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
- Chargemaster: 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 chargemaster
  - 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	$51.82
99282	V	0613	$92.16
99283	V	0614	$143.36
99284	Q3	0615	$229.37
99285	Q3	0616	$344.71

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	$67.78
G0381	V	0627	$54.12
G0382	V	0628	$89.89
G0383	V	0629	$136.30
G0384	Q3	0630	$207.31

OPPS Proposed Rule for E/M

New HCPCS Level II Code	Description	APC	Payment Rate
GXXXA	Type A ED	0635	$245.76
GXXXB	Type B ED	0636	$90.16
GXXXC	Clinic Visit	0634	$96.86

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	0608	$175.79

Composite APC

APC	Description	Criteria
8002	Level I Extended Assessment and Management Composite	1) Eight or more units G0378 are billed-- • On the same day as G0379*; or • On the same day or the day after CPT codes 99205 or 99215; and 2) There is no service with SI=T on the claim on the same date of service or 1 day earlier
8003	Level II Extended Assessment and Management Composite	1) Eight or more units of G0378** are billed on the same date of service or the date of service after 99284, 99285, G0384, or 99291; and 2) There is no service with SI=T on the claim on the same date of service or 1 day earlier.

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)
- Ventilatory 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	$535.86
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

The patient was examined and urgently intubated using 20 mg of Etomidate and 100 mg of succinylcholine. Using direct laryngoscopy, I placed a 7.5 ET tube at 22 cm of the lip with first pass success and clear breath sounds bilaterally. The patient was placed on the ventilator standard settings and went immediately for a CTA. The angiogram was not performed due to the fact that a large parenchymal bleed with shift was found. She was given propofol which controlled the blood pressure. Nicardipine was ordered and hung but not done at this point. It was there just in case she becomes hypotensive again. Her CBC was normal. Normal troponin. EKG normal sinus rhythm with no ST or T-wave abnormalities. The patient's case was discussed with a neurosurgeon who admitted the patient to the Neuro critical care unit.

1. Massive intracranial hemorrhage with midline shift.
2. Respiratory arrest.
3. Hypoxia.
4. Bradycardia, severe.

Critical care time was 36 minutes excluding time spent on separate procedures.

Drug Administration

Nursing Documentation must include:

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

Hierarchy for Administration

- Chemotherapy
- Theurapeutic
- 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

Right hand X-ray shows an acute fracture of the distal aspect of the fifth metacarpal.

I placed the patient in an ulnar gutter short arm splint to the right hand. Patient was given two tabs of Vicodin here for pain. Patient is given a prescription for Vicodin for pain. Patient was told not to drive, drink alcohol, or operate heavy machinery while taking this medication. No additional Tylenol. Patient was given instructions to follow-up with hand surgery, he is to call tomorrow for an. appointment. Patient is to return if worse.

Diagnosis: Acute fracture right fifth metacarpal

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

Time seen by clinician. 2035

Chief Complaint: Ankle and leg injury

HPI: 15-year-old male patient complains of an injury to the leg and foot. The injury occurred shortly prior to arrival. The injury allegedly occurred while playing football at local high school field, another player fell on his leg and foot. Mother states she saw the child when he fell, his leg twisting when the other players fell on him. Patient did not continue playing any more football, mother states he's not walking on his leg at all secondary to pain. No other complaints of pain, injury or illness.

Case 1

Patient's allergies: NKDA
Patient's current medications: no routine prescription medications

Review of systems: All other systems negative.
Social History. Public school, lives with family
Family History: Noncontributory visit today

Case 1

Physical Exam, Vital Signs: Afebrile, VSS
General, well appearing, well nourished
Patient Status. Alert and cooperative
Heart: RRR, no MRG
Lungs: CTAB
Ankle: Right ankle, diffuse tenderness medial and lateral malleolus, minimal swelling laterally, ROM normal flexion, normal plantar flexion , no obvious deformity, skin is intact. Neurovascular status: 2+ pedal pulses, capillary refill less than 2 seconds Achilles tendon non tender, no step off. The foot, knee and hip are without pain or tenderness and with full range of motion

Case 1

Leg: Right, diffuse pain tibia-fibula, no obvious swelling. Patient has poison ivy bilateral lower legs, no infection. Mother states he has medication for his poison ivy.
Intervention X-ray: Right tibia fibula and foot negative for acute bony injury
Immobilization was achieved by the application of OCL stirrup short leg splint applied by ERMD
Immobilization device was then check to assure good neurovascular flow and effectiveness of positioning by me before the patient was discharged
Crutches dispensed. Crutch walking safely with good use of crutches

Case 1

Diagnosis: Ankle injury from trauma, Acute sprain right ankle,
Contusion right leg.
Disposition: The patient was discharged 2045. Discussion regarding radiology to review X-rays and in the event of a discrepancy we will notify patient/family.
Prescriptions: Prescription for Vicodin
Discussion regarding ice, elevation, rest leg and ankle, non-weight bearing until follow up.
Follow up: Instructions given to follow up with MD or orthopedics in 4-5 days. May return to ER or orthopedics sooner for worsening symptoms
Treatment plan discussed with patient/family who are in agreement.

