# The Cure for the Common Code: New and Novel CPTs to Help Your Bottom Line

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# Faculty Disclosure Information

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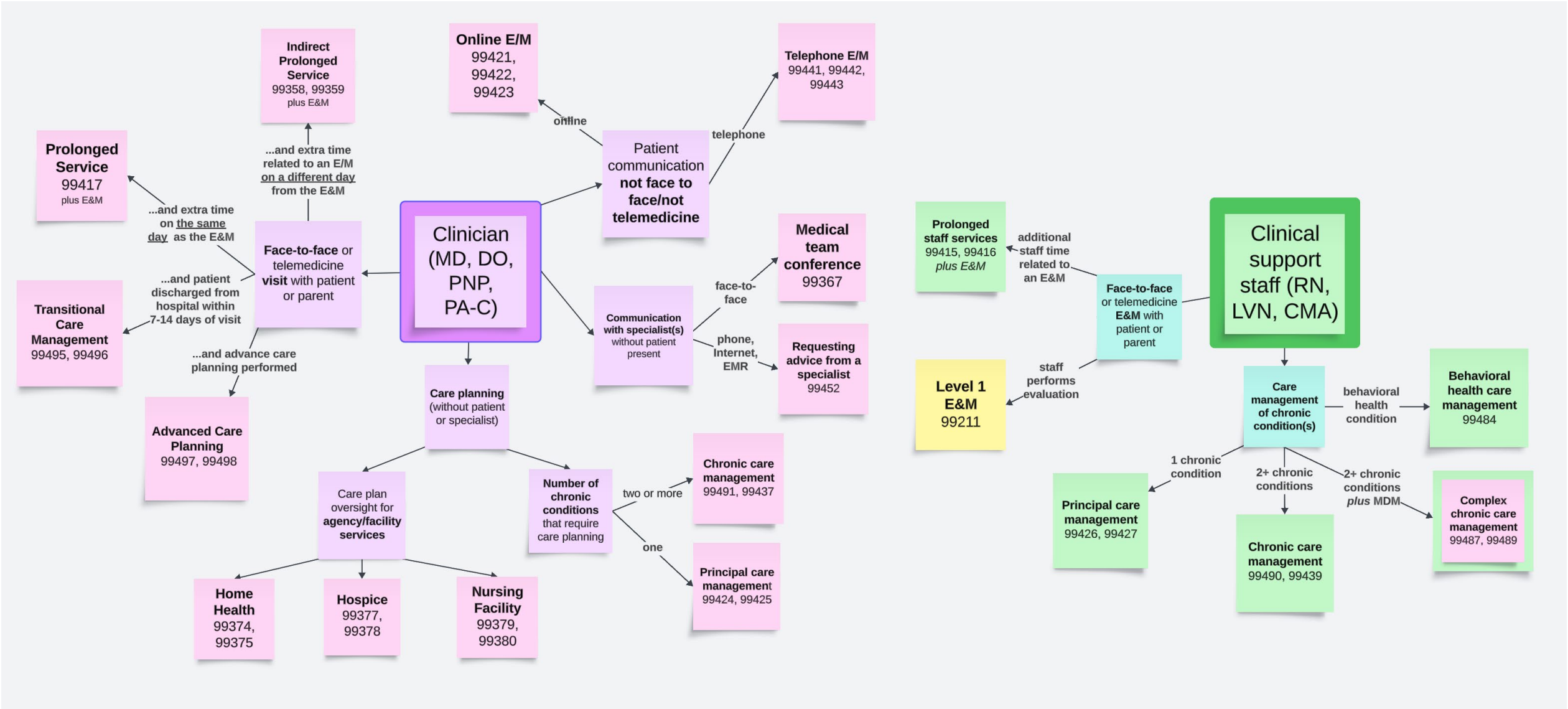
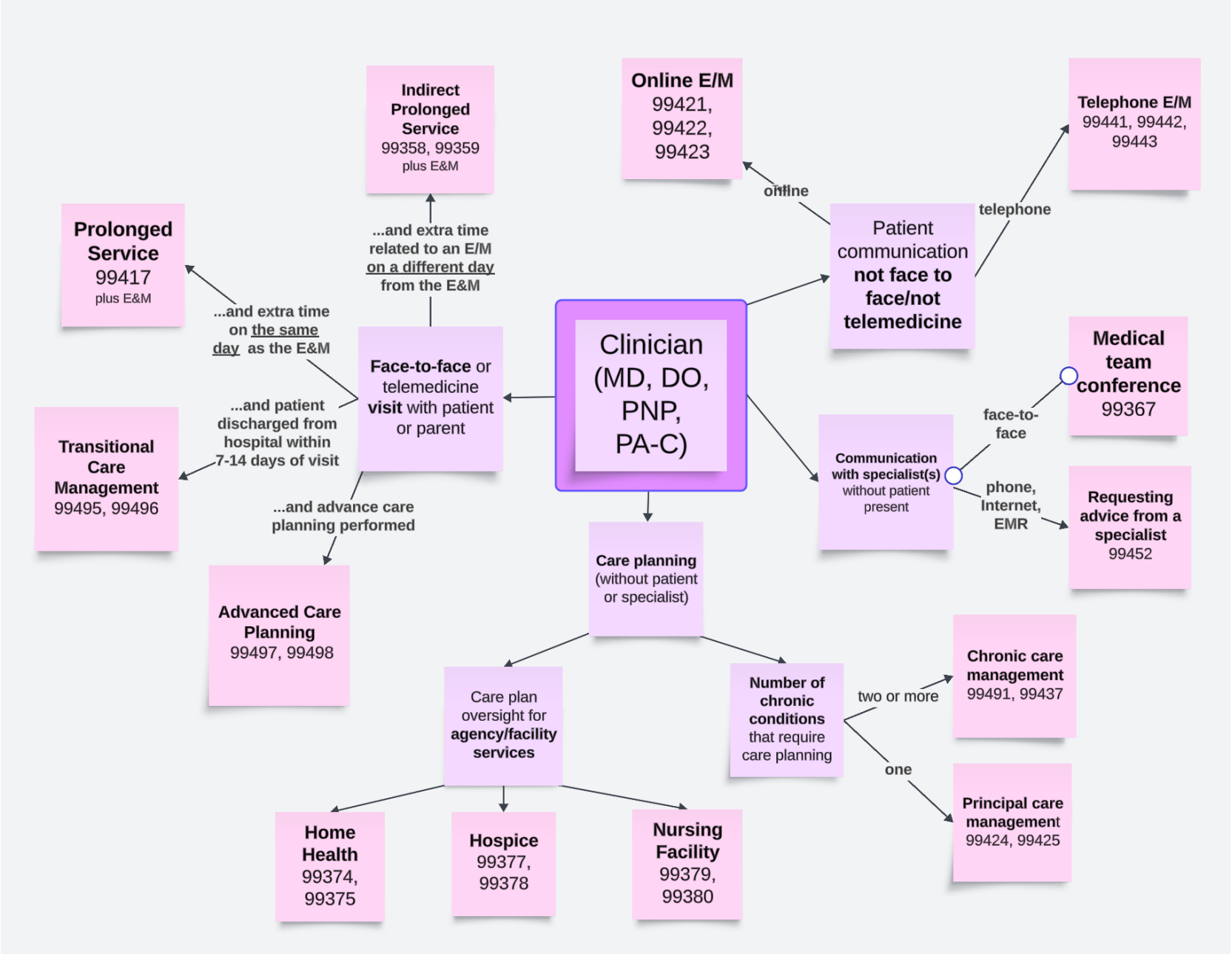
# Learning Objectives

