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Internal Medicine Coding Alert

Consultation Codes vs. Emergency Service Codes: How to Get Paid When Your Patient is Seen in the ED but Not Admitted

As primary care physicians, internists are called to see their patients in a variety of settings. One of the most common places, outside of the physicians office, is the emergency department (ED) of the local hospital.

Because these situations most often involve a critically ill patient, the physician usually ends up evaluating the patient in the ED, then admitting them to the hospital and billing for an inpatient admission (99221-99223).

However, in some cases, the internist may be called to the ED to see a patient, and, after the exam, the physician determines that the case is not critical and releases the patient to go home.

Since the patient was not admitted to the hospital, but was also not seen in the internists office, how should he or she bill for the time spent evaluating the patients condition in the emergency room wonders **Annette Cataldi, CPC**, practice manager for Brenan and Cronin, Internal Medicine, in East Greenwich, RI.

According to several consultants and practice managers interviewed by IMCA, there are three different ways to code this situation: use the emergency department services codes (99281-99285), bill as an outpatient consultation (99241-99245), or use the normal office visit/outpatient E/M codes (99201-99205, new patient, or 99211-99215, established patient) with the ED documented as the place of service. Which codes you choose largely depends on the interaction between the internist and the ED physician, our sources explain.

Consultation Codes

Bi-County Internists, a five-physician practice in Warner, MI, bills these services as outpatient consultations, says practice manager **Carmella Mueller**. Normally, if our patient goes to the emergency department, the ED doctor will call our doctor in, she explains. Our doctor is being called in at the request of the ED doctor, so it is automatically a consult.

The level of examination performed determines the level of service billed, either 99241, 99243, or 99245, and the office just lists the place of service as the emergency department, Mueller notes.

While it is acceptable to use the consultation codes for emergency department services, internal medicine practices should be careful when coding this way, notes **Merrillee D. McGough, RN, CPC**, an independent coding educator and consultant in Seattle, WA.

You must document that you are there at the request of another physician providing care to the patient, says McGough.

To bill as a consult, the internal medicine practice must
also document that they followed up the visit with a recommendation to the physician requesting the consult.

These codes are most often used in the ED by other specialists, such as cardiologists, called in to offer their opinion to the primary provider about a specific problem or complication, she notes. I imagine there are times when an internist would be called in to consult, but it is not as common [as with the other subspecialists].

ED Services Codes

In many cases, a patient may not even see the ED physician. When they have a problem, they call their primary care

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physician, who instructs them to meet him or her at the nearest emergency department

Thats often the case at Internal Medicine of Dubois County, a three-physician, two-physician extender office in Jasper, IN, says practice manager **Dee Thorndell**.

Their office is next to the hospital, and the internists often see the practices patients in the ED if they present there for care, she says. Patients also often go to the emergency department if they become ill after normal office hours and the internists often meet them there.

If our doctor goes over there to see the patient, we bill the 99281-99285, depending on the level of service, she says. (See box below for a list of emergency department service codes.)

According to CPT, these codes are to be used to report evaluation and management services provided in the emergency department. No distinction is made between new and established patients with these codes.

Note: In many rural communities, local physicians are also required to cover the local hospitals emergency department on a rotating basis. When an internist covers the ED in this capacity, the practice cannot bill for the physician service, only the hospital can.

Office or Outpatient E/M Codes

Interestingly, practices can also bill the normal E/M codes (99201-99205, new patient, or 99211-99215, established patient) for services rendered in the emergency department, says **Patricia Feldner**, a practice management consultant with the state medical society of Wisconsin.

Although these are normally thought of as office-visit codes, the exact definition from CPT is office or **other outpatient services**, she adds. This would include outpatient services in the emergency department.

Feldner recommends using consultation codes if the internist was called to the ED specifically to consult with the emergency physician who was primarily the physician treating the patient. And, she adds, the ED services codes should be used if the internist was the only physician to see the patient in the emergency department.

However, if the ED physician and internist end up treating the patient together, or co-treating the patient, then she recommends that the internist bill the service using the 99201-99205, or 99211-99215 codes.

If the internist bills the emergency department code, then the ED physician cant bill that code, and they get really angry about that, Feldner has found.

If both physicians treat the patient, the ED physician should bill for his services with the emergency department codes, while the internist bills using the regular E/M codes. If both physicians adequately document the services they provide, it should be OK, says Feldner.

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Emergency Department Service Codes

For the ED services codes, there is no distinction between new and established patients.

99281: ED visit requiring a problem-focused history, a problem-focused examination, and straightforward medical decision-making. Problems are self-limited or minor.

99282: ED visit requiring an expanded problem-focused history, an expanded problem-focused examination, and medical decision-making of low complexity. Problems are of low to moderate severity.

99283: ED visit requiring an expanded problem-focused history, an expanded problem-focused examination, and medical decision-making of moderate complexity. Problems are of moderate severity.

99284: ED visit requiring a detailed history, a detailed examination, and medical decision-making of moderate complexity. The problems are usually of high severity, requiring urgent evaluation, but do not pose an immediate significant threat to life or physiologic function.

99285: ED visit requiring, within the constraints of the patients clinical condition, a comprehensive history, a comprehensive examination, and medical decision-making of high complexity. Presenting problems are of high severity and pose an immediate significant threat to life or physiologic function.

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