Additional Revenue Streams – Observation and Sedation Services

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Todd Thomas, CPC, CCS-P

Traditional Observation Model

- Extension of ED: Space, Providers, Nursing, MSW and Other Resources
- Cross Coverage With ED Attending/APP
- Limited Diagnostic Lists
- Sacrifice ED E&M Levels for Observational Codes
  - Able to Carry Over Procedures with Modifier 25
  - “Same Physician” = “Same Specialty/Group”
- Fairly Easy to Institute
- Some Additional Documentation Required
- Provider Satisfaction ???
- Minimal Financial Incentive
Why Have a Traditional Obs Unit Then?

- Minimal Financial Incentive
- It Can Be a Hassle
- What are the True Benefits?

Provider Benefits of ED Observation Services

- Improves ED Throughput
- Decreased Boarding of Obs Admits vs Inpatient
- Decreased ED Provider Risk
- Patient Satisfaction
- Provider Satisfaction Variable
  - Initial ED Physician- Yes
  - Disposition Obs Provider- Not so Much
- Hospital/Administration Satisfaction
  - “Team” Player
  - Contract Security
- Additional Revenue Stream
  - Potential Hybrid Models
Hospital Benefits of ED Observation Services

- Increasing Facility Reimbursement Pattern
  - 2018 Comprehensive Obs Services - $2349.66
- Improved Metrics
  - Increased ED Throughput/Decreased ED LOS
  - Decreased Time from Admission to Floor
  - Decreased Hospital LOS
  - Decreased Readmission Rates
- Decreased Boarding/Opens Up Hospital Beds
- Patient/Provider/Staff Satisfaction
- Safety/Lessens Medicolegal Risks/Short Hosp Stay Risk
- Consultant Satisfaction
  - Brings ED Mentality in House
- Allows Transfers from Outlying Sites
  - Both in System and Out/Expands System Footprint
- Multiple Reasons to Justify Support for Service

Comprehensive Observation Services - Facility Payments

- CMS Facility Payments for Observation Services Progressively Increasing Year Over Year
  - 2010 - $705.27
  - 2018 - $2349.66
  - 333%
- CMS Short Stay Hospitalization Payment
  - Averages ~ $5142
Observation Dilemma

- Is There Another Business Model?
- Is There a Way to Capture Full Revenue From the Observation and ED Side?
- Is There a More Provider Friendly Model?
Alternative Observation Model

- Allows Additional Charge Capture
- Allows Additional/Expanded Accepting Diagnostic Lists
  - Growth Without the Pain
- Allows Potential Alternative Service Lines
- Dedicated Observation Team Approach
  - Providers, Nursing, MSW, Discharge Coordinators
- Greatly Improves Observation Provider Satisfaction

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Financial Considerations - ED

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## Financial Considerations - Obs

### Same Day Obs Admit/DC >8hrs

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### Initial Obs Day, <8hrs

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### Discharge Obs

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Alternative Observation Model

The How to Approach

• Establish a New Corporate Entity
  • Application Though State (online)
  • Can be New Parent Corp. or a Subsidiary of Current Parent Corp.
  • Fast and Nominal Fee
  • Attorney Fees
  • Requirements Include
    • Name of Entity
    • Address of Entity
    • Name of Establishing Individual
  • Apply Through IRS for New TIN (Tax Identification Number)
    • Short Online Application
    • Immediate Results and No Fee

Alternative Observation Model

The How to Approach

• Apply for New NPI# (National Provider Identifier) Through CMS
  • Short Online Application
  • <48 Hour Results
  • No Fee
• Apply for Group Insurance Enrollment and Contracts
• Apply for Provider Insurance Enrollment
• Establish Bank Account/Lock Box
• Establish Accounting Services
• Establish Back Office Support
  • HR, Scheduling, Enrollment and Credentialing,
    Billing/Coding/RCM
New Entity

[Website Screenshot]

**BUSINESS**

**Hot Jobs For 2026**

This publication highlights Michigan occupations that show a favorable mix of long-term job growth, projected annual job openings, and median wages through 2026. Learn More About Michigan's Hot 50 Jobs

**ONLINE SERVICES**

**BUSINESS ENTITY SEARCH**

Search for records of corporations, limited liability companies, and limited partnerships authorized to transact business in the State of Michigan.
New TIN (EIN)  

www.irs.gov

Employer ID Numbers

Alert
You must complete each EIN application individually instead of using an automated process.

