Advanced Procedure Coding for Emergency Medicine

February 5-7, 2013
San Diego, California

Lightning Rounds: Don’t Get Struck – ICD-10 Preparation and Other Hot Topics

- Identify the most common controversies in emergency medicine coding, including EHR documentation and scribes.
- Review ED implementation strategies for ICD-10.
- Discuss coding strategies for conscious sedation and pediatrics patients.

2/6/2013
1:30 PM - 2:30 PM

(+) No significant financial relationships to disclose.
Pediatrics: kids, codes, records and payment pitfalls

Candace E. Shaeffer RN, MBA, RHIA
Chief Compliance Officer, LYNX Medical Systems, now part of Optum

The Pediatric Population

- Pediatric data
  - 22.1% of all ED patients are pediatric
  - 19.3% of EDs have pediatric trauma services
  - 28.6% of all peds ED visits are to children’s hospitals and hospitals with PICUs

- Peds age parameters vary: under age 18 is common
- The majority of peds ED visits are for respiratory problems and injuries
- Most peds encounters will be private pay or insured by Medicaid or commercial payer
- Peds has one specific PQRS condition category: AOE

National Health Statistics Reports, March 2012
Pediatric E/M CPT Codes

- **99464** attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn
- **99465** delivery/birthing room resuscitation—positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output
- Newborn care services, **99460-99463**, are inpatient per day codes and not appropriate for reporting in the ED
- **99406-99408** Behavior change interventions smoking/tobacco use and alcohol/substance abuse

Pediatric CPT Procedure Codes

- **99143** MCS provided by same physician performing the service that the sedation supports, <5 years, first 30 min of intra-service time; **99144** age 5 years or older,
- **99148** MCS provided by a physician other than the MD performing the service that the sedation supports, <5 years, first 30 min of intra-service time; **99149** age 5 years or older
- **99170** Anogenital examination with colposcopic magnification in childhood for suspected trauma
- **99100** Anesthesia for patient of extreme age, younger than 1 year and older than 70; + other anesthesia codes
### Pediatric CPT Procedure Codes

- **36400-36406** Venipuncture, younger than 3 years necessitating physician skill; **36410** age 3 years or older
- **36420** Venipuncture, cutdown younger than age 1 year; **36425** age 1 or over
- **36510** Catheterization of umbilical vein for diagnosis or therapy, newborn
- **36555** Insertion of non-tunneled centrally inserted central venous cath, <5 years; **36556**—5 years or older
- **36568** Insertion of PICC <5 years; **36569** 5 years or older

### Pediatric CPT Critical Care Codes

- Critical Care rules are consistent peds to adult, but presenting problems vary: pediatric fever, dehydration, croup
- Critical care provided in an outpatient setting is generally reported with **99291** and **99292**
- Neonatal critical care codes **99468—99469**, and Pediatric critical care codes **99471—99476**, are inpatient per day codes and are not usually reported by the ED physician
  - **UNLESS** critical care is provided on the same day by the same physician in both the inpatient and outpatient settings, then **ONLY** neonatal/peds critical care codes are reported
- **99466** critical care services by MD, face to face, during an inter-facility transport of a critically ill or injured pediatric patient, 24 months or younger, first 30-74 minutes. **99467** each additional 30 minutes
Age Affects Documentation Needs

- Peds clinical info is often provided by another person: document the source of information in the record--1 point in MCT, MDM
- Limited communication ability affects encounter complexity
- “Normal” varies between peds age groups and individual patients, so best practice: be more specific
- Pediatric critical care may not be as apparent to coders, documentation needs to be explicit
- While the CMS and CPT documentation guidelines apply to both adults and peds, CMS states in DGs: For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical record of infants, children, adolescents and pregnant women may have additional or modified info recorded in the history and exam…these patient group variations on history and exam are appropriate.

Examples of “Other or Modified” Information

- General appearance in peds is more important than with adults in documenting the severity of the presenting problem
- For newborns/infants include in the history as appropriate: pregnancy history, type of delivery and complications, health of newborn, feeding issues, etc.
- Social history will include family structure
- Family history should address any congenital or hereditary disorders in the family
- Peds patient documentation should include a weight—either an accurate weight or a standard estimate method for critical patients
Examples of Peds Documentation Variations

- Peds pain scale:

- Rule of Nines varies adult to pediatric burns:

Special Peds Documentation Best Practices

- Vaccinations—specifics are preferable to “UTD”
- Include notation of alleged/suspected physical/sexual assault or molestation and domestic abuse/neglect of children
- Query tobacco use—don’t forget passive exposure, alcohol and drug history—and what about steroid use in those young would-be athletes?
- Query lead exposure, if applicable
- Explain MCS for lac repairs, CT, etc.
- Peds have fewer interventions, tests; etc., Hx and PE are more extensive—explain rationale connecting PP to w/u and plan
MDs support coders by explicitly documenting severity/criticality and diagnoses

- Subtle changes in an infant’s or child’s behavior and appearance can have significant meaning in terms of severity of an illness or injury—coders won’t always recognize these nuances
- Peds Critical Care: meaning of signs and symptoms, CC indicators
- Evaluation is different for some conditions in pediatric patients—fever, seizure, abdominal pain, etc. MD may order fewer tests/interventions; difficult for coders to assess MDM when work-up is less than for an adult
- Sick kids with severe and/or multiple chronic problems requiring daily management present to ED with one chief complaint which is addressed; which factors will the coder consider for E/M coding?
- A patient presents to ED with asthma, hx of same, and is treated and released—diagnosis should be acute exacerbation of asthma; asthma unspecified is a source of frequent denials; RAD also codes to asthma, unspecified

Records at Risk for Downcodes and Denials

- Condition has been ongoing for more than a day
- Presenting problem is not urgent
- Condition has resolved, PP is a “recent history of”
- Diagnosis is on a payer non-urgent list
- Dx not specified as “acute” or “acute exacerbation”
- No problem found, dx is a V code
- Medical necessity not documented
- Encounters where “nothing was done”
- Medicaid coverage
- EHR and shortcuts: cut and paste, carry forward, etc.
Documentation to Support Payer Audits

- Document for “medical necessity,” keep 99283s from being downcoded to level 2 or 1
- If MD discusses diagnostic options with the family and together decide not to do a test, document this thought process for consideration in MDM
- Document connections between patient’s condition, history, exam, orders, findings, risks and plan of care
- No one wants to send a sick kid home, documentation often emphasizes how well the peds patient looks, no distress etc., if appropriate, mild distress is preferable
- Document rationale for orders, they don’t stand on their own
- If condition is “acute,” document term with diagnosis
- Proceed with caution with macros and other short cuts—review and modify for current encounter

Contact Information

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Medical Decision-Making
Marshfield, CPT, DG’s or ???

Dennis Beck MD FACEP
CEO Beacon Medical Services
2/6/13

Medical Decision Making (MDM)

- History, Exam and MDM are the three key elements in E/M selection
- E/M level determined by lowest of the three
- History and Exam are quantifiable and clearly identifiable
- MDM is subjective and
  - Often requires scrutiny of entire record
  - May need to be inferred
  - Multiple interpretations of MDM may be utilized in audits: CPT, 95/97 Documentation Guidelines and Marshfield
Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed
- The risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s), and/or the possible management options

Four types of medical decision making are recognized: straightforward, low complexity, moderate complexity, and high complexity. To qualify for a given type of decision making, **two of the three elements in Table 1 must be met or exceeded.**

Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless their presence significantly increases the complexity of the medical decision making.

