CODING & DOCUMENTATION

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New and improved rules for chronic care management

Q What are the 2017 changes to Medicare's requirements for chronic care management?

A Medicare has expanded coverage for chronic care management (CCM) and has relaxed some of the billing requirements. The key changes are as follows:

• Medicare now covers *complex* CCM (code 99487 for the first 60 minutes per month, and code 99489 for each additional 30 minutes per month),

• An initiating visit is required only for new patients or patients not seen within one year prior to the start of CCM,

• When an initiating visit is required, add-on code G0506 is billable if beneficiaries require extensive face-to-face assessment and care planning by the billing provider (as opposed to clinical staff),

• Patient agreement to receive CCM services no longer has to be written; it can be verbal and documented in the medical record,

• Physicians are no longer required to obtain patient authorization for electronic communication of medical information with other treating providers,

• Medicare adopted CPT language to clarify that "24/7 access" applies to urgent care needs and ensures access to the care team, not necessarily the individual physician,

• Medicare no longer specifies how providers must share continuity of care documents,

• Medicare now requires timely electronic sharing of care plan information within and outside the billing practice, but not necessarily on a 24/7 basis, and allows transmission of the care plan by fax.

For more information about the changes, see "New Codes, New Payment Opportunities for 2017," *FPM*, January/February 2017, http://bit.ly/2kcZ89b.

Dietitian "incident-to" billing

Q Should a registered dietitian's services be billed "incident to" a physician's services?

A It depends on the service rendered and the payer. Medicare allows a registered dietitian (RD) to provide most services in continuation of a physician's plan of care as incident to the physician's service as long as all other incident-to requirements are met. Examples include intensive behavior therapy for obesity when ordered by a primary care physician and provided within the physician's office by an RD who qualifies as auxiliary personnel to the physician. RDs may also provide an annual wellness visit (alone or as part of a team) when working under direct physician supervision and within the state-specific scope of practice rules. You should verify individual payers' policies.

Incident-to billing rules do not apply to Medicare billing for diabetes self-management training or medical nutrition therapy services. However, in general, an RD may not be the sole provider of the diabetes self-management training service, and a physician who provides other Medicare services may bill for the entire self-management service as long as the program is accredited. Only an RD, nutritionist, or hospital that has received reassigned benefits from an RD or nutritionist can bill for medical nutrition therapy.

Electronic health record problem lists

Q If my electronic health record (EHR) pulls the patient's problem list from past visits and adds it to my current assessment, should I include all of those problems when considering the level of medical decision-making?

A No. Only those that affected management decisions at the current encounter are pertinent to medical decision-making (e.g., a patient's controlled hypertension has little to no impact on treatment decisions if a patient presents with sore throat). You should be able to alter the documentation to include only the problems addressed at the current encounter. See http://go.cms.gov/2hrb3jd for more information on appropriate EHR documentation and related coding concerns. **FPM**

Editor's note: Some payers may not agree with the advice given. Refer to current coding manuals and payer policies.

About the Author

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