Appendix C: Modifications Submitted by Members of the Provider Roundtable

EMERGENCY DEPARTMENT E/M MODEL 6/16/03 DRAFT

Definition of Emergency Department Visit

A patient who presents to the emergency department for services, is registered and receives one or more of the clinical interventions listed below.

Level 1 (Low Level) Interventions

At least one item below qualifies for low level. Additional explanations, examples and clarifications appear in italics. Items below as performed by hospital staff, rather than physician. Three or more of the interventions identified by an asterisk qualify for mid-level (level 2). Each line item may only be used once towards this increase.

*** Administration of oral, topical, ~~rectal, PR, NG~~ or SL medication(s) #1**	
* ~~**Administration of single disposable enema**~~ **#1**	
*** Application of preformed splint(s)/elastic bandage(s)/sling(s), or immobilizer(s) for non-fracture or nondislocation injuries**	*Preformed are off-the shelf. If creating a splint from plaster or fiberglass or other material, would have separate code. Splints are not billed separately.* *Splints, casting, etc. for fractures and/or tendon repairs are separately billable and paid under the fracture management and/or surgical repair codes.* **#2**
*** Assisting physician with examination(s)**	*Pelvic exam included here. Includes eye exam/slit lamp exam of eye. Nursing documentation must support assistance, unless there is a hospital protocol regarding assistance with exam.*
*** Bedside diagnostic testing, unless tests are separately billed.**	*Examples: Dip stick urine testing, capillary blood sugar (Accucheck, Dextrostick), hemoccult, occult blood tests. Strep test is not included because it is separately billable.*
*** Cleaning and dressing of a wound, single body area, not repaired (but includes butterflies)**	*Examples: steri-strips and ~~other adhesives~~, eye patch . Cleanse and remove secretions and/or dry sterile dressing application Use of wound adhesives (such as Dermabond) are separately billable.* **#3**
*** First aid procedures**	*Examples: control bleeding of abrasions and/or lacerations not requiring suture, ice or heat pack* application, *monitor vital signs 1-2 full or partial sets, including initial assessment, ~~cool body~~,.* **#4**
*** Prophylactic Flushing of Heplock #5**	*Do not use for the routine flushing of heplocks following the administration of injections/infusions, as routine flushing is bundled into the injection/infusion charge.*
***Administration of one status "N" immunization #6**	*Example: Tetanus or Rabies shot*
Follow-up visit #6	*Definition: Patient ~~instructed to~~ return for wound check, single set of vital signs, etc…~~suture removal or rabies injection series.~~*
*** Foreign body(ies) removal from skin, subcutaneous or soft tissue without anesthesia or incision one body area. #7**	*Example: Splinter, rocks from an abrasion etc… remove stinger from insect bite. (Includes dressing application).*
Initial clinical assessment / Triage #8	*Example: Vitals, chief complaint, and clinical assessment of symptom. All elements must be present.*
Measurement/Assessment of fetal heart tones	
Nursing ~~visual~~ acuity assessment ~~(e.g. Snellan exam)~~ #9	*Examples: vision (e.g. Snellen exam) Simple hearing (e.g. Pitchfork)*
*** Specimen(s) collection other than venipuncture, e.g. mid-stream urine samples, cultures**	*Example: nursing instruction of patient on proper specimen collection (e.g. mid-stream urine, sputum). Includes collection of specimen (not the performance of the lab test), e.g. throat culture collection.*
Documentation/update/review of home medication list	
Discharge teaching 1-3 topics #9A	*Examples: Diabetic, diet (Not performed by individual charging separately) exercise, care of wound, crutch training, arranging follow-up appointment, (each appointment scheduled =1 topic), medication (each medication =1 topic) etc… For teaching lasting >29 mins. see contributing factors and level 3 visit.*

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General comment: Our concern overall (as it was when we built levels at our own facilities) is tailoring a scorecard for the Medicare payer, as private insurers and Medicaid may separately reimburse some of the activities included in the levels. For example, Medicaid and private insurers separately reimburse for immunizations, pulse oximetry (single, multiple, continuous determinations) and ankle brachial indexes. Therefore, on our levels we have made notations that these activities can only be counted towards determining a level for Medicare patients. We are concerned that the proposed AHIMA levels do not address this issue.

