



Emergency Medicine Coding AAPC Englewood Chapter April 9, 2009

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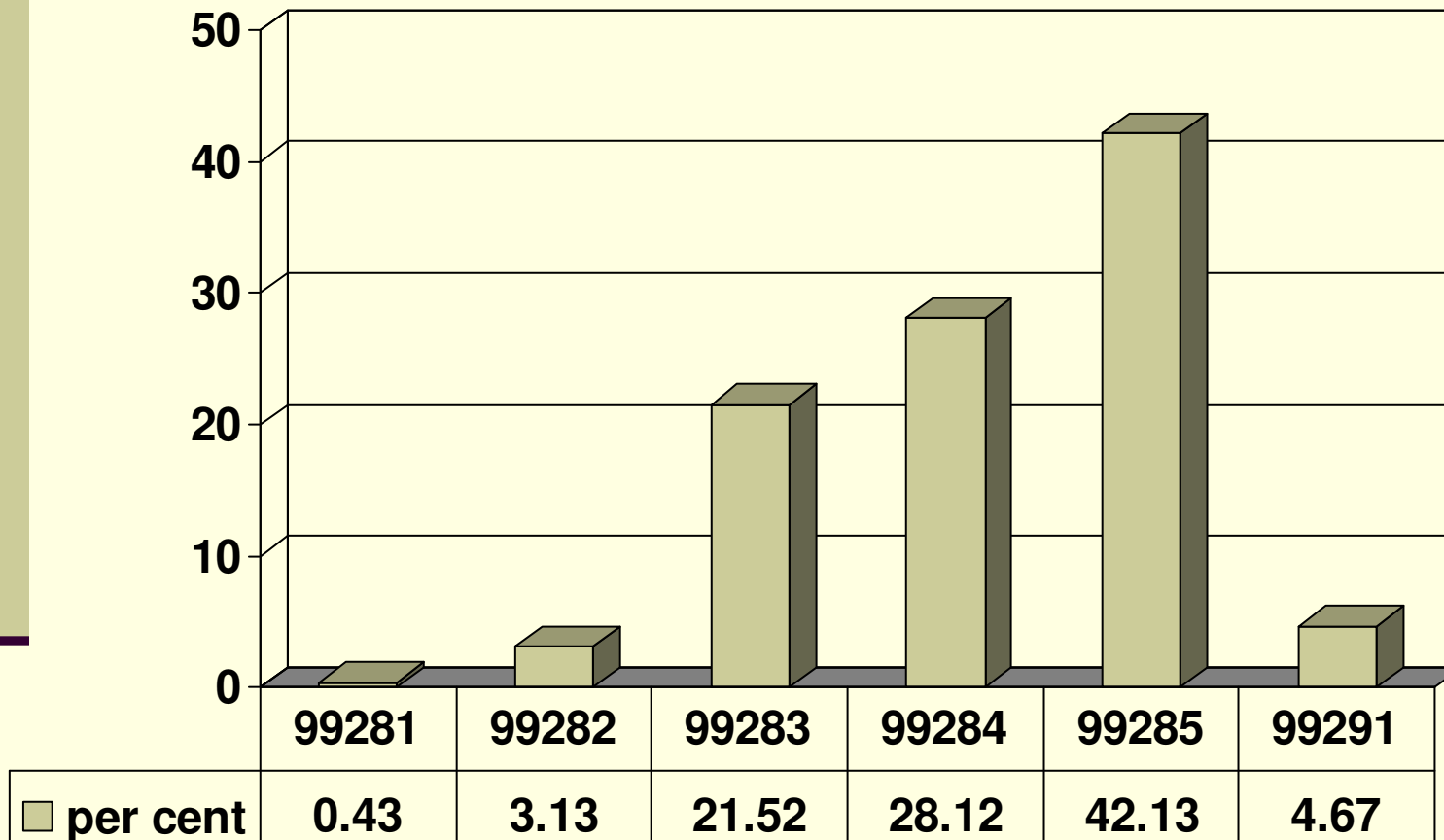
Objectives

- To provide overview for ED coding
 - ED Evaluation & Management Codes (E/M)
 - Critical Care
 - Observation
 - Procedures
 - Teaching physicians
 - Mid-levels

ED E/M Codes

- 5 ED Evaluation & Management Codes:
 - 99281-99285
- Described by site of service - not specialty
- 85-90% of revenue comes from these codes!
- Audit exposure resides in 9928X and maybe 99291!

2006 BESS Data National



What's an RVU?

- Relative Value Unit
- Every E/M service and procedure has an RVU

$$\begin{aligned} \text{Total RVU} = & (\text{work RVU} \times \text{work GPCI}) \\ & + (\text{practice expense RVU} \times \text{practice expense GPCI}) \\ & + (\text{malpractice RVU} \times \text{malpractice GPCI}) \end{aligned}$$

$$\text{Payment} = \text{Total RVU} \times \text{Conversion Factor}$$

- *WRVU's are used to track individual and group productivity!*

Conversion Factor



- CF is Medicare payment rate per RVU
- 2009 CF is **\$ 36.0666**
 - Down from 08 CF of 38.0869 (5.3%)
- Emergency Medicine net increase: 4%!
 - MIPPA 2008: 1.1% increase in MFS BUT Budget Neutrality (BN) adjuster applied to CF rather than WRVU
 - Big gain for EM because our codes are heavily weighted to WRVU (about 70% as opposed to other E/M's typically around 50%)
- RUC Five Year Review gains for EM will be fully realized
- EM 4% increase - highest of any specialty

CMS 2009 Fee Schedule

CPT Code	2008 Tot BN RVUs	2008 CMS Pmt	2009 Total RVUs	2009 CMS Pmt	% Chg
99281	.51	\$19.42	.56	\$20.20	4%
99282	.96	\$36.56	1.09	\$39.31	8%
99283	1.55	\$59.03	1.70	\$61.31	4%
99284	2.86	\$108.93	3.17	\$114.33	5%
99285	4.27	\$162.63	4.72	\$170.23	5%
99291	5.36	\$204.15	5.88	\$212.07	4%