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**MDM Complexity is described in narrative table format**

- No quantitative scoring
- **Table 1**

<table>
<thead>
<tr>
<th>Number of diagnoses or management options</th>
<th>Amount and/or complexity of data to be reviewed</th>
<th>Risk of complications and/or morbidity or mortality</th>
<th>Type of decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>
Expands on CPT description with additional editorial comments that are favorable to emergency medicine:

*Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem.* The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected.

And adds a “Table of Risk”

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### TABLE OF RISK

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Pernicious Problem(s)</th>
<th>Diagnostic Procedure(s) (ordered)</th>
<th>Management Options Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimally</td>
<td>One or more self-limited problems; eg cold, acute tonsillitis, bone fractures.</td>
<td>Laboratory tests requiring vasopressor therapy, nasogastric intubation, fluid resuscitation, etc.</td>
<td>Nasogastric intubation, etc.</td>
</tr>
<tr>
<td>Low</td>
<td>Two or more self-limited or minor problems.</td>
<td>Physical exam, blood work, ECG, etc.</td>
<td>Blood work, ECG, etc.</td>
</tr>
<tr>
<td>Moderate</td>
<td>One or more chronic illnesses; eg diabetes mellitus, hypertension, osteoarthritis.</td>
<td>Physical exam, blood work, ECG, etc.</td>
<td>Physical exam, blood work, ECG, etc.</td>
</tr>
<tr>
<td>High</td>
<td>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment.</td>
<td>Physical exam, blood work, ECG, etc.</td>
<td>Physical exam, blood work, ECG, etc.</td>
</tr>
</tbody>
</table>
And in 1995 Along Comes Marshfield

- 1992: CPT E/M codes introduced
- 1995: CMS and CPT issue ‘95 Documentation Guidelines
  - Oklahoma City bombing
  - Windows 95 released
  - Jerry Garcia dies
  - OJ found innocent
  - Best Picture?
  - Super Bowl?
- 1997: ‘97 DG’s

Marshfield MDM

- Where did it come from
  - Beta tested by Marshfield Clinic as part of 95 DG’s but never officially incorporated into CMS or CPT
  - Widely used by many MAC’s as basis for audit score sheet
  - No “official” definitions or descriptions exist so Marshfield may be interpreted and re-written from the perspective of the auditing entity
What does “New problem; additional work-up planned” really mean?

Possibility of unintentional up-coding based on Marshfield MDM score

Marshfield fails to accurately reflect complexity of MDM in our current environment
New problem; additional workup planned

- CPT: 9928X codes do not make any distinction between new and established patients
- Marshfield Options refers to new or established problems
- According to Catherine Fischer, reimbursement policy adviser for Marshfield Clinic, it was Bart McCann, MD, former executive medical officer at HCFA, who offered the definition of a new problem… "The decision making guidelines were designed to give physicians credit for the complexity of their thought processes. Giving a physician more credit for handling a problem he or she is seeing in a patient for the first time, even when that problem has been previously identified or diagnosed, is within the spirit of the guidelines."

New problem; additional workup planned

- Novitas website: FAQ #18
  "What constitutes additional workup in the Amount and Complexity of Data grid for Medical Decision Making?"
  The number of possible diagnosis and/or the number of management options that must be considered is based on the number of types of problems addressed during the encounter, the complexity of establishing a diagnosis, and the management decisions that are made by the physician. For each encounter an assessment clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation. Additional workup is defined as anything that is being done beyond that encounter at that time. For example, if a physician sees a patient in his office and needs to send that patient on for further testing, that would be additional workup. The physician needs to obtain more information for his medical decision making."
  Date Posted: 10/16/2009, Date Revised: 10/01/2012
New problem; additional workup planned

Andrew Bloschichak, M.D. (HGSA CMD 1/25/05):

“In the practice of Emergency Medicine, normally the ED physician makes the decision to admit the patient, and then the admitting physician performs the additional workup after the ED encounter, i.e., additional treatment planning. Therefore, the admitting physician provides the additional workup that is planned, not the ED physician.”

Emergency medicine approach

There has been some confusion on what is meant by “Additional work-up planned”. “Additional work-up planned” is the diagnostic testing or consultations ordered during or after the physician completes their history and examination. In other words, the physician has determined that additional information is needed for his/her medical decision making.

Diagnostic laboratory tests, and other diagnostic tests such as x-rays, ultrasound, or CT/MRI scans qualify as “additional work-up planned”. In addition, consultations arranged emergently or as an outpatient also qualify as “additional work-up planned”.
Moderate MDM: 99283 or 99284?

<table>
<thead>
<tr>
<th>Key Components</th>
<th>99281</th>
<th>99282</th>
<th>99283</th>
<th>99284</th>
<th>99285</th>
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<tbody>
<tr>
<td>History</td>
<td>Problem-focused</td>
<td>Expanded problem-focused</td>
<td>Expanded problem-focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Examination</td>
<td>Problem-focused</td>
<td>Expanded problem-focused</td>
<td>Expanded problem-focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Medical Decision Making</td>
<td>Straightforward</td>
<td>Low</td>
<td>Moderate complexity</td>
<td>Moderate complexity</td>
<td>High complexity</td>
</tr>
</tbody>
</table>

Contributory Factors

- Presenting Problem
  - Self-limited or minor
  - Low to moderate severity
  - Moderate severity
  - High severity

Marshfield Myths and Urban Legend

- Potential coding issues occur with Moderate MDM mapping to 99283 and 99284
- Common approach is to divide Moderate MDM into “high” and “low” moderate
  - No existing source documents to base this on
- Code selection may become even more confusing when History and Exam are commonly documented at Comprehensive level
99283 Conundrum

- 22 y/o male with moderately severe ankle sprain
  - Comp H&P documented
  - X ray ordered and viewed by EP
  - Prescription given
- Comp H&P plus Moderate MDM = ???

Moderate MDM Conundrum

- Ankle sprain as 99284?
- Differentiate “low” vs “high” Moderate???
- More fundamentally sound and compliant approach is to use NOPP
- NOPP reflects medical necessity
  - Moderate severity (99283): A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment
  - High severity (99284/285): A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment
High Complexity MDM Conundrum

- Severe pharyngitis
  - Comp H&P
  - Rapid strep plus CBC and monospot
  - Rx’d with IM Penicillin plus parenteral narc
- Comp H&P plus High MDM = 99285 ???
- Consider NOPP to assign correct code
  - Risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment AND an immediate threat to life or physiologic function

Marshfield MDM Tool: Almost 20 Years Old and Not Aging Well

- Then: More testing = greater MDM complexity
- Now: Value = quality/cost
  - Do the right thing: reduce use of low value testing and interventions
  - Should provider get more Options or Data credit simply because they do more tests?
- Consider:
  - Educating providers re MDM documentation strategies
  - Developing internal coding policies to address MDM in 2013
Questions

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Moderate Conscious Sedation and Anesthesia Services

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President LogixHealth

Depth of Sedation

- Minimal sedation (anxiolysis)- patient responds normally to verbal commands
- Moderate Sedation-patient responds to verbal commands accompanied by light tactile stimulation
- Deep sedation-patients responds following repeated painful stimulation. Spontaneous Ventilation may be inadequate
Moderate (Conscious) Sedation

