

# Coding Changes for Family Medicine in 2018

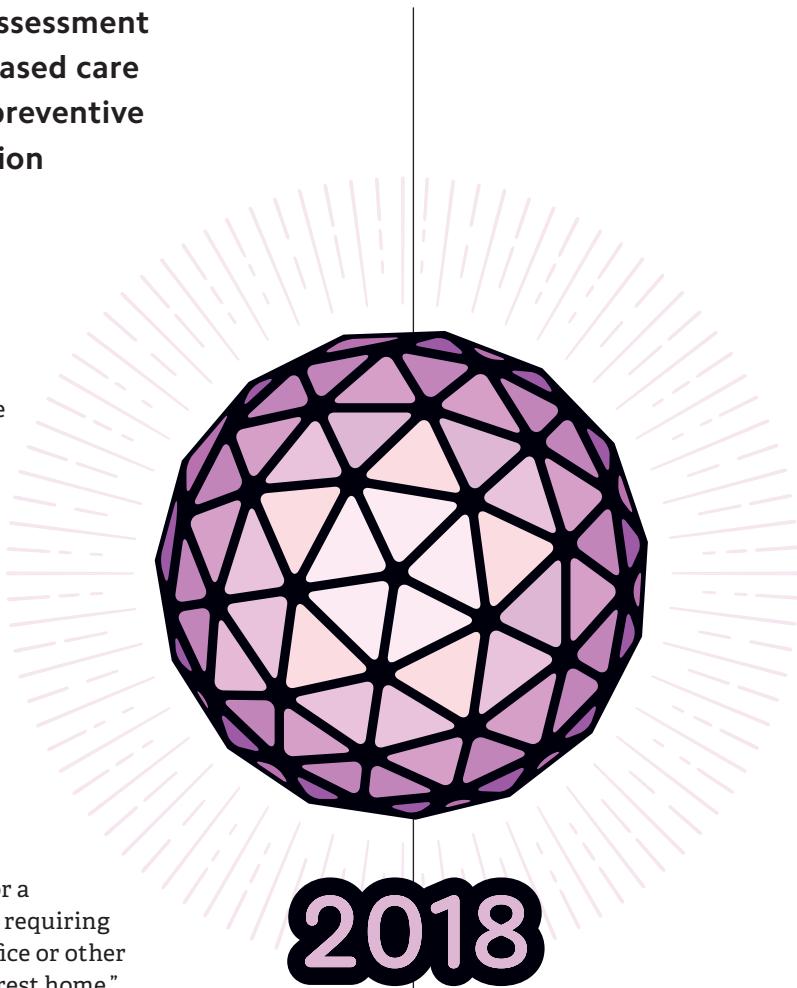
New codes for cognitive assessment and care planning, team-based care management, prolonged preventive services, and anticoagulation management are among this year's changes.

Jan. 1 ushers in CPT code updates and a new Medicare physician fee schedule each year, and 2018 is no exception. This article provides a summary of the changes most likely to affect the way your practice gets paid.

## COGNITIVE ASSESSMENT AND CARE PLAN SERVICES

A new CPT code enables payment for the in-depth assessment and care planning that is often needed for patients who are suffering from cognitive decline. Code 99483, "Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home," can be billed once every 180 days per physician or qualified health professional (QHP) and requires that 10 specific elements of service are provided and documented:

- Cognition-focused evaluation including a pertinent history and examination,
- Medical decision-making of moderate or high complexity,
- Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity,
- Use of standardized instruments for staging of dementia (e.g., functional assessment staging test or clinical dementia rating),
- Medication reconciliation and review for high-risk medications,
- Evaluation for neuropsychiatric and behavioral symptoms, including depression, using a standardized screening instrument,



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- Evaluation of safety, including motor vehicle operation,
- Identification of caregivers and their knowledge, needs, social supports, and willingness to take on caregiving tasks,
- Development, updating or revision, or review of an advance care plan,
- Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neurocognitive symptoms, functional limitations, and referral to community resources as needed

## Medicare's national payment allowance for cognitive assessment in the office setting is \$241.85.

(e.g., rehabilitation services, adult day programs, support groups) shared with the patient, caregiver, or both, with initial education and support.