Basic Principles

- If it isn't documented it wasn't done
 - If it was documented it had **BETTER** be done
- Amount of History and Exam wheels off the NOPP:
Nature of the Presenting Problem
 - Medical necessity concept
- Documentation requirements are a minimum data set for audit defensibility
- A good record should communicate to peers and be defensible from a risk management perspective

ED Evaluation and Management Codes



- 9928X code selection determined by three key elements
 - History
 - Exam
 - Medical decision-making
- Medical necessity is the driver as far as *amount* of history and exam performed and documented and MDM
- Nature of ***Presenting*** Problem (NOPP) is CPT approach to medical necessity

NOPP Redux

- Establishes medical necessity
- Essential to code level assignment
- ED E/M's are driven by Nature of the *PRESENTING* Problem
 - *Not* final dx
- HPI is the place to look for NOPP (i.e. medical necessity)
 - Supported by ED course and work-up

99281

- Problem Focused history
- Problem Focused exam
- Straightforward MDM
- Self -limited or minor problem
 - simple suture removal

99282

- Expanded Problem Focused history
- Expanded Problem Focused exam
- Low complexity MDM
- NOPP: low to moderate severity
 - Sunburn
 - Contusion w/o x-ray
 - E/M associated with laceration repair (no x-ray or Rx)

99283

- Expanded Problem Focused history
- Expanded Problem Focused exam
- Moderate complexity MDM
- NOPP: Moderate severity
 - Minor head injury without LOC, AMS or amnesia
 - Asthma clearing with 1 neb
 - Extremity trauma with x-ray
 - Otitis media requiring antibiotic prescription
 - E/M associated with lac repair with X-ray review or Rx

99284

- Detailed history
- Detailed exam
- Moderate complexity MDM
- NOPP: High severity not posing an *immediate* significant threat to life or physiological function
 - Asthma with >1 neb and/or X-ray/labs
 - Straightforward abdominal pain, pelvic pain
 - Kidney stones
 - IV rehydration
 - DVT work-up (leg pain)
 - Vag bleeding, testicular pain
 - Migraine or low back pain with IV/IM and re-assess
 - Greater than single extremity or Organ System trauma or major trauma mechanism
 - Med clearance only w/o an active medical complaint (eg med clearance for alcohol intoxication, psych eval but no OD or need for IV/IM meds to control behavior)

99285

- Comprehensive history
- Comprehensive exam
- High complexity MDM
- NOPP: high severity with *immediate* life/function threat
- Examples:
 - Chest pain with cardiac work up (EKG, X-ray/CT, labs); admit or DC
 - SOB with PE work-up (EKG, CT, D-dimer and/or Wells criteria); admit or DC
 - Abdominal pain or kidney stone work-up and treatment that includes CT or ultrasound, IV fluids, IV/IM meds for pain, nausea/vomiting and re-assess.
 - Most completed strokes, TIA's
 - OD's requiring lab, treatment and/or re-evals and med clearance
 - Trauma activations or major mechanism

Levels of History ('95 DG's)



Level of History	Chief Complaint (CC)	History of the Present Illness (HPI)		Review of Systems (ROS)		Past, Family, Social History (PFSH)	
		CPT	CMS (Medicare)	CPT	CMS (Medicare)	CPT	CMS (Medicare)
Problem Focused	Required	Brief	1-3 elements	Not Required		Not Required	
Expanded Problem Focused	Required	Brief	1-3 elements	Problem Pertinent	1 system	Not Required	
Detailed	Required	Extended	≥4 elements OR ≥3 chronic or inactive conditions.	Extended	2-9 systems	Pertinent	1 item
Comprehensive	Required	Extended	≥4 elements OR ≥3 chronic or inactive conditions	Complete	≥10 systems	Complete	2 or 3 items 16

ROS Elements ('95 DG's)

- Constitutional Symptoms (e.g., fever, weight loss);
- Eyes;
- Ears, Nose, Mouth, Throat;
- Cardiovascular;
- Respiratory;
- Gastrointestinal;
- Genitourinary;
- Musculoskeletal;
- Integumentary (skin and/or breast);
- Neurological;
- Psychiatric;
- Endocrine;
- Hematologic/Lymphatic; and
- Allergic/Immunologic.

****DG CROS = 10 systems**

Levels of Physical Examination

Level of Physical Exam	CPT Definitions	CMS (Medicare) Documentation Guidelines	
		1995 Guidelines	1997 Guidelines
Problem Focused	Limited exam of affected body area	1 body area or organ system	1-5 bullets in one or more areas/systems
Expanded Problem Focused	Limited exam of affected body area + other symptomatic or related organ systems	2 or more body areas/organ systems including affected area	6-11 bullets in one or more areas/systems
Detailed	Extended exam of affected body area + other symptomatic or related organ systems	5-7 body areas/organ systems including affected area*	12 or more bullets in 2 or more areas/systems OR at least 2 bullets from 6 or more areas/systems
Comprehensive	General multi-system exam or complete examination of single organ system	8 or more organ systems	at least 2 bullets from 9 or more areas/systems

It is the physician's choice which rule to use

*"Bullets" are specific items examined within a system or area

Body Areas & Organ Systems In The Physical Exam



CPT		CMS (Medicare)	
Body Areas	Organ Systems	Body Areas	Organ Systems
<ul style="list-style-type: none"> ■ Head (face) ■ Neck ■ Chest (breasts & axillae) ■ Abdomen ■ Genitalia, groin, buttocks ■ Back (spine) ■ Each extremity 	<ul style="list-style-type: none"> ■ Eyes ■ ENMT ■ Cardiovascular ■ Respiratory ■ Gastrointestinal ■ Genitourinary ■ Musculoskeletal ■ Skin ■ Neurologic ■ Psychiatric ■ HLE 	<ul style="list-style-type: none"> ■ Head (face) ■ Neck ■ Chest (breasts & axillae) ■ Abdomen ■ Genitalia, groin, buttocks ■ Back (spine) ■ Each extremity 	<ul style="list-style-type: none"> ■ Constitutional ■ Eyes ■ ENMT ■ Cardiovascular ■ Respiratory ■ Gastrointestinal ■ Genitourinary ■ Musculoskeletal ■ Skin ■ Neurologic ■ Psychiatric ■ HLE

