the care of trauma patients is now a more complicated process because it involves knowing not only the major surgical procedure codes, but also how to use evaluation and management (E/M) codes effectively. E/M coding remains an area of difficulty for some surgeons due to the numerous rules and guidelines. Furthermore, Medicare's decision to not reimburse consultation codes has made coding for E/M services in trauma care even more complicated for those surgeons using the consult codes.

Effectively using E/M codes for trauma care

This column provides coding guidance and clinical scenarios on the appropriate use of E/M codes during the care of injured or critically ill patients, including the use of critical care codes, the coordination/counseling guide as a coding alternative to the tradition documentation guidelines ("bullets"), and modifiers for coding during the global surgical period.

ATLS and E/M documentation

Most surgeons are familiar with and have completed an Advanced Trauma Life Support® (ATLS®) course. The initial assessment and management tool includes a brief primary survey combined with the opportunity to take a patient's history that includes allergies, medications, past illnesses, pregnancy, last meal, and events/environment related to the injury (AMPLE), followed by a head-to-toe secondary physical exam. Typically, the emergency medical technicians and nurses also capture the past and social history of the patient during their assessment, and this information may be incorporated into the surgeon's initial assessment and management document. If the surgeon performs and fully documents this initial evaluation and secondary survey the service will typically qualify for one of the highest levels of E/M encounters.*

To capture one of the highest level E/M codes, the level of care that must be documented requires a comprehensive history and physical exam and a level of decision making that is of moderate or high complexity. The 1995 guidelines require a general multisystem examination or a

*Department of Health and Human Services, Centers for Medicare & Medicaid Services. Evaluation and Management Services Guide. Available at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval_mgmt_serv_guide-ICN006764.pdf. Accessed April 17, 2013.

TABLE 1. DOCUMENTATION GUIDELINES FOR E/M CODES FREQUENTLY USED IN TRAUMA PATIENTS' INITIAL EVALUATION

HISTORY								
Type of history	History of present illness (HPI)	Review of systems (ROS)	Past, family, and/or social history (PFSH)	CPT code initial hospital care	CPT code hospital consult	Initial observation care	Observe/discharge same date	Emergency department (ED) visit
Detailed	Extended (4)	Extended (2–9)	Pertinent (1)	99221	99253	99218	99234	99284
Comprehensive	Extended (4)	Complete (10)	Complete (2–3)	99222/ 99223	99254/ 99255	99219/ 99220	99235/ 99236	99285

EXAMINATION						
Type of examination	Body areas/ organ systems	CPT code initial hospital care	CPT code hospital consult	Initial observation care	Observe/discharge same date	ED visit
Detailed	An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s) Twelve elements from at least two body areag84					

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complete examination of a single organ system in order to constitute a comprehensive exam. The 1997 multisystem examination requires two bullets from each of the nine organ systems to constitute a comprehensive history and physician exam (see Table 1, this page).

The sickest trauma patients may be unable to provide history, social, family, and other required E/M information. In these instances, to qualify for the highest level E/M (99223 or 99255), the surgeon must document that the information was unobtainable and document high-complexity medical decision making.

However, if the surgeon does not document the patient's history, physical examination, or decision making, the level of E/M cannot be justi ed. Good documentation is important.

Typically the trauma admission forms will cover the multisystem exam, because it is generally recommended that trauma patients receive a comprehensive evaluation. The creation of a standardized evaluation form

TABLE 2. RISK MODIFIED FOR TRAUMA PATIENTS

LEVEL			

Because Medicare has stopped reimbursing for consult codes, and some commercial payors have followed suit, it is critically important that surgeons report the disposition of the patient.

When admitting Medicare patients to the hospital, surgeons should bill an initial hospital care code (99221–99223) and not an ED visit code. Medicare also requires that the admitting physician append modi er AI to the initial hospital visit code (9922X-AI). If the patient is admitted to the hospital as an inpatient and the surgeon sees the patient on the hospital unit on the same day of admission, this additional work should be summed into the one initial inpatient admission service code (99221–99223). However, if the patient also receives critical care services on the day of admission, these services are separately reportable. Subsequent hospital care visits per day are coded using Current Procedural Terminology (CPT)† codes 99231–99233; day of discharge is coded using CPT code 99238. For trauma services in which multiple physicians may play di erent roles (one covers admits, one covers the intensive care unit [ICU]

on the unit and the time spent with the patient or family.

In some instances, a surgeon may need to accompany a critically ill patient during transport between facilities. Critical care codes (99291 and 99292) are used if the patient is 24 months of age or older. For pediatric patients, codes 99466 and 99467 are used to report "the physical attendance and direct face-to-face care by a physician during the interfacility transport of a critically ill or critically injured pediatric patient 24 months of age or younger. Codes 99485 and 99486 are used to report the control physician's non-face-to-face supervision of interfacility transport of a critically ill or critically injured pediatric patient 24 months of age or younger."*

As noted previously, critical care and other E/M activities may be provided and coded for on the same patient on the same day. Thus, if a patient was seen earlier in the day and then deteriorated clinically and required subsequent critical care, both the E/M service and critical care may be reported.

