CODING & DOCUMENTATION

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Advance care planning

Q Who can provide advance care planning (CPT codes 99497 and 99498)?

A Only a physician or other qualified health care professional (QHP) may report these evaluation and management (E/M) services. Clinical staff such as medical assistants and registered nurses do not qualify as QHPs. CPT defines a QHP as a person qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service.

The Centers for Medicare & Medicaid Services (CMS) recognized that nonphysician providers working incident-to a physician or QHP may participate in advance care planning, but the physician or other QHP billing for the service is expected to manage, participate, and meaningfully contribute to the provision of the services, in addition to providing a minimum of direct supervision. State scope of practice regulations and individual payers' policies may also impact who may provide these services.

Q Can advance care planning be provided by telephone?

A No. Advance care planning as described by CPT is a face-to-face E/M service.

Q When advance care planning is provided in conjunction with a Medicare annual wellness visit, is it paid as a preventive medicine service?

A Yes. Advance care planning is a preventive service only when provided in conjunction with an annual wellness visit and reported with modifier 33 attached to the advance care planning code (e.g., 99497-33). If advance care planning is provided on a date when no annual wellness visit is provided or when a claim for an annual wellness visit is denied, the advance care planning is not considered a preventive service and the patient will be responsible for the deductible and coinsurance.

Q Does a provider need to spend a full 30 minutes providing advance care planning in order to report code 99497?

A From a CPT perspective, the time requirement for this service is met when the midpoint is passed (i.e., 16 minutes). Payers may adopt different policies requiring that time thresholds be met or exceeded.

Coding bilateral procedures

Q When reporting bilateral procedures to Medicare, should we use modifier 50 or 59?

A For Medicare and other payers that have adopted the National Correct Coding Initiative (NCCI), bilateral surgical procedures for which no bilateral code exists must be reported using modifier 50 (bilateral procedure) with one unit of service. Code descriptors that include "unilateral or bilateral" or "bilateral" do not require a modifier (i.e., one unit of service equals bilateral service).

Multiple units of service may be reported when a service is performed bilaterally at multiple sites (e.g., levels of the spine). This is especially important in relation to code edits that limit the number of services provided by one physician on one date (e.g., medically unlikely edits). When reporting multiple bilateral services, report the first procedure with modifier 50 and report each additional bilateral procedure with modifier 50 and another modifier to identify the separate site (e.g., 59 – separate procedure). Seek individual payer guidance on use of XE, XS, XP, and XU modifiers.

Data elements and medical decision-making

Q If a physician provides an E/M service and an electrocardiogram (ECG) and reviews the ECG tracing during the same visit, can the order for the ECG *and* the review of the tracing both be

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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: Kenneth Beckman, MD, MBA, CPE; 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.

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counted when determining the level of medical decision-making associated with the visit?

A No. Only the order for the test should count toward the medical decision-making associated with the E/M service. The work of reviewing the ECG tracing is accounted for in a separate code and payment, whether reported as interpretation only or global service, so it should not influence code selection for the E/M service.

Multiple digit procedures

Q How should I report that the same procedure (e.g., fracture reduction) was performed on multiple digits?

A Ideally, HCPCS anatomical modifiers (e.g., FA or F1-F9 identifying fingers) should be appended to each procedure code to identify the distinct locations of each procedure. Check with your payers regarding using anatomical modifiers versus less specific options, such as using modifiers 59 (distinct procedure) or XS (separate structure). Note that payers following NCCI guidelines will not allow separate reporting of closed repair of multiple fractures with a single procedure (e.g., multiple carpal or tarsal bones treated with a single cast or splint).

Injured extremity examination

Q When documenting findings for each area of an injured extremity, including findings such as bruising or laceration, range of motion, stability, neurologic, and vascular status, what is the appropriate level of examination under the 1995 version of Medicare's "Documentation Guidelines for Evaluation and Management Services"?

A The 1995 documentation guidelines define an extremity as a body area. The examination you described would qualify as an extended examination of the affected body area and other symptomatic or related organ system(s). Under the 1995 guidelines, this would amount to a detailed examination. Your documentation must support the medical necessity for the examination and include all positive and pertinent negative findings associated with the extremity and related organ systems. A minor injury to an extremity that requires more limited examination would support a lower level of examination. FPM

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