#1: We recommend moving medications administered utilizing a rectal or NG route be moved to a level 2 visit. TSI data and discussion with clinical staff indicate this administration route is much more labor intensive due to the need to prep the patient mentally, as well as physically. Moreover, this route requires gathering and using more supplies than oral or SL routes.

#2: We would clarify this section by including information regarding tendon repairs, since these CPT codes include the application of splints/casts.

#3: We clarified this section by indicating the use of tissue adhesives is separately reimbursable.

#4: We were unsure how to define "control bleeding" in this section. After much debate, we elected to associate this activity with the type of wound in an effort to differentiate between minor and major bleeding. (We did not use the terms minor and major since these are very subjective terms that cannot be assigned precisely.) Also, we would clarify what is meant by vital signs and indicate if partial sets may be used in this category. For the level 3 visit of the scorecard, we assigned vital signs based on frequency, as this make more sense clinically. We would also clarify whether 1-2 reassessments of pulse oximetry, pain reassessment, etc… meet this category. Overall, we were trying to reconcile this category with the *"Frequent monitoring/assessment as evidenced by three sets of vital signs or assessments (including initial set), integral to current interventions and/or patient's condition."* listed in Level 2. For purposes of clarification, it may be best to separate reassessment of vital signs from the "First Aid Procedure" category. Lastly, we moved "remove stinger from insect bite" to the foreign body removal category.

#5: We added the word "prophylactic" for clarity reasons. Per the Medicare Carrier Manual, the flushing of a port or heplock following the administration of medications is considered bundled into the administration procedure. Without further clarification from CMS we believe we must follow this bundling rule.

#6: We were a bit confused regarding the wording of the follow-up example. We assumed the definition meant a patient who has returned for a wound check, etc… as opposed to simply instructing a patient to return. We removed suture removal from this box and moved it to a level 2 visit as we believe these types of visits are labor intensive and require more resources than are reflected in a level 1 visit. Lastly, we made administration of a status "N" vaccine a separate category. We believe this promotes clarity and facilitates multiple immunizations on the same visit date being placed in a level 2 visit. Overall, however, we are concerned about these "follow-up visits" qualifying for the ED codes and revenue center (450). Many FI's have indicated that these services must be billed using clinic levels and an urgent care revenue code (456). This is a very confusing area for all providers due to the need to translate and integrate the various provisions listed in the hospital manual and EMTALA regulations. We believe that placing these visits on the ED scorecard will contribute to inaccurate reporting of emergent versus non-emergent patient services.

#7: For clarity purposes, we added common clinical examples and defined this category based on body areas. We did so to account for patients with multiple abrasions ("road rash") in multiple body areas, as these types of patients are common in the ED and utilize a large range of resources. Basically we were trying to account for patients with a large amount of numerous abrasions due to motorcycle accidents or multiple stingers to be removed. These types of patients are very resource intensive depending upon the number of body areas impacted. Lastly, we delete the star from this category, since we recommended defining it by body areas and more than one body area is accounted for in higher-level visits.

#8: For clarity purposes, we added the word "triage".

#9: We added a simple hearing test and re-arranged the box to match previous boxes.