- Now called “Moderate (Conscious) Sedation”, not “Conscious Sedation”.
- Distinguished from anxiolysis and deep sedation or anesthesia care
- Patient responds purposefully to verbal commands with light tactile stimulation
- No interventions required to maintain an adequate airway
- Ventilation is adequate
- Cardiovascular function is maintained

Moderate Conscious Sedation

- Codes divided into 2 groups:
  - MCS provided by the same physician who is performing the procedure
  - MCS provided by a physician in support of a second health care provider performing the procedure
- Each group further delineated based on age of patient and time increments
MCS Same Physician:  
99143, 99144, 99145

- Moderate sedation by same physician performing the procedure
- Requires the presence of an independent trained observer
- 99143: Under 5 y.o. - first 30 minutes.
- 99144: 5 y.o. and over - first 30 minutes.
- +99145: each additional 15 minutes.
  - Add on Code

MCS Different Physician: 
99148, 99149, 99150

- Moderate sedation by different physician from the one performing the procedure
- 99148: Under 5 y.o. first 30 minutes.
- 99149: 5 y.o. and over, first 30 minutes.
- +99150: each additional 15 minutes.
  - Add on Code
Intra Service Time

- Time based codes not common in the ED
- Starts with the administration of the sedating agent
- Requires continuous face to face contact
- Ends at the conclusion of personal contact by the physician overseeing the sedation

The Downer: 16 minute threshold

- 16 minutes of bedside intra-service time
  - Starts with the administration of the med
  - Ends when MD breaks face to face bedside supervisions
- Is it appropriate to report the moderate (conscious) sedation codes for the first 30 minutes of intraservice time if only 10 minutes of moderate sedation services are provided?
- Answer: No. The standards for time measurement provided in the Introduction of the CPT 2011 codebook shall apply. A unit of time is attained when the midpoint has been passed. Therefore, in order to report a code with a unit of time of 30 minutes, 16 minutes or more of the service described by the code must be provided.
MCS RUC RVU Values

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>99143</td>
<td>.70</td>
<td>C</td>
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</tr>
<tr>
<td>99144</td>
<td>.66</td>
<td>C</td>
<td>$40.75</td>
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<td>99145</td>
<td>.23</td>
<td>C</td>
<td>$14.47</td>
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<tr>
<td>99148</td>
<td>1.75</td>
<td>C</td>
<td>$99.41</td>
</tr>
<tr>
<td>99149</td>
<td>1.65</td>
<td>C</td>
<td>$95.21</td>
</tr>
<tr>
<td>99150</td>
<td>.47</td>
<td>C</td>
<td>$27.04</td>
</tr>
</tbody>
</table>

MCS and Appendix G codes

- Do not report MCS provided by a single physician when performing a service listed in Appendix G
- Appendix G procedures identified by ♻ – ♻ 32551
- You may report MCS involving 2 physicians when an appendix G procedure is performed in the facility setting
MCS and Appendix G Issues

- Appendix G lists ~250 codes that bundle MCS

- ED Important codes:
  - 32551 chest tube insertion
  - 33010 pericardiocentesis
  - 33210 insertion transvenous pacemaker
  - 36555 insertion pediatric (under age 5) central line
  - 36568 insertion pediatric (under age 5) PICC line
  - 92953 transcutaneous pacing
  - 92960 elective cardioversion

MCS and Appendix G Codes

- Do not report MCS for an Appendix G procedure when only a single physician involved
- Do not report codes 99143-99145 with Appendix G procedures

- You may report MCS for an Appendix G procedure when provided by a different physician other than the one performing the procedure
- Do report codes 99148-99150 with Appendix G Procedures
MCS Vignette 1

- The ED physician spends 48 minutes providing sedation with versed and fentanyl for a 38 year old with a dislocated shoulder suffered during a football game
- Code 23650 shoulder dislocation
- 99144-MCS same physician age > 5 y.o. 30 minutes
- +99145 additional 15 minutes (1 unit)

MCS Vignette 2

- The ED physician provides 18 minutes of sedation using IV Ketamine to sedate a 4 year old undergoing a fracture reduction by orthopedics
- Code 99148: MCS provided in support of another physician, age < 5 y.o. first 30 minutes
MCS Vignette 3

- The ED physician provides 20 minutes of MCS in support of the trauma attending who has asked for assistance while placing a chest tube in a very dyspneic COPD patient involved in an MVA
- 32551 is an Appendix G procedure
- However, 2 physicians involved
- Code 99149 MCS provided in support of a second health care provider, 5 years or older, first 30 minutes

Medicare Coverage: MCS

- Transmittal 1316
- Same phys. MCS OK
- Recognition of 99143-99145
- Still Status Indicator C
- Local Carriers encouraged to pay
Deeper Sedation in the ED

- ED physicians perform frequent and important sedation services
- Many groups have expanded beyond versed and fentanyl
  - Etomidate or Diprivan

Anesthesia Services

- Many ED physicians perform “roving” Anesthesia services at the hospital’s request
- Particularly Pediatric Groups
  - GYN Exams
  - Ophto Exams
  - MRIs and Radiology Procedures
- Central tenet of CPT is that any code may be reported by an qualified provider
- There is no CPT/AMA or coding prohibition against ED physicians appropriately reporting Anesthesia Services
Anesthesia Services Reimbursement Reality

- Difficult to get Anesthesia codes paid in place of service (POS) #23
  - Outpatient ED
- Most payers will not recognize Specialty #93 physicians as providers of Anesthesia Services
  - Doubly tough to get the payer to recognize ER doc in the ED
- Recommend prospective payer credentialing
- Pediatric Groups have been successful
- Single dominant payer-Medicaid
  - Gone prospectively
  - Made cost savings argument...saving a trip to the OR
  - OR associated with very high facility fees

Anesthesia Code Assignment

- Located in the second section of CPT
- Codes 00100 – 01999
- The Anesthesia CPT code is determined by the surgical procedure performed:
  - The Orthopedist performs a reduction of a distal radius fracture which is represented by 25605 (Closed treatment of distal radius fracture with manipulation). The appropriate Anesthesia code is 01820... Anesthesia for all closed procedures on radius, ulna, wrist, or hand bones.
Anesthesia Cross Walk Examples

- Surgeon performs 10061 drainage complex abscess (neck)
- Report 00300 Anesthesia for all procedures on the integumentary system, head, neck, and posterior trunk

- Optho performs a 13150 complex eyelid laceration repair
- Report 00300 Anesthesia for all procedures on the integumentary system, head and neck

- Ortho performs 27252 hip reduction
- Report 01200...Anesthesia for all closed procedures involving the hip joint

Cross Walk Resources

- Without extensive clinical background will need an Anesthesia cross walk
- Takes you from the Surgical Procedure code to the Anesthesia Code
- Anesthesia Cross Coder
  - www.optumcoding.com
  - www.supercoder.com
  - www.ASAHQ.org
### Anesthesia Base Units

- Anesthesia codes carry a prescribed number of base units for each service provided
  - Number of Anesthesia Base Units Assigned to the Anesthesia Service provided
    - 00300 abscess/complex lac. 5.0 Base Units
    - 01200 Hip reduction 4.0 Base Units
- Anesthesia Coding and Payment Guide
  - Ingenix
  - Has both the CPT cross walk and Base Units

### Time Units

- Anesthesia services also consider the amount of time involved
- Using the Anesthesia flow sheet determine the number of intra-service minutes
- Reported in field 24 G of the 1500
- Variable reporting methodologies
  - Number of units, start stop time, actual minutes
- Payers have very variable formulas for calculating the number of time units
  - 15 minutes most common
  - 6,10,12 also used at times
  - Very payer specific
Anesthesia Reimbursement

(Base Unit Value + Time Units) X Conversion Factor = Payment

Anesthesia Conversion Factor 2013:
$20.50

Physical Status Modifiers

- Physical status modifier appended to the anesthesia code
  - Example: 01820-P1

- P1-A normal healthy patient.

