CODING Q&A

Splint Applications by Staff, and Proper Use of Modifiers -25, -26, and -59

DAVID STERN, MD, CPC

Q. At the UCAOA Fall Urgent Care conference, you welcomed all questions, so here goes: Can you please let me know if it is appropriate to charge for Ortho-Glass and fiberglass splints in the urgent care setting? In some cases, the splints are applied by a tech under the direct supervision of the physician. In these cases, can the charge for the application of the splint be coded in addition to the Q codes?

- Question submitted by Joan Stephanofsky

A. Yes, cast and splint application codes (in addition to the Q codes for supplies) may be used when appropriate in a physician office, an emergency department, an urgent care center, or any other clinical location. You may use the application codes if the physician applies the splint or if staff that are directly supervised by the physician apply the splint.

Q. We have trouble getting reimbursed for E/M codes on the same claim as procedure codes, even if we use modifier -25 on the E/M code. I have even received a denial of the E/M code when billed with a G0168.

- Question submitted by Lina, Keith & Company 6

A. When calculating reimbursement for the code G0168 (Wound closure utilizing tissue adhesive(s) only), CMS included relative value units (RVUs) for an E/M, the cost of the 2-cyanoacrylate, and the work to apply the tissue glue. Thus, it is not appropriate to add an E/M code to G0168. HCPCS code G0168, however, should be used only for CMS payors.

For other payors, you should review the CPT definition for wound closure: "CPT repair codes (12001-13160) are used to designate wound closure using sutures, staples, or tissue adhesives (i.e., 2-cyanoacrylate), either singly or in combination with adhesive strips."

Thus, for payors that are not governed by CMS, you should use the standard CPT code for wound closure, along with an E/M with modifier -25, as long as a separately identifiable E/M is documented in the chart.

Q. We own our own x-ray equipment and read all of our x-rays. A radiologist also reads each x-ray. I do use modifier -25 on my EM and modifiers -TC & -26 plus body location on my x-ray. I was told that I should not add modifier -TC nor modifier -26 to the bill. Which is correct?

- Question submitted by Kimberly, Express Pediatrics

A. You should use modifier -26 only when you are billing for the professional component alone.

You should use modifier –TC only when you are billing for the technical component alone.

When you are billing for both the professional component and the technical component on the same claim, you should bill the CPT code without modifier -26 and without modifier -TC. Using a modifier to indicate anatomic location (i.e., -R for right and -L for left) is appropriate.

I assume that the radiologist works for you as an employee or independent contractor. If so, you may bill the global radiology code (x-ray code without any modifier) for the x-ray. The code includes the professional component and the technical component. You do not need to add modifier -25 to the E/M code if the only procedure performed during the visit is the x-ray.

David E. Stern, MD, CPC is a certified professional coder. He is a partner in Physicians Immediate Care, operating 12 urgent care centers in Oklahoma and Illinois. Stern serves on the Board of Directors of the Urgent Care Association of America and speaks frequently at urgent care conferences. He is CEO of Practice Velocity (*www.practicevelocity.com*), providing urgent care software solutions to more than 500 urgent care centers. He welcomes your questions about coding in urgent care.

CODING Q&A

Q. If I bill an E/M with 96360 (Intravenous infusion, hydration; initial, 31 minutes to 1 hour) and J7030 (Infusion, normal saline solution, 1000 cc), do I need modifier -59 on the CPT code 96360?

- Question submitted by Francine Nicoletti, Veterans Administration, Northport, NY

A. In general, modifier -59 is reserved for when you are coding for services that would otherwise be considered bundled together. You should not use modifier -59 if neither code could be considered as bundled into the other code.

For example, modifier -59 should be used when a patient has two separate lacerations on two different fingers—one laceration involves the tendon and requires a tendon repair (CPT code: 26418, Extensor tendon repair, dorsum of finger, single, primary or secondary, without free graft, each tendon) and the other laceration involves a simple repair (CPT code: 12001, Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less).

The code for tendon repair assumes and includes a simple skin closure over top of the repaired tendon and the other laceration, so one would not generally add a code for a simple laceration repair to a tendon repair.

In this specific example, however, the simple laceration repair is on a different finger, so it is clearly distinct from the tendon laceration repair. Thus, the simple laceration repair should be coded as a simple skin closure (12001), and modifier -59 should be added to CPT code 12001.

In addition, when the lacerations are on different fingers, the coder should also use the modifiers particular to specific fingers (modifiers -F0 to -F9).

In the specific question that you ask, however, the E/M code and the IV code are obviously distinct procedures that are never bundled together in either code. Thus, it would not be a standard coding procedure to use modifier -59.

In addition, the CPT code for IV hydration (96360) includes the fluids administered to the patient. Thus, it is *not* appropriate to add J7030 to CPT code 96360. ■

OCCUPATIONAL MEDICINE

"It is better to consider your call 'success or deferred success' rather than 'success or failure.'"

with appropriate material right on the spot.

You should review and answer the same types of questions before a face-to-face meeting as you would before placing a phone call. In a face-to-face meeting, there can be a fourth question: "What, if anything, do I need to bring with me so I can hand it out should the need arise?"

Often, the answer to this question is to bring nothing, knowing that you will send them something quickly upon returning to your office (or via a quick call to your assistant at the office).

There are pros and cons to both approaches, depending on the circumstance:

Option 1: Hand it to them.	
Pros	**Cons**
1. Provides instant information to the prospect. 2. Suggests to the prospect that you are prepared. 3. Prolongs the encounter, which may enable you to achieve your initial objective.	1. Suggests that you are pre-programmed. 2. May distract the prospect as they eyeball the handout. 3. May suggest to the prospect that the meeting is over.

Option 2: Send it to them.	
Pros	**Cons**
1. Allows you to fine tune and customize the material. 2. Fast turnaround indicates responsiveness. 3. You buy time to think of additional information you can add.	1. Not turning it around quickly may suggest poor responsiveness. 2. They may receive it at a time they are not focused on you ("out of sight, out of mind"). 3. It gives the prospect time to consider other options ("A bird in the hand…).

It is far better to consider your sales calls results to be "success or deferred success" rather than success or failure. In sales, there is always a tomorrow. ■