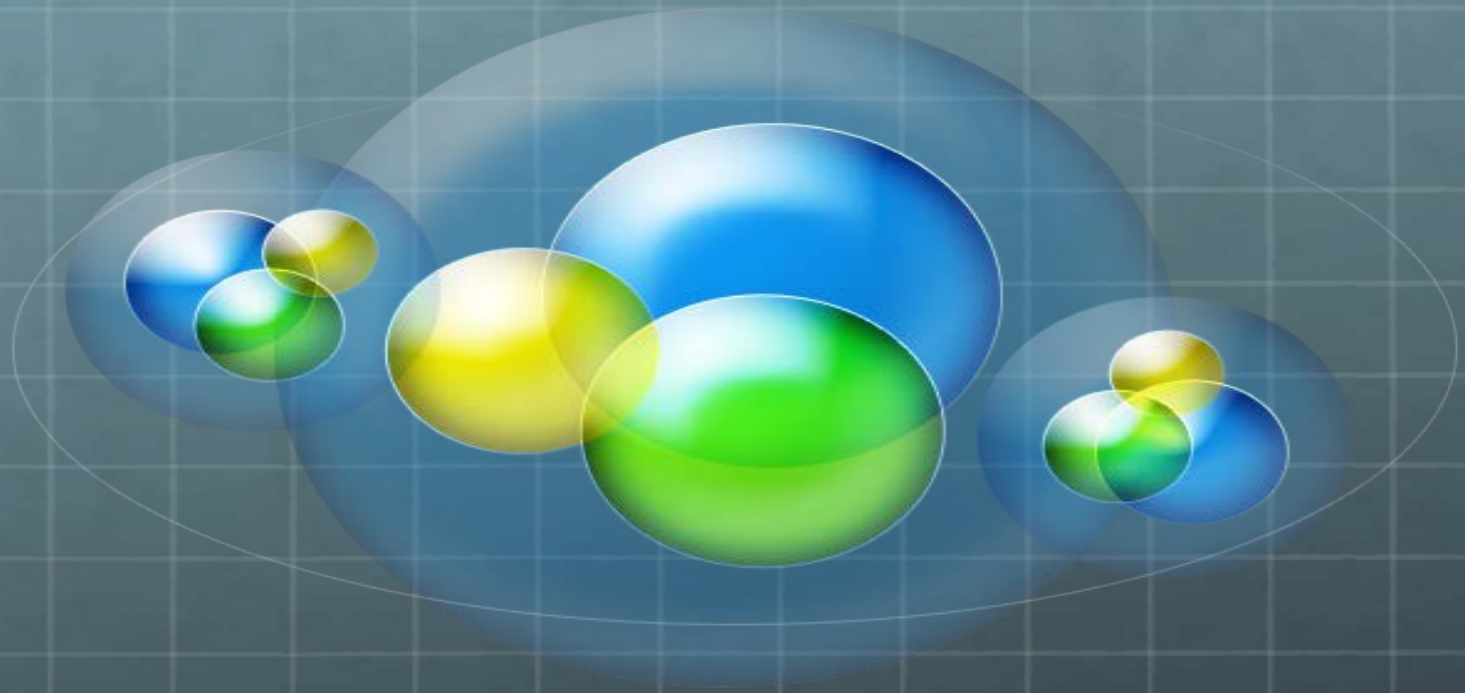

ED Documentaion Update

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OBJECTIVES

1. Basic Documentation
2. Overview of ED billing and coding
3. Critical Care
4. MIPS
5. Contracting and Reimbursement

For Starters:

Documentation

- To be able to collect you must document appropriate
- There are 6 basic ED coding levels
- ED Levels1-5, and Critical care
  - Not related to ESI triage levels
- Timely completion of EMR is critical

	99281	99282	99283	99284	99285
Chief Complaint	Required	Required	Required	Required	Required
History of Present Illness	1-3 Elements	1-3 Elements	1-3 Elements	4-8 Elements	4-8 Elements
PMH, FH, SH	N/A	N/A	N/A	1 of 3 Required	2 of 3 Required
Review of Systems	1 System	2 System	3 System	2-9 Systems	10+ Systems*
Physical Exam	1 System	2-7 Systems	2-7 Systems	5-7 Systems	8+ Systems
Medical Decision Making	Straightforwardd	Low	Moderate	Moderate	High

*** You can list positive responses and pertinent negatives followed by "All other systems negative".**

Level 1-5

HPI Elements	Body Areas	Organ Systems	ROS
Location	Head	Constitutional	Constitutional
Quality	Neck	Eyes	Eyes
Severity	Chest	E.N.T.	E.N.T.
Duration	Abdomen	Cardiovascular	Cardiovascular
Timing	Genitalia	Respiratory	Respiratory
Context	Back	G.I.	G.I.
Modifying Factors	Extremities	G.U.	G.U.
Associated Signs & Symptoms		Musculoskeletal	Musculoskeletal
		Integumentary	Integumentary
		Neurologic	Neurologic
		Psychiatric	Psychiatric
		Hema/Lymp	Hema/Lymp
			Allergic/Immun.
			Endocrine

Medical Decision Making

- Much of coding depends on complexity
- Ankle sprain is an ankle sprain
- 85 yo syncope with ankle sprain is not
- You MUST tell a story in the MDM

