Readers' Coding Inquiries

DAVID STERN, MD, CPC

Q. I had a patient who presented with a hydrofluoric acid burn to the fingertips—right hand worse than left.

First I had to acquire some calcium gluconate gel. I applied this to all of his fingertips for 30 minutes, and it helped a little. I proceeded with a modified bier block with calcium gluconate. I applied a BP cuff tourniquet to his arm, and then injected Ca gluconate intravenously. The blood pressure cuff remained fully inflated for 20 minutes. He remained on an ECG monitor during this procedure. This reduced his swelling and decreased his pain some, but not completely.

I sent him home with his hands in latex gloves holding Ca gluconate paste over all his fingertips, and I will see him again tomorrow.

How would you code this visit?

- Question submitted by Marshall Plotka, MD, Phoenix Emergency Care

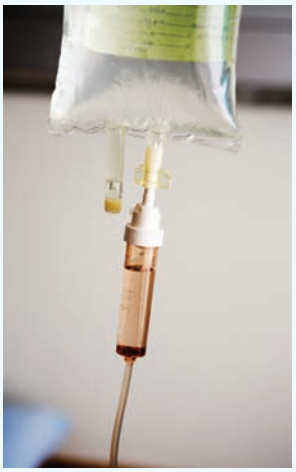
A. This is a great coding conundrum, and a classic case in which correct coding can maximize revenue.

Here are some ideas for coding this visit:

Ca gluconate paste application and dressing: One cannot use the code for treatment of a first-degree burn (16000), as this code is specifically limited to situations in which "no more than local treatment is needed." (Note: If you do perform repeat dressings, you could code future visits with 16000.) The appropriate code in this case, however, is 17999 (unlisted procedure, skin, mucous membrane and subcutaneous tissue).

When billing an "unlisted procedure," make sure that you include documentation of the procedure, time spent, and any difficulties or complications. You could price this code similarly to your fee for 16000.

David Stern is a partner in Physicians Immediate Care, with nine urgent care centers in Illinois and Oklahoma, and chief executive officer of Practice Velocity (www.practicevelocity.com), a provider of charting, coding and billing software for urgent care. He may be contacted at *dstern@practicevelocity.com*.



IV drug push: Code with 90774 (therapeutic, prophylactic, or diagnostic injection—specify substance or drug); intravenous push, single or initial substance/drug).

Ca gluconate IV: Code with J0610 (calcium gluconate, up to 10 ml); code once for each 10 ml or fraction of 10 ml.

Bier block: Code with 64999 (unlisted procedure, nerve). CPT 2007 has been revised to state, "When regional intravenous administration of local anesthetic agent or other medication in the upper or lower extremity is used as the anesthetic for a surgical procedure, report the appropriate anesthesia code. To report a Bier block for pain management, use 64999."

Again, when billing an "unlisted procedure," make sure to include documentation of the procedure, time spent, and any difficulties or complications. Note: Fees across the country seem to range from $180 to $230.

E/M: Document and code the appropriate evaluation and management (E/M) code (99201-99215). If more than half of your time involves counseling the patient about the treatment and prognosis, you may consider time as the determining factor in determining the appropriate E/M code.

This is particularly appropriate in the setting of worker compensation claims, as you will need to investigate and document the circumstances of the injury, determine if the patient is predisposed to complications due to factors such as diabetes or smoking, evaluate the viability of the extremity, discuss your findings and recommendations with the workplace, and spend a significant amount of time reviewing the prognosis and treatment of the injury with the patient.

Don't forget to add modifier 25 to the E/M code, as you have performed a procedure along with the E/M code.

EKG monitoring: Code with 93040. Make sure that you document your reading(s) and include a sample tracing in the medical record.

Q. We recently saw a patient for severe constipation. The physician performed a manual fecal disimpaction—a time-intensive procedure. I looked for a code to charge out for the procedure, but all I could find was an anesthesia code for the procedure. Is there a code for the actual procedure? I would hate to think the doctor did this for free.

- Question submitted by Jennifer Halloway, Physicians Immediate Care

A. There is no specific code for a manual fecal disimpaction. The Centers for Medicare & Medicaid Services (CMS) considers the procedure, although sometimes necessary and always quite time-intensive, to be bundled into the evaluation and management code. However, there are codes for much less time-intensive procedures, such as intramuscular injections.

If you want to try creative billing for the procedure (only for payors not directly regulated by CMS), you could code 45999 (unlisted procedure, rectum) along with a doctor's procedure note describing the procedure, difficulties, and time spent. The payor may consider it and pay, but don't hold your breath.

Q. Am I correct in billing with a place of service (POS) 20 for an urgent care setting? I have heard that in Texas we should bill with a POS 11.

- Question submitted by Celeste Ladyman, Valley Urgent Care

A. The answer really depends on the payor that you are billing and how the payor has set you up in its software.

If you are contracted with a managed care organization as an urgent care center, it may require you to use POS 20; claims filed with POS 11 may be rejected.

Payors with whom you have contracted as a family practice may reject claims filed with POS 20.

The key is finding what each payor requires, but there is no blanket answer for any state or even by payor, as there may be many contracts, even for the same payor. What is really frustrating is that sometimes urgent care centers find that they ask the payor which POS to use and the provider representative gives them the wrong answer.

"In most states, NPs should be able to see and bill for new patients."

Q. As a nurse practitioner, I have been seeing Medicare patients for the past year or so and I have never received a Medicare UPIN number. If we are to follow the guidelines set by Medicare, is it legal to bill Medicare for my services since I am a nurse practitioner and am supposedly not allowed to see new patients? They have never explained this to me. Is there a special rule for urgent care?

- Name withheld by request

A. Unless there are specific regulations to the contrary in your state, nurse practitioners should be allowed to see new patients and bill under their own number, but never under the supervising physician number.

An exception occurs when the chart demonstrates that the physician physically examined and designed a treatment plan for the patient. Then the visit may be billed under the physician number. In the situation that you describe, however, there is no compliant method to bill Medicare visits.

Established patients seen under the incident-to requirements of CMS (a very rare occurrence in most urgent care centers) may be billed under the physician number. All other established patient visits (those that do not meet incident-to requirements) should be billed under the nurse practitioner's number.

Note: As of September 30, 2007, National Provider Identifier (NPI) should be used instead of the UPIN to bill for services rendered. ■

Have a coding question?

Send it to us at editor@jucm.com. We will compile relevant queries and forward them to Dr. Stern to be addressed in upcoming issues of *JUCM, The Journal of Urgent Care Medicine*. Please include your name and practice affiliation.