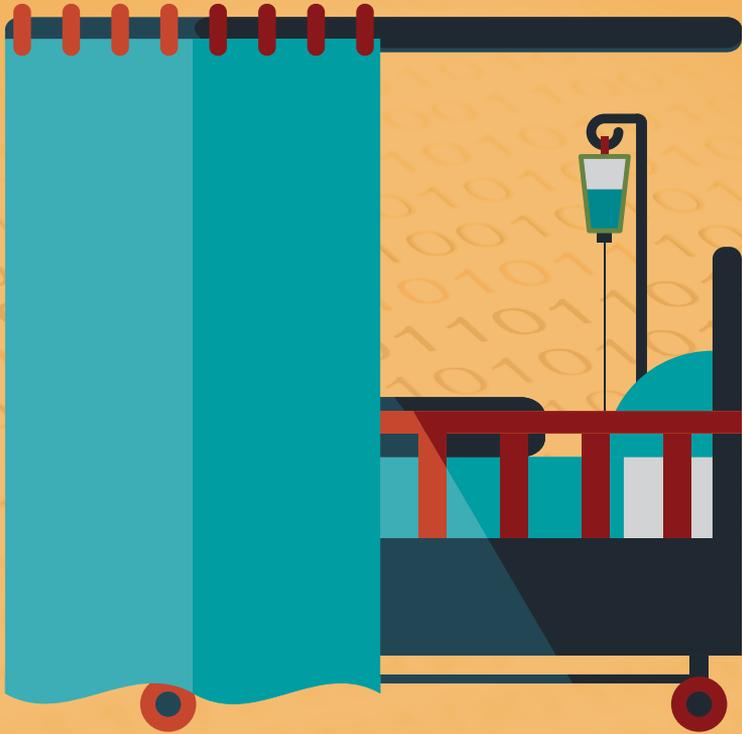
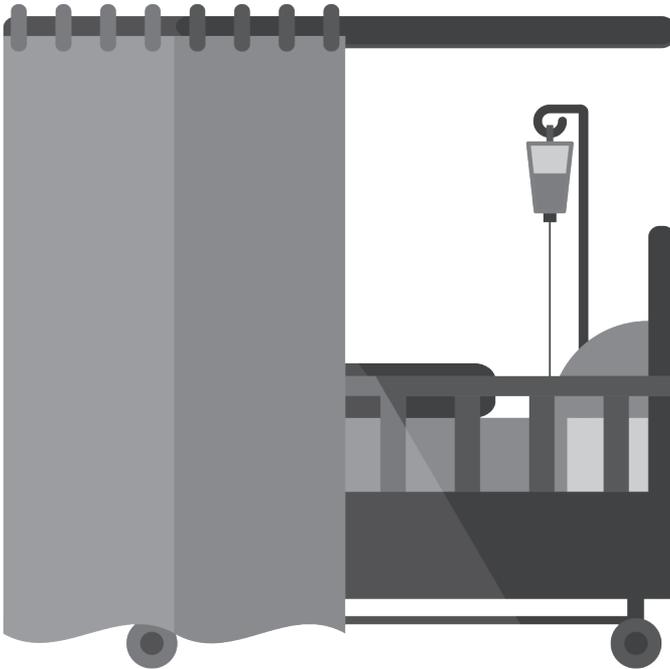


Emergency Department Coding Handbook



**just
coding**

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About the Author

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Nena Scott, MEd, RHIA, CCS, CCS-P, CCDS, AHIMA-approved ICD-10-CM/PCS trainer, has served as an educator in the healthcare industry across numerous organizations over the past two decades. Her experience includes the creation and successful implementation of a Registered Health Information Technology program at a community college in Northern Mississippi where she served as the program director and lead instructor for more than a decade.

Her current role with TrustHCS as director of education includes overseeing ICD-10 educational offerings. As a professional educator, Scott's experience spans a wide range of health information topics including coding, auditing, reimbursement, and healthcare law and ethics. She has trained coding staff and served in a management capacity within the HIM department. Throughout her years educating, she kept a part-time job as an auditor and coder in order to stay abreast of coding and regulatory changes and updates. Throughout her career, she has also performed coding compliance audits.

