



Coding & Billing Strategies 2017 Update

California Academy of Family Physicians

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Learning Objectives

1. Enhance provider understanding of changes to CPT codes, including additions, deletions and edits;
2. Improve practice documentation of visits and procedures;
3. Discuss MACRA and related shifts towards value-based care; and
4. Improve documentation of medical decision-making.



About This Manual

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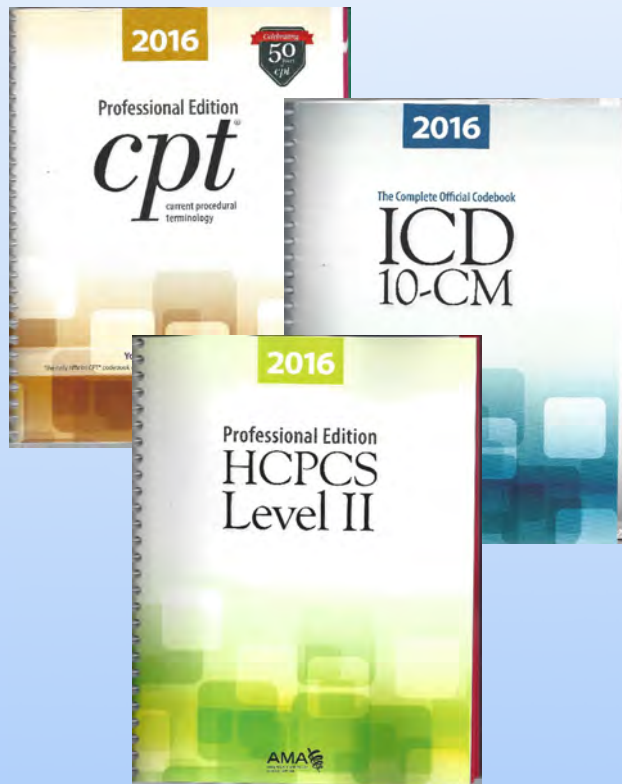
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CPT codes used in this manual are excerpts from the current edition of the CPT (Current Procedural Terminology) book, are not intended to be used to code from and are for instructional purposes only. It is strongly advised that all providers purchase and maintain up to date copies of CPT. CPT is copyrighted property of the American Medical Association.

Today's Agenda

Coding Changes



Medicare Changes

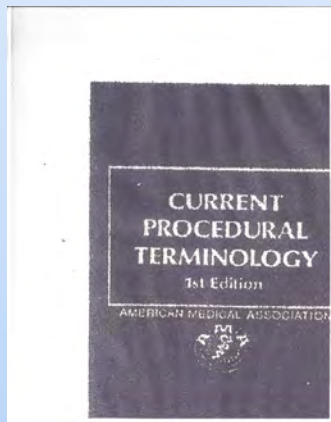




CPT 2017

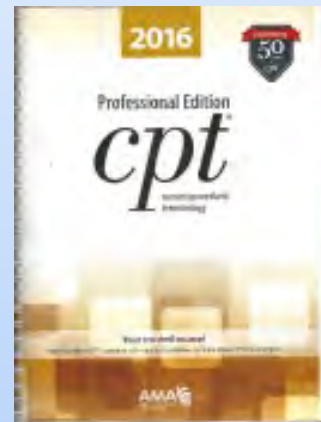
1966

3,554 codes



2017

10,067 codes





What Changed in CPT 2017?

- New CPT section – A Proprietary Laboratory Analyses
- New modifiers
- New appendix
- 149 new CPT codes
- 498 revised CPT codes
- 81 deleted CPT codes



Modifiers

- Modifier FX refers to X-rays taken using film
 - In the transition from traditional x-ray imaging to digital radiography...
 - The Consolidated Appropriations Act of 2016 (CAA) required a 20 percent reduction for technical component (TC) payment of an x-ray taken using film beginning in 2017
 - CMS finalized the new modifier to be reported on claims for film x-rays and is required on all claims for the TC of the x-ray service, including when the service is billed globally, which will result in a 20 percent reduction.

