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# MEDICAL CODING BEST PRACTICES FOR EMERGENCY DEPARTMENTS

According to the CDC, around 130 million people visit the emergency department (ED) in the US each year. An ED is at a critical intersection of inpatient and outpatient services, often the point of contact between patients and the hospital or primary care center. Since people can walk in anytime, via an ambulance or on foot, without a prior appointment, it sees an extremely high patient turnover which makes an ED extremely busy.

Additionally, the emergency rooms (ER) of today are not the same as those two decades ago. Rather than receiving limited workups and then being admitted as inpatients for further evaluation, the ERs now handle evaluation, investigation, examination, diagnostic tests, and treatment of a broad spectrum of injuries and illnesses. They specialize in everything from primary care and minor surgical procedures to observation care and trauma services, as well as advanced critical care if need be.  Some hospitals specializes in offering trauma services.

This added responsibility, in addition to the unplanned, fast-paced, and high-volume nature of an emergency room (ER), presents unique challenges that are not found in any other specialty.

Besides delivering high-quality care, an ED must also maintain appropriate clinical documentation and perform meticulous emergency department coding to receive timely reimbursements from insurance providers. The rapidity and volume of this specialty make emergency room billing guidelines a bit more complicated, requiring careful understanding and ample experience.

This guide breaks down the basics of emergency department coding. After starting with the need for proper coding, we will delve into the specific forms used, CPT codes, modifiers, exceptions, critical care, and the key considerations to ensure effective billing.

# Why is Emergency Department Coding Challenging?

The unpredictable nature of an ER makes emergency department coding complex, relying heavily on patient reports generated at each stage of care. The challenges affecting claim reimbursement in an emergency department can be summarized as follows.

## *Short Execution Time*

The fast pace of an emergency department, coupled with a limited number of beds and resources, requires physicians and healthcare providers to make swift decisions. They assess the patient's condition and the emergency, and utilize their quick cognition to determine a diagnosis and treatment plan, unlike in inpatient and outpatient departments where there is a lot of clinical decision-making time.

Since the time on patient care itself is so limited, the time to maintain appropriate clinical documentation is even lesser. This short execution time often results in providers missing out on some medical services rendered or a diagnosis, which causes high instances of discharges not fully billed (DNFB) or denied claims. Incomplete or illegible doctors' or nurses' notes full of discrepancies are a common occurrence inside the emergency department.

## *Multi-Faceted Team*

A large team full of various specialists and healthcare professionals performs on each patient. This includes the Emergency Medical Technician (EMT) who first responded to the patient, ED physicians, and specialists depending on the patient's problem, physician assistants (PA), nurse practitioners (RNs), registered nurses (RNs), residents, primary care technicians (PCTs), and the ancillary staff among others.

Each member may render some service to the patient and if that is not properly communicated with each other and the emergency department coding personnel, it results in services not being billed. An ED coder needs to have an intimate understanding of what is happening in their EID, besides being aware of each member, confirming their credentials, and ensuring that every task they perform is aptly documented.

## *Longer Stays*

In an emergency room, everything is fast which is why physicians think in terms of minutes and hours, instead of days. If a situation is critical enough to require a stay longer than one day, emergency room billing guidelines become more thorough. This often includes patients with chest or abdominal pain, renal calculi, dehydration, drug overdose, or asthma.

In this case, insurance providers scrutinize every detail and perform comprehensive audits, which is why documentation fullfilling medical necessity is important. Missing out on important information in the reports is common in an ED, but special care is needed to prevent denials.

## *Lack of Experienced ED Coders*

Given the complexity of emergency department coding, experienced ED coders are scarce. They require comprehensive training to  develop thorough understanding of the trends in an ED, understand the nuances of clinical documentation, and keep an eye to spot out and prevent DNFB cases. Well-trained coders are hard to find, expensive to hire, and even more difficult to keep.

# *Extensive List of Services and Coding Guidelines*

As discussed above, an emergency department provides an extensive array of services, higher than any other part of a hospital. Each service and specialty has unique codes and accompanying billing guidelines which are easy to confuse for a beginner. However, a slight error in the terminology used for any service provided or misusing a modifier can significantly delay the claim processing time.

Moreover, emergency room billing guidelines are dynamic. They change often, which is why it is essential to stay updated with the rules.

## Forms Used in Emergency Department Coding

Since the emergency department is at the intersection of outpatient and inpatient services, the coding there is not straightforward but is a combination of two different types – professional coding and facility coding. Each type of emergency department coding has its policies and guidelines, and forms.

Professional coding bills for the physician services provided, including the physical work and cognitive effort. This makes use of the CMS-1500 form or its electronic counterpart 837-P. On the other hand, facility coding bills for the intensity and volume of resources that the facility offers, utilizing the UB-04 claim form or the digital 837-I.

