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Internal Medicine Coding Alert

Navigating the Choppy Waters of Observation Coding

Observation care coding is complicated, but time spent learning about these E/M codes can maximize your office's reimbursement. The biggest obstacle a coder faces is locating all of the observation codes in the CPT manual.

Although a series of observation codes is quite logically listed under the "Hospital Observation Services" section in the CPT manual, there is another often-overlooked set of observation codes listed under the heading of "Hospital Inpatient Services." These codes, 99234-99236 (observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date), are valuable because they can be used not only for observation care patients admitted and discharged on the same day, but also for inpatients meeting the same criteria.

Same-Day Admit and Discharge Rules

Medicare coding rules differ from CPT rules. For 99234-99236, Medicare states that in order for a physician to bill a patient admitted to observation care and discharged on the same date, the patient must have remained in observation care for more than eight hours on that date. If the patient is admitted to observation care and discharged in less than eight hours, only the admission codes 99218-99220 (initial observation care, new or established patient) may be billed. The provider may not bill for 99234-99236 in this case, even if he saw the patient twice that day and wrote a separate admission and discharge note.

Under the heading "Hospital Observation Services," coders can find three levels of admission codes, 99218-99220, as well as one discharge code, 99217 (observation care discharge day management), which may be used only if the patient is discharged on a date other than the admission date.

Applying Same-Day Admit and Discharge

One of the basic principles of inpatient and observation care coding is per-diem billing; both inpatient codes and observation codes carry the description "per day," so only one inpatient or observation code may be billed per day. The total work performed when both the admission and discharge are carried out on the same day is the same as when each of the two encounters is performed on a different day. However, the coding rules prevent billing more than one E/M code per day. In the past, physicians were faced with a dilemma how could they be paid for the work they performed in these situations? In 1998, CPT solved this problem with the introduction of same-day admission and discharge codes (99234-99326).

One of these codes may be used for a same-day admit and discharge for either an inpatient- or observation-status patient. These new codes also allowed relative values units (RVUs) to be assigned that more properly reflected the amount of work done when two services were performed on the same day. Each code has RVUs that are only slightly less than the sum of the RVUs from the admission code (99218-99220) and the discharge code (99217).

Same-day admission and discharge codes should only be billed when the provider actually visits the patient twice during the calendar day and documents both encounters in the medical record. The admission note and discharge note must be documented separately. Both notes may be on the same sheet of paper, but each note must be under its own heading. It would be incorrect to bill 99234-99236 if the patient was admitted shortly after midnight but was not seen by the physician until 9 a.m. the following morning, at which time he was discharged.

Observation Coding Rules

Before billing observation codes, the coder must ensure the documentation clearly indicates that the patient was

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admitted to observation status. The physician's admitting order must state: "Admit to observation status." All observation codes are per-diem codes. Just like the inpatient codes, only one code may be billed per day. However, unlike the inpatient and outpatient codes that coders are more familiar with, there is no time element associated with observation codes for counseling and coordination of care. (This includes the same-day admission and discharge codes.)

Participants in The Coding Institute's audioconference "Valuable Coding Strategies for the Observation Challenge" had the advantage of an excellent guide, **Kathy Pride, CPC, CCS-P,** coding supervisor for the Martin Memorial Medical Group, a 57-physician group practice in Stuart, Fla., to lead them through the complexities of observation coding. Pride detailed for her audience a number of important guidelines that coders must know when using the observation codes.

1. Patients admitted to inpatient status from observation status the same day. Only the inpatient code may be billed. The coding rules treat the observation status stay as they would an outpatient or emergency department stay. The observation care documentation would be combined with the inpatient documentation to come up with one level of inpatient care for that day.

Example: At 8 a.m., Mr. Jones is admitted to observation status for chest pain. At 1 p.m., his EKG begins to show changes consistent with an evolving myocardial infarction. His internist immediately admits him to an inpatient unit. The physician will bill 99221-99223 for his services that day. The observation admission will be included in the inpatient care code.

2. Patient admitted to the observation status from an outpatient setting. All outpatient (such as an office, emergency department or outpatient surgery center) documentation is combined with the observation care documentation to come up with one level of observation care for that day (99218-99220).

Example: Mr. Jones presents with chest discomfort. After examining the patient and observing him for a while in the office, the internist cannot rule out a myocardial infarction, so he admits the patient to the hospital observation unit. The physician will bill 99218-99220 for his services that day. The code level will be based on both outpatient and observation-unit documentation.

