

Emergency Department Facility Charge Manual

Note: A fully updated manual with visible edits is also available for those who are already familiar with this manual and want to easily find the changes made since the previous version.

Algorithm version 3.00.xx for E/Point 6.0-6.2, C/Point 6.1-6.2,
E/Code 5.0 SP 10, and Integrated PulseCheck 4.1

June 23, 2010

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Introduction

The Centers for Medicare and Medicaid Services (CMS) has documented eleven general guidelines that Emergency Departments (ED) must adhere to when coding visit services. CMS states that a hospital's methodology should:

- follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code
- be based on hospital facility resources, not on physician resources
- be clear to facilitate accurate payments and be usable for compliance purposes and audits
- meet the HIPAA requirements
- only require documentation that is clinically necessary for patient care
- not facilitate upcoding or gaming
- be written or recorded, well documented and provide the basis for selection of a specific code
- be applied consistently across patients in the clinic or emergency department to which they apply
- not change with great frequency
- be readily available for fiscal intermediary (or if applicable, MAC contractor) review,
- result in coding decisions that could be verified by other hospital staff, as well as outside sources

The LYNX ED Charging Algorithm complies with each of these guidelines. It is a resource-based patient acuity point system that enables users to evaluate the level of service provided during an ED encounter. Nurses or coders assess the entire record to identify specific elements that are required for coding the visit level. Separate visit level codes are assigned for the professional (physician) and the facility (hospital) components of an outpatient visit. This document will focus on charging for the facility visit level service.

The purpose of this document is to provide to facilities using the LYNX Algorithm with the written documentation necessary to meet the guidelines as stated above. Following a brief discussion of background information, the reader will find an overview of the LYNX ED Facility Charging Methodology; a discussion of ED visit levels 99281-99285 and critical care; instructions for the process and use of the LYNX Facility Charging Algorithm; and finally, a list of frequently asked questions.

As part of each hospital's compliance plan, ED encounters should be audited to verify the accuracy of coded visit levels. In addition to audits, benchmarking and monthly monitoring of the visit level distribution will provide a quick verification that coding is consistent with the patient acuity and ED resource use. LYNX provides clients with a Web-based audit tool to facilitate this process. A logon and password can be obtained within one business day by calling the ED's LYNX Client Relationship Manager.

LYNX Facility Charging for ED Hospital Outpatient Services

Background

Medicare's reimbursement system for outpatient hospital (facility) services is known as the Outpatient Prospective Payment System. OPSS uses the hospital's submitted CPT codes as the basis for reimbursement. It groups CPT codes into classes that have similar costs. These groupings are known as Ambulatory Payment Classifications (APCs)¹ and include visit levels or evaluation and management (E&M) services, procedures and ancillary diagnostic services that may be separately billed and reimbursed. The provider assigns the appropriate CPT codes. The payer is responsible for grouping the codes into the correct APC for reimbursement.

In the OPSS Final Rule published November 24, 2006 CMS finalized its decision to define and distinguish between two types of EDs for OPSS payment purposes: type A and type B (FR 11/24/06 pages 68140, 68133 68134)¹⁴. The primary difference between the two is that Type A EDs, or ED area beds, are open and available 24 hours a day and Type B beds are not. Based on the CMS and CPT guidelines, each ED will determine if the Type B ED coding rules apply. The LYNX ED Algorithm may be used to code either type of ED and the final visit level will be determined by resources expended. The Type A services will be reported using CPT codes 99281-99285. Critical care and the Type B services will be reported using HCPCS G codes, G0380-G0384 and critical care.

Algorithm Overview

The LYNX methodology for facility code assignment is specifically designed to accomplish two objectives:

- Meet the general coding guidelines mandated by Medicare's OPSS rules
- Provide a resource-based facility charge structure

The LYNX Facility Algorithm correlates the resources utilized during a visit with the charge assigned to it. This facility charge calculation approach considers all resources related to an emergency department visit and charges are based on documentation of resources utilized by the facility. The Algorithm identifies two major factors that drive facility resource utilization and are the basis for the CPT code assigned for the level of service:

- Severity of the presenting problem
- Additional resources required for managing a specific encounter. These additional resources exclude separately chargeable procedures.

The Algorithm calculates an ED visit level by assigning points for a patient's presenting problem and adding points for nursing services and other hospital resources used during the encounter. A minimum value is linked to the presenting problem — each presenting problem has a Typical Resource Category (TRC) and each TRC has a base "weight" or point value. Additional services provided by the hospital staff add points toward the threshold for a higher level of service. The final ED level of service is determined by the sum of the presenting problem points plus the resource points and the total points are mapped to one of the ED visit level codes or critical care.

The TRCs are assigned to presenting problems consistent with the clinical examples and visit level descriptors from CPT. The Algorithm Visit Level Threshold points are proportional to the CMS Relative Weights for the same level.

LYNX Algorithm in Detail

Presenting Problem

LYNX has defined over 200 presenting problems. This list includes the full range of services provided in an emergency department. Academic emergency physicians at Oregon Health Sciences University worked with LYNX Medical Systems to develop the problem list and it has been modified and validated through clinical use in emergency departments across the country.

The LYNX ED presenting problem list includes infrequent services as well common problems. By using this comprehensive and field-tested problem list in the charging process, facilities will have a rich source of data to analyze resource utilization, practice patterns, and patient outcomes by presenting problem. LYNX also measures problem frequency based on the age and sex of the patients treated. Using this data, hospitals can compare the frequency of the problems treated in their Emergency Department to other hospitals of similar type, size, and acuity of the patient population.

Typical Resource Category (TRC) 1-5

The TRC indicates the acuity of the presenting problem. LYNX analyzed over 100,000 emergency department visits where the encounter had been assigned both a presenting problem and a facility visit level. The clinical staff in the emergency department assigned the presenting problem(s) at the time of triage. LYNX found the presenting problem (also known as the chief complaint) to be the most important determinant of the level of service assigned. As a result of this analysis, LYNX assigned one of five typical resource categories to each presenting problem.

