Some great questions were submitted in response to Paula Digby's presentation "ED Charge Capture – Stopping the Hemorrhage!". Read on for the questions and the insights from our experts.

1. What if a patient presents to the ED, attending physician enters IP order, several hours later the patient is discharged and either transferred to another facility, behavioral health unit, hospice. What is the correct way to bill the services?
   If the patient was discharged several hours later consider carefully whether the patient truly met inpatient criteria. If the patient met inpatient then it is appropriate to bill as such and use the appropriate discharge disposition codes. IF not, other options can be considered as outlined in question 3.

2. Do these orders have to be authenticated/cosigned by the ED provider before discharge from ED in order to be paid? This question is not clear but appears to be asking if the ED physician can sign the admitting order. If he/she meets all the criteria outlined in the CMS document link below and is considered the admitting/attending physician. Otherwise, the admitting/attending physician would sign the order.

   http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/IP-Certification-and-Order-01-30-14.pdf

3. If a principal diagnosis is not documented as resolved during the stay, how important is it to have documentation supporting that PDx everyday (i.e. in a progress note) and indicating severity (improving, worsening, etc.) and associated related medical decision making and treatment plan. For instance, if sepsis is documented in the H&P and the first 2 days of the stay without any update on severity and then not documented for the next 3 days but mentioned in the discharge summary as 'clinically improved' without any supporting information. Remember the definition of the PDx: the condition determined after careful study to be chiefly responsible for occasioning the admission. From a defense position, the clinical picture may not have been documented in the progress notes after sepsis became less acute but the treatment and monitoring by labs and nurses was likely occurring-a clinical review may be necessary. When a chart is reviewed it is not only substantiated by what the physician has put in the progress notes but it is also supported by how the patient is being treated. If the patient is progressing well with treatment then there may be little new information to put in a note. It is not required that the physician state the condition daily, but one would expect that as care is being provided, changed, etc, it would be. However, best practice warrants the physician document all conditions present at the time of admission that are treated; impact treatment; extend the length of stay; or, utilize resources to the greatest degree of specificity known. Likewise, he/she should provide new details daily as they occur. From the physician billing perspective, one would expect those treated conditions would be documented in the daily notes as well.

4. Are there any scenarios where you can bill for an ER visit on the same date of service that the Inpatient order was written. An example would be a patient was in the ER from 9am to 12 noon and then admitted Inpatient. A self-audit was performed and it was determined the correct status should have been outpatient. The pt was discharged the same day. Can we bill the ER visit on a 131?
   If you are a PPS hospital, this visit is contained in the 3 day payment window when an inpatient stay is also achieved. However, in this instance you are indicating a self-audit was performed. When was the audit performed - during the encounter? After the encounter was completed? This will make a difference in the way you bill. **Was a Condition code 44 appropriate or can this be considered an outpatient visit in total because all services and review took place at the same time prior to discharge**

of the patient? Condition Code 44 is only appropriate prior to the discharge of the patient. So again the self-audit timing is relevant. No Condition Code 44 can be used without notification and explanation of the change to the patient or their representative prior to discharge. We cannot over emphasize the importance of this. The regulatory language surrounding a Condition Code 44 is explicit concerning how, when and where it is to be used. It is not be confused with an easy out from the quagmire of trying to get the patient status right on the front and definitely not an easy way out on the backend.

Another opportunity is clearly defined in the link below from CMS providing information on the FY2014 IPPS Final Rule. This clarifies when the part be services can be billed. There is also a list of services that can go on the Part B claim.

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY-2014-IPPS-Rule-Outreach.pdf

5. If patient is seen in ED but not admitted and all the treatments ordered during ED were entered by a mid-level or a RN but the ED provider did not cosign, in order to be paid will all the orders need to be authenticated prior to the discharge of the patient in order to be a legal order or can it be authenticated by the doctor after the patient has been dcd? Look to the Medicare Benefit Policy Manual Chapter 6: Section 20.3 says "A hospital outpatient "encounter" is a direct personal contact between a patient and a physician, or other person who is authorized by state licensure law and, if applicable, by hospital or CAH staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient."
In other words depending on what the hospital bylaws and state licensure says will dictate this answer. CMS does not have a specific regulation governing this. This is not part of the 2 Midnight rule.

Thanks for the great questions and for attending this event. To see the entire presentation visit AQ-IQ.com http://www.aq-iq.com/ed-revenue-risk/