- P2-A patient with mild systemic disease.

- P3-A patient with severe systemic disease.

- P4-A patient with severe systemic disease that is a constant threat to life.

- P5-A moribund patient who is not expected to survive without the operation.

- P6-A declared brain dead patient undergoing organ harvest
Qualifying Circumstances

- **99100** Anesthesia for patient of extreme age, under 1 year and over 70
- **99116** Anesthesia complicated by utilization of total body hypothermia
- **99135** Anesthesia complicated by utilization of controlled hypotension
- **99140** Anesthesia complicated by emergency conditions
  - (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.)

Overview

- Identify CPT Procedural Code
- Use cross walk to pick Anesthesia code
- Determine Time Units
- Adjust to payer specific format
  - Add Physical Status Modifiers
- Consider Qualifying circumstance
- Report your code and Units!
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Resources

- American Society Of Anesthesiology
  - www.ASAHQ.Org
- CMS Anesthesia Guidance
  - Anesthesia Base Units and Policies
- Anesthesia Coding Alert
- Ingenix Anesthesia Payment Guide
- Contexo Coding/Billing for Anesthesia
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Scribes in the ED 2013

Scribes in the ED

• A scribe accompanies the doctor into each patient encounter to transcribe the doctor’s dictation into the medical record.

• A scribe must document verbatim what is being said by the physician.

• The scribe cannot document any of their own findings.

• The scribe’s documentation should identify the scribe and the physician.
Scribes in the ED

- When using an electronic medical record, the scribe must have their own username and password to access the system.

- Entries in the EMR must be identified as having been made by the scribe.

- The physician must review and verify the scribe documentation and attest to its accuracy in addition to also signing the chart.

Per CMS

- The scribe functions as a recorder of facts and events which occur between the physician and the patient during the encounter.

- Medicare policy is not opposed to the use of personnel as scribes.

- There must be evidence that the physician reviewed and confirmed what is stated by the scribe.
CMS on Scribes...
Joe Kuchler, Spokesman for the CMS

• Under Medicare conditions of participation for hospitals, physicians may delegate the task of entering chart information to scribes or other staff. But the physician remains responsible for dating, timing and authenticating the record entry.

• CMS also expects that scribes would use their own log-in for the electronic medical record system, it would not be appropriate for the scribe to make entries under the physician's user name and password.

CMS on Scribes...
Joe Kuchler, Spokesman for the CMS

• National Government Services recently barred teaching hospitals in one of its regions from using scribes for medical residents and fellows.

• The creation of the medical record is a key part of residents' and fellows' training that is paid for under Medicare's graduate medical education program.

• CMS does not have any national GME payment policy on this, so its regional contractors are free to develop their own policy.
Carrier comments on scribes...

- Medicare auditors have noted some physicians having individuals writing notes in the medical record for them, and then merely signing the note. This may be inappropriate.

- The physician is ultimately accountable for the documentation, and after the scribe's entry should sign and documentation confirmation that the note accurately reflects work done by the physician.

Carrier comments on scribes...

- Record entries made by a "scribe" should be made upon dictation by the physician, and should document clearly the level of service provided at that encounter.

- Medicare expects the person receiving payment to deliver the services and create the record. Thus, the scribe should be merely a person who writes what the physician dictates. This individual should not act independently.
Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) on scribes

- Signing (including name and title), dating of all entries into the medical record—electronic or manual.
  - For those organizations that use Joint Commission accreditation for deemed status purposes, the timing of entries is also required.

- The role and signature of the scribe must be clearly identifiable and distinguishable from that of the physician or licensed independent practitioner or other staff.
  - Example: “Scribed for Dr. X by name of the scribe and title” with the date and time of the entry

Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) on scribes

- The physician or licensed independent practitioner must authenticate the entry by signing, dating and timing (for deemed status purposes) it. The scribe cannot enter the date and time for the physician.

- Although allowed in other situations, a physician signature stamp is not permitted for use in the authentication of “scribed” entries--the physician must actually sign or authenticate through the clinical information system.
Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) on scribes

• The authentication must take place before the physician and scribe leave the patient care area.

• Authentication cannot be delegated to another physician or licensed independent practitioner.

Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) on scribes

• The organization must implement a performance improvement process to ensure that:
  – the scribe is not acting outside of his/her job description
  – that authentication is occurring as required and that no orders are being acted on before they are authenticated.
Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) on scribes

• If the organization determines that the scribe will be allowed to enter orders into the medical record,
  – those orders entered into the medical record cannot be acted on until authenticated by the specific physician/licensed independent practitioner who provided the orders scribed.
  – Authentication includes the physician signature (electronic or manual) and the date and time.

CMS on scribes entering orders...

• the person entering the order could be required to enter the order correctly, evaluate CDS (Clinical Decision Support) either using their own judgment or through accurate relay of the information to the ordering provider, and then either make a change to the order based on the CDS intervention or bypass the intervention.
• We do not believe that a layperson is qualified to do this, and as there is no licensing or credentialing of scribes, there is no guarantee of their qualifications.

  – Federal Register / Vol. 77, No. 171 /
  – Tuesday, September 4, 2012
Scribes in the ED

• The scribe’s note should include:
  – The name of the scribe and acceptable signature.
  – The name of the physician providing the service.
    • Documentation by Kaylee Frye acting as scribe for Malcolm Reynolds, MD.
    • Scribe signature, date & time.

• The physician’s note should indicate:
  – Affirmation that the physician personally performed the services documented.
  – Confirmation he/she reviewed and confirmed the accuracy of the information in the medical record.
  – Acceptable physician signature.
    • I have reviewed the documentation recorded by the scribe and it accurately reflects services performed by me.
    • MD signature, date & time.

Licensed providers as Scribes

• Payers have expressed concern about Residents, Physician Assistants, Nurse Practitioners, Nurses, Medical Students, etc... acting as scribes because of their ability to independently evaluate patients.

• Scribed documentation must be very clear and identifiable in comparison to documentation of services performed as a healthcare provider.
ICD-10 — What’s it all about???
Objectives

- Identify major differences between ICD-9 and ICD-10
- Explore major components of ICD-10 that will effect emergency medicine
- Review common ED coding scenarios
Greatly expanded
Set to go October 1, 2014
Extreme differences in codes and content
You will want to design/research/buy crosswalks from ICD-9 to ICD-10: ACEP is working on this for you!!!!
Consider translating tough medical terms into lay terms for less experienced coders vs. high level medical terminology training for all coding staff
ICD-10-CM has 21 chapters; ICD-9 has 17;

ICD-9-CMs V and E codes are incorporated into the main classification in the ICD-10-CM code set

Diseases and conditions of the sense organs (eyes and ears) have been separated from the nervous system diseases and conditions and have their own chapters in ICD-10-CM.

