CODING Q&A

S9083, Radiology, and E/M Codes

DAVID STERN, MD, CPC

Q. Can CPT code S9083 be billed with an E/M service code or would this be considered double dipping?

A. You would not typically add CPT code S9083 to an E/M service unless instructed to do so specifically by an insurance company. CPT code S9083, "Global fee urgent care centers," would be used in instances where the insurance company has stated that the reimbursement is based on a flat rate (global fee or case-rate) per a contractual agreement. All services performed are bundled into this one code unless carve-outs have been negotiated.

If your urgent care center sees only patients with minor illnesses and injuries, a case-rate contract might be a good fit. However, if your offices are equipped to handle more serious situations, such as dehydration requiring intravenous fluids, fractures, complicated lacerations, etc., then it may be advisable to negotiate a contract based on procedures performed as opposed to a case rate. Unfortunately, however, most payors offer either case-rate or fee-for-service contracts, and are **not** flexible in allowing the urgent care to choose the type of contract. ■

Q. Can x-ray and ultrasound codes be billed separately from global E/M fees? If so, which codes can be used?

A. Typically, the E/M codes 99201-99215 are not "global" E/M fees, but rather, describe the level of evaluation and management services performed during the encounter. However, urgent care contracts for certain payors may use unconventional reimbursement and coding methods. For example, the payor may:

- expect the provider to code the E/M appropriately but will reimburse the same case-rate amount no matter what E/M or procedures are performed;
- pay on a fee schedule with different rates per E/M but will not reimburse for any additional procedures;
- pay on a fee schedule with different rates per E/M but will not reimburse for some specific procedures, such as radiology procedures; or
- expect the provider to use a specific E/M code for every single visit (or one specific code for every new-patient visit and one specific E/M code for every established-patient visit). Payors may forbid you to add procedure codes; others may allow them.

Thus, you need to check your contracts.

Radiology and Imaging codes (70010-79999) are described in the Current Procedural Terminology (CPT) codebook. Under typical arrangements with Medicare and other fee-for service providers, you would bill for radiology and imaging services separately when they are performed by or under the supervision of a physician or other qualified health care professional.

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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.

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- **Modifier -26 Professional Component:** When the professional component is reported separately, the service may be identified by adding modifier - 26 to the usual procedure number. Modifier -26 is used if the only service performed is the reading and report of radiology or imaging service.
- **Modifier -TC Technical Component:** Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances Modifier -TC is used to report that the center is billing for only the technical component of the radiology or imaging service.

As of January 1, 2012, Medicare required that the technical component of advanced diagnostic imaging (specifically, Magnetic Resonance Imaging [MRI], computed Tomography [CT], and Positron Emission Tomography [PET]) be billed only by providers who are accredited by one of the following organizations:

- The American College of Radiology;
- The Intersocietal Accreditation Commission; or
- The Joint Commission. ■

Q. Would we bill CPT code S9083 global fee urgent care centers for Medicare patients?

A. Medicare expects fee-for-service coding, which means billing for each service performed separately rather than coding a global flat-rate fee.

CMS specifically creates "S-codes" at the request of payors for services that Medicare does not reimburse. Thus, Medicare does not reimburse S9083 or any other "S-code." ■