Top Steps for Reimbursements in the ED

A few notes: Below are my best attempts to lay out the most valuable documentation steps our group can take to increase reimbursement. It is not meant to be a definitive list. It is also very difficult to get data on reimbursement for different procedures as charges vs paid rates of different payers with the most transparent data being Medicare which publishes their allowed charges for different procedure codes. Since many payers use CMS as a guide, it is a good proxy for the general differences in payment for different ED procedures. The below data is assembled from a variety of sources and years and is not meant to be perfectly accurate though should provide a good gestalt for why certain documentation steps are valuable. If you have any comments or additions to this list please email me at NoahHawthorne@vituity.com

1) E/M Codes: make up 80% of department and reimbursement. Day to day standard charting of the basic ED visit still makes up the bulk of our reimbursement. Avoiding downcodes, and most importantly charting to maximize appropriate billing of level 5 visits (rather than level 3 or 4) will make a very large difference. The most common downcode for our group is for insufficient ROS. Consider adding "A 10 point ROS was reviewed with the patient and was negative except as mentioned in the HPI". In addition, the ED patient volume, specifically patients/hr for each provider which is a function of staffing as well as how many patients come through the front door is one of the most important drivers of group profitability. It's hard to control how many patients come in a given day, but staffing changes can have a huge effect. An ED visit will average collections between $75-250 per patient depending on acuity and payer mix. National average is around $150 per patient. This essentially means that for our group, seeing one extra patient in a shift leads to the same amount of extra collections as 3 Critical Care patients vs having them be standard Level 5 workups. Simplified: for the most part volume trumps acuity.

2) Critical Care makes up another 10% of overall reimbursement. Since you have little control of who comes into the department, and if they are sick you work hard to help them get better as a part of your job, this is care we are already providing. However, without adding in a statement our billing company can't charge for critical care. See THIS DOCUMENT for a good comprehensive list of CC indications. In general I think that we can use a few basic screens for critical care to capture a much better percentage of cases. These include anyone admitted to the ICU, or needing BiPap. Vitals including HR>150 or <40, RR>30, SBP <80, 02 sat <80% on usual 02, GCS <12. Labs including Na <120 or >150, K<2 or >6.5, Glucose >600 or <40 with intervention and 3+ rechecks, pH <7.25, Hb <7, Lactate >4, Ca2+ >13 or <6 requiring admission, Most elevated troponin that's a real NSTEMI and not insignificant leak. Also anyone who you feel would die in the next few days if you were to send home (catches all the other such as epidural abscess, new ICH/mass, mesenteric ischemia, 3rd degree heart block, PTX etc).

To meet CC requirements, answer YES to all 3 questions:

1) Is at least one vital organ system acutely impaired?
2) Is there a high probability of imminent, life-threatening deterioration?
3) **Did you intervene** by giving a medication/procedure (even calling a consultant who does stuff) to prevent further deterioration of the patient's condition?

..criticalcare

Critical Care Statement:
Upon my evaluation, this patient had a high probability of imminent or life-threatening deterioration which required my direct attention, intervention and personal management. Critical care time is exclusive of time spent on separately billable procedures. Time includes review of laboratory data, radiology results, discussion with consultants, and close monitoring for potential decompensation. It involved high complexity of medical decision making to assess, manipulate and support vital system functions to treat single or multiple organ system failure and/or to prevent further life threatening deterioration of the patient's condition. Interventions were performed as documented above.

TOTAL CRITICAL CARE TIME ELAPSED: [30-74 min, >75 min].
BODY SYSTEM AT RISK/SPECIFIC INDICATION FOR CRITICAL CARE: [***]

$$tip: Critical care time is one of the more important tools to improve reimbursements. Critical care time starts at 30 min and is a single charge for care up to 74 min then increments of 15 min after. Commercial Insurance Level 5 $495, Critical Care $875 ($380 difference). National average is around 8% of patients being critical care. For our group it is likely in the 10-12% range with an older and sicker population.

CPT Code	Vituity Charge	Medicare Allowable	Medical Allowable	Commercial Insurance (Approx)
Level 5 ED Visit 99285	$734.00	$175.41	$97.27	$495
Critical Care 99291	$926.00	$227.83	$135.93	$875
Difference	$192.00	$52.42	$38.66	$380

3) Orthopedic Procedures: Procedures in general make up the last 10% of ED reimbursement. Some of the most common and most well reimbursed procedures are orthopedic. It pays (literally) to be a more aggressive proceduralist. Doing a reduction rather than just a splint and go to ortho can have a major impact on a visit charge. Due to the wide variety of techniques available I just use a very generic template.

