

# Emergency Department: Coding, Billing and Reimbursement

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Presented By:

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Slide # 1

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## Presentation Faculty

**Duane C. Abbey, Ph.D., CFP** – Dr. Abbey is a healthcare consultant and educator with over 20 years of experience. He has worked with hospitals, clinics, physicians in various specialties, home health agencies and other health care providers.

His primary work is with optimizing reimbursement under various Prospective Payment Systems. He also works extensively with various compliance issues and performs chargemaster reviews along with coding and billing audits.

Dr. Abbey is the President of Abbey & Abbey, Consultants, Inc. A wide range of consulting services is provided across the country including charge master reviews, APC compliance reviews, in-service training, physician training, and coding and billing reviews.

Dr. Abbey is the author of eight books on health care, including:

- ***“Non-Physician Providers: Guide to Coding, Billing, and Reimbursement”***
- ***“Emergency Department: Coding, Billing and Reimbursement”***, and
- ***“Chargemasters: Strategies to Ensure Accurate Reimbursement and Compliance”***.

His most recent book, **“Compliance for Coding, Billing & Reimbursement A Systematic Approach to Developing a Comprehensive Program”** is available from the Productivity Press a Division of Taylor and Francis..

## ED: Coding, Billing & Reimbursement Introduction

- **Emergency Department – Complicating Factors**
  - **Physician Coding ← See Also Other Providers/Practitioners**
    - **E/M Levels → E/M Coding Documentation Guidelines**
    - **Surgical/Medical Coding**
    - **Use Of Modifiers**
    - **Generation Of CMS-1500 (Form 837P For HIPAA)**
  - **Hospital Coding**
    - **E/M Levels → No Guidance (2010? 20011? Ever?)**
      - ✓ **Reflect Resource Utilization**
      - ✓ **Point System Approach**
      - ✓ **Narrative/Descriptive Approach**
      - ✓ **Eleven Principles → November 27, 2007 *Federal Register***
    - **Surgical/Medical Coding**
    - **Use Of Modifiers**
    - **Generation Of UB-04 (CMS-1450; Form 837I For HIPAA)**

## **ED: Coding, Billing & Reimbursement Introduction**

- **Emergency Department – Complicating Factors**
  - **Compliance Concerns**
    - EMTALA – Emergency Medical Treatment And Labor Act
    - Provider-Based Status Rules (42 CFR §413.65)
    - Organizational Structuring – Non-Physician Providers
- **Coding, Billing & Reimbursement for the ED**
  - This is a very large topic!
  - CBR are driven by the payment systems.
    - APCs → Hospital Outpatient
    - RBRVS → Physicians
    - Private Third-Party Payers → Various Approaches - Contracts
  - **Primary Goal: Take care of the patients! Then worry about coding, billing and reimbursement (and compliance, of course).**

## **ED: Coding, Billing & Reimbursement Introduction**

- **Payment System Issues**
  - RBRVS Issues For Physicians – Professional Component
  - APCs – Ambulatory Payment Classification – Technical Component
  - Multiple Physicians Providing Services
  - Observation Services
  - Two Or More Visits On Same Day By Same Patient
  - Type A versus Type B EDs Under Medicare
  - Levels Of Services
    - Emergency
    - Urgent
    - Clinic
  - Fast-Track Operations → See Type A versus Type B for Medicare
  - Non-Physician Providers → Compliance Issue Also
  - APGs – Ambulatory Patient Groups → Other Than Medicare

## ED: Coding, Billing & Reimbursement Introduction

- Coding and Billing Flow
  - Charge Master Setup
    - Professional Component
    - Technical Component
    - Other Related Services → Laboratory, Radiology, EKGs, Respiratory Therapy, Etc.
  - Coding Flow
    - Physician Coding
      - ✓ E/M Levels ← Guidelines
      - ✓ Medical/Surgical Procedures
      - ✓ Modifiers?? → See “-25” and “-59”
    - Hospital Coding
      - ✓ E/M Levels ← No Guidelines – Use Hospital’s Own System
      - ✓ Medical/Surgical Procedures
      - ✓ Modifiers?? → See “-25” and “-59”
    - X-Ray & EKG Interpretation → Turf Issue
- Note: The proper use of the “-25” modifier is currently being investigated by the DOJ/OIG.

## ED: Coding, Billing & Reimbursement Introduction

- Documentation Systems
  - Physicians
    - Check-Off Forms → Computer Input Process
    - Dictated Note For Each Encounter
    - Medical Screening Examinations
    - Medical Assessments
  - Hospital
    - Nursing Notes → Drives Point or Descriptive System For E/M Levels
    - EMT Notes
    - Ancillary Services Reports
  - Documentation Standards
    - Delayed Documentation
    - Teaching Situations
  - Under APCs & APGs → Coding can only be as good as the documentation!
- Note: We will look at and compare physician versus hospital considerations. Hospital personnel must understand both the technical and professional sides of ED coding, billing and reimbursement.

## **ED: Coding, Billing & Reimbursement Warm-Up Exercise**

### ➤ **ED Coding/Billing/Documentation Exercise**

- It is Friday morning. Sarah, an elderly Medicare patient, called her physician since she has a stuffy nose. The answering machine at the clinic indicated that the doctor was out of town and that if there were any problems, simply to go to the Apex Medical Center ED. Sarah is now presenting to the ED. The triage nurse determines that it is not an emergency. Sarah insists on seeing a physician. An ER physician sees her, examines her and prescribes an over-the-counter decongestant.

