JustCoding

GUIDE TO Emergency Department CODING

Nena Scott, PhD, MSEd, RHIA, CCS, CCS-P, CCDS
William L. Malm, ND, RN, CRCR, CMAS

JustCoding
Guide to Emergency Department Coding

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Her current role with TrustHCS as director of coding quality and professional development includes overseeing coding quality for more than 500 coders and managing internal and external educational offerings. She previously served as a program director and lead instructor for an HIM department. During this time, she successfully created and implemented a registered health information technology program at a community college in northern Mississippi. Scott has also performed coding compliance audits for hospital inpatient, outpatient, and provider-based departments.

Scott recently obtained 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). In addition, she holds an AHIMA ICD-10-CM/PCS Trainer Certificate.

William L. Malm, ND, RN, CRCR, CMAS, is a managing director at Health Revenue Integrity Services in Cleveland, Ohio, and Melbourne, Australia. He is a nationally recognized author and speaker on topics such as value-based care, healthcare compliance, chargemasters, and Centers for Medicare & Medicaid Services recovery audits.

Malm also brings a decade of experience with payer acute care audits. He has more than 25 years of experience with a combination of clinical and financial healthcare knowledge that encompasses all aspects of revenue integrity. Previously, Malm played a key role in providing revenue integrity and data expertise for Craneware, PLC. He also serves as the president for the Certification Council of Medical Auditors.

He has extensive experience with all pre- and post-payment audits, having worked as a systems compliance officer at a large for-profit healthcare system. Malm also cohosts Appeal Academy's "Finally Friday" discussions.

Introduction

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

This comprehensive guide includes an explanation of evaluation and management (E/M) codes for the ED and how to deal with challenges in the hectic ED environment. Chapter 1 reviews physician E/M coding based on the key components of history, examination, and medical decision-making documented in the medical record. Chapter 2 focuses on facility E/M coding for ED services rendered by nursing and ancillary staff. Several clinical scenarios are included throughout these chapters, which allow readers to test their knowledge of E/M coding for ED encounters.

Chapter 3 reviews the anatomy of the integumentary system and common procedures performed on the skin. The book includes anatomical images of complicated procedures and covers topics such as incision and drainage, debridement, wound repair, and burns. Chapter exercises allow coders to test their ability to select the most specific CPT codes for these services.

Chapter 4 details the anatomy of the musculoskeletal system and how to report musculoskeletal procedures commonly performed in the ED as well as the application of casts and strapping. This chapter includes images, exercises featuring CPT coding for musculoskeletal injuries, and tips for avoiding common reporting errors.

The final chapter reviews facility coding and billing rules for injections, infusions, and hydration services commonly performed in the ED. The book reviews medical record documentation for accurate code assignment, the CPT injection and infusion hierarchy, and associated coding tips and exercises.

CHAPTER 1

Professional Evaluation and Management

Evaluation and management (E/M) services, or visit services for new and established patients, are divided into two pillars: professional E/M and facility E/M.

Professional E/M codes are determined based on the complexity and intensity of provider-performed work. Physicians working for emergency department (ED) servicing companies or hospital facilities can rely on their billing departments to submit claims to Medicare and commercial payers on their behalf.

Facility E/M coding, on the other hand, reflects the volume and intensity of resources utilized by the facility to provide medically necessary services. Facilities always assign E/M codes to receive payment for resources utilized in the ED.

Medicare has developed separate reimbursement methodologies for professional and facility E/M services provided in the ED. Managed care and commercial payers have adopted these reimbursement methodologies to match acute care billing under Medicare.

Documentation of professional E/M services can be broken down into the following elements:

- History
- Chief complaint
- History of present illness (HPI)
- Review of systems (ROS)
- Past family and social history (PFSH)
- Physical examination
- Medical decision-making (MDM)
- Documentation of counseling or coordination of care

Documentation of these elements allows for effective care coordination and drives the matrix from which reimbursement is determined.

