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CODING COMPLIANCE CONSULTING EDUCATION

- OPTIMAL REIMBURSEMENT WITH MINIMIZED COMPLIANCE RISK
- CREDENTIALLED CODERS WHO ARE CURRENT ON CODING INITIATIVES
- PROVEN SOLUTIONS TO ASSURE YOUR FINANCIAL SUCCESS
- OUR SPECIALTY IS EMERGENCY MEDICINE!

ED Golden Rule

ED Golden Rule: You don't get paid for what you do; you get reimbursed for what you document!

Improved documentation equates to increased, appropriate revenues while also reducing compliance risk. Providing documentation deficiency feedback is an important function of the coding process. Over the years, I have both produced and reviewed countless deficiency reports. Here is the Nicka Top Five Documentation Deficiencies List:

5. Diagnostic Studies

EKGs are the most frequently missed charges! To code a 93010, documentation of the EKG interpretation should include at least 3 of the following 6 elements: axis; rhythm; rate; PR intervals, ST wave changes; comparison to a prior EKG if reviewed. Lab values are just that...a value! Interpret your labs – Normal or Abnormal!

4. Splint Applications

While this is not a high dollar procedure, these lost billables do add up! Medicare documentation should support MD placement of the splint. Note for CPT payers, the physician does not have to be the one who actually places the splint, but documentation must indicate that the physician checked splint application, i.e. 'splint in good position, distally neuro-

vascular status intact'.

3. Fracture Care

Fracture care is a high dollar procedure so paying attention to the documentation details will really pay off! Documentation should identify the bone, identify if displaced or non-displaced, stabilization method, pain treatment, orthopedic consultation/referral, and we recommend that the physicians evaluate other sites/injuries or rule out significant 'other' injuries.

2. Critical Care Time Not Documented

Critical care is a time driven code so documentation of time is key! In order to charge for one hour of Critical Care, at least 30 minutes of critical care time must be documented. Note that time spent performing separately billable procedures or services should not be included in the time reported as critical care.

1. ROS Documentation The ROS chart component is the area where the majority of the Level 5 to Level 4 down coding occurs. I encourage you to review the documentation requirements and differences between Level 4s and Level 5s to ensure you are being appropriately reimbursed for the services you provide. Level 4 requires 2 – 9 systems with Level 5 requiring 10+ systems documented and reviewed.

Listing of pertinent positives and/or negatives with statement 'all other ROS negative' currently meets Level 5 requirements. Controversy over the 'all others negative' statement exists – so stay tuned!

Perhaps the biggest area of concern regarding documentation deficiencies is what is actually done with the feedback provided. When was the last time you took a good, discerning look at deficiencies? Become proactive and check it out. Deficient attention to deficiency reporting is both a costly and risky business practice. Shore up your deficiencies!

Sharon's Corner

Those of you who know me well, know I'm a no-nonsense kind of 'gal' eliminating the 'fluff' for stuff that matters — "just cut to the chase", that's me!

Having said that, each and everyone of us have "stuff" that matters to them which, of course, is different that's what matters to me. However, the realities in today's world begin with oneself and the choices we make.

Attitude is Key!

Attitude represents how you look at the world and helps create success and accountability. If you or your company expects to excel, you will!

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THE WEAKEST LINK

Report cards have been distributed - deficiencies have been sent back for review and alas, once again the weakest link of the documentation process is the histories. The management of the ED course and exam may be stellar, but without adequate documentation of the history components, down coding will apply and continue!

The History of Presenting Illness (HPI) is key to the reason the patient presented to the emergency department. Onset, duration, quality, severity, context, signs and symptoms, and modifying factors are questions that are asked in an effort to determine what's going on with the patient. These questions are important in determining the management of the patient's treatment – but frequently documentation is missing or less than adequate for this critical part of the ED encounter.

PEARL

"WHERE THE PAST AND PRESENT MEET!"
For documentation of HPI think **COLDS**: Context, Onset, Location, Duration and Severity! The Physician must conduct and document the HPI to meet documentation guideline requirements.

