



ED Coding and Reimbursement Alert



Your practical adviser for ethically optimizing coding, payment, and efficiency in emergency medicine

• Documentation • Compliance • Reimbursement

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E/M Coding

Reasons Your Review of Systems Documentation Could Be Sabotaging Your Claims

Is "All Other Systems Negative" a ticking time bomb, set to explode your ROS cred?

If you're relying too heavily on the handy phrase "all other systems negative" in documenting a complete Review of Systems (ROS), you could be setting yourself up for an audit feeding frenzy.

The basics: ROS is a crucial element in supporting a 99285 E/M service; CMS E/M Guidelines indicate that documenting pertinent positive and negative findings combined with the statement "all other systems are negative" will be considered a complete Review of Systems. This phrase can be beneficial to allow physicians a shortcut in the documentation process.

Caveat: Physicians should realize the gravity of documenting "all other systems negative", warns **Todd Thomas CPC, CCS-P**, President of ERcoder, Inc. in Edmond, OK. "All other systems negative" is often interpreted to mean that the physician has performed a review of all fourteen systems, and other than the systems documented individually, the rest of the systems had a negative finding, he adds. "I have participated in audits where the physician's use of 'all others negative' was called into question because of the appearance that it was used on a high percentage of charts regardless of the patient's complaint or whether a complete ROS seemed to be clinically appropriate."

Let Medical Necessity Guide Your Documentation

"To quote the auditor in our most recent experience, 'Due to excessive documentation for minor presenting problems, I have been forced to make a judgment call to identify which E/M elements to score as reasonable and necessary for many of the visits,'" Thomas offers.

CMS has addressed the issue of medical necessity in the Medicare Carriers Manual. It states, "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed." In addition to the issue of medical necessity, the accuracy of the statement has been called in to question because of conflicting information in the medical record, the emergency physician documented "All others negative" for the ROS but also documented that they were unable to obtain a complete history due to the patient's condition, says Thomas.

Check out These Payer Policies On AOSN

Payers have become leery of the "All other systems negative" statement, due to a perceived over use and demonstrated inconsistencies in its application, says Thomas. On their website,

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Trailblazer Health Services says, “The Centers for Medicare & Medicaid Services has stated that carriers have the right to interpret the guidelines.” Trailblazers, which is the Medicare carrier for several states, has at times put forth a position that the notation of “all other systems negative” may not be uniformly accepted, though they went on to say that there would not be a clear and distinct deviation from the 1995 Documentation Guidelines permissible.” In addition to Trailblazer, Noridian, Empire, Anthem and HGSA have also at least considered the possibility of not accepting “All other systems negative” for a complete ROS, he adds.

Wisconsin Physician Services (WPS) goes a step further posting the following on their website:

“Due to a recent clarification from CMS, those systems addressed in the ROS must be individually documented. All systems reviewed should be documented, regardless of findings. It is no longer appropriate to just state “all other systems are negative” without specifically listing those systems reviewed.”

They did feel they had supporting documentation, but after two weeks of discussion they reversed their position and the statement was removed from their site, Thomas says.

Not All ROS Statements Are Acceptable, Look For These Kinds of Documented Phrases

In addition to overuse, some payers and auditors have demonstrated a concern about vague or ambiguous statements by physicians in an attempt to satisfy the complete ROS requiring. In audits, Thomas adds, payers have been reluctant to give credit for a complete ROS for the following statements:

- » “10 point review of systems was completed and is negative unless otherwise stated.”
- » “Review of systems per HPI otherwise negative.”
- » “Negative for chest pain, ROS otherwise negative.”

None of the above examples specify that all systems or even 10 systems were reviewed. In a recent *RAC Monitor* article, one of the top 10 audit problems was “poorly documented ROS, including blanket statements like “all systems unremarkable” which many MACs/Part B Carriers do not recognize as legitimate”, Thomas warns.