The American Medical Association's (AMA) *Current Procedural Terminology (CPT) Manual* provides coding guidance for selecting the most specific E/M visit levels based on these components. The Centers for Medicare & Medicaid Services (CMS) developed E/M coding and documentation guidelines, which diverge slightly from the CPT guidelines. CMS' guidance, known as the *1995 and 1997 Documentation Guidelines for E/M Services,* also bases code selection on the above-mentioned components.

E/M documentation elements are described in greater detail throughout this chapter.

History

A patient's medical history is composed of the following:

1. Chief complaint: Documented at the time the patient comes to the ED. Documentation should include the signs, symptoms, problem, condition, and reason for the visit, as stated by the patient.

For example, suppose a provider performs a physical examination for a patient who presents with abdominal pain. A documented gastrointestinal examination might include a review of nondistended (visualization), positive bowel sounds (auscultation), and nontender/no organomegaly (palpation). This would be documented as a detailed examination, provided that the documentation includes findings on two to seven additional body areas or systems.

In addition, providers should remember that comprehensive examinations include a review of eight or more organ systems (not body areas), with documentation of the examination findings.

1997 examination guidelines

The 1997 examination guidelines include a general multisystem examination and examinations for the following single organ systems:

- Cardiovascular
- Ear, nose, mouth, and throat
- Eyes
- Genitourinary (female) and (male)
- Hematologic/Lymphatic/Immunologic
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory
- Skin

The 1997 guidelines provide tables for these single-organ-system examinations that outline the required elements for each examination type:

Figure 1.7: Single-Organ-System Examination (1997 Guidelines)

Type of Examination	Description
Problem Focused	Include performance and documentation of one to five elements identified by a bullet, whether in a box with a shaded or unshaded border.
Expanded Problem Focused	Include performance and documentation of at least six elements identified by a bullet, whether in a box with a shaded or unshaded border.
Detailed	Examinations other than the eye and psychiatric examinations should include performance and documentation of at least twelve elements identified by a bullet, whether in a box with a shaded or unshaded border. Eye and psychiatric examinations include the performance and documentation of at least nine elements identified by a bullet, whether in a box with a shaded or unshaded border.
Comprehensive	Include performance of all elements identified by a bullet, whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least one element in a box with an unshaded border is expected.

AMA. (2016). Evaluation and management services. Retrieved from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf

CHAPTER 2

Facility Evaluation and Management

Facility evaluation and management (E/M) coding is based on the facility resources utilized to provide medical care.

Because the Centers for Medicare & Medicaid Services (CMS) has not created national E/M guidelines for emergency department (ED) services, providers must create their own criteria for each visit level.

Many different reimbursement models have been created by organizations such as the American Health Information Management Association, American Academy of Professional Coders, and American College of Emergency Physicians. In the 2008 Outpatient Prospective Payment System (OPPS) final rule, CMS released a total of 11 guidelines that it uses when auditing facility E/M criteria.

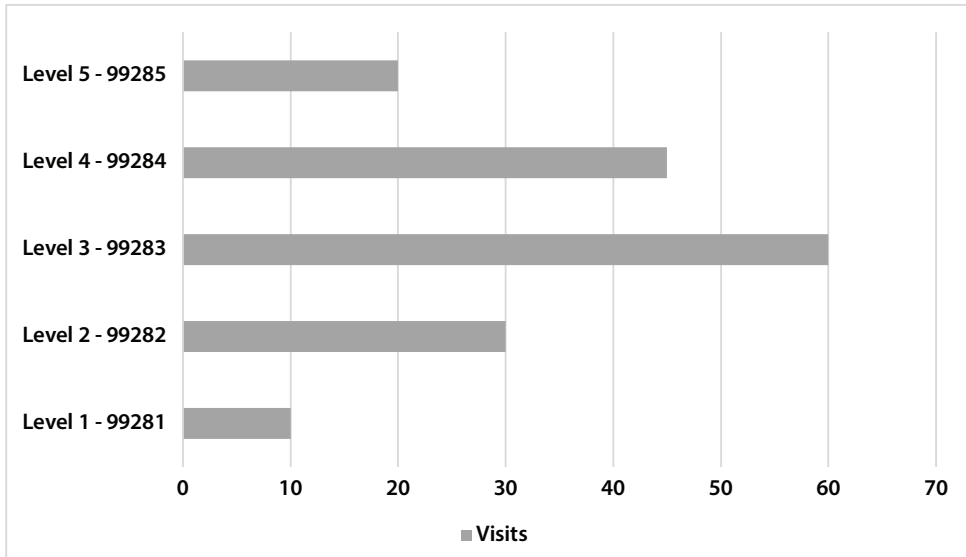
According to CMS, E/M guidelines for ED services should do the following:

Figure 2.1: CMS Facility E/M Guidelines (2008)

- The coding guidelines should follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code.
- The coding guidelines should be based on hospital facility resources. The guidelines should not be based on physician resources.
- The coding guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits.
- The coding guidelines should meet the HIPAA requirements.
- The coding guidelines should only require documentation that is clinically necessary for patient care.
- The coding guidelines should not facilitate upcoding or gaming.
- The coding guidelines should be written or recorded, well documented, and provide the basis for selection of a specific code.
- The coding guidelines should be applied consistently across patients in the clinic or emergency department to which they apply.
- The coding guidelines should not change with great frequency.
- The coding guidelines should be readily available for fiscal intermediary (or, if applicable, MAC) review.
- The coding guidelines should result in coding decisions that could be verified by other hospital staff, as well as outside sources.

Department of Health and Human Services. (2007). Hospital internal guidelines for evaluation and management. Federal Register, 72*(227), 66805. Retrieved from* https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/Downloads/cms1392fc.pdf.

Figure 2.3: E/M Bell Curve



Critical Care

Both physicians and facilities may report CPT code 99291 (critical care; first 30–74 minutes) and add-on code 99292 (critical care; each additional 30 minutes) for critical care services. However, physicians and facilities adhere to different rules for documenting and reporting critical care.

Physician critical care time is based on the services and decision-making that the physician directly administers. Facility critical care is based on facility resource consumption as documented by nursing and ancillary staff. Generally, facility and professional critical care times do not align.

CMS reimburses facilities for critical care only if at least 30 minutes of care is provided and documented in the medical record. If the facility does not provide at least 30 minutes of critical care to the patient, the coder should instead report a Level 4 or 5 ED visit, depending on the facility's E/M criteria.

It is important to note that facilities and physicians calculate critical care time differently. The facility calculates the time that nursing and ancillary staff spend face-to-face with a patient, administering nursing interventions. Physician face-to-face time is not considered in the facility's calculation.

Critical care time for the facility begins when nursing and ancillary staff first become involved in the patient's care until the patient is stabilized, transfers, or expires. In some cases, the treating physician will step away from providing critical care to the patient, but several nurses will continue to provide medication management, monitoring, and ancillary testing.

A facility point system should reflect the resources utilized for patient care. Additional points come from additional resources and diverse nursing interventions used to treat patients with life-threatening conditions. In addition to calculated points, a minimum of 30 minutes of care must be documented for the facility to bill and receive reimbursement for critical care services.

Many electronic health records have clocks embedded in their system that allow for the accurate recording of a start and stop time for critical care. Therefore, points and the time (as described by CPT) create a critical care level that is described by CPT code 99291 and add-on code 99292.

Exercise 2.1

Instructions: Read the following clinical scenario. Using the point system, assign points for each described nursing action.

> A 72-year-old man is brought in, via emergency medical services (EMS), fully restrained after being hit by a car at 5–10 mph while in a crosswalk. EMS determined that the victim was eligible for trauma activation, which was activated in the field at 1302 p.m. (approximately 8 minutes after the accident). The patient is triaged, and the nursing documentation is demonstrated.

PRIMARY TRAUMA ASSESSMENT

Chief complaint:

"I got hit by a car."

