RELATIVE VALUE UPDATE COMMITTEE (RUC) PROCESS

Code changes for all medical specialties take effect on January 1, of each year as a result of the CPT Editorial Panel process. The American Medical Association (AMA) is responsible for CPT and has convened the CPT Editorial Panel to develop and maintain the nomenclature healthcare providers use to report medical procedures and services. The CPT Editorial Panel meets three times a year to evaluate code change proposals for new and emerging technology and is responsible for reorganizing and maintaining the code set. After codes are created or modified by the CPT Editorial Panel, they go before the Relative Value Update Committee (RUC), also convened by the AMA, to be assigned a relative value.

For more information on the RUC process and how to efficiently complete a RUC survey if you are randomly selected to do so, review this 13-minute video: Understanding the RUC Survey Instrument: Surgical Services (https://www.youtube.com/watch?v=z1QFGVizeWs) prepared by the AMA.

NOTE: An AMA CPT code may not be covered/payable per Centers for Medicare & Medicaid Services (CMS) guidelines.

WINTER ~ 2018 CPT Updates—End of Year Newsletter

2018 CPT Code Updates

Each year on January 1, the CPT (Current Procedural Terminology) Codes are updated with new, revised and deleted codes. The CPT updates must be reviewed carefully to ensure the practice makes the necessary changes to their billing protocols. 2018 rings in with 300+ changes in CPT.


2018 PHYSICIAN FEE SCHEDULE (PFS) FINAL RULE

Providers won’t face any earthshaking changes in 2018 thanks to the postponement of some of the most impactful provisions in the proposed rule. The Centers for Medicare & Medicaid Services (CMS) is holding off on any changes to the Evaluation and Management (E&M) guidelines after suggesting in its proposed rule that it could eliminate the history and exam key components and put more focus on medical decision making, medical necessity and time. Also delayed until 2020, is the Appropriate Use Criteria (AUC) for advanced diagnostic imaging.

See the CMS fact sheet, available via https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-02.html?

In this issue...

2018 CPT Changes Summary ................................................................. pg 2
MSI 2018 CPT-HCPCS Code Resource Grid ........................................: pg 2
Tabs: 2018 Code List, 2018 Deleted, 2018 Revised ................................. pg 3
Anesthesia Section ~ Endoscopic Codes .............................................. pg 3
New Modifiers ...................................................................................... pg 3
Surgery Section ~ Nasal/Sinus Endoscopic Codes ................................. pg 4
Surgery Section ~ Spine Coding .............................................................. pg 4
Radiology Section ~ Mammogram Services ........................................ pg 5
Radiology Section ~ X-Ray ................................................................. pg 5
MEDPM/MEDEHR Support File Updates ............................................ pg 6
MEDPM/MEDPM WEB Charge Transaction Master ............................ pg 7
E&M Section REVISED ~ Initial Observation Care Guidelines ......... pg 8
E&M Section NEW ~ Preventive Prolonged Service ............................. pg 8
E&M Section NEW/DELETE ~ Cognitive Assessment and Care Plan Services ........................................................ pg 8
BCBS Post Partum Billing Policy Change ............................................. pg 9
Medicine Section ~ Telehealth Services Modifier Change ..................... pg 10
Office of Inspector General (OIG) Work Plan .................................... pg 10
Quality and Resource Use Report (QRUR) ......................................... pg 11
CMS Web Based Training (WBT) Courses ......................................... pg 11
Novitas Medicare Learning Center ....................................................... pg 12
Novitas Targeted Probe and Educate (TPE) .......................................... pg 12
2017 Calendar Year-End Closing ....................................................... pg 12
Holiday Schedule ............................................................................. pg 12
MEDTRON 2018 CPT-HCPCS CODE RESOURCE GRID


The CPT Resource Grid is an excel spreadsheet that contains:
- **Code List-Index**: CPT Code Range List and Index of available tabs/worksheets.
- **2018 Code List**: Full CPT/HCPCS Code List with Code, CMS Description, MEDPM Description and several code indicators, i.e., 2018 Work RVU, Global Days, Bilateral Surgery, Assist at Surgery, and more!
- **Legend**: Column headers defined.
- **2018 New Codes**: New code list with specialty indicator.
- **2018 Deleted Codes**: Deleted code list with specialty indicator.
- **2018 Revised Codes**: Revised code list with specialty indicator.