Follow This AOSN Documentation Plan

Based on past experiences with audits and discussions with payers, Thomas recommends that ED physicians use the following documentation policy to ensure that ROS statements contain specific language to qualify as a complete ROS:

If the physician elects to use an inclusive negative statement such as “all other systems negative”, the language must include one of the following:

- » “all systems”
- » “10 systems” (or more than 10)
- » “complete ROS”

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Consider this example from Thomas showing how a well worded ROS statement can satisfy the documentation requirement

HPI: Patient presents with a suspected spider bite on her right distal forearm. She noticed redness in the area about a week ago, which has progressively spread and worsened since then.

She denies any previous skin infections of this nature and no trauma or contact with other skin infections during this period. She also denies fever and reports no weakness, numbness or tingling in the area. No relieving or exacerbating factors were reported.

ROS: A ten system ROS was complete and negative except as noted above. ☐

ICD-10 Coding

If You Didn't Do Your Homework, You Got A Reprieve

The ICD-10 Final Rule released announces implementation delay until October 2014; but don't wait too long to get up to speed on the new system.

The ICD-10 final rule was released in late August, which includes a decision on the proposed delay for mandatory compliance. This final rule changes the compliance date for the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding, including the Official ICD-10-CM Guidelines for Coding and Reporting, and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) for inpatient hospital procedure coding, including the Official ICD-10-PCS for Coding and Reporting, from October 1, 2013 to October 1, 2014.

CMS Offered An Explanation for Its Decision To Delay

CMS explained its decision was based on some providers' concerns about being able to meet the ICD-10 compliance date because of problems they had meeting the compliance deadline for the adopted Associated Standard Committee's (ASC) X12 Version 5010 standards (Version 5010) for electronic health care transactions.

According to a recent survey conducted by CMS, up to one quarter of the responding health care providers stated that they will not be ready for an October 1, 2013 compliance date, says **Michael A. Granovsky, MD, FACEP, CPC**, President of LogixHealth, an ED coding and billing company in Bedford, MA.

And The Survey Says...

In February 2012, the Workgroup for Electronic Data Interchange (WEDI) conducted a survey on ICD-10 readiness, receiving responses from more than 2,600 providers, health plans, and vendors showing that the industry is uncertain about its ability to meet ICD-10 compliance milestones. Data from the WEDI survey indicated that nearly 50 percent of the provider respondents did not know when they would complete their impact assessment. In addition, the survey found that approximately 33 percent of providers did not

expect to begin external testing in 2013, while approximately 50 percent of providers did not know when testing would occur. Other segments of the industry, such as health plans and software vendors, also reported that they would benefit from additional time for implementation. While the CMS ICD-10 Implementation Guide recommends that payers begin external testing in the fall of 2012, the WEDI readiness survey found that most health plans do not expect to begin external testing until 2013. In addition, about 50 percent of vendors are not yet halfway through development of ICD-10 products. Vendor delays in product development can result in provider and payer delays in implementing ICD-10, Granovsky adds.

The Size Of Your Organization May Impact How You Feel About This Delay

Many large ED groups are far along in their ICD-10 implementation planning, and therefore have devoted funds, resources, and staff to the effort. According to CMS estimates, a 1-year delay of the ICD-10 compliance date would add 10 to 30 percent to the total cost that these entities have already spent or budgeted for the transition – an additional cost to commercial entities of approximately \$1 billion to \$6.4 billion. For those entities that have already incurred considerable

(Continued on next page)

What's Going On With ICD-9 2013? Typically *ED Coding and Reimbursement Alert* would provide a summary of all the relevant changes for 2013, effective October 1, 2012; however, because of the anticipated transition to ICD-10, no new codes will be added until 2015 unless required by the CDC to track some new disease.

Resource: See *ED Coding and Reimbursement Alert*, Vol. 15 No. 3 for a proposed time line for benchmarks you need to meet for successful ICD-10 implementation. ☐

expense in order to meet the October 1, 2013 deadline, they opposed the delay because of likely additional cost associated with duplicating the investment of time and resources that has been spent on education, outreach, and policy discussions in order to meet the October 1, 2013 compliance date. They argue that coders, students, teaching institutions will need to be retrained because of the delayed compliance date, says Granovsky.

