Codify
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Internal Medicine Coding Alert

Identify Observation Services or Leave $$ on the Table

CPT has codes specifically designed for single-date observation services

When your internist performs observation services for her patients, you'll need to know the difference between the two groups of observation codes. Without this knowledge, you'll risk choosing a code from the improper set.

Further, you must also be able to separate observation services from typical E/M codes, or your bottom line could suffer. In Broward County, Fla., Medicare pays approximately $105.00 for the observation code 99219, whereas it pays about $67.44 for 99214.

Use 99218-99220 for First Day of Longer Stays

The first set of observation codes you should familiarize yourself with are 99218-99220 (Initial observation care, per day, for the evaluation and management of a patient which requires these three key components ...). Use these codes to report the first day of an observation service that spans more than one calendar date, confirms **Mary Falbo MBA, CPC,** president of Millennium Healthcare Consulting Inc. in Lansdale, Pa.

Warning: Only the supervising (admitting) physician can report the observation admission codes. The codes' work units include the observation admit, care plan supervision and continued patient assessment. Make sure your physician performs all of these services before using 99218-99220.

Also, remember to report 99217 (Observation care discharge day management) for services your internist provides the patient on the discharge date (when not the same date as the observation admission date), says **Cindy Parman, CPC, CPC-H, RCC**, co-owner of Coding Strategies Inc. in Powder Springs, Ga. According to CMS, "The physician bills CPT code 99217 for observation care discharge services provided on the second date."

Coding scenario: Check out this example from **Denae M. Merrill, CPC-E/M**, a coder with Covenant MSO in Saginaw, Mich., and secretary of the MBS chapter of the American Academy of Professional Coders:

At 11:00 a.m. Wednesday, a patient meets his internist at the local hospital; the patient is complaining of lower back pain. During the course of a level two observation admit, the internist orders radiology tests, which come back showing lumbar spinal stenosis. The internist performs epidural steroid injections to alleviate the patient's pain.

On Thursday morning, the patient reports that the pain is under control. At 1:00 p.m. Thursday, the hospital discharges the patient.

In this scenario, Falbo confirms you can report an observation code. On the claim, report the following:

• 62311 (Injection, single [not via indwelling catheter], not including neurolytic substances, with or without contrast [for either localization or epidurography], of diagnostic or therapeutic substance[s] [including anesthetic, antispasmodic, opioid, steroid, other solution], epidural or subarachnoid; lumbar, sacral [caudal]) for the injection

• 99219 (Initial observation care, per day ... a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity) for the observation

• modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) attached to 99219 to show that the injection and the observation were

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separate services

• 724.02 (Spinal stenosis, lumbar region) linked to 62311 and 99219 to represent the patient's stenosis

• 724.2 (Lumbago) attached to 62311 and 99219 to represent the patient's back pain

• 99217 for the discharge service.

Include Timed Notes on Your Claims

Make sure your internist provides proper documentation for all of your observation service claims.

"In general, there must be a medical observation record for the patient, which contains: dated and timed physician's admitting orders on the patient's care in observation; nursing notes and progress notes prepared by the doctor while the patient was in observation status," Parman explains.

"This record must be prepared in addition to any emergency department or outpatient clinic department record. The physician order should reflect 'Outpatient Observation' as opposed to 'Inpatient Admission,'" Parman continues.

Same-Day Admit, Discharge Calls for Alternative

When your internist provides observation services during which he admits and discharges the patient on the same calendar date, choose a code from 99234-99236 (Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date ...).

Use these guidelines: "Use the 99234-99236 codes when a patient is seen, the decision to admit to observation is made, and the patient is then discharged from observation on the same calendar date," says Merrill. The hospital admit and discharge date must be the same date to use this code family, she continues.

(Note: CMS has stated that the patient must be in observation for at least eight hours before reporting 99234-99236. Check with your Medicare payers before using these codes on your claims.)

Example: At 10:00 a.m. Friday, the internist admits an established patient to observation. The patient is complaining of a severe headache associated with nausea and vomiting after falling and hitting his head on the ground, and the patient has a past history of bleeding following minor injuries. During the course of a level one observation service, the internist orders a CT scan, which shows no evidence of a hemorrhage.

The internist treats the patient's headache symptomatically, and it resolves within a few hours. The internist instructs the patient to schedule a follow-up visit with a specialist the next week. At 5:00 p.m. Friday, the hospital discharges the patient.

Because the physician admitted and discharged the patient on the same calendar date, you should report 99234 (... a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity) for this service, Merrill confirms. Also, link 784.0 (Headache) and E888.1 (Fall resulting in striking against other object) to 99234 to prove medical necessity for the encounter.

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