How should this be coded and billed?

- As a low-level ED visit?
- As a clinic visit?
- No charge since not an emergency?
- Issue an ABN since it probably won't be recognized as an emergency visit?
- Can the ER Triage Nurse perform the MSE?
- What if the decongestant were a take-home drug?

## **ED: Coding, Billing & Reimbursement APCs & APGs Overview & Summary**

### ➤ **ED Is The Most Heavily Affected Hospital Department Under APCs**

### ➤ **E/M Technical Component Coding**

- Five Levels – 99281-99285
- Will there ALWAYS be an E/M level on the hospital side?
- Required to have a mapping mechanism that translates resources into the level. → See Eleven Principles
  - How is this performed at your hospital?
  - Do you have a documented system?
- CMS Expert Panel Now Meeting To Determine The Guidelines For Proper Coding → 2010? 2011? Ever??
- Additional CMS Criteria – Uniform Distribution
- Use of the “-25” Modifier → Place in Charge Master?
  - See recent OIG studies on the physician side for use of “-25” and “-59” modifiers.
    - ✓ November 2005 OEI-07-03-00470 – “-25” Modifier
    - ✓ November 2005 OEI-03-02-00771 – “-59” Modifier

## ED: Coding, Billing & Reimbursement APCs & APGs Overview & Summary

- APCs → Medicare's Implementation Of OPPS
- APGs → Parent of APCs → Various forms are being used by other third party payers.
- Both Systems Use Grouper/Pricer Software – It is not necessary to group claims before filing claims.
- Coding Systems
  - APCs → Use CPT/HCPCS Only
  - APGs → Some forms of APGs will also use ICD-9-CM codes to drive E/M levels. Otherwise, CPT/HCPCS are the choice.
  - Both Systems Use ICD-9-CM For Medical Necessity
- Window of Service
  - APCs → A 1-Day Window – Date of Service
  - APGs → Generally, a 3-Day Window
  - Two or More Encounters In The Window Create Problems → Related versus Unrelated Services
    - See 'Episode-of-Code' language in November 18, 2008 APC *Federal Register* page 68570. (73 FR 68570)

## ED: Coding, Billing & Reimbursement APCs & APGs Overview & Summary

- Bundling
  - APGs → Generally, the only separately payable items are chemotherapy drugs. For instance, any sort of implantable (DME) device is paid through the underlying APG; there is no separate payment.
  - APCs → Big Mess! Many items are being paid separately outside the APCs themselves. ← Increased bundling starting in CY2007.
  - Both Systems Bundle Inexpensive Supplies
- E/M Visits
  - APGs → If there is any sort of significant procedure, the E/M services are bundled into the procedure. For example, in the ED if a laceration is repaired, then the E/M visit is bundled.
  - APCs → E/M codes are paid separately if the “-25” modifier is used.
- Coverage
  - APGs → Designed To Cover Almost All Outpatient Services Including Laboratory, PT, OT, RT, Etc.
  - APCs → Complicated Interrelated Coverage

## ED: Coding, Billing & Reimbursement APCs & APGs Overview & Summary

- Payment Process
  - Both Systems Use Weights
    - APCs → Developed From Costs (See Cost Report)
    - APGs → Different Methodologies Can Be Used Including Costs – Generally Data Derived From Charges, UCRs, Etc.
  - Both Systems Use A Conversion Factor
    - Payment = Weight \* Conversion Factor (CF)
  - Both APCs and APGs Use Geographic Adjustment Factors
- Edits
  - APCs → OCE
  - APCs → CMS's CCI (Correct Coding Initiative)
- Cost Outliers
- APCs → See November 18, 2008 *Federal Register* for APC Update for CY2009

## ED: Coding, Billing & Reimbursement RBRVS – Medicare's Physician Prospective Payment System

- Started In 1992
- CPT/HCPCS Map To A Relative Value Unit
  - Work
  - Overhead
  - Malpractice

} Facility vs. Non Facility  
} See Provider-Based Rules
- Update Released On or About November 1<sup>st</sup> of Each Year for January 1<sup>st</sup> Implementation
- Payment = RVU \* Conversion Factor
- Geographically Adjusted
- ED Visits Have No Overhead Component
  - Why?
  - In What Year Did This Start?
- CMS's CCI (Correct Coding Initiative) Edits
- See November 19, 2008 *Federal Register* For CY 2009 Update
  - Same as APC update *Federal Register* – Note conversion factor political controversy.

## **ED: Coding, Billing & Reimbursement RBRVS – Medicare’s Physician Prospective Payment System**

- **Global Surgical Package (GSP) Definition**
  - Medicare + Other Third Party Payers
  - Pre-Operative – 1-Day – Doesn’t Really Apply To ED
  - Post-Operative – 0-Days, 10-Days, 90-Days
  - **Modifiers**
    - “-54” – Surgical Care Only
    - “-55” – Postoperative Management Only
    - “-56” – Preoperative Management Only
    - “-57” – Decision for Surgery
  - ER Physicians Must Make Decision As To Whether They (As A Group) Will Provide Postoperative Care
    - If patient is directed to return to ED, then no modifier is used.
    - If patient is directed to see their own physician for follow-up care, then “-54” should be used. There is a reduction in payment for Medicare.
  - Question: Is there a GSP for hospitals?

