CME

CINDY HUGHES, CPC, CFPC

INITIATING VISITS FOR CHRONIC CARE MANAGEMENT

Q When providing a chronic care management (CCM) initiating visit, how do you document for add-on code G0506, "Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring CCM services"?

A The Centers for Medicare & Medicaid Services (CMS) has not provided specific documentation guidance, but the final rule for the 2017 Medicare Physician Fee Schedule may be helpful. It stated that if the billing provider who initiates CCM personally performs extensive assessment and care planning beyond what is described by the billed E/M code, the provider could bill G0506 in addition to the E/M code for the initiating visit (or in addition to the Annual Wellness Visit or Initial Preventive Physical Exam), as well as CCM codes 99487, 99489, and 99490, assuming the CCM requirements are met.

Code G0506 requires that the physician or other qualified health care professional must personally perform and document a face-to-face assessment "that is not already reflected in the initiating visit itself (nor in the monthly CCM service code)" and also personally perform care planning (which does not necessarily have to be performed face-to-face). In the final rule, CMS also said this should "help ensure that the billing practitioner personally performs and meaningfully contributes to the establishment of the CCM care plan when the patient's complexity warrants it." CMS further stated that "the work that is reported under G0506 (including time) could not also be reported under or counted toward the reporting of any other billed code, including any of the monthly CCM services codes."

The care plan created to bill G0506 would have to follow the same requirements as one included in the monthly CCM services. Specifically, "it must be an electronic, patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports."

The key takeaways are that there must be clear documentation of the work involved in the assessment and care planning that is separate from that of the initiating visit, all required elements of the care plan must be documented, and the work must bear the signature of the performing physician or other qualified health care professional.

FLU VACCINE CODING

Q We reported HCPCS code Q2036 for influenza immunizations to Medicare patients, but our claims were denied. Were we supposed to use another code?

A Yes. To determine the correct code, you should verify what vaccine was provided, including the brand, whether the product was trivalent or quadrivalent, and whether the product was preservative-free. Code Q2036 was put in place to report the trivalent FluLaval vaccine, but this product was no longer available in the 2017-2018 flu season. To bill for the quadrivalent flu vaccines offered under the FluLaval brand or other brands, you should use the following codes:

- 90686, "Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use."
- 90688, "Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use."

You can find the current codes and payment allowances for flu vaccines billed to Medicare Part B at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html. Codes not included in the lists likely represent products not available for the current flu season.

FISH HOOK REMOVAL

Q My patient presented with a fish hook in his left ear lobe. I pushed the hook through the lobe to cut off the barb and pulled the hook out of the incision this created. Can I bill for removal of a foreign body by incision?

A No. Pushing the hook through the lobe may have increased the size of the wound, but this was not an incision made to locate and extract a foreign body. This service is included in the E/M service provided. Report ICD-10 code S01.342A, "Puncture wound with foreign body of left ear, initial encounter," to describe this injury. You could also report code W26.8XXA, "Contact with other sharp object(s), not elsewhere classified, initial encounter." FPM

ABOUT THE AUTHOR

Cindy Hughes is an independent consulting editor based in El Dorado, Kan., and a contributing editor to *FPM*. Author disclosure: no relevant financial affiliations disclosed.

EDITOR'S NOTE:

Reviewed by the *FPM* Coding & Documentation Review Panel. Some payers may not agree with the advice given. Refer to current coding manuals and payer policies.

Send comments to **fpmedit@aafp.org,** or add your comments to the article online.