

Part B Insider (Multispecialty) Coding Alert

Hospital Discharge Coding: Watch Out For These Discharge Planning Pitfalls

6 mistakes that could cost you thousands

If you manage to train your physicians to document the time they spend on hospital discharges (99238-99239), that won't be the end of your worries. There are still many other potential problems with discharge planning, including:

1. **Non-eligible patients.** Sometimes a patient may not be eligible for a discharge code, notes **Jennie Horner**, a coder with **Southern Ohio Medical Center** in Portsmouth, OH. This can happen if the patient never left the emergency room and thus was never admitted as an inpatient, in which case the physician should use the observation codes instead. This can also happen for a same-day admission and discharge, or a patient who's had a surgery with a global period.
2. **Lost documentation.** One physician billed for several hospital discharges, but a carrier audit failed to find the discharge summaries at the hospital, recounts **Maxine Lewis**, a consultant with **Medical Coding Reimbursement Management** in Cincinnati, OH. The physician had discharged the patients, but the hospital had failed to transcribe several discharge summaries, or just lost all the paperwork. The physician had to repay \$77,000 to Medicare because of this and other documentation issues, Lewis recalls.

Lewis recommends asking the hospital to send copies of all discharge summaries to the physician office. Not only will this request ensure that you can produce that documentation in the event of an audit, you'll also ensure the physician will have all the information on the patient's post-hospital plan of care. A good discharge summary can be helpful to the physician because the summary includes information on what tests the patient had.

Most hospitals still won't allow physician office staff to come in and look at their medical records, Lewis points out.

Beware Gray Areas

3. **Next-day discharge.** Sometimes the physician will see a patient in the evening and say that if the patient doesn't have any more vomiting or pain, he or she can leave in the morning. The physician won't see the patient the next day before discharge, so there's a gray area as to whether the physician can bill for discharge planning, according to consultant **Joan Gilhooly** with **Medical Business Resources** in Evanston, IL.

Many experts believe that the physician must see the patient face-to-face on the same date as the discharge to [bill 99238](#) or 99239, Gilhooly notes. So if the physician last saw the patient the night before, then he or she can only bill for subsequent hospital care. On the other hand, the code descriptor in the CPT manual appears to give some latitude to include only some of the elements of discharge planning in 99238. And you can certainly bill 99238 for all the work associated with the death of a patient in the hospital, which doesn't necessarily involve a face-to-face visit. So you may also be able to bill that code for an overnight discharge.

The **Centers for Medicare & Medicaid Services** hasn't clarified this situation, and the CPT Assistant for January 1998 merely stated that there are no documentation guidelines for hospital discharge coding. So until CMS issues clarification, it may be better to bill for subsequent care in this situation.

4. **Discharge followed by E/M.** If the patient checks out of the hospital and then visits the physician's office in the afternoon, can the physician bill for a separate evaluation and management service on the same date? Some physicians

have tried to bill for this, but Gilhooly says this practice won't wash, unless the afternoon E/M is really unrelated to the discharge. The presumption is that the discharge code includes taking care of all the patient's needs post-discharge, she says.

5. **Varying carrier interpretations.** **Cahaba GBA** recently posted on its Web site that it expected physicians to list the amount of time they spent with the patient when billing 99238 as well as 99239. Most coding experts (and many carriers) believe that you only need to note time if you're billing 99239 for more than 30 minutes. But Cahaba believes that both 99238 and 99239 are "timed codes."
6. **Multiple physicians.** There can be up to three physicians managing the care of a patient, and all three can try to bill for the discharge, notes **Charol Spaulding**, vice president of **Coding Continuum** in Tucson, AZ. Say an internal medicine physician admitted the patient, and then consulted with a cardiologist, who follows the patient through the episode of care. Both doctors might try to bill the discharge, says Spaulding.

But only the physician who actually admitted the patient can bill for the discharge, Spaulding insists. The only exception is if the admitting physician explicitly transferred the patient's care to the other doctor.