# Part B Insider (Multispecialty) Coding Alert

## YOUR PART B QUESTIONS ANSWERED

Editor's note: Due to popular demand, Part B Insider will now be alternating the "Part B Coding Coach" feature with a question and answer article every other week. To submit your question, write to editor Torrey Kim, CPC, at torrey@partbinsider.com.

Dual 87804 Results: AMA Issues Modifier Directive

**Question:** When reporting 87804 to describe testing for rapid influenza virus A&B, should the second test have modifier 91?

Answer: Per the AMA, the correct choice for two rapid influenza test results (87804, Infectious agent antigen detection by immunoassay with direct optical observation; influenza) is modifier 59 (Distinct procedural service).

"When two units of code 87804 are submitted, modifier 59 may be used to indicate that the two results represent separate services (codes 87804 and 87804-59)," according to CPT Assistant (May 2009). Because the same CPT code describes the rapid testing of both strains, you should use modifier 59 to indicate separate results.

Alternatively, the payer may prefer no modifier and two units of 87804 reported on one line (87804 x 2). If a payer instructs you to instead use modifier 91 (Repeat clinical diagnostic laboratory test) with two distinct influenza tests, keep a copy of the guideline in your compliance binder.

Typically, you'll use modifier 91 when a patient's treatment requires repeating the same lab test on the same day to obtain subsequent results. "An example is repeated blood testing for the same patient, using the same CPT code, performed at different intervals during the same day (e.g., initial and three subsequent potassium levels)," states the AMA in "Coding Brief: Rapid Influenza Virus A and B Testing (Code 87804)."

Scalpel Use Cuts Swath to I&D

Question: A 48-year-old established patient reports to the internist for management of her type II diabetes mellitus. The patient also makes note of a painful left index finger. She says the digit has been red and swollen for the past three days, and she rates the pain a 6 on a 10-point scale. The internist provides a level-three E/M service, during which he notes "fluctuance limited to area surrounding lateral nail fold. Final Dx: Paronychia" In addition to advising the patient to continue current diabetic management, the internist uses a scalpel to perform incision and drainage (I&D), flushes the area with saline, and has the nonphysician practitioner (NPP) dress the wound. Does this qualify as an I&D for coding purposes?

Answer: Since the internist used a scalpel and irrigation to treat paronychia, this qualifies as an I&D. On the claim, report the following:

• 10060 (Incision and drainage of abscess [e.g., carbuncle, supprative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia]; simple or single) for the I&D

• 99213 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity ...) for the E/M

• modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) appended to 99213 to show that it was a separate service from the I&D

• 681.02 (Cellulitis and abscess of finger and toe; Onychia and paronychia of finger) appended to 10060 and 99213 to represent the patient's injury.

Note: Since the internist provided an evaluation of the patient's diabetes during this encounter, append 250.00 (Diabetes mellitus without mention of complication; type II or unspecified type, not stated as uncontrolled) to 10060 and 99213 as a secondary diagnosis.

Let Payers Reduce Your Multiple Procedure Fees

Question: Are insurance companies allowed to reduce our fees for multiple procedures performed during the same session? If so, should I be reducing the fee before sending the claim?

Answer: Many payers, including Medicare, follow a reduced fee policy for multiple procedures performed during the same operative session. Generally, the policy looks something like this:

• Procedure 1 is paid at 100 percent of the allowable

• Procedure 2 is paid at 50 percent of the allowable

• Procedure 3 is paid at 25 percent of the allowable for some payers and 50 percent of the allowable for other payers, such as Medicare.

Important: Even if the payer in question follows a multiple procedure reduction policy, you should not reduce the fee before you send your claim. Let the payer reduce the fee -- that way you don't risk reducing the fee yourself and then having the payer reduce it again.

Hint: If you need to apply modifier 51 (Multiple procedures) to a surgical code, be prepared for multiple procedure fee reductions.

**2 Ways to Code Complaint From Past Injury**

Question: We have a patient with previous spinal injury that is now causing neck pain. How should I code the diagnosis?

Answer: Document and code prior conditions that contribute to a patient's current complaint -- if they affect the management of the current condition. Prior trauma, such as a previously broken bone or other injury, can cause patients to experience back pain. If the patient's pain stems from a previous condition, you may code that diagnosis to justify pain management procedures your physician performs.

Depending on the situation, there may be late-effect codes or V codes that you may report in addition to the current complaint that show a late effect or a personal history of trauma.

Option 1: If the patient's chronic neck pain is documented as due to a prior traumatic vertebral fracture -- at C2-C3, for instance -- you could code this as:

• 338.21 -- Chronic pain due to trauma

• 723.1 -- Neck pain

• 905.1 -- Late effect of cervical closed fracture.

Option 2: If your provider's documentation does not include a "cause and effect" link to the current condition, you could code this scenario as 338.21, 723.1, and V15.51 (Personal history of injury, healed traumatic fracture).

Personal history "V codes" provide additional information to the payer indicating that the patient has had this condition or disease in the past but do not include any causality for the patient\'s current complaints.

The key to the correct coding of these contributory conditions is making sure they are appropriately documented in the

medical record. This information is central to justifying medical necessity.