..reduction

PROCEDURE NOTE: [right distal radius fracture] reduction

The patient was consented regarding the risks and benefits of reduction. The site was manipulated using traction and countertraction to accomplish optimal anatomical alignment. The site was then immobilized using a [sugar tong splint] that was placed under my direct supervision. Postprocedure

exam was completed and there are [no neurovascular deficits detected]. Tolerated well, no complications observed. Post reduction x-rays of the were completed and reviewed by myself.

$$tip: Put down all fractures in your final ED diagnosis so they aren't missed by billing and coding, even if they require minimal intervention. For example a nasal bone fracture adds CPT code 21315 to the chart and an extra $168 for a Medicare patient. Fracture and dislocation ortho procedures are some of the highest compensated things we do. Be sure to put in a note. Treatment of a shoulder dislocation is around 8.18 RVU ($332 Medicare) (plus your E/M Level V ED visit code at $175 for Medicare). $362 for distal radius fx without reduction, $585 with reduction for definitive fracture care with >3d ortho follow up for cast placement etc.

..splint

Procedure Note: Splint Application

[Long leg splint] splint is applied. Patient was neurovascularly intact before and after the procedure. Patient advised to follow up with orthopedics in approximately 3-7 days for re-evaluation and voices understanding of follow up and splint/fracture care which was reviewed verbally.

$$tip: Document all splints either in procedure note regarding fracture care or separately. Long arm splint $197, short arm splint $134 in terms of charges. If you don't directly place it you must check and document neurovascular status. These are the highest value downcodes we get hit with on a regular basis, averaging about $160 per missed splint. You can only bill for splint/strap OR restorative fracture care such as a reduction but not both. Follow up with ortho in 3 or more days is considered definitive treatment and is reimbursed much higher for fracture care (note how this is mentioned in the above template for that reason). Follow up time is not required to bill higher for restorative fracture care for clavicles, nose, fingers and toes. You can and should document any sedation that is needed as a separate procedure.

4) General High Acuity Procedures: These include intubation, chest tube, LP, cardioversion. Also don't forget CPR even if you are supervising a resuscitation with a tech performing CPR. Don't forget to also bill for critical care with many of these patients!

..CPR

Procedure Note: CPR

INDICATION: [Patient pulseless and apneic.]

INFORMED CONSENT: [Patient unable to consent due to critical condition.]

PROCEDURE: Patient was noted to be pulseless on physical exam. Cardiac compressions were performed by staff in order to sustain blood flow under my direct supervision. The patient was ventilated and

oxygenated. The patient received appropriate ACLS measures and these were repeated as necessary throughout the resuscitation.

FINDINGS: [Regained spontaneous circulation with palpable pulse]

$$tip: CPR has a total RVU of 5.39 for Medicare payment of ~$211 in the facility setting (compare the addition to Critical care total RVU 6.38 and Medicare payment of ~$227). This includes defibrillation if needed during ACLS.

..centralline

Procedure Note: Ultrasound Guided Central Line Insertion

INDICATION: [Emergency vascular access for fluid and drug administration].

INFORMED CONSENT: The risks of the procedure including [bleeding, pneumothorax, and infection were explained to the patient]. The patient verbalized their understanding of the procedure, the risks, benefits and alternatives and wished to proceed.

PROCEDURE: The patient was placed in [Trendelenburg position] and the [LEFT/RIGHT] [Internal Jugular] area was prepped and draped in a typical sterile fashion. Maximal sterile barrier technique was utilized for this procedure. The area was anesthetized with [5] cc's of [Lidocaine 1%]. The vein was identified using bedside ultrasound. A permanent recording of target vein was created for the patient record. After successfully identifying a patent vessel, ultrasound guidance was used to advance needle under real time guidance with continuous aspiration on the syringe until the vein was entered with free flow of venous blood. A Seldinger technique was then utilized to advance a wire, and the wire placement was verified again using ultrasound before dilation, then placing a [3-lumen] central venous catheter over the guidewire before securing the catheter in place with sutures. Biopatch and tegaderm was then applied in the usual manner. A Portable Chest X-ray was ordered to confirm the catheter position.

EBL: [<10 mL]

COMPLICATIONS: [None.]

$$tip: Ultrasound guided procedures add about $20 to the reimbursement to this procedure, and makes it safer for the patient. In order to bill the extra amount for an ultrasound guided procedure you will need to save/print/archive a shot of the target vein. You don’t need real time imaging during the procedure which would likely be too distracting and difficult to obtain. Total around $112 + US access payment $20 for CPT code 36556. Note that central line insertion is a MIPS (Merit based Incentive Payment System) quality reporting measure with a 4% reimbursement penalty associated for 2019 as part of central line infection prevention measure must document insertion with statement similar to “with all elements of maximal sterile barrier technique including hand hygiene, skin preparation, ultrasound techniques etc”.

