

## Review of Emergency Medicine Evaluation and Management (E/M) Levels One through Five (CPT Codes 99281 to 99285)

### 1. AMA/CPT E/M Code 99281 or Emergency Medicine Level One

Level One codes are very infrequent. The choice of this E/M code is usually restricted to patients who are provided a brief encounter by the physician, such as a blood pressure check, an isolated tetanus injection, or in those circumstances where the physician only documents the wound appearance during a wound recheck or suture removal. Consultants always advise its clients to make sure an exam of the surrounding area of a wound, including tendon function, nerve supply, and pulses are charted for all wound recheck visits or suture removals. Having an exam documented on the chart should elevate code choice to Level Two.

### 2. AMA/CPT E/M Code 99282 or Emergency Medicine Level Two

Level Two codes have historically been applied to those cases where a “Regular Exam” (Equivalent to an Extended Problem Focused Exam) is provided to the patient. These exams consist of physician evaluation of the Head, Neck, Chest, and Abdomen areas of the body. Two systems under the Review of Systems must also be reviewed. Local exams of areas of the body are also included in this category. Traumatic conditions *without* an x-ray ordered or interpreted also fall within the Level Two category. These patients may receive one prescription on discharge, although this depends on the coder’s definition of “Prescription Drug Management.”

**Coders** may or may not decide to use a Level Two for all those discharged with a written prescription. This decision should be made based on the patient’s presenting problem to help differentiate the Level Two from Level Three type patient. **CONSULTANTS** again suggest having full documentation of your definition of “Prescription Drug Management,” as stated previously, in both your Coding Policies and Procedures and your active compliance plan. Monitoring of E/M code distribution for payers such as Medicaid would be helpful to make sure that your choice of Level Two vs. Level Three is not too shifted to the Level Three percentage. You may wish, as an example, to make sure that patients receiving only one prescription on discharge remain at Level Two, especially for those patients who are covered by a governmental payer such as Medicare, Medicaid or CHAMPUS. In this way, your E/M code distribution will contain some Level Twos without an overabundance of Level Threes for these governmental payers.

### 3. AMA/CPT E/M Code 99283 or Emergency Medicine Level Three

The choice of Level Three generally requires more extensive numbers or types of prescriptions in addition to more acute and problematic presentations of the patient. Some companies have also elected to start all patients who have received any prescription at Level Three. Other different coding entities have established a more objective methodology to help differentiate Level Two from Level Three. As stated

previously, they elect to have patients who are discharged with only one prescription at the Level Two, especially for governmental payers. They have found that this produces a more natural E/M distribution that is relatively consistent with the Medicare published E/M distributions and what they have estimated is the statewide Medicaid E/M code distribution.

The following types of cases have enhanced MDM as compared to the Level Two cases. We have presented these and the following clinical examples to make it easier for **CODERS** to include more subjective criteria and objective examples when determining code selection along with adjusting coding policies and procedures and the compliance program.

The list that follows helps a coding group with more specific criteria for choosing the Level Three E/M code levels. These choices generate a distribution more consistent with national statistics, and reduce reliance solely on the Risk table for this differentiation between Levels Two and Three.

Some of the objective types of cases that are used for Level Three include:

- Patient who is provided a “Regular Exam” of the head, chest and abdomen (Also called an Extended Problem Focused Exam) with an additional exam of one or more of the following areas:
  - Pelvic exam.
  - External Genitalia exam.
  - Rectal exam.
  - Neurological exam.
- Patients discharged with multiple written prescriptions.
- Patients discharged with any written prescriptions as long as the physician group has documented this definition of “Prescription Drug Management” in both their Coding Policies and Procedures and their compliance plan.  
*CONSULTANTS* suggest the use of this type of criteria for non-governmental payers only but it is certainly up to the discretion of **CODERS**.
- Patients who present to the ED with multiple presenting problems.
- Patient discharged with a prescription for a controlled substance (all narcotics or anti-anxiety drugs such as Xanax®, Valium® or Ativan®).
- Patients who are given oral, eye, ear, or rectal medication in the ED, whether at time of service or on discharge.
- Patients who are being evaluated for fevers over a certain temperature (*CONSULTANTS* focus is on temperatures over 101°F since there is usually no debate as to this representing a true fever).
- Trauma patient requiring one set of x-rays to an isolated area, whether for a traumatic event or not.
- Abdominal cramping, as seen in gastroenteritis.
- Respiratory complaints with one nebulizer treatment.
- Patients receiving one isolated IM injection with no other ancillary studies ordered.

- Patients referred to a specialist for follow-up with documented conversations on the chart.
- Patients with one to three ancillary studies ordered with results and interpretations found on the chart.

