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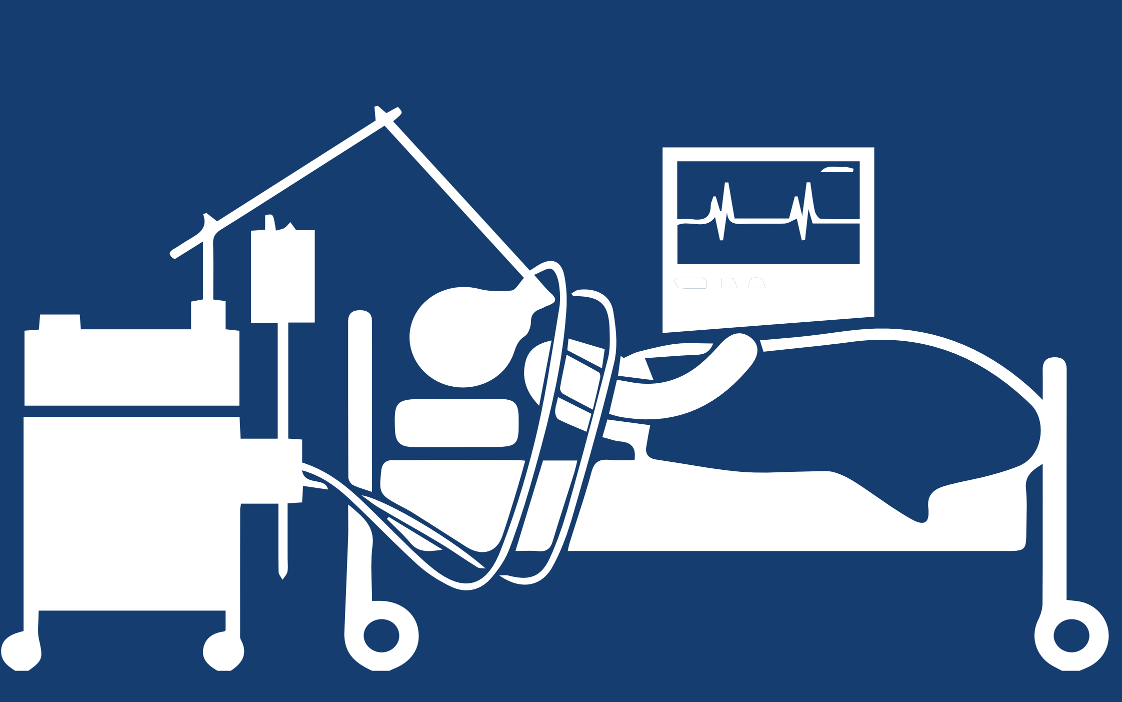
Medical Coding Best Practices for Emergency Departments



Summary

Delivering quality care, while ensuring effective clinical documentation and compliant medical coding has always been a challenge for healthcare providers. This gets even trickier in emergency departments, which are fast-paced environments spread across multiple specialties. Therefore, emergency departments present unique medical coding and billing challenges. Alongside knowledgeable clinical staff, specialized medical coders and billers with the requisite experience and strong analytical skills are required to obtain necessary reimbursements. In this paper, we share our perspectives on the unique medical coding and billing challenges presented by emergency departments and the best practices to ensure optimal reimbursements.

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Three challenges impacting the quality of care and claim reimbursements in ED

Why challenging?	Factors influencing Quality of care	Factors influencing claim reimbursement
The nature of Emergency Departments: Unscheduled and an Emergency	**Fast Paced Environment.** Unlike Outpatient and Inpatient visits that provide adequate clinical decision-making time, the fast-paced ED environment demands instant cognitive clinical decisions and shorter execution time depending on the criticality of the patient's condition and by definition, an emergency itself.	**Revenue Leakage.** The shorter execution time means that the documentation time available to providers is limited as well. Providers often miss capturing all medical services rendered along with medically necessary diagnosis, leading to high instances of discharges not fully billed (DNFB cases) and denied claims.
Coordination with multiple faculty staffs	**Timely Coordination of services.** The ED team involves a wide range of healthcare experts from Emergency Medical Technicians (EMT) initiating emergency clinical support from the moment the patient is boarded into the ambulance, and then taken over consecutively by multiple skilled faculty members that include ED Physicians, Specialists, Residents, Nurse Practitioners (NPs), Registered Nurses (RNs), Physician Assistants (PAs), Patient Care Technicians (PCTs) etc.	**Differentiating Physician vs Facility services.** Detailed information on coordination of care provided by ED physicians vs the nursing and ancillary staff is pivotal for the coders to distinguish physician/ professional services vs facility services and provide credit on coding accordingly.
Length of stay	**Longer hours of stay at ED could be tricky.** EDs think in terms of minutes and hours, not hospital days. Shaving precious minutes off a patient encounter can vastly improve patient experiences. The most common reasons for a longer ED stay could be the medical condition demanding a longer observation or unavailability of beds when the decision is made to admit to inpatient environment.	**Distinguishing emergency department services vs observation care.** While coding for instances of longer stays, especially those spanning beyond a day, coders need to be diligent in reviewing the clinical documentation to correctly classify ED services vs observation care. In most cases, there is a thin line and right interpretation of the documentation is key to appropriately coding for these services.