Medical Decision Making

- Do not use this medical decision making

MDM

Number of Diagnoses or Management Options
MVC (motor vehicle collision): new and requires workup
Thigh contusion: new and requires workup

Amount and/or Complexity of Data Reviewed
Tests in the radiology section of CPT®: reviewed and ordered

Risk of Complications, Morbidity, and/or Mortality
Presenting problems: moderate
Diagnostic procedures: low
Management options: low

Medical Decision Making

- **Tell story but include thought process - DDx**

ED Course/Re-Evaluation Here we have a [redacted] female who comes in with a history of abdominal pain, nausea or vomiting, fevers. On exam she has a low-grade fever, abdomen soft and nontender, hemodynamically stable. Lab work results show mild leukocytosis, otherwise unremarkable. After medications she feels much better, abdomen remains benign, I see no indication for emergent imaging on her exam. Given the long duration of symptoms I will start her on a antibiotic regimen. Advised to return for any worsening symptoms.

Critical Care Billing

99291
HPI with 4 modifiers required
30+ Minutes Required
Time Excludes Procedures
Only include time spent on Pt.
Not all Time is Face-To-Face
Labs, X-Rays, Consults, Etc.

- Must dictate critical care time is exclusive of procedure time

Critical Care

- A 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.

- Critical care involves high complexity decision making to assess, manipulate, and support vital system functions(s) to treat single or multiple 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

- Give a story
- Document “critical care” time excluding procedures
  - Exact number, not a range
- Poor example

DOCTOR NOTES
NOTES: Pulmonary emboli. Heparin as per PE protocol. Pt. admitted by hospitalist. [redacted]
CRITICAL CARE: Time spent providing critical care to patient was 30-74 minutes, 60 minutes, Total number of minutes spent in care of this critically ill patient excluding procedure time. [redacted]

Critical Care

- Some indicators of Critical Care
- Acidosis
- Anaphylactic shock
- Pneumothorax
- Angina, unstable, aggressive mgmt
- Pulmonary edema , emboli
- Atrial fibrillation w/ tachycardia
- Rapid heart rate requiring IV therapies
- Blood, loss, PRBC’ s hung, GI bleed
- Seizure, new onset or w/disorder hx, postictal w/ intensive drug mgmt
- Cardiac arrest
- Comatose/unconscious, unknown cause
- Sepsis/septicemia
- Severe bleeding, requiring transfusion
- COPD/CHF w/severe exacerbation
- Shock – unresponsive patient
- Dehydration w/ significant metabolic/ blood chemistry changes
- Status Asthmaticus
- Status Epilepticus
- Glasgow Coma Scale below 14
- Stroke
- Head injury, severe unresponsive
- Hypoxia/hypoxemia

Proper Coding

- Every miscoded chart can cost you $11,000 in fines and penalties
- If you think this is a problem get an external audit by a qualified ED Coding expert
- Correct problems immediately and self report if necessary after seeking counsel
- Notify your employer if your receive correspondence from payers

Physician Extenders

- PA’s and NP’s
- Can bill either 85% if seen alone
- Can bill 100% if physician has face to face time

MIPS-ED

- Yes, the government is incentivizing us to practice medicine within published guidelines
- Know which measures you are participating in
- If you are doing something that is not part of MIPS, plan to document why

MIPS- ED

- Measure 66- Children with pharyngitis
  - Must indicate that a strep test was performed to give abx
  - No excuse not to
- Measure 116: No abx for bronchitis
  - Can document a reason

MIPS-ED

- Measures 415/416 CT for minor head trauma
  - If obtaining a CT, identify why

History of Present Illness

The patient presents following MVC xPTA. Pt reports he was a seatbelted driver when he was hit head on by a truck pulling wood. EMS at bedside captured picture of accident showing pts van had significant vehicle damange with near complete removal of front end of his vehicle up to his windshield. Pt states airbag did not deploy. Pt states HA, back pain, and neck pain and currently is on a backboard, c-collar in place per EMS. Pt denies syncope, head injury, LOC, back pain, abdominal pain, N/V/D, SOB, or chest pain. The onset was just prior to arrival. The Collision was front impact and moderate speed. The patient was the driver. There were safety mechanisms including seat belt, no airbag. Location: neck, back head. The degree of pain is moderate. The degree of bleeding is none. Risk factors consist of none and not unrestrained. Therapy today: emergency medical services.

  - Dangerous mechanism- need to say this
  - Special populations
  - ASA not a good reason

MIPS-ED

- Measure 187- Stroke and Thrombolytic Therapy
  - If patient presents within the window and meets criteria, they should gey TPA or document why not
  - Many reasone NOT to give TPA
    - Contraindications
    - CT findings
    - NIH too high or low
    - Stroke Team opinions

Contracting

- Most contracts are based off percentage of Medicare
- Consider using percentage of billed charges as alternative
- Consider Non-Par as ED is unique due to “Prudent Layperson” definition of an Emergency
  - 3rd party payer litigation
- Monitor Contract Payments Closely

Why does this matter?

- Reimbursement declining, salaries increasing
  - This is not sustainable
- Increased scrutiny/declining from payers
- We must maximize our payments for the work we do

Questions