Base Weight

Base Weight points are assigned to each of the five TRCs. Base weight points comprise the minimum resource valuation for each presenting problem and do not include any services that have been assigned additional resource points. These base weight services include nursing and ancillary staff time (for a routine arrival, triage, registration, basic patient/family communications, routine discharge instructions and a routine discharge), the room, creation of a medical record, coding, and billing. The visit level is determined by the sum of the Base Weight points plus any points associated with additional ED services provided. Critical Care has the same base weight as TRC 5.

Additional Resources

LYNX has identified five additional categories of services that impact facility resource utilization. These services require resources associated with general visit services that not every patient will expect to receive. When identifying additional resources, separately billed nursing and surgical procedures or services are specifically excluded.

Depending on the type of clinical presentation and required management, the identification of these additional resources provides an excellent proxy measure for hospital staff and facility resource utilization. By adding consideration of these additional services to the value of the presenting problem, the level of service is accurately correlated with the hospital's resource utilization. The additional resource options include mode of arrival, order management, process management, nursing assessment and disposition.

Additional Resource Categories	Choices	Select Single or Multiple Choices
Mode of Arrival	2	Single
Order Management	5	Multiple
Process Management	5	Multiple
Nursing Assessment	4	Single
Disposition	5	Single

Additional resource selections are intended to be minimal for the lower three ED visit levels. These cases represent over fifty percent of emergency department visits. Minimizing the need to add points for every visit simplifies the process of visit level determination and reduces the chance of coding error.

Variation in Assigned Visit Levels for the Same Presenting Problem

The presenting problem's base weight determines the minimum level of service. The base weight will determine the level of service at the lowest two levels. For levels three through critical care, additional services must be provided to reach the minimum point threshold for the E/M visit level, 99281-99285. Exceeding the TRC is expected to occur only in those cases where above average amounts of resources are required. Using the Algorithm, lower severity presentations of a specific presenting problem are assigned a lower level of service and more serious illnesses or injuries that require more services and a longer stay in the ED are assigned a higher level of service.

To see how the point additions affect the visit level, consider the following example of an ankle injury presenting problem with a TRC of 3. Unless additional services are required for the patient's evaluation and management, the assigned level of service will be a level 2 or 99282. However, for the majority of ankle injuries additional resources are required, such as an X-ray. The order management work for the X-ray adds points to the total for the encounter and the assigned level of service would be a 99283.

An ankle injury that requires prolonged care, X-rays and perhaps a consultation from an orthopedic specialist represents an even higher level of acuity for the same presenting problem. In addition to the presenting problem base weight, X-rays are ordered, three separate nursing notes are documented and a nurse assists the consulting physician. The sum of the base weight and resource points meets the point threshold for 99284. If the patient had a more severe injury to the ankle, such as a complicated fracture, where additional nursing assessments, lab and hospital admission were required, the total points would meet the threshold for a 99285.

Critical Care

Critical care is a unique level of service that refers to the provision of the highest acuity care that meets the CPT Critical Care definition. Unlike the other levels of service, critical care has a minimum 30 minute time requirement before it meets the CPT requirements for coding. Critical care does not have a unique TRC. It shares the same TRC and base weight as a level 5 service. Management of a critical care patient requires a significant amount of additional services compared to the typical level 5 visit. In these exceptional cases, the additional resources add sufficient resource points so that the total exceeds critical care's threshold value when the 30 minute minimum time is also documented.

CMS stated in the OPPS Final Rule for 2007 that both CPT codes, 99291 and 99292, should be coded for services meeting the critical care CPT descriptor. Documentation of 30 - 74 minutes of critical care time is required within the nursing and/or physician record to support assignment of 99291 and documentation of additional 30 minute increments beyond 74 minutes are required to support assignment of 99292 (FR 11/24/06 page 68134 ^[4]).

The CPT descriptor for critical care includes several procedures (e.g. chest x-ray, pulse oximetry, etc.) that are included in critical care; time spent performing these procedures does not need to be deducted from critical care time. CPT also specifies that the time spent performing services which can be separately reported cannot be included in the calculation of the critical care time (e.g. CPR). The time spent performing these separately reported services must be subtracted from the total critical care time. (CMS Hosp OPPS Q/A #8809) ^[5]

Assigning Facility Procedures

When coding procedures in addition to the visit level, facility resources are allocated either to the visit level or a procedure, but not to both (FR 11/27/07 page 66790 #1) ^[2]. Component resources for a service or procedure are not billed twice (i.e., in the procedure and the visit level). Procedures will be assigned based on the ED's chargemaster/CDM.

Documentation must support performance of the procedure and the utilization of facility resources (FR 01/31/05 page 4860) ^[6] (FR 11/27/07 page 66805) ^[2]. Both the nursing and the clinician documentation may be used to support facility procedures. However, if the ED clinician refers to a nursing procedure, such as an injection or IV infusion, the nurse's documentation must support that the service was provided. Procedures performed by private physicians in the ED should be coded only if the procedure performed can be accurately identified. If the procedure cannot be accurately coded based on the available documentation, feedback to nursing staff or the physician should be provided. CMS requires that orders for services provided to Medicare patients be documented in the medical record (FR 11/27/07 §482.24(1) (i) page 68693) ^[9]

ED Facility Scope of Service Summary for E/M Services

Facility visit levels are mapped to the corresponding CPT codes, 99281 through 99291. The higher levels represent increasing patient acuity, both in severity of illness or injury and intensity of service.

Level 1, 99281, is used for very simple and limited services. The presenting problem is usually minor in nature and no additional facility resources are needed. An example is an ED visit for removal of sutures.

Level 2, 99282, is characterized as a clinical presentation that requires a single “in-room” encounter with the nurse and physician to determine the appropriate treatment. It is typically assigned for an acute episodic illness and/or minor injury evaluation that requires no additional facility resources. An example is an ED visit for treatment of a laceration.

