Coding Changes for 2017

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PRACTICE **POINTS**

- The conversion factor has increased more than 0.2%, which means you will be paid a bit more this year.
- Review *Current Procedural Terminology* codes carefully for pain control or moderate sedation as well as nail surgery and slide consultation.
- Reflectance confocal microscopy now has relative value units assigned by the Centers for Medicare & Medicaid Services.

All physicians will see changes in reimbursement in 2017. A new president with a new agenda makes for an interesting time ahead for health care in the United States. However, in this time of flux, there is one constant: the Final Rule, an informal term for the annual update on how the Medicare system will function and how much you will get paid for what you do.[1] The document is 393 pages and outlines what is new in the Medicare system, with lots of supplements giving granular details about physician work, overhead, and supply and labor costs. In this column, I have taken the liberty of dissecting the Final Rule for you and to bring attention to its high and low points for dermatologists.

Changes in Relative Value Units

The conversion factor has gone up, meaning you will be paid a bit more this year for what you do; it is not enough to account for inflation or the increasing cost of unfunded mandates, but it is better than nothing. Although the conversion factor was $35.8043 in 2016, it increased by more than 0.2% on January 1, 2017, to $35.8887.[1] How is this conversion factor calculated? We go up 0.5% due to MACRA (Medicare Access and CHIP Reauthorization Act), down 0.013% due to budget neutrality, down 0.07% due to multiple procedure payment reduction changes, and down another 0.18% due to the misvalued code target.[1] The misvalued code target is related to targets established by statute for 2016 to 2018 and payment rates are reduced across the board if they are not met.

If payments suffer from reductions in work value, they may not happen all at once. If the Centers for Medicare & Medicaid Services (CMS) reduce total relative value units (RVUs) by more than 20%, reductions will take place over at least 2 years with a single year drop maximum of 19%.[1] Unfortunately, such limits do not apply to revised codes, which can take as big a hit as the CMS cares to make.

Changes to Global Periods

In 2015, we learned that 10- and 90-day global periods would be eliminated in 2017 and 2018, respectively, with great concern on the part of the government about the number and level of evaluation and management services embedded in these codes. The implementation of global policy elimination was prohibited by MACRA and the CMS was required to develop and implement a process to gather data on services furnished in the global period from a representative sample of physicians, which they will use to value surgical services beginning in 2019.[1] The CMS decided to capture this data with a new set of time-based G codes (which would be onerous for all practicing physicians), not just the unlucky folks who were to be the sample mandated under MACRA.[2] During the comment period, it became obvious to the CMS that this concept was

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flawed for many reasons and it decided to hold a town hall meeting at the CMS headquarters on August 25, 2016, on data collection on resources used in furnishing global services in which 90 minutes of live testimony in the morning was followed by another 90 minutes by telephone in the afternoon.[3] This meeting, which I attended, resulted in the CMS changing the all-practitioner reporting program to a specified sample with others allowed to opt in. Practitioners in groups of less than 10 are exempt, and only physicians in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island must capture data beginning in July 2017.[1] These data only have to be captured on codes that are used by more than 100 practitioners and are furnished at least 10,000 times or have allowed charges of greater than $10,000,000 annually. If you are lucky enough to live in one of the testing states, you must start on July 1 but can start before July 1 if you wish. Practitioners in smaller practices or in other geographic areas are encouraged to report data if feasible but are not required to do so. *Current Procedural Terminology* (*CPT*) code 99024 will be used for reporting postoperative services rather than the proposed onerous set of G codes, and reporting will not be required for preoperative visits included in the global package or for services not related to the patient's visit.