} Proper Use Is On  
OIG FY2008  
Work Plan

## **ED: Coding, Billing & Reimbursement ED Professional Coding Physician Strategies**

- **ER Physician Calls Family Practice Physician, Then:**
  - Both Physicians Work On The Patient – Codes?
  - Family Practice Physician Advises ER Physician – Codes?
  - ER Physician Provides Services, Family Practice Physician Admits To Acute Care – Codes?
  - ER Physician & Family Practice Physician Both Provide Critical Care – Codes?
- **ER Physician Calls Specialist, Then:**
  - ER Physician Provides Care, Specialist Advises
  - ER Physician Provide Care, Specialist Takes Over Care
  - ER Physician Does Initial Assessment, Surgeon Consults, Family Practice Admits To Hospital
  - ER Physician Does Initial Assessment, Surgeon Consults, Surgeon Performs Surgery
- **How Is The Hospital Billing Affected In Each Of the Scenarios Described Above?**

**ED: Coding, Billing & Reimbursement**  
**ED Professional Coding Physician E/M Selection**

- **E/M Documentation/Selection Guidelines for Physicians**
  - **E/M Guidance Has Been Controversial**
    - Old Guidelines - 1995
    - Newer Guidelines – 1997 (Withdrawn)
    - Newest Guidelines -???
  - **Three Primary Criteria**
    - History
    - Examination
    - Medical Decision Making
  - **Additional Criteria**
    - Counseling/Coordination
    - Presenting Problem(s)
    - Time ← Not Considered Pertinent For ED
  - **New Versus Established Patients → See Provider-Based Clinics**
  - **Use Of “-25” Modifier – Significant, Separately Identifiable E/M Plus Significant Procedure**

**ED: Coding, Billing & Reimbursement**  
**ED Professional Coding Physician Medical Services**

- **Special ED Medical Services – Physicians**
  - **CPR → CPT=92950 (\$175.28 – Facility RVUs)**
    - Not Time Based
    - Be Careful Of Overlap With Critical Care
    - Some Carriers Have Rules Disallowing Both CPR and Critical Care To Be Billed
    - Relatively Good Payment
  - **Critical Care → CPT=99291/99292 (\$210.63/\$105.31 – Facility RVUs)**
    - Time Based → First Hour+Subsequent Half Hrs
    - Half-Time Unit Rule
    - **Specific Services Included → If a given service is not on the list, then code and bill separately**
      - ✓ Interpretation – Cardiac Output/Chest X-Rays
      - ✓ Pulse Oximetry, Blood Gases, Vascular Access, Ventilator Management
      - ✓ Gastric Intubation, Transcutaneous Pacing
    - See Also – Neonatal Critical Care < 30 Days Old

**ED: Coding, Billing & Reimbursement**  
**ED Professional Coding Physician Medical Services**

- **Special ED Medical Services - Physicians**
  - **Cardioversion → CPT=92960/92961 (\$135.97/\$265.87)**
    - Elective (?)
    - External vs. Internal
    - Relationship To Defibrillation
  - **Pediatric Critical Care Patient Transport**
    - CPT=99289/99290 – Timed – Hour+Subsequent Half Hours → Pediatric
  - **Patient Transport – Greater Than 24 Months**
    - Use 99291/99292
      - ✓ Apply to Non-Physician Practitioners?
  - **Physician Direction Of EMS**
    - CPT=99288 (Status="B")

**ED: Coding, Billing & Reimbursement**  
**ED Technical Component Coding - Hospital E/M Selection**

- **Technical Component Coding ← Measures Resource Utilization**
  - **Point System Approach**
  - **Descriptive Approach**
  - **CMS Guidance To Come In CY2010, 2011(??)**
    - **CMS Is Formulating Guidelines**
    - **Series Of Eleven Criteria**
      - ✓ Should Only Reflect Use Of Resources
      - ✓ Uniform Across All Facilities
      - ✓ Be Reproducible, Be Simple
      - ✓ Be Reproducible, Be Easily Assigned
  - **Adopt Approach, Document Approach and Then Use It!**
  - **Do Not Mix E/M Services With Medical/Surgical Services – APCs Pay Them Separately**
- **Use Of "-25" Modifier ← Sensitive Issue For APCs**
- **Starting CY2007 – Type B DEDs – Not open 24/7 – Use G0380-G0384 – Paid as Clinic Level Services → Fast Track?**

## ED Technical Component Coding E/M Selection

➤ Point System Example (Partial)

**Nursing Assessments**

- Assessments – Initial & Discharge 15 Points
- Assessments – 1-2 Additional Reassessments 25 Points
- Assessments – 3-4 Additional Reassessments 35 Points
- Assessments – More than 4 Additional Reassessments 40 Points

Choose One Of The Above

➤ Admission/Discharge

- Transfer Out Points 20
- Transfer In Points 10
- Hospital Admission Points 20
- Psych Admission Points 20
- DOA/Patient Expired Points 20

Choose All That Apply

## ED: Coding, Billing & Reimbursement ED Technical Component Coding - E/M Selection

- CMS Has Created A Special Panel To Develop A Comprehensive, Uniform Process For The Selection and Associated Documentation Requirements for Technical E/M Coding In The ED and also Provider-Based Clinics
- A Draft Version of a Proposed System Has Been Jointly Developed By AHA and AHIMA. This draft version can be downloaded from either:
  - [www.aha.org](http://www.aha.org) or
  - [www.ahima.org](http://www.ahima.org)
- Whatever System Is Developed, There Will Be Controversy! Anticipate extended discussions and disagreements about technical component E/M coding.
- While it would be wonderful if the new system would go into effect in the near term, this new system is probably a good three years away!
  - What does this mean to you? What should you do in the meantime?