- Identify care coordination CPTs that can be used to report non-face-to-face work by clinicians and clinical staff.

- Evaluate situations in which 99211 may be appropriately used for nurse face-to-face visits, nurse triage, and nurse telephone calls.


Clinician (MD, DO, PNP, PA-C)
Face-to-face or telemedicine visit with patient or parent
...and extra time on the same day as the E&M
Prolonged Service 99417 plus E&M
...and extra time related to an E/M on a different day from the E&M
Indirect Prolonged Service 99358, 99359 plus E&M
...and patient discharged from hospital within 7-14 days of visit
Transitional Care Management 99495, 99496
...and advance care planning performed
Advanced Care Planning 99497, 99498
Patient communication not face to face/not telemedicine
online
Online E/M 99421, 99422, 99423
telephone
Telephone E/M 99441, 99442, 99443
Communication with specialist(s) without patient present
face-to-face
Medical team conference 99367
phone, Internet, EMR
Requesting advice from a specialist 99452
Care planning (without patient or specialist)
Care plan oversight for agency/facility services
Home Health 99374, 99375
Hospice 99377, 99378
Nursing Facility 99379, 99380
Number of chronic conditions that require care planning
two or more
Chronic care management 99491, 99437
one
Principal care management 99424, 99425
Clinical support staff (RN, LVN, CMA)
Face-to-face or telemedicine E&M with patient or parent
additional staff time related to an E&M
Prolonged staff services 99415, 99416 plus E&M
staff performs evaluation
Level 1 E&M 99211
Care management of chronic condition(s)
behavioral health condition
Behavioral health care management 99484
1 chronic condition
Principal care management 99426, 99427
2+ chronic conditions
Chronic care management 99490, 99439
2+ chronic conditions plus MDM
Complex chronic care management 99487, 99489

# Clinician work: CPT codes



# Prolonged Service

Clinician (MD, DO, PNP, PA-C)

After 99215 for 40 minutes total time, what's next?

| Total Time on DOS | Code(s) |
|---|---|
| 40-54 minutes | 99215 only |
| 55-69 minutes | 99215 + 99417 |
| 70-84 minutes | 99215 + (99417 x 2) |
| Each additional 15 minutes | An additional unit of 99417 |

Example: any total time on the DOS that's 55+ minutes

Documentation: "I spent xx total minutes today caring for this patient, including time face to face with the patient plus time before/after the visit [selected list of activities]."

Documentation is essentially the same for any time-based attestation.

# Indirect Prolonged Service

Clinician (MD, DO, PNP, PA-C)

| Time on a Different Day | CPT Code(s) |
|---|---|
| <30 minutes in a single day | Not reported |
| 30-74 minutes in a single day | 99358 |
| 75-104 minutes in a single day | 99358, 99359 |
| 105-134 minutes in a single day | 99358, 99359 x2 |
| Each additional 30 minutes | An additional unit of 99359 |

Example: The day before Melissa, a medically fragile patient, comes in for a visit, you spend 45 minutes reviewing her chart, cleaning up her problem list, and making a list of dropped followup items.

Documentation: “Prior to the patient’s visit on 9/9/24, I spent 45 minutes on 9/8/24 in preparation reviewing her chart, updating her problem list and medication list, enumerating dropped follow up items….”

