Internal Medicine Coding Alert

How to Code Next-Day Hospital Services Correctly

Coding for visits to hospitalized patients can become complicated when two (or more) physicians are treating the same patient at the same time.

If the primary care physician is overseeing the care of the patient, should all other physicians bill their services as consultations? Or, should they also use the hospital inpatient visit codes?

A reader question recently illustrated this dilemma: If I am consulting on a patient in the ICU [intensive care unit], doing medical or respiratory management, how should I bill it: 99262-99263 (follow-up consult), 99232-99233 (daily visit), or 94656-94657 (ventilator) or 99291 (critical care)? writes **Robert Westlake, MD, PC,** an internist and respiratory specialist at Community Hospital Physicians in Syracuse, NY.

Westlakes case is complicated by the fact that he is a subspecialist in respiratory management who regularly sees patients at the request of the primary internist, says **Joanne Colbert,** Westlakes office manager.

He is there managing the ventilator and the respiratory management of this patient, she explains.

I dont think that the follow-up consults would really apply in this case, Colbert continues, But I would like to know if the ventilator management would be coded in addition to the E/M code for the hospital visit (99232 or 99233)?

Colbert is on the right track, but, in fact, the visit probably should be reported with a critical care code (99291-99292) and these codes include ventilator management, says **Cynthia Thompson, CPC,** senior consultant with Gates, Moore, and Co., a medical practice consulting firm in Atlanta, GA.

In this case, I am assuming the patient is critically ill because the person is still in the ICU and on a ventilator, which indicates to me that they are unstable, she explains. This meets the criteria for reporting critical care. If the patient were stable, then you would report a code for subsequent hospital care services (99232-99233).
The CPT manuals description of critical care services indicates that ventilator management is included.

The following services are included in reporting critical care when performed during the critical period by the physician providing critical care: interpretation of cardiac output measurements (93561, 93562), chest x-rays (71010, 71020), blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data [99090]); gastric intubation (91105); temporary transcutaneous pacing (92953); ventilator management (94656, 94657, 94660, 94662); and vascular access procedures (36000, 36410, 36415, 36600), CPT reads.

Note: For more information on reporting critical care services, see the articles Remember to Use -25 Modifier when Reporting Critical Care and Separate Procedures and Four Key Strategies for Billing Critical Care pages 25-28 in the April issue of ICA.

Thompson adds that she is assuming the physician is providing evaluation and management services to the patient in addition to managing the ventilator.

If the patient were stable, and the physician reported the visit with a subsequent hospital care code, the ventilator management code (94656-94657) could be reported in addition to the E/M code.

Follow-Up Consult is Not Correct

Consult codes are only appropriate when the opinion of one physician is requested by another, Thompson continues. If the physician assumes the care of the patient, and even, as in this case, he or she assumes care of the patient for only a specific problem (respiratory management), then consult codes cannot be used.

I would definitely question whether it is appropriate to report the initial consult code on the first day, she says. It appears that this physician is there to treat the patient, not to offer an opinion to the physician managing the care of the patient.

Note: For more information on reporting consultation codes, see the article Correct Coding for Consults and Referrals: Dont Confuse a Request for an Opinion with a Transfer of Care, on page 17 in the March issue of ICA.

Reimbursement Problems

Although both physicians caring for this patient should most likely be reporting their services with critical care codes, they will run into problems seeing payment for these services if they are both listed with their carriers under the internal medicine specialty, adds Thompson.

If the physician performing the respiratory management is not listed under a different specialty or a subspecialty, the carrier might consider this concurrent care and deny the claim, she says.

In that case, Thompson recommends that both physicians include notation of the exact time that they saw the patient in their supporting documentation for the critical care service.

The critical care codes are based on the amount of time the physicians spent in constant attendance with the patient, but I would also include the time in and time out information, she states.

It is unlikely that both physicians will see the patient at the same time of day, clarifying that both physicians saw the patient at different times will help the carrier understand that they saw the patient for different reasons.

In addition, the physicians should be sure that the diagnosis codes reported with the critical care codes accurately reflect the condition for which each physician is treating the patient.

If one physician comes in and takes over treatment for the respiratory condition, then the initial physician should stop reporting that diagnosis, she adds.