CorroHealth

Emergency Department - Charge Process

December 2023

ED Charge Process – December 2023

Table of Contents

Components of Charge Process for Emergency Room

There are five components to the charge process for the Emergency Room:

1. Assignment of Evaluation and Management Level
2. Nursing Procedures
3. Hospital Technical Component of Physician Procedures
4. Medical Supplies
5. Drugs Sold to Patients

Assignment of the Facility E/M Levels

The assignment of an ED E/M level is based on Nursing and hospital resources used for treating the patient. The process is to assign a point value to each Nursing service or resource which cannot be separately charged to the patient, the sum of the point values is then "fitted" to a scale to determine the level. There are several different approaches to assigning point values to services accumulating to a visit level – examples are provided later in this paper.

CMS has stated that it is not expecting to see the same E/M level charged for the Hospital as the physician.

There are six E/M levels available for assignment:

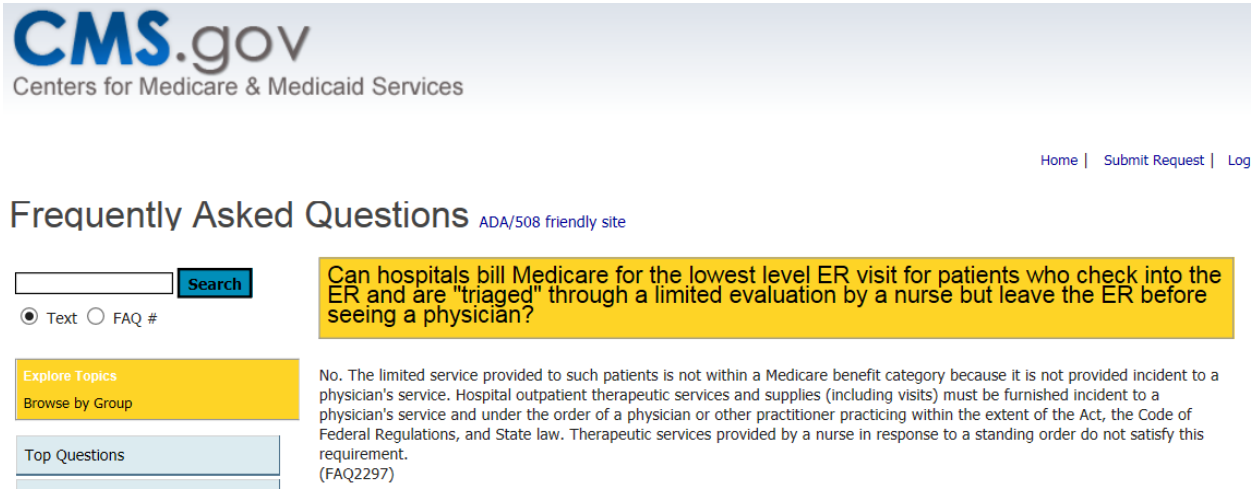
1. Brief – exam only with possibly a med script
2. Limited – Requires the assessment of a single symptom with limited testing or time spent with the patient.
3. Intermediate – several different diagnostic tests, child requiring restraint.
4. Extended – Interventions and diagnostic testing, possible admission to hospital as observation or inpatient.
5. Comprehensive – Major interventions or diagnostic testing, possible admission to hospital as an inpatient.
6. Critical – Requires close attendance and major interventions or diagnostic testing for an extended period of time, admit to hospital.

Hospitals may also charge a "sub brief visit" for the following:

1. Suture removal
2. Wound check

Medicare does not recognize a "triage-only" encounter to meet the requirements for an encounter.

CMS Frequently Asked Question #2297 states:


CMS.gov
Centers for Medicare & Medicaid Services

Home | Submit Request | Log

Frequently Asked Questions ADA/508 friendly site

Search

Text FAQ #

Explore Topics
Browse by Group

Top Questions

Can hospitals bill Medicare for the lowest level ER visit for patients who check into the ER and are "triaged" through a limited evaluation by a nurse but leave the ER before seeing a physician?

No. The limited service provided to such patients is not within a Medicare benefit category because it is not provided incident to a physician's service. Hospital outpatient therapeutic services and supplies (including visits) must be furnished incident to a physician's service and under the order of a physician or other practitioner practicing within the extent of the Act, the Code of Federal Regulations, and State law. Therapeutic services provided by a nurse in response to a standing order do not satisfy this requirement.
(FAQ2297)

HCPCS code sets to apply for ED visit level depending on the type of Emergency Department – Type A or Type B.

Under Medicare's OPPS payment system, all emergency department visits are APC status Indicator J2. J2 indicates that the HCPCS may be paid at a single-code rate, or the HCPCS may be paid at a comprehensive rate for APC 8011 "Observation Care" if certain criteria are met. See Observation – Charging, Billing, Compliance and Reimbursement for additional information.

1) **The Point Assignment process** associates a point value to services rendered by the facility that are not otherwise separately billable services (as identified by a billable HCPCS code.) The points are accumulated to represent the resources consumed, and the accumulated value is fitted to an ED visit level.

