New Revenue Opportunities for 2017

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CODING INTELLIGENCE AND ANALYTICS

About the Author

Betsy Nicoletti, M.S., CPC

In 1988, CodingIntel.com founder Betsy Nicoletti started a Medical Services Organization for a rural hospital, supporting physician practice. She has been a self-employed consultant since 1998. She estimates that in the last 20 years her audience members number over 22,100 at in person events and webinars. She has had 2,500 meetings with clinical providers and reviewed over 40,000 medical notes. She knows what questions need answers and developed this resource to answer those questions.

Betsy is also the author of The Field Guide to Physician Coding and Auditing Physician Services. Besides doing auditing and compliance work, she is a speaker, writer and consultant in coding education and compliance. For more about Betsy visit www.betsynicoletti.com.

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Non face-to-face prolonged services

Starting January 1, Medicare will recognize and pay for non-face-to-face prolonged services using existing CPT codes.

These codes are for prolonged services by the billing physician/ NP/PA when provided in relation to an E/M service on the same or different day as an E/M service. If the clinician meets half of the threshold time for the prolonged service without face-to-face contact (31 minutes), use 99358.

99358 - Prolonged evaluation and management service before and/or after direct patient care, first hour (National payment of $113.41)

+ **99359** - each additional 30 minutes (List separately in addition to code for prolonged services) (National payment of $54.55)

Key points

- This service may be provided on the same day or on a different day than the face-to-face service.
- It is for extensive time in addition to seeing the patient, and must relate to a service for a patient where direct face-to-face patient care has occurred or will occur and be part of ongoing patient management.
- Code 99358 is not an add-on code. That is it can be reported on the day when no other service is provided.
- Code 99359 is an add-on code to code 99358.
- The time during the day a non-face-to-face service does not need to be continuous.
- CPT tells us not to report these services during the same month as complex chronic care management (99487, 99489) or during the service time of transitional care management (99495, 99496).
- You cannot double count the time for these non-face-to-face prolonged services codes and time spent in certain other activities represented by specific CPT codes. However, the list of CPT codes are mostly those which have a status either non-covered or bundled by Medicare. (Care plan oversight: 99339, 99340, 99374—99380; anticoagulant management: 99363, 99364, medical team conferences: 99366—99368, online medical evaluations: 99444, or other non-face-to-face services that have more specific codes and no upper limit in the CPT codes.)

HCPCS code G0505: Cognitive assessment for patients with dementia

📖 *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.*

Effective January 1, 2017. National non-facility payment $238.30; facility $178.02.

Only clinicians who have E/M services within their scope of practice may perform these services. CMS describes these professionals as physicians and "eligible non-physician practitioners, such as nurse practitioners and physician assistants."1 Psychologists and neuropsychologists may not bill G0505, because those professionals are not eligible to perform E/M services.

According to the Final Rule, these are the requirements for reporting G0505:

- Cognition-focused evaluation including a pertinent history and examination.
- Medical decision making of moderate or high complexity (defined by the E/M 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 instrument(s).
- Evaluation of safety (for example, home), including motor vehicle operation, if applicable.
- Identification of caregiver(s), 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, support groups); care plan shared with the patient and/or caregiver with initial education and support.

[1] 2017 Physician Fee Schedule Final Rule, page 318

These services may not be reported on the same day as G0505	
Psychiatry services	
90785	Psychiatric complexity interactive
90791	Psychiatric diagnostic interview
90792	Psychiatric diagnostic interview with E/M
Testing/assessment	
96103	Psych testing
96120	Neuropsych testing
96127	Brief emotional behavioral assessment
E/M	
99201--99215	E/M office/outpatient services
99324--99337	Domiciliary rest home visits
99341--99350	Home visits
99366--99368	Team conferences (not paid by CMS)
99497 99498	Advanced Care Planning

These services may not be reported during the same time period as G0505	
99374	Care plan oversight (not paid by CMS)
G0101	Care plan oversight
G0182	Care plan oversight
G0506	Initiating CCM visit

G0505 may be reported:

- In the same time period as transitional care management services (TCM) **99495, 99496**
- With behavioral health integration code services (**G0502, G0503, G0505, G0507**) and
- During the same time period as chronic care management services (CCM) 99487, **99488**, and **99490**.