*Does not apply to mammography

CPT 2017 – The Breakdown

Sections	Added	Revised	Deleted
E/M	0	0	1
Anesthesia	0	0	0
Surgery	51	360	29
Radiology	4	7	11
Pathology / Lab	11	6	8
Medicine	26	109	13
Category II	0	1	0
Category III	56	15	18
Appendix A (modifiers)	1	0	0
Totals	149	498	81



The CPT Coding Changes For Primary Care



New Modifier and Related Appendix

- Modifier 95 – A service generally reported as a face-to-face service that is performed via a real-time interactive audio and video telecommunications system.
 - Appendix P lists current CPT codes with evidence of some payer approval for use when provided via interactive audio and video telecommunications systems
 - Codes are identified with small pointed star symbol (*)

Radiology Changes

- Dialysis Imaging Deletions
 - 6 deleted
- Fluoroscopic Guidance
 - Definitive Instructions Added
- Mammography
 - 3 added
 - 5 deleted



Pathology / Laboratory Changes

- Drug Testing
 - 3 added
 - 5 deleted
- Tier 1 Molecular Pathology Services
 - 3 deleted
- Genomic Sequencing Procedures / MAAA
 - 5 added
- New Proprietary Laboratory Analysis (PLA) Section



Medicine Changes

- Vaccine Nomenclature – Revised
 - Reflects dosage amounts instead of age indications
 - Dosage **remains the same**
 - Age-ranges have been deleted
- New Codes
 - 90674 – Influenza virus, quadrivalent, derived from cell cultures, subunit, preservative and antibiotic free, 0.5 ml dosage, for IM
 - 90653 – Influenza, inactivated, subunit adjuvanted, for IM
 - 90625 – Cholera, live, adult dosage, 1 dose schedule for oral use



Medicine Changes (cont'd)

- Psychotherapy
 - 8 revised code descriptors
 - Guidelines now specify to choose the code closest to the actual time;
 - Clarifies distinction between individual and family psychotherapy services;
 - Clarifies face-to-face time reporting; and
 - Added a time component to codes 90846 and 90847 for family psychotherapy.





Medicine (cont'd)

- PT/OT/AT Evaluations
 - 12 new
 - 6 deleted

- Moderate Sedation
 - 6 new
 - 6 deleted

***Moderate sedation symbol (Ⓢ) removed from 180 codes in Surgery, Radiology & Medicine subsections (no longer bundled)**



Health Risk Assessment Changes

Focused on the biopsychosocial factors important to physical health problems and treatments

- 96160 – Administration of **patient focused** health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument
- 96161 – Administration of **caregiver-focused** health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument



Health Risk Assessment Changes (cont'd)


Codes 96160 and 96161:

- Are applied per instrument used;
- Do not include interpretation or diagnoses;
- Includes scoring and documentation;
- Is typically completed by a non-physician clinical staff member; and
 - Valued by practice expense only
- When interpretation, further history, assessment and subsequent treatment planning are completed by the physician/QHP, services are reported as E/M or as another face-to-face visit service.

Health Risk Assessment Changes (cont'd) Example for 96161


An intellectually disabled patient is accompanied by his parent/caregiver during a preventive medicine service visit. The caregiver admits the patient is increasingly more difficult to manage and that things are falling apart at home.





Health Risk Assessment Changes Example for 96161 (cont'd)

- 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 care professional.



Health Risk Assessment Changes Example for 96161 (cont'd)

Question: Codes 96160 and 96161 reside in a section of the CPT code set that is accompanied by an introduction stating that these codes are **not** to be used by professionals who report E/M. Does this restriction apply to codes 96160 and 96161?

Answer: No. While it does apply to the **health and behavioral assessment and intervention** codes 96150 – 96155, the restriction does not apply to codes 96160 and 96161.



Health Risk Assessment Changes Example for 96161 (cont'd)


Question: Codes 96127 and 96110 are applied per standardized instrument when screening for emotional/behavioral and developmental status respectively. May these services be reported with code 96160 or 96161?

