CODING Q&A

Revenue Per Patient, Prescription Drug Management for MDM, Medicare and HCPCS J3301 Denials

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Q. What is an acceptable income per patient visit for an urgent care clinic?

A. The recent benchmarking survey completed by the Urgent Care Association of America (UCAOA) found that the average urgent care center collects $110 per patient. However, the "acceptable" net revenue per patient visit varies widely from center to center and state to state. It fluctuates based on many variables:

- Existing contracts from payors
- State (e.g., payors in California and Arizona typically have lower reimbursement fee schedules than most states)
- Percentage of Medicaid and Medicare patients
- Percentage of patients seen by midlevel providers (many payors pay a 15% or more discounted fee for midlevel providers)
- Acuity of patient visits
- Range of services offered. Examples of services that might be offered, but often are not, include:
  - Procedural sedation
  - IV hydration
  - Pre-packaged medications
  - Definitive treatment for fractures
  - Removal of rust rings from corneas
  - Tendon repairs

I know of one chain (with >10 centers in rural America) that uses only midlevel providers and performs their own billing and is delighted with $90 per visit. Although we find this to be lower than optimal (and they are making proper changes to get it to at least $100 per visit), this group was at $72 per visit when they began to make improvements in their revenue cycle management. Other clinics expect per-patient revenue to always be over $140. That is definitely possible for some centers, but it is somewhat uncommon. ■

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Q. When a provider writes a prescription, should we automatically assess a Moderate Medical Decision Making (MDM) Complexity?

A. There are three components to consider when calculating the final result of the complexity of MDM:

- Number of Diagnoses and/or Treatment Options
- Amount and/or Complexity of Data Reviewed
- Risk of Complications, Morbidity, and/or Mortality.

When reviewing the number of diagnoses and/or treatment options, you will consider the number and types of problems addressed, the complexity of establishing a diagnosis, and the management decisions that must be made by the physician. The initiation of, or changes in, treatment should be documented.

The amount and/or complexity of data to be reviewed are based on the types of diagnostic testing ordered or reviewed. The data could encompass old medical records, ordering and reviewing medical and lab tests, and discussing test results with the performing physician.

"Risk is only one of the three components used to determine the final level of MDM. You must review the data from all three components to determine the final MDM."

The risk of complications, morbidity, and/or mortality is based on the risks associated with presenting problem(s), diagnostic procedure(s), and possible management options. The level of risk is calculated as Straight Forward, Low, Moderate, or High. CMS provides a Table of Risk that can be found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf. I believe this is the area where the confusion lies. The provider gets credit for moderate risk if the medical record documentation shows he or she is either writing a new prescription for the patient or evaluating any current prescriptions, including determining whether the drug, dosage, and frequency are still appropriate for the patient's condition. However, risk is only one of the three components used to determine the final level of MDM. You must review the data from all three components to determine the final MDM. ■

Q. When we bill HCPCS code J3301 to Medicare, we cannot get it to pass through audits. We get a message stating that we need a different description. We have tried "Injection, triamcinolone acetonide, not otherwise specified, 10 mg," but this is not working. Do you have any suggestions?

A. HCPCS code J3301, "Injection, triamcinolone acetonide, not otherwise specified, 10 mg" can be used for Kenalog-10, Kenalog-40, Tri-Kort, Kenaject-40, Cenacort A-40, Triam-A, and Trilog. You will want to check with your clearinghouse to see if they prefer to see the specific description.

You will also want to check your Local Determination Coverage (LCD) listings for any restrictions, such as the number of injections a patient will be covered for in a certain time period, or if there are specific diagnosis codes they will cover for an injection. ■