   Following is an example of point assignment using services (resources) that are not separately billable:

Total Points – **Category I**

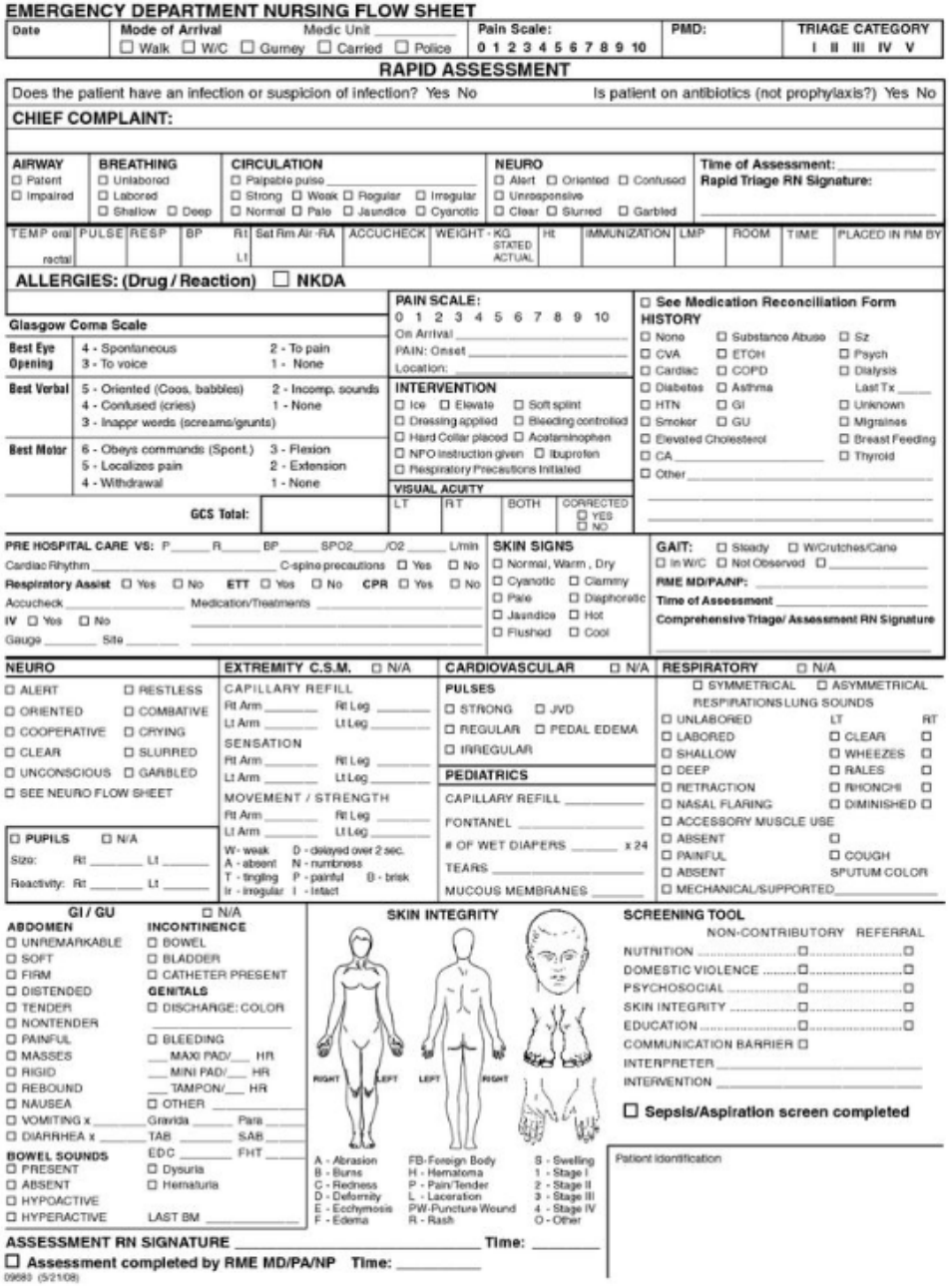
PTS	Value	Description
	1 PER VISIT	ARRANGE FOR ADMISSION
	3 PER VISIT	ARRANGE TRANSFER/MOT/TRANSPORTATION
	1 PER 15 MIN.	ASSIST W/SETUP PHYSICIAN PROCEDURE
	1 PER VISIT, EA	ASSIST RESTRAINT/MOBILITY/FEEDING/BATHING
	1 PER VISIT	DIAGNOSTICS ORDERED-CARDIOPULMONARY
	1 PER VISIT	DIAGNOSTICS ORDERED-IMAGING
	1 PER VISIT	DIAGNOSTICS ORDERED-LABORATORY
	1 PER VISIT	DISCHARGE INSTR. GIVEN & REVIEWED
	2 PER VISIT	MICN SERVICES
	1 PER VISIT	MULTIPLE CALLS FOR ANCILLARY SERVICES

The Total Points (all categories) are calculated to crosswalk to the appropriate visit level code:

PTS	Value	Description
1	TRIAGE	
2	LEVEL 1	99281
3-5	LEVEL 2	99282
6-8	LEVEL 3	99283
9-12	LEVEL 4	99284
13-16	LEVEL 5	99285
17 & >	LEVEL 6	99291 = 1ST 30-74 MINUTES

2) **Automated Level Assignment** is available in many third-party software vendors. Level assignment is driven by clinician/nursing entries into the electronic medical record. Examples are Linx E-Point, EPIC, and MedHost, to name just a few. Hospitals should periodically audit claims based on automated system-level assignments to ensure fair, consistent, and accurate charges. The responsibility for the accuracy of the charge remains with the hospital, as it has adopted the vendor design within the level assignment software.

