Communicating The Value Of Emergency Care

IEPC Billing and Documentation Update 2014

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Documentation: Preparing For ICD-10

KEY RULE: Use language that supports the severity of the patient's problem. Claims are denied due to use of "chronic" or "unspecified" codes that are considered simple conditions.

1. Must state "diabetes out-of-control", otherwise it's coded "unspecified". DM w/ hyperglycemia or "poorly controlled" cannot be coded DM OOC.
2. HTN w/ aggressive management must be documented "malignant/accelerated HTN" or it is reported as "unspecified" no matter how high the pressure is or how aggressive the workup.
3. "HTN OOC" or "hypertensive urgency" are seen by payer equal to a BP 150/90 that just needs medication management, assumed to be no crisis unless stated as "malignant" or "accelerated" HTN.

Preparing For ICD-10

4. All chronic conditions must be stated as "acute" onset. Final dx "bronchitis" might not appear emergent. "Exacerbation" is key as different codes pertain to bronchitis, asthma, COPD acute vs. exacerbation.
5. Renal failure must always be "acute" as you are not seeing them in the ED for ongoing maintenance..
6. Anxiety, altered mental status or other psych-related.symptoms need other signs/symptoms, if possible, to justify ECG, CXR, labs, such as dyspnea, chest pain, headache, etc. Anxiety isn't the initial reason for testing and full workup, usually. It's to rule out other medical conditions. Payers consider AMS, confusion alone to be non-payable as psych conditions. If encephalopathy exists, note toxic, septic, hepatic or metabolic, if known.

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7. Drug-induced tachycardia or dyspnea are forms of “drug poisoning” and codes are selected related to the inducing drug. “Drug abuse” is not useful as it’s unspecified as to which drug. Payers pay for “poisoning” but consider “drug abuse” as a psych condition. Per # 6 above, “abuse” alone equals non-payment.
8. State cause for anemia and as “acute”. “Unspecified” can be just technical in nature, a decimal point below the norm, for example. There are numerous anemia codes better than “unspecified”.
9. Avoid “Well baby” or “normal exam” in the Dx area if any other sigh/symptom can be found. “Baby brought by mom w/ SOB, H&P ruled out acute illness.” Brought by police for asymptomatic “pre-booking check” is almost guaranteed no pay, no matter what your contract with PD says.

Preparing For ICD-10

10. Dental diagnoses are not medical problems and not covered by medical insurance by Medicaid, Medicare and almost all others. When a dental complaint appears, not other symptoms like facial swelling, jaw pain, etc.
11. Document "present on admission" conditions when you admit someone. Medicare and other payers will NOT pay your hospital for complications occurring during an inpatient stay. For admits, if present **or suspected,** document UTIs in all pts with indwelling Foleys, all decubitis ulcers, all pneumonias. Your business partner, the hospital, will be helped greatly by your attention to conditions POA.

ICD-10 Example

Dx: *"Displaced, closed fracture, distal phalanx of left 5th finger."*

ICD-9 coded as **816.02** – Fracture, distal phalanx, closed

ICD-10 coded as **S62.63 7 A**

S62.63	7	A
Displaced fracture of distal phalanx	of **left little finger**,	**initial encounter** for closed fracture

- The appropriate 7th character is to be added to each code from category S62. A fracture not designated as open or closed should be coded to closed
  - A - initial encounter for closed fracture
  - B - initial encounter for open fracture
  - D - subsequent encounter for fracture with routine healing
  - G - subsequent encounter for fracture with delayed healing
  - K - subsequent encounter for fracture with nonunion
  - P - subsequent encounter for fracture with malunion
  - S - sequela

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276.51	DEHYDRATION	E86.0	Dehydration
787.03	VOMITING ALONE	R11.11	Vomiting with nausea
789.03	ABDMNAL PAIN RT LWR QUA	R10.31	Right lower quadrant pain
427.31	ATRIAL FIBRILLATION		
		I48.0	Paroxysmal atrial fibrillation
		I48.1	Persistent atrial fibrillation
		I48.2	Chronic atrial fibrillation
		I48.91	Unspecified atrial fibrillation

