CODING Q&A

Medicare Modifier PD, Fracture Visit Coding, Coding for Emergent Transport, 'Big Ticket' Reimbursement Codes, Medicare CLIA-Waived Codes

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Q. What is the new modifier PD?

A. If your urgent care center is owned by a hospital or health system, then Medicare has a new modifier for your center. The ***new HCPCS Level II Modifier PD*** is defined as a "diagnostic or related non-diagnostic item or service provided in a wholly owned or wholly operated entity to a patient who is admitted as an inpatient within 3 days, or 1 day." The modifier expands the Center for Medicare & Medicaid Services (CMS) "three-day payment window" for outpatient services provided within 72 hours of an inpatient admission by applying it to both diagnostic and non-diagnostic services. ***Medicare pays a reduced fee for services that are clinically related to an inpatient admission; occur within 72 hours of the admission; and are furnished by a facility owned by a hospital.***

The modifier applies only to hospital-run urgent care centers and went into effect January 1, 2012. Even though compliance with the Final Rule is delayed until July 1, 2012, entities should begin using modifier PD on applicable claims as soon as possible. It is recommended that hospital-run urgent cares hold claims for 3 days before submitting them to ensure that patients are not admitted within 72 hours, thus requiring modifier PD to be added to the claim. Urgent care centers should be reimbursed the full amounts when services are for visits that are "unrelated" to the hospital admission. However, CMS has refused to identify all non-diagnostic services that should be considered "clinically related." CMS reasons that these determinations should be made on a case-by-case basis. Thus, consultants are encouraging facilities to document the reasoning for why the clinic visit is "not clinically related" so the clinic can "receive full payment." In the urgent care center, however, a manual appeal for each individual exception is rarely likely to be cost effective, so the center will likely just lose the income on these cases. ■

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Q. How should I code for a visit when a patient presents with a fracture, and the physician performs x-ray and splinting and then refers the patient to an orthopedic physician?

A. Use CPT codes 29000-29550 (initial application of cast, splint or strapping). Don't forget to code for splint supplies (such as Q4017 and following). Make sure you have a separate, identifiable procedure note. Add the code for the appropriate radiologic study. You should also document and code the appropriate E/M code for assessing the injuries related to the accident and add modifier 25 (significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service). ■

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Q. I heard about the "Y" code at the 2008 urgent care conference in Memphis. We were told if a patient is transported out of our urgent care center to the emergency department (ED) via ambulance, then we should do the following: start the protocol; document the visit appropriately; contact the ED; mark the superbill as level 5; and mark or write down the "Y" code, which I thought represented an emergent transport. Is this code still valid? My billing office says this code can only be used for ED, not urgent care centers. I cannot find any information online about the "Y" code.

A. I am not aware of a "Y" code. Perhaps they were referring to 99058, which is for service(s) provided on an emergency basis in the office (in addition to basic service) that disrupt other scheduled office services. CPT Assistant has recommended that this code not be used in clinics that routinely offer services on a walk-in basis. However, CPT Assistant opinions are not official rulings, and some urgent care coders object to this limitation, noting that emergency disruptions in an urgent care center can be just as disruptive to staffing and to care for other patients as they are in a primary care center.

In addition, if you code a level 5 E/M code, make sure that your documentation supports that code. For the history, it is compliant to take credit for a comprehensive history and simply note that a full history was not obtained because of the emergency nature of the visit. The physical exam and the complexity of medical decision-making, however, do not follow this rule, and appropriate levels of documentation for these sections are required to support a level 5 E/M. ■

Q. What is the most common highest reimbursement code for urgent care center billing?

A. That is an interesting question. However, it is like asking, "What is the most common big ticket item at the Dollar Store?" Urgent care revenue cycle management is not about collecting on big ticket items. The vast majority of visits (more than 95%) do not have any so-called "big ticket" items. Thus, urgent care revenue cycle management is not about cherry picking big ticket codes; rather, it is all about intense, punctilious accounting for every detail in the revenue cycle. ■

Q. My urgent care center uses Clinical Laboratory Improvement Amendments-waived (or CLIA-waived) laboratory tests to perform drug test screening for multiple drug classes. We bill CPT code 80104 (drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure) for non-Medicare payors. What code should we use for Medicare claims?

A. For Medicare, use code G0434 (drug screen, other than chromatographic, any number of drug classes, by CLIA-waived test or moderate complexity test, per patient encounter). Add modifier QW if you have a CLIA certificate of waiver. ■