# Part B Insider (Multispecialty) Coding Alert

## Inpatient Coding: Achieve Seamless Inpatient Coding in 5 Easy Steps

**Office E/M codes may come easily to you—but investigate your hospital coding prowess.**

Even if your physicians spend the majority of their time in the office, chances are strong that they see inpatients from time to time—and you should know how to report these services. When you perform E/M visits for hospital patients, you won't be billing the standard 99201-99215 series—instead you've got to be on top of the appropriate hospital codes.

Read on for five recent questions submitted to the Insider about inpatient E/M codes, along with solutions that will help you collect for your hospital services.

**1. Where's the 'Admit' Code?**

**Question:** Our physician admitted a patient to the hospital and asked me to report the admit code for the service, but I can't find it in the CPT® manual. Is it with the E/M codes near the front of the book, or elsewhere in the manual?

**Answer:** CPT® does not include a code for hospital admission itself, even though physicians often document that they performed an "admit."

The admitting physician should report codes 99221-99223 for his care if he documents the elements contained within the codes (appropriate history, exam and medical decision-making). He is not billing for the admit itself—he's billing for the care that he provides, based on the documentation.

CPT® states that the initial hospital care codes "are used to report the first hospital inpatient encounter with the patient by the admitting physician." Physicians get paid for the care they provide, not for administrative work—processing the admission, including dictating the required H&P, counts as administrative work, not medical care.

**2. How Should We Report Two E/M Codes?**

**Question:** I saw a patient in the office for potential bronchitis, but when I evaluated her, I determined she had pneumonia. Based on her coexisting conditions, I admitted her to the hospital that same afternoon. Should I report the outpatient E/M code, the inpatient E/M code, or both?

**Answer:** If you see a patient in your office and subsequently perform initial inpatient care for the same patient on the same date, you should report just the inpatient E/M code.

According to CPT®, "when the patient is admitted to the hospital as an inpatient in the course of an encounter in another site of service (eg, hospital emergency department, observation status in a hospital, office, nursing facility), all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission." CPT® advises that you include the outpatient E/M notes when considering the level of inpatient service to report.

**Keep in Mind:** Suppose you perform a history of present illness and review of systems, you've asked about past, family

and social history, and you perform a detailed exam in the office setting—and the decision-making results in wanting to send the patient to the hospital. When the physician sees the patient in the hospital, he's probably not going to do all of those history elements again, so those become part of the documentation in the initial hospital care code that the doctor will report.

**3: Do I Need A Modifier?**

**Question:** Our surgeon performed a hospital E/M service and then performed surgery on the patient within the next few hours. Should we append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) to the E/M code?

**Answer:** If surgery immediately follows a hospital E/M service, you should append modifier 57 (Decision for surgery) to the inpatient E/M code to differentiate it from the usual preoperative exam included in the global package.

**Example:** Suppose a patient presents to the hospital with abdominal pain after falling off a railing. During the history and physical, the patient begins to have abdominal pain, dizziness and nausea. Concerned about the possibility of internal injury, the physician admits the patient and, upon diagnostic testing, identifies a liver laceration requiring surgical repair.

If surgery is performed the day of or the day after this type of admission to the hospital, you should append modifier 57 to the appropriate E/M code. Then, separately report the liver repair (47350, Management of liver hemorrhage ...) as well.

**4. Who Reports the Discharge?**

**Question:** One of our patients had a complex health history and we were among four different practices seeing her. When we billed the discharge code, it got denied—we're assuming because another one of the doctors billed it before us. Should that doctor split the payment with the other physicians?

**Answer:** Several physicians might be managing the care of a patient, and all might try to bill for the discharge—but only the attending physician should collect for it, CMS indicates.

MLN Matters article MM5794 notes, "Only the attending physician of record (or physician acting on behalf of the attending physician) shall report the hospital discharge day management service (CPT® code 99238 or 99239)." Any other physicians should instead report a subsequent hospital care code (99231-99233) for a final visit with the patient.

Keep in mind that sometimes a patient may not be eligible for a discharge code. This can happen in various circumstances—for instance, if the patient never left the emergency room and thus was never admitted as an inpatient, in which case the physician would report an ED service code (99281-99285).

**5. What Constitutes Intensive Care?**

**Question:** When our doctor sees patients in the intensive care unit (ICU), he circles critical care codes—but I disagree that all of his services constitute critical care. When are these codes billable and when are they not reportable?

**Answer:** You cannot bill the critical care codes 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) and 99292 (... each additional 30 minutes [List separately in addition to

code for primary service]) simply because the place of service is the ICU.

**Here's why:** Critical care is not location based  the term describes a type of care. The physician must meet three criteria before billing for critical care:

- The patient must have a critical illness or injury (usually defined as a critical organ system failure or a shock-like syndrome with a high probability of imminent or life threatening deterioration in the patient's condition)
- The physician must document at least 30 minutes of time spent directly with the patient or in the hospital unit, limited only to that patient
- The physician must document highly complex decision making to assess, manipulate, and support vital system function(s) to treat the critical illness or to prevent further deterioration of the patient's condition.

**Better option:** If your physician evaluates a patient in the ICU but does not perform critical care services, you'll report an initial hospital care code such as 99221 (Initial hospital care, per day, for the evaluation and management of a patient ...) or an appropriate subsequent hospital care code (99231-99233).