Billing Essentials

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1. Tips & Trends Articles

REIMBURSEMENT ESSENTIALS TIPS & TRENDS
FOR EMERGENCY MEDICINE
 PROFESSIONAL MEDICAL BILLING IS DEDICATED TO
APPROPRIATE EMERGENCY MEDICINE REIMBURSEMENT

HCFA Proposes New Reimbursement Model for Observation Codes in 2001 Fee Schedule

In a development that could impact emergency medicine reimbursement beginning next year, the Health Care Financing Administration has proposed a new method for determining reimbursement for observation codes. The proposed 2001 Medicare Physician Fee Schedule cuts relative values for certain observation codes approximately in half.

This change came without input from specialty societies such as ACEP. Accordingly, ACEP plans to submit comments to express concern that HCFA is disregarding the CPT descriptors for the observation codes and has rewritten the codes to impose hourly thresholds on observation services instead of the previous one-day or next-day method.

HCFA proposes to break down the codes into three categories:

For observation of eight hours or less, Medicare will reimburse only the admission codes on that day.
Between eight and 24 hours, for observation, or if a patient is admitted as an inpatient, HCFA would pay for both the admission and discharge services under CPT codes 99234 and 99236, with a reduction in physician work relative value units (RVUs).
For observation of 24 hours or more, Medicare will pay for both inpatient hospital admission services and hospital discharge services.
ACEP officials are concerned that the new method adds significant potential for confusion.

The good news coming out of the fee schedule, however, is that HCFA has restored the critical care relative value units to the 1998 levels for code 99281 and 99282 for a difference of 10%.

The proposed 2001 physician fee schedule is available online at:
www.access.gpo.gov/su_docs/fedreg/a000717c.html. Scroll down to Health Care Financing Administration and find the link to "Physician fee schedule (2001CY) payment policies."

Important Changes to Critical Care Reimbursement « Back to top »
New standards include prevention
New CPT guidelines for critical care in the year 2000 remove the requirement that the patient must be unstable, and thus may allow broader utilization of the critical care codes. Prior to January 1, 2000, it was a challenge to appropriately bill for critical care services required to prevent further deterioration in a patient likely to become unstable, since the critical care codes required the patient to actively be unstable. Here is an overview of the new standards for critical care reimbursement:

Critical care reimbursement now applies to prevention
Critical care services include but are not limited to the treatment or prevention of further deterioration of central nervous system failure, circulatory failure, shock-like conditions, renal, hepatic, metabolic, or respiratory failure, postoperative complications or overwhelming infection. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility.

Critical care for infants

Critical care services provided to infants older than one month of age at the time of admission to an intensive care unit are reported with critical care codes 99291 and 99292. Critical care services provided to neonates (30 days of age or less at the time of admission to an intensive care unit) are reported with the neonatal critical care codes 99295, 99296, 99297 and 99298. The neonatal critical care codes are reported as long as the neonate qualifies for critical care services during the hospital stay. The reporting of neonatal critical care services is not based on time, the type of unit (eg, pediatric or neonatal critical care unit) or the type of provider delivering the care.

Services included in critical care
The following services are included in reporting critical care when performed during the critical period by the physician(s) providing critical care:
the interpretation of cardiac output measurements (93561, 93562)
chest X-rays (71010, 71020)
blood gases, and information data stored in computers, including ECGs, blood pressures, hematologic data (99090)
gastric intubation (91105)
temporary transcutaneous pacing (92953)
ventilator management (94656, 94657, 94660, 94662)
vascular access procedures (36000, 36410, 36415, 36600)
Any services not listed above should be reported separately.

Tracking your critical care time
The critical care codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured patient, even if the time spent by the physician on that date is not continuous. For any given period of time spent providing critical care services, the physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time. Time spent with the individual patient should be recorded in the patient's record. The time that can be reported as critical care is the time spent engaged in work directly related to the individual patient's care whether that time was spent at the immediate bedside or elsewhere on the floor or unit. For example. … Time spent in the emergency department reviewing test results or imaging studies, discussing the critically ill patient's care with other medical staff or documenting critical care services in the medical record would be reported as critical care, even though it does not occur at the bedside. Also, when the patient is unable or clinically incompetent to participate in medical decisions, time spent in the emergency department with family members or surrogate decision-makers obtaining a medical history, reviewing the patient's condition or treatment may be reported as critical care, provided that the conversation bears directly on the medical decision-making. It is absolutely essential that you document your total critical care time in the patient's ED record. It is important that there is sufficient documentation in the medical record (such as nurse's notes) to support the total time you designate as critical care time.

Medicare guidelines may differ
The bad news is that HCFA lowered the RVUs for critical care by about 9%, thus decreasing Medicare's reimbursement for critical care services. Critical care code 99291 now has RVUs of 5.09 for Medicare payment, vs. RVUs of 4.23 for E/M code 99285. As with most HCFA reimbursement changes, individual Medicare carriers may have some latitude regarding how they will interpret and implement the new guidelines. Therefore, refer to your local Medicare carrier's written instructions in its monthly Medicare Part B Bulletin which describes the carrier's critical care reimbursement policy changes. (For PMB clients in Indiana and South Carolina, Medicare carrier policies in these states follow the new CPT guidelines.)

Don't bill critical care time when…
Time spent in activities that occur outside of the unit or off the floor (e.g., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care since the physician is not immediately available to the patient. Time spent in activities that do not directly contribute to the treatment of the patient may not be reported as critical care, even if they

are performed in the critical care unit (e.g., participation in administrative meetings or telephone calls to discuss other patients). Code 99291 is used to report the first 30-74 minutes of critical care on a given date. It should be used only once per date even if the time spent by the physician is not continuous on that date. Critical care of less than 30 minutes total duration on a given date should be reported with the appropriate E/M code. Code 99292 is used to report each additional 30 minutes beyond the first 74 minutes. It also may be used to report the final 15-30 minutes of critical care on a given date. Critical care of less than 15 minutes beyond the first 74 minutes, or less than 15 minutes beyond the final 30 minutes, is not reported separately.

