Coding & Documentation

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ALTERNATIVE CODES FOR CHRONIC CARE MANAGEMENT

Q Most private insurance companies in our area do not pay for chronic care management (CCM) services (e.g., 99490, 99487, and 99489). Are there other codes for capturing this work?

A Yes, but typically these codes are not allowed for services provided by clinical staff. Some health plans that do not pay for CCM because they consider it bundled with face-to-face services will pay for other non-face-to-face physician services. These examples are from past reimbursement policies of commercial health plans:

Care plan oversight. While many health plans follow Medicare and don't pay for less than 30 minutes of care plan oversight in a calendar month when performed by a physician or other qualified health professional (QHP), some pay when the time exceeds 30 minutes. This may include only the following services:

- 99340, 99375, 99378, and 99380 (care plan oversight codes for ≥ 30 minutes of physician time),
- G0179 and G0180 (physician certification or recertification of a home health patient for Medicare-covered home health services under a home health plan of care),
- G0181 (physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency),
- G0182 (physician supervision of a patient under a Medicare-approved hospice).

Virtual and remote services. Health plans are increasingly paying for these services:

- 99421-99423 (online digital E/M for an established patient, for up to seven days, cumulative time),
- 99452 (interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes),
- G2010 (remote evaluation of recorded video and/or images submitted by an established patient),
- G2012 and G2252 (brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional; G2012 for 5-10 minutes of medical discussion, and G2252 for 11-20 minutes).

See each health plan's individual reimbursement policies to determine opportunities to bill for non-face-to-face services in your area.

ONLINE DIGITAL E/M BY NON-PHYSICIANS

Q When nurse practitioners or other advanced practice professionals provide an E/M service via our portal, should they report codes 99421-99423 or 98970-98972?

A All QHPs whose scope of practice includes providing and independently reporting E/M services should report 99421-99423, because these codes are specifically for E/M services. Codes 98970-98972 are for assessment and management services by health care professionals who cannot independently provide E/M services but whose scope of practice includes assessment and management services (e.g., registered dietitians and physical therapists).

REMOTE MONITORING WITH CCM

Q If I provide remote physiologic monitoring (code 99457) to a patient also receiving CCM services (99490) during the same month, do I need to use a modifier?

A These codes are not bundled under the current National Correct Coding Initiative edits and are separately reportable in the same month as long as no time is counted toward both services. For example, if you or your clinical staff call patients to discuss weight gain per their remote physiologic monitoring data, the time spent addressing the weight gain counts toward remote physiologic monitoring treatment management and not towards CCM. Commercial health plans and Medicare contractors may have different payment policies, so check with them individually.

RETINAL IMAGING

Q When reporting retinal imaging for detection or monitoring of disease (e.g., code 92229 for unilateral or bilateral point-of-care automated analysis with diagnostic report), should I report two units of service for the bilateral procedure or append modifier -50?

A Do neither. When a code descriptor includes the term "unilateral or bilateral," report only one unit of service and do not append modifier -50 (bilateral procedure). The term "unilateral or bilateral" indicates that the code includes a bilateral service, and the imaging is reported the same whether it's performed unilaterally or bilaterally. FPM

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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.

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