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Internal Medicine Coding Alert

Capture 'Patient Limbo' Period With These Observation Coding Steps

Internist deciding on admission? That's your signal to look at observation family.

You can quickly pin down which observation code (99218-99220 or 99234-99236) pair to use, and whether to add a discharge code (99217), if you zoom in on the stay's date(s) and length.

Ensure your observation claims are 100 percent accurate simply by following this 5-step plan.

Step 1: Confirm Observation Service

Before coding, be sure that the service qualifies as an observation, confirms **Carol Pohlig, BSN, RN, CPC, ACS**, senior coding and education specialist at the University of Pennsylvania department of medicine in Philadelphia.

Observation is a hospital-based outpatient service used to determine if a patient needs inpatient care. So when you're reviewing the notes, ensure claim correctness by checking the encounter specifics against this observation definition.

Observation: The internist meets a patient at the hospital who is experiencing pain in his chest and left arm; the internist admits the patient to observation status to run tests and make sure the patient does not need inpatient care for cardiac issues.

Not an observation: A patient reports to the hospital in severe pulmonary distress. The internist conducts a brief exam and attempts to stabilize the patient, then speaks to the patient's pulmonologist, who admits the patient to the intensive care unit (ICU) immediately to begin active treatment and patient care measures.

Step 2: Tally Observation Length

Next, you'll need to revisit the encounter notes to see how many calendar days the observation service spanned. If the patient is in observation for more than one calendar day, you'll choose from the 99218-99220 (Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components ...) code set for the first day of care, confirms Cheryl Allard, RHIT, clinical data analyst at Saint Francis Medical Center in Grand Island, Neb. Use these codes "for all the care rendered by the admitting physician on the date the patient was admitted to observation," Allard says.

Example: Consider the earlier scenario featuring the patient with arm and chest pains; let's say that the internist admits the patient to observation at 9 p.m. Wednesday. The internist performs blood tests to check the patient's enzyme levels and an echocardiogram (EKG); results of both tests are normal. The patient is kept overnight for monitoring; notes indicate a level-two observation.

For the internist's Wednesday services, you'd report 99219 (... a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity) with 786.50 (Chest pain, unspecified) and 729.5 (Pain in limb) appended to 99219 to represent the patient's symptoms.

Step 3: Choose Discharge Code for Multi-Day Stays

For patients whose observation status lasts more than one calendar date, you'll also report 99217 (Observation care discharge day management ...) on the date of discharge service, says Pohlig.

Example: A patient presents to the hospital with persistent non-bilious vomiting and mild dehydration. The patient is placed in observation status to ensure she can maintain oral intake at 11 p.m. Thursday. After a dose of ondansetron

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(Zofran), the patient is able to tolerate sips of liquid. At 8 a.m. Friday, the internist discharges the patient. Notes indicate a level-one observation.

On this claim, you should report the following:

- 99218 (... a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity) for the observation on day one
- 99217 for the discharge from observation on day two
- 276.51 (Dehydration) linked to 99217 and 99218 to represent the patient's dehydration
- 536.2 (Persistent vomiting) linked to 99217 and 99218 to represent the patient's vomiting.

Step 4: Use Different Code for Same-Day Discharge

If the physician admits a patient to observation status and discharges him on the same calendar date, you'll report 99234-99236 (Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components ...), says **Sarah Goodman, MBA, CPC-H, CCP**, president and CEO of SLG Inc. in Raleigh, N.C.

On observation claims for a single calendar date, omit the 99217 discharge code, confirms Pohlig. Also, your 99234-99236 claims need to show that the internist "completes the initial [observation] visit, and comes back to evaluate the patient for discharge," she says.

Example: The internist admits a patient with a headache and blurred vision to observation on Tuesday at 2 p.m. for serial neurological exams and further testing.

The internist then orders a consultation with a neurologist, who examines the patient. All tests come back normal, so the internist discharges the patient at 11 p.m. Notes indicate a level-two observation service.

In this instance, you should rely on the 99234-99236 observation codes. On the claim, report the following:

- 99235 (... a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity) for the observation
- 784.0 (Headache) appended to 99235 to represent the patient's headache
- 368.8 (Other specified visual disturbance) appended to 99235 to represent the patient's blurred vision.

Remember: The physician who admits the patient to observation and attends to the oversight of his care bills the observation code. In the previous example, the internist would report the observation service, and the neurologist would likely report an outpatient consultation code.

Step 5: Observe Feds' 8-Hour Rule

For Medicare payers, and payers that follow federal guidelines, you must confirm that the patient spent at least eight hours in observation before reporting 99234-99236. "When a patient is admitted for observation care for less than 8 hours on the same calendar date, the Initial Observation Care, from CPT code range 99218--99220, shall be reported by the physician," states the Medicare Claims Processing Manual. "The observation care discharge service, CPT code 99217, shall not be reported for this scenario."

So let's say a Medicare patient is admitted to observation at 6 a.m. and discharged at 10:23 a.m. one Friday. In this scenario, you'd select a 99218-99220 code, depending on the specifics of the encounter.

Also: In these circumstances, coders must not report the 99217 code for discharge, warns Pohlig.

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