CODING Q&A

Writing Off Patient Responsibility, Modifier-51, and More on New vs. Established E/M Codes

DAVID STERN, MD, CPC

Q. I listened to your UCAOA coding webinar, and it raised a question. You mentioned that if we bill insurance for a 99051 and the payor denies payment as "patient responsibility," then we should bill the patient and not write it off. Does that hold true to the S9088, as well? I often see this code either denied or applied to the patient's coinsurance/deductible.

– Question submitted by Megan Fontenot, Integrity Urgent Care, Colorado Springs, CO

A. If the code is denied, then it is appropriate to write it off. If it is applied to patient responsibility or to patient deductible, then you need to invoice the patient for any balance that the payor makes patient responsibility.

It is not compliant to bill a payor for a service that you will write off if the payor applies it to patient deductible or patient responsibility. Otherwise, you are merely using the old BIO (bill-insurance-only) method for that line item. This is not compliant, as the patient is either 1) getting credit for payment toward a deductible that the patient never paid or 2) you are billing for a service for which you don't really expect payment. In addition, if you are contracted with the payor, writing off these balances would not only be noncompliant, it would likely be an illegal violation of your contract with that payor. ■

Q. I have been using the -51 modifier, but never knew that you were supposed to put it on specific procedure codes (based on their reimbursement). I didn't know insurance companies would reimburse differently. Will you explain that to me again?

– Question submitted by Amanda Strickland

A. Reimbursement is reduced on codes with modifier -51 attached. Putting the modifier on codes with lower reimbursement will allow you to get full reimbursement on the code with the highest reimbursement. Codes with lower reimbursement will be reduced in payment, but these reimbursement reductions will be less than if they were taken on the code with the highest reimbursement rate. Thus, by putting modifier -51 on codes with lower reimbursement rates, you will maximize reimbursement on the whole claim. ■

Q. Why do the payors reduce reimbursement on a code if performed on the same day as other procedures? The doctor does the same work on the procedure, whether it is combined with other procedures or not.

A. The rationale that the payors use is that much of the work pre-procedure and post-procedure for a given procedure is not repeated when two or more procedures are performed. The work of the actual procedure is repeated, but the work before and after the procedure is supposedly similar whether one or two procedures are performed on a given visit. ■

Q. The doctor performed a 2.0 cm simple laceration repair on the index finger and a 1.2 cm simple laceration repair on the middle finger. I coded 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) for the first laceration and 12001-51 for the second laceration. The payor denied

Continued on page 50

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2. **Learn—and remember—what is really important.** Learn what is really important to a prospect/client—both professionally and personally—and go back to these issues time and again. Remember, sales are always about "them."

3. **Check in frequently, and with balance.** Most salespeople establish contact with clients or prospects only when there is a professional objective. However, it is important to balance sales-oriented contacts with no-obligation "social calls."

4. **Do little favors.** In the e-mail era, it does not take much effort to send a short note, or forward a relevant attachment or a timely link. Yet, sales professionals rarely take the time to do this.

   Once you know what is important to one or more of your prospects/clients, you can scour for relevant material and send it on (or, at times, on to more than one client/prospect interested in the same topic).

   Do this frequently for contacts and you are likely to grow quickly from "just another salesperson," to an "exceptional salesperson."

5. **Note critical dates.** Gather birthdates and acknowledge them (a personal e-mail will do). Also, pay attention to any hints you may pick up, such as "I'm getting married August 19."

6. **Be selective.** You cannot cultivate exceptional relationships with every prospect/client; you need to be selective. "Red hot" prospects that offer great professional opportunity for your clinic's program warrant a seat in the front of the bus.

   But what about chemistry? There are certain people that you are unlikely to cultivate an exceptional relationship with: you are from Mars and they are from Pluto. In such circumstances, you should avoid trying to fit the proverbial square peg into a round hole and consider even a "fair relationship" to be a victory.

Sales professionals should be "people-people." As such, building strong relationships with others should be inherent in their fabric and a vital part of their professional day.

As occupational health becomes more complex, extraordinary relationships are essential. ■

the second code. How can I get them to reimburse for the second laceration? After all, the doctor really did perform two procedures.

A. Wound repair codes are a little different than many other codes. If the laceration repair was of the same complexity and the code for the repair includes repairs on the same body areas, then you should add the lengths of the repaired wounds and select the CPT code based on the sum of the lengths of the wound repair. Thus, to code these procedures, you should add the lengths of the two lacerations (2.0 cm + 1.2 cm = 3.2 cm) to select the proper code, which for this claim would be 12002 (Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities [including hands and feet]; 2.6–7.5 cm). ■

Q. I code for emergency room physicians. Our physicians also work for our urgent care center. If a patient is seen in the ER by one of our physicians, then a week later seen at our urgent care center, on the second visit is that patient considered a new or established patient?

– Question submitted by Cathy Stover, Richmond Hill, GA

A. Choosing a new or established code depends on the specific scenario:

- If the patient is seen by the same physician in both locations, then the second visit is coded with an established E/M code, no matter how each of the businesses is incorporated.
- Assuming that the physicians are employed by a different group in each location and assuming that the patient is seen by a different physician on each visit, then the second visit is coded with an new E/M code.
- If the physicians are employed by the same group in both locations, then the second visit (if seen by a physician of the same specialty) is coded with an established E/M code.
- If the physicians are employed by the same group in both locations and the two different physicians practice different specialties, then the second visit is coded with a new E/M code. ■