
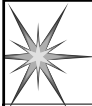

**EMRA/FERNE
 ED Documentation Session:
 Optimizing the Care of
 ED Patients with
 Neurological Emergencies**


Mark Mackey, MD, MBA 




**Coding and Documentation
 Primer**

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Disclosures


- None
- Material extracted from Webinar series on acep.org in reimbursement section
- Thanks to Dave Mckinzie ACEP staff


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**Purpose of Medical Record
 Documentation**


- Provide a chronological record of pertinent facts relevant to continuity of patient care
- Allows for appropriate utilization review and quality of care evaluations
- Facilitates collection of data for research and education
- *Is used for accurate and timely claims review and payment*


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What is an E/M service?

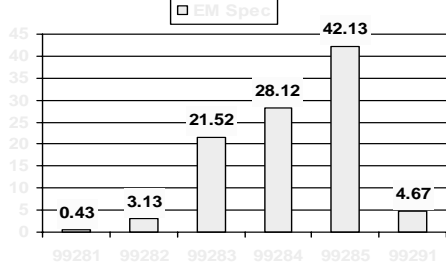
- E/M refers to Evaluation and Management
- E/M codes describe physician cognitive interactions with patients as opposed to procedures
- There are five levels of ED E/M codes represented by CPT codes 99281-88285, plus 99291/99292 (Critical Care)
- These five codes make up over 80% of the reimbursement for most emergency physicians

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**USA 2006 Bess Data
 National**

Emergency Medicine




CPT Code	EM Spec
99281	0.43
99282	3.13
99283	21.52
99284	28.12
99285	42.13
99291	4.67

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CMS 2008 Fee Schedule


CPT Code	2008 Tot BN RVUs	2008 CMS Pmt	2007 CMS Pmt	% Chg
99281	.51	\$19.42	\$19.33	.05
99282	.96	\$36.56	\$37.14	(.16)
99283	1.55	\$59.03	\$60.64	(2.7)
99284	2.86	\$108.93	\$108.39	.50
99285	4.26	\$162.25	\$165.23	(1.8)
99291	5.36	\$204.15	\$208.81	(2.23)

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Documentation Rules: Who makes them?


- CPT book language and code descriptors
- Additional clarification from CPT (CPT Assistant, letters)
- Payer rules, transmittals, software edits
- The CMS “Documentation Guidelines”
 - 1995 and 1997 versions available

The 1995 CMS documentation guidelines are almost universally used for emergency medicine practice and the basis for this material.

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Documentation — The Basics

- The patient’s progress, response to and changes in treatment, and revision of diagnosis should be documented
- The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

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5 most common omissions


- 4 elements HPI for 99285
- 10 ROS or “all other systems neg” for 99285
- No SH/FH (can’t be negative)for 99285
- No reason given for inability to get history
- Timed critical care time not documented

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Emergency Department E & M Codes

There are three key components that must be met to correctly assign an Evaluation and Management code to a patient chart. These components are:


- History
- Physical Exam
- Medical Decision Making

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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)

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Chief Complaint (CC)

- A statement describing the symptom, problem, condition, diagnosis or other reason for the patient's visit, usually stated in the patient's words.

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**Counting requirements
 Hx/PE for level 5**

- 4/10/2/8
 - HPI- 4 elements
 - ROS-10 systems
 - PM/SH/FH- 2/3
 - PE-8 body areas

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**History
 History of Present Illness**

- Location
- Context
- Quality
- Timing
- Severity
- Duration
- Modifying Factors
- Associated Signs & Symptoms

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**History
 History of Present Illness**

- Insufficient HPI is an expensive problem for emergency department charts.
- Charts that would otherwise be coded as 99284 or 99285 must be downcoded to a 99283 if the HPI does not have at least 4 elements or the status of 4 chronic conditions.

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History of Present Illness (HPI):

- This 47 year old male with past medical history of seizures presents to the ED after having multiple seizures at home this morning. He was brought by EMS in a postictal state. Upon arrival to the ED, he began seizing again. Shortly after arrival, he woke up and was talking and alert and stated he thought he may have had a seizure. He reports that his seizures are getting worse. He can not recall whether he had taken his Dilantin.

