Internal Medicine Coding Alert

2 Scenarios Reinforce Your Modifier -Q5 and -Q6 Use

Ensure payment when the doc's out

When your internist takes Christmas vacation, how will you report the substitute physician's services? The key is knowing when and how to report modifiers -Q5 and -Q6.

Pick Between Reciprocal Billing and Locum Tenens

Reciprocal billing allows a physician to submit claims and receive Medicare payments when he has arranged for a substitute physician's services. To report this arrangement, attach -Q5 (Service furnished by a substitute physician under a reciprocal billing arrangement).

Locum tenens also allows the physician to receive payment for services another physician performs, but a locum tenens physician cannot work for another practice, and your physician cannot restrict the locum's services to your office. Also, the physician pays a locum on a per-diem or fee-for-time basis, says **Jean Acevedo, CPC, LHRM**, senior consultant, Acevedo Consulting Inc., Delray Beach, Fla.

When a locum performs a service or procedure, attach modifier -Q6 (Service furnished by a locum tenens physician) to the appropriate code.

Take a look at two locum tenens scenarios and the expert coding advice that follows to help you apply the -Q modifiers correctly:

Scenario One: Your practice hires a locum tenens internist for 90 days while your practice searches for candidates to fill a vacant position. The locum physician repairs a complex, 2.0-cm laceration on a patient's chest (13100, Repair, complex, trunk; 1.1 cm to 2.5 cm) and removes a 0.5-cm lesion (11400, Excision, benign lesion including margins, except skin tag [unless listed elsewhere], trunk, arms or legs; excised diameter 0.5 cm or less) on the same patient on the same day.

Coding Advice: Many internal medicine coders and internists mistakenly believe a practice cannot hire a locum physician or use modifier -Q6 for a locum's services if the substitute physician works for an internist who has left the practice.

But you could attach modifier -Q6 to 13100, although you would not report 11400 separately, which the National Correct Coding Initiative, version 9.0, bundles into 13100. By attaching -Q6, you tell Medicare that it should pay your physician for the locum's laceration repair.

Medicare, however, doesn't allow you to use modifier -Q6 if the locum physician performed the procedure after his or her 60th day working for your practice, Acevedo says.

Therefore, if the locum administered the complex repair (13100) on the 61st day of service, you could not use -Q6. If, on the 60th day, the locum performed the excision (11400) but performed the repair two days later, you could appropriately attach modifier -Q6 to 11400.

Scenario Two: While on vacation, the internist in your group practice arranges for another internist in the same practice to see a patient for asthma management. The substitute physician performs an office consult (99244, ... for a new or established patient) and an allergy injection (95115, Professional services for allergen immunotherapy not including

provision of allergenic extracts; single injection).

You report 95115-Q5, which means the substitute internist performed the injection under a reciprocal agreement. You don't list 99244 because you believe you can't report E/M services with 95115. Your billing specialist submits the claim under the practice's group number.

Coding Advice: The Medicare carrier will probably deny your claim because you cannot use reciprocal billing arrangements for services or procedures that a member of the same group provides.

CMS rules state that it reimburses only for reciprocal billing agreements made among independent physicians who bill under their own names.

Therefore, you would submit 95115, linking diagnosis code 477.x (Allergic rhinitis) as medical justification. Also, you may be able to bill for 99244.

To help support the medical necessity of the office consult, consider linking a different diagnosis code to the office visit than you used for the injection, says **Karen Jernigan, CPC, CMIS**, office manager at the Asthma, Allergy, and Immunology Clinic LLC in James Island, S.C. For example, link V58.69 (Long-term [current] use of other medications) and 493.xx (Asthma) to 99244.

Also attach modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to 99244 or Medicare will deny your claim, says **Deborah Grider, CPC, CPC-H, CCS-P, CCP**, president of Medical Professionals Inc. in Indianapolis.

If, however, your internist works in a group practice that submits your physician's claims under his or her provider identification number (PIN), not the group number, you may use modifier -Q5 for reciprocal billing arrangements. That's because Medicare considers physicians who bill under their names to be "independent" of the group practice in reciprocal billing agreements, the MCM states.