All tabs have filters applied to enable users to easily manage/search for data/information.

MEDTRON 2018 CPT-HCPCS CODE RESOURCE GRID - 2018 CODE LIST & LEGEND TABS

**2018 Code List** tab ~ All codes listed are active codes with the CMS and MEDPM descriptions and include indicators, i.e., Bilateral Surgery, Assist at Surgery, Co Surgeon, Global Days, MUE, ASA codes, WRVUs and more!

The MEDPM Description column represents the description as it “presents” in the MEDPM Transaction (Charge) Master, see page 6.

**Legend** tab ~ defines values available in each column.
**2018 New Codes** tab ~
All codes listed are new codes with the code descriptions.

**2018 Deleted Codes** tab ~
All codes listed are deleted codes, including descriptions and replacement codes if known.

**2018 Revised Codes** tab ~
All codes listed have revised descriptions.

---

### ANESTHESIA SECTION ~ ENDOSCOPIC CODES

New codes have been established to report anesthesia management of upper and lower endoscopic procedures.

<table>
<thead>
<tr>
<th>Deleted CPT</th>
<th>New CPT</th>
<th>Description</th>
<th>Base Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>00740</td>
<td>00731</td>
<td>Anesthesia for upper gastrointestinal endoscopic procedures, endoscope</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>introduced proximal to duodenum; not otherwise specified</td>
<td></td>
</tr>
<tr>
<td>00740</td>
<td>00732</td>
<td>Anesthesia for upper gastrointestinal endoscopic procedures, endoscope</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>introduced proximal to duodenum; endoscopic retrograde</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>cholangiopancreatography (ERCP)</td>
<td></td>
</tr>
<tr>
<td>00810</td>
<td>00811</td>
<td>Anesthesia for lower intestinal endoscopic procedures, endoscope</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>introduced distal to duodenum; not otherwise specified</td>
<td></td>
</tr>
<tr>
<td>00810</td>
<td>00812</td>
<td>Anesthesia for lower intestinal endoscopic procedures, endoscope</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>introduced distal to duodenum; screening colonoscopy</td>
<td></td>
</tr>
<tr>
<td>00810</td>
<td>00813</td>
<td>Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum</td>
<td>5</td>
</tr>
</tbody>
</table>

---

### NEW MODIFIERS

**96 - Habilitative Services:** When a service or procedure that may be either habilitative or rehabilitative in nature is provided for habilitative purposes, the physician or other qualified health care professional may add modifier 96 to the service or procedure code to indicate that the service or procedure provided was a habilitative service. Habilitative services help an individual learn skills and functioning for daily living that the individual has not yet developed, and then keep and/or improve those learned skills. Habilitative services also help an individual keep, learn, or improve skills and functioning for daily living.

**97 - Rehabilitative Services:** When a service or procedure that may be either habilitative or rehabilitative in nature is provided for rehabilitative purposes, the physician or other qualified health care professional may add modifier 97 to the service or procedure code to indicate that the service or procedure provided was a rehabilitative service. Rehabilitative services help an individual keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the individual was sick, hurt, or disabled.
SURGERY SECTION ~ NASAL/SINUS ENDOSCOPIC CODES

CMS has introduced 5 new nasal/sinus endoscopy codes that each represent previous bundled services, i.e., codes frequently reported together.

- **31259** [WRVU 8.48] represents a combination of the services previously described by CPT: 31255 [WRVU 6.95] and 31288 [WRVU 4.57] (formerly the combination was 11.52 WRVUs).
- **31298** [WRVU 4.50] represents a combination of CPT: 31296 [WRVU 4.94] and 31297 [WRVU 2.64] (formerly the combination was 7.58 WRVUs).

