Stop the Bleeding: Avoid Procedure Coding Pitfalls

DESCRIPTION
The typical emergency department performs over 100 different procedures on a regular basis. Learn the ins and outs of correct documentation and coding from both a CPT and clinical perspective.

OBJECTIVES
- Discuss coding challenges related to high RVU emergency medicine procedures
- Identify the key aspects of documentation that impact procedure code selection
- Review specific emergency medicine procedures and their documentation requirements including abscesses, orthopedic care and advanced airway tools

1/31/2020, 8:00 AM - 9:00 AM, Stop the Bleeding: Avoid Procedure Coding Pitfalls

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DISCLOSURE
(+) No significant financial relationships to disclose
Stop The Bleeding: Avoid Procedure Coding Pitfalls

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Mutual Understanding Will Stop The Bleeding!

- Procedures - important part of RVU capture
- Documentation is key
  - Coding can be complicated
  - Often 30% RVU difference between codes
- A good understanding combines the coding and the clinical together
Medicare Minor Procedures

- Defined as global period < 10 days
- Clinically meaningful separate and distinct service to bill and add -25 modifier to E/M code
  - Generally supported by an appropriately documented EMTALA mandated screening exam
- “Visits on the same day as a minor procedure by the same physician are included in the payment for the procedure unless a significantly separately identifiable service is also performed.”
“For example: a visit on the same day could be properly billed in addition to suturing a scalp wound if a full neurological examination is made. Billing for a visit would not be appropriate if the physician only identified the need for sutures and confirmed allergy and immunization status”

Medicare Carriers Manual Section 4821
Medicare Major Procedures

- Defined as global period of 90 days
- Typically fracture care and dislocations in the ED
- Use modifier 57 on the E/M

“Instruct billers to use modifier 57 (decision for surgery) to identify a visit that results in the decision to perform surgery.”

- MCM Section 4822
Medicare Global Periods In Flux

<table>
<thead>
<tr>
<th>0 Day</th>
<th>10 Day</th>
<th>90 Day</th>
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<tbody>
<tr>
<td>Simple Lacerations (12001-12018)</td>
<td>Abscess Drainage (10060-10061)</td>
<td>Fracture Care</td>
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<tr>
<td>Intubation (31500)</td>
<td>Intermediate Laceration Repair (12031-12057)</td>
<td>Dislocations</td>
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<td>Epistaxis (30901-30905)</td>
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<td>Impacted Cerumen (69210)</td>
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What are the reimbursement issues for procedures and teaching physicians working with residents?
Teaching Physicians Procedures

- Governed by MCM Transmittal 1780/811
  - Doesn’t apply to students of any kind
- Different Than E/M services

**Procedures**

- Minor surgical procedures (<5 minutes), the TP must be physically present during the entire service.
- Major procedures (>5 minutes), the teaching physician must be physically present during the "key portion(s)" of the service and must be immediately available to furnish service during the entire procedure.
Arthrocentesis by Resident

Resident Procedure Note:
Procedure performed: Knee arthrocentesis. 
Anesthesia: 4 cc Lidocaine
Site marked and prepared with betadine. Wheel of lidocaine placed. Lidocaine then introduced into the joint space. 60cc of clear yellow fluid was removed from the joint space. Samples were sent to the lab for analysis. The patient tolerated the procedure well without complications.

Attending Physician Note:
Procedure performed: Knee arthrocentesis. I confirm that I have examined the patient, was present during the key aspects of the procedure.
How can I ensure that all the RVUs are captured for PA/NP visits?
Mid-Level Providers

- Governed by CMS Transmittal 1776
  - Applies to Medicare and payers that credential PAs
  - Increasingly Medicaid, BCBS, Aetna
- Attending documents a clinically meaningful face-to-face interaction with the patient may use the MD’s NPI number...paid at 100%
  - Only co-signed then use the PA’s NPI...paid at 85%
- Does not apply to procedures
  - PA procedures typically billed out under the PA
- Does not apply to critical care-time based
- Harness your manpower!
# Common ED Service RVUs