...cardioversionAdenosine

CHEMICAL CARDIOVERSION NOTE

Indications: [Supraventricular Tachycardia]

Procedure: The patient was kept on continuous cardiac monitoring. The patient was kept in the supine position with the respiratory therapist as well as the ER nurse at the bedside. The patient received [12mg] of Adenosine IV via a fast push. Reexamination reveals that the patient was in [sinus rhythm with a normal rate]. Blood pressure is normal. There was no complication during the procedure. Post procedure EKG was ordered for confirmation.

..cardioversionElectrical

Procedure Note: Electrical Cardioversion

Indications: [Symptomatic atrial fibrillation with rapid ventricular response]

Procedure: Written consent was obtained after detailed explanation of the risks/benefits of the procedure and associated sedation. The patient was kept on continuous cardiac monitoring in a supine position with the respiratory therapist as well as the ER nurse at the bedside. Supplemental oxygen with continuous capnography and end tidal CO2 monitoring was provided. Patient received [propofol 70 mg ×1] for sedation. The patient was adequately sedated and was shocked with synchronized electrical Energy at [200] J. Reexamination showed [sinus rhythm]. Blood pressure is normal. There was no complication during the procedure.

$$tip: Cardioversion has a total RVU of 3.63 for a Medicare payment of $126 in a facility setting. Private insurance reimbursement is 2-3x higher. This is for elective cardioversion. If the patient had to be sent to the ED it is usually emergent and one could argue that failing outpatient trial of meds is an emergency and is frequently associated with critical care billing. CPT code 92961 is for internal cardioversion and reimburses higher but is rarely performed in the ED. During a CODE, defibrillation is incorporated into CPR billing code for shockable rhythms such as Vfib etc, so be sure to do a separate note for CPR which covers everything. This is for SVT, afib etc requiring cardioversion without CPR. Usually adenosine cardioversion is not a billable separate procedure but is included in Critical Care E/M code as a hospital/nursing provided infusion therapy. I like to put in a specific note for physician to physician communication. Again, best to chart it and let MBSI billing and coding decide.

..LP

LUMBAR PUNCTURE PROCEDURE NOTE

INDICATION: evaluation of possible [meningitis]

INFORMED CONSENT: The risks of the procedure including bleeding, headache, and infection were explained to the patient. The patient verbalized their understanding of the procedure, the risks, benefits and alternatives and wished to proceed.

PROCEDURE: The patient was placed in a [lateral decubitus] position and prepped and draped in typical sterile fashion. Local anesthesia was accomplished using [Lidocaine 1% without Epi infiltration] to skin and subcutaneous tissue. A total of [ ] cc's were used. A spinal needle was then introduced slowly over

the interspinous space and directed toward the umbilicus. The stylet was removed when the dural space was entered and CSF was collected and sent to the lab for appropriate studies. A total of [8] ml of CSF was removed. A sterile Band-Aid was applied to the puncture site. There were no complications and the patient tolerated procedure well.

$$tip: $88.90 Medicare limiting charge in 2018

..intubation
PROCEDURE NOTE: Rapid sequence Endotracheal intubation
Indication: [Respiratory failure]
An oral airway assessment was completed prior to any attempt of intubation. The patient was placed in the supine position. Continuous cardiac monitoring was performed. A crash cart was in the room as well as respiratory therapist to help with airway management. The patient was given medications for rapid sequence intubation including [etomidate 20 mg IV ×1 and rocuronium 100 mg IV ×1]. Using video laryngoscopy, the vocal cords are identified and an endotracheal tube size[7-0] was passed through the vocal cords. The stylette was then removed and Colorimetric CO2 detector was used to assess appropriate tube placement. There are adequate breath sounds bilaterally and good chest rise with ventilations along with misting in the ET Tube. This was followed up with at portable chest x-ray. There were no complications. Oxygenation post intubation was re-evaluated and noted to be [100]%. Patient tolerated the procedure well with no apparent complications.

$$tip: Currently a total Medicare charge of $159 in 2018

5) EKGs: Don't reimburse in a particularly high rate per unit, however they are VERY frequent occurrences during your shift. They are charged at $36 per study ($9.64 Medicare reimbursement). Documentation must include the time of the EKG, and at least 3 clinical findings (such as rate, rhythm, axis, intervals, presence of ischemia, t wave changes, right heart strain, comparison to an old etc). Repeat EKGs need documentation of time interpreted and reason for repeated EKG in addition to 3 findings. Example "EKG performed at 12:55pm shows sinus tachycardia, rate of 110, no acute ST or T wave changes."

