Part B Insider (Multispecialty) Coding Alert

Part B Coading Coach: Keep An Eye On Observation Coding To Avoid Blurry E/M

Many coders have no trouble following CPT rules for hospital observation services, but they need to be familiar with the intricacies of both the CPT rules and Medicare's observation policy to get optimum benefits from observation care.

Since the inception of Medicare's observation coding policy, which conflicts with CPT guidelines, there has been some confusion regarding the appropriate way to bill for observation care.

Reserve Observation Codes for Special Cases

1. Typically, physicians use observation care codes for emergency department (ED) cases, particularly for situations involving trauma. Physicians often admit patients who have had traumatic accidents to observation status until he or she is sure that no additional injuries manifest or to ensure that any treatment provided is adequate for a patient's problem, says **Marcella Bucknam, CPC, CCS-P, CPC-H**, HIM program coordinator at Clarkson College in Omaha, Neb.

2. In addition, physicians may admit patients to observation care from the ED who present with a nonspecific complaint such as abdominal pain, says **M. Trayser Dunaway, MD, FACS**, a general surgeon in private practice in Camden, S.C. For example, the physician may see the patient and decide that he or she should be admitted to observation overnight for monitoring and to check lab results.

3. Physicians may also admit a patient to observation overnight for monitoring after certain surgical procedures, such as laparoscopic cholecystectomy, Dunaway says. However, keep in mind that observation care after same-day surgical procedures is always bundled into the procedure and can't be separately billed, Bucknam says.

Know What Observation Status Means

There are certain criteria you must follow in observation care coding.

For instance: According to Empire Medicare's (New Jersey's Part B carrier) local medical review policy, "Only the physician who admitted the patient to hospital observation and is responsible for the patient during his stay in observation may bill the hospital observation codes."

All other physicians who see that patient must bill the appropriate office or other outpatient consultation codes. The global surgery fee includes payment for most hospital observations. According to Medicare, payment is made for observation services in addition to the surgical package only if two criteria are met:

The hospital observation service justifies using modifier -24 (Unrelated evaluation and management service by the same physician during a postoperative period), -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) or -57 (Decision for surgery)

The hospital observation service meets all the criteria for the hospital observation code billed.

In addition, the physician must include a medical observation record for the patient that includes dated and timed admitting orders concerning the patient's care, along with nursing notes and progress notes prepared while the patient is in observation status.

Make Sense Out of CPT Guidelines

Know the patient's status: Use observation service codes (99218-99220) to report E/M services provided to patients admitted to observation status in such locations as hospital emergency departments and the physician's office. The patient does not have to be in a specified observation area, only admitted as observation status, according to CPT. But you would not bill observation care when the physician admits the patient to inpatient status, Bucknam says.

Look for documentation: Codes 99218-99220 report the initial observation care and apply to new or established patients. All three of the key components (history, examination and medical decision-making) must meet or exceed the requirements to qualify for the level of service.

Documentation of the patient's history and physical exam is crucial to billing observation care codes, Bucknam says. If these documentation requirements are not met, physicians should use other outpatient codes, such as new or established outpatient visits or outpatient consultation codes, she says.

Important: In addition, observation services codes are not time-based, so you would not report prolonged services codes with them, coding experts stress.

Determine dates of service: For the discharge service on a subsequent day, use 99217 (Observation care discharge day management), which reports the final examination, discussion of the stay, instructions for continuing care, and preparation of discharge records. Report this code only when discharge is on a day other than the initial date of observation status.

Also, do not use observation codes to report hospital observation services with admission and discharge on the same day. In this case, you should use the observation or inpatient care codes (99234-99236). These codes include the discharge services provided to patients discharged from either observation status or inpatient hospital care.
Once again, all three of the key components must meet or exceed the requirements to qualify for the level of service. You should apply these observation codes "per day."

Don't Ignore Medicare's 'Eight-Hour Rule'

Medicare and a few local carriers add another factor to the observation care equation: time. Time is only a factor with Medicare, says **Kathy Pride, CPC, CCS-P**, a consultant with QuadraMed in Port Saint Lucie, Fla.

In all other instances, the important factor is that the services occur on the same day. The Federal Register lays out Medicare's policy regarding the "eight-hour rule": You should bill observation or inpatient care services (99234-99236) only when the patient remains under observation for more than eight hours and leaves on the same day.

If the surgeon keeps the patient under observation for less than eight hours and discharges him or her on the same day, then you should use the hospital observation service codes (99218-99220). Do not code for the discharge.

The rules remain the same for patients admitted to observation status and discharged on different days. Use the hospital observation codes 99218-99220 to report the initial observation and 99217 to report the discharge.

Check Carrier Guidelines

You may be wondering why there is such a discrepancy between CPT guidelines and Medicare policy.

FYI: The most direct answer is money and technology. According to a former member of the CPT advisory panel, hospital payment for observation services is much less than inpatient services. Also, the other factor is technology and the ability of computers to recognize different dates. For physician services, the codes 99234-99236 have relative value units (RVUs) ranging from 3.6 to 5.93, while codes 99218-99220 have RVUs ranging from 1.78 to 4.16.

Therefore, coding for the lesser observation codes for admission and discharge on the same day (99234-99236) will

allow you to be reimbursed for more money and will cost Medicare more.

Plan of action: If you have been coding using CPT rules and are being reimbursed, continue down that road, coding experts say. Most non-governmental payers follow the CPT guidelines, and local medical review policies usually use the 24-hour rule instead of the eight-hour criteria.

If you are having difficulty getting paid for observation services, however, the problem may be the extra eight-hour rule that Medicare tags onto the observation coding guidelines. If you're in doubt about your local carrier's policy, simply ask them which rules they follow.