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CODING AND BILLING RULES IN 2016: OUT WITH THE OLD, IN WITH THE NEW

Incident-to rules and advance care planning
top the list of changes.

Jan. 1 ushers in a new Medicare physician fee schedule and regulations, as well as a new edition of CPT. The 2016 versions clarify Medicare's "incident-to" rules and formalize codes and billing rules for Medicare's new advance care planning benefit, among other changes. Here is a summary of the changes most likely to affect family physicians.



incident-to services must be the same person who directly supervised the ancillary personnel who provided the services. The direct supervision requirement for incident-to services has not changed – the physician must be present in the office suite (but not the exam room) and immediately available to furnish assistance and direction throughout the performance of the service.

This does *not* mean that the billing/supervising physician also has to be the one who initiated the original care plan or service upon which the incident-to service is based. Under the clarified regulations, scenarios like the following are acceptable: Dr. A treats Mrs. Jones on Monday, initiating a plan of care and asking her to

"Incident-to" services

First, the Centers for Medicare & Medicaid Services (CMS) has amended its incident-to regulations to clarify that the physician or other practitioner who bills for

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THE PHYSICIAN WHO BILLS FOR INCIDENT-TO SERVICES MUST BE THE SAME PERSON WHO DIRECTLY SUPERVISED THE ANCILLARY PERSONNEL WHO PROVIDED THE SERVICES.

return in one week for follow-up with the nurse. Dr. A is on vacation when the patient returns and his partner, Dr. B, directly supervises the nurse visit and bills for the service under his own provider number.

When incident-to services are provided, practices will need to decide which physician qualifies as the supervising physician. Although claims don't identify that services were provided incident to a physician's care, medical record documentation should clearly name the supervising physician.

Note that services and supplies provided incident to transitional care management and chronic care management services remain an exception to the direct supervision requirement. These can continue to be provided under the *general supervision* of the physician (or other practitioner). General supervision means the service is furnished under the physician's overall direction and control, but the physician's presence in the office suite is not required.

CMS also amended its regulations to clarify that ancillary personnel are prohibited from providing incident-to services if they have been excluded from Medicare, Medicaid, or any other federally funded health care programs by the Office of Inspector General or have had their Medicare enrollment revoked for any reason. Such individuals are technically prohibited from providing services to Medicare beneficiaries, but CMS makes it explicit in this case.

Advance care planning

CPT established two new codes in 2015 to describe advance care planning services that are being paid by Medicare beginning in January 2016:

- 99497, "Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health profes-

sional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate,"

- +99498, "each additional 30 minutes (list separately in addition to code for primary procedure)."

You can use these codes to report the face-to-face service, regardless whether the visit includes completing the relevant legal forms. CPT describes an advance directive as "a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time." Some examples of these forms are a health care proxy, durable power of attorney for health care, living will, and medical orders for life-sustaining treatment.

CMS has assigned a total of 2.40 relative value units (RVUs) to 99497 and 2.08 RVUs to 99498 in the non-facility setting (e.g., physician office), which translates to \$85.99 and \$74.52, respectively, using the 2016 Medicare conversion factor (unadjusted for geography, sequestration, and any applicable Medicare payment adjustments). Payment may still depend on local coverage determinations.

CMS offers the following example of how a physician might provide and bill for advance care planning:

A physician sees a 68-year-old male with heart failure and diabetes who takes multiple medications. She provides evaluation and management (E/M) of these two diseases, including adjusting medications as appropriate. In addition to discussing the patient's short-term treatment options, the physician learns of the patient's interest in discussing long-term treatment options and planning. The patient inquires about the possibility of a heart transplant if his congestive heart failure worsens. The physician and patient also discuss advance care planning for care and treatment if he suffers a health event that adversely affects his decision-making capacity.

In this example, the physician would report

■ The supervising physician does not have to be the one whose professional service initiated the incident-to service.

■ Ancillary personnel cannot provide incident-to services if they have been excluded from a federally funded health care program.

■ Advanced care planning can be provided and billed as a stand-alone service.

a standard E/M code and one or both of the advanced care planning codes, depending on the duration of the service. The physician would not count the time spent on the E/M portion of the visit toward the time used to code 99497 and 99498; per CPT, no active management of the problem or problems is undertaken during the time period for which these two codes are reported.

Note that the advance care planning service described in the example above would not necessarily have to occur on the same day as an E/M service. Advance care planning can be billed as a stand-alone service.

Two new vaccine codes have been added: Cholera, 90625, and DTaP-IPV-Hib-HepB, 90697.

Preventive medicine counseling codes are reportable on the same day as an E/M service by appending modifier 25.

New code 69209 can be reported for removal of impacted cerumen without the use of instrumentation.

Other CPT changes

Family physicians should also note the following CPT changes for 2016.

Vaccines. The following vaccine codes have been added:

- 90625, “Cholera vaccine, live, adult dosage, 1 dose schedule, for oral use,”
- 90697, “Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use.”

Both of these vaccines are pending approval by the Food and Drug Administration (FDA).

CPT also includes two new codes for meningococcal vaccines that were introduced in February 2015:

- 90620, “Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB), 2 dose schedule, for intramuscular use,”
- 90621, “Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB), 3 dose schedule, for intramuscular use.”

Two codes that were pending FDA approval when they appeared in the 2015 edition of CPT have now received approval:

- 90630, “Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use,”
- 90651, “Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule, for intramuscular use.”

Preventive medicine counseling.

Changes to the CPT descriptions within the

subcategories of counseling risk factor reduction and behavior change intervention allow codes 99406-99409 to be reported for a preventive service on the same day as a problem-oriented E/M service.

Additionally, preventive medicine individual and group counseling codes (99401-99404 and 99411-99412) have been clarified as being reportable with a distinct E/M service performed on the same day. In these cases, use modifier 25 to indicate that the additional service was significant and separately identifiable.

Obstetric HIV testing panel. A new obstetric panel that includes HIV testing has been added. This panel, code 80081, differs from the existing obstetric panel, code 80055, in that it includes “HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result (87389)” as a component. Remember that if a single component of the panel is not performed, you need to separately report the codes for the components that were performed.

Ear irrigation services. To assist practices when reporting services for removal of impacted cerumen without the use of instrumentation, a new code, 69209, “Removal impacted cerumen using irrigation/lavage, unilateral,” was created. This new code should not be reported on the same day code 69210, “Removal impacted cerumen requiring instrumentation, unilateral,” is used. For bilateral cerumen removal, use modifier 50.

Going forward

These are just some of the changes to be aware of in 2016. You should review Appendix B in the CPT manual and the sections of CPT that you use most often to identify other changes that may be relevant to your practice. Also be sure to periodically review the errata and technical changes posted by the American Medical Association (<http://bit.ly/1Lx0p4k>). Using the correct codes will facilitate payment of your claims in 2016. **FPM**

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