Internal Medicine Coding Alert

Design Tracking Form to Ensure Accurate Charge Capture for Hospital Services

Its a problem in almost all internal medicine practices: losing money from services provided to your practices patients in the hospital, but never billed.

Sometimes, the internist goes to the hospital to see one patient or make rounds, then is unexpectedly called to the ER to admit another patient. At other times, he or she may just lose track of the number of services performed on a busy day.

Unless the coders and billers are careful to follow up with their internists after a day at the hospital, or have a system for tracking procedures performed on the practices inpatients, these scenarios mean lost revenue.

And the amounts can add up. I usually find quite a lot [that was not charged] there, says **Annette Cataldi**, practice manager for the two-physician practice Brennan & Cronin, Internal Medicine, in East Greenwich, RI. Cataldi makes a point of cornering her doctors daily. She goes over the days events regarding inpatient visits and procedures.

The physicians at her practice are given an index card to take with them to the hospital to write down the procedures they perform on each of their patients.

I get a copy of the discharge form and check that against the doctors schedule or the cards for the day he was there, she states. Then, I follow up with the physician. Basically, I have them re-trace their day with me. Its normally just carelessness when something has been eliminated in our paperwork.

At Internal Medicine Associates of Southern Hills, a two-physician practice in Nashville, TN, the office computer system is linked to the hospitals information system, so their staff is immediately notified when one of their patients has been admitted to the hospital, or discharged, says practice manager **Sheila Manis**.

What I try to do is go to a physician who I know has been in the hospital that day. I say, Did you do anything with Mrs. Smith? and hell usually reply, Oh, I did this, or I discharged her.

Manis finds that about half of the times she asks, she discovers there is something the internist did with the patient that is missing from the record.

Tracking Hospitalized Patients

Whether the method used is simple or complex, a practice must have an organized, reliable way of capturing hospital charges, says **Catherine A. Brink, CMM, CPC**, the president of Healthcare Resource Management, Inc., a practice management consulting firm based in Spring Lake, NJ.

Most of the problems lie in the fact that most internal medicine practices keep track of [the services delivered to hospital patients] in a very inefficient way, asserts Brink.

She has found that the typical internal medicine practice uses a variation of one of two methods: issuing index cards listing the patients name and diagnosis with space provided for the physician to write in the procedures performed; or, obtaining a discharge face sheet from the hospital and checking this against what the physician has reported to the practices billing department. Or, a combination of both methods may be used.

While this may work well in smaller practices, in medium to large-sized ones, this method can become too cumbersome.

In many offices, the doctors carry around an index card, maybe different colors for different physicians in the practice. If a patient is in the hospital for five days and different physicians from the office see him, at the end of five days the practices coders and billers have all these different colored cards with different charges on them.

This can often be a nightmare to interpret. And that isnt even considering the fact that the physician might not have written in all procedures or communicated every service rendered to the hospital billing personnel, she adds.

Brink recommends developing a separate form for tracking your practices hospitalized patients. It should look different from other encounter forms used in your office and be kept in a different placea separate file or desk tray until the patient is discharged from the hospital. A separate form should be kept for each hospitalized patient, with the patients name, account number, and other information listed at the top.

Designing an Inpatient Tracking Form

Though most practices prefer to design their own form and customize it to their specific needs, Brink explains, there are some typical items that all of these forms should have in common.

1. A list of all E/M codes for hospitalized patients most commonly used by your internal medicine practice. Even if a physician generally uses Level II or Level III, also be sure to list all levels. This will ensure the physicians can accurately code the appropriate level of care (i.e., consult, subsequent hospital care, etc.) rendered for an inpatient., notes Brink.

You should list all hospital codes, she adds. Having a form that only lists higher level-of-service codes can be a red flag to auditors.

2. A list of all the services and procedures normally performed on an inpatient or outpatient basis at the hospital. This step will make it easier for the physician to record each service provided.

3. Space for the date of each service and the physician providing the service. Next to each E/M code should be a space for the internist to note the date of service and his or her name. This not only ensures that the services are accurately tracked, but also that they are reported under the correct physician, notes Brink. In some practices, different physicians may see the practices inpatients during the course of the hospital stay. If all charges are linked to one physicians provider number or a group (the physician who discharges the patient, for example) then that can cause problems for the other physicians in the practice who also saw the patient when managed care payers analyze their productivity, says Brink.

