CME

BETSY NICOLETTI

USING THE NEW CHRONIC CARE MANAGEMENT CODE

Q Who may perform chronic care management (CCM) services described by CPT code 99491?

A CPT introduced code 99491 this year to cover services provided by a physician, nurse practitioner (NP), or physician assistant (PA) who personally performs 30 minutes of CCM during a calendar month. CCM codes 99487-99490 are for work performed by clinical staff and are valued accordingly. Code 99491 is valued at a higher rate because it describes work that only a physician, NP, or PA may perform. It is worth 1.45 work relative value units and a national, nonfacility rate of about $84.

The CCM codes share these requirements:

- A care plan is established for a patient with two or more significant chronic illnesses expected to last at least 12 months or until the death of the patient.
- Verbal consent for CCM services is required and must be documented in the medical record.
- The activities performed and the time spent on these activities must be documented in the medical record.
- The threshold time to bill 99491 is 30 minutes in a calendar month. This time can be spread over multiple days during the month.
- The service can be provided to patients who are living at home, in assisted living, or in a rest home or domiciliary care.

PESSARY CARE

Q How should we code for the initial evaluation of a patient with pelvic organ prolapse or stress urinary incontinence?

A You would code for a problem-oriented office visit. This could be for a new or established patient or billed in addition to a preventive medicine or wellness visit if there is a distinct history, exam, and medical decision making related to the patient's condition. If a pessary is fitted and supplied on the same day as the E/M service, bill CPT code 57160, "Fitting and insertion of pessary or other intravaginal support device," and HCPCS code A4561, "Pessary, rubber, any type," or A4562, "Pessary, nonrubber, any type," and report the E/M service with modifier 25, "Significant, separately identifiable E/M service by the same physician on the same day of the other procedure or other service."

Often, the pessary fitting and insertion occurs at a separate appointment, after the device has been preauthorized by the patient's insurance company. In that case, when the patient returns for the scheduled appointment, bill only for the fitting and insertion and the pessary itself. Although there is a code for a syringe, and some durable medical equipment providers suggest billing it, supplies used in connection with a procedure are included in the procedure payment.

When a patient returns to the office to have the pessary removed, cleansed, and reinserted, bill only an E/M service, according to *CPT Assistant*.[1] The fitting and insertion code should not be billed for removal, cleansing, and re-insertion of the pessary.

DOCUMENTING AN INTERVAL HISTORY

Q What is an "interval" history, as required for billing subsequent hospital services or subsequent nursing facility services?

A The Documentation Guidelines for E/M Services states, "For the categories of subsequent hospital care ... and subsequent nursing facility care, CPT requires only an 'interval' history. It is not necessary to record information about the PFSH (past, family, or social history)."[2] For example, code 99233, "Subsequent hospital visit," requires at least two of these three key components:

- A detailed interval history,
- A detailed examination,
- Medical decision making of high complexity.

A detailed history, in contrast with a detailed interval history, is defined as having four elements of the history of the present illness (or the status of three chronic diseases), the review of at least two systems, and one PFSH element. A detailed *interval* history does not require you to document a PFSH element. This makes sense because the history was documented in the initial hospital visit note and likely hasn't changed on the second or third day of an inpatient stay. FPM

1. *CPT Assistant*. June 2000;10(6).

2. Centers for Medicare & Medicaid Services. 1995 Documentation Guidelines for Evaluation & Management Services. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf. Accessed May 13, 2019.

ABOUT THE AUTHOR

Betsy Nicoletti is a speaker and consultant in coding education, billing, and accounts receivable. She lives in Northampton, Mass. 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.