Both these codes need to adhere to the emergency room billing guidelines, with the professional type being more complex.

# Professional Billing Guidelines

According to the emergency department coding guidelines 2020, the evaluation and management (E/M) services offered by an ED are coded with CPT codes from 99281 to 99285, each one representing a different level of service. The level designated to each patient is determined by three key components: history, examination, and medical decision-making (MDM). The severity and nature of the presenting symptoms, diagnostic testing required, exams performed, and the complexity of decision making required and care provided is the differentiating factor between each code.

For example, a patient who requires a simple procedure like a prescription refill or a wound recheck would qualify for 99281 (Level 1) but a complex procedure like central line insertion warrants a 99285 code.

When you submit a claim for reimbursement, the supporting medical records and documentation should identify,justify and reflect the E/M code you chose. These additional documents are even more crucial if you appeal a denial.

## 99281

This code is used when the presented problem is minor, uncomplicated, and self-limited, requiring no home treatment, such as an insect bite, wound recheck, a tuberculosis test, suture removal, booster dose, or a medication refill. If the patient has a wound, its signs and symptoms are explained to the patient, and they are asked to return if the situation exacerbates.

Such visits have  problem-focused history and examination, problem oriented investigations and straightforward/ easy decision making because there is no permanent threat to the patient's health status, Some patients visit the emergency department to show proof of absence at work or school, which is also billed with this code.


## 99282

While 99281 coded for very low or no severity visits, the presented problems that need 99282 have low to moderate severity such as a mild urinary tract infection, ear pain, minor bruises or sprains, localized skin rash or lesion, or a minor viral infection. The problem has a very low risk of morbidity without treatment, and no functional impairment is to be expected.
Such problems require an expanded problem-focused history and examination, with low complexity of medical decision making. Emergency department coding under 99282 includes services such as those offered in 99281, as well as:

- over the counter/non-prescription medications
- repair of a wound with a skin adhesive
- simple dressing changes
- cast removal
- collection of specimens by lab
- repair of a wound with a skin adhesive
- minor laceration repair
- drainage of a minor abscess


## 99283

Compared to the previous two codes, 99282 is more widely used as it caters to a wide range of problems with moderate severity such as a non-lethal head injury, headache, eye pain (corneal abrasion or infection), mental health problems such as anxiety and depression, mild asthma, GIT bleeds, hemorrhoids, cellulitis, abdominal pain that does not need advanced imaging, and GI or muscle-related chest pain.

These problems have a moderate risk of mortality or detriment to the quality of life if there is no prompt medical intervention. Consequently, these problems requires an expanded problem-focus history and examination and MDM of moderate complexity history, examination, and MDM than the above two codes.
Common services, offered under the emergency department coding of 99283 but are not covered under 99281 and 99282 include:

- reviewing side effects of any new medications
- preparation for lab tests and plain X-rays of one or more body parts
- nebulizer treatment
- C-spine stabilization
- corneal exams with dye
- oxygen therapy
- routine psych medical clearance
- discharge with a medication prescription, including non-parenteral ones

