Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Part B Mythbuster: 99221-99223: Are These Merely 'Admit' Codes, or Can Non-Admitting Docs Report Them?

Get to the bottom of this growing myth and you'll be on the road to easier claim reimbursement.

Now that Medicare doesn't pay for consult codes, you may be a bit lost when it comes to reporting inpatient hospital visits--in fact, many practices avoid reporting codes from the 99221-**CPT 99223** range unless their physician is the admitting doctor. This, however, is a common Part B myth that has continued to grow over the past year following CMS's denial of consult codes.

The reality: CMS actually expects you to report codes from the 99221-99223 (Initial hospital care) range for your physician's first hospital visit with a patient.

Know Why The Rules Are Topsy-Turvy

Background: CMS eliminated pay for outpatient and inpatient consultations in 2010, which made reporting hospital consults particularly difficult. This issue was compounded by the fact that most coders referred to the 99221-99223 codes as "admit codes," and therefore were unwilling to report them unless their physician actually performed the hospital admission.

CMS came out with MLN Matters article MM6740 in Jan. 2010, advising practices to "bill an initial hospital care code" when appropriate, with the principal physician of record appending modifier AI (Principal physician of record) to signal which physician is overseeing the patient's inpatient care.

Although the CMS release seemed to quell confusion for a short period, it didn't last long. Over the past few months, several readers have written to the Insider noting that they not only faced issues when billing initial hospital visits for non-admitting doctors, but that even some coding consultants have told them that they should instead be using subsequent visit codes, even for physicians who have never met the patient before. This, however, is incorrect coding.

Correct way: "The AI modifier should be used by the admitting doctor for the initial hospital visit," says **Victoria Holmes, CPC,** with New England Orthopedic Surgeons. "Other doctors that examine the patient for the first time can bill for initial hospital visits (we do this quite often). We bill subsequent hospital visits when the patient has been seen by our doctor more than once."

What may be throwing off some practices is the fact that many physicians still write the word "consult" in their documentation, which is perfectly appropriate--however, it can stump coders who are seeking simple ways to bill consultations.

"It is what we have to do since Medicare no longer accepts consult codes," says **Nancy Williams, CPC, ACS-OR** with the Center for Sports Medicine and Orthopaedics in Chattanooga, Tenn. "If your doctor is asked to see a Medicare patient for a consult he cannot bill a consult code but can bill an admit code (99221, 99222, **CPT 99223**) without the modifier AI appended."

Follow These Examples for Guidance

If you're still unsure of how modifier AI fits into the coding picture, consider these examples of hospital visits and check out the coding solutions.

Example 1: An emergency room (ER) doctor sees a patient who was involved in a motor vehicle accident. He calls in a

trauma surgeon because of possible intra-abdominal damage, and the trauma surgeon admits the patient because of possible bleeding. The patient is pregnant, so an ob-gyn comes in for a consultation. The trauma surgeon would report 99221-99223 with modifier AI appended.

The ob-gyn then bills a code from the 99221-99223 range with no modifier.

Example 2: A patient falls at home and presents to the hospital for evaluation. An orthopedic surgeon performs a level-three initial evaluation and admits the patient to the hospital for an emergency hip replacement. Following the procedure, the patient complains of severe throat pain. The orthopedist is concerned that the patient's throat was injured during anesthesia intubation during the procedure, and calls an otolaryngologist to consult on the patient's sore throat. The otolaryngologist performs a level two evaluation on the patient.

In this example, the orthopedic surgeon would report 92223-AI for his first visit with the patient, and the otolaryngologist would report 99222 with no modifier appended.