Answer: Yes. As long as the instruments are unique, all the codes can be used per standardized instrument. Codes 96110 and 96127 are simply more specific.



Psychiatric Collaborative Care Management Services – Coming soon!


- CMS is currently working on appropriate valuation of services furnished under the Collaborative Care Model (CoCM). This model is used to treat patients with common psychiatric conditions in the primary care setting through a defined set of services:
 1. Patient-Centered Team Care/Collaborative Care
 2. Population-Based Care
 3. Measurement-Based Treatment to Target
 4. Evidence-Based Care



Psychiatric Collaborative Care Management Services (cont'd)

The three new codes apply when a **primary care physician** works with a **behavioral health manager** and **consulting psychiatrist** to manage patient psychiatric care.

- The psychiatrist can consult with a primary care physician via non face-to-face methods
- The primary care physician must work with a specialist through means of:
 - Extensive Discussion
 - Information sharing
 - Planning



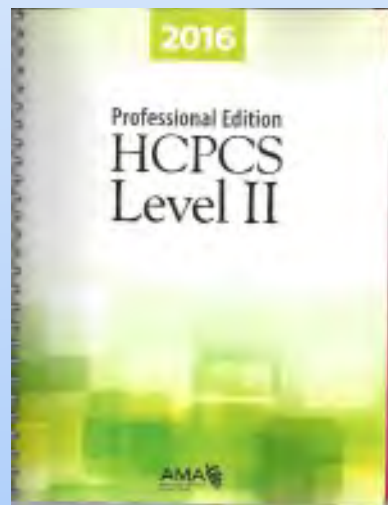
Psychiatric Collaborative Care Management Services (cont'd)

There is One Catch!

- These CPT codes will not be accepted by Medicare for 2017 and instead are set to be valued for 2018.
- INSTEAD, three G-codes (HCPCS Level II) have been developed for 2017



HCPCS – Level II New Codes (2017)





Primary Care & Management (CoCM)

Behavioral Health Integration Codes

1. Psychiatric Collaborative Care
 - G0502 – Initial; 70 minutes
 - G0503 – Subsequent; 60 minutes
 - G0504 – Initial or subsequent, each additional 30 min.
2. Care management for behavioral health conditions
 - G0507 – 20 min., clinical staff time, per calendar month



Primary Care & Management (CoCM)

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 QHP with the following elements:

- Outreach to and engagement in treatment of a patient directed by the treating physician or other QHP;
- Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;



Primary Care & Management (CoCM)

G0502 – Initial psychiatric collaborative care management (cont'd)

- Review by the psychiatric consultant with modifications of the plan if recommended;
 - Can be done by video or conference call
- Entering patient 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



Primary Care & Management (CoCM)

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, with the following required elements:

- Tracking patient follow-up and progress using the registry, with appropriate documentation;
- Participation in weekly caseload consultation with the psychiatric consultant;
- Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other QHP and any other treating mental health providers;



Primary Care & Management (CoCM)

G0503 – Subsequent psychiatric collaborative care management (cont'd)

- Additional review of progress and recommendation 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;
- 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.
 - PHQ9 is typically used



Primary Care & Management (CoCM)


G0504 – Initial or subsequent psychiatric 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 QHP
 - Use in conjunction with G0502 and G0503




Remember. . . .

- **Three** professionals are involved
 1. Primary Care Physician
 2. Psychiatrist
 - There should be a contract between the PCP and psychiatrist
 3. Behavioral Care Manager
 - There are no defined credentials at this time, but the behavioral care manager should be selected based on the clinical skills needed
 - Licensed clinical social worker (LCSW)
 - Psychiatric Nurse
- The time counted is the time of the care manager
- Services are billed once per calendar month by one individual (PCP)



Cognitive Impairment Assessment and Care Plan Services


- This service is provided when a comprehensive evaluation of a new or existing patient exhibiting signs of cognitive impairment is required to establish a diagnosis etiology and severity for the condition. The service includes a thorough evaluation of medical and psychosocial factors potentially contributing to increased morbidity.
- Typically these patients are referred by a primary caregiver. There are 10 required elements for the service, and all 10 must be performed in order for the code to be reported.
- The service includes two distinct activities – assessment of the patient and establishment of a care plan – that are shared with the patient and caregiver, along with education.
- Other face-to-face E/M codes **cannot** be reported on the same date as this service to prevent any overlap with E/M codes.



