2017 Coding and Medicare Changes for Physician Fee Schedule Billing

Presented by
Jean Acevedo, CHC CPC CENTC LHRM

Disclosure Statement

No financial relationships to disclose.
2017 Coding and Medicare Changes for Billing

Disclaimer

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This presentation is a general summary that explains certain aspects of the Medicare Program and other reimbursement and compliance information, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

SPECIAL NOTE: This content is based on the 2017 MPFS Rule; attendees should rely on information from the Rule and other forthcoming guidance from CMS before implementing any of the material discussed here.

All italicized quotations are from CMS-1654-F, the final 2017 MPFS rule.

Objectives

Hospice and Palliative Care physicians and nonphysician practitioners (NPPs)* will be able to

• Discuss Medicare’s coverage criteria for new and revised covered physician services, including non face-to-face prolonged services, and the role these services play in CMS’s quality payment programs.
• Identify payment risk areas when billing dually eligible Medicare beneficiaries, and recoupment or offset of payments to providers sharing the same taxpayer ID.

*NPP is the official CMS term when it is referring to a specific subset of nonphysician practitioners who can and should have a Medicare provider number. Recognizing there are industry-specific terms and acronyms that vary by region, NPP is used here to most accurately reflect CMS policy and avoid any misconceptions.
Agenda

• Improving Payment Accuracy for
  – Primary care
  – Care management
  – Patient-centered services
• Billing dually eligible Medicare/Medicaid beneficiaries.
• Medicare Advantage and Medicare Enrollment

2017 Proposed MPFS Rule

“In recent years, we have been engaged in an ongoing incremental effort to update and improve the relative value of primary care, care management/coordination, and cognitive services within the PFS by identifying gaps in appropriate payment and coding. These efforts include changes in payment and coding for a broad range of PFS services. This effort is particularly vital in the context of the forthcoming transition to the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) incentives under The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10, enacted April 16, 2015), since MIPS and many APMs will adopt and build on PFS coding, RVUs and PFS payment as their foundation.”
Goals of Improving Payment Accuracy

- Improve payment for care mgmt. services provided for patients with behavioral health conditions
- Improve payment for cognition and functional assessment, and care planning for beneficiaries with cognitive impairment
- Adjust payment for routine visits furnished to beneficiaries whose care requires add’l resources due to their mobility-related disabilities.
Goals of Improving Payment Accuracy: Tangibles

• Recognize for Medicare payment additional CPT codes within the Chronic Care Management family of codes (for complex CCM) and an add-on code to the initiating visit during which CCM services are initiated to reflect resources associated with the assessment for, and development of, a new care plan.

• New coding and payment mechanisms for behavioral health integration services including substance abuse disorder treatment.

• Recognize for Medicare payment CPT codes for non-face-to-face Prolonged E&M services by the physician/NPP that are currently bundled, and increase payment rates for F2F prolonged E&M services.

Let’s look at a few of these...
CoCM and BHI

- CoCM is a new collaborative approach to treating mental health issues
  - Psychiatric
  - Substance abuse treatment
- Behavioral Health Integration (BHI) is a team-based approach to care that focuses on integrative treatment of patients with medical and mental or behavioral health conditions.

Psychiatric CoCM
(There will be ‘G’ codes until CPT publishes for 2018)

- G0502: Initial psychiatric collaborative care management, 1st 70 minutes in the 1st calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or NPP, with the following required elements:
  - Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional;
  - Initial assessment including administration of validated rating scales, w/the development of an individualized treatment plan;
  - Review by the psychiatric consultant w/modifications of the plan if recommended;
  - Entering patient in a registry and tracking f/up and progress using the registry, participation in a weekly caseload consultation w/ the psyche consultant; and
  - Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies.
Psychiatric CoCM
(There will be ‘G’ codes until CPT publishes for 2018)

• G0503: subsequent psychiatric CoCM, 1st 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or NPP, with the following required elements:
  – Tracking patient f/up and progress using the registry, with appropriate documentation;
  – Participation in weekly caseload consultation w/the psychiatric consultant;
  – Ongoing collaboration with and coordination of the patient’s mental health care w/the treating physician or other qualified health care professional and any other treating mental health providers;
  – Additional review of progress & recommendations for changes in tx, as indicated, including medications, based on recommendations of the psyche consultant;
  – Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies;
  – Monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other tx goals and are prepared for discharge from active treatment.

