CME

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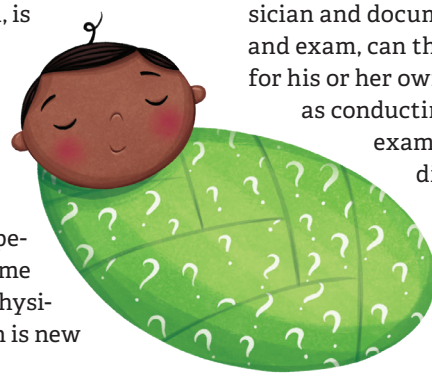
LAB TESTS REQUIRING MODIFIER QW

Q How do I know which laboratory tests require modifier QW?

A Medicare uses modifier QW to indicate that a test is CLIA-waived and the reporting physician's practice has a CLIA certificate that allows the physician to perform and report CLIA-waived tests. You can verify that a test is CLIA-waived at https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/waivetbl.pdf. Certain codes describe only CLIA-waived tests and therefore are exempt from the requirement to add the QW modifier. The CPT codes for the tests currently exempt from the requirement are 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651.

NEWBORN: NEW PATIENT OR NOT?

Q If a hospitalist in my group practice provided hospital care to a newborn, is the patient new to me when I provide the first well-child visit?



A It depends on your and your colleague's specialties. Let's assume you are a family physician. The newborn is new to you only if no other family physician in your group practice has provided a face-to-face service to the newborn prior to your service. CPT states that a new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the *exact same specialty and subspecialty* in the same group practice, within the past three years. However, some plans do not recognize subspecialties for purposes of defining a new patient service. If the physician who previously provided care to the patient was a family physician with a subspecialty (e.g., a hospitalist), your staff should review your health plans' reimbursement policies to determine whether they use the CPT standard or their own definition of new patient.

SHARED SERVICES FOR NEW PATIENTS

Q If a nurse practitioner sees a new patient before the physician and documents the history and exam, can the physician bill for his or her own services, such as conducting an additional exam or establishing a diagnosis and plan of care?

A No. New patient visits are not covered by incident-to rules, so they are not eligible for billing as split or shared E/M services in the office setting. If a nurse practitioner (or another qualified health care professional who can report E/M services) performs a portion of the E/M service for a new patient (other than documentation of the past, family, and social histories and review of systems), the service must be billed by that individual. Medicare pays 85% of the regular physician fee schedule amount.

CODING SEX-SPECIFIC SERVICES FOR TRANSGENDER PATIENTS

Q Is there a way to indicate that services typically identified with one sex were rendered to a patient of the opposite sex, as in the case of a transgender patient, so that we can bypass automated claims edits?

A Yes. For Medicare claims, physicians can append modifier KX (requirements specified in the medical policy have been met) to the code for services that may be identified as only applicable to the opposite sex. Other payment policy criteria may apply (e.g., elapsed time since last preventive service). Check with your other health plans for their policies and billing specifications.

PACEMAKER DUE TO SICK SINUS SYNDROME

Q When following a patient with a pacemaker due to sick sinus syndrome, should I report a diagnosis code for the sick sinus syndrome or only for the presence of the pacemaker?

A Report code I49.5 (sick sinus syndrome) followed by Z95.0 (presence of cardiac pacemaker). When a chronic condition exists but is managed by a medical device (e.g., a pacemaker or defibrillator), assign codes for both the underlying condition and the device. FPM

Send comments to **fpmedit@aafp.org,** or add your comments to the article online.

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EDITOR'S NOTE

Reviewed by the *FPM* Coding & Documentation Review Panel. Some payers may not agree with the advice given. Refer to current coding manuals and payer policies.