Related Topics
- Taxpayer Identification Numbers TIN
- Correcting Business Information Where a Nominator Was Used

Publication
- Publication 1635, Employer Identification Number Understanding Your EIN (PDF)

Video
- EIN Video

Need an Employer Identification Number
Apply for an Employer Identification Number (EIN) Online

**Individuals**
- Business and Self-Employed
  - Employer ID Numbers
  - Business Taxes
  - Reporting Information
  - Returns
  - Self-Employed
  - Starting a Business
  - Operating a Business
  - Closing a Business
  - Industries/Professions
  - Small Business Events
- Online Learning
- Mail

**Hours of Operation**
Monday to Friday, 7 a.m. to 10 p.m.
Eastern Standard Time.

**Small Business/Self-Employed**
- Businesses with Employees
- Related Topics
  - State and Federal Online Business Registration
  - Online EIN Frequently Asked Questions
  - Employer ID Numbers
  - System Requirements
  - Privacy Act Statement and Paperwork Reduction Act Notice

**Step 1: Determine Your Eligibility**
- You may apply for an EIN online if your principal business is located in the United States or U.S. Territories.
- The person applying online must have a valid Taxpayer Identification Number (SSN, ITIN, EIN).
- You are limited to one EIN per responsible party per day.

**Step 2: Understand the Online Application**
- You must complete this application in one session, as you will not be able to save and return at a later time.
- Your session will expire after 15 minutes of inactivity, and you will need to start over.

**Step 3: Submit Your Application**
- After all validations are done you will get your EIN immediately upon completion. You can then download, save, and print your EIN confirmation notice.

**Apply Online Now**

---

**New NPI Number**

**NPPES**
http://nppes.cms.hhs.gov/
Log in to view, update your National Provider Identifier (NPI) record... a small delay while the application retrieves the NPPES profile related information.
Apply for NPI/Provider... NPPES FAQs. The NPPES help.

**Registered User Sign In**
Log in to view, update your National Provider Identifier (NPI) record.

**User ID**
NPPES User ID, used to access NPPES, EHR & FHIR

**Password**

- **Sign In**
- **Forgot User ID or Password?**

*If your User ID is associated with a large number of providers, you could experience a small delay when the application retrieves all NPPES profile related information.

**Create a New Account**
You need an Identity & Access Management System (IAM) User ID and Password to create and manage NPIs.

**Individual Providers, Organization Providers, Users working on behalf of a provider**

If you don’t have an IAM account, need to update your existing IAM account, or don’t remember your User ID or Password, select the CREATE or MANAGE AN ACCOUNT button below to go to IAM.

After successfully creating your IAM account, you will receive an e-mail to verify your NPI. After verifying your NPI, you can return to NPPES and use your IAM User ID and Password to log into NPPES where you can create and manage the NPI data associated with your provider(s).
Alternative Observation Model
The How to Approach

• File Separate Tax Returns
  • If a Subsidiary Then it Can be Incorporated into Consolidated Tax Return Under Parent Company
• Acquire Malpractice Insurance*
• Acquire Workman’s Comp Insurance*
• Acquire General Business Liability Insurance*

* Usually Added Under Existing Parent Company Policies

Traditional vs. Alternative Models

34yo Asthmatic (moderate persistent) presents to ED in Status Asthmaticus. Seen and evaluated. Given serial duonebs and steroids. CXR, EKG and labs are fairly unremarkable. After several re-evaluations patient continues tachypneic, wheezing and requires supplemental O2.

• Decision for Observation placement is made
• Patient placed in Observation on day 1
• Remains in Observation overnight
• Discharged on day 2
Traditional Obs Model Billing/Coding/Reimbursement

- **ED Services-** 99285
  - Medicare- $174
  - In-Network Insurance at 150% Medicare- $261
  - OON Insurance at 300% Medicare- $522

  **OR**

- **Observation Services-** 99220 + 99217
  - Medicare- $186 + $73 = $259
  - In-Network at 150% Medicare- $279 + $109.5 = $388.5
  - OON at 300% Medicare- $558 + $219 = $777

Alternative Obs Model Billing/Coding/Reimbursement

- Separate **ED Service and Observation Service TIN Allows Charge Capture of Both**
- **ED Service**
  - Medicare- $174
  - In-Network at 150% Medicare- $261
  - OON at 300% Medicare- $522

- **Observation Service**
  - Medicare- $259
  - In-Network at 150% Medicare- $388.5
  - OON at 300% Medicare- $777

- **Combined**
  - Medicare- $174 + $259 = $433
  - In-Network at 150% Medicare- $261 + $388.5 = $649.5
  - OON at 300% Medicare- $522 + $777 = $1299
Alternative Obs Model Staffing