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Improve first pass ratio of ED Claims and improve reimbursements while being compliant

In this section, we provide a few best practices that aid compliant coding and improve first pass ratio of ED claims. Understanding the claim journey, documentation requirements, and coding rules is the triad of delivering compliant coding services.

1 Recognize that Emergency Departments are at a Critical Intersect of Care

The Emergency Department lies at the intersect of outpatient and inpatient services. The claim cycle, therefore, diverges into two paths:

- Professional Coding and billing through CMS 1500 representing physician services rendered.
- Facility coding and billing through UB 04 representing facility services rendered.

2 Understand Key Documentation Attributes that Influence ED level

Irrespective of the type of care (Professional or Facility), it is imperative that the physicians, nursing and support staff capture **complete** details for **all** medical services rendered. Here are some pointers to improve Professional and Facility ED documentation:

a) Determining Professional ED Level

Professional ED level is determined by the extent of clinically significant documentation furnished by the ED physicians under history, examination, and medical decision making relevant to the patient's current condition as evidenced during the ED visit. We share a few best practices below:

- Enable clinicians to concurrently deliver care and document the charts by using well-designed electronic ED charting tools. Not only will this reduce revenue leakage on account of missed procedures, but also improve the effectiveness of clinical decision-making, ensure safe hand-off, and reduce unnecessary admissions.
- **Potential to utilize Scribes.** With emergency physicians working under constant pressure to deliver high-quality care, utilizing medical scribes could be a potential solution to improve clinical documentation and coding effectiveness. Scribes help chart Physician-patient encounters real time on electronic health record (EHR) systems. When EHRs are documented using scribed services, it should indicate who performed the service and who recorded the service. The scribed notes should include the name, title, and signature of the scribe followed by the name of the practitioner providing and attesting the service.

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b) Determining Facility ED Level

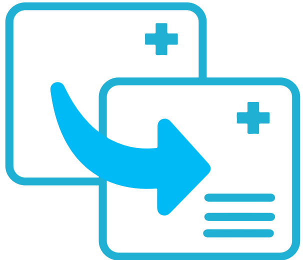
The facility ED level, on the other hand, is determined by the extent of services rendered by nursing and ancillary staff and not by ED physicians; we share a few best practices below:

- ACEP (American College of Emergency Physicians) recommends a coding model that references possible Interventions/procedure examples and complexity of discharge instructions that serve as a proxy referencing the typical intensity of facility services provided for patients requiring them.
- Based on the patient's symptoms, procedures may vary from ***simple*** interventions like Prescription refill, suture removal or wound recheck that usually qualify for 99281/Level 1 to more complex interventions like frequent monitoring of vitals, Prep for procedures like CT, MRI, central line insertions etc. that qualify for 99285, taking into consideration the entire documentation.

3 Educate Physicians on Documentation Requirements

Relevant clinical information is vital

Educating ED clinicians on clinically significant and relevant documentation is key to achieving compliant coding and optimizing end revenue/reimbursement. Most practice management systems today have inbuilt functionality that includes pre-defined Electronic Medical Record (EMR)/Electronic Health Record (EHR) templates to aid in documentation of areas that require focus. While it is the provider's choice to choose free text vs. EMR templates, EMR templates definitely aid in ensuring better and complete documentation using the cues available. Adoption of these templates is one of the key physician education areas.