Chronic Care Management

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)

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, 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;
- Comprehensive care plan established, implemented, revised, or monitored.

Requirements

- Care provided by a physician or non-physician practitioner and their clinical staff in a calendar month
- Requires use of certified electronic health record
- Patient must have 24-hour-a-day, 7-day-a-week access to address urgent needs
- Continuity of care with a designated physician/NPP
- Comprehensive care management and planning
- Coordination with home and community based services

- Enhanced communication such as email
- Management of care transitions within healthcare
- Advance consent—does not need to be in writing starting 2017
- Care management for chronic conditions including systematic assessment of the patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.
- Starting 2017, faxing is allowed as a means to share care plan with other team members
- Give the patient a copy of the care plan

In consultation with the patient, any caregiver and other key practitioners treating the patient, the provider must create a patient-centered care plan. See CPT book for description of care plan.

Requires an initiating face-to-face visit for new patients, or patients not seen within a year

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However, CMS recommends an initiating visit for established patients. It gives the opportunity for informed consent and development of the care plan. This could be a welcome to Medicare visit, annual wellness visit, or E/M service 99212—99215, or the post-discharge service provided as part of Transitional Care Management.

3

May bill an add-on code (**G0506**) once at the time of the initiating visit, starting January 2017.

+**G0506** Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)

- Billing practitioner personally performs extensive planning, separate from the work of the E/M service or wellness visit
- Pays for the assessment and planning for CCM
- May only be billed once, at the initiation of CCM

From CMS's Chronic Care Management Services Changes for 2017				
Code	**National payment, non-facility rate**	**Clinical staff time**	**Care planning**	**Billing practitioner work**
99490	$43	20 minutes	Established, implemented, revised or monitored	• Ongoing oversight, direction and management. • Assumes 15 minutes of work
99487	$94	60 minutes	Established or substantially revised	• Ongoing oversight, direction, and management • Medical decision making of moderate-high complexity • Assumes 26 minutes of work
+99489	$47	30 minutes	Established or substantially revised	• Ongoing oversight, direction, and management • Medical decision making of moderate-high complexity • Assumes 14 minutes of work
+G0506	$64		Established	• Personally performs extensive assessment and CCM care planning beyond the usual effort described by the separately billable CCM initiating visit

CMS assumes the billing practitioner will spend time in the CCM services, but the times in the chart above do not need to be tracked or documented. Track and document staff time.

Date of service

Services are for a calendar month. Bill on the date when the time threshold is met, or at the end of the month.

- 🕮 Clinical staff, per CMS: “Practitioners should consult the CPT definition of the tem “clinical staff.” And “If the billing practitioner provides the clinical staff services themselves, the time of the billing practitioner may be counted as clinical staff.”

- 🕮 CPT defines a clinical staff member as "a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service; but who does not individually report that professional service."

Bundling

Look in your CPT book for long list of bundled codes—most are not payable under the physician fee schedule. Per CMS, do not report with Care Plan Oversight G0181, G0182.

Key points

- Requires care plan development for a chronically ill patient at an initiating visit for new patients or patients not seen in one year
- The initiating visit and an add-on code may be billed at the start of CCM
- Clinical staff, under the general supervision of a physician or NPP, provides and documents non-face-to-face care coordination during a calendar month
- Requires 24/7 access for urgent care needs
- Patient must consent to the service, and there is a patient due co-pay
- While typically non-face-to-face services, there may be educational or motivational counseling that is provided face-to-face and this may be included in the clinical staff time
- Time may never be counted twice to report two different services

Collaboration of Care Model for Behavioral Health Integration (CoCM/BHI)

Definition

HCPCS codes that describe collaboration of care services in primary care practices for patients with behavioral health conditions.

Explanation

CMS is recognizing and paying for non-face-to-face care collaboration services for patients with behavioral health conditions as part of their support for primary care physicians.

Codes

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, with the following required elements:

- 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 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, 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 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;
- 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 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 qualified health care professional (List separately in addition to code for primary procedure) (Use G0504 in conjunction with G0502, G0503).

