Choosing the Right Fee Schedule—and the Right Resource

DAVID STERN, MD, CPC

Q. My office has started to provide urgent care. Should these services be reimbursed at a higher price than for our family practice services? Is there a different fee schedule?

Question submitted by Nicole Phelps, First Health Medical, Fresno, CA

A. Here is the scoop on coding and reimbursement for urgent care:

- Some payors will pay more for urgent care services over primary care services, but you will almost certainly need to operate under a separate taxpayer identification number. You may need to negotiate and/or educate payors to get higher rates.
- Many payors will not pay more for urgent care (some may even want to pay less).
- Medicare will not pay more for urgent care.
- 99051: You may use this code for evening, weekend, and holiday reimbursement. Many payors do not pay. You may need to share with them the fact that you incur significant increased costs (in downtime and employees requiring higher wages) by operating during off-hours.
- S9088: You may add this code to existing codes for services that you provide in an urgent care center. Some payors will pay an additional amount. You may need to educate the payors as to the increased costs that you incur in rendering true urgent care services.
- Urgent care copay: If you bill as an urgent care center, some payors may require you to collect the copay for urgent care as listed on the insurance card. This copay may be substantially higher than the copay for a visit to a primary care physician. Payors use this higher copay as a disincentive for patients to utilize urgent care services.

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*.

Q. I am consulting with a hospital regarding coding practices at their hospital-owned urgent care centers. At issue is the use of the 1995 vs. the 1997 Centers for Medicare & Medicaid Services' Documentation Guidelines for E&M Services as a basis for E&M code selection and physician/non-physician practitioner documentation education.

The American College of Emergency Physicians strongly recommends the use of the 1995 guidelines for coding, as they are more beneficial to reimbursement in the emergency department setting. The providers who staff our urgent care centers also staff our ED. I would anticipate that at least some of the issues making the 1995 guidelines more advantageous would apply as well in the urgent care setting.

Even CMS clearly directs its carriers to conduct reviews using both the 1995 and the 1997 guidelines "(whichever is more advantageous to the physician)…." The hospital, however, is reluctant to consider using the 1995 guidelines.

I am wondering if the Urgent Care Association of America has an opinion on this issue. I have searched your website but cannot find anything of this nature. If UCAOA does have an opinion, I am sure it would be an important contribution to our local discussion.

Question submitted by Judith M. Carr, CPC, Optimum Physician Services Corp., Queensbury, NY

A. UCAOA does *not* have an official position on this coding issue. I suspect that this is because CMS has a clearly stated position (that the physician may use either '95 or '97 guidelines), and this position is widely accepted by virtually all payors. The physician is not even required to state which set of guidelines was used to code any particular visit, and CMS has clearly indicated that the physician may switch between 1995 and 1997 guidelines from chart to chart.

CODING Q & A

The 1997 guidelines have several problems:

- They are virtually impossible for a physician to master due to the scores of bulleted items that are only valid for certain types of exams (examples: musculoskeletal vs. eye vs. genitourinary, etc.)
- The 1997 guidelines generally work with specialized electronic medical records systems or with multiple pre-formatted templates that include the required bullets. It is virtually impossible to accurately extract the 1997 bullets from a dictated chart; if this extraction is done, physicians will invariably not document to appropriate levels due to the punctilious specificity of the bullets.
- When followed to the letter, the 1997 guidelines reduce revenue by making a truly compliant comprehensive exam virtually impossible in the real world of medical practice. When I fully explained what a comprehensive general multisystem exam entails as defined by the guidelines, one physician exclaimed, "Why, no doctor ever does all that!"

Using both sets of guidelines can bring improved revenue to urgent care centers. Thus, it makes sense to be aware that, for any given chart, the guidelines that you use may often make a significant difference in the final E/M code.

As a consultant, you are merely suggesting that the hospital follow accepted best practices. Since this hospital administration (on the advice of one or two well-meaning coders) is deviating from generally accepted practice, I would encourage you to ask the administration for a statement from some official organization that recommends that hospitals deviate from CMS's official position.

Q. How does one code for a one-view radiograph of the thoracolumbar spine? The code (72080) clearly states that it includes "two views." In the past, we marked the actual number of views and then appended modifier-52 (reduced services). Is this correct or is there another code that we should use?
Question submitted by Julie Gretchmann, Physicians Immediate Care, Rockford, IL

A. You have been coding correctly. Another way to code this would be using an "unlisted services" code. But this would require appending documentation, and reimbursement would be hit or miss, depending on the payor.

OCCUPATIONAL MEDICINE

- Reinforce patient service daily. It is far easier to design a patient service plan than to continuously maintain a genuine patient service ethic. Create constant reminders of your clinic's commitment to the highest standard of patient service. For example, use some form of the term "service" every time someone answers the phone (e.g., "Hello. Midtown Urgent Care. My name is Judy. How may we serve you today?")

Evaluation

Assessing your performance is paramount to a strong patient satisfaction program. Your clinic should:

- Embrace the "customer-driven" concept that relies on patients' input to garner ideas for additional protocols.
- Assess patient satisfaction daily.
- Send out a questionnaire to employer clients yearly.
- Conduct a quarterly telephone blitz with top clients.

Rewards and Recognition

Add a little fun in the form of rewards and recognition. Not only do rewards provide gratification to those doing a good job, but they keep the concept of exemplary patient service on the front burner. For example, a "patient service moment of the month" might be rewarded with a gift certificate for a local restaurant. The patient service employee of the year could be acknowledged with a reserved parking spot.

Outstanding patient service provides its own intrinsic daily reward: a sense of immediate gratification and satisfaction that you can see in your constituents' faces. Over-the-top customer service requires an ongoing, systematic, and proactive approach.

Sample Protocol: Handling a Disgruntled Patient

Inevitably, a patient will become upset and express open concern in the clinic. Clinic staff should follow these steps:

- Never show anger or contempt, no matter how irrational the behavior.
- Escort the angry patient to a quiet, neutral place.
- Ask the patient to thoroughly express their concern.
- Probe to acquire more details about the concern.
- Show empathy ("I can understand your concern, Mr. Dunn").
- Ask what you can do to "make things right." (Caution: never offer a solution; let the other individual propose one first.) If possible, quietly meet their request. Ask if they are satisfied with your resolution.
- Follow-up later, via e-mail, voicemail or letter, and express that you are sorry there was a problem and pleased that "we were able to work it out."

Remember, your biggest critic often becomes your greatest advocate if you are willing to go the extra mile. ■