Evaluation and Management Coding for Emergency Medicine

By
Sarah Todt RN, CPC, CEDC

Emergency Department Evaluation and Management Codes

- 99281
- 99282
- 99283
- 99284
- 99285
- Critical Care 99291
  - +99292
ED Evaluation & Management Codes

- There are three key components that must be met to correctly assign an Evaluation and Management code:
  - **History**
  - **Exam**
  - **Medical Decision Making**

CPT E/M Components Other

- **Nature of the presenting problem**
  - 99283 vs. 99284
- **Time**
  - Critical Care
Medical decision making dictates the highest level code that can be chosen – *Proper documentation supports your choice*
Levels of Medical Decision Making

- Straight Forward
  - 99281
- Low Complexity
  - 99282
- Moderate Complexity
  - 99283 and 99284
- High Complexity
  - 99285

DOCUMENTATION OF MEDICAL DECISION MAKING

- The number of possible diagnoses that must be considered
  - Chest pain patient
  - Diff Dx chest pain: Angina, PTx, GERD
  - Final Diagnosis GERD
- The type of management options
  - Rx drug management, IV fluids, parenteral narcotics
- The amount and/or complexity of information that must be obtained, reviewed, and analyzed
  - Labs, X-rays, EKGs, Medical records reviewed
Medical Decision Making
Scoring Systems

- Most use the Marshfield Clinic Type Audit Tool to expand on the Documentation Guidelines
- Not an official part of the DGs
- Tool used to score the overall Medical Decision Making
- Evaluates 3 components:
  - Number of Diagnosis and Management Options
  - Amount and Complexity of Data
  - Risk

Medical Decision Making:
Number of Diagnosis or Management Options

CPT® does not distinguish between new and established patients in the ED

- New problem no additional Work up
  - Patient seen and discharged
- New problem with additional Work up
  - Admit, Transfer, OR, ....
Medical Decision Making:
Amount or Complexity of Data

- Review and/order clinical lab test 1 point
- Review and/order radiology test 1 point
- Review and/order medicine test 1 point
- Discussion of test results with performing physician 1 point
- Decision to obtain old records and/or history from someone other than the patient 1 point
- Review and summarization of old records or obtaining history from someone else or discussion of case with another health provider 2 points
- Independent visualization of image, tracing, or specimen 2 points

Risk

- The third part of the overall Medical decision Making
- The Risk Table is an official part of CMS Documentation Guidelines
- Is scored independently
  - Along with Management Options and Amount and Complexity of Data
- Highest level of risk in any category determines the overall risk score
### Risk Table

**Risk of complications and/or Morbidity or Mortality**

*Highest Level In Any Category Prevails*

<table>
<thead>
<tr>
<th>99281</th>
<th>99292</th>
<th>99283</th>
<th>99284</th>
<th>99285</th>
</tr>
</thead>
<tbody>
<tr>
<td>MINIMAL</td>
<td>LOW</td>
<td>MODERATE</td>
<td>HIGH</td>
<td></td>
</tr>
<tr>
<td>Suture removal (placed at other facility)</td>
<td>OTC med only; acute uncomplicated injury or illness</td>
<td>Rx management; Acute illness with systemic symptoms; Acute complicated injury; Exacerbation of chronic condition</td>
<td>Abrupt neuro change; Potential life threatening illness; Severe exacerbation of chronic illness; Medications requiring monitoring; Parenteral controlled medications</td>
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</table>

### Scoring MDM

**Must Meet 2 out of 3**

<table>
<thead>
<tr>
<th>Mgt. Options</th>
<th>Data</th>
<th>Risk</th>
<th>Overall MDM</th>
<th>ED E/ M Supported</th>
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</thead>
<tbody>
<tr>
<td>------</td>
<td>1 pt.</td>
<td>Minimal</td>
<td>Straight forward</td>
<td>99281</td>
</tr>
<tr>
<td>------</td>
<td>2 pts.</td>
<td>Low</td>
<td>Low Complexity</td>
<td>99282</td>
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<tr>
<td>New pt/ no Add’l w/u</td>
<td>3 pts.</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
<td>99283 and 99284</td>
</tr>
<tr>
<td>New pt with add’l w/u</td>
<td>4 pts.</td>
<td>High</td>
<td>High Complexity</td>
<td>99285</td>
</tr>
</tbody>
</table>
CPT® Specific Rules

