CODING Q&A

S9088 Coding for Medicare or Medicaid, Coding for SVT, and Coding 99211

DAVID STERN, MD, CPC

Q. In one of your articles concerning the S9088 code (services provided in an urgent care center), you indicate this code cannot be billed to Medicare or Medicaid. However, I read in another source that S9088 and S9083 (global fee for urgent care centers) had been approved by the Centers for Medicare and Medicaid Services (CMS) for billing these services.

What is the current status of these codes as they relate to Medicare?

- Ned Peple

A. All Healthcare Common Procedure Coding System (HCPCS) codes are created by CMS. Part of the Health Insurance Portability and Accountability Act (HIPPA) was to require CMS to develop a standard set of codes for all payors. Thus, in order to keep a standard set of codes for all payors, CMS began making HCPCS codes specifically at the request of non-Medicare payors (i.e., commercial carriers). These codes are never for use by Medicare (even though they are created by CMS), and they all begin with the letter S. The resulting S codes are not "approved" for use by Medicare, but they were created by CMS. Thus, no S codes are billable to Medicare.

Individual Medicaid payors can decide to accept S codes, but Medicaid rarely accepts S codes. ■

Q. How do you suggest coding for a patient who presents to urgent care in a supraventricular tachycardia (EKG performed—SVT), then converted to a normal sinus rhythm with carotid sinus massage?

- Robert Laney

A. If you use external electrical shock to the heart, then you would use 92960 (cardioversion, elective, electrical conversion of arrhythmia; external).

If you perform intravenous medication (e.g., adenosine) for cardioversion, then you would use 90784 (therapeutic, prophylactic, or diagnostic injection (specify material injected); intravenous). You would add the appropriate HCPCS code(s) for the medication(s) injected. When billing for adenosine, use HCPCS code J0150 (injection, adenosine, 6 mg) to specify the injected medication.

For cardioversion via other methods, such as valsalva, carotid massage, etc., there is no specific CPT or HCPCS code. You would include this procedure as part of the evaluation and management (E/M) code. ■

Q. Must a physician be present in order to bill a 99211?

- Name withheld

A. A physician need not always be present to code services with 99211. The code allows practices to report E/M services that are rendered by non-provider staff members. According to CPT (as published by the AMA), the guidelines for coding a 99211 are much less strictly defined. The staff member may communicate with the physician, but the physician's direct involvement in the episode of care is not required.

Medicare, however, interprets the requirements for this code differently. While the physician's face-to-face presence is not required to code a service with 99211, the physician must have initiated the service as part of a continuing plan of care in which he or she will be an ongoing participant (i.e., following "incident-to" guidelines). In addition, the physician must be physically present in the office suite when the service is provided.

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.

Thus, for services billed to Medicare, the physician must be physically *on site*.

For services billed to other third-party payors, your practice may instead opt to follow CPT guidelines, as long as this is allowed by your contract with the payor. If a provider is in the office, list the rendering provider as the provider who was in the office suite at the time services were rendered. ■

Disclaimer: JUCM *and the author provide this information for educational purposes only. The reader should not make any application of this information without consulting with the particular payors in question and/or obtaining appropriate legal advice.*

"Competitive Analysis" continued from page 32

get into the schools to promote free physicals as a grassroots tactic and loss leader for athletic injury cases?

Likewise, say you want to build your workers compensation business but notice two or three occupational medicine competitors en route to the industrial businesses where injuries occur. Could your efforts be better invested in services that appeal directly to consumers?

Competition and Site Selection

Ignoring competition can lead to critical mistakes when developing a business plan—including whether to open the center in the first place. Before committing to a new location, it's important to understand:

- What competition is present and how is it positioned relative to consumer traffic and residential growth patterns?
- Can the area's population and demographics support one or multiple urgent care centers?
- Is there sufficient new business to support your center, or will you rely on capturing market share from an existing, weaker competitor?

Don't be deterred, however…

The presence of urgent care competition should not necessarily deter a prospective center. In fact, the more urgent care competition, the more marketing activity and the greater consumer awareness of how and when to utilize urgent care—benefiting all centers in the market. In most cases, a concentration of urgent care centers is merely reflective of high population density—in large markets, there are simply more people, and more urgent care centers are able to thrive.

Because many urgent care entrepreneurs open centers where they want to live and work—and not based on optimal demand or market potential—they frequently enter into highly competitive situations and then struggle to build their practices.

For example, major cities in Arizona, Florida, and Texas have a high density of urgent care centers, while nationally there are many other metropolitan areas with more than 50,000 people that could support at least one center but currently have none. Not only are these outlying communities ripe for an independent operator, but there is likely little to no competition except for the local hospital ED, meaning consumers should embrace urgent care as a long-awaited and much-needed community resource.

Where there are too many urgent care providers chasing too little business, eventually one or a few will "fall out." For example, a recent news story in Lancaster, PA (population 55,351) describes how urgent care centers are "taking off" with local hospitals, out-of-state operators, and physician entrepreneurs opening a total of 12 walk-in centers by 2011 (five of which are within a 1.5-mile radius).[1] Another story out of Charlotte, NC reports that three urgent care centers have opened on one city block, each operating 12 hours per day, seven days a week.[2] It's likely after several years of these competitors "duking it out," markets like Lancaster and Charlotte will be a prime example of "survival of the fittest."

In such markets, it's even more critical to understand the strengths and weaknesses of competition and to position your business accordingly.

Conclusion

Whether an urgent care center survives or thrives is dependent upon how well it differentiates itself from competitors. Unlike other medical practices, urgent care depends on consumers to decide when, how, and where they seek care. Competitive research that takes the consumer's perspective in evaluating the strengths and weaknesses of various healthcare options can yield insights that help the urgent care operator better position his or her center to increase visits and capture market share. ■

References

1. "A dozen clinics will be operating her next year," Lancaster, PA: *Intelligencer Journal*, December 12, 2010. *http://articles.lancasteronline.com/local/4/323584*.
2. "1 Block in Charlotte; 3 Urgent Care Facilities, A Lot of Head Scratching," Charlotte, NC: *Mecklenburg Times*, February 15, 2011.