ED CODING ALERT

• Documentation • Compliance • Reimbursement

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

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Affect ED's Bottom Line With Nosebleed Repair Smarts

▶ *ED coders often under-report their ED's epistaxis claims.*

If you can't differentiate a complex anterior nosebleed repair from a simple one, you're costing your ED nearly $20 per misidentified claim.

Further, coders who cannot discern a reportable nosebleed repair encounter from an E/M will subject the practice to upcoding concerns. Check out these basics for each type of nosebleed repair to nail your coding each time.

Consider E/M for Non-Active Nosebleeds

If a patient reports to the ED with a nosebleed, and the physician stops the bleeding with basic methods, the coder usually chooses an E/M code, confirms **Linda Martien, CPC, CPC-H,** coding specialist at National Healing Inc. in Boca Raton, Fla.

These methods can include minimal attempts at stoppage, including ice or brief, direct pressure. The key to these encounters is that the physician did "not perform a billable procedure, so the E/M is the only way to capture the services the physician provides," Martien explains.

Also: Any treatment of an active nosebleed is likely going to trigger the assignment of a nosebleed repair code, relays **Todd Thomas, CPC, CCS-P,** president of ERcoder Inc. in Edmond, Ok.

"There are patients that present [to the ED] with a complaint of a nosebleed, but there is no active bleeding. In that situation, only the E/M would apply," says Thomas.

Methods Mark Most 30901 Claims

Several factors can up the nosebleed fix to the level of procedure, according to Thomas. You might be able to report 30901 (*Control nasal hemorrhage, anterior, simple [limited cautery and/or packing] any method*) if the notes indicate that the ED physician performed one of the following to treat a nosebleed:

- applied continuous pressure
- inserted pledgets soaked with an anesthetic-vasoconstrictor solution into the nasal cavity
- administered nasal spray to anesthetize/shrink nasal mucosa
- performed chemical cautery with a silver nitrate stick.

Key terms: When deciding on a nosebleed repair code, "look for phrases such as 'hemostasis' (control of bleeding), 'bovie,' 'silver nitrate,' 'electrocautery,' and 'chemical cauterization.' These terms would indicate a procedure," relays Martien.

Example: A patient presents to the ED with an active nosebleed. The physician anesthetizes the nasal mucosa with Cetacaine, and cauterizes the septum area with silver nitrate to stop the bleeding.

This is a simple anterior repair, confirms Thomas. On the claim, report 30901 with 784.7 (*Epistaxis*) appended.

Remember: If the ED physician treats bleeding on both sides of the patient's nose, report the nosebleed repair code (30901, 30903) with modifier 50 (*Bilateral procedure*) appended.

When Physician Gets 'Aggressive,' Select 30903

ED physicians will also perform complex anterior nosebleed repairs, says Martien. You'll have to dig through the notes to identify complex repairs, but the extra work will pay off.

An easy $20: The average payout for 30903 (*Control nasal hemorrhage, anterior, complex [extensive cautery and/or packing] any method*) is approximately $77 per claim (2.13 relative value units [RVUs] using the 2009 Medicare Physician Fee Schedule multiplied by Medicare's conversion rate of 36.0666). Code 30901 pays approximately $59 per claim (1.64 RVUs).

There are several scenarios that might indicate a complex repair. You should consider 30903 when the physician makes several attempts to stop the bleeding, either via the same method or different methods. Also, the physician might use "more aggressive treatment" on complex nosebleed repairs, Thomas says. These methods include traditional nasal packing (gauze), a prefabricated nasal sponge, or an epistaxis balloon.

Consider this detailed clinical scenario from Martien:

A 12-year-old boy reports to the ED with a nosebleed that started about 30 minutes ago; he was chasing his brother through the house and ran into a sliding glass door he thought was open. Notes indicate he hit face first and suffered trauma to his nose, brow, and chin from the impact with the door and subsequent fall.

There is frank bleeding from both nares, and erythema and bruising to the patient's left brow and chin, but no broken skin. The physician cleans off the blood and examines the nares, finding several small areas of bleeding from the internal mucosa but no fractures — a fact confirmed by an x-ray. ED staff places nasal tampons before the x-ray, then has to replace them when the patient returns to the ED. Before the patient achieves satisfactory hemostasis, the ED physician replaces the tampon, ultimately packing the entire nasal vestibule. Once

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bleeding abates, the physician gives the patient detailed discharge instructions and sends him home.