Level 3, 99283, is a more complex version of the problems treated at level 2. They generally require additional facility resources including X-ray or laboratory testing to arrive at an appropriate treatment plan. There may be additional nursing time associated with Level 3 that is not related to separately billable nursing services. An example is an ED visit for a minor ankle injury.

Level 4, 99284, is coded for encounters associated with acute illnesses or injuries that require prolonged evaluation compared to level 3 patients. They typically require diagnostic studies, repeat nursing evaluations and may need IV fluids or other therapeutic interventions to treat the patient’s symptoms. They generally do not require admission to the hospital, but the patient will remain in the ED pending testing and further evaluation, and may require a consultation. An example is an ED visit for flank pain and hematuria.

Level 5, 99285, is coded for encounters that are associated with serious presenting symptoms, often a life threatening disease or injury. The severity of illness usually requires treatment that is complex and/or resource-intensive. The majority of these patients will require admission. An example is an ED visit for chest pain.

Critical Care, 99291 and 99292, is coded when there is a high probability of imminent or life threatening deterioration in the patient’s condition. Typically, multiple interventions and assessments are necessary to evaluate and manage the patient. 99291 and 99292 can be coded when services meet the critical care CPT descriptor. Documentation of 30 -74 minutes of critical care time is required within the nursing and/or physician record to support assignment of 99291 and documentation of additional 30 minute increments of time beyond 74 minutes is required to support assignment of 99292. The CPT descriptor for critical care includes several procedures (e.g. chest x-rays, pulse oximetry, etc.) and specifies that the time spent performing services which can be separately reported cannot be included in the calculation of the critical care time (e.g. CPR). Time spent performing these separately reported services is not to be included in determining the 30-minute threshold needed to assign CC^[B]. An example is an ED visit for a multiple trauma after a motor vehicle collision.

LYNX Algorithm Facility Charging Instructions

ED Visit Level Charge Process Overview

Selection of the correct **presenting problem** is critical to accurate visit level assignment. Patients present to the ED facility with a variety of medical conditions, injuries and complaints. For each ED encounter, the presenting problem that is the most accurate reason for the ED visit must be determined.

The presenting problem is based on the clinical information available in the medical record. The presenting problem may be selected by the ED triage nurse, the physician or a coder. The individual coding the record must be thoroughly familiar with the Presenting Problem List. For example, there is a combined section for traumatic injury and non-traumatic musculoskeletal pain. There is also a category for re-evaluation. A patient presenting for re-evaluation of abdominal pain has a different presenting problem from a patient presenting with abdominal pain that has not yet been evaluated.

Presenting Problem Selection

Starting Out

In order for the user to select the presenting clinical problem(s) the patient demographic data must first be entered into the clinical log. This is usually accomplished through a computer link to the hospital's registration system but it can also be done manually. Once a patient is entered into the log and a problem selected, the charging process may proceed.

Determining the Presenting Problem

The problem selected should be the clinician's interpretation of the patient's chief complaint or reason for seeking medical care and is usually identified as an illness or injury. This reason or complaint is usually documented in the triage notes. Occasionally, however, this stated problem is inaccurate—the patient may not have known exactly why he or she didn't feel well or the chief complaint may have been inaccurately stated on purpose.

For most encounters, a user can determine the correct presenting problem by reading documentation of the chief complaint and the triage history in the nurse's and/or the physician's clinical notes. Once the presumed presenting problem is identified, the user should quickly review documentation of the ED course to validate that this presenting problem accurately aligns with the services provided.

Occasionally, the presenting problem documented in the clinical record does not accurately reflect the true scope of nursing and ancillary services performed during the encounter. If this is the case, the user must consider ED course documentation in addition to the chief complaint and triage notes. This might include a review of the nurse's notes and flow sheets, as well as the physician's notes and final diagnosis. Once this documentation is considered, the accurate presenting problem is selected.

It is **important** that, in the process of determining the patient's presenting problem, the **user stay focused on the presenting problem and not get it confused with the final diagnosis.** The presenting problem establishes the medical necessity for the level of service provided and may or may not be the same as the final diagnosis. One example of this difference is a patient who presents to the ED with chest pain. After a full cardiac work-up the physician diagnoses the patient with gastritis. The correct presenting problem would be chest pain.

The Finer Points of Determining a Presenting Problem

Three additional factors should be considered when selecting the patient's presenting problem:

- The problem should be as specific as possible.
- Accurate problem selection will be facilitated if the user becomes familiar with all the presenting problem options available in the problem tree.
- In addition, the user should be aware of the issues of multiple problems, simple versus complicated problems, and major and minor problems.

Multiple Problems

Patients often present with more than a single complaint or injury. In this case the user should identify the discrete presenting problems treated during the ED encounter; this is usually not more than two or three. It is appropriate to select multiple problems only if they are in different system categories in the problem list and each is distinct and treated during the ED encounter. For example, a patient may have had a seizure and sustained a scalp laceration as a consequence of the seizure. Both of these clinical events should be selected as problems. Conversely, if a patient presents to the ED with abdominal pain, nausea, vomiting and diarrhea, for the purposes of selecting a problem to start the Algorithm visit level calculation, selecting the single presenting problem of abdominal pain would be sufficient. It would not change the visit level if the other three problems were added, but it is not necessary to add them. The base weight for calculation of the visit level will be derived from the problem with the highest TRC/base weight.

For multiple injuries resulting from an accident, the user should select a problem from the Trauma – MS (musculoskeletal) Non Traumatic categories such as Trauma - Major or Trauma - Minor - Multiple.

Simple or Uncomplicated Versus Complicated Problems

The presenting problem list contains some problems labeled simple or uncomplicated and others labeled complicated. It is necessary for the user to read the hints associated with these problem choices to ensure accurate problem selection in these areas.

Major and Minor Problems

The presenting problem list contains several types of “Major and Minor” problem choices including illnesses or injuries.