Psychiatric CoCM
(There will be ‘G’ codes until CPT publishes for 2018)

• G0504: Initial or subsequent psychiatric collaborative care management, each additional 30 in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (list separately in addition to code for primary procedure).
CMS’s nuances for these services...

- “The behavioral health care manager furnishes these services both face-to-face and non-face-to-face, and consults with the psychiatric consultant minimally on a weekly basis. We would expect that the behavioral health care manager would be on-site at the location where the treating physician or other qualified health care professional furnishes services to the beneficiary.”
- “This care manager is a member of the practice’s staff with specialized training in behavioral health…which could include a range of disciplines, for example, social work, nursing, and psychology.”
- On the other hand, the psychiatric consultant is expected to be a physician, and able to prescribe medications.

Physician Supervision

- With so many non-face-to-face services proposed to be covered, where CMS is not stating they must be personally provided by the billing provider:
- “we are proposing to…better define general supervision and to allow general supervision not only for CCM services and the non-face-to-face portion of TCM services, but also for proposed codes G0502, ...99487 and 99489. Instead of adding each of these proposed codes requiring general supervision to the regulation….to allow general supervision of the non-face-to-face portion of designated care management services, and we would designate the applicable services through notice and comment rulemaking.”
Patients with Cognitive Impairment

Intended for a broader application of behavioral health integration in the primary care setting:

• G0505: cognition and functional assessment using standardized instruments with development of 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 office or other outpatient setting or home or domiciliary or rest home.
  – Provide separate payment to recognize physician/NPP work in assessing and creating a care plan for beneficiaries with cognitive impairment, such as from Alzheimer’s disease or dementia, at any stage of impairment.
• G0507: Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional time, per calendar month.

• Temporary codes as a similar CPT code is planned for CY 2018

G0505 Requirements

• Cognition-focused evaluation including a pertinent history & exam
• MDM of moderate or high complexity
• Functional assessment such as Basic and Instrumental ADL and 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 instrument(s).
2017 Coding and Medicare Changes for Billing

G0505 Requirements, continued

• Evaluation of safety (e.g., home) including motor vehicle operation, if applicable.
• Identification of caregiver(s), 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.
  – Note: do not bill ACP/99497 with G0505, same date of service
• Creation of a care plan, including initial plans to address any neuropsychiatric symptoms and referral to community resources as needed (e.g., adult day programs, support group); care plan shared with the patient and/or caregiver with initial education and support.

G0505 Restrictions

• The service must be personally performed by the physician or NP
• Cannot be billed on the same date as other face-to-face services such as:
  – The following psyche codes: 90785, 90791, 90792, 96103, 96120, 96127
  – Office/ALF/Home E&M codes:
    • 99201-99215
    • 99324-99337
    • 99341-99350
  – Team conference: 99366-99368
  – Advance Care Planning: 99497, 99498
  – Other care planning activities: 99374, G0181, G0182, GPPP7
G0505 Allowances

- G0505 can be billed on the same date of service or within the same service period as:
  - CCCM: 99487, 99489
  - CCM: 99490
  - TCM: 99495, 99496
- Total RVUs – 6.64
  - ~$252 Outpatient (not adjusted geographically)
  - For comparison, 99345
    - Total RVUs – 6.25
    - ~$242.00 (not adjusted geographically)

Payment Accuracy for Care of People with Mobility-Related Disabilities

- G0501: Resource-intensive services for patients for whom the use of specialized mobility-assistance technology (such as adjustable height chairs or tables, patient lifts, and adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient E&M visit (Add-on code, list separately in addition to primary procedure).
  - Proposed Total RVUs – 1.24
    - perhaps a $50 allowable?

