



DECEMBER 2011

EXCELLENCE IN EMERGENCY MEDICINE & URGENT CARE SERVICES
CREDENTIALLED, EXPERIENCED CODERS & AUDITORS
OPTIMAL REIMBURSEMENT WITH MINIMIZED COMPLIANCE RISK
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Nicka Notes

CODING • COMPLIANCE • CONSULTING • EDUCATION

SHARON'S CORNER



The long traveled year is fast approaching an end. The last mile ahead can seem exhausting with all the holiday preparations and flurry of activities. It is also a very special time of shared traditions, family gatherings and merriment!

This isn't a perfect world. Life is all about ups and downs. When things are on the upswing, life feels good. And when situations look or turn downward, I have learned it can be the best time to take an intentional, constructive look in the mirror.

Looking back over 2011, there have been times where it has felt like a roller coaster ride. This year has challenged me to take a closer look at professional goals and what changes are needed for success. Having worked through some 'tough stuff' issues to successfully move forward, I approach 2012 with a sense of accomplishment and optimism in the year to come.

Wishing you and yours a spirit filled holiday and promising New Year ahead!



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

Hot Topics "preparing the way" ICD-10 Transition

by Sharon L. Nicka, RN, CPC

The clock is ticking, the alarm set – October 1, 2013 – transition day! The wide-reaching transition from ICD-9 to ICD-10 will have a significant operational and financial impact. There are numerous organizations with written suggestions, timelines to meet, tasks to assign and resources to consider. What have you and your organization done to prepare?

The actual definitive new code sets are still a work in progress. In the interim, here are some things you can and should be considering and pursuing NOW.

Documentation

Clinical documentation will need to change and improve. Detailed specificity of the medical record will be important to code accurately and appropriately. Remember we are going from 3, 4 and 5 digit codes to codes that use double digits.

Hospital Based providers should consult with your HIM department to ensure you are getting their ICD-10 newsletter because there may be differences between documentation requirements for your facility and what is needed for your billing. Details of the cause of injuries and illnesses and environmental factors that may be minimally related to the illness or injury will now be required documentation. Payers will likely seize this opportunity with a host of new denials to delay payments

requesting additional information. Triage folks may need a system of prompts based on different presenting signs, symptoms and conditions in order to capture all the new information required to code ICD-10.

Take proactive steps now to develop and schedule documentation education for physicians, MLPs, clinical nurse, medical directors and hospital/location administration.

Coding

The specificity of the ICD-10 codes will require all coders to truly be 'in the know' of anatomy. Now is the time to seek out course work (on line or on campus) to serve as a refresher and/or to expand and obtain in depth understanding and knowledge of anatomy.

IT Considerations

ICD-10 will require a systems inventory and new database applications to bridge and/or accommodate the new format of ICD-10 for both coding and billing. This IT conversion/adaptation will require formal project management and resources for successful development, testing and implementation.

Preparedness and assessment of all aspects of documentation, coding and billing for ICD-10 is a must! If you haven't started preparing, the time is now!

2012 1st QUARTER CONFERENCES & EXHIBITS

NICKA & ASSOCIATES, INC. WILL BE PARTICIPATING IN THESE EVENTS

January 23-25, 2012	ACEP 2010 Reimbursement	Planet Hollywood, Las Vegas, NV
February 1-2, 2012	THA 2010 Annual Conference	Austin Convention Center, Austin, TX
February 8-10, 2012	AAEM 18th Annual Scientific Assembly	Hotel Del Coronado, San Diego, CA

Nicka & Associates, Inc. Corporate Office — 5501 Independence Parkway, Suite 316 — Plano, TX 75023

Office: 972-964-5330 — Toll Free: 866-556-5976 — Fax: 972-964-1056

Email & Website: info@nicka-associates.com — www.nicka-associates.com

ED Facility Overview *by Sharon L. Nicka, RN, CPC & Margherita Rader, MEd*

In 2011, we conducted compliance audits on facilities across the nation. Audits are a great way to obtain benchmarking and trending information on coding and areas of documentation strength and improvement.

ED facility acuity varies by hospital, region, and facility tool, nursing documentation and coding skill. Because of the many variables, hospitals continue to be a moving target.

Overall, documentation of IV therapeutic, prophylactic and diagnostic injections and infusions continue to be problematic. Start and stop times are a must as IV hydration times are time based. Documentation guidelines for all time based codes are specific – time must be accurate and documented with medical necessity supported. No way around it – document those start and stop times!

Physician orders for cardiac monitors, EKGs and cath UA's continue and are also a target for outside audits. Many facilities have protocols or policies in place that allow the nurse to provide these services. Written protocols are good and a must in the ED environment – but they do need to be detailed in design, included in the client coding profile and/or transcribed in the order sheet. Here in lies the "risk": in absence of a documented MD order and/or statement of specific written protocol used for chest pain, asthma, abdomen pain, etc. coders, auditors or billing companies cannot appropriately bill for those services. Many dollars are lost or have been billed inappropriately. The potential for recoupment from this CMS transmittal is huge. We recommend that in the absence of an order the nurse's note indicate, "...EKG per protocol..." and physicians and coders should note procedures that seem inconsistent with the patient's condition and standard treatment protocols.

Looking ahead to 2012, we encourage facilities to consider obtaining a base line compliance audit and feedback on current facility tool, coding and documentation practices. Follow up education on areas identified in the audit results is key to both compliance and reimbursement success. Go for it!

Save The Dates!



February 29, 2012
March 1, 2012
March 2, 2012

Emergency Medicine & Urgent Care Coding Academy

- FACILITY
- PROFESSIONAL
- FSED
- URGENT CARE

www.nicka-associates.com
Plano, Texas

Nicka & Associates, Inc. specializes in Emergency Medicine Services. The **Nicka & Associates 2012 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, FSED 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 2012 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, February 29, March 1 & 2, 2012 to attend the **Nicka & Associates 2012 Emergency Medicine Coding Academy in Plano, Texas!**

FRACTURE CARE *by Sharon L. Nicka, RN, CPC*



Fracture care documentation in the ED, urgent care or free standing ED setting continues to be both challenging and confusing. The RVU's for fracture care codes are among the highest CPT codes reimbursed so documenting the details of the encounter equates to better reimbursement.

Fracture care procedure note documentation should include:

Location & Type of Fracture

- ⇒ Exact bone

- ⇒ Exact location
- ⇒ Displaced
- ⇒ Non-displaced
- ⇒ Angulated
- ⇒ Transverse

Treatment

- ⇒ With manipulation/reduction
- ⇒ Without manipulation
- ⇒ Type of anesthesia
- ⇒ Materials/devices utilized

Neurovascular Re-checks

- ⇒ Post procedure
- ⇒ Post splint placement

Note: Medicare - documentation should

support placement of splint by the MD. Indicating "a splint will be placed" is inadequate. Documentation must note that splint was actually placed.

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."

Follow-up Treatment

- ⇒ Pain medication
- ⇒ Referral & follow-up timeline... can the patient wait 24, 48, 72 hours for follow-up care?

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