



## ED Facility Level Coding Guidelines

### Introduction

A part of the Federal Balanced Budget Act of 1997 required HCFA (now CMS) to create a new Medicare "Outpatient Prospective Payment System" (OPPS) for hospital outpatient services; analogous to the Medicare prospective payment system for hospital inpatients known as "Diagnosis Related Groups" or DRG's. APC's or "Ambulatory Payment Classifications" are the government's method of paying for facility outpatient services for the Medicare program. APC's apply only to hospitals, and have no impact on physician payments under the Medicare Physician Fee Schedule. For further information about APC's, see the Frequently Asked Questions on the ACEP website.

Facility coding guidelines are inherently different from professional coding guidelines. Facility coding reflects the volume and intensity of resources utilized by the facility to provide patient care, whereas professional codes are determined based on the complexity and intensity of provider performed work and include the cognitive effort expended by the provider. As such, there is no definitive strong correlation between facility and professional coding and thus no rational basis for the application of one set of derived codes, either facility or professional, to the determination of the other on a case-by-case basis.

In 2011 OPPS, CMS restated its position on "Triage-only" visits confirming that it does not specify the type of staff who may provide services. "A hospital may bill a visit code based on the hospital's own coding guidelines which must reasonably relate the intensity of hospital resources to different levels of HCPCS codes. Services furnished must be medically necessary and documented."

# Emergency Room Coding Guidelines

**Clifford Lane**



## **Emergency Room Coding Guidelines:**

**Emergency Room Coding** Ba Kobayashi, 2010-07 Emergency Room Coding will prepare you for the real world of coding in the emergency department setting. The text provides the beginning coder with a solid foundation of how to code ER charts. We focus on the diagnoses and procedures seen in the majority of community based hospitals. The scenarios in this book are based on real life experiences and will provide the coder with situations s he will most likely encounter in the emergency room coding environment. The study guide contains 32 emergency room records. The case studies are representative of what is commonly treated in most emergency rooms. Each case study contains an ER report and an answer worksheet. The ER record serves as a good teaching tool for new coders because ER records do not require as much clinical background to code as inpatient records. However some of the injury cases may present a challenge for new coders. Also unlike most coding textbooks this study guide contains a complete ER report with a full explanation not just thumbnail sketches. Therefore Emergency Room Coding is more realistic than the one to two line diagnostic statements encountered in most coding textbooks. Finally the Answer Key for the case studies contains a rationale for all code assignments as well as directions for locating the correct diagnostic and procedure codes. A multiple choice final review quiz is included at the end of this study guide as an opportunity for coders to test their coding skill set. Emergency Room Coding is updated annually to reflect the annual coding changes. Who is this book for? Coders needing to develop ER coding skills. Students. Beginning coders trying to get their first job. Anyone needing to understand ER code assignment. Coding supervisors. HIM Directors. Auditors. Compliance Officers. Case Managers. What's Inside: 32 Case Studies. Dictated ER Reports. Answer Key. Rationale. Instructions on how to locate codes in ICD 9 Coding Book. Final Exam. Linda Kobayashi BA RHIT CCS has been a coder and coding manager for almost 20 years. Since 1998 Ms Kobayashi has owned and operated Codebusters Inc a nationwide coding consulting company. Widely regarded as a medical coding and auditing expert she has conducted workshops on a variety of coding topics including CCS Exam preparation workshops. Throughout her career the author has remained professionally active as an AHIMA member as well as a member of her state association CHIA California Health Information Association. Her formal training includes a teaching credential from California State University Los Angeles a B A degree in English Literature from University of California Los Angeles an RHIT from AHIMA after completing the RHIT program at East Los Angeles College and a CCS certificate from AHIMA. Extensive experience as a hands on coder auditor and educator and has given the author the expertise to help coders prepare for the professional coding environment. **Understanding Hospital Billing and Coding** Debra P. Ferenc, 2013-02-26 Updated Claim Forms chapter covers the UB 04 claim form. Updated information covers diagnosis and procedural coding with guidelines and applications. Updated claim forms and names are used throughout. **JustCoding's Guide to Emergency Department Coding** Nena Scott, 2019-07 JustCoding's Guide to Emergency Department Coding will help coders by clearly explaining how to interpret CPT codes and coding guidelines to accurately

report procedures performed in the ED and billed by the facility The book guides coders through assigning the most specific CPT E M codes for both physician and facility services It also offers detailed CPT coding and reporting guidance for integumentary and musculoskeletal procedures commonly provided in the ED and billed by the facility The final chapter breaks down complex documentation and coding requirements for hospital intravenous injection and infusion services

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