

Internal Medicine Coding Alert

Avoid Hospital Admission Coding Errors When Billing For Absent Internists

There are two arrangements absent internists can make with other providers to get paid for inpatient services on-call billing and reciprocal billing. On-call billing refers to the coverage arrangements internists make within a group practice using a common tax identification number. Reciprocal billing refers to an agreement made with other internists with different tax identification numbers.

One billing dilemma faced by internists within a group practice occurs when two internists provide separate services to the same patient on the same day. For example, an on-call physician admits one of his or her colleagues patients to the hospital after midnight. Then the patients regular physician makes rounds on the patient later that morning. Because most carriers deny reimbursement for two E/M services for the same patient on the same day, the second visit is often provided for free.

According to **Michael Haynes, MD, FACP**, an internist and pulmonologist who is also the compliance director at University Medical Associates in Augusta, Ga., the only way the patients physician can bill for the second E/M visit is to code it as critical care [99291-99292].

Critical care, as defined by CPT, allows that other E/M services may be provided to the same patient on the same date by the same physician.

However, situations that permit upcoding to critical care are infrequent for internal medicine practices. If its not a life-threatening situation and it remains an elective visit, even if the regular doctor is doing things that he might be doing in critical care such as adjusting a ventilator or changing a drip, the second visit cant be billed, Haynes says.

How to Coordinate Same-day E/M Services

Theres only one clear-cut solution to the dilemma, says **Jim Stephenson**, president of North Central Medical Management in Elyria, Ohio, who understands the frustration experienced by Haynes. The best option for both internists in an on-call arrangement is to coordinate same-day services and bill them under one E/M service.

Technically, what should happen is either the covering physician bill the overnight admit [e.g., 99221, initial hospital care, per day, for the evaluation and management of a patient which requires a detailed or comprehensive history and examination and medical decision making that is straightforward or of low complexity], or the regular physician, who did morning rounds, bill a higher-level E/M admit [99222 or 99223]. The second visit should include either a comprehensive or detailed history, exam and medical decision-making of moderate or high complexity, Stephenson says.

Unless its an emergency situation, the on-call doctor would normally consult the patients physician by telephone, order the admit, ensure the patient is stable and leave the billing to the doctor doing the rounds in the morning. Stephenson says that critical care would only be an option for the regular physician if the patient had taken a serious downside in the time since the admit.

For example, if the patient is admitted with stable congestive heart failure at 1 a.m. by the on-call physician, but then takes a sudden turn for the worse around 9 a.m., the patients regular physician would be called in to deal with a critical care situation. In this instance, coders should bill 99291 (critical care, evaluation and management; first 30-74 minutes), and the earlier admit (e.g., 99221). Modifier -25 (significant, separately identifiable E/M service by the same physician on the same day of a procedure or other service) should be appended to the critical care code.

Upcoding Must be Warranted

Haynes outlines another troublesome on-call scenario, this time where the patient's physician makes routine hospital rounds in the morning, and that evening the on-call physician is called in to see the patient for a new complaint or exacerbation of the existing problem. Haynes says that in this case, internal medicine coders should abandon the routine inpatient visit code (99231, subsequent hospital care, per day, for the evaluation and management of a patient, which requires a problem focused history and examination and medical decision making of straightforward complexity), in favor of a higher-level code by the on-call physician in the evening, likely a 99232 (... expanded history and exam, medical decision making of moderate complexity ... 25 minutes) or 99233 (... detailed interval history and exam, medical decision making of high complexity ... 35 minutes).

Alternate On-call Billing Scenarios

When Stephenson previously worked for a group practice, he says the physicians made a concerted effort to avoid the situations described above. They had a rule: Whichever doctor admitted a patient, whether the doctor was on-call or not, would continue to follow that patient for the entire first day.

Another on-call billing situation occurs when the regular physician makes rounds early in the day and then the on-call doctor performs a procedure that evening. Suppose the on-call physician performs the placement of an I.V. catheter [36000]. According to CPT, coders should attach modifier -25 to the E/M performed before the I.V. placement and bill it in addition to the E/M visit performed earlier in the day by the regular physician, Haynes says.

Reciprocal Billing: No Money Changes Hands

Reciprocal billing arrangements are often informal, and Medicare does not require them to be in writing. No money changes hands, and the regular internist compensates the covering internist by reciprocating in the future under similar circumstances. Reciprocal billing applies to times when physicians from different practices are covering for one another. This is often the arrangement used by solo practitioners or two-physician practices.

Again, there are coding problems if both doctors provide E/M services to the same patient on the same day, Stephenson says. As with on-call arrangements, only one service can be billed. Typically, the regular physician's coder should include additional documentation outlining the lesser service and then code both services at a higher level under a single billing.

The billing internist must keep a record of each service provided by the substitute internist, along with the substitute's UPIN (unique provider identification number). Medicare requires this information be available on request, but it's not necessary to document it on the claim form.

Follow the Requirements for Reciprocal Billing

Coverage periods for reciprocal billing are usually brief and typically include one internist covering for another during extended office hours, at night or during the weekend. But there are situations when longer coverage periods apply. According to the Medicare Carriers Manual (MCM), section 3060.6, The patient's regular physician may submit the claim, and (if assignment is accepted) receive the Part B payment for the covered services (including emergency visits and related services) that the regular physician arranges to be provided by a substitute physician on an occasional reciprocal basis if:

The regular internist is unavailable to provide the services;

The Medicare patient has arranged or seeks to receive the services from the regular internist;

The substitute internist does not provide the services to the patient over a continuous period of longer than 60 days; and

The regular internist must identify the services as substitute physician services by using the modifier -Q5.

The modifier is placed in item 24D on the HCFA 1500 claim form. The substitute internists UPIN is entered in field 23, while the billing internists UPIN is listed in field 33 if he or she is a solo practitioner; if the internist works in a group practice, it should be listed in field 24K.

According to the MCM, if the only substitute services are postoperative services provided during the global period, then the -Q5 modifier need not be entered on the claim form because the services are bundled to the original procedure performed by the regular internist and are not payable.

If the patient has a separately identifiable problem, the visit could be billed by the original physicians office with modifier -24 (unrelated evaluation and management service by the same physician during a postoperative period).