Welcome!

Assigning ICD-10-CM codes to diagnoses and CPT/HCPCS Level II codes to procedures/services for emergency department office records can be somewhat intimidating to students at first. No fear! I am going to walk you through this entire process, page-by-page, so you learn how to assign diagnosis and procedures.

You will also see where the codes are entered on a UB-04 claim, which is submitted to third-party payers for processing, resulting in reimbursement being provided to the hospital (for emergency department services).

**NOTE:** Chapter 19 of your UHI textbook contains content about the purpose of the UB-04, which you can review. You will also take the MEDR 4214 (Insurance and Reimbursement Processing) course in future where you will learn how to complete the UB-04.
Before Assigning ICD-10-CM, CPT, and HCPCS Level II Codes

Before coding the EDCases, review the following definitions.

**First-listed Diagnosis** – the condition treated or investigated during the relevant episode of care; coded according to ICD-10-CM.

**NOTE:** When there is no definitive diagnosis, the first-listed diagnosis is the main symptom, abnormal findings or problem.

**Secondary Diagnosis** – the condition(s) that co-exist during the relevant episode of care and affect the treatment provided to the patient; coded according to ICD-10-CM.

**NOTE:** Assign or ICD-10-CM codes to secondary diagnoses only if one or more of the following are documented in the patient’s record: clinical evaluation of the condition, therapeutic treatment of the condition, diagnostic procedures performed to evaluate the condition.

**First-listed Procedure or Service** – the procedure or service that has the highest payment associated with it; coded according to CPT and HCPCS Level II. For emergency department cases, the first-listed service is coded from the CPT Evaluation and Management (E/M) section.

**Secondary Procedure(s) or Service(s)** – the procedure(s) or service(s) that are less complex than the primary procedure; coded according to CPT and HCPCS Level II. Third party payers usually discount payment of secondary procedures and services by 50%.
Face Sheet of Emergency Department (ED) Record

The face sheet of the emergency department (ED) record contains demographic information about the patient and nursing documentation.

The face sheet can be reviewed when assigning ICD-10-CM and CPT/HCPCS level II codes. This means that when you assign codes to diagnoses, procedures, and services when reviewing physician documentation (page 2 of the ED record), the face sheet can serve as a resource for coding specificity.

CASE 1 (EDCASE001)

Global Care Medical Center
100 Main St
Alfred NY 14802
(607) 555-1234

EMERGENCY DEPARTMENT
RECORD

PATIENT INFORMATION:
NAME: CAMERON, Adam E.
ADDRESS: 4 Blue Spruce
CITY: Brockport
STATE: NY
ZIP CODE: 14420
TELEPHONE: 585-637-2524
GENDER: Male
DATE OF BIRTH: 05-09-YYYY

PATIENT NUMBER: EDCase001
ADMISSION DATE & TIME: 03-09-YYYY 1610
DISCHARGE DATE & TIME: 03-09-YYYY 1630
CONDITION ON DISCHARGE:
☐ Satisfactory ☐ AMA
☐ Home ☐ DOA
☐ Inpatient Admission ☐ Code Blue
☐ Transfer to: ☐ Died
☐ Instruction Sheet Given

NURSING DOCUMENTATION:
ALLERGIES: ☐ No ☐ Yes
EXPLAIN: No known allergies.
CURRENT MEDICATIONS: ☐ No ☐ Yes
EXPLAIN: Last tetanus toxoid more than 10 years ago.
BP: 122/80 P: 76 R: 24 T: 98.8
CC:
HPI: Small two-inch puncture wound noted on the lateral aspect below right knee. No drainage noted.
CONDITION: Puncture wound, right leg with nail today.
ASSESSMENT: Dr. Beeson cleansed wound with pHisolHex.
SIGNATURE OF NURSE: Reviewed and Approved: Marilyn Hillman RN ATP-B-
S:02:1001261385: Marilyn Hillman RN (Signed: 3/9/YYYY 2:20:44 PM EST)

ICD CODES:

CPT/HCPCS LEVEL II CODES:
First-listed Diagnosis

The first-listed diagnosis is the condition treated or investigated during the relevant episode of care, and it is coded according to ICD-10-CM. It is documented by the physician as the "diagnosis" or "assessment" in the progress note (of the physician documentation section of the patient record).

