

APS Update

ER Newsletter

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Foreign Body Removal

Foreign Body Removal is common to the emergency department setting and, in most cases, is separately reportable. Location of the foreign body and method of removal are two of the variables that often affect billing; therefore, a thoroughly documented procedure note is essential. Consider the guidelines for these sites:

Subcutaneous Tissues (excluding the foot)

- ◆ An incision must be made to retrieve the f/b
- ◆ Codes are differentiated by simple vs complicated removals

Foot

- ◆ An incision is not required to report removal
- ◆ Codes are differentiated by depth of the f/b: subcutaneous, deep, complicated

Nose

- ◆ May or may not require a small incision to access the f/b
- ◆ Retrieval typically performed using hemostats or forceps
- ◆ Codes are differentiated by complexity of the service (ie, office-type procedure vs that requiring general anesthesia)

Eye – External

- ◆ Codes are differentiated by location, depth, and method of removal
 - ⇒ Conjunctiva – superficial: removal typically accomplished with a cotton swab, tweezers, etc.
 - ⇒ Conjunctiva - embedded, subconjunctival, or scleral nonperforating: often the f/b is dislodged with the use of a needle or spud and then removed with the spud or tweezers
 - ⇒ Cornea, without use of slit lamp
 - ⇒ Cornea, with use of slit lamp

Congress and the Administration Working Overtime

As noted previously, the “fix” for physician payment under Medicare enacted in the waning days of 2007 will expire on July 1, 2008 at which point payment will drop by 10.1% across the board. As of this writing the Senate is working on a bill to match with a House bill passed last year to revise the physician payment system by dropping out the SGR (sustainable growth rate) formula which consistently calls for drastic reductions physician payments with another system. The House version breaks physicians into six separate groups based on specialties, with growth targets for each group. Proponents of the revision say this permits a focusing of funding to promote better results. Skeptics note that this breaks a large lobbying group (the AMA) into splinter groups permitting easier passage of reductions in the future.

The Administration, not to be outdone, has reintroduced the potential to use the ICD-10 and has suggested that there be a trigger provision to reduce Medicare payments. The ICD-10 has been introduced before and is a radical revision of the diagnosis coding process which would require major reprogramming of virtually every clinical and financial information system package in the industry. The switch is targeted for implementation in 2011. The trigger provision calls for payment cuts to all provider types whenever less than 55% of the Medicare outlays are funded by the Medicare payroll taxes (meaning that the general fund revenues necessary to fund the program were higher than desired). The reductions would grow each year until the target was reached. Congress has been cool to the trigger provision but the use of ICD-10 outside the United States is now routine resulting in a higher likelihood that the ICD-10 will be required in the future.

2008 EDUCATION CALENDAR Hope to see you there!

Mar 6: Oak Lawn, IL
IL College of Emergency
Physicians

Apr 7: Indianapolis, IN
IN College of Emergency
Physicians

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

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

Frequently Asked Questions from Emergency Physicians

Q: *What is the "Acuity Caveat?"*

A: Per CPT, the "Acuity Caveat" relieves the physician of performing the required history and examination elements of the highest-level E/M code, 99285, when prevented by the patient's clinical status or mental condition. It is important to note that, for its beneficiaries, Medicare extends this allowance to the history requirements but *not* the physical exam, with the argument that a presenting problem of this acuity obligates the physician to perform the comprehensive examination required of this code level. To justify the use of this caveat, the medical record should clearly indicate the clinical circumstances of the encounter and that there were no alternative sources of information available.

Q: *For my review of systems to be considered 'comprehensive,' do I have to document the findings of every body system reviewed?*

A: No. Per Medicare's 1995 and 1997 Documentation Guidelines for E/M services, upon performance of a complete ROS, the physician may document all pertinent positive and negative findings followed by the statement "all other systems reviewed and negative" to achieve comprehensive status.

Q: *Why am I required to submit a statement of time to bill Critical Care?*

A: Unlike the Emergency Services E/M code set (99281 - 99285), Critical Care codes include a time component for reporting. The first hour of critical care is reported with CPT code 99291 and is used to reflect the first 30-74 minutes spent by the physician providing this high intensity service. Add-on code 99292 is used to report additional blocks of 30 minutes.

- ◆ Tip: The stated time should not include time spent performing separately billable procedures.
- ◆ Tip: The stated time does not have to be continuous.

Q: *Is it appropriate for me to refer to the nurse's notes in my dictation?*

A: Yes, as long as you indicate that you have personally reviewed the information found there. For example, the statement "vitals: see nursing notes" is considered unacceptable because there is no guarantee that the information was reviewed by the dictating physician. Adding a few key words will make this an appropriate part of your dictation, "vitals reviewed as listed in the nursing notes." The notes should also be initialed to indicate your review.

Q: *Why do I have to give the exact length of each laceration I repair?*

A: Wound repairs reported according to length (in centimeters), anatomic location, and type of repair performed (simple, intermediate, complex). Absence of the size of the wound forces the billing to default to the lowest level repair code. This is an especially costly omission in cases of multiple wounds of the same location and repair type where the sizes are added together to determine the final code. Special attention should be given to accurate and complete measurements of stellate, angular and other irregularly shaped wounds.

Q: *Why is it necessary for me to dictate a procedure note for even the simplest procedures?*

A: A well-documented procedure note satisfies many criteria for both the payor and the biller. Payors often review documentation to ensure that the procedure was performed by the reporting physician, that the procedure matches the CPT description of the billed code, and that medical necessity exists for performing the procedure or converting to another procedure. From a billing perspective, the procedure note ultimately directs correct code assignment. In many cases multiple codes may exist for a given procedure, differentiated by wound size, technique used, etc. For example, there are two CPT codes that describe drainage of a superficial hematoma - one via puncture aspiration, the other requiring an incision. Thorough documentation of the procedure allows correct billing and provides optimal charge capture for the service rendered.