

Use of the Medicare Audit Tool for Emergency Medicine Evaluation and Management Coding September 2009

Overview

There are a variety of different publications related to emergency medical coding, the use of the Medicare Audit Tool, and the AMA/CPT Evaluation and Management (E&M) Documentation Guidelines (DGs). Most coding organizations believe it is necessary to construct and maintain reference material that assists coders in selecting the correct Evaluation and Management code level, with a particular focus on Medical Decision Making (MDM). The chosen MDM level is used in conjunction with the History and Exam levels to assist coders in determining the proper Evaluation and Management code for services provided by emergency physicians. The original “Marshfield Clinic Audit Tool” and the current “Medicare Documentation Worksheet”¹ are commonly used by emergency medicine coding organizations with the realization that these guidelines were originally developed for use by multi-specialty clinics and office-based medical practices, and not for the practice of emergency medicine.

We have elected to use the “Medicare Documentation Worksheet” as the baseline for this document. This document defines items in each of the three tables in an attempt to obtain a higher degree of clarity, and to explain each with a focus on the practice of emergency medicine. In addition, we have added numerous clinical examples for many of the words, phrases, and sentences found in the three tables. We have also included a more detailed discussion of the moderate level of the Risk Table as this level incorporates the biggest range of MDM. Comments related to the types of patient presentations, procedures, and management options have also been provided for the Critical Care-type patient. The clinical examples and comments regarding patient presentations described herein are all fictitious.

This document provides guidelines for determining the level of Medical Decision Making based on the provider documentation present in a patient record; however, it should be noted that the coder is also expected to review the documentation for reasonable medical necessity along with the severity of the patient’s presenting problem(s). For example, if the History, Exam, and Medical Decision Making indicate a level five service, but the patient presented with a minor laceration and was discharged with a simple laceration repair and nothing more, then we would expect the coder to refer this chart to management or to the provider for review prior to coding and billing.

¹ “HGS Administrators Documentation Worksheet”, HGS Administrators (CMS Pennsylvania Carrier.), www.hgsa.com, April 2008

Disclaimer: Interpretation of compliance matters and medical coding and billing guidelines are continually subject to review and these opinions are offered for purposes of discussion and as a basis for learning and not as a complete and final authority. As a snapshot frozen in time, this information may be incomplete, outdated, or contingent on other information not otherwise referenced. Though all of this information is carefully researched and checked for accuracy and completeness, **COMPANY NAME** accepts no responsibility with regard to errors, omissions, misuse or misinterpretation. These examples and guidelines are based on common or typical scenarios, but nevertheless they are fictitious and any similarity to actual patient encounters is coincidental. Compliance with rules, regulations, and laws are paramount in all aspects of our industry. **COMPANY NAME** works diligently to assist our clients and our coding staff with information, tools, and knowledge intended to facilitate compliance in their coding and billing endeavors.

Using the Coding Grid

The expanded grid consists of the following tables:

- Table A: Number of Diagnosis and Treatment Options
- Table B: Amount and/or Complexity of Data Reviewed
- Table C: Table of Risk of Complications and/or Risk of Morbidity and/or Mortality
- MDM Choice Summary Table.

The grid should be used in the following manner:

1. The coder should review Tables A, B, and C, evaluate the Emergency Department Treatment Record (EDTR), and choose the number of points or level attained for each table. The coder's review should focus on the following items:
 - a. Is the patient new to the provider?
 - b. Has an additional work-up been ordered for the patient?
 - c. Have lab, x-ray, Special Studies, or an EKG been ordered?
 - d. Has the clinician discussed the interpretation of any of these studies with another clinician?
 - e. Has the provider discussed the case with a family member or other layperson, or another healthcare provider?
 - f. Has the doctor or NPP reviewed an old record?
 - g. Has the clinician visualized and interpreted an image, tracing or specimen?
 - h. What was the patient presentation?
 - i. Where any procedures performed?
 - j. Did the management options include ancillary studies, Special Studies, and/or EKGs, or did the therapeutic intervention include IV fluids, medications by any route, nebulizers or breathing treatments, and/or other modalities.
 - k. What was the final disposition of the patient: admission; transfer; placed in observation; discharged; or deceased?
2. The coder should mark the Summary Table with the results from each of the three tables. The column that includes two or more choices and is the closest in proximity to the right side of the table will determine the level of Medical Decision Making. If no single column includes two or more choices, then the second choice from the right or left (middle choice) should be selected.
3. The level of MDM indicated in the Summary Table must be checked against the level obtained for the History and Physical Exam. If the levels achieved for the History and/or the Exam are below the level of MDM, the coder must select the lowest level of the deficiently documented History and/or Exam.