- Likely Evolution is Dedicated Providers to the Service as Volume Increases
  - Physicians, APP’s, Nursing, MSW, and DC Planners
  - Ancillary Staff Key to a Successful Unit
- ED Providers and Observation Providers Can be 100% Employee Crossover
  - Limit Work to Given Entity for a 24 Hour Period
- Suggest Dedicated CME
  - Expanding Diagnostic Lists Can be Challenging
  - Cardiology, Neurology, IM Emphasis
- Emergency Medicine vs IM/Family Practice

Additional TIN Opportunities

- Sedation Service Line
  - ED
  - In Hospital
  - Out of Hospital
- Proceduralist Service Line
  - Thoracentesis
  - Paracentesis
  - Emergent Epistaxis Care
  - Line Placement
  - Laceration Repair
- May Negate Need for Support
**Additional TIN\nAdditional Opportunities**

- APM Innovations- AUCM*
  - Home Hospital
  - Home Triage Services
  - Emergency DC Follow Up*, MSW and Care Coordination/Transition*
  - Home Care/Re-evaluation* vs Other Place of Service Evaluation
    - Acute Unscheduled Care Service Lines vs Emergency Department Service Only
      - “AUC is a Service NOT a Place”
- Telehealth*

**Observation Reality**

- Likely Will Still Require Some Hospital Support
- Contract to Reflect Minimum Guarantees for Provider Support
- Multiple Wins for Hospital
  - Improved Metrics
  - Expand System Footprint
  - Consolidation of Services Within Systems
  - Decreased Readmission Rates
    - CHF
    - Bundled Payment Savings
  - Increased Observation Facility Reimbursements
  - Faster Obs Throughput vs. IM/Specialists/FP
Observation Denials

• Not Seeing Any Denial Patterns for Observation Services at This Time
• Same Denial Pattern Seen With Sedations/Procedures Performed on Obs Patients as With ED Patients

INSURANCE CLAIM
DENIED

Observation and Medicare

• Medicare Part A
  • Inpatient Services, SNF, Some Home Health Care Services
  • 99% of Medicare Beneficiaries Do not Have a Part A Premium Since They Have at Least 40 Quarters of Medicare Covered Employment
  • Inpatient Deductible is $1364 for 2019
  • SNF Coverage
    • Obs Stay- No Qualifying SNF Medicare Coverage
      • Patient May be Responsible for $5000 (250x20)
      • Typical Stay Starts at $250/Day
    • Qualifying Inpatient Stay Spanning 3 Nights
      • No Patient SNF Cost Sharing for First 20 Days
      • After 20 Days Cost Sharing is $145/Day
Observation and Medicare

- Medicare Part B
  - Covers Physician Services, Outpatient Hospital Services, Certain Home Health Services, Durable Medical Equipment and Other Services Not Covered by Medicare Part A
  - Observation Services is Considered a Outpatient Service
  - Standard Monthly Premium in 2019 for Part B is $135.5
  - Annual Deductible in 2019 is $185
  - Subject to 80/20 Co-insurance
  - If Not Inpatient Then Responsible for SNF Charges (in OIG study 11% stays >3 days)
  - Self Administered (P.O.) Meds Not Covered
  - 20% Co-pays Add Up for Longer More Complex Obs Stays

Bottom Line

- Most Obs Related Visits for Medicare Patients Will be Cheaper Than Admission
- $6750 Total Obs Allowable Charges Breakeven Point
- SNF Placement Still an Issue
Coding Observation in the ED

There are three groups of codes used to report Observation services in the ED.

- Same day observation admit and discharges:
  - 99234
  - 99235
  - 99236

- Stay that spans more than one calendar date:
  - 99218
  - 99219
  - 99220
  - 99217

- Subsequent Observation Care Codes
  - 99224
  - 99225
  - 99226

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Comprehensive history for Obs codes requires 3 of 3 PFS Hx elements
Coding Observation in the ED

Stay that spans more than one calendar date

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Comprehensive history for Obs codes requires 3 of 3 PFS Hx elements

Comprehensive History for Obs Codes - requires 3 of 3 PFS Hx elements

- DG: At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, established patient; emergency department; subsequent nursing facility care; domiciliary care, established patient; and home care, established patient.

- DG: At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; and home care, new patient.
**99217**

- **Question:** Can we code 99217 when the patient is transferred to inpatient from observation?

- **Answer:** Yes, code a discharge code for the final Obs day. Where they go after discharge (home or inpt) is irrelevant.

**99217**

- “The physician may not bill the hospital observation discharge management code (code 99217) or an outpatient/office visit for the care provided in observation on the date of admission to inpatient status.”