4. Space for listing appropriate ICD-9 codes. This step is important because patients are often admitted with an indeterminate diagnosisfor example, abdominal pain of unknown origin (789.0)that is later changed to a definite diagnosis (e.g., abdominal aortic aneurysm [441.4]), Brink says. If a procedure performed after a definite diagnosis has been made is linked to the admitting (or nonspecific) ICD-9 code, the medical necessity for the procedure is not substantiated.

In some cases, practices are not getting reimbursed properly for inpatient services because [the services] were never charged, she states. But many times, the claims are getting denied because the procedure codes were not linked to a correct diagnosis code.

Physician and Biller Communication

Before any sort of inpatient tracking form can be used, a communication system must be implemented. It is up to the physician to communicate with the practices billers to ensure that all services rendered are charged correctly, Brink continues.

The internist is responsible for the documentation of the patients hospital record. This information substantiates the ICD-9 and CPT codes he communicates to the biller.

If the hospital charges are improperly documented, then there is no hope of an appeal if a claim is denied payment or downcoded by the payer, she says.

Instituting Checks and Balances

Before the hospital charges are entered by the practices billing department, the doctors involved should go over the form one last time to ensure accuracy.

The physician is the only one who knows what services he or she performed, explains Brink.

Ideally, the practice should put one staff member in charge
of keeping track of hospitalized patients, she recommends. This person would be responsible for scheduling all in-hospital procedures and tests, ensuring that the practice correctly captures all of the charges for the hospital care.

In larger practices, this service may actually have to be performed by several people, she admits. But, these people should always be designated to keep track of inpatient charges.

Periodically, the office should also do an audit of randomly selected hospital records, comparing the physician documentation and discharge summary to the patients payment report to ensure that all charges are being captured.

This is really the only way to know whether or not you are losing revenue, she says.

E/M Codes for Inpatient Services

Hospital Observation Services - 99218-99220 - Initial Observation Care - New or Established Patient

Hospital Inpatient Services - 99221-99223 - Initial Hospital Care-New or Established Patient; 99231-99233 Subsequent Hospital Care

Observation or Inpatient Care Services - 99234-99236 (Includes admission and discharge when patient admitted and discharged on the same day.)

Hospital Discharge Services - 99238 - Hospital discharge day management- 30 minutes or less. 99239 - More than 30 minutes

Initial Inpatient Consultations - 99251-99255 - New or Established Patient

Follow-Up Inpatient Consultations - 99261-99263 - Established Patient

Confirmatory Consults - 99271-99275.

Customizing the Inpatient Billing Form for Your Practice

Keeping track of in-hospital charges is important for any physicians practice. However, individual offices and clinicians have different routines, so its important to consider your own practices needs and the work styles of your doctors when designing these forms.

Stephanie Gajic, CPC, billing supervisor at a
25-physician, multi-site practice in Atlanta, recently designed two different billing forms for her practiceeach will be used at a different practice site. Here are some keys to remember:

1. Keep it simple. Both of Gajics forms are designed in a simple, check-off format. One lists the most common procedures and services her physicians perform on inpatients, the other form lists the same information, but lists the actual codes in front of each item. Each item has a space for a check mark in front of it.

What we used to do was have the doctors take a list of [hospital] patients with them, she says. They used to just scribble in next to the name the procedures they performed.

This, of course, created problems, Gajic adds. The physicians writing was often illegible and they sometimes failed to write down everything they did.

Sometimes, the physicians just got into the habit of walking up to coders and saying, Hey, Connie, I saw Mr. Smith, I did this and that and I admitted the patient, etc., she adds. Everything orally, everything from memory. That didnt work very well. But, there are a lot of people still doing this, Im sure.

The check-off design is faster for the physicians and allows the coders to be sure they are recording everything, she notes.

If we could be sure we got all the charges by them writing things down, then that would be fine, she observes. But, a lot of these guys dont want to do it. They like the idea of checking things off. They dont have to spend a lot of time writing.

2. With or without codes. Both have their advantages, but ultimately you must decide what best suits your practice:

With codes - It is a good idea to familiarize physicians with the actual CPT codes, since they are ultimately responsible for assigning the correct code.

Without codes - This method saves space on the card and allows the physician the room to make detailed notes, if necessary.

3. Size matters. Gajic is planning to condense both sides of her second form and put it on an index card. This, she believes, will ensure that the physicians use the form because it will be easier to carry around.

4. Choosing codes. If you decide to include codes on your card, Gajic recommends determining the procedures that your physicians most commonly perform in the hospital.

Include codes for any services or ancillary procedures that might ordinarily accompany these procedures. Its sort of a guide that reminds the doctors to check off everything that they did, she notes.

She was also careful to include space for listing the diagnoses, and space for any code or procedure not already listed on the form.