Emergency Department Coding

Audio Seminar/ Webinar

October 2, 2007

Practical Tools for Seminar Learning

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Objectives

- What’s included in Critical Care, CPR, and Intubation and Fracture Care for facilities
- Proper Burn Coding
- When to code Splints and Strapping
- What’s considered a Treatment Room
- Identify Problem Procedures
- Guidance for Facility E/M
- Simplify IV Coding
- Identify New Diagnosis Codes Pertaining to the ER
- Understand Coding for Medical Necessity
- Proper Use of Modifiers
- OPPS and how it affects you in FY 2008

OPPS – Facility Charge Guidelines

- In the outpatient arena of healthcare, CMS moved to a system much like DRGs called APCs. The difference is that only one DRG is paid, whereas multiple APC payments may be made for one visit.
- CMS continues to try to construct facility E/M levels to reflect the acuity of care patients receive (national guidelines). Until then, each hospital is allowed to construct their own facility levels based on the acuity of care patients receive and to some extent the resources provided.
Facility Charge Guidelines

- CMS - moving away from fee for service
- OPPS/ APCs - caused restructuring of ED levels
- Facility levels reflect the acuity of care the patient receives
- Status indicator - describes how services are treated under OPPS for hospital outpatient departments

Facility E/M Determination

- Five levels - CPT 99281 - 99285
- Critical care - CPT 99291 - code also any procedures performed
- Third party payers may not pay additional $\frac{1}{2}$ hours of critical care on the facility side
- All procedures performed by physicians and ancillary staff must be coded
- Review nursing notes for procedures performed
Critical Care

- Beginning in 2007, nurses must also document duration of critical care time in order to charge E/M 99291. (Less than 30 minutes of care does not support critical care)
- Remember - if it is not documented, it did not happen.

Cardiopulmonary Resuscitation

- Cardiopulmonary Resuscitation (CPT 92950) found in cardiac arrest only includes the actual bagging of the patient and external cardiac massage.
- Drugs given during cardiac resuscitation should be coded separately using CPT 90774 / 90775.
Intubation

- Endotracheal Intubation (CPT 31500) is an emergency procedure done to establish an airway.
- Rapid Sequence Intubation (RSI) includes total body paralysis in order to control the scene, paralyze the vocal cords (muscle relaxation) and protect the airway from aspiration. For RSI - IVP drugs are used and should be coded in addition to CPT 31500.

Burns

- The burn patient has the same priorities as all other trauma patients
  - Assess - airway, breathing, circulation, disability, and exposure
  - Essential management points - stop the burning, good IV access and early fluid replacement
  - Severity of the burn is determined by burned surface area, depth of burn and determining the percentage of the burn
**Rule of 9s**

- Commonly used to estimate the burned surface area in adults
- The body is divided into anatomical regions that represent 9% (or multiples of 9%) of the total body surface. The outstretched palm and fingers approximate to 1% of the body surface area.
- If the burned area is small, assess how many times your hand covers the area.
- Morbidity and mortality rise with increased burned surface area.

**Estimating the Burned Surface Area in Adults - Rule of 9’s**
Estimating the Burned Surface Area in Children - Rule of 9's

<table>
<thead>
<tr>
<th>Area</th>
<th>By age in years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Head (A/D)</td>
<td>1.0%</td>
</tr>
<tr>
<td>Thigh (B/E)</td>
<td>3%</td>
</tr>
<tr>
<td>Leg (C/F)</td>
<td>2%</td>
</tr>
</tbody>
</table>

Burns - continued...

- Burns greater than 15% in an adult or greater than 10% in a child, or any burn occurring in the elderly or very young are serious
Three Types of Burns - code to the highest degree per site

- First degree burn - erythema, pain, absence of blisters
- Second degree (Partial Thickness) burn - red or mottled skin, flash burns
- Third degree (Full Thickness) burn - Dark and leathery skin, dry skin

Burn Treatments - Dressing and Debridement

- CPT 16000 - treatment of a 1% degree burn. Includes a simple cleaning and application of an ointment or dressing
- CPT 16020 - dressing/debridement of a small area burn without anesthesia
- CPT 16025 - dressing/debridement of a medium area, such as a whole face or whole extremity without anesthesia
- CPT 16030 - dressing/debridement of a large burn area (more than one extremity) without anesthesia
Polling Question #1