- On hold till perhaps 2018.
CMS is Soliciting Comment on Other Coding Changes to Improve Payment Accuracy

- Care of People with Disabilities
  - “We recognize that some physician practices may frequently furnish services to particular populations for which the relative resource costs are similarly systemically undervalued and we seek comment regarding other circumstances where these dynamics can be discretely observed.”

  - Could this be non-English speaking interpreters?
  - Think Section 1557 of the ACA
  - There sure are additional expenses incurred, for interpreters, often exceeding reimbursement
    - Foreign language
    - Hearing impaired

Non-Face-to-Face
Prolonged E&M Services
New for 2017: “Separate payment for existing codes describing prolonged E/M services without direct patient contact by the physician (or other billing practitioner), and increased payment for prolonged E/M services with direct patient contact by the physician (or other billing practitioner) adopting the RUC-recommended values.”

Non-F2F Prolonged Services: CPT Codes

- 99358 – Prolonged evaluation and management service before and/or after direct patient care, first hour
  – ~$118.16
- 99359 – Prolonged evaluation and management service before and/or after direct patient care, each additional 30 minutes (List separately in addition to code for prolonged service)
  – ~$56.79
- A means to recognize the additional resource costs of physicians and other practitioners when they spend an extraordinary amount of time outside the in-person office visit caring for the individual needs of their patients.
Non-F2F Prolonged Services

• “...beginning in CY 2017 we propose to recognize CPT codes 99358 and 99359 for separate payment....We note that time could not be counted more than once towards the provision of CPT codes 99358 or 99359 and any other PFS service.”
• “We agreed that these codes would provide a means to recognize the additional resource costs of physicians and other billing practitioners, when they spend an extraordinary amount of time outside of an E/M visit performing work that is related to that visit and does not involve direct patient contact (such as extensive medical record review, review of diagnostic test results or other ongoing care management work).”

Non-F2F Prolonged Services, cont’d

• “We intended to propose conformity with CPT guidance that requires that time counted towards the codes describe services furnished during a single day directly related to a discrete face-to-face service that may be provided on a different day, provided that the services are directly related to those furnished in a face-to-face visit.”
• “Having considered this feedback, we have decided to finalize our proposal for separate payment of the non-face-to-face prolonged service codes (CPT 99358, 99359) and adopt the CPT code descriptors and prefatory language for reporting these services. We stress that we intend these codes to be used to report extended non-face-to-face time that is spent by the billing physician or other practitioner (not clinical staff) that is not within the scope of practice of clinical staff, and that is not adequately identified or valued under existing codes or the 2017 finalized new codes.”
  – With adoption of CPT conventions, time thresholds are when the mid-point has been passed; e.g., 31 minutes of extended care for 99358
2017 Coding and Medicare Changes for Billing

Nuances of 99358, 99359

- 99358/9 cannot be billed during the same service period of complex CCM (99487/9) or TCM services (99495/6)
- “We note that while these typical times [times assigned to TCM or CCM] are not required to bill the displayed codes, we would expect that only time spent in excess of these times would be reported under a non-face-to-face prolonged service code.”
  - Interesting as G0505, G0506 are not time based codes.

Typical Times per CY2017 PFS Final Rule Time file

- G0505 is a base code for prolonged services
  - Not time-based
  - How to know when to use a prolonged services code?
- G0505 (cognitive impairment assessment/plan)
  - 85 minutes
  - Companion code for 99358/99359
- G0506 (CCM assessment/plan)
  - 28.5 minutes
  - “In association with the CCM initiating visit, a billing practitioner may choose to report either prolonged services or G0506 (if requirements to bill both prolonged services and G0506 are met), but cannot report both a prolonged service code and G0506.”
Chronic Care Management