Better Wording

Weak and dizzy; R/O TIA; TIA vs. CVA	Slurred speech, ataxia, episodic paralysis
Diabetes poorly controlled; Diabetes with hyperglycemia	Diabetes out-of-control
Diabetes Mellitus; Diabetes	Type I Diabetes; Type II Diabetes
Hypertension out-of-control; Hypertensive urgency; HTN poorly controlled; HTN crisis; Aggressive HTN	Malignant/accelerated hypertension; Hypertension with neuro symptoms
Bronchitis; Asthma	Exacerbation (document each treatment); Acute bronchitis; Acute asthma; Status asthmaticus
Renal failure;	Acute exacerbation of renal failure; Hypertension; Elevated potassium/BUN/ creatinine; Dyspnea **due to** RF; fluid build-up/extremity edema **due to** RF

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Better Wording

Anxiety; Hallucinations; Psychosis; Altered Mental Status; Confusion; Decreased level of cognition;	Palpitations; Dyspnea; Chest pain; Headache; Hepatic/septic encephalopathy
Drug abuse;	Tachycardia; Dyspnea; Cocaine **Poisoning**; Drug **Poisoning**;
Anemia;	Anemia **due to** bleeding, renal failure, cancer, chemotherapy, etc.
Well baby exam; Normal exam; In custody clearance;	All signs/symptoms/complaints: Shortness of breath; Alcohol poisoning; Drug poisoning
Toothache; Dental abscess;	Facial swelling; Jaw pain; Headache; Fever;
Patient's problems treated in the ED prior to admission	Presence or absence of UTI, decubitus ulcers, pneumonias.

Emergency Medicine Coding Under Attack

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

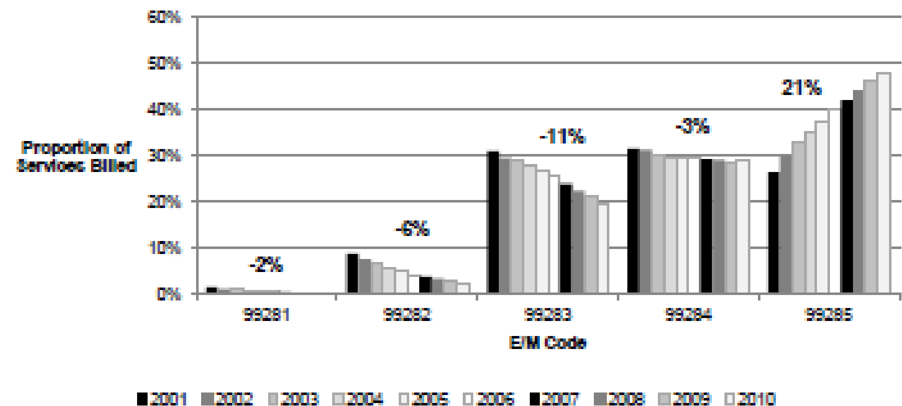
CODING TRENDS OF
MEDICARE
EVALUATION AND
MANAGEMENT SERVICES

- Medicare has advised MACs to audit ED visit codes for upcoding.
- OIG identified 99285 as the fastest growing E/M service of all (129% in 10 years).
- You might get paid for your 99285s today, but will you be able to keep the money?

Emergency department visits

This visit type represented the fifth-largest amount of Medicare payments for E/M services in 2010. Figure 3 shows the percentage of these services billed for each E/M code from 2001 to 2010, with the percentage difference between 2001 and 2010 above each code's set of bars. In 10 years, physicians' billing of the highest level code (99285) rose 21 percent, increasing from 27 to 48 percent. During the same time, physicians' billing of all other codes decreased. Physicians billed the lowest level code (99281) less than 3 percent of the time.

Figure 3: Percentage of E/M Codes Billed for Emergency Department Visits From 2001 to 2010



Template Troubles – "Note Bloat"

"Some of these (electronic health record) programs can automatically generate detailed patient histories, or allow doctors to cut and paste the same examination findings for multiple patients — a practice called cloning — with the click of a button or the swipe of a finger on an iPad, making it appear that the physicians conducted more thorough exams than, perhaps, they did.

"Critics say the abuses are widespread. "It's like doping and bicycling," said Dr. Donald W. Simborg, who was the chairman of federal panels examining the potential for fraud with electronic systems. "Everybody knows it's going on." (NYT 9/21/2012)

The New York Times

Business Day

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Medicare Bills Rise as Records Turn Electronic

By REED ABELSON, JULIE CRESWELL and GRIFF PALMER
Published: September 21, 2012 | 273 Comments

When the federal government began providing billions of dollars in incentives to push hospitals and physicians to use electronic medical and billing records, the goal was not only to improve efficiency and patient safety, but also to reduce health care costs.

