CODING Q&A

S Codes (S9088 and S9083) in Urgent Care

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The urgent care practitioner may not live by coding alone, but proper reimbursement depends on it. To that end, Dr. David Stern, a certified coder who is in great demand as a speaker and consultant on coding in urgent care, will offer answers to commonly asked questions in every issue of *JUCM*.

In this issue, he delves into the sometimes confusing realm of the S codes.

Q. What is an S code?

A. S codes are a set of Healthcare Common Procedure Coding System (HCPCS) codes that were originally requested by Blue Cross/Blue Shield. The codes are listed by the Centers for Medicaid & Medicare Services (CMS), but they *are never for use on claims filed to Medicare*.

Q. Does anyone besides Blue Cross and Blue Shield pay on S codes?

A. Yes, many payors and agencies (including managed care organizations [MCOs] and state workers compensation boards) have found these codes useful for defining specific services that are neither recognized nor reimbursed by Medicare or Medicaid.

S9083: Global Fee for Urgent Care Centers

Q. What is S9083?

A. This is used by payors to bundle all services rendered in an urgent care visit—whether it be for a hangnail or a heart attack—into a single, one-size-fits-all global code for reimbursement with the same single flat-rate fee. Many MCOs in several states (e.g., Florida, California and Arizona) use this case-rate method to reimburse for urgent care visits. Urgent care administrators should point out to the MCOs that this case-rate reimbursement generally means that the urgent care center can take care of only minor ailments profitably.

"Case-rate coding may force an urgent care center to send higher acuity cases to a hospital emergency department."

Case-rate coding works well for clinics that are equipped only to care for minor illnesses and injuries, such as colds, insect bites, and minor bruises. Many urgent care centers, however, are equipped to take care of many moderate acuity injuries and illnesses (e.g., dehydration requiring intravenous fluids, fractures, complicated lacerations, corneal rust rings, and others). Urgent care centers should make it clear to the MCO that using case-rate coding may end up forcing an urgent care center to send higher acuity cases to a hospital emergency department, where total fees will be up to 10 times more than if those same services were rendered in the urgent care center.

Q. What should I do if the MCO insists on using S9083 for urgent care visits?

A. Whenever possible, the urgent care center should work with the MCO to show that it is in everyone's best interest to pay for services rendered, rather than resort to one-size-fits-all reimbursement. Some visits take 20 minutes of work; others take three hours of work. But if the MCO insists on only paying for 20 minutes worth of work, then the urgent care provider will need to refer more complicated cases to other

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providers in order to avoid financial losses.

If the MCO insists on case-rate coding, explain that you can save them the cost of ED and specialist referrals by taking x-rays, treating complex lacerations, and caring for simple fractures. Specify that in order to provide these services, however, you will need a modification to case-rate coding. You will want to negotiate a list of "carve-out" codes that the MCO will allow you to use for reimbursement, in addition to the flat-rate code of S9083. Without carve-outs, you will lose money on any complex care, so you will be forced to refer:

- anything more than simple lacerations to specialists
- even finger tuft fractures to orthopedic surgeons
- any complex care such as IV hydration or other work up to the hospital ED.

This extra care will cost the MCO thousands of dollars for every referral. Suggest that certain codes be carved out (at an appropriate fee schedule) and billed in addition to the S9083. Try to get the MCO to realize that without carve-outs, a flat-rate billing structure will not allow the urgent care center to provide one of its major benefits to the MCO and its clients—namely, reducing the inconvenience and expense of hospital emergency department visits.

Q. When should I use S9083?

A. Use this code only when you are required to use this code. An MCO contract may require just that; if so, make sure that you negotiate carve-outs (or an acceptable case-rate) prior to signing the contract. A few Medicaid payors insist that urgent care providers use this code. In Delaware, for example, freestanding emergency departments (high-level urgent care centers that are equipped to handle all medical emergencies that have life-threatening potential) are required to bill S9083 and receive the exact same reimbursement for any and all visits billed to Medicaid clients through an MCO.

S9088: Services Provided in an Urgent Care Center

Q. What is S9088?

A. Some payors recognize that the services rendered in true urgent care centers cost significantly more than the services that are rendered in traditional primary care physician offices. Thus, this is an "add-on" code to allow urgent care centers to be reimbursed for at least a portion of this increased cost of rendering service.

Q. Who can use this code?

A. Any urgent care center can use this code. An urgent care center, as defined by UCAOA, is an ambulatory medical clinic (with x-ray and CLIA-waved lab testing) that is open to the public for walk-in, unscheduled visits during all open hours and offering significant extended hours, which may include evenings, weekends, and holidays. Some payors may have more specific requirements, including ACLS certified personnel, crash cart with specific supplies, on-site inspections, and others. The State of Colorado has made specific, fairly stringent regulations for an urgent care center to qualify to bill this code for workers compensation cases, and other states may follow suit.

Q. When does S9088 apply?

A. Your urgent care center can use this code for all unscheduled, walk-in visits to the urgent care center.

Q. Can I add this code to codes for other services?

A. Yes. This is an "add-on" code. Unless restricted by contract or regulations, you should add this code to any and all other billed codes.

Q. How much will payors reimburse for S9088?

A. Reimbursement for S9088 is quite variable, ranging from no reimbursement up to $100. Never use this code for Medicare or Medicaid. The fee schedule for workers compensation in Colorado stipulates $75 reimbursement for this code.

Q. Many payors deny this code, so isn't it a waste of time?

A. Many payors deny it, but many will pay on it. It still makes sense to bill the code. Some payors will see the light and begin to pay on the code. Keep track of those that continue to not pay, and make sure that you include payment for this code the next time you negotiate a contract with this payor.

Remember, delivering good, quality urgent care services costs more than delivering scheduled primary care services. Your services are worth it. ■

TAKE-HOME POINTS

- Never use S codes on claims filed to Medicare.
- S9083 is used by payors to bundle all services rendered into a global code for reimbursement with a flat-rate fee.
- Negotiate carve-outs with payors that require you to use S9083.
- S9088 allows urgent care centers to be reimbursed for their higher cost of rendering services.
- S9088 is an "add-on" code that can be used for all unscheduled, walk-in visits.