HCFA Issues Ruling on Independent Contractor Reimbursement « Back to top »

   In April, HCFA Administrator Bruce Vladeck issued a ruling, which reaffirms that HCFA will not allow reassignment of Medicare benefits by independent contractor physicians. An independent contractor physician is one who is not an employee of the hospital, physician staffing company or physician group and receives his/her wages reported on a 1099 form rather than a W-2 form. Although a patient may assign his/her benefits to a physician who provides the patient a service, Medicare restricts a physician's ability to reassign those benefits. Medicare allows an employed physician to reassign benefits to an employer or staffing company. However, Medicare does not allow an independent contractor physician to reassign benefits to an employer group or staffing company. A hospital may be entitled to bill and receive payment for a physician's services if the facility has a direct contractual arrangement with each physician according to the Medicare Carrier's Manual.

When the new ruling takes effect, it appears that the Medicare reimbursement for an independent contractor physician can be handled in one of the following three ways:

The physician can convert from independent contractor status to employee status.
The physician can bill through the hospital.
The physician can obtain a provider number and have Medicare reimbursement directed to him or herself.
HCFA has not decided when this ruling will become effective nationwide. However, Medicare carriers in some states are already enforcing this provision. Until the Indiana Medicare carrier enforces this statute, independent contractor physicians can continue to reassign their Medicare reimbursement to a physician group or staffing company.

Private Insurance Downcoding on the Rise « Back to top »

   PMB has noted an increasing number of private payers trying to downcode evaluation and management (E/M) services. PMB's finding is supported by a recent article in "Indiana State Medical Association Reports" which stated that the ISMA is receiving a number of phone calls from physicians complaining about this issue.
   There are two critical elements in this issue for emergency physicians. The first is that it is vital that whoever does the billing for the emergency physicians must have the ability to identify and resolve inappropriate downcoding by insurance plans. At PMB, expected payments are loaded for each contracted carrier into the billing software, and downcoded claims automatically print to an exception report which is followed-up by PMB's accounts receivable management staff. For non-contracted plans, PMB bills the patient for the balance of the charge. PMB works with patients to help them address inappropriate downcoding and denials by their insurance plan, but ultimately it is up to the patient and their employer to pressure the insurance plan to pay claims appropriately.
   A second key element is for emergency physicians to be very careful when signing insurance contracts. The physicians must ensure that the contract includes clear provisions protecting them against inappropriate downcoding and denials. This includes limitations on which claims can be downcoded or denied, and a timely appeals process the physicians can utilize for claims which they believe are inappropriately denied or downcoded. PMB works closely with its emergency physicians to provide them with valuable data and insights when they are negotiating a contract with a payer, to help the physicians avoid many other contract pitfalls.
On Fraud & Abuse, Emergency Physicians are Vulnerable, ACEP says in Report « Back to top »

Emergency physicians may be more vulnerable to allegations of fraud and abuse according to a report from the American College of Emergency Physicians.

Emergency medicine coding and billing functions are often outsourced to the hospital or to a billing company without direct clinician involvement, according to the report, Fraud, Compliance & Emergency Medicine." The government has made it clear that the physician, if he/she provides the service, is always held accountable for billings in his or her name regardless of who submits or processes the claim.

Concerned that fraud and abuse and improper payments threaten the Medicare program, Congress has mandated that the Health Care Finance Administration and the Office of the Inspector General intensify their investigations of the health care sector. Already a substantial number of physician groups and other providers have been investigated, and the number and amount of identified overpayments and penalties have increased dramatically.

A health care fraud investigation can potentially lead to the imposition of criminal penalties including fines and imprisonment, and civil penalties, including monetary penalties and/or exclusion from the Medicare and Medicaid programs. For the physician, knowledge of compliance regulations is vital. You'll find useful excerpts from this illuminating ACEP report in the enclosed Compliance Digest page.

"Who Pays? You Pay" Initiative « Back to top »
   If a recent "Who Pays? You Pay" initiative to combat fraud takes hold, doctors and hospitals will have a new source of allegations to contend with: senior citizens. The government is expanding programs to train and encourage seniors to read Medicare bills in search of errors that might indicate fraud.
Under the program, the American Association of Retired Persons (AARP) and government officials will teach thousands of elderly patients to read their bills to identify bad claims. Beneficiaries are the "first line of defense" for combating healthcare fraud because they are n the best position to identify it, Attorney General Janet Reno said when announcing the initiative. She encouraged patients to go after even small billing errors, saying, "Your tip may just be the tip of the iceberg." After finding apparent errors, beneficiaries will be told they should call the provider for an explanation. If questions are still not answered, patients are directed to contact the Medicare insurance company listed on their Benefits Statement and the Medicare Fraud Hotline.

This joint AARP-government initiative is the latest development in a program that officially began when HCFA finalized its Reward to Beneficiaries rule and announced it will pay up to a maximum of $1,000 or 10 percent of recovered overpayments.

How do you make sure you don't find yourself on the Medicare fraud list? One way is to do your own coding. Since you are accountable for the resulting charges, even if someone else does your coding, it just makes sense to remove this extra layer and code your cases directly. It's not difficult, and PMB offers valuable training to help your practice meet the letter and spirit of all regulations. When and if questions arise, you'll be able to respond confidently, because you will not be relying on the second-hand interpretation of a coding clerk. Our clients feel this is simply a better way to optimize revenues and rest assured of meeting compliance requirements.

Tips and Traps For Emergency Medicine Billing « Back to top »
   Today, emergency physicians face significant economic challenges as government programs, managed care networks, and private insurers continue to seek ways to reduce your payments for emergency medicine services.
Many emergency physicians say, "I just want to practice medicine." But this approach, understandable as it is, can cost you thousands of dollars and place you at risk for potential compliance violations. In today's environment, you simply must get involved to protect your revenues and manage your compliance risk. The third-party payers want your money, and you need to protect your share while adhering strictly to compliance regulations. The good news is

that the solution is not complicated: Choose a billing company that can provide you with the processes and tools to optimize revenue while helping to assure compliance.

How do you lose revenue?

Getting bad information when a patient registers, such as the incorrect insurance provider.
Charts that never get billed, especially for admitted patients.
Poor documentation of procedures you performed resulting in lost charges.
Poor documentation of evaluation and management services resulting in coding lower than medical necessity would justify, or upcoding and compliance risk.
Be sure your billers are knowledgeable in the rules and regulations and follow them, since you are ultimately responsible for everything billed out under your name.