This is a complex repair, Martien confirms. On the claim, report the following:

- 30903-50 for the repair
- 9928x for the E/M service (check encounter notes for E/M level)
- modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) appended to 9928x to show that the E/M and repair were separate services
- 784.7 appended to 30903 and 9928x to represent the patient's nosebleed
- E917.8 (*Striking against or struck accidentally by objects or persons; other stationary object with subsequent fall*) appended to 30903 and 9928x to represent the cause of the patient's injury
- E849.0 (*Place of occurrence, home*) appended to 30903 and 9928x to represent where the accident took place. ❑

Follow 3 Steps to Establish PQRI Protocol

▶ *Remember, EDs not allowed to report on EHR measure.*

EDs that want to participate in Medicare's Physician Quality Reporting Initiative (PQRI), but don't know where to start, should rely on Medicare's online resources in order to hatch a perfect PQRI plan.

Check out this 3-step plan to getting off on the right foot with PQRI:

Check CMS for PQRI Overview, Specifications

You should first go to www.cms.hhs.gov/PQRI and familiarize yourself with the guidelines for PQRI reporting. You might want to bookmark this site, as it contains an overview of the program and links to resources you might find useful, such as Medicare's "PQRI Tool Kit."

Refer back to this Web site when your have questions about PQRI; it is the definitive source of PQRI info.

Find Applicable Measures

You should then select PQRI measures that line up with your patient panels and the professional services your ED furnishes, says **Caral Edelberg, CPC, CCS-P, CHC,** president of Medical Management Resources for TeamHealth in Jacksonville, Fla. ED coders can check out the 2009 measures at www.cms.hhs.gov/PQRI/Downloads/2009PQRIMeasuresList.pdf.

When you get to the above link, check out these measures, which are relevant to most EDs: 28 54 , 55, 56, 57, 58, and 59.

Know PQRI Requirements for Applicable Measures

Next, make sure you are aware of all of the requirements of the measures you are reporting; claims must contain certain ICD-9 and CPT codes in order to qualify for PQRI.

For example, check out the requirements for measure 54, "Electrocardiogram Performed for Non-Traumatic Chest Pain":

- **Reporting description:** "Percentage of patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain and an applicable CPT Category II code for each episode of non-traumatic chest pain occurring during the reporting period," according to CMS.
- **Performance description:** "Percentage of patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain who had a 12-lead electrocardiogram (ECG) performed," CMS reports.
- **Eligible cases:** In order to report measure 54, the place of service (POS) must be 23 (ED) — and the patient must have one of the following diagnoses: 413.0, 413.1, 413.9, 786.50, 786.51, 786.52, or 786.59.

Also, the ED physician must provide one of the following services in order to qualify for measure 54: 99281-99285 or 99291. Lastly, you'll need to report 3120F to ensure that the claim is included in PQRI.

Example: A 46-year-old patient reports to the ED complaining of chest pain over the heart. The physician provides 48 minutes of critical care for the patient, during which time he orders a 12-lead electrocardiogram (ECG or EKG).

(Continued on next page)

This scenario lines up perfectly for PQRI reporting.

On the claim, you would report the following:

- 99291 (*Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes*) for the critical care
- 786.51 (*Precordial pain*) appended to 99291 to represent the patient's condition
- 3120F (*12-lead ECG performed [EM]*) to show that you are reporting the encounter to PQRI. ❑

Track ROS to Nail E/M Levels

▶ *Multi-system reviews must exceed exam elements in HPI.*

If you choose the wrong review of systems (ROS) level when your ED physician performs an E/M, you risk miscoding the E/M, opening the practice up to lost revenue or audit concerns.

Use System List When Compiling ROS

During the ROS, the provider "asks the patient questions about symptoms he may be experiencing. It's part of the history, done to make sure nothing important has been missed," explains **Robert LaFleur, MD, FACEP,** of Medical Management Specialists in Grand Rapids, Mich.

Providers perform ROS to focus treatment options and rule out any potential problems that they did not spot in the history of present illness (HPI) portion of the exam.

In short: During the ROS, the physician is trying to "learn as much as possible about what other problems a patient has that might affect how he will treat the patient," says **Catherine Brink, CMM, CPC, CMSCS,** president of Healthcare Resource Management in Spring Lake, N.J.

