GEMA Billing Help Sheet

June 2012

The purpose of this document is to encourage accurate billing for all services rendered in the emergency department by all physicians. This should increase billings to an appropriate level across the board.

This document should be used in conjunction with MOHLTC's Schedule of Benefits and the billing code sheets located in the ER.

General Visit Codes

Weekday 0800 – 1700	H101, H102, H103, H104
Weekday 1700 – 2400 (+ ~ 30%)	H131, H132, H133, H134
Weekend 0800 – 2400 (+ ~75%)(no eve premium)	H151, H152, H153, H154
Night 2400 – 0800 (+ ~100%)	H121, H122, H123, H124

H1*1 minor	*Single system and location*. The concept of "minor assessment" has little place in the ER	Ex. Look into ear for FB.
H1*3 multi-system (> 2x minor)	*Detailed hx and px of more than one system, part or region*	Ex. Simple fractures, infections; young with back pain, etc.
H1*2 comprehensive (+ 10% H1*3)	*Full hx [including meds, PMHx, and social], and px, and evaluation of treatment/tests*	Ex. Many chest pain, abdo pain, shortness of breath, weak and dizzy, etc.

Reassessments H1*4

- 2 per physician per day, 3 per patient per day
- must be 2 hours apart
- must involve a new order other than admission or discharge (ex. Gravol, repeat vitals, walk test, imaging, labs, etc.)

Resuscitations

- Each code is for 15min - *or part thereof* – of time spent fully devoted to the patient includes time at bedside, reviewing chart, labs, imaging, talking to consultants, etc.
- May be billed by more than one physician for same patient
- Time unit total may be non-consecutive **–** document this

Life-threatening: G521, G523, G522

Patient must have a critical illness or injury that acutely impairs one or more vital organs or systems such that imminent life-threatening deterioration is highly probable.

- Excludes intubation, lines, defibrillation, cardioversion, ABGs, Foleys, NGTs
- Does not exclude other procedure codes (fractures, lacerations, etc.)
- Ex. STEMI, CHF with intubation or BiPAP, severe sepsis/shock, true anaphylaxis (epi given), status epilepticus, trauma with unstable vitals, croup requiring epi, etc.

Other Critical Care: G395, G391

Where there is a potential threat to life or limb, physician provides resuscitation in order to address the high probability *of loss of limb or requirement for "life threatening" critical care.*

- Excludes intubation, lines, ABGs, catheters
- Does not exclude cardioversion, defibrillation, or other procedure codes (fractures, dislocations, lacerations, etc.)
- Ex. Backboard/collar <u>with</u> imaging, chest pain requiring intervention, abdo pain requiring intervention, head injury requiring CT, OD/intoxication with decreased LOC, extremity requiring immediate reduction, etc.

Resuscitation premiums

- **E420** – adds 50% when ISS is >16 for 16y.o. or older, >12 for 15y.o. or less; must document ISS (Trauma.org)
- **H112** – overnight resuscitation premium
- **H113** – weekend resuscitation premium

Anesthesia ($$$)

- Document time to start and finish, add these 15min "units" to codes
- Shadow bill if on shift; if before or after shift, bill outside AFA
- Can't bill procedure and anesthesia – so, call a colleague

- Age premiums are now automated, but time of day and ASA level are not, so document and bill them (E***C)
- Don't forget that many procedures have different codes if patient is anesthetized (in any way – even oral narcotic/benzo), ex. FB removal Z114 ($24) vs. Z115 ($89)

Other Important Codes

- **H065** – ER consultation, as requested in writing by another MD
- **H105** – "interim" admission orders

K-codes

- **K623** – Form 1; may be billed with G-codes, but not H-codes
- **K005** – episodic psychotherapy (anxiety, depression, etc.); 30min intervals
- **K028** – blood-borne and sexually transmitted disease counseling; 30min intervals
- **K015** – counseling re: terminal illness, i.e. DNR discussions
- **K070** – home care referral
- **K736** – call to criticall
- **K734** – call to consultant (document consultant's name with code)

Suturing

- Bill in addition to visit codes
- **Z176** – simple laceration; if more than one, add up lengths and bill appropriate code (**Z175**, **Z179**, etc.)
- **G231** – peripheral nerve block (ex. Digital block) – cannot be billed with Z-code, but pays more, so bill it instead on simple lac's
- **Z187**, **Z188**, **Z189** – complex lacerations (>20min working time) on face, other than face, and finger, respectively – pays 4x Z176!
- **Z154** – laceration of face, layers, mult bleeders
- Bill 50% of codes if glue used instead of sutures

Fractures & Dislocations

- Bill in addition to visit and resuscitation codes
- Casts/rigid splints applied in absence of fracture are billable separately (**Z203**, etc.)

Ultrasound

- **H100** – by certified MDs; max 2 per day; must suspect one of: cardiac arrest, tamponade, hemoperitoneum, AAA, ectopic.

Eyes

- **Z847** – removal of FB
- **G435** – tonometry

ENT

- **G403** – Epley
- **Z321** – direct laryngoscopy (Z322 with FB removal)
- **Z314** – nasal cautery
- **Z315** – anterior packing
- **Z316** – ant + post packing
- **Z311** – FB nose
- **Z506** – drain oral abscess
- **F136** – closed nasal reduction

ECG

- **G313P** – first come, first served; only for patients discharged from ER

Procedure premiums

- **E412** – evening weekend, holidays +10%
- **E413** – nights + 30%