CODING Q & A

Coding for Rectal Strep and Injury Exposure Visits, Billing for Slit Lamp Exams, and a Follow-up on Splinting

■ DAVID STERN, MD, CPC

Q. **What is the correct ICD-9 code for rectal strep?**

– *Question submitted by Cindy Reisbeck, Littleton, CO*

A. There are several possible codes. The specific ICD-9 code would depend on a more specific diagnosis. For streptococcal infections in the rectal or perirectal area, there are several possible correct codes, as streptococcal species can cause multiple different types of localized conditions.

For cellulitis, the correct code would be 566; for erysipelas, the correct code is 035; for impetigo the correct code would 684; and for necrotizing fasciitis the correct code would be 728.86 (see **Table 1**).

Table 1. Coding Streptococcal Infections in the Rectal or Perirectal Area	
ICD-9 Code	Description
566	Cellulitis, rectal or perirectal
035	Erysipelas
684	Impetigo
728.86	Necrotizing fasciitis ("flesh eating" bacterial infection)

Q. **How do you code out for injury exposure visits (mostly for needlestick injuries) and for hepatitis B immune globulin (HBIg) and subsequent visits for the three-month and six-month labs?**

– *Question submitted by Carlene Cox, Genesis FirstCare, Zanesville, OH*
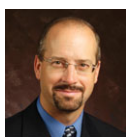
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A. You would code all of these visits with the appropriate E/M code. Follow-up visits that do not involve the doctor may be coded with 99211, if your staff delivers and documents an appropriate level of care.

If more than 50% of provider face-to-face time involves counseling, then E/M codes may be coded by time.

For many of these visits, you might use the ICD-9 code V15.85 (Personal history of contact with and (suspected) exposure to potentially hazardous body fluids). Prior to 2010, there was no appropriate code for patients that had only a suspected exposure to body fluids, but the definition of this code has been updated this year, to include even a *suspected* exposure.

For the HBIg, you should use the injectable supply code 90371 (Hepatitis B immune globulin (HBIg), human, intramuscular use) and the code for intramuscular injection 96372 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular).

Table 2 reviews the updated (in 2009) CPT codes for injections.

Table 2. Updated CPT Codes for Injections			
CPT	Injection type	Route	Add-on code
96372	Prophylactic, Therapeutic or Diagnostic	SQ or IM	No
96373	Prophylactic, Therapeutic or Diagnostic	Intra-arterial	No
96374	Prophylactic, Therapeutic or Diagnostic	IV	No
96375	Prophylactic, Therapeutic or Diagnostic	Additional IV (new substance)	Yes
96376	Prophylactic, Therapeutic or Diagnostic	Additional IV (new substance)	Yes

OCCUPATIONAL MEDICINE

the price objection with a strong return-on-investment argument.

7. Personal accessibility. Many focus group participants have told me that access to a broad array of professionals holds considerable value to them. This is clearly a value best offered by a health system, large hospital, or multi-specialty group. Occupational health often does serve as the access portal to a large healthcare system, thus providing the buyer with a sense of comfort.

Personal accessibility is a card that should be played if available and when appropriate.

8. Comfort. Okay, be honest! How often have you bought something—trivial or significant—primarily because you simply liked (i.e., felt comfortable with) the salesperson. Merits of the product be damned—you just did not want to disappoint the salesperson.

Thus, a salesperson should maintain a keen antenna for those prospects that seem to offer instant chemistry and emphasize the personal relationship when negotiating with such individuals.

9. Continuity of care. Many prospective buyers recognize the inherent value of receiving a tightly knit continuum of occupational healthcare. But not *every* sales prospect is likely to see the inherent value of this attribute. The notion of continuity of care should be part of every sales discussion and used as a value-added feature when it becomes clear that the prospect does recognize its value.

10. Certifications. Many potential buyers are certification wonks; they are unduly impressed by certified credentials and (conversely) uncomfortable with programs that lack such certified personnel. The astute sales professional should have mastery of the certifications and levels/training of key program personnel and be able to articulate the value of each certification.

In Summary
Recognize that the value of the occupational health product may mean different things to different people. All 10 of the values discussed here can be the primary value to a given buyer (and, often, the buyer's perception of value is a combination of two or even more of these values).

Always ask probing questions in order to ferret out the existence and magnitude of each potential value in the buyer's eye.

Develop a cogent reason why your clinic offers particular value in each of the 10 areas, and be prepared to support these values as appropriate. ■

CODING Q & A

Q. **An urgent care physician whose claims I process attended a seminar in Michigan where you lectured. The physician believes that you said that there is a code for a slit lamp exam when there is no foreign body removal.**

I have investigated this situation and the consistent answer I am getting is that if there is not a foreign body removal, then the slit lamp exam is not separately billable from the E/M code.

What is your understanding of this subject?

– *Question submitted by Theresa Krynski, Accurate Billing Service, Warren, MI*

A. You are correct. I am not sure what he understood, but it might relate to one of the following two facts:

1. When the doctor performs an eye exam, you may consider using the ophthalmology E/M codes (92002, 92004, 92012, 92014). Some payors may deny payment with the reasoning that only an ophthalmologist may use these codes. Neither CMS nor the AMA, however, restricts these codes to services provided by ophthalmologists. With good documentation of the level of exam and a clear understanding of the code definitions, you are likely to win an appeal. Per your contract with any specific payor, however, the payor may retain the right to restrict codes to specific specialties.

