



Hospital ED Billing—what every ED Physician should know

Most emergency physicians are aware of the importance of documentation as it relates to physician coding and billing, such as documenting the HPI and ROS. There is another side to coding and billing, one that is not for the physician (otherwise known as the “professional portion”) but is instead for the hospital or “facility” services. Hospitals code for their portion of ED services (room time, nurses, medications, supplies etc.) and send out their own bills, and the ED physician services are coded and billed separately. It is common for hospitals to significantly under-report the actual services that they provided and thus lose a significant amount of potential revenue, often as much as \$50/visit. In this article I want to help you understand the world of hospital facility coding for ED services, and position you to be a valuable partner to your hospital in receiving its proper reimbursement. After all, a key to having what you need to deliver excellent patient care is dependent on the hospital’s financial well being.

HOSPITAL CODING FOR ED SERVICES:

Hospitals, like physicians, code for both procedures and for Evaluation and Management Services (E/M levels). Up until a few years ago hospitals were paid based on their charges, but this all changed with the introduction of a congressionally mandated Outpatient Prospective Payment System (OPPS), which CMS implemented in August of 2000 using Ambulatory Payment Classifications (APCs). Prior to APCs hospitals had always been reimbursed for outpatient services on a cost reporting methodology—higher costs resulted in higher reimbursement. Hospitals used to report costs, and then were paid a percentage of those costs. You can think of APCs as similar to inpatient DRGs. APCs represent a prospective defined payment for outpatient ED services much like DRGs, which also have a fixed payment. One big difference between DRGs and APCs is that DRG payments are based on *diagnosis coding*, the diagnosis that is assigned to the patient, (e.g. a complicated pneumonia diagnosis gets a fixed inpatient payment) and APCs are based on *CPT procedure coding*, what procedures were performed on the patient, (e.g. there is a fixed payment for performing a specific CPT injection code). An important thing that APCs and DRGs have in common is that, except in some exceptions, additional payments *are not* provided outside of the Diagnosis or CPT code submitted, so if the patient stays in the hospital for an extra day the DRG inpatient payment stays the same, or if the medication chosen is expensive the APC outpatient payment for the injection CPT code does not change.

E/M Visit Level Coding

Hospitals should report ED visit levels using CPT codes 99281-99285, and Critical Care codes 99291/99292. Despite years of discussion and review, CMS still has not developed national ED facility level guidelines, and as such each facility should follow its own internally developed guidelines that are reproducible, consistently applied and reasonably relate to the hospital resources used. In 2007, CMS expanded the number of facility level APCs from three to five, and created five corresponding payment levels. Prior to 2007 the five E/M levels mapped to only three APCs, but now each ED visit level has its own APC and own payment amount. Additionally, starting in 2007 CMS began recognizing CPT code

99292 for additional Critical Care time past the first hour, however the payment is bundled into the reimbursement for the initial critical care code 99291.

Medicare ED Visit Level APC Reimbursement

ED Visit Level	2006 APC	2006 Payment	2007 APC	2007 Payment
99281	610	\$73.79	0609	\$50.01
99282	610	\$73.79	0613	\$82.96
99283	611	\$129.18	0614	\$130.00
99284	612	\$224.78	0615	\$209.99
99285	612	\$224.78	0616	\$325.26
99291	620	\$477.73	0617	\$405.04

ED Procedure Coding

Under APCs hospitals are reimbursed by reporting the CPT code for various procedures such as splint placements, tube placements, laceration repairs, drainage of abscesses and IV infusion and injections. The CPT codes that are reported lead to the APC assignment which then determines the actual reimbursement. APCs have a fee schedule based on the reported CPT codes, which is much like the physician fee schedule. Although hospitals may list medications and supplies (such as a laceration kit or NG tube) for many payers, including Medicare, no additional payments are made for these items. There are several hundred procedures performed in the ED, many of them very nuanced, and reporting the myriad of CPT codes can be especially difficult for hospital based outpatient coders to master. Reviewing your hospital's current coding and developing a dialogue with the hospital coders might identify significant coding and revenue opportunities for your department. And again, proving you are a good partner with the hospital and advocating for hospital revenue enhances your ability to get the clinical resources that you need for your department.

How ED Physicians Can Help Their Hospital

Medications: Compared to the pre-APC methodology, payments based solely on fee schedules represent a new dynamic for hospitals. Prior to 2000, hospitals were reimbursed based on their costs, and more expensive medications would result in additional payments. Under APCs there are opportunities for physicians to choose cost effective and evidence based approaches that provide excellent care while controlling additional expenses (such as antibiotic or anti-emetic selection).

High Cost Ancillary Denials: Hospitals are facing increased pressure to meet insurance company medical necessity criteria in order to be reimbursed for imaging studies such as CT scans. Physicians, hospital finance managers, and coders should develop a dialogue to understand the common high cost denials and reasons, and to bring this information back to the physician group. One example of this is using "rule out" as a reason for test such as for a CT of the abdomen or brain. A better diagnosis would be one that relies on symptoms, such as "abdominal pain" or "headache". The clinical information (such as r/o kidney stone) can still be given to the radiologist as a comment, but the formal reason for the test should not include "rule out". Consider having a physician attend the regular hospital ED revenue cycle

meetings to understand the magnitude and trends of your department's denials, and to help educate the physicians and coders.

Procedures: ED facility coders need to be skilled in identifying and assigning appropriate CPT codes for all ED physician and nurse procedures. ED physicians and nurses should be sure to completely document any procedures performed. A specific example is to be sure that the record clearly documents the duration of any infusion of medication or of IV fluids. IV Hydration, Infusions and injections are assigned codes based on their duration. For example, if 2 liters of IV fluid are given over 120 minutes, the time should be clearly documented because if the duration is not clear then the code for the second hour of hydration (90761), could not be assigned.

Chargemaster Maintenance: Hospitals have to maintain and update their chargemasters (the set of codes that they use for billing) and be sure that each service "maps" to the correct code for that specific payer. There are frequent updates that must be made to the ED chargemaster. For instance, there were several changes in 2006 and 2007 to the Medicare reporting of infusion and injection services. These are high volume and high reimbursement procedures, and it is important to keep right on top of these changes. For 2006 Medicare wanted unique Medicare specific "c-codes" used to reflect infusion, hydration and injection services, however effective Jan 1, 2007 CMS required all of these codes to be reported using CPT codes; failure to update the chargemaster and report the codes accurately resulted in significant lost revenue for many institutions. ED physicians can help by having at least one member of the group keep up to date with ED facility issues (reading publications, using the web, attending conferences etc.) and periodically reviewing the hospital ED chargemaster to be sure that all ED procedures are being captured.

Facility Levels: As mentioned above, each hospital is required to develop its own ED Facility Level Guidelines. You should be sure that your hospital has a set of guidelines that they follow, and that the increasing levels relate to the intensity of resources used. Understanding the ED leveling methodology at your hospital will enable you to optimize your documentation to ensure accurate facility level selection.

Putting It All Together

We are working in an environment where resources seem scarce, and service demands are high. Every department I have been in over the past few years could use additional nurses, techs, clerks, equipment and space, and hospital management agrees, but it takes new money to provide these additional resources. By helping to optimize your facility's ED coding, reimbursement, and financial performance, you will be in a strong position to advocate for increased resources for your department. With increased resources you will be better able to consistently provide high quality care, with streamlined throughput and high customer satisfaction.