Changes to Chronic Care Management

There are new and modified chronic care management codes that are not of use to you unless you are the primary provider for the patient and you and the patient meet multiple stringent requirements.[4] The patient must have multiple illnesses, use multiple medications, be unable to perform activities of daily living, require a caregiver, and/or have repeat admissions or emergency department visits. Typical adult patients who receive complex chronic care management services are treated with 3 or more prescription medications and may be receiving other types of therapeutic interventions (eg, physical therapy, occupational therapy). Typical pediatric patients receive 3 or more therapeutic interventions (eg, medications, nutritional support, respiratory therapy). All patients have 2 or more chronic continuous or episodic health conditions that are expected to last at least 12 months or until the death of the patient and place the patient at serious risk for death, acute exacerbation/decompensation, or functional decline.[4]

Changes to Moderate Sedation Codes

The economic value of providing moderate sedation (eg, drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation) used to be embedded in a variety of *CPT* codes, which is no longer the case in 2017. Diazepam or similar drugs swallowed or dissolved under the tongue are not included. The new *CPT* codes 99151, 99152, 99153, 99155, 99156, and 99157 are not to be used to report administration of medications for pain control or minimal sedation (anxiolysis). An independent trained observer, an individual who is qualified to monitor the patient during the procedure and who has no other duties (eg, assisting at surgery) during the procedure, must be present. If you are thinking of using these codes, read the entire section in the *CPT* manual,[4] check your state laws, and consult your malpractice carrier and perhaps even your health care attorney.

Changes to Nail Procedure Codes

Current Procedural Terminology code 11752 (excision of nail and nail matrix, partial or complete [eg, ingrown or deformed nail], for permanent removal; with amputation of tuft of distal phalanx) is now gone, while base code 11750 remains. If you are doing nail surgery and removing underlying bone, instead use code 26236 (partial excision [craterization, saucerization, or diaphysectomy] bone [eg, osteomyelitis]; distal phalanx of finger), 28124 (partial excision [craterization, saucerization, sequestrectomy, or diaphysectomy] bone [eg, osteomyelitis or bossing]; phalanx of toe), or other codes in the same section of the *CPT* manual if they more precisely describe the procedure performed.

Changes to Slide Consultation Codes

The slide consultation codes 88321 (consultation and report on referred slides prepared elsewhere), 88323 (consultation and report on referred material requiring preparation of slides), and 88325 (consultation, comprehensive, with review of records and specimens, with report on referred material) were revalued this year, with the first 2 showing no change but the latter showing an increase in value from 2.50 to 2.85 RVUs.[1] None are meant to be routine. If you have every slide looked at by someone else for "quality assurance reasons," the consultation is not reportable. If you use these consultation codes too often, the CMS might have concerns about fraud and abuse. Visit http://data.cms.gov to see how you compare to your peers.

Changes to Reflectance Confocal Microscopy Codes

Reflectance confocal microscopy had new codes for 2016, which were carrier priced, and in 2017 they

have real RVUs per the CMS. The payments for these codes have a national average reimbursement of $161.85 for 96931 (reflectance confocal microscopy for cellular and subcellular imaging of skin; image acquisition and interpretation and report, first lesion), $104.80 for 96932 (image acquisition only, first lesion), and $45.94 for 96933 (interpretation and report only, first lesion).[5] The respective add-on codes have values of $83.26 for 96934 (image acquisition and interpretation and report, each additional lesion [list separately in addition to code for primary procedure]), $35.17 for 96935 (image acquisition only, each additional lesion [list separately in addition to code for primary procedure]), and $43.78 for 96936 (interpretation and report only, each additional lesion [list separately in addition to code for primary procedure]).

Other Coding Changes

There are a whole bunch of new codes in the "Genomic Sequencing Procedures and Other Molecular Multianalyte Assays" (MMAAs) section of *CPT*. The important thing for you to remember is these codes are for the laboratory performing the assay to report, not the physician ordering it. There is a new Appendix O for proprietary laboratory analysis MMAAs, including those that do not have a Category I code. These MMAAs are identified in Appendix O by a 4-digit number followed by the letter M.[4]

There are some revisions to psychotherapy codes 90832 to 90847. These codes are outside our scope of practice and should only be used by psychiatrists, social workers, psychologists, or other appropriate mental health workers.

Final Thoughts

It has not been a breakout year for telehealth and we still do not have payment for store-and-forward teledermatology, except in a few designated rural areas. With the advent of the rhetoric we have heard after the presidential election, any speculation on what will happen to the brave new world of the merit-based incentive payment system, alternative payment models, and other regulations are anyone's guess.

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