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Mary Ludman, Chief Operating Officer

I want to hear from you!

Hi, I'm Mary.

This pop-up so NGS can make your job easier.

click on "Yes, I'll give feedback" when you see — this is your chance to have your voice heard.
Services with your organization not National Government
request continuing education credit, please contact
organization other than AAPC, and you plan to
If you are accredited with a professional
National Government Services education received,
now receive one CEU from AAPC for every hour of
Provider Outreach and Education attendees can
All National Government Services Part A and Part B
Continuing Education Credits
During this afternoon's session, we plan to:

- Address those concerns
- Learn about your ESMI concerns and how we can expand our educational programs to
- Allow limited remaining time for additional audience questions
- Present Q&A representative of those we received from you
- Review recent trends and updates

Goals for this session
attendeest.

for registration, which is generally limited to 500 attendees. For um within the next two months, so please watch forum.

We will be posting plans for our next EGM Open.

and we will provide an individual response. We will be posting plans for our next EGM Open.

If you submitted a question on a topic not addressed today, please re-submit your question.

Scope of AGM for today’s session
resolved problem is considered "new" again.

Exacerbation or recurrence of a previously

once for same specialty providers in group

Patient with a new problem: new status

practice, regardless of focus

NP (Spec 50) visits: one EGM per day per

same specialty providers in group

New patient billing: once within 3 years for
Denials may be appealed (first claim received) only once NP visit will be reimbursed (usually the specialty group's see the same patient/same DOS).

When multiple NPS' working within different sub-

(Specialty 50) visit per patient per day CMS intent: to pay for one Nurse Practitioner

Practice (Specialty 50) Billing

Nurse Practitioner Billing

NGS has clarified CMS' position regarding Nurse
CMS MLNs: M15972 and M19905

- 99358-99359 (Office, Outpatient, Inpatient)
- Non-Face-to-Face (new as of 1/1/2017): 993556-99357 (Inpatient)
- 99354-99355 (Office or Outpatient)

Prolonged Services
Minutes

- Time must exceed base EGM threshold time by 30+

- Must have start and end times documented

- Always add-on code to a base EGM

- Med Learn Matters 5972

- Manual, Chapter 12, Section 30.6.15.1

- CMS IOM Pub 100-04, Medicare Claims Processing

References

Prolonged Service: Face-to-Face
See CMS MLN: M19905

on same or different dos as related EGM

Codes are not add-on codes; may be billed alone,

Settings

Codes apply to both inpatient and outpatient

as of 1/1/2017

CPT Codes 99358-99359 are newly covered by CMS

Prolonged Service: Non-Face-to-Face
medical team conferences, on-line medical evaluation.

Not for use for CPO, anti-coagulant management.

Not for use with CCM (99490) or TCM (99495-99496).

Primary service may be reported on same or different date than the

Must relate to ongoing patient management.

Did or will occur.

Must relate to an ESM or other service where E2F care

Must relate in relation to both ESM and other services.

CPT Guidelines for Non-Face-to-Face
Non-Face-to-Face Billing Points

Records must support medical necessity and ensure that the service was not duplicated by other billed services. Specification of the content of the non face-to-face documentation of the service and all associated telephone time. If billing now, be careful to retain complete clarification on usage, especially on billing for codes are new – MACs are awaiting further CMS.
P.A.'s and Physician's combined efforts.

The supervising physician should see the patient at the P.A.'s request, and one EBM service should be billed for that DOS, representative of both the

The supervising physician should not qualify as a consultation, or a separately payable visit.

A. Although Sports Medicine is a CMS-recognized area of provider specialty, the P.A. is not eligible to request a consult for the Sports Medicine Practice.

Q. If you have a provider in a Family Practice and Sports Medicine and this provider is

credentials in Family Practice, in Family Practice and Sports Medicine, and this provider is

credentialled, in Family Practice and Sports Medicine, and this provider is

Q. Answers

Questions & Answers
A. Yes, the chief complaint may be repeated within the HPI if elicited repeatedly by the provider in the HPI.

A. Is it ok to use the chief complaint for an HPI element (it is not)?

A. HPI elements can be counted as often as they apply to presenting complaints.

Example: For "location" patient complaining of abdominal pain in the low right quadrant and left knee pain, encounter if it is related to two different complaints?

A. Can a single HPI element be counted twice for the same

Questions & Answers
specifically by the provider, in the medical record.

