CODING Q&A

E/M Coding for Multiple Visits, Contracted Case-rate Billing, Comparing Payor Reimbursement Policies

DAVID STERN, MD, CPC

Q. We sometimes have patients who require two visits to clear impacted cerumen in their ears. In some cases, this procedure requires a 24-hour regimen to soften the cerumen prior to flushing the ear. How do we bill for the second visit and does it change how we bill if we find a second diagnosis after we clear the cerumen?

A. For the second visit, you may code for all services rendered as if the first visit did not happen. A new diagnosis should not change the CPT coding for the visit. ■

Q. What are the guidelines for billing two E/M codes on the same day? The patient was seen in the morning and then returned again in the evening.

A. Only one E/M code is allowed per patient per day. You will need to combine all of the data from both visits and bill it as a single E/M code visit. ■

Q. When a patient returns to our center for suture removal, are we allowed to collect another co-payment and bill for the return visit?

A. You can bill a second E/M code visit for follow up of a *simple* wound repair (not intermediate or complex wound repair.) This is true even if the follow-up visit for suture removal is within the first 10 days after the original procedure. You can bill a case-rate code for each return visit regardless of any procedures performed because procedures are not typically recognized with this type of contract. You would generally also collect a co-payment for the return visit. ■

David E. Stern is a certified professional coder. He is a partner in Physicians Immediate Care, operating 18 clinics in Illinois, Oklahoma, and Nebraska. Dr. Stern was a Director on the founding Board of UCAOA and has received the Lifetime Membership Award of UCAOA. He serves as CEO of Practice Velocity (*www.practicevelocity.com*), providing software solutions to over 750 urgent care centers in 48 states. He welcomes your questions about urgent care in general and about coding issues in particular.

Q. I am a biller for an urgent care clinic in Texas. I have been receiving denials from a payor for CPT Code 99213 as "services enclosed in encounter rate." What is meant by this phrase and what do I need to do to get reimbursement for our clinic?

A. It sounds as though the urgent care provider has signed a contract with the payor for case-rate billing. Under this arrangement, visits are usually coded with S9083 instead of using other CPT codes. The visit will be reimbursed at the same contracted rate regardless if the patient has a hangnail or a heart attack. You should check the contract to see whether this is the correct billing method for this urgent care clinic. ■

Q. When I billed a wound repair to a diabetic patient's insurance company, the office visit was denied and the wound repair charge was applied to the patient's deductible. One of our diabetic neighbors with a different insurance company went to a different urgent care with a <1 cm laceration. The urgent care clinic was paid for visit code 99205, charges for a wound repair, charges for dressing and charges for medicine. Nothing was done in terms of his diabetes because it is well controlled. How can I make sure I also get paid like that other urgent care clinic?

A. Unfortunately, every payor has different reimbursement policies. Thus, what you are really asking is not to be reimbursed in the same way as a different urgent care center, but rather, for the patient's insurance company to process claims the same way that your neighbor's insurance company processes claims. This is not a realistic expectation. In addition, it may be a good idea to investigate whether mistakes in coding or modifiers may be leading to denials. ■