WRVUs for some ENT endoscopy codes will be slashed in 2018.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>2017 WRVU</th>
<th>2018 WRVU</th>
<th>WRVU Reduction</th>
<th>LA MCR Fee Schedule 2018 Area 99</th>
</tr>
</thead>
<tbody>
<tr>
<td>31254</td>
<td>Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery</td>
<td>4.64</td>
<td>4.27</td>
<td>0.37</td>
<td>$ 318.18</td>
</tr>
<tr>
<td>31255</td>
<td>Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and</td>
<td>6.95</td>
<td>5.75</td>
<td>1.20</td>
<td>$ 324.48</td>
</tr>
<tr>
<td></td>
<td>posterior), including frontal sinus exploration, with removal of tissue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>from frontal sinus, when performed (WRVU 9.00)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31257</td>
<td>Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and</td>
<td>3.29</td>
<td>3.11</td>
<td>0.18</td>
<td>$ 180.22</td>
</tr>
<tr>
<td></td>
<td>posterior), including sphenoidotomy (WRVU 8.00)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31259</td>
<td>Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and</td>
<td>5.45</td>
<td>4.68</td>
<td>0.77</td>
<td>$ 266.01</td>
</tr>
<tr>
<td></td>
<td>posterior), including sphenoidotomy, with removal of tissue from the</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>sphenoid sinus (WRVU 8.48 formerly 11.52)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31298</td>
<td>Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid</td>
<td>8.84</td>
<td>6.75</td>
<td>2.09</td>
<td>$ 379.11</td>
</tr>
<tr>
<td></td>
<td>sinus ostia (eg, balloon dilation) (WRVU 4.50 formerly 7.58)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Abbreviated Description</th>
<th>2017</th>
<th>2018</th>
<th>Reduction</th>
<th>LA MCR Fee Schedule 2018 Area 99</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017</td>
<td>2018</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31254</td>
<td>4.64</td>
<td>4.27</td>
<td>0.37</td>
<td>$ 318.18</td>
</tr>
<tr>
<td>31255</td>
<td>6.95</td>
<td>5.75</td>
<td>1.20</td>
<td>$ 324.48</td>
</tr>
<tr>
<td>31256</td>
<td>3.29</td>
<td>3.11</td>
<td>0.18</td>
<td>$ 180.22</td>
</tr>
<tr>
<td>31267</td>
<td>5.45</td>
<td>4.68</td>
<td>0.77</td>
<td>$ 266.01</td>
</tr>
<tr>
<td>31276</td>
<td>8.84</td>
<td>6.75</td>
<td>2.09</td>
<td>$ 379.11</td>
</tr>
<tr>
<td>31287</td>
<td>3.91</td>
<td>3.50</td>
<td>0.41</td>
<td>$ 201.52</td>
</tr>
<tr>
<td>31288</td>
<td>4.57</td>
<td>4.10</td>
<td>0.47</td>
<td>$ 234.49</td>
</tr>
<tr>
<td>31295</td>
<td>2.70</td>
<td>2.70</td>
<td>No change</td>
<td>$ 157.35</td>
</tr>
<tr>
<td>31296</td>
<td>3.29</td>
<td>3.10</td>
<td>0.19</td>
<td>$ 1,860.75</td>
</tr>
<tr>
<td>31297</td>
<td>2.64</td>
<td>2.44</td>
<td>0.20</td>
<td>$ 1,821.29</td>
</tr>
</tbody>
</table>

NEW GUIDELINES:

Vertebral Corpectomy: the term partial is used to describe removal of a substantial portion of the body of the vertebra. In the cervical spine, the amount of bone removed is defined as at least one-half of the vertebral body. In the thoracic and lumbar spine, the amount of bone removed is defined as at least one-third of the vertebral body.

NEW CODE:

20939 + Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision

(List separately in addition to code for primary procedure) [WRVU 1.16]

Previously, CPT code 38220 [WRVU 1.20] was used to report this service; however, CPT code 38220 was redefined to reflect bone marrow aspiration for diagnostic purposes only.