6) APP Supervision/attestation statements: There is a 15% reduction in payments for services provided by an APP under Medicare and Medicaid. To get this back the supervising physician must attest that they have SEEN AND EXAMINED the patient, rather than just sign the chart. Consider a quick addendum with the following dot phrase when you go see the patient so you don't forget. Feel free to add any specific notes about your thought process or exam below the attestation statement, though it isn't technically needed for billing.

..attest

Supervision Attestation:

I have personally seen, evaluated and examined this patient. I agree with the assessment, diagnostic impression, management and disposition of this patient during the care provided by the advanced practice provider.

$$tip: For our group this means that each attestation like this leads to about $19 in extra collections (15% of around $125 average Medicare patient reimbursement) for a medicare patient and $12 for medicaid (15% of about $80). Consider a quick look and attestation for all patients 65 and over both to maximize collections but also as these tend to be higher risk patients and the physician personal supervision may also improve patient satisfaction.

7) Observation Status: This is like a small admission and is currently being used for our psych holds which can take an extended period of time for final disposition. We are placing patients into observation once we know that they are medically cleared and will ultimately be entering the psych pathway either to be placed at a facility or released home. Vituity charge for a level 5 ED visit is $660, a same day admit/discharge observation bills at $780. If the patient's stay passes one midnight then there is a charge of $800. A 2 day observation will have a charge of $566 for the first day, $300 for the second day and discharge charge of $234 for a total of $1100. The initial observation note can be placed in the original ED chart in the re-evaluation section. Additional progress notes can be done as ED Addendums. **Important: Observation requires a separate discharge note that clearly states the time that the patient left the ED in order to calculate the total time of observation, as medicare requires a minimum of 8 hours. All other payers have no specific time threshold. Also please be aware that observation requires all 3 points for past medical history, social history and family history to be filled out. For a level 5 ED chart you only need 2 of the 3. A downcoded observation chart is worth less than a level 5 ED visit so be sure you are filling this out. You can only bill for observations once on a visit, so be careful not to bill for it and then admit someone to the hospitalist for further observation.

..observationInitial

Observation Note

The patient has been transitioned to observation status at [Current Date and Time] for [evaluation of suicidal ideation by Mental Health mobile crisis]. They are medically cleared at this time.

Current holds: [ED Hold]

• Admitting Diagnosis: [Suicidal ideation]

• VS: [q shift]

• Diet: [Regular]

• Medications: [routine and PRN]

• Consultations: [None]

• Observation: [Sitter]

• Restraints: [If needed, none at this time]

..observationProgress

Observation Progress Note

The patient remains in observation status in the ED for [placement is psychiatric facility]. They remain medically cleared.

Current holds: [5150, 5585]

• Admitting Diagnosis: [Suicidal ideation]

• VS: [q shift]

• Diet: [Regular]

• Medications: [routine and PRN]

• Consultations: [Poison Control Center]

• Observation: [Sitter]

• Restraints: [If needed, none at this time]

Medications Given in ED this Visit

[Medications Given]

..observationDischarge

Observation Discharge Summary

The patient has been discharged from the ED at [Current Time].

Please see preceding notes for details on medical clearance and workup during their stay.

Diagnosis: [Depressed Mood, Suicidal Ideation]

Disposition: [Discharged to inpatient psychiatric facility]

$$tip: There is an additional fee for observation status. Medicare requires 8 hours of observation status for billing, many private insurance providers don't have a formal requirement. Every day must have a subsequent note to be completed by the daytime physician including any events, medications as well as the ultimate disposition and time the patient left the ED so that total observation time can be calculated.

8) Laceration Documentation: There is a big difference in reimbursement between simple vs intermediate and complex lacerations, as well as a smaller difference between different sizes. Be

prudent about billing appropriately for the work that you do to maximize billing. Putting in some deep sutures to take tension off a wound can double reimbursement and help with cosmetics for the patient. Measuring correctly and determining a wound is 2.6cm rather than 2.3 also increases reimbursement.

..lacsimple

PROCEDURE NOTE: Simple Laceration repair

Location [***]. Total length [<2.5cm, 2.6-5, 5.1-7.5, >7.5cm]. The wound was anesthetized using [lidocaine with epinephrine] using a total of [ ] cc for local anesthesia. The wound was irrigated using saline solution. There was good hemostasis. [# suture] sutures using [material and size] using simple interrupted technique was utilized in the typical fashion. The wound edges were well approximated and the patient tolerated the procedure well without complications. Topical antibiotic as an applied and the dressing is used to cover the wound.

