Stop the Bleeding: Avoid Procedure Coding Pitfalls

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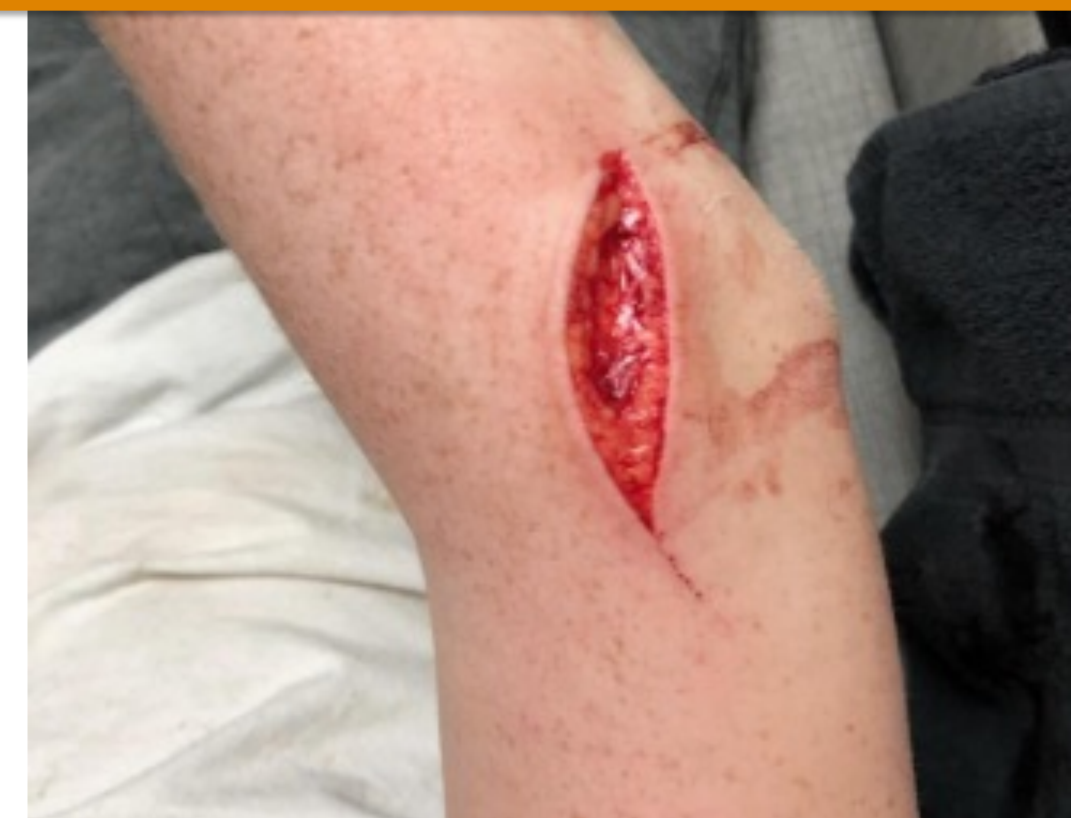
Mutual Understanding - Will Stop the Bleeding!

- Procedures- important component 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

The Doc's View



The Coder's View

CPT 2021

12041 Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less
CPT Changes: An Insider's View 2009
CPT Assistant Sep 97:11, Feb 00:10, Apr 00:8, Jan 02:10, Feb 07:10, Jan 13:15, Sep 18:7

12042 2.6 cm to 7.5 cm
CPT Changes: An Insider's View 2009
CPT Assistant Feb 00:10, Apr 00:9, Jan 02:10, Feb 07:10, Jan 13:15, Sep 18:7

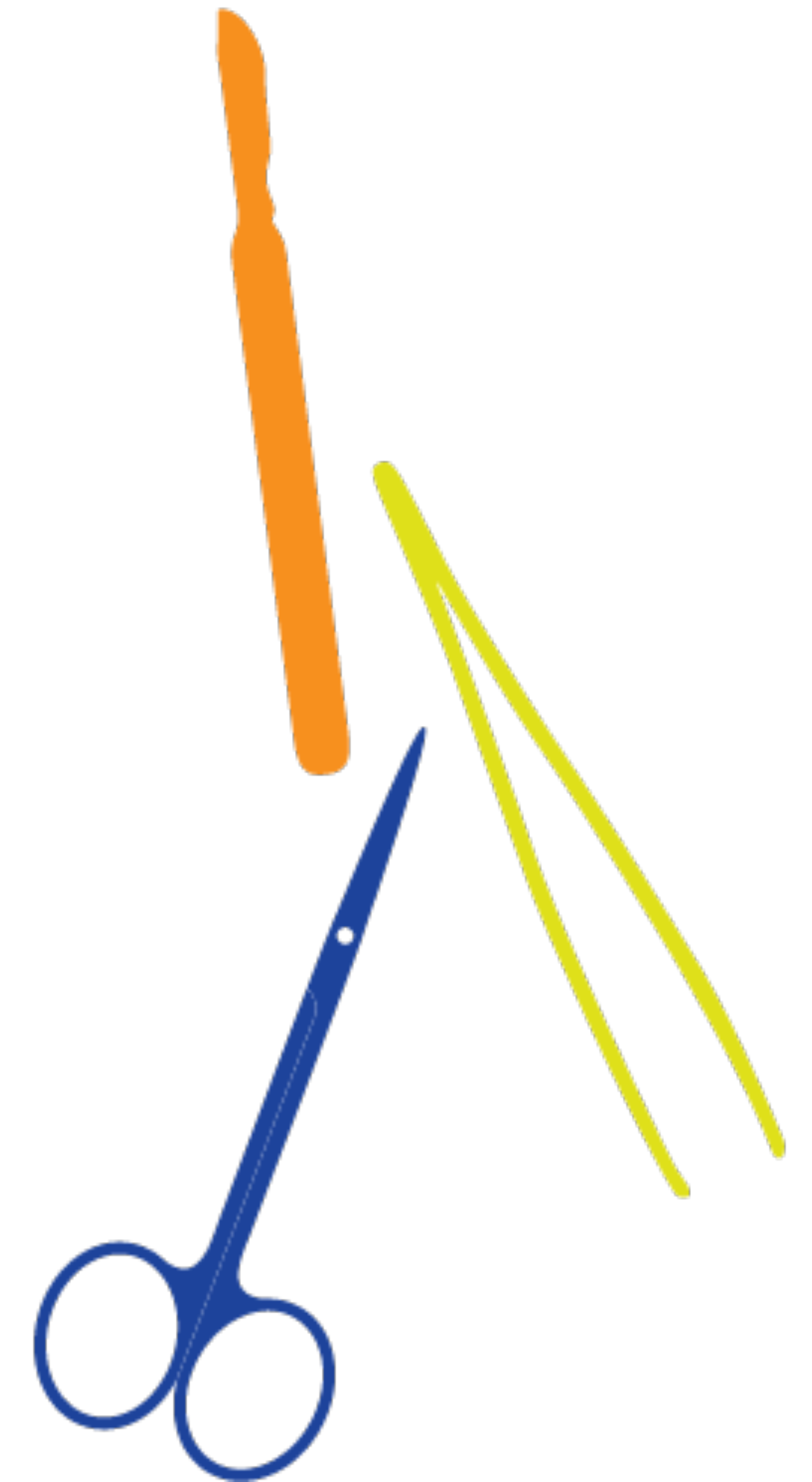
Procedures: Teaching Physicians Working With Residents

Teaching Physicians Procedures

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

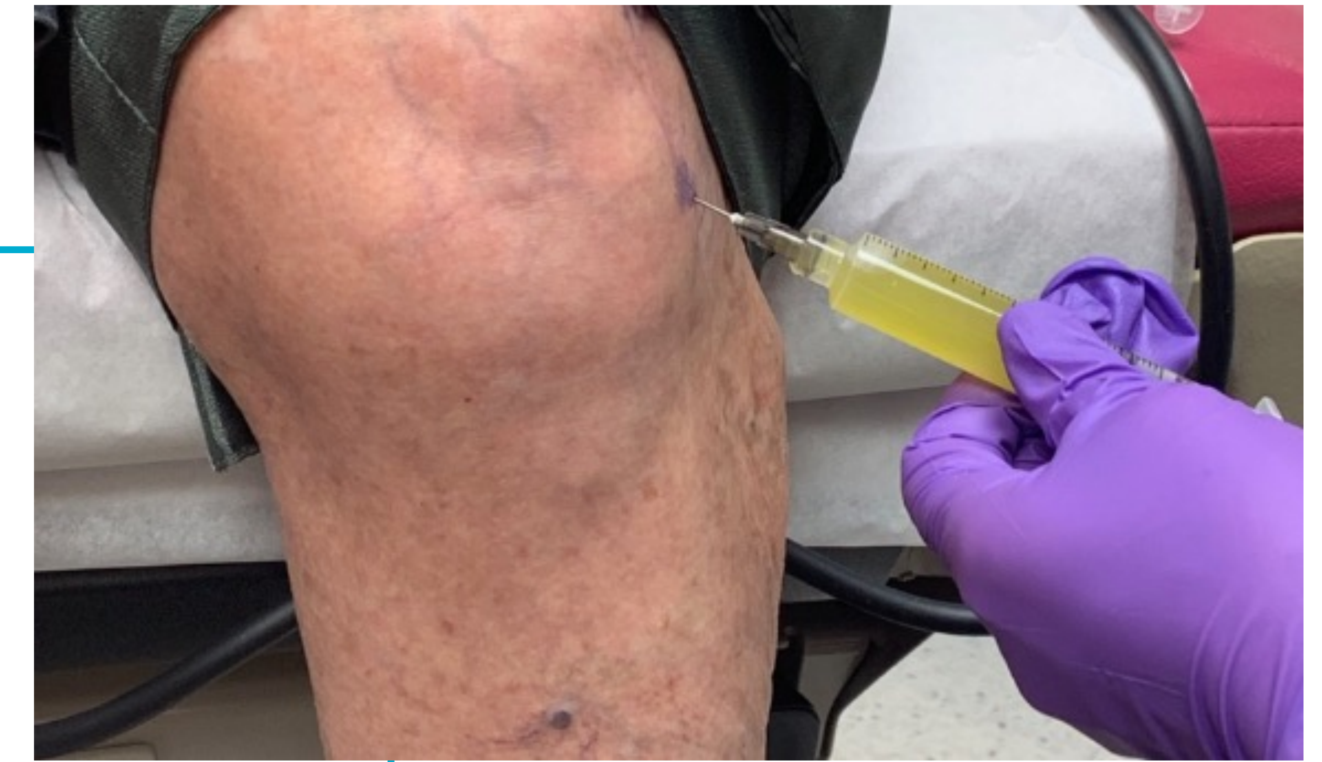
Procedures

- 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 Teaching Physician Example

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.

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

Medicare Minor Procedures Separately Identifiable Service

"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 Claims Processing Manual Chapter 12 Section 40.1

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

"In addition to the CPT evaluation and management code, modifier "-57" (decision for surgery) is used to identify a visit which results in the initial decision to perform surgery."

Medicare Claims Processing Manual Chapter 12 Section 40.2. 4

Procedures: Physician Assistants and Nurse Practitioners

- Original CMS Transmittal 1776
- Attending documents a ***substantive portion*** of the **E/M service** billed under the physician at 100%
  - Did NOT apply to procedures
- 2023 CMS substantive portion definition
  - All of the required Hx or PE or MDM to meet the requirement for the E/M level billed
- Still does not apply to procedures
  - PA procedures typically billed out under the PA

AANP American Association of NURSE PRACTITIONERS®

American Academy of PHYSICIAN ASSISTANTS

Common ED Service RVUs

Procedure	RVUs
EKG (93010)	0.24
Finger laceration: Simple 2.6 – 7.5 cm (12002)	1.75
Facial laceration: Intermediate 2.6- 5 cm (12052)	5.93
Central line placement (36556)	2.48
Chest tube placement (32551)	4.58
CPR (92950)	5.38
Shoulder dislocation reduction (23650)	9.21
Colles' fracture reduction (25605)	15.63

Compare to E/M value	RVUs
99282	1.24
99285	5.21
Critical Care	6.31

Surprises	RVUs
TMJ dislocation reduction (21480)	0.93
A-line insertion (36620)	1.31
LP (62270)	1.86
Patellar dislocation reduction (27560)	10.51

Highlights of Non E/M RVUs

- Complex I and D
  - Packing, probing, loculations
  - 3.14 vs 5.47
- Laceration Repairs
  - Layered/Heavy Contaminated
  - Face- 2 layers 5.93
- CPR
  - 5.38 RVUs
  - Document oversight

- ORTHO

  -Shoulder 9.21

  -Hip (disloc.) 5.37

  -Finger 5.83

- 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!
- ALJ decision
- Typical group > $100 per day
- https://bit.ly/2Qc5vOZ
  - ACEP EKG packet

DEPARTMENT OF HEALTH & HUMAN SERVICES

SEP 14 2005

FAH-II

Robert E. Sutter, DO, MHA, FACEP
President
American College of Emergency Physicians
Suite 325
2121 K Street, NW.
Washington, D.C. 20037

Dear Dr. Sutter:

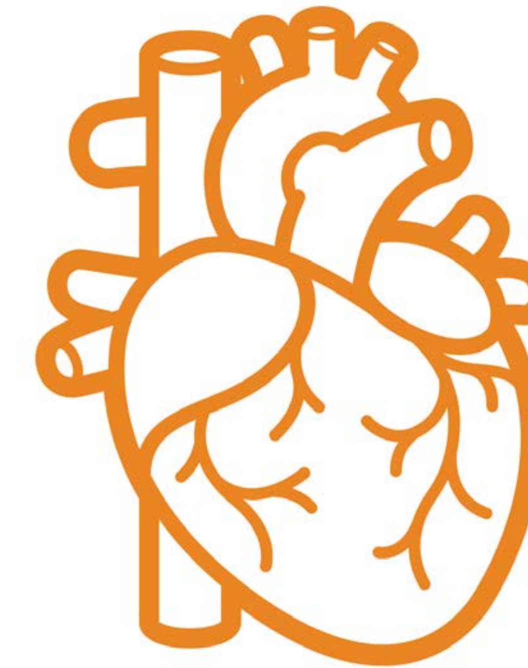
Administrator Mark McClellan asked me to thank you for your letter regarding the timely interpretation of diagnostic tests performed on hospital emergency department patients. Specifically, you are concerned that these interpretations are sometimes not contemporaneous with the emergency room visit. You describe situations where interpretations are performed hours or even days after medical decision-making has occurred, and yet payment is made; by Medicare. You are concerned that this removes any incentive for "contemporaneous interpretations that are in the best interest of the quality-and safety of care provided to emergency department patients." I regret the delay in this reply.

Our policy in this regard is contained in the Medicare Claims Processing Manual in Chapter 13, Section 100; http://www.cms.hhs.gov/manuals/104claims/clm104c13.pdf Carriers should distinguish between an "interpretation and report" of an x-ray and/or electrocardiogram and a "review" of the procedure. Billing for interpretations without a complete, written report similar to that which would be prepared by a specialist in the field does not meet the conditions for separate payment of the service. When two claims are received for the same interpretation, payment should be made for the interpretation that directly contributed to the diagnosis and treatment of the individual patient.

