

APS Update

ER Newsletter

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Services Outside the Emergency Department

It is common for emergency physicians to get called to the floor to provide care to an inpatient in a critical situation, yet attention to documenting and billing for these services is frequently neglected. Endotracheal intubation and CPR are common procedures that are provided in this scenario that are billable with the appropriate CPT codes. Critical care is also reportable if the record clearly indicates that the minimum time requirement of 30 minutes is met. Evaluation and management services not meeting the definition of critical care are reportable with the Subsequent Hospital Care codes, 99231-99233. In all cases, documentation of the encounter should clearly identify all services provided by the emergency physician for accurate charge capture.

NPI Change is Finally Here

May 23rd is the final due date to make the change in all transactions to the National Provider Identifier (NPI). Since the carriers will be implementing new processes to handle these claims, the Centers for Medicare & Medicaid Services (CMS) suggests the following:

1. Initially send claims with both the legacy system ID (e.g. UPIN) and the NPI.
2. Assuming that those claims are processed, begin with a small batch of claims with just the NPI and monitor those claims' processing.
3. Once those are processing correctly, move to including only the NPI.

While carriers are supposed to be ready for the switch over, the many delays in this process were the result of carrier inability to accept the NPI as much as provider inability to bill with the NPI.

APS has pre-tested our clients' NPIs with carriers and have found the most common issues to be ones in which the precise names of corporations were different between the legacy systems and the NPI filings. Those issues have been worked through prior to the required change date.

**2008 EDUCATION
CALENDAR**
Hope to see you there!

Jul 13-16: Traverse City, MI
MI College of Emergency
Physicians

Jul 22-23: Newark, OH
OH College of Emergency
Physicians

Evaluation and Management Services: Documentation Reminder

In billing for physician services, dictation omissions can be costly. Lack of required documentation in the dictated report results in 'downcoding' an Evaluation and Management service from the code that accurately describes the encounter to a lower code that reflects the documentation provided. Further, what is included or omitted affects not only billing, but also future reviews or audits and other medico-legal issues associated with the encounter. To ensure optimal reporting of services, APS reminds physicians to "Document your path to diagnosis." Consistent with the nature of the presenting problem, remember to include all history taken, the exam performed, and all diagnostic and therapeutic maneuvers provided through the course of treatment to establish the complexity level of the medical decision making component and support medical necessity for the service.

Eye Area Matters for Foreign Body Removal Encounters

When a patient is seen in the ER for foreign body of the eye, proper documentation is key so the coder can assign the appropriate CPT and DX code. The CPT and DX depend on 3 details: the wound's depth, the FB's location, and the instrumentation used. Physicians typically treat two types of FBRs: conjunctival and corneal.

Conjunctival foreign bodies can either be superficial or embedded. A superficial FB is exposed to the surface and generally easily moved with a cotton swab. To remove a superficial FB, the ED physician might use a swab, tweezers, or an instrument called a "golf club." An embedded foreign body extends into the conjunctiva. The physician will likely use a needle or spud to dislodge the foreign body and then use the spud or tweezers to remove it.

Corneal foreign bodies can be removed with a slit lamp or without a slit lamp. The documentation should support if a slit lamp was used for a removal of a corneal foreign body.

CMS Plans to Expand PQRI Program for 2008

The Centers for Medicare & Medicaid Services will offer new reporting options to encourage physicians to submit quality data. The Physician Quality Reporting Initiative allows the use of 119 measures, including two "structural measures" focusing on the use of electronic health records and electronic prescribing technology. The other 117 measures are clinical performance measures, developed by leading physician organizations. These measures include factors such as percentage of patients who are receiving cancer screenings and flu shots.

**Information provided by Healthcare Finance News*

Medicare Fix for 7/1/08 Still Not Clear

The Senate has outlined its approach to a Medicare physician pay fix to avert the scheduled July 1, 2008 reduction in payment rates of 10.6%. It is looking at an 18 month fix to provide the time necessary to come up with a more permanent solution to the issue. Even with such a temporary fix, the cost in comparison to the amounts to be paid under the current regulations, are significant. Under current legislative rules, the monies to pay for any such "increase" in expenditures have to be specifically accounted for through either new revenues (taxes or fees not already collected) or through cost reductions. It is not felt that there could be any revenue increases associated with such a fix so the focus will be on finding acceptable cost reductions.

Certainly some of the savings necessary to meet the requirements of a temporary fix will come from changes to the Medicare Advantage program which has been targeted by the Democratic leadership as requiring adjustments in the payment formula. The Administration has fought such changes but has not been able to put forward an argument to avoid the cuts to the managed care programs. Given the size of the savings necessary, however, it may not be possible to get all of the savings necessary from the Medicare managed care payments.

There is currently no consensus as to the other sources of cost savings necessary to avert the payment reductions. Unless sufficient savings are found by the Congress it may not prove possible to avert all of the planned reduction in fees.

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