#9A: We recommend giving credit for discharge teaching performed by non-physician staff. We believe that basing this

Level 2 (Mid-Level) Interventions **At least one item below qualifies for mid-level.** Additional explanations, examples and clarifications appear in italics. Items below as performed by hospital staff, rather than physician. Three or more of the interventions below identified by an asterisk qualify for high-level (level 3). Each line item may only be used once towards this increase.	
*** Administration of rectal, PR, or NG medications(s) #10**	
Administration of two or more status "N" immunizations #11	*Example: Tetanus or Rabies shot*
*** Assistance with or performance of fecal disimpaction (manual disimpaction and/or enema administration ~~or multiple enemas~~) #12**	
*** Cardiac monitoring**	*Includes one or more of the following: physical assessment by the nurse after initiation of cardiac monitoring, and/or pulses, and/or heart sounds, and/or nursing interpretation of strips.*
*** Care of device(s) or catheter(s) (both indwelling and in & out) (vascular and nonvascular) and/or ostomy device(s)--other than insertion or reinsertion-**	*Examples: irrigation, inspection, assessment ,prophylactic* **#17** *flushing, adjustment, positioning, changing of bags, checking. Examples of catheters/devices: foley, ileal conduit, gastrostomy, ileostomy, colostomy, nephrostomy, tracheostomy, PEG tube, central lines, arterial lines, PICC lines.*
Frequent monitoring/assessment as evidenced by three sets of vital signs or assessments (including initial set), integral to current interventions and/or patient's condition. #13	*Example: Additional vital signs, assessment of cardiovascular, pulmonary or neurological status, assessment of pain scale, nausea assessment, vascular checks, measurement of intake & output, pulse oxymetry or peak flow measurement.*
*** Insertion of nasogastric (NG) tube, oral gastric (OT) tube, foley catheter placement or single urinary catheterization #14**	
*** Nasotracheal (NT) or orotracheal (OT) suctioning**	
*** Oxygen administration--initiation and/or adjustment from baseline oxygen regimen**	*Includes conversion to hospital-supplied oxygen with rate adjustments, as well as initiation of oxygen administration.*
***Suture or staple removal with or without dressing application #15**	
Foreign body(ies) removal from skin, subcutaneous or soft tissue without anesthesia or incision / wound care 2-3 body areas. #16	*Example: Splinter, rocks from an abrasion etc… remove stinger from insect bites. Includes dressing application.*
*** Cleaning and dressing of a wound, 2-3 body areas, not repaired (but includes butterflies) #16**	*Examples: steri-strips and ~~other adhesives, eye patch~~. . Cleanse and remove secretions and/or dry sterile dressing application Use of wound adhesives (such as Dermabond) are separately billable.* **#3**
*** Traction set up**	*Application of traction device for comfort (includes hair traction, Sager traction) prior to definitive treatment.*
Discharge Teaching 4-6 topics #16A	*Examples: Diabetic, diet (Not performed by individual charging separately) exercise, care of wound, crutch training, arranging follow-up appointment, (each appointment scheduled =1 topic), medication (each medication =1 topic) etc… For teaching lasting >29 mins. see contributing factors and level 3 visit.*

#10: These items added due to reason listed in #1.

#11: Multiple immunizations require more resources including nursing time and medication.

#12: These items added due to reason listed in #1.

#13: We request clarification requesting what constitutes a set of vital signs. For example, one must perform 3 out of seven possible vital signs. (Possible vital signs = BP, pulse, respirations, temperature, sitting/standing BP, height, and weight.)

#14: We believe it makes clinical sense to add these activities to this category and matches the required resources.

#15: We believe the resources required for suture removal are more appropriate to a level 2 visit.

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#16: We clarified this category based on the recommendations we made in #4.

#16A: See 9A

#17: We clarified this category based on the recommendations we made in #5.

#18: We would add a separate category to account for care given to control heavy bleeding. We debated adding this to a level three visit versus placing it in the contributing factors category. However, we are unsure of the logic behind what is placed in this category, making it difficult to provide a clear determination. Basically, we decided that this was a factor that could influence numerous visit types and therefore placed it in contributing factors.

#19: See issue #7

#20: We believe that morgue care can be a contributing factor to higher visit levels for patients who do not meet a critical care level due to a non-code blue circumstance.