ENMT = Ears, nose, mouth and throat; HLE = Hematologic/lymphatic/immunologic

Scribes

- Increasing utilization
- Credentialing
 - OK as long as they are not “providers”
- Function: Scribe ONLY
 - Cannot independently obtain information unless confirmed or repeated by provider
 - Cannot perform any element of Exam

Medical Decision-Making

- Greatest risk/return for providers
- More subjective and less intuitive
- *Not* captured well in some EMR's and templates

MDM



From TrailBazer's website:

Instructions for Using TrailBlazer's MDM Coding Method

Coding Medical Decision-Making (MDM) begins with separately coding the three distinct components of MDM. Two of the three components determine the final level of MDM complexity documented in a record of Evaluation and Management (E/M) service. These components are:

1. Number of diagnoses and/or management **options**.
2. Amount and/or complexity of **data** reviewed or ordered.
3. **Risk** of complication and/or mortality.

The TrailBlazer MDM coding method corresponds directly to the components above as follows:

- Section A corresponds to number of diagnoses and/or management options.
- Section B corresponds to amount and/or complexity of data reviewed or ordered.

3 MEDICAL DECISION-MAKING (continued)

Determine total points for each diagnosis or problem and associated management options using tables A.1 and A.2. Use the larger of the two "Totals" for Section D. Final Assignment of Medical Decision Making Type.

Table A.1 Number of Diagnoses		Table A.2 Management Options					
A "problem" is defined as definitive diagnosis or, for undiagnosed problems, a related group of presenting symptoms and/or clinical findings.		Important Note: These tables are not all inclusive. The entries are examples of commonly prescribed treatments and the point values are illustrative of their intended quantifications. Many other treatments exist and should be counted when documented.					
Each new or established problem for which the diagnosis and/or treatment plan is evident <u>with</u> or <u>without</u> diagnostic confirmation		Do not count as treatment option's notations such as: Continue "same" therapy or "no change" in therapy (including drug management) if specified therapy is not described (record does not document what the current therapy is nor that the physician reviewed it).					
2 plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation		Drug management, per problem. Includes "same" therapy or "no change" in therapy if specified therapy is described (i.e., record documents what the current therapy is and that the physician reviewed it). Dose changes for current medications are not required; however, the record must reflect conscious decision-making to make no dose changes in order to count for coding purposes.	<table border="1"> <tr> <td>≤3 new or current medications per problem</td> <td>1</td> </tr> <tr> <td>>3 new or current medications per problem</td> <td>2</td> </tr> </table>	≤3 new or current medications per problem	1	>3 new or current medications per problem	2
≤3 new or current medications per problem	1						
>3 new or current medications per problem	2						
Each new or established problem for which the diagnosis and/or treatment plan is not evident	3 plausible differential diagnoses, comorbidities or complications (not counted as separate problems), clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	Open or percutaneous therapeutic cardiac, surgical or radiological procedure; minor or major	1				
	4 or more plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	Physical, occupational or speech therapy or other manipulation	1				
		Closed treatment for fracture or dislocation	1				
		IV fluid or fluid component replacement, or establish IV access when record is clear that such involved physician decision-making and was not standard facility "protocol"	1				
Complex insulin prescription (SC or combo of SC/IV), hyperalimentation, insulin drip or other complex IV admix prescription		2					
Total Points		Conservative measures such as rest, ice/heat, specific diet, etc.	1				
		Radiation therapy	1				
		Joint, body cavity, soft tissue, etc injection/aspiration	1				
		Patient education regarding self or home care	1				
		Decision to admit to hospital	1				
		Discuss case with other physician	2				
		Other	1				
		Total Points					

TB MDM *Options*

- Quantification of Dx/Management Options is single biggest TB change
- Options complexity based on points awarded for number of documented differential diagnoses (A1) *OR* management options (A2)
- Diagnoses (A1)
 - Number of plausible differential diagnoses per problem
 - Problem or symptom is not counted as a diff dx
 - 1 point per diff dx per problem
 - 2 points = low complexity (99282)
 - 3 points = moderate complexity (99283/284)
 - 4 points = high complexity (99285)

MDM Diff Dx Options (A1)

- Moderate MDM (3 points)
 - Must document total of **3** plausible diff dx (includes final or working dx) for Moderate Complexity *Options*
 - Examples:
 - Ankle sprain: no fx, NV intact
 - Otitis: nomastoiditis, no TM perf
- High MDM (4 points)
 - Document 4 diff dx for High Complexity *Options*
 - Any combination of differentials per problem as long as total of 4 for High Complexity (99285)
 - 99285 example: chest pain in 45 y/o male
 - “Differential diagnoses considered include ACS, PE, TAD and chest wall pain”

TB MDM *Options*

- Management options (A2)
 - Alternative pathway (from diff dx) to Options complexity level
 - Points awarded based on number/complexity of management options

3 MEDICAL DECISION-MAKING (continued)

Determine total points for each diagnosis or problem and associated management options using tables A.1 and A.2. Use the larger of the two "Totals" for Section D. Final Assignment of Medical Decision Making Type.

