Basic E/M Coding for Physician Services in the ED

DESCRIPTION
The basics of ED coding can be very intimidating. CPT codes, E/M levels, and scoring medical decision making represent the underpinnings of ED code assignment. Freshen up on the basics to make the most of the Advanced Coding course.

OBJECTIVES
• Review in detail an ED specific approach to the application of the Medicare 1995 Documentation Guidelines
• Review current concepts and myths surrounding the scoring of medical decision making
• Identify documentation requirements for the evaluation and management codes 99281-99285, including the three key elements, and four contributing elements

1/29/2020, 1:15 PM - 2:45 PM, Basic E/M Coding for Physician Services in the ED

FACULTY
Todd Thomas, CPC, CCS-P

DISCLOSURE
(+) No significant financial relationships to disclose
Basic E/M Coding for Emergency Physicians!
ED E&M Codes

99281
99282
99283
99284
99285
Components of an E&M code

- History
- Examination
- Medical Decision Making

- Counseling
- Coordination of Care
- Nature of Presenting Problem
- Time
History

Chief Complaint (CC)

History of Present Illness (HPI)

Review of Systems (ROS)

Past, Family, Social History (PFS)
1995 E&M DG

The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient.

To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.
CHIEF COMPLAINT (CC)
The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.

The medical record should clearly reflect the chief complaint.

Can be documented as part of the HPI.
History of Present Illness

HPI is distinguished by the amount of detail needed to accurately characterize the clinical problem(s).
HPI

Location
- Anatomic descriptor
- Left
- distal
- Epigastric

Quality
- Characteristic of symptoms
- sharp
- pounding
- jagged
Severity
- Intensity of CC
  - moderate
- 8 out of 10
- improving

Context
- Circumstances in which the CC occur
- Tripped and fell
- with exertion
- MVA
Duration
- Length of time since onset or injury
- MVA yesterday
- Just PTA
- Since this morning

Timing
- Pattern of recurrence
- Intermittent
- Continuous
- In the mornings
Modifying Factors
- Factors that relieve or exacerbate symptoms
- Treatment PTA
- Worse with movement
- Previous encounter for same condition

Associated Signs & Symptoms
- Symptoms accompanying CC
- Diaphoresis associated with chest pain
- Blurring vision with a headache
- Denies SOB
**Brief HPI**
Consists of one to three HPI elements.
- 99281
- 99282
- 99283

**Extended HPI**
Consists of 4 or more HPI elements.
- 99284
- 99285
Extended HPI

Patient presents complaining of chest pain since this morning. Shortness of breath with exertion, no diaphoresis, vomiting or dizziness.

Similar symptoms a few weeks ago, mainly on the left side. It was severe at onset but is now moderate.

Extended HPI consists of four or more HPI elements.
Extended HPI

Patient presents complaining of chest pain since this morning. Shortness of breath with exertion, no diaphoresis, vomiting or dizziness.

Similar symptoms a few weeks ago, Mainly on the left side. It was severe at onset but is now moderate.

The medical record should describe four or more elements of the present illness (HPI) or associated comorbidities.
Review of Systems
A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.

In theory, the ROS may illuminate the diagnosis by eliciting information which the patient may not perceive as being important enough to mention to the physician.
Review of Systems

- Constitutional
- Eyes
- ENT
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary

- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hema/Lymphatic
- Allergic/Immunologic
A problem pertinent ROS inquires about the system directly related to the problem(s) identified in the HPI. The patient's positive responses and pertinent negatives for the system related to the problem should be documented.
ROS

The patient's positive responses and pertinent negatives for two to nine systems should be documented.

99284

An extended ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.
99285

A complete ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems.

At least ten organ systems must be reviewed.

Those systems with positive or pertinent negative responses must be individually documented.

For the remaining systems, a notation indicating all other systems are negative is permissible.
It is not necessary to list each system individually.

It is acceptable to document pertinent positive or negative findings combined with the statement “All other systems reviewed and negative.”
"10 point review of systems was completed and is negative unless otherwise stated"

"Review of systems per HPI otherwise negative"

Do not specify that all systems or even 10 systems were reviewed.

Additional concerns:
"All others negative" for a patient that is unconscious with CPR in progress.

"All others negative" and "unable to obtain due to patients condition".
Document an ROS for the system(s) related to the presenting problem. It is required for all levels of systemic review.

Never note the system(s) related to the presenting problem as “negative.”

The ROS may be recorded separately or may be included in the description of the history of the present illness.
Only document systems that have been reviewed.

The review of systems should be a reflection of questions asked in relation to the presenting problem and any pertinent organ systems, not a pre-populated macro of all negatives.
PAST, FAMILY AND/OR SOCIAL HISTORY

Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk);

Social history (an age appropriate review of past and current activities).