<table>
<thead>
<tr>
<th>Procedure</th>
<th>RVUs</th>
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<tbody>
<tr>
<td>EKG (93010)</td>
<td>0.24</td>
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<tr>
<td>Finger laceration-Simple 2.6 – 7.5 cm (12002)</td>
<td>1.73</td>
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<tr>
<td>Facial laceration-Intermediate 2.6- 5 cm (12052)</td>
<td>5.74</td>
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<tr>
<td>Central line placement (36556)</td>
<td>2.46</td>
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<tr>
<td>Chest tube placement (32551)</td>
<td>4.56</td>
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<tr>
<td>CPR (92950)</td>
<td>5.36</td>
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<tr>
<td>Shoulder dislocation reduction (23650)</td>
<td>8.36</td>
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<tr>
<td>Colles’ fracture reduction (25605)</td>
<td>14.73</td>
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<table>
<thead>
<tr>
<th>Procedure</th>
<th>RVUs</th>
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<tr>
<td>Compare to E/M value</td>
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<tr>
<td>99282</td>
<td>1.23</td>
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<tr>
<td>99285</td>
<td>4.91</td>
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<td>Critical Care (99291)</td>
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<th>Procedure</th>
<th>RVUs</th>
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<tr>
<td>Surprises</td>
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<tr>
<td>TMJ dislocation reduction (21480)</td>
<td>0.92</td>
</tr>
<tr>
<td>A-line insertion (36620)</td>
<td>1.28</td>
</tr>
<tr>
<td>LP (62270)</td>
<td>1.79</td>
</tr>
<tr>
<td>Patellar dislocation reduction (27560)</td>
<td>9.88</td>
</tr>
</tbody>
</table>
Highlights of Non E/M RVU Enhancers

- Complex I and D
  - Packing
  - 2.87 vs 5.21
- Laceration Repairs
  - Layered/Heavy Cont.
  - Face- 2 layers 5.74
- CPR
  - 5.36 RVUs
  - Document oversight
- ORTHO
  - Shoulder 8.36
  - Hip (disloc.) 11.66
  - Finger Fx 5.35
- 40,000 visit ED:
  - EKG .24 RVUs
  - $70,000
- X Ray: $160,000
- US: $30,000
EKG Billing

- 80% of groups billing
- We provide the definitive service
  - Bedside reading
  - Acute Care decisions
  - All the risk
- Compliance is even on our side!
- Recent ALJ decision
- Typical group > $100 per day
EKG Interpretation

- Should be similar to what a specialist would provide
- Generally met with 3-4 separate elements
- Report with 93010 - 0.17 work RVUs 0.24 total
- High frequency service

Electrocardiogram:

Interpretation by Emergency Physician: within normal limits, no ischemic changes.

Acep.org > reimbursement > diagnostic interpretations
**ACEP FAQ on CPR**
- “CPR involves the provision of cardiac life support including chest compressions and ventilation of the patient”

**AMA Policy Statement**
- “The physician may report 92950 whether actually performing compressions or directing these activities”
- Documentation: Write a brief oversight note and sign the code sheet
- Typically also report a high level E/M service

- **5.36 RVUs for CPR (92950)**
- E/M Level yields a total of 10+ RVUS
  - Hx and Acuity Caveats…document a Hx and PE
Airway Tools

Common Nomenclature

Glidescope
Ranger
Shikani
McGrath
Storz
Pentax/Airway Scope
Laryngeal Masked Airway

Laryngeal Mask Airway (LMA)

1. Laryngeal mask
2. Laryngeal mask slid along hard palate

Head tilted backward
Endotracheal Intubation

- **31500** Intubation, endotracheal, emergency
  - 31500 4.14 RVUS
  - Includes video: glide, ranger etc...
  - Optical stylets
- LMA - no separate code
78 year old with COPD presents in respiratory failure. SaO2 is 77% and patient requires intubation.

Procedure: Intubation utilizing glidescope. 7.5 Fr ET, 21 cm at the lip. Tolerated well. Bilateral breath sounds, positive end tidal CO2 color change. CXR pending. Sats now 88% and improving. Versed, Propofol drip, vent settings as documented

31500 Intubation, endotracheal, emergent
Fiber Optic Laryngoscopy

- Laryngoscopy, flexible fiberoptic; diagnostic
- 31575 1.90 RVUs
  - CCI edit with intubation
Bronchoscopy

- Bronchoscopy, rigid or flexible,
- 31622 3.79 RVUs
  - No CCI edit with intubation
Cricothyrotomy

- Pt presents to ED after MVA in respiratory arrest. Unable to be intubated by EMTs. ED MD performs Emergent cricothyrotomy

Procedure- ER Physician: Emergent Cricothyrotomy. Patient unable to be intubated due to oral trauma. #15 blade used to cut down on cricothyroid membrane followed by brisk finger dissection and use of tracheal hook. #5-0 ET tube cut short and inserted. Bags easily. Sats improving.