- Services provided under the supervision of a PCP by a behavioral health manager
- Services in consultation with a psychiatric clinician who can prescribe medications
- Time of the behavioral health manager in a calendar month
- For patients with behavioral health conditions who "could have newly diagnosed conditions, need help in engaging in treatment, have not responded to standard care delivered in a non-psychiatric setting, or require further assessment and engagement" before referral to psychiatry

An episode of care begins with the start of this intervention and ends with:

- The attainment of targeted treatment goals, which typically results in the discontinuation of care management services and continuation of usual follow-up with the treating physician or other qualified healthcare professional; or
- Failure to attain targeted treatment goals culminating in referral to a psychiatric care provider for ongoing treatment; or
- Lack of continued engagement with no psychiatric collaborative care management services provided over a consecutive 6-month calendar period (break in episode).
- A new episode of care would or could start after a break of six calendar months or more.

Billing and coding rules

These HCPCS codes (which will be replaced by CPT codes in 2018) describe psychiatric collaboration of care for behavioral health integration. (CoCM/BHI) These codes provide payment to physicians/NPPs in a primary care practice to direct a behavioral care manager in collaboration with a consulting psychiatrist, psychiatric nurse practitioner or psychiatric physician assistant.

Care is directed by the primary care team using structured management and regular assessments, using validated tools and with modifications of the treatment plan as needed. These are services provided by the behavioral health care manager at the direction of the physician/NPP in a calendar month. It requires that the primary care team consult with a psychiatric consultant who is a psychiatric physician/NPP and who is able to prescribe the full range of psychiatric medications.

- No separate payment for psychiatric consultant for consulting with PCP practice
- If psychiatric consultant needs to see the patient, this may be billed separately

CMS has explained it succinctly in the 2017 Final Rule.

"A specific model for BHI, psychiatric CoCM typically is provided by a primary care team consisting of a primary care provider and a care manager who works in collaboration with a psychiatric consultant, such as a psychiatrist. Care is directed by the primary care team and includes structured care management with regular assessments of clinical status using validated tools and modification of treatment as appropriate. The psychiatric consultant provides regular consultations to the primary care team to review the clinical status and care of patients and to make recommendations."

Behavioral health care manager

- Could be a professional who is eligible to bill Medicare, but this is not required
- May be an employee or contracted agent
- Must be able to see the patient face-to-face when needed, but does not need to be in the same location as PCP

Service requirements

- Weekly consultation between the BHM and psychiatric consultant who is a physician, NP or PA who is able to prescribe full range of psychiatric medications
- The medical record should document the components described in the code, including engagement with the patient, the initial assessment and the rating scales used in the assessment. The individualized treatment plan and discussion with the psychiatric consultant needs to be documented. The BHM must enter the patient into a registry that allows for tracking patient follow up and progress.
- The BHM should document any interventions made with the patient. And, since these are time-based codes, the time of the individual activities needs to be documented.
- The PCP may provide medically necessary E/M services during the period.
- The psychiatrist, psychiatric NP/PA could perform needed assessments and bill for those, but are not required to see the patient as part of CoCM services.

Key components

- Care directed by physician/NPP
- An initiating E/M visit is required
- The patient must have a behavioral health diagnosis (new or existing)
- The plan, implementation and changes to the plan need to be documented
- Time spent in the activities by the behavioral health manager must be documented in the medical record
- Behavioral health manager enters patient into a registry and tracks progress
- The continuing involvement and direction of the physician/NPP should be documented
- Weekly consultation with psychiatrist or psychiatric NP/PA who is able to prescribe full range of psychiatric medications
- General supervision for service, not direct; physician/NPP does not need to be in the office with the behavioral health manager when services is provided