## ED: Coding, Billing & Reimbursement ED Technical Component Coding - E/M Selection

- Exercise – Fast Track at the Apex Medical Center
  - Discuss the following situation relative to the CMS concept of Type A versus Type B ED payment processes.
    - Case 1 – The Apex Medical Center has an ED fast track operation staffed by five non-physician practitioners. The fast track simply uses any available ED bed to provide services. The fast track operation is available from 9:00 a.m. to 6:00 p.m. seven days a week.
    - Case 2 – The Apex Medical Center has an ED fast track operation staffed by five non-physician practitioners. The fast track has three dedicated beds in an area adjacent to the ED. The fast track operation is available from 9:00 a.m. to 6:00 p.m. seven days a week. When the fast track is not open, the beds are not used.

## ED: Coding, Billing & Reimbursement ED Technical Component Coding - Hospital Medical Services

- Special ED Services
  - CPR – CPT=92950 → APC=0094 - \$159.74 (\$156.62-CY2008, \$148.96-CY2007)
    - Typically A Team Effort – Physician Directed
    - Be Careful Who Is Billing For This Service – It may appear in the Charge Master under different departments. Should really be billed by the ED even if multiple departments are involved.
    - Watch For Overlap With Critical Care
  - Critical Care
    - CPT=99291 (1s Hour) → APC=0617 – \$485.39 (\$466.02-CY2008, \$405.04-CY2007)
    - CPT=99292 (Sub ½ Hour) → Status="N" – This is bundled, but should be coded anyway(?). ← Charge capture issue.
      - ✓ APC=0618-Trauma Response With Critical Care → \$935.12 (\$330.28-CY2008, \$494.54-CY2007) ← Why the change??
    - Timing Is Different For Hospital Relative To Physician
      - ✓ Physician Time Not Necessarily Continuous
      - ✓ Hospital Time Will Be Continuous – Staff Personnel Will Be Involved

**ED: Coding, Billing & Reimbursement**  
**ED Technical Component Coding - Hospital Medical Services**

- **Special ED Medical Services**
  - Cardioversion → CPT=92960/92961 → APC=0679 - \$361.88 (\$347.15-CY2008, \$148.96-CY2007)
    - Elective (?)
    - External vs. Internal
    - Relationship To Defibrillation
  - Interfacility Transport
    - CPT=99289/99290 – Timed – Hour+Subsequent Half Hours – APCs → Status="N" – Code?
    - Should We Be Coding This Service??
  - Physician Direction Of EMS
    - CPT=99288 – APCs → Status="E"

**ED: Coding, Billing & Reimbursement**  
**ED Coding Observation Services**

- **Physician Coding**
  - Medical Staff Bylaws – Allow ED Physician To Admit To Observation – Otherwise Attending → See CPT Guidelines
  - Must Code Either ED Visit or Observation (Not Both) – Observation Pays Slightly More
  - CPT=99218/99219/99220 & 99217 (Discharge)
  - See Also CPT=99234/99235/99236 (Same Day)
    - 99218 - \$ 62.40                      99234 - \$126.59
    - 99219 - \$103.15                     99235 - \$165.55
    - 99220 - \$143.19                     99236 - \$205.58
    - 99217 - \$ 66.36
  - ✓ Note: The 99217-99220 is stable for payment.
  - ✓ Question: Does this alignment make sense?
    - $\$62.40 + \$66.36 = \$128.76$  vs.  $\$126.59$
  - 24 Hours vs. 48 Hours – Medicare vs. Other
  - Physicians Drive The Whole Observation Admission Process

## ED: Coding, Billing & Reimbursement ED Coding Observation Services

- Hospital Coding
  - By The Hour With RCC=762
  - CPT Coding → Variable By Third Party Payer
    - 99218-99220 versus G0378
  - Technical Component Charges For Both:
    - ED Level → RCC=450
    - Observation Services → RCC=762
  - Medicare Pays Under Certain Circumstances (New In CY2008)
    - 8 Units of G0378, Medical Necessity, Explicit Physician Documentation
    - Composite 8002 – \$375.70 (\$351.04-CY2008)
      - ✓ Direct Admit to Observation = G0379 (Nursing Assessment)
      - ✓ 99215 or 99205 – Provider-Based Clinic (?)
    - Composite 8003 - \$674.73 (\$638.66-CY2008)
      - ✓ 99284, 99285 or 99291 through the ED or G0384 (CY2009)
    - The “-25” modifier does not have to be used with G0379. Maps into APC=0604 - \$54.68 (\$53.43-CY2008, \$50.66-CY2007). When would G0379 be paid separately?

## ED: Coding, Billing & Reimbursement ED Coding Observation Services

- Hospital Coding
  - Standard Requirements In Place – G0378 Hourly, Documentation, Physician Care, Medical Necessity
  - Must be at least eight hours.
    - Question: Is it OK to bill for less than 8 hours?
  - Status Indicator =“T” will continue to be bundled into observation payment since CMS ‘believes’ that this SI indicates post-surgical observation.
    - What kind of problems does this create?
    - Similar to increased packing under APCs starting in CY2008.
      - ✓ “T” Packaging
      - ✓ “STVX” Packaging
        - See also Status Indicator Q1, Q2, Q3
  - Note special requirements if observation exceeds 48 hours. This is not typically an ED concern.