Table A.1 Number of Diagnoses		Table A.2 Management Options		
A "problem" is defined as definitive diagnosis or, for undiagnosed problems, a related group of presenting symptoms and/or clinical findings.		Important Note: These tables are not all inclusive. The entries are examples of commonly prescribed treatments and the point values are illustrative of their intended quantifications. Many other treatments exist and should be counted when documented.		
	Points		Points	
Each new or established problem for which the diagnosis and/or treatment plan is evident <u>with</u> or <u>without</u> diagnostic confirmation	1	Do not count as treatment option's notations such as: Continue "same" therapy or "no change" in therapy (including drug management) if specified therapy is not described (record does not document what the current therapy is nor that the physician reviewed it).	0	
Each new or established problem for which the diagnosis and/or treatment plan is not evident	2 plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	Drug management, per problem. Includes "same" therapy or "no change" in therapy if specified therapy is described (i.e., record documents what the current therapy is and that the physician reviewed it). Dose changes for current medications are not required; however, the record must reflect conscious decision-making to make no dose changes in order to count for coding purposes.	≤3 new or current medications per problem	1
			>3 new or current medications per problem	2
	3 plausible differential diagnoses, comorbidities or complications (not counted as separate problems), clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	3	Open or percutaneous therapeutic cardiac, surgical or radiological procedure; minor or major	1
4 or more plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation	4	Physical, occupational or speech therapy or other manipulation	1	
		Closed treatment for fracture or dislocation	1	
		IV fluid or fluid component replacement, or establish IV access when record is clear that such involved physician decision-making and was not standard facility "protocol"	1	
		Complex insulin prescription (SC or combo of SC/IV), hyperalimentation, insulin drip or other complex IV admix prescription	2	
		Conservative measures such as rest, ice/heat, specific diet, etc.	1	
		Radiation therapy	1	
		Joint, body cavity, soft tissue, etc injection/aspiration	1	
		Patient education regarding self or home care	1	
Decision to admit to hospital	1			
Discuss case with other physician	2			
Other	1			
Total Points		Total Points		

MDM Management Points

Drug management per problem	
< or =3 new or current individually documented meds (includes administered in ED and discharge meds)	1
>3 new or current	2
Closed treatment fx/disloc	1
IV fluids	1
IV drips	2

MDM Management Points



Minor or major surgical procedure	1
Conservative treatment such as rest, ice, diet (includes splints if done in ED, non- billable wound care, Foley, restraints)	1
Injection/aspiration joint, body cavity, soft tissue	1
ACI	1
Admit	1
Documented discussion with another physician	1
Other: ED course	1

TB MDM *Options* Summary

- MDM Management Options points
 - 3 points = moderate complexity
 - 4 points = high complexity
- Real world
 - Moderate MDM (99283/284)
 - Document 3 diff dx (circle 1, backslash 2) **OR** A2 Management options
 - High MDM (99285)
 - Document 4 diff dx (circle 1, backslash 3) *OR* A2 Management options
 - Document any ED reassessments, discussions with other docs

Table B. Data Reviewed or Ordered		Point Value
Order and/or review medically reasonable and necessary clinical laboratory procedures. (Note: Count laboratory panels as one procedure.)	1–3 procedures	1
	≥4 procedures	2
Order and/or review medically reasonable and necessary diagnostic imaging studies in Radiology section of CPT.	1–3 procedures	1
	≥4 procedures	2
Order and/or review medically reasonable and necessary diagnostic procedures in Medical section of CPT.	1–3 procedures	1
	≥4 procedures	2
Discuss test results with performing physician.		1
Discuss case with other physician(s) involved in patient's care or consult another physician (i.e., true consultation meaning seeking opinion or advice of another physician regarding the patient's care). This does not include referring patient to another physician for future care.		1
Order and/or review old records. Record type and source must be noted. Review of old records must be reasonable and necessary based on the nature of the patient's condition. Practice- or facility protocol-driven record ordering does not require physician work thus should not be considered when coding E/M services. Perfunctory notation of old record ordering /review solely for coding purposes is inappropriate and counting such is not permitted.	Order/review without summary	1
	Order/review and summarize	2
Independent visualization and interpretation of an image, EKG or laboratory specimen not reported for separate payment. Note: Each visualization and interpretation is allowed one point.		1
Review of significant physiologic monitoring or testing data not reported for separate payment (e.g., prolonged or serial cardiac monitoring data not qualifying for payment as rhythm electrocardiograms).		1
Total Points		

MDM *Data*

- Data
 - Points again!
 - 1 point each:
 - Order/review 1-3 lab panels
 - Order/review 1-3 imaging studies
 - Order/review EKG
 - Discuss test with performing physician
 - Discuss case with another physician
 - Order and/or review old records
 - Independent visualization of **each** image or EKG
 - 2 points each:
 - Order/review 4 or more lab panels
 - Order/review 4 or more imaging studies
 - Order/review/summarize old records

MDM *Data*

- Data point scoring
 - 3 points = moderate complexity (99283/284)
 - 4 points = high complexity (99285)
- Real world
 - Data points help EP's
 - Document when you
 - order/review labs/x-rays/EKG: list studies
 - **look at an X-ray: per my review or interpretation**
 - review old records
 - talk to another doc

Section C.

Use Table C.1 to determine the highest level of risk associated with each of the following: presenting problems, diagnostic procedure(s) ordered/performed, management option(s) chosen. Then use Table C.2 to determine the “final risk”, which is the highest of the three risks from Table C.1. The “final risk” from Table C.2 is used for Section D. Final Assignment of Medical Decision Making Type.

