Coding for Emergency Department Services

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Documentation - Overview

• Documentation Guidelines
  – CMS 1995
  – CMS 1997
• May choose guidelines that are most favorable to the provider
  – Most will use 1995 Documentation Guidelines
EHR Cloning Under Scrutiny

“There are troubling indications that some providers are using EHR technology to game the system, to obtain payments to which they are not entitled. False documentation is illegal. A patient’s information must be verified by the provider to ensure accuracy and can not simply be cut and pasted. Law enforcement will take appropriate steps…”

-Kathleen Sebelius, Secretary of Health and Human Services

Coding Methodology

- Medical Decision Making determines the highest possible code
- Hx and PE documentation supports the level
- Chest Pain could be a level 5
  - Without appropriate documentation...downcoded
  - Significant revenue loss
- NOPP will prevent over coding due to documentation
E/M Scoring Tools

- Many use Marshfield type audit tool
  - Marshfield clinic developed to quantify elements in DGs
- Many variations
- Review payer rules
Levels of Medical Decision Making

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

Medical Decision Making

Evaluates 3 components:

1. Number of Diagnosis and Management Options
2. Amount and Complexity of Data
3. Risk
MDM Components - Number of Diagnosis or Management Options

<table>
<thead>
<tr>
<th>Category of Problem</th>
<th>Occurrence of problem</th>
<th>Value</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited minor problem</td>
<td>(max 2)</td>
<td>x 1</td>
<td></td>
</tr>
<tr>
<td>Established problem, stable or improved</td>
<td></td>
<td>x 1</td>
<td></td>
</tr>
<tr>
<td>Established problem, worsening</td>
<td></td>
<td>x 2</td>
<td></td>
</tr>
<tr>
<td>New problem, no additional workup planned</td>
<td>(max 1)</td>
<td>x 3</td>
<td></td>
</tr>
<tr>
<td>New problem, additional workup planned</td>
<td></td>
<td>x 4</td>
<td></td>
</tr>
<tr>
<td>Grand total</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

MDM Component - Amount and Complexity of Data

<table>
<thead>
<tr>
<th>Reviewed Data</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order radiology tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order medicine tests</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test result with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other</td>
<td>1</td>
</tr>
<tr>
<td>Summarization of old records and/or obtain hx from someone other than pt and/or discussion of case with other provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image or tracing</td>
<td>2</td>
</tr>
</tbody>
</table>
MDM Components

**Risk**

- The third part of the overall MDM
- 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

<table>
<thead>
<tr>
<th>Presenting Problem</th>
<th><em>Diagnostic Tests</em></th>
<th>Mgt. Options</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 self-limited/minor problem</td>
<td>Lab w/ venipuncture, CXR, EKG, U/A</td>
<td>Rest, Gargle, Ace, Superficial Dressing</td>
<td>Minimal 99281</td>
</tr>
</tbody>
</table>
| 2 or more self-limited/minor  
1 stable chronic illness; Acute uncomplicated illness or injury | Lab w/ arterial puncture  
Superficial needle biopsies | OTC drugs, IV w/o additives | Low 99282 |
| 1 chronic illness w/ exacerbation; 2 or more stable chronic illnesses; New problem w/ uncertain progress; Acute illness with systemic symptoms, eg pyelonephritis, pneumonia, colitis | LP, Thoracentesis, Culdocentesis | Prescription drug mgmt; IV w/ additives; Tx of Fx w/o manipulation; Minor surgery w/ identified risk factors | Moderate 99283 99284 |
| 1 or more chronic illnesses w/severe exacerbation; Acute illness that poses a threat to life or bodily fx, eg multiple trauma, AMI, PE, psych illness with threat to self or others, ARF, Abrupt change in neuro status eg seizure, TIA, weakness, or sensory loss | Endoscopy with identified risk factors | Parental controlled drug therapy; Drug therapy requiring monitoring; Emergency major surgery | High 99285 |
Scoring MDM: Must meet 2 out of 3

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<tr>
<th>Mgt. options</th>
<th>Data Points</th>
<th>Risk</th>
<th>Overall MDM</th>
<th>Level</th>
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<td>2 points</td>
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<td>Low Complexity</td>
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MDM-Example

- Pt with new complaint of severe N/V. Treated immediately with IV fluids and IV Zofran
- Data: Labs, decision to obtain old record and discussion with other provider
- Risk: given prescription for Zofran
MDM-Scoring

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Nature of Presenting Problem

- Not a key component of documentation guidelines
- Useful in determining 99283 vs. 99284

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.
History

- Three components of History
  - HPI
  - ROS
  - PMFSH
History of Present Illness

- **Location** – left sided chest pain
- **Context** – while shoveling snow
- **Quality** – sharp chest pain
- **Timing** – worse at night
- **Severity** – moderate chest pain
- **Duration** – 10 minutes
- **Modifying Factors** – worse with exertion
- **Associated Signs & Symptoms** – diaphoresis

**History of Present Illness**

HPI flushes out the chief complaint in greater detail.

