News from NICKA

Sharon's Corner

By now, you must have noticed the change in name of our newsletter in addition to the change in my title and company name.

Saying 'YES!' to change is a difficult concept and experience for most of us. I confess that my characteristically strong willed attitude (most significantly pronounced during my second year of life and then again in my fifteenth year) has actually served me well in approaching change. Never let it be said that I cannot do something, because I will work at the definition of 'can't do' to develop into what CAN I do! Make sense? Probably just to me, but then again we all have our human moments and now happens to be one for me!

We all know that change in life is inevitable. Without change, we may breed complacency and with complacency, one may risk stagnation and failure to thrive. It is how we approach, plan, respond and implement change that is vital and could very well be the distinguishing factor to success in both our personal and professional matters.

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In emergency medicine, change comes in many forms and disguises: unknown diseases, undiagnosed injuries, new drugs, new treatments and methodologies, new medical records and templated forms, new improved documentation, new guidelines, new codes, complex billing rules and changes, new coders, new billing companies, or new owners of your hospital, group or billing company… the list can go on and on. You may be asking yourself – how can I handle all of this? Well, I for one have had to consider change a lot lately … this first issue of *News from NICKA* will be focused on change. So get ready and go for it! *sln*

The Three Plus One Components of Change

by: Sharon L. Nicka, RN, CPC

Understanding the importance of change and managing it are the first steps to making the right kind of changes that will fit your wants and needs. Consider these three C's:

1. Change – we have to manage change to go forward.
2. Challenge – we need to constantly challenge what we do and why we do it. The challenge is doing the right things and doing those things in the right way. Don't hesitate to look at every aspect of your business and challenge all of your processes, from mal-practice insurance to scheduling physicians. Document your opportunities and develop a logical plan to implement the change. Involve the people that do the work. Quite often, this is our best resource to challenge what we do and how we do it!
3. Commitment – once you step up to the challenge, you and your management team needs to be committed to implementing the plan. This could include developing a training program to communicate and/or implement the change to all individuals in your organization. Everyone needs to be aware of what you want to change and how you are going about it. Everyone needs to be committed.

Once the change is implemented, work with your management team to ensure they implemented the change correctly and achieved the results they desired. Often time, the processes will need to be tweaked to optimize the desired results. Sometimes, you will find that the change did not have the affect you wanted. If that is the case, you didn't fail. You can always go back to where you were before the implementation. Trial and error is a wonderful teacher of implementing change!

Finally, once the three C's have been initiated in your practice and change is ingrained in your management staff, the result will be what I call the payoff, the fourth C component: ***Confidence.***

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Teaching Physician Rules for 2003

by: Sharon L. Nicka, RN, CPC

Though long overdue, changes to the teaching physician rules for 2003 is a win-win for our specialty. The revision clarifies the documentation requirements for evaluation and management (E/M) services billed by teaching physicians. The revised language makes it clear for E/M services, teaching physicians need not repeat documentation already provided by a resident. When assigning E/M codes to services billed by teaching physicians, reviewers can combine resident and teaching physician documentation. The combined documentation by the teaching physician and the resident must support both the medical necessity of the service and the level of service billed by the teaching physician.

To obtain reimbursement, teaching physicians billing E/M services must personally document the following:

- They performed the service or were physically present during the key or critical portions of the service when performed by the resident; and
- They participated in the management of the patient.

In addition, the revisions clarify policies for services involving medical students. Any contribution and participation of a medical student to the performance of a billable service must be performed in the physical presence of the teaching physician or physical present of a resident in a

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Fracture Care

by: Sharon L. Nicka, RN, CPC

As the orthopedist continues to argue that musko-skeletal codes should be used exclusively for their

CMS 2003 Fee Schedule

The CMS 2003 Fee Schedule was approved by President Bush early in February. Good News - instead of the projected decrease of 4.4%, we will receive a 1/6% increase in reimbursement!

CMS 2003 Fee Schedule + 1.6%

CPT Code	2002 RVU	2002 Payment	2003 RVU	2003 Payment	% Change
99281	0.44	$ 15.93	0.44	$ 16.18	1.6%
99282	0.73	$ 26.43	0.73	$ 26.85	1.6%
99283	1.64	$ 59.37	1.64	$ 60.31	1.6%
99284	2.56	$ 92.67	2.56	$ 94.15	1.6%
99285	4.00	$144.80	3.99	$146.74	1.4%

specialty, ACEP continues to support the use of Fracture Care Codes in the ED where the initial care is provided. There are some billing companies out there, *way out there* I might add, that support the political assumptions that the orthopods are correct. If your group is one that is unfortunate to have one of those billing companies that code and bill on the dark side, I say make a change and do so post haste!

It is hard to argue the obvious use of fracture codes in the ED when ED physicians reduce dislocations or a displaced fracture. The controversy, however, continues with the fractures that are 'closed treatment without manipulation'. The descriptors in CPT are clear : the physician providing restorative care and overall management that is comparable to that provided by other physicians performing the same service should bill a fracture care code. The care provided should include restorative or partial restoration care (care directed at repairing the injury) in addition to the subsequent care which is usual for the management of this condition.