# Transitional Care Management

Clinician (MD, DO, PNP, PA-C)

"Level 6 and 7" E&M visits after a child is discharged from the hospital

| 99495 | 99496 |
|---|---|
| Clinical staff contact with family within 2 days of hospital discharge | Clinical staff contact with family within 2 days of hospital discharge |
| Face-to-face or telemedicine visit with clinician within 14 days of hospital discharge | Face-to-face or telemedicine visit with clinician within 7 days of hospital discharge |
| Medication reconciliation and management must occur no later than the date of the face-to-face visit | Medication reconciliation and management must occur no later than the date of the face-to-face visit |
| Moderate to high MDM in the 30 days after the date of discharge | High MDM in 30 days after the date of discharge |

# Transitional Care Management - Example

Clinician (MD, DO, PNP, PA-C)

- On 8/15/24, Joshua is discharged from the NICU.
- On 8/16/24, Pacific Pediatrics' calls Joshua's parents to check in.
- On 8/19/24, Joshua comes in after a night of gradually increasing work of breathing to see Dr Williams at Pacific Pediatrics.
  - Dr Williams does a medication reconciliation on 8/19/24.
  - At the 8/19/24 visit, Dr. Williams does all of the following:
    - Reviews NICU discharge summary, orders a F/U hemoglobin, and talks to parents
    - Calls NICU team about something vague in the discharge summary
    - Evaluates for possible readmission for CLD exacerbation to hospital

- Extensive Data + High Risk => High MDM 99496

Bundle of High MDM Work

99496: wRVU 3.79

vs

99205: wRVU 3.50

99215: wRVU 2.80

99204: wRVU 2.60

# Advanced Care Planning

Clinician (MD, DO, PNP, PA-C)

| Total time spent face to face | Code(s) |
|---|---|
| <15 minutes | Not reported |
| 16-45 minutes | 99497 |
| 46-75 minutes | 99497, 99498 |
| Each additional 30 minutes | An additional unit of 99498 |

20 minutes
Work RVU for 99497 = 1.50
Work RVU for 99213 = 1.30

- Example: Jonah, a young man who is developmentally disabled, recently turned 18. Because he is unable to care for himself, his parents need to establish conservatorship and related forms (healthcare proxy and durable power of attorney for health care). You spend 25 minutes in your office (or via telemedicine) discussing these issues. During this visit, you sign off on some forms the family has brought in.
- Documentation: "I spent 25 minutes with Jonah's parents explaining the need for legal advance care directives for this disabled young man…"

# Requesting Advice: 99452


- Use when you are contacting a specialist for a “pick their brain” kind of advisory consultation, not for arranging a face-to-face referral or transfer
- Needs at least 16 minutes of:
  - reviewing records
  - assembling pertinent materials
  - developing clinical questions/concerns
  - transmitting this information to the appropriate consultant
  - communicating with the consultant.
- Only once per 14 days
- Only when patient is not with you at the time of the consultation
- This service element is already being reported as part of an E&M

# Online E&M

Clinician (MD, DO, PNP, PA-C)

- Online (not audiovisual) digital evaluation management service
  - Established patients only
  - Must be patient/family-initiated
  - Needs to have MDM component – not just communication
- Count all related time in 7 days starting with day physician reviews original patient message
- Can't bill if:
  - The patient message is less than 7 days after an E&M for the same problem
  - An E&M for any problem takes place in that 7 day period

| CPT | Cumulative time during 7 days |
|---|---|
| 99421 | 5-10 minutes |
| 99422 | 11—20 minutes |
| 99423 | 21 or more minutes |

# Telephone E&M

Clinician (MD, DO, PNP, PA-C)

- Telephone (not audiovisual) evaluation/management service
  - Established patients only
  - Must be patient/family-initiated
  - Needs to have MDM component – not just communication
- Can't bill if:
  - The patient call is less than 7 days after an E&M for the same problem
  - An E&M for any problem takes in the next 24 hours/"soonest available"

| CPT | Time of medical discussion |
|---|---|
| 99441 | 5-10 minutes |
| 99442 | 11-20 minutes |
| 99443 | 21-30 minutes |

# Requesting Advice: 99452 - Example


Example: You are evaluating Shanae for precocious puberty. Her bone age is slightly advanced compared to her chronological age, so you order endocrine labs. The results do not point consistently to any particular interpretation, so you'd like to get advice from the endocrinology team at the children's hospital.

You send a copy of Shanae's x-ray and labs to your endocrinology colleague by secure email, asking her to contact you when she's free about this case. Your colleague returns your message at her lunch hour. You discuss Shanae's history, physical exam, and lab results. Your colleague advises one follow up test you omitted and, if that is normal, advises watchful waiting.

Documentation: "Results of lab tests are neither consistent with true precocious puberty nor benign premature thelarche. I contacted Dr. Hormone, pediatric endocrinologist, for consultation. We discussed the patient's presentation and results. Dr. Hormone recommended [summary]. I spent 20 minutes performing this consultative service."

# Medical Team Conference: 99367

Clinician (MD, DO, PNP, PA-C)

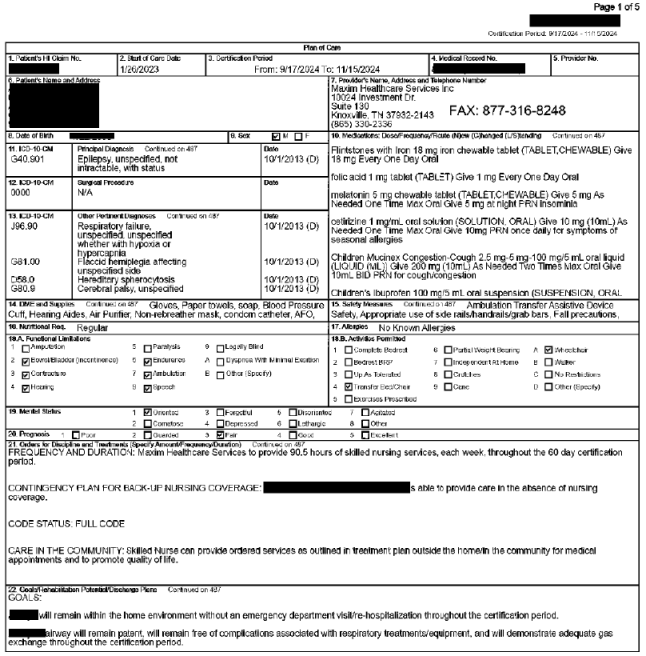
- A minimum of three different types of providers (that is, two plus you)
  - All must have seen the patient face-to-face within the past 60 days
  - All must be able to bill for the team conference in accordance with scope of practice
  - All must be actively involved in the development, revision, coordination, and implementation of health care services needed by the patient
- Patient/parent not present
- 30 minute minimum meeting time

