Part B Insider (Multispecialty) Coding Alert

Part B Revenue Booster: Your Top 3 Hospital E/M Billing Questions Answered

Can you navigate the intricacies of inpatient E/M services? Check these expert solutions.
You may be able to select outpatient E/M codes (**CPT 99201** - **99215**) with your eyes closed, but inpatient E/M coding can be a bit more tricky. With the OIG scrutinizing E/M billing like never before (See our cover story for more), you should consider these commonly-asked questions to get the lowdown on how to report your hospital services.

Physician Presence May Dictate Code

Question: Our physician saw a patient in the office, then admitted her to the hospital later the same day. Can we bill for the office visit and the first day of admission, or do we just bill for the hospital stay?

Answer: The answer depends on whether the physician sees the patient on the same day in the hospital.

Scenario 1: If the physician sees the patient in the hospital on the same day he saw her in the office, you're looking at two face-to-face visits on the same date. Report only the appropriate initial hospital care code (99221-99223, Initial hospital care, per day, for the evaluation and management of a patient ...). According to CPT coding guidelines, all initial hospital care services that begin in another place of location (such as the physician's office) should be combined and coded using the appropriate level of initial hospital care. Since the 99221-99223 code will include the E/M provided in the office, you'll report an initial hospital care code that includes the work done in both sites of service; this may lead to coding a higher level of initial hospital care than if you were considering the hospital services alone.

Scenario 2: If, however, the physician does not see the patient in the hospital until the next day, bill each encounter separately. Choose the appropriate office visit code (99201-99205, Office or other outpatient visit for the evaluation and management of a new patient ...) or 99212-99215(Office or other outpatient visit for the evaluation and management of an established patient ...) for the office visit on day one. Then add an initial hospital care code from 99221-99223 for day two, when the physician sees the patient in the hospital for the first time.

Remember that CPT uses initial hospital care codes to describe the first hospital inpatient encounter by the admitting physician. After that, you'll report subsequent hospital care codes, 99231-99233 (Subsequent hospital care, per day, for the evaluation and management of a patient ...), until the date of discharge. When the physician discharges the patient, you'll submit the appropriate hospital discharge day code, 99238 or 99239.

8 Hours May Be Magic Number for Same-Day Admit, Discharge

Question: Our general surgeon admitted a patient to the hospital at 10:30 a.m., and later that day another general surgeon from our group discharged the patient (at 3:30 p.m.) The admitting physician wants to bill a 99223 and the discharge physician wants to bill a 99217. Which code(s) should each physician report?

Answer: The answer to your question depends on several factors. First, you must determine whether the patient was admitted to inpatient status or to observation. That will help you at least review the appropriate code range. It appears that one of your physicians wants to bill an inpatient code (99223) whereas the other wants to bill a code from the observation range (99217). Therefore, it looks like even the physicians didn't clearly understand whether the patient was in the observation unit or inpatient.

If you bill from the wrong section, it will impact you from not only a correct coding standpoint, but also possibly from a compliance standpoint, since initial inpatient codes reimburse approximately 3.5 percent more than initial observation codes.

If you find that the patient was in observation care, the second issue you must consider is the amount of time that the patient spent in the hospital (five hours). When coding this case, your eyes may go to the 99234-99236 (Observation or inpatient hospital care, including admission and discharge on the same date), but you should avoid this section. **Why?** Medicare requires the patient to be in observation care for a minimum of eight hours to justify reporting this code.

In black and white: According to CMS Transmittal 1466, dated Feb. 22, 2008, "When a patient is admitted to observation status for less than 8 hours on the same calendar date, the physician shall report a code from CPT code range 99218-99220."

Therefore, if it's an observation patient, you should report a code from the 99218-99220 series.

Important: No matter what code you select, you should only report one code to represent both physicians' time with the patient, since they both work for your group and are the same specialty.
In black and white: "Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician," CMS says in Section 30.6.5 of the Medicare Claims Processing Manual. "If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level."