NEWS *from* NICKA

CODING COMPLIANCE CONSULTING EDUCATION

• Optimal Reimbursement With Minimized Compliance Risk •

• Credentialed Coders & Auditors Who Are Current On Coding Initiatives •

• Proven Solutions To Assure Your Financial Success •

• Our Specialty Is Emergency Medicine & Urgent Care Services •

Sharon's Corner

Let's face it, sometimes life throws us a curveball. Location of the batter's box can be anywhere – our homes, business practice or beyond. Certainly our nation has experienced an economic curveball and most of us are feeling the effects of it all. Best way to deal with challenges is to educate yourself on what you are actually dealing with. For example, did you know that a major league curveball can veer as much as 17 1/2 inches from a straight line by the time it crosses the plate? Curveballs do most of their curving in the last quarter of their trip to the plate. Considering that it takes less time for the ball to travel those last 15 feet (about 1/6 of a second) than it takes for the batter to swing the bat (about 1/5 of a second), hitters must begin their swings before the ball has started to show much curve. No wonder curveballs are so hard to hit. Challenging to hit – yes. Impossible – no. Lesson to be learned – keep your eye on the ball and swing!

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

Sharon's Corner

In This Issue

Sharon's Corner	1
Rx For Success	1
The Eyes of OIG May Be Upon You	2
Smoking Cessation	2
Physician Documentation Pearls	2
Facility Documentation Pearls	3
Injection/Infusion Pitfalls — A Mid-Year Update	3
2009/2010 Conferences & Exhibits	3
Free Standing Emergency Department or Urgent Care	4
Save These Dates!	4

Fall 2009

Rx For Success *by Sharon Nicka, RN,*

Given the current national and global economic challenges, it would be wise to take a good, pro-active look at the details of your practice. Three major considerations that affect practice success is the quality of *documentation, coding and billing services.*

Documentation is the key to creating a risk aversive medical record and optimizing appropriate revenues for services provided. When was the last time you requested or received comprehensive documentation education for all the providers in your group? A refresher course on all the documentation guidelines coupled with focused education on identified documentation deficiencies would serve you well from both a compliance and reimbursement perspective. Consider obtaining and providing documentation education as part of your 2010 strategic plan!

Quality of coding services is also an integral component to your overall practice success. Do you know what your coding vendor's coder qualifications and compliance standards are? Coding should be provided by certified, experienced coders. Furthermore, internal audit reviews should be scheduled and performed on a regular basis on the coders providing services for your practice. When was the last time you obtained an external audit on your coding? If it has been more than two years, you may want to consider obtaining an external audit. This will serve to support your overall practice compliance efforts as well as provide a third party assessment of coding services provided.

E/M level acuity distribution reports should be reviewed on a regular basis. Acuity data should result in a bell curve/right shift distribution. Your hospital location and demographics may reveal natural seasonal volume and acuity shifts. Otherwise, minor acuity shifts can be expected from month to month; however any E/M level shift greater than five to seven percentage points are noteworthy. Documentation deficiency feedback is a part of the coding process. Deficiency reports should also be received and reviewed with your providers on a regular basis. Acuity, deficiency and other practice management reports should be provided monthly through your billing company. If report reviews are not part of your practice management routines, I encourage you to include them in your pro-active strategies!

Review your current fee schedule to adjust fees for service, delete outdated codes and add updated codes. This is a good time to also consider the addition of reimbursement opportunities not included in your current coding profile. For example, with the eyes of RACS ever increasingly upon us, Observation Services codes (99217-99220; 99234-99236) could be considered.

Observation is a status – not a location. Coding for OBS services does not require that the patient be placed in a designated OBS unit. You are likely already performing OBS status services on some of your patients. OBS codes carry a higher RVU than E/M levels 99284-99285. Specific documentation and billing rules apply to OBS – so check it out. Other *reimbursement opportunities* may include use of After Hours code 99053 and expanded participation in PQRI.

So there you have it – an Rx for success!

The Eyes Of OIG May Be Upon

As many of you know, the OIG has increased its auditing efforts regarding E/M coding. If you have not received a letter with the "brand" of Mac, Cert or PSC, keep a look out, one may just be lurking around the next mail delivery. The triggering event for the increased OIG scrutiny is audit results indicating significant error rate resulting in overpayments of funds. Remember that famous movie line "Show me the Money"? This may become the OIG's new mantra – and they may be knocking on your door soon.

In response, we encourage you to take proactive measures to support your compliance efforts. First and foremost, you should take a good look at the integrity and expertise of your current coding. Now here is my mantra: Doctors should doctor; nurses should nurse and coding should be performed by certified, experienced coders.

