Coding Concerns: Versajet Debridement, Time Frame for New/Established Patients, Detailed Exams, Denial of S9088, –57 Modifier, and Billing for Injections

DAVID STERN, MD, CPC

Q. How do I code when using Versajet to debride an ulcer?

A. For Versajet debridement, you should report CPT code 97597 (removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g., high-pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel, and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 sq. cm).

When the physician uses a scalpel or scissors for debridement, use codes 11040-11044 (depending on the depth of layer removed).

Q. If I saw a patient in the emergency department up to three years ago and then see the patient in urgent care, is this a new patient or established patient? The emergency department and urgent care have different EIN (employer identification numbers) and corporate structures since the emergency department is non-profit and urgent care is for-profit.

- Reggie Reginella, MD, Pennsylvania

A. Different businesses and for-profit or non-profit status make no difference in determining new or established patients. If the physician has performed professional services for the patient in any setting in the past three years, then the patient is coded as an established patient.

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. Dr. Stern 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.

Q. How do you differentiate between an expanded problem focused exam (EPF) and a detailed exam for coding purposes?

For an expanded problem to be coded as "detailed," numerous sources state two to seven organ systems are needed to equal detailed. However, the hospital and one of the payor representatives wants to partition this out as two to five systems for EPF and six to seven systems or 4x4 [four elements examined in four body areas or four organ systems] for detailed. I use any number between two and seven for an exam to equal detailed, but they want to down-code their own charts based on the above arbitrary criteria.

Is this criteria published somewhere, or is the payor just making more money for itself?

- Reggie Reginella, MD, Pennsylvania

A. Neither method is published by CMS. In the 1995 guidelines, you must document "an extended examination of the affected body area(s) and other symptomatic or related organ system(s)." Per the 1997 guidelines, you must simply document at least 12 specified elements from at least two areas/systems to qualify for a detailed exam.

Ask the payor for an official CMS (or AMA) publication that documents this six- to seven-system rule. It is often cited, but it appears to be an urban legend without any official verification.

Q. It seems that as of 2010 some insurance companies are denying the S9088 (services provided in an urgent care center) code now. We are getting "will not reimburse S9088. S9088 is informational as it pertains to the place of service, not the specific service provided." We were billing the code with our standard 99204 (office or other outpatient visit for the evaluation and management of a new patient) and 99214 (established outpatient) and the S9088.

CODING Q & A

Is there a new code now for 2010 for urgent care?
- Steven Fields, Laguna Niguel, CA

A. It is true that some payors have stopped paying the S9088 code. This was partly due to massive abuse by family practices, which used it for any walk-in patients. There are at least four reasons that a payor may be denying this S9088:

- The practice is not specifically contracted as an urgent care center.
- The practice does not meet the UCAOA criteria as an urgent care center.
- The payor will not pay unless reimbursement for the code is specified in your contract.
- The payor has made a blanket decision to no longer pay for the code.

There is no code out there that replaces the S9088 code. However, you may want to consider:

- *Opening negotiations* with the payor for additional reimbursement for the additional costs of operating an urgent care center.
- *Coding 99051:* This code can be used when you provide services "during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service."
- *Maximize coding capture:* We have found that many physicians significantly undercode E/M codes. Although this may be done from a good motivation to reduce patient costs or minimize audit risks, it is not compliant and can reduce clinic revenues by 10% to 20% or even more.

Q. Can you explain the logic behind using the -57 modifier just because the patient had a procedure with a 90-day global period during the same visit? Let's say we perform restorative treatment for a fracture; wouldn't we add modifier -57 to the E/M code even though the doctor did not necessarily make a decision for surgery?
- Stephanie Boling

A. Modifier -57 is used when the E/M involves a so-called "decision for surgery." This modifier is used to report an E&M service that resulted in a decision to perform a major surgical procedure on the day of or the day before the surgery.

It is easy to get confused by the word "surgery" in this situation. Payors, however, define any procedure with a 90-day global period as major surgery.

This surgery question is the same question that you may get from patients when they get their EOBs. Patients ask, "Why did you charge for 'surgery' when you only splinted my fracture?" Payors and CPT calls a fracture code a "surgery code," but this is not "surgery" in the sense that we normally think of the term. In this case, the "decision for surgery" was really the decision to perform restorative treatment on the fracture.

Q. When patients present for a B-12 injection, Depo-Provera injection, antibiotic-only injection, etc., how would you bill for those services?
- Abbi Olson, Bowling Green, KY

A. In a situation such as this, you should bill the HCPCS code for the medication and the CPT code for the injection. For example:

- J0696 x4: ceftriaxone (Rocephin) 1g
- 90772: Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

Note: If f you are not being reimbursed (i.e., are getting payment denials) for B-12 injections, you may need to look at the ICD-9 that you are using with the injection code. In order to get reimbursement, many payors (including Medicare) limit reimbursement to visits coded for specific conditions related to B-12 deficiency, such as pernicious anemia and dementias secondary to vitamin B-12 deficiency. ■

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OCCUPATIONAL MEDICINE

5. *Brainstorm—without judgment.* Innovations are often spawned by "silly" ideas. Sit down with a colleague and jointly list every conceivable marketing tactic, no matter how seemingly off-the-wall, and you will undoubtedly emerge with several great ideas.
6. *Swing for the fences.* Innovation is all about a willingness to fail some of the time as you search for a few real winners. Many of the greatest personal and institutional success stories in history involved people who failed many times, learned valuable lessons from their failures, and then got it exceptionally right. Resistance to innovation is a ticket to mediocrity for both your clinic and yourself. ■