3) **Diagnosis/Procedure Level Assignment:** Another approach is to calculate the visit level by abstracting information from the visit medical documentation using a combination of diagnosis and procedures to calculate the level. For example, the T-sheet contains information that may be crosswalked to a level assignment worksheet:



EMERGENCY DEPARTMENT NURSING FLOW SHEET

Date | Mode of Arrival ☐ Walk ☐ W/C ☐ Gurney ☐ Carried ☐ Police Medic Unit _____ | Pain Scale: 0 1 2 3 4 5 6 7 8 9 10 | PMD: | TRIAGE CATEGORY I II III IV V

RAPID ASSESSMENT

Does the patient have an infection or suspicion of infection? Yes No — Is patient on antibiotics (not prophylaxis?) Yes No

CHIEF COMPLAINT:

AIRWAY ☐ Patent ☐ Impaired

BREATHING ☐ Unlabored ☐ Labored ☐ Shallow ☐ Deep

CIRCULATION ☐ Palpable pulse _____ ☐ Strong ☐ Weak ☐ Regular ☐ Irregular ☐ Normal ☐ Pale ☐ Jaundice ☐ Cyanotic

NEURO ☐ Alert ☐ Oriented ☐ Confused ☐ Unresponsive ☐ Clear ☐ Slurred ☐ Garbled

Time of Assessment: _____ **Rapid Triage RN Signature:** _____

TEMP oral / rectal	PULSE	RESP	BP	Rt / Lt	Sat Rm Air -RA	ACCUCHECK	WEIGHT - KG STATED / ACTUAL	Ht	IMMUNIZATION	LMP	ROOM	TIME	PLACED IN RM BY

ALLERGIES: (Drug / Reaction) ☐ **NKDA**

Glasgow Coma Scale

Best Eye Opening	4 - Spontaneous	2 - To pain
	3 - To voice	1 - None
Best Verbal	5 - Oriented (Coos, babbles)	2 - Incomp. sounds
	4 - Confused (cries)	1 - None
	3 - Inappr words (screams/grunts)	
Best Motor	6 - Obeys commands (Spont.)	3 - Flexion
	5 - Localizes pain	2 - Extension
	4 - Withdrawal	1 - None

GCS Total: _____

PAIN SCALE: 0 1 2 3 4 5 6 7 8 9 10
On Arrival _____
PAIN: Onset _____
Location: _____

INTERVENTION
☐ Ice ☐ Elevate ☐ Soft splint
☐ Dressing applied ☐ Bleeding controlled
☐ Hard Collar placed ☐ Acetaminophen
☐ NPO instruction given ☐ Ibuprofen
☐ Respiratory Precautions Initiated

VISUAL ACUITY

LT	RT	BOTH	CORRECTED ☐ YES ☐ NO

☐ **See Medication Reconciliation Form**

HISTORY
☐ None ☐ Substance Abuse ☐ Sz
☐ CVA ☐ ETOH ☐ Psych
☐ Cardiac ☐ COPD ☐ Dialysis
☐ Diabetes ☐ Asthma Last Tx _____
☐ HTN ☐ GI ☐ Unknown
☐ Smoker ☐ GU ☐ Migraines
☐ Elevated Cholesterol ☐ Breast Feeding
☐ CA _____ ☐ Thyroid
☐ Other _____

PRE HOSPITAL CARE VS: P_____ R_____ BP_____ SPO2____/O2 _____ L/min
Cardiac Rhythm _____ C-spine precautions ☐ Yes ☐ No
Respiratory Assist ☐ Yes ☐ No **ETT** ☐ Yes ☐ No **CPR** ☐ Yes ☐ No
Accucheck _____ Medication/Treatments _____
IV ☐ Yes ☐ No _____
Gauge _____ Site _____

SKIN SIGNS
☐ Normal, Warm, Dry ☐ Cyanotic ☐ Clammy
☐ Pale ☐ Diaphoretic ☐ Jaundice ☐ Hot
☐ Flushed ☐ Cool

GAIT: ☐ Steady ☐ W/Crutches/Cane ☐ In W/C ☐ Not Observed ☐ _____
RME MD/PA/NP: _____
Time of Assessment _____
Comprehensive Triage/ Assessment RN Signature _____

NEURO
☐ ALERT ☐ RESTLESS
☐ ORIENTED ☐ COMBATIVE
☐ COOPERATIVE ☐ CRYING
☐ CLEAR ☐ SLURRED
☐ UNCONSCIOUS ☐ GARBLED
☐ SEE NEURO FLOW SHEET

☐ **PUPILS** ☐ N/A
Size: Rt _____ Lt _____
Reactivity: Rt _____ Lt _____

EXTREMITY C.S.M. ☐ N/A
CAPILLARY REFILL
Rt Arm _____ Rt Leg _____
Lt Arm _____ Lt Leg _____
SENSATION
Rt Arm _____ Rt Leg _____
Lt Arm _____ Lt Leg _____
MOVEMENT / STRENGTH
Rt Arm _____ Rt Leg _____
Lt Arm _____ Lt Leg _____
W - weak D - delayed over 2 sec.
A - absent N - numbness
T - tingling P - painful B - brisk
Ir - irregular I - Intact