Cloning is another challenge with EMR where providers use the same document of Physical Exam that is comprehensive but might not be pertinent to the chief complaint(s) or reason for the visit resulting in medical necessity evidence becoming questionable. ED providers should ensure that the documentation is pertinent to the visit and often providers need to be sensitized to the need for effective documentation. Coding and Clinical Documentation Improvement experts can help institutionalize comprehensive documentation practices, through iterative reviews and education of providers.

We highlight below some of the documentation aspects requiring focused attention of the Clinicians:

a) Understanding clinical documentation required for Professional ED Level

- **History of Presenting Illness.** Several specific templates, available for documenting HPI (History of Presenting Illness), enable effective capture of elements of for pain, injury, shortness of breath, fever, abscess, etc.

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- **Physical Examination.** Another grey area that needs to be highlighted during education sessions with physicians. The National Government Services (NGS) update effective July 1st, 2017 clearly demarcates Expanded Problem Focused (EPF – 2 – 5 organ systems reviewed) exam from Detailed (6 – 7 organ systems reviewed). This eradicates the room of individual coder interpretation and avoids overlap of ED levels.
- **Documenting all procedures rendered.** It is important that any additional work being done, like tests ordered and management options chosen, are clearly documented. These procedures drive the level of medical decision-making, which is key to determining the final ED level on the physician side.

b) Understanding Clinical documentation required for Facility ED Level

On the facility side, an emphasis is required on documentation of start and stop times, mode/route of administration etc. when handling hydration, injections, and infusions.

c) A few other areas that providers should note:

- All Resident and Fellow services need an attestation.
- Any addendums/updates made to the existing documentation should be added to the actual date the service was performed within 24 – 48 hours from the time of service. This is most often missed.

d) Use trend analytics to identify clinical documentation improvement opportunities

Coders supporting Emergency Departments should focus on identifying and cataloging documentation improvement opportunity for each physician. By capturing opportunities to improve coding specificity, missed documentation of specific procedures or additional notes that could have been captured to reduce DNFB/ denials etc., specific feedback can be provided to the physicians. Armed with these insights, the coding team can work with physician to bring about behavioral changes as well drive adoption of tools and templates to arrest revenue leakage.

4 Know Your CPT Coding Rules to Avoid Up/Down Coding

It is important that the coders correctly understand coding guidelines associated with determining the ED level and ancillary procedure codes reported along.

a) Professional ED coding rules

Like E/M (Evaluation and management), the rules of ED level assignment on the physician side are driven by the 3 key components of history, exam, and MDM (Medical Decision Making).

- Understanding the Nature of Presenting Problem (NOPP) and assigning an appropriate level of MDM is a key on the professional coding front.
- Coders to have exposure to most common procedures rendered at ED like incision and drainage, laceration repairs, puncture aspirations, Electrocardiogram (EKG) interpretations etc. that can be coded separately with appropriate modifiers.

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b) Facility ED coding rules

Unlike Physician ED coding, the rules are a bit more flexible on the facility side. There is no national standard that drives the facility ED level. CMS requires each hospital to establish their own billing guidelines taking into consideration the below general directions as restated by **OPPS (Outpatient Prospective Payment System).**

1. A hospital may bill an ED level based on the hospital's own coding guidelines which must reasonably relate to the intensity of hospital resources utilized.
2. Services furnished must be medically necessary and documented.
3. Hospital outpatient therapeutic services and supplies (including visits) must be furnished secondary to a physician's service and under the order of a physician or other qualified practitioner.

4. Utilizing Grid/Point Systems
   - Most facilities follow a customized grid/point system based on the services most commonly rendered at the facility

Mode of Patient arrival	Isolation services
Triage	Social worker notes
Vital signs	Teaching time
Nurse notes	Care rendered towards ostomy, wound care etc.
Nursing assessments	Specimen collection (urine samples, throat swab, wound swab etc.)
Other assessments include ABC - Airway, Breathing and Circulation, Visual acuity, Pain etc.	Translator and Interpreter services
Psychosocial status	Type of discharge disposition

   - The legend of the grid/point system lists down the multiple service types that are categorized separately to reflect the type, volume, and intensity of resources utilized by the facility to provide patient care.
   - The sum of points assigned determines the final ED level to aid appropriate payment by APC (Ambulatory Payment Classifications – The methodology/unit of payment under OPPS).

