2017

Strategies for Coding, Billing and Getting Paid Appropriately

A Guide for Family Physicians

CALIFORNIA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR CALIFORNIA

As 2017 unfolds, physician practices will face challenges on all fronts: payers will start changing the way they pay physicians, patients will expect more, hospitals will increasingly seek new alignment strategies and competition will mount from new provider types. For some, this unprecedented level of change could threaten financial viability. Others, however, will see this as an opportunity to improve one's bottom line.

Medicare reimbursement rules for 2017 bring about an opportunity for family physicians to be paid for certain regular services that have previously not been paid by Medicare. In this supplement, we will outline some current procedural terminology (CPT) changes for 2017 for family physicians. We will then discuss new Medicare payment possibilities and delve into some reimbursement strategies. Lastly, we will discuss getting ready for a new value-based reimbursement system and review a few health care trends physician practices should be aware of for the coming year(s).

Current Procedural Terminology (CPT) and HCPCS (Level II) Coding Changes for 2017

Vaccine Codes

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

Additionally, there are three new vaccine codes:

- 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; and
- 90625 — Cholera vaccine, live, adult dosage, 1 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.

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.
- 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 being furnished, such as the Medicare annual wellness visit (AWV). For Medicare purposes, you should also not bill 96160 separately if furnished as a preventive service, because at that point 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 (no work value).

Clinical Example
An intellectually disabled patient is accompanied by a parent/caregiver during a preventive medicine service visit. The parent/caregiver admits that the patient is becoming increasingly more difficult to manage and that things were starting to fall apart.

- The clinical staff decides to select and prepare the parent/caregiver to complete a depression inventory. The clinical staff also explains the purpose of the instrument and instructs how to properly complete the inventory.
- Upon the parent/caregiver's completion of the depression inventory, the clinical staff scored and recorded the results.
- The clinical staff then provided the parent/caregiver feedback based on the inventory's results and provided the results to the physician, or other qualified health professional.

In this case, CPT 96160 should be billed in addition to the primary code for the encounter as the service being provided is in addition to the preventive medicine service and not as a part of the preventive medicine service.

Psychiatric Care Management and Behavioral Health

In February 2016, the CPT editorial panel created three new codes to describe a model for providing psychiatric care in the primary care setting. This code set is one of several in response to a request from the Centers for Medicare and Medicaid Services (CMS) to facilitate appropriate valuation of the services furnished under the Collaborative Care Model (CoCM). This CoCM is used to treat patients with common psychiatric conditions in the primary care setting through the provision of a defined set of services which operationalize the following core concepts:

1. Patient-Centered Team Care/Collaborative Care;
2. Population-Based Care;
3. Measurement-Based Treatment to Target; and
4. Evidence-Based Care.

The new code set for psychiatric collaborative care management is intended to include a primary care physician working with a behavioral health manager and consulting psychiatrist to manage patient psychiatric care. In the CY2016 Medicare final rule, CMS stated that they believed that care and management for Medicare beneficiaries with behavioral health conditions may include extensive discussion, information sharing and planning between a primary care physician and a specialist. In 2017 Medicare is reimbursing separate payment for these services under the psychiatric CoCM using three new G-codes. These codes will be temporary for only one year and are expected to be replaced by the CPT codes for 2018.

To report these services use:

G0502 — Initial psychiatric collaborative care management.
First 70 minutes in the first 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. Additional required elements include:

- Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional;
- Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
- Review by the psychiatric consultant with modifications of the plan if recommended;
- Entering patient information in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies.

G0503 — Subsequent psychiatric collaborative care management.
First 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 other qualified health care professional. Additional required elements include:

- Tracking patient follow-up and program using the registry, with appropriate documentation;
- Participation in weekly caseload consultation with the psychiatric consultant;
- Ongoing collaboration and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers;
- Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies; and

- Monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment

G0504 — Initial or subsequent collaborative care management.
Each additional 30 minutes 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 your code for the primary procedure).

Remember these things when providing and documenting the above services:

- Review by psychiatric consultant may be completed by video or conference call;
- The care manager's time is the time that is calculated to determine if service can be billed;
- The Patient Health Questionnaire (PHQ) is a standardized instrument that is typically used;
- There should be a contract between the primary care physician and the psychiatrist; and
- There are no defined credentials listed for the behavioral care manager. The behavioral care manager should be chosen based on the presence of clinical skills needed (e.g., licensed clinical social worker or psychiatric nurse).

CPT Code	MCR Global Period	CMS Work RVU	California MCR Payment
G0502	XXX	1.70	$173.06 - $148.91
G0503	XXX	1.53	$152.71 - $131.60
G0504	ZZZ	0.82	$ 79.71 - $ 68.79

Cognitive Impairment Assessment:

The American Medical Association's (AMA) 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 CPT until 2018. CMS, however, will pay for this service in 2017 using a new G-code (HCPCS) – G0505. The code is defined as, "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 office, outpatient setting, home, domiciliary or rest home."

