

## Emergency Medicine E/M Coder Desktop Reference

Risk Level	Minimal	Low	Low Moderate	High Moderate	High	Critical Care
<b>Parameters and Disclaimer Statement</b>	<p>Choice of any emergency medicine E/M code level is dependent upon proper documentation of the History, Exam, and MDM. Provider documentation must include the correct number of elements, items, or systems required for the HPI, ROS, PFSH and Exam. The MDM is determined through combining the highest level achieved in two out of three of the tables in the audit tool (Table A: The Diagnostic and Management Options, Table B: Amount and Complexity of Data Reviewed, and Table C: the Risk Table). If the documentation of the history or the exam is insufficient to reach the code level that could have been achieved by way of the MDM level, the E/M level will only be at the highest possible code allowed relative to the documentation deficiency discovered. Following are some examples: If the HPI only has two (2) 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 (1) item is listed for Past, Family and/or Social history, the maximum code choice would be 99284. <b>The objective criteria listed are used within the Risk Table of the Medicare audit tool. The ultimate level of MDM is determined by combining two of the three tables where the highest levels have been achieved.</b></p> <ul style="list-style-type: none"> <li>• <b>In those cells that are bold and contain numbers (1, 2, 3, etc.), each number contains a stand alone objective criteria for the particular MDM Risk level addressed.</b></li> <li>• Items that are not stand-alone are not bolded and may or may not be preceded by a bullet (•).</li> </ul>					
<b>Presenting Problems in CPT Manual</b>	Self limited or minor.	Low to moderate severity case and Low Risk on the Table of Risk.	Moderate severity case; <b>*Moderate Risk on the CMS Table of Risk.</b>	High severity case w/out an immediate threat to life or physiologic function; <b>*Moderate Risk on the CMS Table of Risk.</b>	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.
<b>Presenting Problems in CMS Table of Risk</b>	<p><b>Minimal Risk:</b></p> <ul style="list-style-type: none"> <li>• One (1) self limited or minor problem.</li> </ul>	<p><b>Low Risk:</b></p> <ul style="list-style-type: none"> <li>• Two (2) or more self limited or minor problems.</li> <li>• One (1) stable chronic illness.</li> <li>• Acute uncomplicated illness or injury.</li> </ul>	<p><b>Low Moderate Risk*:</b></p> <ul style="list-style-type: none"> <li>• One (1) or more chronic illnesses with mild exacerbation, progression, or side effects of treatment.</li> <li>• Two (2) or more stable chronic illnesses.</li> <li>• Undiagnosed new problems with uncertain prognosis.</li> </ul>	<p><b>High Moderate Risk*:</b></p> <ul style="list-style-type: none"> <li>• Undiagnosed new problems with uncertain prognosis.</li> <li>• Acute illness with systemic symptoms.</li> <li>• Acute complicated injury.</li> </ul>	<p><b>High Risk:</b></p> <ul style="list-style-type: none"> <li>• One (1) or more chronic illnesses with severe exacerbation, progression, or side effects of treatment.</li> <li>• Acute or chronic illnesses or injuries that may pose a threat to life of bodily function.</li> <li>• An abrupt change in neurological status.</li> </ul>	None listed in MDM Risk Table.