..lacintermediate
PROCEDURE NOTE: Intermediate Laceration repair
Location [***]. Total length [<2.5cm, 2.6-5, 5.1-7.5, >7.5cm]. The wound was anesthetized using [lidocaine with epinephrine] using a total of [ ] cc for local anesthesia. The wound was irrigated using saline solution with debridement and removal of particulate matter as appropriate. There was good hemostasis. [# suture] deep sutures using [material and size] were placed in deeper layers of subcutaneous tissue and superficial fascia to relieve wound tension. Subsequently [# sutures] sutures using [material and size] were placed superficially using simple interrupted technique in the typical fashion. The wound edges were well approximated and the patient tolerated the procedure well without complications. Topical antibiotic as an applied and the dressing is used to cover the wound.

..laccomplex
PROCEDURE NOTE: Complex Laceration repair
Location and description [left hand heavily contaminated, involving muscle]. Total length [<2.5cm, 2.6-5, 5.1-7.5, >7.5cm]. The wound was anesthetized using [lidocaine with epinephrine] using a total of [ ] cc for local anesthesia. The wound was debrided and extensively irrigated using saline solution. There was good hemostasis. [# suture] deep sutures using [material and size] were placed in deeper layers of muscle, subcutaneous tissue and superficial fascia to relieve wound tension and approximate anatomical structures. Subsequently [# sutures] sutures using [material and size] were placed superficially using simple interrupted technique in the typical fashion. The wound edges were well approximated and the patient tolerated the procedure well without complications. Topical antibiotic as an applied and the dressing is used to cover the wound.

$$tip: Lacerations are billed based on length and complexity. Length billing goes in increments of 2.5cm for face with a 2.5-7.5cm band for trunk/extremity. Intermediate closure of wounds involve a second layer such as a deep stitch to take tension off the wound followed by superficial suture. A single layer wound requiring extensive debridement also falls under intermediate laceration. Complex wounds require 3+ layers of closure and/or extensive debridement with 2 layers or 2 layers with the deep layer involving muscle belly re-approximation rather than just connective tissue. Note the LARGE increase in

reimbursement for intermediate and complex laceration repair compared to simple. Medicare pays a lower fee of about $26-50 for Dermabond, but lacerations with stitches usually pay at least $100+.

Below is an example of a laceration on a scalp/extremity with 2018 Medicare reimbursement schedule

	Simple	Intermediate	Complex
<2.5cm laceration	$49 (2.59 RVU)	$177 (6.78 RVU)	$237 (9.98 RVU)
2.6-7.5cm laceration	$65 (3.15 RVU)	$226 (8.61 RVU)	$292 (12.16 RVU)

Below is based on Face, Ears/lips, Mucous membranes (pay is slightly higher). This includes an additional length breakdown at 2.6-5cm

	Simple	Intermediate	Complex
<2.5cm laceration	$62 (3.16 RVU)	$198 (7.36)	$288 (10.98)
2.6-5.0cm laceration	$65 (3.31 RVU)	$235 (8.39)	$361 (13.36)
5.1-7.5cm	$83 (3.86 RVU)	$251 (9.85)	(+$149) +5.51 per 5cm over 7.5cm

9) Abscess Drainage: This is a frequent occurrence in the ED, yet there is a big difference between a simple and complex abscess in terms of reimbursement.

..incisionanddrainage

PROCEDURE NOTE:
Complex Incision and drainage
Location [***]
The affected area was cleaned with chlorhexidine. The area of maximal induration and fluctuance was anesthetized using lidocaine 1% with epinephrine and a total of [***] cc was deposited. Using an #11 blade I then made a incision over the area of maximal fluctuance. [5cc of purulent yellow fluid drained] from this abscess. The incision was probed and loculations decompressed. Packing was placed in wound cavity. The patient tolerated the procedure well and there were no complications. A gauze dressing is used to cover the wound. The patient was neurovascularly intact distally following the procedure.

$$tip: A simple or single abscess might be a furuncle, paronychia or very superficial pimple looking lesion. COMPLEX lacerations are far more common and are big enough to bring people to the ED. They require probing OR breaking up of loculations OR packing to qualify. A simple I&D will reimburse about 2.72 RVUs ($113 for Medicare), a complex about 5.07 RVUs ($239) about double.

10) Advanced Care Planning: This helps to avoid unnecessary treatment and helps tailor medical treatment to a patient's needs and goals. If you take the time to discuss goals of care, DNR status, transition to hospice etc then we get to bill for it! It has a procedure code that can reimburse well and bring a total chart charge to the level of critical care or higher.

