Let's Play a Game: Emergency Medical Documentation
Coding for Emergency PHYSICIANS (not coders)
Georgia College of Emergency Physicians
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Definitions:
CPT: Current Procedural Terminology; every billable procedure has its own 5-digit CPT code
E&M: Evaluation & Management code; turns MD evaluation of a patient into a CPT code
ICD-9: International Classification of Diseases; these are the diagnosis codes
RVU: a comparable service measure used to permit comparison of the amounts of resources required to perform various services within a single department or between departments. It is determined by assigning weight to such factors as personnel time, level of skill, and sophistication of equipment required to render patient services.

This lecture and handout covers basic E&M coding.

The Mantra: **Your MEDICAL DECISION MAKING drives your coding, but your documentation must correspond to the level of coding you choose!**

Part I: Select a coding level/E&M code: Medical Decision-Making (MDM)
There are THREE components of the MDM section of your patient encounter:
(1) diagnostic and management options;
(2) data; and
(3) level of risk.

1. Diagnostic and Management Options:

Self limited or minor problems (max. 2):	1 pt each
Established problem, stable:	1 pt each
Established problem, worse:	2 pts each
New problem, no additional workup planned:	3 pts each
New problem, with additional workup planned:	4 pts each

2. Data **(ordered/reviewed)**:

	Value
Clinical lab tests	1
X-rays, imaging studies	1
Medical tests	1
Discuss test results with performing physician	1
Decision to obtain old records/history from someone else	1
Review/summarize old records or history from someone else	2
Doctor's **visualization** of a test/study	2

3. Risk:

Level of Risk	Presenting Problem	Diagnostic Procedure Ordered	Management Options Selected
Minimal	• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	• Laboratory tests requiring venipuncture • Chest x-rays • ECG/EEG • Urinalysis • Ultrasound, e.g., echocardiography • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, e.g., well-controlled HTN or NIDDM, cataract, BPH • Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, e.g., pulmonary function tests • Noncardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• **Over-the-counter drugs** • Minor surgery with no identified risk factors • Physical therapy • IV fluids without additives
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • **Undiagnosed new problem with uncertain prognosis, e.g., lump in breast** • **Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis** • Acute complicated injury, e.g., head injury with brief loss of consciousness	• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram, cardiac catheterization • Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • **Prescription drug management** • Therapeutic nuclear medicine • **IV fluids with additives** • **Closed treatment of fracture or dislocation without manipulation**
High	• **One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment** • **Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure** • **An abrupt change in neurologic status, e.g., seizure, TIA, weakness, or sensory loss**	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous, or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous, or endoscopic) • **Parenteral controlled substances** • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

* Taken from the 1995 Documentation Guidelines for Evaluation and Management Services, available at www.cms.hhs.gov/MLNProducts/20_DocGuide.asp#TopOfPage

CODING FOR EM PATIENT ENCOUNTERS

MEDICAL DECISION MAKING			LEVEL	HISTORY			EXAM (organ systems)
Dx/Mgmt options	Data	Level of Risk		HPI	ROS	PM/F/S	
1	0-1	Minimal	**99281**	1-3	-	-	1
2	2	Low	**99282**	1-3	1	-	2-4
3	3	Moderate	**99283**	1-3	1	-	2-4
3	3	Moderate	**99284**	4 or more	2-9	1 of 3	5-7
4 or more	4 or more	High	**99285**	4 or more	10 or more	2 of 3	8 or more
Middle of the 3 categories determines your E&M code				**You must document ALL of the elements required for the E&M code you selected**			

To determine your E&M code: Plot on the table your scores for your diagnostic/management options, data, and your level of risk. Then throw out your highest (the one closest to 99285) and lowest (the one closest to 99281) scores. The one that remains determines your E&M code.

(Note that E&M codes 99283 and 99284 have identical medical decision-making requirements. The distinction between these two codes comes in the history and physical exam scores.)

Part II: Justify your coding: Documentation

Once you select a coding level (based on your medical decision-making), you must ensure that your chart documentation supports that code. There are requirements for documentation of your history, physical exam, and medical decision-making at every coding level.

The medical history, for the purposes of coding, has three components:
(1) history of present illness (HPI);
(2) review of systems (ROS); and
(3) past medical / family / social history (PM/F/S).

1. History of present illness (HPI): each of the following is worth one (1) point:

- Location
- Duration
- Timing
- Severity
- Quality
- Modifying factors
- Associated signs and symptoms
- Context

2. Review of systems: each of the following systems is worth one (1) point:

- Constitutional
- Eyes
- ENT
- Cardiovascular
- Respiratory
- GI
- GU
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic / Lymphatic
- Allergy / Immunology

3. Past medical, family, and social history is three sections combined. The **maximum** number of points in this section is 3: one for past medical history, one for family history, and one for social history.