For coding purposes, CPT breaks the body into these systems: constitutional symptoms; eyes; ears, nose, mouth, and throat; cardiovascular; respiratory; gastrointestinal; genitourinary; musculoskeletal; integumentary (skin and/or breasts) neurologic; psychiatric; endocrine; hematologic/lymphatic; and allergic/immunologic.

"The ROS assists physicians when they are narrowing down a diagnosis, and it usually focuses on the patient's signs and symptoms," relays **Joan Gilhooly, CPC, CHCC,** president of Medical Business Resources LLC, in Deer Park, Ill.

For example, a patient reports to the ED complaining of a headache. "The headache is a symptom, but what could be causing the headache? It could be muscle tension, a hangover, an aneurysm, etc.," Gilhooly says. By asking ROS questions, physicians get a better idea of the cause of the patient's presenting problem.

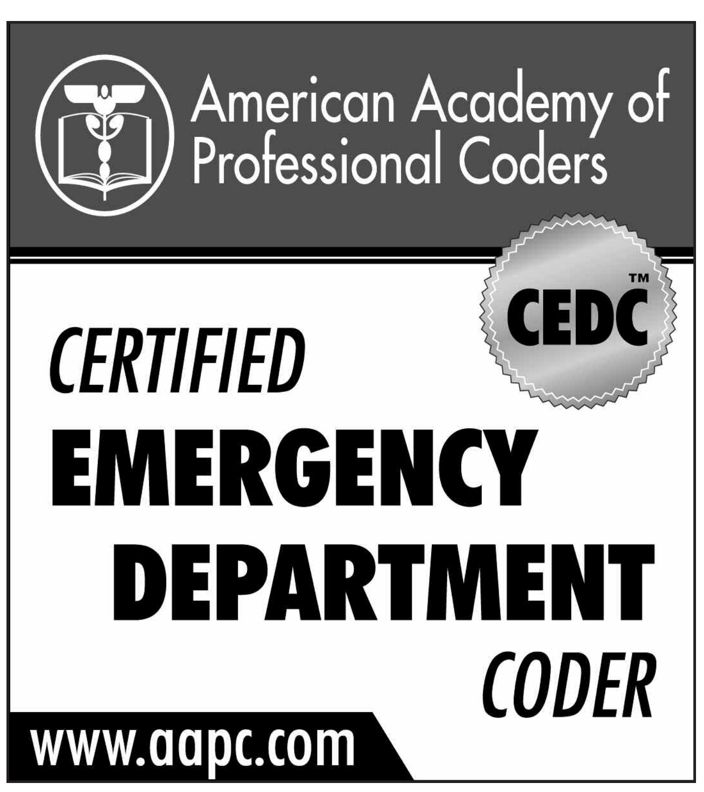
1-Complaint Visits Are Often Problem-Pertinent

Be sure to keep count of the ROS total for each E/M encounter. There are three levels of ROS. The first level is problem-pertinent, which occurs when the physician reviews only the system related to the patient's problem.

Depending on the other encounter specifics, a problem-pertinent ROS can support up to a level-three E/M (99283, *Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of moderate complexity ...*).

Here are some examples of problem-pertinent ROS from Gilhooly:

- "Patient has a headache, and the physician asks about blurred vision." (Eyes)
- "Patient has chest pain, and the physician asks about palpitations." (Cardiovascular)
- "Patient has shortness of breath, and the physician asks if she experiences any coughing or painful respiration." (Respiratory)



Extend Your E/M Options With This ROS Level

When the ED physician reviews between two and nine systems during an E/M, she has performed extended ROS, says LaFleur.

"This means that even a single comment about two separate systems would qualify as an extended ROS," LaFleur continues.

These reviews result in detailed histories and, depending on encounter specifics, can support up to a level-four ED E/M (99284 ... *a detailed history; a detailed examination; and medical decision making of moderate complexity* ...).

Example: A patient presents complaining of chest pain. The physician asks her about the frequency of the pain, and whether or not she has palpitations. He then asks the patient if is she is experiencing shortness of breath or nausea. In this example, the physician reviewed three systems (cardiovascular, respiratory, gastrointestinal), so this is an extended ROS.

Include Key Documentation for Complete ROS

To tally a complete ROS, the physician must review at least 10 systems, says LaFleur.

"The physician has to document all positive findings, plus any pertinent negative findings" for complete ROS, Gilhooly says. "If the symptom is problem-pertinent, the physician needs to specifically document those findings," she continues.

The ED physician should ask pointed questions when conducting the ROS, recommends Gilhooly.