## ED: Coding, Billing & Reimbursement ED Coding Procedure/Surgical Services

- **Note:** The procedure and surgical coding is generally the *SAME* for professional and technical components. This is a compliance issue!
  - **Note:** This will most likely be a RAC issue. The OIG has already identified code correlation as a compliance issue.
- **Laceration Repairs**
  - **Type Of Lacerations**
    - Simple
    - Intermediate
    - Complex
  - **Location Of Lacerations** ← Be Careful! Anatomical Breakdown Is Different Per Type Of Laceration
  - **Length Of Lacerations**
  - **Debridement**
  - **Coding Conventions**
    - Adding Lengths
    - Use Of Modifiers
    - Relationship To Debridement
    - In Conjunction With Open Reductions

## ED: Coding, Billing & Reimbursement ED Coding Procedure/Surgical Services

- **Laceration Repairs**
    - **RBRVS Considerations** → Multiple Discounting
    - **APC Considerations** → Significant Changes Starting in CY2008
      - 0133 Level I Skin Repair SI="T" - \$86.70 (\$81.48-CY2008)
      - 0134 Level II Skin Repair SI="T" - \$227.34 (\$134.08-CY2008)
      - 0135 Level III Skin Repair SI="T" - \$292.68 (\$288.30-CY2008)
      - 0136 Level IV Skin Repair SI="T" - \$1,055.29 (\$958.33-CY2008)
      - 0137 Level V Skin Repair SI="T" - \$1,391.57 (\$1,287.06-CY2008)
- ✓ Status = "T" Multiple Discounting  
✓ Why did APC=0134 go up so much?

## **ED: Coding, Billing & Reimbursement ED Coding Procedure/Surgical Services**

### ➤ **Laceration Coding Example**

An elderly patient presents to the ED. She has fallen and has two lacerations:

- a. A 4.0 cm. simple laceration on the left arm,
- b. A 4.1 cm. intermediate laceration on the right arm.

How should this be coded?

What other concerns/questions should be addressed?

## **ED: Coding, Billing & Reimbursement ED Coding Procedure/Surgical Services**

### ➤ **Fracture Care/Dislocation Services**

- **Single, Most Important Question: Was fracture care provided? This is not always an easy question to answer!**
- **Definitive Fracture Care**
- **Stabilization With Referral To Another Physician**
- **Splinting Services**
- **Fractures For Which The Standard Of Care Is Minimal**
  - Fractured Ribs
  - Fractured Toes
- **Anesthesia**
- **Open Reduction vs. Closed Reduction**
- **“Closed Treatment” Terminology**
- **Modifiers**
- **RBRVS Considerations → Multiple Discounting**

- **Note: APCs are very much a mess in this area. CMS has incorrect coding and charge data that has been provided by hospitals.**

## ED: Coding, Billing & Reimbursement ED Coding Procedure/Surgical Services

- Fracture Care/Dislocation Services
  - APC Considerations→ History
    - APC=0043 – Closed Treatment Fracture Finger/Toe/Trunk → \$112.62 (\$207.18 in 2002)
    - APC=0044 – Closed Treatment Fracture/Dislocation Except Finger/Toe/Trunk → *Deleted* (\$129.30 in 2002)
    - Note: The payment rates in CY2002 were totally turned around. Starting with CY2003 hospitals are paid the same for a broken toe (almost no effort) and a broken leg (significant effort and resources). This is due to inconsistent (improper?) coding and charging by hospitals.
    - APC=0058 – Level I Strapping and Cast Application → \$69.62 (\$65.16 in 2002)
    - APC=0059 – Level II Strapping and Cast Application → *Deleted* (\$113.52 in 2002)
    - There have been significant problems with coding in this area. Note that hospitals are being paid significantly less since 2003 relative to 2002.
    - Status="T" – Multiple Discounting Applies

## ED: Coding, Billing & Reimbursement ED Coding Procedure/Surgical Services

- Fracture Care/Dislocation Services
  - APC Considerations
    - CMS finally made some changes starting for CY2009
  - Closed Fracture Treatment
    - 0129 – Level I Closed Tx Fx Finger/Toe/Trunk → \$105.54
    - 0138 – Level II Closed Tx Fx Finger/Toe/Trunk → \$406.12
    - 0139 – Level III Closed Tx Fx Finger/Toe/Trunk → \$1,312.75
      - ✓ CMS has finally addressed (to some extent) the closed fracture treatment
      - ✓ Strangely, CMS did not change the wording of the APCs to reflect coverage of more than fingers, toes, ribs, etc.
      - ✓ Important to really look at the mappings. Many fractures of the arms and legs still go into the lowest level. Why?
  - APC=0058 – Strapping and Cast Application Not Changed

## **ED: Coding, Billing & Reimbursement ED Coding Procedure/Surgical Services**

### ➤ **Fracture/Dislocation Coding Example**

Elderly patient presents after being thrown off a horse. Besides contusions and some bruises, an x-ray indicates a fractured rib. The patient is sent home with instructions to rest for several days and a pain medication is provided.

How should this be coded?

- ### ➤ **Physician vs. Hospital Coding – When should the coding be different?**
- An interesting exercise is to identify those types of cases in which the physician coding will be different from the hospital coding.