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History of Present Illness (HPI):

- This 47 year old male with past medical history of seizures presents to the ED *after having multiple seizures at home this morning* [timing]. He was brought by EMS in a *postictal state*. [context] Upon arrival to the ED, he began seizing again. *Shortly after arrival* [duration], he woke up and was talking and alert and stated he thought he may have had a seizure. He reports that his seizures are *getting worse*. [quality] *He can not recall whether he had taken his Dilantin*. [modifying factors]

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Review of Systems

- Allergic/Immunologic
- Cardiovascular
- Constitutional Symptoms
 - (fever, weight loss, etc.)
- Ears, Nose, Mouth, Throat
- Endocrine
- Eye
- Gastrointestinal
- Genitourinary
- Hematologic/Lymphatic
- Integumentary
 - (skin and/or breast)
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory

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Review of Systems (ROS)

- The review of systems helps define the problem, clarify the differential diagnoses, identify needed testing, or serves as baseline data on other systems that might be affected by any possible management options. There are three types of ROS identified for the purposes of coding.

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Review of Systems (ROS)

- A problem pertinent ROS consists of the patient's positive responses and pertinent negatives for the system related to the chief complaint. (99282/99283)
- An extended ROS consists of the patient's positive responses and pertinent negatives for two to nine body systems. (99284)
- A complete ROS consists of the patient's positive responses and pertinent negatives for at least ten organ systems. (99285)

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Review of Systems (ROS)

- A chart with no documented review of systems can only be billed as a Level 1 (99281) visit regardless of the rest of the documentation in the record. The only exception is if the ROS was not performed due to the patient's condition.

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Review of Systems (ROS)

- Level 5 requires a complete Review of Systems.
 - A complete ROS consists of the patient's positive responses and pertinent negatives for at least ten organ systems. Documenting any pertinent positives and negatives combined with the statement "all other systems negative" will be considered a complete ROS. However, "all other systems negative" implies that the physician has reviewed all fourteen systems.

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Review of Systems (ROS)

- The ROS can be documented by listing the system followed by negative or normal
 - Ex: respiratory negative, cardiovascular negative.
- The ROS can also be documented by listing the signs or symptoms that the patient has denied
 - Ex: Pt denies shortness of breath or chest pain.
- Documenting "review of systems negative or normal" does not meet any numerical requirement and is not considered a review of systems. Always indicate a "neg" or "pos" statement for each system addressed.

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Review of Systems (ROS)
Example

As in history of present illness, all other systems are negative. He denied headache [neurologic], nausea, vomiting [gastrointestinal], neck stiffness [musculoskeletal], fever, chills [constitutional], chest pain [cardiovascular], or abdominal pain.

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Review of Systems (ROS)
Example


➤ Five organ systems receive individual review. The notation that all other systems are negative is permissible to round out the minimum ten organ systems. ROS-Complete

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Past, Family, Social History (PFS)

➤ **Past History** - A review of the patient's past experiences with illnesses, injuries, and treatments that includes significant info about:


- prior major illnesses and injuries
- prior operations
- prior hospitalizations
- current medications
- allergies (e.g., drug, food)
- age appropriate immunization status

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Past, Family, Social History (PFS)

➤ **Family History** - A review of medical events in the patient's family that includes significant information about:


- health status or cause of death of parents, siblings, and children
- specific diseases related to problems currently experienced by the patient
- diseases of family members which may be hereditary or place the patient at risk

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Past, Family, Social History (PFS)

➤ **Social History** - An age appropriate review of past and current activities that includes significant information about:


- marital status and/or living arrangements
- current employment
- occupational history
- level of education
- use of drugs, alcohol, and tobacco
- sexual history

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Past, Family, Social History (PFS)


➤ There are two types of PFS identified for the purposes of emergency department coding.