CARDIOVASCULAR ☐ N/A
PULSES
☐ STRONG ☐ JVD
☐ REGULAR ☐ PEDAL EDEMA
☐ IRREGULAR

PEDIATRICS
CAPILLARY REFILL _____
FONTANEL _____
OF WET DIAPERS _____ x 24
TEARS _____
MUCOUS MEMBRANES _____

RESPIRATORY ☐ N/A
☐ SYMMETRICAL ☐ ASYMMETRICAL
RESPIRATIONS LUNG SOUNDS

	LT	RT
☐ UNLABORED	☐ CLEAR	☐
☐ LABORED	☐ WHEEZES	☐
☐ SHALLOW	☐ RALES	☐
☐ DEEP	☐ RHONCHI	☐
☐ RETRACTION	☐ DIMINISHED	☐
☐ NASAL FLARING		
☐ ACCESSORY MUSCLE USE		
☐ ABSENT	☐	
☐ PAINFUL	☐ COUGH	
☐ ABSENT	SPUTUM COLOR	
☐ MECHANICAL/SUPPORTED		

GI / GU ☐ N/A
ABDOMEN
☐ UNREMARKABLE ☐ SOFT ☐ FIRM ☐ DISTENDED ☐ TENDER ☐ NONTENDER ☐ PAINFUL ☐ MASSES ☐ RIGID ☐ REBOUND ☐ NAUSEA ☐ VOMITING x _____ ☐ DIARRHEA x _____

BOWEL SOUNDS
☐ PRESENT ☐ ABSENT ☐ HYPOACTIVE ☐ HYPERACTIVE

INCONTINENCE
☐ BOWEL ☐ BLADDER ☐ CATHETER PRESENT

GENITALS
☐ DISCHARGE: COLOR _____
☐ BLEEDING
___ MAXI PAD/___ HR
___ MINI PAD/___ HR
___ TAMPON/___ HR
☐ OTHER _____
Gravida _____ Para _____
TAB _____ SAB _____
EDC _____ FHT _____
☐ Dysuria ☐ Hematuria
LAST BM _____

SKIN INTEGRITY
RIGHT LEFT LEFT RIGHT
A - Abrasion B - Burns C - Redness D - Deformity E - Ecchymosis F - Edema
FB-Foreign Body H - Hematoma P - Pain/Tender L - Laceration PW-Puncture Wound R - Rash
S - Swelling 1 - Stage I 2 - Stage II 3 - Stage III 4 - Stage IV O - Other

SCREENING TOOL

	NON-CONTRIBUTORY	REFERRAL
NUTRITION	☐	☐
DOMESTIC VIOLENCE	☐	☐
PSYCHOSOCIAL	☐	☐
SKIN INTEGRITY	☐	☐
EDUCATION	☐	☐

COMMUNICATION BARRIER ☐
INTERPRETER _____
INTERVENTION _____

☐ **Sepsis/Aspiration screen completed**

Patient Identification

ASSESSMENT RN SIGNATURE _____ **Time:** _____
☐ **Assessment completed by RME MD/PA/NP Time:** _____

09680 (5/21/08)

ED Charge Process – December 2023

The **T-sheet** is abstracted into a Level assignment worksheet based on diagnosis/procedures:

Level 1

Procedures

Triage
Teaching for Patient and family
Discharge instructions
Suture removal

Simple dressing change

Refill Rx

Diagnosis

Insect / spider bite
Suture removal
Wound re-check
Off work order
Return to work order
Med refill
Rash

Level 2

Procedures

PO Meds

Point of care testing
Visual acuity

Diagnosis

Ear Pain
UTI
Simple sprain
Conjunctivitis
Simple wound eval
Upper resp. infection
Chronic Back pain
Sore throat
Chronic cough
Fever
Headache
Leg Pain
Ingrown toenail
1st degree burn

Level 3

Procedures

Hep lock

Single diagnostic test
2 pain assessments
Oxy admin
Complex discharge instruction

EMS
Single therapeutic process

Diagnosis

Acute back pain
Extensive wound eval
Adult asthma
Abd pain
Eval simple fx
Migraine
Chronic chest pain
Acute Bronchitis
COPD
Hypertension
Abscess - simple
Flu
Foreign Body ear / nose
Allergic reaction
Animal bite
Dental Pain
Assault
2nd degree burn

Level 4

Procedures

Slit lamp exam

Morgan lens
Cervical exam
Multi diagnostic test

NG/Peg tube - reinsert
Cardiac monitor / pulse ox
3 - 6 pain assessments
Multiple therapeutic process

Diagnosis

Acute panic
Foreign Body eye
Acute headache
Dyspnea w meds
5150 less than 4 hours
Child asthma
Vaginal bleeding
DOA postmortem care
Altered LOC
Complex fx - open / multi
Admit to Observation
Admit to Med/Surg
Cellulitis
GI Bleed
Kidney stone
Syncope
Hypertension
Short of breath
Angina
Assault with report

Level 5

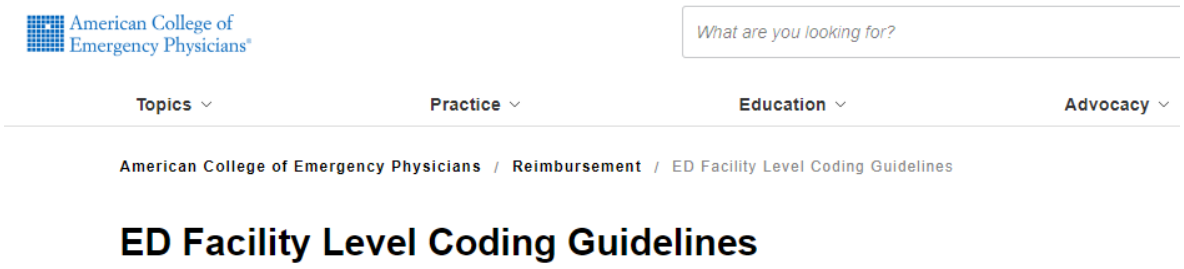
Procedures

Admit to
Transport with RN
Transport with Monitor
Conscious sedation
> 7 pain assessments

