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Virginia College of Emergency Physicians

The Basics of EM Documentation and Getting Paid for your Work

Jason Bavarian, DO
Virginia College of Emergency Physicians Leadership & Advocacy Fellow (2020-2021)

The purpose of this is document to equip EM physicians with the knowledge of documentation so they get properly paid for their work. It should be especially useful to new attending physicians or experienced attending physicians moving to a performance-based pay system. It is not designed to be overly detailed or exhaustive but instead give a brief framework on charting and practical ways to improve. Charting is used for three reasons: Billing, Medical Legal, and Communicating with other providers.

CPT (current procedural technology) codes are used for billing and the focus of this discussion.

CPT codes for Emergency Department Visits are based on Level 1-5

Most ED visits, around 80%, fall under level 4 or 5. I will refer to these as High Level charts. The other 20% fall under level 1-3. I will refer to those as Low Level charts. These percentages will vary heavily on the type of department in which you work.

Lower level charts will have presenting problems that are self limited to moderate. They might require some basic testing and imaging but not always. Their codes are 99281, 99282, and 99283.

Higher level charts will have presenting problems that are high to severe. They would require multiple tests, higher level imaging (CT/MRI/US), IV/IM medications. Many admissions fall under these categories. Their codes are 99284 and 99285.

DOCUMENTATION

What Criteria Determines your Chart Level?

When your chart is being evaluated by coders they generally use the **Medical Decision Making** section to guide the level. After the coders evaluate the MDM, calculating that a chart should be a specified level, they will then review your other documentation on **HPI, PMFSH**, **ROS** and **Physical exam** to see if it fulfills the remaining requirements. It's better to chart as high level as possible for best billing outcome.

What is a good MDM?

This is probably the most important part. There is a point system in place for MDM and you will need 4 points (the maximum given points) in 2 out of the 3 MDM sections to get a level 5 chart. In general the more complex the situation and information documented the more points you will receive. The three sections are listed here as a guide. You don't need to document all of these.

1. Problem – Identifying the presenting problem's level of complexity.
    a. Single or multiple problems
    b. Minor, moderate, or severe
    c. New problem, chronic problem, or acute on chronic
    d. Does the patient need additional ED work up or no work up
2. Data – The interpretation of data that you have ordered and/or reviewed. If you have interpreted the data yourself specify this difference. Document "interpreted by me" instead of "Reviewed by me" when appropriate.
    a. Addressing abnormal vitals
    b. Obtaining history from someone other than the patient
    c. Clinical lab tests or medical tests (ekg, pulse ox)
    d. Radiology tests (x-ray, CT, ultrasound, MRI)
    e. Consulting specialists with documentation of discussion
    f. Reviewing old records then summarizing them.
    g. Reassessing the patient's condition (repeat vitals, symptoms relief)
3. Risk – The level of risk in regards to the problem, testing and treatment plan
    a. Risk of disability, mortality and/or complications of the patient's underlying pathology
    b. Risk in obtaining diagnosis (invasive vs noninvasive tests)
    c. Management/treatment risks (PO vs IV medications, Controlled substance vs non controlled substance prescriptions, splinting/reductions, DNR decision, bipap vs intubation).
    d. Discharge instructions (give specific follow up instructions and return precautions)

What is a good History?

History of Present Illness (HPI) – It can be easy to fall into the habit of adding extra information to your HPI while at the same time miss the necessary elements.

- Lower level chart 1-3 HPI consists of 1-3 elements.
- Higher level chart 4-5 HPI consists of at least 4 elements.

The 8 Elements include: Location, Quality, Severity, Context, Timing, Duration, Modifying factors, associated signs/symptoms.

For mental health cases, it is sometimes difficult to get all these elements. It's better to focus on severity, context, timing, duration and associated signs/symptoms for those cases.

Past Medical, Family, Social history (PMFSH) – Medical, Family and Social history are three separate sections used for billing. You must include one item in each section for it to count. Allergies and surgeries are included under "past medical".

- Lower level charts 1-4 require one out of the three sections

- Highest level chart Level 5 require two out of three sections
- ED observation patients require three out of three sections

Saying that one of the sections is "non-contributory" fulfills the requirement but "not on file" does not count.

Review of Systems (ROS) –This part of the chart is divided not only into low or high, but also a moderate level. This is an extremely common area to get down coded but also easy to mitigate. Documenting positive/negatives in the HPI count towards ROS.

- Lower level charts 1-3, the ROS includes 1 system.
- Moderate level chart 4, the ROS includes 2-9 systems.
- Highest level chart level 5 chart MUST include minimum 10 systems.

The 14 systems include: Constitutional, Eyes, ENT, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Skin, Neurological, Psychiatric, Endocrine, Heme/lymph, Allergic/immune.

To mitigate the potential of losing out on 10+ systems you can document "all other systems reviewed and negative" AFTER at least 2 systems have been noted. Some companies don't allow this tactic so it's recommended to contact your billing department for clarification.

What is a good Physical Exam?

Physical Exam (PE) – It is not recommended to document "body areas". Instead it is better to use "organ systems". The distribution of organ systems evaluated to chart level is more complex than history and ROS. Documenting that an organ system is "negative" or "normal" is ok for normal findings but saying an organ system is "abnormal" without elaboration is insufficient.

- Level 1 chart has 1 organ system
- Level 2 & 3 chart has 2-4 organ systems
- Level 4 chart is 5-7 organ systems
- Level 5 chart has 8 or more organ systems.

The 12 organ systems include: Constitutional, Eyes, ENT/mouth, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Skin, Neurologic, Psychiatric, Heme/lymph/immune.

Note that the "Head" and "Neck" in classic HEENT are body areas, not organ systems. "ENT" is the actual organ system, so documenting the posterior oropharynx or mucous membranes would fall under ENT, but documenting the head is "normocephalic and atraumatic" actually falls under the organ system "skin", and "neck is supple" falls under the organ system "Musculoskeletal". "Back" and "Chest" are other body areas that are often used but do not count as organ systems.

If you're unable to obtain history or examine an organ system due to the patient's critical condition or other circumstance which precludes obtaining the information it must be included in your documentation. Example: "History/exam limited by… post-ictal, dementia, severe dyspnea, unstable vital signs, severe pain, CPR, intubated, ect." This cannot be used for language barriers.

What about Critical Care?

Critical Care is also measured using CPT codes (99291 and 99292). CMS (Center for Medicare and Medicaid services) only pays for critical care if at least 30 minutes of critical care services are provided and documented. BE PRECISE, do not use "time ranges". This includes time spent directly delivering medical care to a critical patient, documentation and discussion with consultation services, patient and/or family.

99291 – Includes the first 30-74 min

99292 – Includes each additional 30 min afterwards

Things not included in critical care time are procedures such as: Intubation, time spent supervising CPR, central line, EKG interpretation, resident teaching time, ect. These procedures are billed for separately which should be indicated in your critical care documentation stating, "Excluding time spent on separately billable procedures."

Chart Level	HPI	ROS	PMFSH	PE	MDM
99281	1-3	-	-	1	Straight Forward
99282	1-3	1	-	2-4	Straight Forward
99283	1-3	1	-	2-4	Low Complexity
99384	4+	2-9	1 of 3	5-7	Mod Complexity
99285	**4+**	**10+**	**2 of 3**	**8+**	**High Complexity**