Part B Insider (Multispecialty) Coding Alert

Part B Payment: January Could Bring Changes for Incident to Services, Gastro Pay

Plus: You could see advance care planning payments in 2016.

For the first time in years, practices didn't open the Medicare Physician Fee Schedule proposal to learn about whether devastating conversion factor cuts would impact their payments. Thanks to the new "doc fix" Medicare payment model that the HHS announced in January, you won't face a 20-plus percent cut in January like in previous years—in fact, you'll get your second scheduled 0.5 percent pay increase on Jan. 1 (the first increase kicked in on July 1).

"This is the first rule that CMS has done regarding physician fees since the repeal of the SGR that many of us have been working on for several years," said CMS's **Sean Cavanaugh** during a July 14 Open Door Forum.

On July 8, CMS released the proposed Medicare Physician Fee Schedule that it created for the 2016 payment year. Although you won't face payment insecurity issues, you will see some changes—and whether they're good or bad depends on your practice mix.

Get Ready for Potential Incident to Adjustments

If you've got the incident to rules for Part B memorized, it could be time to commit a new set of regulations to memory. The proposal suggests changes to the incident to rules, which allow a non-physician practitioner (NPP) to bill under the doctor's ID number and collect a full fee rather than submitting claims under the NPP's number and collecting 15 percent less.

Current way: Right now if you bill incident to, any doctor in the office can be listed on the claim as the person providing direct supervision for the NPP who is performing the service.

Proposed 2016 way: In the proposed fee schedule, CMS suggests only paying for incident to services if the doctor who bills for the incident to service is the same person directly supervising the care.

"To be certain that the incident to services furnished to a beneficiary are in fact an integral, although incidental, part of the physician's or other practitioner's personal professional service that is billed to Medicare, we believe that the physician or other practitioner who bills for the incident to service must also be the physician or other practitioner who directly supervises the service," CMS says in the proposed rule.

In addition, CMS is proposing that the person providing the incident to service does so in accordance with state law and is licensed to do it. The incident to provider also cannot have been excluded from any federal health care program or have had their enrollment revoked for any reason. In other words, just because the service is billed under a supervising doctor's number doesn't mean the performing NPP can be excluded from Medicare.

End-of-Life Counseling Pay Could Be a Reality

The Fee Schedule also includes a proposal to pay Part B practices for advance care planning services. Although you can already collect for this as part of your "Welcome to Medicare" care, some patients request end-of-life counseling during other visits, and in the past you couldn't collect separately for that service. CMS introduced the following two codes in 2015, but didn't attach payment to them:

- 99497: Advance care planning including the explanation and discussion of advance directives such as standard forms [with completion of such forms, when performed], by the physician or other qualified health care

professional; first 30 minutes, face-to-face with the patient, family member[s], and/or surrogate

- +99498 ... each additional 30 minutes ...

Payment could arrive: In the proposed rule, CMS says that it received many requests to attach payment to these services, and the agency is seeking comments on that topic before issuing a final rule this fall.

"For Medicare beneficiaries who choose to pursue it, advance care planning is a service that includes early conversations between patients and their practitioners, both before an illness progresses and during the course of treatment, to decide on the type of care that is right for them," CMS says in its Fact Sheet about the proposed rule.

Gastroenterologists Could Take A Hit

Although most specialists will see reimbursement remain stable in 2016, gastroenterologists would take a five percent hit to their payments effective Jan. 1 if the proposal is finalized, due to adjustments in endoscopic lower GI procedures, including colonoscopies.

Although CMS foresees the cuts impacting this specialty by just five percent, the actual damage could be higher, depending on the mix of services that your doctors perform. For instance, the proposed rule suggests that CMS would like to lower the work RVUs for code 45380 (Colonoscopy, flexible; with biopsy, single or multiple) to 3.59 from its current level of 4.43, resulting in a nearly 19 percent hit to this service.

CMS will be accepting comments on the payment adjustment to what the agency described as "misvalued codes," but in the meantime, the gastroenterology associations are not taking the news lying down. "AGA, ACG and ASGE will fight these cuts," the American Gastroenterological Association said in a July 9 news brief. "We are scheduled to meet with CMS leadership this month and are exploring every means to mitigate these cuts before they are finalized. Cuts of this magnitude could compromise the nation's public health efforts to reduce colorectal cancer."

Prepare to comment: You have until Sept. 8 to comment on any of the proposals listed above. To read the complete proposed fee schedule and learn how to comment, read the rule at https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-16875.pdf.