HPI:

Patient states he was pushed aside and has pain in his right hip and right wrist. Denies loss of consciousness. States pain in wrist is 8/10 scale, and the right hip is a "dull ache." He denies any aggravating or alleviating maneuvers for the pain.

PMH:

History of appendectomy at age 10 and right hip replacement 4 years ago. Denies allergies. Denies cardiovascular disease.

Exam:

Cardiac: S1S2, no murmur. Regular rate and rhythm, normal sinus rhythm at 72 on the monitor without ectopy. Peripheral pulses intact and 4+.

Respiratory: Can take full breaths. Pulse ox 98% on room air. Lungs clear to auscultation and bilaterally symmetrical chest expansion without pain.

Abdominal: Soft, nontender with active bowel sounds in all 4 quadrants.

Neuro: Glasgow Coma Scale (GCS) = 15, extraocular muscle intact, pupils equal and reactive. Sensation intact in fingers of right hand.

Musculoskeletal: Obvious deformity of the right wrist with external rotation, skin intact. Right wrist is swollen and painful to any movement. Palpation demonstrates deformity of the radius. No other deformities. Right hip ecchymosis without skin breakdown.

Integumentary: 2.5 cm laceration on forehead—well-approximated nonbleeding

Vital signs: blood pressure (B/P) 108/80, heart rate (HR) 72, resp 16, pulse ox: 98%, temp 37.2°C

Physician assessment completed at 1322 p.m., critical care time per nurses' notes (start 1311 arrival and stopped at 1400 p.m.). Cervical spine x-rays negative and backboard removed by physician. Taken to radiology for completion of C-spine series, right forearm and wrist radiograph, hip series, and head computed tomography (CT) and pelvic CT.

- **1315 p.m.:** Ice applied to right wrist and immobilized.
- **1430 p.m.:** Patient reassessed. Vital signs (VS) 116/80, 68, 16, 99%. Neuro-assessment GCS=15, pupils equal and reactive. Motor and sensation intact in all extremities.
- **1522 p.m.:** Patient reassessed. VS stable. Pain is 6/10 after 2 mg morphine prior to going to radiology.
- **1553 p.m.:** MD to bedside and talked to patient. Right Colles fracture reduced (closed with manipulation) by the MD. 2.5 cm laceration simple repair with 6–0 Ethilon—5 sutures and well-approximated. CT scan was negative for head and pelvis.
- **1625 p.m.**: Right forearm gutter splint applied. Peripheral pulses 4+ and capillary refill less than 1 sec.
- **1720 p.m.:** Discharge instructions reviewed with the patient. Cast teaching performed. Homegoing medications – Percocet x 5 provided and patient instruction. Prescriptions as documented by MD provided. Follow-up appointment arranged with orthopedics on call for a.m.

CHAPTER

3

Integumentary System

Anatomy of the Skin

The skin is composed of three layers:

- Epidermis: thin, outermost layer; composed of squamous epithelium
- Dermis: dense and fibrous middle layer; contains connective tissue
- Hypodermis: innermost layer; thick and composed mainly of fatty tissue

Figure 3.1: Skin and Subcutaneous Layers

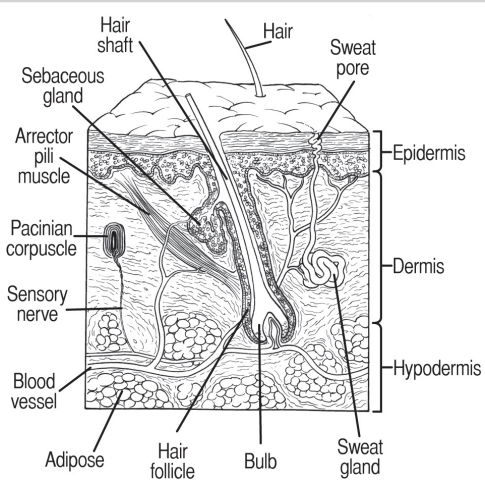
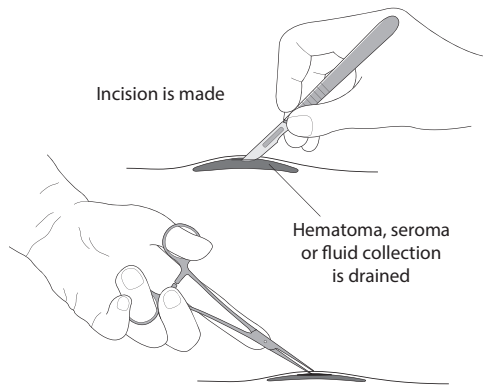