For any given period of time spent providing critical care services, the physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period. This critical care time may include coordinating care with other physicians, obtaining a history from others when the patient cannot give a comprehensive history, or discussing a specific treatment issue with family members when the patient is unable to participate.

Counseling, coordination of care

It is a misconception that an E/M encounter must meet each of the documentation guidelines or "bullets" for the associated service. Even if the documentation guidelines for the history, physical exam, or decision making are unmet, the work and time spent may be reported and are reimbursable as "counseling and coordination of care." CPT defines these activities as follows:

> When counseling and/or coordination of care dominates (more than 50 percent) the encounter with the patient and/or famii2mi i2 5ia a(/)9e5 (tu)20( )]8((o)3

*Department of Health and Human Services Centers for Medicare & Medicaid Services. Evaluation and Management Services Guide. Available at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval_mgmt_serv_guide-ICN006764.pdf. Accessed April 17, 2013.

report those services with code 99233. This code is separately reportable if the patient is not in the global period for a procedure performed by the surgeon. The surgeon must document the total time, must indicate that greater than 50 percent of time was spent counseling/coordinating care, and must summarize the counseling/coordination of care work. Use the add-on prolonged service CPT codes (99356 and 99357), in addition to the standard E/M code, when the face-to-face time exceeds the time allotted for E/M services at any level, by more than 30 minutes. (See Table 6 on this page.)

Standard times are also important when reporting E/M services in which the surgeon spends more than the typical time for an E/M encounter. This situation frequently occurs in trauma, where the surgeon is present during the evaluation and stabilization process waiting

To capture one of the highest level E/M codes, the level of care that must be documented requires a comprehensive history and physical exam and a level of decision making that is of moderate or high complexity.

99291-24, critical care, first 30 minutes; ICD-9 807.4, flail chest).

Modifier 25 (significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) is appended to an E/M service to indicate that on the same day as a procedure, the physician performs an E/M service that is a significant, separate, identifiable service from the procedure. Modifier 25 is only used when the procedure performed on the same day is a minor procedure and has a 0- or 10-day global period. For example, a surgeon provides critical care for a patient following multiple traumas with head injury and pelvic fracture and places a central line to provide pressors and total parenteral nutrition. These activities would be coded using CPT 36556, insertion of nontunneled central venous

- 36556, Insertion of nontunneled centrally inserted central venous catheter; age 5 years or older
- + 76937-26, Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real-time ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)
- 76705-26, Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)
- 76775-26, Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited
- 76604-26, Ultrasound, chest (includes mediastinum), real time with image documentation

Days 2 to 6

- 99232, Subsequent hospital care

Day 7

- 99238, Hospital discharge day management; 30 minutes or less

Codes 99291 and 99292 are used to report the total duration of time spent providing critical care services. CPT code 99223 is used to report the hospital admission and includes evaluation and admission to hospital, including later rounding on patient in ICU (noncritical care) on day of admission, accounting for the face-to-face time of the subsequent care delivered later that day and complexity of the medical decision making. The critical care and hospital admission are separately reportable. Although the surgeon was called in to consult, the consult codes are not reported because the surgeon decided to admit the patient to his service. The AI modifier is necessary to alert the Centers for Medicare & Medicaid Services (CMS) that the surgeon is the admitting physician. The 25 modifier (significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) is necessary on the E/M services because a nontunneled centrally inserted central venous catheter, a minor procedure with a 0-day global period, was performed; however, the E/M services are separately reportable.

The ultrasound procedures require the 26 modifier (professional component) because the surgeon may only bill for the physician component of the service. In addition, any add-on codes must follow the primary code on the claim form.

Case 2: A 45-year-old male is brought to the ED in shock with a gunshot wound to the chest.

The trauma surgeon meets the ambulance in the ED and performs the ATLS, primary and secondary surveys, initial resuscitation, and complex medical decision making, including imaging studies, coordination with specialty services for an operation with multiple teams, and communication with family. The patient is unable to provide a comprehensive history. The surgeon documents th

minutes supervising critical care. Reportable procedures include:

Day 1

- 47361, Management of liver hemorrhage; exploration of hepatic wound, extensive debridement, with or without packing of liver; ICD-9 864.14 (laceration of liver, major with open wound into cavity)

- 32551-50, Tube thoracostomy, includes water seal (eg, for abscess, hemothorax, empyema), when performed (separate procedure); ICD-9 860.5 (traumatic pneumohemothorax with open wound into thorax)

- 76705-26, Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up); ICD 9 958.4 (traumatic shock)

- 76775 -26, Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited

- 76604-26, Ultrasound, chest (includes mediastinum), real time with image documentation

- 99291-25, Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes

- + 99292-25, Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service); ICD-9 958.4 (traumatic shock)

- 99223-25-57, Initial hospital care

Management of the liver hemorrhage is reported with CPT code 47361. CP