Documentation for ED Visits with "Additional Work-Up" Planned

Presented by Rae Jimenez, CPC, CDEO, CPB, CPMA, CPPM, CPC-I, CCS
Course Objectives

• Discuss gray areas for E/M selection for the professional services

• Review payer interpretations of additional work up planned

• Review E/M code determination
OIG: CODING TRENDS OF MEDICARE EVALUATION AND MANAGEMENT SERVICES

Figure 3: Percentage of E/M Codes Billed for Emergency Department Visits From 2001 to 2010

*Percentages do not sum to zero because of rounding.
## Table C-5: Emergency Department Visit

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>(2%)</td>
</tr>
<tr>
<td>99282</td>
<td>9%</td>
<td>8%</td>
<td>7%</td>
<td>6%</td>
<td>5%</td>
<td>4%</td>
<td>4%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>(6%)</td>
</tr>
<tr>
<td>99283</td>
<td>31%</td>
<td>30%</td>
<td>29%</td>
<td>28%</td>
<td>27%</td>
<td>25%</td>
<td>24%</td>
<td>22%</td>
<td>21%</td>
<td>20%</td>
<td>(11%)</td>
</tr>
<tr>
<td>99284</td>
<td>32%</td>
<td>31%</td>
<td>30%</td>
<td>30%</td>
<td>30%</td>
<td>29%</td>
<td>29%</td>
<td>29%</td>
<td>29%</td>
<td>29%</td>
<td>(3%)</td>
</tr>
<tr>
<td>99285</td>
<td>27%</td>
<td>30%</td>
<td>33%</td>
<td>33%</td>
<td>35%</td>
<td>38%</td>
<td>40%</td>
<td>42%</td>
<td>44%</td>
<td>46%</td>
<td>48%</td>
</tr>
</tbody>
</table>

*Percentages may not sum to 100 because of rounding.

*The percentages for E/M code 99281 in 2009 and 2010 are nonzero values that round to 0 percent.

History (Professional E/M)

• ROS and PFSH history can be obtained by ancillary staff. Must be reviewed and an indication of the review in the provider’s note

• HPI must be documented by the provider

• If unable to obtain a history “If the physician is unable to obtain a history from the patient or other source, the record should describe the patient’s condition or other circumstances which precludes obtaining a history.” Per 1995 DG

• Complete PSFH is one item from two of the three elements
Exam (Professional E/M)

• Normal is suitable documentation for normal exam of a system and/or body area

• Must elaborate on abnormal findings

• Expanded Problem Focused versus Detailed using 1995 DGs. Depends on the MAC

• Comprehensive Exam: an exam of 8+ organ systems
MDM (Professional E/M)

- Problems that are new to the examiner.
- Additional workup planned versus no additional workup planned.
- Data points when independent interpretation of image, tracing or specimen is performed.
- Establish risk using the Table of Risk.
## E/M (Professional)

<table>
<thead>
<tr>
<th>E/M</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
<td>PF</td>
<td>PF</td>
<td>SFW</td>
</tr>
<tr>
<td>99282</td>
<td>EPF</td>
<td>EPF</td>
<td>Low</td>
</tr>
<tr>
<td>99283</td>
<td>EPF</td>
<td>EPF</td>
<td>Moderate</td>
</tr>
<tr>
<td>99284</td>
<td>D</td>
<td>D</td>
<td>Moderate</td>
</tr>
<tr>
<td>99285</td>
<td>Comp</td>
<td>Comp</td>
<td>High</td>
</tr>
</tbody>
</table>
• 99285 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
Medical Necessity

Versus

MDM
<table>
<thead>
<tr>
<th>Code</th>
<th>Severity of the Presenting Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
<td>Self-limited or minor</td>
</tr>
<tr>
<td>99282</td>
<td>Low to Moderate</td>
</tr>
<tr>
<td>99283</td>
<td>Moderate</td>
</tr>
<tr>
<td>99284</td>
<td>High and require urgent evaluation; do not pose an immediate significant threat to life or physiologic function</td>
</tr>
<tr>
<td>99285</td>
<td>High and pose an immediate significant threat to life or physiologic function</td>
</tr>
</tbody>
</table>
**MDM: Number of Dx/Tx options**