DELETED CODE:

0309T + Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft, when performed, lumbar, L4-L5 interspace (List separately in addition to code for primary procedure) [WRVU 0.00]

Beginning 01/01/18, use CPT 22899 (Unlisted procedure, spine). [WRVU 0.00]

REVISED CODE:

38220 Diagnostic bone marrow; aspiration(s) [WRVU 1.20]

Prior to this change, CPT code 38220 (Bone marrow; aspiration only) was used to report needle aspiration of bone marrow for the purpose of bone grafting. Beginning 01/01/18, CPT code 20939 [WRVU 1.16] should be used to report bone marrow aspiration for bone grafting in spine surgery.

RESOURCES: CPT Book and the International Society for the Advancement of Spine Surgery:

RADIOLOGY SECTION ~ MAMMOGRAM SERVICES

Effective with dates of service 01/01/2018, HCPCS codes G0202, G0204 and G0206 have been deleted and will be replaced with the below CPT codes:

<table>
<thead>
<tr>
<th>Deleted HCPCS</th>
<th>New CPT</th>
<th>Mod</th>
<th>Description</th>
<th>WRVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0206</td>
<td>77065</td>
<td>-</td>
<td>Diagnostic Mammo incl CAD unilateral</td>
<td>0.81</td>
</tr>
<tr>
<td>G0206</td>
<td>77065</td>
<td>26</td>
<td>Diagnostic Mammo incl CAD unilateral</td>
<td>0.81</td>
</tr>
<tr>
<td>G0204</td>
<td>77066</td>
<td>-</td>
<td>Diagnostic Mammo incl CAD bilateral</td>
<td>1.00</td>
</tr>
<tr>
<td>G0204</td>
<td>77066</td>
<td>26</td>
<td>Diagnostic Mammo incl CAD bilateral</td>
<td>1.00</td>
</tr>
<tr>
<td>G0202</td>
<td>77067</td>
<td>-</td>
<td>Screening Mammo incl CAD bilateral</td>
<td>0.76</td>
</tr>
<tr>
<td>G0202</td>
<td>77067</td>
<td>26</td>
<td>Screening Mammo incl CAD bilateral</td>
<td>0.76</td>
</tr>
</tbody>
</table>


RADIOLOGY SECTION ~ X-RAY

Revisions have been made to the chest radiograph codes in order to remove view-specific codes (i.e., frontal, apical) and to replace them with codes that specify the number of views.

<table>
<thead>
<tr>
<th>Deleted CPT</th>
<th>New CPT</th>
<th>Description</th>
<th>WRVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>71010, 71015</td>
<td>71045</td>
<td>Chest; single view</td>
<td>0.18</td>
</tr>
<tr>
<td>71020, 71023</td>
<td>71046</td>
<td>Chest; 2 views</td>
<td>0.22</td>
</tr>
<tr>
<td>71021</td>
<td>71047</td>
<td>Chest; 3 views</td>
<td>0.27</td>
</tr>
<tr>
<td>71022, 71030, 71034</td>
<td>71048</td>
<td>Chest; 4 or more views</td>
<td>0.31</td>
</tr>
<tr>
<td>71034, 71035, 74000</td>
<td>74018</td>
<td>Abdomen; 1 view</td>
<td>0.18</td>
</tr>
<tr>
<td>74010, 74020</td>
<td>74019</td>
<td>Abdomen; 2 views</td>
<td>0.23</td>
</tr>
<tr>
<td>74010, 74020</td>
<td>74021</td>
<td>Abdomen; 3 or more views</td>
<td>0.27</td>
</tr>
</tbody>
</table>

NOTE: This revision did not impact WRVUs.

MEDPM/MEDEHR SUPPORT FILE UPDATES

≈ Update your system to new 2018 CPT codes effective January 1, 2018 and 2018 ICD-10 codes effective October 1, 2017.

Reminder – there is no grace period for CPT.

MEDPM Users: Support files must be reviewed for updates/additions/deletions via MEDPM, equally as important, if used, are the charge tickets which must be reviewed to confirm all linked diagnosis and/or transaction codes (key codes) using specific CPT codes are current/accurate.

