CODING Q&A

Urgent care codes, E/M Guidelines, ICD-10

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Q. Is there a defined set of diagnosis codes for urgent care services and is there a diagnosis code that indicates the services were urgent?

A. All facilities use the same set of ICD-9 codes to report the patient's diagnosis. There are no diagnosis codes to represent urgent care services, but there are certain procedure codes you can use to indicate that services were rendered in an urgent care clinic and also procedure codes to indicate that the services were urgent.

Healthcare Common Procedure Coding System (HCPCS) Code S9088, "Services provided in an urgent care center (list in addition to code for service)," can be billed for every visit in an urgent care center with an Evaluation and Management (E/M) code. This code is an add-on code and cannot be billed alone.

CPT code 99051, "Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service," is another code that could be billed. Evening hours are generally considered to start at 5 p.m. This code was designed to compensate your practice for the additional costs to provide services during these extended hours and typically is billed to patients seen after 5 p.m. on Monday through Friday, and all day on Saturday, Sunday, and federal holidays.

CPT code 99058, "Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service," could also be used for patients who required immediate emergency services. However, some billers do not use this for services rendered in walk-in clinics.

You will want to check state regulations as well as payor contracts to see whether any of these codes should be billed or not. Medicare does not reimburse for any of these codes. ■

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Q. Is it true that we can now mix 1995 and 1997 guidelines when determining the level of service for an office visit?

A. No. You must use only one set of guidelines for any specific encounter and you are not required to state which set of guidelines you are using.

For services performed on or after September 10, 2013, the status of three or more chronic conditions qualifies as an extended HPI for either the 1997 or 1995 guidelines. This criterion for an extended HPI is part of the 1997 guidelines and previously could only be applied when using the 1997 guidelines. The Centers for Medicare & Medicaid Services (CMS) announced this change in a FAQ on 1995 and 1997 Documentation Guidelines for Evaluation & Management Services (http://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/em-faq-1995-1997.pdf). This is especially good news for centers that provide primary care services to manage chronic medical conditions. ■

Q. My employer is not providing any ICD-10 training. What can I do on my own in order to learn more about ICD-10 without paying hundreds of dollars?

A. There are several entities that offer training, but there is usually a cost involved. If you are a member of the American Academy of Professional Coders (AAPC), check with your local chapter or the AAPC national website for classes, seminars, and boot camps at www.aapc.com.

There are several code translator applications that are also helpful. AAPC offers one without requiring a membership at http://www.aapc.com/ICD-10/codes/index.aspx. I would recommend that you also purchase an ICD-10-CM manual and practice looking up the codes manually. Learn the coding guidelines and focus on situations you are most likely to encounter. Run

a report of your top 100 ICD-9 codes and translate them to ICD-10 codes. Be aware that if you are accustomed to coding "not-otherwise-specified" (N.O.S.) ICD-9 codes, you will need to dig further into more specific codes in ICD-10.

The ICD-10 code set is so extensive because of its increased specificity over ICD-9. For example, today we code a finger fracture as 816.00, "closed fracture of phalanx or phalanges of hand, unspecified." In ICD-10, you will select a code that indicates whether it's an index finger, middle finger, etc., and whether it is an initial encounter for the fracture or a follow-up visit.

To further illustrate this example, a patient presents with a displaced fracture of the medial phalanx of her right middle finger. When using ICD-9, you would use code 816.01, "Closed fracture of middle or proximal phalanx or phalanges of hand." In ICD-10, you would code S62.622A, "displaced fracture of medial phalanx of right middle finger, initial encounter." Not only does the code represent the fracture, but it also reports laterality and the type of encounter. When reporting fracture codes, you will be required to use a 7th digit that represents:

- Initial encounter for closed fracture (A)
- Initial encounter for open fracture (B)
- Subsequent encounter for fracture with routine healing (D)
- Subsequent encounter for fracture with delayed healing (G)
- Subsequent encounter for fracture with nonunion (K)
- Sequela (S)

There are also instances where you are instructed to report external cause codes. For example, when coding diagnoses from Diseases of the Respiratory System (J00-J99), you are instructed to use additional codes that report:

- Exposure to environmental tobacco smoke (Z77.22)
- Exposure to tobacco smoke in the perinatal period (P96.81)
- History of tobacco use (Z87.891)
- Occupational exposure to environmental tobacco smoke (Z57.31)
- Tobacco dependence (F17.-)
- Tobacco use (Z72.0)

Along with practicing looking up the codes, you will also want to review physician documentation to ensure you are able to code to the higher specificity of ICD-10 codes. ■