<table>
<thead>
<tr>
<th>Categories for Problems/Major New Symptoms</th>
<th>Number</th>
<th>Points</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self limited or minor stable, improved, or worsening</td>
<td>1</td>
<td>1</td>
<td>Max – 2</td>
</tr>
<tr>
<td>Established problem stable or improved</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Established problem worsening</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New problem no additional work-up planned</td>
<td>3</td>
<td>3</td>
<td>Max - 1</td>
</tr>
<tr>
<td>New problem additional work-up planned</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Categories of Data to be Reviewed</td>
<td>Number</td>
<td>Points</td>
<td>Results</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------------</td>
<td>--------</td>
<td>--------</td>
<td>---------</td>
</tr>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>and/or discussion of case with another healthcare provider</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MDM

Review and summarization of other records

• “Reviewed records from patient’s hospitalization at …."

– Discussion of case with another health care provider

• “Discussed the psych testing results with Dr. W”
<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problems</th>
<th>Diagnostic Procedures Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>1 self limited or minor problem, 1 more stable chronic illness, e.g. well controlled hypertension or non insulin dependent diabetes, cataract, BPH</td>
<td>Laboratory requiring venipuncture, Urinalysis, KOH prep, Chest x-ray, EKG/EEG, Ultrasound</td>
<td>Rest, gargles, elastic bandage, superficial dressings</td>
</tr>
<tr>
<td>Low</td>
<td>2 or more self limited or minor problems, 1 or more stable chronic illness, e.g. well controlled hypertension or non insulin dependent diabetes, cataract, BPH</td>
<td>Physiologic test not under stress, non cardiovascular imaging studies with contrast, Superficial needle biopsy, Laboratory test requiring an arterial puncture, skin biopsy</td>
<td>CTC drugs, Minor surgery with no risk factors, PT, OT, IV fluids without additives</td>
</tr>
<tr>
<td>Moderate</td>
<td>1 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, Acute illness with systemic symptoms, Acute complicated injury</td>
<td>Physiologic test under stress, Diagnostic endoscopies with no identified risk factors, Deep needle or incisional biopsy, Cardiovascular imaging studies with contrast, no risk factors, Obtain fluid from body cavity</td>
<td>Minor surgery with risk factors, Elective major surgery with no risk factors, Prescription drug mgt, Therapeutic nuclear medicine, IV fluid with additives</td>
</tr>
<tr>
<td>High</td>
<td>1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment, Acute or chronic illnesses or injuries with that pose a threat to life or bodily function, An abrupt change in neurologic status</td>
<td>Cardiovascular imaging studies with contrast with risk factors, Cardiac electrophysiologic tests, Diagnostic endoscopy with risk factors, Discography</td>
<td>Elective major surgery with risk factors, Emergency major surgery, Parenteral controlled substances, Drug therapy with toxicity</td>
</tr>
</tbody>
</table>
MDM

• Table of Risk:
  – This table was developed for use for the Medicare population
  – Some problems can be low, moderate or high depending on the severity (example – asthma)
  – Highest in any column determines the risk level
### MEDICAL DECISION MAKING - Final Result for Complexity: 2 of 3

