CODING Q&A

Modifier -X {EPSU}, Pneumococcal Immunizations

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Q. Have there been any updates from CMS (Centers for Medicare & Medicaid Services) regarding the new -X modifiers that were introduced in January of this year?

A. CMS released MLN Special Edition article SE1503 on January 22, 2015 (see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1503.pdf), stating that there would be forthcoming guidance as to the appropriate use of the new -X {EPSU} modifiers and "that guidance will include additional descriptive information about the new modifiers" before implementing edits or audits.

The bottom line is that you should continue to use the -59 modifier where appropriate. You should not use an -X modifier until CMS publishes "specific guidance."

You will also want to check with Medicare Administrative Contractors (MACs) as well as commercial payors for guidance before using any -X modifiers. It is likely that most payors will wait until CMS releases more information and case scenarios before providing their own rules, or their current rules may change on the basis of what CMS releases in the future.

I will continue to monitor CMS and other payors nationally for updates and offer assistance where I can. ■

Q. I understand that Medicare considers the pneumonia vaccine benefit a "once in a lifetime" benefit unless the patient is at high risk for the disease. Is this true? What do we do in the case where our patients cannot remember whether they have received the vaccine?

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A. There are two vaccines for pneumococcal immunization in adults: 23-valent pneumococcal polysaccharide vaccine (PPSV23) and 13-valent pneumococcal conjugate vaccine (PCV13). The brand names for these are Pneumovax 23 and Prevnar 13, respectively. PPSV23 is the most commonly known and since 1983 has been used for adults aged 65 years and older. PCV13 was approved, effective December 30, 2011, for adults aged 50 years and older.

Medicare states that routine revaccinations of people age 65 or older who are not at high risk are not appropriate and that payment will be denied unless there is a diagnosis to substantiate it.

Examples of chronic diseases and conditions warranting vaccination include cardiovascular disease, diabetes, pulmonary disease, alcoholism, cirrhosis of the liver, and spinal cord leakage. Examples of immunocompromised patients include those with asplenia, splenic dysfunction, lymphoma, Hodgkin disease, chronic renal failure, human immunodeficiency virus, sickle cell disease, malignancies, or nephrotic syndrome and those receiving immunosuppressive chemotherapy or undergoing organ transplantation.

Further, according to the *Medicare Claims Processing Manual*, those administering the vaccine should not require the patient to present an immunization record, nor should they feel compelled to review the patient's complete medical record if it is not available. Instead, they should rely on the patient's verbal history, as long as the patient is mentally competent. If the patient is uncertain about their vaccination history in the past 5 years, the vaccine should be given. However, if the patient is certain that they were vaccinated in the last 5 years, the

vaccine should not be given. If the patient is certain that they were vaccinated more than 5 years earlier, revaccination is not appropriate unless the patient is at highest risk.

Recently, the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP) recommended that both PPSV23 and PCV13 be given routinely as a series to all adults aged 65 years and older. If a patient in that age group has not been previously immunized, or their immunization history is unknown, the CDC recommends a dose of PCV13 first, followed by PPSV23 in the following 6 to 12 months.

This certainly presents a dilemma for the provider trying to care for the patient but also get paid for services provided. Providers should ask Medicare patients to sign an Advance Beneficiary Notice (ABN) prior to receiving the vaccine, depending on frequency or unknown vaccine status. The ABN allows a provider to balance-bill the patient to recoup the cost of the vaccine if Medicare denies the claim.

Each vaccine has its own *Current Procedural Terminology* (CPT) code for billing. Coders should bill as follows:

- Code 90670, "Pneumococcal conjugate vaccine, 13 valent, for intramuscular use," for PCV13
- Code 90732, "Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use," for PPSV23

The administration code for either vaccine is HCPCS code G0009, "Administration of pneumococcal vaccine."

With any revaccination, remember to discuss the risks and benefits with the patient and have the patient sign an ABN.

In addition to the codes for billing, the coder must always be aware of the appropriate modifiers when issuing an ABN or if there is an uncertainty regarding payment:

- **GA:** "Waiver of liability statement issued as required by payer policy, individual case"
- **GK:** "Reasonable and necessary item/service associated with GA or GZ modifier"
- **GZ:** "Item or service expected to be denied as not reasonable and necessary"

As long as there is conflict between the CDC, ACIP, and CMS recommendations, health-care providers must use their clinical judgment, based on the patient's medical history, need, chronic conditions, and degree of risk, when documenting and billing for this service. ■

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