CODING Q&A

How to Define a Type B ED—and Other Vexing Questions

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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 addresses a potpourri of issues raised by urgent care practitioners.

Q. A consultant tells us that we have to use the new codes for type B emergency departments. We are owned by the hospital, but are off campus and do not advertise ourselves to be an emergency department. Are we a type B emergency department?

A. There has been a lot of confusion about type B emergency departments this year. Some consultants have been telling urgent care administrators that they are a hospital-owned urgent care center, so they are a type B emergency department. Simply being hospital owned, however, is not adequate to meet the specific criteria outlined by the Centers for Medicare & Medicaid Services (CMS).

To be a type B emergency department, your center must meet one of the following criteria:

- It is licensed by the state in which it is located under applicable state law as an emergency room or emergency department. *[Unless your center is licensed as an emergency department, this does not apply.]*
- It is held out to the public by name, posted signs, advertising, or other means as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment. *[Rarely does an urgent care clinic hold itself out to the public as treating "emergency conditions." Rather, almost all urgent care centers tell the public specifically that their centers are not appropriate for evaluating or treating true emergency conditions. Instead, most urgent care centers tell the public to go to a hospital emergency department or to call 911 if the problem is thought to be a true emergency.]*
- During the calendar year immediately preceding the calendar year in which a determination under this section is being made based on a representative sample of patient visits that occurred, at least one-third of all outpatient visits to the urgent care center are for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment. *[Very, very few urgent care centers treat over one-third of their patients for true emergency conditions. Some hospital emergency departments may not even meet this criterion.]*

Very few urgent care centers will meet any of the above three requirements, and thus they should not be classified as type B emergency departments.

Some confusion may arise from the third criterion. There are three parts, however, to this final criterion, and your center must meet the definition in *all three parts* (not just one or two parts) to qualify as a type B emergency department. So, if we evaluate all three parts, the question is this: Are over 1/3 of the visits to your center:

- on an urgent basis
- without appointment
- *and* for treating emergency medical conditions?

Many urgent care centers may answer "yes" to the first two components, but for the majority of true urgent care centers, the answer to the last question is almost always "no." Hence, they do not qualify as type B emergency departments.

Q. We frequently remove cerumen from the ears of patients in our urgent care center. We use different methods for removing the cerumen, including irriga-

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tion, spoon, loop, or forceps.

When can I use CPT code 69210, "Removal impacted cerumen (separate procedure), one or both ears"?

A. CMS limits the use of 69210 for cerumen removal to visits that meet *all* of the following criteria:

- Cerumen removal is the only reason for the visit.
- Cerumen removal is personally performed by a physician or midlevel provider.
- The patient is suffering symptoms from excess cerumen.
- Removal requires more than drops, cotton swabs, and cerumen spoon.
- Chart documentation shows that the procedure required significant time and effort.

CPT, however, does not specify what method is used for cerumen removal, and many payors use different guidelines for coding for cerumen removal. You may want to check with individual payors to determine their policies for using this code.

Q. What code should I use for destruction of plantar warts or molluscum contagiosum?

A. The codes for lesion destruction have been changed for 2007. You should now use CPT codes 17110 and 17111 for destruction of common or plantar warts. These codes—17110 and 17111—have been revised to include destruction of benign lesions other than skin tags or cutaneous vascular lesions. Codes 17000 and 17003 now exclude destruction of benign lesions.

Q. How should I code for a fracture of the distil radius that includes a fracture of the ulnar styloid?

A. A 2007 revision to CPT code 25600 for closed treatment of a distal radial fracture now states that this code "includes closed treatment of fracture of ulnar styloid, when performed." Thus, both fractures are bundled into the same code (25600).

Q. Allergists sometimes send patients to us for allergy shots. If we give two allergy shots to a patient on the same day, should I add code 95117 to 95115 or should I use just 95117?

A. Use CPT code 95115 for a single injection on a given date. If you administer more than one allergy injection (two, three, or even 10 allergy injections) on a single date, then code only a single code 95117.

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