#21: We would clarify this category by adding examples. Also we recommend changing this category to reflect one-on-one monitoring/care. We believe that patients requiring simultaneous care (more than one-on-one) belong in the critical care category.

#21A: Nurses have cited patients with poor vascular as very resource intensive when they need to establish IV access.

#21B: Staff reports these patients require a large amount of resources. They do not find documentation related to this topic, as they must document this type of treatment for liability reasons.

#21C: See #9A

General Comment: Unfortunately, many of the patients who will meet this level will end up as inpatients, which will nullify the level three visit. We are concerned about the impact this will have on showing a bell-shaped curve (somewhat even distribution) among the three levels of ED visits.

#22: Per the coding staff, this activity appears to be included in CPT code 66999, which is assigned to APC 232.

#23: Per the coding staff, this activity appears to be separately reimbursable, as we get paid for the delivery of infants regardless of setting or timing. This may need further clarification; should it only be used when a patient is transferred to another hospital for inpatient care? A precipitous delivery patient would never be an OP visit unless transferred to another facility or death of mom.

#24 We would add that a partial set of vital signs taken q 15 minutes (for example blood pressure and pulse) meet the minimum requirement for this category.

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CLINIC E/M MODEL 6/16/03 DRAFT

Definition of Clinic Visit

A patient who presents to the hospital clinic for services, is registered and receives one or more of the clinical interventions listed below.

Level 1 (Low Level) Interventions

At least one item below qualifies for low level. Additional explanations, examples and clarifications appear in italics. Items below as performed by hospital staff, rather than physician.

Bedside diagnostic testing, unless tests are separately billed.	*Examples: Dip stick urine testing, capillary blood sugar (Accucheck, Dextrostick), hemoccult, occult blood tests. Strep test is out, separately billable.*
Blood pressure recheck	
Clinical staff assessment (excluding physician)	*Example: Vitals, or chief complaint, or clinical assessment of symptom.*
Prophylactic flushing of Heplock #1	*Do not use for the routine flushing of heplocks following the administration of injections/infusions, as routine flushing is bundled into the injection/infusion charge.*
Patient registration, room set up, patient use of room, room cleaning—not covered by a separately billable procedure.	
Routine ~~simple~~ discharge instructions, Follow-up care arrangements: 1-3 topics #2	*Examples: Diabetic, diet (Not performed by individual charging separately) exercise, care of wound, crutch training, arranging follow-up appointment, (each appointment scheduled =1 topic), medication (each medication =1 topic) etc… For teaching lasting >29 mins. see contributing factors and level 3 visit.*
Single specialized clinical measurement or assessment	*Example: fetal heart tones, positional blood pressure readings, Snellan exam, and cardiac monitor rhythm strip performed by nurse. Measure ankle edema, assessment for pregnancy induced hypertension.*
Specimen collection(s), where nurse provides patient with instructions and patient self-collects, other than venipuncture, e.g. mid-stream urine samples.	*Example: nursing instruction of patient on proper specimen collection (e.g. mid-stream urine, sputum). Includes collection of specimen (not the performance of the lab test).*
~~Suture or staple removals~~ #3	
Tuberculosis test check	
Wound care management (when not separately billable), not repaired – up to 25 sq. cm. #4	*Includes cleansing, assessment, measurement, photographing, ankle brachial index~~, and/or dressing of wound. Includes steri-strips and other adhesives, eye patch, butterflies.~~ Note: For multiple wounds, add the total size of all wounds.* Note: Excisional debridements are separately billable
*** Cleaning and dressing of a wound, single body area, not repaired (but includes butterflies) #5**	*Examples: eye patch application. Cleanse and remove secretions from abrasion, and/or dry sterile dressing application Use of wound adhesives (such as Dermabond) are separately billable.* **#3**
Face to face <u>preoperative</u> education/instruction 1-3 topics #6	*Example: NPO status, map to surgery center, pre-op routine, post-op routine, post procedure diet, post procedure activity level. (each counts as one topic)*
Document/review/update patient's home medication list #6A	
Physician counseling of patient requiring use of exam room/facility, 1-29 minutes in duration. #7	*Does not require the presence of ancillary staff*

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#1: We added the word "prophylactic" for clarity reasons. Per the Medicare Carrier Manual, the flushing of a port or heplock following the administration of medications is considered bundled into the administration procedure. Without further clarification from CMS we believe we must follow this bundling rule.