# Care Plan Oversight

Clinician (MD, DO, PNP, PA-C)

- At least 15 minutes per month spent in:
  - Development or revision of care plan
  - Reviewing agency/hospice/facility plan of care and updating it
  - Calls from agency/communicating with agency staff
  - Updating/adjusting treatment plans

| Home health agency | Hospice | Nursing facility |
|---|---|---|
| 99374: 15-29 min/ calendar month | 99377: 15-29 min/ calendar month | 99379: 15-29 min/ calendar month |
| 99375: 30+ min/ calendar month | 99378: 30+ min/ calendar month | 99380: 30+ min/ calendar month |



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Plan of Care

1. Patient's HI Claim No. [redacted] | 2. Start of Care Date: 1/26/2023 | 3. Certification Period: From: 9/17/2024 To: 11/15/2024 | 4. Medical Record No. [redacted] | 5. Provider No.

6. Patient's Name and Address: [redacted]

7. Provider's Name, Address and Telephone Number: Maxim Healthcare Services Inc 10024 Investment Dr. Suite 130 Knoxville, TN 37932-2143 (865) 330-2336 FAX: 877-316-8248

8. Date of Birth [redacted] | 9. Sex ☑ M ☐ F

10. Medications: Dose/Frequency/Route (New (Changed (U/S)tanding Continued on 4/7

Flintstones with Iron 18 mg iron chewable tablet (TABLET,CHEWABLE) Give 18 mg Every One Day Oral

folic acid 1 mg tablet (TABLET) Give 1 mg Every One Day Oral

melatonin 5 mg chewable tablet (TABLET,CHEWABLE) Give 5 mg As Needed One Time Max Oral Give 5 mg at night PRN insomnia

cetirizine 1 mg/mL oral solution (SOLUTION, ORAL) Give 10 mg (10mL) As Needed One Time Max Oral Give 10mg PRN once daily for symptoms of seasonal allergies

Children Mucinex Congestion-Cough 2.5 mg-5 mg-100 mg/5 mL oral liquid (LIQUID (ML)) Give 200 mg (10mL) As Needed Two Times Max Oral Give 10mL BID PRN for cough/congestion

Children's Ibuprofen 100 mg/5 mL oral suspension (SUSPENSION, ORAL

11. ICD-10-CM: G40.901 — Principal Diagnosis (Continued on 4/7): Epilepsy, unspecified, not intractable, with status — Date: 10/1/2013 (D)

12. ICD-10-CM: 0000 — Surgical Procedure: N/A — Date:

13. ICD-10-CM: J96.90 — Other Pertinent Diagnoses (Continued on 4/7): Respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia — Date: 10/1/2013 (D)

G81.00 — Flaccid hemiplegia affecting unspecified side — 10/1/2013 (D)

D58.0 — Hereditary spherocytosis — 10/1/2013 (D)

G80.9 — Cerebral palsy, unspecified — 10/1/2013 (D)

14. DME and Supplies (Continued on 4/7): Gloves, Paper towels, soap, Blood Pressure Cuff, Hearing Aides, Air Purifier, Non-rebreather mask, condom catheter, AFO,

15. Safety Measures (Continued on 4/7): Ambulation Transfer Assistive Device Safety, Appropriate use of side rails/handrails/grab bars, Fall precautions,

16. Nutritional Req.: Regular

17. Allergies: No Known Allergies

18.A. Functional Limitations: 1 ☐ Amputation; 2 ☑ Bowel/Bladder (Incontinence); 3 ☑ Contracture; 4 ☑ Hearing; 5 ☐ Paralysis; 6 ☑ Endurance; 7 ☑ Ambulation; 8 ☑ Speech; 9 ☐ Legally Blind; A ☐ Dyspnea With Minimal Exertion; B ☐ Other (Specify)

18.B. Activities Permitted: 1 ☐ Complete Bedrest; 2 ☐ Bedrest BRP; 3 ☐ Up As Tolerated; 4 ☑ Transfer Bed/Chair; 5 ☐ Exercises Prescribed; 6 ☐ Partial Weight Bearing; 7 ☐ Independent at Home; 8 ☐ Crutches; 9 ☐ Cane; A ☑ Ambulation; B ☐ Walker; C ☐ No Restrictions; D ☐ Other (Specify)

19. Mental Status: 1 ☑ Oriented; 2 ☐ Comatose; 3 ☐ Forgetful; 4 ☐ Depressed; 5 ☐ Disoriented; 6 ☐ Lethargic; 7 ☐ Agitated; 8 ☐ Other

20. Prognosis: 1 ☐ Poor; 2 ☐ Guarded; 3 ☑ Fair; 4 ☐ Good; 5 ☐ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) (Continued on 4/7)

FREQUENCY AND DURATION: Maxim Healthcare Services to provide 90.5 hours of skilled nursing services, each week, throughout the 60 day certification period.