- Medical Problem “Major” or “Minor” choices are defined as follows:
 - “Major” - Use for patients that have a major medical complaint (higher risk of morbidity and need for workup) and a specific problem is not available in the problem list.
 - “Minor” - Use for patients that have a minor medical complaint (low risk of morbidity, generally self-limited, minimal need for workup) and a specific problem is not available in the problem list.
- MVC (motor vehicle collision) “Major or Minor” choices are defined as follows:
 - “Major” MVC- select this problem for patients who have been in a major motor vehicle collision and have potential injuries to major organ systems.
 - “Minor” MVC – select this problem for patients who have been in a motor vehicle collision and have only minor injuries as a result of the collision.
- Trauma “Major or Minor” choices are defined as follows:
 - “Major” – select this problem for patients with major trauma-- those typically arriving by ambulance with a high likelihood of multiple internal and extremity injuries that require extensive

work or facility resource consumption, and/or admission. For example: High speed front end motor vehicle collision with head, chest, abdominal and extremity injury.

- “Minor - Multiple” – select this problem for patients if the injury is uncomplicated and/or does not require admission. For example: a patient that presents with an extremity injury that is without obvious dislocation or open fracture.

For other problems listed with a “major or minor” choices, the hints will direct the user to the appropriate problem selection in that category, e.g. “Vomiting (minor)” versus “Vomiting” or “Tongue Swelling – Major” versus “Tongue Swelling – Minor” etc.

Best Practices for Selecting Problems

1. When selecting a problem, identify the real reason the patient presented to the facility.
 - This is usually the chief complaint based upon the clinician’s interpretation and should be verified for accuracy by reviewing the nursing or physician clinical notes.
 - The Chief Complaint or Reason for Visit is usually NOT the final diagnosis.
2. Be as specific as possible in problem selection.
3. The problem hints will help in identifying the most accurate presenting problem.
4. The problems in the problem tree are filtered for age and gender. Only those problems pertinent to the patient’s age and gender will appear for selection.
5. It is appropriate to select multiple problems if they are in different problem categories and each is distinct and treated during the ED encounter. Otherwise, it is recommended that only the one most acute problem be selected.

Once the presenting problem has been determined, the TRC and the base weight points associated with the TRC are established. The base weight for a specific presenting problem incorporates the minimum facility services that every ED patient that presenting problem should expect to receive. This includes:

- Nursing and ancillary staff time for:
 - Routine arrival
 - Brief triage (usually identification of the chief complaint/presenting problem, a brief history, medications, weight if needed, allergies, an initial set of vital signs/pain assessment and assignment of a triage category).
 - Registration
 - Basic patient/family communications
 - Routine discharge and instructions
- Use of the ED room and facility
- Creation of a medical record
- Charging, coding, and billing

The ED nursing documentation is then reviewed to determine which categories of additional resource points can be added to the base weight. Five categories for additional points are listed. Additional resource points are added for services that not every patient receives, or for services that require above average facility resources (routine services included in the base weight do not earn any additional points). These additional resource points are selected. (See below for descriptions of each resource point category.)

The sum of the base weight points and additional resource points determines the total points for the ED visit. The total points map to the ED visit level for the encounter, level 1-5 or critical care.

Determining Additional Resources Points

Resource points may be added based on documentation of the following categories of ED services:

Mode of Arrival

This category can have only one value. No points are added for routine modes of arrival (private car, walk-in arrivals are included in the base weight). Resource points reflect the varying complexity of the ED admit process when patients arrive with police personnel, by ambulance or ALS transport. The intent of this category is to give credit for the additional facility resources required when a patient arrives by ambulance (or police) or ALS transport. These additional facility resources might include work related to communication with EMS personnel and review of the EMS report regarding pre-hospital treatments, assisting with the transfer of the patient to the ED stretcher and transitioning any equipment, supplies, infusions, etc used or started by pre-hospital care providers. Ambulance or other EMS arrivals require varying amounts of work on arrival to the ED and the nurse or coder must determine whether to select basic life support (BLS) or advanced life support (ALS) points based on the complexity of the type of arrival and the patients condition versus the specific type of ambulance personnel on board the EMS transport service.

Depending on the community's emergency response system, an ambulance may be staffed by paramedics or emergency medical technicians (EMT). EMTs usually provide BLS ambulance transports and can perform CPR. BLS/Police transports occur for patients experiencing a condition **not** accompanied by signs and symptoms suggestive of a potential for imminent life threatening deterioration and thus not requiring immediate life and organ system interventions. Examples from CMS of BLS conditions include: Abdominal pain without accompanying signs and symptoms, Allergic reaction—hives, itching, rash, slow onset, local swelling, redness, erythema, acute vision loss and/or severe pain, cold exposure (shivering, superficial frost bite, and other emergency conditions. digit amputation, sexual assault with minor or no injuries and minor burn. Examples of BLS interventions include O2 and patient safety.

Paramedics are trained to provide ALS measures including IV management, medications per protocol, basic ECG interpretation, etc. ALS services in route to the ED may range from providing medications to stabilize a problem to managing a patient in cardiac arrest. ALS transports occur for patients experiencing an emergency condition accompanied by clinically significant signs and symptoms which require life and/or organ system interventions to prevent possible life-threatening deterioration in the patient's condition. Examples from CMS of ALS conditions include: severe abdominal pain with other signs & symptoms (e.g. nausea, vomiting, fainting), abnormal cardiac rhythm/cardiac dysrhythmia, allergic reaction (emergency conditions, rapid progression symptoms, prior history of anaphylaxis, wheezing, difficulty swallowing, cold exposure (temperature <95F, deep frost bite, other emergency conditions) and non-traumatic headache (with neurologic distress conditions or sudden severe onset). EMS practices vary in different communities: any variation from above should be noted in the client coding guidelines.

Best Practice Documentation Guidelines for Mode of Arrival

- Facility staff's communication/coordination of patient care or work associated with ambulance personnel and the notation of pre-hospital interventions should be documented in the ED record. The EMS personnel's documentation of pre-hospital interventions does not count toward Mode of Arrival points.
- LYNX recommends the ambulance run sheet be retained and included as part of the medical record.