We appreciate your bringing this issue to our attention. We intend to explore steps we can take to reemphasize that our policy is to pay for services provided to the patient rather than after-the-fact reviews that are actually quality control measures.

Sincerely,

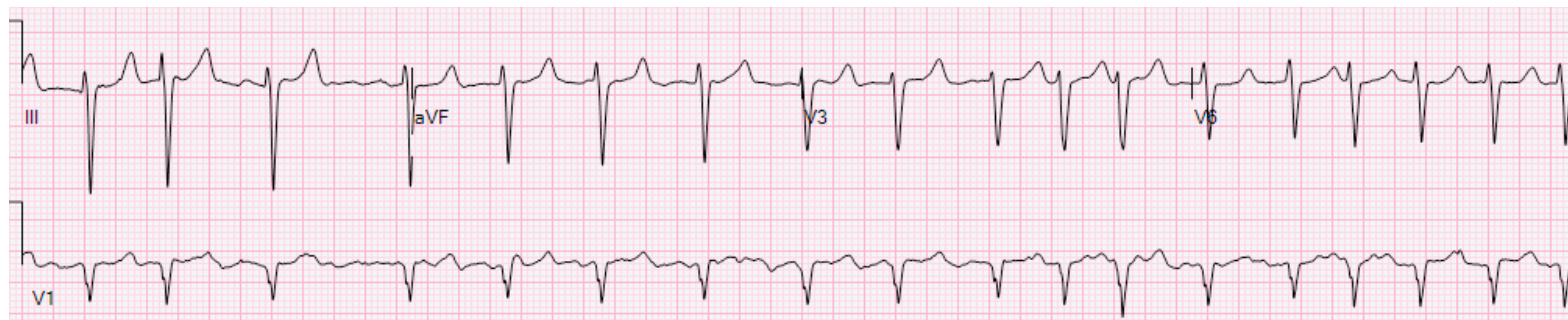
Herbert B. Kuhn
Director, Center for Medicare Management



EKG Interpretation

- Should be similar to a specialist
- Generally met with 3 separate elements
  - Though not a specific requirement
- Report with 93010 - 0.17 work RVUs 0.24 total
- High frequency service

Junctional rhythm
Left axis deviation
Abnormal ECG
No previous ECGs available
Interpreted by [redacted] 12/19/2022 10:55:25 PM

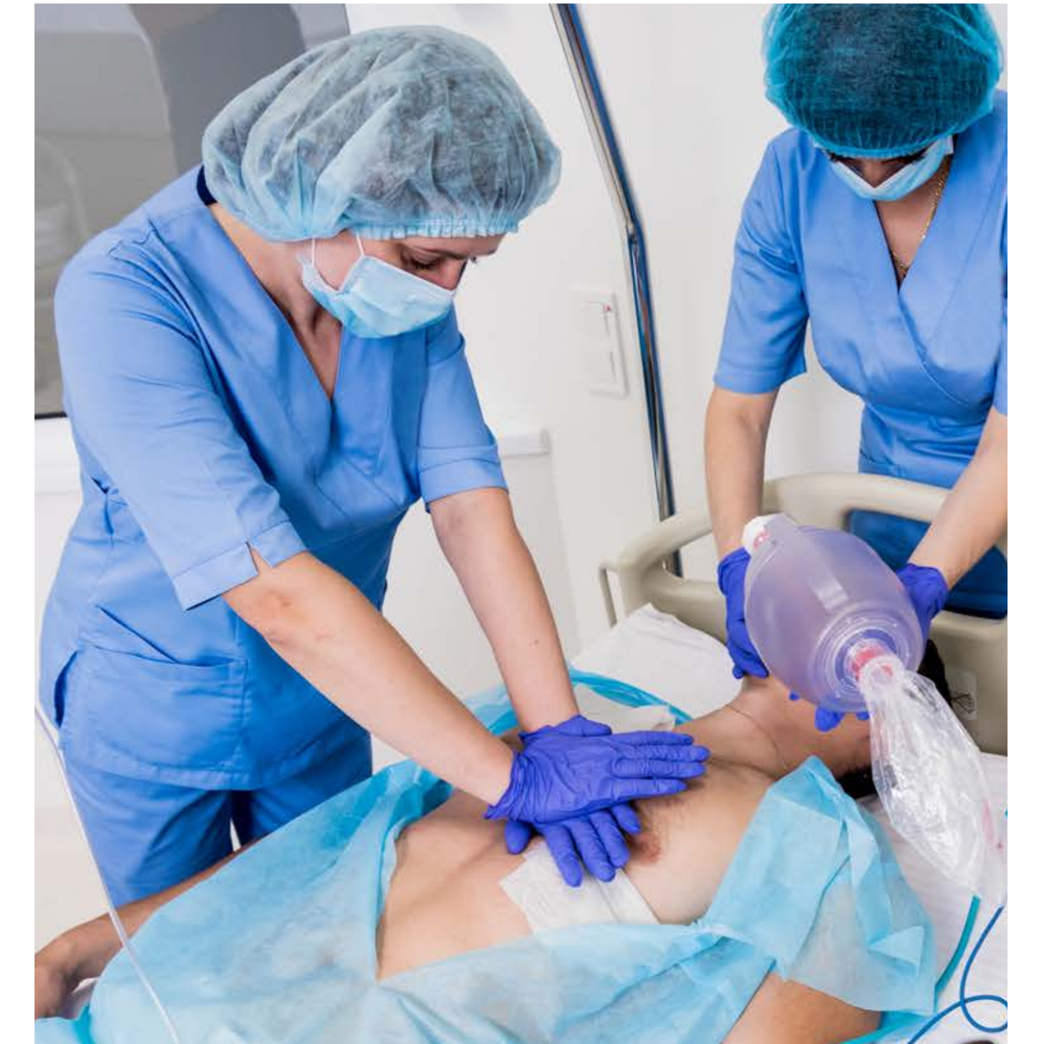


Impression:
Sinus rhythm with occasional Premature ventricular complexes
Left axis deviation
Low voltage QRS
Inferior infarct , age undetermined
Abnormal ECG
When compared with ECG of 10-AUG-2021 06:41,
Premature ventricular complexes are now present
Inferior infarct is now present
Nonspecific T wave abnormality, improved in Anterior leads

Acep.org > reimbursement > diagnostic interpretations

CPR

- **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
  - Typically also report a high level E/M service



- 5.38 RVUs for CPR (92950)
- E/M Level yields a total of 10+ RVUS
  - Document Hx/PE/MDM

Airway Tools Video Assisted Laryngoscopy

Glidescope

Ranger

Shikani

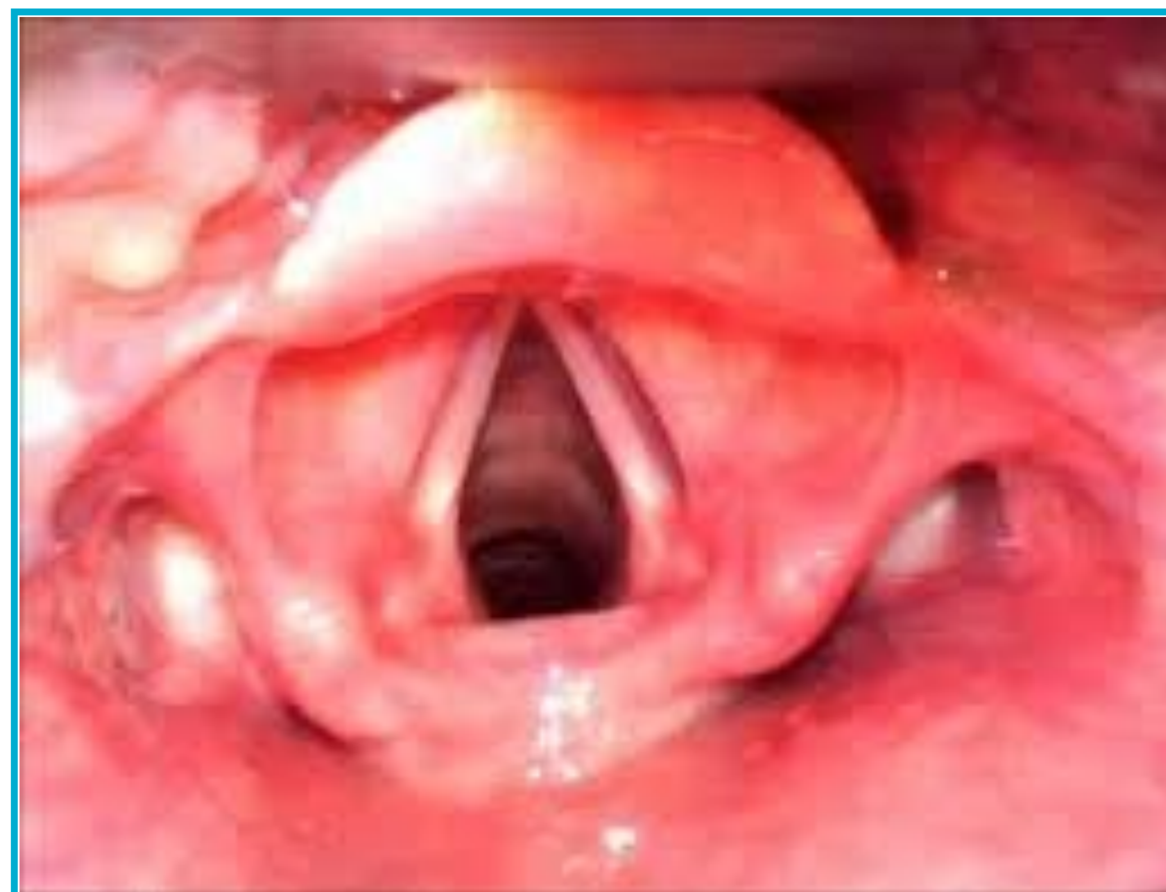
McGrath

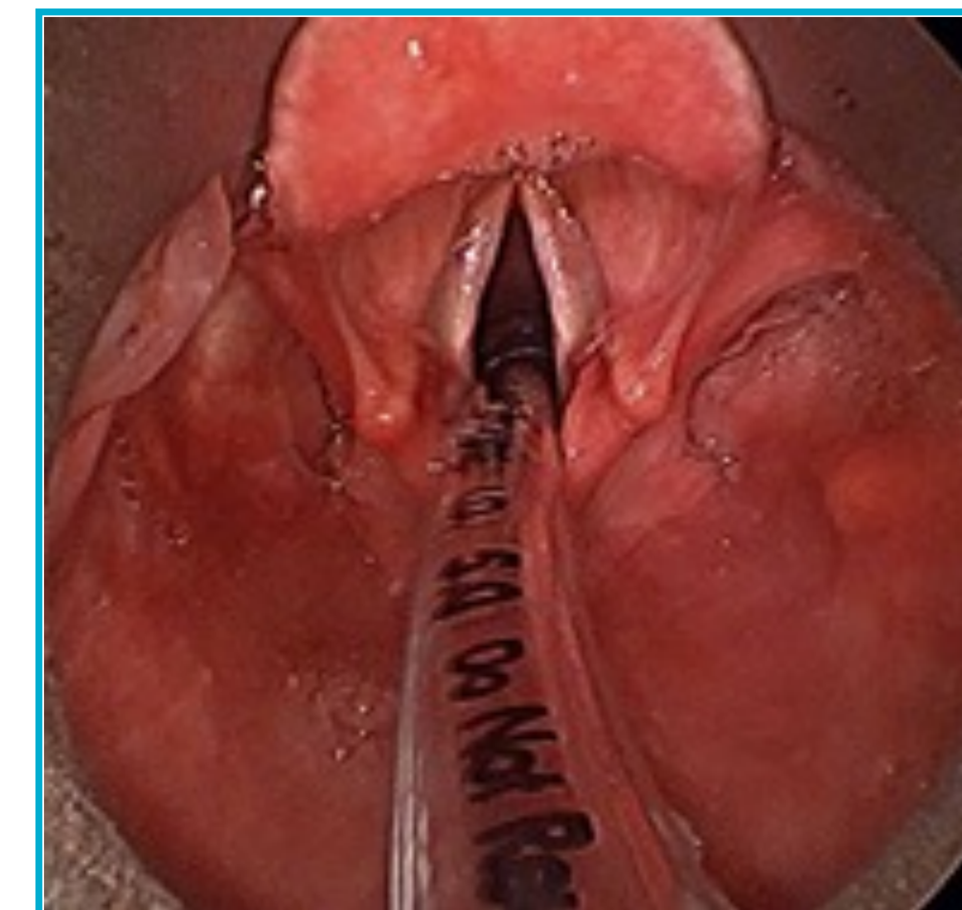
Storz

Pentax/Airway Scope

Endotracheal Intubation

- **<u>31500</u>** Intubation, endotracheal, emergency
  - 31500 4.17 RVUs
  - Includes video: glide, ranger etc…
  - Optical stylets
- LMA- no separate code





Intubation with Videoscope

- 78 year old with COPD presents in respiratory failure. SaO2 is 77% and patient requires intubation.
- 31500 Intubation, endotracheal, emergent

Intubation

Date/Time: **12/20/2022 8:14 AM**
Performed
Authorized

Patient location: **ED**

Pre-procedure
Indications: **Respiratory failure**
Consent obtained: **Emergent situation**
Airway Exam: **Yes**
Drugs:
Drug facilitated intubation?: **Yes** Hemodynamic support given?: **Yes**
etomidate (mg): **30**
rocuronium (mg): **100**

Intubation: Number of attempts: **1**
Technique: **Video laryngoscopy**
Positioning adjuncts: **Shoulder roll**

Airway device details:
Final airway type: **Endotracheal tube**
Tube type: **Cuffed**
Tube size (mm): **6.5**
Placement confirmed by: **auscultation**, **chest rise**, **condensation**, **colorimetric ETCO2 device** and **waveform ETCO2 device**
Breath sounds: **equal**
Tube secured with: **ETT holder**

Complications:
Complications: **None**

Noninvasive Ventilation: BIPAP
How to Report?

