CODING Q&A

New CMS Modifiers, Urgent Care Codes, Supply Codes

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Q. What will be the impact of use of the new HCPCS modifiers related to modifier -59 beginning January 1, 2015?

A. CMS recently announced the creation of four new HCPCS modifiers that will further refine modifier -59, "Distinct procedural service." According to CMS, modifier -59 is the most widely used modifier, and it is being used inappropriately in most cases.

Adding modifier -59 indicates that a code represents a service that is separate and distinct from another service with which it would usually be considered to be bundled. It is also used in circumstances that identify different encounters and different anatomic sites. CMS established the new modifiers to define the following specific subsets of the -59 modifier, which are referred to collectively as –X{EPSU} modifiers:

- XE Separate Encounter, A service that is distinct because it occurred during a separate encounter;
- XS Separate Structure, A service that is distinct because it was performed on a separate organ/structure;
- XP Separate Practitioner, A service that is distinct because it was performed by a different practitioner; and
- XU Unusual Non-Overlapping Service, The use of a service that is distinct because it does not overlap usual components of the main service.

CMS will continue to recognize modifier -59, but be prepared to have claims returned that require a more specific –X{EPSU} modifier. Under CPT guidelines, modifier -59 should not be used when a more descriptive modifier is available. CMS may designate a particular NCCI code pair as payable only with the –XE (Separate Encounter) modifier and not the -59 or other –X{EPSU} modifiers. However, these modifiers are valid modifiers even before the national edits are in place. Thus, Medicare Approved Contractors (MACs) are not prohibited from requiring the use of selective modifiers in lieu of the general -59 modifier when necessitated by local program integrity and compliance needs.

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Q. Are there certain diagnosis codes (ICD) that are not covered when billed with POS 20 (Urgent Care)?

A. An urgent care center can bill any diagnosis code, but coverage will most likely be determined by the payor based on what services were performed and medical necessity.

However, payors usually deny payment for a procedure if the procedure is not linked to a supporting ICD code. An example of this would be a provider submitting a claim for a chest x-ray, but linking the chest x-ray code only to a diagnosis of strep throat (034.0). If the chest x-ray is linked to the diagnosis of cough (786.2), then the payor is much more likely to reimburse for the procedure.

Another common source of denials is a payor-specific denial on a claim or a line item based on the CPT/HCPCS code that is used. Sometimes a denial may be for a specific

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combination of provider (or provider credentials) and the CPT/HCPCS codes. Examples of these scenarios include:

- A payor in New Jersey that will not pay for x-ray studies at some urgent care centers.
- A payor in Mississippi that will not pay for an x-ray of the spine, a strep test, or a urine pregnancy test if that test was ordered by a nurse practitioner or physician assistant unless the patient also had a direct face-to-face encounter with a physician on that visit.

Q. I have a question about billing supplies (L-codes) with fracture codes. More specifically, if a patient has a finger fracture and you provide a finger splint, can you bill HCPCS code L3927 with CPT code 26720?

A. Because there are several descriptions in HCPCS for a finger splint, you will want to verify with your supplier the HCPCS code they recommend you use or review the descriptions in HCPCS to determine the one that best describes what you are using. If you search HCPCS for "finger," you will see choices for "orthotic" and "splint." The code provided for a finger splint is simply A4570, "Splint." You are also directed to ortho codes, or "L" codes.

With just a few exceptions, if the device is described in HCPCS as "orthotic," then fitting and adjustment is included and would not be billed in addition to the fracture care code. If the device is described as "orthosis," then fitting and adjustment is typically not included because it involves strapping, which is considered separate work from the fracture care. Because HCPCS code L3927, "Finger orthosis, proximal interphalangeal (PIP)/distal interphalangeal (DIP), without joint/spring, extension/flexion, may include soft interface material, prefabricated, off-the-shelf" does not include the fitting and adjustment, it would be appropriate for you to bill it with your fracture care code.

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