Scott is in the process of obtaining a doctoral degree in education. She has been honored by the Mississippi Health Information Management Association with the Champion Award (2010), Educator Award (2009), and Distinguished Member Award (2007).

Introduction

The emergency department (ED) is a fast-paced environment that can present documentation and cases that can lead to unique coding and billing challenges. JustCoding's *Emergency Department Coding Handbook* will help coders by clearly explaining how to interpret CPT® codes and guidelines in order to report procedures accurately.

This easy-to-use handbook includes an explanation of evaluation and management codes for the ED and how to deal with the challenges of undercoding. The handbook also offers details on how to determine critical care in order to choose the most accurate code.

In the second chapter, the handbook reviews the anatomy of the integumentary system and common procedures performed on the skin. The book covers topics such as incision and drainage, debridement, wound repair, and burns.

Finally, the third chapter details the anatomy of the musculoskeletal system and how to report procedures on those areas. Coding tips are included to tackle common questions that coders in the ED face. This chapter also reviews injection and arthrocentesis procedures, as well as application of casts and strapping.

1

Evaluation and Management

Because the Centers for Medicare & Medicaid Services (CMS) has not created any national emergency department (ED) evaluation and management (E/M) guidelines, providers must create their own criteria for each visit level. CMS has developed a list of 11 criteria that it uses when auditing facility E/M criteria. According to CMS, E/M guidelines should do the following:

1. Follow the intent of the CPT® code descriptor: Guidelines should be designed to reasonably relate the intensity of hospital resources required to the different levels of effort represented by the code
2. Be based on hospital facility resources, not physician resources
3. Be clear so that they facilitate accurate payments, and be usable for compliance purposes and audits
4. Meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements

5. Require documentation that is clinically necessary for patient care
6. Not facilitate upcoding or gaming
7. Be written or recorded and well-documented, and provide the basis for selection of a specific code
8. Be applied consistently across patients in the clinic or ED to which they apply
9. Not change with great frequency
10. Be readily available for fiscal intermediary or MAC review
11. Result in coding decisions that can be verified by other hospital staff, as well as by outside sources

Note that ED E/M codes do not distinguish between new and established patients. Additionally, because E/M services in the ED vary so widely in intensity, time is not used as a descriptive component of the codes.

Presenting Problem

A patient's presenting problem is the disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for which he or she visits the ED. This problem may be a significant indicator of medical necessity and may support the need for ED treatment, the underlying reason for the ED course, and the medical necessity of diagnostic tests and therapeutic services.

The nature of the presenting problem is one of the three essential elements in determining the level of medical decision-making and

medical necessity for the ED visit. There are five levels of presenting problems, with guidelines and CPT codes defined as follows:

1. Self-limited or minor (99281): a problem that runs a definite and prescribed course, is transient, and is not likely to permanently alter the patient's health status or has a good prognosis with management/compliance.
2. Low severity (99282): a problem in which the risk of morbidity without treatment is low, there is little to no risk of mortality without treatment, and full recovery without functional impairment is expected.
3. Moderate severity (99283): a problem in which the risk of morbidity without treatment is moderate, there is moderate risk of mortality without treatment, or there is an uncertain prognosis or increased probability of prolonged functional impairment.
4. High severity, requires urgent evaluation by the physician but does not pose threat to life or physiologic function (99284): A problem in which the risk of morbidity (illness, disease) without treatment is high to extreme, there is a moderate to high risk of mortality (death) without treatment, or a high probability of severe, prolonged functional impairment.
5. High severity, poses an immediate significant threat to life or physiologic function (99285): A problem in which the risk of morbidity (i.e., illness, disease) without treatment is high to extreme, there is a moderate to high risk of mortality (death) without treatment, or a high probability of severe, prolonged functional impairment.

