

New Diagnosis Codes for October 2011

On October 1, ED coders will have several more ICD-9 codes to prove high-level ED E/Ms.

The new codes will provide the tools to demonstrate medical necessity for some of the higher-level ED encounters.

The following new codes are most relevant to the ED:

- **276.69**—Other fluid overload
- **724.03**—Spinal stenosis, lumbar region, with neurogenic claudication

- **780.33**—Post traumatic seizures
- **784.92**—Jaw pain
- **786.30**—Hemoptysis, unspecified
- **799.50**—Unspecified signs and symptoms involving cognition
- **970.81**—Poisoning by cocaine
- **970.89**—Poisoning by other central nervous system; stimulants. ■

Inside this issue:

<i>New Diagnosis Codes for October 2011</i>	1
<i>Emergency Department Services</i>	1
<i>Critical Care</i>	2

Emergency Department Services

The Centers for Medicare and Medicaid Services (CMS) cautions to pay careful attention to the unique record kept in most Emergency Departments. While multiple individuals, including hospital staff, contribute to the ED service and record, Part B should not pay the physician for services rendered by hospital staff.

Physician coding should be based on the physician's personal Evaluation and Management (E/M) work (or

work shared by a physician and non-physician practitioner in the same group).

All history obtained and recorded by triage and other hospital nursing staff must be specifically repeated by the physician and either re-recorded or annotated with specific comments, additions and/or corrections and notation of the elements of work personally performed by the physician. ■

Critical Care

Before coding critical care, ask and answer the following questions about the service. If the answer is “no” to any of these questions, do not report the service as critical care.

- Does the record demonstrate work performed during the encounter that is more intense than the work of other E/M codes of the same time duration?
- Does the record demonstrate the patient has acute impairment of one or more vital organ systems and has a high probability of imminent or life-threatening deterioration?
- Does the physician’s documentation demonstrate all of the following?
 - Direct personal management.
 - Frequent personal assessment and manipulation (not generally a once-daily visit).
 - High-complexity decision-making to assess, manipulate and support vital system function(s) to treat single or multiple organ sys-

tem failure and/or to prevent further life-threatening deterioration.

- Interventions of a nature that failure to initiate these interventions on an urgent basis would likely result in sudden clinically significant or life-threatening deterioration in the patient’s condition.
- What about the time spent providing critical care?
 - Is it specifically recorded?
 - Is it reasonable considering the documented work provided?
 - Does it exclude time spent performing procedures for which separate payment is made?
 - If it includes time spent with family, was the family member operating as a surrogate decision-maker because the patient is unable to make decisions? ■