Part B Insider (Multispecialty) Coding Alert

Inpatient Coding: Avoid These Hospital Discharge Pitfalls

Making any one of these five mistakes could cost you thousands.

Even coders who have a firm grasp on coding hospital care get confused about how to report discharge services (99238-99239) -- but read on to avoid the following five problems:

1. Multiple physicians.

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 bill for the discharge, CMS indicates.

The Medicare Claims Processing Manual notes, "Only the attending physician of record reports the discharge day management service. Physicians or qualified nonphysician practitioners, other than the attending physician, who have been managing concurrent health care problems not primarily managed by the attending physician, and who are not acting on behalf of the attending physician, shall use Subsequent Hospital Care (CPT® code range 99231- 99233) for a final visit."

2. Patients non-eligible for inpatient codes. 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).

3. Next-day discharge. Suppose the physician sees a patient on Monday and says that if the patient doesn't have any more vomiting or pain, he can leave the next morning (Tuesday). The physician won't see the patient on Tuesday, so some coders don't feel comfortable billing a discharge on the date that the physician doesn't actually see the patient.

CMS, however, doesn't specifically say that the physician must see the patient on the discharge date to bill a discharge code. According to chapter 12 of the Medicare Claims Processing Manual, "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."

Most coding analysts agree that the intent of CMS's change to this section of the manual a few years back was to recognize that in today's world of discharges happening at all times of the day and night, the work defined by the 99238 and 99239 codes may actually be done the day before the discharge.

In the example above, the patient's actual day of discharge is Tuesday, but all of the work (all of the thinking work to plan for the discharge and to do the discharge orders) was actually done on Monday.

Keep in mind: The way CMS wrote the language in the manual leaves it open to interpretation, so until CMS clarifies the issue, follow your local MAC's advice on coding discharges if it has published information on discharge coding.

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 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.

5. Nonphysician practitioners performing discharge. The practitioner performing discharge does not necessarily have to be a physician. Presuming all of the rules are met, a nonphysician practitioner can bill a discharge.

Note the language in the Medicare Claims Processing Manual, which says, "The E/M discharge day management visit

shall be reported for the date of the actual visit by the physician or qualified nonphysician practitioner..." (emphasis added).