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NEW CODES, NEW PAYMENT OPPORTUNITIES FOR 2017

This year's changes include opportunities to get paid for some services that were previously not billable.

This year's CPT and Medicare updates include new and revised codes and billing rules that may enable you to get paid for some work you are already doing. Here is a summary of those opportunities and other changes most likely to affect family physicians.

Chronic care management

Several changes to the scope of service elements for chronic care management (CCM) clarify or simplify Medicare's billing requirements. For code 99490, "Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month . . . ," as well as two additional codes discussed later in this article, the following changes apply:

- The requirement to obtain the beneficiary's *written* agreement before providing CCM services has been removed; documenting in the medical record that the required information was explained and the beneficiary

accepted or declined the services is sufficient,

- The requirement that CCM may only be initiated during a Medicare annual wellness visit (AWV), initial preventive physical exam (IPPE, also known as a "Welcome to Medicare" visit), or face-to-face evaluation and management (E/M) visit applies only to new patients or those patients not seen within the last year rather than all patients,

- 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,

- A care plan must be provided to the patient, but the format is no longer specified,

- 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,

- Access to 24/7 care has been redefined as providing patients and caregivers with a means to make timely contact with health care professionals in the practice

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to address all urgent care needs, not just those needs related to the patient's chronic conditions,

- 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 a certified EHR.

For CCM services that require more clinical staff time, more complex medical decision-making, and more substantive care planning than 99490, Medicare is extending payment to two CPT codes:

- 99487, "Complex chronic care management services, with the following required elements: multiple (two 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 medical decision making; 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 directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)."

A change in medication or treatment modality does not qualify for "substantial revision" of a care plan, according to *CPT Assistant* (November 2013). You can consider identifying beneficiaries who require complex CCM services using criteria suggested in CPT guidance (such as number of illnesses, number of medications or repeat admissions, or emergency department visits) or according to the profile of typical patients described in the CPT introductory language.

However, these criteria and examples do not ensure Medicare eligibility for complex CCM.

Prior to 2017, the Centers for Medicare & Medicaid Services (CMS) considered payment for these codes to be "bundled" with payment made for other services. As with code 99490, you may only report 99487 once per month and only if you are the provider who assumes the care management role with the patient. A beneficiary can be eligible to receive either complex or non-complex CCM during a given month, not both, and only one claim can be submitted to Medicare for CCM for that month.

For 2017, CMS has set the average payment amount (i.e., unadjusted for geography or individual physician bonuses and penalties) for code 99487 at \$93.67 and for code 99489 at \$47.01.

A new code extends payment for CCM initiating visits that require extensive face-to-face assessment and care planning by the billing provider:

- 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."

When 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, the provider could also bill G0506. This is considered an add-on code and does not require a modifier.

You can bill this code separately from the monthly care management service codes (99490, 99487, and 99489). Keep in mind, however, that the time and effort described by G0506 cannot also be counted toward another code. G0506 can only be billed once per patient per provider.

■ A change in medication or treatment modality does not qualify for "substantial revision" of a care plan.

■ Only one claim may be submitted to Medicare for CCM each month for an eligible beneficiary.

■ The average payment for complex care management code 99487 is \$93.67 and for code 99489 is \$47.01.

For 2017, CMS has set the average payment amount for G0506 at \$63.88.

Prolonged services

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

Medicare does not require a modifier when reporting this code with an E/M code; however, you should verify instructions with commercial payers.

For 2017, CMS has set the average payment amount for 99358 at \$113.41 and for 99359 at \$54.55.

Cognitive impairment assessment

The CPT Editorial Panel has approved a code to describe assessment and care planning for patients with cognitive impairment. Although the code will not be ready for use and valuation until 2018, CMS plans to pay for this service in 2017 using a new G-code, 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.”

To report G0505, you must provide the following 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,
- 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.

G0505 must be furnished by a physician or other appropriate billing provider (e.g., nurse provider or physician assistant) and 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,”
- 99201-99215, “Office/outpatient visits,”
- 99324-99337, “Domiciliary/rest home visits,”
- 99341-99350, “Home visits,”
- 99366-99368, “Medical team conferences,”
- 99497 and 99498, “Advanced care planning.”