5. Some drugs, biologicals, diagnostic and nonsurgical therapeutic procedures etc. are paid separately reported in the form of Healthcare Common Procedure Coding System [HCPCS] while a few others are considered Packaged and part of another service that is paid under the OPPS.

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5 Role of Modifiers in ED coding - the Key to Avoiding Denials

Non-compliance is typically not intentional but is often a result of lack of knowledge of correct coding guidelines. Coders should have the right understanding to distinguish inclusive services vs separately payable services and appropriate modifier assignment plays a pivotal role in determining the same.

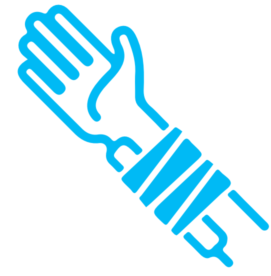
a) Commonly Utilized Modifiers in ED

- **Modifier 25:** Modifier 25 is often over-utilized to unbundle services. The medical service rendered should meet the definition of "*significant, separately identifiable E/M service*" as defined by CPT® as listed below.
  - » ALWAYS append to ED level when provided on the same date as a diagnostic and/or therapeutic medical/surgical procedure
  - » Obtaining patient's BP, temperature, asking how the patient feels, and obtaining written consent is not considered significant to qualify for Modifier 25
  - » Services indicated by S & T indicator allow usage of Modifier 25
- **Other Modifiers**
  - » **Modifier 76 and 77** are used to represent repeat services by the same or different physician
  - » **GC modifier** is used to indicate resident services rendered under the direction of a teaching physician
  - » **Modifier 59/X(EPSU)** comes into play on the facility side when reporting multiple infusions and lines
  - » **Modifier 91** is reported often to indicate repeat clinical diagnostic laboratory tests on the same day on the same patient. This modifier shall not be used when lab tests are repeated to confirm initial results due to testing problems with specimens or equipment or for any other reason when a normal, one-time, reportable result is all that is required
  - » **Modifier QW** is reported on labs that are CLIA (Clinical Laboratory Improvement Amendments) waived tests. These are lab tests waived by CLIA to be simple and have a low/insignificant risk for erroneous results

6 Commonly Overlooked Coding Guidelines

a) Coding splints

- Splint application is reported only when it is an initial service or a replacement service performed without a restorative treatment or procedure to stabilize or protect a fracture, injury or dislocation.
- Coders must as well determine if the application of a splint was fabricated or custom-made. Pre-fabricated or off-the-shelf splints are usually considered inclusive to the ED level and not coded separately.
- To code for splint/splinting, there must be documentation that the provider was involved in applying the splint on the physician side.



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b) Other Practices

- Services performed outside ED are not to be charged on the ED claim.
- **Level 3 vs 4** - Determining a code of choice between Level 3 and 4 on professional ED coding could be tricky considering both the levels support Moderate complexity MDM. There are factors on the risk table that clearly demarcate a low moderate vs. high moderate that serves as a key making this decision around leveling.
- **Self-administered drugs** are not to be assigned credit.

7 Ascertain Diagnosis Specificity to Avoid Medical Necessity Denials

Medical necessity is defined as the complexity and severity of patient's medical condition that necessitated the service to be rendered in an ED set up over a scheduled outpatient visit. This is a key to avoiding medical necessity denials.

a) Aids to determining Medical necessity

- Approach the documentation like reading a story and try connecting the dots. Comprehension is the key.
- It is advisable to choose the diagnosis listed by the physician in the final assessment and plan; more specific information available elsewhere in the documentation can be used if the physician does not contradict the same elsewhere in the document.
- Work up ordered, relevant past medical history are additional cues to determine a medically necessary diagnosis.
- Findings listed under physical exam are not to be coded unless clinical significance is documented by the physician.
- Do not code uncertain diagnoses termed as "probable", "suspected", "questionable", "rule out", or "working diagnosis"

b) Inspector General Sets sights on ED Psychiatric Boarding Practices

- Office of Inspector General (OIG) audits typically look at cases, wherein some providers held the patient for more than what is required in the ED, as non-compliant.
- The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law that requires anyone coming to an emergency department to be stabilized and treated, regardless of their insurance status or ability to pay. This imposed a large EMTALA fine on the hospitals accused of extending the period of patient stays intentionally.
- In cases where the wait for a patient from one facility to another facility is getting delayed, it is important that this is clearly documented to avoid any red flags.
- It is also recommended not to report Psychiatry conditions like suicidal ideation as a discharge diagnosis since the patients with such conditions are not usually discharged until the condition is deemed stable.