Past history (the patient's past experiences with illnesses, operations, injuries and treatments);
A pertinent PFSH -
At least one specific item from any of the three history areas must be documented for a pertinent PFSH.

A complete PFSH -
At least one specific item from two of the three history areas must be documented for a complete PFSH.
"Past medical history is non-contributory" or "Social history is non-contributory." would not indicate the provider had actually addressed the issues.

It must be clear that the PFSH was discussed with the patient. To use the term "non-contributory" alone does not clearly indicate PFSH was addressed.

Documentation of a complete PFSH must include social and/or family history information, such as alcohol consumption, smoking history, occupation, or familial hereditary conditions.

"Non-contributory" or "negative," are not considered appropriate documentation.
PFSH vs ROS

13. Can I use the patients past history in the ROS or HPI elements of the E/M score sheet?

No. The ROS and HPI elements pertain to the chief complaint and the reason for the patients visit that day, not past history information.
PFSH and the NOPP

The patient PFSH can do more than just meet the numerical requirements for a E&M code.

- Related or recent surgeries
- Recent illness or hospitalizations
- A contributory family history
- Daily, recent or long term use of medications

May complicate the diagnostic process and increase the NOPP.
History

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
History

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

= 99284

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

= 99285
The Acuity Caveat

- CPT 99285 - Emergency department visit for the evaluation and management of a patient, which requires these three key components:
  - a comprehensive history;
  - a comprehensive examination;
  - medical decision making of high complexity

Within the constraints imposed by the urgency of the patient’s clinical condition and/or mental status:
The Acuity Caveat

- CMS
If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.
Novitas Acuity Caveat

When a physician is unable to obtain parts of the history component for an encounter, documentation should clearly reflect the components that were not obtained (HPI, ROS, and/or PFSH).

Documentation should also include why the components were not obtained (patient unresponsive, sedated, on a vent, etc.), and attempts to obtain information from other sources; such as a family member, spouse, nurse, etc.
Novitas Acuity Caveat

If the documentation clearly supports that the patient is not able to provide the information necessary (history components) and attempts were made to obtain the history from other sources, a comprehensive history level may be credited.
Global Tech Acuity Caveat

History, physical exam, and medical decision making are the key requirements for emergency department services. These components should be based on the urgency of the patient's clinical condition and/or mental status.

This concept is known as the "acuity caveat" or the emergency medicine caveat. Documentation should include differential diagnoses, procedures, diagnostic studies, interventions, and risk factors if the provider is unable to obtain the history.
The Acuity Caveat

Inability to obtain a history from a patient or perform a comprehensive exam is a clinical decision based on the judgment of the EDMD.

Coders cannot be expected to make a medical decision, therefore the EDMD must document that the clinical condition of the patient limited the history or examination of the patient.
The Acuity Caveat

At a minimum the EDMD must document the reason that the history was not obtained, i.e. "Hx unobtainable due to dementia", "Severity of patients injury precludes obtaining a full history".

Best practice would be to also document the source of any documented history and/or that no other sources of history were available.
Examination

The extent of examinations performed and documented is dependent upon clinical judgment and the nature of the presenting problem(s).

Pertinent findings from the physical examination must be documented for each affected or symptomatic area or system.
Examination

Body areas:
- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity
Examination

Organ systems:
- Constitutional
- Eyes
- Ears, nose, mouth and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic / lymphatic / immunologic
Examination

Documentation of normal or negative is acceptable on any examined body area(s) or system(s) with the exception of the area(s) or system(s) that are symptomatic or affected.
Exam

**Examination**

**Problem Focused**
- a limited examination of the affected body area or organ system
- 1 Body Area or Organ System

**Expanded Problem Focused**
- a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
- 2-7 Body areas or systems
Detailed Exam
- CIGNA - The difference is not the number of systems examined. The difference is the detail in which the examined systems are described.
- NGS - Expanded documentation of areas/systems examined, requires more than checklists, needs to have normal/abnormal findings expanded upon.

Detailed
- an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- 2-7 Body areas or systems
Examination

Comprehensive
- a general multi-system examination or complete examination of a single organ system.

The medical record for a general multi-system examination should include findings about 8 or more of the 12 organ systems.
Medical Decision Making

Medical decision making is measured by:

- the number of possible diagnoses and/or the number of management options
- the amount and/or complexity of medical records, diagnostic tests, and/or other information reviewed
- the risk of complications, morbidity and/or mortality
Marshfield Clinic Scoring

Marshfield Clinic – multispecialty clinic based in Marshfield, WI

The E&M documentation guidelines were beta-tested at Marshfield Clinic before HCFA released them in 1994.