**Level supported**

- Brief (1-3 elements) 99281-99283
- Extended (4 elements) 99284-99285
HPI-Example

HPI: 11 year old male with complaints of severe pain of the right lower arm sustained after falling from a trampoline. The accident occurred 30 min PTA. The patient reports some tingling in hand. Denies neck pain, headache, abdominal pain and chest pain. Pain is improved with ice and immobilization.
Review of Systems

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

Review of Systems (ROS)

Level supported
Problem pertinent (1 system) 99282/99283
Information related to the problem identified in the HPI

Extended (2-9 system) 99284
Information related to the problem identified in HPI plus a limited number of additional systems

Complete (10 or more systems) 99285
Information related to the problem plus all additional body areas
- DG: At least ten organ systems must be reviewed...
ROS-Example

• Patient admitted with chest pain after comprehensive work up and treatment with IV MSO4. Supporting high MDM

**REVIEW OF SYSTEMS**
- Constitutional: No fever, no chills
- Cardiac: See HPI.
- Respiratory: + cough
- GI: See HPI, no sx prior to today.
- GU: No dysuria, frequency or burning.
- MS: + intermittent back pain
- Skin: No skin rash.

ROS-Example

• Patient admitted with chest pain after comprehensive work up and treatment with IV MSO4. Supporting high MDM

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ROS “All others negative”

Those systems with positive and negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible.

— CMS 95 Documentation Guidelines

Past, Family, Social History (PFSHx)

- There are two types of PFSHx for emergency department coding.

  Level supported

  Pertinent (1 PFSH element)  99284

  Complete (2 PFSH elements)  99285
Past, Family, Social History (PFSHx)

An 80 year old is admitted with UTI and dehydration after comprehensive work-up. MDM scored as high.

**Past Medical Hx:** IDDM, chronic renal failure. NKDA

**Social Hx:** Denies smoking, ETOH

**Family Hx:** N/A

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**History Pitfalls**

- If less than 4 HPI elements are documented, the case cannot be coded higher than a 99283

- If there is no PFSHx you cannot code higher than a 99283

- If there is < 10 ROS elements, the case cannot be coded higher than a 99284
Insufficient History

Example: 65 y. o. male presents with neck pain after falling from a tree. He reports history of diabetes and HTN.

He is diagnosed with a spinal fracture and is admitted after a comprehensive work-up and is treated with parenteral narcotics.

Coded 99283

The CMS History 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 95 Documentation Guidelines

The reason history is not obtained must be documented on the record.

– NH patient with dementia
– Postictal
– Severe dyspnea (CHF or Asthma)
History- Nurses Notes

• DG: The ROS and PFSH may be recorded by ancillary staff....To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.

Physical Exam-Body Areas

• Head, including the face
• Neck
• Chest, including breast axillae
• Abdomen
• Genitalia, groin, buttocks
• Back, including spine
• Each extremity
Physical Exam-Organ Systems

- Constitutional
- Eyes
- Ears, Nose, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Heme/Lymph/Immun

Exam-1995 DGs

There are four types of exam:

- **Problem focused**- a limited exam of the affected body area or organ system
- **Expanded Problem Focused**- A limited exam of the affected area and other related organ systems
- **Detailed**- An extended exam of the affected body area and other related organ systems
- **Comprehensive**- a general multi-system exam
  - DG:...should include findings about 8 or more of the 12 organ systems
1995 Guidelines for Physical Exam

99281 (Problem focused)
1 body area/organ system

99282/99283 (Expanded problem focused)
2 – 4 body area/organ systems

99284 (Detailed)
5 – 7 body area/organ systems

99285 (Comprehensive)
8 organ systems

Documentation Summary

<table>
<thead>
<tr>
<th>Level</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
<th>PE</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>99282</td>
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<td>99283</td>
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<td>99284</td>
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<td>1</td>
<td>5</td>
</tr>
<tr>
<td>99285</td>
<td>4</td>
<td>10</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>
Critical Care

“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 2014
“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
- Physician must document that time involved in separately billable procedures was not counted toward CC time

“I provided x minutes of critical care outside of separate procedures”

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
Critical Care: What Is Not Included?

Separately billable procedures
- Endotracheal intubation
- Triple Lumen Catheter insertion
- Transvenous pacer
- EKG interpretation
- CPR

Critical Care Conditions

- Cardiovascular
  - Acute MI, Unstable angina
  - Infusions of Antiarrhythmic or vasoactive
- Respiratory
  - Potential airway compromise (ETT, BiPap or CPAP)
- Sepsis/Bacteremia
  - Vasoactive infusions or fluid resuscitation
  - Unstable VS
Critical Care Conditions

• Metabolic Disturbance
  – Hyperkalemia with EKG changes
  – DKA with aggressive management/ neurostatus changes

• Need for immediate surgery
  – Trauma
  – Ruptured ectopic
  – AAA

QUESTIONS?
Thanks!

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