REMEMBER! Coders never assign an ICD-10-CM code to a qualified diagnosis (suspected condition) on an emergency department case, because it is considered outpatient care. Instead, assign a code for the documented sign or symptom. Physician office records often include a qualified diagnosis because the intent is to identify an established diagnosis as the result of ordered ancillary tests (e.g., laboratory, radiology, and so on).

Global Care Medical Center
100 Main St, Alfred NY 14802
(607) 555-1234

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**EMERGENCY DEPARTMENT PHYSICIAN DOCUMENTATION**

<table>
<thead>
<tr>
<th>PATIENT NAME:</th>
<th>CAMERON, Adam E.</th>
</tr>
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<tbody>
<tr>
<td>LOCATION:</td>
<td>Emergency Room</td>
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<tr>
<td>DATE OF SERVICE:</td>
<td>03-09-YYYY</td>
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<tr>
<td>ED PHYSICIAN:</td>
<td>Jon W. Beeson, M.D.</td>
</tr>
<tr>
<td>DATE OF BIRTH:</td>
<td>05-09-YYYY</td>
</tr>
</tbody>
</table>

**PHYSICIAN NOTES:**

Patient punctured right lateral calf with rusty nail while working in his wood shop at home. Last tetanus over 10 years ago. Small two-inch puncture wound. No erythema, ecchymosis, or peripheral vascular involvement.

**DIAGNOSIS:** Puncture wound of right calf. Wound cleaned.

**PHYSICIAN ORDERS:**

Tetanus toxoid 0.5 ml administered, IM, left deltoid.

**DISCHARGE INSTRUCTIONS:** Ice left arm (tetanus injection). Aspirin, 2 tablets, every four hours. Return if signs of infection are noted in calf.

**SIGNATURE OF ED PHYSICIAN**

Reviewed and Approved: Jon Beeson MD ATP-BSS:02:1001261385: Jon Beeson MD (Signed: 3/9/YYYY 2:20:44 PM EST)
Secondary Diagnosis(es)

Secondary diagnosis(es) are condition(s) that co-exist during the relevant episode of care and affect the treatment provided to the patient, and they assigned ICD-10-CM code(s). They include comorbidities, complications, and other diagnoses that are documented by the physician in the progress note of physician documentation.

A comorbidity is any condition that co-exists during the relevant episode of care and affects the treatment provided to the patient. Examples include hypertension, asthma, and so on, which are considered when administering anesthesia during surgery.

A complication is any condition that arises during the relevant episode of care and affects treatment provided to the patient. Examples include postoperative wound infections, respiratory problems due to anesthesia administration, and so on, which are coded as complications of surgery.

Coders should also review the entire emergency department (ED) record to locate secondary diagnoses that are not documented on the face sheet of the ED record.

- Physicians often document chronic conditions, which are coded only if they impact the patient's treatment.
  - For example, a patient is seen in the ED for acute bronchitis, and the physician also documents chronic asthma. It is acceptable to code the acute bronchitis as the first-listed diagnosis and the chronic asthma as the secondary diagnosis if the latter was medically managed or treated during the encounter.
  - For example, a patient is seen in the ED for a sprained ankle, and the physician also documents hypertension. If the hypertension was not treated or medically managed during the encounter, assign a code to the sprained ankle only.

- Physicians often document personal history (of) and family history (of) conditions, all of which can be assigned codes. However, such codes do not impact the reimbursement rate, and coding them depends on office policy.

- Ancillary reports (e.g., lab data, radiology reports, and so on) document type of bacteria that cause infection (lab data), type of fracture (X-ray report), and so on. Such reports should be reviewed for coding specificity. However, do not assign a diagnosis code based only on the results of an ancillary reports; instead, initiate a physician query to obtain clarification about diagnoses to be coded.