Some diseases have been reclassified or reassigned to a different chapter in ICD-10. For example, gout formerly in endocrine will be found in musculoskeletal chapter in ICD-10. This is just one example of the differences in how conditions will be located.

ICD-10 will classify injuries first by specific site and then by type of injury. ICD-9 classifies injuries by type.

Post-operative complications will now be located specific to the procedure-specific body system.
Post-operative complications will now be located specific to the procedure-specific body system.

ICD-10 codes are alpha numeric and can be up to seven characters in length/ICD-9 codes were only three to five characters.

ICD-10-CM includes full code titles for all codes so it is not necessary to reference back to common fourth and fifth digit categories.

Seventh characters are required for obstetrics, injuries and external causes of injuries.

Placeholders (X) will be required to hold places followed by additional characters.

Combination codes for conditions and common symptoms or manifestations, e.g.

- Poisoning by penicillin, accidental (unintentional), subsequent encounter (36.0x1D);
- Swimmer’s ear, left ear (H60.332);
- Cocaine dependence with intoxication delirium (F14.221);
- Concussion with loss of consciousness of 30 minutes or less, initial encounter (S06.0x1A)
All codes are alphanumeric and first digit of each is an alpha character
- Subsequent characters (2-7) may be alpha or numeric

Some categories require 7th place characters. If no 4th-6th characters, insert “x”

Two types of excludes notes
- 1=condition not coded here and never used in conjunction with code above it
- 2=notes mean condition not included here but patient may have both and is appropriate to report two codes together
NEC and NOS used in same manner

Punctuation used in same manner

The term “and” means “and/or”

Coding conventions remain unchanged
  - Other/unspecified
  - Notes
  - Inclusion terms

Categories are three characters as in ICD-9

Official guidelines have been revised (!)
Alphabetic index provides only the first three or four values of each code.

Balance ‘built” by using a table in the tabular index to select the remaining three to four values.

Initially you will use the alphabetic, then when more experienced, tabular.
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)

- Only if no related dx established or confirmed
- Not routinely associated with dx (sequence definitive dx first)
- Not routinely associated w/disease process should not be assigned unless otherwise instructed by classification

Combination codes identify definitive dx and common symptoms.

- R29.6 Repeated falls
- Patient has recently fallen and cause is being investigated
- Z91.81- History of falling
- Patient has fallen in the past and is at risk for future falls
- Both may be assigned if appropriate
Glasgow Coma Scale (R40.2-)

- Used in conjunction with traumatic brain injury codes or sequelae of CVA codes
- Sequenced after the diagnosis code
- Three codes, one from each subcategory, are needed to complete the scale.
- 7th character indicates when scale was recorded
- 7th character must match for all three codes
Hypertension

- Hypertension with Heart Disease
- Hypertensive Chronic Kidney Disease
- Hypertensive Heart and Kidney Disease
- Hypertensive Cerebrovascular Disease
- Hypertensive Retinopathy
- Hypertension, Secondary
- Hypertension, Transient
- Hypertension, Controlled
- Hypertension, Uncontrolled
COPD

Acute respiratory failure

Acute respiratory failure as secondary dx

  Sequencing depends on whether other acute condition is respiratory or non-respiratory
Sepsis
  - Add appropriate code for underlying systemic infection

Severe sepsis
  - Minimum 2 codes
    - Underlying systemic infection
    - Code from subcategory R65.2 severe sepsis
    - “due to complex nature of severe sepsis, some cases may require querying the provider prior to assignment of the codes
    - If POA and is principal diagnosis, underlying systemic infection should be assigned a principal followed by code from category R65.2
Septic shock

- Circulatory failure associated with severe sepsis (acute organ dysfunction)
- Sequence underlying systemic infection first
- Then code R65.21, severe sepsis w/septic shock
- Code additional organ dysfunctions
## Examples of Common ED Dx
### Chest Pain

<table>
<thead>
<tr>
<th>Condition</th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atypical chest pain</td>
<td>786.59</td>
<td>R07.89</td>
</tr>
<tr>
<td>Precordial chest pain</td>
<td>786.51</td>
<td>R07.2</td>
</tr>
<tr>
<td>Ischemic chest pain</td>
<td>413.9</td>
<td>I20.9</td>
</tr>
<tr>
<td>Abnormal ECG</td>
<td>794.31</td>
<td>R94.31</td>
</tr>
</tbody>
</table>
## Examples: Cardiac

<table>
<thead>
<tr>
<th>Condition</th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute, transmural MI, anterior wall, involving left anterior descending artery (initial episode of care)</td>
<td>410.11</td>
<td>121.02</td>
</tr>
<tr>
<td>Subendocardial acute inferior wall MI following a new inferolateral MI 3 weeks prior to this one</td>
<td>410.71</td>
<td>I22.2, I21.4</td>
</tr>
<tr>
<td>Unstable angina in a former smoker who had a 10-year pack-a-day habit</td>
<td>411.1, V15.82</td>
<td>I20.0, Z87.891</td>
</tr>
<tr>
<td>Atherosclerosis of coronary arteries with angina on exertion</td>
<td>414.01, 413.9</td>
<td>I25.118</td>
</tr>
</tbody>
</table>
### Examples: Signs, Symptoms and Abnormal Findings

<table>
<thead>
<tr>
<th>Condition</th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced vital capacity values on pulmonary function test</td>
<td>794.2</td>
<td>R94.2</td>
</tr>
<tr>
<td>Unidentified spot lesion on lung x-ray</td>
<td>793.1</td>
<td>R91</td>
</tr>
<tr>
<td>Condition</td>
<td>ICD-9-CM</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>--------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Extreme epistaxis requiring cauterization and packing</td>
<td>784.7</td>
<td>R04.0</td>
</tr>
<tr>
<td>Dyspnea and shortness of breath with intercostal pain in left-sided rib</td>
<td>786.05, 786.09, 786.50</td>
<td>R06.02, R06.00, R07.82</td>
</tr>
<tr>
<td>cage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency encounter for respiratory arrest in patient with myasthenia</td>
<td>799.1, 358.01</td>
<td>R09.2, G70.01</td>
</tr>
<tr>
<td>gravis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic, productive cough with stabbing pleural pain and visible blood</td>
<td>786.3, 786.52</td>
<td>R04.2, R07.81</td>
</tr>
<tr>
<td>in expectorated mucus</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Don’t let the complexities of the new system fool you! Because so many conditions are combined into one ICD-10 code where before they were identified individually, you will see complex statements like those below bundled into one specific code:

<table>
<thead>
<tr>
<th>Condition</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe generalized abdominal pain with abdominal rigidity</td>
<td>R10.0</td>
</tr>
<tr>
<td>Initial Encounter for electrocution</td>
<td>T75.4xxA</td>
</tr>
<tr>
<td>Acute bacterial food poisoning due to Salmonella with no current complications</td>
<td>A02.9</td>
</tr>
<tr>
<td>Coma Scale, eyes open, never, in the field (EMT or ambulance)</td>
<td>R40.2111</td>
</tr>
</tbody>
</table>
ICD-10 Implementation Checklist:

1. Identify staff training needs and complete the necessary training.
2. Design programs to help you begin parallel coding with ICD-9 and ICD-10 for current ED cases to provide feedback to providers well in advance of go-live dates.
3. Forget extensive classroom training for providers. Teach them the essentials of documentation through individualized chart critique and ongoing feedback.
4. Begin the process of identifying YOUR most common diagnoses and how the will be coded with ICD-10.
5. Arrange for assistance with coder training for YOUR system—using YOUR records, critiquing YOUR current documentation issues and identifying best (and worst) documentation practices and solutions.
6. Design reporting mechanisms for coders to use to provide feedback and suggestions to providers.
7. Conduct internal testing to make sure you can generate transactions you send with the ICD-10 codes.
8. Conduct external testing with your clearinghouses and payers to make sure you can send and receive transactions with the ICD-10 codes.
9. Prepare for drop in production and revenue for first 4-6 months following implementation.
<table>
<thead>
<tr>
<th>Condition</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skateboarder colliding with stationary object</td>
<td>V00.132</td>
</tr>
<tr>
<td>Person on outside of car injured in collision with pedestrian or animal in non-traffic accident.</td>
<td>V40.2</td>
</tr>
<tr>
<td>Spacecraft collision injuring occupant</td>
<td>V95.43</td>
</tr>
<tr>
<td>Struck by turtle</td>
<td>W59.22</td>
</tr>
<tr>
<td>Bitten by dolphin</td>
<td>W56.01</td>
</tr>
<tr>
<td>Activity involving handheld interactive electronic device (texting???)</td>
<td>Y93C2</td>
</tr>
</tbody>
</table>
Questions?!
2013 CMS Update--ED Facility Coding Rules

ACEP Procedure Coding Conference
San Diego, CA
February 6, 2013

Agenda

• OPPS overview
• ED visit coding under scrutiny
• 2013 ED visit level reporting and payments
• Type A and B EDs
• CMS discussion items on other visit services
• Procedures and 2013 payment changes
• Hospital outpatient quality reporting
CMS Outpatient Prospective Payment System

- OPPS is the payment system CMS uses to pay hospitals for outpatient services provided to Medicare beneficiaries
- Applies to hospital ED and clinic services; not physician services
- In addition to a visit service, separate payment is allowed for most surgical, diagnostic and therapeutic procedures
- The ED or clinic bills one or more CPT codes for an encounter
- The OPPS uses Ambulatory Payment Classifications (APCs) to determine a hospital’s payments
  - APCs are the outpatient counterpart to inpatient DRGs and include grouped CPT codes that have a common $ payment; each CPT code maps to an APC
  - Medicare determines the correct APC and payment based on the billed CPT code(s)
- OPPS rules are updated annually via proposed and final rules published in the Federal Register
- CMS visit guidelines are intended for coding all encounters in the ED or clinic where they apply (applicable to all payers)

The Absence of National Guidelines Causing a Firestorm

- In May 2012 the OIG released a report describing a trend of right shifting visit level frequencies between 2001 and 2010; the report looked at pro coding of established office visits, subsequent inpatient, and ED visits and indicated that there may also be issues with hospital facility coding
- In September, the NYT, Washington Post and investigative organization, CPI, published reports expanding on the OIG data, identifying hospital coding outliers based on CMS data, and citing the primary causes for this rise in higher acuity visits to be: aberrant documentation and coding practices
- In response to above, on September 24th HHS and the DOJ sent a letter to 5 healthcare group executives warning them that the use of IT/EHRs to commit upcoding and fraud would not be tolerated
AHA and AHIMA Weigh In

- AHA’s response to HHS and DOJ: there are other issues contributing to current concerns: complexity of CMS rules, lack of national guidelines for facility outpatient coding, and burdensome CMS audit programs
- AHIMA likewise responded in a press release on October 1 calling for national standards for IT and outpatient coding
- The 2013 OIG workplan includes plans to review hospital outpatient payments
- On October 1 the House W&M and Energy and Commerce committees sent a letter to HHS with questions re: EHRs, meaningful use, and ED and Clinic coding guidelines
- On November 12, AHA sent a second letter to HHS and DOJ addressing concerns about national guidelines, EHRs and CMS compliance guidelines; AHA stated that national coding guidelines would lead to greater understanding and compliance with CMS rules; AHA’s CEO requested a meeting for further discussion.

2013 Visit Level Reporting

- Amid all the discussions and scrutiny CMS publishes the OPPS final rule on November 15, 2012
- No changes to CMS 11 guidelines or other rules for determining ED visit levels were included
- Hospitals will continue to report visits according to their own internal hospital guidelines
- CMS comment:
  - “We note recent reports in the public media of billing inaccuracies in hospital outpatient clinic visits, and remind hospitals that we are committed to vigorously enforcing our payment policies and will pursue appropriate action against any potentially fraudulent activities we identify” (2013 OPPS Final Rule, pg. 68401)
11 CMS Outpatient Coding Guidelines

A hospital’s internal guidelines should:

1. Follow the intent of the CPT code descriptor—reasonably relating the intensity of hospital resources to the different levels of effort represented by the code
2. Be based on hospital facility resources, not on physician resources
3. Be clear to facilitate accurate payments and be usable for compliance purposes and audits
4. Meet the HIPAA requirements
5. Only require documentation that is clinically necessary for patient care
6. Not facilitate upcoding or gaming
7. Be written or recorded, well documented and provide the basis of selection of a specific code
8. Be applied consistently across patients in the clinic or emergency department to which they apply
9. Not change with great frequency
10. Be readily available for fiscal intermediary (or if applicable, MAC contractor) review
11. Result in coding decisions that could be verified by other hospital staff, as well as outside sources

CMS Continues to Differentiate Two ED Types: Type A and Type B

• Type A EDs meet the CPT definition of an ED and must meet EMTALA requirements
• Type B EDs are dedicated EDs that meet EMTALA requirements but do not meet the “open 24/7” ED CPT requirement
• ED visit codes include five Type A CPT codes: 99281-99285 and five Type B ED Level II HCPCS codes: G0380-G0384
• Critical Care, 99291, may be provided in either setting
• CMS continues to believe that this configuration pays hospital EDs appropriately based on analysis of resource data from 2011 claims
Type A ED Payment Comparisons: 2012 vs. 2013

<table>
<thead>
<tr>
<th>Type A ED Visits</th>
<th>2012 Payment Rate</th>
<th>2013 Payment Rate</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1 – 99281</td>
<td>$50.61</td>
<td>$51.82</td>
<td>$1.21</td>
</tr>
<tr>
<td>Level 2 - 99282</td>
<td>$86.25</td>
<td>$92.16</td>
<td>$5.91</td>
</tr>
<tr>
<td>Level 3 - 99283</td>
<td>$137.24</td>
<td>$143.36</td>
<td>$6.12</td>
</tr>
<tr>
<td>Level 4 - 99284</td>
<td>$220.86</td>
<td>$229.37</td>
<td>$8.51</td>
</tr>
<tr>
<td>Level 5 - 99285</td>
<td>$328.24</td>
<td>$344.71</td>
<td>$16.47</td>
</tr>
<tr>
<td>Critical Care - 99291</td>
<td>$473.25</td>
<td>$535.86</td>
<td>$62.61</td>
</tr>
<tr>
<td>Critical Care w/Trauma Activation – G0390</td>
<td>$808.06</td>
<td>$914.47</td>
<td>$106.41</td>
</tr>
</tbody>
</table>