Additional information and instructions for proper utilization of Tables A, B, and C are included immediately following each table.

Table C: Risk of Complications and Morbidity/Mortality

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	<ul style="list-style-type: none"> One self-limited or minor problem (e.g., cold, insect bite, tinea corporis) 	<ul style="list-style-type: none"> Lab Test requiring venipuncture Chest x rays EKG/EEG Urinalysis Ultrasound 	<ul style="list-style-type: none"> Rest Gargles Elastic bandages Superficial dressings
Low	<ul style="list-style-type: none"> Two or more self-limited or minor problems One stable chronic illness (e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH) Acute uncomplicated illness or injury (e.g., cystitis, allergic rhinitis, simple sprain) 	<ul style="list-style-type: none"> Physiologic test not under stress (e.g., pulmonary function tests) Non-cardiovascular imaging studies with contrast (e.g., barium enema) Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies 	<ul style="list-style-type: none"> Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives
Moderate	<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 problem with uncertain prognosis (e.g., lump in breast) Acute illness with systemic symptoms (e.g., pyelonephritis, pneumonitis, colitis) Acute complicated injury (e.g., head injury with brief loss of consciousness) 	<ul style="list-style-type: none"> Physiologic tests under stress (e.g., cardiac stress test, fetal contraction stress test) Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors (e.g., arteriogram, cardiac catheterization) Obtain fluid from body cavity (e.g., lumbar puncture, thoracentesis, culdocentesis) 	<ul style="list-style-type: none"> Minor surgery with identified risk factors Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation without manipulation

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
High	<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 pose a threat to life or bodily function (e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure) An abrupt change in neurologic status (e.g., seizure, TIA, weakness, or sensory loss) 	<ul style="list-style-type: none"> Cardiovascular imaging studies with contract with identified risk factors Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors Discography 	<ul style="list-style-type: none"> Elective major surgery (open, percutaneous, or endoscopic) with identified risk factors Emergency major surgery (open, percutaneous, or endoscopic) Parental controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis

Table C: Overview

Note: Table C, the Risk Table, is only one of three tables to consider when determining the appropriate level of MDM. Exclusive use of the Risk Table to determine the appropriate level of MDM is not appropriate, and should never be considered.

Table C, The Risk of Morbidity and/or Mortality Table, has not been modified from its original state. It is identical to the table found in the 1995 Documentation Guidelines, and on the CMS web site. Table C is used by many Medicare carriers, and by other payers and coding organizations. In an attempt to illustrate how Table C should be used for the practice of emergency medicine, we have provided clinical scenarios, presenting problems, and management options that include objective criterion based on the subjective phrases in the table. These examples should assist a coder in selecting the Risk level that most appropriately represents the severity of the case intermixed with the amount of workup and data review, and the degree of therapeutic intervention performed by the emergency medicine provider.

We have added some objective concepts that will help provide the coder with additional guidance in determining the proper MDM Risk levels for any given case. We have elected to pay particular attention to the Moderate risk level where the MDM Risk of two of emergency medicine's CPT codes - 99283 and 99284 - are represented. We have also included a comprehensive review of Critical Care that will assist the coder in verifying that a Critical Care-type case actually exists.