<table>
<thead>
<tr>
<th>1-Number of Diagnoses or Treatment Options</th>
<th>0-1 Minimal</th>
<th>2 Limited</th>
<th>3 Multiple</th>
<th>4 or more Extensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-Amount and/or Complexity of Data</td>
<td>0-1 Minimal or low</td>
<td>2 Limited</td>
<td>3 Moderate</td>
<td>4 or more Extensive</td>
</tr>
<tr>
<td>3-Table of Risk</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Overall Type of Decision Making (2 of 3)</td>
<td>Straightforward</td>
<td>Low Complexity</td>
<td>Moderate Complexity</td>
<td>High Complexity</td>
</tr>
<tr>
<td>CPT® Code Reviewed by CERT Contractor</td>
<td>Percentage of Services Incorrectly Coded</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **99222** - Initial hospital care, per day, for the evaluation and management of a patient, which **requires these three key components:**  
  - Comprehensive history  
  - Comprehensive exam  
  - Medical decision making of moderate complexity | 50% |
| **99285** - Emergency department visit for the evaluation and management of a patient, which **requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status:**  
  - Comprehensive history  
  - Comprehensive exam  
  - Medical decision making of high complexity | 50% |
| **99233** - Subsequent hospital care, per day, for the evaluation and management of a patient, which **requires at least two of these three key components:**  
  - Detailed interval history  
  - Detailed examination  
  - Medical decision making of high complexity | 49% |
When an electrocardiogram (EKG) is ordered and performed in a physician's office during an evaluation and management (E/M) visit, the ordering of the EKG would be part of the Medical Decision Making (MDM) under the Risk category under Diagnostic Procedures Ordered. The interpretation of the ordered EKG is considered part of the EKG reimbursement, and as such is not part of the Amount and/or Complexity of Data to be Reviewed category under the MDM portion of the E/M service. Counting both a review of the ordered EKG and billing for the interpretation and report of the same EKG is incorrect.

Both the 1995 and 1997 Documentation Guidelines discuss documentation for E/M services.
In the NGS tool under “Number of Diagnoses or Treatment Options”, the chart references “workup planned” and “no additional workup planned”. Some MAC’s consider tests performed during the same encounter and others consider it to be tests scheduled following the encounter. How does NGS interpret “additional work up”?

Answer: NGS does not differentiate between diagnostic tests done on the same DOS as the encounter, and those scheduled following the encounter. Either would be considered “additional workup planned”.

Source: NGS Evaluation and Management FAQs
Does “additional workup” include request for consultation with a specialty provider?

Answer: Additional workup includes all requests by the provider to obtain further diagnostic information to help establish a final diagnosis and plan of care. This includes orders for diagnostic tests and requests for consultative input from other specialty providers.

Source: NGS Evaluation and Management FAQs
• Guidance specific to additional work up plan is not provided.
Q3. Please clarify if "new problem to provider, additional workup" means that the additional workup must be done beyond that encounter at that time. For example, if a physician sees a patient in his office and needs to send that patient on for further testing, that would be additional workup. The physician needs to obtain more information for his medical decision making. Or, does additional work-up consist of any diagnostic testing, laboratory testing, etc. that can be performed during the visit.

A3. There is no specific indication that "further workup needed" must be completed at a future date. Diagnostic and management criteria are determined by a multitude of factors, including the following, which is taken from the Evaluation and Management Services Guide.

- The number of possible diagnoses and/or the number of management options that must be considered is based on:
  - The number and types of problems addressed during the encounter;
  - The complexity of establishing a diagnosis; and
  - The management decisions that are made by the physician.

Source: Noridian ACT Questions and Answers – April 16, 2015
16. What constitutes additional workup in the Amount and Complexity of Data grid for Medical Decision Making?

The number of possible diagnoses and/or the number of management options considered is on the number of types of problems addressed during the encounter, the complexity of establishing a diagnosis, and the management decisions made by the physician. For each encounter, you should document an assessment clinical impression or diagnosis. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.

Additional workup is anything done beyond that encounter at that time. For example, if a physician sees a patient in his office and needs to send that patient on for further testing, that would be additional workup. The physician needs to obtain more information for his medical decision-making.

Source: Novitas Evaluation and Management Services FAQs
- Guidance specific to additional work up plan is not provided.
'Additional Work-up' consists of any diagnostic testing, laboratory testing, etc. and may be performed at the time of visit.

