

Emergency Medicine E/M Coder Desktop Reference

E/M Codes	99281	99282	99283	99284	99285	99291
Parameters and Disclaimer Statement	<p>Choice of any code level is predicated on the proper documentation of the History, Exam and MDM. Provider documentation must have the correct number of elements, items or systems required for proper charting of the HPI, ROS, PFSH and Exam to the level of MDM as determined by the objective criteria as listed below. If the documentation is insufficient to reach the code level as indicated by any objective criteria, the code choice level will be at the highest possible code that is allowed relative to the documentation deficiency discovered. (i.e. If the HPI only has two elements, the highest code choice for governmental payers is 99283; If the Review of Systems has less than 10 systems listed without comment (e.g., "All other systems reviewed and negative" or similar), the maximum code choice would be at 99284; If only one item is listed for Past, Family and/or Social history, the maximum code choice would be at 99284).</p> <ul style="list-style-type: none"> • In those cells that are bold and contain numbers (1, 2, 3, etc.), each number contains a standalone objective criteria for the particular MDM level addressed. • Items that are not stand-alone are preceded by a bullet (•) and are not bolded. 					
Presenting Problems in CPT Manual	Self limited or minor.	Low to moderate severity case and Low Risk on the Table of Risk.	Moderate severity case; *Moderate Risk on the CMS Table of Risk.	High severity case without an immediate threat to life or physiologic function; *Moderate Risk on the CMS Table of Risk.	High severity case with an immediate threat to life or physiologic function; High Risk on the Table of Risk.	High complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or prevent further life threatening deterioration of the patient's condition.
Presenting Problems in CMS Table of Risk	<p>Minimal Risk:</p> <ul style="list-style-type: none"> • One self limited or minor problem. 	<p>Low Risk:</p> <ul style="list-style-type: none"> • Two or more self limited or minor problems. • One stable chronic illness. • Acute uncomplicated illness or injury 	<p>Low Moderate Risk*:</p> <ul style="list-style-type: none"> • One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment. • Two or more stable chronic illnesses. • Undiagnosed new problems with uncertain prognosis. 	<p>High Moderate Risk*:</p> <ul style="list-style-type: none"> • Undiagnosed new problems with uncertain prognosis. • Acute illness with systemic symptoms. • Acute complicated injury. 	<p>High Risk:</p> <ul style="list-style-type: none"> • One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment. • Acute or chronic illnesses or injuries that may pose a threat to life of bodily function. • An abrupt change in neurological status. 	None listed in MDM Risk Table.

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E/M Codes	Management Options	Clinical Scenarios
99281	No ancillary studies. No meds in ED unless the patient requests Tetanus No Rx on discharge.	Usually recheck visits with isolated exam. Suture removal for patient treated at another facility.
99282	No ancillary studies. No meds in ED. No Rx on discharge. At discharge, instructions to purchase OTC meds.	<ol style="list-style-type: none"> 1. Exam may be isolated to head, chest and abdomen. 2. Local exam of body area(s). 3. Trauma w/out an x-ray. 4. Visual acuity.
99283	<ol style="list-style-type: none"> 1. Fleet's™ enema or digital disimpaction. 2. Urinary or Foley™ catheter for urine sample or output determination. 3. Evaluate, change or replace gastrostomy, ileostomy or cystostomy tube(s). 4. Documented call or on-site consultation with PCP, referral physician, social worker, or poison control but not psych related. 5. Oral, eye, ear, nasal, rectal, topical meds given in ED (includes OTC meds). 6. One or more Rx OTC or non-OTC at DC. 7. Rx at DC for controlled substance (e.g., Lortab, Percocet, Tylox, Vicodin, Lorcet, Xanax, Valium, Ativan, Tylenol#3). 8. Isolated IM injection w/out ancillary studies or oral, rectal, eye, ear, nasal or topical meds in ED. 9. One set of x-rays to an isolated area (CXR, hip/pelvis, shoulder or C-spine alone) or > 1 set of adjacent x-rays for distal extremities (hand/wrist, foot/ankle). 10. 1 to 3 ancillary studies (lab and/or x-ray) ordered and may include bedside studies (UA, UCG, AccuCheck). 11. Eye exam with fluoresceine stain or slit lamp. 12. Provider review/adjusts current patient meds (drug reconciliation). 13. Fetal heart tone determination. 	<ol style="list-style-type: none"> 1. Multiple presenting complaints. 2. Pregnant patient with any complaint. 3. Non trauma patients who present via ambulance or EMS 4. Fever > 100.5 F or 38.0 C. 5. Exam of head, chest and abdomen with neurological exam added. 6. Pelvic, rectal and/or external genitalia exam on patient w/out abdominal pain. 7. Gastroenteritis type case with 1-3 ancillary studies and no therapy in ED. 8. Vaginal discharge or bleeding with no abdominal pain. 9. Fleet's™ enema or digital disimpaction. 10. Urinary or Foley™ catheter for urine sample or output measurement. 11. Re-examination by provider. 12. Non cardiac chest pain with CXR and no EKG.

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* Trauma or Injury such as MVC (Auto Accident) or Fall	<ol style="list-style-type: none"> 1. Recheck of injury previously treated in the same ED. 2. Suture removal when sutures placed in different ED. 	<ol style="list-style-type: none"> 1. Trauma to one body area without an x-ray ordered. 	<ol style="list-style-type: none"> 1. Trauma with one set of x-rays or select adjacent x-ray series like ankle/foot, hip/pelvis and wrist/hand. 2. Trauma to more than one non-adjacent areas w/out x-rays. 	<ol style="list-style-type: none"> 1. Multiple sets of x-rays (up to and including three sets) on non-adjacent areas. 2. More than one set of spinal films. 3. Post MVC (Motor Vehicle Collision) arriving via EMS (Rescue) 	<ol style="list-style-type: none"> 1. Four (4) or more sets of x-rays. 2. Two (2) or more Special Studies (such as CT of both head and cervical spine). 3. Admitted or transferred to another facility. 	<ol style="list-style-type: none"> 1. Unstable vital signs. 2. Need for patient to go immediately to surgical suite for immediate stabilization or exploration (e.g. Ruptured liver or spleen, perforated viscous, free air or excessive blood in abdomen, torn thoracic or abdominal aorta, torn pulmonary vasculature or bronchus, ruptured esophagus). 3. Tension pneumothorax or large pneumothorax. 4. Arrival via rescue or helicopter may occur but not a stand-alone criteria for CC.
* Chest Pain	No workup or therapy provided.	No workup or therapy provided.	<ol style="list-style-type: none"> 1. 1-3 ancillary studies (lab or x-ray) w/out an EKG or cardiac enzymes. 	<ol style="list-style-type: none"> 1. EKG alone. 2. EKG, CXR, and two other lab ancillary studies w/out cardiac enzymes. 	<ol style="list-style-type: none"> 1. Extensive workup which may include CXR, EKG, CBC, BMP, cardiac enzymes (CPK and Troponin) with or without admission or transfer. 2. Chemical cardioversion if use one dose of Adenocard or Diltiazem and other vital signs stable, no chest pain, SOB or palpitations. 	<ol style="list-style-type: none"> 1. Unstable vital signs or cardiac meds as listed in "Types of Medications" as listed above. 2. Acute MI taken to cath lab. 3. Acute MI with thrombolytic meds given in ED. 4. Chemical or electrical cardioversion if unstable.