- 31605 - Tracheostomy, emergency procedure; cricothyroid membrane
  9.70 RVUs

- 31603 - Tracheostomy transtracheal
  9.30 RVUs
Laceration Repair Key Concepts

Documentation of location, length, and layers

- **Location**
  - 12 cm scalp laceration: 2.15 RVUs
  - 12 cm Facial Laceration: 2.78 RVUs
    - 29% increase

- **Length** Cut offs
  - 2.6 cm, 5.1 cm, 7.6 cm, 12.6 cm... Measure!
    - Frequently a 25% difference

- **Layers**
  - Simple- single layer
  - Intermediate- 2 layer or heavily contaminated
  - Frequently a 30% difference
Intermediate Repair

Getting it all right yields 6.20 RVUs

Patient fell while hiking on a rocky trail striking her left forehead on the ground.
Exam reveals a 5.2 cm wound of the forehead with significant gravel and debris.
Procedure note: Laceration repair Left forehead
Prepped with betadine, wound explored. cleaning with normal saline under pressure, extensive debris removed.
Wound closed with 4-0 vicryl and 6-0 nylon (7 sutures).
Dressing applied.
Complex Laceration Repair

- Complex repair - more than layered closure. Requires: **debridement** (such as for traumatic lacerations or avulsions), extensive undermining...

**Procedure Documentation:**
Laceration Repair – Length 6 cm  
Location: Forearm  
Description of procedure- Wound was 6 cm in length and was gaping, the fascia and muscle were exposed. Edges were jagged. Extensive cleaning was performed with jet lavage. Moderate **debridement and revision of wound edges** was required. Deeper tissues were re-approximated with 4-0 monocryl, incorporating deep buried simples, figure of 8s and deep running closure of extensor muscle fascia. The skin was brought together with 4-0 prolene in running fashion. **Additional debridement of skin flaps performed to allow good closure.**

- 13121 Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm- **7.50 RVUs**
2020 Intermediate vs. Complex Laceration

- **Intermediate repair**
  - **Limited** undermining
- **A distance less than the maximum width of the defect**
- **Complex repair**
  - **Extensive** undermining
- **A distance greater than or equal to the maximum width of the defect**
4 year old boy is brought in by his parents after striking his head on the edge of the coffee table. He has a nearly full thickness laceration on his forehead. The parents want to know if you have “that glue stuff.”
Laceration Repair: Dermabond

Medicare:

- Single layer alone use G code
- Multiple layer with deep sutures use intermediate repair code
- Other Payers-laceration codes
Dermabond Valuation

Medicare:
- Single layer alone use G0168 0.54 RVUs
- Multiple layer with deep sutures use intermediate repair code 12052 5.74 RVUs

Other Payers—always use laceration codes
- Single layer face 12013 1.72 RVUs
- Multiple layers face 12052 5.74 RVUs
35 year old male auto mechanic presents to the ED with a red injected painful eye. He states “feels like needles sticking in my eye.” He reports it started suddenly while replacing a rusty muffler.
Ocular Foreign Bodies

- Location
  - Conjunctival
    - Superficial 65205  0.83 RVUs
    - Embedded 65210  1.04 RVUs
  - Corneal
    - No slit lamp 65220  1.19 RVUs
    - With Slit lamp 65222  1.46 RVUs
- Rust Ring Burr Tx 65435
  - 1.98 RVUs
26 year old male presents to the ED with a moderate nosebleed after crashing his bike in a peloton pile up. He states it has been going on for 45 minutes while he finished the race.
Epistaxis

- Anterior Epistaxis
- Limited Cautery/Packing
- Extensive Cautery/Packing
- Nasal Tampons

Inserted a 5 cm rhino rocket in left nare; profuse bleeding continued, pressure held, replaced with a 7.5 CM rhino rocket with maximal inflation. Patient experienced moderate discomfort but consented. Balloon deflated slightly for patient tolerance. Bleeding controlled