CONTINGENCY PLAN FOR BACK-UP NURSING COVERAGE: [redacted] is able to provide care in the absence of nursing coverage.

CODE STATUS: FULL CODE

CARE IN THE COMMUNITY: Skilled Nurse can provide ordered services as outlined in treatment plan outside the home/in the community for medical appointments and to promote quality of life.

22. Goals/Rehabilitation Potential/Discharge Plans (Continued on 4/7)

GOALS:

[redacted] will remain within the home environment without an emergency department visit/re-hospitalization throughout the certification period.

[redacted] airway will remain patent, will remain free of complications associated with respiratory treatments/equipment, and will demonstrate adequate gas exchange throughout the certification period.

These codes can't be used in the same month as any other care management codes

# Chronic Care Management: 99491, 99437

Clinician (MD, DO, PNP, PA-C)

- Requirements:
  - Patient has 2+ chronic conditions (lasting 1 year or until death);
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
  - Physician personally spends at least 30 minutes in a calendar month on establishing, implementing, revising, and/or monitoring a comprehensive care plan*
  - Copy of the comprehensive care plan* provided to patient/caregiver
  - Practice must be a comprehensive medical practice**

| Time spent per calendar month | CPT |
|---|---|
| ≤29 min | Not reported |
| 30-59 min | 99491 |
| 60-89 min | 99491 + 99437 |
| Each additional 30 min | Additional unit of 99437 |

# What's a comprehensive care plan*?

- A comprehensive care plan* addresses all significant health problems typically includes:
  - Problem list
  - Expected outcome and prognosis
  - Measurable treatment goals
  - Symptom management
  - Planned interventions
  - Medication management
  - Community and social services ordered
  - How agencies/specialists outside the practice will be directed and coordinated
  - Identification of the individuals responsible for each intervention
  - Requirements for periodic review
- Similarly, a condition-focused care plan* addresses a single health problem, but typically includes the same components.

# What's a comprehensive medical practice**?

- Provide 24/7 access to physicians, other qualified health care professionals, or clinical staff;
- Provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;
- Provide timely access and management for follow-up after ED/facility discharge;
- Use an EHR system so that care providers have timely access to clinical information;
- Use a standardized methodology to identify patients who require care management services;
- Have an internal care management process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner;
- Use a form and format in the medical record that is standardized within the practice; and
- Engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

# Chronic Care Management: 99491, 99437

- Example: 23 week gestation ex-preemie with CLD, GERD, now with multiple behavior problems has complex social situation and difficulty keeping appointments with specialists.  Patient is at risk for being discharged from multiple specialists for no-shows.

- Documentation: Should justify and document time spent.

Care Plan for August 2024.
Goals:
1) Keep scheduled appointments with specialists.
2) Keep scheduled appointments with PCP.
3) Call to reschedule appointment with ETCH Physiatry as soon as possible.

**Patient History**

History reviewed and *updated* as appropriate
Medication List Reviewed [redacted] 08/30/2024 10:41:38

**Assessment**

DX 1:  P07.22 Extreme immaturity of NB, gestatnl age 23 completed weeks
DX 2:  J98.4 Other disorders of lung
DX 3:  F80.2 Mixed receptive-expressive language disorder
DX 4:  G40.89 Other seizures
DX 5:  K21.9 GERD
DX 6:  F98.29 Other feeding disorders of infancy and early childhood
DX 7:  F90.2 Attention-deficit hyperactivity disorder, combined type
DX 8:  H57.02 Anisocoria
DX 9:  G47.9 Sleep disorder, unspecified
DX 10:  R62.0 Delayed milestone in childhood
DX 11:  R76.8 Other specified abnormal immunological findings in serum
DX 12:  F84.0 Autism

**Counseling**

**Plan**

We Have:
1) Updated care plan for the month of August 2024 (10 minutes).
2) Updated problem list (2 minutes).
3) Reviewed Erlanger EpicCare to verify past/upcoming appointments (3 minutes).
4) Reviewed ETCH Meditech to verify past/upcoming appointments (5 minutes).
5) Called Boyd Family Eye Care to verify past/upcoming appointments (2 minutes).
6) Called Appalachian Audiology to verify past/upcoming appointments (1 minute).

# Principal Care Management: 99424, 99425

Clinician (MD, DO, PNP, PA-C)

