GOTTLIEB
Achieving Optimal Revenue Results

Documentation Reminders for Procedures in Emergency Medicine

Wound Repairs:

1. Be precise measuring wound(s) to record lengths. Avoid documenting "about" or "approximately" with you lengths as we may have to select a lower suture code.
2. If lengths are not documented and repair note is documented your coders will not send back but will code as less the lowest length laceration (typically 2.5 cm or less).
3. Single layer closure of heavily contaminated wound + extensive cleaning or removal of particulate matter/foreign body qualifies for intermediate repair.

- ✓ **Document:** Heavily contaminated plus extensive cleaning and/or removal or particulate matter/foreign bodies. Examples: Dog bites and motorcycle/bicycle accidents often qualify if documented.

I & D:

Be **detailed** on your procedure notes so that your coders may make the correct code choice based on your documentation. Note: Any insertion of a drain, packing, probing to break up loculations, send for culturing, deep abscess requiring US guidance or multiple simple I & D's.

Moderate Conscious Sedation: **In 2017 there were changes with the most important change to code for the initial moderate sedation the intra-service time decreased from 16 minutes to code to 10 minutes. The second change AMA made was unbundle moderate sedation from every procedure. Only a handful affect emergency medicine.**

1. Time based code(s) and billed in addition to any procedure performed by ED physician or if a non-ED physician performs procedure and the ED Physician provides moderate conscious sedation.
2. Start time for intra-service "face to face by ED Physician" is the time the agents are administered. Can be pulled from nursing but best practice the physician should also document time agents are given in their procedure note.
3. End time for intra-service or "face to face by ED Physician" is at the conclusion of your personal contact with the patient.
4. Cannot use nurse notes stop time as we need the stop time of your face to face with the patient
5. Gottlieb will return the chart as incomplete with note "Need Moderate Sedation Stop Time")
6. Document intra-service start time and stop time or Total intra-service time. Either is acceptable.

TIP: Update any procedure templates to include intra-service start and stop time or total intra-service sedation time.

Splints:

Routinely document when a splint is applied to include:

1. Type of splint
2. Who applies splints (**by me, by nurse, by ortho tech, by EDP (Emergency Dept. Provider**)
3. Post splint assessment include note "Placement check & NV intact"

Note: Most splints are separately billable unless there is a reduction and would be included in the procedure except Medicare requires the physician/mid-level personally apply the splint to code and bill separately.

Casting: Document type of cast, who applied and post splint assessment.

Recommended documentation: "short leg cast applied by me" when ED physician/mid-level applies.
Note: We only charge for casting if the physician/mid-level personally applies

Impacted Cerumen:

1. If you remove impacted cerumen using irrigation/lavage document: Removal of impacted cerumen using irrigation or lavage **"by me."** We do not charge if nursing performs.
2. If you remove impacted cerumen using a curettes, hooks, forceps to break up and remove, document: Removal of cerumen impaction with curette, hook, forceps.

Note: If the physician or mid-level determines there is ear wax, **but it is not impacted**, the removal (if any) is not separately reportable and is considered bundled into the evaluation and management service for that day.

Foreign Body Removal from Eyes, Ears, Nose:

1. Document use of instruments in procedure note when used to remove foreign bodies as there is a separate procedure codes coders will add in addition to the visit level.
   I.e. curettes, forceps, Katz extractors, fine gauge needle, etc.

Note: Removal of foreign body with irrigation or air pressure does not qualify for separate procedure code and will be part of medical decision making in the visit level.

Smoking Cessation:

Include In Medical Decision Making:

- Face to Face Time counseled: > 3 minutes and < 10 minutes and we will code an bill CPT 99406 & for CMS G0436

Example of note to include in Course/Plan:

I counseled patient face to face > 3minutes and < 10 minutes to quit the use of tobacco products and provided tobacco cessation strategies.