Diagnosis

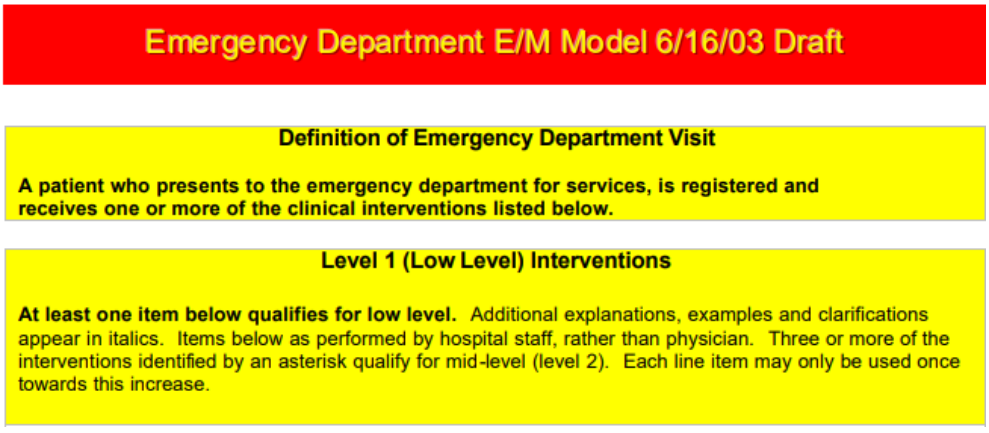
Acute chest pain
Sepsis
DKA
HHNT
5150 greater than 4 hours
ETOH / Overdose
Resp. distress
Hypertensive Crisis
Angina

4) The American College of Emergency Physicians provides guidance and examples through its website.
ED Facility Level Coding Guidelines :



5) **American Health Information Management Association (AHIMA)** offers guidance:

Emergency Department Model



- *Continued*

*** Administration of oral, topical, rectal, PR, NG or SL medication(s)**	
*** Administration of single disposable enema**	
*** Application of preformed splint(s)/elastic bandage(s)/sling(s), or immobilizer(s) for non-fracture or nondislocation injuries**	*Preformed are off-the shelf. If creating a splint from plaster or fiberglass or other material, would have separate code. Splints are not billed separately.* *Splints, casting, etc. for fractures are separately billable and paid under the fracture management.*
*** Assisting physician with examination(s)**	*Pelvic exam included here. Includes eye exam/slit lamp exam of eye. Nursing documentation must support assistance, unless there is a hospital protocol regarding assistance with exam.*
*** Bedside diagnostic testing, unless tests are separately billed.**	*Examples: Dip stick urine testing, capillary blood sugar (Accucheck, Dextrostick), hemoccult, occult blood tests. Strep test is not included because it is separately billable.*
*** Cleaning and dressing of a wound, single body area, not repaired (but includes butterflies)**	*Examples: steri-strips and other adhesives, eye patch*
*** First aid procedures**	*Examples: control bleeding, ice, monitor vital signs, cool body, remove stinger from insect bite, cleanse and remove secretions*
*** Flushing of Heplock**	
Follow-up visit	*Definition: Patient instructed to return for wound check or suture removal or rabies injection series.*
*** Foreign body(ies) removal of skin, subcutaneous or soft tissue without anesthesia or incision**	
Initial clinical assessment	*Example: Vitals, chief complaint, and clinical assessment of symptom. All elements must be present.*
Measurement/Assessment of fetal heart tones	
Nursing visual acuity assessment (e.g. Snellan exam)	
*** Specimen(s) collection other than venipuncture, e.g. mid-stream urine samples, cultures**	*Example: nursing instruction of patient on proper specimen collection (e.g. mid-stream urine, sputum). Includes collection of specimen (not the performance of the lab test), e.g. throat culture collection.*

6) **Critical care level assignment** may not rely on points due to their extreme resource consumption; several of the life-saving interventions a critical care patient may have (based on the Emergency Severity Index, Version 4) are as follows:

1. BVM ventilation
2. Intubation
3. Surgical airway
4. Emergent BIPAP/CPAP
5. Defibrillation
6. Emergent cardioversion
7. External pacing
8. Chest needle decompression
9. Pericardiocentesis

10. Open thoracotomy
11. Intraosseous access
12. Significant IV fluid resuscitation
13. Blood administration
14. Control of major bleeding
15. Admin of medications – Naloxone, D50, Dopamine, Adenocard

Patients referred to observation or admitted to inpatient status must meet medical necessity standards; physician documentation is key to justifying patient status assignments as medically necessary.

Patients held an extended period of time to be prepped for surgery, stabilization or admission may be assigned additional points or resources for ED level assignment.

It is usually the case that a pregnant woman will be triaged at the ED and then "referred" to the obstetric department for an OB medical screening. This sometimes results in duplicate evaluation and management charges, ED and OB. It is suggested that the discharging department be the department to charge the E/M visit charge.

Type A Emergency Department Facility Visits

A Type A provider-based emergency department must meet at least one of the following requirements:

> (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department and be open 24 hours a day, 7 days a week; or
>
> (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment and remains open 24 hours a day, 7 days a week.