- Posterior Epistaxis
- Packs/Cautery-any method
Epistaxis RVU Valuation

- Anterior Epistaxis
  - Limited Cautery/Packing 30901  1.64 RVUs
  - Extensive Cautery/Packing 30903  2.28 RVUs...**39%**
  - Nasal Tampons 30903  2.28 RVUs
Epistaxis Treatment

45 year old presenting with epistaxis. Evaluation showed posterior bleed

Control of Hemorrhage, posterior, with posterior nasal packs and/or cautery

Location to determine correct procedure

Topical anesthesia: Afrin.
Procedure details:
Treatment site: R posterior
Repair method: Rhino Rocket.
Treatment episode: recurring
Post-procedure details:
Assessment: Bleeding stopped
Patient tolerance of procedure: Tolerated well, no immediate complications
27 year old with complaint of sore throat and difficulty swallowing.

Procedure note: Benzocaine gel was applied. After 5 minutes, Lidocaine 1% w/o epi was injected. Incision was made with 11 blade and approximately 5cc of purulent drainage was noted. Wound left open. Patient tolerated well with no complications.

CPT 42700 Incision and drainage abscess, peritonsilar
(1.67 wRVU; 3.86 total RVU)
Can ED physicians bill for fracture care?
Fracture Manipulation

- Code for all manipulations
- Use the without anesthesia codes
- Splint is bundled
- Hematoma block no separate code
- Extremely high RVUs
Distal Radius Fracture w/ Manipulation

- Capture with 25605-54
- >10 RVUs

Joint Reductions…Giant RVUs

- Hip traumatic 5.33 RVUs
- Hip post arthroplasty 11.66 RVUs
- Shoulder 8.36 RVUs
- Elbow nursemaid’s 2.26 RVUs
- Elbow formal 9.71 RVUs
- Ankle 11.10 RVUs
- Finger IP 7.87 RVUs
Shoulder Dislocation Reduction

CPT Code 23650 8.36 RVUs!

Procedures
Joint/Fracture Reduction
Joint/Fracture Reduction:
Fracture Reduction Site: upper extremity (R), successfully reduced
Describe Method of Reduction
Non-sedated reduction of right anterior shoulder dislocation, we use Stimson's technique which required the patient to be placed supine with right arm hanging off of stretcher while traction was held the right tip of the scapula was manipulated immediately well rotating the superior aspect of the scapula laterally in a clockwise direction. A palpable clunk signified adequate reduction there was no sulcus sign for obvious deformity. Patient tolerated the procedure well complications
Hip Dislocation Reduction

- 27250 Closed treatment of hip dislocation, traumatic; without anesthesia 5.33 RVUs

**Procedure:** Joint Reduction with procedural sedation: Patient identification confirmed, Written consent obtained. Pre-Procedure assessment: capillary refill less than 2 seconds. Distal sensation intact, Distal motor function normal. Indication: posterior dislocation left hip. With use of flexion at the hip, traction/counter traction technique used; Joint reduced left hip. After procedure, x-ray ordered, knee immobilizer applied, Post procedure assessment; capillary refill less than 2 seconds, Distal sensation intact, Distal motor function normal, Patient tolerated procedure well.
Post Arthroplasty Hip Reduction

- 27265 Closed treatment of post hip arthroplasty dislocation; without anesthesia
  - 11.66 RVUs!

### Procedures
**Joint/Fracture Reduction**

**Fracture Reduction Site:** lower extremity (L)

**Anesthesia (List Med Given):** IV

**Attempts:** 1

**Post Joint Reduction Film:** adequate positioning

**Immobilization:** Joint immobilized w/ (hip abductor pillow)

**Patient tolerated procedure:** well

**Complications**

**Reduction of left hip arthroplasty:**

The left hip arthroplasty was dislocated as reviewed in hip radiograph. I placed the patient on oxygen by nasal cannula placed her supine. Upon anesthesia with etomidate IV patient adequately anesthetized. Flexion of the left hip with internal rotation of the hip and traction with one attempt successfully reduced the left hip arthroplasty. Postreduction films obtained and acceptable.
Our ED sees lots of abscesses. Which aspects of the procedure impact my RVUs?
Abscess Drainage

- Simple or single
  - Furuncle, paronychia
  - Superficial
  - Single
- Complex or multiple
  - Probing
  - Loculations
  - **Packing**
Well Documented I&D

Procedure
Incision and drainage
Confirmed: Patient, procedure, side, and site correct.
Consent: Patient.
Indication: Abscess.
Pre procedure exam: Circulation, motor, and sensory intact.
Procedural sedation: None.