Order Management

Order management points are added to account for the ED resources expended so that orders are noted, communicated, and followed up as needed. This includes nursing or other staff time required prior or subsequent to the performance of the order itself. Order management points do not include time spent in actual performance of separately billable tests/procedures.

- Lab Tests may be credited only one time regardless of how many labs are ordered. It does not matter whether ED staff or lab staff draws the blood as long as the ED staff managed the order.
- X-ray - Plain Films may be credited one time even if the nurse or facility staff managed orders for two or more diagnostic x-rays.
- EKG/RT/Ancil Svc may be credited one time even if two or more orders were managed.

Note: Assign Ancil Svc points when any other ancillary order that is not already listed under the Order Management category occurs in the ED and the facility documentation does not support facility staff involvement with this service. An example is management of a physician order requesting Diabetic Dietary Teaching prior to D/C. The nurse is involved in the order management by calling dietary to come to the ED to provide this education, but the nursing documentation only supports the fact that dietary staff was at the patient's bedside teaching, and there is no notation of facility staff's assist with the education.

- CT/MRI/Ultrasound may be credited only one time even if two or more orders were managed.
- Accessing medical records in either a paper or electronic format refers to the additional resources required to obtain/access old records stored in paper or online. The physician order to obtain an old medical record is not sufficient documentation to support assignment of these facility resources. Facility documentation must support nursing or ancillary staff involvement or work in obtaining the medical record for the physician, These points cannot be assigned when the physician obtains or accesses an old medical record.

Process Management

Multiple points may be added depending on the types of services provided and documented. The intent of this category is to give credit for facility resources required to either coordinate with other medical or facility staff, or to manage a patient requiring certain resource-intensive services.

- MD consult points are added when a consulting physician (including residents) sees the patient in the ED and the ED staff performs additional work to assist the physician and/or manage the patient after the ED physician has seen and treated the patient. Facility documentation identifying facility staff involvement in working with the second physician is required, e.g. "ED nurse assisted consulting physician with exam." Noting only that a consulting physician is at the bedside is not enough documentation to support these resource points being assigned.

Note: **Reminder regarding double billing:** If the only facility documentation present regarding assist of an "MD Consult" is that which supports assist with a procedure that will be separately billed, e.g. laceration repair or administration of medications ordered during the consult, the points for "Consult MD" should not be assigned as this facility work will be captured in the separate billing of the procedure.

A telehealth or telemedicine consultation service occurs when an originating site requests an interactive patient encounter with a healthcare provider at a distant site. Telehealth or telemedicine consultations are examples of countable Facility "MD consult" points in the LYNX Algorithm when the

service is medically necessary, the nurse's or other facility staff member's involvement is well documented, and the following guidelines have been met at your facility:

In a telehealth or telemedicine consultation, it is appropriate to assign the "MD consult" points in the LYNX algorithm if the client does not currently bill CPT Q3014 for this service and the patient encounter includes interactive audio and video telecommunications, permitting real-time communication between the distant site physician or practitioner, the facility staff and the patient. Documentation must support the patient and facility staff's presence and participation in the telehealth visit.

- Consult Social/Ancil Svc includes social workers, discharge planners, pastoral care or other hospital support staff called to evaluate or provide services to the patient in the ED. These staff members offer services not routinely provided to all patients. Examples include cases when a sitter is present to monitor the patient to prevent accidental removal of lines, tubes, equipment or dressings or when a non-ED staff member assesses a patient with suicidal ideation to determine if further treatment is necessary. This resource point category does not include services where the ED or other facility staff has provided frequent or ongoing 1:1 attention as in a "Psych-social crisis" (see below).

Note: When hospital staff "consultants" (like PT, OT, speech) come to the ED and evaluate a patient, the ancillary service consultant points are added only if there is no separate bill submitted by the "consultant" and the facility documentation clearly supports facility staff assistance with the consulting service. If the consulting staff member will submit a separate bill for their services or the facility documentation does not support that ED facility staff assisted with the consultation, then only Ancillary Service "Order Management" points would be selected to account for the work of the nurse/ED staff to coordinate and manage the order.

- A social or psychological crisis is defined as management of a significant patient behavioral issue that requires the frequent or ongoing 1:1 attention of nursing, ancillary, or security staff. An example is an abusive, intoxicated patient requiring security and ED staff to manage the situation. Other examples include a suicidal or homicidal patient or a patient who is a flight risk and receiving frequent monitoring. An example of a patient that would not be considered in "social or psychological crisis" is a calm, non-threatening depressed patient who is cooperative and objectively does not appear to be at risk to harm themselves or others. Facility documentation must support and indicate that frequent or ongoing 1:1 attention of nursing, ancillary or security staff was provided.
- Restraint points are added to account for the extra staff time required when a patient is placed in restraints and monitored.
- 30 Minutes of Critical Care Management. Additional resource points are assigned for management of a patient who meets the CPT definition for critical care and for whom a minimum of 30 minutes of critical care services were provided and documented. These resource points give credit for the high intensity of facility resources required to provide critical care services. This 30 minutes of critical care time may be documented in either the nursing or physician's portion of the ED record.

The CPT descriptor for critical care includes several procedures (e.g. chest x-ray, pulse oximetry, etc.) that are included with critical care; time spend performing these procedures does not need to be deducted from critical care time. CPT also specifies that the time spent performing services which can be separately reported cannot be included in the calculation of the critical care time (e.g. CPR). The time spent performing these separately reported services must be subtracted from the total critical care time. (CMS Hosp OPPS Q/A #8809)^[5]

CPT and CMS have not provided guidelines regarding the minutes of time that must be subtracted from critical care to account for the performance of these separately billable CPT procedures. LYNX recommends that the hospital's ED clinicians and the compliance department determine internal guidelines for how long each separately billable procedure takes and therefore how much time must be subtracted when a specific separately billable procedure is performed during a period of critical care. A

best practice for procedure documentation includes the time it takes to perform the procedure; when that time is noted in the clinical record it should be used to determine how many minutes must be subtracted from critical care.