- CMS assessment of claims data for 99490 in CY 2015
  - CCM may be underutilized relative to the intended patient population.
  - To-date, only approximately 513,000 unique Medicare beneficiaries received the service an average of 4 times each ($93M in allowed charges)
- Reminds physicians that “CMS did not limit the eligible population to any particular list of chronic conditions other than the language in the CPT code descriptor.
- Goal is access to advanced primary care services to support patients with chronic diseases to achieve health goals.
- “Stakeholders have stated that CPT 99490 is underutilized because it is underpaid relative to the resources involved in furnishing the services, especially given the extensive Medicare rules for payment...”
2017 Changes to CCM

- “...more appropriately recognize and pay for the other codes in the CPT family of CCM services...”
- 99487 – Complex CCM services, 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
- 99489 - ...each additional 30 minutes of clinical staff time (List separately in addition to code for primary procedure)

NOTE: CMS is requiring 60 minutes for reporting CPT 99487 and 30 additional minutes for each unit of 99489 and not to adopt CPT rules on time-based codes.

CCCM Code Requirements

- 99487 – Complex care management services, with the following required elements:
  - Multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
  - Establishment or substantial revision of a comprehensive care plan;
  - Moderate or high complexity of medical decision making;
  - 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

~$96.47 NonFacility/~$54.69 Facility
2017 Coding and Medicare Changes for Billing

**CCCM Code Requirements**

- 99489 – each add’l 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to the code for primary procedure)
  ~$48.89 Outpatient/$27.53 Inpatient

**CCM and CCCM Requirements**

- All requirements in CMS Table 11 apply, whether reporting 99487, 99489 or 99490
- The 3 codes differ in
  - The amount of clinical staff service time provided;
  - The complexity of medical decision making; and
  - The nature of care planning that was performed
    - Establishment or substantial revision of the care plan for complex CCM
    - Establishment, implementation, revision or monitoring of the care plan for non-complex CCM.
CCM and CCCM Requirements

• Consider identifying beneficiaries who require complex CCM services using CPT guidance
  – Number of illness
  – Number of medications
  – Repeat admissions or emergency department visits

A CCM Add-on Code

• G0506: 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 (billed separately from monthly care management services) (Add-on code, list separately in addition to primary service).

**NOTE**: For use in developing the CCM or CCM care plan at your initiating visit.
2017 Changes to CCM

**Initiating Visit:** Must be Face-to-face, but

- The F2F visit included in TCM counts
- IPPE or AWV visits count
- Levels 2-5 of E&M visits count
  - A level 4 or 5 is not required
- Nurse visit/99211 does not qualify

*CHANGE:* An Initiating visit is required only for new patients or patients not seen within one year of initiating CCM/CCCMM instead of for all beneficiaries receiving CCM/CCCMM services.

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2017 Changes to CCM

- New add-on G-code
- **G0506:** Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services (billed separately from monthly care management services) (Add-on code, list separately in addition to primary service).
  - “We believe G0506 might be particularly appropriate to bill when the initiating visit is a less complex visit (such as a level 2 or 3 E/M visit) although G0506 could be billed along with higher level visits if the billing practitioner’s effort and time exceeded the usual effort described by the initiating visit code. It could also be appropriate...when the initiating visit addresses problems unrelated to CCM, and the billing practitioner does not consider the CCM-related work he or she performs in determining what level of initiating visit to bill.”
  - ~$66.15 NonFacility/~$48.20 Facility
G0506 add-on code

• Accounts specifically for add’l work of the billing practitioner in personally performing a F2F assessment of a beneficiary requiring CCM services
• Personally performing CCM care planning that is not already reflected in the initiating visit itself
• Report only when the initiating visit addresses problems unrelated to CCM and the billing practitioner does not consider the CCM-related work in determining the level of initiating visit to bill.
• Use once, at CCM initiation visit only
  – Not for CCM “re-initiation”

2017 Changes to CCM

• G0506, cont’d
• The care plan that must be created to bill G0506 would be subject to the same requirements as the care plan included in monthly CCM services:
  – Electronic patient-centered care plan
  – Based on a physical, mental cognitive, psychosocial, functional and environmental (re)assessment and
  – An inventory of resources and supports;
  – A comprehensive care plan for all health issues.
2017 Changes to CCM

- Many requirements have been simplified
  - Table 11 provided here
  - CCM requirements for RHCs and FQHCs have also been reduced so they are not more burdensome than for practitioners billing under the PFS.

