



NEWS FROM NICKA



- Optimal reimbursement with minimal risk
- Credentialed coders who are current on coding initiatives
- Proven solutions to assure your financial success
- Our specialty is emergency medicine!

Sharon's Corner

Those of us that are considered baby boomers have experienced many firsts along the pathway of life. Some good, others not so good, but that is life as we know it.

Joining the force of independent business owners and entrepreneurs, I've learned from the

"school of hard knocks". Believe me, things and people are not always what they seem or how you anticipate it is going to be.

Our growth continues! It seems just like yesterday, I took a pen in hand and began our first News from Nicka. The change and

transition has been great. Nicka & Associates began with mini steps as we entered the world of coding, compliance, and consulting. Today our steps are focused and directed in helping the emergency medicine specialty move forward in their quest for independent status and financial stability.



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Starred Procedures

The stars are white and Big and Bright...

The stars are gone Without much thought Deep in the heart of Coding.

Physicians entered the year of 2004, no longer enjoying the benefits of the starred procedure rule. You may or may not experience a dip in revenue depending on how your group adequately bills for the minor surgical procedures performed in your ED.

For example, many groups billed for nerve blocks, suture removal, or wound checks. Consider this hypothetical scenario that will show you the potential financial impact. Laceration repair generates a payment of \$100, the nerve block \$50, the return visit or suture removal \$50. So, payment was about \$200. In 2004 you are only able to bill for the laceration repair and the payment goes from \$200 to approximately \$100. That

is a potential loss of \$100 per minor surgical encounter! Depending on your volume this could be significant.

Billing for an E/M with a procedure remains the same. Think of it this way. Unscheduled procedures would always have a separate evaluation (E/M code) to determine the appropriateness of the procedure. Any exam performed outside the area of complaint, and any history taken other than allergy and immunization status, in addition to what is directly related to the procedure warrants a separate E/M service.

Physicians frequently do not realize the importance of the E/M with a procedure and documentation is less than adequate! Remember you must include the CC, HPI, ROS PE and MDM to get a E/M code. So document it!!



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Orthopedic Codes - The Controversy Continues!

“Is the care you are rendering the same as a specialist would render?”

It is not surprising that the orthopedic codes continue to cause controversy and angst. More important than the controversy is the reimbursement issue. When used appropriately, Fracture Care Codes Services 2000- 2999 in the CPT book can contribute significantly to your bottom line.

First and foremost when deciding whether to code for fracture care or code the E/M and splint., consider the care you are providing. “Is the care you are rendering the same care a specialist would render?” If so why would you not bill for the

service provided?

A good example; patient presents to the ED with a broken toe. (8260) the definitive care is buddy taping. How would the orthopedist treat a broken toe? Thought so – Buddy taping!

Documentation must be thorough and complete for the coder to identify the correct fracture code. The initial stabilization and definitive care provided should be included as well as the displaced or non-displaced status. Additionally, identify the bone treatment, including the pain management and referral for

follow-up care.

As a rule the ED physician does not provide the follow- up care for the initial fracture care, so a 54 modifier will need to be appended to the fracture code.

Based on CPT definition an E/M code might also be coded which will appropriately represent the work the physician has preformed subsequently to the evaluation of the patient screening for other injuries, diagnostic x-rays and the physicians determination that fracture case was needed.

E/M Documentation Tips

HPI: Insufficient documentation of history of present illness (HPI) is one of the most common documentation errors. An inadequate HPI will not meet CMS guidelines or more importantly meet Medicare payment rules.

The HPI is part of the history and one of the key elements. There are eight elements in the HPI including location, duration, (onset) timing, context, modifying fractures and associated signs and

symptoms. One to three (1-3) elements of E/M service, codes 99281-99283 and four (4) or more are required to support the higher levels of service 99284—99285.

The HPI must be completed by the physician. The nurse, resident, PA or other ancillary staff may provide the ROS or PMSH, but the HPI is the physicians responsibility!

Of course, if the service is being billed by the (NPP) non-physician practitioners then the NPP must personally document the HPI.

One of the major causes of an inadequate HPI is of course when the physician includes a statement in the ROS that states; “as above.” While it is ok to document the ROS in the HPI, you must have at least the required elements 1-3 or 4 for correct code assignment.



How is your documentation?
Allow N & A to provide you with the feedback you desire.