Table C is divided into three main columns. The choices in the three columns mimic the natural progression of Medical Decision Making that occurs given a patient's presentation and the treatment options chosen by a provider up to the point of patient discharge, transfer, admission, or death. The progression of Risk levels from minimal to high can be observed by referring to the various areas of the patient's medical record. The medical record includes the order sheets, treatment record, and nurses' notes, along with all ancillary studies, Special Studies or therapeutic interventions ordered and the results and interpretations of these ancillary studies. These interpretations and the results of therapy ultimately guide the clinician in selecting further therapy, and the final disposition of the patient. Patient presentations can be found in the chief complaint(s) and the HPI sections of the chart. Initial vital signs found on the nursing triage or ongoing nursing notes may also be repeated in the constitutional system of the exam. These vital signs are also relevant to the severity of a patient presentation. Any procedures that have been performed can generally be found by reviewing documentation that is located near the results and interpretation section of the MDM section of the EDTR. These procedures can sometimes be verified by reference to the procedure being performed in the nurses' notes. Therapeutic efforts are most frequently found in the order sheets that are separate from the main EDTR. By observing all activity performed for the patient from presentation to final disposition, a coder should be able to recognize the severity of patient presentations, procedures that are performed, and the therapeutic efforts that should indicate if a threat to life or physiological function exists, and how immediate this threat is in any given case.

Presenting Problems Column

This column presents the coder with grades of severity for patients who present to an ED for care. Presentations range from minor recheck visits to various high-risk conditions that require rapid evaluation and therapy on the part of the emergency physician. The majority of bullets represent subjective statements regarding types of illnesses or injuries. We will be providing multiple objective examples or criterion for various presenting problems that can help define these subjective statements. The presenting problems increase in potential severity as the user moves from the top to the bottom of the Presenting Problems column.

In the Presenting Problems column, there are various types of patient complaints or presenting problems that direct the clinician to provide different types of exams, and order various medication, or ancillary studies. We will describe distinct types of exams and orders that, while overlapping and being repeated in the management options section, will help describe the potential severity of cases based on how and why the patient presented to the emergency department (ED).

Diagnostic Procedure(s) Ordered Column

This column includes the number and types of procedure(s) that are ordered or performed by the provider in order of increased risk to the patient during and following the performance of the various procedures. **This list of diagnostic procedures is one of comparative risk and does *not* represent the severity of the patient's presentation or condition that led the clinician to perform various procedures or order various ancillary studies. Example statements for each level of Risk and thoughts related to each include:**

- **Lab test requiring venipuncture (minimal risk)** - Risks to the patient include pain, hematoma, and subsequent inflammation or infection at the puncture site, but the severity of the case can be as high as a Critical Care-type case when any blood studies are ordered.

- **Chest x-rays (minimal risk)** – There is a slight risk to the patient of radiation exposure, but the severity of the case may be at a moderate to a high severity level for patients who may have conditions such as pneumonia, pneumothorax, pulmonary edema, or lung carcinoma.
- **EKG/EEG (minimal risk)** - Risks to the patient include pulling chest or scalp hairs, or pinching of skin when the EKG is performed, but the severity of the case is usually high considering that the EKG is used to evaluate chest pain, syncope, shortness of breath, or palpitations, and the EEG is used to determine the presence of ongoing seizure activity or to examine a focal area of the brain that generates seizure activity.
- **Urinalysis (minimal risk)** – Risks to the patient include spilling or touching the urine, but the severity is moderate to high for patients being evaluated and ultimately treated for urinary tract infection, hematuria, dehydration, acidosis/ketosis, or bilirubin in the urine.
- **Ultrasound (minimal risk)** – Risks to the patient include feeling a cold, gooey substance on the skin of the area being evaluated, but the severity of the case may be at a high or Critical Care level secondary to such conditions as cholecystitis, kidney stones, ovarian cysts, ovarian or testicular torsions, uterine fibroids, intrauterine pregnancies, deep vein thromboses, or more severe conditions including rupturing aortic aneurysms or ectopic pregnancies.
- **Lumbar puncture (moderate risk)** - Risks to the patient include pain, hematoma, or subsequent infection at the lumbar puncture (LP) or spinal tap site, or subsequently in the brain or spinal cord areas. LPs are performed on cases that are of a high severity with an immediate threat to life or physiologic function such as meningitis, subarachnoid cerebral bleed, or encephalitis.