#2: We found the word "simple" discharge instructions to be subjective. Therefore, we added what we feel is an objective measurement. For more complex discharge instructions, time can be used as listed in the "Contributing Factors" and "Level Three Visit.

#3: We believe the amount of resources required to perform suture removal qualify this activity for a Level Two Visit.

#4 and #5: We are concerned about the administrative burden of requiring nurses not seeing patients in wound care centers to document wound size in centimeters, photography, etc… This level of detail is not documented in non-wound care settings. For example, a patient who is receiving antibiotics in an infusion clinic may receive a wet-to-dry dressing change also. Generally, the wound will not be measured daily, as it is not medically necessary. Therefore, we propose splitting out the wound care management box to reflect this dissonance in wound care management.

#6: In some of the surgical clinics, the non-physician staff's main function is to perform preoperative teaching. However, this teaching does not always take 30 minutes or greater. Therefore, we created a separate category to address this issue.

#6A: Nurses in clinic areas generally perform this function.

#7: We realize this box is controversial on a number of levels, one of which is the requirement of the staff to document time. However, the providers with Cancer Clinics felt strong about adding this box. Regarding the documentation of time, most stated the physician was already placing this in his notes for professional billing issues. Also, they stated the staff generally documented an in and out time for these patients. More importantly, these providers felt these types of visits were common and utilized facility time. Aside from utilizing electricity etc… they felt they should be reimbursed for the time the room was not available to see other patients. The assignment of the level was based on these patients requiring half of the resources that would be required if the non-physician staff was performing the counseling.

