CODING Q&A

Mid-level Providers, Resident Providers, Non-payment for S9088, Non-payment for E/M 99205, POS -20 for Family Practice

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Q. Our urgent care is staffed by nurse practitioners (NP) 6 days per week and all of the billing is processed under the medical director for all insurance companies. I have three separate questions:

1. **Is it legal for a new Medicare patient entering the urgent care setting to be billed under the medical director if he is not on site and has never seen the patient?**
2. **Is it better for the NP to be covered under the entire urgent care malpractice policy for Individual Professional Liability which includes all providers, or to be covered as an add-on under coverage B, which includes Partnership Liability?**
3. **How do we protect a Medicare patient that needs a tetanus vaccination per recommended guidelines after an injury if Medicare does not pay for it? Our billing staff states that the providers can no longer order/give vaccinations to Medicare patients.**

A. It is considered fraudulent billing to bill a new Medicare patient under a provider who has never seen the patient. Medicare requires individual credentialing for providers as well as mid-level providers, including NP.

Regarding malpractice coverage, the answer depends on your state laws and the specific policy involved. I would recommend reviewing this issue with a healthcare attorney.

Tetanus vaccination can be provided in a network provider's office. In this situation, however, the patient should pay for the vaccine costs up front and then submit the claim to receive reimbursement from the Medicare Part D plan. The beneficiary should contact his/her Medicare Part D plan in advance for detailed instructions on reimbursement for Tetanus vaccination. ■

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. Absent any express guidance in the applicable managed care contracts between an urgent care facility and commercial payors, will commercial payors reimburse urgent care facilities for services provided by moonlighting residents who are licensed with the state and enrolled in Medicare, but not credentialed with the commercial payors?

A. You are unlikely to find any express guidance for moonlighting residents in commercial payor contracts. You would need to contact each payor because payors have many different policies, such as:

- Allowing billing for services rendered by resident physicians without credentialing;
- Requiring credentialing of resident physicians; and
- Refusing to credential or allow billing for services rendered by physicians who are not board eligible.

If you bill in these situations without confirming the payor's policy, a payor may:

- Deny all claims;
- Pay but do "take-backs" if they discover it was done; or
- Pay but cancel contracts if they discover it was done. ■

Q. We used S9088 and 99204 to bill for an urgent care service. The insurance only paid for 99204. In speaking with the insurance company, they stated that we need to add a modifier to either S9088 or 99204 in order to be reimbursed. What modifier do we use for either S9088 or 99204?

A. Since S9088 ("Services provided to an urgent care center - list in addition to code for service)" is considered an add-on code, you would not typically need a modifier. The request for the modifier is uncommon, so you will want to review your contract with the payor regarding payment of this code or

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contact your provider relations representative and ask what specifically is required. There could be several reasons the payor denied S9088. A few of them are:

- The practice is not specifically contracted as an urgent care center.
- The payor will not pay unless reimbursement for the code is specified in your contract.
- The payor has made a blanket decision to no longer pay for the code. ■

Q. We used E/M 99205 and CPT code 10060 for an incision and drainage procedure, however, the insurance only paid CPT code 10060 without paying E/M 99205. The payor stated that we needed to add a modifier to code 99205 in order receive reimbursement. What modifier do we add to 99205?

A. When performing a significant, separate procedure in addition to the E/M, you should append modifier -25, ("Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service") to the E/M code. Therefore, if the documentation supports both the E/M code and the procedure in your specific example, you would bill 99205-25 and 10060. The procedure notes should be separate from the notes for the E/M portion of the visit. ■

Q. Our family practice office offers urgent care from 8 a.m. to 8 p.m., 365 days a year. We also have a group of physicians who keep their family medicine patients on their regular, non-urgent schedule. We are offering urgent care services but do not have an urgent taxonomy, only family physician and DME taxonomies. What are the steps to add urgent care onto our list of taxonomies so that we can bill our urgent care visits under the urgent care taxonomy? Will we need to apply and go through credentialing like we did with DME?

A. You can simply use POS -20 for Medicare. It will make no difference in reimbursement and no registration is needed.

For non-government payors, you typically need to contract (generally under a separate TIN for the urgent care) with the payors for urgent care. Payors will rarely allow the same TIN to have contracts for both primary care and urgent care. However, some payors still use POS -11 for their urgent care contracts. ■