<i>History of Present Illness</i>		
Element	Definition	Example's) of good documentation
1. Location	Area of the body or organ system affected by the symptoms the patient describes	Lower back, elbow, stomach
2. Quality	Characteristic of the chief complaint	Stabbing pain, radiating pain
3. Severity	Measurement of discomfort or physical pain	8 on a scale of 1-10, pain so bad the patient can't catch breath
4. Duration	Length of time the illness is present or ongoing	The pain has been present for three days
5. Timing	Measure of how long each episode has lasted or time of day the problem presents	The stomach pain became worse after eating, the pain is worse in the morning
6. Context	Circumstances surrounding the event	Shortness of breath occurs when climbing stairs
7. Modifying factors	Any influence that makes the illness better or worse	Tylenol makes the pain subside for a few hours
8. Associated signs & symptoms	Any other problem the patient can identify with the chief complaint	Before the headaches starts, my eyes hurt or become sensitive to the light

Source: *Part B News, Vol. 18, No. 16*

Advanced Version of 2005 Medicare Physician Fee Schedule

Good news for 2005! The Medicare physician fee schedule is set to increase physician payments by 1.5% next year.

The regulation which was recently published in the *Federal Register* on August 5th, allows for a sixty day

comment period.

As you may recall, the 1.5% increase in payment to physicians was mandated by a provision of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA). The MMA

provision fixes what was predicted to be a reduction in physician payments of 3.7% in 2005...ouch!

To further understand the impact, review the table below.

Impact of Proposed 2005 Physician Fee Schedule Update				
Code	Description	Current	Proposed 2005	% Change
99282	Low Complexity	\$27.63	\$27.67	0.0 %
99283	Moderate Complexity	\$61.61	\$62.15	1.0 %
99284	Moderate Complexity	\$95.58	\$97.02	2.0 %
99285	Comprehensive	\$149.72	\$151.97	2.0 %

Diagnostic Studies

The federal register has Medicare's final ruling on billing for EKG's and x-rays. In essence, the ruling states that diagnostic studies interpreted contemporaneously and when management of the patient and disposition are based on that read, it is considered a patient care service and is a billable service.

Importantly, any interpretation

read that is provided after the patient is discharged is a quality over-read and therefore not billable. Thus, a non-billable service.

Therefore, for services which are billed as a patient care service, when in fact a quality over-read has been provided, you have just submitted a false claim.

CMS sets policy, OIG enforces

policy and has once again placed diagnostic reads on their radar screen.

For more information, you may go to ACEP's website at (www.acep.org/2930.htm). A quick over-view of the facts will assist you in determining how you and your group wish to proceed on this vital issue.

“Any interpretation or read which is performed after the patient is discharged is a non-billable service”

Frequently Asked Questions

Q. Is it appropriate to bill for services our ED physicians provides to an inpatient?

A. Yes, you should report the subsequent hospital care codes (99231-99233) supported by the documentation in the record. All procedures provided in addition to the E/M should also be coded and billed. Remember, the inpatient place of service code is 21 and should be on

the CMS 1500 form.

Q. Many workers compensation carriers will not pay for an E/M with a procedure but will pay a flat fee if we use 99025. May we still use this code?

A. Coding is unique! If a payer wants a specific code and will pay that code and it accurately reflects the care you have provided, give it to them.

Q. I code for both the facility and professional components, should I always match the physician and the hospital diagnoses?

A. When the patient is admitted, the hospital will frequently code the overall condition, which includes the R/O, but the professional or MD diagnosis will be based on the chief complaint for the encounter.



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Let Nicka & Associates, Inc., provide for your needs today!

Is Your Coding Compliant? Risk Aversive?



“An external audit provides an objective approach ...for developing a remedy for concerns.”

Nicka & Associates recommends a baseline audit performed by an organization which specializes in compliance audits for the specialty of emergency medicine. Importantly, at Nicka & Associates, we not only specialize in emergency medicine, but offer a tradition of experience which spans over thirty years in the emergency medicine arena. Drawing upon our experience, our external audit provides an objective approach to determining whether problems exist and provides a framework for developing a remedy for concerns.

The process of a compliance audit is simple and easy to arrange. The client forwards copies of the ED records along with the codes assigned to each chart. Nicka & Associates' auditor will utilize the CMS Documentation Guidelines to determine the correct evaluation and management level, CPT procedure codes and modifiers for each chart. The assignment of evaluation and management levels is based on the physician's documentation of history, physical and medical decision making. Once our evaluation is complete, a detailed report and as-

essment will be submitted to the client.

Compliance Audit Report includes:

- The error and accuracy rates for E/M level coding.
- A list of each record in the sample, the codes assigned by the client's coders as compared to those assigned by Nicka & Associates and our rationale for different code assignments.
- An assessment of whether physician documentation of history and physical examination supports the level of medical decision-making for each record in the sample.