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Risk Level	Management Options	Clinical Scenarios
<b>Minimal</b>	No ancillary studies. No meds in ED unless the patient sent by PCP for tetanus shot only. No Rx on discharge.	Usually recheck visits with isolated exam. Suture removal for patient treated at another facility. Patient sent into ED to receive tetanus shot only.
<b>Low</b>	No ancillary studies. No meds in ED. No Rx on discharge. No consultations. At discharge, instructions to purchase OTC meds.	<ol style="list-style-type: none"> <li>1. <b>Exam may be isolated to head, chest and abdomen (no neuro, pelvic, rectal or external genitalia exam).</b></li> <li>2. <b>Local exam of body area(s).</b></li> <li>3. <b>Trauma w/out an x-ray ordered.</b></li> <li>4. <b>Visual acuity; eye exam w/out slit lamp or stain.</b></li> </ol>
<b>Low Moderate</b>	<ol style="list-style-type: none"> <li>1. <b>Fleet's™ enema or digital disimpaction.</b></li> <li>2. <b>Urinary or Foley™ catheter for urine sample or output determination.</b></li> <li>3. <b>Evaluate, change or replace tracheotomy, colostomy, gastrostomy, ileostomy, cystostomy tube(s) or Foley™ catheter.</b></li> <li>4. <b>Documented call or on-site consultation with PCP, referral physician, social worker, or poison control but not psych related.</b></li> <li>5. <b>Oral, eye, ear, nasal, or rectal meds given in ED (includes OTC meds).</b></li> <li>6. <b>Topical meds specifically ordered by the provider (e.g., Neosporin, Silvadene, Bacitracin, Polymycin) excluding topical anesthetics such as LET, TAC and EMLA).</b></li> <li>7. <b>Any Rx at DC whether OTC, non-OTC or controlled.</b></li> <li>8. <b>Isolated IM or subq injection (non-controlled) w/out ancillary studies or oral, rectal, eye, ear, nasal or topical meds in ED.</b></li> <li>9. <b>One (1) set of x-rays to an isolated area (CXR, hip/pelvis, shoulder or C-spine alone) or &gt; one (1) set of adjacent x-rays for distal extremities (hand/wrist, foot/ankle).</b></li> <li>10. <b>One (1) to three (3) lab studies ordered and may include bedside studies (UA, UCG, AccuCheck).</b></li> <li>11. <b>One (1) set of x-rays with either oral meds in ED or Rx on discharge.</b></li> <li>12. <b>Eye exam with fluorescein stain or slit lamp.</b></li> <li>13. <b>Provider reviews/adjusts current patient meds (drug reconciliation with signature).</b></li> <li>14. <b>None usually ordered except Doppler studies to hear the pulse and/or FHTs (Fetal Heart Tones) during pregnancy.</b></li> <li>15. <b>One (1) nebulizer (with one (1) medication).</b></li> <li>16. <b>Placement of patient on oxygen (nasal or mask).</b></li> </ol>	<ol style="list-style-type: none"> <li>1. <b>Multiple presenting complaints.</b></li> <li>2. <b>Pregnant patient with any complaint.</b></li> <li>3. <b>Non trauma patients who present via ambulance or EMS.</b></li> <li>4. <b>Fever <math>\geq</math> 100.5°F or 38.0°C.</b></li> <li>5. <b>A condition that requires an exam of head, chest and abdomen with a neurological exam added. (some examples: head, scalp or facial trauma, extremity laceration with possible nerve damage, dizziness, abnormal gait, headache, mentation and/or coordination change)</b> <ul style="list-style-type: none"> <li>- Please note: a neurological exam may include any of the following statements in the exam section of chart:</li> <li>- <b>General/Constitutional: Awake, Alert, Oriented times 3</b></li> <li>- <b>Eyes: PERLA, EOM intact.</b></li> <li>- <b>Musculoskeletal: Extremity strength, motion, and sensation (e.g., N/V intact, strength 4/5, strength symmetrical)</b></li> <li>- <b>Neuro: CN 2-12 intact, DTRs intact. Babinski, Kernigs and cerebellar findings.</b></li> </ul> </li> <li>6. <b>Pelvic, rectal, breast and/or external genitalia exam on patient w/out abdominal pain.</b></li> <li>7. <b>Gastroenteritis type case (nausea, vomiting, diarrhea with +/- abdominal cramping) with no therapy in ED.</b></li> <li>8. <b>Vaginal discharge or bleeding with no abdominal pain.</b></li> <li>9. <b>Constipated or fecal impaction requiring a Fleet's™ enema or digital disimpaction.</b></li> <li>10. <b>Need for urine sample or urine output measurement and order insertion of urinary or Foley™ catheter.</b></li> <li>11. <b>Re-examination by provider.</b></li> <li>12. <b>Non cardiac chest pain with CXR and no EKG.</b></li> <li>13. <b>Trauma with one (1) set of x-rays or select adjacent x-ray series (e.g., ankle/foot, hip/pelvis and wrist/hand only).</b></li> <li>14. <b>Psych evaluation by ED provider with no request for psych professional evaluation (stable anxiety, depression, bipolar may/ may not be off meds).</b></li> </ol>

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<p><b>*Abdominal Pain (May also be related to pregnancy)</b></p>	<p>No workup or therapy provided.</p>	<p>No workup or therapy provided.</p>	<ol style="list-style-type: none"> <li>1. UA, UCG with or w/out pelvic or rectal exam performed and no abdominal pain.</li> <li>2. Vaginal discharge or bleeding w/out abdominal pain.</li> <li>3. An isolated IM/SQ medication, non controlled substance, such as Zofran™, Phenergan™, Bentyl™ or Rocephin™.</li> <li>4. Abdominal pain or cramping w/out a pelvic or rectal exam.</li> </ol>	<ol style="list-style-type: none"> <li>1. Abdominal pain with one of the following:                             <ol style="list-style-type: none"> <li>a. Pelvic or rectal exam</li> </ol> </li> <li>2. Four (4) or &gt; ancillary studies (four (4) labs w/out an x-ray or three (3) labs with an x-ray).</li> <li>3. Abdominal pain with a Special Study that may or may not be visualized by the ED provider.</li> <li>4. Abdominal pain with IV fluids, IV meds, or IM meds multiple, a single IV or IM controlled substance with or w/out oral or rectal medication added.</li> <li>5. EKG ordered alone w/ or w/out an interpretation.</li> </ol>	<ol style="list-style-type: none"> <li>1. Three (3) of the following:                             <ol style="list-style-type: none"> <li>a. Ancillary studies (3 or &gt;)</li> <li>b. IV fluid</li> <li>c. Any IV or IM/SQ meds, and/or</li> <li>d. A Special Study.</li> </ol> </li> <li>2. If order enough ancillaries (lab, x-ray and/or EKG) for additional work-up (3 or &gt;) and visualize or interpret the Special Study, don't need the IV or IM/SQ therapy secondary to data review.</li> <li>3. Multiple Special Studies such as a CT and an Ultrasound.</li> <li>4. Two (2) or &gt; IV or IM controlled substances (narcotics and/or benzodiazepines)</li> <li>5. May be admitted or transferred.</li> </ol>	<ol style="list-style-type: none"> <li>1. Patient with unstable vital signs or in need of immediate surgery for conditions such as AAA, ectopic pregnancy, ruptured viscous like ulcer perforation or for ruptured organ such as spleen or liver.</li> <li>2. Vomiting, diarrhea that leads to dehydration and need for large bolus of IV fluids.</li> <li>3. Mesenteric thrombosis.</li> </ol>