Fraud and abuse issues can result in substantial fines and penalties per claim plus twice the amount claimed for each service and possible suspension from participation in Medicare and Medicaid. This newsletter will show you some of the ways PMB helps clients comply with the letter and spirit of all compliance regulations while optimizing their revenues.

2. Procedures Articles

Ophthalmic Procedures
A foreign body (FB) must be removed to charge for the procedures that describe a foreign body removal (codes 65205, 65210, 65220, 65222).

If a foreign body is not removed, charge a level of service. If an eye exam was performed with a slit lamp, but no foreign body was removed, E/M code 99283 is generally the appropriate code. If a foreign body is noted, one of the ophthalmic procedure codes (65205, 65210, 65220, 65222) may be charged in addition to an E/M code (usually 99281).

Lacerations involving only the skin of the eyelid are billed using the laceration repair code.

Always document when a slit lamp examination was performed.

Code Procedure Description

65205   Removal of a superficial foreign body from the conjunctiva of the external eye.

65210   Removal of a foreign body which is embedded in the conjunctiva (including concretions), subconjunctiva, or sclera (non-perforating) of the external eye. Generally, a slit lamp is used when removing an embedded foreign body, and an incision of the conjunctiva may be necessary to remove the foreign body.

65220   Removal of a superficial foreign body from the cornea, without a slit lamp.

65222   Removal of an embedded foreign body from the cornea, with a slit lamp.

Tonometry measurements are generally included in the E/M code. The only exception is for serial tonometry measurements, whereby multiple measurements of intraocular pressure are taken over an extended period of time (generally the course of a day) and for which an interpretation and report are produced.

Fractures and Dislocations
Procedures such as the dislocation codes and fracture codes are global charges. That is, these codes include all evaluation and management (E/M) services, and all pre- and post-operative care related to the procedure. For global procedures, an E/M code should not be charged, unless it is for a separately identifiable service (such as an E/M code for a syncope workup charged in addition to a shoulder dislocation reduction code). The documentation in the medical record (including additional diagnoses) should indicate that services beyond the global procedure were medically necessary and separately identifiable.

The emergency physician must perform the definitive treatment for the fracture or dislocation to bill these codes. If the emergency physician simply identifies and splints a fracture or dislocation and refers the patient to the family physician or orthopedic surgeon for definitive casting or care, an E/M service rather than a fracture or dislocation code should be billed. (The emergency physician should also bill for the splint application if he/she applied the splint, since fracture or dislocation care is not being billed.)

Only one physician can bill for each portion of a fracture or dislocation code (i.e. preoperative, operative, and postoperative care). When the emergency physician bills for fracture or dislocation care, the billing company must attach a modifier to the service to indicate that the postoperative care will be provided by another physician. Splinting, strapping and casting are included in the fracture or dislocation code, and are not separately billable in addition to the fracture or dislocation care code.

When the emergency physician reduces a dislocation, he/she clearly provides the definitive care. However, for fractures that do not require manual reduction, it may be controversial who is providing definitive care. The emergency physician may argue that he/she provided definitive care through initial splinting and pain management. The orthopedist may argue that he/she provided the definitive care if the patient is referred to him/her for casting. In general, PMB recommends that the emergency physician only bill for fracture or dislocation care when he/she is clearly providing the definitive reduction and/or splinting/casting.

If the patient returns to the emergency department for postoperative care after definitive fracture or dislocation care was provided by the emergency physician, the same fracture or dislocation code as the initial visit should be billed with a note on the ED face sheet that this is a postoperative follow-up visit. (This will allow the billing company to assign the proper modifier for this service.)

If the code appropriate to the fracture service performed is not listed on the charge sheet, the physician should list the following information on the ED chart or physician charge sheet to allow the billing company to assign the appropriate fracture-care code:

1. The bone that is fractured.

2. Whether manual reduction was performed.

3. The location of the fracture (distal, mid-shaft or proximal).

Incision and Drainage; Incision and Foreign Body Removal
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Use these codes for the drainage of an abscess, or the removal of a foreign body from skin and subcutaneous structures. These codes require an incision. If the physician simply removes a foreign body (such as a splinter) with a hemostat and no incision is made, incorporate this service as part of the medical decision-making into the E/M code billed.

Local or peripheral block anesthesia and suturing of the wound are included in these codes, and not billed separately.

Procedure Codes:

10120 Incision and removal of a foreign body from the subcutaneous tissue.

20520 Incision and removal of foreign body in muscle, simple.

28190 Foreign body removal from the foot that does not require an incision.

10060 Incision and drainage of a simple abscess, such as a carbuncle, cutaneous or subcutaneous abscess, cyst, or paronychia.

10061 Incision and drainage of a complex abscess, or multiple abscesses. A complex abscess I & D involves significant hemorrhage that requires the ligation of blood vessels; an abscess deep in the muscle, tendon, bone or an adjacent structure; the presence of infection; delayed

treatment; or a procedure that took significantly longer than usual to perform (this needs to be documented).

10160 Puncture aspiration of abscess, hematoma, bulla or cyst. Use this code for needle aspiration of these conditions as appropriate.

Burns « Back to top »
The three CPT procedure codes for local treatment of burns which require the physician to debride and/or dress the burn without anesthesia are:

16020:
Dressings and/or debridement, initial or subsequent, without anesthesia, office or hospital, small.

16025:
Dressings and/or debridement, initial or subsequent, without anesthesia, office or hospital, medium (e.g., whole face or extremity).

16030:
Dressings and/or debridement, initial or subsequent, without anesthesia, office or hospital, large (e.g., more than one extremity).

Key Points
The physician must apply the dressing or perform the debridement to bill one of these codes (you cannot bill this code if the nurse applies the dressing or does the debridement). An evaluation and management (E/M) code is appropriate to bill in addition to one of these codes for the preoperative service for codes 16025 and 16030, or for a separately identifiable E/M service in addition to all three codes. These codes differ based on the size of the burn, and it is probably rare that you would bill a code other than 16020, since this is the appropriate code for dressing or debriding burns covering less than an entire extremity. There is a separate code for performing an escharotomy. If you perform this procedure, be sure to write this in on your charge sheet. Also, be aware that these patients are likely to have a higher medical necessity visit, and therefore will probably have an evaluation and management level most appropriately coded 99283 or higher.

