CODING Q&A

S9083 & Secondary Insurance, Laceration Repair, and More

DAVID STERN, MD, CPC

Q. We bill S9083 to several carriers. Occasionally, a patient will have secondary insurance. If the primary insurance is contracted to pay the S9083 code but transfers the balance to the deductible, how do we bill the secondary carrier if they do not accept the code?

- Question submitted by Paula Seify, Back Office MD

A. Many secondary payors do not accept S9083, but these payors still will often cover the actual services that were rendered under this code if you bill them using typical fee-for-service codes.

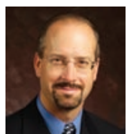
To my knowledge, there is no official CMS or AMA guideline for appropriate coding to a secondary payor under this situation. Most coders would suggest that you recode the services using standard coding methods, i.e., E/M, CPT, and HCPCS codes as appropriate.

In order to avoid compliance issues, the total dollars billed for the aggregate of these codes, however, should not exceed the initial amount billed to the primary insurance under the S9083 code. ■

Q. A 25-year-old new patient presented to our urgent care center with two lacerations—a 2 cm laceration on the face and a 2.2 cm on the leg. He was otherwise healthy.

Can I code an E/M code since I spent 45 minutes for both suture repairs, then add 12011 for the facial laceration repair and 12001 for the leg with modifier -51, as there are more than one laceration? I know that we can add the two cuts into one and use 12004, but I wonder if billing this way you would get less reimbursement since there are two different sites.

- Physician, Name withheld, California



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.

A. Let me answer in several parts. First, the time spent repairing the laceration should not count toward an E/M code, as this time is already accounted for in the code(s) for the laceration repair.

Second, is it appropriate to code an E/M code? You say that he was "otherwise healthy," so I assume that you took an appropriate history and performed an appropriate physical exam. Is this information documented and separately identifiable in the chart? If so, then you may code for the E/M that is appropriate for this documentation and medical complexity. You need to add modifier -25 to the E/M code to indicate that the E/M was performed in addition to the procedure(s).

Third, the coding method that gets more reimbursement should not determine code selection. Instead, use the compliant method per CPT, CMS, or other applicable payor.

Fourth, if the laceration repairs are of the same complexity and if the laceration repairs are located in anatomic regions that are grouped together under the same general heading in the code descriptors for that complexity of laceration repair, then the coder should add the lengths of the two lacerations together to determine the appropriate CPT code. In your example, however, the anatomic locations (face and left leg) are *not* grouped under the same general heading for simple laceration repairs. Thus, you should *not* add the lengths of the lacerations together. Instead, you should *code each laceration separately*, with **12001** (Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, and/or **extremities** (including hands and feet), 2.5 cm or less) and **12011** (Simple repair of small wound of **facial** area, 2.5 cm or less).

Remember to measure the lacerations after the repair is completed. ■

Q. We had a patient who needed intravenous fluids and monitoring for five hours. We found the CPT codes 96360-96361 to use for the intravenous hydration therapy. However, the doctor cannot believe the paltry reimbursement for these codes is correct. We did bill an office visit

"Outright resignation negates opportunity that may be a question or two away."

failed to get a hit 63.5% of the time. So it is with a sales professional in almost any industry. You have to anticipate a mix of home runs, base hits, walks, and strikeouts.

A company's national contract obligation may in fact close the door on your clinic—at least for the time being. It is inevitable and part of your sales management function. However, remember to ask questions and probe to seek opportunities when dealing with such companies. Nowadays, outright resignation seems to be the norm, thus negating opportunities that may be only a question or two away.

National contracts suggest that occupational health services are a commodity, when in fact they should be seen in terms of a relationship. Armed with such an understanding, the national contract roadblock should be viewed as less onerous than it is in many cases.

The accompanying table presents a series of appropriate responses to common contract scenarios. ■

Condition	Strategy
Long-term contract	Probe for other service needs
Short-term contract	Position to bid for business at conclusion of contract
Contract with actual company	Stay in touch with decision maker
Contract with national office	Identify contact and correspond with national office
Meeting with decision maker	Learn hot buttons; stay in touch
Decision maker in home office	Identify contact and correspond with national office
Contract covers limited scope of services	Tout value of your broad, integrated services
All, or nearly all, exclusive contract	Look for missing pieces
Contract compliance is mandatory	Look for missing pieces
Contract compliance is discretionary	Treat as traditional prospect; emphasize ROI
Contract involves price discount	Emphasize ROI issues
Contract involves vague obligation	Treat as traditional prospect

in addition to the intravenous hydration. Is this all we can bill? Does this seem right to you?

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

A. You are using the correct codes. Don't forget, however, to list the 96361 multiple times (once for each additional hour after the first hour) when appropriate. If the visit in question is properly documented, for example, you would code an E/M code (e.g., 99203), 96360, 96361 x 4. ■

Q. Is it appropriate to add modifier -59 to after-hour codes?

- Question submitted by Sharon Dear

A. Using modifiers on these codes is *not* helpful for compliance or reimbursement. Modifier -59 is for pointing out to a payor that you are referring to a service that might otherwise be bundled into another code, but because of special circumstances, they are really distinct. For the NCCI edits, the primary purpose of modifier "-59" is to indicate that two or more procedures are performed at *different anatomic sites* or during *different patient encounters*. ■

Q. Can 94760 (Non-invasive ear or pulse oximetry for oxygen saturation; single determination) be reimbursed in addition to an E/M code?

- Question submitted by Linda, Keith & Co., El Cajon, CA

A. The code 94760 should be used only when the physician orders a single measurement of oxygen saturation (O2sat) level. Do not use this code when the clinic is documenting pulse oximetry as a routine part of patient intake.

Some basic guidelines for coding 94760 (per Medicare) include:

1. It is only covered if the patient exhibits any signs or symptoms that may be suggestive of oxygen desaturation.
2. A physician order for the pulse oximetry must be documented in the medical record.
3. When pulse oximetry for oxygen saturation is utilized to monitor a patient's respiratory status, oxygen saturation (during a surgical procedure or conscious sedation) oximetry is considered included in the primary service and not separately reimbursable.

Many, but not all, payors follow similar guidelines. If you are following these guidelines but a payor is denying payment for this code, you should consider an appeal. As always, however, any individual payor may have a policy to deny payment for any particular service. ■

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