Type B ED Payment Comparisons: 2012 vs. 2013

<table>
<thead>
<tr>
<th>Type B ED Visits</th>
<th>2012 Payment Rate</th>
<th>2013 Payment Rate</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1 – G0380</td>
<td>$39.38</td>
<td>$67.78</td>
<td>$28.40</td>
</tr>
<tr>
<td>Level 2 – G0381</td>
<td>$56.81</td>
<td>$54.12</td>
<td>(-$2.69)</td>
</tr>
<tr>
<td>Level 3 – G0382</td>
<td>$90.43</td>
<td>$89.89</td>
<td>(-$0.54)</td>
</tr>
<tr>
<td>Level 4 – G0383</td>
<td>$136.42</td>
<td>$136.30</td>
<td>(-$0.12)</td>
</tr>
<tr>
<td>Level 5 – G0384</td>
<td>$261.30</td>
<td>$207.31</td>
<td>(-53.99)</td>
</tr>
</tbody>
</table>
Other OPPS “Visit” Discussion Items

- No major changes for observation services
  - Continue to report Obs services with G0378 and CMS will make payment under composite APCs 8002 and 8003
  - We’ll take a deep dive into Facility Observation coding tomorrow
- Hospitals continue to report critical care, 99291, per the CPT descriptor; CMS comments:
  - CMS will not pay for the unbundled critical care ancillary services and procedures (2011 CPT change) such as x-rays, pulse oximetry, and transcutaneous pacing, but hospitals should continue to report
  - CMS identified in 2011 data that hospitals did not substantially change their low frequency reporting of ancillary service/procedure codes
  - CMS implemented claims processing edits to conditionally package these ancillary services CPTs and avoid overpayments
- CMS requests public comment on time based criteria for inpatient determination

2013 ED Facility Procedure Reporting

- No reporting requirement changes to commonly performed ED procedures
- Many changes in payment rates
- Drug administration rules did not change—continue to follow CPT descriptors
## 2013 Procedure Payment Comparisons

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>2012 Payment Rate</th>
<th>2013 Payment Rate</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>12001</td>
<td>Repair superficial wound(s)</td>
<td>$84.27</td>
<td>$85.75</td>
<td>$1.48</td>
</tr>
<tr>
<td>12002</td>
<td>Repair superficial wound(s)</td>
<td>$84.27</td>
<td>$85.75</td>
<td>$1.48</td>
</tr>
<tr>
<td>12011</td>
<td>Repair superficial wound(s)</td>
<td>$84.27</td>
<td>$85.75</td>
<td>$1.48</td>
</tr>
<tr>
<td>29125</td>
<td>Apply forearm splint</td>
<td>$78.99</td>
<td>$94.54</td>
<td>$15.55</td>
</tr>
<tr>
<td>29515</td>
<td>Application lower leg splint</td>
<td>$78.99</td>
<td>$94.54</td>
<td>$15.55</td>
</tr>
<tr>
<td>31500</td>
<td>Insert emergency airway</td>
<td>$158.09</td>
<td>$160.83</td>
<td>$2.74</td>
</tr>
<tr>
<td>51702</td>
<td>Insert temp bladder catheter</td>
<td>$46.78</td>
<td>$49.64</td>
<td>$2.86</td>
</tr>
<tr>
<td>71020</td>
<td>2-view CXR</td>
<td>$44.55</td>
<td>$45.95</td>
<td>$1.40</td>
</tr>
<tr>
<td>93005</td>
<td>Electrocardiogram, tracing</td>
<td>$27.04</td>
<td>$26.67</td>
<td>($0.37)</td>
</tr>
</tbody>
</table>

## 2013 Drug Administration Payment Comparisons

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>2012 Payment Rate</th>
<th>2013 Payment Rate</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>96365</td>
<td>Therapeutic/prophylactic/diagnostic iv infusion, initial</td>
<td>$132.71</td>
<td>$146.24</td>
<td>$13.53</td>
</tr>
<tr>
<td>96366</td>
<td>Therapeutic/prophylactic/diagnostic iv infusion, add on</td>
<td>$26.24</td>
<td>$27.01</td>
<td>$0.77</td>
</tr>
<tr>
<td>96367</td>
<td>Therapeutic/prophylactic/diagnostic additional sequential iv infusion</td>
<td>$36.65</td>
<td>$39.13</td>
<td>$2.48</td>
</tr>
<tr>
<td>96368</td>
<td>Therapeutic/prophylactic/diagnostic concurrent infusion</td>
<td>$0.00</td>
<td>$0.00</td>
<td>---</td>
</tr>
<tr>
<td>96372</td>
<td>Therapeutic/prophylactic/diagnostic injection, SC/IM</td>
<td>$26.24</td>
<td>$39.13</td>
<td>$12.89</td>
</tr>
<tr>
<td>96374</td>
<td>Therapeutic/prophylactic/diagnostic injection, iv push</td>
<td>$36.65</td>
<td>$39.13</td>
<td>$2.48</td>
</tr>
<tr>
<td>96375</td>
<td>Therapeutic/prophylactic/diagnostic injection new drug add on</td>
<td>$36.65</td>
<td>$39.13</td>
<td>$2.48</td>
</tr>
<tr>
<td>96360</td>
<td>Hydration iv infusion, initial</td>
<td>$73.22</td>
<td>$74.69</td>
<td>$1.47</td>
</tr>
<tr>
<td>96361</td>
<td>Hydration iv infusion, add-on</td>
<td>$26.24</td>
<td>$27.01</td>
<td>$0.77</td>
</tr>
</tbody>
</table>
Hospital Outpatient Quality Data Reporting

- There are no new outpatient quality measures for CY 2013 reporting
- Measure changes affecting the ED in 2013 include:
  - deleted Troponin Levels in chest pain and AMI within 60 min of arrival
  - suspended Transition Record provided on ED discharge
- Hospitals failing to meet quality reporting requirements will have a 2% reduction in the following year’s payment update
- Review the Quality Net website for more information: http://www.qualitynet.org

Additional Resources

- ACEP web site www.acep.org
  - 2013 OPPS Changes Summary document
  - 2013 OPPS Final Rule
- CMS website: www.cms.gov see Outpatient Hospital, then Outpatient Prospective Payment System
Contact Information

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Electronic Medical Records
Friend or Foe?

Electronic Medical Records
• ED Categories
  – Using an EMR
  – In transition to an EMR
  – In the planning stages for implementation of an EMR.
  – Shopping for a different EMR
Electronic Medical Records

• There are many positive aspects of using an EMR:
  – Improved Legibility
  – Faster chart completion
  – Prebuilt Templates for common presenting complaints
  – Real time access to record for previous encounters and diagnostic studies
  – Copy and paste functions allow for inserting past history and previous ROS.
  – Ease of sending records to other providers for continuity of care
  – Helps optimize reimbursement

Electronic Medical Records

However, some positives are also on the list of negatives:

• Faster chart completion
  – Speed is not the same as efficiency, nor should it be achieved by sacrificing accuracy. The EMR should help physicians work quickly while maintaining optimal care and compliant documentation.