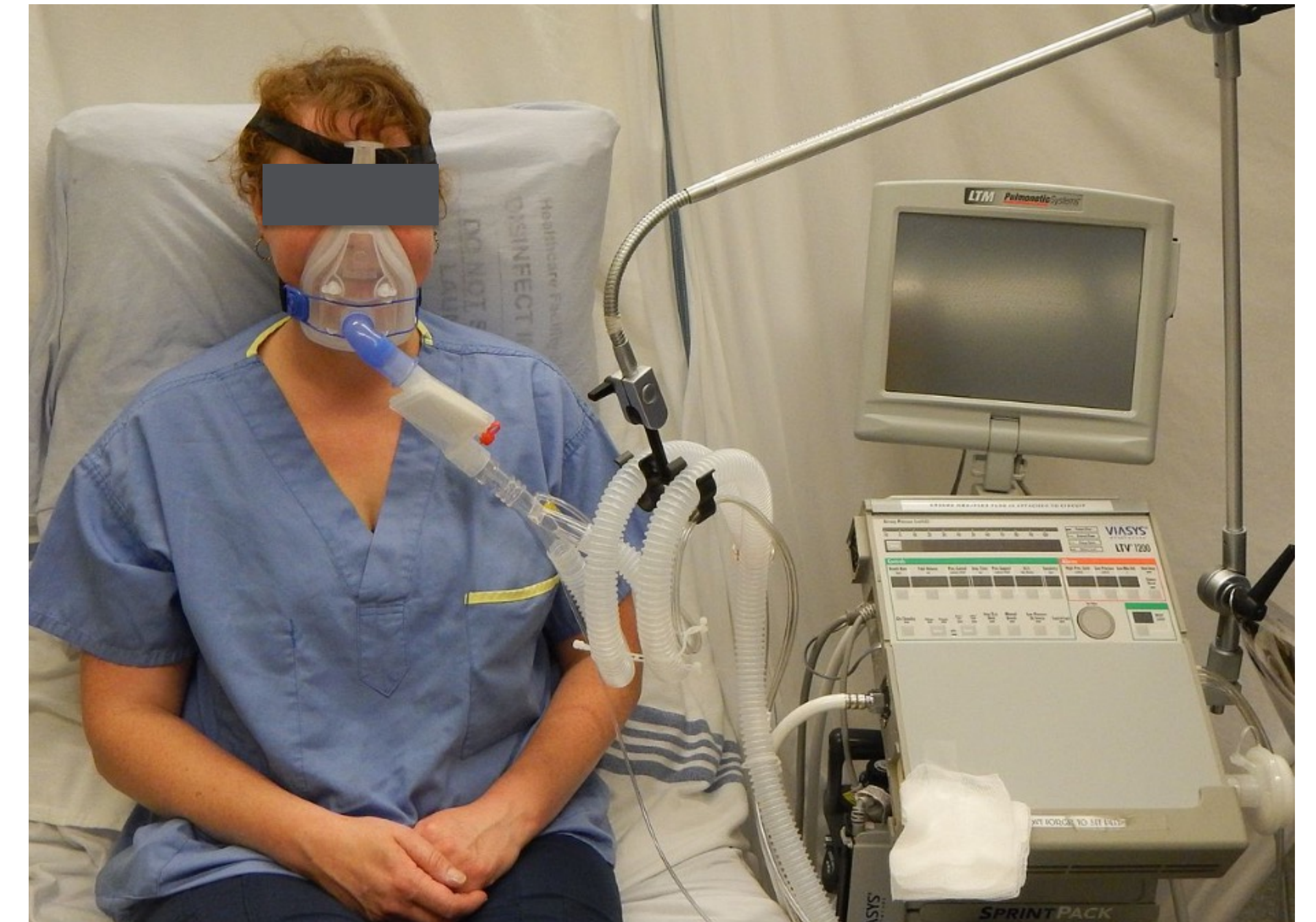
CPT Assistant January 1999, page 10:

- What is the appropriate code for reporting BiPAP?

  -BiPAP is noninvasive mechanical ventilation.

  Since it includes CPAP, CPT code 94660 is used.

  1.09 RVUs
- Frequently critical care patients!
- Count time managing non-invasive ventilation with **critical care time**
  - 94660 not separately billable with 99291



Cricothyrotomy

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

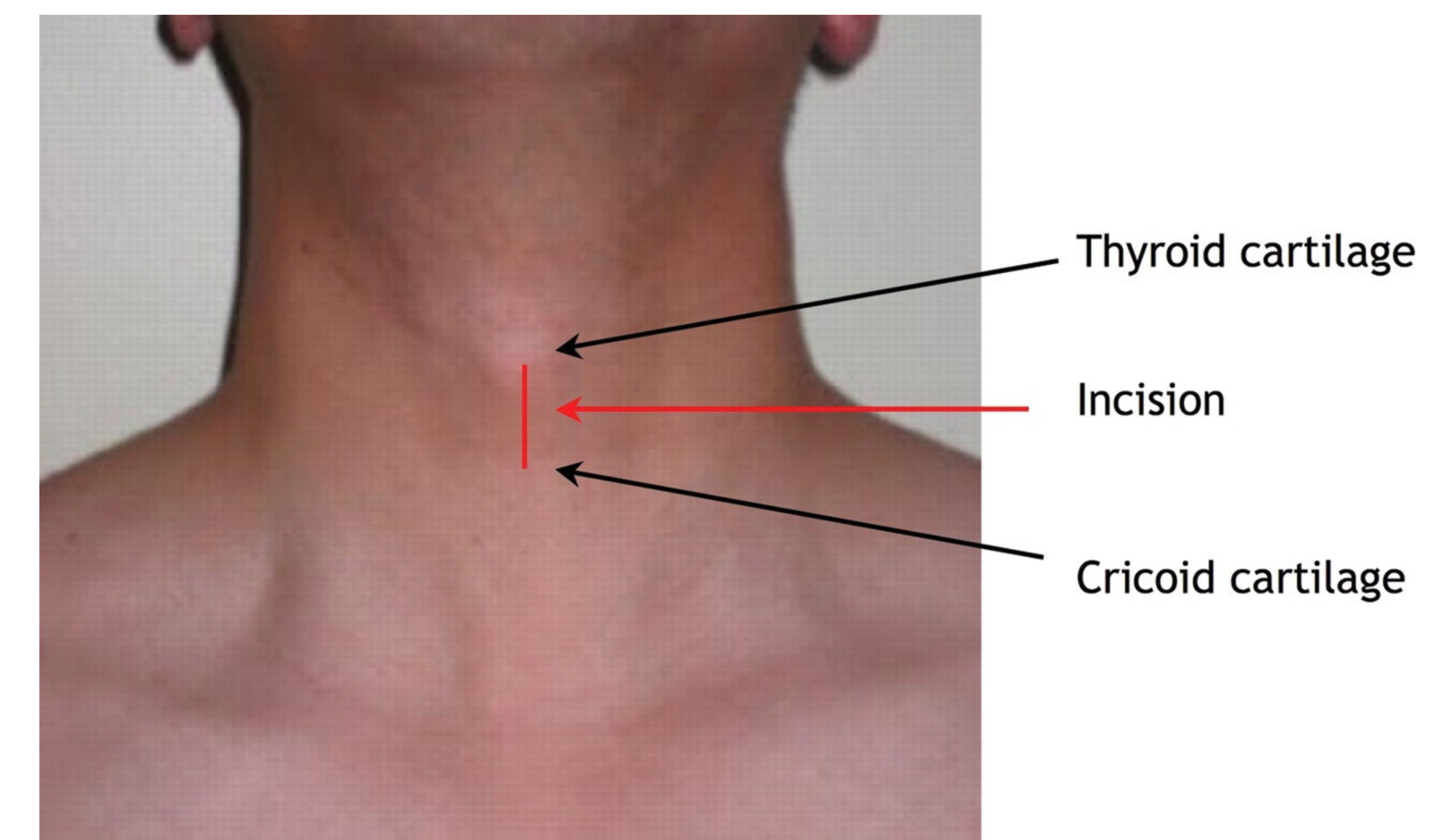
Procedure- ER Physician: Emergent Cricothyrotomy. Patient unable to be intubated due to oral trauma. #10 blade used to make vertical incision down to SQ fat. Horizontal stab incision made through Cricothyroid membrane. Bluntly dissected through CTM with finger/hemostat. Introduced bougie through tract and threaded a 6.0 cuffed ET tube. Bags easily. Sats improving.

- 31605 - Tracheostomy, emergency procedure; cricothyroid membrane

  9.85 RVUs

- 31603 - Tracheostomy transtracheal

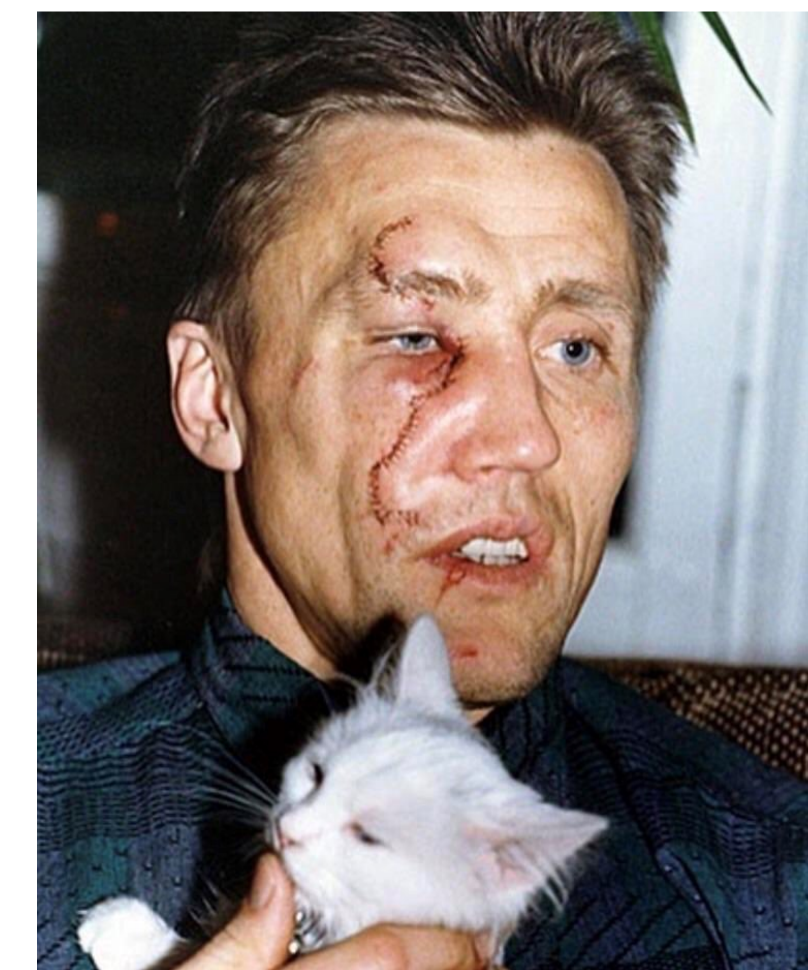
  9.51 RVUs



Laceration Repair Key Concepts

Documentation of location, length, and layers

- **Location**
  - 12 cm scalp laceration: 2.17 RVUs
  - 12 cm Facial Laceration: 2.80 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

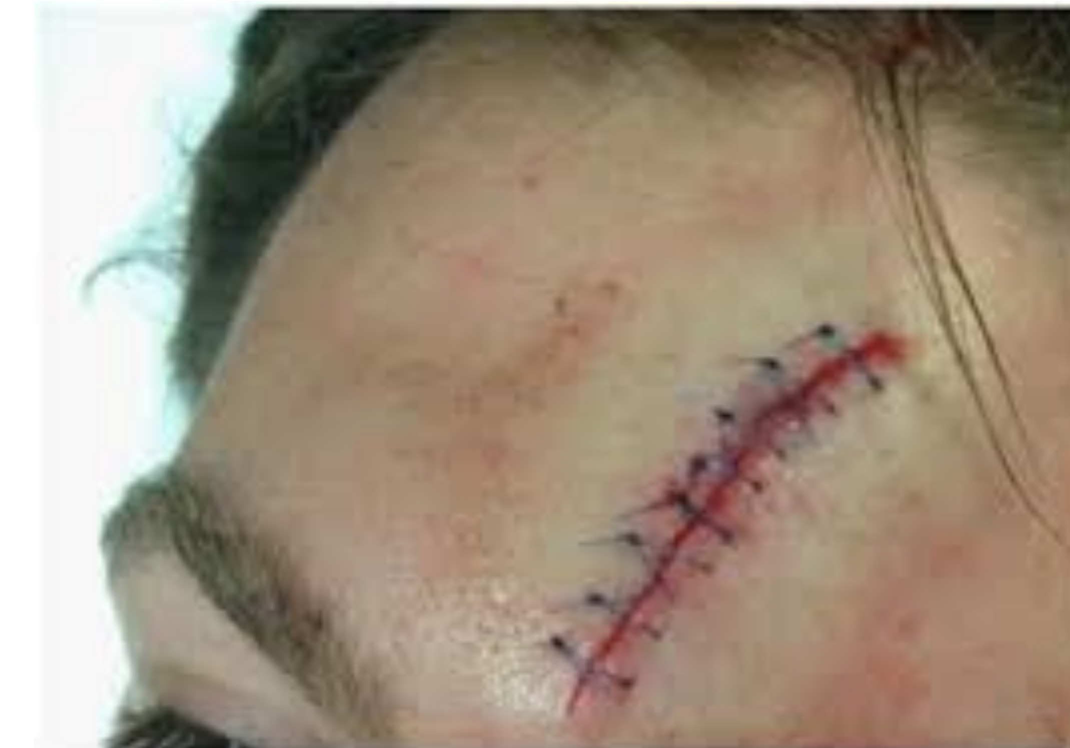


Intermediate Repair

Getting it all right yields 6.40 RVUs

Location
Length
Layers
Foreign Material

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

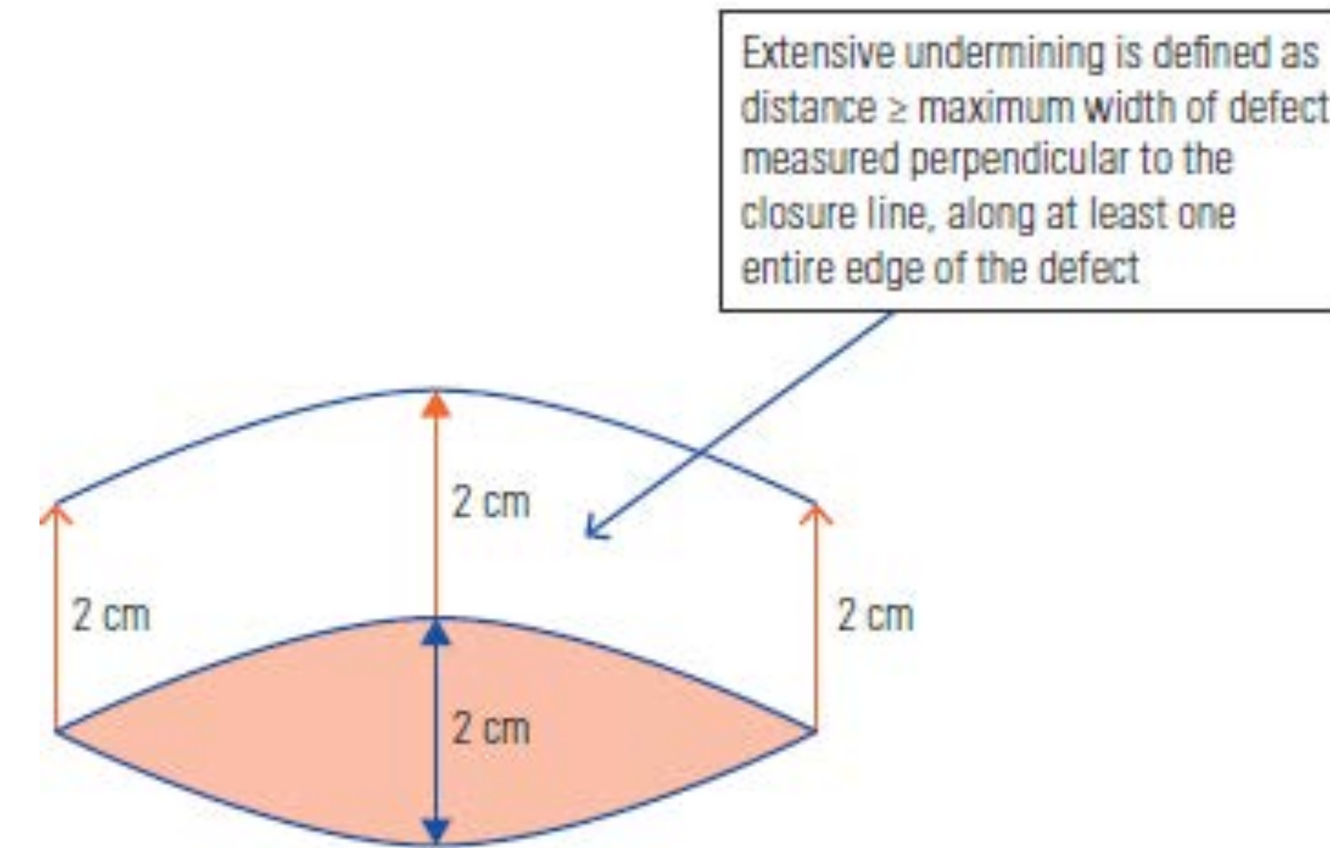
- Complex repair - more than layered closure. Requires: **debridement** (such as for traumatic lacerations or avulsions), extensive undermining…

