CODING & DOCUMENTATION

Cindy Hughes, CPC, CFPC

CHRONIC CARE MANAGEMENT Q&A

The Centers for Medicare & Medicaid Services released a set of questions and answers about billing requirements for chronic care management. For more information, see this *FPM* Getting Paid Blog post: http://bit.ly/263gskU.

New-patient history requirements

Q Does Medicare's "Documentation Guidelines for Evaluation and Management Services" require a *complete* past, family, and social history (PFSH) for all new patient E/M services?

A No. A complete PFSH is required only for those services that require a comprehensive history overall, such as level IV and level V new patient office visits. New patient office or other outpatient visits, observation services, initial hospital care, consultations, comprehensive nursing facility assessments, new patient domiciliary and new patient home visits must include all three PFSH elements to support a complete PFSH. A complete PFSH for *established patient* visits in the office, domiciliary or home, and emergency department requires only two PFSH elements.

Prolonged clinical staff services

Q When should prolonged clinical staff services be reported, and when does the time begin?

A New for 2016, code 99415 is defined by CPT as "Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management (E/M) service in the office or outpatient setting, direct patient contact with physician supervision: first hour (list separately in addition to code for outpatient E/M service)." According to CPT, the total duration of the prolonged clinical staff service has to exceed 45 minutes to be billable. The service should be provided by clinical staff under the supervision of a physician or qualified health care professional, and the time of service must be documented. Including start and stop times is recommended.

For example, a physician orders oral rehydration for a patient that is to be administered over a two-hour period immediately following the office visit. The physician remains available in the office suite during the service and a nurse spends a total of 95 minutes face-to-face with the patient during the two hours. Let's assume the physician's E/M service is reported as a 99214 office visit, which CPT says typically involves 25 minutes of face-to-face time. The nurse's face-to-face time of 95 minutes is reported as 70 minutes of prolonged clinical staff service because the prolonged services "clock" starts after the typical time of the related E/M service ends. A prolonged clinical staff service time of 70 minutes is reported with code 99415.

New code 99416 should be reported in addition to 99415 for each additional 30 minutes. The CPT manual includes a helpful table that illustrates how the time intervals relate to billing for these new codes.

Check with individual payers to confirm their coverage policies. Medicare does not pay separately for prolonged clinical staff service, considering it bundled to any other service that is provided to the patient on the same date.

Incident-to diagnostic testing

Q Can qualified health care professionals such as nurse practitioners and physician assistants bill Medicare for diagnostic x-rays performed incident-to their services in the office?

A No. Physician supervision is required for diagnostic testing. Qualified health care professionals (QHPs) cannot provide this supervision. (See Medicare Benefit Policy Manual, Chapter 15, Section 80.)

If the QHP's state scope of practice law allows him or her to perform the technical component as well as the professional component (interpretation and report), the QHP can bill for personally performed diagnostic tests.

In cases where ancillary staff provide the technical component of the test with the appropriate physician supervision, and the QHP performs the interpretation and report, billing is split with the physician reporting the technical component with modifier TC appended and the QHP reporting the professional component with modifier 26 appended. FPM

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

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.

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