The Past, Family, Social History (PFSH) may not seem a high priority to the treatment of the patient, but is part of the required documentation guidelines. I can attest to many a down codes when this component is missing or has inadequate documentation.

The Review of Systems (ROS) is the number one weakest link chart component that results in down codes. A single missing ROS element may potentially create a down coding effect of one or two Evaluation Management (E/M) levels. Not only is this

unacceptable from a coding perspective but think of the lost revenue to your group! Remember, the ROS requires questions about ten different systems, not two different systems! It is noteworthy to say that the controversy continues on use of the statement 'remainder of systems reviewed and negative'. The prudent approach is to definitively document all ten systems.

A pearl of ROS documentation advice – avoid the word 'noncontributory'. Use of this terminology has different connotations to different auditors. The construed inference may be 'not medically necessary' or it may even raise questions if the system was inquired or reviewed at all. Don't take the chance – avoid this terminology!

The History caveat may be applied to an E/M Level 5 encounter if the provider is unable to obtain the histories or any part of the history component. Both the 95 and 97 Guidelines are clear that documentation must describe the reason the provider was unable to obtain the history from the patient or other source for the caveat to apply.

Caveat documentation examples: 'Patient demented – unable to obtain histories.' 'Patient intoxicated – histories limited and unreliable due to altered state.'

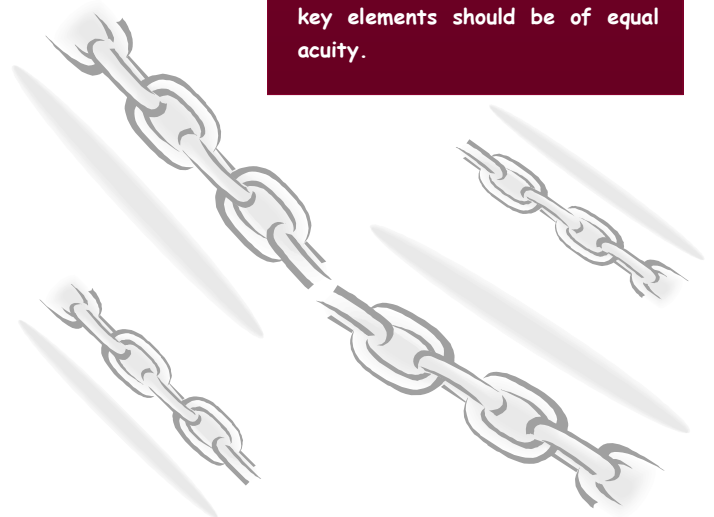
Again, Medical Decision Making and Physical Exam may be comprehensive, but without proper documentation of the histories, the chart will be appropriately down coded. The variances in E/M levels 3, 4 and 5 can shift revenues as much as 15% - 20% depending on the payer. Can your group afford this potential dollar loss? Strengthen the documentation link with accurate, complete histories.

PEARL

E/M LEVEL 5 CAVEAT...

...considers the documented constraints imposed by the urgency of the patient's clinical condition and mental status. It applies to all key elements of the E/M Level: HISTORY, PHYSICAL EXAM & MEDICAL DECISION MAKING.

If the MDM level is high complexity, it is generally an indication that the two remaining key elements should be of equal acuity.



PEARL

Physical Exam Chart Component

EXAMINE THE EXAM!

- All patients must be examined to be coded and billed.
- A minimum of two body parts is required for E/M code 99281-99283.
- A 99284 PE requires five to seven body parts, while a 99285 requires an eight organ systems exam.
- A combination of body parts and organ systems for 99285 is not acceptable.

RETURNED RECORDS

Recently, I have encountered a lot of discussion regarding deficient vs. returned records. What is or should be the distinguishing factor between these two? I can tell you that this is a hot OIG question as well!

Deficiency charts are records that have identified deficiencies and have been coded 'as is'. Down-coding and missed procedure charges occur with inadequate or missing documentation of a chart component(s). A returned record is a chart that has not (or can not) be coded and is returned for further documentation or clarification. A general policy is to return charts that have missing whole sections of the HPI and PE, Critical Care, and/or for clarification of procedures.