Nature of The Presenting Problem
Nature of Presenting Problem

- **99281** Usually, the presenting problem(s) are self limited or minor

- **99282** Usually, the presenting problem(s) are of low to moderate severity

- **99283** Usually, the presenting problem(s) are of moderate severity

- **99284** Usually, the presenting problem(s) are of high severity, and **require urgent evaluation** by the physician but do not pose an immediate significant threat to life or physiologic function.

- **99285** Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life of physiologic function.
Level III: General comments

- Moderate presenting problem but not requiring urgent evaluation
- Prescription Drug Management
  - Includes Rx meds given in ED
    - Eye drops, ear drops, Antibiotics, pain meds
- Limited diagnostic studies
  - Single X-ray

Level III: General comments

- Systemic symptoms
  - Viral illness

- Mild exacerbation of chronic condition
  - Recurrent condition
Level IV:
General Comments

- Urgent Tx of condition
- Multiple diagnostic studies
- Special studies alone (CT, MRI, US)
- ED Interventions:
  - Nebs
  - Parenteral medications
- Usually not admitted

Level V:
General Comments

- Many Admissions

Frequently Involve:
- Prolonged services in ED
- Special Studies with other tests (CT/MRI/US)
- Multiple reassessments
- Interpretations of EKG or x-rays
- Old record review
- Documented conversations
HISTORY

History

The history portion of a patient’s chart includes some or all of the following elements:

- Chief complaint (CC)
- History of present illness (HPI)
- Review of systems (ROS)
- Past, family and/or social history (PFS)
History of Present Illness

- **Location** - left sided chest pain, upper, lower, posterior
- **Context** - while shoveling snow, while cutting a roll, during the football game, scratched by the cat
- **Quality** - sharp chest pain, throbbing headache, crampy belly pain
- **Timing** - worse at night, daily, constant, frequent

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History of Present Illness

- **Severity** - moderate chest pain, 6 out of 10
- **Duration** - 10 minutes, for a week
- **Modifying Factors** - worse with exertion, unrelieved by Tylenol
- **Associated Signs and Symptoms** - diaphoresis, fever, vomiting
History of Present Illness

- HPI flushes out the chief complaint in greater detail
- There are two types of HPI identified for the purpose of coding
  - A brief HPI consists of 1-3 elements (99281-99283)
  - An extended HPI consists of at least 4 elements (99284-99285)

HPI Examples:

- Brief- 32 year old male with left shoulder injury, occurred 4 hours ago

- Extended-45 year old female with left sided, sharp chest pain for 30 minutes with left arm numbness and diaphoresis. The pain is worse with exertion
HPI Examples
Multiple Modifying Elements

Child with Chief Complaint of fever:
4 hours of fever, with moderate vomiting,
diaphoresis that is worse at night, right
lower quadrant abdominal pain, unrelieved
by Tylenol

Review of Systems (ROS)

- An inventory of body systems
- "Patient’s positive responses and pertinent
negatives should be documented”
- "For the remaining systems, a notation
indicating all other systems are negative is
permissible”

*CMS 1995 Documentation Guidelines*
Review of Systems (14)

- Allergic/Immunologic
- Cardiovascular
- Constitutional Symptoms
- Ears, Nose, Mouth, Throat
- Endocrine
- Eye
- Gastrointestinal
- Genitourinary
- Hematologic/Lymph.
- Integumentary
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory

Review of Systems (ROS)

- A **problem pertinent** ROS addresses 1 system (99282/99283)

- An **extended** ROS addresses 2-9 body systems (99284)

- A **complete** ROS addresses at least 10 organ systems (99285)
Past, Family, Social History (PFS)

- Past History - A review of the patient's past experiences with illnesses, injuries, treatments, past hospitalizations, surgeries, medications, allergies, immunizations

- Family History - A review of medical events in the patient's family with regard to chronic illness, cause of death, or diseases related to the current complaint

- Social History - An age appropriate review of past and current activities such as drug and alcohol use, living situation, and job history

There are two types of PFS in emergency department coding.

