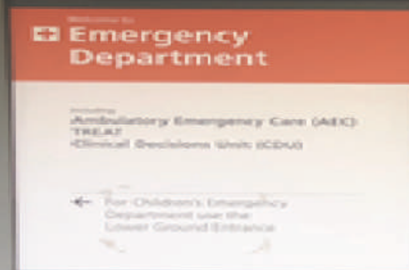
Emergency Department



The Practical Guide to ED Facility Coding

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How ER Facility coding guidelines are determined?

"Outpatient Prospective Payment System" (OPPS) for hospital outpatient services; analogous to the Medicare prospective payment system for hospital inpatients known as "Diagnosis Related Groups" or DRG's. APC's or "Ambulatory Payment Classifications" are the government's method of paying for facility outpatient services for the Medicare program. APC's apply only to hospitals, and have no impact on physician payments under the Medicare Physician Fee Schedule.

ED coding is unique and requires expertise. If coder knowledge is incorrect or inconsistent, facilities can lose millions of dollars annually.

Facility coding guidelines are inherently different from professional coding guidelines. Facility coding reflects the volume and intensity of resources utilized by the facility to provide patient care, whereas professional codes are determined based on the complexity and intensity of provider performed work and include the cognitive effort expended by the provider.

How ER Facility coding guidelines are determined?

As such, there is no definitive strong correlation between facility and professional coding and thus no rational basis for the application of one set of derived codes, either facility or professional, to the determination of the other on a case-by-case basis.

> Facility billing guidelines should be designed to reasonably relate the intensity of hospital services to the different levels of effort represented by the codes.

A hospital may bill a visit code based on the hospital's own coding guidelines which must reasonably relate the intensity of hospital resources to different levels of HCPCS codes. Services furnished must be medically necessary and documented. “Facility billing guidelines should be designed to reasonably relate the intensity of hospital services to the different levels of effort represented by the codes.”

Coding guidelines should be based on facility resources, should be clear to facilitate accurate payments, should only require documentation that is clinically necessary for patient care, and should not facilitate upcoding or gaming

When will you code Observation in Emergency department?

Observation is defined by the service provided, not the area of the hospital a patient is located in, that is, the patient does not have to be admitted to an observation unit in order for the emergency room physician to provide observation care.

Emergency physicians can use observation codes whenever there is diagnostic uncertainty requiring extended evaluations, treatments and serial examinations to determine whether a patient requires admission or can be safely discharged home.

These codes are used for Medicare patients who spend <8 hours in observation status.

Observation care codes are not separately reimbursable services when performed within the assigned global period as these codes are included in the global package.

