Can an Urgent Care Use an ED E/M Code and Three Other Coding Challenges

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Our series on medical decision making in E/M coding will continue next month. This month, we address four challenging coding questions that *JUCM* readers submitted.

Q. Can 99283 and 99214 procedure codes be used for an urgent care visit? The codes were used by an urgent care facility, and I am told that 99283 is categorized as an emergency room code.

A. Code 99283 is for an emergency department visit for the evaluation and management of a new or established patient with an expanded problem focused history and examination and medical decision making of moderate complexity. Code 99214 is for an office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history, a detailed examination and medical decision making of moderate complexity.

Code 99283 is reserved for use in an ED. Even if services are provided by a board-certified emergency physician, ED E/M codes should never be used in an urgent care, unless the urgent care is actually part of a licensed emergency department.

Both 99283 and 99214 would never be appropriate for the same patient encounter for at least two reasons:

- Only one E/M code per visit is appropriate
- The two codes indicate mutually exclusive services, since 99214 is for services rendered in a outpatient setting (appropriate for most urgent care centers) and 99283 is for evaluation services rendered in an ED.

Note: For urgent care centers that operate under POS-22, an E/M code may be billed on the CMS-1500 claim form for professional services and an additional (often different) E/M code may be billed on the UB-04 claim form for ancillary services. In this case, however, both E/M codes should come from the same set of E/M codes.

Q. A patient received minor surgery in our clinic (CPT code 12041: layer closure of wounds of neck, hands, feet, and/or external genitalia; 2.5 cm or less), and we also gave the patient an injection (CPT 90471: immunization administration; 90715: tetanus, diphtheria toxoids, acellular pertussis vaccine for use in individuals 7 and older). We used modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) with the 12041 code and modifier GA (waiver of liability statement on file) for codes 90471 and 90715. The payor denied CPT 12041 because the modifier was wrong. Can you tell me what modifier I should use for 12041?

A. The answer is much simpler than the question. Modifier -25 should only be appended to an E/M code, never to a surgical code.

Q. We can't get Medicare to pay for clindamycin 600 mg in our urgent care. We are using S0077 (injection, clindamycin phosphate, 300 mg). Is there another code we can use that Medicare will cover?

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A. S codes are codes that have been requested by *non-Medicare payors* for procedures or supplies that have no code in the CPT or HCPCS systems. The Centers for Medicare and Medicaid Services (CMS) creates the codes at their request, as required by HIPAA. S codes are specifically created for services or supplies that are not covered by Medicare. Thus, Medicare will always deny payment on an S code. There is no reimbursable code for billing Medicare for injectable clindamycin.

Q. What CPT code would you bill for a visit with the doctor in an urgent care facility that resulted in a diagnosis of gastroenteritis with no other services rendered?

A. Assuming the physician delivered and documented a face-to-face evaluation of the patient, it would be appropriate to code an E/M code based on the level of service documented in the medical record. If testing or IV hydration was performed, then additional CPT codes might be appropriate.

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