A New Year: New Payment Opportunities

This year’s CPT and Medicare changes provide new reimbursement opportunities for health care providers. These opportunities include both new and revised codes and some new billing rules that will enable physicians to get paid for work they are already doing. Below is a summary of code changes particularly important to family physicians.

Prolonged Services
Beginning January, 2017 CMS will no longer bundle payments for non-face-to-face prolonged services with payment for other evaluation and management service (E/M) services. Codes 99358 (prolonged E/M service before and/or after direct patient care, first hour) and 99359 (each additional 30 minutes) may be billed separately as long as the time is not also counted toward the provision of any other service. Remember 99359 is an “add-on” code and should be listed separately in addition to the primary code for prolonged service.

For 2017, payment for 99358 will range from a high of $128.13 to a low of $115.70. Payment for the add-on code (99359) will range from $61.80 down to $55.71. Payment is dependent upon the geographic location of your practice.

Cognitive Impairment Assessment
The American Medical Association’s (AMA’s) CPT Editorial Panel has developed a code to describe assessment and care planning for patients with cognitive impairment. This code will not be valued or ready for use by CMS until 2018. But, CMS plans to pay for this service in 2017 using a new G-code (HCPCS) – G0505. The code is defined by: Cognition and functional assessment using standardized instruments with development of a recorded care plan for the patient with cognitive impairment; history obtained from patient and/or caregiver by the physician or other qualified health care professional in an office, other outpatient setting, home, domiciliary or rest home.

While that is a long definition, here are the intended service elements:

- Cognition-focused evaluation, including a pertinent history and examination;
- Medical decision making of moderate or high complexity (defined by the E/M documentation guidelines);
- Functional assessment (for example, basic and instrumental activities of daily living), including decision-making capacity;
- Use of standardized instruments to stage dementia;
- Medication reconciliation and review for high-risk medications, if applicable;
- Evaluation for neuropsychiatric and behavioral symptoms (including depression), including use of standardized instruments;
- Evaluation of safety (for example, home safety), including motor vehicle operation, if applicable;
- Identification of caregivers, caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks;
- Advance care planning and addressing palliative care needs, if applicable and consistent with beneficiary preference; and
• Creation of a care plan, including initial plans to address any neuropsychiatric symptoms and referral to community resources as needed (for example, adult day programs or support groups); care plan shared with the patient or caregiver with initial education and support.

To use G0505, services must be furnished by a physician or other appropriate billing provider such as a nurse practitioner or physician assistant. The service cannot be billed on the same date of service as any of the following CPT codes:

- 90785: Interactive complexity for psychotherapy,
- 90791 and 90792: Psychiatric diagnostic evaluation, with or without medical services,
- 96103: Psychological testing administered by a computer,
- 96120: Neuropsychological testing administered with a computer,
- 96127: Brief emotional/behavioral assessment,
- 99201 – 99210: Office/outpatient visits,
- 99324 – 99337: Domiciliary/rest home visits,
- 99341 – 99350: Home visits,
- 99366 – 99368: Medical team conference
- 99497 and 99498: Advanced care planning.

In addition, Medicare prohibits billing G0505 with other care planning services, such as home health care and hospice supervision (G0181 and G0182), or the new add-on code for chronic care management (CCM) services (G0506).

According to an official from CMS, they do not believe the services described by G0505 will significantly overlap with medically necessary CCM services or transitional care management (TCM) services. Therefore, physicians can bill G0505 on the same date of service or within the same service period as the three CCM codes (99487, 99489, 99490) or two TCM codes (99495 and 99496).

For 2017, CMS reimbursement for this service is between $274.22 and $246.97 in California, dependent on your specific location. This is slightly higher than other areas of the country. Join CAFP on Tuesday, January 31, 2017 at 12:15 for the annual “Coding and Billing Strategies Update for 2017” to learn more about how to practically implement this service in your practice and collect your entitled reimbursement.