As part of that process, clinic staff helped their regional Medicare carrier develop an audit worksheet that included a scoring system for the MDM.
Marshfield Clinic Scoring

CMS acknowledges that its reviewers use score sheets but says their use is neither encouraged nor prohibited.

The score sheets never made it into the documentation guidelines.

Used by physicians, professional coders and payers to evaluate documentation.
CMS MDM Guidelines

The number of possible diagnoses and/or the number of management options is based on:

- the number and types of problems addressed during the encounter,
- the complexity of establishing a diagnosis
- the management decisions that are made by the physician.
Number of Diagnoses / Treatment Options

- Minimal diagnoses or mgmt options
- Limited diagnoses or mgmt options
- Multiple diagnoses or mgmt options
- Extensive diagnoses or mgmt options
Marshfield Scoring-
Number of Diagnoses / Treatment Options

Assigns points based on the presenting problem.

- Self-limited or Minor problem = 1 point
- Est. Problem (to examiner) stable or improving = 1 point
- Est. Problem (to examiner) worsening = 2 points
Marshfield Scoring-
Number of Diagnoses / Treatment Options

New Problem (to examiner) no additional work-up planned
= 3 points

New Problem (to examiner) additional work-up planned
= 4 points
Q: Some of my colleagues claim that a new problem is one that is new to the examining physician. Are they correct?

A: "The decision making guidelines were designed to give physicians credit for the complexity of their thought processes.

Giving a physician more credit for handling a problem he or she is seeing in a patient for the first time, even when that problem has been previously identified or diagnosed, is within the spirit of the guidelines."
2 common definitions

A. Additional diagnostic work-up after the current E&M service is completed.

B. Diagnostic work-up during the current E&M service.

Marshfield Scoring-Number of Diagnoses / Treatment Options

New Problem, no add’l work-up planned = 3 points

New Problem, add’l work-up planned = 4 points
Marshfield Scoring - Number of Diagnoses / Treatment Options

3 points = multiple diagnoses or mgmt options

1 point = minimal diagnoses or mgmt options

2 points = limited diagnoses or mgmt options

4 points = extensive diagnoses or mgmt options
Marshfield - Amount and/or Complexity of Data to be Reviewed

Review and/or order of clinical lab tests = 1 point

Review and/or order of tests in the radiology section of CPT = 1 point

Review and/or order of tests in the medicine section of CPT = 1 point

Discussion of test results with performing physician = 1 point
Decision to obtain old records and/or obtain history from other than patient = 1 point

Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider = 2 point

Independent visualization of image, tracing or specimen itself (not simply review of report) = 2 point
<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem</th>
<th>Diagnostic Procedures Ordered</th>
<th>Management Options Selected</th>
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</thead>
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<td>Laboratory tests via venipuncture X-rays, EKG/EEG, Urinalysis Ultrasound</td>
<td>rest; gargles bandages; Dressings</td>
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<td>Low</td>
<td>2 or more self-limited or minor problems; 1 stable chronic illness; acute uncomplicated illness/injury</td>
<td>Physiological w/o stress; lab tests via arterial puncture; superficial biopsies; non-cardiovascular imaging w/contrast</td>
<td>minor surgery no risk factors; OTC drugs; IV therapy no additives; PT&amp; OT</td>
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<td>Moderate</td>
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<td>Physiological tests w/stress; deep biopsies; obtain fluid from body cavity; endoscopies or cardiovascular imaging no risk factors</td>
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The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment.
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<tr>
<td><strong>Must meet or exceed 2 out of 3</strong></td>
<td>Straight Forward</td>
<td>Low Complexity</td>
<td>Moderate Complexity</td>
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<td><strong>Dx or Treatment Options (points)</strong></td>
<td>1 = Minimal</td>
<td>2 = Limited</td>
<td>3 = Multiple</td>
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<td><strong>Data Points</strong></td>
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It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted.

The volume of documentation should not be the primary influence upon which a specific level of service is billed.

Nature of Presenting Problem

Medicare Carrier's Manual section 30.6.1 (A)

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.
A minor presenting problem which requires low level decision making usually does not warrant extensive history taking or an extensive physical examination.

Nature of Presenting Problem

The nature of the presenting problem will normally determine the extent of the history and exam required.
Nature of Presenting Problem

If the physician elects to perform a comprehensive history with a comprehensive exam for a chronic, minor or stable problem that does not require a significant change of therapy, it is not appropriate to bill for a high level code.

Documentation that is aimed to meet the guidelines for payment but is excessive for the treatment of the patient on the visit in question will not increase the level assigned to that visit.
Even if a "complete" note is generated, only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate level of an E/M service. Information that has no pertinence to the patient's situation at that specific time cannot be counted.