Nursing Assessments

Only one value may be selected under nursing assessment. Nursing documentation quality and quantity may vary considerably between nurses and at different times. For instance, there may be extensive notes for a lower acuity problem if the ED is not busy and the nurse has extra time to spend on documentation. The coder must use his or her judgment, based on the presenting problem and services documented, to determine the weight the nursing documentation will have in determining the final facility visit level. A nursing note contains clinical assessment information and is defined as a **timed** (FR 11/27/06 §482.24(1) page 68694)^[7] entry that addresses one or more body areas or organ systems. This might include entries for coordination of care, social issues, or documentation of extensive teaching. Nursing Notes related to performance or outcome at the time of a separately billable procedure are not counted. The additional points are assigned based on the number and quality of nursing notes (1-2, 3-5, 6+, or critical care nursing notes).

Other important considerations include:

- Nursing assessments may be documented on nursing progress notes, flow sheets, templates or in electronic formats.
- A triage note is included in the base weight for every patient and does not constitute a nursing assessment for the purpose of adding resource points. A physical assessment performed in triage does count as the first nursing note.
- Documented comments such as “physician to see patient” or “discharged home” or “to X-ray” do not count as nursing notes when determining the ED visit level. Multiple entries for vital signs would not be considered as nursing assessments. However, if a patient requires frequent vital signs and the nurse documents the correlation of abnormal (or normal) signs with clinical symptoms, response to interventions, etc. the note may be counted. The same would apply if postural vital signs were taken.
- There may be one to multiple systems assessed/documented in the same timed note and will be counted as one nurse’s note.
- Notes related to education (except “routine” discharge instructions) are counted as nursing notes.
- Nursing documentation related to a separately billable procedure noting either the performance or outcome at the time the procedure is performed do not count as nursing notes (FR 11/27/07 page 66790^[2] (FR 01/31/05 page 4860^[6] (FR 11/27/07 page 66805)^[2]). For example, a note describing a procedure such as burn care would not count as a nursing note if the procedure was coded. But a note describing a patient’s increase in pain 30 minutes after the burn dressing was applied may be counted. Another example is an IV infusion: a note such as “IV started and infusing at 100cc/hr” applies to the procedure and would not be counted. However, a note assessing the site of the infusion at a later time such as “Patient complains of burning at IV site, IV is intact and infusing without any signs of inflammation or infiltration” would count as a separate nursing note. Two examples of nursing notes that cannot be counted are: a numeric pain assessment at the time of a medication administration and a note describing a patient complaint of increased abdominal pain, now 9/10, and in the same entry the nurse documents that he/she administered morphine. These two notes would be considered part of the Medication Administration procedure.

- Facilities may have a contract service, meaning that the “staff member” from a contract service comes to the clinic and works in the role of a nurse or other clinic staff member in caring for the patient. Documentation from the contracted staff member could potentially be counted as nursing assessments if the documentation meets the definition of a nursing assessment under the LYNX Algorithm definition. For example, when a staff member from a contracted Mental Health Service comes to the clinic, assesses and provides care to the patient, consider the documentation for nursing assessments as long it meets the LYNX definition
- Any pain assessments beyond triage, including numeric ones that are not a part of a separately billed procedure and post treatment or post intervention are countable. Using the nurses notes, the coder should be able to determine the body area or organ system related to the pain being assessed.
- Sometimes procedure codes are used for tracking rather than billing purposes. Nursing notes regarding these procedures may be counted if the procedure is not separately billed.
- The critical care flow sheet points are intended to provide extra points for frequent, concise, appropriate nursing documentation in a critical situation without the coder having to take time to count nursing notes. A critical care flow sheet does not have to be a specific form or template; other forms of documentation used during a critical care scenario may count such as a nursing progress note or other running account of nursing assessments and interventions. The duration of the critical care will vary and the record may or may not have 30 minutes of critical care documented. These critical care flow sheet points may be selected even if less than 30 minutes of critical care was provided. Selection of “critical care flowsheet” does not drive the assignment of the 99291 critical care CPT code.

Disposition

Only one value may be selected. Discharge instructions and the routine disposition are included in the base weight and earns no extra points. Disposition points may be added in circumstances where care is continued after the ED, or when disposition documentation and teaching require extensive time.

- Routine is the default in the Disposition category and does not add any additional points in the visit level calculation. Dispositions including “left without being seen” (LWBS), “left before treatment” (LBT) or against medical advice (AMA) are included here.
- An Immediate Referral is defined as transferring the care of the patient directly to a physician’s office or clinic for consultation or further treatment. “See your physician tomorrow” would not be an immediate referral.
- Transf/return to Hosp/(SNF)nursing home occurs when the patient is discharged directly to another facility—a hospital, or returned to a nursing home for continued care. Additional facility resources may include coordination with the patient, family and receiving facility, completion of treatment forms, preparation of the patient and securing transportation. An example of a patient transfer that **would not** be included here is a patient who has been brought to the ED by EMS from an “Assisted Living” situation and is returned to “Assisted Living” by EMS because the patient has no other way to get back. In this case this type of transfer is to be considered a “Routine” disposition in the algorithm.
- Admit to an inpatient, observation unit, or other outpatient unit points account for the extra work involved in the admission process.
- Admit to CCU or ICU or ALS/Airlift Transport points account for the extra work involved in these high acuity admissions and transfers. Factors such as arranging for portable oxygen and/or a monitor during transfer, or nursing staff assisting in the transfer increases the use of ED facility staff resources.

- Admissions to other areas such as Telemetry, Operating Room, a Cardiac Catheterization Lab, or a Step- down unit all require varying amounts of staff resources. Based on the documentation, the nurse or coder must assess whether the admission most closely resembles a routine admission or an admission to a critical care area.
- Patient Expired points account for the extra work required of the nursing and other facility staff to care for a patient who has expired or who was “pronounced” in the ED.