MEDDATA Clients—Setup and Support files are up to date and ready to proceed with ICD-10 for 2018. Setup and Support files will be updated automatically for 2018 CPT updates.

**Practice staff should review charge tickets/templates for applicable updates and forward changes needed to the Admin Services Dept via email: adminservices@medtronsoftware.com.**

MEDEHR Users: Support files must be reviewed for updates/additions/deletions via MEDEHR, equally as important are the encounter templates which must be reviewed to confirm all linked diagnosis and/or transaction codes (key codes) using specific CPT codes are current/accurate.

Timeshare/iSeries:
Contact MSI Software Support to order systematic updates for the above, i.e., 2018 CPT, ICD-10, Allowables, NCC, etc. Remember to make internal revisions to your charge tickets, if applicable.

≈ After new/revised/deleted CPT codes are loaded, run a Charge Application Report for usage by CPT to identify all deleted CPT codes prefixed with “I17” prefix. These codes must be replaced in applicable charge tickets and templates.

≈ Update your Charge Master for the new 2018 fee schedules (allowables) published by Medicare, Medicaid and any of your managed care relationships.

≈ After new/revised/deleted fee schedules (allowables) are loaded, run an Allowable vs. Charge Comparison Report and update any standard prices in your Charge Master to ensure that all charge amounts are higher than published allowables.

≈ Implement the scanning of your patients’ insurance cards and driver’s licenses into MEDPM/MEDEHR.

REMINDER: Medicare is introducing new cards and policy # scheme, see 072517 News Blast: New Medicare Cards.

≈ Utilize Online Eligibility via MEDPM/MEDEHR.

NOTE: Medicare returns patients’ address, Part C, i.e., Medicare Advantage replacement coverage information and/or Medicare Secondary Payer (MSP) status as applicable and preventive code availability per patient.

LA Medicaid returns patient’s policy #, Medicaid Managed Care Organization (MCO-BHP) [formerly referred to as Bayou Health Plan (BHP)]. Take Charge information and Primary Insurance/Third Party Liability (TPL) codes as applicable.

≈ Update your system for Medical Necessity (MN), National Correct Coding Initiative (NCC/NCCI) edits, National Provider Identifiers (NPI), Medigap (MGP), Global Surgical Periods (GSP), Relative Value Units (RVU), and the new Charge Master Indicators, i.e., modifiers, frequency, status, and sex.

NOTE: All clients who requested the Medigap update; please review your Medicare EOBs carefully for payments with Remark MA18: ‘FORWARDED TO PT INSURER’.

When received, update the associated Insurance Company Master’s Medigap field to ‘Y’.

MEDEHR clients: To assist providers in reconciling any newly published ICD-10/CPT codes, MEDTRON can run a query of the EHR Templates used to show all linked codes in each encounter template listed in MEDEHR.

Each practice should contact MSI Software Support to request a query of all CPT codes linked to MEDEHR encounter templates to reconcile against the 2018 CPT updates/additions/deletions and make necessary updates.

Contact MSI Software Support for assistance or any questions via:
From MEDTRON Sign On screen, double click on ‘support@medtronsoftware.com’ to compose an email to the Software Support Dept.
-OR-
Phone: (985) 234-0599 (local), (800) 978-0599 (toll free)
-OR-
Fax: (985) 234-0609
** IMMEDIATE ACTION IS NEEDED **

Immediately identify and update any deleted or revised CPT codes that are referenced or used in any of your practice resources, i.e., charge tickets/superbills.
E&M SECTION REVISED ~ INITIAL OBSERVATION CARE GUIDELINES ~

Guideline Update:
The following codes are used to report the encounter(s) by the supervising physician or other qualified health care professional with the patient when designated as outpatient hospital “observation status.” This refers to the initiation of observation status, supervision of the care plan for observation and performance of periodic reassessments.
For observation encounters by other physicians, see office or other outpatient consult codes (AMA only 99241-99245) or subsequent observation care codes (99224-99226) as appropriate.

