

HIGHMARK CODING TIPS

JULY 2019

Pathology and Laboratory Panel Codes

A laboratory panel (80047-80081) are often ordered together. Panels were developed for coding purposes and should not be interpreted as clinical parameters. They are also not intended to limit the performance of other tests.

The American Medical Association (AMA) Current Procedural Terminology (CPT) Pathology and Laboratory guidelines caution against reporting two or more panel codes that include any of the same constituent tests performed from the same patient collection. If a group of tests overlaps two or more panels, report the panel that incorporates the greater number of tests to fulfill the code definition and report the remaining tests using individual test codes.

However, please note it would not be appropriate to unbundle and bill for all or some of the individual tests within a panel to receive greater reimbursement including leaving out one panel test just to be able to bill all others independently.

Coding and Billing for Physical Medicine and Manipulation Services

PROPER USE OF MODIFIERS:

Modifier-59 should not be appended to physical medicine modalities and procedures (97124, 97140) when performed on the same body area as manipulation services (98940, 98941, 98942).

Per Highmark Medical Policy Y-9:

Joint mobilization and massage are considered an inherent part of a manipulation procedure and are not eligible for separate payment when performed on the same body region and reported on the same day as the manipulation.

Modifier -25 should not routinely be appended to Evaluation and Management services when reported on the same day as physical medicine and manipulation services. (For more information on modifiers 59 and 25 reference Reimbursement Policy RP-009.)

Per Highmark Medical Policy Y-9:

A separate Evaluation and Management (E/M) service should not be routinely reported with manipulation or time-based physical medicine services. This means a separate (E/M) service should only be paid in the following circumstances:

- Initial examination of a new individual or condition, **or**
- Re-examination of a new individual within an episode of care to assess individual progress, current clinical status, and determine the need for any further medically necessary therapeutic level care, **or**
- Acute exacerbation of symptoms or a significant change in the individual's condition, **or**

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- Distinctly different indications, which are separately identifiable and unrelated to the manipulation.

PROPER REPORTING OF UNITS OF SERVICE FOR TIME BASED THERAPY CODES

Effective April 1, 2016, Highmark began following Medicare's method of counting minutes for timed therapy codes for professional services for Commercial Plans. When more than one service represented by 15-minute timed codes is performed in a single day, the total number of minutes of service determines the number of timed units billed.

Based on the work value of these codes, the expectation is the provider's direct patient contact time for each unit will average fifteen (15) minutes in length. If only one service is provided in a day, providers should not bill for services performed for less than eight (8) minutes.

**Please refer to the Highmark Provider Manual and Medical Policy for additional information.

Immunization Administration for Vaccines/Toxoids Reporting

According to the American Medical Association (AMA) Current Procedural Terminology (CPT) guidelines, report vaccine immunization administration codes (90460, 90461, 90471-90474 001A, 0002A, 0011A, 0012A, 0021A, 0022A, 0031A, 0041A, 0042A) in addition to the vaccine and toxoid code(s) 90476-90749, 91300, 91302, 91303, 91304.

Codes 90460 and 90461 are to be used when face-to-face counseling is provided to the patient/family during the administration of the vaccine. Codes 90471-90474 are used when face-to-face counseling is not performed. Simply providing an information sheet to the patient/family without discussion would not be considered face-to-face counseling.

The vaccine and toxoid administration codes can be reported in addition to an Evaluation and Management (E/M) service if a significant, separately identifiable service is performed.

Please note the vaccine and toxoid administration codes should not be reported in addition to services such as, allergy immunotherapy (95115, 95117) as these codes are not vaccine and toxoid administration codes. As per AMA CPT guidelines, codes 95115-95199 include the professional services necessary for allergen immunotherapy.

Also, the vaccine and toxoid administration codes should not be reported in addition to skin tests for tuberculosis (PPD; 86580). This test is an intradermal tuberculosis skin test not vaccine administration. If this is the only service provided during the visit, no other codes should be reported, including a nurse visit code (99211). If on a later date the site is examined for a reaction, then an E/M code can be reported for the services rendered on that date.

