


Procedures in the ED

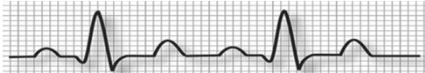
Most \$\$\$ ED CPT Codes
(not including E&M codes)

93010	Electrocardiogram report
31500	Insert emergency airway
36556	Insert non-tunnel CV cath
92950	Heart/lung resuscitation CPR
12001	Repair superficial wound(s)
12002	Repair superficial wound(s)
12011	Repair superficial wound(s)
12013	Repair superficial wound(s)
10061	Drainage of skin abscess
11042	Debride skin/tissue
30901	Control of nosebleed



Interpretations

- Per CPT “the actual performance and/or interpretation of any diagnostic tests or studies performed in conjunction with a patient’s visit should be reported in addition to the appropriate E&M service”.
- EKGs X-rays Ultrasounds



CMS Carriers Manual

- Distinguish between an "interpretation and report" of an x-ray or an EKG procedure and a "review" of the procedure.

CMS Carriers Manual

- The review of the results is already included in the emergency department evaluation and management (E/M) payment.

CMS Carriers Manual

- For example, a notation in the medical records saying "fx-tibia" or EKG-normal would not suffice as a separately payable interpretation and report of the procedure and should be considered a review of the findings payable through the E/M code.

CMS Carriers Manual

- An “interpretation and report” should address
- the findings,
- relevant clinical issues, and
- comparative data (when available).

EKG Interpretations

- Suggestion for defining EKG “interpretation”
- An EKG interpretation should include at least 3 of the following 6 elements.
 - Rhythm
 - Rate
 - Axis
 - Intervals
 - ST Segment change
 - Comparison to a prior EKG
 - Summary of clinical condition

EKG Interpretation

- Billable EKG interpretation:
EKG NSR, no ST changes, unchanged from prior EKG with no evidence of ischemia.
- Unbillable EKG interpretation:
EKG normal.

Signing EKG Tracing

Most payers want more than a signature on the printout from the machine.

- " An ECG that has been interpreted by a computer alone is not recognized as a properly interpreted ECG."
- "Any computer generated ECG interpretation must be over-read, modified as appropriate and signed by the interpreting physician."

National Government Services

- "Electrocardiograms and Interpretation reports (computer generated reports): It is not adequate simply to sign a computer-generated report. It is expected the physician would read, measure, interpret, prepare a report of, and sign the reading of the EKG."

Lacerations

The repair of wounds may be classified as:

- Simple
- Intermediate
- Complex

Procedure note should reflect depth, length and location of repaired wound.

Simple Lacerations

- Simple repair is used when the wound is superficial ; e.g., involving primarily epidermis or dermis, or subcutaneous tissues without significant involvement of deeper structures, and requires simple one layer closure .

Intermediate Lacerations

- Intermediate repair includes the repair of wounds that, in addition to the above, require layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure .
- Single-layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter also constitutes intermediate repair .

Simple vs Intermediate

- 12001 Simple 2.5cm < - 1.29
- 12031 Intermediate 2.5 cm < - 4.34

Wound Repairs w/ tissue adhesive

- Wound closure utilizing tissue adhesives only (G0168)
- FDA data shows that the time needed to close a wound with tissue adhesive is, on average, one quarter of the time needed to close a wound with traditional methods (including use of wound closure tapes).

Wound Repairs w/ tissue adhesive

For Medicare

- Wound closure w/Dermabond only:
 - Use G0168
- Wound closure w/Dermabond and sutures:
 - Use appropriate CPT code.

For All other payers

- Use appropriate CPT repair codes.


40650 - Repair lip, full thickness; vermilion only

- Important for the coder to recognize when this procedure has been performed in the ED.
- More important for a coder to recognize when the procedure performed by the emergency physician does not rise to the level described by this code.

40650 - Repair lip, full thickness; vermilion only

- Coders will frequently focus on the vermilion border language in the code descriptor and lose sight of the fact that the code descriptor specifies a full thickness repair.
- Single layer or simple repairs that happened across over the vermilion border do not rise to the level necessary to report 40650.

40650 - Repair lip, full thickness; vermilion only



- Laceration does cross into the vermilion border.
- Depth and complexity of the injury do not meet the requirements of a full thickness laceration described by CPT code 40650 and would most accurately be coded with a 1201x CPT code.

