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Pain Management Coding Alert

Mythbusters: Get Your Info Right on ED E/Ms

Several factors make these codes different from office E/Ms.

When you have to report your provider's office evaluation and management (E/M) visit, odds are that the code selection is pretty straightforward. But do you know that you need to change coding gears when that E/M occurs in an emergency department (ED) setting?

Why? While there are similarities between the two services, there are also several key differences you'll need to know in order to stay on top of your ED E/M claims.

Check out these mythbusters to get the straight dope on ED E/Ms.

Myth: Office E/Ms and ED E/Ms Use the Same Code Set

This might seem basic, but some coders have made the mistake of using office E/M codes 99201 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making …) through 99215 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity …) in an ED setting.

Do this: Choose one of the codes from 99281 (Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a problem focused history; problem focused examination; and straightforward medical decision making…) through 99285 (Emergency department visit for the evaluation and management of a patient, which requires these 3 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 ...) to code for ED E/Ms.

Myth: You Have to Know Patient Status for ED E/Ms

All patients are new in the ED; there is no such thing as an established ED patient, confirms **Jim Strafford, CEDC, MCS-P**, principal of Strafford Consulting in Bryn Mawr, Pa.,

"By definition ED visits are new … due to the episodic, no-appointment nature of the visits. And an entirely new workup and chart are required for each new ED visit," he says.

Myth: You Can Code for Prolonged Services in the ED

Unlike office E/M codes, time is not a factor in ED E/Ms.

"Prolonged services require that an E/M service that includes a typical time must be billed before the prolonged services can be added on, and that prolonged service must exceed the typical time in the E/M code by 30 minutes before it can be added," says **Melanie Witt, RN, CPC, MA**, an independent coding expert based in Guadalupita, New Mexico.

According to CPT®, "guidelines instruct that if a time-based add-on code is reported, it can only be used with E/M codes with typical or specified times included in their descriptors." The 99281 through 99285 code set does not have specified times in its descriptors.

"Time is not measured in ED coding unless you are coding a critical care case," in the ED, explains **Joshua**

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Tepperberg, CPC, senior coding analyst at caduceus Inc., in Jersey City, NJ.

"For ED EM level selection, you base your code on the three key components: history, exam and, most importantly, medical decision making [MDM]," Tepperberg says.

And if you are coding a critical care case, you'll be using 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes …) and +99292 (… each additional 30 minutes (List separately in addition to code for primary service) to report the service - not ED E/M codes.

However: While prolonged services codes are off-limits, a long ED stay can end up as a different encounter altogether, for coding purposes. "You cannot use prolonged services E/M with the ED E/M levels," confirms Tepperberg. "However, the ED doctors can admit the patient to observation status and continue observing the patient until the decide to discharge or admit."

When the physician starts out with a patient in the ED and ends up placing the patient in observation, check with the physician before choosing the correct coding path.

… and Some Parting Advice

While your practice won't see a steady flow of ED E/M claims, you should be able to handle them when they come across your desk.

We asked our experts if they had any advice for those unfamiliar with ED E/M coding. Here's what they had to ay:

Tepperberg
"My best advice on coding EM levels in the ED is to take notice of your overall MDM first. That should drive your level. Once you are sure of your MDM, go back and ensure that the history and physical exam documentation is there to support the MDM. That, plus having an open channel of communication between the coder and provider, is essential to help both understand what is truly going on with each case."

Strafford
"ED coders need to keep in mind why the patient came to the ED, The chief complaint [CC] and nature of presenting problem [NOPP] is critical in determining the medical decision making (MDM) by the provider.

"Also, the risk section of the Documentation Guidelines doesn't reflect the reality of emergency medicine well.
A detailed history and physical with an ankle sprain with moderate decision making is categorically different from a detailed [history and physical] for abdominal pain with moderate decision making. Often I see the more acute scenario undercoded - and sometimes the less severe scenario overcoded - based on a strict reading of the guidelines and lack of understanding of medical necessity."

Remember the X Factor

Modifier 59 isn't the only modifier you can - or should - use to separate procedures. CMS provides multiple modifiers that might do the job and be more appropriate and specific than 59. Alternative modifiers may include the following, among others, depending on the circumstances:

The X{ESPU} modifiers describe the specific circumstance that justifies overriding an edit pair:

- XE (Separate Encounter)
- XS (Separate Structure)
- XP (Separate Practitioner)
- XU (Unusual Non-Overlapping Service).

Although CMS officially accepts these modifiers, you should ensure that your payer processes claims using them before you report them.

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For accuracy's sake, you might also use anatomic modifiers to represent laterality, such as LT (Left side) and RT (Right side). Again, check with the payer before proceeding down this path.

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