- A pertinent PFS consists of any one element from the PFS.
- A complete PFS consists of one element from two of the PFS history areas

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Past Family Social History (PFSH) Example


Seizure disorder Current Medications: Dilantin Allergies: No known drug allergies [Medical History] Smokes one pack of cigarettes per day. Drinks alcohol. Denied any illicit drug use. [Social History]

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History

To qualify for a given type of history all of the elements must be met or exceeded


- **Problem Focused History**
 - Chief Complaint
 - Brief History of Present Illness.
- = 99281
- **Expanded Problem Focused History**
 - Chief Complaint
 - Brief History of Present Illness
 - Problem Pertinent Review of Systems.
- = 99282 / 99283

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History

To qualify for a given type of history all of the elements must be met or exceeded


- **Detailed History**
 - Chief Complaint,
 - Extended History of Present Illness
 - Extended Review of Systems
 - Problem Pertinent Past, Family Social History.
- = 99284

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History


To qualify for a given type of history all of the elements must be met or exceeded

- **Comprehensive History**
 - Chief Complaint
 - Extended History of Present Illness
 - Complete Review of Systems
 - Complete Past, Family Social History
- = 99285

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Documentation Guidelines History

- Any record format for any component of history is acceptable
- ROS and PFS can be completed by patient, other informant, and/or ancillary staff - physician must document review to supplement or confirm
- Components may be combined in any of three history components, i.e., HPI

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Documentation Guidelines History

- If unable to obtain from patient or other source, record should describe patient's medical condition/other circumstance which precludes obtaining a history
 - urgent/emergency conditions
 - patient's inability to communicate
 - patient at very high level of risk
 - immediate action necessary
- Documentation of circumstances equal to comprehensive history

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Unable to Obtain History???

- You must document the reason why the history is not obtainable from the patient or another source
 - Patient too ill to speak, Uncooperative, Unconscious.
- If partial history is available from EMS or a nursing home, state specifically where the documented history was obtained and why additional history is unavailable.
- 5 recognized sources for emergency history: family, nursing home staff/records, prior hospital charts, EMS, personal physician
- Not the same as the Level 5 acuity caveat!

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1995 Guidelines for Physical Exam
 The level of exam is based on the number of systems/areas examined and documented

- To determine the extent of an examination CPT recognizes the following body areas:
 - Head, including the face
 - Neck
 - Chest, including breasts and axilla
 - Abdomen
 - Back
 - Genitalia, groin, buttocks
 - Each extremity

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1995 Guidelines for Physical Exam
 The level of exam is based on the number of systems/areas examined and documented


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

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1995 Guidelines for Physical Exam
 The level of exam is based on the number of systems/areas examined and documented

- Expanded Problem Focused - a limited examination of the affected body area or organ system and any three symptomatic or related body area(s) or organ system(s).
 - 2-4 Body areas or systems including affected area


= 99282 / 99283

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1995 Guidelines for Physical Exam
 The level of exam is based on the number of systems/areas examined and documented

- 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

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1995 Guidelines for Physical Exam
 The level of exam is based on the number of systems/areas examined and documented


- Comprehensive - a general multi-system examination.
 - 8 or more systems including affected area
 - Body areas not included in counting elements for comprehensive exam

= 99285

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**Documentation Guidelines
Physical Exam**

- Record format
 - Any is acceptable
 - Checklists to indicate performance of any item ok
 - Brief statement or notation “negative” or “normal” ok for normal findings
 - Specific abnormal and clinically relevant negative must be documented- “abnormal” without elaboration insufficient

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**Documentation Guidelines
Physical Exam**


VITAL SIGNS: Temp 98.8, Resp 24, Pulse 102

General appearance: The patient, when I saw him was initially actively seizing and had bilateral tonic clonic movements, greater on the right side, with his eyes deviated to the right [Constitutional]

HEAD: The head showed no evidence of bony deformity. Large bump on forehead over left brow consistent with fall. [Head]

EYES: His pupils were equal, round, and reactive to light. [Eyes]

ENT: Oropharynx was clear and mucous membranes moist. Poor dentition, with no evidence of acute trauma. [Ears, Nose, Throat and Mouth]

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**Documentation Guidelines
Physical Exam**


NECK: Neck supple, non-tender. Trachea midline. No thyromegaly. [Neck/Musculoskeletal/Hematologic]

