MANAGED RESOURCES

Case Study

Emergency Department Evaluation & Management Level Codes:

How a Clinical Charge Audit Can Evaluate Billing Practices & Documentation

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Client Challenges

Our client, a large, hospital system was facing a difficult problem:

THE CLIENT HAD IMPLEMENTED A NEW EMR AND NOTICED A DIFFERENT CONFIGURATION OF THE LEVEL OF CARE CHARGED.

The client also wanted to revise policies for Critical Care and Elopement. The client had concerns from both a financial and compliance perspective.

Our Solution

RN Auditors reviewed 170 accounts based on client specifications and noted:

- Level charged by the facility
- Level indicated by the EMR program calculation
- Criteria that were missing from the EMR calculation due to lack of documentation
- Level determined by ACEP (American College of Emergency Physicians) criteria
- RN Auditor agreement or disagreement of level billed

Findings indicated issues with coding of 99281, 99282 and 99291 (Critical Care)

Level Charged		Recommended Level Based on Documentation					
		99281	99282	99283	99284	99285	99291
99281	29	12	5	12			
99282	31	2	19	10			
99283	38			34	4		
99284	29			1	24	4	
99285	18				1	17	
99291	25				2	15	8

Our Solution

Example #1

Patient sent by PMD for elevated BP of 191/113. Seen for Medical Screening Exam by PA @1059. Labs drawn; EKG completed. Hypertension, PA Exam, Triage Nursing Assessment, Labs, & EKG, repeat BP 180/100 but not seen by MD prior to elopement. Facility billed a Level 99281 but according to regulations and ACEP criteria, this account warranted a charge of 99283.

Finding

Elopement Prior to MD face-to-face not being charged or charged a lower level than indicated. Prior to the patients leaving the ED, most were seen in the Triage Area by a Physician Assistant or Nurse Practitioner, examined and testing ordered and completed.

Recommendation

The visit can be billed when the PA or NP provides a medical Screening Exam and initiates the care for the patient. We also recommended a fast-track in the Triage Area for patients with straight forward problems that could be managed by the NPs and PAs to decrease elopements.

Our Solution

Example #2

86 y/o from group home transported to ED by BLS with c/o shortness of breath on awakening, no improvement w/Albuterol nebulizer x3, O2 sat 82% on 2L. On 6L O2, saturation increased to 91% on arrival. Altered mental status also reported by group home. Afebrile, BP 143/104, Pulse 105, SpO2 95%. CT Head, CTA- chest, X-ray all neg. Labs indicated no significant changes from prior. U/A showed infection. Treatment with Ceftriaxone, Azithromycin, IV Fluids, Nebulizer.

Level Determination Factors: Admit IP Telemetry, Chief complaint of Dyspnea, EKG, Lab, X-Ray, transport by BLS, CT, Nurse assessments, admit to inpatient. Factors indicated Level 6. Does not meet Critical care level of service based on nursing documentation which lacked the documentation of frequent assessments and treatments.

Finding

Critical Care visit documented by ED Physician, but nurse documentation did not support Critical Care.

Recommendation

Develop a policy for the content and frequency of Nurse documentation to better support the facility charge for Critical Care.

Finding

Physician Critical Care time was being documented using a drop-down menu, so most accounts had the same time indicated.

Recommendation

Use the actual physician time, not the drop-down menu time, or change the drop-down times to allow for more specific, credible times for ER physicians.