CMS instructs Type A EDs to report E/M levels with these CPT codes. CMS defines a Type A ED as an ED that is available 24 hours

a day, 7 days a week and is either licensed by the state in which it is located under applicable state law as an ED, or it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

Coders will use HCPCS level II codes G0380–G0384 to report E/M visits for Type B EDs. CMS defines a Type B ED as an ED that meets the definition of a “dedicated emergency department” as defined in 42 CFR 489.24 under the Emergency Medical Treatment and Active Labor Act regulations. It must meet at least one of the following requirements:

- It is licensed by the state in which it is located under applicable state law as an emergency room or emergency department
- It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment
- During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment

The Challenge of Undercoding

In the ED, undercoding is more of a problem than overcoding. It’s common for the nurses who design the criteria not to fully understand the coding rules and other elements that go into the orders that they get from their physicians. Likewise, the coder designing

the criteria may have good background in the clinical ED piece of the puzzle, but he or she may not understand some of the triggers for these services. In either case, lack of information can lead to undercoding.

To properly determine E/M levels, it's important to understand the presenting problem, history, and findings of the physical examination. Taken together, these elements determine the level of medical decision-making. They present a more complete picture of the problem and the care required during the ED stay or the level of follow-up/disposition required.

It's also important to understand that facility E/M levels and physician E/M levels do not always align. Physician and nursing rules and resources, which play a part in determining E/M levels, are different in the ED than they are in other settings. For example, physicians generally don't provide one-on-one care to a difficult patient, but in the ED, a nurse may have to stay at that patient's bedside for an extended period of time.

To code properly for a visit, coders also have to look at the times of interventions—that is, how long patients spend with the nurses. Is the patient receiving one-on-one nursing care, or is one nurse responsible for several patients? Facilities also need to define what is considered observation or assessment.

Finally, consider the intensity of the resources used. Some services don't take a lot of time but require an incredible amount of intensity.

Critical Care

Coders may report critical care provided in the ED. Critical care is defined as the direct delivery of medical care by a physician or provider to a critically ill or injured patient. Typically, in such a case,

one or more vital organs or organ systems are impaired, and the patient's condition has a high probability of immediate deterioration. In addition, if critical services are not immediately rendered, the patient faces a high probability of death.

Delivering critical care in a moment of crisis or upon being called to the patient's bedside emergently is not the only criterion for providing critical care services. While not necessarily emergent, treatment and management of a patient's condition under threat of imminent deterioration also meets the requirement. In such a case, failure to initiate interventions on an urgent basis would likely result in sudden, clinically significant, or life-threatening deterioration in the patient's condition.

The *CPT Manual* provides two codes for critical care services:

- 99291, critical care for a patient with high probability of imminent deterioration causing a threat to life or limb; first 30–74 minutes
- 99292, critical care, each additional 30 minutes

Because critical care codes are time-based, providers must document time not just for proper reporting but also so the facility can bill for its part of the services. CMS only pays for critical care if at least 30 minutes of critical care services are provided and documented. If the facility does not provide at least 30 minutes of critical care, coders should report a level 4 or 5 ED visit, depending on the facility's E/M criteria.

Some of the CMS rules may make it more difficult for coders to count critical care time for the facility. Under the OPPS, the time spent by physicians and/or hospital staff engaged in active, face-to-face critical care of a critically ill or critically injured patient is counted. If the physician and hospital staff are simultaneously

engaged in this care, that time can only be counted once. As a result, if a physician and a nurse are both providing critical care during the same 30-minute time span, coders can only report a total of 30 minutes of critical care time, not 60 minutes (30 for the physician and 30 for the nurse).

Consider a slightly different scenario: A nurse provides 15 minutes of critical care and leaves. A physician comes in and provides 15 minutes of critical care and leaves. The nurse then returns to provide an additional 15 minutes of care. Because none of the care overlapped, coders would add each time together and report 45 minutes of critical care.



Emergency Department Coding Handbook

**Nena Scott, MEd, RHIA, CCS, CCS-P, CCDS,
AHIMA-Approved ICD-10-CM/PCS Trainer**

This handbook is a quick reference guide for coders in emergency department (ED) settings. It guides coders through assigning visit levels and documentation requirements for a variety of common ED services. The handbook also includes anatomical illustrations for fractures.

This handbook will help you:

- Determine how to report consistent visit levels based on accepted standards
- Learn proper documentation for commonly performed ED procedures, such as fractures, removal of foreign bodies, and burns
- Correctly assign codes for common ED procedures

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