CHEST: No retractions or deformity. Breath sounds bilaterally, no rubs [Respiratory]

HEART: Heart had regular rate and rhythm, no murmurs. [Cardiovascular]

CHEST: No retractions or deformity. Breath sounds bilaterally, no rubs [Respiratory]

HEART: Heart had regular rate and rhythm, no murmurs. [Cardiovascular]


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**Documentation Guidelines
Physical Exam**

ABDOMEN: Abdomen soft, non distended, no masses. Bowel sounds normal. No organomegaly or bruit [Abdomen/Gastrointestinal]


EXTREMITIES: No edema, capillary refill less than two seconds. Skin had a good turgor and no rash. Peripheral pulses palpable. [Extremities/Skin]

NEUROLOGICAL: Upon awakening, A&O X2 (not time). Cranial nerves intact, DTR's 2+ all extremities. Cooperative, pleasant. [Neurologic]

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**Documentation Guidelines
Physical Exam**

- Findings are recorded for ten organ systems. This exceeds the minimum of eight organ systems required for a complete general multisystem examination.

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**DOCUMENTATION OF MEDICAL
DECISION MAKING**


- Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:
 - The number of possible diagnoses and/or the number of management options that must be considered.
 - The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed.
 - The risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

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DOCUMENTATION OF MEDICAL DECISION MAKING


➤ **NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS**

➤ The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

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Documentation of Medical Decision Making


➤ Documentation for purposes of medical decision making is good care...lab/xray results, consultants, review of records, repeat exams, discussion of differential diagnosis.

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DOCUMENTATION OF MEDICAL DECISION MAKING

➤ **AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED**

➤ The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed.

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DOCUMENTATION OF MEDICAL DECISION MAKING

➤ **RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY**

➤ The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.



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TABLE OF RISK


Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
<i>Minimal</i>	One well limited or minor problem, eg. cold, insect bite, sinus congestion	• Laboratory tests requiring no special preparation • Chest x-ray • EKG/ECG • Urinalysis • Ultrasound, eg. echocardiography • X-ray	• Zant • Omeprazole • Elastic bandages • Topical ointments
<i>Low</i>	Two or more well-limited or minor problems One stable chronic illness, eg. well controlled hypertension or non-insulin dependent diabetes, osteoarthritis, BPH Acute uncomplicated illness or injury, eg. cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, eg. pulmonary function tests • Non-cardiovascular imaging studies with contrast, eg. barium swallow • Inpatient cardiac bypass • Clinical laboratory tests requiring special practice site logistics	• One-to-one care • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
<i>Moderate</i>	One or more chronic illnesses with mild exacerbations, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed acute problem with uncertain prognosis, eg. hazy in breast Acute illness with systemic symptoms, eg. pneumonia, peritonitis, colitis Acute complicated injury, eg. head injury with brief loss of consciousness	• Physiologic tests under stress, eg. cardiac stress test, high resolution stress test • Diagnostic endoscopy with no identified risk factors • Deep sedate or general anesthetic • Cardiovascular imaging studies with contrast and no identified risk factors eg. angiogram, cardiac catheterization • Clinical laboratory tests requiring special practice site logistics	• Major surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Percutaneous drug management • Therapeutic endovascular medicine • IV fluids with additives • Clinical treatment of fracture or dislocation without manipulation
<i>High</i>	One or more chronic illnesses with severe exacerbations, progression, or side effects of treatment Acute or chronic illness or injuries that pose a threat to life or bodily function, eg. multiple trauma, acute MI, pulmonary embolism, severe respiratory distress, progressive severe rheumatoid arthritis, pyelonephritis Illness with potential threat to self or others, peritonitis, acute renal failure A clear change in neurologic status, eg. seizure, TIA, weakness or sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopy with identified risk factors • Thoracotomy	• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Emergent controlled substance • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to deescalate care because of poor prognosis

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DOCUMENTATION OF MEDICAL DECISION MAKING

➤ The levels of E/M services recognize four types of medical decision making


- Straight-forward = 99281
- Low complexity = 99282
- Moderate complexity = 99283 / 99284
- High complexity = 99285