While all coding should be quality monitored through a written internal compliance plan, physicians groups, hospitals and urgent care centers should also develop and implement an active compliance plan. Taking a closer, intentional look at your current coding/billing should be integral to your operations.

It is best practice to perform an annual outside audit of E/M coding for the following reasons:

- E/M coding represents an integral part of the revenue cycle and is potentially subject to over- or underpayment
- E/M audits help identify areas of opportunity for increased revenue, as well as ways to reduce compliance risks
- CMS has stated that providers have a responsibility to know the rules and regulations that apply to all services billed to Medicare
- Providers often unintentionally code incorrectly due to the complexity of assigning a code
- Providers often inappropriately assign E/M levels because they don't understand which elements of the documentation support an E/M level

There are two ways to approach E/M auditing; prospective or retrospective. Both have their advantages and disadvantages. Prospective auditing occurs prior to when a claim is generated, allowing easy changes in the event that an auditor discovers an error. Retrospective auditing occurs after a provider bills a claim to a third party or carrier.

Keep in mind that while rules and guidelines abound, there is a degree of subjectivity in coding that can result in areas of grey. Coding guidelines are general rules for measuring and categorizing the work of clinicians, therefore the specific application of the guidelines is subject to human interpretation. Differences of opinion may not necessarily mean that one person is right and the other is wrong.

Once preliminary audit results have been received, it is important to communicate with all parties involved to review, discuss and clarify variances. This is an opportunity to identify any areas for focused education and/or protocol changes. There may be instances where the final outcome is that you 'agree to disagree' on a given chart or variance. A revised/final audit report should then be provided from the auditing entity.

Hospitals continue to run on razor thin margins and physician groups feel the pressure of reimbursement cuts putting emphasis on improving revenue through coding optimization. Why then put those revenues at risk? Take pro-active action now to support your compliance efforts and protect your revenue dollars!

Smoking Cessation *by Sharon Nicka, RN, CPC & Margherita Rader,*

If you are not currently providing or documenting patient tobacco use cessation counseling, you are missing out on some revenue dollars. Smoking and Tobacco Cessation code 99406 may be assigned for a documented counseling encounter of greater than 3 minutes / less than 10 minutes. This code has an RVU value of 0.33. Medicare math calculates an $11.89 reimbursement on this code. Code 99407 is assigned for documented cessation counseling of greater than 10 minutes. The RVU on this code is 0.66 which nets out a Medicare payment of $23.79. Remember, these are time driven codes – documentation must state counseled tobacco use cessation and applicable time. While these codes do not have significant individual reimbursement rates, they can add up! Given our current economy, every dollar counts!

Physician Documentation Procedure Pearls

Do You Know?

Rhythm Strip Code 93042

- Must have an order to bill and a triggering event to code.

Medical Necessity for Code 93042 Rhythm Strip:

- Document a change in clinical condition or document the patient's response to medication, i.e., response to cardizem and/or short run of v-tach.

Splinting & Strapping

- The ED physician must either apply the splint or review the placement (i.e., neurovascular check by ERMD) in order to bill for service.
- For Medicare patients, the ED physician must personally place the splint in order to code the procedure.

Lacerations

- Describe length, location, and number of layers or significant debridement and/or irrigation.
- Medicare reimburses approximately $120 for a 3 cm finger laceration which is more than a level 4 visit and almost as much as a level 5.

Injection/Infusion Pitfalls

Infusions, injections, and vaccine administration continue to represent a compliance and reimbursement risk from overcharges and lost revenues.

The documentation necessary to support these charges is extensive and includes:

- Start and stop times
- Clearly labeled sites (e.g., "A, B, C" or "1, 2, 3")
- Clearly labeled piggyback (IVPB) administration according to site, start and stop times, and medication included within the bag
- Consistently stated facility IVPB nomenclature

Consistently stated push-drug administration nomenclature for your facility (e.g., if your facility uses "IV push," you should not say "IVP").

We realize that many requirements make it difficult for your nursing staff members to comply, however, compliance and reimbursement is an important part of your hospital's requirements and operational success.

This information was adapted from the article "*Solve the Twin Problems of ED revenue loss and compliance risk*" from the May issue of Briefings on APCs in the APCs Weekly Monitor dated May 29, 2009.

Facility Procedure Pearls

Injection Definitions

- An *injection* where the provider is continuously present to administer the *injection* and observe the patient.
- An *infusion* of 15 minutes or less.
- Sequential – considered to be an *infusion/push* of a different drug.
- SQ/IM – no initial or subsequent designation required; may report *multiple injections* of same drug.
- Concurrent does not apply if IV pump is used to treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Do You Know?