- A **pertinent** PFS consists of any 1 element from the PFS (99281-99284)

- A **complete** PFS consists of one element from 2 of the 3 PFS history areas for ED E/M codes (99285)
History Issues

- ROS and PFSH may be recorded by others
  - The provider must reference the elements
  - ROS not as easy to obtain from NNs

- No need to record things in more than one place
  - ROS elements may be documented in the HPI
    - A chief complaint will generally include at least one ROS
  - Chest pain associated with nausea and vomiting
    - HPI element for associated signs/sxssxs
    - GI ROS element
  - Same statement may not satisfy multiple sub-elements of HPI or ROS
    - Chest pain since this morning can not be both timing and duration

THE “EMERGENCY MEDICINE” CAVEAT

"If the physician is unable to obtain a history from the patient or other source, the record should describe the patient’s condition or other circumstances which precludes obtaining a history."

CMS 1995 Documentation Guidelines
CMS History Caveat

- Documentation must include the reason history is not obtained
  - NH patient with dementia
  - Postictal
  - Severe dyspnea (CHF or Asthma)

Exam
1995 Guidelines for Physical Exam

- To determine the extent of an examination CPT recognizes the following 11 organ systems:
  - Eyes - Psychiatric
  - Cardiovascular - Respiratory
  - Gastrointestinal - Genitourinary
  - Musculoskeletal - Skin
  - Neurologic
  - Hematologic/Lymphatic/Immunologic
  - Ears, Nose, Mouth and Throat
  - (CMS recognizes constitutional)

1995 Documentation Guidelines
7 Body Areas

- Head-including face
- Neck
- Chest-including breast and axillae
- Abdomen
- Back including spine
- Genitalia, groin, buttocks
- Each extremity
1995 Guidelines for Physical Exam

- **Problem Focused-1 Body System including affected area (99281)**

- **Expanded Problem Focused** - a limited examination of the affected body area or organ system and related body area(s) or organ system(s)
  - **2-4 Body systems including affected area (99282/99283)**

- **Detailed** - an extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s)
  - **5-7 Body areas or systems including affected area (99284)**
  - Comprehensive - a general multi-system examination
  - **8 or more organ systems including affected area (99285)**
Documentation Guidelines
Physical Exam-Record Format

- Checklists to indicate performance of any item
  - Lungs CTAB
- Brief statement or notation “negative” or “normal” ok for normal findings
  - ENT-normal
- Specific abnormal and clinically relevant
  - Negative must be documented- “abnormal” without elaboration insufficient
  - Abdomen soft, tender RLQ, BS poor

Common Documentation E/M
Down Codes for Medicare records

- HPI-need 4 HPI elements for 99285
  - With 3 or less go down to 99283

- ROS-need 10 ROS for level 99285
  - If 2-10 go down to 99284

- Physical Exam-need 8 systems for 99285
  - If <8 go down to 99284
- Past/Family/Social- need 2 for 99285
  - If just one go down to 99284
99285 Acuity Caveat

- **99285 ED visit** for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status:
  - Severe Dyspnea - COPD, Asthma Pneumonia
  - Unstable Vital Signs - Trauma, Sepsis
  - Severe Pain - Long bone fractures, open fractures
  - CPR/intubated
  - Should state on chart: Hx/Exam limited by____

Documentation Guidelines

<table>
<thead>
<tr>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
<th>Exam</th>
<th>Level of Service</th>
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<tr>
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<td>4</td>
<td>10</td>
<td>2</td>
<td>8</td>
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2010 RVUs

Critical Care
Critical Care Overview

- Evaluation and Management (E/M) Code
- Found in first section of CPT®
- Reported using 99291
- Additional work reported with the add on code +99292

Critical Care Overview

- Unlike other E/M codes no specific key element requirements
  - History, Physical Exam, Medical Decision Making
- No Specific HPI, ROS, Physical Exam documentation requirements
- Time based code
- Patient must meet certain clinical criteria
Critical Care Definition

"A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition."