In addition, Medicare plans to prohibit billing of G0505 with other care planning services, such as home health care and hospice supervision (G0181 and G0182) or the new add-on code for CCM services (G0506, described earlier in this article).

CMS does not believe the services described by G0505 will significantly overlap with medically necessary CCM services (CPT codes 99487, 99489, or 99490) or transitional care management services (99495 or 99496), so you can bill G0505 on the same date of

■ CMS will no longer bundle payment for non-face-to-face prolonged services with payment for other E/M services.

■ New G-code G0505 allows you to bill for the assessment and care planning for patients with cognitive impairment.

■ Medicare prohibits the billing of G0505 with other care planning services.

service or within the same service period as these codes.

For 2017, CMS has set the average payment amount for G0505 at \$238.30.

Health risk assessments

Two new CPT codes 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,”
- 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 bill 96160 separately when the service is explicitly included in another service being furnished, such as the Medicare AWW. For Medicare purposes, you also should not bill 96160 separately if furnished as a preventive service, because at that point it would describe a non-covered Medicare service.

For 96161, submit the claim using the patient’s beneficiary information, and be sure the health risk assessment documentation resides in the patient’s chart, not the caregiver’s, because the service is being delivered on behalf of the Medicare beneficiary. Medicare plans to pay an average of \$4.67 for codes 96160 and 96161.

New and revised vaccine codes

Several influenza vaccine codes have been redefined to reflect dosage amounts in lieu of age indications. The revised codes include the following:

- 90655, “Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.25 mL dosage, for intramuscular use,”
- 90656, “Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 mL dosage, for intramuscular use,”
- 90657, “Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use,”

- 90658, “Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use,”

- 90661, “Influenza virus vaccine, trivalent (ccIIV3), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use,”

- 90685, “Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use,”

- 90686, “Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use,”

- 90687, “Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use,”

- 90688, “Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use.”

CPT 2017 includes these new vaccine codes as well:

- 90674, “Influenza virus vaccine, quadrivalent (ccIIV4), 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, 1 dose schedule, for oral use.”

Two other new vaccine codes that are effective Jan. 1, 2017, won’t appear in the CPT manual until 2018. Both codes represent vaccines that are pending Food and Drug Administration (FDA) approval but are usable as soon as the vaccines are approved by the FDA:

- 90682, “Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use,”

- 90750, “Zoster (shingles) vaccine (HZV), recombinant, sub-unit, adjuvanted, for intramuscular injection.”

Post-procedure visits for procedures with 10- and 90-day global periods

Some procedures have a 10- or 90-day “global period,” which means that any related follow-up visits in the designated global period are not separately payable by Medicare. Under current law, CMS is required to gather data on these visits so it can more accurately value the procedural services to

■ The average payment amount for code G0505 is \$238.30.

■ Two new CPT codes, 96160 and 96161, may be used to report health risk assessments.

■ Several influenza vaccine codes have been redefined to reflect dosage amounts in lieu of age indications.

which the visits are related. To facilitate this analysis, CMS will now require submission of current CPT code 99024, “Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure,” by practices with 10 or more providers in the following states: Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island.

CMS estimates about 260 surgery package codes will be affected by the mandatory reporting. A list will be published on the CMS website prior to the start of the July 1, 2017, reporting period. There is no payment for code 99024 and no penalty for not reporting in the states not listed.

Send comments to fpmedit@aafp.org, or add your comments to the article at <http://www.aafp.org/fpm/2017/0100/p7.html>.

Psychiatric care management and behavioral health

The CPT Editorial Panel has approved four new codes to describe services furnished consistent with a psychiatric collaborative care management model. Although these CPT codes will not be ready for use and valuation until 2018, CMS plans to pay for these services in 2017 using a series of new G-codes, G0502-G0504 and G0507, which will be described in an upcoming *Family Practice Management* article.

■ Four new G-codes now allow payment for collaborative care of patients with behavioral health conditions.

Looking ahead

These are just some of the changes to be aware of for 2017. Review Appendix B in the CPT code book and the additional sections of CPT that you use most often to identify other changes that may be relevant to your practice. You should also review the errata published by CPT and available at <http://bit.ly/2h5C0cm>. Using the correct codes will facilitate payment of your claims in 2017. **FPM**

■ Review CPT’s Appendix B and errata for additional code changes that may be relevant to your practice.



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