Figure 3.4: Incision and drainage of hematma, seroma or fluid collection

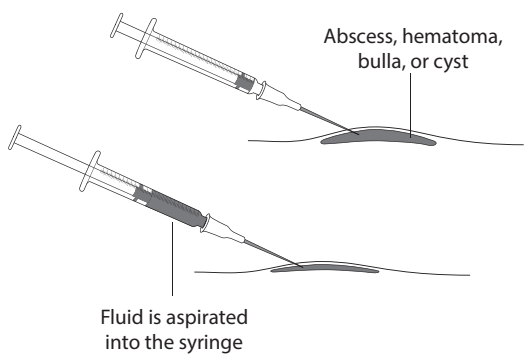


Puncture aspiration: Abscess, hematoma, bulla, or cyst

During a puncture aspiration, a physician uses a large bore needle to aspirate fluid. The following CPT code is used to report a puncture aspiration of an abscess, hematoma, bulla, or cyst:

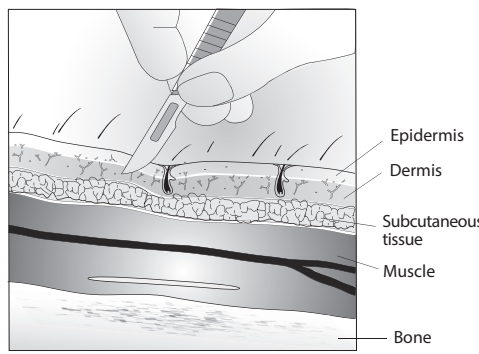
- 10160, puncture aspiration, abscess, hematoma, bulla, or cyst

Figure 3.5: Puncture Aspiration of Abscess, Hematoma, Bulla, or Cyst



- Do not report 11042–11047 with active care and management of same wound (97597–97602).
- Modifier -59 can be appended for additional wound debridement.

Figure 3.10: Debridement



Subcutaneous tissue (11042, 11045); subcutaneous tissue, muscle and/or fascia (11043, 11046); subcutaneous tissue, muscle and/or fascia, bone (11044, 11047)

11042

- Includes debridement of the first 20 sq cm or less of subcutaneous tissue debrided, regardless of the number of wounds debrided at this depth
- Includes the debridement of epidermis and dermis, if performed
- Reported by the total wound area debrided at the deepest level, not for each wound debrided when multiple wounds are involved

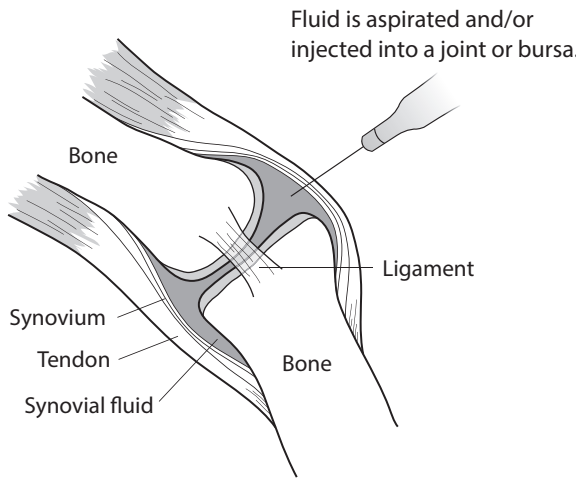
11043

- Includes debridement of the first 20 sq cm or less of muscle and/or fascial tissue, regardless of the number of wounds debrided at this depth
- Includes debridement of epidermis, dermis, and subcutaneous tissue, if performed
- Reported by the total wound area debrided at the deepest level, not for each wound debrided when multiple wounds are involved

- For an intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa), use code 20605
- For a major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa), report code 20610

Example: A patient underwent aspiration of fluid from his left knee joint. The physician then injected an anesthetic/steroid mixture into the same joint. Report 20610-LT.