While that is a *long* definition, below 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). The care plan should be 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 – 99215 — Office/outpatient visits,
- 99324 – 99337 — Domicilary/rest home visits,
- 99341 – 99350 — Home visits,
- 99366 – 99368 — Medical team conference and
- 99497 and 99498 — Advanced care planning.

In addition, Medicare prohibits 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 chronic care management 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 the two TCM codes (99495 and 99496).

Important Changes to Medicare Billing Rules for 2017

Prolonged Services:

Beginning in January 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) may be billed separately **as long as** the time is not also counted toward the provision of any other service. Remember 99358 is an "add on" code and should be listed separately in addition to the primary code for prolonged service.

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

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 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 still 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 a 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" services 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:

CPT Code	Fee Range
99487	$114.99 - $98.09
99489	$ 57.74 - $ 49.25
99490	$ 50.53 - $ 44.20

Medicare Patients and CCM Initiating Visits

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). However, the time and effort described by G0506 cannot also be counted toward another code. G0506 can only be billed once per patient per provider.

Your Billing Department – New Challenges for 2017 and Beyond

Collecting from Patients with High-Deductible Health Plans

Though the rate of health care spending may have slowed over the past few years, the share absorbed by patients has increased. As a result, patient collections now refers to much more than the usual collection of $10 copays. Smart and consistent patient collection tactics must be a part of every practice's financial strategy. Below are some basics to consider when discussing how to improve your patient collections:

- **Develop a financial policy**
  Every practice should have a financial policy and every patient should sign it. This document is in essence a memorandum of understanding. In signing it, the patient agrees to follow your rules regarding payment. Fees for no-shows, copays, deductibles and the forms of payment you accept should all be included.

- **Know in advance what your patients will owe**
  Most clearinghouses permit real-time and batch eligibility processing. It is important to know in advance whether you should collect more than just a copay.

- **Let patients know in advance how much they will need to pay**

Many physicians are asking patients to only bring a copay to every visit. For patients with existing balances or whose services will drop straight to their deductible, physicians must let them know before the service how much they must pay.

- **Give patients the option**
  For patients who have a history of "forgetting" copays or are frequent no-shows, offer the option of either pre-paying a nominal non-refundable deposit or rescheduling their appointment until they are ready to pre-pay. Patients adjust to this policy, and you will find that your late-cancel and no-show rates will decline.

- **Accept multiple forms of payment**
  Most practices permit patients to pay by cash, check, money order, credit card, debit card and PayPal. When accepting credit cards, consider accepting multiple types – patients like those cards who have a "cash back" rewards systems and will often use them for medical expenses.

- **Consider keeping a credit card on file**
  With appropriate safeguards, practices can keep patients credit cards on file and charge them for patient balances if the patient has given you **written** permission to do so. This should be a voluntary option for the patient and not mandatory to be part of your practice. You do not want the liability in keeping the patients' credit card information onsite, so use a certified and secure third party to retain the information.

- **Offer payment plans**
  It is hard for most patients to come up with a $1,000 on the spot. Offer patients a chance to pay large balances over several months. Some practices charge interest; some do not, but you have every right to do so. Charging interest is sometimes an incentive for the patient to pay a larger portion of the balance.

- **Make patients aware of pharma subsidies**
  Subsidies will enable patients to save money on their prescriptions, which will contribute to their ability to pay your practice.

- **Have a heart**
  There are some patients in poor or dire health who simply do not have the money. There will be times when you care for patients with no expectation of getting paid. That is okay, just make sure you are clear in your financial policy how you decide who that is and how you administer the policy in your practice.

Your Practice and MACRA – 2017 and Beyond!

In October 2016, the Centers for Medicare and Medicaid Services (CMS) issued final regulations implementing the Quality Payment Program that is part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Quality Payment Program policy changes Medicare payments for more than 600,000 clinicians across the country. Payment changes start in 2019, but are based on 2017 data.

The Quality Payment Program will eventually supplant the Meaningful Use program (MU), Physician Quality Reporting System (PQRS) and the Value-Based Payment Modifier (VBM) and leave physicians to choose from two tracks: the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (APMs). It is important that you understand nuances of this new program. To do well in MIPS, for example, you must score well in as many performance categories as possible - every single point in MIPS translates into dollars up or down. This is in marked contrast to existing all-or-nothing programs. In accordance with such novel changes, CMS has developed a Quality Payment Program website, which explains the new program and helps clinicians identify the measures and activities most meaningful to their practice or specialty. This tool also allows interested clinicians and practice managers to browse and explore the program options that best fit their practices.

In its final rule, CMS additionally made changes to the roll-out of MACRA. CMS had previously proposed that physicians' Medicare payment would be positively or negatively adjusted based on performance and utilization data for the entire year of 2017. **What it is most important for physicians in MIPS to know is that they can avoid a negative adjustment in 2019 by reporting any information at all in 2017.** Physicians who submit more data will get a higher payment. Along with CMS' QPP website, to learn more about the "pick your pace" option, please visit CAFP's additional resources on their Quality Payment Program Playbook webpage.