Description
Location: L axilla.
Anesthesia: 5 ml, 1% lidocaine.
Preparation: skin prepped with betadine.
Incision: 1 cm incision was made, using a # 11 blade scalpel.
Technique: wound probed, loculations decompressed.
Drainage: moderate amount, 5 ml, purulent, cultures obtained.
Irrigation: minimal.
Wound: packing placed in wound cavity.
Post procedure exam: Circulation, motor, sensory examination intact.
Patient tolerated: Well.
Complications: None.
Follow-up: In the emergency department, In 2 days, Antibiotic: Keflex, and bactrim.
Performed by: Self.
Abscess Valuation

- Simple or single 10060  2.87 RVUs
- Complex or Multiple 10061 5.21 RVUs… 84%
- 2+ RVU difference….typical practice 80 abscesses per month

Additional 2,300 RVUs per year!
Pilonidal Cyst

- Patient presents with painful lump in gluteal fold
- Pilonidal cyst drainage 10080
  - 2.95 RVUs

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**PROCEDURE:**

The area of pilonidal cyst was steriley prepared using Betadine. Two percent lidocaine was then used to anesthetize the area around which there was some drainage occurring. A # 11 scalpel blade was used to expand this area to approximately 1.5 cm in size. Mosquito forceps were then used to exude more purulent material from this larger opening.

Copious amounts of purulent drainage were exuded. This was then packed with one-half inch lodoform gauze. The patient tolerated this well.
Cardioversion

- Patient presents with A-fib with RVR that did not respond to medications. Consent was obtained and the patient was premedicated.

**CARDIOVERSION**

Pre-procedure rhythm: atrial fibrillation  
Patient position: patient was placed in a supine position  
Electrodes: pads  
Electrodes placed: anterior-posterior  
Number of attempts: 1  
Attempt 1 mode: synchronous  
Attempt 1 waveform: biphasic  
Attempt 1 shock (in Joules): 100  
Attempt 1 outcome: conversion to normal sinus rhythm  
Post-procedure rhythm: normal sinus rhythm  
Complications: no complications  
Patient tolerance: Patient tolerated the procedure well with no immediate complications

Elective cardioversion 92960 3.12 RVUs
INTRAOSSEOUS INFUSION: The right proximal tibia was prepped and draped. A 16 gauge needle was inserted at a 90 degree angle and advanced in a rotating fashion until a loss of resistance was felt. IV tubing was connected and flowed easily.

- 36680 Placement of needle for intraosseous infusion
  - 1.74 RVUs
Patient presents with neck pain unrelieved by OTC meds. Osteopathic manipulation performed.

- **OMT Codes**: arranged by # of regions manipulated
  - Head, cervical, thoracic, lumbar, sacral, pelvic, lower/upper extremities, rib cage, abdomen, viscera
- 98925 Osteopathic manipulation 1-2 body regions
  - 98926-98929 for additional # of body regions
Needle insertion not requiring an injection

- **20560** Needle insertion(s) without injection(s); 1 or 2 muscle(s) (0.47 RVUs)
- **20561** Needle insertion(s) without injection(s); 3 or more muscles (0.71 RVUs)

Needle inserted into “knotted area”
Trigger Point Injection

- 22 year old presents with complaints of chronic neck pain. No relief with home meds. Declines narcotics.

**TRIGGER POINT INJECTION:** Trigger point injection indicated for pain control, Single or multiple trigger points(s), 1 or 2 muscle(s) injection performed, Patient tolerated the procedure well, patient injected with 1.5 cc of Marcaine approximately 5 cm on either side of C7 spinous process into the trapezius muscle.

- 20552 Injection of single or multiple trigger points 1-2 muscles
  - 20553 - 3 or more muscles

1.11-1.25 RVUs
Procedures and Radiologic Guidance
Evolution

- More and More codes have definitions that incorporate imaging guidance
- A single code which includes imaging guidance
- 2 codes that differentiate with and without imaging guidance
- A code that requires a specific type of imaging guidance
2020 Pericardiocentesis Code Changes
Now A Single Code

- New unifying code which adds the description of including imaging guidance

New Code:
- **33016** Pericardiocentesis, including imaging guidance, when performed (6.85 RVUs)

A 46 y/o. oncology patient presents with BP 80/50 and is tachypneic. JVD is prominent. Rapid echo demonstrates a large pericardial effusion and impending tamponade. Urgent Pericardiocentesis under US guidance performed.
Thoracentesis: With and Without Imaging Guidance

The site was prepped with chlorhexadine. A tube was inserted over a needle into the 6th intercostal space. 20 ml bloody fluid drained and sent to the lab. Patient tolerated the procedure well.