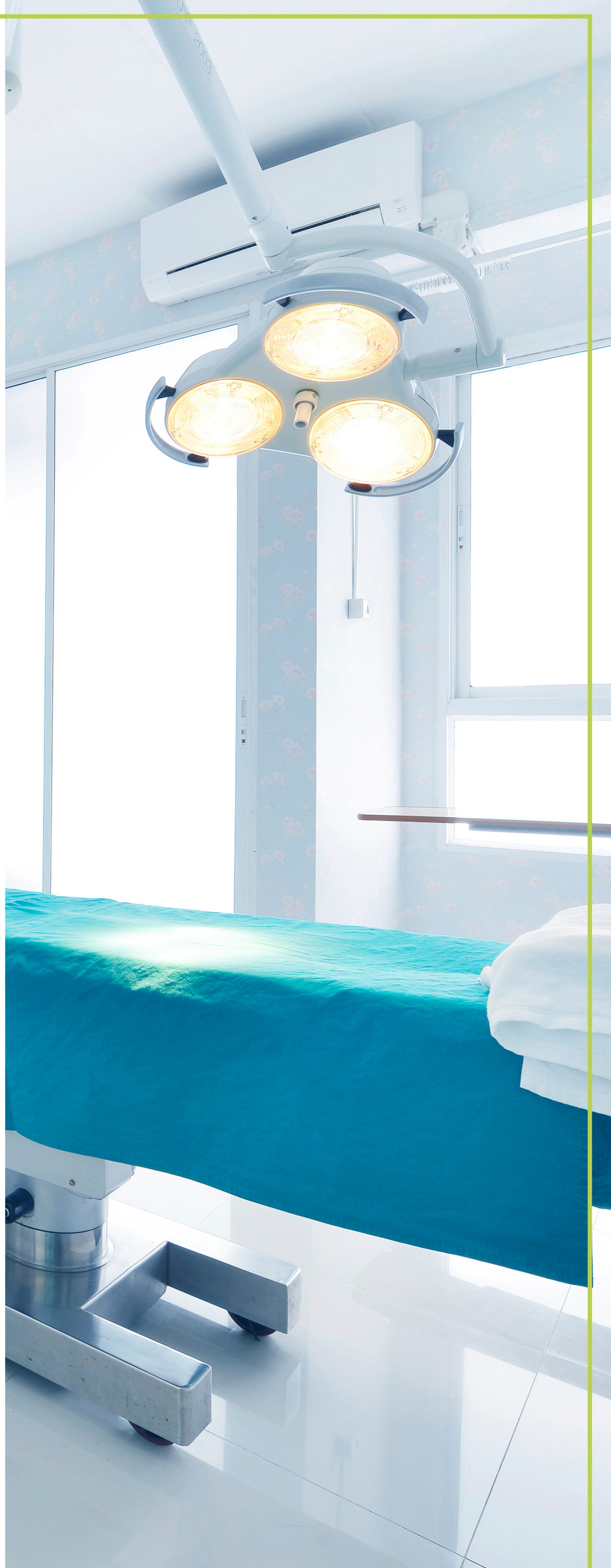
# 99284

When emergency department coding needs 99284, the presenting complaint is of moderate to high severity that needs prompt medical attention. However, the problem does not immediately threaten the life of the patient, which is the distinguishing factor between 99284 and 99285.

This includes symptoms such as a head injury with brief loss of consciousness and a Glasgow Coma Score between 13 and 15, severe dehydration, severe chest pain, intermediate trauma with a low triage score between Level 3 and 4, dyspnea (shortness of breath), abdominal pain that needs advanced imaging, and kidney stones among others. As expected, medical decision-making in these cases is a of moderate complexity and requires a detailed history and examination.

The services offered when this code is used are also more complex than those mentioned above, such as:

- Two nebulizer treatments
- Preparation for radiological imaging like CT, MRI, and ultrasound
- Sexual assault examinations (no specimen collection)
- Management of a non-suicidal but psychotic patient
- Pelvic exam
- EKG
- Multiple tube placements
- Assistance with or preparation of medical procedures like eye irrigation with Morgan lens or bladder irrigation with a 3-way foley
- Administration of parenteral medications



## 99285

The most complex of all, 99285 is only utilized in emergency department coding when the presenting problem is of high severity and can cost the patient their life if help is not obtained immediately. Such complaints require detailed examination and history, in addition to high complexity of decision-making. Given its extremity, thorough documentation must support the use of 99285.

Examples of high-severity problems include severe and unstable chest pain hinting at myocardial infarction, severe respiratory distress, critical trauma with a Level 5 triage score, suspected sepsis, uncontrolled diabetes, or diabetic ketoacidosis (DKA), severe 3rd degree or 4th-degree burns, toxic ingestions, new neurological symptoms like slurred speech or staggered walking), and suicidal or homicidal tendencies.

Management of 99285-requiring symptoms utilizes the most resources and the most advanced care of an emergency department, including services such as:

- Oxygen via a face mask
- Procedural sedation
- Blood transfusions
- Central line insertions, paracentesis, or other invasive procedures
- Using specialized resources such as police, rehab, social services, and crisis management
- Sexual assault exams with forensic specimen collection
- Physical/chemical restraints or a personal sitter
- More than one radiological exam
- ICU admission
- Serial cardiac studies such as EKG or cardiac enzyme tests
- Coordination of inpatient admission or transfer to a higher level of care

## *Modifiers*

Choosing one of these five CPT codes is not the end of emergency department coding. A code is often supplemented with a letter 'modifier' that further specifies the service provided. Most common modifiers include:

- Modifier 25 to bill identifiable services separately, rather than as a bundle
- Modifier 76 and 77 for repeat services provided by the same or different physician
- Modifier GC to bill services offered by a resident under the oversight of a teaching physician
- Modifier 59/X (EPSU) to report multiple infusions and lines
- Modifier 91 when the same test is repeated more than once, unless due to a processing error
- Modifier QW for simple and low-risk lab tests that are waived under the Clinical Laboratory Improvement Amendment (CLIA)

## *Procedure Codes*

While the codes mentioned above bill for a bundle of general services, many specific procedures such as laceration repair, central lines, puncture aspiration, paracentesis, and fracture treatment among others have a distinct CPT code or a modifier. It is important to document each procedure and report it with its designated code to receive appropriate reimbursement.

