AUDITING & COMPLIANCE TIP

Auditing Tip Series #1 of 5

During this 5-week series, we will be breaking down an ER record through the audit process. Our series will first include an overview of auditing ER services and then the following weeks, we will breakdown the History, Exam, MDM, and Medical Necessity of the encounter.

OVERVIEW OF ER AUDITING

The emergency room is a very busy place in a hospital and the complexities of the patient that present range from runny noses to life- threatening situations. Due to these wide-ranging variations of complexity, the documentation guidelines of services performed in an ER vary more than those in other designated areas.

In the ER, there are 5 levels of service just as office-based E&M services, but in the ER the documentation elements are scored differently.

HISTORY COMPARISON		
99201	PF	99281
99202	EPF	99282, 99283
99203	D	99284
99204, 99205	COMP	99285

The history portion of the documentation of an ER level 4 encounter (99284) requires fewer elements than an office visit level 4 new patient (99204).

We would think that a patient presenting to an ER would be more acute than one presenting for a new patient office visit, but that is actually not the case as noted in the comparison chart above.

EXAM COMPARISON		
99201	PF	99281
99202	EPF	99282, 99283
99203	D	99284
99204, 99205	COMP	99285

A comparison of the exam documentation components for ER services notes the same finding with respect to the extent of the exam required. The lower level codes require the same minimal exam (2 organ systems per 1995) while allowing the level 4 encounter in the ER to be supported with the same type of exam as the established patient level 3. Actually, although a significant difference, it does stand to reason since most patients that report to the ED will have a problem that is concentrated to one organ system and the detailed exam includes that one organ system in detail with associated system(s). However, the most troublesome part of ER auditing for most is when it comes down to the MDM, and equating the difference between the 99283/99284 with both requiring a moderate level of MDM. The difference here is noted in the CPT description of the codes. The descriptor of the 99283 indicates only that the problem is of moderate level, but the 99284 description takes it much further than that. First, the descriptor tells us that even though we are scoring it as moderate complexity, these patients actually have a *HIGH level of severity requiring URGENT evaluation.* It goes further to indicate that the biggest difference will be that these patients are not at immediate jeopardy of threat to life or bodily function during this encounter. Keep in mind that the immediate jeopardy is not what could have happened to the patient, or what may happen to the patient, but what ACTUALLY occurred (according to the documentation) during the encounter.

MDM COMPARISON		
99201, 99202	SF	99281
99203	LOW	99282
99204	MODERATE	99283, 99284
99205	HIGH	99285

During the next few weeks as we break down an ER note, keep these comparisons in mind as we explore the differences in the noted record.