Source: 2018 CPT Book, see book for complete guidelines.

Code Description:
Initial observation care, per day, for the evaluation and management (E&M) of a patient which requires the below 3 key components. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.

<table>
<thead>
<tr>
<th>CPT:</th>
<th>99218 [WRVU 1.92]</th>
<th>99219 [WRVU 2.60]</th>
<th>99220 [WRVU 3.56]</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>Detailed or Comprehensive</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Exam</td>
<td>Detailed or Comprehensive</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Medical Decision Making (MDM)</td>
<td>Straight Forward or Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Time in Minutes</td>
<td>30</td>
<td>50</td>
<td>70</td>
</tr>
</tbody>
</table>

E&M SECTION NEW ~ PREVENTIVE PROLONGED SERVICE ADD-ON CODES

In an effort to increase payments for Primary Care Providers (PCP), CMS created add-on codes that allow providers to report and be reimbursed for some preventive services that last at least 30 minutes longer than the typical time.

Part of the 2018 fee schedule addenda released by CMS includes the typical time for each of the 19 codes “assumed for valuation” (see chart below).

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. [WRVU 1.17]

G0514+  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; each additional 30 minutes. [WRVU 1.17]

The expected reimbursement for G0513+/G0514+ is approximately $65.00 each; coinsurance and deductible are waived.

Part of the 2018 fee schedule addenda released by CMS includes the typical time for each of the 19 codes “assumed for valuation” (see chart).

For example, the typical time for an initial Annual Wellness Visit (AWV) (G0438) is 30 minutes, per CMS. If the provider spends an hour with the patient to discuss counseling or for another reason, G0513 can be reported, which would add $65.00 onto the $173.00 rate for the AWV service.

Providers can expect to report G0513 after an additional 16 minutes and G0514 after 46 minutes.

NOTE: As of the date of this publication, Medicaid has not published the fee schedule to determine if these codes are payable for Medicaid patients.

For more information on Prolonged Service codes, see the Prolonged Services section of MEDTRON’s Evaluation and Management (E&M) Information Packet, available via: https://www.medtronsoftware.com/User Guides/E&M_Resources/E&M Information Packet General.pdf

NOTE: User ID and Password required, contact Software Support via email: support@medtronsoftware.com.

E&M SECTION  NEW/DELETE~ COGNITIVE ASSESSMENT AND CARE PLAN SERVICES

HCPCS Code G0505 [WRVU 3.44] has been deleted! Replacement CPT code is 99483 [WRVU 3.44].

Cognitive assessment and care plan services are provided when a comprehensive evaluation of a new or existing patient, who exhibits signs and/or symptoms of cognitive impairment, is required to establish or confirm a diagnosis, etiology and severity for the condition. This service includes a thorough evaluation of medical and psychosocial factors, potentially contributing to increased morbidity. Do not report cognitive assessment and care plan services if any of the required elements are not performed or are deemed unnecessary for the patient’s condition. A single physician or other qualified health care professional should not report 99483 more than once every 180 days.

99483 – Assessment of and care planning for a patient with cognitive impairment, requiring an independent history, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements:
- 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 [FAST], Clinical Dementia Rating [CDR])
- Medication reconciliation and review for high-risk medications
- Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s)
- Evaluation of safety (e.g., home), including motor vehicle operation
- Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks
- Development, updating or revision, or review of an Advance Care Plan (ACP)
- 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 (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support

Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver. [WRVU 3.44]
(Source: 2018 CPT Book, page 47)

DO NOT report 99483 in conjunction with other E&M Services!

See MEDTRON’s Evaluation and Management (E&M) Information Packet, available via:

NOTE: User ID and Password required, contact Software Support via email: support@medtronsoftware.com.

Remember to review Charge Tickets and EHR Templates for appropriate updates!

BCBS POST-PARTUM BILLING POLICY CHANGE

Blue Cross/Blue Shield (BCBS) of LA has changed their global billing policy for maternity care, effective December 1, 2017.