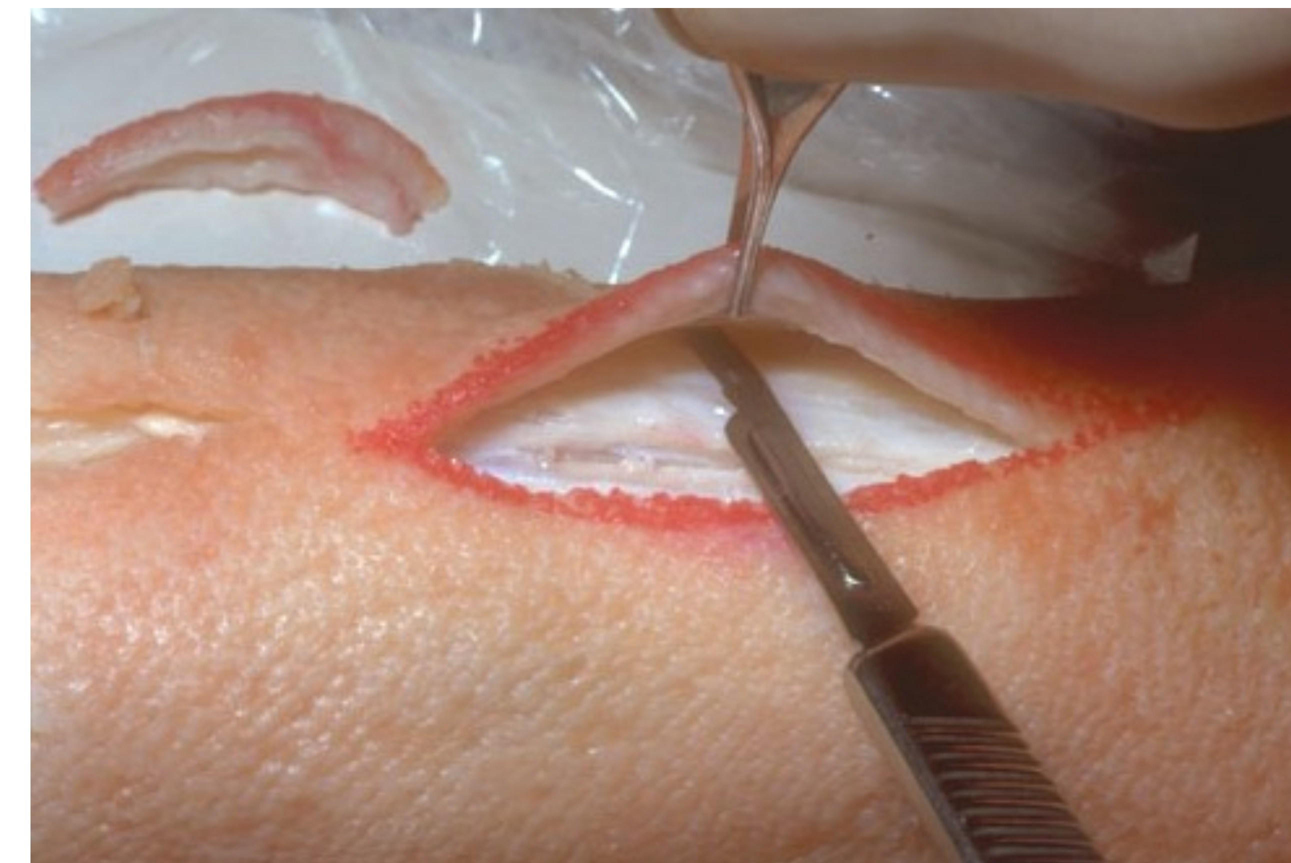
Procedure Documentation: Laceration Repair – Length 6 cm   Location: Forearm
Description of procedure- Wound was 6 cm in length and was gaping, the fascia and muscle were exposed. Edges were jagged. Extensive cleaning was performed with jet lavage. Moderate **debridement and revision of wound edges** was required. Deeper tissues were re-approximated with 4-0 monocyrl, 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- **7.62 RVUs**

Intermediate vs. Complex Laceration

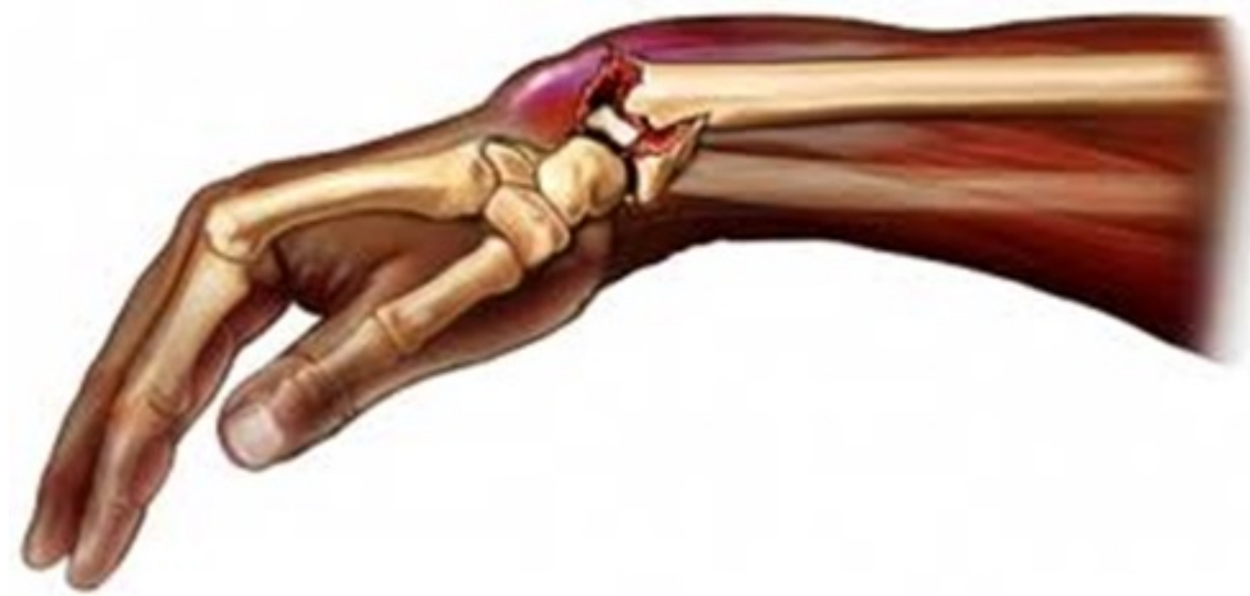
- Intermediate repair
  - Limited undermining
- A distance less than the maximum width of the defect
- Complex repair
  - Extensive undermining
- A distance greater than or equal to the maximum width of the defect

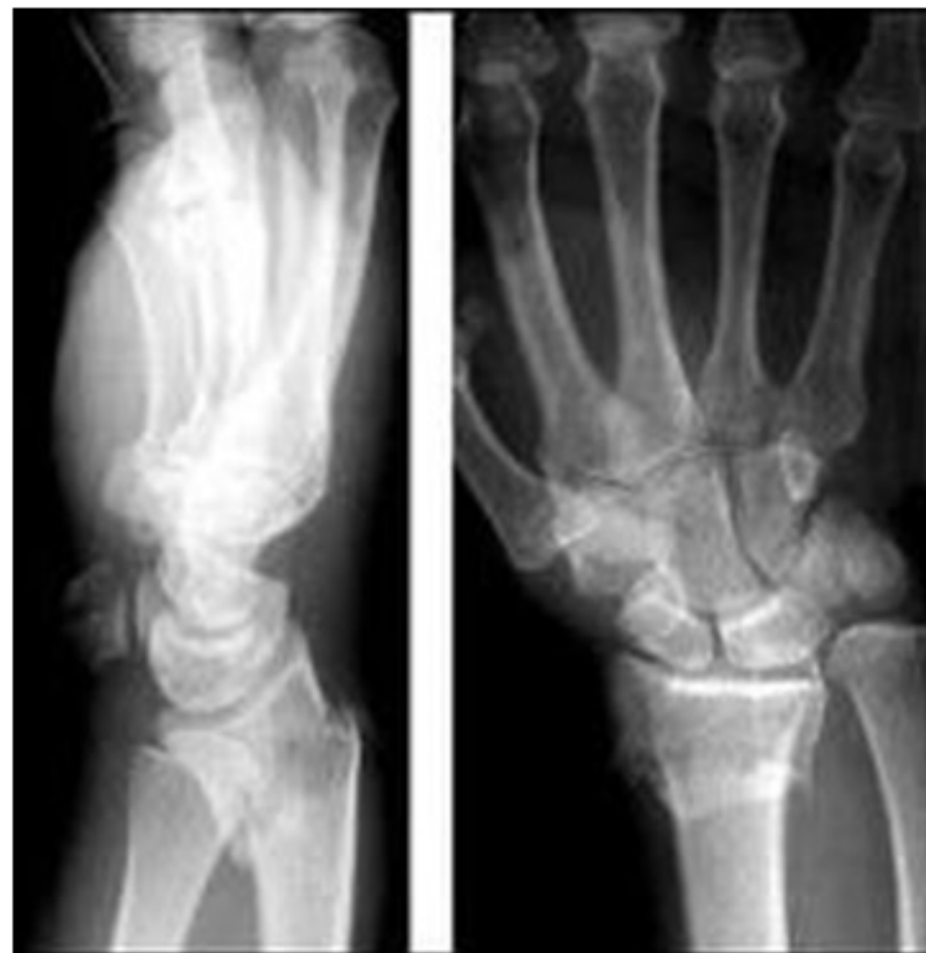




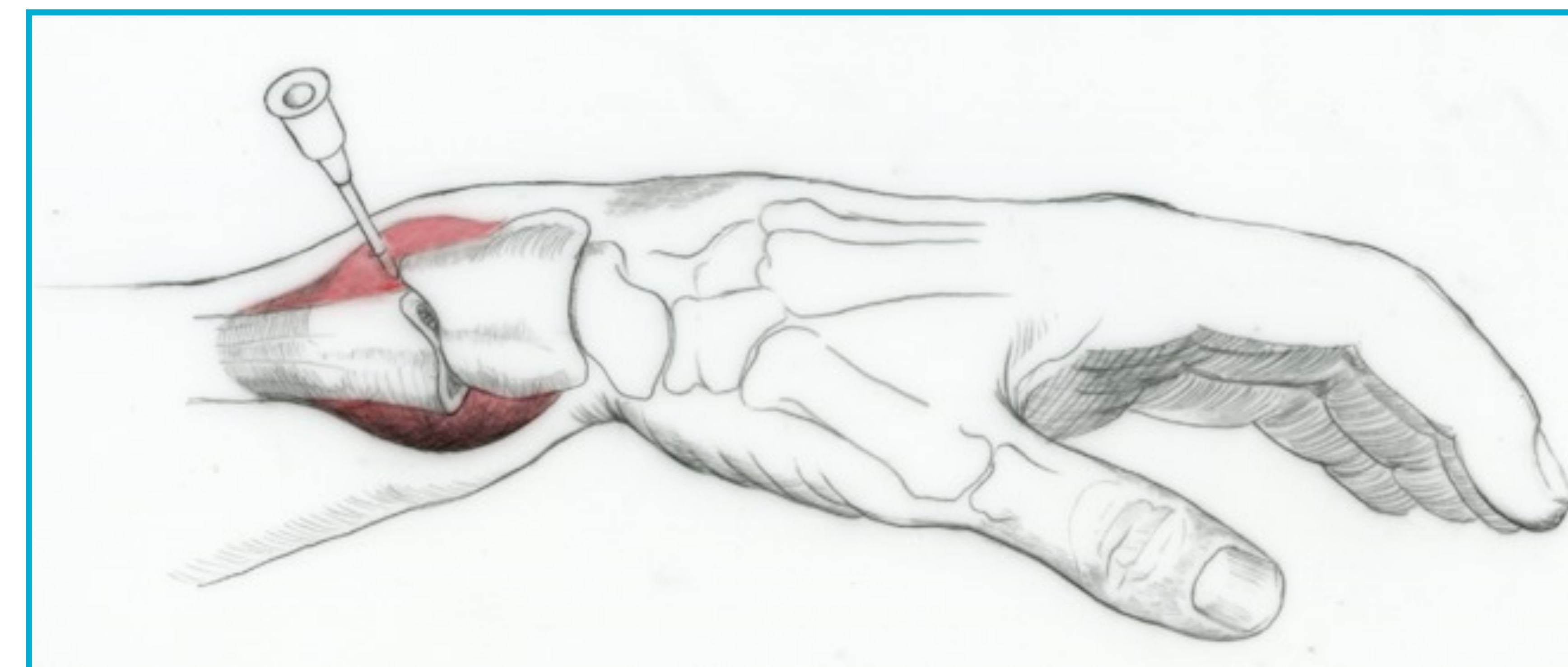
Can ED physicians bill for fracture care?