Points for the selected additional resource categories are added to the presenting problem’s base weight points to determine the visit level. The visit level should never be increased higher than the total points support. The nurse or coder then verifies the accuracy of the final visit level. If there are extenuating circumstances, such as when a patient leaves before the completion of treatment, the final visit level should be overridden to a lower visit level as follows.

LYNX Policy for Use of Override Function

The coder may override the visit level to a lower level if, when considering the presenting problem and all documentation for services provided, the calculated visit level does not accurately reflect the facility resources utilized. Overrides might occur as a result of a patient leaving AMA, when the problem does not accurately reflecting the acuity of the patient, or if the problem was incorrectly selected. Other examples of when an override might be appropriate include those patients who leave without being seen (LWBS), leave before treatment (LBT) or if there is a client specific coding guideline for a particular presenting problem. Another example of when the visit level should be overridden is when the visit level was increased as a result of an excessive number of nurse’s notes that are not medically necessary. This might have occurred because the patient’s care was delayed or the ED was not busy and the nurse had more than the usual amount of time to document for a particular patient problem.

Note: It is never appropriate to override to a higher level than what automatically calculated.

Overriding of the visit level should be an infrequent occurrence. LYNX analysis of aggregate client data shows that overriding the visit level occurs in less than one percent of encounters. LYNX recommends that each facility develop and document an internal protocol or guideline for when/when not to override a visit level and that coding or ED management personnel be involved in this decision. This internal guideline should be documented in the hospital’s Client Coding Guidelines (CCGs) so that the override function is used consistently by all staff.

If a TRC or base weight points associated with a presenting problem do not accurately reflect a specific ED’s resource utilization for the service provided, this information should be communicated to LYNX for review rather than routinely overriding the calculated visit level.

LYNX ED Outpatient Facility Charging FAQs

General

Q: I've worked with other facility point systems where the visit level was increased when multiple injections and IV narcotics were given. This was because of the increased work and the increased risk for the encounter. Fever and age also increased the risk. In the LYNX Algorithm, do these types of situations affect the visit level?

A: No, neither of these examples affect the Algorithm visit level calculation. A basic principle in coding is that you don't want to code for a service twice. CMS said that any methodology used for visit level coding should minimize the extent to which separately billable procedures are included in the calculation of the visit level. Injections are separately billable procedures and as such are not included in the visit level calculation in the LYNX algorithm. Risk is a component of Medical Decision Making (MDM) and is a concept used in professional (physician) coding, not facility.

Q: Would I ever have a professional assignment for critical care without coding critical care for the facility?

A: It would be rare, but because the time for separately billable procedures must be subtracted from critical care the physician's and facility's critical care time may be different. There are often more separately billable procedures reported for the facility than the physician. If the facility critical care time, after the subtraction of time spent on facility procedures, is less than 30 minutes, critical care would not be assigned.

Q: If the documented presenting problem is incorrect based on other documentation in the ED record, do I still use it to determine the typical resource category?

A: No. Look at the chief complaint, triage information, and the physician's HPI information and determine the presenting problem that best represents the patient's evaluation and treatment in the ED.

Q: What if the final visit level seems too high for the services provided?

A: The LYNX Algorithm takes into account resources expended by all staff, not just nursing. In some encounters the patient's care requires above average use of resources. If the visit level is higher than expected and the documentation does not indicate above average facility resource use (for example, because the patient left AMA) then consider overriding the final visit level. Assigning a final visit level lower than what the final point total justifies should be rare.

Q: Why is there nothing in the point system regarding an elderly patient?

A: The fact that the patient is elderly does not necessarily impact facility resources the way it may impact the physician's MDM. If the patient has special safety needs or if restraints are required you may give points as appropriate for nursing notes documenting such or under Process Management for "Restraints."

Q: When a physician does not document critical care time but the points add up to 18 and the nursing supports critical care, can it be assigned to the facility?

A: Yes. Critical care time may be documented by the physician or the nurses. There must be at least 30 minutes of critical care time documented (meeting CPT's definition of critical care) in the medical record and the Algorithm's 18-point criteria for critical care must be met. There are several cases where this may happen: an example would be if a trauma team takes over the medical direction of care from the ED physician. In this case, the facility will accumulate more critical care time than the physician.

Order Management

Q: What about orders that are performed by ED staff? Can you count a point for order management?

A: Yes. It is not uncommon for ancillary services to be based in the ED or even for nurses to provide point of service testing, such as I-Stat labs, fingerstick glucose, or dipstick urine testing. The order management points are added to account for the ED resources expended so that orders are noted, communicated, and followed up as needed. All ancillary services performed in the ED should have an order. The points are not for performance of the procedure itself.

Q: Is pulse oximetry considered a lab under the "Order Management" category?

A: Pulse oximetry is an exception and should not be counted. It is not a lab and is considered similar to obtaining a vital sign, such as blood pressure.

Q: How does order management for an ancillary service differ from an ancillary staff consult?

A: An ancillary staff consult is assigned when ED nursing/staff documentation supports interaction with the social or ancillary service staff in the ED, and the consulting staff performs an evaluation of a specific problem. The ancillary staff member will usually coordinate care with the ED nurses.. Order management for ancillary service is assigned when the ED staff member only coordinates an order for a service, test or procedure to be performed by a non-ED hospital employee.

Process Management

Q: Our psychiatric patients are seen by a Psychiatric Assessment Clinician. Would this count as a consult like Social Services?

A: Yes.

Q: How is a "Psych/Social Crisis" different from "Restraint"? Can both be assigned?

A: Psych/Social Crisis is defined as management of emotional or behavior factors affecting the commitment of nursing time. This involves significant behavioral issues that require the frequent or ongoing 1:1 attention of nursing, ancillary, or security staff. This may or may not result in the patient being placed in restraints. More than one type of process management may be counted from this section if documentation supported extra management time in addition to restraints, both could be counted. The same work/time however can not be counted twice.