Good ROS question: "Have you had any recent feelings of hopelessness, anxiety, or irrational fear?"

Bad ROS Question: "Any psychiatric issues I should know about?"

"He must ask directly about each system," says Gilhooly. Even if the findings for those systems are negative, you can still count them toward total ROS.

There are several ways that the physician can appropriately document a complete ROS, LaFleur says. "The first is to list the patient's specific responses to questions about 10 or more systems."

Example: "Patient denies fever, blurred vision, sore throat, chest pain, shortness of breath, nausea or vomiting, swollen joints, rash, headaches, or swollen glands."

This note is acceptable documentation for a complete ROS, as it proves the physician inquired directly about the following systems: Constitutional; eyes; ear, nose, mouth, and throat; cardiovascular; respiratory; gastrointestinal; musculoskeletal; integumentary; neurologic; and lymphatic.

(Continued on next page)

You Be the Coder

Moderate Sedation and Fracture Care

Question: *A patient reports to the ED with a badly injured right foot; he was using a snow plow to clear his driveway, and the plow overturned and fell on his lower body. The physician takes x-rays that confirm a closed navicular fracture with some bones out of alignment. Notes indicate a level-three E/M, and also a high level of patient pain and anxiety. To calm the patient, the physician provides 19 minutes of moderate sedation while she resets the foot and puts it in a plaster cast. There is a nurse on hand during the sedation to monitor the patient's status. Can we report the sedation?*

Pennsylvania Subscriber

Answer: See page 31. ❑

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"The other option is for the provider to document pertinent positives and negatives relative to the presenting complaint, and then use a summary statement for the rest of the systems," LaFleur explains.

Example: "Admitted for chest pain, patient reports to difficulty breathing, diaphoresis, and nausea, but a complete ROS is otherwise negative." Provided the physician asks the patient direct questions about each negative system, this also satisfies requirements for complete ROS.

Remember: "The 'all other systems negative' shortcut in the 1995 documentation guidelines is a documentation exemption, not a performance exemption," says **Michael Granovsky, MD, CPC, FACEP,** president of MRSI, an ED coding and billing company in Woburn, Mass. ❑

Reader Questions

Physician Role Drives Debridement Coding

Question: *Encounter notes indicate that the ED physician performed a partial thickness excisional debridement of a patient's wound. Should I use 97597 or 11040 for this service*?

California Subscriber

Answer: Since the physician performed the debridement and the notes indicate that it was an excisional debridement, you should report 11040 (*Debridement; skin, partial thickness*) for the service. Coders typically choose 97597 (*Removal of devitalized tissue from wound[s], selective debridement, without anesthesia [e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps] ...*) when non-physician providers (physical therapists, wound care nurses, etc.) perform non-surgical debridement on a patient's wound. If the ED physician performs a surgical debridement, choose from the debridement codes (11040-11044).

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❑

Submit Separate Code for G Tube Monitoring

Question: *A hospice patient presents to the ED with a malfunctioning gastrostomy tube (G tube). The tube was installed two weeks earlier, and seems to have just "popped" out of place. The ED physician puts the tube back in place and ensures that it is in the proper position using contrast monitoring. Is this part of the G tube placement code, or can I code the monitoring separately?*

Minnesota Subscriber

Answer: When the physician needs to use contrast monitoring while replacing a G tube, it is separately reportable. On the claim, report the following:

- 43760 (*Change of gastrostomy tube ...*) for the tube replacement
- 75984 (*Change of percutaneous tube or drainage catheter with contrast monitoring [e.g., genitourinary system, abscess], radiological supervision and interpretation*) for the contrast monitoring
- modifier 26 (*Professional component*) appended to 75984 to show that you are only coding for your physician's role in the monitoring
- 536.42 (*Mechanical complication of gastrostomy*) appended to 43760 and 75984 to represent the malfunction.

❑

Remember, There Is No 'Extra' CPR Time

Question: *A 56-year-old disabled patient presented to the ED with nausea, vomiting, and diarrhea, along with extreme weakness. While staff was initiating an IV and blood draw, the patient went into full cardiopulmonary arrest. The notes indicate 43 minutes of critical care time. Outside of that 43 minutes, the physician performed CPR for 66 minutes before the patient finally stabilized. Is there any way to account for the "extra" CPR time?*

North Carolina Subscriber

Answer: No. CPR is not a time-based code, and you are supposed to report the same code regardless of total CPR time. On the claim, report the following:

You Be the Coder

Moderate Sedation and Fracture Care

Answer: You should be able to report the moderate sedation separately, provided the documentation clearly indicates the presence and role of the nurse during the encounter.

