Eli's Rehab Report

Fee Increase and New HCPCS Codes for 2001

On Nov. 1, HCFA published its Final Rule for Revisions to Payment Policies under the Physician Fee Schedule for 2001, introducing a 4.5 percent overall increase in payment rates to physicians for Medicare Part B services. The 2001 fee schedule conversion factor has increased to $38.2581, while the separate 2001 national average anesthesia conversion factor is $17.26. In announcing the increase, HCFA Acting Administrator **Michael Hash** said, We will continue working with physicians to refine our methodologies to enhance benefits for seniors and ensure that payments are as accurate as possible when they are completely based on the new, resource-based system.

The Final Rule lists individual relative value units (RVUs) for each CPT and HCPCS code and outlines estimated changes in payment rate by specialty. Some specialties, such as optometry, will see dramatic increases of 12 percent, while others, such as gastroenterology, will see no change in estimated payment rate. HCFA does not break down physiatrists estimated increase or decrease amount, but the Final Rule contains some important information for physical medicine and rehabilitation (PM&R) providers.

RVUs for New Therapy and Wound Care Codes

The Final Rule introduces RVUs for new codes 97532 and 97533 (for more information, see CPT Codes 2001 Codes Contain Changes For Therapeutic Procedures on page 89). Unfortunately, HCFA assigned the same RVU, 0.44, to these codes that it assigned to deleted 97770 despite the American Occupational Therapy Association (AOTA) and the American Physical Therapy Association (APTA) recommendation of 0.51 for 97532 and 0.48 for 97533.

HCFA similarly reassigned the RVU for deleted code G0169 temporary code for removal of devitalized tissue without use of anesthesia to the new wound care codes 97601 (removal of devitalized tissue from wound; selective debridement, without anesthesia [e.g., high pressure waterjet, sharp selective debridement with scissors, scalpel and tweezers], including topical application[s], wound assessment, and instruction[s] for ongoing care, per session) and 97602 (... non-selective debridement, without anesthesia [e.g., wet-to-moist dressings, enzymatic, abrasion], including topical application[s], wound assessment, and instruction[s] for ongoing care, per session). The RVU for these codes remains 0.50.

Alternative Communication Device Codes

The Final Rule also covers new codes for fitting and evaluating augmentative and alternative communication (AAC) devices, such as speech synthesizers that help stroke (436) or ALS (335.20) patients communicate. In April, HCFA announced it would allow regional Medicare carriers to decide whether to cover AAC devices on an individual-carrier basis. This decision was a shift from HCFAs earlier stance that AAC devices were personal convenience items and, therefore, not covered by Medicare.

Leslie Stein, JD, regulatory counsel in the reimbursement and regulatory department at AOTA in Bethesda, Md., stresses that HCFAs reversal of its long-standing policy on assisted technology is a great benefit to patients with speech impairments. HCFAs April coverage decision asked questions that needed to be looked into, and it appears that a lot of research and analysis is still needed to satisfy HCFAs requirements before they can make a national coverage decision, Stein says. But devices like these help keep people independent, and that helps keep Medicare costs down, so its a win-win situation.

According to the Final Rule, HCFAs April decision was the impetus for replacing certain CPT codes in this category with new HCPCS codes. Although listed in CPT 2001, codes 92597 (evaluation for use and/or fitting of voice prosthetic or augmentative/alternative communication device to supplement oral speech) and 92598 (modification of voice prosthetic

or augmentative/ alternative communication device to supplement oral speech) have been replaced effective Jan. 1, 2001, with the following new HCPCS codes:

G0197 evaluation of patient for prescription of speech-generating devices

G0198 patient adaptation and training for use of speech-generating devices

G0199 re-evaluation of patient using speech-generating devices

G0200 evaluation of patient for prescription of voice prosthetic

G0201 modification or training in use of voice prosthetic

The RVUs for codes G0197 and G0200 will remain the same as code 92597, but G0198 and G0201s RVUs will be cross walked to the RVUs used for 92598. Only G0199 will be paid at a lower rate (75 percent of the value for 92597) because its for the less intensive re-evaluation.

HCFA has also introduced the new HCPCS code G0168 (wound closure utilizing tissue adhesive[s] only) for the use of wound repair using Dermabond. This service carries no global period.

New Care Plan Oversight Codes

Because CPT 2001 changed the language for its care plan oversight evaluation and management (E/M) codes, 99374-99380, to include language about nonphysician professionals, HCFA has chosen to introduce new G codes for billing these services. HCFA will no longer accept codes 99375 and 99378.

According to the Final Rule, CPTs new definitions for 99375 and 99378 in general, physician supervision of home health or hospice patients, 30 minutes or more which refer to communication (including phone calls) with other healthcare professionals and other non-physician professionals involved in patients care, are inconsistent with Medicare policies.

The Final Rule states, While we recognize that non-physician health professionals contribute to the care of both home health and hospice patients, our long-standing policy has been that payment for these services is included in the payment for evaluation and management services ... It was always our intent to count the time spent with other health professionals toward the 30-minute threshold ... We feel the revised definitions of codes 99375 and 99378 necessitate the establishment of temporary HCPCS codes G0181 and G0182 to assure consistency with current Medicare policy.

To that end, HCFA has introduced the following codes. All past policy and payment guidance for 99375 and 99378 apply to these codes, which carry RVUs of 1.73:

G0181 physician supervision of a patient under care of Medicare-covered home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of laboratory and other studies, communication (including telephone calls) with other healthcare professionals involved with the patients care, integration of new information into the treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more.

G0182 physician supervision of a patient under care of Medicare-covered hospice (patient not present) requiring complex and multi-disciplinary care modalities involving regular physician development and/or revision of care plans, review of laboratory and other studies, communication (including telephone calls) with other healthcare professionals involved with the patients care, integration of new information into the treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more.

Under the new fee schedule, physicians will also be able to receive separate payment for certifying and re-certifying that patients are eligible for Medicare home health services. Previously, these services were included in the physicians evaluation and management (E/M) codes, but HCFA is now introducing new HCPCS codes for certification and re-

certification of home health services to emphasize the importance of physician involvement in home health services under the new home health PPS system:

G0180 physician services for the initial certification of Medicare-covered home health services, for a patients home health certification period.

G0179 physician services for the recertification of Medicare-covered home health services, for a patients home health certification period.

These codes can be billed once every 60 days, except in the rare situation when the patient starts a new episode before 60 days elapses and requires a new plan of care. The RVU for G0179 is 0.45, and the RVU for G0180 will be 0.67.

No News on $1,500-cap Moratorium and Supervision Issue

The Final Rule addresses the two-year moratorium on Medicare Part Bs $1,500 outpatient therapy cap, but unfortunately does not indicate whether the $1,500 cap will be eliminated or whether the moratorium will be extended. The document states that HCFA intends to submit a report to Congress by Jan. 1, 2001, recommending ways to ensure proper use of outpatient therapy and ways to establish an alternative therapy payment policy (for both inpatient and outpatient services), versus uniform dollar limitations, in a budget-neutral way.

In addition, HCFA did not clarify its requirement that therapy assistants must be personally supervised by a therapist in private practice. Despite the fact that AOTA and APTA requested that the language be changed to direct supervision to reflect that the therapist should not have to be in the room with the assistant, HCFA reports that this issue is being examined. No changes will be addressed in the near future.

The full, more-than-800-page Final Rule can be downloaded from the Federal Register by visiting the Web site, www.access.gpo.gov/su_docs/fedreg/a001101c/.html, and scrolling to the section on Health Care Financing Administration, 2001 Fee Schedule.