Applying Facility E/M Codes in the Hospital Emergency Department

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Evaluation and management (E/M) codes were added to the CPT codebook in 1992 to classify physician services. Use of these codes increased when they became integral to physician practice reimbursement. E/M codes became a tool for practices to trend individual physician profiles and reimbursement issues as well as patient visit statistics.

More recently, hospitals began using E/M codes when the Centers for Medicare and Medicaid Services (CMS) required them to identify hospital outpatient service levels. However, E/M codes often do not fit the type of services provided by hospitals.

In response, CMS required facilities develop a methodology for code assignments that would promote consistency, at least within the facility. However, the lack of clear definitions and standard guidelines continues to cause confusion and inconsistent coding practices.[1]

This article outlines how one facility, Oklahoma University (OU) Medical Center in Oklahoma City, standardized the E/M coding function in the emergency department by moving the E/M assignment functions to the HIM department.

The New Procedure

E/M emergency department (ED) codes are included in code range 99281–99285. As mentioned, the definitions in the CPT codebook do not always match the hospital definition. Examples of OU Medical Center's definitions for each emergency room evaluation and management code appear in the table on the opposite page.

In addition to the CPT code definition, OU Medical Center uses a point system to assign code levels. This point system assists the facility in ensuring that the E/M levels assigned match the definitions, creating a check and balance for accurate and complete coding. The point system is divided into five sections, which are listed on a point sheet given to each patient on admission to the ED.

- **Section I: ED care.** ED care is further divided into four levels: basic, intermediate, extensive, and resuscitative. Each has a minimum set of recorded vital signs and assessments to charge for each level.
- **Section II: Arrival and disposition.** This pertains to how the patient arrives and departs. Examples include medical transport (air, ground), against medical advice, or intrahospital admissions.
- **Section III: Additional patient needs.** This area is useful when additional staff is needed to care for the patient. This section would include services such as consults, faxing of information, isolation, and violent or aggressive patients.
- **Section IV: Medications.** This small section delineates PO, suppository, topical, or inhaled medications.
- **Section V: Interventions.** There are many services that a patient may receive in the ED for which a particular CPT code may not exist. These services are incorporated into the ED E/M code. The list may differ from facility to facility due to the type of interventions that the facility provides. Examples of OU Medical Center interventions include visual acuity, photography, ring and piercing removals, elastic wraps, cleaning and dressing wounds, and suctions and irrigations.

Each item on the point sheet is given a value that is weighted based on staff time or nursing resources related to patient care. As care is provided to the patient, items on the point sheet are marked by the caregiver. Staff in the HIM department review the documentation within the record and on the point sheet to total the points and assign the appropriate CPT code.

OU Medical Center found that clear communication and specific procedures must be instituted for this process to work well. For instance, the HIM department staff worked with the ED staff to establish a universal pick-up location for discharged patient records. The ED at OU Medical Center is very large, with different bays that have individual nursing stations and physicians. A universal pick-up location is necessary to minimize lost or missing records.

In addition, HIM staff work together to code the entire ED visit. Staff review the documentation within the medical record, tally the point sheets, ensure accuracy between points and E/M level, and place the appropriate CPT code indicating the correct E/M level in the abstracting system. The record is then forwarded to the HIM clinical coding staff for appropriate ICD-9 diagnostic and procedural coding. This process was implemented to separate the E/M assignment and clinical coding processes in order to establish a check and balance system.

Prior to implementing this system, OU Medical Center recognized the potential for inaccurate E/M coding through their internal quality monitoring system. Reasons for inaccuracies included a lack of education of clinical staff, difficulties in meeting annual training requirements in response to CPT updates, the size and complexity of the clinical staff, and the volume of patients seen in the ED. More than 200 nurses covering multiple shifts and treating up to 200 patients a day made the ED an incredibly busy environment, one not always suited to education. It soon became apparent that a simplified process was needed for compliance and consistency in point assignment.

By consolidating the process in the HIM department, the updates continue annually and training is limited to the HIM staff whose primary responsibility is assigning levels. The HIM department can focus on training, ensure understanding of definitions, provide immediate feedback, and standardize procedures. As a result of the consolidation of this process, the HIM department hired two new HIM professionals. These professionals concentrate on the application of consistent guidelines, definitions, and standards.

Results of the New Process

As a result of the new process OU Medical Center found that it had been potentially undercoding E/M levels in the ED. HIM staff determined that items were often missed by clinical caregivers on the point sheet. The new process allows staff to complete the point sheet with the clinical documentation, increasing accuracy between the point sheet and documentation.

Consolidating the training and education needs to a set of specific HIM staff has been successful as well. For instance, the changes for the 2006 injection and infusion CPT codes posed a challenge for facilities. At OU Medical Center, the HIM department was able to educate nurses to improve the overall documentation of the interventions relating to injections and infusions, thus increasing accuracy in code assignments.

Above all, the process has allowed the HIM department to serve as the knowledge expert in E/M code assignments and increase awareness of the need for complete and accurate coding in all patient care areas within the organization.

As the focus on reimbursement and revenue cycle management continues to increase, correct assignment of the facility E/M codes will become more important to the financial success of an emergency department. As demonstrated by OU Medical Center, HIM professionals are in a unique position to provide quality and accurate coding of the E/M facility codes.

Note

1. For more information on efforts to standardize E/M codes, refer to the AHIMA-AHA white paper “Recommendation for Standardized Hospital Evaluation and Management Coding of Emergency Department and Clinic Services,” produced by the Hospital Evaluation and Management Coding Panel of the American Hospital Association and American Health Information Management Association, which is available online in the FORE Library: HIM Body of Knowledge at http://www.ahima.org.

Sample E/M Definitions at the OU Medical Center Emergency Department		
99281	Level I	This is the lowest level. Patients classified under this level require simple decision making. An example would be a patient with ear pain who is given a prescription for an oral antibiotic.
99282	Level II	Level II patients are classified as Level I patients who have an additional intervention. Patients classified in this level would be those with a simple sprain, ear pain, or laceration with the addition of an intervention. An example

		would be a patient with a wrist sprain who has an elastic wrap placed.
99283	Level III	Level III patients are classified as those with a condition that require more than one additional intervention. Patient types under this level have more nursing assessments due to the nature of their condition, increasing the level of care. An example would be a patient with noncardiac chest pain who receives both a subcutaneous injection and elastic wrap for a muscle sprain.
99284	Level IV	Patients classified at this level are those who remain in the ED for an extended amount of time, require numerous interventions and assessments, are clinically unstable, and have potential to be admitted. An example would be a patient with cardiac chest pain who remains in the ED for several hours, requiring vital signs every 15 minutes, nitroglycerin sublingually, cardiology consultation, and multiple EKGs prior to discharge from the ED in 10 hours.
99285	Level V	Level V patients are classified as those who are admitted to the hospital. These patients are similar to Level IV patients in terms of diagnosis and treatment including consultation visits and multiple interventions. An example would be a patient who presents with cough, chest congestion, fever with a chest x-ray positive for pneumonia. The patient requires IV antibiotics, breathing treatments, and frequent vital signs in the ED and is admitted for a four-day course of IV antibiotics and follow-up chest x-rays and breathing treatments.

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