Don't forget this documentation: an "independent observer" is required for moderate sedation coding).

On the claim, report the following:

- 28455 (*Treatment of tarsal bone fracture [except talus and calcaneous]; with manipulation, each*) for the fracture care
- modifier 54 (*Surgical care only*) appended to 28455 to show that you are only coding for the initial fracture care
- 99144 (*Moderate sedation services [other than those services described by codes 00100-01999], provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; age 5 years or older, first 30 minutes intra-service time*) for the sedation
- 99283 (*Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity ...*) for the E/M
- modifier 25 (*Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service*) appended to 99283 to show that the E/M and fracture care were separate services
- E820.0 (*Nontraffic accident involving motor-driven snow vehicle; driver of motor vehicle other than motorcycle*) appended to 28475, 99144, and 99283 to represent the cause of the patient's injury
- 825.22 (*Fracture of other tarsal and metatarsal bones, closed; navicular [scaphoid], foot*) appended to 28455, 99144, and 99283 to represent the patient's fracture. ❑

- 99291 (*Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes*) for the critical care
- 92950 (*Cardiopulmonary resuscitation [e.g., in cardiac arrest]*) for the CPR
- 427.5 (*Cardiac arrest*) appended to 99291 and 92950 to represent the patient's heart attack.

CPR or critical care: CPR is separately reportable from critical care, meaning you must carve out CPR minutes when counting time for 99291 and +99292 (*... each additional 30 minutes [List separately in addition to code for primary procedure]*). In the scenario above, you may report the 45 minutes of critical care and the 66 minutes of CPR. You cannot, however, count the minutes spent in CPR both ways. Remember to include the statement that the critical care time was carved out of all separately billable procedures.

❑

Check Notes Before Separating E/M, Injection

Question: *A patient with carpal tunnel syndrome (CTS) in her right wrist reports to the ED; she says even though she has kept the wrist in a short splint and attended physical therapy, it still "hurts bad" — specifically that her hand is tingling, her wrist hurts constantly, and she has trouble using her fingers. After performing a problem focused history and an expanded problem focused exam, the ED physician decides to perform a carpal tunnel injection (CTI). He injects 40 mg of Depo-Medrol, puts the wrist back in the splint and sends the patient home. How do I code this encounter? Is there enough evidence for a separate E/M service?*

Minnesota Subscriber

Answer: You should go back and check the encounter specifics to be sure, but it sounds as though the ED physician provided a low-level E/M before the CTI.

On the claim, report the following:

- 20526 (*Injection, therapeutic [e.g., local anesthetic, corticosteroid], carpal tunnel*) for the CTI
- 99281 (*Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making ...*) for the E/M
- modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician*

(Continued on next page)

on the same day of the procedure or other service) appended to 99281 to show that the E/M and injection were separate services

• 354.0 (*Carpal tunnel syndrome*) appended to 20526 and 99281 to represent the patient's condition.

Explanation: You mentioned that the physician performed an expanded problem focused exam and focused history. Also, the physician's decision to perform the CTI was a straightforward medical decision. Based on this information, you would choose 99281 for the E/M.

❑

Online Errata Completes Your CPT '09 Changes

Question: *My CPT manual says that the definition for modifier 22 is "unusual procedural services." I thought this changed last year. Has the AMA changed the definition again?*

South Carolina Subscriber

Answer: You are correct that the definition of modifier 22 should not be "unusual procedural services." The correct definition is "increased procedural services." The definition appears as "unusual services" on the inside cover of the CPT 2009 book, with the new "increased services" definition appearing in Appendix A of CPT 2009.

Visit the American Medical Association (AMA) Web site to review all the CPT 2009 errata information. Navigate to www.ama-assn.org/ama/pub/category/3896.html and click on "Corrections in CPT 2009."

Good practice: Have your CPT manual on hand and go through it, marking all of the fixes directly in your manual so that you're sure to be working with the most correct, up-to-date information when you're coding procedures.

— Reader Questions *and* You Be the Coder *reviewed by* ***Michael A. Granovsky, MD, CPC, FACEP,*** *president of MRSI, an ED coding and billing company in Woburn, Mass.* ❑

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