Billing Laceration Repairs « Back to top »
   Laceration repairs are commonly performed procedures in the emergency department, and may generate a significant portion of emergency medicine revenues. Thus, it is very important for emergency physicians to understand how to document and code laceration repairs to make sure they are accurately billed for appropriate reimbursement.
   There are three elements which determine how a laceration repair should be coded. These are the anatomical location of the laceration, the length of the laceration, and the complexity of the repair. Each of these components must be clearly documented to ensure appropriate reimbursement for the laceration repair.
Anatomical Location
   There are five general anatomical groupings for laceration repairs.
These are as follows:

scalp, trunk, arms and wrists, legs and ankles
face and lips
neck, hands, feet, and genitalia
mouth (oral mucosa)
tongue

It is extremely important for the physician to document the location of every laceration which is repaired, to enable the physician's billing staff to determine the appropriate laceration repair code(s).

Length of Laceration

The length of each laceration must also be clearly documented. Within each of the laceration repair anatomical groupings, the total length of lacerations in that category for a given level of complexity must be added together to determine the appropriate repair code. The length of the laceration should be measured after the repair has been performed, and each of the components of a stellate laceration should be added together to determine the total length repair.

Complexity of Repair

There are three types of laceration repairs: simple, intermediate, and complex. Simple repairs are performed when the wound does not extend beyond the subcutaneous tissue, does not involve deep structures, and requires only a single layer suture closure. Simple repairs also include wounds which are chemically or electrically cauterized and not closed.

A laceration repair is considered intermediate complexity when the wound requires layered closure, or when extensive cleansing of the wound is required (the extensive cleansing should be documented).

A complex repair is performed when the wound requires more than an intermediate repair. For example, repairs which require extensive revision, undermining, or debridement are considered complex.

General Points

All laceration repairs include local or digital block anesthesia. In addition, the laceration repair code includes ligation of blood vessels, and simple exploration for deep structure involvement such as nerves, blood vessels, or tendons. A laceration repair code is not used when a wound is closed with sterile tapes (this service is incorporated into the evaluation and management code which is billed).

An evaluation and management (E/M) code often can be billed in addition to the laceration repair. CPT guidelines consider some laceration repairs to be minor procedures (the procedure includes the operative service only, and not pre-op or post-op services). For minor procedures, CPT guidelines allow the billing of an E/M code for the pre-operative evaluation of the patient. Generally, this would be E/M code 99281. For any separately identifiable E/M service which the physician performs such as a post-fall exam, IM/IV medications, x-rays, etc., a higher level E/M code can be billed.

Conscious Sedation « Back to top »

For 1998, CPT has added codes for billing conscious sedation. Code 99141 is for IM, IV, or inhalation conscious sedation, and code 99142 is for oral, rectal, or intranasal conscious sedation.

A key issue is that these codes require physician administration of the conscious sedation agent. Thus, you should not bill these codes if the nurse administers the conscious sedation agent. However, managing the administration of the conscious sedation may increase the complexity of your medical decision making and raise the E/M level which is appropriate. PMB recommends that you clearly document that you administered the conscious sedation agent when billing these codes.

Other important requirements to bill conscious sedation are the performance and documentation of pre and post-sedation evaluations of the patient, monitoring of cardiorespiratory function, and the presence of an independent trained observer.

Coding Foreign Body Removal from Skin Structures
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Now that summer is upon us, it is common for patients to present to the emergency department with a foreign body embedded in a skin structure. Several possible coding scenarios for this situation are discussed below.

A patient presents with a superficial foreign body embedded in his foot. The most appropriate CPT procedure code is 28190 (removal of foreign body, foot; subcutaneous). This code does not require that an incision be made to remove the foreign body. If the foreign body is deeply embedded in the foot, the most appropriate CPT code is 28192, and if the foreign body removal from the foot is complicated, the appropriate CPT code is 28193.

A patient presents with a foreign body embedded in the forearm. If the foreign body is embedded only to the depth of the subcutaneous tissue, the appropriate CPT code to remove the foreign body is 10120 (incision and removal of foreign body, subcutaneous tissues; simple). If the removal from the subcutaneous tissue is complicated, the appropriate CPT code is 10121. Both of these codes require that an incision be made to remove the foreign body. If an incision is not made, only an evaluation and management code would be billed as described below.

A patient presents with a fishhook in his thumb. If an incision is made to remove the fishhook, the appropriate procedure code is 10120, described above. If a peripheral or digital blocks is performed to provide anesthesia for this procedure, it would not be billed separately, since it is bundled into the foreign body removal code. In this case presentation, as well as those above, evaluation and management code 99281 would also be billed for the preoperative service (a higher evaluation and management code should be billed for a separately identifiable evaluation and management service).

If the fishhook is extracted without making an incision, an evaluation and management code only would be billed for this service (typically CPT code 99282 or 99283, depending on the complexity of medical decision-making in the removal). If a digital or peripheral nerve block is provided (CPT code 64450), this code can be billed since it has not been provided as part of a bundled procedure code.

3. Coding Articles

REIMBURSEMENT ESSENTIALS: CODING
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Evaluation and Management Code 99282 Review

The following are key points to remember in determining whether the medical necessity of a patient service is consistent with E/M code 99282:

The presenting problem(s) is usually of low to moderate severity (i.e., acute uncomplicated illness such as allergic rhinitis, or two or more self-limited or minor problems).
An expanded problem-focused history and examination are required (Documentation requirements include: 1-3 HPI elements, problem-focused ROS, no past/family/social history, 2-4 body areas or organ systems examined, one of which may include vital signs review)
Medical decision-making is low complexity (i.e. limited diagnostic or management options, limited amount and complexity of data reviewed, low risk of complications or morbidity/mortality).
In general the following are not required lab tests: X-rays, IM/TV medications, re-examinations, or review of old medical records.
Typical case scenarios for code 99282 include uncomplicated upper respiratory infection, pharyngitis, uncomplicated otitis media with a low-grade fever, localized impetigo, uncomplicated toothache, uncomplicated conjunctivitis, and uncomplicated contact dermatitis.
Source: Phycian Reimbursement Training Manual, © 2000 PMB.