(AMA/CPT 2008)

Organ System Failure

- Central nervous system failure
  - Stroke
- Circulatory failure
  - Acute MI
- Shock
  - Severe trauma
- Renal failure
  - New onset
  - Hyperkalemia
- Hepatic Failure
  - Encephalopathy
  - Coagulopathy
- Metabolic failure
  - Toxic Ingestion (methanol)
  - Severe Acidosis
- Respiratory Failure
  - Pneumonia
Critical Care Requirements

- Clinical Requirement of high probability of deterioration
- Time requirement
- Minimum 30 minutes
- Excludes separate procedures

“Full Attention And Physician Time”

- Time counted must be exclusively devoted to patient
- Does not have to be continuous
- Physician must document total time on chart
- Must document that time involved in separately billable procedures was not counted toward CC time
- Attestation with check box or fill in the blank OK
Critical Care Time
What Counts?

- Bedside patient care
- Reviewing ancillary studies
- Discussions with:
  - Family, rescue, nursing, physicians as related to care
- Chart documentation and completion
- Bundled Procedures
  - CXR

Critical Care Bundled Services

- Cardiac Output
  - 93561/93562
- CXR
  - 71010/71015/71020
- Pulse Oximetry
  - 94760/61/62
- Computer Data
  - 99090
- Transcut. Pacing
  - 92953
- Ventilator Mgt.
  - 94002-94004, 94660, 94662
- Vascular Access
  - 36000/36410/15/40
  - 36600
- Gastric Intubation
  - 43752/91105
Critical Care:
“What is not included?”

- Endotracheal intubation 31500
- CPR 92950 (time must be subtracted)
- Triple Lumen Catheter insertion 36556
- Transvenous pacer 92953
- EKG interpretation 93010

Bill these separately

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**Critical Care Time Requirements**

<table>
<thead>
<tr>
<th>Critical Care Time</th>
<th>Code</th>
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<tbody>
<tr>
<td>&lt;30 minutes</td>
<td>Approp. E/M code</td>
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<tr>
<td>30-74</td>
<td>99291</td>
</tr>
<tr>
<td>75-104</td>
<td>99291, 99292</td>
</tr>
<tr>
<td>105-134</td>
<td>99291, 99292 X 2</td>
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</tbody>
</table>
Clinical Conditions Consistent with Critical Care (1)

- Severely altered mental status
- Cardiac or respiratory arrests
- Airway compromise
- Need for immediate surgery
  - Trauma
  - Ruptured ectopic
  - Perforated Viscous
  - AAA

May Not Qualify For Critical Care

- Admission to Critical Care services secondary to no other bed in hospital
  - Tele Borders
  - Hospital Specific Rules such as:
    - nebs Q 2 hours
    - in otherwise stable patients
Critical Care: Other Facts

- “All other billable procedures not included in CC time”
- Requires 30 to 74 minutes for first hour of CC
- Frequently feedback

Teaching Physicians Critical Care

- Resident time does not count
- TP personal time must be clearly documented
- Teaching time does not count
- Subtract time for separately billable procedures
Critical Care and CPR

- Critical reporting requires subtracting minutes spent performing separately billable procedures
- 92950 CPR is not a bundled service should be reported separately
- Must subtract out amount of time spent supervising CPR

QUESTIONS?
Thank you

Sarah Todt RN, CPC, CEDC
stodt@mrsiinc.com
www.mrsiinc.com