These are examples of the only procedures performed by the emergency physician that fall in the Diagnostic Procedures Ordered column. Referring to the above list of ancillary studies ordered in the minimal area of the Risk table, we will review lab, x-ray, and Special Studies in relationship to the severity of the cases requiring such studies. In addition, we will focus on additional exam areas that require a greater degree of provider evaluation and a greater level of MDM as compared to the regular exam performed on patients in an emergency center. We will also list other procedures that are not included in the Medicare audit tool, though they are commonly performed by emergency physicians and/or NPPs.

Within the audit tool, procedures performed are placed in the various levels of risk based on the risk to the patient during the performance of the procedure, and during the the time following these efforts up to the time of the patient's disposition. We will focus on the types of patient presentations that create the need for more enhanced workups (e.g., ancillary studies such as lab, x-ray, EKG, or Special Studies), more comprehensive exams (e.g., beyond the head, neck, chest and abdomen) and additional procedures. The types of patients these procedures and orders are performed on will also be addressed. Discussion of these issues will focus on the severity of the patient (e.g., low, moderate or high), the immediate threat to life or physiologic function, and the increased risk of morbidity and/or mortality.

Management Options Selected Column

This column presents the provider's therapeutic orders and the patient's final disposition. The items listed in this column represent the risk to the patient during and after the performance of these treatments. **This list of management options is one of comparative risk and does *not* represent the severity of the patient's presentation or condition that led the clinician to order specific management or treatments. Example statements with reference to various bullets in the Management Options Selected column in the Risk Table and thoughts related to each include:**

- **Rest, gargles, elastic bandages and superficial dressings (minimal risk)** – This statement represents various instructions at discharge or treatment modalities during the care of the patient or on discharge. These modalities present a minimal risk to the patient during and after they are ordered, whether during the ED visit or on discharge; however, the severity of the patient who receives these modalities can have a higher Risk than minimal or low as seen in cases such as a sprained ankle or a sore throat. These types of cases can be of at least a moderate severity when considering the evaluation of a fever, the degree of pain, the need for ordering ancillary studies (e.g., lab, x-rays, and/or cultures), the need to administer medications in the ED, and the need for any prescriptions on discharge.
- **Over-the-counter drugs (low risk)** - This represents a low risk as compared with other management options in this column, but the types of cases that require these kinds of medications (e.g., Tylenol™ and Motrin™) are usually of moderate severity when these medications are used for fever control or for mild to moderate pain.
- **Minor surgery (low risk)** – Minor surgery represents a low risk when compared with other high level management options such as major surgery. Minor surgery (e.g., laceration repairs or incision and drainage (I&D) of abscesses) is common in cases that are considered moderate to high severity. These cases may require the administration of medication in the ED, the ordering of Special Studies such as CT scans, x-rays of various extremities to determine if foreign bodies or fractures are present, and/or prescriptions on discharge.
- **IV fluids without additives (low risk)** – This risk of the administration of IV fluids without additives is attendant to the pain created during catheter insertion, and the potential for a hematoma formation, or infection or inflammation at the IV site. IV fluids (with or without additives) are ordered in moderate or high severity cases where the patient needs therapy for various levels of dehydration, or in cases requiring administration of medication or electrolytes via an IV bag. Even though the risk may be low, the types of cases managed using IV fluids alone – with or without medications or electrolytes - are cases that are considered high moderate or high severity with or without an immediate threat to life or physiologic function.
- **Prescription drug management (moderate risk)** - Prescription drug management carries more risk, as a general rule, when compared to non-prescription drugs. Cases requiring one or more prescriptions are considered to be of moderate to high severity cases.
- **IV fluids with additives (moderate risk)** - Administration of IV fluids with additives carries the risk of pain, hematoma, infection and/or inflammation at the site of catheter injection, and the added risk of medication reactions to any medication or electrolytes added to the IV solutions. While IV fluids with additives carry a greater risk than IV fluids without additives, both are ordered and given to patients in high severity type case with or without an immediate threat to life or physiologic function.
- **Parenteral controlled substances (high risk)** – Administration of parenteral controlled substances can create a significant change in the patient’s mental status up to the point of threatening respiratory efforts or airway patency. Parenteral medication is given either by the Intramuscular (IM) or Intravenous (IV) routes. Controlled substances include narcotics for moderate to severe pain control, and benzodiazepines which are used for anxiety, agitation, seizures, muscle relaxation, and vertigo or dizziness. All of these types of cases as high severity cases that may or may not have an immediate threat to life or physiologic function.
- **Decision not to resuscitate (high risk)** – This decision is made either at the conclusion of resuscitative efforts, or prior to the institution of resuscitative efforts. This decision is a difficult one made on the highest severity of cases.