- “If the same physician who admitted a patient to observation status also admits the patient to inpatient status”
99217

Observation Discharge Management -

- The treating/supervising physician may submit the discharge management service on the date the patient left observation care.
- If the treating/supervising physician admits the patient to an inpatient status, the appropriate inpatient hospital procedure code is submitted.
- This physician does not have to be the same as the ordering physician, nor must they be in the same group with the same specialty.

Question: Would Medicare cover an observation discharge (CPT code 99217) for the ED physician when a patient is admitted to observation by an ED physician on day 1 and on day 2 the patient is admitted as an inpatient by another specialty (e.g., orthopedist)?

Answer: The ED physician who admitted the patient to observation on day #1 may perform and bill an observation discharge service on day #2 (99217), with a medical record order indicating that the patient is being admitted as an inpatient by a provider of another specialty. The admitting provider, who will be responsible for the patient’s care during the inpatient stay, may perform and bill an initial hospital admission service (99221-99223) on that same date.
99217

• Is it required that an examination be documented in order to bill 99217 on the date of observation discharge?

99217

There are some terms used in CPT that can influence code choice if their grammatical intention is misinterpreted.

Common example is the use of "requires" versus "includes".

• Requires means the provider must perform the indicated elements in order to use the code.
• Includes means if the provider reports the code the indicated elements are not separately reportable.
99217

The description of 99217 does not use a "requires these components" statement. According to CPT and CPT Assistant 99217 includes the elements:

- Final examination of the patient,
- Discussion of the hospital stay,
- Instructions for continuing care,
- Preparation of discharge records

These elements are not separately billable if performed on the same day as 99217 is reported.

There is certainly a requirement for discharge note or summary to show physician involvement on the final day of care but there is no content requirement for that note.

Observation in the ED

There must be a separate observation record which documents:

- an order "admit to observation status" with time and date;
- the reason/medical necessity for the observation admission and stay;
- a treatment plan;
- progress notes; and
- a discharge summary, plan and discharge time.
Observation in the ED

- The observation record must be in addition to any record prepared as a result of an emergency department encounter.
- The observation record may refer to the history and exam documented in the ED chart.
  - Only if the ED and Observation by the same Physician/Group.

Observation in the ED

- CPT does not specify a mandatory time threshold for observation codes.
- CMS requires that use of the same day observation admit/discharge codes 99234-99236 for Medicare patients must involve lengths of stay of at least 8 hours.
- No minimum time if crossed midnight.
Observation in the ED

The observation services should be used to potentially forestall a lengthy inpatient admission. There are two basic circumstances when observation is appropriate:

**Lack of diagnostic certainty**, where a more precise diagnosis could decide inpatient admission or discharge to home, or

**Therapeutic intensity**, where extensive therapy has a reasonable possibility of abating the patient's presenting condition, and thereby prevents inpatient admission.

- Observation codes should not be used for when the workflow of a busy ED causes an extended ED stay.
- Or patients that are admitted as inpatients but waiting for a bed.
- However.... CPT Assistant, July 2019 makes an allowance for patients waiting on psych bed.
Procedural Sedation Service Lines

Developing a New Line of Service

• Requires Development of New/Alternate Entity From Core EM Service
• New TIN and NPI#
• Additional Requirements of New TIN
  • Dedicated Providers and Work Flow
  • Services- HR, Scheduling, Credentialing and Enrollment, Billing/Coding/RCM
  • Separate Accounting and Tax Filing
  • Separate Contracts and Group/Provider Enrollment
  • Insurance- Malpractice, Workers Comp, General Business Liability
• Allows Additional ED Charge Capture
• Alternate Business Lines
• Can Be Combined With Other Lines of Service
  • Observation/Proceduralist
Procedural Sedation Line of Service

- Often Requires Discussions With Anesthesia
- Suggest Some Degree of Specialized Training/Education
  - Dedicated CME Requirements
  - EM Board Certification (ICU/Anesthesiologists)
- Benefit to ED Staff
  - Time- allows continued patient flow
  - Patient Safety/Satisfaction/Quality Measures
- Benefit to Patient
  - Time- not waiting for ED staff availability
  - Safety- dedicated/experienced sedation team
  - Quality- dedicated/experienced sedation team
- Benefit to Consultant
  - Time- not waiting for ED staff availability
  - Safety- no non-ED supervised sedations, no “quick “sedations
  - Quality- no partial/unsuccessful sedations

- Provides Additional Revenue Stream to...
  - ED Services
  - Inpatient Floor/ICU Sedation Needs
  - Outpatient Sedation Needs
- True Capture of Deep Sedation Reimbursement
- Ability To Start Service to Accommodate Your Needs
  - Dedicated Sedation Cart
  - Dedicated RT Support
  - Dedicated Nursing Support
  - Hours of Coverage
"I need a sedation......Please"