Enlarge This Image

Jessica Kourkounis for The New York Times
Robert Burleigh was overbilled for an emergency-room visit because the hospital's electronic records included examinations he had not been given.

Multimedia

But, in reality, the move to electronic health records may be contributing to billions of dollars in higher costs for Medicare, private insurers and patients by making it easier for hospitals and physicians to bill more for their services, whether or not they provide additional care.

Hospitals received $1 billion more in Medicare reimbursements in 2010 than they did five years earlier, at least in part by changing the billing codes they assign to patients in emergency rooms, according to a New York Times analysis of Medicare data from the American Hospital Directory. Regulators say

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REPRINTS

THE SESSIONS COMING SOON

Noridian Healthcare Solutions, LLC
P.O. Box 6713
Fargo, ND 58108-6713

Medicare
Administrative Contractor

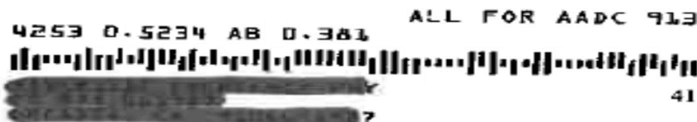
201312303301

00133
54,1
5DQA

1 OF 2 F

Return Service Requested

ENV 4253



4253 0.5234 AB 0.381 ALL FOR AADC 913

41

010/5DQA 174/EMC5

DATE: 12/27/2013
ICN:
HIC:
ACCT.#
RE:
PHYS/SUPL:
DOCUMENT # 01112000000213359617540PR

DEAR DOCTOR OR SUPPLIER

WE ARE PROCESSING A CLAIM FOR
RECEIVED ON 12/25/2013, AND WE CANNOT COMPLETE THIS
PROCESSING WITHOUT THE INFORMATION REQUESTED BELOW. PLEASE
ANSWER EACH QUESTION AND RETURN THIS LETTER WITHIN 30 DAYS.
WE APPRECIATE YOUR ASSISTANCE.

PLEASE RETURN THIS LETTER WITH THE REQUESTED INFORMATION.
IF THE REQUESTED INFORMATION HAS NOT BEEN RECEIVED WITHIN
45 DAYS, PROCESSING OF THE CLAIM WILL BE DECIDED BY THE
INFORMATION PRESENT. PAYMENT MAY BE REDUCED OR DENIED
IF THIS INFORMATION HAS NOT BEEN RECEIVED.

PLEASE PROVIDE DOCUMENTATION SUPPORTING THE MEDICAL NECESSITY
FOR THE SERVICE(S) RENDERED ON 12/16/2013. S01 32 349

MEDICARE CONTRACTORS ARE REQUIRED BY CENTERS FOR MEDICAID AND
MEDICARE SERVICES (CMS) TO REVIEW DOCUMENTATION FOR PAYMENT OF
SERVICE UNDER THE PROGRESSIVE CORRECTIVE ACTION (PCA)
GUIDELINES ESTABLISHED BY CMS.

THE MEDICAL REVIEW (MR) WEBPAGE AT
HTTPS://WWW.NORIDIANMEDICARE.COM/PARTB/COVERAGE/ HAS LINKS TO
THE CURRENT SSR'S, THE PROVIDER NOTIFICATION, REQUIRED
DOCUMENTATION TO SUBMIT, AND REFERENCES THAT WILL BE USED TO
REVIEW THIS TYPE OF PROCEDURE. EMAIL QUESTIONS REGARDING THE
SSR TO MEDICALREVIEWPARTB@NORIDIAN.COM.

YOU MUST SUBMIT ALL APPLICABLE REQUIRED DOCUMENTATION LISTED
ON THE WEBSITE FOR THIS SSR. THE DOCUMENTATION YOU SUBMIT IN
RESPONSE TO THIS REQUEST SHOULD COMPLY WITH THESE

BASIS OF ADMISSION VERSUS OUTPATIENT HOSPITAL CARE

I. Reviewing Hospital Claims for Inpatient Status: Inpatient Admission Order Requirements

CMS plans to direct MACs that when they are conducting patient status reviews they should assess whether the requirements for order for inpatient admission were met. Requirements related to the inpatient order can be found at:
http://www.cms.gov/Center/Provider-Type/Hospital-Center.html

II. Reviewing Hospital Claims for Inpatient Status: The Inpatient Certification Requirements

CMS plans to direct MACs that when they are conducting patient status reviews they should assess whether the requirements for inpatient certification were met. Requirements related to the inpatient order can be found at:
http://www.cms.gov/Center/Provider-Type/Hospital-Center.html

III. Reviewing Hospital Claims for Inpatient Status: The 2-Midnight Benchmark

The 2-midnight **benchmark** represents guidance to medical reviewers to identify when an inpatient admission is generally appropriate for Medicare Part A payment under CMS-1599-F.