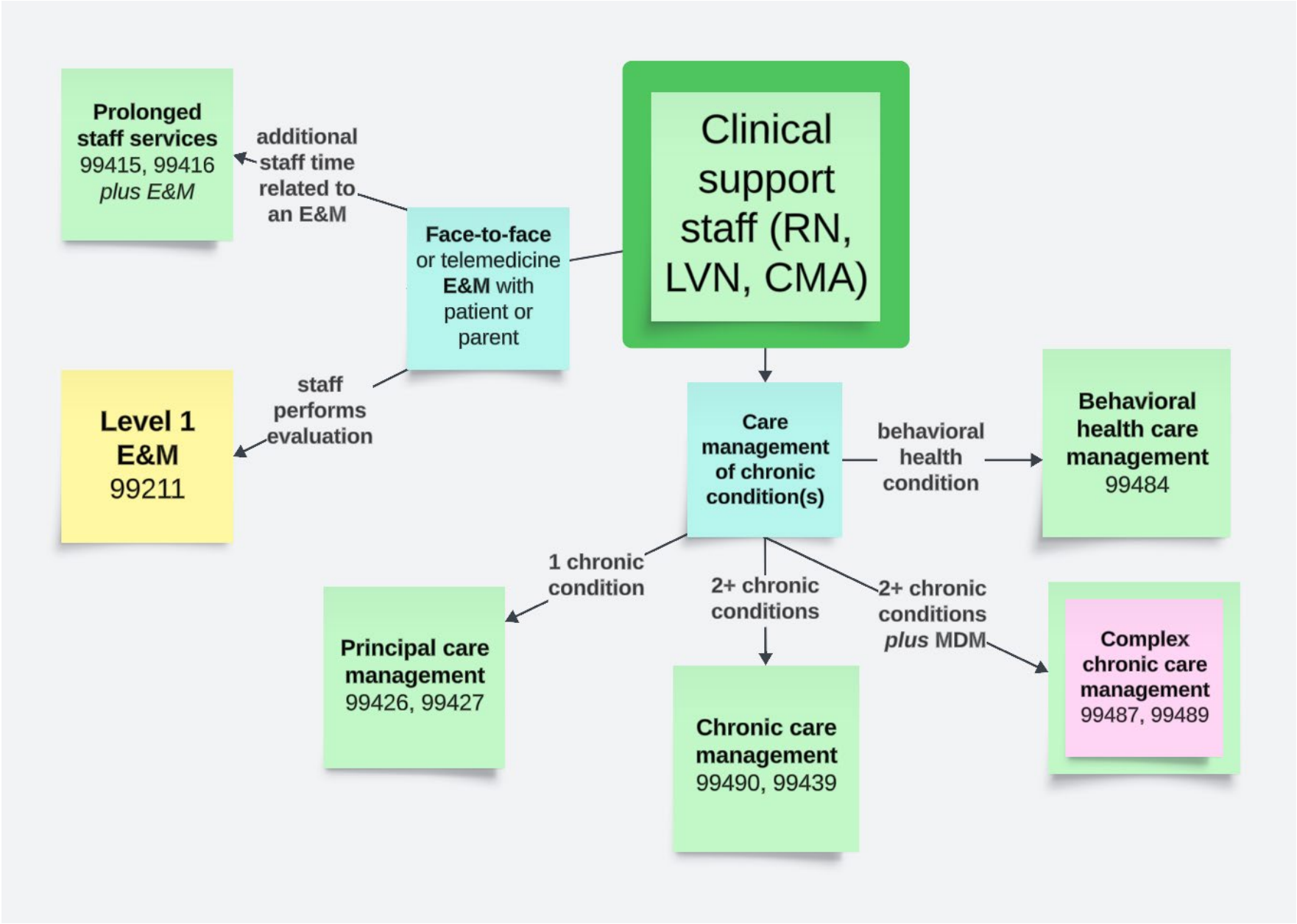
- Principal care management (PCM) provides CCM for patients with a single chronic condition (or with multiple chronic conditions but focused on a single high-risk condition.)
- The chronic condition should:
  - Be expected to last at least 3 months
  - Place patient at risk of hospitalization, exacerbation, decompensation, functional decline, or death
  - Require development, monitoring, or revision of a disease-specific care plan
  - Require frequent adjustments in medication, OR management is unusually complex due to comorbidities
  - Require ongoing communication and care coordination between relevant practitioners furnishing care
- Care plan should be a single high-risk condition-focused care plan* (not comprehensive care plan*)

# Principal Care Management: 99424, 99425

- Physician personally spends at least 30 minutes in a calendar month on establishing, implementing, revising, and/or monitoring a condition-focused care plan*
- Copy of the condition-focused care plan* provided to patient/caregiver
- Practice must be a comprehensive medical practice**

| Time spent per calendar month | CPT |
|---|---|
| <30 min | Not reported |
| 30-59 min | 99424 |
| 60-89 min | 99424 + 99425 |
| 90-119 min | 99424 + 99425 x2 |

# Clinical support staff work: CPT codes



# Prolonged Staff Services: 99415, 99416

Clinical support staff (RN, LVN, CMA)

- Prolonged face-to-face staff time spent with patient/family with direct physician supervision* with an E&M at the same session**

| Base service CPT | 99415 time (min) | 99415 + 99416 time (min) | 99415 + 99416 x2 time (min) |
|---|---|---|---|
| 99211 | 46-90 | 91-120 | 121-150 |
| 99212 | 54-98 | 99-128 | 129-158 |
| 99213 | 57-101 | 102-131 | 132-151 |
| 99214 | 70-114 | 115-144 | 145-174 |
| 99215 | 75-119 | 120-149 | 150-179 |
| New E&M times are slightly different | | | |

Direct physician supervision* = present in the office suite and immediately available if needed
An E&M at the same session** = 99202-99205 or 99211-99215

# Prolonged Staff Services: 99415, 99416

- Example: Jazmine is a newborn whose mother is having trouble breastfeeding. Jazmine comes in for a weight check to see the physician. Dr. Jackson provides a brief visit (99212) and then asks Lisa, her LPN/lactation counselor, to come in. Dr. Jackson goes on to see other patients.
- Documentation (in addition to 99212 documentation): "I spent 60 minutes today working with mother-baby dyad on hold, latch, feeding cues [list]. Counseling provided on [list]. At the end of session, baby demonstrated good milk transfer. --Lisa, LPN, IBCLC"

# Chronic Care Management by Clinical Staff: 99490, 99439

Clinical support staff (RN, LVN, CMA)

- Requirements are the same as for chronic care management physician codes (Clinician (MD, DO, PNP, PA-C)) 99491, 99437 except the time thresholds:

| Staff time spent per calendar month | CPT |
|---|---|
| 0-19 minutes | Not reported |
| 20-39 minutes | 99490 |
| 40-59 minutes | 99490 + 99439 |
| 60+ minutes | 99490 + 99439 x2 |

