Emergency Department Coding for the Facility

Raemarie Jimenez, CPC, CPMA, CPC-I, CANPC, CRHC
Director of Education, AAPC

Course Objectives

• Discuss E/M Code Selection for the Facility
• Discuss Common Procedures Reported in the Emergency Department
• Discuss Charge Capture in the Emergency Department
ED Facility E/M

• There is not a national standard. Each facility must determine an internal policy.
  – Must provide reproducible results
  – All hospital personnel must follow the same policy
  – Policy for E/M code selection should be based on hospital resources
  – Not the same code as the professional E/M
  – Do not include billable services as criteria for code selection

ED Facility E/M

• Type A-available 24 hours a day, 7 days a week and is either licensed by the State in which it is located under applicable state law as an emergency room or emergency department or it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.
ED Facility E/M

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>SI</th>
<th>APC</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
<td>V</td>
<td>0609</td>
<td>51.77</td>
</tr>
<tr>
<td>99282</td>
<td>V</td>
<td>0613</td>
<td>87.25</td>
</tr>
<tr>
<td>99283</td>
<td>V</td>
<td>0614</td>
<td>139.14</td>
</tr>
<tr>
<td>99284</td>
<td>Q3</td>
<td>0615</td>
<td>222.58</td>
</tr>
<tr>
<td>99285</td>
<td>Q3</td>
<td>0616</td>
<td>329.54</td>
</tr>
</tbody>
</table>

- Type B-dedicated emergency department. Must meet one of the following:
  - It is licensed by the state in which it is located under applicable State law as an emergency room or emergency department
  - It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment
  - Provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment
## ED Facility E/M

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>SI</th>
<th>APC</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0380</td>
<td>V</td>
<td>0626</td>
<td>41.36</td>
</tr>
<tr>
<td>G0381</td>
<td>V</td>
<td>0627</td>
<td>59.23</td>
</tr>
<tr>
<td>G0382</td>
<td>V</td>
<td>0628</td>
<td>101.52</td>
</tr>
<tr>
<td>G0383</td>
<td>V</td>
<td>0629</td>
<td>165.48</td>
</tr>
<tr>
<td>G0384</td>
<td>Q3</td>
<td>0630</td>
<td>273.24</td>
</tr>
</tbody>
</table>

7 CPT® copyright American Medical Association, All Rights Reserved

## Composite APC

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

- Observation time must be documented.
- The time begins when observation services are initiated in accordance with a physician’s order for observation services.
- The time ends when all clinical or medical interventions have been completed.
- Total units must equal or exceed eight.
- Documentation must include assessments, reassessments and discharge.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>SI</th>
<th>APC</th>
<th>Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0378</td>
<td>Hospital Observation per hour</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G0379</td>
<td>Direct Referral Hospital Observation</td>
<td>Q3</td>
<td>0604</td>
<td>52.36</td>
</tr>
</tbody>
</table>
Critical Care

• Critical care coded based on the patient’s condition NOT site of service

• According to CPT®
  “A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.”

Organ System Failure

• Central nervous system failure
• Circulatory failure
  – Acute MI
• Shock
  – Severe trauma
  – Coagulopathy
• Renal failure
  – New onset
  – Hyperkalemia

• Hepatic Failure
  – Encephalopathy
  – Stroke
• Metabolic failure
  – Toxic Ingestion (methanol)
  – Severe Acidosis
• Respiratory Failure
  – Pneumonia
Critical Care

Critical Care Time “under the OPPS, the time that can be reported as critical care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient”.