- Recent studies indicate less than 40% of providers have not adequately considered all resources when assigning the E/M level, resulting in 'millions of underpayments'.
- Research shows that improperly coded claims and billing omissions cost the average 250-bed hospital about $750,00 in Medicare out-patient revenue annually. Is your facility one of them?

2009/2010 Conferences & Exhibits

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

Date	Event	Location
October 3-7, 2009	ACEP Scientific Assembly 2009 **GIVEAWAY**	Boston, MA
January 27-29, 2010	ACEP 2010 Reimbursement: Trends & Strategies	Las Vegas, NV
February 15-17, 2010	AAEM 16th Annual Scientific Assembly	Las Vegas, NV
April 15-18, 2010	TCEP Annual Meeting 2010	Frisco, TX
May 25-28, 2010	UCAOA 2010 Spring Urgent Care Convention	Orlando, FL
June 21-23, 2010	EDPMA Solutions Summit XIII	Key Biscayne, Miami, FL
July 11-14, 2010	Michigan ACEP	Boyne Falls, MI
July 29-August 1, 2010	FEP Symposium By The Sea	Boca Raton, FL
September 28-October 1, 2010	ACEP Scientific Assembly 2010 **GIVEAWAY**	Las Vegas, NV

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

Free-Standing Emergency Department

The growth of Urgent Care Centers has been significant in the past ten years. Urgent Care Centers provide valuable patient services designed to diagnose and treat illness or injury for unscheduled ambulatory patients seeking immediate attention. Established patients may also seek routine care such as health examinations, updated immunizations, etc. While Urgent Care Centers are free standing facilities, they generally are not open 24/7 and may or may not accept ambulance patients. Centers are becoming increasingly more sophisticated in their equipment, resources and services provided. From this, a 'hybrid' breed of patient care facility and services has evolved: Free Standing Emergency Departments.

Freestanding Emergency Departments are currently in operation and expanding across the USA. Market demand for accessible, quality, and affordable ED services without customary wait times have contributed to the interest and growth of these facilities. Free standing EDs are physically distinct from an inpatient, traditional hospital. With the exception of trauma, free standing EDs are designed to offer the same services as traditional EDs, are open 24/7, accept ambulance service and are accompanied by ancillary services. Free standing EDs must meet all the same physical plant, occupancy and construction requirements as hospital-based EDs and are subject to identical regulation.

Since freestanding EDs are relatively new additions to health care services, there is debate regarding identification and classification. The definition of Emergency Department Services provided in The Current Procedural Terminology (CPT) Manual is: "An emergency department is defined as an organized *hospital-based* facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24-Hours a day." The Centers for Medicare and Medicaid Services (CMS) also recognizes this definition.

The CPT Place of Service (POS) 23 Emergency room also includes hospital based language: "A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided." The CPT POS 20 Urgent Care Facility is defined as "Location, distinct from a hospital emergency department, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention."

The current CPT and CMS inclusion of the term 'hospital based' in defining emergency department POS and CPT codes creates a grey area of controversy regarding reimbursement of services. *Non-hospital* based free standing ED facilities generally need to negotiate reimbursement classification definitions (ED vs. Urgent Care POS & Code Sets) with each commercial payer as it is currently a state and payer specific issue. To avoid potential payment denials, clarify and negotiate up front with each payer!

Save The Dates!

MARCH 3-5, 2010

EMERGENCY MEDICINE CODING ACADEMY

- FACILITY
- PROFESSIONAL
- URGENT CARE

DALLAS, TEXAS

www.nicka-associates.com

Nicka & Associates, Inc. specializes in Emergency Medicine Services. The Nicka & Associates 2010 Emergency Medicine Coding Academy is designed to improve upon the coders basic knowledge of CPT and ICD-9 coding. Building upon this foundation, the three-day seminar will provide the necessary skills to code the Professional, Facility Emergency Department and Urgent Care encounter with confidence and proficiency.

The seminar focus will be on critical updates and specialty specific coding that will enable the participant to stay on target with the best practices of the industry, expand and update current coding skill set and obtain meaningful CEU credits.

The Nicka & Associates 2010 Emergency Medicine Coding Academy will provide the essential elements and educational experience to support accurate coding practices and promote Emergency Medicine Coder success!

Mark the dates, March 3-5, 2010, to attend the Nicka & Associates 2010 Emergency Medicine Coding Academy!