Summary of Palliative Care Opportunities

- 99495
- 99496
- 99490
- 99487
- 99489
- 99497
- 99498
- G0507
- G0505
- G0506
- 99358
- 99359

Keep in mind that “While we recognized that there may be some overlap in the patient populations for the proposed new codes, we noted that time spent by a practitioner or clinical staff could not be counted more than once for any code (or assigned to more than one patient), consistent with PFS coding conventions.”
Final note on these services: Information from CMS available as of 11/18/16 was relied upon in developing this webinar. Keep on the alert for Transmittals, Change Requests and CMS articles to further refine coverage criteria.

Important Reminder from CMS
Prohibition on Billing Qualified Medicare Beneficiary Individuals for Medicare Cost-Sharing

- Federal law prohibits providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments, from beneficiaries enrolled in the Qualified Medicare Beneficiaries (QMB) program
- QMB is a Medicaid program which helps certain low-income individuals with Medicare cost-sharing liability
- States can limit provider payment for Medicare cost-sharing to the lesser of the Medicare cost-sharing amount, or the difference between the Medicare payment and the Medicaid rate for the service

Prohibition on Billing Qualified Medicare Beneficiary Individuals for Medicare Cost-Sharing

- Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full. Sharing from the beneficiary) as payment in full for services rendered to a QMB individual.
- Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions.

QUESTIONS?

Acevedo Consulting Incorporated
2605 West Atlantic Avenue, Suite D-102
Delray Beach, FL 33445

561.278.9328
info@AcevedoConsulting.com
www.AcevedoConsultingInc.com
TABLE 11: Summary of CY 2017 Chronic Care Management Service Elements and Billing Requirements

<table>
<thead>
<tr>
<th>Initiating Visit</th>
<th>Initiation during an AWV, IPPE, or face-to-face E/M visit (Level 4 or 5 visit not required), for new patients or patients not seen within 1 year prior to the commencement of chronic care management (CCM) services.</th>
</tr>
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<tbody>
<tr>
<td>Structured Recording of Patient Information Using Certified EHR Technology</td>
<td>Structured recording of demographics, problems, medications and medication allergies using certified EHR technology. A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination and ongoing clinical care.</td>
</tr>
</tbody>
</table>
| 24/7 Access & Continuity of Care | • Provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week.  
• Continuity of care with a designated member of the care team with whom the beneficiary is able to schedule successive routine appointments. |
| Comprehensive Care Management | Care management for chronic conditions including systematic assessment of the beneficiary’s medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of beneficiary self-management of medications. |
| Comprehensive Care Plan | • Creation, revision and/or monitoring (as per code descriptors) of an electronic patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues.  
• Must at least electronically capture care plan information, and make this information available timely within and outside the billing practice as appropriate. Share care plan information electronically (can include fax) and timely within and outside the billing practice to individuals involved in the beneficiary’s care.  
• A copy of the plan of care must be given to the patient and/or caregiver. |
| Management of Care Transitions | • Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.  
• Create and exchange/transmit continuity of care document(s) timely with other practitioners and providers. |
| Home- and Community-Based Care Coordination | • Coordination with home and community based clinical service providers.  
• Communication to and from home- and community-based providers regarding the patient’s psychosocial needs and functional deficits must be documented in the patient’s medical record. |
| Enhanced Communication Opportunities | Enhanced opportunities for the beneficiary and any caregiver to communicate with the practitioner regarding the beneficiary’s care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods. |
| Beneficiary Consent | • Inform the beneficiary of the availability of CCM services; that only one practitioner can furnish and be paid for these services during a calendar month; and of their right to stop the CCM services at any time (effective at the end of the calendar month).  
• Document in the beneficiary’s medical record that the required information was explained and whether the beneficiary accepted or declined the services. |
| Medical Decision-Making | Complex CCM services require and include medical decision-making of moderate to high complexity (by the physician or other billing practitioner). |