Source: Palmetto GBA Medical Decision Making Component
How to determine further work-up under number of diagnoses

Q. In medical-decision making, how does one determine further work-up under “number of diagnoses”?  

A. A key element of the medical-decision making category includes management decisions made by the physician to determine a diagnosis and treatment. Evidence of further work-up within documentation would include: indicating a problem is worsening/probable and/or listing possible management options, advice sought, referrals or consultations, and the initiation of or change in treatment.

Source: First Coast Service Options, Inc FAQ
“No Additional Work-up Planned” vs. “Additional Work-up Planned”

There has been some confusion regarding what is meant by “additional work-up planned”. “Additional work-up planned” refers to information (including diagnostic testing results and consultations) which can be obtained, either during or following the initial E/M encounter, in order to sift through the number of possible diagnoses and/or management options.

The Marshfield Clinic scoring tool is a method for assessing the underpinning CPT and Medicare E/M Documentation Guidelines Medical Decision Making criteria. (See FAQ3.) Neither CPT nor Medicare specify “additional work-up planned” be performed after the Evaluation & Management service. Certainly any additional work-up planned needed for patient care should be performed as soon as practical.
Emergency Room/Department E/M documentation:

1. New Problem- No Additional Work-up Planned: A patient presents with a low grade fever and pharyngitis. An examination is provided and the patient is sent home with a prescription and instructed to follow-up with their primary care physician as needed. Three (3) points would be assigned for New Problem- No Additional Work-up Planned score.

2. New Problem – Additional Work-up Planned: A patient presents with abdominal pain and hematuria. The ER/ED physician (or staff) schedules an outpatient MRI and/or communicates directly with the patient’s primary physician or other specialist after discharge from the ER/ED and the discussion has been documented in the medical record. Four (4) points for Additional Work-up Planned would be scored. Credit is not given for Additional Work-up Planned if the clinical testing/consultation occurred during the ER/ED Encounter or in the instance when the patient is instructed to contact their primary physician. This application is consistent with a more complex E/M code level.
Q: What if the Encounter doesn’t require Additional Work-up Planned but does require high complexity medical decision making (MDM)?

A: The provider may submit medical records for review. Consideration will be given to the medical record provided. The Additional Work-up is a component of the number of diagnoses and management options. There are two other elements – amount/complexity of data and the table of risk which contribute to the medical decision making element. CPT also notes that when counseling and/or coordination of care dominates more than 50% of the encounter with the patient and/or family, then time shall be considered the key or controlling factor to qualify for a particular level of E/M services.
Medical Decision Making:
Td 0.5 ml IM-Ancef one gram IV-IV saline one liter over 2 hours-CBC, CMP, PT, PTT, Brain CT w/o contrast.

Procedure:
Laceration repair description: 13 cm linear laceration on right upper forehead, shape linear.
Local anesthesia: Lidocaine 1%, with epinephrine, 10cc sq
Repair: 2 layers, deep layer repaired with simple interrupted absorbable 3-0 vicryl sutured and skin layer repaired with staples, 13 staple. Performed by ER physician.

Diagnosis:
Head injury NOS, without skull fracture
13 cm forehead laceration

Rx: Cephalexin 500 mg PO QID #5days

Discharged Home. Wound check in 2 days, staples removed 12-14 days. Return if severe headache occurs, or nausea, nor fever or wound redness or discharge.
MEDICAL DECISION MAKING:
X-ray RT Foot: Per radiology no fracture or foreign body
Td 0.5ml IM x1, Ibuprofen 800mg po x1, Rocephin 1 gram IM x1

DIAGNOSIS:
Puncture wound of the food

Rx: Keflex 500 mg, Ibuprofen 800 mg
MEDICAL DECISION MAKING: At this time the patient appears stable, but she did have a motor vehicle accident. Rule out fracture or intraabdominal injuries.

LABORATORY STUDIES: A FAST exam was done by myself. This is a bedside limited ultrasound to rule out intraperitoneal fluid or pericardial effusion. Splenorenal, hepatorenal and bladder views reveal no evidence for intraperitoneal fluid. Cardiac view reveals no evidence for pericardial effusion. Impression, normal FAST examination.

