Coding Symptoms of Infections, Modifiers for X-rays, and Counseling Family Members

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Q. Our doctor saw a patient for a sore throat. The rapid strep screen was positive, so she placed the following diagnoses on the chart:

- **034.0: Streptococcal sore throat**
- **780.61: Fever presenting with conditions classified elsewhere**
- **784.1: Throat pain**
- **780.79: Other malaise and fatigue**

I told her that since we had a specific infection that was the cause of second, third, and fourth diagnoses, we should code the confirmed infection, but not the sore throat. She said that she was addressing each symptom in her plan (for example, acetaminophen for the pain and fever and rest for the malaise), so it was appropriate to code the symptoms as well as the diagnoses. Who is right?

Question submitted by Jenni Rosenbalm, CPC, PV Billing

A. You are right. In general, the physician should code symptoms when the underlying diagnosis that is causing the symptom has *not* yet been determined.

In your example above, the second diagnosis (780.61: "fever presenting with conditions classified elsewhere") does seem to be correct at first glance, since strep throat is a "condition classified elsewhere." When you look at the specific definition of the code, however, this code specifically *excludes*:

- [fever as an] effect of heat and light
- [fever] associated with a confirmed infection.

Rather, this code is for use with conditions that are frequently associated with fever but are not the specific cause of the fever. Often, there is an associated and presumed infection, but there is not yet a specific "confirmed infection." These conditions "classified elsewhere" include neutropenia, leukemia and sickle-cell disease.

Q. We do x-rays at our urgent care and would like to know if there are different modifiers for the procedures that we do in the office. Could you provide me with a list of modifiers used with x-rays?

Question submitted by Michelle, Defiance Family Physicians

A. Modifiers for x-rays are not unique to the urgent care setting. Commonly used modifiers for x-ray procedures in the urgent care setting include:

- **-R: right**—Use this modifier for a film series performed on the right side of the body.
- **-L: left**—Use this modifier for a film series performed on the left side of the body.
- **-TC: technical component**—Use this modifier when coding only for performing the technological procedure of taking the x-ray; the physician reading is not included in the code.
- **-26: professional component**—Use this modifier when coding only for the physician reading; performing the technological procedure of taking the x-ray is not included in the code.
- **-52: reduced services**—Use when performing fewer views than the code stipulates. For example, you use modifier -52 when performing a single-view ankle x-ray and the lowest number of views for an ankle x-ray

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listed in CPT is for 73600 (radiologic examination, ankle; two views).

- **-76: repeat procedure by same physician**—Use this modifier when you perform the same film series on the same day. Examples include films retaken after fracture reduction, after foreign body removal, etc.

Q. I have a question about a Medicare patient. The patient's daughter came in alone to discuss her mother's care with the physician, and we're not sure how to bill it because the G codes for Medicare don't cover this. Any suggestions?

Question submitted by Tiffany, San Antonio Urgent Care

A. I don't believe that there is any method (reimbursable by Medicare) to code for discussions with the family of a patient, when the patient is not physically present. Medicare recognizes time a physician spends counseling a family member and/or other care decision maker only if the patient is present. The physician cannot count any time for counseling when the patient is not physically present in the room.

Medicare makes only one exception to this requirement, and this exception is rarely applicable to the urgent care situation.

When, and only when, a physician is providing critical care to a patient, the physician time involved in obtaining a history or discussing treatment options with family members or other surrogate decision-makers may be counted toward critical care time, and only when the chart documents all of the following:

1. that the patient is unable or incompetent to participate in giving a history and/or making treatment decisions;
2. that the discussion is absolutely necessary for treatment decisions under consideration that day; and
3. the treatment decisions for which the discussion was needed; and
4. the substance of the discussion as related to the treatment decision.

Sorry that I don't have a better answer on this one, but we continue to wish you great success in your clinic. ■

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mentality candidates should be peppered with appropriate testimonials.

- *Create a knockout reference list.* Develop a broad client reference list to share with prospects at just the right time. Typically, occupational health salespeople provide a prospect with three or four references. This does little to inspire confidence or create a sense of differentiation from other programs; who couldn't come up with a list of three or four friendly users?

  Venture well beyond the norm by listing as many references as you can. If you have 400 clients dating back to 1985, list them by industry type. The thinking is to let the prospect know that you have an exceptionally broad client history, which in turn suggests a "400-plus programs can't all be wrong" sense of confidence.

  Develop this list by formally asking employers if you can use their company name as a reference during an annual client survey. Rotate the order of references so the names at the top are not "bothered" too often.

  Remember, the herd mentality kicks in when the defensively minded prospect feels that he cannot afford *not* to use the market leader.

Market Challenger Strategies

Most markets also have numerous market challengers who offer viable services, but do not possess a plurality of market share. If you represent such an urgent care occupational health program, you should embrace herd mentality selling as well—but with a different emphasis.

Whereas the core strategy for the market leader is to mention being number one at every turn, the inherent strategy for the market challenger is to emphasize market share growth and industry-specific expertise. If the market leader's basic recurrent message is, "Come with us, we are the leaders, and the bulk of your fellow employers can't be wrong," then the inherent message from the market challenger should be, "Come with us, for many of your fellow employers have done so recently, so we must be the best choice."

Indeed, you receive bonus points in this instance; not only will the herd mentality prospect view your program favorably because of this momentum, but they are likely to view the (unnamed) market leader *less* favorably because of presumed client attrition.

In sum, a significant number of your prospects buy defensively and are easily swayed to a safe course of working with the market leader. Market *leaders* must realize this mindset and take full advantage of it. Market *challengers* can also capitalize on the herd mentality mindset by selectively citing their successes.

In both cases, a far more aggressive approach than is typical is recommended. ■