The typical time spent face-to-face with the patient, caregiver, or both is 50 minutes, according to the CPT manual. Code 99483 replaces HCPCS code G0505. Medicare's national payment allowance, not adjusted for geography, for this service in the office setting is \$241.85.

### PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT CODES

Codes for team-based care management services continue to expand with the addition of psychiatric collaborative care management codes 99492 – 99494, which replace HCPCS codes G0502 – G0504. If you want to report these codes, the patient must have an established psychiatric disorder. The treatment team must consist of at least three individuals working together:

- A physician or other QHP directing the patient's care,
- A behavioral health care manager (a clinical staff member with a master's or doctoral degree in behavioral health or specialized training),
- A psychiatric consultant (a medical professional trained in psychiatry or behavioral health who is allowed to prescribe medications) authorized to provide psychiatric or behavioral health advice and

recommendations on behalf of the patient.

The care must be directed by the primary care team and include regular assessments of the patient using validated tools and subsequent necessary treatment. Additionally, the psychiatric consultant must assess the patient's condition regularly and make recommendations to the physician or other QHP through the behavioral health manager. The psychiatric consultant typically does not see the patient or prescribe medication for the patient, except in rare circumstances.

Codes 99492 – 99494 are time-based services that represent care provided during a calendar month. Code 99492 is for the initial service, 99493 is for the subsequent service, and 99494 is an add-on code that can be used to bill for each additional 30 minutes of service. Specific requirements for the initial and subsequent care management codes are described in the CPT manual.

Here's an example of a typical scenario: You see a patient for his or her psychiatric disorder on Feb. 1. This visit represents the initiation of an episode of care. During the course of the rest of the month, the behavioral health care manager spends 100 minutes in psychiatric collaborative care management related to the patient. You bill code 99492, "Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities ...," and also code 99494, "Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month ..." In March, the behavioral health care manager spends 60 minutes in psychiatric collaborative care management related to the patient. You then bill code 99493, "Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month ..." Medicare's national payment allowances in the office setting are \$161.24 for 99492, \$128.84 for 99493, and \$66.58 for 99494.

### GENERAL BEHAVIORAL HEALTH INTEGRATION CARE MANAGEMENT

Another new behavioral health code incorporates collaborative care management principles but has somewhat less

intensive requirements. Code 99484, “Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other QHP, per calendar month,” can be billed for the initial assessment and creation of a care plan by the physician or other QHP, as well as when clinical staff spend at least 20 minutes in subsequent months following the care plan. Service and documentation requirements include assessing or monitoring the patient, developing and revising the care plan, coordinating treatment with the patient and affected parties, and maintaining a continuous relationship with a member of the care team. This code replaces HCPCS code G0507. Medicare’s national payment allowance for code 99484 in the office setting is \$48.59.

### PROLONGED PREVENTIVE SERVICES

To more accurately reflect the difference in resource costs when additional time is required to provide a Medicare-covered preventive service (e.g., “Welcome to Medicare” physical, annual wellness visit, or cancer screening), the Centers for Medicare & Medicaid Services (CMS) added two new HCPCS codes:

- G0513, “Prolonged preventive service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service),”
- G0514, “... each additional 30 minutes.”

CMS has posted the time requirements for all eligible Medicare-covered preventive services in “CY 2018 List of Preventive Services Billed With Prolonged Preventives Code” at <http://go.cms.gov/2AcEKOA>.

These codes can be used only in the office or other outpatient setting, and both codes are add-on codes, according to CMS. Code G0513 can be added to the preventive service, and code G0514 can be added to G0513. Beneficiary coinsurance and deductibles do not apply for either code because you can bill the codes only to describe prolonged portions of services where beneficiary coinsurance and deductible are not applicable. Medicare’s national payment allowances in the office setting are \$66.22 for both G0513 and G0514.

