CODING Q&A

Addressing Problem-based Coding and Other Challenges

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Q. We are a fairly new urgent care center and could use some help on E/M coding. I have read on various urgent care websites that we can bill each visit as a new patient visit (as long as it isn't a follow-up to an existing problem). Can you please give me some direction on where I can find this information?

A. What you are referring to is "problem-based coding." Never code in this way unless you have clearly communicated with the payor about this method. Problem-based coding is one way for urgent care centers to receive appropriate compensation for the additional expenses incurred in providing urgent care services. You can access an article on this subject at: *http://www.ucaoa.org/info/resources.html* (click on "problem-based coding").

Q. We are starting an urgent care clinic. Should we bill using place-of-service (POS) -11 (office) or POS-20 (urgent care facility)?

A. In this situation, CMS defines an *office* as "[a] location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis."

An *urgent care facility* is defined as "[a] location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention."

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Of course, if you are operating a facility that would meet the UCAOA definition of an urgent care center, then POS-20 would be the most accurate code to use.

In coding, there is a general rule to use the most accurate code to describe the services rendered. In the case of place-of-service codes, another common rule comes into play. This rule is what I sometimes jokingly refer to as the "make-sure-that-you-give-the-payors-what-they-want" rule. Some payors will refuse to pay on the POS-20 code. Others may have their computers set up to only accept POS-20 from your center.

In some cases, payors will accept either code. Some payors may use POS-20 to trigger a rule to allow problem-based coding. Others never allow problem-based coding. For Medicare, each fiscal intermediary is different—some require POS-20 and others want you to use POS-11. You must determine the preference of your fiscal intermediary, or your claims will be denied. Some payors cannot tell you which code you should use, but they will deny any claims submitted from your center with POS-11.

This has been a source of 100% denials for at least one urgent care center in dealing with one particular payor. The payor was unable to tell the urgent care center what the reason was for the denials. After six months of having every single claim denied, the urgent care center tried using POS-20; and, *voila*, suddenly rejections ceased and their claims were processed and paid.

So, you can see some payors may not even be aware of their own software rules for place-of-service codes for your urgent care center.

Q. We saw a patient for bronchopneumonia and the physician removed an ear wax impaction on the same visit. We coded a 99213 (level 3 E/M code), 69210 (removal impacted cerumen), and 71020 (two-view chest radiograph). Payment for the E/M code was denied. Why?

A. Code 69210 should have been attached to the diagnosis for impacted cerumen (380.4) and the chest radi-

ograph code should have been attached to the code for bronchopneumonia (485).

The E/M should have been attached to the ICD-9 code for bronchopneumonia (485), with or without the code for impacted cerumen (380.4). The E/M code should have been modified with modifier -25.

Generally, this coding should result in payment, because these codes do not have work components that overlap. Assuming that you coded as noted, however, your payor may have expected modifier -59 on some of the services to indicate that these services were distinct procedural services.

As always, the coding consultant caveat applies, "Check with the payor to understand the payor requirements."

Q. Patients sometimes mistakenly use our urgent care center for visits that are true emergencies, such as myocardial infarctions. In those cases, we are equipped to provide oxygen therapy to the patients. What is the code for administering oxygen in our urgent care center?

A. In the hospital setting, reimbursement for these types of expenses is included in reimbursement for the facility code. All codes for physician services in the office setting, however, include a component to include practice expenses. That is generally why facility codes are not billed in addition to other codes for services rendered in an urgent care center.

Among other items generally included as bundled into practice expenses are syringes, dressings, drapes, and surgical trays and syringes. Many payors are coming to recognize that true urgent care centers do incur expenses that are above and beyond the practice expenses incurred in simple physician office setting. Thus, many payors are reimbursing for these additional expenses by reimbursing physicians for the code S9088 (services rendered in an urgent care center).

Q. Our urgent care center saw a patient with a 2 cm laceration caused by contact with a grinder in a factory. The wound was grossly contaminated with grease and metal filings, so the physician removed the metal filings and performed extensive scrubbing and irrigation of the wound, and sutured the wound with a single-layer closure.

We submitted a claim coded with 12001 (simple repair of superficial wounds of scalp...and/or extremities...2.5 cm or less). Four days later, the doctor rechecked the wound and found it to be infected. The wound was reopened, irrigated clear of pus, and dressed. The patient returned daily for wound checks, packing, and redressing for three days.

Medicare denied payment for all rechecks. What can we do to get paid for these recheck visits?

"Check with the payor to understand the payor's requirements."

A. This wound repair code has a 10-day global period. Medicare defines the global period as covering all related services during the global period, with the exception of complications that require a visit to the operating room.

Under CPT rules as published by the AMA, however, "Postoperative complications, exacerbations, and recurrences are not included in the surgical package and should be reported separately. Postoperative complications include conditions such as wound dehiscence, infection, and bleeding." Thus, it is legitimate to bill payors for such complications.

Of course, some payors may choose to follow CMS guidelines in this situation and may refuse to reimburse you for services rendered to treat the complication. Make sure that you add a diagnosis code to indicate the specific complication when you are billing for services rendered to treat the complication.

One caveat applies to this specific situation: Because the initial closure of the wound involved extensive cleaning and removal of particulate matter, the wound closure should be coded as 12031 ("Layer closure of wounds of scalp...and/or extremities...2.5 cm or less").

Yes, even though the wound was not a "layer closure" and was closed with a single layer of sutures, AMA defines the "intermediate" wound closure codes to include, *"single layer closure...if the wound is heavily contaminated and requires extensive cleaning or removal of particulate matter."*

Now, aren't you glad that you read to the end of the column? That one point could pay for your annual subscription to *JUCM*. (OK, I know it is free, but even if they charged $500, this point would pay for itself.) ■