2.59 RVUs

3.22 RVUs
Arthrocentesis: Joint Size and US

- **Joint Size without Ultrasound:**
  - Small (finger) 1.04 RVUs
  - Intermediate (wrist) 1.08 RVUs
  - Large (knee) 1.32 RVUs

- **With Ultrasound**
  - Adds additional .3 - .7 RVUs

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**PROCEDURES - Physician**

08/30/14 12:55 Aspiration of left suprapatellar bursa under US guidance, sterile prep with betadine and sterile technique. 10mL of yellowish fluid removed with 18g needle after anesthetized with 3mL 1% lidocaine with epinephrine. Tolerated well, no complications, sent to lab...

- Arthrocentesis large joint with US 1.73 RVUs
Lumbar Puncture and Specific Imaging Guidance Modalities

- Code both the Ultrasound and the procedure for the few remaining procedures that don’t have a CPT code for the procedure with US
- Make sure both notes individually meet the documentation requirements

62270– Spinal puncture, lumbar, diagnostic

#62328– Spinal puncture, lumbar, diagnostic; with fluoroscopic or CT guidance

No code for with US

LP under US Guidance: 62270 + 76942
Solutions and Strategies

- Procedures are a key contributor to RVU production
- Often a 30% RVU difference based on specific elements
- Identify the frequent and high RVU procedures
- Determine the key documentation elements
- Incorporate into your recurring process
Contact Information

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Educational Appendix
RVU Resources

- ACEP Top 20 Codes and RVUs

- AMA: Medicare RBRVS: The Physicians' Guide
  (800) 621-8335 Order Number: OP059616

- Acep.org>Practice>Reimbursement>
  Medicare RVUs by CPT code
“All diagnostic ultrasound examinations require permanently recorded images.”

“A final, written report should be issued for inclusion in the patient's medical record.”
  - Does not require a separate sheet

“Use of ultrasound, without thorough evaluation of organ(s) or anatomic region, image documentation, and final, written report, is not separately reportable.”

CPT 2020
US Documentation Requirements

- **Medical Necessity** – medical record documentation must indicate why the test was medically necessary.

- **Interpretation** – a written interpretation and report must be completed and be maintained in the patient’s medical record and describe the structures/organisms studied and include an interpretation of the findings.
  - identify provider performing/interpreting the study

- **Image Retention** – appropriate image(s) of the relevant anatomy/pathology must be permanently stored and available for future review.
“For those anatomic regions that have "complete" and "limited" codes, note the elements that comprise a "complete" exam. The report should contain a description of these elements or the reason that an element could not be visualized (eg, obscured by bowel gas, surgically absent).”

“If less than the required elements for a "complete" exam are reported (eg, limited number of organs or limited portion of region evaluated), the "limited" code for should be used
Payments Macro View

- 40,000 visit ED
- 1-2% of patients receive US
- ~1500 studies annually
  - More if additional procedure protocols
- $30k in revenue
- Non par relationships significantly improve per case revenue
US Hospital Issues

- ED Limited Study & Radiology Complete
- CPT Theory: It is generally allowable under CPT for two different physicians to report a limited and a complete exam of the same anatomic description at different exam sessions…”
- Reimbursement reality- most payers will only reimburse for the Complete when both a Complete and Limited are submitted for the same date
US Hospital Strategies

- Start with low hanging fruit
  - Line placement...quality and safety
  - Cardiac Activity during codes
  - FAST Exam...if + may be followed by a CT
  - Post Void Residual...non invasive
  - Procedure Assistance...abscess vs cellulitis

- Areas of frequent Radiology Pushback
  - Ectopic Evaluation
  - Biliary Studies
Example: “a complete abdominal ultrasound (76700) would consist of real time scans of the: liver, gall bladder, common bile duct, pancreas, spleen, kidneys, upper abdominal aorta and inferior vena cava.”
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