A patient presents to the ED with an order from their PCP for IM Rocephin x 3 days for otitis media. How do you code?
Choose applicable diagnosis code(s)

*1 ICD - 382.9 CPT 99281 / 90772
*2 ICD - 382.9 CPT 99281
*3 ICD - 382.9 CPT 90772

Fracture Care Services

- Physician in ED must provide the definitive care such as “manipulation,” “stabilization,” “fixation,” or “restorative care.”
- Initial treatment and stabilization of a fracture is considered the “significant portion” of care under CMS rules.
Fracture Care Services not included:

- Follow-up care
- Evaluation and Management services prior to the procedure and/or unrelated to the injury necessitating the fracture care service
- Billing a facility E/M is appropriate as long as there are separately identifiable services performed, documented, and medically necessary.

Splints and Strapping

A device that provides emergency immobilization for any injury suspected of fracture, dislocation or subluxation

- Static Splints - keep an injury immobilized
- Dynamic Splints - allow for movement (splints that have a joint or are hinged)
Splints / Strappings not coded

- Ace bandages
- Slings
- Post op shoe or boot
  (These are considered supplies and are reported only as supply items)
- Off the shelf splints?????

When to Code Splints (facility)

- Code splints when the definitive fracture care is not provided (coded)
- Normally splints are coded in addition to an E/M code, they are not coded in addition to a fracture care code.
ED Treatment Rooms

- Do not bill E/M with drug administration charge when an infusion is the sole reason for the visit.

- 2007 OPPS Final Rule - “Providers should bill a low-level visit code in such circumstances only if the hospital provides a significant, separately identifiable low-level visit in association with the packaged service.”

Polling Question #2

Patient presents to ED with a fish hook embedded in the forearm while fishing in a pond. Physician removed fish hook by pulling it through the skin. Choose diagnosis and procedure code(s)

* 1 ICD 881.10+ E-codes, CPT E/M level
* 2 ICD 881.10+ E-codes, CPT E/M level and 10120
* 3 ICD 881.10+ E-codes, CPT 10120
Problem ED Procedures: I & Ds

- CPT 10060 is used for simple/single incision and drainage of abscess. The physician makes a small incision through the skin overlying an abscess allowing it to drain.
- CPT 10061 is used for multiple or complicated incision and drainage of abscess. The physician may place a drain or packing to allow continued drainage.

Problem ED Procedures: Suture Repairs

- Simple - superficial single layer suture or staple (or Dermabond)
- Intermediate - layered closure or single layer with debridement or removal of foreign body. Extensive cleaning, debridement or removal of particulate matter with a 1-layer closure qualifies as an intermediate repair.
- Complex - multi-layers or revisions
Problem ED Procedures: Fish Hook Removal

- Fish hook removal in the ED is an on-going coding discussion
- Two ways to code:
  - Go up one E/M level
  - Code CPT 10120 (Foreign body removal with incision)

IV Hierarchy

November 2005 CPT Assistant, Volume 15, refers to this as a primary and secondary hierarchy

- Chemo infusions (96409)
- Chemo injections (96413)
- Non-chemo, therapeutic infusions (90765, 90766, 90767, 90768)
- Non-chemo, therapeutic injections (90774, 90775)
- Hydration infusions (90760, 90761)
**IV Documentation**

- **Sample Nursing Documentation**
  - Documented as IV, IVP, or IVPB
  - “IV med given over 30 minutes” can be coded as an IVPB (90765, 90766, 90767, 90768)
  - “Rocephin IVPB started at 10:30. No other times documented;” codes to one IVP.
**Emergency Department Coding**

**IV PUSH AS INITIAL SERVICE**

If hydration therapy is begun but it’s not the primary service, code 90761 for each hour infused.

- Did IV push infusion last less than 16 minutes?
  - Yes: Code to initial IV Push 90774
  - No: Code to initial therapeutic infusion 90765

- Were IV meds or infusions lasting 16 minutes or more given?
  - Yes: Code 90766 as many times as needed for each hour of infusion of same type of med
  - No: Code 90772 for each IM injection

- Was a second or subsequent drug started after the initial drug?
  - Yes: Code 90767 (can only be used once per drug)
  - No: Code 90768 can only be reported once per pt encounter

**THERAPEUTIC/DIAGNOSTIC THERAPY AS INITIAL SERVICE**

If hydration therapy is begun but it’s not the primary service, code 90761 for each hour infused.