# Principal Care Management by Clinical Staff: 99426, 99427

Clinical support staff (RN, LVN, CMA)

- Requirements are the same as for principal care management physician codes Clinician (MD, DO, PNP, PA-C) 99424, 99425 except the time thresholds:

| Staff time spent per calendar month | CPT |
|---|---|
| 0-19 minutes | Not reported |
| 20-39 minutes | 99490 |
| 40-59 minutes | 99490 + 99439 |
| 60+ minutes | 99490 + 99439 x2 |

# Behavioral Care Management by Clinical Staff: 99484


- 20+ minutes of clinical staff time per calendar month with:
  - Initial assessment or follow-up monitoring with validated scales
  - Care planning around behavioral/psychiatric problems
  - Facilitating and coordinating treatment
  - Continuity of care with a designated member of care team

Treatment plan must be documented, but comprehensive care plan* and/or condition-focused care plan* not needed.

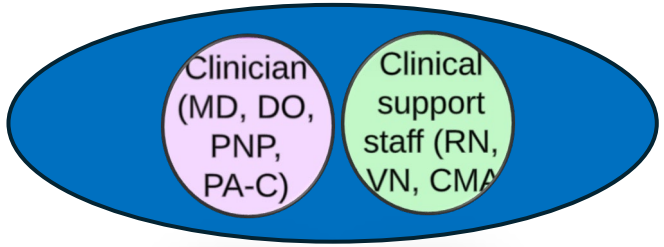
Clinical staff don't need special qualifications (e.g. "behavioral health care manager")

Can use in the same month as chronic care management, principal care management, and complex chronic care management codes

# Behavioral Care Management by Clinical Staff: 99484

- Example: Seth is a young man with anxiety causing multiple somatic symptoms and school avoidance. His PCP is prescribing medication and he's getting counseling through a local BH agency. Ruth, the practice's behavioral health nurse, reaches out on a monthly basis to see how he's doing. She contacts her pediatrician, Dr. Jackson, if an issue arises that's outside Ruth's protocol.
- Documentation: "I called Seth to see how he's doing. Seth indicated [interval history.] Seth denies current or recent thoughts of self-harm. Seth also wanted me to speak with his mother. Seth's mom indicated [problems family is having.] I offered to [assistance]. After the phone call, I [document follow up work]. Spent 25 minutes this month on behavioral care management." (Message forwarded to Dr. Jackson for routine review)

# Complex chronic care management: 99487, 99489




All the requirements of chronic care management, PLUS:

- Moderate or high level MDM during the calendar month
- At least 60 minutes of total physician time + clinical staff time combined in a calendar month

| Physician + staff time | CPT |
|---|---|
| 60-89 min | 99487 |
| 90-120 min | 99487 + 99489 |
| 120-150 min | 99487 + 99489 x2 |

# Tips for Choosing Care Plan CPTs

- Only one "flavor" of medical care plan management per month
  - Pick one of: Care Plan Oversight, Chronic Care Management, Principal Care Management, and Complex Chronic Care Management
  - Behavioral Care Management <u>can</u> be used with the others
- Patients can't have a physician code (Clinician (MD, DO, PNP, PA-C)) and a staff code (Clinical support staff (RN, LVN, CMA)) in the same month. Choose wisely:

e.g. for Chronic Care Management, need 30 min of physician time OR 20 min of staff time:

| Physician time | Staff time | What to bill? |
|---|---|---|
| 30 min | 20 min | Physician (pays better) |
| 5 min | 25 min | Staff (meets threshold) |
| 5 min | 10 min | Neither |
| 15 min | 15 min | Staff (can count MD time) |
| 30 min | 30 min | Consider complex CCM code 99487 instead |


99211

# 99211: What's It Good For?

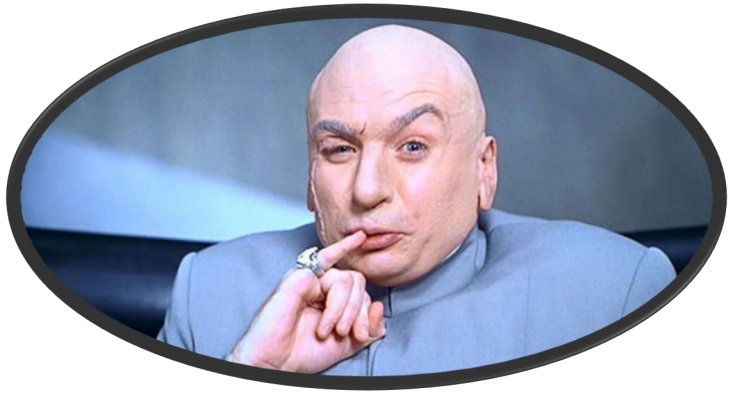
- 99211 – Office visit for E/M of established patient that may not require the presence of a physician

Doctor doesn't have to see or be in the same room as the patient

BUT

The 99211 is billed under the physician's NPI as the rendering provider as if it was personally furnished by the physician

- Is this billing fraud?



# Rules for Using 99211: "Incident To"

- Supervising physician must have already evaluated the patient for the problem, and already planned the course of care for the problem
  - No new patients
  - No new problems
  - No med changes
  - No changes in the plan
  - "Normal course of treatment"

- After incident-to services, the supervising physician must continue to provide face-to-face services for the patient.
  - No one-offs
  - Preventive vs problem?

