Codify
BY AAPC

Psychiatry Coding & Reimbursement Alert

Reader Question: Select Apt Inpatient E/M Depending on Level of Service

Question: On a recent claim, I used a CPT® code for subsequent hospital care to report my psychiatrist's first E/M service with a new patient during their hospital stay. Will the claim be denied?

Nebraska Subscriber

Answer: The answer can be payer specific -- and also may depend on the level of history, physical exam, and medical decision making. Per CPT®, the first hospital inpatient encounter with the patient by the admitting physician should be reported using an initial hospital care code, such as 99221 (Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity ...).

Note that a patient might have multiple initial evaluations in a single day, if multiple physicians from different specialties see him. CPT® directs that for initial inpatient encounters by physicians other than the admitting physician, you should use either initial inpatient consultation codes (99251-99255) or subsequent hospital care codes (99231-99233) as appropriate.

As noted, the answer may vary depending on the payer. For example, Medicare does not recognize the CPT® consultation codes for payment. See section 30.6.9 of chapter 12 of the Medicare Claims Processing Manual for Medicare instructions on proper reporting of inpatient hospital visits. In particular, section 30.6.9.1(F) states, in part, "Physicians may bill initial hospital care service codes (99221-99223), for services that were reported with CPT® consultation codes (99241 99255) prior to January 1, 2010, when the furnished service and documentation meet the minimum key component work and/or medical necessity requirements."

Thus, if your psychiatrist was consulting for another physician on a Medicare patient, he may still report an initial hospital care services code to Medicare, even though he was not the admitting physician. The manual does state that physicians must meet all the requirements of the initial hospital care codes, including "a detailed or comprehensive history" and "a detailed or comprehensive examination" to report CPT® code 99221, which are greater than the requirements for consultation codes 99251 and 99252.

Option: Because some evaluations may not meet the requirements for 99221, carriers shouldn't find fault with those who use a "subsequent" code even if it's the initial service (assuming the subsequent code better describes the level of service). In that case, you might be better served by reporting a subsequent hospital care code, such as 99231 (Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity ...).

Consistent with this approach, section 30.6.9.1(F) of chapter 12 of the Medicare Claims Processing Manual, referenced above, also advises, in part, "Physicians may report a subsequent hospital care CPT® code for services that were reported as CPT® consultation codes (99241 99255) prior to January 1, 2010, where the medical record appropriately demonstrates that the work and medical necessity requirements are met for reporting a subsequent hospital care code (under the level selected), even though the reported code is for the provider's first E/M service to the inpatient during the hospital stay."

CPT® 2023 American Medical Association. All rights reserved.