7 million Uninsured in California

Medi-Cal expansion: About 3 million

ACA extends Medi-Cal to all nonelderly adults at 138% of poverty or below ($15,856-single adult or $32,499 for family of four)

- Childless adults
- Parents
- not disabled

Children up to 266% of poverty

Figure 1

Income Eligibility Levels for Medicaid/CHIP and Marketplace Tax Credits in California as of 2014

Medicaid/CHIP | Tax Credits | Unsubsidized Marketplace

Childless Adults

Parents

Children

0% FPL

138% FPL ($32,499 for a family of 4, $15,856 for an individual)

266% FPL ($62.643 for a family of 4)

400% FPL ($94,200 for a family of 4, $45,960 for an individual)

Notes: Medicaid eligibility is based on current Medicaid eligibility rules converted to MAGI. Applies only to MAGI populations. Medicaid eligibility levels as a share of poverty vary slightly by family size; levels shown are for a family of four. People who have an affordable offer of coverage through their employer or other source of public coverage (such as Medicare or CHAMPUS) are ineligible for tax credits. Unauthorized immigrants are ineligible for either Medicaid/CHIP or Marketplace coverage.

Source: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels.

THE HENRY J. KAISER FAMILY FOUNDATION

Covered California

Covered California estimates that 1.8 million Californians eligible to buy insurance through the health care exchange

Eligible for Tax Credits

- People with incomes 100-400% (family of four $94, 200) of the poverty level are eligible to buy coverage in Marketplaces and do not have other affordable coverage available

SGR Repeal

- SGR (sustainable growth rate) repeal with 0.5% raise for first three months of 2014
- Now need to consider how to shift compensation from fee-for-service to pay-for-performance
- Sequestration (2% cuts) extended until 2023

Quantified Quality is the New Payment System

- RVU production is a failed system – focuses only on volume, little on quality.
- "Quality" is the new paradigm. SGR fix will be based on quality improvement.
- Payers don't like the attention on "cost". But the new paradigm will still largely translate to reducing cost.

Quantified Quality is the New Payment System

- The payers will define the desired results, we will decide how we get there.
- Take back the conversation - be ahead of the game by defining your own desired quality results now.
- Results must be definable and measurable and we must show how we are managing toward them.

Where Are We Going

- Look where the hospital's been – Voluntary reporting led to pay for reporting led to pay for performance.
- 1% DRG withhold as part of the VBM payment system
  - 70% core measures, 30% HCAHPS patient satisfaction surveys