# Rules for Using 99211: "Incident To"

- Direct supervision – present in the office suite and available
  - No late entry or scooting out early
  - No lunch leaves
  - Not "just cosign"
- The physician, support staff, and billing practice must all have formal employer/IC relationships.
  - No informal freelancing using school nurses
- Support staff must not be OIG-excluded
  - Check the List of Excluded Individuals and Entities (LEIE) at oig.hhs.gov/exclusions

# Rules for Using 99211: "Incident To"

- A cost must be incurred in providing services
  - Staff expense alone is a legitimate cost
  - No billing for samples
- Services must not be in a hospital or skilled nursing facility
- Documentation must support incident-to billing
  - Show, don't tell.
- Support staff performing procedure on behalf of physician must also be licensed to provide the service within the state scope of practice.

# 99211: What's It Good For?

| Legitimate 99211 | Improper use of 99211 |
| --- | --- |
| Nurse assessment by protocol: newborn weight check/jaundice check<br>MD sees newborn who is feeding well, but bilirubin slightly high and weight slightly low. MD orders return nurse visit in 2 days. MD specifically documents in note what expected weight and bilirubin should be in 2 days. On recheck visit, nurse reweighs baby and rechecks bili. Weight is above plan threshold and bili is below plan threshold. Nurse reassures mom and schedules routine followup.<br><br>Nurse assessment by protocol: blood pressure check<br>MD notes elevated BP at checkup and orders nurse recheck in 6 months. MD specifically documents future plan for normal BP, persistently elevated BP, or extremely elevated BP. When patient returns, nurse measures BP per protocol, determines that elevated BP persists, and follows existing plan for next steps.<br><br>Nurse assessment by protocol: tuberculin skin test interpretation<br>Child high risk for TB and PPD is placed(86580). When child returns in 24-48 hrs, nurse evaluates forearm as per practice's procedure manual, documents negative PPD, and counsels family on results. | • For lab draw (use 3641x and 8xxxx instead)<br>• For immunization-only visits (immunization administration code already covers routine nurse assessment and counseling)<br><br>• With a well visit<br>• Any time assessment requires a change in the plan (but forking plan is OK) |

# 99211: What About Telemedicine?

| Legitimate 99211 | Improper use of 99211 |
|---|---|
| * MD sees patient for mental health problem in office and starts medication. MD schedules nurse phone visit for 1 week recheck; if OK at recheck, see back in a month.<br><br>RN reviews chart and meets with patient via telephone. RN assesses compliance with meds (good), side effects (minimal), and answers questions per protocol. Since patient is doing well per RN assessment, RN schedules 1 month recheck with MD. | * Simple communication of test results/lab results (no assessment)<br><br>* Simple counseling without any assessment |
| * MD sees patient for illness/injury and counsels patient on expected timetable for improvement and asks parent to call back if not improving. Parent calls back in 3 days, concerned that child is not improving.<br><br>RN reviews chart and meets with patient/parent via telemedicine. RN does telephonic assessment with parent about child's current symptoms. Assessment reveals child IS actually improving as expected. RN reinforces expected course with parent who is grateful for extra support. | * Telephonic assessment of new problem/new complaint<br><br>* Telephonic assessment that results in a new/different plan |

# How do you report 99211 for tele-nurse?

Clinical support staff (RN, LVN, CMA)

| Service | CPT Code/Modifier | Place of Service (POS)** |
|---|---|---|
| Synchronous audio-visual (telemedicine, e.g. Doxy.me, GoToMeeting, VSee) | 99211-95 per CPT Appendix P<br>or<br>99211-GT if payer desires | POS 10 (if patient is at home) or POS 2 (if patient is elsewhere, e.g. school, traveling) |
| Synchronous audio-only (phone) for follow-up on mental health/substance use disorder treatment | 99211-FQ | POS 10 (if patient is at home) or POS 2 (if patient is elsewhere, e.g. school, traveling) |
| Synchronous audio-only (phone) for other issues | No clear CPT-approved method. Payers might:<br>• Disallow entirely<br>• Permit -93 (even though 99211 not in Appendix T)<br>• Permit -95 or -GT (if treating AV and audio-only the same)<br>• Require custom modifier (Medicaid plans) | |

**Some payers' payment policies state to use the "typical" POS (11) and only use the CPT modifier to reflect that the service was conducted using telemed/telephone.


Discussion

# Medicare's incident-to rules

- Code of Federal Regulations (CFR) 410.2: https://www.law.cornell.edu/cfr/text/42/410.26
- CMS Medicare Benefit Policy Manual, chapter 15, section 60: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf
- Claims Processing Manual, 100-04, chapter, 26, section 10.4: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c26pdf.pdf

# AAP Clinical Practice Guideline, Hypertension

4.3a Normal BP

If BP is normal or normalizes after repeat readings (ie, BP <90th percentile), then no additional action is needed. Practitioners should measure the BP at the next routine well-child care visit.

4.3b Elevated BP

1. If the BP reading is at the elevated BP level (Table 3), lifestyle interventions should be recommended (ie, healthy diet, sleep, and physical activity); the measurement should be repeated in 6 months by auscultation. Nutrition and/or weight management referral should be considered as appropriate;
2. If BP remains at the elevated BP level after 6 months, upper and lower extremity BP should be checked (right arm, left arm, and 1 leg), lifestyle counseling should be repeated, and BP should be rechecked in 6 months (ie, at the next well-child care visit) by auscultation;
3. If BP continues at the elevated BP level after 12 months (eg, after 3 auscultatory measurements), ABPM should be ordered (if available), and diagnostic evaluation should be conducted (see Table 10 for a list of screening tests and the populations in which they should be performed). Consider subspecialty referral (ie, cardiology or nephrology) (see Table 11); and
4. If BP normalizes at any point, return to annual BP screening at well-child care visits.

Source: https://publications.aap.org/pediatrics/article/140/3/e20171904/38358/Clinical-Practice-Guideline-for-Screening-and