

# Hot Topics

## Pulse Ox in the ED

by Sharon Nicka, RN, CPC  
& Margherita Rader, MEd

Professional billing for pulse ox in the ED is and has been a 'no go' with CMS payers. For other payers pulse ox interpretations that meet the medical necessity criteria for the patient encounter, could potentially be considered a separately billable service.

So where's the heat?

- Pulse ox 94760 is considered a technical only code. This 'technically' means you can bill for it on the professional side where the reporting physician owns the equipment used for the procedure.

We have made inquiries on billing and reimbursement of this code. The feedback received is only a small percentage of overall practice encounters receive payment with a net reimbursement ranging from \$.05 up to \$2.00 per code. The bottom line practice revenue impact attributed to of pulse ox coding is minimal.

Appropriate use and professional billing of pulse ox is a real area of grey and we do not know what the future holds. In our current environment of ever increasing audit scrutiny, professional pulse ox billings could become a potential target for audit review and payment recoupment.

*Do the benefits of 94760 code utilization outweigh the risks on the ED professional side? Upon reviewing the current data and code details, our professional opinion is no. We further recommend professional ED coding of 94760 be discontinued and removed from professional ED coding profiles.*



## URGENT CARE: NEW & ESTABLISHED PATIENTS

by Terri Perkins, CPC  
& Margherita Rader, MEd

The hot topic at a recent national Urgent Care convention was new and established patients. The basic definitions of these two different categories are:

- **New Patient:** A patient who has not been registered or seen in the UC Center in the last three years
- **Established Patient:** A patient that has been registered and seen in the UC Center within three years prior to the current visit.

Sounds straightforward – right? Well, not really. The reality is, depending on circumstances, a 'Twilight Zone' effect is created. One example that comes into play is when an Urgent Care Center is directly affiliated with a hospital system. A patient that has been registered at a hospital with an affiliated Clinic/ UC Center would technically be considered an established patient to the affiliated Clinic /UC Center even if the hospital created their medical records more than three years ago. You can see the dilemma – unless specifically documented or noted, how can the coder determine the correct new vs. established patient E/M level on these hospital affiliated Urgent Care Centers? It is important that the hospital and UC center department develop a policy to communicate/work together to identify the correct patient classification.

We will continue to keep our eyes and ears open on this topic. Stay tuned for further clarifications as they become available.

*This information should not be considered to be legal. Changes in CMS and private payer guidelines constantly change. Nicka & Associates cannot guarantee the accuracy or timeliness of the information.*

## SHARON'S CORNER

*The journey to year end is rapidly coming to a close! End of year is always a good time to reflect on goal setting for the coming New Year. In that spirit, we thought we'd provide a brief '2010 Year in Review'. We hope this overview of the year's hot topics, government audit results and documentation feedback will kick start your new year's planning!*

*We hope everyone enjoys a safe and wonderful holiday season ahead with family and friends.*



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## CERT CITATIONS

by Margherita Rader, MEd

An official laundry list of documentation errors were identified by CERT (Comprehensive Error Rate Testing) government reviews conducted in Colorado and Texas. Take a close look at these cited areas:

- Missing or illegible provider signatures
- Missing results/interpretations for diagnostic tests
- Missing MD orders for procedures performed
- Documentation did not support medical necessity for service or services
- Illegible documentation – service was denied or down coded
- Exam component not meeting E/M level requirement
- History component not meeting E/M level requirement
- Documentation of service not meeting definition of critical care
- Documentation of service not meeting definition of a new patient (Urgent Care)
- Incomplete or missing plan of care (Urgent Care)

We encourage you to pay attention to the details and take proactive measures to provide thorough documentation that accurately reflects the entire patient encounter.

# DOCUMENTATION DEFICIENCIES

by Sharon Nicka, RN, CPC  
& Margherita Rader, MEd



**Document, Document, Document!** You have heard this mantra time and time again. Thorough documentation is truly the best way to create a risk averse chart and optimize appropriate reimbursement for all the services you have provided.

During the course of the year, we review thousands of deficiencies. Deficiency trends have likely been noted or identified on your own practice or location reports, yet we continue to see definite repeated trends in our ongoing reviews. If any of the deficiencies listed below look 'familiar' – the time is now to focus on the details of documentation requirements for charge capture!

Here are the top deficiencies encountered on the Facility and Professional side:

## FACILITY

1. **Hydration/Infusion Codes:** are the most missed/down coded services on the facility side. Nursing documentation of START and STOP times is a must!
2. An MD written order should be documented for all nursing procedures provided (i.e. cardiac monitors, splints, foleys etc.) during the patient encounter. It is the nurses' responsibility to ensure all verbal orders are written and signed by the MD. Absence of a written MD order results in a lost charge for the procedure(s) performed.
3. Remember to document all patient reassessments!

## PROFESSIONAL

1. **E/M Level 5 Down Codes:** Inadequate chart component documentation is the number one area of deficiency on the pro fee side. Listed below are the documentation requirements for this level of service:
  - Comprehensive History and Exam
  - History Elements of Chief Complaint – Concise statement describing the symptom
  - HPI – Extended 4+ elements or status of 3 chronic or inactive conditions
  - ROS – Complete 10+ systems. List all pertinent positives with T-System check-off box statement "all other ROS negative is acceptable"
  - PE – Complete, general multi-system exam (8)

- PSFH – At least 2 specific items
- MDM – High complexity

2. **EKGs:** While the individual reimbursement is not a high dollar value, the cumulative effect of missed EKGs can really add up to some good chunk change.

EKG interpretations require documentation of 3 of the following components:

- Axis
- Presence or absence of ectopy
- Rhythm
- Rate
- PR intervals
- ST wave changes
- Comparison to a prior EKG if reviewed

3. **Reassessments:** Documentation of patient reassessments can contribute to the E/M level code assignment. Remember to document all the services you provide!

4. **Splint Applications:**

This procedure is another relatively low dollar reimbursement item that can add up when documented appropriately.

Documentation requirements for splint application are as follows:

- **Medicare:** Documentation should support placement of splint by the MD
- **Other Carriers:** The ED MD does not have to be the one who puts on the splint, but if someone else (e.g. nurse) applies it, the MD must document that he/she checked it, e.g. "splint in good position and alignment, neurovascular status intact"

5. **Documentation Legibility:**

In our last issue of Nicka Notes, we focused on legibility of physician signatures. For all of you non-EMR users, legibility of documentation is important throughout the medical record to appropriately capture procedures and level of service provided.

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