**Health Risk Assessments**

There are two new CPT codes for 2017 that may be used to report health risk assessments:

- 96160: “Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument” and
- 96161: “Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument”

You may bill this service if the instrument was administered and scored in a diagnostic setting in conjunction with an office visit. You should not, however, bill 96160 separately when the service is explicitly included in another service such as the Medicare annual wellness visit (AWV). For Medicare purposes, you also should not bill 96160 separately if furnished as a preventive service, because it would describe a non-covered Medicare service.
As this service is typically done by non-physician clinical staff, only practice expense values are assigned to the service. The reimbursement, therefore, ranges from $6.03 to $5.03 in California.

**Vaccine Codes**
A few influenza vaccine codes have been redefined in CPT for 2017 to reflect dosage amounts instead of age indications. So while the dosage remains in the code, the age-range has been deleted.

Additionally there are three new vaccine codes:
- 90674: Influenza virus vaccine, quadrivalent (cclIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use
- 90653: Influenza vaccine, inactivated (IIV), subunit adjuvanted, for intramuscular use
- 90625: Cholera vaccine, live, adult dosage, one dose schedule for oral use

Two other new vaccine codes are effective 1/1/2017, but won’t appear in the CPT manual until 2018. Both codes represent vaccines that are pending FDA approval. They are:
- 90682: Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use, and
- 90760: Zoster (shingles) vaccine (HZV), recombinant, sub-unit, adjuvanted, for intramuscular injection

**Chronic Care Management (CCM)**
CMS has changed the status of CCM codes 99487 and 99489 for 2017 from “B” (bundled) to “A” (active) and will begin payment for them in 2017. CMS will continue to pay for 99490 as they have in the past, but several changes have been made to the scope of service elements that will help clarify and/or simplify Medicare’s billing requirements for these services. The following changes apply to all three of these codes:
- The requirement that CCM may only be initiated during a Medicare annual wellness visit (AWV), initial preventive physical exam (IPPE), or face-to-face evaluation and management visits now applies only to new patients or those patients who have not been seen within one year rather than to all patients as before.
- The requirement to obtain the beneficiary’s written agreement before providing CCM services has been removed. Instead, documentation in the medical record that the required information was explained and the beneficiary accepted or declined the services is sufficient.
- A care plan must be provided to the patient, but the format is no longer specified.
- The requirement for structured recording of patient information using certified electronic health record (EHR) technology no longer includes the creation of a structured clinical summary record.
- Electronic sharing of the care plan with other providers has been redefined as electronically capturing care plan information and making it available in a “timely” manner, not necessarily 24/7, including via fax.
- Communication with home- and community-based providers regarding the patient’s psychosocial needs and functional deficits must be documented in the patient’s medical record, but not necessarily in a certified EHR.
- Access to 24/7 care has been redefined as providing patients and caregivers with a means to make timely contact with health care professional in the practice to address all urgent care needs, not just those related to the patient’s chronic conditions.
Remember, these services are furnished “once a calendar month” and may be reported only by the provider who assumes the care management role with the patient. A Medicare beneficiary can be eligible to receive either complex or non-complex CCM during a given month, but not both and only one claim can be submitted to Medicare for CCM for that month.

For 2017, CMS has set the payment for these services for California providers at:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Fee Range</th>
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<tbody>
<tr>
<td>99487</td>
<td>$114.99 - $98.09</td>
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<tr>
<td>99489</td>
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<tr>
<td>99490</td>
<td>$50.53 - $44.20</td>
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</tbody>
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A new HCPCS level II code provides payment for CCM initiating visits that require extensive face-to-face assessment and care planning by the billing provider. The code G0506 is described as “comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services, including assessment during the provision of a face-to-face service.”

If the provider billing and initiating CCM personally performs extensive assessment and care planning beyond the usual effort described by the E/M, AWV, or IPPE code, then he/she may also bill G0506. This is considered an add-on service and therefore, a modifier is not required when billing. This service can be billed separately from the monthly care management service codes (99487, 99489 and 99490). The time and effort described by G0506 cannot be counted toward another code. G0506 can only be billed once per patient, per provider.

For further information about how to effectively incorporate these services and more into your family physician practice, please join us on Tuesday January 31, 2017 at 12:15 pm for CAFP’s Strategies for Coding and Reimbursement: 2017 CPT Updates webinar.

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