## *Other Codes*

In the emergency department, physicians commonly assess radiological reports such as X-Rays and ultrasounds, as well as interpret other exams such as an EKG. This information impacts their clinical decisions and plan of action. Like procedure codes, these activities also have specific codes which must be reported with every

# *Injury and Worker's Compensation*

One of the most common reasons why people visit the emergency department is accidents in the workplace that may be minor or major. Given its regular occurrence, the emergency room billing guidelines account for this specific cause with a special series that elaborates on the problem. This includes:

- S & T series for Injury Code to differentiate between fractures, sprains, dislocation, etc.
- V, W, X, Y series codes to demonstrate the cause of injury/intent such as tripping, slip, fall, or accident
- Y92 series for Place of Occurrence
- Y93 series for Activity Code such as walking, running, or climbing
- Y99 series for Status Code to highlight between leisure or work

While the first three codes are mandatory, no code may be assigned to activity and status if there isn't enough information.

# Facility Billing Guidelines

In the facility type of emergency department coding, the rules are much laxer and more flexible. Each hospital has the liberty to draft its own emergency room billing guidelines per the general directions mentioned under the Outpatient Prospective Payment System (OPPS).

Most hospitals utilize a grid/point system that lists multiple service types and then notes down the type, volume, and intensity of resources administered to each patient. These factors include:

- Social worker notes
- Nurse's notes
- Triage
- Assessments such as airway, breathing, circulation, pain, and vitals
- Care rendered towards wounds
- Specimen collection (blood, urine, throat swab)
- Translator and interpreter services
- Type of discharge

Any care provided off-grounds such as by the EMT staff is not billed under the ED claim.

In the professional side of emergency department coding, the nature of presenting problem (NOPP) and the level of MDM are evaluated but in facility billing, there is special emphasis on the documentation of start and stop times, and mode/route of administration of fluids, medications, injections, and infusions.

As for drugs, biologicals, and nonsurgical therapeutic or diagnostic procedures, some of them are packaged under a consolidated hospital facility code while others need to be paid separately reported in the form of the Healthcare Common Procedure Coding System (HCPCS).

All the services provided must be medically necessary. Failure to demonstrate this may lead to medical necessity denials.

# Critical Care Emergency Department Coding

Besides offering on-the-go services, emergency departments are also capable of advanced critical care. Administered when there is a life-threatening deterioration in the patient's condition, the codes used to encapsulate these services are not the same as the emergency department coding guidelines mentioned above.

The CPT codes used are 99291 and 99292, and these are time-based codes. Reported only once each calendar date, this time-based nature means that 99291 is used when (first) 30 to 74 minutes of critical care services are provided and 99292 for each additional 30 minutes. Consequently, a minimum of 30 minutes of critical care must be rendered to bill these CPT codes.

Examples of critical care services include:

- Cardiopulmonary resuscitation (CPR)
- Defibrillation, cardioversion, or pericardiocentesis
- Non-invasive ventilation
- Endotracheal intubation or chest tube insertion
- Major trauma care with many surgical consultants
- Care for major burns

# Ensuring Effective Emergency Department Coding

Besides ensuring a thorough understanding of the CPT and other codes highlighted under the emergency department coding guidelines 2020, there is a lot more that hospitals and primary care centers can do to improve the first-pass ratio of ED claims.

## *Proper Documentation*

The primary responsibility of each ED is to ensure thorough documentation, irrespective of the type of care (professional or facility). The staff must illustrate a proper record of the problems, diagnosis, and medical services rendered. While the professional side would focus on the history, physical examination, workups, and management, the facility side emphasizes start and stop times and the volume of resources used.

Given the burden emergency physicians already have, investing in medical scribes to chart physician-patient encounters on electronic health records (HER) systems can significantly improve medical records, expediting claims.

Additionally, all the resident and fellow services and documentation must be attested.

## *High Specificity in Coding*

It is pertinent for emergency department coding to be as specific as possible and reported in the appropriate sequential order of diagnosis. A confirmed diagnosis always takes precedence over uncertain terms such as ‘probable’, ‘suspected’, ‘rule out’, or ‘working diagnosis’ which must be avoided at all costs.

Resultantly, medical coders in the emergency department require high comprehension skills to accurately identify the most specific diagnosis that necessitated the ED visit. This includes an analysis of diagnostic tests ran, past medical history, and additional cues in the team’s notes to determine the proper diagnosis.

Each special service has a unique code and failure to mention each will result in DNFB and loss of revenue.

# The Bottom Line

Emergency department coding is a specialized procedure, made challenging by the high volume and fast-paced nature of the ER. Besides the two types of coding, there are additional CPT codes, modifiers, and guidelines to consider. Any error may result in a significant loss of revenue via slowed or denied claims, given the rapid turnover of the emergency department.

For this reason, outsourcing emergency department coding is a popular choice. This allows the hospital or primary care center to exclusively focus on providing top-notch patient care and helping the greatest number of people. If you want to improve your facility's coding consistency, maximize cash flow, and ensure error-free claims processing, join hands with America's top medical billing company – **Precision Hub**.