Codify
BY AAPC

Outpatient Facility Coding Alert

Influenza Information: Make a Rightful Claim for Second-Strain Flu Testing

The issue is whether to report two line items for two different stains.

If your facility's physicians perform two tests to screen for two different strains of the flu, it is important to determine whether you report two line items of the same code. That's the issue in question as practices struggle to collect for multiple units of 87804 (Infectious agent antigen detection by immunoassay with direct optical observation; influenza).

Report 87804-QW for Optical Analysis

Code 87804 describes the rapid flu test approved by the FDA requiring Clinical Laboratory Improvement Act (CLIA)-waived status. Use this code for detection by visual identification.

Reporting tip: Many Medicaid states require you to follow Medicare modifier guidelines and append modifier QW (CLIA-waived test) to 87804. To keep coding uniform, many practices use modifier QW regardless of payer.

Apply 87804 Coding Rule to When Testing for Strains A and B

When your office uses an A & B influenza test, you should code multiple units of 87804 when appropriate.

For an in-office test that does not identify the influenza strain, report one unit of 87804. For instance, if you perform a test that picks up only the presence of influenza with a single positive/negative, you should report one unit of 87804.

If you use a product that differentiates between influenza A & B and the physician documents both results, you should report 87804 twice. Technically it is two tests just done in one so you are correct in billing it twice, because the physician is documenting two results. If the test does not differentiate between the strains (by just delivering a positive/negative result), then you would bill the code once.

Consider This Alternative for 87804 Denial

You may confront variations in the way payers require you to report multiple units of 87804. Here's how to decide which method to use:

Best practice: Report two units of 87804 if the payer allows it. Many MACs allow you to report 87804 x 2 without a problem, because the MUEs (medically unlikely edits) that Medicare and some other payers utilize to auto-deny second and subsequent line items limits you to two units of 87804. This means that your carrier will process two units of the code but would most likely auto-deny three or more units billed together.

For payers that do not recognize two units of 87804 and deny the second charge as a duplicate, use modifier 59 (Distinct procedural service) on the second 87804 entry. This modifier indicates that the physician performed a different test for a distinct strain.

Fallback method: In some rare cases (such as with certain state Medicaid providers), you may be advised by your payer to use modifier 91 (Repeat clinical diagnostic laboratory test) on the second listing of 87804. However, before using this coding method, which contradicts current coding guidelines, obtain a written recommendation from the payer.

The May 2009 CPT Assistant backs up the advice that modifier 59 is a better option than modifier 91, stating, "Use modifier 59 when separate results are reported for different species or strains that are described by the same CPT code. This advice should serve to clarify the use of the modifier in these instances. As a matter of differentiation, modifier 91 is

used when, in the course of treating a patient, it is necessary to repeat the same laboratory test on the same day to obtain subsequent tes results."