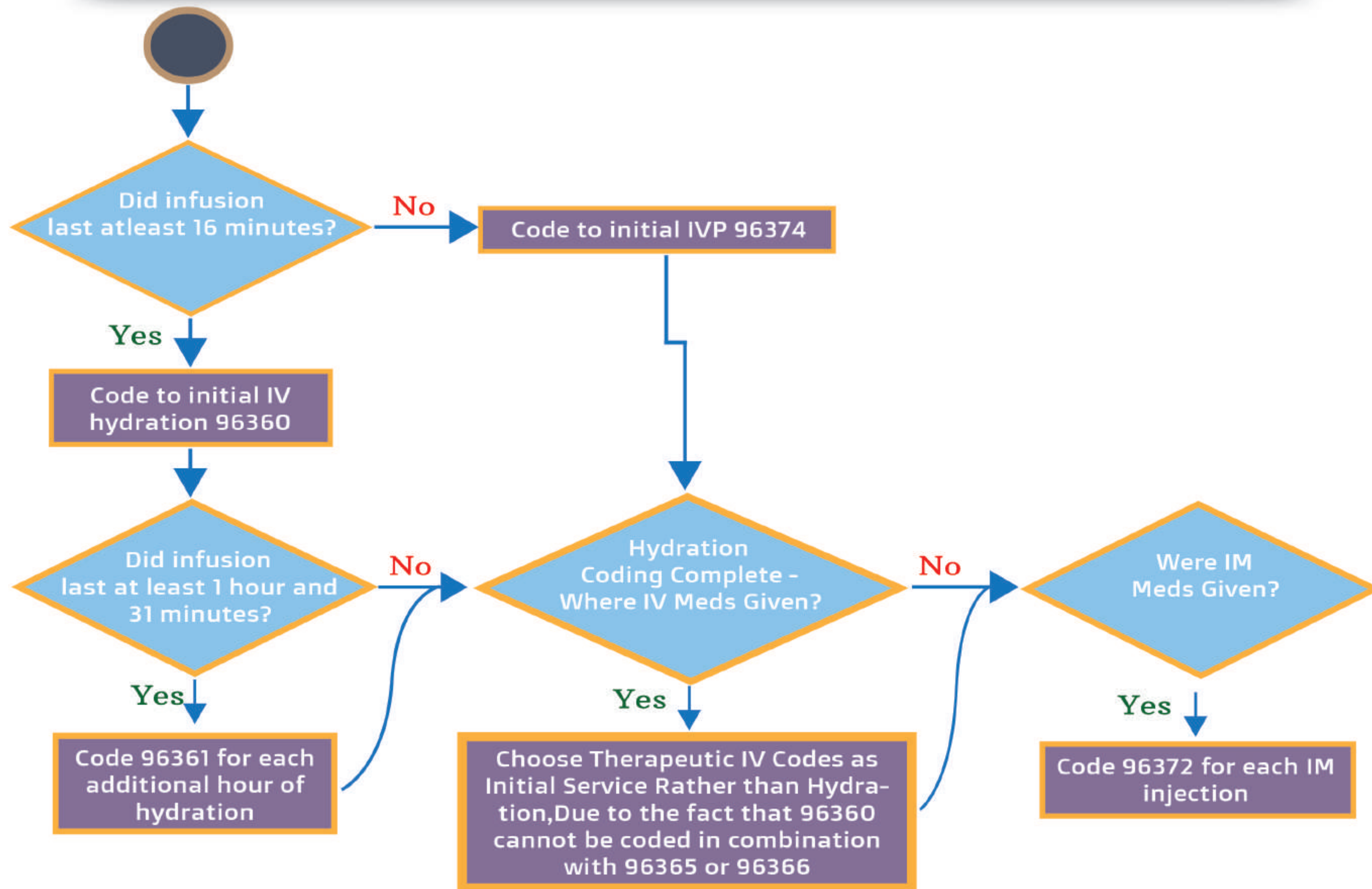
There is no national standard for hospital assignment of E&M code levels for the ED. CMS requires each hospital to establish its own guidelines. With coding guidelines being up to the hospital's discretion – under coding is more prevalent because of the lack of confidence in submissions and fear of audits.

