Mitigating Reimbursement Shortfalls in the ED

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By Susan Miller, CCS

Hospital emergency departments (EDs) continue to face volume increases and reimbursement declines. In a recent hospital survey, executives predict an 84 percent increase in ED patient volumes. The same executive survey predicts a 65 percent decrease in ED reimbursements over the next three years.[1] Patient flow bottlenecks, growing consumer demand, and primary care physician shortages combine to fuel these ED concerns.

Organizations cope by streamlining workflows and embracing new ED management strategies. Point-of-care patient education, updated collection techniques, and bed control technologies are all being discussed and explored. HIM professionals lend a helping hand by ensuring correct ED coding, especially in preparation for ICD-10-CM/PCS (ICD-10).

ICD-10's Impact on the ED

In order to receive correct reimbursement under ICD-10, hospitals must meet new code requirements and documentation needs. CPT codes and accompanying Evaluation and Management (E&M) levels for procedures performed within the ED will still drive reimbursement under ICD-10. No change is expected for these codes. However, diagnosis codes for ED patients must transition from ICD-9 to ICD-10 by the October 1, 2014 implementation date.

Hospital HIM departments are expected to maintain responsibility for coding the hospital component of ED cases under ICD-10 while physician coding and billing are still mostly performed by outside third parties. For the 70 percent of hospitals with 30,000 or more annual ED visits, improving documentation granularity and training clinical coders are important steps to ensure a smooth transition to ICD-10.

Extend Training to the ED

ICD-10 training plans and educational budgets must include ED coding staff and physicians. Under ICD-10, these professionals are responsible for documentation and coding for three systems simultaneously: CPT procedures, E&M levels, and ICD-10 diagnoses. ED coders will not be able to move successfully from ICD-9 to ICD-10 unless they are adequately trained.

In addition to education, ED coders should receive hands-on experience coding actual ED visits at least six months prior to ICD-10 go-live. Extending all dual coding initiatives and clinical documentation improvement (CDI) programs to the ED and assessing revenue cycle flow and documentation quality now, under ICD-9, is considered best practice.

Assess ED Revenue Cycle

ED revenue cycles are complex and involve multiple stakeholders. Now is a good time to conduct end-to-end auditing of the ED documentation, charging, coding, billing, and reimbursement workflows. Any problems with interdepartmental communication and technology handoffs in ICD-9 will be exacerbated in ICD-10. It's also a good idea to test processes, procedures, interfaces, and clearinghouses for ICD-10 transaction readiness to identify red flags and mitigate revenue risks.

Second, a focused documentation review alongside dual coding of ED cases identifies documentation gaps and targets your organization's educational efforts. Physicians must be made aware of additional documentation requirements.

HIM Directors should work together with IT counterparts to expand documentation templates within the ED (voice recognition or electronic health records) to accommodate deeper levels of documentation granularity, which is mandatory.

Plenty of time should be allowed for physicians and other ED documenters to adjust to new documentation requirements. One area that should be targeted for intense review, focus, and documentation template upgrades is injury and trauma.

Injury and Trauma Coding in ICD-10

According to the US Department of Health and Human Services' Agency for Healthcare Research and Quality, five of the top ten ED diagnosis discharges nationwide relate to trauma or injury.[2] Sprains, strains, superficial injuries and contusions top the list with 53 percent of all ED visits due to some form of injury or trauma. ICD-10 expands the coding of these cases by requiring greater specificity with regard to:

- Specific anatomical location
- Exact type of injury
- Timing of encounter
- Cause of injury

For example, in ICD-9, an open laceration of the right index finger is coded to 883.0 (open wound of finger). Required E codes would have been added to document how the injury occurred/cause of injury, the place of occurrence, and activity.

The same case in ICD-10 requires documentation of the type of wound (laceration), the specific finger (right index), and timing of the encounter (initial). The ICD-10 code for this case is S61.210A. Required External cause codes would be added to document how the injury occurred/cause of injury, the place of occurrence, and activity.

ED documentation to the finest level of granularity must be the rule—not the exception.

Prepare for the Tornado

In 2013, 61 percent of hospital executives report overcrowding in the ED and volumes are expected to rise steadily over the next five years.[3] The tornado of ICD-10 coding for millions of ED cases is coming. HIM professionals can't stop the tornado, but we can certainly help our organizations prepare for it.

Notes

[1] HealthLeaders Media. HealthLeaders Media Intelligence Report, ED Solutions: Preparing for Increased Volume and Decreased Margins. May 2013. www.healthleadersmedia.com/intelligence/.

[2] HCUP-US NEDS Overview. Healthcare Cost and Utilization Project (HCUP). June 2013. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/nedsoverview.jsp.

[3] Ibid., HealthLeaders Media Intelligence Report.

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