Cognitive Impairment Assessment and Care Plan Services (con't)

- G0505 – Cognition and functional assessment using standardized instruments with the development of a recorded care plan for the patient with cognitive impairment, history obtained from patient and/or caregiver by the physician or other QHP in office or other outpatient setting, home, domiciliary or rest home.


***This code is temporary (will be replaced with CPT in 2018)**



Cognitive Impairment Assessment and Care Plan Services (con't)

Required Elements of G0505:

1. Cognition-focused evaluation including a pertinent history and examination;
2. Medical decision making of moderate or high complexity (defined by the E/M guidelines);
3. Functional assessment (for example, basic and instrumental activities of daily living), including decision-making capacity;
4. Use of standardized instruments to stage dementia (MMS);
5. Medication reconciliation and review of high-risk medications, if applicable;



Cognitive Impairment Assessment and Care Plan Services (con't)

Required Elements of G0505 continued:

6. Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized instrument(s);
7. Devaluation of safety (for example, home), including motor vehicle operation, if applicable;
8. Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks;
9. Advance care planning and addressing palliative care needs, if applicable and consistent with beneficiary preference; and
10. 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, support groups); care plan shared with the patient and/or caregiver with initial education and support.



Cognitive Impairment Assessment and Care Plan Services (con't)

G0505 can not be billed on the same day as:

- 90785
 - 90791
 - 90792
 - 96103
 - 96120
 - 96127
 - 99201 – 99215
 - 99324 – 99337
 - 99341 – 99350
 - 99366 – 99368
 - 99374
 - 99497
 - 99498
- Also:
- G0181
 - G0182
 - G0506

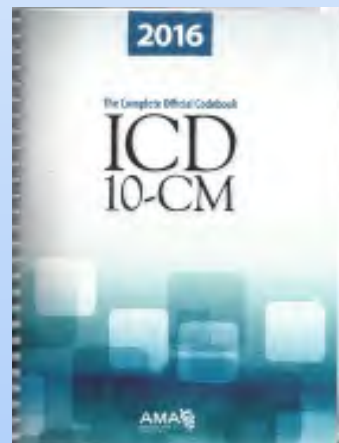


ICD-10-CM

New Code

Guideline Revisions

Few Deletions





Fully Implemented on 10/1/2016

- Approximately 5,500 new codes
 - 1,974 additions
 - 311 deletions
 - 425 revisions
- Total Codes for ICD-10-CM
 - 71,486
- Guideline Revisions Include:
 - Excludes 1 (Type of Excludes Notes) is defined
 - Definition of “with”
 - Further explanation of 7th character episode of care codes for injuries



ICD-10-CM Resources

- CMS ICD-10-CM book
 - <https://www.cms.gov/Medicare/Coding/ICD-10/2017-ICD-10-CM-and-GEMS.html>



Medicare Changes



New Year, New Payment

- Medicare Part B Deductible
 - \$183.00
 - Up from 2016 (\$166.00)
- Conversion Factor
 - \$35.8887
 - 0.24 percent increase from 2016
- Payment will increase for some specialties
 - +3 percent for family practice




Coding-Related Changes

- Prolonged Services
 - Non-face-to-face prolonged services are no longer bundled and instead will receive separate payment:
 - 99358 – After direct care; first hour
 - 99359 – Each additional 30 minutes



Chronic Care Management – More codes now payable!