Skin Repair

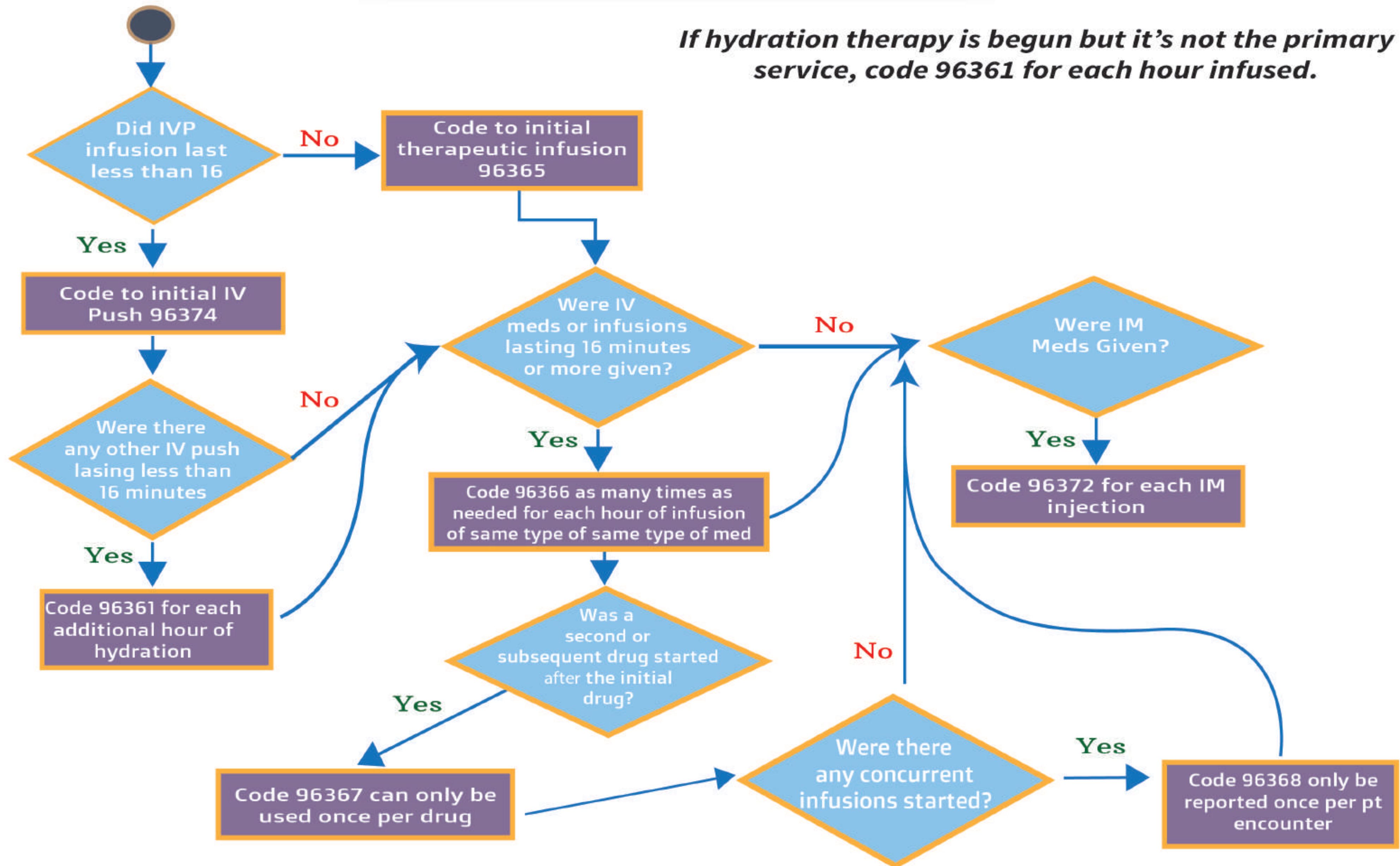
Simple – superficial single layer suture or Staple (or Derma-bond) Intermediate – layered closure or single layer with de-bridement or removal of foreign body. Extensive cleaning, de-bridement or removal of particulate matter with a 1-layer clo-sure qualifies as and intermediate repair. Complex – multi-lay-ers or revisions

Fracture Care Services

Physician in ED must provide the definitive care such as "ma-nipulation," "stabilization," "fixation," or "restorative care." Initial treatment and stabilization of a fracture is considered the "sig-nificant portion" of care under CMS rules.