## **ED: Coding, Billing & Reimbursement ED Coding Procedure/Surgical Services**

- ### ➤ **Other Types Of Services**
- Foreign Body Removal – Various Sites
  - Burn Care
  - Psych Exams
  - Fecal Impactions
  - Enemas
  - Foley Catheter Insertion
  - Other
- ### ➤ **Outside Physicians Using ED As Clinic**
- Hospital Coding/Billing Concerns
  - Documentation Concerns
- ### ➤ **Consulting Physicians Working With ED Physicians**
- Hospital Coding/Billing Concerns → Code and Bill For All Services
  - Only A Single E/M Level Is Used
- ### ➤ **Teaching Institutions**
- Documentation Issues
  - Special Modifiers

**ED: Coding, Billing & Reimbursement**  
**ED Coding/Billing Injections/Immunizations - Facility**

- **Injections**
  - Usually Provided By ER Nursing Staff
  - Combination of CPT and HCPCS Codes
    - Totally Revised in CY2006 ← CMS Adopted For CY2007 – Additions for CY2008 – Renumbered in CY2009!!
    - Physician and Hospital Coding Is Different
  - Substance Injected – J-Code – Payment Bundled
  - Multiple Guidance Documents – CY2006 Q&A, Transmittal 785, July, 2001 *CPT Coding Assistant*.
  - See ‘not separately billed’, ‘not separately reported’ and ‘integral part’ issues.
- **Immunizations**
  - Usually Provided By ER Nursing Staff
  - Code/Bill for Administration – Status Indicator “N”
  - APC Payment Is For Vaccine or Toxoid – CPT=90476-90749 – The payment is variable, see APC mappings.

**ED: Coding, Billing & Reimbursement**  
**ED Coding/Billing Other Areas For Concern**

- **Multiple Visits On The Same Day**
  - “-27” Modifier
  - “G0” Condition Code
  - Unrelated Services → Two E/M versus One E/M
- **ED To Surgery Back To ED ← Coding/Billing For All Services**
- **Use Of NPPs In The ED**
  - PAs, NPs, CNSs → Billing Independently?
  - ED Is Part Of Hospital – No “Incident-To” Billing
- **Medical Screening Examinations versus Triage Assessments → Who is qualified under EMTALA?**
- **EMTALA Compliance → Major Issues – Coding, Billing Related**
  - Medical Screening Examination (MSE) – Who can perform? Should we bill? What if the patient elopes? (Leaves against medical advice.)
  - Non-Emergency Services – How determined? MSE needed? Coding and billing.
  - Non-Physician Providers – Who is performing services? Meet EMTALA requirements?

## **ED: Coding, Billing & Reimbursement Case Studies/Exercises**

- **The following exercises and brief case scenarios are taken from real cases. Due to the need for brevity, the amount of information needed to perform complete and accurate coding is not available.**

**As we work through the exercises, various areas of concern and areas where additional details are needed will be discussed.**

**In developing possible solutions, it is permissible to include any assumptions that might be made relative to providing coding solutions.**

**Coding personnel should follow all coding conventions.**

**Financial personnel can look for the way to optimize reimbursement, but you will have to reconcile any of your solutions with coding personnel following the coding conventions.**

**We will discuss these exercises at a conceptual level. If you want suggested solutions and/or the intent of the exercise, then e-mail for additional information.**

## **ED: Coding, Billing & Reimbursement Case Studies/Exercises**

- **Exercise 1 –**

**Sam presents to the ER with an injured finger. ER physician performs a screening examination and then a problem-focused examination since Sam has no other presenting symptoms. No laceration, but he twisted it while working. X-rays indicate no break. ER physician applies a finger splint and prescribes a mild pain medication. Sam is instructed to see his personal physician in a day or two for follow-up care.**

## **ED: Coding, Billing & Reimbursement Case Studies/Exercises**

### **➤ Exercise 2 –**

Sam presents to the ER with severe chest pains. An MI is suspected. An assessment is made along with lab tests and x-rays. A detailed examination is performed and detailed history is taken. A cardiologist is called in for a consultation. A definitive diagnosis cannot be made. A decision is made to place Sam in observation for 24 hours to observe and monitor.

## **ED: Coding, Billing & Reimbursement Case Studies/Exercises**

### **➤ Exercise 3 –**

Patient presents in the ER. There is manipulation of the nasal bone for stabilization. A nasal endoscopy is performed for debridement and to control bleeding. A 12 cm., deep laceration on the right forearm, a 9 cm. simple laceration on the left forearm requiring extensive debridement of foreign material, and an 11 cm. forehead laceration requiring debridement for removal of crushed skin are all addressed surgically.

**ED: Coding, Billing & Reimbursement  
ED Coding & Billing Case Studies/Exercises**

➤ **Exercise 4 –**

The ED is busy and there is a patient that has a badly sprained elbow. An ED physician requests that a Physical Therapist come to the ED to fabricate and apply a splint for the elbow.

How should this be coded and billed for both the professional and technical components?

**ED: Coding, Billing & Reimbursement  
Case Studies/Exercises**

➤ **Exercise 5 –**

A worker from a local factory presents with metal shavings in his eye. The ER physician through the use of slit lamp assesses the situation and then removes the foreign bodies. No other medical complaints are made.