Q: I sometimes see the ED Clinician (EDC) do a phone consultation where the EDC gets very detailed instructions as how to treat the patient, however the consultant does not come to the ED. Can I count a consult?

A: No. Consult MD points are added only when a consulting physician/resident comes into the ED requiring that additional work be performed by the ED nursing and ancillary staff.

Nursing Assessment

Q: Does there have to be a nurse's signature in order to give credit for "Nursing Assessment?"

A: All entries must be authenticated in written or electronic format consistent with hospital policies and procedures. (FR 11/27/06 page 68694)^[7] Ideally, the nurse should initial each entry and sign the bottom of the record. If a signature is not present credit the assessment data for coding purposes and send feedback to the nurse.

Q: Can you discuss what constitute a nurses' note and clarify the "timed nursing entry"? What about frequent vital signs?

A: A nursing note contains clinical assessment information and is defined as a **timed** (FR 11/27/06 page 68694)^[7] entry by nursing or ancillary staff that is related to the patient's clinical condition. One to multiple systems might be assessed in a single nurses note. Multiple entries for vital signs would not be considered as nursing assessments. However, if a patient requires frequent vital signs and the nurse documents the correlation of abnormal (or normal) signs with clinical symptoms, response to interventions, etc. the note may be counted. The same would apply if postural vital signs were taken. Two examples:

0945 -- The patient complains of 6/10 pain in her left chest. She is diaphoretic and states she feels more short of breath. Dr. Jones notified.

1012 -- All lung fluids clear at this time. O2 continues at 4LPM.

Documentation related to the performance or outcome at the time of a separately billed procedure does not count toward Nursing Assessment points. Documentation of patient clinical assessment information related to a procedure and documented at a time later in the ED encounter may be counted. You can also use notes about procedures as a "timed nursing note" if the procedure is not separately billed as long as it meets the criteria for a timed NN. The rule is you cannot bill twice—you charge for the service either as a separately assigned procedure or consider the work in the visit level.

Routine discharge instructions are an expectation for every patient. This work is included in the base weight. A signed instruction sheet or simple statement "discharged home" with a set of vital signs would not count as a timed entry. Signing off for medications given to the patient at discharge would not count. To count as a timed nursing note, resources, instructions, etc. beyond the standard discharge instructions for a particular presenting problem must be documented.

Q: What about multiple nursing assessment notes that add enough points to increase the final visit level above where it seems seems justified?

A: In some cases the number of nursing notes is related to how much time the nurse has to document. Coders need to use their judgment when assessing the final facility E/M level. An important concept for coding visit levels is to consider the documentation as being sufficient to support the visit level assigned and not as a way to increase code assignment when documentation is more extensive than you would expect. The record should be evaluated and coded based on the services provided. The coder must be certain that the documentation supports code assignment, but you should not search out additional information in order to code the highest level possible when it is not medically necessary. For example, multiple nursing notes for a patient with a simple cough should not raise a facility visit level above the TRC for cough.

Q: Is documented “crutch walk teaching” considered a nursing assessment? There is usually a return demonstration by patient.

A: If the nurse’s documentation for this instruction is medically necessary and more extensive than what is expected in discharge instructions, such as an assessment of the patient’s limitations, abilities, learning, etc., it can be counted as a nursing note.

Q: Are numeric pain assessments considered countable nurse assessments?

A: Numeric pain assessments beyond those performed at “triage” are countable if they **are not** performed at the time of a separately billed procedure, e.g. Med Administration. If pain assessments are a “routine” part of the nurses documentation of vital signs, we would recommend not counting all entries but instead only the initial assessment and those which follow post treatment interventions to prevent the risk of over valuing the patient visit. Internal policy regarding this should be noted in the CCGs to promote consistency in nurses assessment counts.

Disposition

Q: If the physician orders an ED patient to be transferred to another hospital and the nurse documents “see transfer sheet” in his discharge note, but I do not have access to this sheet, can I still add points for a transfer under disposition?

A: Yes.

Q: If a patient is returned to a nursing home or sent home by ambulance, what accounts for the extra points assigned here?

A: This type of a disposition creates additional work for the ED staff. Copies of the ED records have to be made, order sheets sent and often the nurse must call the nursing facility to give a verbal report. Transfer by ambulance requires coordination of transportation, transfer forms need to be completed and the ED RN must also provide a report to the ambulance personnel. This additional facility resource use is included in the disposition category selected for the patient which, in this scenario, would be “Transfer/Return to Hospital/SNF.”

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Addendum: Summary Changes

Material Changes

- Introduction - Added the current 11 CMS OPPS coding guidelines.
- Algorithm Overview – Added detailed information regarding explanation of the E/Point algorithm basis.
- Presenting Problem – Added information regarding correct problem selection when “Multiple Problems” are presented by the patient at time of triage. Added additional information regarding “major and minor” problems, as well as “simple or uncomplicated versus complicated” problems.
- Mode of Arrival – Added further information to clarify the type of resource utilization being given credit for in this resource category.
- Order Management – Made changes to category names to match as noted in LYNX RMS applications. Added information to clarify what documentation is required to support assignment of Ancil Svc points. Added detailed information regarding documentation required to support assignment of points for “Access Medical Records”.
- Process Management – Made change to category name for physician consult and consult of social/ancillary services to match as noted in LYNX RMS applications. Added detailed information regarding documentation required to support assignment of points for “MD Consult” and “Consult Social/Ancil Svc”. Added reminder about double billing issue around assistance of consulting MD with procedures that will be separately billed. Added detailed explanation of how to handle consult services for those who submit their own bill. Added detailed explanation of how to handle telehealth or telemedicine consultations and consultation services for those who submit their own bill.
- Disposition – Added “Patient Expired” with definition. Added “Routine” with definition. Made change to “Transfer” category name to match as noted in LYNX RMS applications and added detailed information on how to handle an EMS transfer of patient back to “Assisted Living”.
- Added FAQ regarding correct counting of pain assessments.
- Override Function – added detailed information on LYNX Policy regarding correct use of and when to use this function in LYNX RMS applications.