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BY AAPC

Part B Insider (Multispecialty) Coding Alert

Reimbursement: An ED Visit and a Hospital Admission on the Same Day? Earn Proper Payment

How can you code for optimal reimbursement if the surgeon sees a patient in the emergency department (ED) and subsequently admits him or her as an inpatient? Although general coding principles prohibit reporting two E/M services on the same date of service, there is a way to receive payment based on the total effort the surgeon provides.

Neurosurgeons often see patients in the ED and, after examination, admit them to the hospital. The pre-admission examination can be extensive, lasting an hour or more in some cases. Under most payers' guidelines (and as explicitly stated in the Medicare Carriers Manual, section 155047[G]), however, the surgeon can report only an initial hospital care code (**CPT 99221** -99223) if the ED visit and subsequent hospital admission occur on the same day.

"You can't bill for two E/M codes on the same day. Most carriers will only pay for one service, and physicians generally choose the code that has the higher reimbursement. That's usually the inpatient history and physical," says **Barry Haitoff**, president of **Medical Management Corporation of America**, a billing and management firm in Brewster, N.Y.

Additionally, according to CPT, the initial hospital care codes include any care provided elsewhere on that date: "When the patient is admitted to the hospital as an inpatient in the course of an encounter in another site of service (e.g., hospital emergency department, observation status in a hospital, physician's office, nursing facility) all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission."

You may, however, consider the work done in the emergency room when determining which level code to use for the admission. CPT advises, "The inpatient care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of services as well as in the inpatient setting." In other words, there is usually overlap between the ED examination and the examination, history and medical decision-making (MDM) associated with the inpatient admission, and you may therefore consider the work involved in the pre-admission ED visit when selecting among the initial care codes.

If You Document It, Use It

When selecting among the initial hospital care codes, documentation is the key to supporting your code selection: If it isn't documented, the payer will assume it wasn't done. "Medical decision-making is generally the deciding factor when choosing an initial care code, because even the lowest-level service requires a 'detailed or comprehensive' history and examination," says **Cindy Parman, CPC**,
CPC-H, co-owner of **Coding Strategies Inc**., an Atlanta-based coding and reimbursement firm. When determining the level of MDM, the physician must consider three factors:

1. Mortality and morbidity. What are the risks of significant complications, death, or comorbidities associated with the patient's presenting problems, diagnostic procedures and/or possible management options?

2. Diagnosis and management options considered. Has a definitive diagnosis been established, or are there differential diagnoses? Will further studies or consultations be performed?

3. Records and tests reviewed. How many and how complex were the tests and medical records that had to be reviewed and analyzed?

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