Assign ICD-10-CM codes to secondary diagnoses only if one or more of the following are documented in the patient’s record:

- clinical evaluation of the condition (e.g., ancillary tests such as an x-ray to determine if the ankle is broken or sprained, and so on)
- therapeutic treatment of the condition (e.g., prescribed medication, office surgery, and so on)
- diagnostic procedures performed to evaluate the condition (e.g., ancillary tests ordered, such as a urinalysis, to determine if the patient has a urinary tract infection)

REMEMBER! Secondary diagnoses are documented by the physician on the:

- Face sheet of the ED record
- Diagnosis or Assessment section of ED progress notes
- Narrative of the ED progress note

NOTE: If you have a question about whether a secondary diagnosis code should be assigned, generate a physician query to obtain clarification (and have the physician amend the list of diagnoses if appropriate). (In this course, post the query in the Discussion Board so your instructor can respond.)

NOTE: When assigning ICD-10-CM codes to secondary diagnoses, review the patient record to locate supporting documentation that allows you to assign the most specific code possible. For example, the face sheet documents “urinary tract infection” as a secondary diagnosis. Upon review of laboratory test results, the coder determines that E. coli bacteria is the cause of the urinary tract infection. Thus, the coder assigns a code for the urinary tract infection and another code for the E. coli bacteria.

NOTE: Secondary diagnoses might not be associated with a ED encounter. Thus, if only a first-listed diagnosis is documented, it is acceptable to report a code for just that condition. This is common for acute conditions (e.g., flu) or trauma encounters (e.g., sprained ankle).

(See image on next page.)
<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Cameron, Adam E.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location:</td>
<td>Emergency Room</td>
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<td>Date of Birth:</td>
<td>05-09-YYYY</td>
</tr>
<tr>
<td>ED Physician:</td>
<td>Jon W. Beeson, M.D.</td>
</tr>
</tbody>
</table>

**Physician Notes:**
Patient punctured right lateral calf with rusty nail while working in his wood shop at home last tetanus over 10 years ago. Small 2-inch puncture wound. No erythema, edema, or peripheral vascular involvement.

**DIAGNOSIS:** Puncture wound of right calf. Wound cleaned.

**Physician Orders:**
Tetanus toxoid 0.5ml administered, IM, left deltoid.
DISCHARGE INSTRUCTIONS: Ice left arm (tetanus injection). Aspirin, 2 tablets, every four hours. Return if signs of infection are noted in calf.

**Signature of ED Physician:**
Reviewed and Approved: Jon Beeson MD ATP-B-210213001261385: Jon Beeson MD (Signed: 3/9/YYYY 2:20:44 PM EST)

Assign external cause codes, as follows:
- accidental puncture
- home as place of occurrence
First-listed Procedure or Service

In the emergency department (ED), the first-listed procedure (or service) is usually assigned a code from the CPT Evaluation and Management (E/M) section. The only except to this rule is when the patient undergoes ED surgery (e.g., excision of benign lesion), in which case a code is assigned from the CPT Surgery section (instead of the CPT E/M Section).

**NOTE:** If the patient receives E/M services during the same encounter as ED surgery, and the E/M services resulted in performing the ED surgery add modifier -25 to the E/M code. Report the CPT Surgery code as the first-listed code and the CPT E/M code as the secondary code (adding modifier -25).
Secondary Procedure(s) or Service(s)

Secondary procedures (or services) are usually less complex than the primary procedure.

Secondary procedures are assigned CPT and HCPCS Level II codes, and they may require the addition of a modifier. Refer to the appendix of modifiers, located at the back of your CPT and HCPCS level II coding manuals. Third-party payers typically discount payment of secondary procedures by 50%.

The patient received an intramuscular (IM) injection of tetanus toxoid. Thus, assign two codes from the CPT Medicine section.
Sample UB-04 for an Emergency Department (ED) Case

This sample UB-04 contains patient data, ICD-9-CM diagnosis codes and a CPT procedure code.

In "real life," no one actually completes a UB-04 claim. Patient data and codes (e.g., ICD-9-CM, CPT) are entered in the hospital's computer system, and the UB-04 claim is populated (filled out) with the data and codes.

The hospital's billing department is responsible for reviewing the completed UB-04 claim to verify its accuracy and submitting it to third-party payers. When third-party payers deny a claim, the billing department collaborates with the health information department to re-review the submitted claim to fix data entry and coding errors.