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2008 Changes & Reimbursement Implications *by Sharon Nicka, RN, CPC*

The 2008 CMS changes are a mixed bag. The good news is that the proposed 10.1% CMS 2008 pay cut was initially voted down by Congress. President Bush signed a bill for a 0.5% pay increase effective January 1, 2008. As a result, the conversion factor increased to 38.0870. The only catch is that this payment increase runs for six months only and will end on June 30, 2008. In absence of further Congressional action, the original 10.1% pay cut will then take effect on July 1, 2008. This presents obvious challenges for ED groups in creating an annual budget.

Two important 2008 CPT changes that affect ED physicians and reimbursement are:

- ***Infusion codes 90760 – 90761:*** Just when physician groups were catching on to the financial benefits of using these codes, CPT's language change on hydration injection and infusion codes 'makes it clear' that these codes are not intended for physician reporting in the ED setting for 2008. (Hydration codes may still be billed for the facility, office or clinic setting.)
- ***Rhythm Strip code 93042:*** Revised 2008 CPT language states rhythm strips are produced by a 12 lead EKG and therefore bundled or considered part of the 12 lead EKG.

Note that CMS has never reimbursed physician use for hydration therapy codes 90760 – 90761 and has also bundled rhythm strips 93042 into the EKG code. If a cardiac monitor (93042) is ***ordered***, medically necessary and interpreted by the provider, it may be appropriate to code. CPT and Medicare are now mirror images of each other on these codes.

For physician groups that have previously billed for hydration and/or rhythm strips, the 2008 reimbursement impact will be significant. These CPT coding changes will ***negatively*** impact your procedural frequency data, monthly charges and your financial bottom line.

If you haven't already done so, this would be a good time to look at some alternative reimbursement opportunities. Certainly for ED groups that billed rhythm strips 93042 instead of EKG 93010, it is time to reconsider the EKG issue. While EKG billing in the ED has some political implications, it would be worth the battle to pursue.

SPRING 2008

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Sharon's Corner

Have you ever found yourself saying or thinking "back when…"? It may be nice to reminisce — but the reality is that 'times, they keep a changing' and change we must.

Health care is an evolving industry and changing every day. Peruse through the 2008 Changes & Reimbursement Implications article included in this issue and you will see what I mean. I'm sure many physician groups have experienced the negative impact from the deleted hydration codes. And, does anyone have a crystal ball for the reimbursement outlook after July 1st? We all need to stay tuned and position ourselves for responsive action! This year may be the prime time to consider and implement alternative reimbursement opportunities.

Sharon L. Nicka, RN, CPC
President & CEO
Nicka & Associates, Inc.

IT'S TIME FOR MOVING FORWARD!

The changes and reimbursement forecast for 2008 presents a challenging road ahead. Early projections for 2009 appear to be 'more of the same'. Now more than ever, it is time to pay attention to the details of thorough, complete documentation to appropriately capture all the services and related dollars you deserve!

REIMBURSEMENT OPPORTUNITIES *by Sharon Nicka, RN, CPC & Margherita Rader, MEd*

Reimbursement opportunities actually do exist, but alas, so few are maximized. You know our mantra, *Improved Documentation - Not More,* is key. Simplifying the challenges of the patient encounter by following the logical sequence of care given and documenting the record to meet and follow the Documentation Guidelines is the primary reimbursement opportunity.

Re-assessing the structure of your practice group may also be beneficial to your revenue stream. The use of qualified mid levels (PAs or NPs) to provide partial double coverage or as an alternative to 100% physician staffing for all shifts is a cost effective strategy to consider. Provided the PAs or NPs are employed or contracted by the physician group and are supervised according to Medicare and Medicaid requirements, their services can be billed on a fee for service basis. A shortage of physicians, cash flow or both can be addressed with the effective use of mid level providers. Under this scenario, physician staffing schedules could experience improved efficiencies and become less demanding. Bottom line revenues should also improve as mid level salary requirements are significantly lower than physician salaries. Please refer to the Mid Level Provider Documentation Requirements article in this issue for additional information.

Opportunities could also be identified through a formal review of your current coding processes. Outside audit feedback obtained is valuable information to assess and verify if compliance standards are being met and if appropriate revenues are being captured within the coding process. One quick indicator of your coding integrity is your acuity distribution. ED distributions should be bell curved with a slight shift to the right. Generally speaking, minor E/M level fluctuations may occur from month to month, but overall distribution should reflect stable patterns.

