Part B Insider (Multispecialty) Coding Alert

E/M Coding: Keep Your Inpatient E/M Claims Flowing With These 5 Tips

Medicare overspends millions on upcoded inpatient visits.

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

Problems: Initial hospital visits had a higher Part B error rate than any other E/M services at 26.9 percent last year, according to the 2012 Comprehensive Error Rate Testing (CERT) report, which came out last month. These high error rates with inpatient visits could lead to additional scrutiny on your hospital visit claims, so consider the

following five tips to ensure you continue to code these services accurately.

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.

Example: Suppose a 77-year-old male with chest pains presents to his physician's office. After performing a history, evaluation and medical decision-making, the physician admits the patient to the hospital as an inpatient but does not see the patient in the hospital that day.

In this case, you should report the appropriate-level office visit code (99201-99215). Because the physician doesn't see the patient in the hospital on the admission date, you should use the E/M code that reflects where the physician delivered the services. Since the physician performs an office visit only, you should only report that day's service.

If, however, the office visit and initial hospital care occur on the same day, you should roll both services into one E/M code. For instance, a patient presents with vomiting and a high fever. Upon evaluation, the physician finds that the patient has 10 percent dehydration. So, the physician sends the patient to the hospital with admission and intravenous infusion orders. That evening, the physician visits the patient in the hospital and checks on her progress.

In this example, you should combine the office visit and initial inpatient hospital care into one hospital E/M code (99221-99223). Because the initial hospital care's date coincides with the admission date, you should consider all related E/M services that the physician provides on that day part of the initial hospital care and submit only the initial hospital care codes.

CPT® states that when a physician admits a patient to inpatient status during another service site encounter, you should consider all E/M services that the doctor performs with that admission to be part of the initial hospital care when performed on the same date as the admission. That means 99221-99223 encompass all of the day's related initial hospital care services.

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 E/M visit before you submit any charges for the hospital charge.

3. **Watch diagnosis coding.** Problems arise when one patient is in the hospital with multiple problems. 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.

For instance, if your physician is a nephrologist who is called to evaluate a patient with three fractures in his feet and legs from a car accident who is also suspected of having kidney trauma, you'll bill the appropriate kidney injury codes

(with an E code for the car accident) but most likely not the foot and leg fracture codes.

4. **Distinguish between observation and inpatient admission.** Pay attention to the documentation to confirm that the patient was admitted as an inpatient and not in the observation unit. You may need to follow up with a query to the doctor and even the hospital to verify the patient's admission status. The patient's observation status should be noted on the admission note.

5. **Look for discharge summary.** Physicians sometimes dictate the discharge summary before the patient's actual discharge. But if the physician doesn't actually see the patient on the day of discharge, you can't bill for the discharge.

"Discharge day management is a face-to-face E/M service between the attending physician and the patient," according to the Medicare Claims Processing Manual Chapter 12, Section 30.6.9.2. "The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified nonphysician practitioner even if the patient is discharged from the facility on a different calendar date."