reference books, and the internet.