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DOCUMENTATION OF MEDICAL DECISION MAKING Example


Labs:

- WBC 6.5, RBC 4.89, Hgb 15.1, Hct 44.8, Platelets 120,000. Chem: Na 134, K 4.1, Cl 96, CO2 19, BUN 13, Creatinine 1 Glucose 82, Ca 8.6, Mg, 0.5, Phosphorus 4.7, Albumin 4.2, AST 252, ALT 110, alk phos 105, GGT 483, Total bili 0.7

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DOCUMENTATION OF MEDICAL DECISION MAKING Example

- ETOH .9 Urine drug screen was negative. Dilantin level 5. Urine hazy, yellow, leukocyte esterase 1+, nitrates negative, urobilinogen normal, bile negative, blood +1, RBC's 1-5, WBC's negative, epithelials 1-5, bacteria +1, CT of the head showed no abnormality.

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DOCUMENTATION OF MEDICAL DECISION MAKING Example

- Course in the emergency department: Repeat exam revealed no evidence of acute neuro deficit. Conjunctivae clear. Eyes: PERRL. Neck supple without adenopathy or evidence of meningismus. Heart regular rate and rhythm without murmurs. Lungs were clear. Abdomen was soft and non-tender.

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DOCUMENTATION OF MEDICAL DECISION MAKING Example

Extremities: He moved all equally and muscle strength remained 5/5 and equal. He was given Thiamine 100mg IM. When his Dilantin level was noted to be subtherapeutic, he was loaded with Dilantin 1 gm IV over half an hour. He was also given D50 1 amp IV and Magnesium Sulfate 2gm IV over one hour to lower his seizure threshold. He was encouraged to take his Dilantin and to avoid alcohol.


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DOCUMENTATION OF MEDICAL DECISION MAKING Example

Diagnoses:


- Subtherapeutic Dilantin Level
- Seizure disorder
- History of ETOH abuse
- Brow contusion

Disposition: Discharged
Condition on Discharge: Stable and improved

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DOCUMENTATION OF MEDICAL DECISION MAKING Example

Amount and/or Complexity of Data Reviewed: The physician ordered a number of lab tests and a CT scan. The emergency physician also reviewed the CT scan, "the head showed no evidence of bony deformity." The amount and complexity of data reviewed is extensive.

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DOCUMENTATION OF MEDICAL DECISION MAKING Example

➤ **Risk of Complications or Morbidity:** This patient has experienced a severe episode of a chronic problem, a change in neurologic status, and required IV medication monitoring. These elements make the risk high.

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DOCUMENTATION OF MEDICAL DECISION MAKING Example

➤ The combination of extensive number of diagnoses or management options, extensive amount and complexity of data reviewed, and high risk make the medical decision making of high complexity. Medical decision making – High Complexity

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DOCUMENTATION OF MEDICAL DECISION MAKING Example

➤ Under the current documentation guidelines, this chart has a comprehensive history, a comprehensive physical exam, and medical decision making of high complexity, making this a solid level 5 chart. The emergency department Evaluation and management (E/M) code assignment would be 99285.

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MDM Score Sheet
Number of Diagnoses or Management Options

Problems to Examining Physician	Points
Self-Limited or Minor	1 point
Est. Problem (to examiner) stable or improves	1 point
Est. Problem (to examiner) worsening	2 points
New Problem (to examiner) no add'l work-up planned	3 points
New Problem (to examiner) add'l work-up planned	4 points

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MDM Score Sheet
Amount &/or Complexity of Data Reviewed


Review and/or order of lab tests	1 point
Review and/or order of radiology tests	1 point
Review and/or order of other tests (EKG's etc)	1 point
Discussion of tests w/the performing physician	1 point

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MDM Score Sheet
Amount &/or Complexity of Data Reviewed

Review and summarization of old records	2 points
Obtaining history from someone other than patient	2 points
Discussion of case with another physician	2 points
Independent visualization of image, tracing, or specimen	2 points

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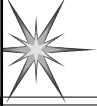
ED E/M level 1- 99281