Just Because The Delay Has Been Finalized Does Not Mean You Can Forget About ICD-10!

Don't just forget about ICD-10 preparation. ED groups should look at this as an extension rather than a reprieve. The

transition for ICD-9 to ICD-10 will take many months of preparation, training and external testing, so make sure you have a schedule and stick with it so you will be ready when the time comes. If you were well on your way in preparing for the transition next fall, you have some breathing room, but may need to consider some refresher her education because of the significant lag time between initial training and actual implementation. If you have not started getting ready, you should consider the extension a lucky break, because it will take time to be ready by 2014, warns Granovsky.

The link to the ICD-10 final rule appears below.

http://www.ofr.gov/OFRUpload/OFRData/2012-21238_PI.pdf □

Facility Coding

Ace Your Critical Care Coding: Pay Attention to Trauma to Avoid Future Drama

Carefully documented time and resources spent is the key to accurate facility coding

Identifying and reporting the hospital component of ED critical care presents a challenge for hospitals as the rules differ enough from the professional rules to create a significant challenge. This is especially true when the hospital's trauma team is activated to deal with a critical injury presentation.

As of January 1, 2007, critical care services were paid at two levels, depending on whether or not there was also activation of the hospital's trauma team. Hospitals will receive one payment rate for critical care without trauma activation and will receive additional payment when critical care is associated with trauma activation.

When critical care services are provided without trauma activation, the hospital may bill CPT® code 99291, (*Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes*). If additional critical care time is documented over 74 minutes, 99292 (... *each additional 30 minutes [List separately in addition to code for primary services]*) would be billed for each additional 30 minutes of critical care, says **Caral Edelberg, CPC, CPMA, CAC, CCS-P, CHC**, President of Edelberg Compliance Associates in Baton Rouge, LA.

If trauma activation occurs under the circumstances described by the National Uniform Billing Committee (NUBC) guidelines that would permit reporting a charge, the hospital may also bill one unit of code Trauma Activation code G0390, which describes trauma activation associated with hospital critical care services.

Tip: Time, intensity and content of the service form the foundation of this E/M service.

Critical care is defined as a critical illness or injury that acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.

The key to understanding appropriate billing of critical care in the ED is an understanding of how a routine E/M service makes the jump to critical care. As the CPT® guidelines indicate, hospitals that provide less than 30 minutes of critical care should bill for a visit, typically an emergency department visit, at a level consistent with their own internal guidelines, says Edelberg. Critical care requires decision making of high complexity to assess, manipulate, and support vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition. Examples of vital organ system failure include, but are not limited to, central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure, she adds.

Compare the payments for critical care APCs with and without trauma activation

APC	Descriptor	Relative Weight	Payment
0617	Critical care	6.6520	\$465.75
0618	Trauma response with critical care	11.5051	\$805.54 □

Count Time as Your Critical Factor

The time spent managing the critical patient is crucial to assigning the correct code. For the hospital to bill the facility component of this service, documentation must support a minimum of 30 minutes of critical care service to the patient.

Medicare PUB 100-94 MCP, Transmittal 1139, Dec 22, 2006 stated this 30 minute minimum has always applied under the OPSS and will continue to apply, says Edelberg. CMS says that under the OPSS, the time that can be reported as critical care is the time spent by a physician and/or hospital staff engaged in active *face-to-face* critical care of a critically ill or injured patient, she adds.

If the physician and hospital staff or multiple hospital staff members are simultaneously engaged in this active face-to-face care, the time involved can only be counted once. Thus, to

assure you can code this service correctly, documentation must clearly state that the 30 minute threshold has been met. It is important to include start and stop times spent with the patient by each health care provider so that coding professionals can accurately count individual and group provider times while preventing overlap of critical care time claimed when more than one provider is at the bedside, Edelberg explains.

Don't Forget Any Separately Identifiable Procedures

Critical care includes certain other separately identifiable procedures or services that cannot be billed separately; such as interpretation of cardiac output measurements, chest X-rays, pulse oximetry, blood gasses, information data stored in computers, gastric intubation, temporary transcutaneous pacing, ventilator management and vascular access procedures. (CPT® provides the codes related to each of these bundles services.)