40650 - Repair lip, full thickness; vermilion only

- When asked about the use of this code for a single repair that extends beyond the vermilion, CPT assistant responded with "Code 40650, Repair lip, full thickness; vermilion only, identifies the repair of a laceration that involves the full thickness of the lip and the vermilion border."

40650 - Repair lip, full thickness; vermilion only



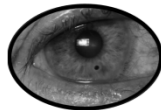
- In this diagram, the laceration and the repair seem to be consistent with the CPT description of 40650 as well as this Coder's Desk Reference explanation of the procedure "The physician repairs a full thickness laceration of the lip. The tissues of the vermilion border are closed with layered sutures."

Foreign Body Removals

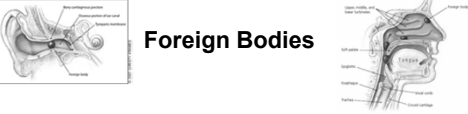
- Anatomic Location
- Depth of tissue penetration
- Technique of removal
 - Irrigation
 - Incision
 - Dissection

Foreign Body Eyes

- The **conjunctiva** is a mucous membrane that covers the sclera and the inside of the eyelids.
- The **cornea** is the transparent front part of the eye that covers the iris, pupil, and anterior chamber.



- Conjunctival
 - Superficial - 65205
 - Embedded - 65210
- Corneal
 - No slit lamp - 65220
 - With Slit lamp - 65222



Foreign Bodies


- Ear Foreign body – 69200
- Nasal Foreign Body - 30300

Many techniques are available, and the choice depends on the clinical situation, the type of foreign body suspected, and the experience of the physician. Options include water irrigation, forceps removal (e.g., alligator forceps), cerumen loops, right-angle ball hooks, and suction catheters.

Impacted Cerumen

Are these procedures appropriately reported with CPT code 69210, Removal impacted cerumen (separate procedure), one or both ears?

1. Removal of "ear wax" done by the nurse via irrigation or lavage.
2. Removal of "ear wax" by the EDMD via irrigation or lavage.
3. Removal of "ear wax" described as impacted cerumen because it completely covers the eardrum and the patient has hearing loss. The impacted cerumen is removed with magnification provided by an otoscope or operating microscope and instruments such as wax curettes, forceps, and suction.



Impacted Cerumen

If any one or more of the following are present, cerumen should be considered 'impacted' clinically:

- Visual considerations: Cerumen impairs exam of clinically significant portions of the external auditory canal, tympanic membrane, or middle ear condition.
- Qualitative considerations: Extremely hard, dry, irritative cerumen causing symptoms such as pain, itching, hearing loss, etc.
- Inflammatory considerations: Associated with foul odor, infection, or dermatitis.
- Quantitative considerations: Obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentations requiring physician skills."

Impacted Cerumen

If the wax is truly impacted, its removal can be reported if performed by a physician.

69209 - using irrigation or lavage.

69210 - via suction, a cerumen spoon, forceps or other instrumentation. -

Soft Tissue Foreign Bodies

- 10120 - Incision and removal of foreign body, subcutaneous tissues; simple

- _____
- 10121 - Incision and removal of foreign body, subcutaneous tissues; complicated



Soft Tissue Foreign Bodies

- Foreign bodies that are deep or complicated may be more accurately coded with the site specific codes.

- Arm (upper and lower) • hip
- elbow • leg (upper only)
- foot • shoulder

Not Finger - 26705 = arthrotomy
"cutting into joint."

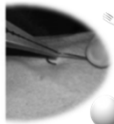
Soft Tissue Foreign Bodies

- Cast cutter was used to remove shoe through which nail was embedded. Following placement of a nerve block, the nail was then cut at the surface of the foot with bolt cutter and removed with steady pulling, with remaining nail fragment traveling from plantar to dorsal foot surface.