..advancedcare
Advanced Care Planning: Aggregate face to face time discussing end of life advanced care planning with patient and family for a duration between 16-30 min. Discussed POLST, CPR, intubation, treatment goals, quality of life and intensity of care. Patient desires: [Full code]

$$tip: face to face service between a physician and other health care professionals, family and patient is charged at $264 ($90 medicare reimbursement) in addition to the E/M visit charge. Not applicable when critical care is billed. Time code for at least 16-30 min. Additional charge for each 30 min after.

11) Sedation: In addition to the sedation checklist which Dignity requires, be sure to document the actual process as a procedure note for billing. A minimum of 15 minutes is required.

..sedationprocedure

PROCEDURE NOTE: Procedural Sedation

The risks and benefits of sedation as well as the procedure itself were explained to the patient who voiced understanding. Written consent was obtained. Moderate sedation protocol followed, see flow sheet and MAR for details. Written consent obtained, patient was placed on continuous monitoring with nursing and respiratory therapy at bedside for the duration of the sedation procedure. Total intraservice time was [20 minutes]. No complications observed, patient tolerated procedure well. Post sedation precautions were discussed with patient and family.

$$tip: Moderate sedation needs 15 or more minutes. Medicare has a 15 min initial fee and then additional billing in increments of 15 min. This includes pre, intra, and post service work associated with sedation (including all that hospital documentation and risk/benefit counseling/instructions we are asked to do). Medicare $14 for the first 15 min, $13 for each 15 min after. If you do this with a fracture reduction or other procedure don't forget to bill for both. Pediatric sedation pays a few dollars more. Sedation notes frequently get sent back to providers via TAD list for missing the time component for billing.

12) Ultrasound. We are currently working on getting our ultrasound program running and being able to save images into PACS. In the meantime, ultrasound procedures rather than non ultrasound guided reimburse higher. It is now considered standard of care to use ultrasound for guidance in a central line, paracentesis etc almost everyone is doing it. The difference? For CPT code 49082 Paracentesis without ultrasound guidance, Medicare reimburses at $219. With ultrasound guidance include just using a probe to locate a fluid pocket CPT code is 49083 and reimburses at $332. To do this you will need to save an image of the fluid pocket that you are utilizing for your target but do not need image of needle in site.

Ultrasound guided vascular access either peripheral or central adds CPT 76937 for around $20 professional fee. From ACEP: “In the past, the requirement for image retention was a point of discussion. As of 2005, CPT clearly states that image retention is **mandatory** for all diagnostic and procedure guidance ultrasounds. CPT does not specify how the images are to be stored or how many images are required. Appropriate image(s) demonstrating relevant anatomy/pathology for each procedure coded should be retained and available for review.” On average, cardiac/abdominal/retroperitoneal/MSK ultrasounds reimburse around $30 each (billed around $90-110 each). Doing 3 ultrasounds in a shift therefore leads to about $10 per hour higher earned hourly. Not bad!

13) Other little stuff that adds up:

..burntreatment

Procedure Note: Burn Treatment

Total body surface area affected is estimated to be [***]% and is [superficial partial thickness (second degree)]. I have personally evaluated the wound and assisted with cleaning/debridement as necessary, analgesia and application of topical antibiotics.

$$tip: Documentation must include % body surface involved and depth of burn for appropriate coding. Clinician must personally perform the burn treatment. $148-438 based on surface area involved ($60-100 Medicare reimbursement). Remember that the palm of their hand is about 1% of BSA, and the rule of 9’s. We are unlikely to see more than the usual 1st or 2nd degree burn, but documenting this can make a level 3 chart reimburse like critical care.

..cerumenremoval

Procedure Note: Cerumen Removal

Cerumen was removed using instrumentation including curette by myself. Irrigation/lavage was then used for residual material.

$$tip: Using curette to get a better look or irrigation to evaluate TM for AOM or other is an extra charge. $48 for irrigation lavage and $106 for instrumentation ($37 Medicare fee for 2018).

..PIV

Procedure Note: Ultrasound guided peripheral IV

Indication: Difficult venous Access, RN unable to obtain access

Linear probe was utilized to visualize upper extremity vasculature. Skin and probe were prepped with chlorhexidine carefully. Sterile petroleum jelly was utilized. An 18-gauge 1.75 inch IV catheter was inserted into the basilic vein in one attempt. Tolerated well. Sterile procedures observed. No apparent complications.

$$tip: Take a printout/save image of target vessel per standard ultrasound program protocol. Reimburses around $20.50 for Medicare patients.