Did you know... « Back to top »
Question: Could you explain the difference in simple, intermediate and complex laceration repair codes?
Answer:

A simple repair is used when the wound is superficial and requires simple one-layer closure suturing. This also includes chemical or electrocauterization of wounds not closed.
An intermediate repair requires layered closure of one or more of the subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure. Single-layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter also constitutes intermediate repair.
Complex repair includes the repair of wounds requiring more than layered closure, scar revision, debridement (e.g. traumatic lacerations or avulsions), extensive undermining, stents or retentions sutures. It may include creation of the defect and necessary preparation for repairs or the debridement and repair of complicated lacerations or avulsions.

Coding ICD-9-CM « Back to top »
  Diagnosis codes come from the International classification of Diseases, ICD-9-CM and are very important for claims to be reimbursed appropriately by all insurance carriers. It is essential that diagnosis codes be coded out to the proper fourth or fifth digit of specificity by a physician's billing staff. This can only be accomplished with assistance from the physician.
The emergency department medical record must contain a complete diagnosis for each patient's visit. Sometimes the emergency physician cannot determine a definitive diagnosis, in which case it is important to give the key symptoms which led the patient to come to the emergency department such as chest pain or shortness of breath. However, if the physician can determine a definitive diagnosis such as myocardial infarction, it is important to list as many specific details as possible such as the location of the infarction and complications such as arrhythmias. A

diagnosis, which contains specific details, is often reimbursed more appropriately than a non-specific diagnosis, since many insurance carriers now frown on ICD-9-CM diagnoses which are defined as "unspecified".

Example: A patient presents to the ED with chest pain and the physician diagnoses that the patient is suffering from an acute myocardial infarction of the anterolateral wall. This should be coded by the billing staff with a detailed diagnosis code of 410.01. The physician has provided the site of the infarction (fourth digit) and unless specified by the physician that this is a subsequent episode (within 8 weeks of a previous infarction), the fifth digit for an initial episode of care is used.

Billing for Direction of CPR « Back to top »
   CPT code 99250, direction of cardiopulmonary resuscitation (CPR), is important to consider billing for patients with cardiac arrest. Direction of CPR is considered to be a basic life support service, and can be billed in addition to evaluation and management codes 99281 – 99285 or in addition to critical care. Direction of CPR does not require the physician to actually provide chest compressions. Other codes are not bundled into CPR, so the physician can also bill for procedures such as intubation.
The reimbursement for code 99250 is significant, so the physician must determine if the work he/she performed ethically justifies billing this code. As an example, this code probably should not be billed for a cardiac arrest patient who is worked extensively in the field by EMS personnel, and the emergency physician simply pronounces death on the patient's arrival in the ED.

Coding for Dermabond « Back to top »
   The CPT Editorial Panel recently clarified how to code for the application of tissue adhesives such as Dermabond. Previously, there was a question whether the application of a tissue adhesive to close a laceration should be coded using laceration repair codes, or an unlisted procedure code.
The CPT Editorial Panel has recently recommended that repair codes should be utilized to designate wound closure with tissue adhesives. Use of repair codes for tissue adhesive application is not limited to "simple" repairs (one layer closure without extensive cleansing or removal of particulate matter). Thus, the appropriate complex repair code can be utilized with tissue adhesive application for complex repairs, and intermediate repair codes can be used for closure of wounds repaired with tissue adhesive which require extensive cleansing or removal of particulate matter, or layered closure.

Example: Dermabond is used to close a 1.5 cm laceration of the forehead. Extensive cleansing or removal of particulate matter is not required. The appropriate CPT code is 12011 (simple repair of superficial wounds to the face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less).

4. Documentation Articles

REIMBURSEMENT ESSENTIALS: DOCUMENTATION
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Medical Decision-Making: Helpful Hints For Effective Documentation
In emergency medicine reimbursement, documentation that supports your medical decision-making process is vital. Payers need to know exactly what services they are paying for, and "if it wasn't documented, it wasn't done." The key is to eliminate ambiguity and misinterpretation. With that goal in mind, here are some habits that can help you provide effective documentation to enhance your group's reimbursement and compliance:

Note all clinical interventions ordered such as oxygen, inhalation treatments, medications, IV fluids and rate, and any procedures (procedure notes should always be documented).
List all diagnostic tests ordered with pertinent results and your interpretation of the results (for example, note "metabolic acidosis" rather than simply "pH = 7.2").
Document any nursing notes or old records reviewed.
Document discussions (and what was discussed) with other physicians, other medical providers (paramedics, nursing home personnel, etc.), and other family members.
Document clear discharge plans and follow-up, including where, when, and by whom the patient is to be seen again.
Always note when ECGs, rhythm strips, ABGs, and X-rays are performed and/or interpreted by the physician. Documenting these cognitive services is important, even if some of them are not separately billable. Note "reviewed by me" in your documentation of X-ray findings if you reviewed the X-ray. Note "performed by me" when you do a procedure (especially when other physicians or ancillary staff such as paramedics are involved with the patient's care, since it may be unclear to the payer who performed each service).
Document the patient's condition on discharge and any improvements in the patient's condition from the time of admission to the ED.
Note all admissions and transfer of care to other physicians.
Comment on differential diagnoses when appropriate.
Careful documentation of all management activities and risks, diagnostic procedures and risks, and cognitive activities by the physician is critical to showing the value of the physician's decision-making to third-party payers.

New Draft Documentation Guidelines Released
HCFA recently released the draft of its new guidelines of documentation requirements for evaluation and management (E/M) services. The guidelines are intended to simplify the requirements for documenting E/M services and make them less burdensome to physicians. Currently, physicians can use either the 1995 or 1997 documentation guidelines previously issued by HCFA, depending on which set of guidelines is more beneficial to the physician. The new draft documentation guidelines are scheduled to be studied through the spring of 2001, and then implemented in January, 2002. A copy is available at www.hcfa.gov/medicare/2000emd.doc.

There are some significant changes in the new guidelines from the 1995 documentation guidelines (HCFA's starting point for the new guidelines). A worrisome change for emergency physicians is the elimination of the history caveat. The 1995 guidelines contain the following history caveat: "If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history." This caveat allows emergency physicians to obtain documentation credit for a complete history when they document why they were unable to obtain a history from the patient. If the history caveat is not reinstated in the documentation guidelines, it will be much more difficult for

emergency physicians to bill E/M code 99285 for those patients who are unable to give a complete history.