- Chronic Care Management – ***continues to be paid***
 - 99490 – 20 min
- Complex Chronic Care Management – ***now payable***
 - 99487 – 60 minutes
 - 99489 – each additional 30 minutes
 - Codes changed from status “B” (bundled) to status “A” (active)



Chronic Care Management (cont'd) Changes to Scope

- The requirement that CCM may only be initiated during a Medicare annual wellness visit (AWV), initial preventive physical exam (IPPE), or face-to-face evaluation and management visits now applies **only to new patients or those patients not seen within one year** rather than to ALL patients.



CCM – Scope of Service (cont'd)

- The requirement to obtain the beneficiary's written agreement before providing CCM services has been removed. Instead, documenting, in the medical record, that the required information was explained and that the beneficiary accepted or declined the services is sufficient.



CCM – Scope of Service (cont'd)

- 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.




CCM – Scope of Service (cont'd)

- Electronic sharing of the care plan with other providers has been redefined as electronically capturing the care plan information and making it available in a “timely” manner, not necessarily 24/7, including via fax.



CCM – Scope of Service (cont'd)

- 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 HER.



CCM – Scope of Service (cont'd)

- Access to 24/7 care has been redefined to 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 condition.



Remember with CCM...

- You can only bill “once a calendar month”
- CCM is reported only by the provider who assumes care management role with the patient
- An eligible Medicare patient can receive complex or non-complex CCM during a given month, but **not both**
- Only one claim can be submitted to Medicare for CCM per month



CCM and the Face-to-Face Visit

- **G0506** – Comprehensive assessment of and care planning by the physician or other QHP for patients requiring chronic care management services, including assessment during the provision of a face-to-face service
 - This is an add-on service to E/M – no modifier needed
 - Can only be billed once per patient per provider
 - Code should be replaced next year with CPT

Other Medicare Changes

- Methodology used to calculate Geographic Practice Cost Indices (GPCI) for California has been revised:
 - Finalized California locality implementation plan
 - Eight counties, not designated as transition areas, may see a slight decrease in GPCI values
 - Orange
 - Los Angeles
 - Alameda / Contra Costa
 - San Francisco
 - San Mateo
 - Santa Clara
 - Ventura





Other Medicare Changes (cont'd)

- Expansion of Medicare Diabetes Prevention Program (MDPP) has been finalized
 - Payment begins in 2018
 - Practices that wish to participate need to begin to plan and register in 2017 to be able to participate in 2018



Other Medicare Changes (cont'd)

- Provider and Supplier requirements for Medicare Part C has changed
 - Providers must now be enrolled as a Medicare participant in order to see Medicare Advantage patients