Fracture Manipulation





- Code for all manipulations
- Splint is bundled
- Hematoma block no separate code
- Extremely high RVUs



2022 Fracture Care Update

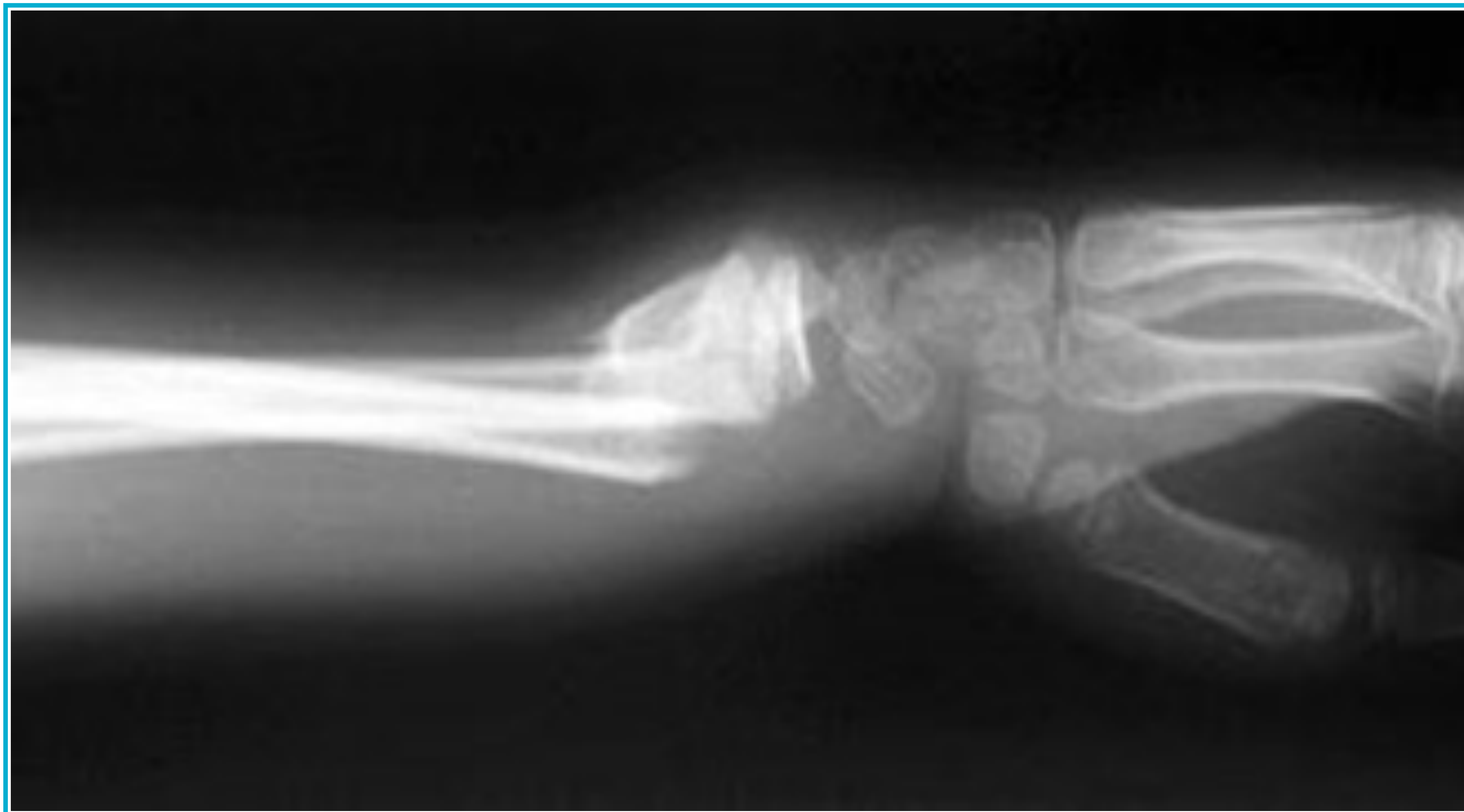
Reporting Fracture and/or Dislocation Treatment Codes

The physician or other qualified health care professional providing fracture/dislocation treatment should report the appropriate fracture/dislocation treatment codes for the service he or she provided. If the person providing the initial treatment will **not** be providing subsequent treatment, modifier 54 should be appended to the fracture/dislocation treatment codes. If treatment of a fracture as defined above is not performed, report an evaluation and management code.

Bolded by CPT

Distal Radius Fracture w/ Manipulation

- Capture with 25605-54
- >10 RVUs



Fracture Procedure

Date/Time: **12/20/2022 8:28 AM**
Performed by: [redacted]
Authorized by: [redacted]

Consent:
  Consent obtained: **Verbal**
  Consent given by: **Patient**
  Risks, benefits, and alternatives were discussed: **yes**
  Risks discussed: **Nerve damage and vascular damage**
  Alternatives discussed: **Delayed treatment**
Injury:
  Injury location: **Forearm**
  Forearm fracture type: **distal radius and ulnar styloid**
Pre-procedure details:
  Distal neurologic exam: **Normal**
  Distal perfusion: **distal pulses strong**
  Range of motion: **reduced**
Anesthesia:
  Anesthesia method: **Local infiltration**
Procedure details:
  Manipulation performed: **yes**
  Reduction successful: **yes**
  X-ray confirmed reduction: **yes**
  Immobilization: **Splint**
  Splint type: **Volar short arm**
  Supplies used: **Plaster**
Post-procedure details:
  Fracture management: **I provided definitive fracture management**

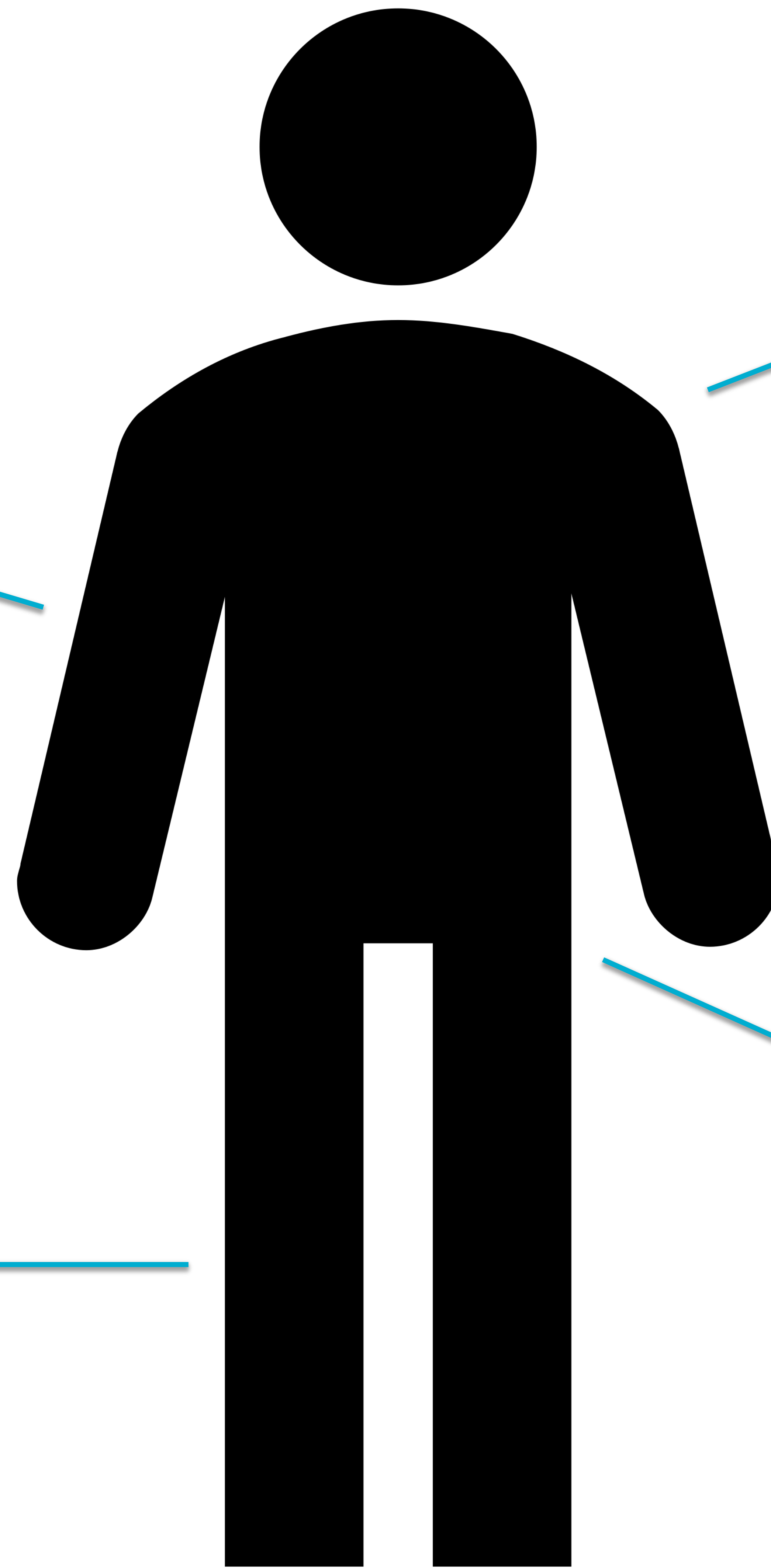
Colle's Fracture

Joint Reductions - Giant RVUs

Shoulder 9.21 RVUs

Elbow nursemaid’s 2.39 RVUs

Elbow formal 10.51 RVUs



Finger IP 8.07

Hip traumatic 5.37 RVUs

Hip post arthroplasty 12.67 RVUs

Ankle 11.82 RVUs

Shoulder Dislocation Reduction

Procedures

Joint/Fracture Reduction

Joint/Fracture Reduction :

Fracture Reduction Site: upper extremity (R), successfully reduced

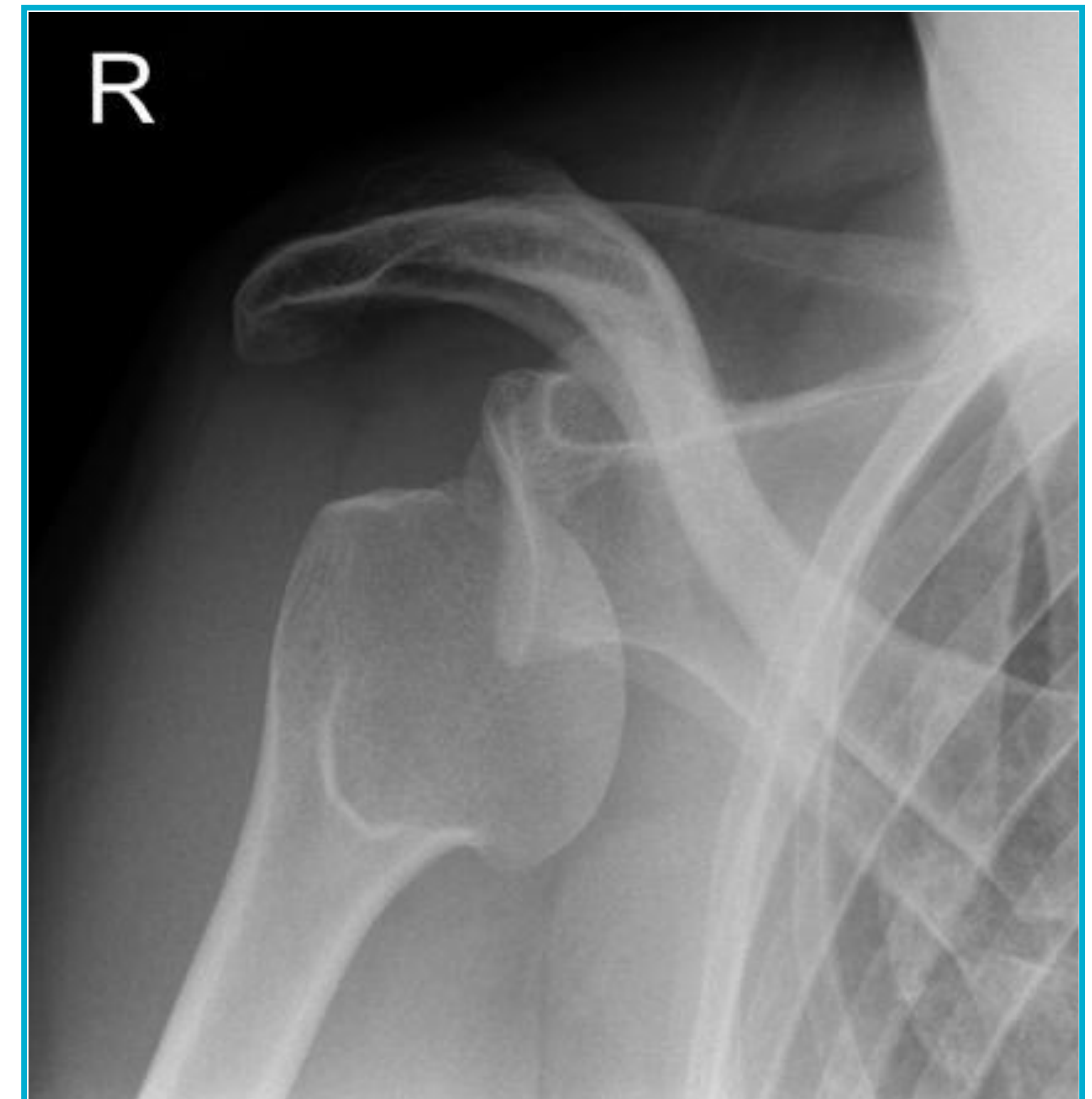
Describe Method of Reduction

Nonsedated reduction of right anterior shoulder dislocation, we use Stimsons 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

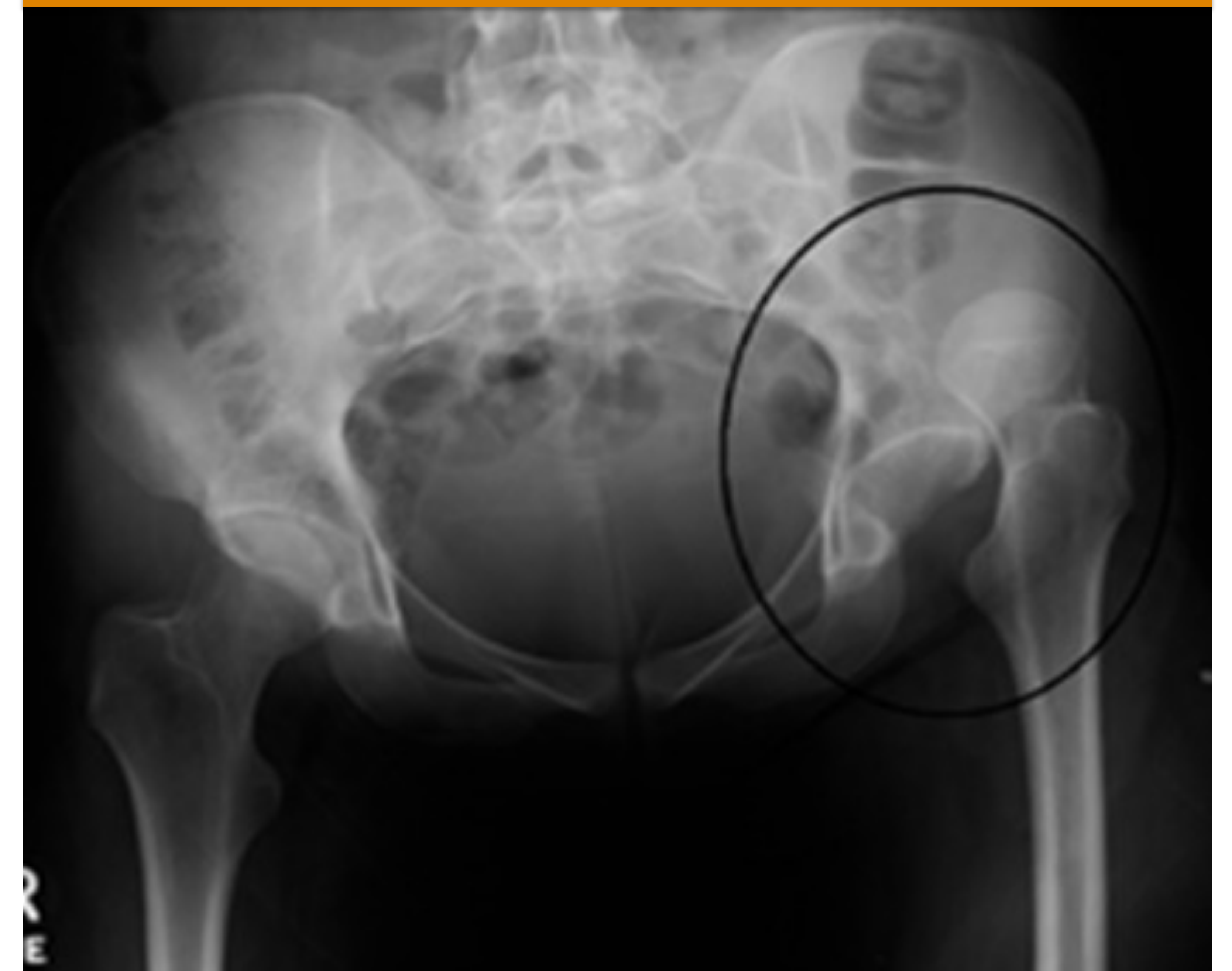
CPT Code 23650 9.21 RVUS



Hip Dislocation Reduction

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.