## **ED: Coding, Billing & Reimbursement Case Studies/Exercises**

### **➤ Exercise 6 –**

**Elderly patient presents via ambulance after a serious automobile accident. Patient is assessed, briefly stabilized and taken immediately to surgery where abdominal surgery is performed. Unfortunately the patient dies in the operating room. The patient is not admitted to the hospital.**

## **ED: Coding, Billing & Reimbursement Case Studies/Exercises**

### **➤ Exercise 7 –**

**Dr. Brown of the Acme Medical Clinic has instructed a patient to meet her at the ER. The patient presents, is registered and placed in a special procedures room. Dr. Brown arrives and provides services that involve the removal of several splinters that require sutures.**

**Note: The Acme Medical Clinic, Apex Medical Center, Summit Nursing Facility and Pinnacle Home Health Agency are all fictitious health care providers used by Dr. Abbey in his books.**

## **ED: Coding, Billing & Reimbursement Case Studies/Exercises**

### **➤ Exercise 8 –**

**Patient presents to the ER with closed humeral shaft fracture. Closed reduction is performed, however, casting is not possible due to pain and swelling. A splint is applied.**

- **The patient returns to the ER two days later for casting. How to code?**
- **The patient is referred to an orthopedic surgeon for follow-up care. How to code?**

## **ED: Coding, Billing & Reimbursement Case Studies/Exercises**

### **➤ Exercise 9 –**

**Sam presents to the ER at the directions of Dr. Brown, a local physician, for IV administration of several drugs. ER nurse provides the services. Approximately \$500.00 worth of drugs is provided.**

### **ED: Coding, Billing & Reimbursement Case Studies/Exercises**

➤ **Exercise 10 –**

After a snow blower accident, a patient presents to the ER with a broken finger (right index). There is a 3.5 cm. laceration noted and an open reduction of the fracture is necessary. An incision is made to reduce the fracture (right index finger) and a pin is inserted. Sutures are applied and the patient is sent home.

### **ED: Coding, Billing & Reimbursement Case Studies/Exercises**

➤ **Exercise 11 –**

Sarah, an elderly patient who lives alone, presents to the ED with difficulty in swallowing. The ER physician is unable to determine the cause. An ENT physician is called for a consultation. An esophagoscopy is performed and a small food pack is eventually pushed down into the stomach. Sarah is observed for several hours. By the time she is ready to leave, it is 1:00 a.m. and the ED physician decides to keep her over night since “no one is at home to care for her”.

## **ED: Coding, Billing & Reimbursement Case Studies/Exercises**

➤ **Exercise 12 –**

Susan presents to the ED not feeling well. An IV is started and she is put on oxygen while she is evaluated. EKG, chest x-ray and various laboratory tests are performed. During her 6-hour stay, she receives two IM injections and three IV injections through her IV. She is eventually released to go home. Indicate how the various injections should be coded.

## **ED: Coding, Billing & Reimbursement Case Studies/Exercises**

➤ **Exercise 13 –**

Stanley, a middle-aged gentleman, presents to the Apex Medical Center's ED after a radial saw accident. The right index finger along with the two adjacent fingers have been injured. Luckily, there are no broken bones. The ER physician carefully debrides (to the bone) two of the fingers (necrotic skin and foreign materials) and then carefully sutures a 7 cm. laceration on the index finger, a 5 cm. laceration on the next finger. The ring finger has only a 3.5 cm. laceration and required no unusual debridement before closure.

What if the index finger had a fracture that required no reduction, but a finger cast was applied?

**ED: Coding, Billing & Reimbursement  
ED Coding & Billing Case Studies/Exercises**

- **Exercise 14 – Code the professional and technical components for the following case:**

A patient presents to the ED with two lacerations.

a. The patient has no other presenting symptoms and is sent by the triage nurse to the distinct part, Fast Track where a specially trained 'Suture Technician' assesses the patient and repairs the two lacerations.

b. The patient is examined by an ED physician and is then sent to the distinct part, Fast Track where a specially trained 'Suture Technician' also assesses the patient and repairs the two lacerations.

c. The patient is sent by the triage nurse to the distinct part, Fast Track where a specially trained 'Suture Technician' assesses the patient and repairs the two lacerations. One of the ED physicians stops by to see the patient just before the patient leaves.

**ED: Coding, Billing & Reimbursement  
ED Coding & Billing Case Studies/Exercises**

- **Exercise 15 –**

Sylvia, the Chargemaster Coordinator at the Apex Medical Center, is concerned about charging or not charging for Dermabond (and/or other skin adhesives). There is a HCPCS code:

**G0168 – Wound closure utilizing tissue adhesive(s) only**

On the physician side this pays \$24.53 while on the hospital side this code is SI="N" so there is no separate payment (i.e., packaged).

Discuss what is going on here and advise Sylvia as to the correct approach to take for both physician and hospital coding/billing.

**Hint: For the physicians, CPT=12001 (minor laceration repair) pays \$93.77.**

## ED: Coding, Billing & Reimbursement Charge Master Setup

- Hospitals Always Bill For Technical Component Charges – Some Hospitals May Also File 1500s For Professional Services → This affects the approach to the Charge Master construction. See separate webinar/teleconference.
- Professional Component Billing
  - This is basically a physician's fee schedule.
  - All of the possible CPT/HCPCS codes that can be used are put into the fee schedule. This includes E/M, medical and surgical codes.
  - This goes into the Charge Master and can be quite lengthy.
  - Fees are typically generated using RBRVS with chosen conversion factor. (\$75.00-\$100.00 is typical – Medicare pays about \$38.00).
  - Coding and thus charge entry can be generated from encounter forms or generated by coding staff from the medical record.
  - Modifiers must be generated separately and do not typically go into the Charge Master.

