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# Part B Insider (Multispecialty) Coding Alert

## Part B Coading Coach: 4 Tips Clear Your Confusion About Hospital Transfer Coding

**If you're stumped by physician transfers, you're not alone**

When a physician transfers a patient from one hospital to another, you need to select the right codes based on accepted coding guidelines - and the selection process can be harder than you think.

The Government Accountability Office (GAO) asked **Centers for Medicare & Medicaid Services** call centers how to code a physician transferring a patient and found that 96 percent of the time, the CMS call centers' answers were inaccurate, only partially correct, or incomplete.

However, even the GAO's correct responses leave coders with something to be desired.

**Know the Official Guidelines**

**The GAO asked:** How should you code a physician transferring a patient from one hospital to another?

**What the GAO counted as the correct and complete response:** "Physicians may bill both the hospital discharge management code and an initial hospital care code when the discharge and admission do not occur on the same day if the transfer is between (1) different hospitals, (2) different facilities under common ownership which do not have merged records, and (3) between the acute care hospital and a PPS-exempt unit within the same hospital when there are no merged records. In all other transfer circumstances, the physician should bill only the appropriate level of subsequent hospital care for the date of transfer."

**What's left out:** CMS' response mentions nothing about transfers between physicians in the same group practice, hospital care versus consult codes, or place of service. Nor does this response take into account discharges performed by a nonphysician practitioner (NPP) or physician assistant (PA).

Use these four expert tips to help you cope with the confusion of coding for transferred patient services:

**1. Group practice physicians obey different rule**

Physicians may transfer a patient to another member of their group practice.

According to the Medicare Carriers Manual (MCM), section 15501.1, if a patient undergoes more than one E/M service on the same day by more than one physician in the same group, then "**only one E/M service** may be reported unless the E/Ms are for unrelated problems." Assuming the services were related, both physicians would select the combined E/M level and submit the one appropriate code.

**Note:** If the second physician belongs to the same group practice but is of a different specialty (for example, an internal-medicine specialist transfers the patient to a cardiologist), you should report the E/M codes separately.

**2. Physicians may share visit with NPP**

**Question:** The **CPT manual** 's introduction to codes 99238-99239 says these "codes are to be used to report the total duration of time spent by a physician for final hospital discharge" - but does that include work provided by nonphysician practitioners?

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**Answer:** The term "physician," with regard to E/M services, applies to NPPs when they provide services within their scope of practice, licensure, collaboration rules and billing rules for Medicare, says a CMS official. This means NPPs may report the codes for "hospital discharge, management," and for "initial hospital care."

**Keep in mind:** A physician may also participate in the E/M service, which means you can qualify the claim according to the **shared-visit rule**.

"We do permit the hospital discharge day management service to be split or shared between the physician and the NPP," the CMS official says.

In the hospital facility setting, the physicians must provide some aspect of the E/M service face-to-face with the patient - meaning you must have both the physician's and the NPP's personal documentation regarding what each did during his portion of the service.

**3. Choose consult or subsequent care**

The GAO's correct and complete response states, "in all other transfer circumstances, the physician should bill only the appropriate level of subsequent hospital care for the date of transfer." But what happens when, for example, a cardiologist admits a patient to hospital A, then transfers him to hospital B on the same day because hospital A does not have a cardiothoracic surgery backup?

In this circumstance, you should only report the applicable initial hospital care code (99221-99223), says **Cynthia Swanson, RN, CPC**, senior managing consultant for **Seim, Johnson, Sestak & Quist LLP**, in Omaha, NB. "The cardiologist is considered the admitting physician at both facilities [A and B]," Swanson says.

**Pay attention:** You'll want to make sure you report the right level of service for that code because there's an $80 difference between 99223 (Initial hospital care) and 99233 (Subsequent hospital care), based on Medicare national averages.

Suppose a physician provides a consult to the patient in hospital A and subsequently transfers and admits the patient to hospital B.

**Other choices:** In this case, you should report the appropriate level of subsequent hospital care, according to the GAO's correct response. However, you could also report the consult at the applicable level (for example, 99255) instead of the subsequent hospital care code (99233) - that's a difference of $120, based on national averages.

Or you could report the admission to hospital B. After all, when a doctor provides a consult in the emergency department and admits the patient on the same day, most coding experts say you should only report the admission.

**4. Don't forget place of service**

The GAO response does not mention the place of service, which can be a problem in transfer situations. Using the previous example, if the consult took place at hospital A and then a transfer occurred to hospital B and you report a consult code (99255), which place of service should you choose - hospital A or hospital B?

Many coding experts vary  on their interpretations. For example, "If the consultation was performed at hospital A, you should list the name and address of that facility in the field location 32 of the CMS-1500 claim form," Swanson says. Remember that you have to submit a separate CMS-1500 claim form for the corresponding services that the physician provided at hospital B.

Others coding experts may tell you that if your physician performs a consult in hospital A and admits the patient to hospital B, you should bundle the consult code into the admission code, not the other way around.

**The bottom line:** The GAO's correct and complete response remains far from black-and-white. If you have questions,

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your best bet for now is to ask your payers how they prefer you to report patient transfer services.

**Editor's note:** To read the full GAO report, go to www.gao.gov/new.items/d04669.pdf.

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