

CODING & DOCUMENTATION

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Changes to supervision of transitional care management

Q Do “incident-to” provisions no longer apply to transitional care management services?

A The Centers for Medicare & Medicaid Services removed the requirement of direct supervision (in the office suite) and instead require only general supervision of clinical staff performing the tasks associated with transitional care management or chronic care management services. All other incident-to requirements remain – clinical staff must be either direct or leased employees or individuals contracted to provide services for your practice, and the physician or other qualified health care professional must have personally performed an initial service and remain actively involved in the course of treatment.

Coding newborn visits

Q If a family physician from our practice delivers a baby in the hospital, and then another family physician from our practice examines the newborn later in the office, would the newborn be a new or established patient at the office visit?

A The newborn would be an established patient to family physicians in your practice if the hospital newborn care was provided by one of the family physicians in your practice. A new patient is “one who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.”

The practice may have physicians of other specialties, and the newborn could be a new patient to one of those physicians. The newborn could also be a new patient if the family physician previously provided care only to the mother and not to the infant (i.e., a physician of another group practice provided the hospital newborn care).

About the Author

Cindy Hughes is an independent consulting editor. Author disclosure: no relevant financial affiliations disclosed. These answers were reviewed by members of the *FPM* Coding & Documentation Review Panel, including Kenneth D. Beckman, MD, MBA, CPE, CPC; Robert H. Bösl, MD, FAAFP; Marie Felger, CPC, CCS-P; Thomas A. Felger, MD, DABFP, CMCM; Emily Hill, PA-C; Joy Newby, LPN, CPC; and Susan Welsh, CPC, MHA.

If the post-discharge visit includes preventive medicine services that meet the Bright Futures guidelines, then this would be the first preventive medicine service for the newborn (99391). If the infant is only seen by a nurse, report 99211. If the visit does not meet the Bright Futures guidelines, the physician would report 99212-99215 depending on the extent of the service performed.

Replacing modifier 59 with HCPCS modifiers

Q Should we report the new Medicare HCPCS modifiers XE, XP, XS, and XU in all cases where modifier 59 would have been reported?

A It depends on the payer. For now, Medicare administrative contractors are continuing to accept modifier 59, but they may soon start requiring use of the X {E,P,S,U} modifiers. Some private payers have recommended continued use of modifier 59 but only when a service is separately reportable for a reason other than those described by the new modifiers: XE (separate encounter), XP (separate practitioner), XS (separate structure), or XU (unusual non-overlapping service).

For the time being, you should collect instructions regarding X {E,P,S,U} modifier use from your most common payers. Some payers consider these modifiers informational only (i.e., they will not bypass National Correct Coding Initiative edits), but they may accept the new modifiers in conjunction with modifier 59. When the new modifiers are used in payment determination, you should report only the modifier that most specifically describes the indication for reporting.

Just as modifier 59 should never be appended to an E/M service, the new modifiers should not be appended to an E/M service (unless directed by a payer in writing).

At this time, it is unclear if the XS or XU modifier would replace modifier 59 for procedures on multiple sites of the skin (e.g., removal of lesions on shoulder and chest) as the skin is a single structure/organ. **FPM**

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

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