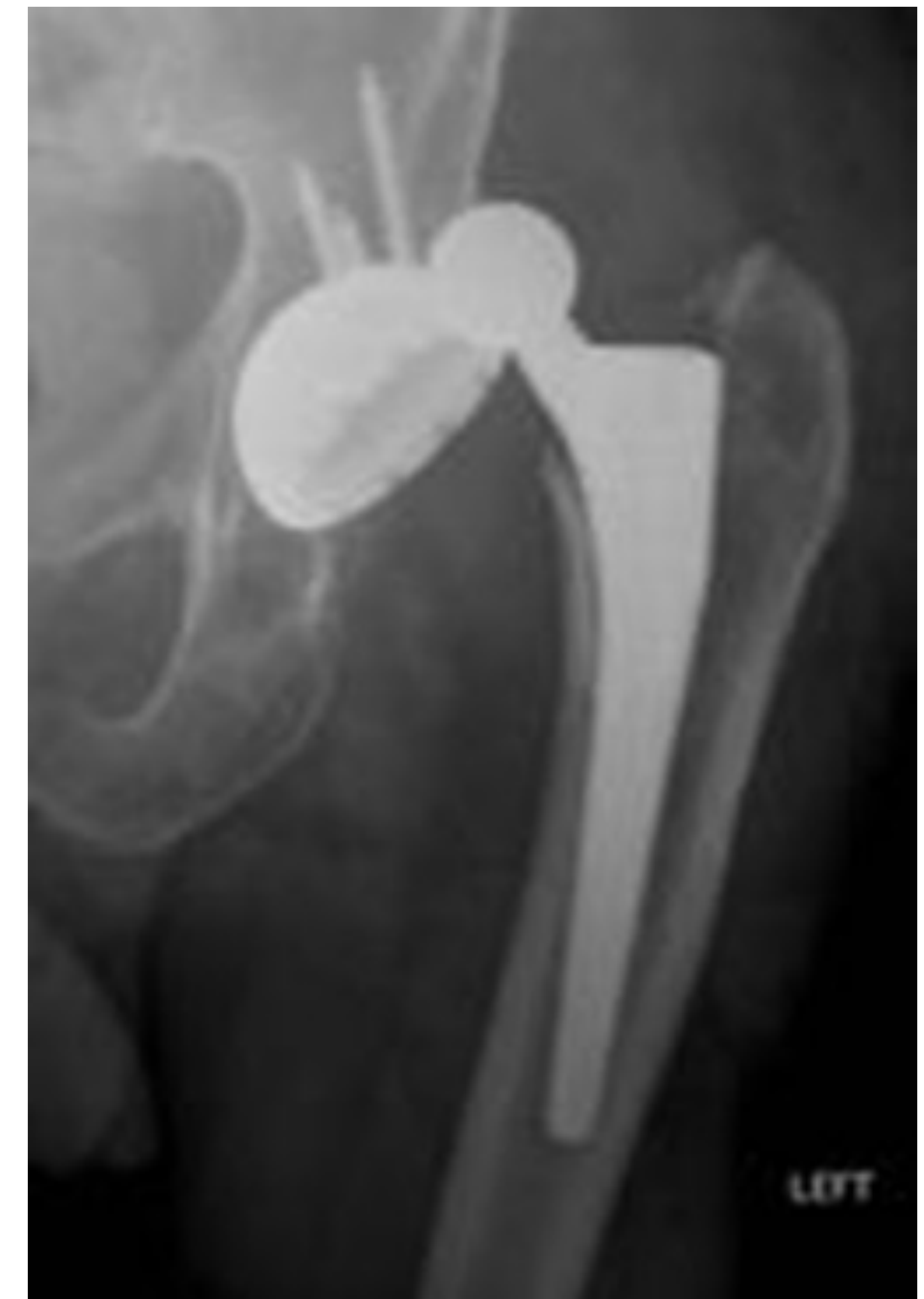
27250 Closed treatment of hip dislocation – 5.37 RVUs



Post Arthroplasty Hip Reduction

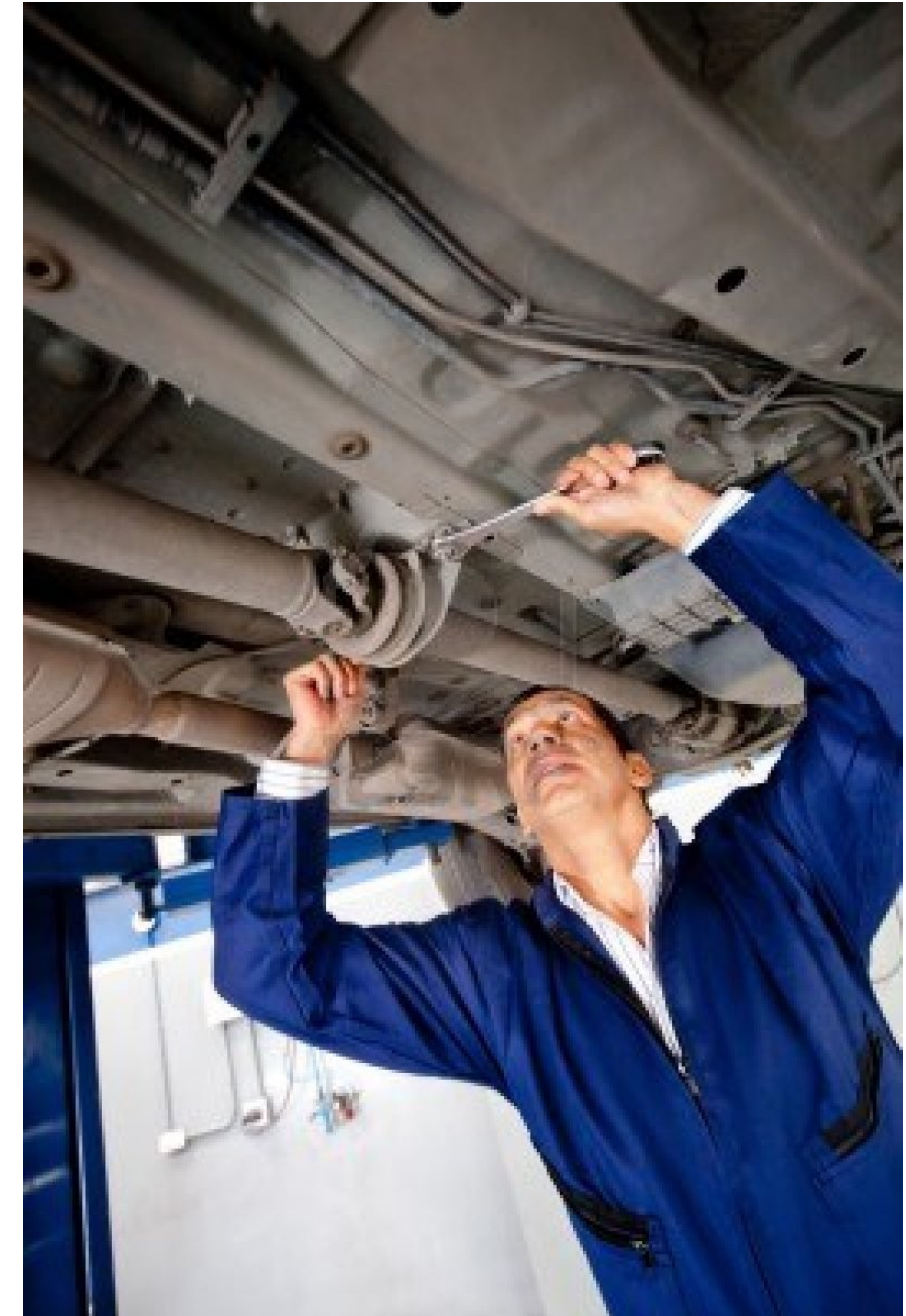
- 27265 Closed treatment of post hip arthroplasty dislocation; without anesthesia
  - 12.67 RVUs!

Procedure Note:
Dislocation – Lower Extremity, left hip, arthroplasty
Consent obtained: Written, from patient
Sedation: None
Anesthesia: Method, nerve block. 22g spinal needle, bupivacaine 0.5% without epi
Technique: L hip flexion with internal rotation and traction, one attempt, successful
Patient placed in L knee immobilizer, post-reduction films obtained and joint in proper position



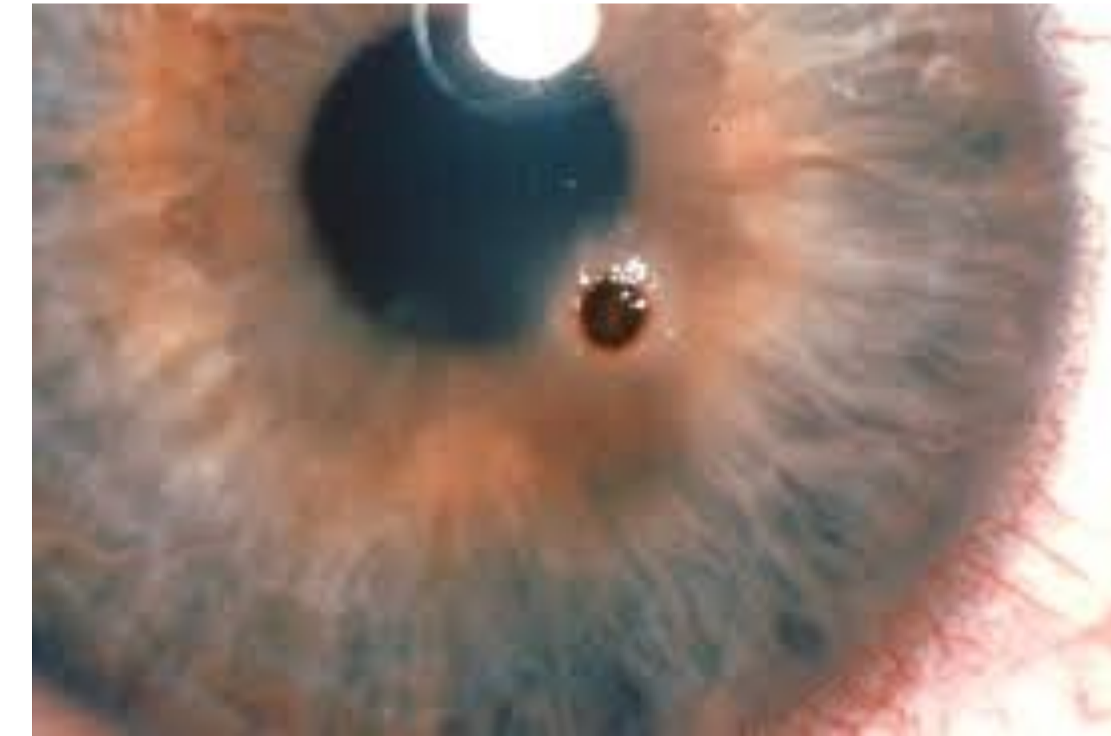
Painful Eye

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.



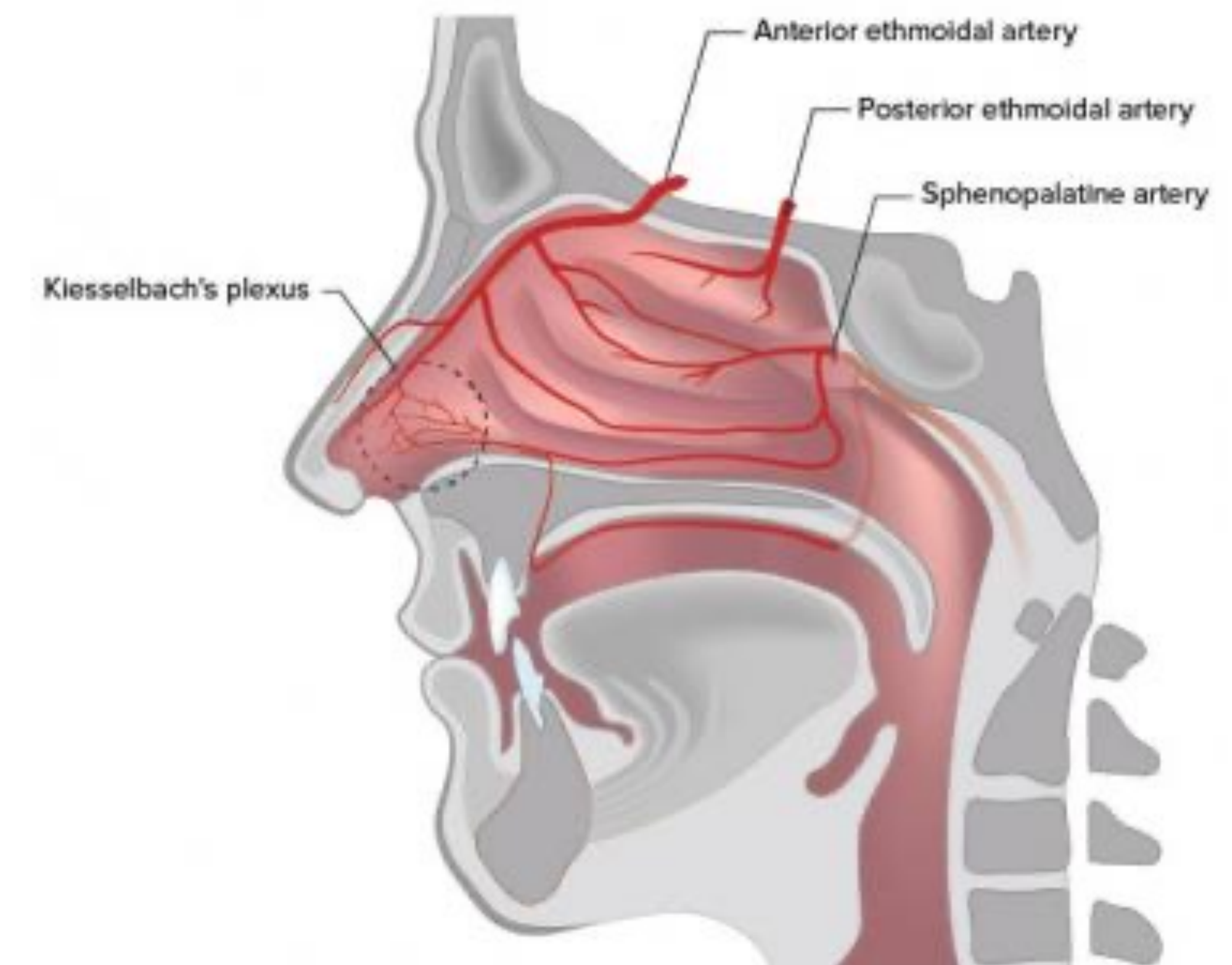
Ocular Foreign Bodies

- Location
  - Conjunctival
    - Superficial 65205   0.86 RVUs
    - Embedded 65210 1.06 RVUs
  - Corneal
    - No slit lamp 65220 1.23 RVUs
    - With Slit lamp 65222 1.47RVUs
- Rust Ring Burr Tx 65435
  - 2.03 RVUs