Collaboration of care management/behavioral health integration codes G0502, G0503, G0504		
Primary care provider (PCP)	**Behavioral Health Care Manager (BHM)**	**Psychiatric consultant within the practice**
Directs the work of the BHM	Is a part of the primary care clinical team with a specialty in behavioral health; could be social worker, nurse or psychologist	A psychiatrist, psychiatric NP, psychiatric PA qualified to prescribe full range of psychiatric medications
PCP time may be included in the time of CoCM but the PCP may not double count the time of any other service in the time of the CoCM	Provides management Does outreach Performs assessment Administers validated assessment scales Does care plan development Collaborates with PCP Provides brief interventions Services face-to-face and non-face-to-face included in time Enters patient into registry and maintains registry Consults with psychiatric consultant on a weekly basis (minimum)	Available to the practice to provide advice to PCP Consult at least weekly about each patient receiving CoCM with the BHM Recommend follow up care and other strategies Advise regarding medications and complications of psychiatric conditions Final Rule does not require the psychiatrist/NP/PA to perform this consultation on site
May provide necessary E/M services	Behavioral health manager may or may not be able to independently furnish and report services to Medicare	May perform 90791, 90792 or an E/M service on patients receiving CoCM, but may not double count any of the time
CoCM may be done by other specialty physicians but would most typically be primary care	BHM must have a "collaborative, integrated relationship with the rest of the care team members." Although CMS is not requiring that the BHM be on site, the BHM must be able to perform face-to-face services when needed (although face-to-face services are not required.)	Psychiatric consultant does not bill for CoCM PCP bills for CoCM and arranges for psychiatric consultant

Care management for behavioral health conditions

Definition

CMS developed a HCPCS code for care coordination performed by clinical staff for patients with behavioral health conditions.

Explanation

This service describes care management by clinical staff members for patients with behavioral health conditions. It is a non-face-to-face service, and the 20-minutes of time in the calendar month may be provided by the physician/NPP or clinical staff members.

Code

G0507: Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.
- To be eligible, patients must have an identified psychiatric or behavioral health condition that requires assessment, planning and treatment. These conditions may be pre-existing or newly diagnosed. Patients may have other medical conditions, but this isn't a requirement for the use of the code.

The 20-minute threshold may be met by time spent by the physician/NPP or by the clinical staff, under the direction of the physician/NPP.

Unlike codes G0502, G0503, G0504, the clinical staff member doing the work does not need to be a behavioral health specialist. CMS notes that they are applying the term clinician in the same sense as CPT, *"We will apply the same definition of the term "clinical staff" that we have applied for CCM to G0507, namely, the CPT definition of this term, subject to the incident to rules and regulations and applicable state law, licensure and scope of practice at 42 CFR 410.26. For G0507, then, we note that the term "clinical staff" will encompass or include a psychiatric or other behavioral health specialist consultant, if the treating practitioner obtains consultative expertise."*

CMS is allowing contracted clinical staff to do this work of **CoCM** and **G0507**, and states the person providing the service does not need to be on-site and does not have to be eligible to bill Medicare.

Key points

- Lower payment than CoCM codes but fewer requirements
- May be performed by existing clinical staff, behavioral health manager not required
- A verbal consent is sufficient to start the service, but must be obtained
- Requires an initial assessment, use of validated rating scales such as the depression scale, behavioral health care planning and revisions to the plan, facilitating and coordinating treatment such as psychotherapy medication management or psychiatric consultation if required, and continuity of care with the designated team member
- Like the CoCM/BHI codes, the supervision requirement is general not direct

Many primary care practices do provide care management services for patients with psychiatric diagnoses. Some may be able to meet the requirements of the CoCM/BHI codes but many more will be able to document twenty minutes of case management.

Are you ready?

You're ready to perform this service:		If you have these resources:
G0505	Assessing cognitive function for patients with dementia	• Clinical assessment tool to assess dementia • Template to document a care plan in medical record
G0502 **G0503** **G0504**	Collaboration of care/behavioral health integration	• Employed or contracted behavioral health manager • Consulting psychiatrist, or psychiatric NP/PA for weekly consultation • Clinical assessment tools to assess psychiatric conditions • Clinical assessment tools to monitor patient outcomes • Ability to enter patient into a registry • Ability to track and document time and activities of behavioral health manager monthly
G0507	Care management for behavioral health conditions	• Clinical staff to perform services • Clinical assessment tool for assessing psychiatric conditions • Ability to track and document time and activities of clinical staff member
99487 **99489** **99490**	Chronic care management	• Clinical staff to perform services, such as a nurse or care manager • Template to document a care plan in medical record • Using certified electronic health record • Allow patients access to enhanced communication, such as email • Ability to share care plan with other health care professionals caring for patient (fax allowed in 2017, but not encouraged) • Ability to track and document time and activities of clinical staff