A. The HPI must be elicited and documented by the performing provider. Since eliciting the correct scope of HPI information requires

Questions & Answers
A. Can a nurse document the chief complainant? Can a provider demonstrate the provider’s review and acknowledgment of the identity the chief complainant within the HPI?

A. The nurse may document the chief complainant but the record must restate the chief complainant or corroborate or re-state the chief complainant within the context of the HPI.

Questions & Answers
whether there were findings relative to any element.
The provider must document that all ten elements were addressed.

A. For a complete ROS, required at the Comprehensive Level of Care:

ROS?
- Does documentation need to state 10 point ROS to count as a complete
- Was negative other than as noted in the HPI?

Q. If a provider documents "the 10 point ROS was completed and

Questions & Answers
A. Unless an examination is performed and documented, it cannot be
included as a required element of an EBM service.

Does this apply to physical examination?

Complete history if he/she documents all attempts to elicit history.

A. When a patient is unable to provide a history (e.g., patient is
unconscious or intubated), the provider may take credit for a

Questions & Answers
A. "Screening colonoscopy" is not a valid chief complaint; an E&M visit prior to a colonoscopy is not medically necessary unless the patient has a clinical condition or complaint that would warrant separate evaluation and care prior to the scheduled procedure.

Q. Can 'screening colonoscopy' be a valid chief complaint?
Q. Can you provide further clarification of the expectations of the Detailed 6-7 exam?

A. Differentiation between EPF and Detailed levels will now be determined by the number of systems or body areas examined by the provider. This will eliminate previous subjectivity when expectations were the same for both levels. Documentation for a Detailed level of examination should include pertinent positive findings and indication of "no findings" or "negative" as applicable.
Detailed: 6-7 body areas or organ systems

Expanded Problem Focused: 2-5 body areas or organ systems

Q. As of 7/1/217, examination requirements will be:

A. Please clarify the upcoming changes to examination requirements for EPF and detailed levels of service, effective on

Questions & Answers
should be coded based on the actual service performed.
should document the medically necessary scope of care, the visit
performs and documents the medically necessary level. Once the provider
guidelines define elements for every coding level. The CMS 95 and 97
components for single-system exams, and both the CMS 95 and 97
medical decision making. The CMS 97 guidelines define necessary
documentation of elements expected within the history, examination and
level of coding is established by the provider’s performance and
being “a potential new cancer patient” is incorrect.
A. The concept of billing a particular level of coding based on a patient
be at least a 99203.
might only be able to be billed at a 99202 level if service, when it should
many notes will now only qualify as EPF. Potentially, new cancer patient
A. With the change in number of systems required for EPF and detailed,
Are there any changes to the 1997 Guidelines and 99214 apply to services coded using the CMS 1995 Guidelines. We understand that the changes in exam expectations for 99213

Questions & Answers
As a reminder, 1995 and 1997 guidelines cannot be combined in detail. Organ systems can be combined in assessing the level of coding problem-focused and detailed exam levels. Combine body areas and organ systems towards the expanded Examination guidelines, it is still permissible to...

Questions & Answers
A. "no JVD" (meaning no Jugular Venous Distention) could receive credit under Body Area (neck) or Organ System (Cardiovascular).

A. What body area or organ system is applicable for documentation of "no JVD" in an examination?
A BMI calculation requires measurement of height and weight and cannot count as an additional vital sign when height and weight are measured and documented. When height and weight are not identified, documented BMI can be counted as a vital sign.

Questions & Answers
examination is performed.

A. One point is allotted per body area or organ system when bilateral examination is performed. On each side are documented?

Q. Will bilateral examinations count as 2 body areas if the findings of each side are documented?

Q. Will segment of organ systems also count as 1 body area?

Q. Will 1 vital sign also count as 1 body area?

Q. Under the new guidelines will 3 vital signs count as 1 body area?

Questions & Answers
examinitation.
represent examination at any level, including a problem-focused
a body area or organ system and would not be adequate to
A. Documentaition of vital signs does not represent an examinitation of

A problem focused exam under 95 or 97 Guideline?
A. Would documentation of "vital signs stable" be sufficient for a

Questions & Answers
necessary. Care, preparation of records and prescriptions and referral forms as necessary.

reflect a discussion of the hospital stay and plans for post-discharge patient's clinical status on the date of discharge. The note must discharge service (CPTs 99238-99239) unless indicated by the discharge service (CPTs 99238/99239).