Crashed and It Won't Stop Bleeding

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

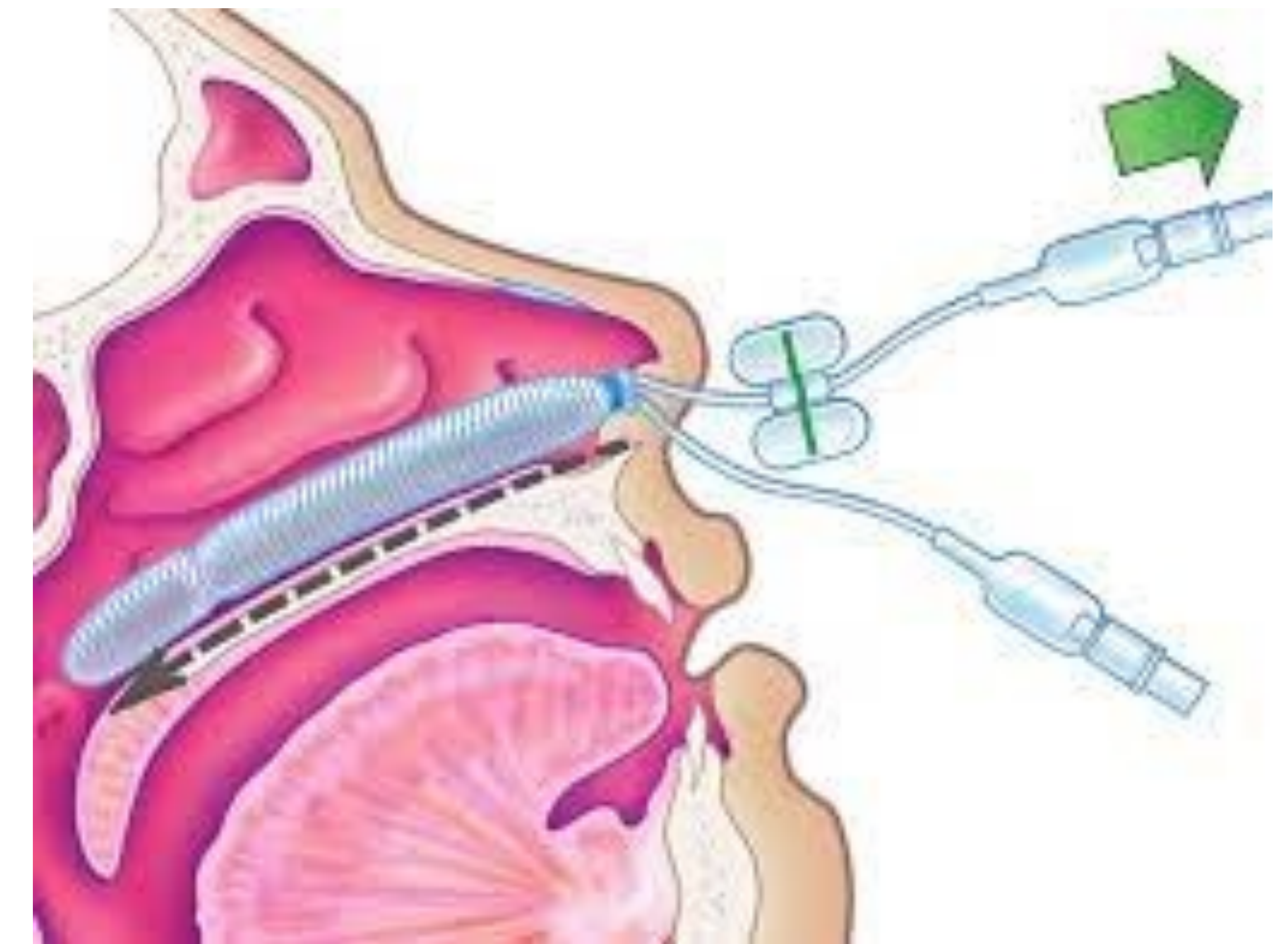
- Anterior Epistaxis
- Limited Cautery/Packing
- Extensive Cautery/Packing
- Nasal Tampons

Consent obtained from patient; local nasal anesthesia applied. Nasal tampon applied in L nare, bleeding subsequently stopped. Pt tolerated the procedure, moderate discomfort (though he did consent), bleeding is now controlled.

- Posterior Epistaxis
- Packs/Cautery-any method

Epistaxis RVU Valuation

- Anterior Epistaxis
  - Limited Cautery/Packing 30901 1.69 RVUs
  - Extensive Cautery/Packing 30903
    2.31 RVUs…**39%** ↑
  - Nasal Tampons 30903 2.31 RVUs



Posterior Epistaxis Treatment

45 year old presenting with epistaxis. Evaluation showed posterior bleed

Epistaxis

Date/Time: **12/20/2022 9:35 AM**
Performed by:
Authorized by:

Consent:
Consent obtained: **Verbal**
Consent given by: **Patient**
Risks discussed: **Infection, nasal injury and pain**
Alternatives discussed: **Alternative treatment**
Anesthesia:
Anesthesia method: **Topical application**
Procedure details:
Treatment site: **L posterior**
Treatment method: **Foley catheter**
Treatment complexity: **Extensive**
Post-procedure details:
Assessment: **Bleeding stopped**
Procedure completion: **Tolerated well, no immediate complications**

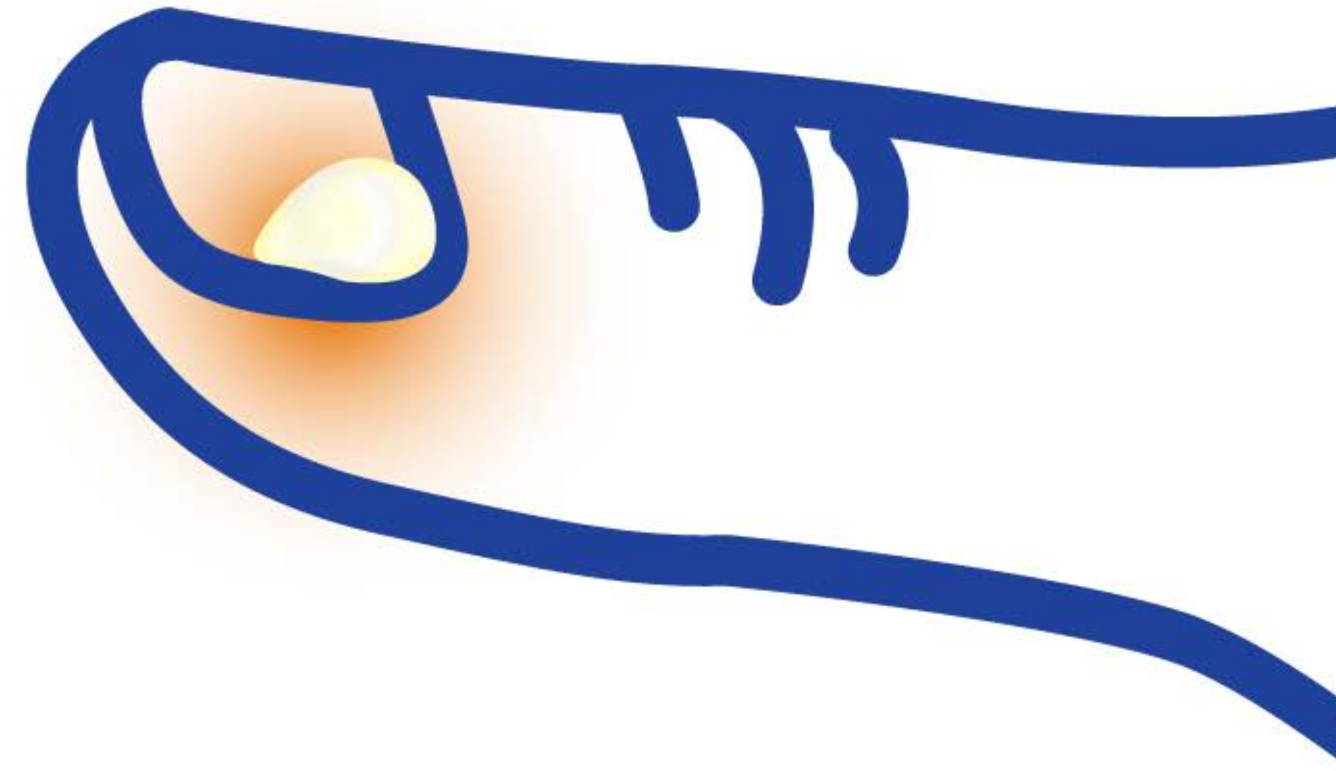
30905 Control of Hemorrhage, posterior, with posterior nasal packs and/or cautery

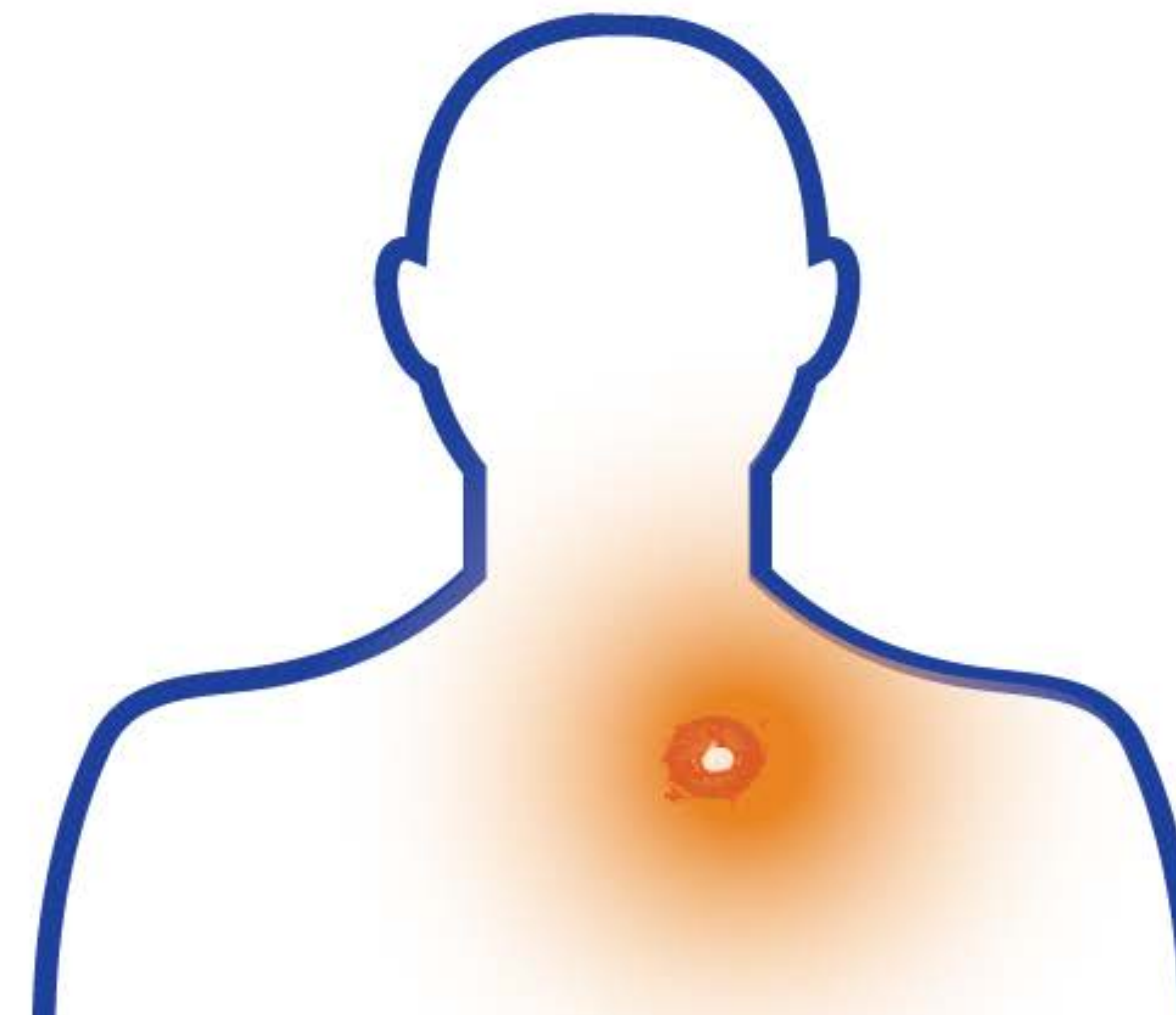
1.97 wRVU / 3.16 total RVU

Location to determine correct procedure

Abscess Drainage

- Simple or single
  - Furuncle, paronychia
  - Superficial
  - Single
- Complex or multiple
  - Probing
  - Loculations
  - Packing





Well Documented I&D

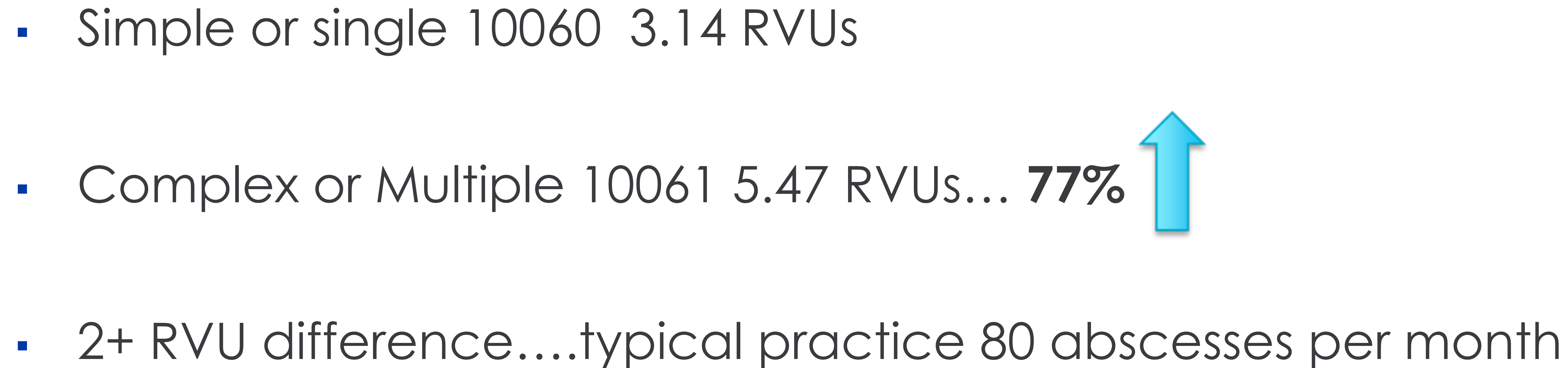
38 year old female presents with worsening "boil" on her left forearm. No fevers, chills, or change in appetite. No spontaneous drainage.