3. Patient admitted to inpatient status from observation on a day subsequent to the initial observation date. The physician may bill an initial inpatient admission (99221-99223) on that subsequent day. However, the physician may not bill for the discharge from observation status (99217). This is in keeping with the coding rule that all observation and inpatient codes are per-diem codes.

Example: Mr. Jones has spent a comfortable night in the observation unit. However, in the morning, his EKG begins to show changes consistent with an evolving myocardial infarction. His internist discharges him from the observation unit and admits him to an inpatient unit. The physician will bill only the inpatient initial visit code (99221-99223) for his E/M services that day. Services provided in the observation unit that day will be combined into the inpatient code selected. The discharge-from-observation code (99217) cannot be billed if the patient is admitted to an inpatient unit that day. This is consistent with the inpatient-observation coding rule of billing only one E/M code per day. Thus, Mr. Jones' stay in observation would be coded 99218-99220 for the first day and 99221-99223 for the second day of initial hospital care. His observation care services for the second day are bundled into the code for inpatient hospital care.

4. Patient admitted to observation status and discharged on a different calendar date. The physician would use code 99217 for the discharge visit.

Example: Mr. Jones is admitted on Thursday afternoon to an observation unit. By Friday morning his chest pain has resolved, his cardiac enzymes have returned to normal, his vital signs are stable and his EKG is normal. His internist sends him home from the observation unit and bills 99217 for his services that day.

5. Patient in observation for more than two calendar days. The physician must bill the services between the initial visit and the discharge visit using the outpatient office codes, 99212-99215.

Example: Mr. Jones is admitted to the observation unit from his internist's office on Thursday evening for chest

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discomfort. His physician bills 99218-99220, initial observation care, for Thursday's services. On Friday, Mr. Jones continues to complain of chest pain, his cardiac enzymes are inconclusive, his EKG is normal and his blood pressure is elevated. The physician elects to continue observation care on Friday. For Friday's services, the physician will bill 99212-99215, the outpatient office codes. By Saturday morning, the patient's chest pain is gone, his blood pressure and EKG are normal, and his physician discharges him and reports 99217 for his services that day.

6. Encounters by physicians other than the admitting physician. These services should be billed using the appropriate outpatient consultation code or office visit code.

Example: Mr. Jones, a Medicare patient, is admitted to observation status at 9 a.m. on Thursday for chest pain with nonspecific EKG changes. His internist orders a cardiology consult. The cardiologist sees the patient at noon and feels that cardiac disease can be excluded and recommends that the patient be discharged. The internist sends Mr. Jones home at 2:30 p.m. The cardiologist will bill an outpatient consultation code, 99241-99245, for his services. The internist will bill 99218-99220 for his services. Because this is a Medicare patient and his stay was less than eight hours, the internist is precluded from billing for the same-day admit and discharge codes, 99234-99236. Had Mr. Jones been discharged at 5:30 p.m. or later, his internist could have billed 99234-99236.

7. Only the admitting physician may use the observation care codes. All other physicians seeing the patient in observation care would use either the outpatient consultation codes, 99241-99245, or the outpatient office codes, 99212-99215.

Example: Ms. Smith is admitted to observation by her allergist. Upon admission, her allergist notes that her blood pressure is quite high at 170/100. The allergist asks an internist to consult on the management of Ms. Smith's blood pressure. In this example, the allergist will use the observation admission code, 99218-99220. The internist will use an outpatient consultation code, 99241-99245.

Clinical Indications for Observation Care

What types of illnesses would prompt an admission to observation care? According to **Michael Haynes, MD,** compliance director for University Medical Associates in Augusta, Ga., any patient who meets one of the following criteria can be admitted to observation:

a) Patient requires a longer period of observation than is practical in the emergency room.

b) Patient has a potentially serious diagnosis that can be worked up within 24 hours.

c) Patient is marginal for admission because of medical or social issues. Some examples of these conditions would be an acute asthma exacerbation that the physician anticipates will be brought under control within 24 hours, atypical chest pain that needs to be evaluated and observed before the patient is sent home, and a patient with kidney stones that the physician expects can be managed conservatively.

Note: Readers wishing to obtain a tape of the audioconference "Valuable Coding Strategies for the Observation Challenge" may do so by calling (800) 508-2582 or by visiting www.codinginstitute.com/conference. This seminar covers physician billing as well as facility billing for observation care and contains the latest APC information about facility coding for observation care. The 60-minute tape is $99 for subscribers.

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