During repeated reviews, we have observed the tendency to "over document" and consequently to select and bill for a higher level E/M code than medically reasonable and necessary. Word processing software, EHRs, and formatted note systems facilitate the "carry over" and repetitive "fill in" of stored information.
99281
presenting problem(s) are self limited or minor.

99282
presenting problem(s) are of low to moderate severity.

99283
presenting problem(s) are of moderate severity.

99284
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.
99285
presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

The complexity of the patients ED encounter and final code choice is driven by the presenting problem, not the final diagnosis.
Communicating NOPP

Medical necessity of an encounter is often visualized only when viewed through the prism of its characteristics captured in specific History of Present Illness (HPI) elements.

- Cigna

Patient / complaint specific documentation
- ROS
- Exam
- ED summary
Communicating NOPP

- Accurately represent the severity of the presentation.
- Differential diagnosis
- Progress notes

- Repeat evaluations
- Clinical discussions with other providers
Selecting the E&M Code

History, exam and MDM combine to determine the highest available E&M code for the encounter.

NOPP is final piece of the puzzle for final code assignment.
CPT Clinical Examples

99281

- Patient for removal of sutures from a well-healed uncomplicated laceration.
- Patient with several uncomplicated insect bites.

Patient tetanus toxoid immunization.
CPT Clinical Examples
99282

20 year old student who presents with painful sunburn with blister formation on the back.

A child presenting with impetigo localized to the face.

Patient with a minor traumatic injury of an extremity with localized pain, swelling and bruising.
CPT Clinical Examples

99282

An otherwise healthy patient whose chief complaint is a red, swollen cystic lesion on the back.

Patient presenting with a rash on both legs after exposure to poison ivy.
CPT Clinical Examples

99283

Sexually active female complaining of vaginal discharge who is afebrile and denies experiencing abdominal or back pain.

Well-appearing 8-year-old child, who has a fever, diarrhea and abdominal cramps, is tolerating oral fluids and not vomiting.

Patient with an inversion ankle injury, who is unable to bear weight on the injured foot and ankle.
Healthy young adult patient who sustained a blunt head injury with local swelling and bruising without subsequent confusion, loss of consciousness or memory deficit.

CPT Clinical Examples

99283

Patient who has a complaint of acute pain associated with a suspended foreign body in the painful eye.
CPT Clinical Examples

99282 vs. 99283

99282 - Patient with a minor traumatic injury of an extremity with localized pain, swelling and bruising.

99283 - Patient with an inversion ankle injury, who is unable to bear weight on the injured foot and ankle.
CPT Clinical Examples

99284

Female present with flank pain and hematuria.

4-year-old child who fell off a bike, sustaining a head injury with a brief loss of consciousness.

Female presenting with lower abdominal pain and vaginal discharge.
CPT Clinical Examples

99283 vs. 99284

99283 - Healthy young adult patient who sustained a blunt head injury with local swelling and bruising without subsequent confusion, loss of consciousness or memory deficit.

99284 - 4-year-old child who fell off a bike, sustaining a head injury with a brief loss of consciousness.
CPT Clinical Examples

99283 vs. 99284

99283 - Sexually active female complaining of vaginal discharge who is afebrile and denies experiencing abdominal or back pain.

99284 - Female present with flank pain and hematuria.

99284 - Female presenting with lower abdominal pain and vaginal discharge.
CPT Clinical Examples

99285
Patient with a complicated overdose requiring aggressive management to prevent side effects from the ingested material.

Patient exhibiting active, upper gastrointestinal bleeding.

Patient with an acute onset of chest pain compatible with symptoms of cardiac ischemia and/or pulmonary embolus.
Previously healthy adult patient who is injured in an automobile accident and is brought to the emergency department immobilized and has symptoms compatible with intra-abdominal injuries or multiple extremity injuries.

CPT Clinical Examples 99285

Patient who presents with a sudden onset of “the worst headache of her life”, and complains of a stiff neck, nausea, and inability to concentrate.
CPT Clinical Examples

99285

Patient with a new onset of a cerebral vascular accident.

Acute febrile illness in an adult, associated with shortness of breath and an altered level of alertness.
Selecting the E&M Code
Must meet all elements for a selected code.

<table>
<thead>
<tr>
<th>E&amp;M</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
<th>NOPP</th>
</tr>
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<tbody>
<tr>
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<td>Problem Focused</td>
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<td>Straight Forward</td>
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<td>Low to Moderate</td>
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<td>Moderate</td>
<td>High</td>
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<td>99285</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
<td>High w/ threat to life or function</td>
</tr>
</tbody>
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Feel Free to Contact Me

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