Emergency Department Facility Services

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AAPC

Course Objectives

- Discuss E/M Code Selection for the Facility
- Discuss Common Procedures Reported in the Emergency Department
- Discuss Charge Capture in the Emergency Department

ED Services

Professional	Facility
•E/M Codes-1995 or 1997 CMS Documentation Guidelines •Procedures performed by the provider •Interpretations of EKG and X-rays if not billed by specialist	•E/M codes determined by facility resources •Procedures performed by the provider •Procedures performed by hospital staff (e.g. drug administration, EKGs) •Labs, X-rays, EKGs, etc •Medications administered •Supplies •DME if credentialed

Charge Capture

- Coders: E/M, procedures
- Charge master: medications, diagnostic services

Charge Capture

- Facility services reported by ED Facility include services performed by all physicians, NPP, nurses, techs, etc.
- Nursing and provider documentation is crucial
- Must have an up to date charge master
  - CPT®/HCPCS Level II Codes
  - Revenue Codes
  - Charges

Charge Capture

- Multiple departments select facility charges for services rendered in the ED
  - Lab services
  - Radiology
  - Drugs
  - Supplies
  - Procedures
  - E/M Levels

ED Facility E/M

- There is not a national standard. Each facility must determine an internal policy.
  - Must provide reproducible results
  - All hospital personnel must follow the same policy
  - Policy for E/M code selection should be based on hospital resources
  - Not the same code as the professional E/M
  - Do not include billable services as criteria for code selection

ED E/M Models

- Type of staff interventions
- Time spent with patients
- Point system based on interventions by staff
- Patient severity

ED Facility E/M

- Type A-available 24 hours a day, 7 days a week and is either licensed by the State in which it is located under applicable state law as an emergency room or emergency department or it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

ED Facility E/M

CPT Code	SI	APC	Payment Rate
99281	V	0609	$55.62
99282	V	0613	$100.91
99283	V	0614	$166.47
99284	Q3	0615	$293.93
99285	Q3	0616	$455.93

ED Facility E/M

- Type B-dedicated emergency department. Must meet one of the following
  - It is licensed by the state in which it is located under applicable State law as an emergency room or emergency department
  - It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment
  - provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment

ED Facility E/M

CPT Code	SI	APC	Payment
G0380	V	0626	$51.92
G0381	V	0627	$61.67
G0382	V	0628	$91.71
G0383	V	0629	$163.27
G0384	Q3	0630	$312.42

OPPS Proposed Rule for E/M

New HCPCS Level II Code	Description	APC	Payment Rate
GXXXA	Type A ED	0635	$212.90
GXXXB	Type B ED	0636	$84.85

OPPS Final Rule for Clinic E/M

New HCPCS Level II Code	Description	APC	Payment Rate
G0463	Clinic Visit	0634	$92.53

Comparison

Procedure	Number of Visits	Total Reimbursement
99281	0	$0.00
99282	150	$13,824.00
99283	1000	$143,360.00
99284	1450	$332,586.50
99285	2400	$827,304.00
Total	5000	$1,317,074.50
GXXXA	5000	$1,064,500.00
Difference		$252,574.50

CMS FAQ:

Can hospitals bill Medicare for the lowest level ER visit for patients who check into the ER and are "triaged" through a limited evaluation by a nurse but leave the ER before seeing a physician?

CMS Answer:

No. The limited service provided to such patients is not within a Medicare benefit category because it is not provided incident to a physician's service. Hospital outpatient therapeutic services and supplies (including visits) must be furnished incident to a physician's service and under the order of a physician or other practitioner practicing within the extent of the Act, the Code of Federal Regulations, and State law. Therapeutic services provided by a nurse in response to a standing order do not satisfy this requirement.

https://questions.cms.gov/faq.php?id=5005&faqId=2297

Observation

- Observation time must be documented
- The time begins when observation services are initiated in accordance with a physician's order for observation services.
- The time ends when all clinical or medical interventions have been completed.
- Total units must equal or exceed eight.
- Documentation must include assessments, reassessments and discharge.

Observation

Code	Description	SI	APC	Payment Rate
G0378	Hospital Observation per hour	N		
G0379	Direct Referral Hospital Observation	Q3	0633	$327.85

Composite APC

APC	Description	Criteria
8009	Extended Assessment and Management Composite	G0379 G0463 99284 99285 G0384 99291 8 Hours of observation care

AAPC ED Facility Services

Observation Examples

Do the following examples qualify for observation?

- Patient is brought in the ED with a head injury. The ED physician repairs the laceration and orders observation for the head injury.
- Patient is seen for an allergic reaction. The ED provider documents he wants to observe the patient to see if he responds to the Benadryl that was administered.

