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Internal Medicine Coding Alert

Bury a Popular Misconception: Internists CAN Code an ED Visit Along with the ED Physician (and Get Paid by Medicare)

One of the chief misconceptions among coders is that internists and other primary care physician (PCPs) and an emergency physician cannot use emergency department services codes (99281-99285) for care of the same patient on the same day and both get paid by Medicare.

However, the Medicare Carriers Manual (MCM) contains a very clear directive on this issue. The directive, which many coders are unaware of, specifically instructs carriers to advise physicians that they **should** use emergency department (ED) codes when they provide care to a patient in the ED but do not admit the patient to the hospital. Medicare says PCPs should use the ED codes even when the ED physician also uses those codes.

Coders who follow this directive say they have no problems in securing reimbursement from Medicare for internists. **Barbara Holley, CPC, CCSP,** coding specialist at the Stuart, Fla.-based Martin Memorial Medical Group, which includes more than 50 physicians and several hospitals, says she is not aware of any denials by Medicare during the more than two years her office has coded ED visits according to this directive. Holley suggests that offices that have been denied when using ED codes properly for internists' services should copy the appropriate section of the MCM and send it to the carrier with their claims.

Medicare's Directive Is Clear

The directive advising internists to use ED codes for care provided in the ED to patients who are not admitted is in Section 15507 of the MCM, which also notes, "any physician seeing a patient registered in the emergency department may use these codes." Section F-2 specifically addresses how to code when a patient's personal physician sees the patient in addition to the ED physician, but does not admit the patient:

"If the ED physician, based on the advice of the patient's personal physician who came to the emergency department to see the patient, sends the patient home, then the ED physician should bill the appropriate level of emergency department service. The patient's personal physician should also bill the level of emergency department code that describes the service he or she provided in the emergency department. The patient's personal physician would not bill a consultation because he or she is not providing information to the emergency department physician for his or her use in treating the patient. If the patient's personal physician does not come to the hospital to see the patient, but only advises the emergency department physician by telephone, then the patient's personal physician may not bill."

Section G outlines the proper procedure when the ED physician requests that another physician (not necessarily the patient's private physician) see the patient in the ED or other office/outpatient setting:

"If the emergency department physician requests that another physician evaluate a given patient, the other physician should bill a consultation if the criteria for consultation (see 15506A) are met. If the criteria for a consultation are not met and the patient is discharged from the Emergency Department or admitted to the hospital by another physician, the physician contacted by the Emergency Department physician should bill an emergency department visit. ..."

When to Use ED Service Codes

The key factor to whether the visit should be coded as a consultation or with ED services codes is the intent behind the ED physician's request to the internist. "Is the ED physician asking for an opinion?" says **Jean Ryan-Niemackl, LPN, CPC,** compliance analyst for MeritCare Health Systems, a multispecialty system in Fargo, N.D., that includes clinics,

hospitals and physicians. "Or is the ED physician asking the internist to take over care of the patient?"

If the ED physician is asking the internist to assume care of the patient and the patient is not admitted to the hospital, the ED codes should be used. Ryan-Niemackl says coders in her 350-physician system use ED codes for the internist when that criterion is met and have had success in securing reimbursement from Medicare and private payers.

Holley gives the following example of when an ED code would be used. An elderly patient with a history of heart disease calls her internist and complains of indigestion and abdominal pain. The internist directs her to the ED. The ED physician examines the patient, is not sure whether she should be admitted, and asks the internist to come to the ED to evaluate her. After arriving, the internist takes a history, examines the patient and decides not to admit, instead advising the patient to come to the office the next day for tests and blood work.

The ED physician codes the appropriate ED code based on his or her level of involvement in the case, and the internist does the same. Both diagnosis codes can be the same.

The ED codes are properly used here because the internist saw the patient in the ED and assumed care of the patient rather than simply rendering advice to the ED physician.

When selecting an ED code in this scenario, internists should be aware that time cannot be used as a factor for code selection and that all three key components required for the code must be met. This is different from the criteria for an established patient E/M visit (99212-99215), where a code can be used if two of the three key components are met and time can be a factor.

For example, to code a midlevel ED visit of 99283, the physician must complete an expanded problem focused history, perform an expanded problem focused examination, and use medical decision-making of moderate complexity. If the physician's visit meets the first two criteria but includes medical decision-making of low complexity, 99282 should be billed instead of a 99283.

Ryan-Niemackl says it is critical that the physician document all three components in the chart fully or proper reimbursement may not be given. For reimbursement, the physician needs to remember that it "doesn't matter what they do; it matters what they document," she says. In other words, payers will consider only what the physician documents in the record in determining the proper payment.

In addition, internists should note that they cannot bill any charges if they simply talk with the ED physician via phone rather than coming on-site.

"That is key," Holley notes. "The primary care physician has to actually come in to the ED. He can't bill unless there is a face-to-face encounter."

When to Code a Consultation

The internist may use one of the consultation codes (99241-99245) for a visit to the ED to see a patient at the request of the ED physician. If the ED physician is seeking an opinion only, the internist would use a consultation code, Ryan-Niemackl says. For example, a patient with diabetes comes to the ED with high blood-sugar levels and disorientation. The ED physician calls in an internist to evaluate the patient. To qualify as a consultation, the internist's visit to the ED must meet certain criteria, including what are often referred to as the three R's: The ED physician needs to **request** the internist's advice, the **reason** needs to be stated, and a **report** from the internist needs to be completed. All three R's should be documented in the patient's ED record.

The internist must also recommend treatment to the ED physician rather than provide it to the patient. For example, in the diabetic example above, the internist might recommend that the ED physician change insulin levels and advise the patient, who has been drinking, to stop using alcohol due to its effect on blood-sugar levels.

However, if the internist assumes care of the patient and makes those recommendations directly to the patient before

sending the patient home, the consultation codes would not be used. Instead, an ED code would be used.

When to Use an E/M Code

Although Medicare says an ED code not an outpatient E/M code should be used when the internist sees a patient in the emergency department, some private carriers do not follow Medicare guidelines and may balk at paying an ED code for both an internist and the ED physician. In those cases, some coders advise using the appropriate outpatient E/M codes (99201-99215) instead of the ED codes for the internist's treatment of a patient who is seen in the ED but not admitted to the hospital.

However, coders who have been successful in using the ED codes recommend trying the ED codes again with private payers if you have not done so in six months. In addition to Medicare's directive on this issue, the CPT manual advises coders to use ED codes when services are provided in the ED. In the opening section for "office or other outpatient services" in the Evaluation and Management section, the CPT manual states: "For services provided by physicians in the emergency department, see 99281-99285."

Payment May Be Better with ED Codes

Internists who follow Medicare's directive regarding ED codes can expect slightly higher reimbursement if they typically have used the E/M codes for care of ED patients who are not admitted. For example, for relatively equal examination, history and medical decision-making levels in Florida, ED code 99283 will pay $61.94 compared to $35.04 for outpatient E/M code 99213. However, a consultation carries the highest reimbursement, with a midlevel 99242 paying $71.05. Figures in other areas will vary slightly from these amounts.

Note: The reimbursements for E/M and consultation codes above may appear less than the normal amounts for those codes. That is because the physician must take a site-of-service reduction when using the outpatient E/M (99201-99215) and consultation (99241-99245) codes in the ED. Because the services are not performed in the office, the overhead portion of the relative value unit (RVU) is deducted from reimbursement. The physician will be paid only for the work value and malpractice portions of the RVU. The figures above reflect this reduction.