The new draft guidelines change the requirements for multi-system examinations. A comparison of the examination requirements for the 1995 guidelines and the new draft guidelines is listed below. (BA/OS refers to body areas or organ systems that must be examined):

E/M 1995 2000
Code Guidelines Draft Guidelines

99281 1 BA/OS 1 - 2 BA/OS
99282 2 - 4 BA/OS 1 - 2 BA/OS
99283 2 - 4 BA/OS 1 - 2 BA/OS
99284 5 - 7 BA/OS 3 - 8 BA/OS
99285 8 BA/OS 9 BA/OS

Medical decision-making has been condensed from four categories (straightforward, low, moderate or high complexity) to three categories (low, moderate, and high complexity). The medical decision-making categories and language have also been revised. The following language was added: "In order to determine the level of decision-making for an encounter, the medical record should include documentation of an assessment and plan for each problem evaluated during the encounter. The assessment and plan for each problem should include documentation of (1) the status/severity/urgency of the problem(s) and the risk of complications and deterioration, (2) the amount and complexity of data reviewed and differential diagnosis(es), (3) the diagnostic and therapeutic tests, procedures, and interventions ordered, and the treatment plan."

The new medical decision-making table is shown below. (As with the 1995 guidelines, two of the three elements in the table must either meet or exceed the requirements for that type of decision-making):

Severity/urgency of the problem(s) and risk of complications and deterioration Differential diagnoses and amount/complexity of data reviewed Treatment plan including diagnostic and therapeutic tests, procedures and interventions Type of decision-making
Low Limited Straightforward Low
Moderate Detailed Complicated Moderate
High Extensive High Complex High

An important element of the new documentation guidelines for medical decision-making, multi-system examinations, and single-system examinations will be the development of specialty-specific vignettes.

Even though implementation of the new documentation guidelines is still over a year away, emergency physicians need to begin educating themselves on the new guidelines and making plans for how they will address the requirements of the new guidelines in their practice.

Important Diagnosis Documentation Tips
   The diagnosis is one of the most critical pieces of information required for appropriate reimbursement. An inaccurate or illegible diagnosis can result in decreased, delayed, denied or inappropriate reimbursement.

One of the greatest challenges for billing staff is to read physician handwriting. It is important to remember that for medico-legal and reimbursement purposes, illegible documentation is the same as no documentation. If the billing staff cannot read the physician's handwriting, they must either return the chart to the physician for clarification (resulting in billing delays and potential lost charts) or make a "best guess" as to what the physician has written.

Diagnosis Documentation Tips

Write clearly and firmly enough to print on all chart copies (billers often receive the last copy).
Only use standard, accepted abbreviations.
List as the first diagnosis the most important reason/problem for which the patient came to the emergency department.
Note complications such as "vomiting with dehydration".
Utilize appropriate symptoms when a definitive diagnosis is not possible.
Avoid non-urgent diagnoses such as constipation (use presenting symptoms such as generalized abdominal pain instead).
Diagnosis specificity is important. List the site of pain or injury. It is especially important to give the specific site of abdominal and pelvic pain. Possible specific sites for abdominal pain include right upper quadrant, right lower quadrant, left upper quadrant, left lower quadrant, periumbilic, epigastric or generalized.

5. Compliance Digest

Physicians Can Control Compliance Risk Through Education And Self-Monitoring
Examining "inadvertent risk" vs. "intentional fraud"

Physicians Can Control Compliance Risk Through Education And Self-Monitoring

Surveys and anecdotal feedback indicate that compliance issues rank near the top of the concerns of emergency physicians. Compliance should be a concern but not a barrier to practicing medicine. What many physicians really fear is a pervasive sense of lack of control over the issues surrounding compliance regulations.

This article is intended to provide emergency physicians with news you can use to take control of some of these challenging compliance issues. When you adopt certain principles as "standard operating procedure," you can practice medicine more confidently.

Inadvertent error vs. intentional fraud

For example, from a reimbursement compliance perspective, what is an "inadvertent error?". When does an error cross the threshold and qualify as intentional fraud? How can physicians possibly guard against inadvertent errors in their billing? After all, physicians and their coders and support staff are human, and prone to a certain degree of human error even under the best of circumstances.

Compliance regulations are designed to prevent, identify and punish intentional wrongdoing. But what if you are among the vast majority of honest, ethical physicians? Should you have to lose sleep at night fearful of inadvertent compliance violations committed by yourself or someone on your team? These are some of the vexing questions that make emergency physicians uneasy about compliance with regulations relative to reimbursement.

Asserting control over compliance risk

"An ethical physician can't ignore compliance, but by making an effort to become educated about compliance issues and implementing some fairly straightforward practices, physicians can assert control and greatly reduce the likelihood of a serious compliance violation," said Jean Schendel, a partner with the law firm of Hunt Suedhoff Kalamaros in Fort Wayne, Indiana, who practices in the areas of health care and compliance issues.

So what's the solution? There are several strategies that emergency physicians can use to take control of their compliance risk:

Operate ethically, with only honest intent. For the vast majority of physicians, this is the easy part. But being honest and ethical is not enough. Some important programs must be in place to show evidence of your good-faith intentions.
Educate yourself and your staff about compliance issues. This is absolutely crucial. You cannot bury your head in the sand relative to compliance issues, because you can be penalized for "deliberate ignorance of the truth" or "reckless disregard for the truth."
Establish and maintain an effective compliance program. Seven key elements of a compliance program are outlined in the article entitled 'OIG Releases New Draft Compliance Program for Physician Practices'.
Conduct periodic internal reviews. Expect to find occasional irregularities perhaps due to human error or other circumstances. If you discover overpayments, make arrangements to refund the appropriate amount of money immediately.

When conducting internal reviews, know when to bring in outside counsel from an attorney or other professionals, and know when/whether to document the corrective action you have taken.

The good news is that with prudent "due-diligence" efforts, a physician who practices medicine ethically can optimize appropriate revenues while controlling compliance risk.

The concept of intent is important

"Many of these steps are designed to demonstrate that the physician has no intent to commit fraud," Schendel said.