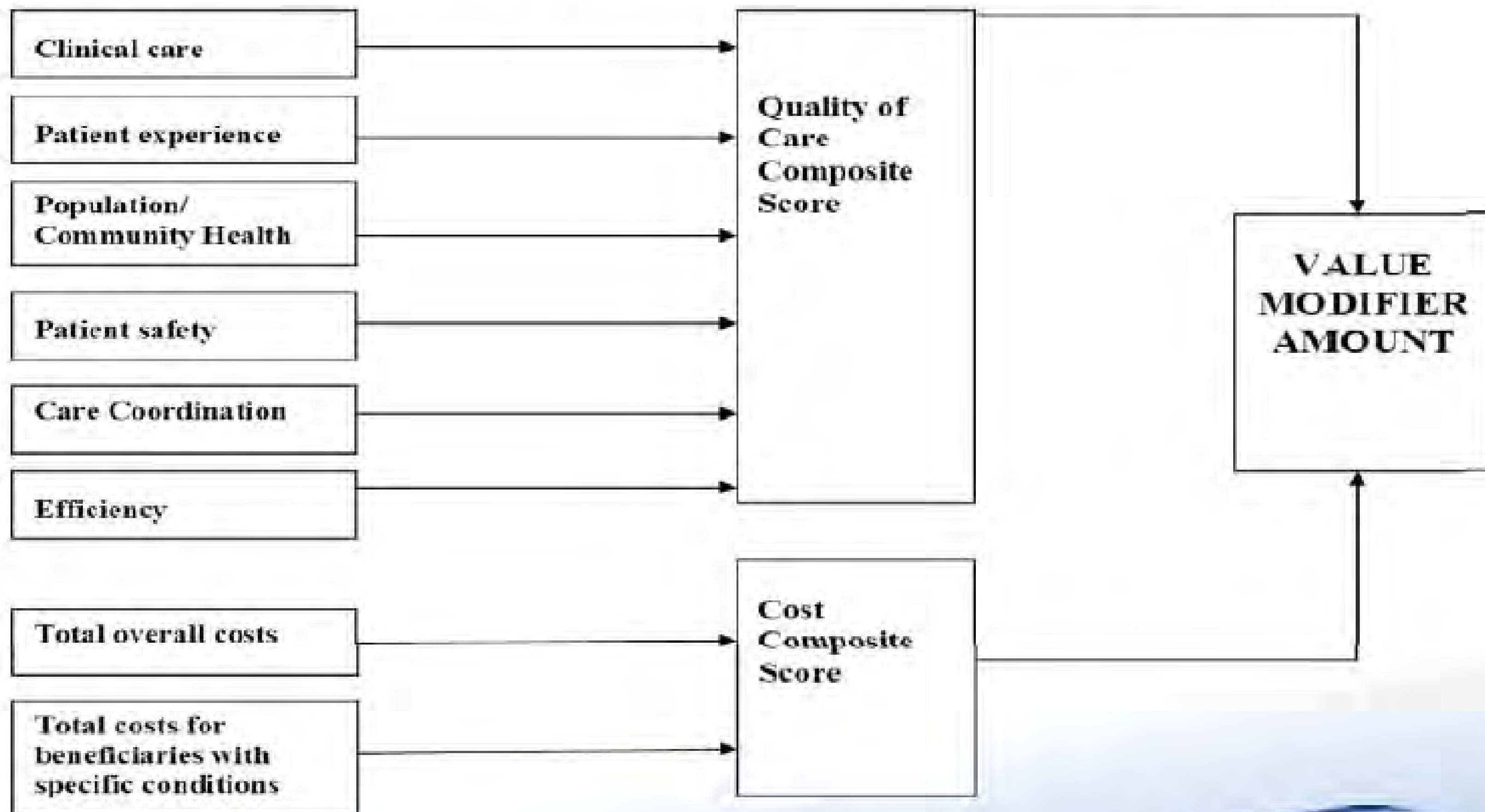
Medicare's Physician Compare website tells if you now participate in PQRS, will soon show PQRS scores (individual performance scores now due in 2015, but might not include ED measures).

Starting Now – Medicare's Value-Based Payment Modifier

- VBM started 2013 with a defined formula for groups (single TIN) of 100+ providers who submitted claims. By 2017 all physicians will be affected in some as yet undefined way.
- Two components of any future pay formula: Quality and Cost. No changes for Emergency Medicine for now but the future pay paradigm will have similar constructs for EDPs.
- Before Oct. 2013, large groups must **"self-nominate" the Admin Claims Option,** (not Quality Tiering Option). Later this year, go to www.qualitynet.org to sign up or you automatically lose 1.0% of Medicare money in 2014.

Quality- Tiering Methodology

Use domains to combine each quality measure into a quality composite and each cost measure into a cost composite



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare's Value-Based Payment Modifier

VBM in 2015 rewards or penalizes groups based on composite of PQRS scores, quality data and cost data. Scores measured against benchmarks. The cost/quality tier will work something like this:

	Low Cost	Average Cost	High Cost
High Quality	+2.0x%	+1.0x%	+0.0%
Average Quality	+1.0x%	+0.0x%	-0.5%
Low Quality	+0.0%	+0.5%	-1.0%

Physician group choses which acute quality measures (all-cause readmissions, pneumonia, UTI, dehydration) or chronic (COPD, Pulm dz, HF, DM) to report data to prove high-quality performance. Primary care-based, no EDPs.

Cost measures are total Part A/B for COPD, HF, CAD, DM.