Past Medical History (1 pt)
- Illnesses
- Hospitalizations
- Surgeries
- **Medications**
- **Allergies**
- Immunizations

Family History (1 point)
- Health and illnesses of family members
- Causes of death

Social History (1 point)
- Marital status
- Employment
- Education
- Alcohol / tobacco / drug use
- Sexual history

4. Physical Exam: Most institutions use the 1995 guidelines, which use **ORGAN SYSTEMS,** not body areas, for the physical exam. The following are the recognized organ systems from those 1995 guidelines:

- Constitutional (includes vital signs)
- Eyes
- ENT
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurologic
- Psychiatric
- Hematologic / Lymphatic / Immunologic

You must have **ONE** item in a particular organ system for you to be able to count that organ system as part of your physical exam. Each organ system you mention grants you a point.

Here is the rule: once you select a coding level, **EVERY SINGLE ONE OF THE FOUR COMPONENTS of your history and physical exam must meet criteria for the level of billing you selected.**

This means that if you miss even *one* point in *one* section of the history and physical exam portion of the chart, your *entire* chart will be downgraded to the level at which you qualify. This is VERY important.

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If you cannot obtain history for any reason, you will be given credit for the HPI, ROS, and PMFS elements for a 99285 patient. However, you MUST state why you could not obtain further history ("further history not able to be obtained because the patient was obtunded (or demented, in cardiac arrest, etc.)."

How to document your medical decision-making: You should document all of the elements of the MDM which influenced your coding. If you do so, then your chart will adequately reflect your medical decision making to the level of the code you've selected.

There are a few easy ways to do this:

- **DMO:** If someone is being admitted for further workup, state it in your chart
- **DMO:** If someone is being discharged with further workup planned, state that in your chart.
- **Data:** If you visualize a study yourself, state it in your chart ("ECG which I ordered and *visualized myself* shows….; CXR which I ordered and *visualized myself* shows….")
- **Data:** If you obtained history from someone else, or reviewed an old chart, state it in your note ("Review of the old chart shows…." Or "I spoke with the patient's daughter, who provided further history of….")
- **Risk:** If you give IV/IM narcotics, state it in your chart ("IV morphine given for pain"); demonstrates HIGH level of risk
- **Risk:** If someone is at high risk based on his/her presentation (as seen on the risk table), state it ("patient was at high level of risk because this was an MVC that could pose threat to life", or "patient had acute change in neurologic status", or "patient has a psychiatric illness and is at risk to himself", etc.)

Critical Care Coding

Documentation of a critical care patient works differently than the level 1-5 (99281-99285) system. Unlike the 99281-99285 system, critical care billing is ***time-based***.
However, there are some important requirements for a critical care chart:

1) You have to know what constitutes a "critical care" patient, for the purposes of billing. CMS defines critical care as a problem which **"impairs one or more vital organ systems, that there is a high probability of imminent or life-threatening deterioration in the patient's condition."**

2) Next (I know this seems self-evident), you must **document** why that patient was at risk for imminent or life-threatening deterioration.

   Don't assume the coders know what you know about critical illness; coders are not clinicians! The words "emergency", "immediately", and "critically elevated" will give the coders the correct impression of your thought process.

3) **You must document the amount of time you spent in care of the patient.**

   a. The total time must be **greater than 30 minutes**.
   b. The time is ***additive*** and includes every single task you do for the patient, whether at the bedside or not. With one exception…..
   c. ….The time must **exclude** any separately-billed procedures performed on the patient. So you cannot include the time you spent intubating a patient, or placing a central line; since those **procedures will be billed separately** from the critical care time, the time to perform those procedures cannot count in your critical care time.

   However, certain procedures are bundled into the critical care charge, and **can** be counted as part of the time spent in care of the patient. These are:

   - Interpretation of cardiac output
   - Chest x-rays
   - Pulse oximetry
   - Blood gases
   - Gastric intubation (i.e., NG tubes)
   - Temporary transcutaneous pacing
   - Ventilator management
   - Vascular access (except central venous access)

   The time requires direct **attending physician** involvement. So if a resident spends an hour with a patient, but the attending is only involved in 10 minutes of care, that patient cannot qualify for critical care billing.

4) If you meet all of the above requirements (patient is critically ill, **why** he's critically ill, and document the **time**), then you do NOT have to document a review of systems, a physical exam, or anything else! Now, here's the flip side: If you do **NOT** document why the patient was critically ill, or if you do **NOT** document the time, then you **CANNOT** bill for critical care. If this happens, **your coders will then revert to the previous 99281-99285 system**. Be very careful here! If you document a brief "critical care" type note (and leave out things like a review of systems), but forget to document the time, for instance, then your chart will be downcoded appropriately (in this case, with no review of systems, your chart would be downcoded to a 99281!).