### KEY POINTS

- New CPT code 99483 allows payment for cognitive assessment and care planning with a patient or caregiver.
- Codes for team-based care management services continue to expand with the addition of several new CPT codes focused on behavioral health care management.
- New HCPCS codes for prolonged preventive services – G0513 and G0514 – recognize that additional time is sometimes required to provide a Medicare-covered preventive service.
- New HCPCS codes G0516, G0517, and G0518 allow separate payment for the insertion, removal, and removal with reinsertion of subdermal implants for the treatment of opioid addiction.
- Anticoagulation management codes 99363 and 99364 have been replaced with home and outpatient international normalized ratio monitoring services codes 93792 and 93793.

### ANTICOAGULATION MANAGEMENT

Another important CPT coding change is that anticoagulation management codes 99363 and 99364 have been deleted and replaced with home and outpatient international normalized ratio (INR) monitoring services codes 93792 and 93793. Code 93792 can be used to bill for the initial set up and education given to a patient or caregiver when a patient is placed on an INR regimen. This service can be provided under the direction of a physician or QHP and billed in conjunction with a distinctly separate office visit by appending modifier 25 to the appropriate evaluation and management

**Codes for team-based care management services continue to expand.**

code (E/M) code. Code 93793 can be used to bill for the review and subsequent management of a home, office, or lab test once per day regardless of the number of tests reviewed. Code 93793 is not billable with an E/M service, and neither 93792 nor 93793 is billable with chronic care management or transitional care management services because INR monitoring is considered included in those services. Medicare’s national payment allowances in the office

setting are \$55.06 for 93792 and \$12.24 for 93793. Unlike codes 99363 and 99364, which Medicare considered “bundled,” codes 93792 and 93793 are separately payable under the Medicare physician fee schedule.

### **NEW AND REVISED VACCINE CODES**

Four new vaccine codes have been added for 2018:

- 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, subunit, adjuvanted, for intramuscular use,”

**Anticoagulation management codes 99363 and 99364 have been deleted and replaced.**

- 90587, “Dengue vaccine, quadrivalent, live, 3 dose schedule, for subcutaneous use,”
- 90756, “Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use.”

The vaccine described in code 90587 is still pending approval from the U.S. Food & Drug Administration.

The descriptors for vaccine codes 90621 and 90651 are also changing in 2018 so that each encompasses either a two- or three-dose schedule, instead of only a three-dose schedule. Code 90621 is now “Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB-FHbp), 2 or 3 dose schedule, for intramuscular use,” and code 90651 is “Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2 or 3 dose schedule, for intramuscular use.”

### **PATIENT RELATIONSHIP CATEGORY MODIFIERS**

CMS has approved five new modifiers to indicate patient relationships. These modifiers are intended to assist with cost

measurement under Medicare’s Quality Payment Program. The following modifiers will be voluntary in 2018 in order to give CMS time to monitor trends, provide education and outreach to physicians and staff, and determine if the modifiers need to be altered before they begin affecting claims payment. Although additional reimbursement is not available for submitting these modifiers now, the data CMS collects on what is reported can and will influence payment in the future. Family physicians will likely use modifier X1 the most. The HCPCS modifier patient relationship categories are as follows:

- X1, Continuous/broad services,
- X2, Continuous/focused services,
- X3, Episodic/broad services,
- X4, Episodic/focused services,
- X5, Only as ordered by another clinician.

### **SUBDERMAL DRUG IMPLANTS FOR THE TREATMENT OF OPIOID ADDICTION**

CMS is adding three new HCPCS codes that will allow separate payment for the insertion, removal, and removal with reinsertion of buprenorphine subdermal implants. The codes are as follows:

- G0516, “Insertion, nonbiodegradable drug delivery implants, four or more,”
- G0517, “Removal, nonbiodegradable drug delivery implants, four or more,”
- G0518, “Removal with reinsertion, nonbiodegradable drug delivery implants, four or more.”

CMS intends these new HCPCS codes to be distinct from existing CPT codes 11981–11983 that broadly describe the insertion and removal of nonbiodegradable drug delivery implants. Medicare’s national payment allowances in the office setting are \$239.33 for G0516, \$263.09 for G0517, and \$454.19 for G0518.

These are just some of the changes to be aware of in 2018. Review Appendix B in the CPT manual for a summary of additions, deletions, and revisions to identify other changes that may be relevant to your practice. **FPM**

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