2. In addition, if you code using 99201-99215, you get credit for additional elements in the CMS 1997 E/M guidelines (eye algorithm) when you use a slit lamp.

Q. **This question is directly related to a question that was printed in the July/August 2010 issue of *JUCM*. In regard to coding and billing for splints, you stated that it is appropriate to bill Q4022 [or other appropriate supply code] for splint supplies. I would like to know if it is appropriate for us to bill that code, as we also use molded fiberglass splints. We are hospital-based and the physicians are employed. Thus, we split bill our claims. I have been told that Q4022 is not appropriate for facility billing [UB-04]. However, is it appropriate to bill it on the professional side [CMS-1500]?**

– *Question submitted by Marie Garcia, Casa Grande Regional Medical Center Urgent Care, Casa Grande, AZ*

A. If your hospital has chosen to split bill the urgent care visits, then the supplies are not billed on the CMS-1500, as the CMS-1500 is used (in the case of split billing) only for professional services (not supplies). As a general rule, you should code all applicable HCPCS codes on the UB-04. However, per the Medicare Claims Processing Manual (*http://www.cms.gov/manuals/downloads/clm104c04.pdf*):

"When medical and surgical supplies (other than prosthetic and orthotic devices as described in the Medicare

Claims Processing Manual, Chapter 20, §10.1) described by HCPCS codes with status indicators other than 'H' or 'N' are provided incident to a HCPCS codes with status indicators other than 'H' or 'N' are provided incident to a physician's service by a hospital outpatient department, the HCPCS codes for these items should not be reported because these items represent supplies."

Q4022 is a code with a Status Indicator of "B" (Codes not recognized under OPPS—Outpatient Prospective Payment System), so you do not report this code (or other splint supply Q codes) on the UB-04. ■

HEALTH LAW

trol at different airspeeds, and constant-speed propellers whose pitch had to be regulated with hydraulic controls, among other features.

"While doing all this, Hill had forgotten to release a new locking mechanism on the elevator and rudder controls. The Boeing model was deemed, as a newspaper put it, 'too much airplane for one man to fly.' The Army Air Corps declared Douglas's smaller design the winner. Boeing nearly went bankrupt. Still, the Army purchased a few aircraft from Boeing as test planes, and some insiders remained convinced that the aircraft was flyable. So a group of test pilots got together and considered what to do.

"They could have required Model 299 pilots to undergo more training. But it was hard to imagine having more experience and expertise than Major Hill, who had been the U.S. Army Air Corps' Chief of Flight Testing. Instead, they came up with an ingeniously simple approach: they created a pilot's checklist, with step-by-step checks for takeoff, flight, landing, and taxiing. Its mere existence indicated how far aeronautics had advanced.

"In the early years of flight, getting an aircraft into the air might have been nerve-racking, but it was hardly complex. Using a checklist for takeoff would no more have occurred to a pilot than to a driver backing a car out of the garage. But this new plane was too complicated to be left to the memory of any pilot, however expert.

"With the checklist in hand, the pilots went on to fly the Model 299 a total of 18 million miles without one accident. The Army ultimately ordered almost 13,000 thousand of the aircraft, which it dubbed the B-17. And, because flying the behemoth was now possible, the Army gained a decisive air advantage in the Second World War, which enabled its devastating bombing campaign across Nazi Germany."

In the 1970s, philosophers Samuel Gorovitz and Alasdair MacIntyre wrote an essay on human fallibility, titled Toward a Theory of Medical Fallibility. In it, they attempt to answer why humans fail at certain endeavors. They broke down the reasons to one of three root causes:

1. Necessary fallibility. We attempt to do something that is simply beyond our capabilities despite all the tools we possess. If we take out the things we should not even be attempting (necessary fallibility) there are two other reason why we fail in areas in which we do have the ability to be successful.

2. Ignorance. We fail because we do not yet have a complete understanding of everything we need to know to be successful.

3. Ineptitude. We have the knowledge; we simply fail to apply it correctly.

Over the last century, humans have made great strides to conquer ignorance. As a species, we know more about ourselves and our surroundings than ever before.

Where we still have challenges, though, is ineptitude. Odd as it sounds, our *lack of ignorance* may even contribute to our ineptitude. For example, in the old days (1960s), treating a patient with a heart attack simply meant putting them in the hospital, giving them oxygen, morphine for pain, and placing them on strict bed rest for two or three weeks.

Contrast today where patients I admit with an acute myocardial infarction get multiple drugs, are in the cath lab in less than 90 minutes, and are typically home the next day or, at most, the day after. There is simply so much more to know than there used to be, yet a provider cannot simply "plead ignorance" inasmuch as the information, thanks to Google, etc. is often just a few clicks or a phone call away.

When providers fail, it is often because of ineptitude; we miss the diagnosis, we cause an iatrogenic injury, we prescribe the wrong drug or dose or combination of medicines, we don't document appropriately.

With all of our training and knowledge, how is this possible? How are we forgetting to latch the proverbial door?

For all of you who have worked in a busy urgent care center, the answer is obvious: the volume and complexity of information necessary to practice safely is nearly beyond our ability to interpret, synthesize, and react to it in a timely fashion.

In short, the depth of our knowledge has become both a blessing and a burden.

In the next issue, I will discuss how we can reduce the likelihood of errors due to ineptitude. If you are like me and can't wait until next month, the answer is: The Check List. ■