
CODING Q&A

# Coding for Services Attempted But Not Completed, and Other Reader Queries

DAVID STERN, MD, CPC

**Q. I can't find any documentation that tells us specifically how we should code when a provider tries to remove a foreign body, but is not successful and decides that the patient should go to the ER. Do we just code for an office visit or do we also code for the removal of the foreign body since the provider did try, albeit unsuccessfully, and decided the patient needed to be seen at the hospital?**

– *Question submitted by both Nancy Wilkes, UCI Medical Affiliates, Columbia, SC and Alexis Adams, Louisiana Urgent Care, New Orleans, LA*

**A.** You may code both:

- the E/M (if one was documented and performed) with modifier -25
- and the procedure code (with a separate and identifiable procedure note) with modifier -53 (discontinued procedure).

A payor may discount the procedure because of the modifier, but you should bill out at full rate. Medicare does not reduce payment for CPT codes with modifier -53 appended.

Do not use modifier -53 for procedures that were planned but never actually performed.

Neither modifier -53 nor modifier -52 (reduced services) should ever be reported with an E/M service. Rather, you should report the actual level of service performed.

In the case of a patient visit for an emergency condition (under 1997 CMS E/M coding guidelines), if the physician is unable to take a full history because of the emergency nature of a visit (example: full review of systems was not performed because of emergency visit), you may indicate this reason for an incomplete history on the chart and take credit for a comprehensive history.

**David Stern** is a partner in Physicians Immediate Care and chief executive officer of Practice Velocity. Dr. Stern and Frank H. Leone, MBA, MPH, are scheduled to speak at a pair of half-day seminars, Urgent Care: 40 Ways to Increase Profitability, in Tampa and Boca Raton, FL July 25 and 26. For more information about the seminars, call Megan Montana at (800) 666-7926, extension 13. Dr. Stern may be contacted at *dstern@practicevelocity.com*.

Note: This only applies to the history part of the E/M documentation. On the physical exam, credit is given only for the actual exam elements and systems that were examined and documented on the chart. No credit should be given for any exam elements that were omitted because of the emergent nature of the visit. ■

**Q. Is it better to use add-on S9088 or the global code S9083 for urgent care at a primary care facility with extended hours for walk-in patients?**

– *Question submitted by Susan Nation, Camp Creek Urgent and Family Care Center, Atlanta, GA*

**A.** First: These codes are *only for true urgent care centers*. They should not be used by primary care offices that operate extended hours where they take walk-in patients. Abuse of these codes by practices that do not operate true urgent care centers (defined as those that provide significant extended hours, advertise themselves as providing services to the public on a walk-in basis, have x-ray on site and allow walk-in visits during all open hours) creates problems for everyone in the industry.

Second: You will need to use the proper codes, *based on your contracts with third-party payors*:

- Use S9083 if you have flat-rate per visit contracts.
- Use S9088 if a specific payor agrees to reimburse this code.
- Never use either code for Medicare. ■

**Q. We are a urology practice that offers daily "on call" services in which patients can be seen on an urgent basis. What are the requirements of being able to bill as an "urgent care" center and/or state licensing requirements?**

– *Question submitted by Patricia Williams, Urological Associates, Davenport, IA*

**A.** You would qualify as an urgent care if:

- your office advertises walk-in services to the public
- your office operates a center that offers walk-in care to patients at all times that you are open

- you operate x-ray on site
- you offer all basic CLIA-waved labs (urinalysis, *Strep* screen, rapid flu, urine pregnancy, etc.)
- *and* you offer significant hours beyond 9-5 (Monday through Friday).

If you meet all of these criteria, you may qualify for using the POS -20 and for using the only two codes (S9088 and S9083) that are unique to urgent care.

However, if you simply offer walk-in services to a small number of patients each day, this would simply be a case of open scheduling, as seeing a few walk-in patients each day is typical for physician offices. It would not make a physician office an urgent care center.

State licensing is required for urgent care centers in Arizona, but licensing is not required (or even available) in most other states. ■

**Q. In a recent column, you stated that CMS allows one to "double dip" with the HPI and ROS. Where does CMS state that one can count the same item in both the history of present illness (HPI) section and the review-of-system (ROS) section?**

– *Question submitted by Alex Trimpe, St. Vincent Health, Carmel, IN*

A. The traditional interpretation that one may count an item of history in both the HPI and ROS was documented in 1997 in a letter from the chief medical officer of the Department of Health and Human Services. You can read the letter on this website: *www.ercoder.com/Downloads/CMS%20letters%20re%20HPI-ROS.pdf.*

Even though CMS has not released any official statement changing this position, the issue is still not fully settled. This issue remains confusing because many, often contradictory, oral statements on the issue have been made by officials of CMS and individual carriers; it has become very carrier-specific.

Some carriers are using the previous method and giving physicians credit as described.

Some carriers seem to be requiring "further development" (whatever that means) in order to count in the ROS.

The payors, however, do seem to read *JUCM*. Since the *JUCM* column you cite was published (October 2006, available at *www.jucm.com/2006-oct/coding.shtml*), one carrier—Trailblazer, in Virginia, Maryland, Delaware, Texas, and Washington, DC—has noted in an audio conference that it will not allow this type of "double dipping" (see Trailblazer Audit Template for E/M, available at *www.ouhsc.edu/bc/WatchingtheNews.asp*). ■

**Q. Is it compliant for our urgent care center to code as a facility with place-of-service (POS) -22 to Medicare and as non-facility POS -11 to commercial carriers? Note: Our urgent care center is operated on a hospital campus, so it is fully compliant for us to code the POS -22. Can you define the place of service, depending upon the carrier?**

**You are probably wondering why anyone would do that. Bluntly, to maximize reimbursement from Medicare while remaining competitive with commercial payors and other free-standing urgent cares. My gut says, "No," but I have searched the Medicare website and did not come up with an answer. Is there a specific OIC or CMS ruling on this issue?**

– ***Name withheld, Idaho***

A. I do think that your "gut" feeling is probably correct. I am unaware of any specific ruling on this specific POS coding method, but I suspect that an enterprising OIG investigator might deem it as violating CMS rules. The reasoning might be that you are billing in such a way to cause Medicare to pay more than other payors for the same service.

CMS has a most-favored-nation status for billings to Medicare, i.e., you may not bill Medicare more than you bill other payors. The specific regulations, interpreting Section 1128(b)(6)(A) of the Social Security Act, are available at *http://edocket.access.gpo.gov/2007/E7-11663.htm*.

They state, in part, that the OIG may exclude an individual or entity that has "[s]ubmitted, or caused to be submitted, bills or requests for payments under Medicare or any of the State health care programs *containing charges or costs for items or services furnished that are substantially in excess of such individual's or entity's usual charges* or costs for such items or services."

One can infer the intent of the existing rule from the OIG statement in the preamble to the September 15, 2003 proposed (but not implemented) rule: "When market forces cause a provider's usual charge to most of its customers to drop substantially below the Medicare fee schedule allowance, some providers continue to charge Medicare at least the fee schedule amount. In this situation, *the provider creates a two-tier pricing structure with Medicare paying more than other customers.* Unless the price differential can be justified by costs that are uniquely associated with the Medicare program, the provider is simply overcharging Medicare. In such circumstances, section 1128(b)(6)(A) of *the Act obligates providers to either charge Medicare and Medicaid approximately the same amount as they usually charge their other purchasers for the same items or services or risk exclusion from all Federal health care programs*."

This statement would seem to ban the POS coding method that you describe. After releasing this proposed rule for feedback, however, the OIG decided not to implement this rule. Thus, we are left without a clear ruling on the subject. ■