**Billing & Coding: Emergency Department Procedures & Point-of-Care Ultrasound: Summary Handout**

**Purpose of Documentation**

Documentation serves multiple purposes. Communication to other providers and preservation of information is critical. It may serve a purpose for quality assurance and data collection for research purposes. Good documentation can serve the purpose of providing medicolegal protection. Good documentation, especially structured paper or electronic records with built-in prompts, is also key to maximizing billing and reimbursement.

**Reimbursement**

Reimbursement is driven by two forms of revenue-generating patient care, namely cognitive work and procedures. Under the category of “cognitive work” are the Evaluation and Management (E/M) codes as well as the critical care codes. It is not uncommon for the procedural codes to generate reimbursement rates that significantly add to or even surmount the actual E/M codes generated by the chart that is documented.1,2 Current Procedural Terminology (CPT) codes are maintained by the American Medical Association. Selection few E/M codes are utilized in emergency medicine, and specific procedures each have their own respective CPT codes.2,3

The Center for Medicare and Medicaid Services (CMS) dictates reimbursement for claims submitted to Medicare and/or Medicaid. Reimbursement for the E/M codes may differ between CMS and CPT depending on the group and payer mix. If an organization is non-participatory with a payer, the CPT guidelines apply. As a general rule of thumb, CPT codes guide procedural reimbursement.4 Whenever an E/M code or CPT code is generated for a procedure, Relative Value Units are applied and correspond to a monetary value. A national committee representative of all medical specialties reviews and makes recommendations to the CMS Medicare Fee Schedule. The total RVU is a sum of the physician’s work, the “practice expense” and a factor representing liability insurance. Once the RVU value is determined, the various factors at play may be adjusted according to regional economies.2

**General Approach to Procedures**

As noted above, many different procedures commonly performed in emergency departments have their own CPT code, in addition to the E/M services associated with the basic documentation of care.5 Although it may be slightly more time consuming, it is wise to document each and every procedure individually, as this will making billing and prompt reimbursement easier, and more financially productive.1 As noted in the ACEP document *Coding and Reimbursement Pearls*, “Remember, you do not get reimbursed for what you do, you get paid for what you document about what you do!”6 Whenever applicable, as many of these components as possible should be documented in a given procedure note: procedure performed, indication, location, laterality, complexity, technique, and supplies used.1,2 Additional modifiers can be added onto the specific procedural CPT code, each with different meanings. Some modifiers denote bilateral procedures, multiple procedures, extended timing of procedures, discontinued procedures, repeat procedures, as well as anatomic modifiers and those that comment on or account for performance measures.7

Many procedures performed in emergency departments only have one associated CPT code, making coding and billing more straight-forward, while other procedures may have multiple options. We will now take a closer look at some of the more complex procedures in terms of billing:

* Laceration Repair: RVUs increase significantly with increasing size and/or complexity of wounds. Multiple lacerations are added together under the same CPT code if they are both within the same anatomic group and level of complexity. The summative length of these lacerations determines the CPT code. If multiple lacerations occur in either different anatomic groups or varying levels of complexity, they would be coded individually under each of their respective CPT codes.1,6 Wound repairs are coded first by complexity, then by anatomic site, then by size.8 Wounds can vary greatly in terms of coding, billing and reimbursement depending on documentation, so details matter, and one should accurately measure wounds instead of estimating length whenever possible.8,9 Factors that may change the level at which a wound repair is coded include extensive cleaning, debridement, revision of wound edges, foreign body removal, in addition to the complexity of the closure itself.9 Although adding diagnoses does not increase an E/M service level, listing associated diagnoses that correspond with the injury does support the E/M service billed for a particular encounter.1
* Abscess Incision and Drainage: A simple I&D is determined by a single fluid collection, with only a small amount of purulent material, for which an incision alone is sufficient. There are other factors that can increase the coding to the higher CPT code associated with complex/multiple abscesses, such as multiple abscesses, probing and disruption of loculations, or packing of an abscess.9,10
* Fracture Care: Procedures in this category fall under two categories. If a bone requires any kind of manipulation to achieve proper alignment, it may meet the standard of “restorative care” and fracture-care services could be billed. Additionally, if management of a fracture in the ED is identical to what a specialist would perform in follow-up, i.e. a nondisplaced fracture that is splinted that does not require subsequent casting, this also meets the requirement of fracture-care services.1,11 In scenarios where fracture-care services would be billed, a separate splint code does not need to be applied.1 However, if the management in the emergency department does not meet the description for fracture-management services, but the patient does receive a splint (only to subsequently be casted in follow-up), then a splint code would be utilized.1 Since fracture/dislocation codes are categorized under surgical “global care,” all facets of care are billed under that code, and a modifier should be added if the emergency physician is only involved in the initial care, but not the definitive care or follow-up.1,11 If emergency care is isolated to a fracture and/or dislocation, then only the fracture/dislocation CPT code may apply. However, if there is management of another issue that is associated with a fracture/dislocation, an E/M code can be billed with a modifier in addition to the fracture/dislocation code. A detailed history and exam, including mechanism, neurovascular integrity, assessment for and exclusion of other injuries, and the possibility of prescription medications, all support a billable E/M service.11 Fracture/dislocation management services yield high levels in terms of RVUs. These procedures are often associated with other separate, billable procedures, such as procedural sedation or X-ray interpretation.2,11
* Procedural sedation: Procedural sedation (moderate sedation, “conscious sedation”) can be billed when performed by the emergency physician, either on their own or in coordination of care with a specialist doing a different procedure for the patient. The timing of the procedure starts at the time medications are administered, and ends when direct patient observation ends, i.e., the physician steps out of the room and away from the patient. Included in procedural sedation coding are assessment of the patient, intravenous access and fluids, administration of medications and continued sedation as needed, vital sign (cardiac, pulse oximetry) monitoring and recovery. The initial assessment and recovery periods are not included in the billable service time.6,12 Procedural sedation codes are separated by the initial portion of sedation, time 0-30 minutes, which is met after 16 minutes have been completed, and a subsequent sedation code, which is separated into 15-minute intervals, with each interval met after 8 minutes of completion.6 Should endotracheal intubation be required with procedural sedation, it may be billed separately.12
* Ultrasound: In order to appropriately bill for use of point-of-care ultrasound in the emergency department, the documentation must support the indication for the procedure, the body structures imaged and interpretation of these images, as well as a retained copy of at least one or more images, with corresponding measurements or labels of anatomic and/or pathologic findings. This holds true for both diagnostic ultrasound and sonographic guidance of procedures.13 If you are unable to obtain images, you should document this as well, similar to failed procedures. Again, appropriate and thorough documentation is important for billing and coding, but also from a medicolegal and communication of care perspective.
  + Diagnostic: CPT codes for ultrasound imaging are defined by the body area imaged, and not the procedure itself, such as abdomen, pelvis, etc. It is rare that a complete exam, as defined by all of the normal and pathologic structures in a given anatomic region, is performed in an emergency department setting. More frequently, a limited exam is completed, looking at a particular structure plus some adjacent structures, such as the aorta, kidneys/bladder, gallbladder, etc.13 For pelvic ultrasound, transabdominal or transvaginal, the CPT codes and billing also change given pregnancy status, so it is important to incorporate that in the indication or elsewhere in the note.13 There are several modifiers that are frequently used for point-of-care ultrasound, especially those completed in an emergency department: -26 for professional (and not technical) services only, -76 and -77 for repeated exams of the same area, and -52 service reduction for when the complete exam is not performed but no limited option exists.13
  + Procedural Guidance: The same rules for documentation as noted above apply for sonographic guidance used for procedures, including image acquisition. For most procedures, the procedure and the ultrasound study are billed separately, such as central line placement, lumbar puncture, abscess localization and drainage, etc. There are some select procedures where the CPT code includes both the procedure and the ultrasound, namely thoracentesis, paracentesis, and arthrocentesis.13 There are some special requirements for use of sonographic guidance for vascular access. Static images (pre-procedure localization of the intended vessel, but no further use of ultrasound) do not count, and only procedures performed under dynamic guidance (the needle/catheter is visualized on ultrasound directly entering the intended vessel) can count toward billing. Since this may be very difficult to obtain as a solo operator, and the clinician should ideally be focusing on the patient and the procedure, it may not be possible to obtain imaging during the actual needle and/or catheter insertion, but a single image or video clip of the catheter correctly located in the vessel immediately post-procedure does qualify.13

\***Comparison of Common ED Procedures**9

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| **Procedure** | **CPT Code** | **RVU** | **Approximate Payout** |
| Endotracheal Intubation | 31500 | 4.07 | $146.68 |
| Diagnostic Fiberoptic Laryngoscopy  (w/o intubation) | 31575 | 1.91 |  |
| Intraosseous Line | 36680 | 1.69 | $60.91 |
| Central Line | 36556 | 2.45 | $88.30 |
| Cardioversion | 92960 | 3.13 | $112.80 |
| Chest Tube | 32551 | 4.53 | $163.26 |
| CPR |  | 5.35 |  |
| Lumbar Puncture | 62270 | 2.23 | $80.37 |
| Thoracentesis (including US) | 32555 | 3.22 | $116.05 |
| NG/OG Tube | 51702 | 0.63 | $22.70 |
| G Tube Replacement (not revision) | 43762 | 1.09 | $39.28 |
| Foley Catheter Insertion  (RN unsuccessful, by physician) | 51702 | 0.73 | $26.31 |
| Suprapubic Catheter  (place/change cystostomy tube) | 51705 | 1.50 | $54.06 |
| Corneal FB removal (w/slit lamp) | 65222 | 1.48 |  |
| Corneal FB removal (w/o slit lamp) |  | 1.19 |  |
| Simple/Single Abscess I&D | 10060 | 2.81 | $101.27 |
| Complex/Multiple Abscess I&D | 10061 | 5.16 | $185.96 |
| Epistaxis Control Anterior, simple  (Silver nitrate) | 30901 | 1.62 |  |
| Expistaxis Control Anterior, complex (packing, nasal tampon) | 30903 | 2.25 |  |
| Epistaxis Control Posterior (packing) | 30905 | 3.01 |  |

\*List generated utilizing 2019 National Physician Fee Schedule Relative Value File, published by CMS.

**Summary**

Procedures are a common part of the daily practice of emergency medicine, serving both diagnostic and therapeutic purposes. In addition to the expected elements associated with patient care noted in the chart, procedures have their own requirements in terms of documentation. In order to be coded properly and billed for maximal reimbursement, it is imperative that our learners understand the critical elements of a generalized procedure note, as well as the nuanced documentation requirements for specific procedures. Point-of-care ultrasound is one of those procedures with its own specific requirements, whether it is for diagnosis or procedural guidance. Procedures generate RVUs above and beyond the basic patient care noted in the main chart, and some can be quite lucrative. If these procedures are coded and billed properly, this is revenue potentially available to the physician and/or their department for services they are already providing.

**References**

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