Transmittal 1139, Change, Request 5438

Critical Care

Bundled Services for professional services NOT facility:

- Interpretation of cardiac output measurements (93561, 93562)
- Chest X-rays (71010, 71015, 71020)
- Pulse oximetry (94760, 94761, 94762)
- Blood gases, and information data stored in computers (eg, ECGs, blood pressures, hematologic data [99090])
- Gastric intubation (43752, 91105)
- Temporary transcutaneous pacing (92953)
- Ventilatory management (94002-94004, 94660, 94662)
- Vascular access procedures (36000, 36410, 36415, 36591, 36600)
Critical Care

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>SI</th>
<th>APC</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>99291</td>
<td>Critical care, 30-74 minutes</td>
<td>Q3</td>
<td>0617</td>
<td>464.75</td>
</tr>
<tr>
<td>99292</td>
<td>Critical care, addl. 30 minutes</td>
<td>N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Commonly Performed with Critical Care

- CPR
- Central Venous Access
- Intubation

Time spent performing billable services can not be included in Critical Care time.
Charge Capture

• Services reported by ED Facility includes services performed by all physicians, NPP, nurses, techs, etc.
• Nursing and provider documentation is crucial
• Must have an up to date charge master
  – CPT/HCPCS Level II Codes
  – Revenue Codes
  – Charges

Charge Capture

• Multiple departments select charges for services rendered in the ED
  – Lab services
  – Radiology
  – Drugs
  – Supplies
  – Procedures
  – EM Levels
Common Errors

• Incorrect units for medications administered
• Drugs charged with no administration codes
• Administration codes with no drugs charged
• Failure to report procedures performed by all health care providers involved in the encounter (MDs, NPPs, nurses, techs, etc.)
• Reporting same EM as the physician/NPP

Drug Administration

Nursing Documentation must include:
• Substance
• Dose
• Route
• Start and stop times
• Mixed with saline
• Complications
Hierarchy for Administration

- Chemotherapy
- Theurapeutic
- Hydration
- Infusion
- IV Push
- Hydration
- Injections

Common Procedures Performed in the ED

Incision and Drainage
- 10060 Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
- 10061 Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple
- 10080 Incision and drainage of pilonidal cyst; simple
- 10081 Incision and drainage of pilonidal cyst; complicated
Lacerations

- Codes are grouped anatomically
  - Face/ears/lips/mucous membranes
  - Scalp/neck/extremities
- Complexity of repair:
  - Simple-single layer
  - Intermediate-layered closure
  - Complex-creation of a defect, extensive undermining, retention sutures…
- Extensive cleaning and removal of debris may elevate repair from superficial to intermediate

Laceration Repair

- Simple repair: the wound is superficial; involving primarily epidermis without significant involvement of deeper structures, and requires simple one layer closure.
  12001-12021

- Intermediate repair: the repair of wounds that, in addition to the above, require layered closure of one or more of the deeper layers. Single-layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter also constitutes intermediate repair.
  12031-12057
Laceration Repair

• Complex repair: the repair of wounds requiring more than layered closure, such as scar revision, debridement, (eg, traumatic lacerations or avulsions), extensive undermining, stents or retention sutures. Necessary preparation includes creation of a defect for repairs (eg, excision of a scar requiring a complex repair) or the debridement of complicated lacerations or avulsions.

13100-13153

Foreign Body Removals

• Codes selected by anatomic site, depth and technique
  – 30300 Removal foreign body, intranasal; office type procedure
  – 69200 Removal foreign body from external auditory canal; without general anesthesia
  – 65205 Removal of foreign body, external eye; conjunctival superficial
  – 65210 Removal of foreign body, external eye; conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating
  – 65220 Removal of foreign body, external eye; corneal, without slit lamp
  – 65222 Removal of foreign body, external eye; corneal, with slit lamp
Coding Soft Tissue Foreign Bodies

- 10120 Incision and removal of foreign body, subcutaneous tissues; simple
- 10121 Incision and removal of foreign body, subcutaneous tissues; complicated
- 28190 Removal of foreign body, foot; subcutaneous
- 28192 Removal of foreign body, foot; deep

Toe Nail Resection

- 11730 Avulsion of nail plate, partial or complete, simple; single
- 11750 Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal
- 11765 Wedge excision of skin of nail fold (eg, for ingrown toenail)
Splint Coding