Figure 4.3: Arthrocentesis



Coding tips

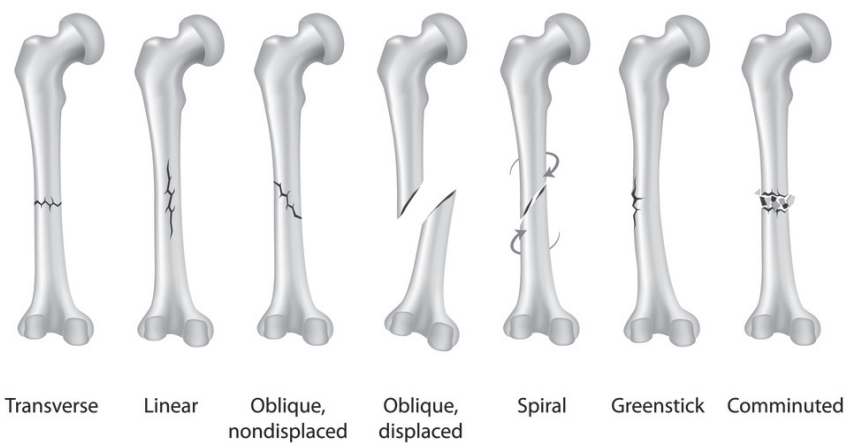
- Apply the appropriate modifier: either -LT (left side), -RT (right side), or -50 (bilateral procedure).

- Report these codes only once per joint regardless of the number of injections or if an arthrocentesis or aspiration is performed in conjunction with an injection.
- Do not use these codes for aspiration or injection of ganglion cysts; instead, see code 20612. Do not use these codes for injections to the carpal tunnel; instead, see code 20526.

Fractures

Emergency department physicians commonly treat fractures. A fracture can be the result of a traumatic injury, such as a fall, or may be pathologic (i.e., due to a disease process). In general, fractures can be classified as open or closed, displaced or nondisplaced.

Figure 4.4: Types of Bone Fractures

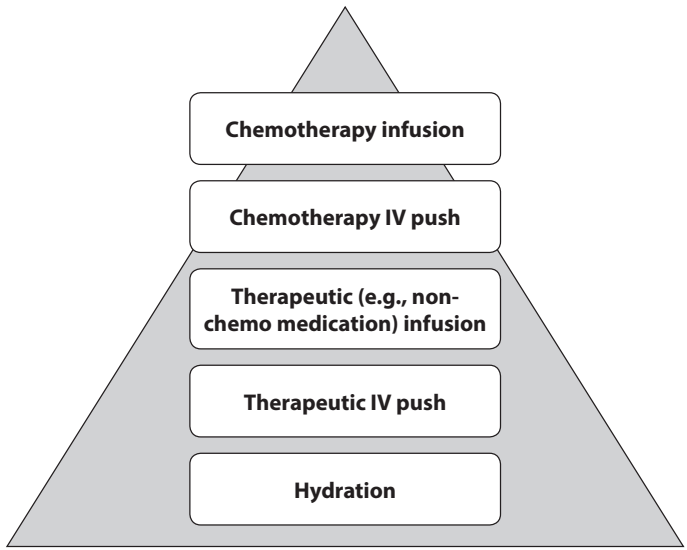


Types of fractures

- Buckled fracture: Also known as an *impacted fracture*, a buckled fracture is one with ends that are driven into each other. This is commonly seen in arm fractures in children.

- The initial code should be selected using a hierarchy whereby chemotherapy services are primary to therapeutic, prophylactic, and diagnostic services, which are primary to hydration services.
- Infusions are primary to pushes, which are primary to injections.