Critical Care

- Critical care coded based on the patient's condition NOT site of service
- According to CPT®

  "A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.."

Organ System Failure

- Central nervous system failure
- Circulatory failure
  - Acute MI
- Shock
  - Severe trauma
  - Coagulopathy
- Renal failure
  - New onset
  - Hyperkalemia
- Hepatic Failure
  - Encephalopathy
  - Stroke
- Metabolic failure
  - Toxic Ingestion (methanol)
  - Severe Acidosis
- Respiratory Failure
  - Pneumonia

Critical Care

Critical Care Time “under the OPPS, the time that can be reported as critical care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient”.

Transmittal 1139, Change, Request 5438

Critical Care

Bundled Services for professional services NOT facility:

- Interpretation of cardiac output measurements (93561, 93562)
- Chest X-rays (71010, 71015, 71020)
- Pulse oximetry (94760, 94761, 94762)
- Blood gases, and information data stored in computers (eg, ECGs, blood pressures, hematologic data [99090])
- Gastric intubation (43752, 91105)
- Temporary transcutaneous pacing (92953)
- Ventilator management (94002-94004, 94660, 94662)
- Vascular access procedures (36000, 36410, 36415, 36591, 36600)

Critical Care

Code	Description	SI	APC	Payment
99291	Critical care, 30-74 minutes	Q3	0617	$634.94
99292	Critical care, addl. 30 minutes	N		

Commonly Performed with Critical Care

- CPR
- Central Venous Access
- Intubation

Time spent performing billable services can not be included in Critical Care time.

Critical Care Example

MDM:

Labs: CBC, CMP, PT, PTT, Type + Screen

Radiology: Chest 1 view

Heart Station: EKG, Adult

Prior Records

Calls/Consults: 6:50, Dr. Bays, Oncology. Did not answer page.

Notes: Patient became hypotensive to 55/30, given IVF with some improvement, immediately ordered PRBC and PLT 6, stat CT ordered to evaluate for Retrop. Hematoma.

Critical Care Example

ICU called: No Beds

Hospice Called: No Beds

CT Scan: No Hematoma

Trauma Surgery service called to evaluate patient.

Called MICU: No Beds

Critical Care Example

Patient went into respiratory failure.

ET Tube 8.0mm placed. Sedation: None. Number of attempts: 1

Breath Sound after intubation: Equal

O2 saturation: 100%

Total time: 15 minutes

Critical Care Note: Total Time: 90 Minutes

Diagnosis: Septic Shock, Respiratory Failure, Neutropenia, Thrombocytopenia

Packaged Services

- Services packaged for 2014
  - Add on codes
  - Device removal
  - Supplies
  - Lab tests
  - Skin substitutes
  - Stress agents
- Found in Addendum P

Drug Administration

Nursing Documentation must include:

- Substance
- Dose
- Route
- Start and stop times
- Mixed with saline
- Complications

Hierarchy for Administration

- Chemotherapy
- Therapeutic
- Hydration
- Infusion
- IV Push
- Hydration
- Injections

Procedures

- Global Periods:
  - Professional: Minor 0-10 days; Major 90 days
  - Facility 1 day. Professional global periods do not apply in the facility setting.

Fracture Care Coding

- The ED physician provides the same care as the orthopedist (Definitive care)
  - Must be the same
  - Not a temporary measure but the same ultimate care provided by the specialist

  Types of Fracture Care:
- Strictly supportive measures and pain control
- Splinting
- Casting
- Operative fixation

Fracture Care Coding

Restorative care is provided any time the ED physician manipulates the bones

- Reduce the fracture
- Restore or improve anatomic positioning

Fracture Care Coding

To select appropriate fracture care code, you must know:

- Anatomical site
- Open or Closed treatment: ED fracture care is closed
- Use of Manipulation
- Significant and separately identifiable E/M, append modifier 25 for the facility.

CPT® Definitions
Open and Closed Fractures

- ***Closed treatment:*** *"specifically means that the* fracture site is not surgically opened (exposed to the external environment and directly visualized)."
- ***Open treatment****: "is used when the fractured bone is either (1) surgically opened (exposed to the external environment) and the fracture (bone ends) visualized and internal fixation may be used or (2) the fractured bone is opened remote from the fracture site in order to insert an intramedullary nail across the fracture site."*

Open vs. Closed Treatment

- This is a description of the technique used to treat the fracture, not the fracture itself.
- Even if the fracture itself is open the ED physician likely did not provide open fracture care.
- ED physicians almost never perform open treatment of a fracture
- ED fracture care involves closed treatment

Fracture Care Codes
"Without" vs. "With Anesthesia"

- The AMA and CPT® have stated that the "with anesthesia codes" are to be used in the Operating Room Setting with general anesthesia.
- These codes do not apply to the ED setting.
- Even if Moderate Conscious Sedation or Deep Sedation is employed report the "without anesthesia" codes.