Table C.1 Risk of Complications and/or Morbidity or Mortality			
LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Minimal	<ul style="list-style-type: none"> One self-limited or minor problem, e.g., cold, insect bite, tinea corporis 	<ul style="list-style-type: none"> Laboratory tests requiring venipuncture Chest X-rays EKG/EEG Urinalysis Ultrasound, e.g., echo KOH prep 	<ul style="list-style-type: none"> Rest Gargles Elastic bandages Superficial dressings
Low	<ul style="list-style-type: none"> Two or more self-limited or minor problems One stable chronic illness, e.g., well-controlled hypertension or non-insulin dependent diabetes, cataract, BPH Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain 	<ul style="list-style-type: none"> Physiologic tests not under stress, e.g., pulmonary function tests Non-cardiovascular imaging studies with contrast, e.g., barium enema Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies 	<ul style="list-style-type: none"> Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives
Moderate	<ul style="list-style-type: none"> One or more chronic illnesses with mild exacerbation, progression or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, e.g., lump in breast Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis Acute complicated injury, e.g., head injury with brief loss of consciousness 	<ul style="list-style-type: none"> Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath Obtain fluid from body cavity, e.g., lumbar procedure, thoracentesis, culdocentesis 	<ul style="list-style-type: none"> Minor surgery with identified risk factors Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation without manipulation
High	<ul style="list-style-type: none"> One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss 	<ul style="list-style-type: none"> Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors Discography 	<ul style="list-style-type: none"> Elective major surgery (open, percutaneous or endoscopic with identified risk factors) Emergency major surgery (open, percutaneous or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis

TB MDM *Risk*

- Risk of Presenting Problem *or* Risk of Management Options
 - Not quantified – no points
 - Risk drivers
 - Risk of presenting problem
 - Document good HPI and differentials (Moderate or High MDM)
 - Document PMH: exacerbation of existing problem counts
 - Risk of management options
 - Prescription drug management (Moderate MDM)
 - IV med infusions (High MDM)
 - Parenteral controlled substances (High MDM)
 - Always document route of administration

MDM Summary

Section D.

Final Assignment of Medical Decision Making Type

1. Line A – Use Total Diagnosis Points or the Total Management Option Points from Section A (Tables A1 and A2).
2. Line B. – Use Total Points from Section B. (Table B.)
3. Line C. – Use highest level of risk from Section C. (Table C.2)
4. Choose final Type of Medical Decision Making. Final Type Requires 2 of the 3 MDM Components below be met or exceeded

Table D. Final Assignment of Medical Decision Making Type

A. Number of diagnoses or management options	1 Point – Minimal	2 Points – Limited	3 Points – Multiple	≥ 4 Points – Extensive
B. Amount and complexity of data reviewed/ordered	≤ 1 point – None/Minimal	2 Points – Limited	3 Points – Multiple	≥ 4 Points – Extensive
C. Risk	Minimal	Low	Moderate	High
Type of medical decision-making	Straightforward	Low Complexity	Moderate Complexity	High Complexity

Final Medical Decision-Making requires 2 of 3 components above met or exceeded

MDM Summary

- MDM pearls
 - Options : 4 diff dx or Management options
 - Psych or med clearance – use A1 or A2 Table plus Risk as Data is typically minimal for this population
 - Data
 - Document ordered lab panels and imaging studies
 - Document EKG or X-ray interp
 - Document any discussion with rads
 - Document any discussion with consultant or f/u docs
 - Document any old records reviewed
 - Risk
 - Good HPI and PMH
 - Parenteral narcs

10 IRON RULES OF MEDICARE

1. Just because it has a code, that doesn't mean it's covered.
2. Just because it's covered, that doesn't mean you can bill for it.
3. Just because you can bill for it, that doesn't mean you'll get paid for it.
4. Just because you've been paid for it, that doesn't mean you can keep the money.
5. Just because you've been paid once, that doesn't mean you'll get paid again.
6. Just because you got paid in one state doesn't mean you'll get paid in another state.
7. You'll never know all the rules.
8. Not knowing the rules can land you in the slammer.
9. There's always some schlemiel who doesn't get the message.
10. There's always some schmendrik (jerk) who gets the message and ignores it.

Critical Care

CPT:

- Critical illness or injury that
 - 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.*
- And requires
 - decision making of high complexity to assess, manipulate, and support vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition. Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure.

Critical Care

- Time-based code
- Time spent *by the provider*
 - engaged in work *directly related to the patient's care*
 - providing bedside care
 - reviewing test results or imaging studies
 - discussing the case with other providers
 - documenting the medical record
 - discussions with the family as to History or medical decision-making aspects of the case (eg DNR)

Critical Care

- Time that doesn't count as CC time:
 - Time spent performing separately billable procedures
 - intubation
 - chest tubes
 - central lines
 - ultrasound interpretation
 - laceration repairs or orthopedic procedures
 - CPR
 - Teaching time or resident time at the bedside
 - "Shared service" with mid-level
 - Total ED time
 - Time speaking with family, authorities
 - Time spent reviewing medical records

Critical Care

- Total (all payer) rate: 3-6% of E/M codes
 - Varies with type of ED
- '07 BESS (Medicare only)
 - National: 5%
 - CO: 7.5%
- Should be audit defensible
 - 17% increase in 2006 Medicare 99291 !!!

Critical Care

- Beacon reviews
 - CC >2 hours
 - Questionable medical necessity
- Coder (or auditor) may not have clinical knowledge or sufficient documentation to make an accurate decision
- Importance of “medical necessity” documentation

Critical Care Documentation

- Accurate time statement always required
 - Exclusive of separately billed procedures
 - Avoid “about” or “approximately”
 - Document in Major format if any potential to be down-coded to 99284-285
- ED Course
 - Should support high complexity MDM
 - Include diagnostic and therapeutic interventions performed and/or considered
 - Serial assessments

Critical Care Documentation

- “Medical necessity” statement
 - “Organ system(s) at risk is...”
 - “What and why” as far as diagnostic or therapeutic interventions undertaken by *YOU*
 - Critical lab, imaging EKG findings documented
 - ED Course reflects frequent re-assessments and decision-making
 - Likelihood of life-threatening deterioration

Critical Care Documentation

- Summary
 - Explicit time statement
 - ED Course
 - Medical necessity statement
 - Supplemental dictation recommended

Critical Care

- Is it CC?
 - Need presentation consistent with vital organ system impairment
 - *PLUS* likely to or already experiencing “high probability” of imminent or life-threatening deterioration
 - *PLUS* high complexity MDM to assess/manipulate/treat

