Internal Medicine Coding Alert

Reader Question: ED Versus Outpatient Codes

Question: Some of our internists are called to see patients in the local hospital emergency department (ED). When they do, we always bill the emergency department codes (99281-99285). Recently, we received some denials for these codes and we are wondering if we are using these codes properly. Can you clarify the use of these codes?

Arkansas Subscriber

Answer: The key to emergency department coding is to remember that many carriers (Medicare and private) do not reimburse two ED E/M codes (99281-99285, emergency department visit for the evaluation and management of a patient) on the same day, even though the Medicare Carriers Manual (section 15508) says to report the services with these codes.

There are three possible ways to code an ED visit:

1. outpatient consultation (99241 - 99245) if the visit meets the criteria/definition of a consultation

2. emergency department visit (99281-99285)

3. other outpatient visit (99211-99215).

When an internist is called to see a patient in the emergency room by an emergency department physician, coders can choose to bill the appropriate level of outpatient E/M service unless your internist admits the patient to the hospital. If the patient is admitted to the hospital or observation unit, coders should combine all of the E/M services rendered in the ED as well as those in the hospital or observation unit and bill only one code for inpatient or observation care for all services rendered that day.

If, on the other hand, the internist is called to a small hospital or rural hospital that is not staffed by emergency department physicians, coders should not have a problem using the emergency department codes since a hospital-based emergency room physician will not be participating in the patients care.

One of the most common coding scenarios arises when a private-community physician asks a patient to meet him or her in the local hospital emergency department. The physicians intention is to evaluate and care for the patient, not have the patient evaluated by the on-duty emergency department physician. If the ED physician does not provide care to your physicians patient, the internist could bill for his or her services with the emergency department codes.

In practice, however, the answer may depend on the policies of the individual hospital. It is important to remember that a federal law, EMTALA (Emergency Medical Treatment Active Labor Act), requires hospitals to provide a screening examination (for which the emergency department physician is entitled to bill) regardless of any other arrangements the patient may have made with his or her private physician or insurance company. You should only bill the emergency department codes in this scenario if you are absolutely certain that your patient has not been screened by an emergency department physician. It is also important to remember that the emergency department codes do not differentiate between new and established patients.

The emergency department codes require all three key components (history, exam and medical decision-making) be documented. Documentation requirements for the emergency department codes are different from those that you may be used to in the office and the hospital. There are no time factors for conference or counseling and some of the medical decision-making requirements are higher for some of the emergency department codes (99282 and 99283).

Answers for You Be the Coder and Reader Questions were provided by **Kathy Pride, CPC, CCS-P,** coding supervisor for the Martin Memorial Health Group in Stuart, Fla.