99281- ED visit for the evaluation and management of a patient, which requires these three key components:

- a problem focused history;
- a problem focused examination; and
- straightforward medical decision making

Usually the presenting problem(s) are self limited or minor

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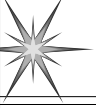
ED E/M level 2- 99282

99282- ED visit for the evaluation and management of a patient, which requires these three key components:

- an expanded problem focused history;
- an expanded problem focused examination; and
- medical decision making of low complexity

Usually the presenting problem(s) are of low to moderate severity

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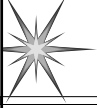
ED E/M level 3- 99283

99283- ED visit for the evaluation and management of a patient, which requires these three key components:

- an expanded problem focused history;
- an expanded problem focused examination; and
- medical decision making of moderate complexity

Usually the presenting problem(s) are of moderate severity

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ED E/M level 4- 99284

99284- ED visit for the evaluation and management of a patient, which requires these three key components:

- a detailed history;
- a detailed examination; and
- medical decision making of moderate complexity

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.

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ED E/M level 5- 99285

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:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity


Usually the presenting problem(s) are of high severity, and pose an immediate significant threat to life or physiologic function.

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CODING AND DOCUMENTATION FOR CRITICAL CARE SERVICES

- **Critical Care - Evaluation and Management of the unstable critically ill or critically injured patient, requiring the constant attendance of the physician.**
 - Critical Care is the only E/M service rendered by the emergency physician that is based on time.
 - Critical Care services are billed based on the total physician "attention" time. The physician does not need to be constantly at the patient's bedside, but should be engaged in physician work directly related to the individual patient's care.
 - Time reported does not need to be continuous. The time can be totaled from multiple encounters on the same day. Critical Care can be billed once the total time exceeds 30 minutes.

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Critical Care (99291, 99292..)


- Physician must be managing the care of an *unstable* or potentially unstable critically ill or injured patient
- Must document critical care time of greater than 30 minutes
- Does not include:
 - time performing billable procedures
 - time spent by residents managing the patient
- Does include:
 - conversations
 - review of results (e.g. lab, x-ray, CT...)
 - documentation
 - time in attendance

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Examples of Critical Care


- Central nervous system failure
- Circulatory failure
- Shock-like conditions
- Renal hepatic failure
- Respiratory failure
- Overwhelming infection

Documentation must support provision of critical care service ...must be able to discern a time of greater than 30 minutes in management of unstable critically ill patient!!!

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Procedures Included in 99291


- 93561, 93562 - Interpretation of cardiac measurements
- 71010, 71020 - Chest X-Ray
- Blood Gasses
- 99090 - Information stored in computers (ECUs, blood pressures, hematologic data)
- 91105 - gastric intubation
- 92953 - temporary transcutaneous pacing
- 94656, 94657, 94660, 94662 - ventilator management
- 36600, 36410, 36415, 36600 - vascular access procedures

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Procedures Not Included in 99291


- ED Procedures commonly billed with Critical Care
 - 92950 CPR
 - 31500 Endotracheal Intubation
 - 33010 Pericardiocentesis
 - 36556 Central Venous Catheter
 - 32020 Chest Tube
 - Any additional miscellaneous procedures

Note:
Remember to add the -25 modifier to the 99291 when additional procedures are billed

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Review


- CPT descriptors indicate what is needed to report a given level of ED E/M service
- Documentation Guidelines identify what elements are needed to satisfy the terms used in the CPT descriptors
- Chart documentation must provide the coder and the auditor enough information to assign the level of service and support medical necessity

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5 most common omissions


- 4 elements HPI for 99285
- 10 ROS or "all other systems neg" for 99285
- No SH/FH (can't be negative) for 99285
- No reason given for inability to get history
- Timed critical care time not documented

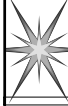
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Resources

- ACEP web site www.acep.org
- Fundamentals of Reimbursement
 - Frequently Asked Questions
- ACEP News articles
- ACEP Reimbursement Department:
1.800.798.1822 Ext. 3232
- ACEP courses Reimbursement and Coding
- ED List Serve www.coding911.com

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Questions?

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