Documentation should include pain management, patient education and referral for follow-up. We (ED docs) do not provide follow-up care, therefore the -54 Modifier must be appended.

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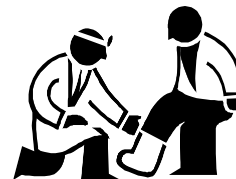

Teaching Physician Updates

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service that meets the teaching rule requirement. Medical students may now document services in the medical record. Any contribution and participation of the medical student to the performance of a billable service must be performed in the physical presence of either the teaching physician or resident. In addition, the teaching physician may refer to the student's documentation of the ROS and/or PFSH. The physician may not refer to the resident's documentation of the physical exam findings or medical decision making in his/her personal note without actual participation.

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APC's - The Issues

by: Sharon L. Nicka, RN, CPC

The Ambulatory Patient Classification (APC)

system has had a dramatic impact on how ED services are billed to Medicare. While the APC methodology was designed to be a straightforward process, the reality is that it requires a fine tuned coordination of documentation, coding and charge entry to accurately capture reimbursement dollars for all services rendered. Simply stated, the final outcome of that coordination process can result in the difference between financial success or failure.

Many problems plague the ED on the APC facility side. To begin with, many services are provided in the emergency department but often are missed in the billing process unless a system of checks and balances is maintained and monitored. The average ED stands to lose between $5 and $8 million in charges resulting from the following:

- Problematic facility assessment, level assignment, and missed procedures;
- Incomplete and/or outdated charge master listings;
- Inconsistencies resulting from what is entered through charge entry and what actually appears on the UB-92;
- Omission or inaccurate use of correct modifier or condition codes.

Both nursing and physician documentation should be complete, detailed and must establish medical necessity for the emergency services. Medical necessity begins with the chief complaint and extends throughout the ED encounter. In addition, all documentation must support the level of service provided as well as all the procedures identified for payment.

Nursing documentation must support the assessment units and provide compliance with the ED criteria in place at their facility. Incomplete or inaccurate nursing documentation will affect the process of assigning the appropriate level and/or could jeopardize the issue of medical necessity for the visit. This in turn, may result in lower charges and acuity level than what was actually provided. It is important to note that the only method many hospitals have for tracking ED acuity is the reporting on assignment of nursing assessment levels! Accurate, complete documentation is the name of the game!

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Double Dipping Dilemmas

by: Sharon L. Nicka, RN, CPC

Double dipping is dangerous stuff: it is not only a social indiscretion - it can also get your practice into compliance trouble fast! Now, having said that, you also need to know that in certain circumstances, you can use the same E/M documentation statement twice. Here's the deal:

The definition of double dipping on E/M billings is when you count the same documentation statement as two different elements within one E/M component. You can count the same statement, however, for two different elements in different components. For example, you can use the statement "Patient has shortness of breath" for the respiratory element in the ROS and an associated sign and symptom in the HPI.

Many coders may not be aware of this nuance - or they may be afraid to follow it! As a result, many charts that could and should be coded at a higher E/M level are down coded. So coders - beware AND be wise!

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Frequently Asked Questions

Q. *In performing a laceration repair on a patient's finger, I used a digital block instead of a local anesthetic. Can I bill for both the digital block and laceration repair?*

A. Yes and No. The digital block when used with a starred procedure for CPT payers may be billed as a separate procedure. Medicare, on the other hand, does not recognize starred procedures and would therefore bundle digital block into the laceration repair.

Q. *How do I document my X-ray interpretation to be reimbursed by Medicare?*

A. An ED physician may bill for the interpretation and report of an X-ray for a Medicare patient when a 'complete written report similar to that prepared by the specialist in the field" is documented. CMS has not identified a relevant clinical issues, comparative data and study findings. To these three categories, the American College of Radiology Standard to Communication, Diagnostic Radiology has suggested the addition of a description of the procedure and materials, any limitations and clinical impression, conclusion or diagnosis. CMS has not expressly adopted these specific suggestions. A separate written report is not required by CMS. However, some Medicare carriers have independently established more restrictive criteria.

Q. *Which procedure codes are considered to be bundled into the critical care code?*

A. The following services should not be reported separately if performed during the critical care period by the physician providing the critical care:

- the interpretation of cardiac output measurements (CPT 93561, 93562)
- pulse oximetry (CPT 94760, 94761, 94762)
- chest X-Rays (CPT 71010, 71015, 71020)
- blood gases
- gastric intubation (CPT 43752, 91105)
- information data stored in computers (CPT 99090)
- transcutaneous pacing (CPT 92953)
- ventilator management (CPT 94656, 04657, 04660, 94662)

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News from NICKA

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Sources

ACEP Conference: *Getting Control: Effective Procedure Coding for Emergency Medicine* , New Orleans, LA, January 2003

Edelbert, Caral, *APC Billing: An ED Manager's Primer,* Journal of Emergency Nursing, December 2002

Emergency Coding Wire March 4, 2003

Part B News, February 2003

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News from NICKA is designed to provide educational support and current information for ED documentation, coding and compliance.. We strive to make every reasonable effort to ensure the accuracy of the material provided. Should you have any questions, concerns or comments, please feel free to contact us. Email: NickaAssociates@aol.com or FAX - 972-964-1056.

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