

**Problem-Based Coding (PBC) for Evaluation and Management (E/M) codes in Urgent Care Medical Coding** by David Stern, MD, CPC

**WARNING:** Urgent care centers must not use problem-based coding (PBC) without clear communication between the payor and the urgent care. Physician practices which are not true urgent care centers treating patients on a walk-in basis should not use PBC. The Center for Medicaid/Medicare Services (CMS) expressly prohibits the use of PBC for patients covered under Medicare. Use of PBC may result in prosecution for violations of both state and/or federal laws. Information contained on this website is for informational purposes only and is not intended to be used as legal advice or as a substitute for legal counsel. **No practice should utilize problem-based coding without first consulting appropriate legal counsel.**

**Problem-Based Coding (PBC) in Urgent Care Defined:** Problem-based coding can be used in urgent care to code the evaluation and management code (E/M) for a patient being seen in an urgent care. A “new” patient code is a patient being seen for a new problem or a problem that has resolved since the previous visit. An “established” patient code is used to code the E/M for a patient being seen for a problem that has not resolved since the patient was last seen for that problem.

**Problem-Based Coding (PBC) is a reasonable method of coding in the urgent care center for two main reasons:**

1. **Consistent Medical Coding:** In urgent care a patient is not truly “established” with the complete intake history and physical that is typical in primary care medicine. In fact, the patient is being seen and evaluated for a specific “problem.” Unless the patient is being seen as a follow-up visit for a problem that was previously seen in the urgent care, the patient is evaluated from scratch for the presenting problem, much as in a visit to an emergency department (ED) of a hospital. Thus, an urgent care visit is more akin to a low-acuity emergency department visit than it is to a visit to a family doctor. Because patients are not established in an ED, patients in the ED are not separated into “new” and “established” patients for the purpose of E/M coding, so a single set of E/M codes is used for these visits. Short of developing a single set of unique E/M codes for visits to urgent care centers, PBC may be the most accurate method for E/M coding of urgent care visits.
2. **Additional Expenses in Urgent Care:** Urgent care expenses, while not as high as those of an emergency department, are significantly higher than in an office-based practice. Additional expenses borne by the urgent care include:
  - **Additional staffing:** Urgent care centers generally retain more nursing staff full-time equivalents (FTEs) to deal with the need to triage patients, take additional patient history, and deal with surges in patient flow.
  - **Intermittent patient flow:** Office-based physicians can usually keep their staff steadily busy during the entire day with carefully scheduled appointments. An urgent care center, however, does not schedule appointments. Patients walk in as the need arises. This means that at

times few patients will be in the urgent care center, and it is not unusual for a typical urgent care center to have a four hour period during the week when less than two patients present to the center. Although little or no income is generated during these hours--several nurses, a radiology technologist, a receptionist and a physician are drawing full wages. Thus, instead of staff working near maximum efficiency (as is done in office-based medical practice), staff average efficiency in an urgent care center will generally be below maximum.

- **Staffing on evenings, holidays and weekends:** Bonuses or after-hour premiums must often be paid to attract and keep staff to work shifts that are generally less convenient than hours worked in an office-based practice.
- **Higher wages:** Because urgent care centers are open during non-traditional work hours, urgent care centers generally have to pay a premium wage over office-based wages in order to attract the same quality staff.
- **Higher facility costs:** Urgent care centers incur higher costs than office-based physicians. Urgent care centers generally need to keep one or even two larger exam rooms (often called “trauma rooms”) open to deal with minor emergencies (lacerations, fractures, crush injuries, etc.) that are expected to occur without warning during the normal hours of operation. Radiology equipment and staff must be kept at the ready, even if often not needed for hours during the day. Larger waiting rooms (with larger rents, utilities and furniture costs) are needed to accommodate the unpredictable patient flow.
- **Higher advertising costs:** A primary care physician can retain a base of about several-thousand patients and stay busy. These visits are naturally scheduled through the ongoing relationship between the physician office and the patient, and little advertising is needed to maintain patient volume. An urgent care center, however, receives many fewer patient visits per patient. Thus, the urgent care center must continually invest substantial capital to keeping top-of-mind awareness of urgent care for the entire community of at least 30,000. If public awareness of urgent care slips, many of these low acuity visits end up turning into costly hospital emergency departments. Thus, advertising urgent care is an investment in reducing costs for the entire healthcare system.
- **Medical liability insurance** is generally more expensive on a per visit basis than it is for the primary care physician.

#### **Myths about PBC:**

- **Myth: PBC is about to be approved by CMS.** False. Representatives of CMS have made it clear that CMS is not currently seriously considering problem-based coding. CMS has not officially ruled out PBC or even a new set of E/M codes for urgent care centers, but much work must be done by the urgent care community to prepare to lobby for distinct E/M coding in urgent care.
- **Myth: If a managed care organization (MCO) does not accept Problem-Based Coding (PBC), you may threaten the MCO with a national boycott of**

- the MCO by urgent care centers.** False. Certain individuals have recommended this tactic in recent years, but it is not appropriate to threaten boycotts or organizational collusion to force acceptance of PBC. These tactics violate antitrust statutes. The Federal Trade Commission has remained emphatic in its disapproval of any form of collective bargaining by physicians or of any legal exemptions to this policy. ([Click here to read testimony by an FTC official on the issue of physicians and collective bargaining.](#))
- **Myth: Urgent care centers may unilaterally implement PBC if they meet certain criteria or if they are accredited by a specific accrediting organization.** False. Accreditation by UCAOA (or any other organization) does not give an urgent care center the right to use PBC. CMS has prosecuted urgent care centers for using new patient codes for patients defined as established. ([Click here to review a legal case, where an urgent care center was forced to pay refunds and penalties for billing new patient E/M codes for established patients.](#))
  - **Myth: As long as the point of service is identified with code 20, it is fine to use problem-based coding.** False. Although the point of service code 20 was a move in the right direction, the urgent care industry euphoria over the new code was misplaced. CMS has not specifically defined what criteria define a center as an urgent care. For the purpose of billing and coding, CMS currently treats services rendered using point of service 20 no differently than office-based services. In fact, CMS software simply crosswalks point-of-service 20 to point-of-service 11. Thus, the CMS software treats these two codes identically.