..triggerpoint

Procedure Note: Trigger Point Injection

Indication: Trigger Point, localized muscle spasm and pain

Location: [Left quadricep muscle]

Verbal consent was obtained. The area of maximal pain and muscle spasm was palpated, localized and confirmed by the patient. Subsequently the area was cleaned with chlorhexidine, a 27-gauge needle was inserted into the area with dry needling in the 4 quadrants superior, inferior, medial and lateral to the pinpoint with subsequent injection of [2 cc of 0.5% bupivacaine] after trial aspiration to ensure no vascular involvement. Tolerated well, no complications observed.

$$tip: Trigger point injections are recognized treatments for Myofascial Pain Syndrome. Medicare reimburses at around $44 for one trigger point site, $49 for multiple sites for 2018.

..arthrocentesis
Procedure Note: [Right knee] arthrocentesis
Indication: [Evaluation for septic joint, gout, pseudogout]
Verbal consent was obtained. Patient was counseled on the risk of the procedure including but not limited to bleeding, infection and local trauma to the injection site. The target area was carefully prepared using chlorhexidine and a needle was inserted into the joint space using sterile procedures. Tolerated well, no complications observed.
Results: [10cc of straw colored fluid aspirated][sent for cell count, culture, gram stain, crystal evaluation]

$$tip: $52.44 allowable charge for Medicare in 2018 for large joint like the knee. Smaller joints like finger or wrist pay lower, even though they are harder.

..dentalblock
Procedure Note: [Apical Dental Nerve Block]
Indication: Dental Pain
Verbal consent was obtained. [3cc] of [0.5% bupivacaine] was injected at the base of the area maximal dental pain at the gingival/buccal fold. Tolerated well, no complications observed.

$$tip: One of the most effective, safe and fast treatments for dental pain, a dental block is reimbursed at $52 for CPT code 64450 (somatic nerve block) or $80 for CPT 64400.

..sphenopalatineblock
Procedure Note: [Sphenopalatine Ganglion Block]
Indication: Headache

Verbal consent was obtained. [3cc] of [0.5% bupivacaine] was placed into a swab and inserted into bilateral nares. This was left in place for approximately 20 minutes and patient was re-assessed. Tolerated well, no complications observed.

$$tip: Great migraine treatment, $105 reimbursement. Try using wound culture swabs that have a hollow core and you can fill with bupivacaine for a constant mild drip while the patient is being treated. https://www.aliem.com/2017/03/trick-sphenopalatine-ganglion-block-primary-headaches/

A few things are CMS reimbursable CPT codes, but we are not billing for them. These include blood transfusions in the ED as on 1/31/18, and health behavior counseling (smoking, alcohol, drugs)

Ultrasound Templates:

Below you will find some ultrasound templates which are provisional. Note that in order to bill you need to

1) Archive at least one image from the study. Our workflow for this is still being developed but this could involve printing a "polaroid" of a study image, or multiple representative images and taping them to a sheet of paper with patient sticker for scanning into the EMR later. Ideally a full integrated electronic upload process with QI, ability to review on PACS and share with other consultants will be completed soon.
2) Image study must be qualified as ED Ultrasound, or Bedside Ultrasound for appropriate coding
3) Medical has some more stringent requirements including an a) indication for the study b) at least 3 findings and c) an impression of the study with d)electronic signature or if not allowed by EMR than a certification statement. Note that the below templates include all of those components.

..usFAST

Procedure Note: ED bedside FAST Abdominal Ultrasound

Indication: Evaluation for intra-abdominal free fluid

Technique: Right upper quadrant (hepatorenal), Left upper quadrant (splenorenal) and bladder/pelvic views were obtained

Findings:

- [No evidence of intra abdominal free fluid]

Impression: [Negative study]

Performed and interpreted at the time of patient care, scan image(s) archived. Certified by [Your Name and title]

..usEFAST

Procedure Note: ED bedside Extended FAST (limited Abdominal, Cardiac, Thoracic) Ultrasound

Indication: Evaluation for intra-abdominal free fluid, Pneumothorax, Pericardial Effusion/Tamponade

Technique: Right upper quadrant (hepatorenal), Left upper quadrant (splenorenal) and bladder/pelvic views were obtained as well as subxiphoid/parasternal long cardiac view and bilateral anterior thoracic views along 3 or more rib spaces.

Findings:

- [No evidence of intra abdominal free fluid]

- [No evidence of pericardial effusion or tamponade]

- [No pneumothorax with bilateral lung sliding]

Impression: [Negative study]

Performed and interpreted at the time of patient care, scan image(s) archived. Certified by [Your Name and title]

Procedure Note: ED Bedside Limited Cardiac Ultrasound

Indication: Evaluation of systolic function, general assessment of volume status, evaluation for pericardial effusion, tamponade, gross abnormalities of cardiac anatomy

Notes: Parasternal long, parasternal short, apical 4 chamber, subxiphoid and inferior vena cava views were obtained.

