CODING Q&A

New vs. Established Patients, Medicare Exam, ICD-10 Delay

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Q. A patient with Medicare as his primary insurance needs a physical and EKG for clearance for an MRI with sedation ordered by his neurologist. Symptoms are imbalance along with pain in the shoulder, neck, and upper spine. Can I use the pre-op code V72.81 because there is sedation even though there is no actual surgery? Or should I just get a signed Advanced Beneficiary Notice (ABN) and expect a denial?

A. Yes, you can use code V72.81, "Pre-operative cardiovascular examination" because it also represents pre-procedural exams. According to ICD-9 guidelines, you should use this code for pre-procedural and pre-operative examinations. You will want to check your Medicare Local Coverage Determination (LCD) guidelines for approved diagnosis codes to determine whether to have the patient sign an ABN. In some cases, Medicare will cover EKGs with code V72.81 but you must also include the codes for the medical condition(s) that prompted the surgery or procedure.

Because Medicare does not recognize consultation (99241-99245) or preventive medicine (99381-99397) CPT codes, you will want to code the appropriate E/M code based on the level of work completed for history, examination, and medical decision-making. Please note that the chief complaint should be the complaint that the patient is suffering that requires surgery, and the HPI should relate back to that chief complaint. ■

Q. Most of our payor contracts require us to use HCPCS code S9083 "Global fee urgent care centers" which has not been an issue based on our case mix. For Medicare, Medicaid, and managed Medicaid, we are billing Evaluation & Management (E/M) codes with a Place of Service (POS) 20. What criteria are used to bill a new patient vs. established patient? Aren't all urgent care patients new patients? We do have patients return for follow up visits but we direct them to their primary care physician.

"According to ICD-9 guidelines, you should use V72.81 for pre-procedural and pre-operative examinations."

A. Unless specifically stated otherwise in a payor contract, urgent care centers follow the same guidelines for new vs. established patients as primary care practices. According to CPT guidelines, a new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the same specialty and subspecialty who belongs to the same group practice within the past 3 years. Professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may provide E/M services. You can read more on this subject in my columns in a previous issue of *JUCM*: http://jucm.com/magazine/issues/2009/0209/files/36.html

Obviously, those rules do not apply in cases where your contract calls for the use of HCPCS code S9083, "Global fee urgent care centers." That code is used in place of the E/M code, and (depending on the specific payor contract) often it is the only code billed, even when other services have been performed. ■

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"Simply having the physician perform the venipuncture because no other staff is qualified is not a sufficient reason to bill 36410."

Q. In our urgent care center, the physician always inserts IVs because there is no other staff qualified to perform the procedure. Can we bill CPT code 36410?

A. CPT code 36410, "Venipuncture, age 3 years or older, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)" would only be used in cases where the physician's skill is required. Simply having the physician perform the venipuncture because no other staff is qualified is not a sufficient reason to bill 36410. CPT guidelines direct you to code 36415, "Collection of venous blood by venipuncture" for routine blood collection from a vein.

If the physician is also starting intravenous (IV) lines, the correct CPT code for an IV start is 36000, "Introduction of needle or intracatheter, vein." However, if you are also billing a procedure for IV therapy (96360-96549), then it would not be appropriate to bill 36000 with those codes. The National Correct Coding Initiative edits bundle 36000 into most invasive surgical services because it is not possible for the physician to perform such services without inserting a needle first. ■

Q. Has ICD-10 implementation really been delayed again?

A. Secretary of Health and Human Services, Kathleen Sebelius was absolutely adamant that there would be no further delays and ICD-10 would be implemented on October 1, 2014. On a bipartisan basis, however, Congress and the President stepped in and overruled her on April 1, 2014. On a side note, Ms. Sebelius resigned 10 days later. ■

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