A. A physical examination is not a required component of an E&M

Questions & Answers
count those actually performed and documented.

A. In counting performed bullet points for a visit, the provider may only

patient refused this element of examination

counted if the provider intended to evaluate gait/station but the
portion of the exam? For example, can the bullet for gait/station be
service if the patient refused to allow the provider to perform that

Q. Can an exam bullet be counted to base an E&M code level of

Questions & Answers
considered new to that specialty physician. Different specialties see the patient for the first time, the problem is within a group practice or in different practices. When a provider of a specialty group?

A. The guideline does not apply to different specialties, whether or not more than once in a multi-

Questions & Answers
worsening" under Problem Points in MDM. Making this may be counted as an "established problem, since it now requires the provider's assessment and medical decision.

recurs or presents as an exacerbation, it is considered "new" again.

Asthma) and has been successfully stabilized, and that problem
returns or worsens, is this considered "new" or known?

Q. If a patient has a known problem (not "new") and the problem

Questions & Answers
A. The concept of a "new" or "established" problem does not apply to "established" problems.

Q. When a patient is seen in the ED, does the concept of "new" vs. same date of service apply?
Family history is not required. A Family history which is described as "non-contributory" would not
be referenced in a service billed at a lower level of service, for which
quality for a detailed or comprehensive level of coding, but may be
A. In Family History does "Family History noncontributory" meet?

Questions & Answers
Q. When a patient arrives for scheduled chemotherapy and a physician performs a detailed exam, including evaluation for drug toxicity and medication adjustment, can the physician bill an E&M service, since the hospital bills for the chemotherapy administration? The physician is not an employee of the hospital.

A. A physician may perform an E&M service in a hospital outpatient setting (POS 22) and may bill that service, whether employed by the hospital or practicing as an independent practitioner. If the patient presents for scheduled chemotherapy, the medical necessity for an E&M visit is based on a separately defined problem. A routine evaluation for evidence of toxicity and medication adjustment is included in the chemotherapy administration fee and would not support the need for a distinctly separate E&M service.
A. A family history of breast cancer is a factor within the patient’s medical decision making. It is not included as a management option.

B. Could family history of breast cancer be used for a diagnosis/management option.

C. Unless the provider has included this factor as part of his/her PFSH.

D. Questions & Answers
Regardless of time spent, MDM meet the 99214 level, the service can be billed as such coordination of care. When documentation of history, exam and which 50% or more of the visit was spent in counseling and

A. Time is only used as a level-setting factor for an E&M service in

Questions & Answers
A. What is the requirement for billing based on time?

A. Both CMS guidelines (97 and 95) are acceptable.

A. Do you accept 97 and 95 guidelines for coding services?

Questions & Answers
the time spent.

discussion in order to support the medical necessity of the visit and
coordination of care, the note must reflect the content of the
based on 50% or more time in the visit spent on counseling or
A. If time has been used in establishing a coding level of 99233,

documentation for 99233, if the coding is based on time?
Q. Is the statement "I spent 35 mins in care today" considered valid?
would be 99213. Documented 20 minutes in face to face care, the appropriate code minutes and 99214 is 25 minutes. If the provider spent and coordination of care. The suggested CPT timeframe for 99213 is 15 of the time was spent on counseling and/or which 50% or more of the time was spent on counseling and/or

A. Billing based on time is only appropriate for EBM visits during about rounding up or down when billing is based on time?

Please clarify how to code a time based established patient visit

Questions & Answers
A. Documentation for Prolonged Services must clearly describe the prolonged, extended timeframe and/or discussion that took place during both the base code and the general content of care. Reasons for the prolonged time and the general content of care should be documented.

Questions & Answers

A. Is there a documentation requirement when billing for prolonged services in the hospital? Is the statement ">30 minutes" adequate for documenting prolonged service?
Questions & Answers

service time. Combine cumulative time over a 24 hour period to reflect prolonged service.

A. Yes, same specialty hospitalists working within a group may be calculated as provided by several Group members on a single date.