So, do you know what your group or hospital policies are regarding deficient vs. returned charts? I encourage you to take a good look at your practices through both reimbursement and compliance perspectives. If the chart is code-able and being sent back primarily for reimbursement purposes, red compliance flags may be waving your way.

Having said that, let's focus on returned charts. All physician groups and hospitals should have policies to address how a chart can be amended. Specific proce-

dures and time frames should be developed and followed for processing an amendment. A separate entry (progress note, form, typed letter) can be used for amendment documentation.

Late Entry - When a pertinent entry was missed or not written in a timely manner, a late entry can be used to record the information in the **original** medical record.

- Identify the new entry as "late entry."
- Enter the current date and time. Do not try to give the appearance that the entry was made on a previous date or time.
- Identify or refer to the date and incident for which the late entry is written.
- If the late entry is used to document an omission, validate the source of additional information as much as possible (e.g., where you obtained the information to write the late entry).

When using late entries, document as soon as possible. There is no time limit to writing a late entry; however, the more time that passes, the less reliable the entry becomes.

Addendums - An adden-

dum is another type of late entry that is used to provide additional information in conjunction with a previous entry. With this type of correction, a previous note has been made and the addendum provides additional information to address a specific situation or incident. When making an addendum:

- Document the current date and time.
- Write "addendum" and state the reason for the addendum referring back to the original entry.
- Identify any sources of information used to support the addendum.
- When writing an addendum, complete it as soon after the original note as possible.
- In an electronic system it is recommended that organizations have a link to the original entry or a symbol by the original entry to indicate the amendment. ASTM and HL7 have standards related to amendments.

Details, Details, Details!
Details, Details, Details!



Urgent Care Injections & E/M Codes



Question: Can an evaluation and management code be billed along with the code for administration of intravenous injection in an urgent care setting?

Answer: Yes - Medicare now reimburses for a separate E/M (99201-99205, 99212-99215) when performed at the same time as IV drug administration. The Medicare Claims Processing Manual states, "Medicare will pay for medically necessary office/outpatient visits billed on the same day as a drug administration service with modifier 25 when the modifier indicates that a separately identifiable evaluation and management (EM) service was performed that meets a higher complexity level of care that a service represented by CPT code 99211...for an E/M service provided on the same day, a different diagnosis is not required."

Example: A patient presents with chief complaint of a migraine headache. The physician determines that the best course of action is an IV injection of prochlorperazine. Medical necessity is established for this procedure as patient response to the injection will determine/confirm the migraine diagnosis or rule out another more serious problem (i.e. meningitis). In this example, an E/M with modifier 25 should be coded and billed. Even though there may be only one diagnosis of migraine headache (ICD-9 = 346.00), it is still appropriate to bill both for the therapeutic injection and the physician's evaluation of the patient.



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EXCELLENCE IN CODING, COMPLIANCE, CONSULTING & EDUCATION

Given the continued scrutiny of OIG, many within our industry are concerned that percentage based billing arrangements can create a conflict of interest. Through the separation of coding and billing parameters, physician groups reduce this compliance risk. In fact, this model benefits and protects the interests of all parties involved.

Nicka & Associates, Inc. provides expert, optimal, appropriate ICD-9 and CPT emergency medicine and

HAVE YOU CONSIDERED?

urgent care coding services. To ensure high quality and compliant coding, we employ only credentialed, experienced coders. And, all of our work is performed in the USA. *Nicka & Associates, Inc.* strives to be the best overall value in emergency medicine reimbursement services. We ask our potential

clients to consider the benefits that expert coding, compliance, consulting, and education services will add to optimizing appropriate revenues while minimizing compliance risk. If you are also interested in new billing solutions, we have strong business relationships with multiple billing associates or we can partner with the vendor of your choice.

Experience the '*Nicka*' Difference with Excellence in Coding, Compliance, Consulting, and Education!

News from Nicka is designed to provide educational support and current information for Emergency Medicine documentation and coding. 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 at: www.nicka-associates.com.