CODING Q&A

Billing for Medications, Supplies, and X-rays

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Q. What is the CPT code for Tetracaine Ophthalmic used in an urgent care setting?

A. If you are referring to the drops used as part of the treatment in the office, then you should not charge separately for them. They are part of the E/M service.

If you are providing a bottle of the solution for a patient to use at home, there are a few practical issues to consider. Payors very rarely pay for dispensed meds, and if they do, they pay only extremely reduced fees. Thus, if you plan to dispense medications, there are several other factors for you to keep in mind:

- Dispense only prepackaged medications
- Have patients pay at time of service (cash, credit card, etc.)
- Do not bill to insurance
- Use a dispensing company that is integrated with your electronic medical record (EMR) so that
  - duplicate entry of patient demographics is eliminated
  - orders are taken right from the EMR
  - inventory is kept in the EMR
  - verification can be performed to see if the bar code on the bottle exactly matches what the provider prescribed.

That being said, unless the manufacturer has provided you with a more specific code, the HCPCS code most appropriate for Tetracaine Ophthalmic solution is J3490, "Unclassified drugs." ■

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.

There is no "right" way to perform, read, code, and bill radiographs in urgent care.

Q. We had a patient who came in with a wrist injury. We applied a cock-up splint (HCPCS code L3908) with an Ace bandage. Can we bill out a strapping code and a splint application code together?

A. No. You would not bill splint or cast application codes with strapping codes for the same procedure. Billing for the splint application depends on whether the splint applied was prefabricated or was constructed in the clinic. The American Medical Association (AMA) stated in *CPT Assistant (May 09:8)* that "splint application requires creation of the splint."

According to HCPCS, L3908 is defined as "Wrist-hand orthotic (WHO), wrist extension control cock-up, nonmolded, prefabricated, includes fitting and adjustment." Therefore, billing a splint application code along with this code would not be appropriate because the fitting and adjustment is included with the code. If an elastic bandage was used to secure the splint, you would bill a HCPCS code from range A6448-A6450 depending on the size of the bandage.

Alternatively, if a short arm splint was made in the clinic from fiberglass materials for an 8-year-old, you would use HCPCS code Q4024, "Cast supplies, short arm splint, pediatric (0-10 years), fiberglass." You would then assign CPT code 29125, "Application of short arm splint (forearm to hand); static." In that case, the elastic bandage (and all other splint supplies) is included in the supply code.

If you bill a splint application code, 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. How do you bill for radiology service in an urgent care center and what modifier should be used?

A. There is no "right" way to perform, read, code, and bill radiographs in urgent care. Each urgent care center will need to do an analysis of what will work best in its particular center. To summarize, x-ray billing and coding options in urgent care include:

1. Performance and reading of x-rays in the urgent care center by the urgent care physicians. Bill a global code for both the professional and technical components. Having all x-rays cross-read by a second urgent care physician can help reduce the chance of significant misreading. Also, having an arrangement for a radiologist to cross-read any films that the physician(s) is unsure of will help to ensure quality. You can bill radiologist cross-reads in two different ways:
   a. Employ the radiologist as an independent contractor (per film series). You pay the radiologist a wage and bill the global code.
   b. Allow the radiologist to bill the professional component. For situations in which the radiologist is billing the professional component, you should bill only the technical component using modifier –TC.
2. Perform x-rays and employ a radiologist as an independent contractor to read the films. Bill the global fee, and pay the radiologist a separate wage.
3. Perform x-rays and send the films to a radiologist to read all films. This radiologist can bill the professional component, and you will bill only the technical component using modifier –TC.

Effective January 1, 2012, Medicare requires that the technical component of Advanced Diagnostic Imaging (e.g., Magnetic Resonance Imaging (MRI), Computed Tomography (CT), and Nuclear Medicine Imaging, including Positron Emission Tomography (PET)) be billed by only those providers/suppliers who are accredited by one of the following organizations:

- The American College of Radiology
- The Intersocietal Accreditation Commission
- The Joint Commission ■

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