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Part B Insider (Multispecialty) Coding Alert

Hospital Care: Report Hospital Visits Properly to Avoid Being A CERT Statistic

These 7 quick steps will help you ensure that you bill inpatient visits properly.

If CMS's latest CERT report is any indication, Part B practices could use a quick refresher on how to report initial hospital care and other inpatient visits to avoid paybacks or underpayments (See cover story for more on this). Consider the following tips to ensure that you report these services appropriately.

1. Know who should report initial hospital care" Many coders believe they can bill for initial inpatient care (99221-99223) just because the doctor performed a face-to-face visit with the patient in the hospital on the day he was admitted. But if he has already been admitted by another physician, his attending physician, you should instead select a subsequent hospital care code (99231-99233).

2. Check the documentation. Try to review the physician's progress note or bedside note which shows that the physician actually spent time with the patient in the hospital and performed at least some of the key components of the evaluation and management visit.

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. But if you forge a good relationship with the hospital staff, you can get the information you need.

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, urologist and others. Make sure your physician is using diagnosis codes that directly relate to his specialty area, and use modifiers where appropriate.

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. The patient's observation status should be noted on the admission note.

5. Make sure inpatient visits are clearly documented. Ensure that the hospital and other providers send all inpatient notes to your office. Ask the hospital or other physician to mail or fax to you any documentation that you may be missing.

6. Educate your doctor about the proper levels of inpatient service. Few hospitals allow templates, so it's harder for your doctor to remember the requirements of the levels of service. If you find any errors when reviewing inpatient coding trends in your practice, use them as a springboard to prompt a training session at your office.

7. Look for a discharge summary. Physicians sometimes dictate the discharge summary before the patient's actual discharge. 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 a 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.

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