Critical Care

- Is it CC?
 - Urgent call and arrival of specialist is not CC unless substantial portion of workup and initiation of treatment by you
 - Abnormal lab values alone do not support CC unless MDM reflects high complexity MDM and initiation of life-saving assessment/treatment

Critical Care

- Is it CC?
 - Clinical condition
 - Disposition can be a *very useful* tool
 - Likely CC
 - ICU admits (*not all* ICU admits will be CC)
 - Immediate dispo to OR
 - Death in ED (not DOA or CPR only)

Critical Care

- Is it CC?
 - Disposition suggesting likely NOT CC
 - Floor or tele admit
 - Discharged home
 - Clinical condition suggesting NOT CC
 - “NAD”
 - normal VS
 - “resting comfortably”
 - ED Course doesn’t support medical necessity
 - Psych
 - Above scenarios ALWAYS require Medical Necessity statement

Critical Care Examples

- Chest pain
 - Consider CC
 - EKG compatible with ischemia
 - Enzyme changes
 - Arrhythmias
 - Hypotension
 - Co-morbidity such as coke/crack use
 - Pain requiring ongoing IV NTG or opioids
 - Use of IV beta blockers, heparin, lytics
 - Immediate dispo to cath lab or ICU
 - Likely not CC
 - EKG normal and given ASA per protocol
 - Repeat EKG, enzymes normal
 - SL or topical NTG only
 - Dispo home

Examples

- Arrhythmias
 - Consider CC
 - If symptomatic or
 - Treated with IV drip or multiple doses/drugs
 - Probably not CC
 - PAT converted in field
 - Post spontaneous conversion in stable patient
 - Asymptomatic AF with single bolus of diltiazem

Examples

- Hypertension
 - Consider CC
 - Hypertensive *emergency*
 - End organ(s) affected
 - Brain
 - Heart
 - Kidney
 - Treatment ongoing and typically ICU admit
 - Probably not CC
 - Hypertensive *urgency*
 - Incidental finding unrelated to main problem
 - May get PO or IV Rx but usually discharged or floor admit

Examples

- Syncope
 - Consider CC
 - Syncope *plus* a significant co-morbidity. For example
 - Arrhythmias such as new onset AF
 - Lower or UGI bleed
 - Significant hypovolemia
 - Altered mental status or seizure
 - PE
 - Dialysis patient
 - Dispo: admit
 - Probably not CC
 - “Weak and dizzy”
 - No significant comorbidity
 - Simple faint

Examples

- Seizures
 - Consider CC
 - Status
 - Complex febrile
 - New onset *plus*
 - Trauma in differential
 - OD or ETOH
 - ETOH withdrawal *plus*
 - Probably not CC
 - Recurrent with noncompliant or sub-therapeutic meds

Examples

- Stroke syndromes
 - Consider CC
 - Abnormal vital signs requiring treatment
 - Any airway issues
 - Start TPA or rapid assessment and transfer for definitive treatment at a stroke center
 - Uncertain diagnosis or evolving clinical status
 - Probably not CC
 - Stable patient with completed stroke

Examples

- Dyspnea
 - Consider CC when most of below are present
 - Continuous nebs
 - CPAP
 - High flow oxygen required
 - Altered mental status
 - Respiratory failure in differential
 - Intubation considered
 - Probably not CC
 - 2-4 nebs plus steroids and clear
 - Dispo home

Examples

- Belly pain
 - Consider CC
 - Immediate dispo to OR
 - Hemodynamic instability
 - ICU admit plus
 - Probably not CC
 - Routine appy
 - Most discharges/floor admits

Examples

- Trauma
 - Consider CC
 - Hemodynamic instability
 - Respiratory distress
 - Altered mental status/suspicion of cord injuries
 - Major procedures such as chest tube, intubation
 - Dispo to OR or transfer to Trauma Center
 - Trauma activation
 - Probably not CC
 - Mechanism alone in alert patient w/o complaints
 - Isolated extremity injuries w/o neurovascular compromise
 - Procedural sedation

Examples

- Ingestions
 - Consider CC
 - High lethality agent requiring intervention or close monitoring
 - Seizures, coma, arrhythmias, hypotension
 - Probably not CC
 - Benign overdose with watchful waiting
- Severe allergic reactions
 - Consider CC
 - Stridor, wheezing, hypotension
 - IV steroids, epi or pressors
 - Probably not CC
 - SubQ epi and clears

Examples

- DKA
 - Most admitted DKA would be CC
 - Mild DKA treated in ED and DC'd would not be CC
- Sepsis
 - Sepsis bundle management and ICU admit
- Pediatric dehydration
 - Consider CC
 - Any shock-like state
 - More than one IV bolus to initiate fluid resuscitation

Examples

- Environmental
 - Hypothermia: either PLUS another problem or more than passive external re-warming
 - Lightning
 - CO with signs/symptoms and HBO treatment or emergent transfer
- Psych
 - When delirium or organic diff dx worked up and documented
 - Agitation/pure psych – almost never CC

Summary

(CC for Dummies)

- Consider the following before documenting CC:
 - Was patient admitted to ICU?
 - If no – is it really CC?
 - If yes then need medical necessity note
 - Patient may die (soon) if you don't do something (quickly)
 - If no – is it really CC?
 - If yes then need medical necessity note

Observation Services

- Formal observation unit not required
 - Obs is a “status” not a location
 - Medical necessity: expectation that the patient needs to be observed
 - Diagnostic uncertainty: eg chest pain r/o or
 - Therapeutic challenge: asthma Rx and
 - 80% usually go home
- Hospital and physician requirements differ

Observation Codes

- Two families of codes to address two types of services
 - Admit and discharge same calendar day (99234-236)
 - Medicare: 8 hour duration requirement
 - Admit on day one (99218-220) and discharge on subsequent calendar day (99217)
- Three levels within each family
 - NOPP driven
 - Determined by H&P and MDM complexity
 - Discharge code used only when day of discharge is subsequent to admission date

