October 2016 CPT® and HCPCS® Revisions

ISN'T THE CG MODIFIER ENOUGH?

Every October 1st, the beginning of the new federal fiscal year, brings with it additions, revisions and deletions of HCPCS® codes--some of which we more commonly call CPT® codes. In the RHC community, we are still getting our heads around the HCPCS® reporting on our UB-04 claims and the new use of the CG modifier to identity the qualifying visit code and trigger our AIR payment. Plenty has been written about these changes in our TA calls and on the Listserv. However, there are a few other code changes which may matter to you as well. Make sure that your practice management systems and EHRs have been updated in order to report any code changes.

Last year CMS granted a one-year grace period giving providers the flexibility to code within the correct "family of codes" without any consequences in reimbursement if the code assignment did not reflect the highest level of specificity as clinically documented. Opinions vary on what the fallout will be now that the grace period ended on September 30, 2106. However, we should be coding to the highest level of specificity. Many EHR crosswalks and tools are still lacking in giving providers a complete picture of their code choices. If a provider had old ICD-9 codes memorized and is now using the GEM tool alone, chances are that the ICD-10 code assignment may not be accurate. Remember that if the clinical documentation states laterality, degree of severity, etiology, complications or other anatomical detail it is probably not correct to report an unspecified code. An unspecified code is not a catch-all code for the code family.

There has also been a code replacement effective 10/1/2016 for Smoking Cessation Counseling. G0436 has been replaced by 94406 for 3-10 minutes of counseling; and G0437 has been replaced by 99407 for >10 minutes of counseling. Time-based codes should always be supported by clinical documentation. The corresponding diagnosis code should support medical necessity.

RHC encounters by RNs of LPNs in a Home Health Agency shortage area have been a recent Listserv topic. These services are rarely performed in the RHC community at large. However, CMS has recently issued a program memorandum on the reporting of new HCPCS® code G0490 which should be used to report a face-to-face home health nursing visit as a RHC encounter. That criteria includes the following components to be a billable RHC encounter. Please refer to the cited chapters in the Medicare Policy Benefit Manual and use this code carefully.

- The service complies with Chapter 13 of the Medicare Policy Benefit Manual, Section 190;
- The service area has been formally designated by the state office as a HHA shortage area;
- The patient must meet the definition of a homebound patient as defined in Chapter 7 of the Medicare Policy Benefit Manual, Section 30.1.1;
- The nursing services follow a written plan of care by the provider;
- The patient must require skilled nursing care or care that he is unable to provide for himself;
- The service must be within the nurse's scope of practice;
- The service must be intermittent;
- No drugs or biologicals are not provided.

Refer to other CMS publications and RHC guidance for information on how CPT® and HCPCS® codes normally reported by your RHC may have changed on October 1st. And, watch that CG Modifier!

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