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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 5 Steps Ensure Your Observation Care Success

Code service only when making admittance decision to prevent denials.

Although CPT offers two observation code sets, and encounters that look like observations may actually be other E/M services, your observation coding can be spot on every time simply by following this five-step plan.

Step 1: Confirm Type of E/M Service

Before coding, be sure that the service qualifies as an observation. "Observation is a hospital-based outpatient service used to determine if a patient needs inpatient care. Most payers limit the time a patient may be in observation status to 23 hours, though some (Georgia Medicaid, for example) allow as long as 48 hours," explains **Jeffrey Linzer Sr., MD,FAAP, FACEP,** associate medical director for compliance at Emergency Pediatric Group Children's Healthcare of Atlanta at Egleston.

So when you are reviewing the notes, ensure claim correctness by checking the encounter specifics against Linzer's observation definition.

Observation: A patient reports to the ED with chest pains; the ED physician admits the patient to observation status to run tests and make sure the patient does not require inpatient care for his cardiac issues.

Not an observation: A patient reports to the ED in severe cardiac stress. After examination and attempts at stabilization, the emergency physician speaks to the patient's cardiologist, who admits the patient to the critical care unit (CCU) immediately to begin active chest pain treatment and other patient care measures.

Step 2: Tally Observation Length

Next, you'll need to check the notes to see how many calendar days the observation service spanned. For episodes in which the patient is in observation for more than one calendar day, you'll choose from the 99218-99220 (Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components ...) code set for the first day of care, confirms **Cheryl Allard, RHIT,** clinical data analyst at Saint Francis Medical Center in Nebraska.

Use these codes "for all the care rendered by the admitting physician on the date the patient was admitted to observation," Allard says.

Remember: For observation service, you'll need to satisfy all three past family social history (PFSH) elements, unlike the ED E/M codes, which require only two of three PFSH elements.

Step 3: Submit Discharge Code for Multi-Day Stays

For patients whose observation status lasts more than one calendar date, you'll also report 99217 (Observation care discharge day management ...) for the discharge service, says Linzer.

Example: A patient presents to the ED with persistent non-bilious vomiting and mild dehydration. The patient is placed in observation status at 11 p.m. Tuesday to ensure she can maintain oral intake. After a dose of Ondansetron,the patient is able to tolerate sips of liquid. At 8 a.m.Friday, the physician discharges the patient. Notes indicate a levelone observation.

On this claim, Linzer says you should report the following:

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• 99218 (... a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity ...) for the observation on day one

• 99217 for the discharge from observation on day two

• 276.51 (Dehydration) linked to 99217 and 99218 to represent the patient's dehydration

• 536.2 (Persistent vomiting) linked to 99217 and 99218 to represent the patient's vomiting.

Step 4: Alter Coding for Same Day Discharge

If the physician admits a patient to observation status and discharges him on the same calendar date, you'll report 99234-99236 (Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components ...), says **Tracey Koch, CCS-P,** ER Client Support Coding and Education Manager at Comprehensive Medical Management.

On observation claims for a single calendar date, omit the 99217 discharge code, confirms Linzer.

Example: A patient reports to the ED with a headache on Tuesday. Following labs and ahead CT scan, the patient experiences decreased visual acuity, so the physician admits the patient to an observation unit at 2 p.m. for serial neurological exams and further testing.

The ED physician then orders a consultation with an ophthalmologist, who examines the patient with a slit lamp and ophthalmoscope.All tests come back normal,so the ED physician discharges the patient at 11 p.m. Notes indicate a level-two observation service.

In this instance, you shouldrely on the 99234-99236 observation codes. On the claim, report the following:

• 99235 (... a comprehensive history; a comprehensive examination;and medical decision making of moderate complexity ...) for the observation

• 784.0 (Headache) appended to 99235 to represent the patient's headache

• 368.8 (Other specified visual disturbance) appended to 99235 to represent the patient's blurred vision.

Remember: The physician who admits the patient to observation and attends to the oversight ofhis care bills the observation code.

Step 5: Observe Feds' 8-Hour Rule

For Medicare and Medicaid payers, and payers that follow federal guidelines, you must confirm that the patient spent at least eight hours in observation before reporting 99234-99236, Koch confirms.

"CMS Transmittal 1466 [Feb.22, 2008] stated that if a Medicare beneficiary was admitted and discharged on the same calendar day for less than eight hours of observation,the physician should report only 99218-99220 instead of 99234-99236," Linzer says.

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