A. In a hospitalist group, can Face to Face prolonged care be
time spent and the EXM visit to which the services are related.
use these codes cautiously and to fully document all details relative to the
Since these are newly payable as of 1/7/2017, we are advising providers to
this code.
have specific guidance on whether telephone time can be considered for
to a scheduled visit may qualify for use of these codes, but we do not yet
Extravasation codes.
A CMS has not yet provided any further clarification on the non-F2F
without direct patient contact?
A. Has there been any clarification on the Prolonged Service codes

Questions & Answers
examination and high level of complexity in MDM is required.

set by the lowest-ranking element. In order to bill a 99233, a detailed
score at 99233 instead of 99232?

documentation of a PF physical exam and complex MDM — can this
level of visit? For example, a subsequent hospital visit with

A. Can complex MDM become the determining factor in assigning a

Questions & Answers
plan of care has been established.

a history and examination have been documented, but no
difficult to determine medical necessity for a visit in which
assessed individually. Providers must bear in mind that it is
2/3 elements, visits that do not include MDM will be
which require 3/3 elements. For subsequent visits requiring
A. MDM is a required element for all new patient visits
established patients?

Q. Is the MDM one of the required elements for an
Questions & Answers
A. A referral to another specialty provider is included under "new specialty provider.

How are points assigned when a provider refers a patient to a specialty provider?

A. Please clarify EBM data points assigned for provider referrals.
circumstances must be individually interpreted in this regard.

question appear to qualify on this level; each set of clinical
would merit a moderate level of risk. The problems noted in your
which is associated with potentially serious prognostic outcome, this
A. If a patient presents with a problem that is yet undiagnosed, and

patient presents with abdominal pain, hair loss and hematuria.

bloodwork to determine the next course of action? As an example,

Can this be applied for cases where physician is ordering

"undiagnosed new problem with uncertain prognosis"?

A. How does Medicare determine conditions that qualify for

Questions & Answers
determining the MDM or service. Nurse notes, while corroboratory, are not assessed.

For the DOS should reflect the administration (including drug, dosage, risk assessment for the EDM service. As such, the billing provider's note.

A. Administration of parenteral medications is included in MDM risk.

Questions & Answers
Q. A patient presents to the emergency room for chest pain, and the provider documents several chronic conditions in the ROS (HTN, CHF, CAD, COPD). The MDM only includes reference to the chest pain and a diagnosis of "Atypical chest pain". In assessing risk for the MDM, would the chronic conditions be included?

A. In order to include consideration of a chronic condition(s) in the MDM risk assessment, the provider must include the chronic condition(s) within the MDM portion of the record. In this scenario, if only the atypical chest pain was considered, a chronic condition mentioned in the ROS or HPI will not count in assessing the complexity of the MDM.
is associated with moderate risk, as per the CMS Table of Risk.

A. All prescription drug management, including prescription renewal?

prescription management? medication and the prescription is refilled, is this considered
management options for MDMP. If a patient is currently stable on

Q. What does NGS consider prescription drug management under

Questions & Answers
accurate HPI in most, if not all, clinical circumstances. If not aged stade of intellectual development, are not capable of providing an accurate decision. A baby or child can't provide a complete HPI due to their age and concepts detectors not apply to babies and small children, since no actual condition represents the provider's decision and extra effort to elicit an HPI when the patient is unable to provide an HPI due to his/her clinical condition (e.g., patient is unconscious, disoriented or intubated). The A. Credit for obtaining history from someone other than the patient when the patient is unable to provide an HPI due to his/her clinical condition on a pediatric patient.

Summarizing history obtained from parents/guardian, when it is appropriate to assign MDM data points for reviewing and:

Questions & Answers
Low level of MDM.
management of an acute, uncomplicated illness is associated with a moderate level of MDM. Would the medical decision-making be assigned as low by the provider? The provider writes a prescription for an OTC medication, such as acetaminophen.

Questions & Answers
Both initial and subsequent services by other specialty providers, "appropriately" billed, are billed using the other specialty's E&M outpatient codes for initial and subsequent services. Usually, in a consultative capacity, are billed only using the other specialty’s E&M codes for initial and subsequent services. Once a group-member hospitalist performs an initial observation service, the subsequent and discharge observation services may be performed by other same-specialty members of a group hospitalist practice. Please clarify billing for initial and subsequent observation services.
Clinical status on presentation.

Medical necessity for these services must correlate to the patient’s medical condition. History and examination may be appropriately done but the examination and MDM that is medically necessary. A comprehensive examination and MDM that is medically necessary.

A. The presenting problem sets the direction for the level of history.

High severity or life-threatening?