Fracture Care Coding

- When fracture care is performed, splinting/casting is included and not reported separately.
- When a cast is placed for temporary treatment until the patient can be seen by a specialist, report the code for casting not fracture care.

Fracture Care Example

CC: Won't move left arm

HPI: This 17-month-old fell earlier today and has not wanted to move her left arm since. She will move in certain ways but does not want to move her elbow.

PMHX: No significant medical illness

ALLERGIES: ACCURATELY RECORDED ON NURSING NOTES

MEDICATIONS: ACCURATELY RECORDED ON NURSING NOTES

Fracture Care Example

SOCIAL HISTORY: Lives with mother

REVIEW OF SYSTEMS: ALL OTHER SYSTEMS NEGATIVE FOR ACUTE COMPLAINTS

VITAL SIGNS: NURSING RECORDS & DEMOGRAPHICS REVIEWED

Fracture Care Example

PE: GENERAL: Alert. Co-operative.

Extremities: There is no discrete bony tenderness of the left upper extremity. I reduced a subluxation of the left radial head.

INTERVENTIONS: I reduced a subluxation of the left radial head. Mother was reassured.

Dx: Nursemaid's elbow

Splints

- Replacement or initial application of splint/strap (CPT® codes 29000 – 29799)
- Use E/M code with cast/splint/strap code
- If using Fracture care code, splint service is bundled

Common Facility Errors

- Incorrect units for medications administered
- Drugs charged with no administration codes
- Administration codes with no drugs charged
- Failure to report procedures performed by all healthcare providers involved in the encounter (MDs, NPPs, nurses, techs, etc.)
- Reporting same E/M as the physician/NPP

Auditing ED Facility Services

- Post payment Review
  - Medical Record
  - Services billed
  - Remittance Advice
  - Payer policies and contracts
  - Audit Tool

Auditing ED Facility Services

- Services Targeted for Audit
  - OIG Work Plan
    - **Hospitals—Outpatient Observation Services During Outpatient Visits**
  - MAC: Review information on MAC website
  - CERT: Review audit results
  - RAC: Review services that are approved for audit
    - IV Hydration Therapy

Case 1

HISTORY OF PRESENT ILLNESS: Patient is a 37-year-old male who has been having an ongoing sore throat since Sunday. He went to the Urgent Care on Sunday, was treated with one Penicillin injection and was discharged home. He is not getting any better and actually feels like he is getting worse and therefore presents here for reevaluation. He was initially seen by the PA in Urgent Care once again today and she had some concerns about his exam and wanted him seen by me. I have seen and evaluated him and he has a left sided peritonsillar abscess.

Case 1

PAST MEDICAL HISTORY: None.

ALLERGIES: NONE.

MEDICATIONS: Noncontributory.

SOCIAL HISTORY: Noncontributory.

REVIEW OF SYSTEMS: All systems reviewed and are negative unless stated in HPI.

Case 1

PHYSICAL EXAMINATION: CONSTITUTIONAL: Vital signs: B/P: 134/92. Pulse: 69. Resp: 16. Temp: 98.2. 02 sat l00g. GENERAL APPEARANCE: This is a healthy-appearing 37-year-old male in mild distress. EYES: The pupils are symmetrical, and reactive to light. The conjunctivae and lids appear grossly normal. ENT: The patient's ENT exam shows there to be some mild cellulitis of the left side of the soft palate. He also has a clearly visible peritonsillar abscess with edema and uvular deviation. NECK: The neck is supple, very mild left sided peritonsillar lymphadenopathy. RESPIRATORY: Equal chest wall excursion. There are no intercostal retractions or the use of accessory muscles with respirations. Breath sounds are clear and symmetrical. There are no wheezes, rales, or rhonchi.

Case 1

CARDIOVASCULAR: The chest wall is normal in appearance. The heart has a regular rate and rhythm. GASTROINTESTINAL: The abdomen is soft and non-distended. There is no tenderness to palpation, rebound, or guarding. SKIN: There is no significant rash or ulceration. NEUROLOGIC: Grossly normal/baseline. HEME/LYMPH: No petechiae. MUSCULOSKELETAL: Strength and tone are grossly normal to the upper and lower extremities. PSYCHIATRIC: Normal affect.