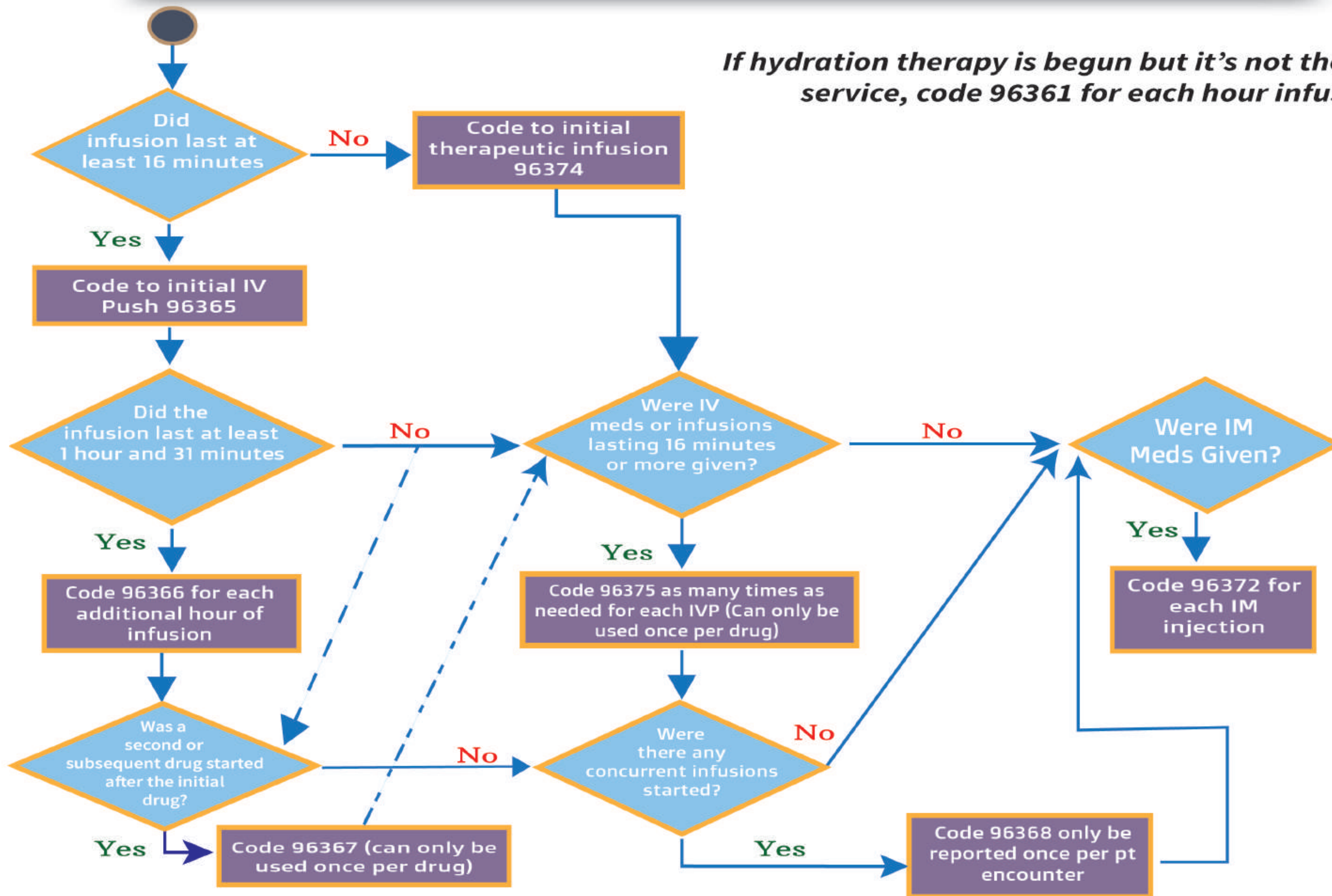


Did infusion last atleast 16 minutes?
No
Code to initial IVP 96374
Yes
Code to initial IV hydration 96360
Did infusion last at least 1 hour and 31 minutes?
No
Yes
Code 96361 for each additional hour of hydration
Hydration Coding Complete - Where IV Meds Given?
No
Yes
Choose Therapeutic IV Codes as Initial Service Rather than Hydra-tion,Due to the fact that 96360 cannot be coded in combination with 96365 or 96366
Were IM Meds Given?
Yes
Code 96372 for each IM injection


IV PUSH AS INITIAL SERVICE
If hydration therapy is begun but it's not the primary service, code 96361 for each hour infused.
Did IVP infusion last less than 16
No
Code to initial therapeutic infusion 96365
Yes
Code to initial IV Push 96374
Were IV meds or infusions lasting 16 minutes or more given?
No
Were IM Meds Given?
No
Were there any other IV push lasing less than 16 minutes
Yes
Code 96366 as many times as needed for each hour of infusion of same type of same type of med
Yes
Code 96372 for each IM injection
Yes
Code 96361 for each additional hour of hydration
Was a second or subsequent drug started after the initial drug?
No
Yes
Were there any concurrent infusions started?
Yes
Code 96367 can only be used once per drug
Code 96368 only be reported once per pt encounter

THEURAPEUTIC / DIAGNOSTICTHERAPY AS INITIAL SERVICE

If hydration therapy is begun but it's not the primary service, code 96361 for each hour infused.



About RevMedi INC

Facility coding demands high standards from the coding staff certification, years of experience in the patient types they code, annual education on coding updates and emphasis on CMS coding standards.

Our ED facility coders are skilled in identifying and assigning appropriate CPT codes for all ED physician and nurse procedures.

We have deep depth knowledge of coding the E/M levels (99281-99285), critical care codes (99291-99292), IV infusions, the medications supplies and other procedures frequently done in ED facility

Our trained medical coding professionals Can better handle issues such as medical necessity, claim denials, bundling issues and charge capture.

We offer 15 days free trial period for all Coding Services.

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