For many groups, improved bottom line revenues could be actualized with a review and update of fee schedules. During a fee schedule process, revenues can be improved by adjusting fees as well as adding services not previously included on the fee schedule (i.e. hydration, observation status services, pulse ox or after hour codes). When was the last time your fee schedule was updated? What services are included in your coding profile?

Sometimes it's the little things that make an impact. A perfect example is EKG charges. Diagnostic EKGs are performed on 30 – 50% of the patients we see in the ED. CMS rules are specific on this issue: the physician who provides the contemporaneous read should bill for that service. While the individual charge value for an EKG is relatively low in comparison to other ED procedure charges, lost EKG charges can add up quickly! Consider this: Medicare average reimbursement for EKGs is $9.10. If 750 EKGs are performed each month, this results in $6,825 in monthly revenue or $81,900 annually. EKG interpretations should include at least 3 of the following 6 elements: axis; presence or absence of ectopy; rhythm or rate; PR intervals; ST wave changes; comparison to a prior EKG if reviewed.

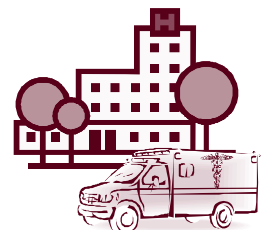
As we all know, some 'reimbursement opportunities' lead to little actualized revenues. Moderate Sedation falls into this category. I have never quite understood the rationale of why this high risk procedure results in such little reimbursement return – but that is the ED reality. Twenty cents on the dollar from most payers on this procedure is almost ludicrous. X-Ray charges in emergency medicine is yet another example of a great opportunity – but very political. Frankly most of us are hesitant to rock that heated boat. FAST ultrasounds are another opportunity, but infrequently utilized, and rightly so. The ultrasound machine must be purchased, physicians must be trained and certification obtained. Furthermore, documentation for fast exams is detailed and images must be stored in the record. This most certainly requires a high investment of time and dollars for little financial return.

Ultimately, we all know that revenue success is dependent on the documentation effort you use, the coding expertise you employ, and the billing company follow through. Pay attention to the details of your practice, look for additional reimbursement opportunities and you should experience improvements to your bottom line!

Facility Facts *by Jean Poe, RN, CPC*

Q: How do you appropriately code/bill facility services for an IV started in an ambulance and continued upon arrival?

A: According to CMS policy, the hospital may bill infusion for a patient who arrives via ambulance with an ongoing intravenous infusion initiated by paramedics during transport. Infusion coding/billing are time driven codes. In this instance, the facility infusion coding/billing 'clock' would start based on the documented time of patient arrival. Remember, regardless of where the infusion is initiated, medical necessity must be documented/ established to code and bill for this service.



Clinical vs. Reimbursement Diagnosis *by Sharon Nicka, RN, CPC*

The topic of diagnosis is seemingly filled with myth and mystery. The truth is, terminology that would generally be considered adequate in terms of a clinical diagnosis is not always considered adequate for purposes of third-party reimbursements. To assist with the gap that may exist between a clinical diagnosis and a reimbursement diagnosis, signs and symptoms often help the transition that reflects medical necessity of the work up and patient encounter.

The key point here is to be as specific as possible when describing your assessment as it relates to the diagnosis or again, signs and symptoms of the patient. The ability to bill for a specific diagnosis often warrants a higher percentage of reimbursement on the E/M level coded and billed. For example, have you had a patient that presents with palpitations and shortness of breath and after extensive testing, the outcome is anxiety? Sure you have. Here's another example and distinction. From a clinical perspective, the best explanation or description of a pathophysiologic process is documented throughout the medical encounter and diagnosis. From a coding perspective, the description of presentation, symptoms, signs and disease entities that substantiate the need for urgent medical care should be coded.

Listed below are some additional clinical vs. reimbursement diagnosis encounters:

If the Clinical Diagnosis Is…	*Possible Reimbursement Diagnosis Could Be:*
Esophagitis	Acute chest pain
U.R.I.	Acute febrile illness secondary to cough Acute tracheobronchitis
Gastroenteritis	Acute, severe abdominal pain Acute Dehydration (volume depletion) secondary to nausea/vomiting Electrolyte imbalance
Flu / Viral Illness	Acute viremia Acute volume depletion secondary to nausea/vomiting Acute febrile illness
Musculoskeletal Pain	Acute cervical pain Acute chest wall syndrome Acute strain or pain to specific area (lumbar, etc.) secondary to MVA/fall
Otitis media	Acute febrile illness secondary to Acute otitis media Acute otalgia
Well-Baby ~ No apparent injury	Blunt trauma secondary to MVA Contusion secondary to seat belt placement
Bronchitis	Acute bronchitis

In the coding and reimbursement world, words help to describe the encounter. Listed below are some general words to avoid and good words to capture for documentation purposes.