"The concept of intent is key," Schendel said," because to successfully prosecute a criminal charge, the government must prove that the violation was intentional."

Three criteria define fraudulent intent

Criteria for defining "intentional" fraud include the presence of one or more of the following conditions:

The physician had actual knowledge of a misdeed.
The physician exercised deliberate ignorance of the truth or falsity of a claim. ("A good compliance program provides solid evidence that a physician is not acting out of deliberate ignorance," Schendel said.)
The physician acted in reckless disregard of the truth or falsity of a claim.
"The key to avoiding these situations is to conduct effective self-monitoring," Schendel said. "People are human physicians and their staff and coding professionals. So occasional irregularities are by themselves not alarming, if it can be shown that there was no fraudulent intent, and if they can be quickly remedied."

Steps for self-monitoring

Schendel suggests certain steps to follow when an irregularity is found during an internal review:

Review the facts and circumstances.
Determine the best person to conduct the review. This may be the physician, or the group's appointed compliance officer, or an outside attorney or consultant. Determine what documents -- charts, charge sheets, etc., may be relevant to the situation.
Take corrective action, i.e. returning an overpayment immediately.
Determine steps that can be taken to prevent recurrence.
Determine whether "intent" exists or seems apparent, based on the following three criteria.
"If the physician discovers a violation that suggests a fraudulent intent, he or she should stop the investigation and immediately bring in an attorney," Schendel said. "Other consultants may be helpful as well -- a professional coder, for example. Consulting unbiased outsiders displays evidence that the physician is not operating out of fraudulent intent. Consulting an attorney can also increase the likelihood that certain information can be protected by the attorney-client privilege," Schendel said. "There are few certainties in this area regarding keeping documents protected under the attorney-client privilege. But one thing is certain -- without your attorney involved, you obviously forfeit any possibility of asserting the privilege to protect documents."
Consult with your attorney on whether a verbal or written final report is appropriate.
"The process need not be complex," Schendel said. "For a minor problem, these steps can be handled quite easily. For more serious violations, any steps you take to correct the problem and prevent recurrence will be well worth the effort."

OIG Releases New Draft Compliance Program for Physicians Practices
The Office of the Inspector General (OIG) released the draft compliance plan for physician practices on June 7, 2000. (A copy of this document is available at:

http://www.hhs.gov/progorg/oig/modcomp/cpgphysiciandraft.htm.) The draft compliance program is intended to provide guidance to individual and small group practices in developing and implementing internal controls and procedures to promote compliance with the Federal health care program regulations.

The seven elements set forth in the Federal Sentencing Guidelines are the basis of the compliance plan draft guidelines. The draft compliance program description makes clear that the OIG does not seek to subject physicians to criminal or civil penalties for innocent errors, or even negligence. The False Claims Act serves as the primary enforcement tool for Federal health care program regulatory enforcement, and this statute covers offenses that are committed with "actual knowledge of the falsity of the claim, reckless disregard, or deliberate ignorance of the falsity of the claim." However, "reckless disregard" and "deliberate ignorance" are rather subjective concepts, and they clearly imply substantial risk to any physician who chooses to ignore compliance issues in the hope that "this too shall pass."

The seven key elements of a compliance program are as follows:

Establishing compliance standards through the development of a code of conduct and written policies and procedures;
Assigning compliance monitoring efforts to a designated compliance officer or contact;
Conducting comprehensive training and education on practice ethics and policies and procedures;
Conducting internal monitoring and auditing focusing on high-risk billing and coding issues through performance of periodic audits;
Developing accessible lines of communication, such as discussions at staff meetings regarding fraudulent or erroneous conduct issues and community bulletin boards, to keep practice employees updated regarding compliance activities;
Enforcing disciplinary standards by making clear or ensuring employees are aware that compliance is treated seriously and that violations will be dealt with consistently and uniformly; and
Responding appropriately to detected violations through the investigation of allegations and the disclosure of incidents to appropriate Government entities.

The draft guidelines note that a physician's participation in another provider's compliance plan (such as a hospital or third party biller) could help satisfy recommended elements of the physician practice's compliance plan. However, the compliance plan developed by each practice should be specific to the particular needs of that practice, and not simply a copy of the compliance plan elements from another physician practice. One of the key steps in determining which particular areas each practice's compliance program needs to address is to conduct a risk assessment to list areas where the practice may be vulnerable. These risk areas should include coding and billing, reasonable and necessary services, documentation, and improper inducements, kickbacks, and self-referrals. Billing areas that have been frequent subjects of investigations and audits by the OIG include:

Billing for items or services not rendered or not provided as claimed;
Submitting claims for equipment, medical supplies and services that are not reasonable and necessary;
Double billing;
Billing for non-covered services as if covered;
Knowing misuse of provider identification numbers which results in improper billing;
Billing for unbundled services;
Failure to properly use coding modifiers;
Upcoding level of service provided.
All physician practices should develop a compliance program that addresses the seven basic compliance elements, while taking into consideration the practice's particular needs and issues. Although many physicians regard compliance planning as an intrusion into their ability to provide clinical care, an effective compliance program can actually have the opposite effect, and make a physician's clinical practice more effective and efficient. This occurs as a result of establishing

clear policies and procedures for the physicians and office staff to follow, and the resulting streamlining and standardization of work processes, training, and lines of communication. In short, a good compliance program makes good business sense beyond reducing exposure to civil and criminal penalties from noncompliance.

Understanding the New Ambulatory Patient Classification System
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Ambulatory Patient Classifications (APC) became effective for hospital outpatient payment on

August 1, 2000. The new payment system divides all hospital outpatient services into 451 groups which are clinically similar and require similar resources to provide. In essence, APCs are a fee schedule that will reimburse hospitals based on the services they provide. Previously, hospital outpatient services were reimbursed based on reported costs.

The final rule from HCFA establishing the APC methodology for outpatient payments was published in the April 7, 2000 Federal Register. (The final rule on APCs is available on-line at http://www.hcfa.gov/regs/hopps/default.htm.) The final APC methodology did not include any linkage of diagnoses to the APC to modify payment, although hospitals will still have to report diagnosis codes. In addition, the final rule made clear that HCFA does not expect correlation between the physician's coding of a visit level and the hospital's coding of the same visit. The APC final rule also does not require hospitals to ensure that physician documentation supports the level of APC visit billed, and the evaluation and management code documentation guidelines that apply to physicians do not apply to APCs. However, hospitals are required to establish and consistently apply an internal system for assigning codes and ensuring adequate documentation and medical necessity of services billed.