PQRS Measures in 2013 –
Report 50% of the time on any 3 measures

PQRS Measure	Measure Description	PQRS Measure	Measure Description
#28	Aspirin at arrival for AMI	#91	Acute otitis Externa: topical tx
#31	Stroke: DVT prophylaxis for ischemic stroke or ICH	#93	Acute Otitis Externa: Systemic antimicrobial tx avoidance
#35	Stroke: Screening for dysphagia	#187	Stroke: Thrombolytics
#54	12 lead ECG performed for non-traumatic chest pain	#228	Heart Failure: LVF testing
#55	12 lead ECG performed for syncope	#252	Anti-coag for acute pulm embolism
#56	Community-acquired pneumonia – Vital signs	#254	Ultrasound of pregnancy location for pregnant patients with abd. pain
#59	Community-acquired pneumonia – Antibiotic	#255	Rhogam for Rh-neg. pregnant women at risk of fetal blood exposure
#76	Prevention cath related bloodstream infection: Venous cath insertion protocol	#317	Screening for high blood pressure

ED Quality Reporting 2014

Old ED reporting criteria: 3 of 16 measures 50% of the time they pertain to the patient

New in 2014 for Claims Reporting: ED reporting criteria: 9 of 25 measures 50% of the time, none with zero performance, measures assigned to domains

Future: Report from 3 Nat'l Quality Strategy (NQS) domains:

1. Pt Experience 2. Pt Safety 3. Care Coordination/Comm'n
4. Population Health 5. Efficiency/Cost 6. Effective Care

Reporting Mechanisms Options:

Claims: 9 measures in 3 domains, (OR report up to 8 if 9 don't apply)
Registry: 9 measures in 3 domains
Clinical Data Registry: 9 measures in 3 domains, 1 outcome measure

ED Quality Reporting 2014

NO.	MEASURE TITLE
1	Diabetes: Hemoglobin A1c Poor Control
2	Diabetes: Low Density Lipoprotein (LDL-C) Control (<100 mg/dL)
28	**Aspirin at Arrival for Acute Myocardial Infarction (AMI)**
35	**Stroke and Stroke Rehabilitation: Screening for Dysphagia**
54	**Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic CP**
55	**Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Syncope**
56	**Emergency Medicine: Community-Acquired Bacterial Pneumonia (CAP): Vital Signs**
59	**Emergency Medicine: Community-Acquired Bacterial Pneumonia (CAP): Empiric Antibiotic**
65	Appropriate Treatment for Children with Upper Respiratory Infection (URI)
66	Appropriate Testing for Children with Pharyngitis
91	Acute Otitis Externa (AOE): Topical Therapy
93	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use
106	**Adult Major Depressive Disorder (MDD): Comp Diagnostic Evaluation: Dx and Severity**
107	**Adult Major Depressive Disorder (MDD): Suicide Risk Assessment**

ED Quality Reporting 2014

NO.	MEASURE TITLE
116	**Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**
117	Diabetes: Eye Exam
119	Diabetes: Medical Attention for Nephropathy
163	**Diabetes: Foot Exam**
254	Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain
255	Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure
317	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
331	**Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Appropriate Use)**
332	**Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Patients with Acute Bacterial Sinusitis**
333	**Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse)**
334	**Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse)**

2015 ED PQRS Registry Care Coordination Measures

ED-1a: Median Time from ED Arrival to ED Departure for Admitted ED Patients - Overall Rate:

ED-1d: Median Time from ED Arrival to ED Departure for Admitted Patients -Psychiatric/Mental Health Patients:

Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department

Rationale: This measure satisfies 1848(k)(2)(C)(i) of the Act as this measure is NQF-endorsed. CMS believes this measure addresses **a performance gap for eligible professionals** providing care to patients assessed in the emergency department (ED).

This measure would provide statistical **data representing individual eligible professionals** providing and coordinating medical care for patients seeking medical attention from the emergency department.

Including this measure from Hospital Inpatient Quality Reporting (IQR) in the PQRS measure set is in accordance with our intent to align measures throughout CMS reporting programs.

PQRS – This Now Matters to Emergency Physician Payment

Measures PQRS data reporting ability, not performance yet.

Impact of PQRS 2013 and 2014 participation and reporting

PQRS Incentive	+0.5% in 2014	+0.5% in 2015
PQRS MOC Incentive	+0.5% in 2014	+0.5% in 2015
Total Carrot	**+1.0% in 2014**	**+1.0% in 2015**
PQRS Penalty	-1.5% in 2015	-2.0% in 2016
VBM Failure to report	-1.0% in 2015	-1.0% in 2016
Total Stick	**-2.5% in 2014**	**-3.0% in 2015**

Start Planning Now for CQI

Practice Transformation for Continuous Quality Improvement including measured assessment in

- Change Mgmt
- Clinical Quality
- Business Process
- Technology
- Outcomes