Findings:

- [Grossly normal systolic function]

- [No evidence of pericardial effusion]

- Inferior vena cava with between [25 - 50%] collapsibility with respiratory variation consistent with [euvolemia and normal CVP]

Impression: [Normal cardiac ultrasound without evidence of acute pathology]. This study did not evaluate for valvular or diastolic dysfunction.

Performed and interpreted at the time of patient care, scan image(s) archived. Certified by [Your Name and title]

Procedure Note: Emergency Department bedside abdominal aortic ultrasound

Indication: Evaluation for abdominal aortic aneurysm

Technique: Proximal mid and distal transverse views of the aorta were obtained, longitudinal view of the aorta was also obtained.

Findings:

-No evidence of abdominal aortic aneurysm

- Aorta max diameter [1.3cm]

- No evidence of intra-abdominal free fluid

Impression: [Normal abdominal aorta exam, no aneurysm]

Performed and interpreted at the time of patient care, scan image(s) archived. Certified by [Your Name and title]

Procedure Note: ED Bedside Abdominal limited bladder ultrasound

Indication: Evaluation for urinary retention

Notes: Suprapubic transverse and sagittal views were obtained

Findings:

- Bladder dimensions [8x9x10cm]

- Estimated bladder volume [1.1 L]

- No pelvic free fluid

Impression: [Urinary retention] with approximately [1.1 L] of post void residual urine

Performed and interpreted at the time of patient care, scan image(s) archived. Certified by [Your Name and title]

Procedure note: Limited Musculoskeletal ED bedside ultrasound

Indication: Evaluation for drainable soft tissue fluid collection

Notes: Transverse and sagittal views of area of maximal swelling were obtained

Findings:

- [soft tissue cobblestoning present]

- [No evidence of drainable fluid collection]

- [No obvious retained foreign body]

Impression: [Cellulitis and localized tissue edema without evidence of drainable fluid collection]

Performed and interpreted at the time of patient care, scan image(s) archived. Certified by [Your Name and title]

..usObstetric

Procedure Note: ED Bedside Limited Transabdominal Pelvic Obstetric Ultrasound

Indication: Evaluation for intrauterine pregnancy, fetal viability

Notes: Transverse and sagittal view of the uterus were obtained

Findings:

- [Intrauterine pregnancy identified]

- [Fetal movement visualized]

- Fetal heart rate of approximately [110 BPM]

Impression: Viable Intrauterine Pregnancy

Performed and interpreted at the time of patient care, scan image(s) archived. Certified by [Your Name and title]

..usOcular

Procedure Note: ED bedside limited ocular ultrasound

Indication: Visual changes and/or eye pain concerning for possible ocular pathology

Technique: Transverse and sagittal views of the eye were obtained

Findings:

- [Normal retinal contour without evidence of free floating posterior ocular membrane]

- [No echogenic material within the vitreous body consistent]

- [Normal appearing lens]

Impression: [Normal study, no evidence of posterior vitreous detachment or retinal detachment]

Performed and interpreted at the time of patient care, scan image(s) archived. Certified by [Your Name and title]

Procedure Note: ED Bedside Renal Retroperitoneal Ultrasound

Indication: Evaluation for renal obstruction, flank pain

Notes: Bilateral renal and bladder views were obtained

Findings:

- Normal appearing renal sonogram without evidence of hydronephrosis

- Intrarenal or ureteral calculi

- No evidence of perinephric fluid collection

Impression: Normal renal sonogram without evidence of unilateral hydronephrosis. No clear evidence of stone.

Performed and interpreted at the time of patient care, scan image(s) archived. Certified by [Your Name and title]

Procedure Note: ED Bedside Thoracic Ultrasound

Indication: [Shortness of breath]

Notes: Focused exam of the pleural spaces bilaterally was performed to evaluate for pneumothorax, pulmonary edema or pleural effusion

Findings:

-No evidence of pneumothorax

- No comet tails/B-lines suggestive of abnormal pulmonary edema

- No pleural effusion

Impression: Normal thoracic evaluation, no pneumothorax, pulmonary edema or pleural effusion

Performed and interpreted at the time of patient care, scan image(s) archived. Certified by [Your Name and title]

Further resources:

2018 Medicare Reimbursement Guide based on CPT codes

Critical Care Indications

Bedside Ultrasound Tutorials

Noah Hawthorne is the Reimbursement/Finance Director at French Hospital and Arroyo Grande Community Hospital and is based out of San Luis Obispo, CA.