Level 2 (Mid-Level) Interventions **At least one item below qualifies for mid-level.** Additional explanations, examples and clarifications appear in italics. Items below as performed by hospital staff, rather than physician.	
Administration of oral, topical, rectal, PR, NG or SL medication(s)	
Administration of disposable enema(s)	
Assistance with or performance of fecal disimpaction (manual)	
Application of preformed splint(s)/elastic bandages/sling(s), or immobilizer for non-fracture or nondislocation injuries, when not separately billable as a procedure.	*Preformed are off-the shelf. If creating a splint from plaster or fiberglass or other material (custom-made splint), would have separate code Splints are not billed separately.* *Splints, casting, etc. for fractures are separately billable and paid under the fracture management.*
Assist physician with examination	*Pelvic exam included here. Includes eye exam/slit lamp exam of eye. Neurological exam, Nursing documentation must support assistance, unless there is a hospital protocol regarding assistance with exam.*
Blood draw(s) through specialized vascular access device	
Care of device(s) or catheter(s) (both indwelling and in & out) (vascular and nonvascular) and/or ostomy device(s)--other than insertion or reinsertion #8	*Examples: irrigation, inspection, assessment, prophylactic flushing, adjustment, positioning ,dressing change, changing of bags, checking. Examples of catheters/devices: foley, ileal conduit, gastrostomy, ileostomy, colostomy, nephrostomy, tracheostomy, PEG tube, central lines, arterial lines, PICC lines.*
First aid procedures	*Examples: control bleeding of abrasions and/or lacerations not requiring suture, ice or heat pack* application, *monitor vital signs 1-2 full or partial sets, including initial assessment* ~~*cool body, remove stinger from insect bite*~~, ~~*cleanse and remove secretions*~~
Foreign body(ies) removal from skin, subcutaneous or soft tissue without anesthesia or incision, when not a separately billable procedure, <u>one to two body areas</u>. #9	*Example: Splinter, rocks from an abrasion etc…* remove stinger from insect bite. *(Includes dressing application).*
Cleaning and dressing of a wound, <u>2 body areas</u>, not repaired (but includes butterflies)	*Examples: Cleanse and remove secretions and/or dry sterile dressing application Use of wound adhesives (such as Dermabond) are separately billable.* **#3**
Wet to dry dressing change one body area #10	*Includes any size gauze soaked in a wetting solution and placed over or into a wound.*
***Suture/staple removal with or without dressing application**	
Frequent monitoring/assessment as evidenced by two sets of vital signs or assessments (including initial set), integral to current interventions and/or patient's condition.	*Example: Additional vital signs, assessment of cardiovascular, pulmonary or neurological status, assessment of pain scale, nausea assessment, vascular checks, measurement of intake & output, pulse oxymetry or peak flow measurement.*
Oxygen administration--initiation and/or adjustment from baseline oxygen regimen	*Includes conversion to hospital supplied oxygen with rate adjustments, as well as initiation of oxygen administration.*
Specimen collection(s) other than venipuncture, performed by nursing staff, e.g. cultures	*Collection of specimen (not the performance of the lab test), e.g. throat culture collection.*
Vaginal exam by nurse	*Must be performed by RN not billing separately for her services*
Routine discharge instructions, Follow-up care arrangements: greater than 6 topics #11	*Examples: Diabetic, diet (Not performed by individual charging separately) exercise, care of wound, crutch training, arranging follow-up appointment, (each appointment scheduled =1 topic), medication (each medication =1 topic) etc… For teaching lasting >29 mins. see contributing factors and level 3 visit.*
Wound care management (when not separately billable), not repaired – 26-50 sq. cm.	*Includes cleansing, assessment, measurement, photographing, ankle brachial index,* ~~*and/or dressing of wound. Includes steri-strips and other adhesives, eye patch, butterflies.*~~ *Note: For multiple wounds, add the total size of all wounds.*
Face to face preoperative education/instruction 4-6 topics #12	*Example: NPO status, map to surgery center, pre-op routine, post-op routine, post procedure diet, post procedure activity level. (each counts as one topic)*
Physician counseling of patient requiring use of exam room/facility, 30-60 minutes in duration. #13	*Does not require the presence of ancillary staff*

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#8: Reason same as issue #1. A dressing change was added to the box to clarify that dressing changes for VADs is included in this category and not the dressing change categories.

#9 - #13: Based on the utilization of resources and the need to differentiate non-wound care center patients from those seen in a wound care center, we are recommending these categories be added. See above explanation.

Contributory Factors For Clinic E/M Model
From Low Level to Mid-Level OR From Mid-Level to High Level

Contributory factors are services, or other factors that when present may increase the E/M level from mid-level to high level. Only one factor is required. These factors apply only to the low level and the middle level. A high level E/M may not be increased to critical care by a contributory factor. Additional explanations, examples and clarifications appear in italics.

