

CPT CODE 99285

EMERGENCY DEPARTMENT VISIT

FACT SHEET

Emergency Department Services (New/Established Patients)

Components Required: 3 of 3	99281	99282	99283	99284	99285
History & Exam					
Problem Focused	●				
Expanded problem focused		●	●		
Detailed				●	
Comprehensive					●
Medical Decision Making					
Straightforward	●				
Low		●			
Moderate			●	●	
High					●
Presenting Problem (Severity)					
Self-limited or minor	●				
Low to moderate		●			
Moderate			●		
High				●	
High severity/immediate significant threat to life for physiological function					●
Typical Time: Bedside/Floor/Unit	-	-	-	-	-

Medicare allows only the medically necessary portion of a **face-to-face** visit. Even if a complete note is generated, only the necessary services for the condition of the patient at the time of the visit can be considered in determining the level/medical necessity of any service.

For billing Medicare, a provider may choose either version of the documentation guidelines, not a combination of the two, to document a patient encounter. However, beginning for services performed on or after September 10, 2013 physicians may use the 1997 documentation guidelines or an extended history of present illness.

Comprehensive History

Includes:

- Reason for admission
- Problem pertinent review of systems
- Extended history of present illness (HPI)
 - Includes 4 or more elements of the HPI or the status of at least three chronic or inactive conditions
- Review of systems directly related to the problem(s) identified in the HPI
- Medically necessary review of ALL body systems' history
- Medically necessary complete past, family, and social history

This Fact Sheet is for informational purposes only and is not intended to guarantee payment for services, all services submitted to Medicare must meet Medical Necessity guidelines. The definition of "medically necessary" for Medicare purposes can be found in Section 1862(a)(1)(A) of the Social Security Act – Medical Necessity (http://www.ssa.gov/OP_Home/ssact/title18/1862.htm).

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HPI – History of Present Illness

A chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. Descriptions of present illness may include:

- Location
- Quality
- Severity
- Timing
- Context
- Modifying factors
- Associated signs/symptoms significantly related to the presenting problem(s)

Chief Complaint

The Chief Complaint is a concise statement from the patient describing:

- The symptom
- Problem
- Condition
- Diagnosis
- Physician recommended return, or other factor that is the reason for the encounter

Review of Systems

An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.

For purpose of Review of Systems the following systems are recognized:

- Constitutional (i.e., fever, weight loss)
- Eyes
- Ears, Nose, Mouth Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurologic
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

Past, Family, And/or Social History (PFSH)

Consists of a review of the following:

- Past history (patient's past experiences with illnesses, operations, injuries, and treatments)
- Family History (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk)
- Social History (an age appropriate review of past and current activities)

Additional Information:

- Medicare Providers are responsible for assuring that visits are coded accurately; the unique provider number used when a service is billed ensures that the provider has reviewed and authenticated the accuracy of everything on the submitted claim.
- Clearly document your clinical perception of the patient's condition to assure claims

Comprehensive physical exam:

- General, multisystem exam OR complete exam of a single organ system
- Body areas recognized:
 - Head/including face
 - Neck
 - Chest/including breasts and axilla
 - Abdomen
 - Genitalia/groin and buttocks
 - Back
 - Each extremity
- Organ systems recognized
 - Eyes, ears, nose, mouth, throat
 - Cardiovascular
 - Respiratory
 - Gastrointestinal
 - Musculoskeletal
 - Skin
 - Neurologic
 - Psychiatric
 - Genitourinary
- Hematologic/Lymphatic/Immunologic

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are submitted with the correct level of service.

- Comorbidities and other underlying diseases in and of themselves are not considered when selecting the E/M codes UNLESS their presence significantly increases the complexity of the medical decision making.
- Practitioner's choosing to use time as the determining factor:
 - MUST document time in the patient's medical record
 - Documentation MUST support in sufficient detail the nature of the counseling
 - Code selection based on total time of the face-to-face encounter (floor time), the medical record MUST be documented in sufficient detail to justify the code selection
- Face-to-face time refers to the time with the physician ONLY. The time spent by other staff is NOT considered in selecting the appropriate level of service

Please note that ALL services ordered or rendered to Medicare beneficiaries MUST be signed. Signatures may be handwritten or electronically signed; exceptions for stamped signatures are described in MLN Matters article MM8219. (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8219.pdf>). You should NOT add late signatures to a medical record but instead make use of the signature authentication process outlined in MLN Matters article MM6698. (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf>) A sample attestation statement is available on the CGS website (http://www.cgsmedicare.com/partb/cert/attestation_form.pdf). Guidelines regarding signature requirements are located in CMS Publication 100-08, Chapter 3, section 3.3.2.4 (<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf>).

References:

- CMS Publication 100-04, Chapter 12, sec 30.6; Evaluation and Management Service Codes <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>
- Medicare Learning Network; Documentation Guidelines for Evaluation and Management (E/M) Services <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html>
- American Medical Association CPT (current procedural terminology) Codebook