## ED: Coding, Billing & Reimbursement Charge Master Setup

- Professional Component – Charge Master  
- Using RBRVS (CY2009) With Arbitrary CF=\$100.00

CPT	RCC	RVU	CF	Charge
99281	981	0.56	\$100	\$ 56.00
99282	981	1.10	\$100	\$110.00
99283	981	1.68	\$100	\$168.00
99284	981	3.18	\$100	\$318.00
99285	981	4.71	\$100	\$471.00
99291	981	5.84	\$100	\$584.00
99292	981	2.87	\$100	\$287.00
92950	981	4.86	\$100	\$486.00
92960	981	3.77	\$100	\$377.00

## **ED: Coding, Billing & Reimbursement Charge Master Setup**

- **Technical Component Setup**
  - **Hospital Charge Master Setup Will Vary Depending On How The Coding Is Accomplished**
  - **In The Following – It is assumed that all the ancillary services (radiology, laboratory, EKGs, etc.) are elsewhere in the Charge Master.**
  - **Approach 1**
    - **Put The E/M Codes In The Charge Master & Have ER Staff Check-Off The Level Based On A Point System or Narrative System**
    - **Put The Typical Medical Services In The Charge Master (Critical Care, Cardioversion, Etc.) and Have ER Staff Check-Off Through An Encounter Form**
    - **Put a limited number (typically three to six) of surgical level charges in the Charge Master and have ER Staff pick a level based upon overall surgical interventions. This will generate a charge.**
    - **Coding Staff Will Code The Surgeries From The Medical Record – These will hook up with the surgical charge generated from the levels.**

## **ED: Coding, Billing & Reimbursement Charge Master Setup**

- **Technical Component Setup**
  - **Approach 2**
    - **Mirror The Hospital's Charge Master To Be Essentially The Same As The Physicians**
    - **Note: There will need to be some changes, but these are relative minor such as radiology interpretation, EKG interpretation, etc.**
    - **Charges can then be developed for all of the codes.**
    - **Note: There is no relative value system for the hospital, technical component. Charges should be based on cost analyses.**
    - **Coding staff code from the overall medical record and drive both the coding, charging and modifier development through the Charge Master.**

## ED: Coding, Billing & Reimbursement Compliance Concerns

- **OIG FY2005/FY2009 Work Plans**
  - The OIG is worried about the 'excessive' number of diagnostic tests being performed in the ED. For FY2008 the emphasis is on diagnostic radiology services in the ED. This may also be a RAC (Recovery Audit Contractors) audit area.
  - The OIG is investigating the correlation of coding between the physicians and the hospital. The E/M codes do not need to match, but other codes should generally match.
- **EMTALA**
  - May 9, 2002, *Federal Register* proposed a number of changes to EMTALA and associated interpretation. Changes are embodied in the September 9, 2003 *Federal Register*. Some changes occur each year. See August 19, 2008 *Federal Register*. See separate teleconference.
- **Bundling/Unbundling Services**
  - During an ED encounter a patient may be taken to an 'outside' facility for diagnostic testing. The hospital providing ED services must bill for the diagnostic testing.

## ED: Coding, Billing & Reimbursement Compliance Concerns

- **Shared E/M Services**
- **Transmittal 1776 – October 25, 2002**
  - "When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice<sup>[1]</sup> and the physician provides *any face-to-face portion* of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record), then the service may only be billed under the NPP's UPIN/PIN." (Emphasis added.)
    - <sup>[1]</sup> The same group practice apparently can be interpreted to mean sharing the same employer or collegially employed such as by a hospital.
- **Note: This directive addresses only E/M services. What about other types of services, e.g., suture technician repairs a laceration without the direct participation of the physician.**

## **ED: Coding, Billing & Reimbursement Special Charge Master Exercise**

➤ **Take-Home Exercise (Continued in ED Chargemaster  
Webinar/Teleconference)**

The Chief Compliance Officer and the Charge Master Coordinator at the Apex Medical Center have been studying the coding and billing compliance concerns under EMTALA.

They have noted the following Revenue Center Codes (RCCs):

RCC=451 – EMTALA Emergency Medical Screening Services

RCC=452 – ER Beyond EMTALA Screening

RCC=456 – Urgent Care

Notes: 451 can be used alone. If other RCCs are used they can be only 452, 456 or 459. 452 cannot be used alone and must be used with 451. 456 can be reported only with 451 or 459.

Explain how to use these RCCs. Be sure to indicate what kinds of codes can be used with each!

Warning! Don't try to use these RCCs without first checking with various third-party payers.

## **ED: Coding, Billing & Reimbursement Summary and Conclusion**

- **ED Coding & Billing Is Complex!**
- **Need To Carefully Separate *Professional* From *Technical* Component**
- **E/M Level Development Is Completely Different For Physicians versus Hospitals**
  - **Physicians – Code for services performed within guidelines.**
  - **Hospitals – Code for resource utilization through a mapping.**
- **Medical/Surgical Procedures Should Be Coded The Same Way**
- **APC/APG Type Payment Systems Are Becoming The Norm For Technical Component Coding**
- **RBRVS and Other Fee Schedules Are The Norm For Professional Coding**
- **Modifiers Are Needed In Many Instances**
- **The Coding and Billing Process Flow May Vary Significantly Between Emergency Departments In Different Hospitals**
- **There Are A Number Of Significant Compliance Concerns In The ED Including EMTALA**