Additional procedures provided during the visit are identified separately and paid separately within the CPT® and CCI (Correct Coding Initiatives) rules for separate procedures, warns Edelberg.

Often, critical patients require life-saving interventions in the emergency department. One of the most frequent is CPR. The

(Continued on next page)

You Be the Coder

Don't Fall Apart Over E/M With Fracture Care

Question:

Consider the following Chart documentation:

A nine year-old patient comes in with a history of having fallen off the playground equipment at school. There is an area of tenderness on the distal forearm. Below are some elements of the chart documentation:

PFSH- lives with parents, no medical problems,

ROS - all negative

PE, general exam: vs. normal, HEENT: Nml, CHEST - CTAB, ABD - nml

Extremity- tender area of swelling just proximal to wrist. ROM of wrist is limited by pain, sensory intact to light touch. cap refill <2sec.

X-Ray is ordered-

X-Ray reading by the ED attending: Torus fracture of distal radius.

Treatment: Sugar tong splint is ordered and applied by a cast tech with direct supervision documented by the attending physician including a distal neurovascular check post splinting. A prescription was written for acetaminophen with codeine.

Follow up: Patient and his parents were told to see orthopedist in a week.

How would you report these services?

Answer: See page 79.

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levels of critical care are determined by time; when CPT® code 92950 is reported, the time required to perform CPR is not included in critical care. Additional procedures provided by ED staff or consultants supported by ED staff are separately

billable by the hospital in addition to critical care as long as the time spent performing these procedures is removed from the time used to determine critical care, says Edelberg. □

Reader Questions

Consider the supervision time required to determine a minor or major procedure

Question:

What is the rule of supervision of a procedure in ED? Must I, the supervising physician, be present during the whole procedure if it is done by resident or student? If I wasn't in the room for the procedure, I assume that I can't say I directly supervised. Correct?

Massachusetts Subscriber

Answer:

Assuming this is a Medicare patient (or a patient whose insurance follows Medicare's teaching physician rules), it's not billable at all if the procedure was performed by solely the student. If you are physically present and participate in the procedure along with the student, you should be able to report the service as if you did it yourself with the student acting as an assistant.

For a resident, the minor procedure designation for teaching physician rules is different than the rules for global surgeries. A zero or 10 day global designation is not the determining factor for teaching physicians. The determining factor is how long the procedure takes. CMS defines a minor procedure as one that takes 5 minutes or less to perform. If it takes more than 5 minutes it is a major procedure.

The Medicare manual uses simple suture as an example of a minor procedure but in reality even those usually take more

than 5 minutes and many groups apply the major procedure guidelines.

For a minor procedure, the teaching physician must be present for the entire procedure in order to bill for the procedure.

For a major procedure the teaching physician must be present for the key/critical aspects of the procedure. Of note, it is at the attending physician's discretion to determine which aspects of the procedure represent the key/critical components. □

It's the total dosage not the pill size that counts for prescription strength OTC medicines

Question:

I am looking for assistance on this. I have a provider who has stated that if he recommends that a patient take OTC meds at prescription strength, such as Ibuprofen, this qualifies as moderate for decision making. I am looking for some guidance on this.

Thank you in advance.

South Carolina Subscriber

Answer:

Moderate decision making involves other factors besides the risk. In the typically applied carrier audit grid, there are three components that determine MDM; the number of diagnostic and management options, the amount and complexity of data, and finally the level of risk. He is correct that recommending prescriptive therapy can be moderate risk. However, at least two of the areas of MDM must be supported in order to qualify for a given level of MDM complexity. So you have to score all three components of decision making: Risk (here prescriptions are moderate risk), number of diagnoses and management options, and data.

In order to get to moderate MDM, you need to meet or exceed the criteria in two of the three of these areas. Most providers typically write actual prescriptions for prescription strength medications to make sure the directions are formally made and clear. Just to clarify, though, it's the dosage that determines whether certain medications are "prescription" medications, since that's where the risk comes from. The risk isn't from the act of simply filling out an Rx form (such as for a surgical donut) – nor does it come from the act of a pharmacist dispensing the medication.