APC visit payments contain bundled services such as pharmacy, central service, and other departments. However, additional payment will be provided for additional procedures and services such as casting and splinting, certain drugs and pharmaceuticals, blood and blood products, wound repair, radiology studies, and lab tests, among others. However, observation services will not be paid separately, since observation services are considered bundled into the APC payment for the emergency department visit.

The 4 APCs for ED visits

The four APCs for emergency department visits are based on the CPT evaluation and management (E/M) codes. These APCs are:

610 (based on E/M codes 99281 and 99282)
611 (based on E/M code 99283)
612 (based on E/M codes 99284 and 99285)
620 (based on critical care code 99291)

The bottom line with APCs is that even though they do not directly affect emergency physician reimbursement, they will have a significant impact on hospital billing and reimbursement of outpatient services. Thus, it is important for emergency physicians to become educated in APCs and work constructively with their hospital to help prevent hospital interpretation of APC rules from negatively impacting the emergency physicians.

Teaching physicians (Medicare Policy) « Back to top »
Teaching hospitals represent approximately one forth of the hospitals participating in the Medicare program. In 1995, HCFA began to clarify the conditions under which a teaching physician can bill for patients jointly seen with residents. A brief note indicating "discussion" with

or "supervision" of the resident is insufficient, because HCFA considers that this level of the teaching physician's responsibilities is already reimbursed to the institution through Graduate Medical Education (GME) payments.

The teaching physician must be personally involved in the key components of patient care, and must document in the medical record his or her participation in the service. The key components include 1) relevant history of present illness and prior diagnostic tests, 2) major findings on physical examination, 3) assessment, clinical impression or diagnosis, and 4) plan of care. Documentation of key elements in each of these components may be satisfied by combination of medical record entries made by the resident and the teaching physician.

When billing for minor procedures (i.e., those taking five minutes or less to complete), the teaching physician must be present during the entire procedure. For all other procedures, the teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure (the teaching physician must document his/her presence in the key portion of the procedure).

When billing for critical care services, the medical record must demonstrate that the teaching physician documented that he/she was physically present for the time for which the claim is made. This documentation of time spent caring for the patient could be substantiated in nursing notes if absent from physician documentation. Time spent by the resident in the absence of the teaching physician cannot be included. No other methodology is as good as timed physician notations documenting the time the physician spent in constant attendance of the patient. This applies to any time-based code.

In summary, if a teaching physician relies upon any part of a resident or fellow's documentation in order to substantiate a service billed to Medicare in his/her name, he/she must follow the Medicare documentation rules for teaching physicians. HCFA requires the use of the "GC modifier" when coding all claims where the service was performed in part by a resident under the supervision of a teaching physician. The complete text of the HCFA final rule for teaching physicians is available on the ACEP Web site at www.acep.org.

Source: American College of Emergency Physicians, © 1999, 2000.

Compliance Q & A « Back to top »
The following questions and answers are excerpted with permission from the ACEP report, "Fraud, Compliance & Emergency Medicine." The complete report is posted on the ACEP Web site at www.acep.org.

Q. Is it better to have an outside entity do our group's routine compliance audits, and how many charts should be reviewed in this exercise?

A. The purpose of a periodic internal review is to self-monitor your compliance program. There may be a perceived benefit from having an outside entity perform this function. In either case, the sample of charts used for such monitoring should be of sufficient size to provide a good cross-section of your coding and billing practices. HCFA provides no guidelines regarding the absolute number of charts to be audited, and there is wide variability with regard to what constitutes an appropriate number. The real issue is to evaluate each of the physicians in the group to determine whether there are patterns.

Q. Is there any special compliance requirement for the 99285 acuity caveat?

A. The key components of emergency department E/M code 99285 are a comprehensive history, comprehensive physical examination, and medical decision-making of high complexity. The level 5 acuity caveat that pertains to code 99285 is based on the language in the CPT book that reads "...requires these three key components within the constraints imposed by the urgency of the

patient's clinical condition and mental status." HCFA has apparently adopted the CPT coding principle that allows a physician to defer the usual requirements of performing these key components of 99285, if the patient's condition and mental status do not reasonably allow these elements of the E/M service to be fully provided, and if the patient's presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function. However, some regional Medicare carriers apply the caveat to only the history component, while others apply the caveat to both the history and examination components, but not medical decision-making. Physicians should state why the caveat is being invoked in their documentation of the patient encounter.

Source: American College of Emergency Physicians, © 1999, 2000.

Frequently Asked Questions on Compliance Issues « Back to top »
Q. Am I liable for any coding errors made by the hospital that does my billing?
A. The government maintains that ultimately the provider of services is responsible for claims filed using his/her provider number. The principal is responsible for the acts of the agent.

Q. I never see the charts after I finish with them. Someone else does the coding and billing. Am I in compliance?
A. Perhaps. Compliance is an outcome measure. If your documentation and the subsequent coding and billing are in compliance, then you will be in compliance. If, however, the documentation, coding, and/or billing are not in compliance, then you might not be in compliance. The best way to assure that you are in compliance is to be familiar with the billing practices and compliance plan of any facility or group with whom you do business.

Q. Can I just use the OIG Model Compliance Plan for my group/facility compliance plan?
A. No, the OIG specifically states that its document is not a model compliance plan or program but rather only provides suggested guidelines with regard to what should be taken into account for the content of your plan. You must tailor these guidelines to your specific situation for your plan and program to have any value.

Q. Won't a compliance plan just be used against me in the case of an audit?
A. Absence of a compliance plan will not help you in cases of bad audit outcomes. Making the effort to produce an effective compliance plan demonstrates an attempt to understand and follow the rules and makes it harder to apply the "willful and knowingly committed fraud" or the "willful blindness" tests for fraud, unless you fail to follow your compliance plan. A compliance program is essentially a quality control devise. It can't hurt you unless you don't pay attention to it.

For more information on how PMB can help you control your compliance risk, simply call Linda Pearce at (260) 407-8003 or email us.