28190 - Removal of foreign body, foot; subcutaneous

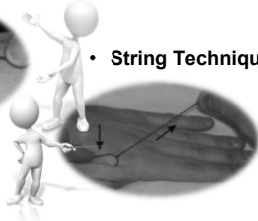
Soft Tissue Fishhooks

- Retrograde Technique



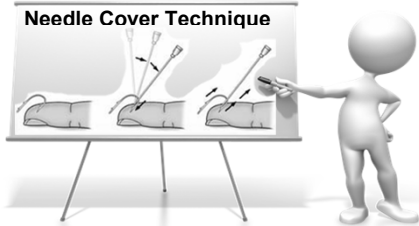
No applicable CPT codes

- String Technique



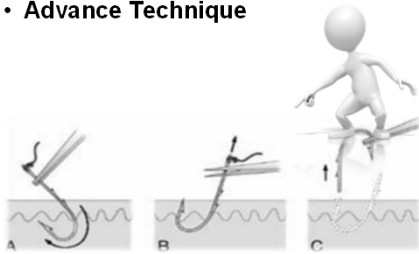
Soft Tissue Fishhooks

Needle Cover Technique



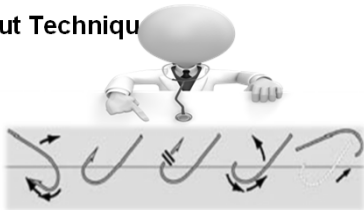
Soft Tissue Fishhooks

- Advance Technique



Soft Tissue Fishhooks

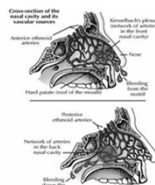
- Advance and
- Cut Technique



Epistaxis

- 30901 - Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method
- 30903 - Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method
- 30905 - Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial

↔ 90 %



Epistaxis Simple vs. Complex

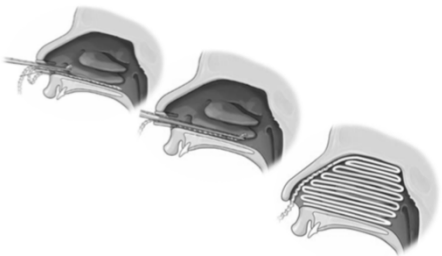
30901 – “simple”

- Limited packing - cotton ball or gauze
- Silver nitrate cautery for ~10 seconds

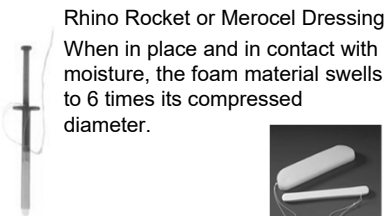
30903 – “complex”

- Multiple attempts limited packing
- Multiple attempts cautery
- Extensive packing
 - Complete occlusion of nasal cavity

Epistaxis Simple vs. Complex



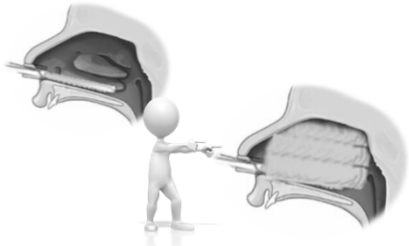
Epistaxis Simple vs. Complex



Rhino Rocket or Merocel Dressing
When in place and in contact with moisture, the foam material swells to 6 times its compressed diameter.

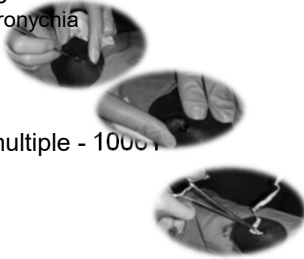


Epistaxis Simple vs. Complex



Incision and Drainage

- Simple or single - 10060
 - Furuncle, paronychia
 - Superficial
 - Single
- Complex or multiple - 10061
 - Probing
 - Loculations
 - Packing
 - Drain



Abscesses that are deep or complicated may be more accurately coded with the site specific codes.

- | | | |
|---------|---------|---------|
| • 10160 | • 26011 | • 41005 |
| • 21501 | • 26990 | • 41800 |
| • 23030 | • 26991 | • 42700 |
| • 23031 | • 27301 | • 46050 |
| • 23930 | • 27603 | • 56420 |
| • 23931 | • 30020 | • 69000 |
| • 25028 | • 40800 | • 69005 |
| • 25031 | • 40801 | • 69020 |
| • 26010 | • 41000 | |

Coding Orthopedic Care in the ED

- The key issue in coding orthopedic treatment in the ED is whether the treatment is “supportive” or “restorative”.