#### **4. AMA/CPT E/M Code 99284 or Emergency Medicine Level Four**

Level Four patients are those in which enhanced activity is provided to the patient as compared to Level Three patients. There are multiple items that a coder looks for when reviewing a chart that indicate an increase in the Medical Decision Making of the practitioner. A non all-inclusive list that follows helps the coder choose the Level Four E/M code includes:

- Multiple ancillary studies (Three or greater lab and x-rays) with results and interpretations found on the record.
- Special Studies including:
  - CT scans
  - Ultrasounds
  - Doppler Studies
  - V/Q Lung Scans
  - Arteriograms
- IM Medication when given with at least one of the other bulleted criteria or with any additional ancillary studies including lab and x-ray.
- Abdominal Pain Evaluation with at least two ancillary studies.
- IV fluids administered.
- IV Medication.
- Post traumatic need for multiple x-rays on greater than or equal to two areas of the body.
- Evaluation of a patient after a Motor Vehicle Collision (MVC), especially if brought in via rescue or an ambulance.

To feel comfortable in choosing Level Four, the coder generally desires to see at least two items on the chart from the bulleted list above. For example, a coder may find three or more ancillary studies in addition to a CT or ultrasound that would assist in the choice of Level Four. A coder may also see IV fluids and multiple ancillary studies without any special studies or IV medication, again making the appropriate code choice a Level Four. Patients with abdominal pain (except those patients with abdominal cramping secondary to gastroenteritis) also generally start at Level Four since this type of patient is clearly used as an example in the last few AMA/CPT Manuals.

A non all-inclusive summary of Level Four charts includes:

1. Abdominal Pain workup (except simple cases of gastroenteritis with abdominal cramping).
2. Chest pain with limited workup (EKG and CXR).

3. Psychiatric evaluation with involuntary admission procedures without ancillary studies.
4. Kidney stone without IV fluids or narcotic analgesia.
5. Respiratory problems with three or more breathing treatments.
6. Isolated pelvic or hip fracture with no other workup in the ED except the pertinent x-rays.

## 5. AMA/CPT E/M Code 99285 or Emergency Medicine Level Five

As a general rule, Level Five cases are very frequently used for admitted or transferred patients. For those patients admitted or transferred, with the exception of routine psychiatric admissions or those admitted with hip or pelvic fractures without a workup, the group must develop criteria that will reinforce the choice of a Level Five based on the provider's Medical Decision Making. Of course, all providers must document adequately for this to occur.

Level Five cases are generally part of this non all-inclusive list:

- Most admissions.
- Most transfers that ultimately end up with an admission.
- Psych admits with:
  - Involuntary Admission Form completion.
  - Need for restraints or multiple ancillary studies.

Patients who are not admitted may still be coded at Level Five. Medical Decision Making, and certainly malpractice risk, may increase when the patient is sent home instead of being admitted. Many coding instructors have their coding staff focus on certain types of charts to consider using Level Five when the patient is discharged. ***Of course, the provider must have listed all reviews of old records, conversations with family and other physicians, and the results and interpretations of ancillary and special studies.*** Under these circumstances, many billing and coding firms choose a Level Five if the following types of cases are present, as they generally involve a high complexity of Medical Decision Making:

- Prolonged services in the ED usually over 6 hours when combined with other MDM activities.
- Respiratory insufficiency with both:
  - Three or greater respiratory treatments.
  - Lab, x-ray and IV therapy.
- Dehydration with IV therapy and multiple ancillary studies.
- Kidney stone with therapeutic intervention.
- Acute drug ingestions.
- Abdominal pain workup, then observation.
- Seizure disorder with medication non-compliance.
- Chest pain workup beyond only an EKG and CXR followed by observation.
- IV medication, IV fluids with multiple ancillary studies.

- Those with Special Studies as listed above under Level Four section but with the addition of IV fluids, IV/IM medication and other ancillary studies.
- Those patients with the following significant orders may end up being coded at Level Five when one evaluates the additional MDM activities:
  - Blood gases.
  - Blood cultures.
  - Blood or blood products ordered.
- Those patients who have significant procedures performed usually are also coded at Level Five since they generally have multiple MDM activities done in addition to the procedures. These procedures include:
  - Lumbar puncture.
  - Peritoneal tap.
  - Pleural tap.
  - NG tube or Lavacuator.
  - Triple lumen or other CVP line if not Critical Care.

## Suggestions for Critical Care AMA/CPT Code Choice

1. **Limit the use of CPT E/M code 99292 (Critical Care each half hour after 74 minutes) unless the chart clearly delineates this additional time with the patient.**

Many billing and coding companies, dedicated solely to coding for emergency physician groups and hospitals, are very concerned about the overuse of AMA/CPT code 99292. They believe that this code creates a potential “red flag” for auditors. This code can certainly be used, but only in cases in which there is no question as to the physician’s presence during the extended care of the patient. These coding companies, with our concurrence, look for additional documentation from the physician describing the situation, and why he or she needed so much Critical Care time to manage the patient. In **CODERS’s** client’s case, dictating a more comprehensive note that allows the provider to better describe the “ED Course” will help reinforce the complexity and may help with time determination.

Why has the use of Critical Care AMA/CPT Code 99292 created controversy? Many believe this controversy is related to the infrequent occurrence of the physician actually spending this much Critical Care time with the patient. These companies, and many auditors, do not believe Critical Care time should be determined from the time the patient arrived at the ED to the time the patient left the department. Although this can occur, generally it is not the case. This practice has generated payer concern and has created some denials of these claims, especially those submitted without additional documentation to support the time of “constant attention” of the physician.