### **Current Evaluation and Management (E/M) Coding Methods and Application to Urgent Care**

- **Primary Care Evaluation and Management (E/M) Coding:** For the initial visit of the patient, in a primary care physician office, the physician generally obtains a very thorough and extensive history and physical examination. All of the past, current, or even future problems related to the patient's health care are addressed. The patient is, thus, "established" and becomes an "established patient" in that particular physician's office. Thus, the E/M code for this "new patient" visit is likely to result in a significantly higher E/M code in the primary care physician's office than if the patient was seen for a specific problem in an urgent care center. At subsequent patient visits, the physician will generally refer to the extensive history and physical obtained at the initial visit. In the urgent care center, however, the physician generally addresses only the medical problems that pertain to the acute problem being addressed at that particular visit. Thus, the urgent care center does not have an extensive initial history and physical to refer back to at each subsequent visit for different medical problems. Each patient visit, the patient is evaluated and managed as a "new patient."
- **Specialty Physicians Evaluation and Management (E/M) Coding:** Many visits to specialist physicians are coded with consult evaluation and management (E/M) codes. Consult E/M codes are necessarily "problem-based;" that is the referring physician is seeking the opinion of the specialist in regard to a specific problem. Thus, consult code sets do not distinguish between new and established patients. Although the specialist may have been consulted multiple times, each visit is to

evaluate a specific problem, so it is coded with the same consult E/M code set. Thus, the consult code set shows precedent for not using the “new patient” versus “established patient” concept for visits that are problem-based.

- **Emergency Department (ED) Evaluation and Management (E/M) Coding:** As in the urgent care setting, patient are not given complete intake history and physical exams on the initial visit to the emergency department. This is because, emergency visits (as with urgent care) visits are problem oriented—i.e., the patient is presenting with a specific problem, which the ED physician evaluates and treats. Thus, the ED evaluation and management codes do not distinguish between “new” and “established” patients. Also, the hospital receives reimbursement for an additional code (the facility E/M code) to cover the additional costs inherent in seeing patients in the emergency department.

**Alternatives or Additions to Problem-Based Coding:** The Urgent Care Association of America realizes that PBC is a less-than-ideal compromise method for reimbursing urgent care centers for the extra costs of running an urgent care center. There are several other options (none currently available for Medicare, Medicaid or other government-run programs) for the urgent care to use instead of or in addition to PBC:

- **Specialist Fee Schedule:** Some Managed Care Organizations (MCOs) are not willing or able to use a different coding method in urgent care. MCOs often, however, do want to find a reasonable method to recognize the additional costs of delivering urgent care. One way that many MCO’s already use to cover the additional costs incurred by certain physician offices is the specialist fee schedule. Specialist fee schedules are often 30-50% more than primary care fee schedules. Utilizing these fee schedules in the urgent care setting is perfectly reasonable and may become more-and-more utilized as urgent care gains respectability as a unique specialty. Hiring only physicians who are board-eligible or board-certified in urgent care medicine may help MCOs see the rationality of this argument.
- **Negotiating higher fee schedules** has been done successfully by urgent care centers. Rates at 120-150% of the MCO fee schedule for primary care seem reasonable, as the per-visit cost to deliver urgent care is up to twice the cost in a primary care physician office. Specific methods for negotiating these higher reimbursement rates in urgent care will be hot discussion points in networking conversations at the annual national UCAOA conference.
- **Negotiating the use of an additional “facility” E/M code for urgent care** is another reasonable method to reimburse the urgent care for the added costs (outlined above) of delivering urgent care.
- **New Evaluation and Management (E/M) Codes specific for urgent care centers.** Specific codes (similar to the E/M codes for consults or ED visits) would be the ultimate solution to this problem. Emergency departments are already highly regulated, unique centers for delivering medical care. What constitutes an urgent care, however, is not yet been clearly delineated. Urgent care centers range from nothing more than a family physician office that is open until 6PM on weekdays to twenty-four-hour centers open 365-days per year that are essentially free-standing emergency rooms. In order to clearly

delineate which centers are true urgent care centers, the Urgent Care Association of America will need to use strict criteria to inspect and accredit several hundred urgent care centers. This is one of the reasons that UCAOA was formed, as it was clear that only a large, nonprofit, member-voting association would be able to bring appropriate respect and legitimacy in the eyes of governmental and regulatory bodies for the benefit of the whole industry. UCAOA unveiled its new accreditation process at the 2005 annual convention. UCAOA members present at the convention will be able to apply for the initial wave of accreditation. Once several hundred centers are accredited, it seems reasonable to believe that UCAOA members will be able to successfully lobby the AMA and CMS to institute a new E/M code set that is only available to accredited urgent care centers.

**Dangers of Problem-Based Coding (PBC) in Urgent Care Centers:**

Never use PBC without prior written notification of your billing methods to the payor. The Urgent Care Association of America accepts no responsibility for legal liability for urgent care centers in regard to implementing PBC in their coding process. Urgent care centers should never implement PBC without consulting legal advice from an attorney with specific expertise in medical coding and compliance.

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