Coding Orthopedic Care in the ED

- Splinting a fracture that will require reduction or other additional treatment at a later time is considered “supportive” or temporary.
- The appropriate coding would be to code only for splint placement if supported by documentation.

Coding Orthopedic Care in the ED

- If the fracture is definitively treated by splinting or other care provided in the ED, the treatment is considered “restorative” or definitive.
- The appropriate coding would be to code for fracture care if supported by documentation.

Coding Orthopedic Care in the ED

- For Medicare patients the ED physician must personally place the splint/cast in order to code for the fracture care or splint placement.
- For non-Medicare patients the emergency physician must either apply the splint/cast or for some payers it is acceptable for the physician to perform a post-placement evaluation of the application and bill for the service.

Coding Orthopedic Care in the ED

- Clear physician documentation is crucial to accurate coding for orthopedic services in the ED.
 - Displaced Fractures
 - Was the fracture manipulated?
 - Exactly where is the fracture located?
 - Fx radius = 25500, 25505, 25510, 25515, 25520, 25525, 25526, 25530, 25535, 25560, 25565, 25565, 25574, 25575, 25600, 25605, 25611, 25620
 - Fracture/Dislocation at or close to a joint
 - If there is a reduction is it of the displaced fracture?

Coding Orthopedic Care in the ED

- Non-Displaced Fractures
 - What treatment was rendered in the ED?
 - Who performed the placement of a cast/splint?
 - Is there a post placement evaluation of a cast/splint?
 - Is this care the definitive treatment of the fracture?
 - If yes how is the coder to know?
 - » Follow-up timeline
 - » Follow-up physician

ED Fracture Policy

- Displaced Fractures –
 - Code fracture care if the EDMD manipulates the fracture.
- Non-Displaced Fractures -
 - Medicare
 - Code fracture care if the EDMD documents that they placed splint/cast
 - Non-Medicare
 - Code fracture care if the EDMD documents that they placed splint/cast
 - Code fracture care if the EDMD documents that the splint/cast was placed under their supervision or if the EDMD documents a post placement evaluation of the splint/cast.

ED Fracture Policy

- DO NOT report fracture care for non-displaced fracture if the patient is instructed to follow-up with Ortho.
- DO NOT report fracture care for non-displaced fracture if the patient is instructed to follow-up in less than 48 hours.
- DO NOT report fracture care for non-displaced fracture if the treatment is a premade/off the shelf splint.

ED Splints

- **Splint Placement** - If the procedure does not qualify as fracture care, code the appropriate splint code if:
 - Medicare - The EDMD places the splint.
 - Non-Medicare - The EDMD performs a post placement evaluation of the splint.
- DO NOT report splint placement if the treatment is a premade/off the shelf splint.
- DO NOT report splint placement if also reporting fracture care.

Coding Orthopedic Care in the ED

- Non-Displaced Distal Radius Fracture
– 25600 – 8.48
- Short Arm Splint
– 29125 – 1.09

What exactly is Moderate Sedation?

- Moderate Sedation is a drug induced depression of consciousness.
- The patient maintains the ability to respond purposely to verbal direction or verbal direction either alone or accompanied by light tactile stimulation.
- Interventions are not required to maintain the patient's airway.

Moderate Sedation

- For coding, there are 2 groups of codes that can be reported.
 - When the MS is provided by the same physician performing the procedure that requires the sedation.
 - When the MS is provided in support of another physician performing the procedure that requires the sedation.
 - Each category is separated by codes for under age 5 and over age 5.

CPT 2017

- **New for 2017.** Intra-service time thresholds have dropped from 30 minutes to **15 minutes**.
- There is a code for “initial 15 minutes’ intra-service time” and then an add on code for “each additional 15 minutes of intra-service time”.

MS Documentation

- To report the moderate sedation the EDMD must document at least 10 minutes of intra-service time.
- To qualify for the additional 15 minute code, you still need to pass the half way point of the extra 15 minutes (23 minutes).

MS Documentation

- Intraservice starts with the administration of the sedation agent,
- Continues during constant face to face attendance,
- Ends at the conclusion of personal contact by the EDMD.

MS Documentation

- Once the EDMD personal contact is broken the clock on reportable MCS time stops.
- Re-assessment of the patient and recovery are not included in intraservice time.
