Part B Insider (Multispecialty) Coding Alert

E/M CODING: 7 Tips To Keep Your Inpatient E/M Coding On The Up-And-Up

Medicare overspends millions on upcoded inpatient visits

The carriers are scrutinizing your inpatient hospital visits more than ever. Will you be ready?

Problems: Medicare overspent $112 million on claims for subsequent hospital visit code 99233 and $41 million on 99232, according to the Nov. 2006 Comprehensive Error Rate Testing report. In both cases, visits were upcoded by one level, claims the **Centers for Medicare & Medicaid Services** (CMS).

Also, Medicare overspent $57 million on upcoded claims for initial inpatient consult code 99254. And CMS says upcoded claims for initial inpatient visit code 99222 cost the program $26 million.

Meanwhile, more than one doctor often tries to bill for an initial hospital visit (99221-99223) for the same patient, warns a bulletin from **Healthnow New York's Upstate Medicare Division** (UMD). -Only the attending physician may file a claim for the initial hospital visit,- says UMD, which warns this is a -common source of error.-

High error rates with inpatient visits are leading to more scrutiny, says **Linda Martien**, coding consultant with **National Healthcare Review** in Woodland Hills, CA. She and other experts offer these 7 tips:

1. Don't confuse -initial visit- with -admission.- Many coders believe they can bill for an initial inpatient visit just because the doctor performed a history and physical exam in the office before admission. The doctor may believe because he or she dictated the history and physical for the patient without a face-to-face visit in the hospital, the practice can bill an initial inpatient visit, but this is incorrect, says **Maxine Lewis** with **Medical Coding Reimbursement Management** in Cincinnati.

2. Check the documentation. Try to see the physician progress note or bedside note that shows the physician actually spent time with the patient in the hospital and performed at least some of the key components of the evaluation & management visit, says Martien.

Note: It can be -tedious- to obtain inpatient documentation because the hospital staff is busy, and sending you information is -way down on their to-do list,- says Lewis.

3. Watch diagnosis coding. Problems arise when one patient is in the hospital with multiple problems, says Martien. For example, a patient could be in a car accident, and need an orthopedist, neurologist, pulmonary specialist and others. Make sure your physician is using diagnosis codes that directly relate to his/her specialty area, and use modifiers where appropriate, Martien adds.

4. Distinguish between observation and inpatient admission. Pay attention to the documentation. You may need to follow up with a query to the doctor and even the hospital to verify the patient's admission status, says Martien. The patient's observation status should be noted on the admission note, says Lewis.

5. Make sure inpatient consults are clearly documented. Make sure the hospital and other providers send all consult notes to your office, Lewis urges.

6. Educate your doctor about the proper levels of inpatient service, Lewis adds. Few hospitals allow templates, so it's

harder for your doctor to remember the requirements of the levels of service.

7. Look for discharge summary. Physicians sometimes dictate the discharge summary before the patient's actual discharge, Lewis says. The physician or another member of the same group may not actually see the patient on the day of discharge, which means you can't bill for the discharge. Instead, the doctor may write a note instructing that, if Mrs. S. has no fever for 24 hours, she can go home. Make sure the hospital sends all discharge notes to your office, so you can see when the doctor dictated them.

Watch out: Several recent carrier audits have also focused on inpatient critical care services, warns Lewis.