Can a visit be billed as 99285, when the presenting problem is not of immediate threat or life or physical function.

Immediate assessment of a physician for problems of high severity should support that the presenting problem requires the

O. NGS guidance for CPT code 99285 states The Documentation

Questions & Answers
Modifer 25. Chemotherapy, and may be separately billed as an E/M visit for chemotherapy
service is distinctly separate from the patient's scheduled visit for patient, orders x-rays and prescribes mild pain medication. This having sustained a fall the prior day. The provider examines the example: The patient presents with a swollen and bruised left wrist, separate and distinct from the chemotheraphy administration. An appropriate when the patient presents with a problem that is An office visit on the same day as chemotherapy may be same day as chemotherapy.

Questions & Answers
Coding.

Visit, they should not be included as a means of achieving a higher level of presenting complaint, and are not being evaluated in the context of the patient's clinical status relative to the chronic conditions do not impact the patient's clinical status relative to the necessity for each element of history, examination and MDM. If non-related medical.

A. The level and scope of an E&M service is determined by the medical calculation of the E&M level of service.

E&M or should only the acute condition and related care be used for the chronic conditions be taken into consideration when assigning the E&M. The provider does a complete HPI, ROS and exam as shoulder strain, and the provider sees a patient presenting with an acute complaint, such as shoulder strain.
Residents' note.

Service and document that service in a note separate from the provider must perform his/her own face-to-face participation in the for any service being billed by a Teaching Physician, the billing A. Services performed by residents are not billable to Medicare.

Attestation to the resident's discharge summary:
Teaching Attending Supervising a resident simply provide an

A. To support billing a hospital discharge (99238-99239), can the

Questions & Answers
Questions & Answers

A. An initial level of service requires elements 3/3 elements. If only 2/3 elements are present, the service can be billed as a subsequent service.

Q. When documentation is missing one of the three required CPT codes (99201-99205), what exam code should be billed?
would be adequate to support the physician's participation.

An example: "I have seen and examined the pt. with the PA and agreed the service performed.

A. Split/shared services in the hospital setting require performance by one or both the billing physician and NPP. The only required element by both the billing physician and NPP.
appearance and manual findings (e.g., distention, hepatomegaly),
of the Abdomen (body area) includes an assessment of physical
assessment of GI function (e.g., bowel sounds), while an examination
An examination of the Gastroinestinal System (GI) includes an
Abdomen exam?
A: Can you please clarify the difference between a GI exam and an
A. Could chest pain be considered a moderate level of risk in the absence of other symptoms such as diaphoresis or shortness of breath? High if chest pain was accompanied by other symptoms such as diaphoresis or shortness of breath, or might it be considered a moderate score as noted by the patient was clinically stable or non-determined. Chest pain of suspected cardiovascular condition would probably score as a low risk, while chest pain of suspected cardiovascular condition would probably score as a low risk, while chest pain of suspected cardiovascular condition would probably score as a low risk. Finding such as a skin abscess or dermatoindoligical condition would be considered, chest pain from recent external trauma or a physical exam finding, and particularly the context in which the pain was reported. Chest pain from recent external trauma or a physical exam finding, and particularly the context in which the pain was reported. The level of risk for chest pain would be based on the history and context in which the pain was reported.
member in the prior three years.

patient had not been seen by any same-specialty group practice

specialty practice would be considered a new patient visit. If the

provider seeing the patient for the first time. An initial office visit to a

Medicare counted in considering whether a patient is new to a Medicare

care provided by a resident is not billable to Medicare and not

to the specialty provider. If the patient considered "new" or "established"

A patient is seen in the ER by a resident and referred to another

Questions & Answers
actual clinical status at the time of the surgery, conditions, prior surgical and anesthesia problems and the patient's more risk than knee replacement, the patient's age, co-morbidity specific nature of the surgery (e.g., aortic aneurysm repair carries risk based on many factors that include (but are not limited to) the A. Elective major surgery is considered as either moderate or high

High Risk?

Q. What makes a surgery in MDM cover a moderate risk to a Moderate & Answers
correlate to the date of service on the submitted claim.
which it is performed, since the documentation of date and signature must
Generally speaking, the service should be documented on the same date on
performing provider
represented by the billing code and is not dated and signed clearly by the
care
A note is incomplete when it does not support the elements of care
CMS does not define a specific timeframe.
Although medical record, "CMS 100-04, Chapter 12, Section 30.6.1); although
soon as practicable after it is provided in order to maintain an accurate
A providers are expected to complete service documentation during or as
consider a note incomplete?
A. How long does a provider have to complete a note?