Case 1

EMERGENCY ROOM COURSE: While in the ER, the patient seen and examined by myself. The patient received an IV of normal saline. Received a 2 liter fluid bolus followed by 200 cc per hour. The patient received 3 grams of Unasyn and 25 mg of Solu-Medrol and 10 mg of morphine IV. The patient has been reassessed. He is doing much better. He does need incision and drainage. He was additional mg of Dilaudid IV for pain.

Case 1

The following procedure was then performed using an overhead light and ENT tray, a 27 gauge needle was used to produce anesthesia over the distal soft palate, just anterior to the abscess. A needle guard was used to protect the depth. He was anesthetized using approximately 1 cc of Lidocaine, #15 blade was then used to incise the area. Pus was able to be expressed. A small straight hemostat was used to help assist in expressing more of the pus. Caution was made as to not go any deeper than the abscess pocket. Suction was used to help suction out the abscess as well as collecting the blood from the injury. He tolerated the procedure well and at this time he is stable for discharge home.

Case 1

FINAL DIAGNOSES:

1. Pharyngitis.

2. Left peritonsillar abscess

Case 2

HISTORY OF PRESENT ILLNESS: This is a 6-year-old male presenting with complaints of worsening shortness of breath noted to fall as low as oxygen saturation of 52% with bilateral rhonchi and productive cough. Noted to have probable respiratory distress. He has a history of chronic pulmonary disease, reactive airways disease, a history of multiple congenital defects, history of cardiopulmonary failure in the past as well as sepsis. The patient has had no recent nausea, vomiting or diarrhea. The patient, after his last hospitalization status post tracheostomy placement. Mother noted the child to have worsening shortness of breath and productive cough as well as a fever to as high as 103. He had no nausea, vomiting or diarrhea.

Case 2

ROS AND PFSH: Review of systems negative except as stated in HPI. PMFSH positive for profound MR with trach placement 5 years ago, chronic pulmonary disease and multiple congenital defects; secondary smoke exposure at home

PHYSICAL EXAMINATION: CONSTITUTIONAL: Vital Signs: Pulse: 161. Resp: 30. Temp: 102.4. Oxygen saturation 90% GENERAL APPEARANCE:

Case 2

The patient reveals profound mental retardation. Tracheostomy is in place. EYES: Conjunctivae are slightly anemic. ENT: Oral mucosa is dry. NECK: The neck is supple and the trachea is midline. Range of motion is normal. There are no masses, crepitus or tenderness of the neck. The thyroid gland has no appreciable goiter. RESPIRATORY: The lungs reveal transmitted upper airway signs and bilateral rales, wheezes and rhonchi. CARDIOVASCULAR: The chest wall is normal in appearance. Regular rate and rhythm. No murmurs, rubs or gallops are noted. There is no significant edema to the lower extremities.

Case 2

GASTROINTESTINAL: The abdomen is soft and no distended. There is no tenderness, rebound or guarding noted. There are no masses. No organomegaly is appreciated. SKIN: The skin is pale and slightly diaphoretic. NEUROLOGIC: Cranial nerves h-Vu appear intact. The patient moves all 4 extremities symmetrically. No lateralizing signs are noted. Gross sensation is intact to all extremities. LYMPHATIC: There are no palpable pathologic lymph nodes in the neck or axilla. MUSCULOSKELETAL: Gait and station are normal. Strength and tone to the upper and lower extremities are normal for age with no evidence of atrophy. There is no cyanosis, clubbing or edema to the digits.

Case 2

LABORATORY EVALUATION: Chest x-ray reveals bilateral perihilar infiltrates. White count is 7, H and H is 12 and 38, platelets of 328. Arterial blood gas pH 7.36, pCO2 75, p02 178, saturation 99%

DIAGNOSES:

1. Respiratory failure.

2. Bilateral pneumonia.

Case 2

EMERGENCY DEPARTMENT COURSE: The patient was given 500 mg IV of Rocephin. Continuous nebulized treatments with Decadron and albuterol were provided. We increased his portable ventilator to as high as 25 breaths per minute, subsequently raising again to 30 breaths per minute.

Progress note: On reexamination the patient was hemodynamically stable although he had one episode of possible apnea and symptomatic bradycardia. Suctioning was performed and a large accumulation of mucous was removed during suctioning. The patient tolerated the procedure well and now is resting more comfortable. The patient will be prepared and we will treat the patient symptomatically until arrival of the transport team.

Case 2

DIAGNOSIS: Unchanged. Respiratory failure, bilateral pneumonia.

PROCEDURE NOTE: Interosseous line placement. The patient was noted to have no IV access. It is very difficult to obtain blood draw or IV medications. The patient's right lower extremity was cleaned and prepped in a sterile fashion using Betadine. An interosseous needle was placed on the medial aspect of the tibia and interosseous line was introduced into that bone. The line was flushed appropriately

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Questions?