Words to Avoid :	*Words to Capture:*
Mild	Acute
Minor	Severe
Possible	Sudden
Chronic	Serious
Probable	Distress
Questionable	Pain
Versus	Fever
Rule Out	Unstable

We all know the ED environment is chaotic with multiple life altering events taking place simultaneously. The last thing you may be truly thinking about is documenting your chart or remembering to document for medical necessity. However, when you fail to do so, a legitimate E/M Level 5 could be down coded to a Level 3 and reimbursement may be negatively impacted up to 65% in revenue loss.

The diagnosis myth is dismissed and the mystery solved – signs and symptoms can and should be used in the final diagnosis/impression. Be sure you document accordingly!

Clarification

Mid Level Provider Documentation Requirements

by Margherita Rader, MEd

Controversy continues with MLP documentation practices for coding and billing. Here are some MLP clarifications for both shared E/M visits and billable procedures.

'Shared' E/M Level Visit: CMS definitively states that a face to face encounter by the physician must be documented for the physician to receive 100% of allowable payment for the E/M service provided. In absence of a documented face to face encounter, the E/M should be billed to the MLP.

While we strongly encourage the physician to provide their own documentation of the face to face encounter, upon further research there is currently nothing in the regulations requiring written documentation directly from the MD about his/her care.

Please note the following possible MLP examples that technically meet CMS documentation requirements:

- Dr. MD saw the patient and discussed test results.
- Dr. MD has seen and evaluated the patient and agrees with treatment plan.

The following MLP documentation examples would NOT meet CMS requirements as no MD face to face is indicated:

- Dr. MD reviewed his chart as well as history.
- Treatment plan has been reviewed with Dr. MD. Due to patient's current presentation, patient will be admitted.

MLP Procedures Performed in the ED: Procedures are never 'shared'. Documentation should clearly state what provider performed the procedure – applicable procedure charge(s) should be coded to the provider (MD or MLP) that actually provided the service.

EXCELLENCE IN CODING, COMPLIANCE, CONSULTING & EDUCATION

Urgent Care Connections

by Jean Poe, RN, CPC
& Margherita Rader, MEd

Place Of Service: Urgent Care billing can be a challenge – especially when it comes to assigning the place of service (POS) code. The two most common POS codes utilized for urgent care services are POS-20 (urgent care facility) and POS-11 (office).

CMS defines an *urgent care facility* as "a location, distinct from a hospital emergency room, an office or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention".

An *office* is defined as "a location other than a hospital, skilled nursing facility, military treatment facility, community heath center, state or local public health clinic, or intermediate care facility where the health professional routinely provided health examinations, diagnosis and treatment of illness or injury on an ambulatory basis".

Generally speaking, we recommend assigning the most accurate code to describe the services rendered. In the reimbursement world, one must also consider the nuances and preferences of individual payers to determine the POS code.

For Medicare, each intermediary is different – some require POS-20 and others require the use of POS-11. Other payers will accept either POS code. 'Know thy payers' is the name of the game for minimizing denials and optimizing appropriate revenues!

Coming Event!

Fall 2008

Nicka & Associates, Inc.

Annual

Emergency Medicine

Coding Academy

Texas

(Specific Information TBA)

5501 Independence Parkway
Suite 316
Plano, TX 75023

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Phone: 972.964.5330
Fax: 972.964.1056
www.nicka-associates.com

2008 Conferences & Exhibits

Nicka & Associates, Inc. will be participating in the following events:

February 7-9, 2008	AAEM	Amelia Island, FL
February 17-21, 2008	ACEP	Las Vegas, NV
February 28-March 2, 2008	ENA	Honolulu, HI
March 24-28, 2008	FEP	Orlando, FL
April 24-27, 2008	TCEP 2008	The Woodlands, TX
April 29-May 2, 2008	UCAOA	New Orleans, LA
May 14-16, 2008	EDPMA Summit XI	Las Vegas, NV
July 13-16, 2008	MCEP	Traverse City, MI
July 31-August 4, 2008	Symposium by the Sea	Boca Raton, FL
October 26-31, 2008	ACEP Scientific Assembly	Chicago, IL

If you are planning to attend any of these conferences, we welcome you to contact us or stop by our exhibit!

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.