Airway insertion (nasal, oral)	
Altered mental status	*Includes coma, lethargy, dementia, delirium, alcohol/drug intoxication or drug toxicity, need for restraints or additional observation to maintain safety.*
Arrangements and/or social service intervention (includes required reporting)	*Examples: Arrangements and/or social intervention for child abuse, battery, elder abuse, etc.*
Scheduling/coordination of ancillary services	
Arrival/transfer via paramedic/ambulance	
Assessments or care related to multiple catheters or devices	*Examples of catheters/devices: foley, gastrostomy, ileostomy, colostomy, tracheostomy, PEG tube, central lines, arterial lines, PICC lines.*
Face to face patient education requiring 30-59 minutes.	*Documentation will support the content of the education, time involved, and any factors that impacted on the time required. Examples include crutch training, diabetic teaching, counseling regarding diet, exercise, and other lifestyle changes.*
Isolation	
Patient acuity warrants ~~simultaneous~~ care by hospital staff (~~more than~~ one-on-one) #14	*Examples: Seizure patient, patient on suicide watch, combative patient requiring constant monitoring*
Control of active, heavy, bleeding #15	*Example: control of active bleeding of lacerations requiring sutures or need to apply pressure to wound for >10 minutes. (Must have documentation of active heavy bleeding or need to apply pressure for >10 minutes.)*
Patient discharge status other than home or discharge to facility other than originating facility (includes also admission to hospital inpatient or observation)	
Reporting to law enforcement or protective services (e.g., gunshots)	
Special needs requiring additional specialized facility resources (e.g. language/cognitive, communication impairment) - age appropriate	*Example: Patient doesn't understand English and requires use of an interpreter. However, if patient doesn't understand English, but nurse speaks the same language and is able to translate, then no additional specialized resources were required and would not qualify as a contributory factor. Mentally challenged or moderate to severely retarded patients.*
Difficult IV insertion requiring two or more RNs with at least 2 attempts by the first RN. #16	*Example: ED RN tries twice to start an IV on an elderly patient and calls in the IV therapy nurse who gets the patient on the first try.*
Patients with <u>physical</u> disabilities/disorders requiring additional facility resources #17	*Example: Bowel or urinary incontinence requiring management/linen changes, requires assistance of 2 or more staff for transfers, lifting, turning, etc… Requires bed pans or assistance of one for ambulation/bathroom.*

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#14: We would clarify this category by adding examples. Also we recommend changing this category to reflect one-on-one monitoring/care. We believe that patients requiring simultaneous care (more than one-on-one) belong in the critical care category.

#15: We would add a separate category to account for care given to control heavy bleeding.

#16: Nurses have cited patients with poor vascular as very resource intensive when they need to establish IV access.

#17: Staff reports these patients require a large amount of resources. They do not find documentation related to this topic, as they must document this type of treatment for liability reasons.

Level 3 (High Level) Interventions **At least one item below qualifies for high level.** Additional explanations, examples and clarifications appear in italics. Items below as performed by hospital staff, rather than physician	
Assessment, crisis intervention and supervision of imminent behavioral crisis threatening self or others	
Assistance with or performance of fecal disimpaction (manual disimpaction or multiple enemas)	
~~**Continuous irrigation of eye using therapeutic lens (e.g. Morgan lens)**~~	
Face to face patient education requiring more than 60 minutes.	*Documentation will support the content of the education, time involved, and any factors that impacted on the time required. Examples include crutch training, diabetic teaching, counseling regarding diet, exercise, and other lifestyle changes.*
Frequent monitoring/multiple assessments as evidenced by more than two sets of vital signs or assessments (including initial set), integral to current interventions and/or patient's condition.	*Example: Additional vital signs, assessment of cardiovascular, pulmonary or neurological status, assessment of pain scale, pulse oxymetry or peak flow measurement.*
Nasotracheal (NT) or orotracheal (OT) suctioning	
Wound care management (when not separately billable), not repaired – 51 sq. cm. or greater	*Includes cleansing, assessment, measurement, photographing, ankle brachial index, ~~and/or dressing of wound. Includes steri-strips and other adhesives, eye patch, butterflies~~. Note: For multiple wounds, add the total size of all wounds.*
Foreign body(ies) removal from skin, subcutaneous or soft tissue without anesthesia or incision, when not a separately billable procedure, more than two body areas.	*Example: Splinter, rocks from an abrasion etc… remove stinger from insect bite. (Includes dressing application).*
Cleaning and dressing of a wound, more than two body areas, not repaired (but includes butterflies)	*Examples: Cleanse and remove secretions and/or dry sterile dressing application Use of wound adhesives (such as Dermabond) are separately billable.*
Wet to dry dressing change more than one body area	*Includes any size gauze soaked in a wetting solution and placed over or into a wound.*
Preparation for transfer to emergency room	
Prepare and send patient for unplanned/unscheduled surgery or major procedure.	
Physician counseling of patient requiring use of exam room/facility, greater than 60 minutes in duration.	*Does not require the presence of ancillary staff*
Morgue Care	*Example: DOA and/or DNR* *Example: Morgue care given to a DNR patient.*
Assistance with or performance sexual assault exam by clinic nursing staff	