- 29505 Application of long leg splint (thigh to ankle or toes)
- 29105 Application of long arm splint (shoulder to hand)
- 29515 Application of short leg splint (calf to foot)
- 29125 Application of short arm splint (forearm to hand); static
- 29130 Application of finger splint; static

CPT® Definitions

Open and Closed Fractures

- **Closed treatment**: “specifically means that the fracture site is not surgically opened (exposed to the external environment and directly visualized).”
- **Open treatment**: “is used when the fractured bone is either (1) surgically opened (exposed to the external environment) and the fracture (bone ends) visualized and internal fixation may be used or (2) the fractured bone is opened remote from the fracture site in order to insert an intramedullary nail across the fracture site.”
Open vs. Closed Treatment

- This is a description of the technique used to treat the fracture, not the fracture itself.
- Even if the fracture itself is open the ED physician likely did not provide open fracture care.
- ED physicians almost never perform open treatment of a fracture.
- ED fracture care involves closed treatment.

Fracture Care Codes “Without” vs. “With Anesthesia”

- The AMA and CPT® have stated that the “with anesthesia codes” are to be used in the Operating Room Setting with general anesthesia.
- These codes do not apply to the ED setting.
- Even if Moderate Conscious Sedation or Deep Sedation employed report the “without anesthesia” codes.
Dislocation Codes

• Use dislocation codes for any documented reductions
  – Fingers and Toes
  – Shoulders
  – Hips
  – Ankles
  – Patella
  – Mandible
  – Elbow

Moderate Conscious Sedation

• Patient responds purposefully to verbal commands with light tactile stimulation
• No interventions are required to maintain a patent airway
• Spontaneous ventilation is adequate
• Cardiovascular function is maintained
Moderate Conscious Sedation

• Codes divided into 2 groups:
  • MCS provided by the same physician who is performing the procedure
    – Requires an independent trained observer
      99143-99145
  • MCS provided by a physician in support of a second health care provider performing the procedure
      99148-99150
  • Age of the patient

MCS: Intra Service Time

• Intra-service time starts with the administration of the sedation agents

• Required continuous face-to-face attendance

• Ends at the conclusion of personal contact by the physician providing the sedation
Auditing ED Facility Services

• Prepayment Review
  – Medical Record
  – Services selected for billing
  – Payer policies and contracts
  – Audit Tool

Auditing ED Facility Services

• Post payment Review
  – Medical Record
  – Services billed
  – Remittance Advice
  – Payer policies and contracts
  – Audit Tool
Auditing ED Facility Services

• Services Targeted for Audit
  – OIG Work Plan
    • Payments for Diagnostic Radiology Services in Hospital Emergency Departments
    • Observation Services During Outpatient Visits
  – MAC: Review information on MAC website
  – CERT: Review audit results
  – RAC: Review services that are approved for audit
    • IV Hydration Therapy

Case 1

Time seen by clinician. 2035
Chief Complaint: Ankle and leg injury
HPI: 15-year-old male patient complains of an injury to the leg and foot. The injury occurred shortly prior to arrival. The injury allegedly occurred while playing football at local high school field, another player fell on his leg and foot. Mother states she saw the child when he fell, his leg twisting when the other players fell on him. Patient did not continue playing any more football, mother states he’s not walking on his leg at all secondary to pain. No other complaints of pain, injury or illness.
Case 1

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

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

Case 1

Physical Exam, Vital Signs: Afebrile, VSS
General, well appearing, well nourished
Patient Status. Alert and cooperative
Heart: RRR, no MRG
Lungs: CTAB
Ankle: Right ankle, diffuse tenderness medial and lateral malleolus, minimal swelling laterally, ROM normal flexion, normal plantar flexion, no obvious deformity, skin is intact. Neurovascular status: 2+ pedal pulses, capillary refill less than 2 seconds Achilles tendon non tender, no step off. The foot, knee and hip are without pain or tenderness and with full range of motion
Case 1

Leg: Right, diffuse pain tibia-fibula, no obvious swelling. Patient has poison ivy bilateral lower legs, no infection. Mother states he has medication for his poison ivy.

