CODING Q&A

Coding for Observation, and More on Established vs. New Patients

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Q. Is it possible for observation status codes (99217-99220) to be billed in an urgent care facility?

– Question submitted by Andrea Manfredi-Rivera, CCS-P, Staten Island Physician Practice

A. Observation codes will require the point of service (POS) to be a hospital. If your urgent care is operated by a hospital and you can legitimately use a hospital POS, then you may be able to use these codes. If you use the physician office (POS -11) or urgent care (POS -20) place-of-service codes, then you could not use these codes compliantly.

With these types of issues, however, there is always one caveat. If, for some reason, you find that your center is positioned such that you frequently provide (or would be able to provide) observation status for patients that would otherwise receive hospital admission or hospital observation, then using observation services in your urgent care (instead of the hospital) could significantly reduce costs to payors. If this is the case, you may want to consider going directly to the payors, educating them as to the value to them for patient satisfaction and cost reduction. If they are convinced, then they may be willing to sign a contract addendum that allows you to bill for observation from POS -11 or POS -20.

Q. Is there another way (in addition to the E/M code) to code for prolonged observation or treatment of a patient in the urgent care setting?

A. Yes. Prolonged observation in the urgent care setting can be coded with the following codes:

- 99354: Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (e.g., prolonged care and treatment of an acute asthmatic patient in an outpatient setting); first hour (list separately, in addition to the code for office or other outpatient Evaluation and Management service)
- 99355: Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (e.g., prolonged care and treatment of an acute asthmatic patient in an outpatient setting); each additional 30 minutes (list separately in addition to code for prolonged physician service)

It is important to note that these codes require the provider to be "face-to-face" for the entire time that is used for calculating the proper code.

For example, code 99354 can be used if the physician spends 45 minutes in the room caring for a very ill patient. Do not, however, use these codes simply to code for time that the patient ties up a room while getting nebulizer treatments or hydration therapy.

In the urgent care setting, it is very rare for the physician to spend this amount of time in "face-to-face" contact with the patient. Thus, it is very rare that these codes would be appropriate in the urgent care setting.

Q. Can an urgent care facility do away with the established patient codes and just use new patient codes all the time, since the patient will more than likely not see the same provider at the urgent care?

– Question submitted anonymously by e-mail.

A. You make an interesting suggestion, but this would not be a compliant method for coding. Instead, you would have to make sure that any physician(s) who saw the patient in the last three years in your practice was actually of a different specialty than the specific physician who is seeing the patient for today's visit. If the patient had not received services from a physician of that specific specialty, then it would be compliant to code a new patient E/M code.

David E. Stern, MD, CPC is a certified professional coder. He is a partner in Physicians Immediate Care, operating 12 urgent care centers in Oklahoma and Illinois. Stern serves on the Board of Directors of the Urgent Care Association of America and speaks frequently at urgent care conferences. He is CEO of Practice Velocity (*www.practicevelocity.com*), providing urgent care software solutions to more than 500 urgent care centers. He welcomes your questions about coding in urgent care.

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Since tracking the actual specialties of physicians performing the services for each and every visit involves so much work, most practices simply look to see if a patient has been treated by a physician (without regard to specialty) in the urgent care in the past three years. If so, then the visit is coded with an established patient E/M code.

Q. Can 99211 be used for a new patient visit that has been referred to urgent care from the emergency room only for antibiotic injections? In this situation, the patient presents with a prescription for doctor's orders and the injections are given by the nurse.

– *Question submitted by Ruth J. Lawson, CCS-P, McAlester, OK*

A. CPT code 99211 should not be used for a *new* patient visit to the urgent care. One possible exception to this rule would be if the emergency department was operated by the same hospital and billed under the same TIN. In that case, the patient would already be an *established* patient in the hospital. If this is not the case, however, then the patient should be seen by the physician on the first visit to establish the patient in the practice.

On follow-up visits, or visits by patients who are already established in the urgent care, you may use 99211 to code for the visit. A physician should be on site during the visit. The medical record should include more documentation than simple vital signs and "injection given."

In order to qualify for a 99211, the nurse should document pertinent history, physical, and instructions, i.e., there needs to evidence of true "evaluation and management" by the non-physician staff member. Here is an example chart note:

- S: Patient states pain from abscess is decreasing. Denies fevers and chills.
- O: Abscess in right calf with 5x5cm of redness with minimal discharge.
- A: Abscess, right calf
- P: 1. Rocephin, 500 mg, IM, right gluteus maximus, lot number...
  2. Recheck 6/5/09
  3. Patient instructed to return or go to ED if pain increases, fever >101 or any other concerns.

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