Incision and Drainage

Date/Time: **12/21/2022 2:57 PM**
Performed by:
Authorized by:

Consent:
  Consent obtained: **Verbal**
Location:
  Type: **Abscess**
  Location: **Upper extremity**
  Upper extremity location: **Arm**
  Arm location: **L lower arm**
Pre-procedure details:
  Skin preparation: **Povidone-iodine**
Anesthesia:
  Anesthesia method: **Local infiltration**
  Local anesthetic: **Lidocaine 1% WITH epi**
Procedure details:
  Incision types: **Single straight**
  Wound management: **Probed and deloculated and irrigated with saline**
  Drainage: **Purulent**
  Drainage amount: **Moderate**
Post-procedure details:
  Procedure completion: **Tolerated well, no immediate complications**

Abscess Valuation

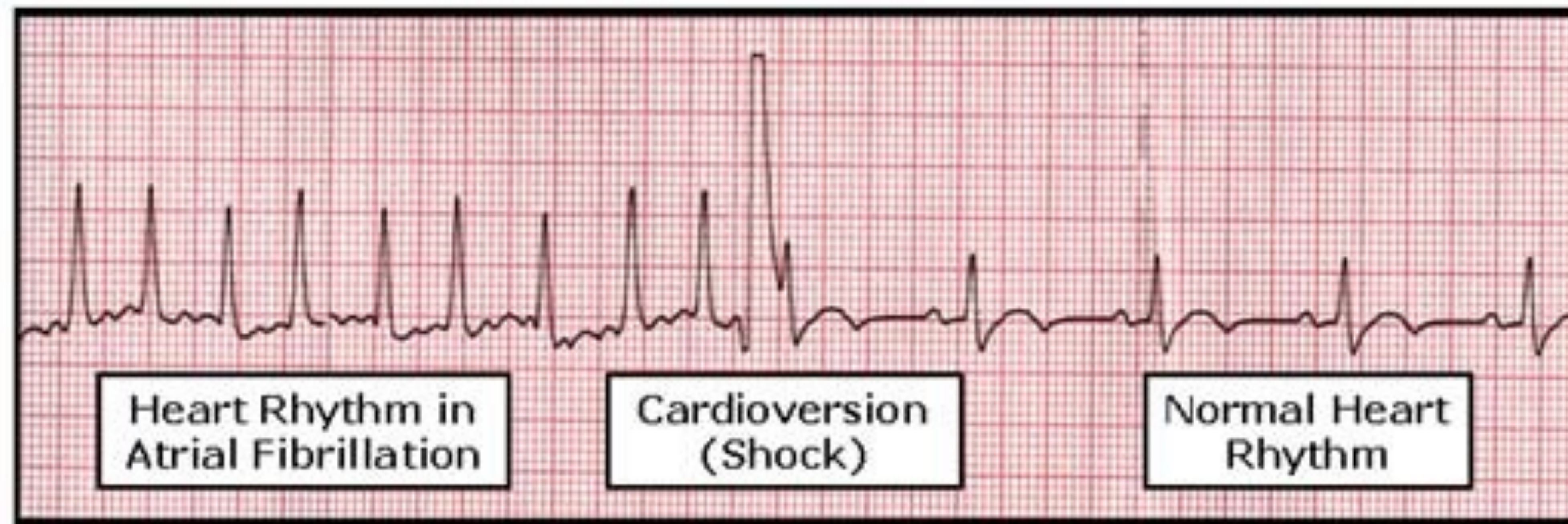


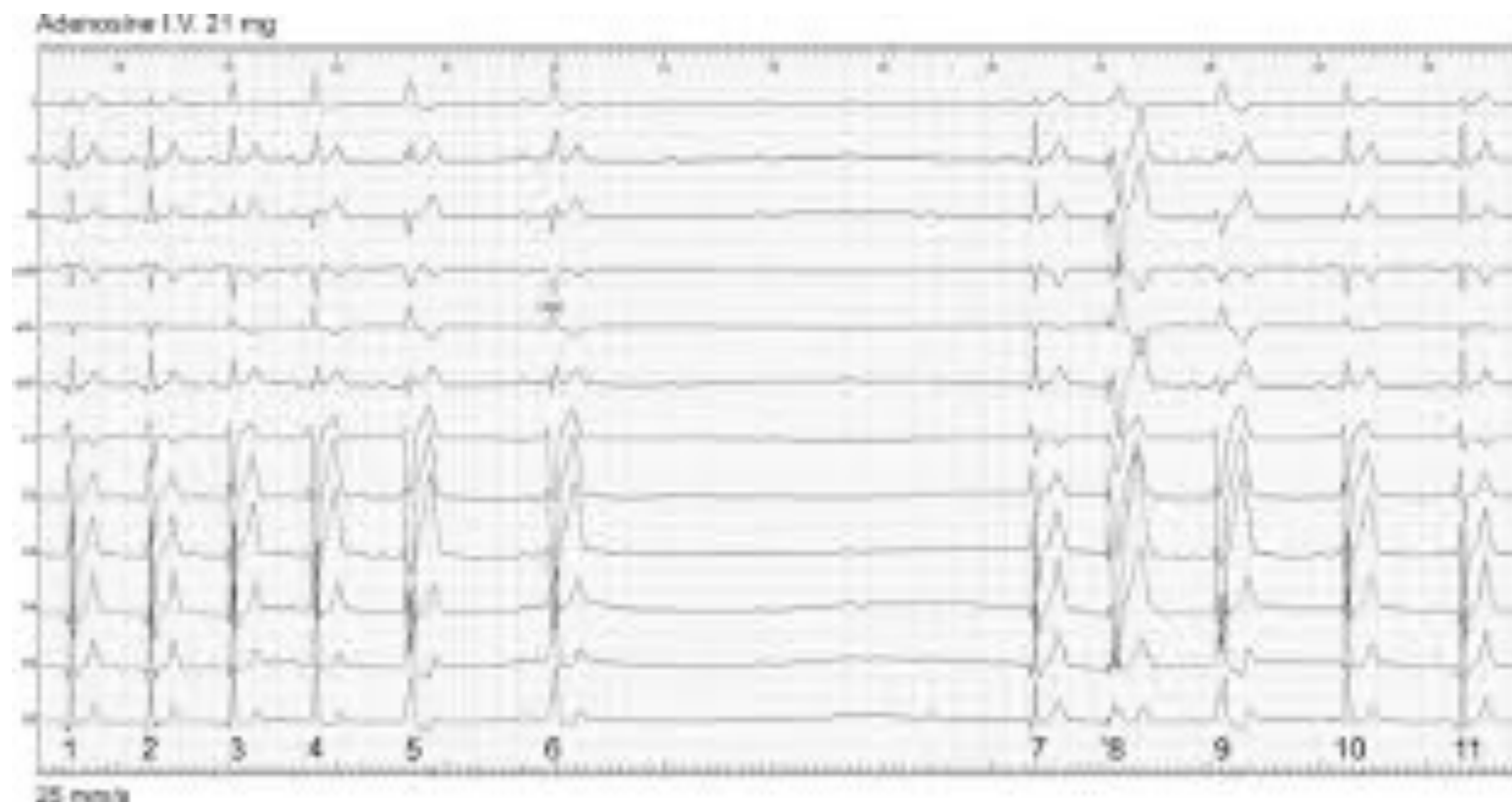
- Simple or single 10060 3.14 RVUs
- Complex or Multiple 10061 5.47 RVUs… **77%**
- 2+ RVU difference….typical practice 80 abscesses per month

Additional 2,300 RVUs per year!

Cardioversion

75 y.o with A-fib with RVR that did not respond to medications SBP 100.





Cardioversion

Date/Time: **12/19/2022 12:33 PM**
Performed by:
Authorized by:

Consent:
- Consent obtained: **Verbal**
- Consent given by: **Patient**
- Risks, benefits, and alternatives were discussed: **yes**
- Risks discussed: **Cutaneous burn and induced arrhythmia**
- Alternatives discussed: **Delayed treatment**

Pre-procedure details:
- Rhythm: **Atrial fibrillation**
- Electrode placement: **Anterior-lateral**

Attempt one:
- Cardioversion mode: **Synchronous**
- Waveform: **Biphasic**
- Shock (Joules): **200**
- Shock outcome: **Conversion to normal sinus rhythm**

Post-procedure details:
- Patient status: **Alert**
- Procedure completion: **Tolerated well, no immediate complications**

Elective cardioversion
92960 3.19 RVUs

Osteopathic Manipulation

- Patient presents with neck pain unrelieved by OTC meds. Osteopathic manipulation performed.

Region of Somatic Dysfunction: Cervical
Pre procedure exam: left paraspinal tenderness of c4-c7
Procedural sedation: none
Technique: FPR and muscle energy
Post procedure exam: PT was treated with OMT as described with good results
Patient tolerated: Well
Complications: None
Performed by: Self
Total time: 10 minutes

.69-1.72 RVUs

- OMT Codes: arranged by **# of regions manipulated**
  - Head, cervical, thoracic, lumbar, sacral, pelvic, lower/ upper extremities, rib cage, abdomen, viscera

Trigger Point Injection

- 22 year old presents with complaints of chronic neck pain. No relief with home meds. Opioids not indicated.

Procedure: Trigger Point Injection
Indication: Pain control at multiple trigger points
Technique: patient injected with 1.5cc of Marcaine approximately 5cm on either side of C7 spinous process into the trapezius muscle
Pt tolerated procedure well. Reported immediate pain relief

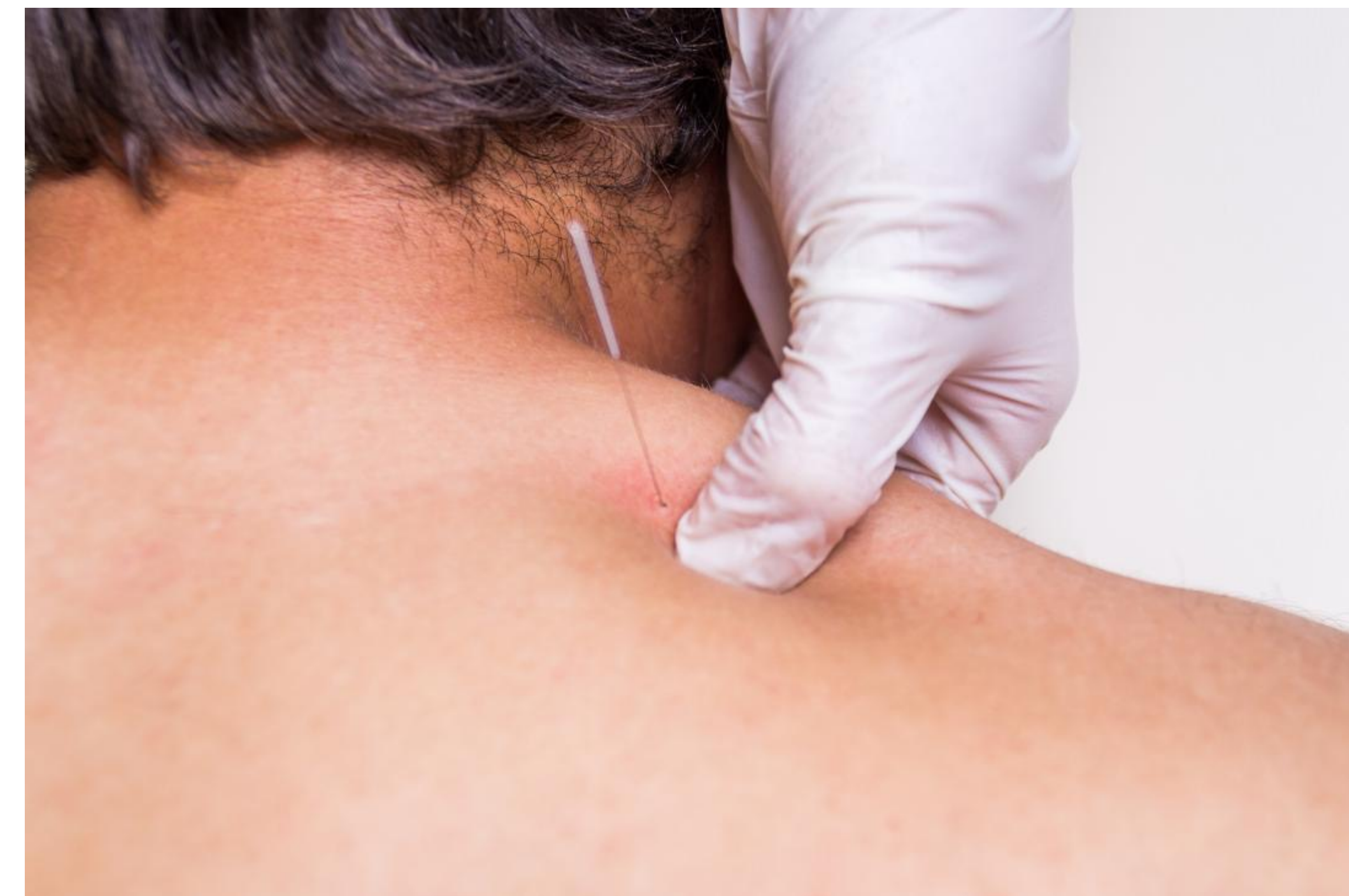
- 20552 Injection of single or multiple trigger points **1-2 muscles**
  - 20553 - 3 or more muscles
  - 1.10-1.26 RVUs

Dry Needling

Needle insertion not requiring an injection

- **20560** Needle insertion(s) without injection(s); 1 or 2 muscle(s) .44 RVUs
- **20561** Needle insertion(s) without injection(s); 3 or more muscles .66 RVUs

Needle inserted into “knotted area”



Conclusion

- Procedures remain an important contributor to ED charge capture
- Understand key items that indicate complexity
- Often impact the coding
- Can be a 30% difference !

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