For post-partum visits on and after date of service (DOS) December 1, 2017, obstetricians are required to submit a claim for the member’s post-partum visit using the non-payable reporting Category II code 0503F with a charge of $0 [WRVU 0.00].

This visit should be performed no later than 60 days after the date of delivery.

These claims will be used to better report the quality performance measures as well as provide information to understand new areas for member engagement. This information will also be used to ensure claims payments match the services provided. If 0503F is not billed to indicate post-partum services were performed, recoupment’s to the global delivery code will be made to reflect the allowable applicable to the post-partum care service.

Questions about the above should be directed to BCBS Provider Relations at provider.relations@bcbsla.com.
OFFICE OF INSPECTOR GENERAL (OIG) WORK PLAN

The Office of Inspector General's (OIG) work plan is the most important compliance blueprints for healthcare providers and organizations. It lays out the audits, evaluations and other projects for the Centers for Medicare & Medicaid Services (CMS) and others that the Department of Health and Human Services (HHS) OIG plans to conduct in the year ahead.

The OIG work planning process is dynamic and adjustments are made throughout the year to meet priorities and to anticipate and respond to emerging issues with the resources available. Previously, OIG updated its public-facing Work Plan to reflect those adjustments once or twice each year. In order to enhance transparency around OIG's continuous work planning efforts, effective June 15, 2017, OIG updates its Work Plan website monthly.

For more information about OIG's Work Plan, how work is planned, and how the work plan is updated, please visit: https://oig.hhs.gov/reports-and-publications/workplan/index.asp

Review the active Work Plan items to better understand where to focus attention when it comes to fraud and investigative activities of the federal government, and to help nip problems in the bud to avoid expensive and time-consuming audits. https://oig.hhs.gov/reports-and-publications/workplan/active-item-table.asp

MEDICINE SECTION ~ TELEHEALTH SERVICES MODIFIER CHANGE

The CMS requirement of appending the Telehealth modifier ‘GT’ to codes that are performed for telehealth services has been eliminated in 2018. Instead, the new Place of Service (POS) code: 02 (Telehealth) is sufficient to indicate on a claim that the CPT code(s) being billed were performed via telehealth.

In addition to the codes listed in Appendix P: Synchronous Telemedicine Services of the CPT code book, more codes have been identified as ‘billable’ in 2018:

- **90785**: Interactive complexity; add-on code paired with a primary psychiatric service code to indicate the patient had difficulty communicating which made the service more difficult [WRVU .33]
- **90839** and **90840**: Psychotherapy for crisis [WRVU 3.13; 1.50]
- **96160** and **96161**: Health Risk Assessment (HRA), patient-focused and caregiver-focused respectively [WRVU 0.00]
- **G0296**: Visit to determine Low Dose Computer Tomography (LDCT) eligibility [WRVU .52]
- **G0506**: Care planning for Chronic Care Management (CCM) [WRVU .87]

Source: The Business of Medicine, Vol 5, Issue 11

See the CMS Telehealth Services Fact Sheet available via: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf

Medicaid will continue use of modifier ‘GT’ and not POS: 02 until further notice.

THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)  
WEB BASED TRAINING (WBT) COURSES

CMS has developed the Medicare Learning Network (MLN) Learning Management System (LMS), a web-based training (WBT) module, which has been recently redesigned to provide free 24/7 access to WBT courses, including required Compliance, Fraud, Waste and Abuse, Quality Initiatives and more!

All staff including providers, nurses, laboratory and radiology technicians, therapists, medical coding staff, medical records staff, billing staff, clinical receptionists, schedulers and admission clerks with access to protected health information (PHI) and member ID cards play a vital role in protecting the integrity of the Medicare Program and should evaluate the WBT and the courses available.

NOTE: Many carriers are now requiring proof of completion of these courses!