These are examples of the only management options performed by the emergency physician that fall in the Management Options Selected column. Referring to the above list of splinting/strapping, non-parenteral or parenteral medication in the ED, IV fluids, or resuscitative

efforts, we will review various medications, routes of administration, and administration of IV fluids, in addition to other treatment modalities such as nebulizer breathing treatments, and their relationships to the severity of the cases requiring such treatments.

Within the audit tool, management options are ordered for various levels of risk based on two factors: 1) the risk to the patient during the performance of the management option; and 2) the risk to the patient during the time following these orders up to and following the patient's disposition. These final dispositions following treatment in the ED refer to whether the patient was discharged, transferred, admitted, placed in observation, or deceased, with each implying a level of severity usually starting at moderate and progressing to Critical Care.

We will focus on the various degrees of patient severity that create the need for the administration of enhanced therapies (including medication and IV fluids as an example) in the emergency department. Discussion of these issues will focus on not only the severity of the patient (low, moderate or high), but also on the immediate threat to life or physiologic function, and the increased risk of morbidity and/or mortality.

Specific Items Related to the Risk Table

The Risk Table includes many elements that are common to the practice of emergency medicine. To facilitate the use of the Risk Table, we have elected to provide a breakdown and an explanation of each subjective item pertinent to emergency medicine. We will examine each level of Risk independently, and will initially review Presenting Problems, followed by Procedures Performed, and Management Options selected. We will present additional examples and define various terms while also explaining these items as they relate to the practice of emergency medicine and the subsequent choice of Risk level based on the patient's risk of increased morbidity and mortality, the severity of a case, and the risk of an immediate threat to life or physiologic function. The items listed in the Risk table are preceded by bullets (•). Other examples and additional objective criteria are preceded by a dash (–).

Minimal Risk

Presenting Problems

- One self-limited or minor problem (e.g., cold, insect bite, tinea corporis)

Self limited or minor problems are defined as those problems requiring no ancillary studies or therapeutic intervention including medication administered in the emergency department (ED) or on discharge. Other examples of self-limited or minor problems include:

- An isolated tetanus shot w/ no other presenting complaint, ancillary studies, or therapeutic intervention.
- Recheck: wound repaired at other location.
- Recheck: I&D, burn, cellulitis (healing).

Diagnostic Procedures Ordered

- Lab Test requiring venipuncture
- Chest x rays
- EKG/EEG
- Urinalysis
- Ultrasound

The risks in performing a venipuncture, taking a chest x-ray, performing an EKG or EEG, obtaining a urinalysis, or having an ultrasound performed on a patient poses only minimal risk to the patient. The risk following the performance of these procedures is also minimal; however, **it is important to note that while the risk of performing these procedures may be minimal, the severity of the presenting problem of the patient may be much greater. This subject will be addressed later in the Risk Table review.**

Management Options Selected

- Rest
- Gargles
- Elastic bandages
- Superficial dressings

While the risk of performing these efforts may be minimal, the severity of the presenting problem of the patient may be much greater. As a general rule, orders for medication or ancillary studies do not occur at this level.

Low Risk

Presenting Problems

- Two or more self-limited or minor problems
- One stable chronic illness (e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH)
- Acute uncomplicated illness or injury (e.g., cystitis, allergic rhinitis, simple sprain)