



YOUR 'JOHN HANCOCK'

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

We are all aware of the stereotype that physicians must have failed handwriting instruction in grammar school. However, your John Hancock is an integral component of chart documentation. Illegible signatures create both compliance and reimbursement issues.

With the ever increasing scrutiny of government and third party audits, an illegible signature on a medical record or physician order equates to no signature/no order! The impact is significant: it is estimated that multiple billions of dollars are subject to Medicare recoupment alone.

If your practice has adopted an RVU based compensation incentive plan, your John Hancock is directly tied to your monthly paycheck. The ability to discern and accurately match squiggle signatures to the correct provider is a real error prone challenge. We all want to avoid the scenario of another provider to mistakenly receive credit and compensation for work you have performed. If and when an error is discovered, it takes quite a collaborative feat to re-review, correct and process.

What's the solution? While CMS will not accept a stamped provider signature, a stamped provider name or number with countersignature will ensure compliance and reimbursement issues are addressed up front!

SHARON'S CORNER

One thing that has remained constant in life is that change is inevitable! In this age of fast-paced information, we are changing the format and increasing the frequency of our newsletter publications. Our new look is designed to provide you, the reader, with quick up-to-date notes and commentary on current topics in the emergency medicine and urgent care arena. We hope you enjoy reading and staying informed!



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URGENT CARE — A CLOSER LOOK AT HISTORY

by Terri Perkins, CPC & Margherita Rader, MEd

The number one deficiency for Urgent Care services is new patient E/M Level 99205 and 99204 due to inadequate history. The Past Family Social History (PFSH) component is usually the culprit for the E/M down codes. Remember you need elements from all three components of the PFSH to be documented on new patient encounters to meet the 99205 and 99204 E/M level requirements.

Appropriate E/M level documentation and coding is integral to your bottom line revenues. Pay attention to the details of documentation to ensure a compliant encounter that supports reimbursement for the services you provided!

RAC ATTACK!

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

It appears CMS has clearly defined targets for the RAC (Recovery Audit Contractors). IV hydration codes are on the hit list...are you informed and prepared for a potential RAC attack?

IV hydration documentation and coding can be confusing and can lead to inaccurate reporting. One of the most misunderstood codes is the initial IV hydration code (96360) and the initial therapeutic infusion code (96365). Simply stated, you can code/bill only one unit of this service per patient per date of service regardless of where the service was provided. Patient transfers from one department to another (i.e. ED to Observation) can result in billing errors for this code. Effective communications between departments should support accurate documentation practices and coding of this service.

Another reporting pitfall to avoid involving hydration or therapeutic infusion is only one initial service may be reported for the same IV site. When administering multiple infusions, injections or combinations, only one "initial" service should be reported, unless protocol (i.e. Dopamine and NTG drips) requires that two separate IV sites must be used. In the facility setting, there are specific guidelines regarding the hierarchy and precedence of these codes. Once the primary or initial service is selected, any other services should be reported as secondary (e.g. additional, sequential, or concurrent) in accordance with the established hierarchy.

Nursing documentation is key in supporting IV hydration services. Be sure your staff is up to date on best practices!

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