Observation Documentation

- History criteria differ from 9928X:
 - Need 3 of 3 PFSH for Comprehensive
- Time driven codes so document:
 - Date/time 1st seen by you
 - Date/time obs admit order
 - Date/time obs discharge order
 - Course in obs
 - Hand-offs
 - Discharge summary

Observation Codes

MDM	Admit/DC <i>same day</i>	Admit/DC over 2 days
Low	99234	99218 + 99217
Moderate	99235	99219 + 99217
High	99236	99220 + 99217

Observation Values

E/M	RVU
99234	3.56
99235	4.69
99236	5.85
99285	4.74

E/M	RVU
99218 + 99217	3.64
99219 + 99217	4.80
99220 + 99217	5.99
99220	4.12

Procedures

- Procedures are usually billed with an E/M so document E/M appropriately
- Laceration repair
 - Total *repaired* wound length in cm
 - Exam and repair note clear for each lac
 - Document debridement
 - Layered closure
- Burns
 - Document size and depth
 - Any provider performed debridement

Ortho

- Document fractures with anatomic precision
- Document reductions and post reduction films as indicated
- Document follow-up timing and any anticipated procedures by ortho
- Splints
 - Document whether pre-formed out of box vs configured
 - Document personal application or direct supervision

EKG and Ultrasound Interpretations

- General Principles: Interpretation vs Review
- Interpretation
 - “Complete written report similar to that usually prepared by a specialist in the field”
 - “Potentially” billable service for EP
- Review
 - Provider reviews an image or EKG and makes a note
 - Not separately reimbursed *but* contributes to MDM

EKG and Ultrasound Interpretations

- Documentation
 - Can be reported within main body of ED note
 - Consider separate header
 - “Normal” won’t withstand audit
- EKG documentation requirements:
 - rate and rhythm
 - QRS axis
 - relevant intervals
 - if indicated: morphology of complexes, ST-T segment and T wave status
 - impression

EKG and US Interpretations

- Ultrasound documentation
 - Separate procedure note
 - Indications for study
 - Type of study and/or anatomic area visualized
 - Typically: “limited bedside ultrasound performed by me”
 - Eg FAST exam or anatomic area/organs visualized
 - Description of findings
 - Impression

EKG and US Interpretations

- Procedure guidance documentation included in procedure note
- Image archiving required
- Document repeat exams with times and medical necessity statement

Teaching Physicians (TP's)

- CMS payment policy addresses performance, documentation and payment for services provided by TP's supervising residents and interns
- Private payer rules usually follow CMS policy

Teaching Physicians (TP's)

■ Definitions

- "resident" means an individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting
- "student" means an individual who participates in an accredited educational program (eg a medical school) that is not an approved GME program. A student is never considered to be an intern or resident. ***Medicare does not pay for any services furnished by a student***

Teaching Physicians

- E/M Services paid at MFS if
 - Personally provided by TP *or*
 - TP was physically present during key portions of a service performed by a resident *and*
 - TP participated in the management of the patient *or*
 - TP reviewed resident H&P and independently performed “key elements” *and*
 - TP participated in management

Teaching Physicians

- Three performance scenarios:
 - TP performs *all* elements of service
 - TP physically present during key elements of H&P performed by resident
 - TP and resident perform portions of service independently and TP personally confirms key elements of service

Teaching Physicians

- Documentation
 - TP performs all elements of service
 - Document entire record
 - TP physically present during key portions
 - TP (not resident) must document physical presence during key elements
 - Resident notes plus TP notes are considered for payment purposes
 - TP performs key portions independently
 - TP must document personal performance of key elements
 - Resident notes plus TP notes are considered for payment purposes

Teaching Physicians

■ Documentation

- All scenarios require documentation of TP participation in management of patient
- Unacceptable
 - "Agree with above" followed by legible countersignature or identity
 - "Rounded, Reviewed, Agree" followed by legible countersignature or identity
 - "Discussed with resident. Agree" followed by legible countersignature or identity
 - "Seen and agree" followed by legible countersignature or identity
 - "Patient seen and evaluated" followed by legible countersignature or identity

Teaching Physicians

- Acceptable documentation of management participation

“I performed a history and physical examination of the patient and discussed his management with the resident.”

“I reviewed the resident's note and agree with the documented findings and plan of care.”

“I was present with resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note.”

“I saw and evaluated the patient. I reviewed the resident's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs.”

Teaching Physicians

- Procedures
 - Types
 - Minor: lasting 5 minutes or less
 - Major: all others
 - Supervision
 - Minor: TP present during entire procedure
 - Major: TP present during key portion of procedure
 - Present means “same room”

Teaching Physicians

- Critical Care
 - Resident time doesn't count toward TP CC time requirement
- Students
 - Includes medical, PA/NP, paramedic, others
 - CMS Transmittal 811: "Medicare does not pay for any service furnished by a student."

Teaching Physicians

- Medical Students
 - E/M services
 - May independently obtain ROS, PFSH
 - Physician must perform CC, HPI, PE and review ROS, PFSH performed by ancillary staff
 - Procedures
 - Communication from CMS somewhat vague:
“To the extent that a medical student is involved in procedures under the personal supervision of the teaching physician who is performing the service, there is no prohibition against the teaching physician billing for these services.”