- Did infusion last at least 16 minutes?
  - Yes: Code to initial IVP 90774
  - No: Code to initial infusion 90765

- Did the infusion last at least 1 hour and 31 minutes?
  - Yes: Code 90766 for each additional hour of infusion
  - No: Code 90767 as many times as needed for each IVP (can only be used once per drug)

- Were IM meds given?
  - Yes: Code 90772 for each IM injection
  - No: Code 90768 (can only be reported once per pt encounter)
2008 ICD-9-CM Diagnosis Codes

Herpes Simplex
Old 054.9

- 058.1x Roseola infantum
  Exanthema subitum (sixth disease)
  Subdivided by that caused by HHV-6 or HHV-7
- 058.2x Other human herpesvirus encephalitis
  Subdivided by that caused by HHV-6 or HHV-7
- 058.8x Other human herpesvirus infections
  Subdivided by that caused by HHV-6 or HHV-7
  HHV-8, also known as Kaposi’s sarcoma
  associated herpes virus

Diagnosis Codes continued

Coronary Atherosclerosis
Old 414.00-414.07

- New 414.2 Chronic total occlusion of coronary artery
  Complete occlusion of coronary artery
  Total occlusion of coronary artery
  Code first coronary atherosclerosis (414.00-414.07)
  Excludes: acute coronary occlusion with myocardial
  infarction (410.00-410.92)
  Acute coronary occlusion without myocardial infarction
  (411.81)
- New 440.4 Chronic total occlusion of artery of the extremities
  Complete occlusion of artery of the extremities
  Total occlusion of artery of the extremities
  Code first atherosclerosis of arteries of the extremities
  (440.20-440.29, 440.30-440.32)
  Excludes: acute occlusion of artery of extremity (444.21- 444.22)
Avian Influenza Virus
Old Codes 487.0 - 487.8

- New Code 488
- Influenza caused by influenza viruses that normally infect only birds and, less commonly, other animals
- Excludes: influenza caused by other influenza viruses (487)

Dysphagia
Old Code 787.2

- 787.20 Dysphagia, unspecified
  Difficulty in swallowing NOS
- 787.21 Dysphagia, oral phase
- 787.22 Dysphagia, oropharyngeal phase
- 787.23 Dysphagia, pharyngeal phase
- 787.24 Dysphagia, pharyngoesophageal phase
- 787.29 Other dysphagia
  Cervical dysphagia
  Neurogenic dysphagia
**Diagnosis Codes continued**

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**Ascites**

- **789.51 Malignant ascites**  
  Code first malignancy, such as: malignant neoplasm of ovary (183.0), secondary malignant neoplasm of retroperitoneum and peritoneum (197.6)

- **789.59 Other ascites**

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**Diagnosis Codes continued.**

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**Personal History Codes**

- **V12.53** Sudden cardiac arrest  
  Sudden cardiac death successfully resuscitated

- **V12.54** Transient ischemic attack (TIA), and cerebral infarction without residual deficits

- **V13.22** Personal History of cervical dysplasia
Family History Codes

- V16.52 Family History of malignant neoplasm, bladder
- V17.41 Family History of sudden cardiac death (SCD)
- V17.49 Family History of other cardiovascular diseases
- V18.11 Family History of multiple endocrine neoplasia (MEN) syndrome
- V18.19 Family History of other endocrine and metabolic diseases

Old Codes Worth Mentioning...

Fussy Infant - 780.91
Excessive Crying of Infant - 780.92
Long-term use of Meds - V58.6x
Medical Necessity

- Medically Necessary means that a service, supply or medicine is necessary and appropriate and meets the standards of good medical practice in the medical community for the diagnosis or treatment of a covered illness or injury, as determined by the insurance company.