ED Charge Process – December 2023

HCPCS / CPT®
99281 - Emergency Department visit for the evaluation and management of a patient, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor.
99282 - Emergency Department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.
99283 - Emergency Department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.
99284 - Emergency Department visit for the evaluation and management of a patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician physicians, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
99285 - Emergency Department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

HCPCS / CPT® - *continued*
99291 - Critical Care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
99292 - Critical Care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (list separately in addition to code for primary service)

Type B Emergency Department Facility Visits

Type B Provider-Based Emergency Departments must meet at least one of the following requirements:

(1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department, and open less than 24 hours a day, 7 days a week; or

(2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment, and open less than 24 hours a day, 7 days a week; or

(3) During the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment, regardless of its hours of operation.

HCPCS / CPT®
G0380 - Level 1 Hospital Emergency Department visit provided in a Type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0381 - Level 2 Hospital Emergency Department visit provided in a Type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0382 - Level 3 Hospital Emergency Department visit provided in a Type B emergency department; (the ed must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)

HCPCS / CPT® - *continued*
G0383 - Level 4 Hospital Emergency Department visit provided in a Type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0384 – Level 5 Hospital Emergency Department visit provided in a Type B Emergency Department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment) Note: **J1 – Hospital Part B services that may be paid through a comprehensive APC**.

Systems for ED Visit Level Assignment

CMS instructs each facility to develop internal guidelines for assigning the E/M level to a visit. In the Federal Register (11/27/2007) notice of Medicare program changes, Medicare offers:

> "…CPT® E/M codes were defined to reflect the activities of physicians and do not necessarily fully describe the range and mix of services provided by hospitals during visits of clinic and emergency department patients and critical care encounters…"
>
> "…. In the April 7, 2000 OPPS final rule with comment period (65 FR 18434), we instructed hospitals to report facility resources for clinic and emergency department visits using CPT® E/M codes, and to develop internal hospital guidelines to determine

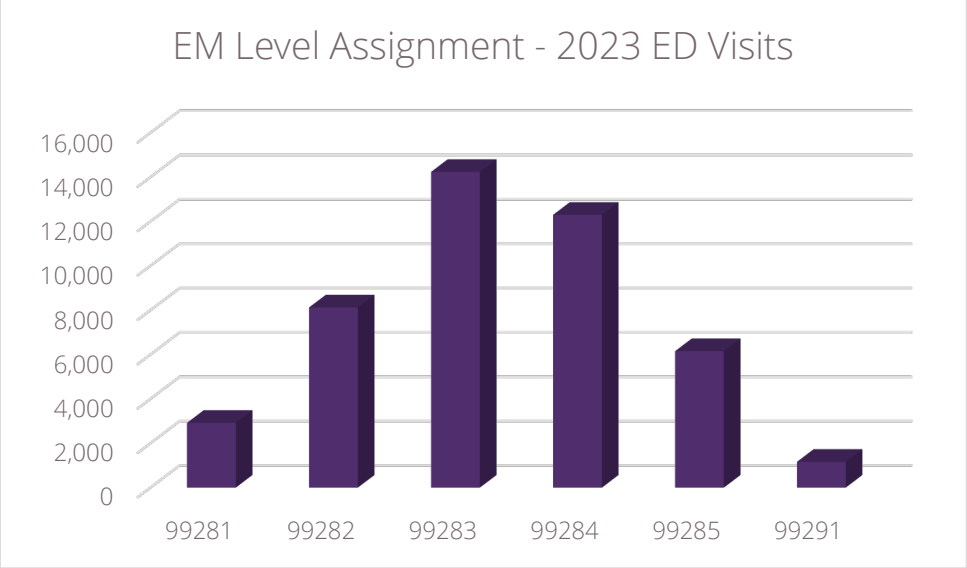
> what level of visit to report for each patient. While awaiting the development of a national set of facility-specific codes and guidelines, we have advised hospitals that each hospital's internal guidelines should follow the intent of the CPT code descriptors, in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes."

Several systems are acceptable in determining the facility fee ED level. A visit level may be calculated by the Point Assignment process, the T-sheet diagnosis/procedure process, or any other reasonable process by which a facility can consistently and fairly assign a visit level that corresponds to the hospital resources expended. This paper provides concise information on level assignment as outlined below:

1. Point assignment, accumulation of resources, and "fit" to a level
2. Automated level assignment derived from 3rd party software
3. T-sheet documentation and leveling (manual or paper process)
4. American College of Emergency Physicians guidelines
5. AHIMA document on ED level assignment
6. Critical Care level assignment

Evaluation and Management Distribution

As presented, several methods may determine the E/M levels. Within the annual release of the OPPS Rule, there is a yearly recommendation that a hospital establish a process to assign the levels and that the process be documented for replication. There is also an expectation that the distribution of the E/M levels (from 99281 – 99285 and 99291) by frequency of visits follow a normal distribution (i.e., bell shape curve).



Nursing Procedures

Many separately billable nursing procedures create line-item reimbursement; if the service is separately billable, it should not factor into the E/M level assignment. Examples of billable nursing services include:

1. IV therapy
2. Hydration therapy
3. Injections sq/IM and injection into IV lines
4. Catheter insertions
5. Vaccine injections
6. Strapping and casting (if no reduction or relocation)
7. PICC line inserts
8. Point of care lab tests
9. Blood draw from a fully implanted port
10. Blood draw from a central or PICC line
11. Declotting by a thrombolytic agent of an “implanted” vascular access device

ED Charge Process – December 2023

Charges for nursing procedures should be listed for selection on the paper ED charge form or triggered by documentation in the electronic health record. Multiple services may be charged when additional and subsequent procedures are performed.