## Traditional ED Sedation Model

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<th>ED E&amp;M</th>
<th>Shoulder Reduction</th>
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Traditional ED Sedation

- If Bill Moderate Sedation Then Able to Bill E&M, Procedure, and Sedation
- If Bill Deep Sedation/Anesthesia Codes Then May Bill E&M and Procedure OR Sedation
- Anesthesia Codes Based On Body Area the Procedure is Being Performed On and if the Procedure is Open or Closed
- Base Unit For Medicare is $22.78
  - Assigned by American Society of Anesthesiologists Based on Difficulty and Risk
- Time Multiple by Minute/15min Block (Additional Base Unit)
- 01610 Deep Sedation for Shoulder Reduction- Medicare
  - 5 base units plus $1.52/min
  - $22.78 x 5 ($113.9) plus $1.52 x 20min($30.40) = $144.30
- Private Payors
  - Same Base Units Plus Two 15min Blocks/Units (20min)
  - 150% Medicare- ($22.78 x 5) x 150% + ($1.52 x 30min) x 150% = $239.25
  - 300% Medicare- ($22.78 x 5) x 300% + ($1.52 x 30min) x 300% = $478.5

Anesthesia Codes—Modifiers

- AA- Physician (Anesthesiologist???) Personally Performed the Care
- QS- Monitored Anesthesia Care
- P1-P6- Physical Status Modifiers
  - ASA Classification
    - P1 = 0 Units
    - P2 = 0 Units
    - P3 = 1 Unit
    - P4 = 2 Units
    - P5 = 3 Units
CMS CPT Instructions

• “Select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided.”
• “Moderate” vs “Deep”

Alternate Sedation Model

• Capture E&M Level, Procedure and Deep Sedation
• Dedicated Sedation Consult Service
Alternate ED Sedation Model

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<th>Shoulder Reduction</th>
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Inpatient Sedation Opportunities

- ICU
  - Tracheostomy
  - PEG tube placement

- Burn Unit
  - Debridement
  - Dressing changes

- Floor
  - I&D’s
  - Surgical debridement
  - Orthopedic reduction, traction pin placement, hardware manipulation
Outpatient Sedation Opportunities

• Radiology
  • MRI
  • IR procedures
  • CT guided procedures

• Oncology
  • Bone marrow biopsies
  • Prostate biopsies and radiation seed placement

• Orthopedics
  • Fracture clinic

• Advanced Dentistry

Market It
Sedation Documentation Requirements

- Brief HPI
- Indication/Procedure
- Specific Diagnosis
- Location of Sedation (ED, Obs, MRI, Burn Unit, etc)
- ASA Classification
- Mallampati Score
- NPO Status
- Exam- Airway, Neck, CV, Resp, Neuro

Sedation Documentation Requirements

- Risks/Benefits
- Consent for Deep Procedural Sedation
- Monitoring- IV, O2, Telemetry, Cont. Pulse Ox, q5 min VS, +/- ETCO2
- Time Out
- Start/Stop Times
- Medication/Route/Dose
- Post Sedation Exam
- Post Sedation Instructions
Sedation Denials

- Medicaid - Successfully Challenged
- UHC - Successfully Challenged
- Anesthesia Codes and the Non-Anesthesiologist
- Recently Updated ASA Sedation Guidelines Problematic
  - Annals of Emergency Medicine Review, August 2018

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:
  • 99151 – 99152 - When the MS is provided by the same physician performing the procedure that requires the sedation; initial 15 minutes of intra-service time.
  • 99155 – 99156 - When the MS is provided in support of another physician performing the procedure that requires the sedation; initial 15 minutes of intra-service time.
  • Each category is separated by codes for under age 5 and over age 5.

CPT Time Based Codes

• As of 2017. Intra-service time for Moderate Sedation thresholds have dropped from 30 minutes to 15 minutes.
  • Each code is for “initial 15 minutes’ intra-service time” and then an add on code for “each additional 15 minutes of intra-service time”.

11/18/2019
CPT Time Based Codes

• The following standards shall apply to time measurement, unless there are code or code-range–specific instructions in guidelines, parenthetical instructions, or code descriptors to the contrary...
  • A unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes). A second hour is attained when a total of 91 minutes have elapsed.

MS Documentation

• To report the moderate sedation the EDMD must document at least 10 minutes of intra-service time.
• To report for the additional 15-minute code, intra-service time must pass the halfway point of the extra 15 minutes (23 minutes).
MS Documentation

- Intra-service 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 intra-service time.