Chest x-ray 1-view was reviewed by myself. This shows no mediastinal widening. No infiltrates, no cardiomegaly, Impression normal chest x-ray.

C-spine, T-spine and L-spine films were reviewed by myself and these show no fracture or dislocation. Left forearm x-ray also reviewed by myself. Right shoulder x-ray shows no fracture or dislocation.

Urinalysis, complete metabolic panel, lipase, amylase, CBC were normal.

EMERGENCY DEPARTMENT TREATMENT AND COURSE: The patient received some IV morphine for her pain, tetanus prophylaxis, normal saline IV, after which she was reexamined. She still had some mild C-spine tenderness. Because of this, a CT of the C-spine was ordered which was read by the radiologist as having no acute fracture. The patient remained hemodynamically stable. Pain has improved.

CLINICAL IMPRESSION:
1. Motor vehicle accident.

DISPOSITION: Home in good and stable condition with plan to follow up p.r.n. He was given a prescription for Vicodin and Motrin.
ED EVALUATION & INTERVENTIONS: ER MD interpretation: EKG shows normal sinus rhythm with first degree AV block moderate left axis deviation. No acute ST T wave changes. No acute ischemic abnormality. This x-ray shows no acute change. Laboratory evaluation includes a Chem-8, cardiac enzymes, CBC, and cardiac enzymes. All were reviewed and within normal limits. Patient received Diltiazem 1 mg IV, Phenergan and aspirin in emergency department. He is resting comfortably.

CONSULT
Will admit for rule out MI, observation and possible stress test tomorrow.

RE-EVALUATION: Patient has been resting. Upon waking, he complains of persistent nausea, pain chills and shortness of breath. He is somewhat uncomfortable going home because he still feels poorly.

DIFFERENTIAL DIAGNOSIS MEDICAL DECISION MAKING:
DIAGNOSES:
1. Chest pain, rule out acute MI versus unstable angina.
2. Anxiety
3. Chronic pain syndrome

DISPOSITION: Admit to telemetry for observation.
HPI: 40 year old male with palpitations and with ESRD, on hemodialysis, underwent cardiac cath. No CP, SOB, NV. Feels heart beating like this for months. Quality: Fast. Severity: 7 on scale 1-10. The onset was gradual. The course is constant. No atrial fibrillation, no premature atrial contractions, no paroxysmal supraventricular tachycardia and no premature ventricular contractions.

ROS:
- Constitutional: Negative
- Syncope: Negative
- Shortness of Breath: Negative
- ENT: Negative
- Eye: Negative
- Gastrointestinal: Negative
- Genitourinary: Negative
- Skin: Negative
- Neurologic: Negative
- Lymphatic: Negative
- Allergies: Negative
PAST Medical/Family/Social
Medical History: Cardiac: HTN, Valvular Diseases, CRF
Surgical: AV Graft
Family: HTN, Mother: Breast cancer
Social History: Alcohol: Denies use  Tobacco: Denies use  Drugs: Denies

Physical Examination
General Appearance: No acute distress
Temperature: 98.6 degrees  Pulse Rate: 101 bpm  Blood Pressure: 166/85
Skin: Warm
Eye: Pupils equal, round, and reactive to light. Extraocular movements intact. Normal Conjuctiva
Ears, nose, mouth and throat: Oral mucosa moist
Neck: Supple
Heart: Regular rate and rhythm, systolic murmur at LSB radiating Ailla 3/6, diastolic murmur at aortic 2/6
Respiratory: Lungs clear to auscultation bilaterally. Respirations not labored.
Chest Wall: No tenderness
Extremity: Normal range of motion. AV fistula to rue with +Bruit and thrill
Neurologic: Alert and oriented times 3
MEDICAL MAKING DECISION:
Labs, EKG ordered

Patient Discharged. Has appointment with PCP tomorrow morning.

DIAGNOSIS:
HTN
Chronic Renal Failure
Aortic Valve Disorder
Questions?