Services that are not separately billable should be considered in the assignment of the ED level charge (part of the point / resource assignment process):

1. **IV starts**
2. **Install Hep line / Saline lock**
3. **Fecal impaction**
4. **Ear wax removal**
5. **Steri-strip application**
6. **Cleaning of wounds without a closure**
7. **Hep / saline lock flush**

There are many rules on the admin of IV hydration, IV med therapy, and injections into an IV line. The basic rule is that only a single "initial or 1st" infusion or injection can be charged. See Hydration, IV Infusions, Injections and Vaccine Charge Process for additional tools and guidance.

1. 96365 – IV med therapy - 1st hour
2. 96366 - IV med therapy - each additional hour
3. 96374 – IV med injection – 1st med
4. 96375 – IV med injection – 2nd med subsequent injection
5. 96376 – IV med injection – 1st med subsequent injection
6. 96360 – IV hydration – 1st hour
7. 96361 – IV hydration – each additional hour

Triage Only/Left Without Being Seen

Medicare does not permit a visit charge for patients who undergo thorough triage and are "roomed" within the ED but leave without having been seen by the physician. To be consistent in charge practices, facilities should adopt a policy that sets standards for patient charges in such circumstances. In some cases, those patients may have undergone imaging studies and EKGs, which are billable if performed on the order of a physician. On the other hand, a patient who presents with a sore throat waits a few hours in the waiting room, and leaves without being seen should not be charged. In any event, the likelihood of collecting payment on these visits without dissatisfaction from the patient is low.

Critical Care and Trauma Activation Charges

Critical Care and Trauma Activation fees may be billed by hospitals with a trauma center designation. Medicare will pay for critical care at 2 levels, depending on the presence or absence of trauma activation. Providers will receive one payment rate for critical care without trauma activation and will receive additional payment when critical care is associated with trauma activation.

Critical care is urgent medical care that is delivered directly by a physician(s) where the nature of the patient's condition is critical due to illness or injury. A critical illness or injury is one that acutely impairs one or more vital organ systems in such a way there is a high probability of imminent or life-threatening deterioration in the patient's condition. Critical care involves high-complexity decision-making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ systems and/or to prevent further life-threatening deterioration of the patient's condition.

Critical Care codes (99291 and 99292) are time-based codes. The time spent in providing critical care may be continuous, intermittent and aggregated. Both physician time and nursing time may be used to calculate the time in critical care, but the same time period cannot be duplicated by two different individual providers (nurses and/or doctors.) Critical care time is calculated only once for one single period of time, even if more than one physician or nurse is providing care.

Trauma Activation HCPCS (G0390) is billed under revenue code series 068x. It can be used only by trauma centers/hospitals as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons.

HCPCS	Status Indicator
G0390 – Trauma Response Team Associate with Hospital Critical Care Services	**S –** Procedure or service, not discounted when multiple

When critical care services are provided without trauma activation, the hospital may bill CPT® code 99291, Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes (and 99292, if documentation of critical care time supports more than 74 minutes, as appropriate). If trauma activation occurs under the circumstances described by the NUBC guidelines that would permit reporting a charge under 68x, the hospital may also bill one unit of code G0390, which describes trauma activation associated with hospital critical care services.

The NUBC guidelines include the following paragraph:

"Report HCPCS code G0390 Trauma response team associated with hospital critical care service, under revenue code 068X. It should be reported only when trauma activation occurs under the circumstances that would permit reporting a charge under revenue code 068X. (Medicare Claims Processing Manual, Pub. 100-04, chap. 4, sec. 160.1)

- HCPCS code G0390 must be reported on the same day as the critical care visit, CPT code 99291.
- Report only one unit of G0390 per date of service.
- An additional OPPS payment will be made for G0390. This is in addition to the usual payment for 99291–99292.
- CPT® code 99291 is defined by the CPT® book as the first 30 to 74 minutes of critical care. Hospitals that provide less than 30 minutes of critical care should bill for a visit, typically an emergency department visit, at a level consistent with their internal guidelines. Hospitals that provide less than 30 minutes of critical care when trauma activation may report a charge under 068X, but they may not report HCPCS code G0390."

There are five levels of Trauma Center designation. The American Trauma Association provides detailed guidance regarding trauma center levels; a link and an excerpt are provided on the next page.

Trauma Center Levels Explained

Designation Vs. Verification

Trauma center levels across the United States are identified in two fashions – A designation process and a verification process. The different levels (ie. Level I, II, III, IV or V) refer to the kinds of resources available in a trauma center and the number of patients admitted yearly. These are categories that define national standards for trauma care in hospitals. Categorization is unique to both Adult and Pediatric facilities.

Trauma Center designation is a process outlined and developed at a state or local level. The state or local municipality identifies unique criteria in which to categorize Trauma Centers. These categories may vary from state to state and are typically outlined through legislative or regulatory authority.

Trauma Center Verification is an evaluation process done by the American College of Surgeons (ACS) to evaluate and improve trauma care. The ACS does not designate trauma centers; instead, it verifies the presence of the resources listed in Resources for Optimal Care of the Injured Patient. These include commitment, readiness, resources, policies, patient care, and performance improvement.

Hydration must be supported by a diagnosis; the 1st hour of IV med therapy must last a minimum of 15 minutes, otherwise, it is to be considered an IV injection.