Questions & Answers
would need to be met.

All of the "Incident to Services" and not a higher level for these services. Any of the 99211 may be billed as long as they are medically necessary. Only a 99211 may be billed for "Incident to a physician and the physician may bill for them as a Clinical Pharmacist can provide services within his or her scope that

Questions & Answers
Q: What drugs are designated as "requiring intensive monitoring" for toxicity?

A: Drugs in this category generally include certain cardiac drugs.

Q: Where can I find a list of drugs that are considered high risk for toxicity?

A: CMS has not published a specific list of such drugs; NGS is modifying the posted NGS Q&A on this topic to read:

Q: Where can I find a list of drugs that are considered high risk for toxicity?
are not included within the scope of covered Medicare benefits.

reason for the visit, to support the medical necessity of the care, and
serivices other than the IPPE and AWV require a clinicl compilitment or
An annual physical exam is not a covered Medicare service; E8M

acuity, psychologiacal health and various safety and lifestyle factors.
medications and scope of overall performance regarding mental

A. A Medicare-covered Annual Wellness Visit (AWV) is intended as an

Questions & Answers
beneficiaries to avail themselves of the benefit. For providers to perform this service, nor is there a requirement for preventive resources. There is, however, no mandatory requirement visits to their Medicare beneficiaries, since these are voluntary. CMS encourages primary care providers to offer the IPFE and AWV.

Questions & Answers
Questions & Answers

Q. When a patient is scheduled for a follow up visit of several chronic conditions, is it allowed for the provider to separately bill an Annual Wellness Visit performed on the same day?

A. If a patient has several chronic conditions, all of which are clinically stable, there is no medical necessity for an E&M service on the same day as the Annual Wellness Visit (AWV), since a review of those conditions will be included in the AWV. A separate E&M service would only be medically necessary if the patient were to present for a scheduled AWV with signs and symptoms warranting separate assessment and clinical care.
Classification of codes:

Care Management (CPT 99490) is included within the E8M.

A. Yes, the E8M guidelines for MDM are applicable, since Chronic Care Management (CCM) is included within the E8M.

Q. The guidelines state Moderate or High Complex MDM. Should we use the E8M guidelines for MDM to determine this?

A. Complex Chronic Care Management (CCM) guidelines are included within the E8M.
A. Documentiation of Chronic Care Management must include a
within the E&M service (including the IPE or AWV).
status assessment and plan for all chronic conditions identified
the IPE, AWV or E&M to establish CCM?
documentation to warrant "Comprehensive Assessment" on top of
what would Medicare expect to see in the service.
separately in addition to Primary monthly care management
for patients requiring chronic care management services-I list
A. Code G0506 (comprehensive assessment of and care planning

Complex Chronic Care Management

Questions & Answers
Services.

The Medicare Allowed Amount, not the usual provider's fee for the
that you are reducing the billed amount by the appropriate percentage of
"Please make sure that when you submit any CPT code with modifier 52
lower rate, based on this situation:
Claim Submission Billing Reminder, which instructs providers to bill at a
Please see the NGS Job Aid on www.ngsmedicare.com titled "Modifier 52
fully completed.
reduce service; this would be the appropriate modifier for a service not
Modifier 52 describes a situation in which the physician performs a
appropriate?
Is this a reduced or discontinuing procedure? What modifier is
(e.g. remove a foreign body by incision and no foreign body is removed)
A. If a provider attempts to perform a procedure which is unsuccessful
the day after the patient was admitted to inpatient status. The note should include an explanation for his/her service taking place on day by the attending teaching physician. The attending physician, a resident, had not been seen until the subsequent day by a resident, late on a given day, and not seen until the subsequent day by a resident, late on a given day, and not seen until the subsequent day by an attending physician. A. CMS does not define a specific time for "late at night." Responsibly admitting for Teaching Physician billing. 

Questions & Answers
than a procedure scheduled for that date (e.g., diabetic foot care). A Podiatrist may perform an E8M service if the patient is not diabetic and billed for a distinct, separately payable service. Please clarify when a Podiatrist can bill an E8M visit for a diabetic patient.
Open Forum

We’re pleased to address your other questions during this timeframe.