Non-Physician Practitioners (NPP's)

- Physician Assistants (PA's) and Nurse Practitioners (NP's)
- Scope of practice:
 - state boards
 - hospital credentialing
- Payment policy:
 - CMS
 - Private payor contracts

NPP Payment Policy

- CMS
 - NPP may provide E/M service independently or jointly with EP
 - NPP independent service
 - EP has no face to face contact with patient
 - “Supervision” is not necessarily face to face
 - Billed using NPP NPI and paid to NPP employer at 85% of MFS
 - Service must be medically necessary and within NPP scope of practice
 - No “incident to” service in the ED

NPP Payment Policy

- CMS
 - Shared E/M service: can be billed using EP NPI and paid at 100% MFS
 - “Shared” means “...any face to face portion...” of an E/M service
 - NPP’s may bill for procedures
 - NPP provided services: 85% MFS
- Private payors
 - Par: determined contractually
 - Non-par: bill using NPP NPI

PQRI 2009

- Background
- Financials and methodology
- Conclusions

PQRI Background

- Who participates?
 - “Eligible professionals”
 - Includes NP’s and PA’s
- Voluntary program
 - Hospitals will expect and may require EP’s to participate
- No registration or application
 - NPI required
- Claims-based quality reporting system

PQRI Background

- Data will not be publicly reported...yet
- Reporting period
 - 1/1/09 to 12/31/09
- Reporting requirements
 - At least 3 measures must be reported
 - Provider determines which measures he/she will report on by actually reporting
 - Measure must be reported on in at least 80% of eligible cases
 - Measures and reporting rates are reported at an individual NPI level *not* group

PQRI Payment

- Providers are eligible for 2% bonus
 - Based on all allowed charges under Medicare Fee Schedule
 - Includes all Medicare as secondary payer not just Medicare portion
 - Includes beneficiary co-pay portion
 - Determined by individual NPI charges for reporting period

2009 PQRI Payment

- Reported and analyzed at NPI level
- CMS recommends reporting on every applicable measure to
 - Increase likelihood that at least 3 measures will meet 80% rate
 - Avoid validation implications
- Paid at TIN (group) level
- Payment in fall 2010

Hypothetical Group Economics

- Assume 30,000 visit/yr ED
 - 2 pts/hr
 - 15,000 hrs annual coverage
 - 10 FTE docs
 - \$125/pt or annual group cash \$3,750,000/yr
 - 25% Medicare
 - $(\$3,750,000) \times (.25) \times (.02)$
 - \$1,875per doc
 - \$18,750 for group

Emergency Medicine Measures

- There are **7** ED measures that have denominators that include 9928X *and* 99291
- There are **2** 99291 only denominator measures for the ED
- There is **1** procedure defined measure

9928X and 99291

Denominator Measures

- #28: Aspirin at Arrival for Acute Myocardial Infarction (AMI)
- #54: EKG performed in patients >40y/o with a diagnosis of non-traumatic chest pain
- #55: EKG performed in patients >60y/o with a diagnosis of syncope
- #56: Vital signs reviewed in patients >18 y/o with diagnosis of community acquired pneumonia
- #57: Oxygen saturation reviewed in CAP >18y/o
- #58: Mental status assessed in CAP >18 y/o
- #59: Empiric antibiotics in CAP >18 y/o

99291 *Only* Denominator Measures

- #31: DVT prophylaxis for stroke (ischemic or hemorrhage)
- #34: t-PA considered for ischemic stroke
- #47: Advance care plan - NOT for ED
- #75: Prevention of ventilator associated pneumonia – NOT for ED

1 Procedure Denominator Measure

- #76: Prevention of Catheter-Related Bloodstream Infections (CRBSI) – Central venous catheter insertion protocol
- Denominator is CPT procedure code:
 - 36555, 36556, 36557, 36558, 36560, 36561, 36563, 36565, 36566, 36568, 36569, 36570, 36571, 36578, 36580, 36581, 36582, 36583, 36584, 36585
- Defined:
 - central venous catheter (CVC) insertion with all elements of maximal sterile barrier technique (cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis)

P Modifiers

- Exclusion modifiers:
 - 1P: Medical reasons. For example, patient allergic to ASA
 - 2P: Patient reasons. For example, patient declined for economic or religious reasons
 - 3P: System reasons. For example insurance declined or hospital ran out of ASA
- Reporting modifier
 - 8P: Measure not performed and reason not documented

Beacon Strategy

- All clients participating
- Measures reported on are:
 - #28: Aspirin at Arrival for Acute Myocardial Infarction (AMI)
 - #54: EKG performed in patients >40y/o with a diagnosis of non-traumatic chest pain
 - #55: EKG performed in patients >60y/o with a diagnosis of syncope
 - #56: Vital signs reviewed in patients >18 y/o with diagnosis of community acquired pneumonia
 - #57: Oxygen saturation reviewed in CAP >18y/o
 - #58: Mental status assessed in CAP >18 y/o
 - #59: Empiric antibiotics in CAP >18 y/o

Defined as fluoroquinolones, macrolides, doxycycline, beta lactam with macrolide or doxycycline (as defined by current ATS/IDSA guidelines)

PQRI 07 Review

- First year of program
- Six months of reporting
- 16-20% of eligible providers reported
- Above average reporting rates from 3 specialties
 - Anesthesia
 - Ophthalmology
 - ***Emergency Medicine***

Medicare quality reporting called a promising start
The program continues this year with added quality measures. Government officials expect it to be extended through 2009 and are seeking to include new assessments.

By [Doug Trapp](#), *AMNews* staff. March 17, 2008.

Washington -- About one in six eligible physicians and other health professionals participated in a new Medicare quality reporting program during its first five months, according to preliminary figures from the Centers for Medicare & Medicaid Services. About half of them are on track to get up to a 1.5% bonus for their efforts. Doctors and CMS were generally encouraged by the early participation results for the 2007 Physician Quality Reporting Initiative. Physician organizations credited CMS and their own education efforts for the results. But one doctor expressed concern that the 1.5% bonus might not be enough to attract widespread doctor participation.

AMNews



"At 1.5%, it's not getting a lot of people's attention," said Dennis Beck, MD, chair of the American College of Emergency Physicians' quality and performance committee. "To have real meaning, pay-for-performance programs probably have to have a more substantial economic impact." He suggested that a 5% to 10% bonus might attract more attention

Conclusions

- P4P conventional wisdom
 - Incentives need to be 5-10%
 - Paid to individual at least quarterly
- PQRI dollars are minimal at best
- PQRI is low risk low return
- There are non-economic reasons to participate
- Now's the time to dip a toe in the water

Questions

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