**CONSULTANTS** generally suggest that our clients, if they desire to use Critical Care time over 74 minutes, submit additional documentation to support the claim if the payer, especially Medicare, requires a paper claim after the group has submitted an electronic one. If the group finds this occurring with regularity, paper claims sent

initially may help adjudicate the claim earlier and diminish the number of denied claims that ultimately require an extensive review, future paper claim submission, and delay in payment.

2. Focus on choice of Critical Care AMA/CPT code (99291) for governmental enrollee patients who are clearly “unstable”, and “potentially unstable” for those payers for whom the coders use AMA/CPT criteria only.

The Center for Medicare and Medicare Services (CMS), formerly known as the Healthcare Financing Administration (HCFA), the organization that oversees both the Medicare and each state’s Medicaid programs, generated a memorandum about Critical Care in January 2000. In this document, CMS stated that Critical Care should be chosen in cases where:

“The failure to initiate treatment on an urgent basis would likely result in sudden, clinically significant life-threatening deterioration in the patient’s condition.”

CMS also presented two medical review criteria in addition to AMA/CPT definitions that focused on both clinical condition and treatment criterion.

**The clinical conditions include:**

- *High probability of imminent or life-threatening deterioration*
- *Highest level of physician preparedness.* (Italics added by **CONSULTANTS** )

***The treatment criterion includes:***

- Direct personal management by physician.
- Life and organ supporting interventions.

In this same memo, CMS lists some conditions that may **not** qualify for Critical Care. The examples of cases that should not be listed as Critical Care are as follows:

- Admission to Critical Care services secondary to no other beds in hospital.
- “Patients admitted to a critical care unit for close observation and/or frequent monitoring of vital signs.”

Because this memo overrides the AMA/CPT Manual for Medicare, Medicaid, and other governmental patients such as CHAMPUS/TRICARE, we suggest using Critical Care only when the patient is clearly unstable, and not when the patient is “potentially unstable.” For non-governmental payers, use of the AMA/CPT Manual definitions allowing “potentially unstable” patients permits the coder more latitude in choosing the Critical Care codes for these patients.

Multiple references also exist in the AMA/CPT 2003 definition of Critical Care. This is found on pg. 20 of the *2003 AMA/CPT Manual*.

“Critical Care is the direct delivery by a physician of medical care for a critically ill or critically injured patient. *A critical illness or injury acutely impairs one or more vital organs such that there is a high probability of imminent life threatening deterioration in the patient’s condition.* (Italics added by **CONSULTANTS**) Critical care involves high complexity decision making to access, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and /or to prevent further life threatening deterioration of the patient’s condition. Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure.”

Additionally, the *2003 AMA/CPT Manual* lists the following statements related to Critical Care:

- Usually, but not always, given in a critical care area, such as the CCU, ICU, PICU, Respiratory Care Unit, or the **emergency care facility**.
- Services for a patient who is not critically ill but happens to be in a critical care unit are reported using other appropriate E/M codes. (Italics added by **CONSULTANTS**)

Because of these statements, **CONSULTANTS** believe that each ED group should be careful in choosing the Critical Care code, especially when no abnormal vital signs exist, and the patient’s life is not directly threatened. This is especially true for governmental payers, as they will rely more on the January 2000 CMS/HCFA memo over what is written in the AMA/CPT manual. Most coding entities use AMA/CPT criteria for non-governmental payers and therefore prefer to use the Critical Care code for “potentially unstable” admits to the telemetry or critical care units such as ICU and CCU. Using Critical Care codes for all admissions to ICU, CCU, PICU, or Surgical ICU is not considered to be appropriate use for Medicare and other governmental payers, but may be more acceptable for some admissions for non-governmental payers when there is a *high probability of imminent deterioration of the patient’s condition* that has really mandated the decision to admit to a monitored bed with a much higher patient to nurse ratio.

### 3. *What are the more common conditions that generate a Critical Care Code choice?*

Coding companies usually list the conditions that warrant the use of the Critical Care codes. A non all-inclusive list of these conditions includes:

- Increased shortness of breath.
- Acute MI with the use of TPA.
- Unstable vital signs.

- Dehydration or electrolyte imbalance creating unstable vital signs.
- Sepsis and Bacteremia.
- Changing mental status.
- Cardiac or respiratory arrest.
- Airway compromise.
- Trauma with immediate surgery.
- Non-traumatic conditions requiring immediate surgery (AAA, perforated viscous, etc.)
- If survival is jeopardized, consider use.
- Many, not all, admissions to ICU or CCU if any instability for governmental payers.
- Chest pain, progressive angina or R/O MI for non-governmental payers admitted to the ICU or CCU who have a high probability of imminent deterioration.
- Cases where IV medication such as IV Nitroglycerin®, Dopamine®, Dobutamine®, Epinephrine®, Norepinephrine® or Nitroprusside®.