Case 2

HPI: 41-year-old male who presents with foot puncture wound. The occurrence was today at 11 am. Location: RT foot. Degree of pain is moderate 6/10. Degree of dysfunction: Pain with weight bearing. Stepped on a rusty nail which pierced sole of construction boot and went approx 0.5 inches into the RT food. Foreign body: Possible. The accident occurred while at work at a construction site.

ROS: Constitutional: Fever; Neurologic: Negative; Allergies: NKA

Case 2

Past Medical/Family/Social History
Medical History: Negative; Surgical History: Negative; Social History: Married
PHYSICAL EXAMINATION:
General Appearance: Mild Distress
Skin: Warm. Dry. No Rash. Good Skin Turgor.
Heart: Regular rate and rhythm, no extra heart sounds
Respiratory: Lungs Clear to auscultation bilaterally
Abdominal: Non tender; no masses, normal bowel sounds
Extremity: Normal range of motion. Normal tone. Puncture wound sole of the foot at the first toe, mild swelling and redness to anterior foot, FROM of ankle and toes.

Case 2

MEDICAL DECISION MAKING:
X-ray RT Foot: Per radiology no fracture or foreign body
Td 0.5ml IM x1, Ibuprofen 800mg po x1, Rocephin 1 gram IM x1

DIAGNOSIS:
Puncture wound of the food

Rx: Keflex 500 mg, Ibuprofen 800 mg

Case 3

HISTORY OF PRESENT ILLNESS: This is a 26-year-old male complains of a 3-day history of nausea, vomiting, diarrhea, fevers and chills, headache, neck ache. The patient denies any rash. No cough. No sore throat. Denies any significant abdominal pain. The patient states he cannot keep anything down.

REVIEW OF SYSTEMS: As per HPI. All other systems are reviewed are negative.

Case 3

MEDICATIONS: None.
ALLERGIES: NONE.
SOCIAL HISTORY: The patient does not smoke, drink or use drugs.
PHYSICAL EXAMINATION: VITAL SIGNS: Temperature is 102, respirations 22, pulse 116, blood pressure 122/72, satting 100% on room air. The patient is alert and appropriate in no acute distress. EYES: The pupils are symmetrical and reactive to light. The conjunctivae and lids appear grossly normal. ENT: The oral mucosa is moist and appears normal. NECK: The neck is supple and the trachea is midline.

Case 3

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. CARDIOVASCULAR: The chest wall is normal in appearance. The heart has a regular rate and rhythm. GASTROINTESTINAL: The abdomen is soft and nondistended. 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.

Case 3

LABORATORY DATA: CBC shows a white count of 12.9, H&H of 15 of 44, platelets of 152, with 74% segs, 23% bands, 2% lymphs. BMP is normal except for slightly low potassium of 3.3. Chest X-ray shows normal cardiac silhouette, normal lung fields. No acute infiltrates, ef fusions, normal diaphragms. CSF shows a protein of 20, glucose of 75, white blood cell count of 2, red blood cell count of 2.

Case 3

This 26-year-old patient's presentation of headache, neck pain and fever were concerning for meningitis, therefore, it was felt the lumbar puncture would need to be performed. The risks, benefits, alternatives were discussed with the patient and his family. They agreed to the procedure. The patient was placed in the sitting position. He was given 0.5 mg Ativan IV. His back was prepped and draped in sterile fashion, anesthesia was performed with 1% lidocaine. A 20-gauge needle was introduced between L4 and L5 with the return of clear fluid. The patient tolerated this well.

Case 3

CSF was reviewed and showed no sign of meningitis. The patient was feeling better at this time. He still had a slight fever which was treated with Motrin. At this time, the patient is complaining of headache, fever, chills, nausea and vomiting, and diarrhea. The patient may have acute viral syndrome. Do not feel it is meningitis at this time with negative CSF. The patient is nontoxic appearing and is feeling better.

Therefore, at this time, he will be discharged home. He will be instructed to rest, drink plenty of fluids. Follow up with his doctor and return for any problems.

CPT® Disclaimer

Questions?