Eli's Rehab Report

3 Tips Increase Your Discharge Reimbursement of $75-$100

Don't let poor documentation sink your 99238-99239 claims

Physiatrists report hospital discharge codes more often than they report all of the joint/bursa injection codes (20600-20610) combined - so you can't afford to glaze over the requirements for these codes. Increase your chances of collecting the $75 to $100 that Medicare allocates for discharge services with these key documentation details.

If a physician performs surgery and discharges the patient during the global period, he cannot report hospital discharge codes. But because physiatrists often see patients for nonsurgical reasons, PM&R practices can normally report the hospital discharge codes 99238 (Hospital discharge day management; 30 minutes or less) or **CPT 99239** (... more than 30 minutes) for these services.

Scenarios when physicians should report discharge codes include:

1. **Postoperative complications.** When a physiatrist admits a patient for a postoperative complication (such as muscle spasms following a hip replacement) and treats that complication without performing surgery, he can report discharge services.

2. **Trauma not requiring surgery.** Physiatrists may also report discharge services when they admit trauma patients who do not require surgical treatment.

3. **Nonsurgical conditions.** If a physiatrist admits a patient for treatment of nonsurgical conditions like multiple sclerosis, discharge services may be appropriate.

   CPT specifies that you should report 99238 and 99239 for "all services provided to a patient on the date of discharge, if other than the initial date of inpatient status." These codes are time-based, so you should report 99239 only if the physiatrist spends more than 30 minutes performing discharge services.

   Coding experts recommend these three strategies for improving payment for discharge services.

   1. Don't Forego Face-to-Face Meetings

   What should you do if the physiatrist gives a discharge order for a patient, then talks to the nurses and dictates the summary but does not conduct an actual patient exam before the patient leaves the hospital?

   CPT does not directly state that face-to-face encounters are necessary during discharge (leaving it to physicians to determine whether such encounters are appropriate), but the guidelines imply that physicians should meet with patients during the discharge process. Face-to-face contact with patients is inherent in all CPT E/M codes, including discharge summaries, so most coding consultants believe that physiatrists should document that they were physically in the room with
   the patient.

   Indeed, the whole issue of face-to-face encounters with physicians during discharges is controversial, says **Catherine Brink, CMM, CPC**, president of Healthcare Resource Management of Spring Lake, N.J.

   Consult your carrier if you're not sure about face-to-face exam requirements, Brink says. Some payers publish specific

guidelines that address this topic. HGSAdministrators, a Pennsylvania Part B carrier, printed the following in its E/M Documentation Guideline FAQs:

"When a patient is discharged prior to the daily visit by the physician, a discharge day management service can be billed to Medicare if the medical record includes documentation of a service rendered, e.g., instructions for continuing care to all relevant caregivers and preparation of discharge records, prescriptions and referral forms." The insurer states, however, that it "would expect to see that this is rare, and that the majority of the patients that are discharged are seen face-to-face by the physician for a final examination."

2. Count Total Time for 99238 and 99239

Because hospital discharge codes are time-based, the physiatrist must document the total time that he spends with the patient during discharge.

The physician should record start and stop times, Brink says. Including start and stop times shows an auditor that you're conscious of time management, whereas documenting total minutes is less definite.

If you plan to document the total time spent, rather than recording the service provided in time increments, you should make sure that you have enough documentation in the record to demonstrate that you provided the discharge services within 30 minutes or less for 99238, Brink says.

If, for instance, the physiatrist states that he spent 20 total minutes providing all services - including examin-ing the patient, giving instructions on exercise and diet, and completing records - his discharge notes should de-tail all services that he provided in that 20-minute period.

And, if the physician reports 99239, the discharge report should include direct statements such as, "I started the discharge service at 9:00 a.m. and finished at 9:50 a.m." or "I spent a total of 50 minutes providing discharge planning and other services." Physicians should never use 99239 unless they spend more than 30 minutes in discharge planning and document what they did to justify the time, says **Charol Spaulding, CCS-P, CPC, CPC-H**, vice president of Coding Continuum Inc. in Tucson, Ariz. "If they do not document any time at all, then the code should default to 99238," she says.

3. Don't Report Discharges for Same-Day Admits

You should not report the hospital discharge codes 99238-99239 if you admit and discharge a patient on the same date. According to the March 1998 CPT Assistant, "For a patient admitted and discharged from observation or inpatient status on the same date, codes 99234-99236 should be reported as appropriate."

If you discharge an inpatient but admit her to a nursing facility on the same date, you can report both the hospital discharge (99238-99239) and the nursing facility admission code (99303), according to CPT.