Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Dispel This Common E/M Myth: Initial Hospital Care Codes Are Not For Admits Only

Follow these 4 easy steps to ensure you don't report admits incorrectly

Are you sure you're reporting initial hospital care correctly? Many coders are getting it wrong.

If you report initial hospital care when the physician admits a patient without rendering bedside care that day, you need to rethink this coding practice.

The popular misconception among physicians and coders has been that initial hospital care codes (99221-99223) are for patient admission, says **Suzan Hvizdash, BSJ, CPC,** physician education specialist in the Department of Surgery at the **University of Pittsburgh Medical Center** in Pittsburgh, PA. But you can only bill for initial hospital care if the admitting physician also sees the patient in the hospital on the same day, she clarifies.

Follow these four easy steps to make sure you report initial hospital care correctly every time:

1. Check the dates of admission and discharge.

First you must make sure the patient wasn't admitted and discharged on the same date of service, says **Marvel Hammer, RN, CPC, CHCO,** president of **MJH Consulting** in Denver, CO. For same-day admission and discharge you will report observation or inpatient care services codes (99234-99236).

If the medical record shows separate admission and discharge dates, your physician's service may qualify for an initial hospital care code.

2. Determine same or different dates of service.

Next you must look at the exact time the physician admitted the patient and treated him in the hospital. If a physician admits a patient at 2 pm and then visits the patient to render initial inpatient treatment at 4 pm, you should bill an initial hospital care code to recoup for all of the physician's services that day.

Watch out: Suppose your physician examines a patient in his office late in the afternoon on Monday and sends the patient to the hospital to be admitted. If the physician doesn't actually have a face-to-face encounter with the patient in the hospital until Tuesday morning, you should bill two separate codes for the two separate dates of service, Hammer says. You would bill an outpatient E/M code to account for the services on Monday. Then you would report an initial hospital care code to account for the initial treatment on Tuesday morning, she adds.

Face-to-face is a must: The physician may admit a patient and call in orders to direct the plan of care, but you cannot bill for initial hospital care until the physician renders a face-to-face visit with the patient in the hospital, Hammer says.

Beware office admits: If your physician doesn't often admit patients, you may stumble if he admits a patient directly from the outpatient office. Remember, unless the physician also sees the patient in the hospital on the admission date, you can only report a new or established patient visit or consultation, Hvizdash says. If your physician renders initial treatment in the hospital on the following day, you can then bill an initial hospital care code. Otherwise, a treating physician at the hospital will bill for the service.

Even if you don't get to bill for initial hospital care, the good news is a patient admission may increase your office E/M

level of service because it involves extra paper work and decision making, Hvizdash adds.

3. Add up all documentation to determine level of service.

Medicare and most other payers will only pay for one E/M service in a 24-hour period, Hammer says (the only exception to this rule is if the physician renders critical care services and another E/M on the same date of service).

Add as you go: Because your physician may have several encounters with a patient during the day of admission and initial hospital care, you need to carefully add up all the services rendered so you can report the highest level code appropriate, Hammer says.

Example: Suppose your physician treats a patient with chest pain in the emergency department, then places the patient under observation status and later the same day admits the patient and performs initial bedside care. "You can combine documentation from all of these services," Hammer advises. "You may have enough documentation to support a 99223, depending on how acute the patient is."

Teaching physicians beware: In a busy hospital setting, a physician may render the first exam and document it in the medical record, but residents may tend to all subsequent patient encounters. In order for a resident's documentation to count toward the overall level of service for the day, a teaching physician attestation must be present in the medical record for each of the resident's patient encounters.

At the bare minimum, a teaching physician attestation has to state the attending physician had face-to-face contact with the patient and performed his own examination, Hvizdash says. The physician must also reference the resident's notes on the patient - either agreeing or disagreeing with the resident's observations and plan of care, she says.

Choose carefully: If you are selecting a level of service for an initial encounter or any subsequent visits by both the physician and resident without a teaching physician attestation, you should only base your level of service on the physician's documentation, Hvizdash advises.

Tip: Physicians can increase their reimbursement if they spend a few extra minutes on more detailed documentation and follow-up on resident-patient encounters.

4. Use prolonged services codes for extended time.

You should report prolonged inpatient services codes (99356, 99357) when the physician spends time above and beyond the initial hospital care code's estimated time allotment. Prolonged services codes are especially helpful with acutely ill patients who don't meet the definition of critical care, but who consume a great deal of the physician's time, Hammer says. For example, if your physician's documentation qualifies for a 99223, but he spent 60 additional minutes (beyond the 70 minutes included in the 99233) on the patient's floor rendering and coordinating care, you would report 99223 and 99356.

Don't Forget Discharges

Selecting the appropriate hospital discharge code (99238, 99239) is much simpler than selecting an initial hospital care code: 30 minutes or less merits 99238, more than 30 minutes merits 99239. Although documentation of all work surrounding a discharge is important, CPT specifies you only need to note the amount of time the physician spent orchestrating the patient's discharge The problem is physicians often report 99238 for the first patient encounter of the day and don't account for additional time spent considering other options for the patient, Hvizdash notes.

Suggestion: Be sure to document and add up any time spent considering the details of a patient's discharge or other options such as rehab or home care. An additional 10 minutes here and there can easily boost you up to a 99239, Hvizdash says.