Intervention X-ray: Right tibia fibula and foot negative for acute bony injury

Immobilization was achieved by the application of OCL stirrup short leg splint applied by ERMD

Immobilization device was then check to assure good neurovascular flow and effectiveness of positioning by me before the patient was discharged

Crutches dispensed. Crutch walking safely with good use of crutches

Diagnosis: Ankle injury from trauma, Acute sprain right ankle, Contusion right leg.

Disposition: The patient was discharged 2045. Discussion regarding radiology to review X-rays and in the event of a discrepancy we will notify patient/family.

Prescriptions: Prescription for Vicodin

Discussion regarding ice, elevation, rest leg and ankle, non-weight bearing until follow up.

Follow up: Instructions given to follow up with MD or orthopedics in 4-5 days. May return to ER or orthopedics sooner for worsening symptoms

Treatment plan discussed with patient/family who are in agreement.
Case 1

Services to code:
Facility EM
X-rays
Splint Application: 29515

Case 2

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

ROS: Constitutional: Fever; Neurologic: Negative; Allergies: NKA
Case 2

Past Medical/Family/Social History
Medical History: Negative; Surgical History: Negative; Social History: Married

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

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

DIAGNOSIS:
Puncture wound of the food

Rx: Keflex 500 mg, Ibuprofen 800 mg
Case 2

Services to Code:
EM Facility
Foot X-ray
IM Injection and Rocephin
Td vaccine and administration

Case 3

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

REVIEW OF SYSTEMS: As per HPI. All other systems are reviewed are negative.
Case 3

MEDICATIONS: None.
ALLERGIES: NONE.
SOCIAL HISTORY: The patient does not smoke, drink or use drugs.

PHYSICAL EXAMINATION: VITAL SIGNS: Temperature is 102, respirations 22, pulse 116, blood pressure 122/72, satting 100% on room air. The patient is alert and appropriate in no acute distress.
EYES: The pupils are symmetrical and reactive to light. The conjunctivae and lids appear grossly normal. ENT: The oral mucosa is moist and appears normal. NECK: The neck is supple and the trachea is midline.

Case 3

RESPIRATORY: Equal chest wall excursion. There are no intercostal retractions or the use of accessory muscles with respirations. Breath sounds are clear and symmetrical. There are no wheezes, rales or rhonchi. CARDIOVASCULAR: The chest wall is normal in appearance. The heart has a regular rate and rhythm. GASTROINTESTINAL: The abdomen is soft and nondistended. There is no tenderness to palpation, rebound or guarding. SKIN: There is no significant rash or ulceration.
NEUROLOGIC: Grossly normal/baseline. HEME/LYMPH: No petechiae.
MUSCULOSKELETAL: Strength and tone are grossly normal to the upper and lower extremities.
Case 3

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

Case 3

This 26-year-old patient’s presentation of headache, neck pain and fever were concerning for meningitis, therefore, it was felt the lumbar puncture would need to be performed. The risks, benefits, alternatives were discussed with the patient and his family. They agreed to the procedure. The patient was placed in the sitting position. He was given 0.5 mg Ativan IV. His back was prepped and draped in sterile fashion, anesthesia was performed with 1% lidocaine. A 20-gauge needle was introduced between L4 and L5 with the return of clear fluid. The patient tolerated this well.
Case 3

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

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

Case 3

Services to Code:
EM Facility Code
Lumbar puncture (62270)
Ativan IV (Need Nursing note)
Chest X-ray
CBC w/ diff
BMP
CPT® Disclaimer

CPT copyright 2010 American Medical Association. All rights reserved.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

CPT is a registered trademark of the American Medical Association.