• Prebuilt Templates for common presenting complaints
  – History and physical exam documentation content should be determined by the clinical circumstances of the patient as it relates to the presenting problem and not be driven by the template.
  – History or exam components that are not performed should not be documented simply to complete the template.
Electronic Medical Records

• Copy and paste functions allow for inserting past history and previous ROS.
  – Inappropriate use of the copy and paste function can cause the physician to inadvertently falsify the medical record or create an ED chart that appears to have been cloned.

• Helps optimize reimbursement
  – More documentation does not equal more money. Over documented charts make it very easy to upcode the E&M service.
  – Prompts to add more documentation for higher codes do not recognize medical necessity.

Electronic Medical Records

• A primary compliance concerns is the automatic populating of the physician notes from previous ED visits, the nurses notes or the prebuilt template.
EMR Coder Concerns

• “EMR vendors are telling our physicians that the ancillary staff may enter the HPI information from the patient and the physician may mark a box as reviewed.

• Our physicians are very excited about that. Must the physician physically sit at the computer and input the information, even though he has reviewed it? “

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EMR Coder Concerns

Medicare B News Issue 255

The HPI must be obtained by a physician during the E/M service. Reviewing this information obtained by ancillary employees and writing a declarative sentence DOES NOT suffice for obtaining history of present illness.
Electronic Medical Records

- Attempts to streamline the documentation process can create inaccurate or cloned notes. Physician notes created by copy and paste or auto population are frequently contradicted by the nurses’ notes or even the physicians own documentation.
  - For instance, the physician’s exam states “patient ambulates well” and the nurses’ notes indicate “patient arrives in a wheelchairs”
  - the HPI documented by the EDMD shows a presenting problem of chest pain and shortness of breath but the ROS is documented as "Cardiovascular - no chest pain. Respiratory - no SOB".

Questionable Records

**History:**
70 yo M w/ PMH of liver cirrhosis hepatitis C hypertension and hepatic encephalopathy worsens emergency department brought in from Federal prison after he was diagnosed with cellulitis of the left lower extremity has been on Augmentin b.i.d. for the past 4 days but the symptoms continue to worsen. patient reports that he has been having intermittent fevers and chills. He reports that he has increased swelling in the left lower extremity as well as worsening redness and warmth and pain which he says is 5/10 and constant burning located in the left lower leg and foot. He says it is tender to palpation but denies any other area alleviating factors. does report mild confusion over the past day or 2. He denies chest pain shortness of breath nausea vomiting dysuria abdominal pain worsening abdominal distention abnormal stools or any other symptoms.

**Constitution:**
The patient is negative for fever and chills.

**Musculoskeletal:**
The patient is negative for joint swelling.

**Skin:**
The patient is negative for rash.
Questionable Records

**Skin:**
Normal Findings: The patient's skin appears normal, warm and dry.

**Differential Diagnosis:**
Cellulitis versus necrotizing fasciitis

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Questionable Records

**History:**
This is a 73 yo M with PMH of multiple ED visits and admissions recently for dysuria, hesitancy, feelings of retention secondary to possible BPH. He is here now for the same complaints despite being discharged from UPH yesterday. He states that he cannot urinate and complains of pain with attempts to urinate. According to records, he has not been shown by bladder scans to have actual retention problems and has had numerous normal bladder scans. Also, he just finished ciprofloxacin for a UTI. He states that he has some confusion on which medications he is to take for these problems. He has a follow up appointment with Dr. Funk in 5 days, but has missed several appointments in the past. He denies any abdominal pain, N/V, F/J, D/C, HA. He lives alone.

**Genitourinary:**
The patient is positive for dysuria and hesitation.
The patient is negative for frequency, dark urine, bloody urine and flank pain.

**Male GU:**
The patient is negative for penile bleeding, penile pain, penile discharge and testicular pain.

**Female GU:**
The patient is negative for vaginal discharge and vaginal pain.
CMS Concerns

• Providers are liable to include more data than is reasonable and necessary leading to upcoding especially of E&M visits

• Cloned notes may meet coding criteria but are not medically necessary if nothing changes from visit to visit

CMS Transmittal 438 - November 9, 2012

• "Template" -- a tool/instrument/interface that assists in documenting a progress note. Templates may be paper or electronic.

• CMS does not prohibit the use of templates to facilitate record-keeping. CMS also does not endorse or approve any particular templates. A physician/LCMP may choose any template to assist in documenting medical information.
• Some templates provide limited options and/or space for the collection of information such as by using “check boxes,” predefined answers, limited space to enter information, etc.

• CMS discourages the use of such templates. Claim review experience shows that limited space templates often fail to capture sufficient detailed clinical information to demonstrate that all coverage and coding requirements are met.

CMS Transmittal 438 - November 9, 2012

• Physician/LCMPs should be aware that templates designed to gather selected information focused primarily for reimbursement purposes are often insufficient to demonstrate that all coverage and coding requirements are met.

• This is often because these documents generally do not provide sufficient information to adequately show that the medical necessity criteria for the item/service are met.
CMS Transmittal 438 - November 9, 2012

• If a physician/LCMP chooses to use a template during the patient visit, CMS encourages them to select one that allows for a full and complete collection of information to demonstrate that the applicable coverage and coding criteria are met.

MAC Concerns

• “Default documentation is a problem because it is difficult to tell what work was actually provided for the current visit.”

• “Medical necessity documentation is a cognitive process that is difficult to document with templates and macros.”
Mac Concerns

- Electronic medical records and formatted note systems facilitate the “carry over” and repetitive “fill in” of stored information. Even if a “complete” note is generated, only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter can be considered when selecting the appropriate level of an E/M service. Information that has no pertinence to the patient’s situation at that specific time cannot be counted.

- cignagovernmentservices.com

OIG Concerns

- Medicare contractors have noted an increased frequency of medical records with identical documentation across services.

- We will also review multiple E&M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments.
EMR Audit Findings

- The history of present illness is a review of prior encounters instead of an update of the patient’s health between visits.

- Review of system macros indicated systems as negative while the HPI held contradictory information.

- Exams appeared to be the same from visit to visit and did not always reflect the chief complaint or HPI.

- Contradictory information was carried forward over several dates of service, sometimes caused erroneous diagnosis coding.

EMR Audit Findings

- Patient complaints of inaccurate medical records after receiving medical records.

- In a few instances, patient never disrobed or were examined, however documentation revealed a comprehensive exam.

- Audit indicated record cloning (cut and paste) in the majority of records.
EMR Audit Findings

• Nature of presenting problem appeared irrelevant in comparison to the comprehensive documentation in a significant number of charts.

• Medical necessity for comprehensive ROS and Exam was rare and often conflicted with the HPI

• Many patient notes were identical other than the HPI and parts of the plan or MDM

EMR Documentation Reminders

• The HPI should reflect information about today's presentation, illness or symptoms.

• The HPI is not a description of the patient’s past encounters or medical history.
EMR Documentation Reminders

• The review of systems should be a reflection of questions asked in relation to the presenting problem and any pertinent organ systems, not a pre-populated macro of all negatives.

EMR Documentation Reminders

• Physical exam documentation should contain the clinical circumstances of the patient as it relates to the presenting problem and history of present illness.

• The exam should not be driven by a template and appear unchanged from one patient to the next.
EMR Documentation Reminders

• The medical record should be accurate, complete, and concise.

• Structured (macros and templates) and unstructured chart entries should meet quality and medical necessity standards.

• Each note should contain patient specific data that supports the medical necessity of the visit or procedures.