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- What do you like?
- What topics would you like to see us cover?
 - What can we improve on?

We'd love to hear from you.

Please email **Mary Compton** at maryc@codinginstitute.com

Thank you in advance for your input!

In other words, an order for 600 mg of ibuprofen is an order for prescription medication, regardless of whether the pharmacist dispenses one 600 mg pill or the patient is instructed to take three 200 mg caplets. □

Don't get too creative when counting HPI elements

Question:

Can you give me the total number of elements in the HPI example that follows:

You Be the Coder

(Question on page 77)

Don't Fall Apart Over E/M With Fracture Care

Answer:

Many groups would report the fracture code 25600 (*Closed treatment of distal radius fracture [e.g., Colles or Smith type] or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; without manipulation*), which has a global surgical period of 90 days and is therefore classified (by Medicare) as a major procedure. If this 9 year old were a Medicare patient, then modifier 57 would be applied to the E/M. Medicare will recognize an E/M for major procedures (global surgical packages of 90days) with a 57, but request the 25 modifier for minor procedures (defined as 0, 10 day global periods).

The documentation also supports an E/M code (likely 99283 or 99284), depending on the extent of the history documented. If the child had not fractured the arm, the visit would easily have justified an E/M code (History, Physical Exam and the MDM points for reading the x-ray). Knowing that the radius was fractured led to the fracture care (definitive-restorative care) which should be an additional service. This child probably does not have Medicare and is governed by the rules of CPT®. Though the fracture care code has a 90 day global period and Medicare directs the use of a modifier 57, some private payers still direct the use of modifier 25.

The area of whether to code an E/M in addition to procedures can be gray and is somewhat determined by the extent of the History and Physical outside of the surgical service. However, in the case of fracture codes (which are really considered surgical procedures by CPT®, even if no manipulation is done), a 57 seems justifiable. The child had a fall, had a head to toe exam screening for other injuries, and that work up lead to the decision to treat the fracture. Given this, you could consider reporting the appropriate ED E/M code with modifier 57. □

70 year-old white male with history of renal colic and abdomen fistula presents with flank (location) pain consistent with prior episodes of renal colic. Patient is a 70 year-old male presenting with kidney stones. Pertinent negatives no chills (associated signs and symptoms), urinary frequency, hematuria, nausea, urgency or vomiting. His past medical history is significant for kidney stones.

Nebraska Subscriber

Answer:

There are two clear HPI elements for location and associated signs and symptoms. You could make an argument for adding severity as implied by the statement “consistent with prior episodes of renal colic”, which would yield three elements. If the provider had stated when the pain started or how bad it was, then it would have been easy to get to a extended HPI using location, duration, severity, associated signs and symptoms. Unfortunately, the provider did not mention the onset. This would not make the grade for an extended HPI. □

Take a global view when dealing with typical postoperative care

Question:

Our ED doctors have patients with abscess I&Ds come back multiple times during the 10 day treatment period. When asked why this was a routine process, the physician said “he wasn't sure the patient would keep it clean and it would heal, so he wanted the ED nursing staff to take care of it.” He himself seldom looks at the wound, unless asked to do so by the nurse. According to CMS, this has a 10 day global period. I have not given the professional side any billing. The doctors are disagreeing with this; what would do you do?

Alaska Subscriber

Answer:

For codes such as an I&D with a 10 global, dressing changes and wound checks would be included in that global period so you would not be able to bill again for the physician services. If the follow up care was atypical non-routine care, such as for curetting, changes of medications, or additional treatments, then you would consider reporting an additional service.

Typical Post-Operative Care is included in the global period. Packing removals may represent “typical care,” as the packing removal is an inherent and expected component of the original Incision and Drainage. □

— Reader Questions and You Be the Coder reviewed by **Michael A. Granovsky, MD, FACEP**, president of *Logix Health*, a medical coding and billing company in Bedford, Mass.

ED Coding and Reimbursement

We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to *ED Coding and Reimbursement Alert* to the Editor indicated below.

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