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CRITICAL CARE E/M MODEL 6/16/03	
Critical Care Interventions **The following interventions qualify as critical care.** Additional explanations, examples and clarifications appear in italics. Items below as performed by hospital staff, rather than physician	
Interventions/care for critically ill or critically injured patients, e.g. central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. This may include, but is not limited to the following interventions:	*Examples of critical ill or critically injured patients include: cardiopulmonary arrest or near arrest related to primary cardiac* *or respiratory causes, drug overdose, hyper/hypo-thermia, trauma (including severe burns), and other shock events such as anaphylaxis, diabetic shock, internal bleeding sepsis, etc.*
Assist in induction/monitoring pharmaceutical-induced coma	*Examples: barbiturate coma for status epilepticus*
Assist with rapid sequence intubation (that with provision/administration of sedative and/or paralytic agents), and/or airway management	*Examples: AMBU, frequent ETT suctioning, set up for tube thoracostomy and assist physician with procedure, assist hysician* *in performance of emergent cricothyrotomy, tracheostomy, endotracheal intubation, chest tube insertion, or any other emergency airway.*
Code team/crash team/trauma team intervention #1	*Multidisciplinary team approach to life or limb threatening situation. Some of the interventions will be separately billable, but this intervention requires additional facility resources with the activation and initiation of code interventions. Examples: performance of cardiopulmonary resuscitation, application and use of external, percutaneous or intracardiac pacemaker, set up for peritoneal lavage, resuscitation for hypothermia, CPR, defibrillation/emergent cardioversion, thoracotomy, periocardiocentesis.*
Death of a patient requiring resuscitation (e.g. full, partial or *chemical code only* situations) #2	
Patient acuity warrants simultaneous care by hospital staff (more than one-on-one) #3	*Examples: Combative patient who's strength requires multiple staff to control.*
Control of major hemorrhage such as for threatened exsanguination leading to hemodynamic instability	*Control of hemorrhage for example for major trauma, post surgical, including monitoring, IV fluids, emergent administration of multiple concurrent blood products, etc.*
Initiation, monitoring and titration of thrombolytic agents and vasopressors.	*Monitoring and potential intervention for clinical instability in regard to vasoactive drips or push, antiarrhythmics for life-threatening arrhythmias (e.g. Nitroglycerin, Nitroprusside, dopamine, dobutamine, levophed, Isuprel, amiodarone, lidocaine, procainamide) and thrombolytic agents for acute myocardial infarction, strokes, pulmonary embolism (Streptokinase, TPA)*
Continuous and on-going reassessment until stabilized, requiring immediate aggressive interventions in an unstable patient with potential for rapid deterioration and demonstrated instability.	
Post mortem C-section	*Example: trauma pregnant woman who expires, emergency Cesarean section is performed to resuscitate and save the baby.*

#1: We are concerned that the recent creation of the trauma activation revenue codes may cause "double-dipping" issues, as we are now allowed to enter a charge for trauma activation and claim it on the cost report. Although CMS does not separately reimburse, many commercial payers do.

#2: These patients by virtue of their situation mandate a level of sources that meet a critical care visit level. This helps to simplify the assignment of this level also.

#3: Our data shows that a patient requiring this type of care utilizes enough resources to qualify for a critical care level.

Appendix C: Modifications Submitted by Members of the Provider Roundtable

Other General Comments: Per many of the APC publications, it has been written that an eloped patient who has been registered and triaged may be charged a low level visit. However, this seems contrary to billing information in the hospital manual, which leads us to believe the patient must at least be seen by a resident in order to bill. Could this issue be clarified?