Figure 5.1: Injection and Infusion Coding Hierarchy



Per the *CPT Manual*, the hierarchy supersedes parenthetical instructions for add-on codes that in some cases may suggest a base code of a lower position be reported in conjunction with an add-on code of a higher hierarchical position.

This guideline can be particularly confusing for coders. The coder should only report one initial service per session and everything else as an add-on code.

For example, suppose a physician administers antibiotic A from 3 to 5 p.m. and then administers another drug, antibiotic B, from 5 to 7 p.m.

Coders should report the administration of antibiotic A with CPT code 96365 (IV infusion for therapy, prophylaxis, or diagnosis; initial, up to one hour). This is the initial infusion. Add-on code 96366 (IV infusion for therapy, prophylaxis,

Documentation and Billing Considerations

At present, albeit shrinking, reimbursement for injections and infusions is separately payable under Medicare. However, some commercial payers package IV infusions with other services or only pay a percentage of what Medicare pays for an injection or infusion service.

Detailed documentation is key to successful charge capture for all injection and infusion services. In most facilities, provider documentation is recorded in the MAR.

The following documentation elements are required for **injections:**

- Physician order
- Name of the medication
- Dosage
- Route
- Confirmation of order and patient identification (usually by scanning)
- Injection location
- Patient response to the medication

The following documentation elements are required for **infusions:**

- Physician order
- Name of the medication
- Dosage
- Route
- Confirmation of order and patient identification (usually by scanning)
- IV location (site-specific)
- Start time for the infusion
- Stop time for the infusion
- Patient response to the medication

Exercise 5.6

A patient presents with abdominal pain and dehydration. He receives the following services:

- Normal saline @ 125 cc/hour; start time 2:30 p.m.; stop time 4:30 p.m. (total 45 minutes)
- Pepcid 20 mg IV push; start time 3 p.m.
- Toradol 30 mg IV; start time 3:15 p.m.; stop time 4:30 p.m. (total 75 minutes)

Chapter 5: Exercise Answers

Exercise 5.1 answers

- 96374, therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug. This is reported for the primary initial IV push of morphine 4 mg.
- Add-on code 96375, …; each additional sequential intravenous push of a new substance/drug. This is reported for the secondary IV push of ondansetron 4 mg. This is a new drug on the same line.
- 96360, IV infusion, hydration; initial, 31 minutes to one hour. This is reported for the hydration that ran from 1322 to 1435 (one hour of hydration).

Exercise 5.2 answers

Code each of the drugs as an IV push because there are no stop times. Do not code for the hydration because hydration infusions that are 30 minutes or less or concurrent are not reportable.

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JustCoding's Guide to Emergency Department Coding is a comprehensive reference for coders working in emergency department (ED) settings. It guides coders through assigning the most specific CPT E/M codes for both physician and facility services. The book also provides detailed guidance on CPT coding and reporting for integumentary and musculoskeletal procedures commonly provided in the ED and billed by the facility. The final chapter breaks down complex documentation requirements and CPT coding for hospital intravenous injection and infusion services.

All five chapters include figures and real-life case scenarios that allow coders to practice and refine their skills in a hands-on way.

This book will help you to:

- Determine how to report visit levels based on accepted standards
- Learn proper documentation and CPT coding for commonly performed ED procedures, such as fractures, removal of foreign bodies, and burns
- Follow the drug administration hierarchy to properly code and bill for the administration of injections and infusions

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Simplify Compliance, with its three pillars of thought leadership, expertise, and application, provides critical insight, analysis, tools, and training to healthcare organizations nationwide. It empowers healthcare professionals with solution-focused information and intelligence to help their facilities and systems achieve compliance, financial performance, leadership, and organizational excellence. In addition, Simplify Compliance nurtures and provides access to productive C-suite relationships and engaged professional networks, deploys subject matter expertise deep into key functional areas, and enhances the utility of proprietary decision-support knowledge.

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