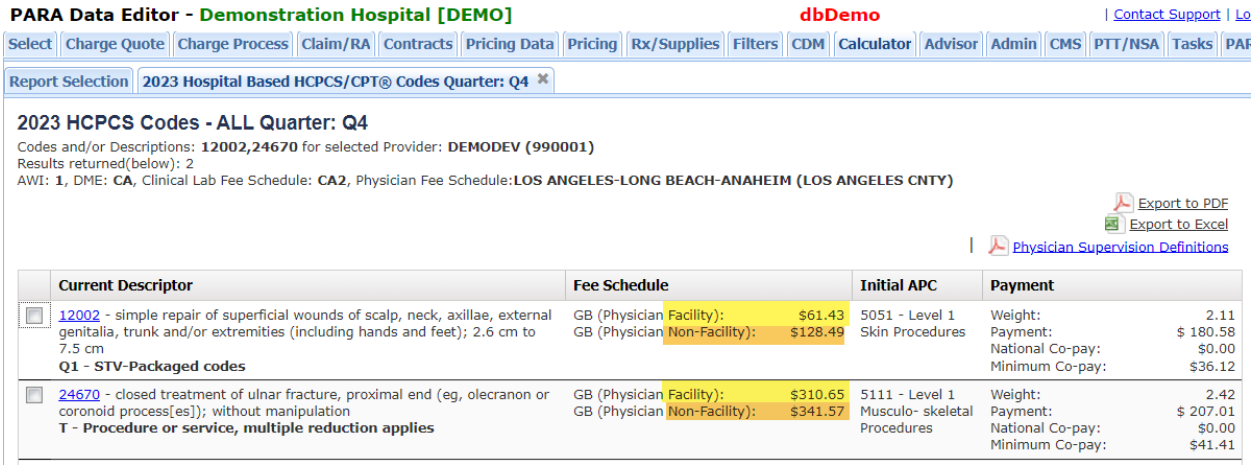
Hospital Technical Component of Physician Procedures

Physicians assign their professional fee E/M level based on the complexity of the medical decision process; the Hospital E/M is based on patient resource consumption; therefore, it will occur that the physician and Hospital E/M level assignment may differ.

When physicians perform procedures in the hospital ED setting, the physician is required to bill with place of service (POS) indicator 23 on the 1500/837p form representing "hospital emergency department." This indicator informs the payors that costs were incurred by both the physician and the hospital; physician payment is reduced slightly because the physician's office incurs no expense in providing care – patient care was delivered at the hospital. The payor will expect a claim from the hospital as well.

The example below shows the difference between facility (hospital-based) and non-facility reimbursement for the professional fee:

ED Charge Process – December 2023



Place of service codes indicate whether reimbursement is claimed for a facility or non-facility setting. Most commonly, POS codes 21, 22, and 23 are facility POS codes on pro fee claims.

Place of Service Codes for Professional Claims Database (updated September 2023)

Place of Service Code(s)	Place of Service Name	Place of Service Description
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On Campus-Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016)
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

Medical Supplies

There are four types of supplies used in the ED, some of which should not be charged to the patient. The supplies and their billing status are as follows:

1. **Routine items** – Low-cost, bulk stock items, (i.e., Band-Aids, syringes, wipes) are not to be charged.
2. **Sterile** – higher cost items, are to be charged, they are itemized on the charge form; multiple units are allowed.
3. **DME exempt** – These are DME items that can be billed to the Medicare program, they include orthotics (i.e., splints, braces, collars and belts).
4. **DME non-exempt** – Non-billable DME items (i.e., crutches, canes and walkers) are not to be billed to the Medicare program on a bill type UB04.

CorroHealth offers concise guidance on Billing for Supplies.

> Adminastar Federal, a Fiscal Intermediary, also created a checklist for providers to use when determining if a supply is billable or not. Adminastar Federal used the Medicare Reimbursement Manual, Section 2203.2 as a guide in creating this checklist:
>
> 1. Is the item medically necessary and furnished at the discretion of a physician? (not a personal convenience item such as slippers, powder, lotion, etc.)
> 2. Is the item used specifically for or on the patient? (not gowns, gloves, masks, used by staff or oxygen available but not specifically used by the patient)
> 3. Is the item not ordinarily used for or on most patients or was the volume or quantity used for on patient significantly greater than normally used for or on most patients in the billed setting? (not blood pressure cuffs, thermometers, patient gowns, soap)
> 4. Is the item not basically stock (bulk) supply in the billed setting and the amount or volume used is typically measured or traceable to the individual patient for billing purposes? (not pads, drapes, cotton balls, urinals, bedpans, wipes, irrigation solutions, ice bags, IV tubing, pillows, towels, bed linen, diapers, soap, tourniquet, gauze, prep kits, oxygen masks, and oxygen supplies, syringes)
>
> There is no CMS list of billable supply items, it is up to your facility to create a process to use in determining if a supply is billable or not. It is also important for the methodology to be used for all supply items, consideration of Managed Care Contracts supply billing requirement is also a requirement.

Drugs Sold to Patients

All drugs consumed by the patient are to be charged, multiple units are allowed.

PO drugs administered at the same time are to be "counted" as a single event for the purpose of determining the E/M level. Each "event will result in "points" or a similar resource assignment.

PO, topical and some injections are to be billed as non-covered to Medicare outpatients under the CMS self-administered drug rule.

CorroHealth offers concise guidance on the Self-Administered Drug Billing and Compliance.

Table of Contents