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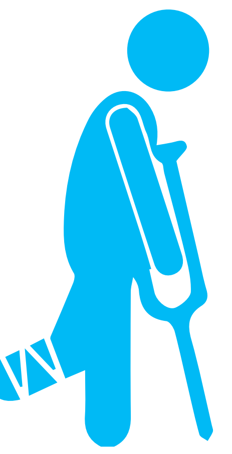
c) Code to the highest degree of specificity

- A confirmed diagnosis takes over a related sign/symptom. Specificity around laterality, anatomical site etc. are ad-hoc factors that determine the ICD 10 CM code to be chosen.
- Code all documented conditions that coexist and require or affect patient care treatment or management.
- Chronic diseases may be coded and reported as many times as the patient receives treatment and care for the condition.

d) Injury and worker's compensation, Rules to remember

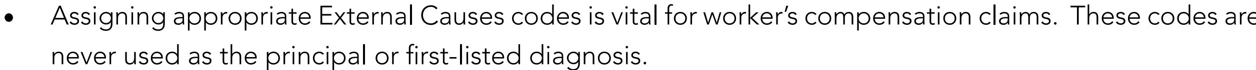
- In a case of Injury, here is the recommended sequencing order per general coding guidelines.
  - » Injury Code (S & T series codes that indicate Fracture, Dislocation, sprains etc.)
  - » Cause of Injury/Intent (V, W, X, Y series codes that indicate Accidents, tripping, slipping, fall etc.)
  - » Place of Occurrence (Y92 series)
  - » Activity code (Y93 Series that indicate Walking, running, climbing etc.). When not specified, no code is assigned
  - » Status code (Y99 Series that indicate Leisure, Work etc.). When not specified, no code is assigned
  - » Codes on sequence 1, 2 & 3 are mandatory while activity and status are assigned only when specified.



- Assigning appropriate External Causes codes is vital for worker's compensation claims. These codes are never used as the principal or first-listed diagnosis.

e) Diagnosis coding rules for Facilities

- Admit and discharge diagnosis are reported separately on the facility front. Admit diagnosis indicates the reason for the encounter which is usually the clinical signs/symptoms patient presents with and discharge diagnosis in most cases is the confirmed diagnosis the patient is treated for.
- It is appropriate to report diagnosis that resolved during the ED encounter. E.g., Asthma exacerbation that resolved with a nebulizer.



8 Critical Care, a Critical Branch of ED coding

Critical care is rendered when there is a life-threatening deterioration in the patient's condition. Here are few things that need attention while dealing with critical care codes.

- These are time-based codes. A minimum of 30 minutes of care must be provided, not including time spent on any separately billable procedure done along.
- Under 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. If the physician and hospital staff or multiple hospital staff members are simultaneously engaged in this active face-to-face care, the time involved can only be counted once.
- An ED level and critical care cannot be reported together on the same day.

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- Critical care should be reported only once per calendar date, even if the time is not continuous or if multiple staff members are simultaneously engaged in care.
- Listed below are other services that are performed along with Critical care and are considered inclusive/ Bundled to professional ED coding and can be reported separately by facilities.
  - » The interpretation of cardiac output measurements
  - » Chest x-rays
  - » Pulse Oximetry
  - » Blood gases and information data stored in computers (e.g., ECGs, blood pressures, hematologic data)
  - » Gastric intubation
  - » Temporary transcutaneous pacing
  - » Ventilator management
  - » Vascular access procedures

Conclusion

Unlike Outpatient and Inpatient visits that provide adequate clinical decision-making time, the fast-paced ED environment demands instant cognitive clinical decisions and shorter execution time considering the criticality of the patient's condition. Insufficient documentation, inaccuracies in demonstrating medical necessity, dropped charges, lack of awareness of coding rules and other such reasons, result in revenue leakage. It is therefore imperative that not only do you need to have a great coding team but also empower them to sensitize clinicians on issues causing higher denials and sub-optimal reimbursements.

About the Author:

Gayathri Natarajan is a certified professional coder with over a decade of experience in leading large-scale medical coding teams across a diverse range of specialties. As the director of coding services, she provides leadership to education & training programs, compliance, medical coding process automation, and process transition activities at Access Healthcare.

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