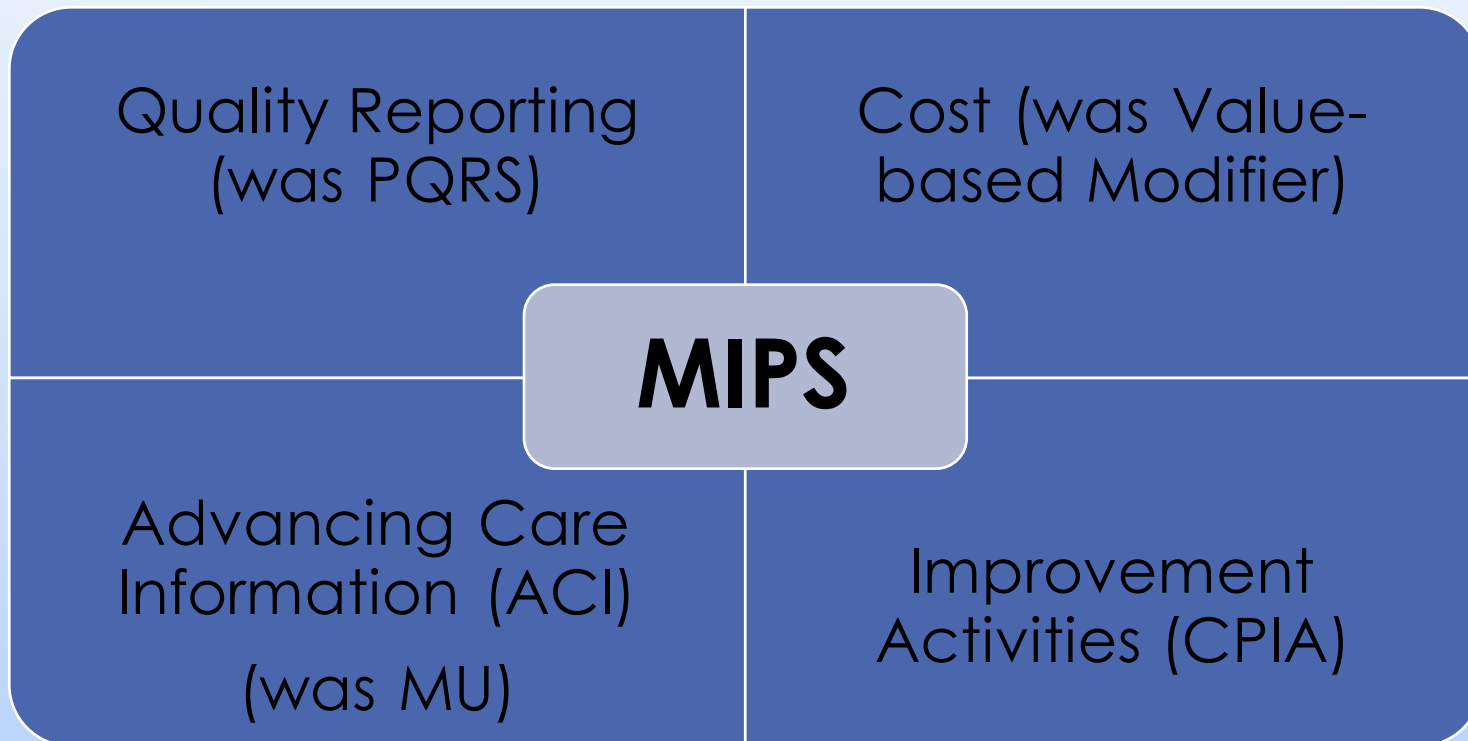
Other Medicare Changes (cont'd)

- Transition from traditional x-ray imaging to digital radiography
 - See discussion above of modifier FX
- CMS to begin gathering data on postoperative visits by
 - Testing projects in nine states (not California) and
 - By surveying 5000 physicians.



MACRA
Medicare Access and CHIP Reauthorization Act
2017 Biggest Challenge for Physicians

Merit-Based Incentive Payment System (MIPS) Components



***Payment changes in 2019 will be based on 2017 data.**



Clinicians exempt from MIPS

- If you are in your first year of Medicare Part B participation
- Medicare allowed charges \leq \$30K or have \leq 100 Medicare patients
- Advanced APM participants



Major Takeaway...

All California family physicians who are eligible for MIPS should submit data this year and avoid a payment penalty!



Pick Your Pace:

2017 Transitional Performance Reporting Options

1. MIPS Testing
2. Partial MIPS Reporting
3. Full MIPS Reporting
4. Not Participating in QPP



1. MIPS Testing

- Report some data at any point in CY 2017 to demonstrate capability
 - 1 quality measure, or 1 improvement activity or 4 required ACI measures
- No minimum reporting period
- Avoid downward payment in 2019



2. Partial MIPS Reporting

- Submit MIPS data for at least 90 consecutive days
 - 1+ quality measures, or 1+ improvement activities, or 4 required ACI measures
- No negative adjustment in 2019
- Potential to earn neutral or small positive payment adjustment in 2019



3. Full MIPS Reporting

- Meet all reporting requirements for the full year of 2017
- No negative adjustment in 2019
- Maximum opportunity to earn a moderate positive payment adjustment in 2019



4. Not Participating in QPP

If you do not send in any 2017 data, you will receive an automatic negative four percent payment adjustment.



Resources to Prepare for QPP

- CMS Quality Payment Program website
 - www.qpp.cms.gov/
- CAFR MACRA/QPP Playbook
 - www.familydocs.org/payment-reform



Thank you and now ...

Questions?



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