COMPLIANCE TIP

TO: Compliance Alert Distribution List

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SUBJECT: New 2017 HCPCS Level II Procedure Codes

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These new codes are used by Medicare. Other payers may utilize these codes as well but that it up to the discretion of the individual payer.

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, in office or other outpatient setting or home or domiciliary or rest home.

Work RVUs 3.44
Florida Allowance Non-Facility Setting: $235.98
Florida Allowance Facility Setting: $178.34

Georgia Allowance Non-Facility Setting: $227.35
Georgia Allowance Facility Setting: $173.14

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

Work RVUs 0.87
Florida Allowance Non-Facility Setting: $63.27
Florida Allowance Facility Setting: $46.45

Georgia Allowance Non-Facility Setting: $60.78
Georgia Allowance Facility Setting: $44.97

For additional work of the billing practitioner in personally performing a face-to-face assessment of a patient requiring CCM services, and personally performing CCM care planning (the care planning could be face-to-face and/or non-face-to-face) that is not already reflected in the initiating visit itself (nor in the monthly CCM service code).

CMS believes that G0506 might be particularly appropriate to bill when the initiating visit is a less complex visit (such as a level 2 or 3 E/M visit), although G0506 could be billed with high level visits if the billing practitioner’s effort and time exceeded the usual effort described by the initiating visit code. It could also be appropriate to bill G0506 when the initiating visit addresses problems unrelated to CCM, and the billing practitioner does not consider the CCM-related work he or she performs in determining what level of initiating visit to bill. Initiating visit required for new patients or patients not seen within one year instead of all patients receiving CCM services. This would allow practitioners with existing relationships with patients who have been seen relatively recently to initiate CCM services without furnishing a potentially unnecessary E/M visit. G0506 will be an add-on code to describe work performed by the billing practitioner (as opposed to clinical staff) once, in conjunction with the start or initiation of CCM services.

Allowed only once per patient by the billing practitioner. Work and/or time reported under G0506 could not also be reported under or counted towards the reporting of any other billed code, including any of the monthly CCM services codes.

The care plan that the practitioner must create to bill G0506 would be subject to the same requirements as the care plan included in the monthly CCM services. G0506 will not be an add-on code for the BHI initiating visit (G0507) or BHI services. G0506 will be a one-time service code for CCM initiation, and the billing practitioner must choose whether to report either G0506 or prolonged services in association with CCM initiation (if requirements to bill both are met).

G0501
New Add-on Code for E/M Visits with Mobility-assisted Technology

Resource-intensive services for patients for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lifts, and
adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient evaluation and management visit (Add-on code, list separately in addition to primary procedure).

An adjustment to payment for routine visits furnished to beneficiaries for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lifts, and adjustable padded leg supports) is medically necessary.

Effective January 1, 2017, CMS proposed that this add-on code could be billed with new and established patient office/outpatient E/M codes (CPT codes 99201 through 99205, and 99212 through 99215), as well as transitional care management codes (CPT codes 99495 and 99496), when the additional resources described by the code are medically necessary and used in the provision of care.

While CMS believes that improving the payment accuracy of physicians’ services is necessary and appropriate, and can help to address the underlying access issues for individuals with disabilities, they also acknowledge that implementation of new or revised payments can result in unanticipated, and potentially undesirable, consequences. Before implementing payment for code G0501, CMS plans to further analyze and address the concerns raised. As such, they are not finalizing payment for code G0501 at this time. Over the next 6 months CMS will engage with interested beneficiaries, advocates, and practitioners to continue to explore improvements in payment accuracy for care of people with disabilities. CMS intends to discuss this issue again in future rulemaking.

Although CMS is not finalizing separate payment for code G0501 for CY 2017, they are including the code in the CY 2017 code set as G0501. The HCPCS code G0501 will not be payable under the Medicare PFS for CY 2017, though practitioners will be able to report the code, should they be inclined to do so.