- Review National Coverage Decisions (NCD)
- Review Local Medical Review Policies (LMRP)
- NCDs take precedence over LMRPs

Medical Necessity continued

- Code Signs and Symptoms to support test
- May code diagnoses from the Radiology Report
- “Rule out” or “probable” diagnoses not acceptable
- May not code results from Lab tests
Supporting Coding References

- AHA Coding Clinic for ICD-9-CM
  - 2Q 2002, Volume 19, Number 2, Page 3
  - 1Q 2000, Volume 17, Number 1, Page 4
- 10/01/07 ICD-9-CM Official Guidelines for Coding Section IV: Diagnostic Coding and Reporting Guidelines for Outpatient Services

Modifiers

- Modifier 25
- Modifier 52
- Modifier 59
- Anatomical Modifiers
Modifier -25

- Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service
- Use on E/M codes only
- Ask yourself “is the patient presenting with a chief complaint requiring evaluation to determine treatment?”

Modifier -52

- Services that were partially reduced or eliminated at the physician’s election.
- Procedure or service is being performed at a lesser level.
- Not for use on procedures requiring anesthesia (general, regional, or local.)
**Modifier -59**

- Procedure or service was distinct or independent from other services performed on the same day.
- Indicates that the procedure is not considered to be a component of another procedure, but instead is a distinct independent procedure.

**Anatomical Modifiers**

- Often used incorrectly.
- Shouldn’t be used on codes which cover multiple body areas.
- Do not use LT or RT to report bilateral procedures.
**OPPS Changes for 2008**

- Expand the use of “packaging” under OPPS
- Use composite APCs (2 in 2008)
- Implement a set of “general principles” that CMS believes hospitals should adhere to in formulating their own internal facility visit coding guidelines
- Establish a hospital outpatient quality data reporting program for 2008

**CMS-2008**

**E/M Guideline Direction**

- Based on hospital facility resources
- Clear and usable for compliance purposes and audits
- Meet the HIPAA requirements
- Require documentation that is clinically necessary for patient care
- Should not facilitate upcoding or gaming
- Written or recorded, well-documented, and provides the basis for selection of a specific code
- Applied consistently across patients in the clinic or ED to which they apply
- Should not change with great frequency
- Readily available for fiscal intermediary (or, if applicable, Medicare Administrative Contractor) review
- Should result in coding decisions that could be verified by other hospital staff members, as well as outside sources.
Case Study #1

- 2 year old patient presents to the ED with a fever of 103.2 for 2 days. CBC, Chem 7, and CXR were all negative. Spinal tap was attempted with no fluid obtained. Patient given IM Rocephin and told to follow-up with PCP in the morning.
- DX - fever, unknown origin
- Code diagnosis and procedures.

Case Study #2

- 12 year old fell off skateboard and hurt left wrist.
- DX - undisplaced fracture of distal radius and ulna. Ulnar gutter splint applied and patient told to follow-up with ortho in 1 week.
- Code diagnosis and procedures.
Case Study #3

- Patient admitted to ED with nausea, vomiting and diarrhea. 
  DX - gastroenteritis, nausea and vomiting with dehydration
- Patient given IVP Zofran @ 2010, IVP Reglan @ 2015, IVP Zofran @2115 and IV NS Bolus @ 2000. No other nursing documentation.
- Code diagnosis and procedures.

Case Study #4

- Patient admitted to the ED with rash on his legs. 
  DX - cellulitis of both legs
- I&D performed with minimal pus obtained from one abscess and none from the other. Patient given IM Rocephin.
- Code diagnosis and procedures.
Resource/Reference List

- NCD/LMRP

- CMS MedLearn Matters Articles
  http://www.cms.hhs.gov/MLNMattersArticles/

- CMS Modifier 59 Article

- NCCI Edits
  http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCI Edits/NCCI HOPPS/List.asp#TopOfPage

- American College of Emergency Physicians
  www.acep.com


Resources continued....

- Federal Register
- Program Transmittals
- AMA’s 2007 CPT Book and Coder’s Desk Reference
- Part B Coding Answer Book by Ingenix
- ED Answer Book - Decision Health
- APC Weekly Monitor
- ED Coding Alert
- AHIMA Coding Assessment and Training Solutions - Emergency Room Coding in Hospitals
  http://campus.ahima.org/campus/course_info/CATS/CATS_newtraining.html#er
Audience Questions

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• October 18, 2007

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• October 30, 2007
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