For more details, see the 120517 News Blast: CMS Compliance Web Based Training (WBT) available via: https://www.medtronsoftware.com/pdf/newsblasts/120517_CMS_Compliance_Web_Based_Training.pdf

Resources:
User Guide: CMS Web Based Training (WBT) Courses
(User ID and password required, contact Software Support via email: support@medtronsoftware.com)

QUALITY AND RESOURCE USE REPORT (QRUR)

Providers now have access to the 2016 QRUR report, which describes the practice’s cost performance in 2016 and the payment impact for 2018 under the Value-Based Payment Modifier (VBM) program. This will be the last QRUR providers receive because the VBM program will go away in 2018 to be replaced by the Cost performance category of the Merit Based Incentive Payment Systems (MIPS).

The Cost performance category will account for 10% of the providers overall MIPS score during the 2018 measurement year, which will be used to set providers’ MIPS payment adjustment in 2020.

To access the QRUR, providers will need to log into the CMS Enterprise Portal available via: https://portal.cms.gov/wps/portal/unauthportal/home/

MEDTRON News Blast Resources:
Quality and Resource Use Report (QRUR)
MACRA Summary:
MACRA Updates - Quality Category
MACRA Updates - Advancing Care Information Category
MACRA Updates - Improvement Activities Category
Reporting MIPS Measures & HEDIS via MEDPM using $0 Encounters
NOVITAS MEDICARE LEARNING CENTER

Learn more about the Medicare program and discover ways to improve the accuracy and efficiency of the Medicare billing process by participating in the FREE educational events hosted by Novitas Solutions, Louisiana’s Medicare Administrative Contractor (MAC).

Visit the Novitas Medicare Learning Center (your gateway to Medicare knowledge) to review and register for scheduled events. User name and password are required, sign up for your FREE account today!

E-learning Participants Guide:

Upcoming events:
12/19/17—Are you ready for the new Medicare card?
12/19/17 - Part B Novitasphere Claim Correction Overview

Novitas Targeted Probe and Educate (TPE)
Targeted Probe and Educate (TPE) is one process that a Medicare Administrative Contractor (MAC) can utilize when providers are selected by Medical Review. The TPE review process includes three rounds of a prepayment probe review with education.

Visit the Targeted Probe and Educate section of the Novitas Solutions website to review “Topics for Review”.
https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00161300&_afrLoop=143768135680392#%40%40%3F_afrLoop%3D143768135680392%26contentId%3D00161300%26_adf.ctrl-state%3Dilxqce7zp_135

2017 CALENDAR YEAR-END CLOSING

MEDDATA and Timeshare Clients: This will automatically be done for your practice when we run your December Month-End.

DO NOT RUN ‘END OF YEAR’ (EOY) BEFORE ‘END OF MONTH’ (EOM)!!

For assistance, contact Software Support: by double clicking support@medtronsoftware.com from MEDPM or MEDEHR Sign-On screens.

iSeries Clients: If your ‘Fiscal Year’ ends on December 31st, DON’T FORGET to run the YEAR-END CLOSING procedure IMMEDIATELY AFTER closing the month of December.

The Year-End process will back-up the files and only produce reports you specified in Setup & Support (option #2), Practice Control (option #1), Closing Reports Criteria, Year End Reports (option #6).

NOTE: Your Year-End totals are reflected on December’s Month-End reports under “Year-To-Date”.

INSTRUCTIONS TO COMPLETE YEAR-END:

Procure a sufficient number of tapes. (You will need one set for the Month-End and a second set for the Year-End.)

If any new tapes will be used, they must first be initialized.

From the MEDPM Master Menu:

Select Option #8 Closing and Backup Menu
Select Option #3 Month-End Closing to perform the regular month-end

Once completed, you will receive a screen indicating that it is time to close the year, and will have the option to run the Year-End without having to select option #5 Year-End Closing from the Closing & Backup menu.

If you encounter any problems contact Software Support immediately at (985) 234-0599. **DO NOT** attempt to rerun.

Holiday Schedule

MEDTRON’s office will be closed:
Monday, December 25th, 2017 for Christmas!
Statements received after 12pm on Friday, December 22nd will be mailed on Wednesday, December 27th

MEDTRON’s office will be closed:
Monday, January 1st, 2018 for New Years!
Statements received after 12pm on Friday, December 29th will be mailed on Tuesday, January 2nd