Inpatient and Observation Services

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CERT data – hospital services

- High error rate for hospital services
- Coverage issues within a practice
- Hospitalist services have their own complexity
- Inaccurate dates due to charge capture issues

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Hospital services

- Initial hospital services 99221-99223
- Subsequent hospital services 99231-99233
- Discharge visits 99238-99239
- Observation visits 99218-99220, 99217
- Admit and discharge same date 99234-99236

Initial hospital care

- Bill on day physician has face-to-face service with patient
- “Initial encounter” not admission, per CPT® definition
- Second visit, same day, same group: so sorry!
- Starting Jan 1 2010: admitting physician uses modifier AI
Hospital services

- Coverage by physicians in same practice
- Different specialties
- Pay for physicians in a group

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Hospital visits

- Subsequent hospital visits are per day, not per visit
- Two physicians from the same group cannot each bill for hospital visit, even if both see the patient
- Physicians from different specialties providing medically-needed services can bill in same day (different dx helps)

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Hospital visits

• Patients admitted during the course of another E/M visit can only be billed for the admission
• The date that the admission is billed should be the same date as the date of the face-to-face service with the MD

Discharge day services

• Time based
• 99238 for less than 30 minutes; 99239 for 30 minutes or more
• Document time in the medical record
Prolonged care

• CPT® definition and CMS definition are different!
• Add-on codes for initial hospital services, inpatient consults, and subsequent hospital visits

CPT®: unit time

• Allows the additional, prolonged services to include unit time
• May be used when the total time for the visit is 30 minutes more than the typical time for that level of service
  – Sort of a moving target, isn’t it?
• Total time must be documented
CMS: face to face time

• Additional 30 minutes must be face-to-face with the patient *not unit time as per CPT®*
• Start and stop time required in medical record, not just total time

Coverage MDs??

• They want to use prolonged services codes for second visit of day
• Requires that the first physician documented time
• For Medicare patients, second visit must be at least 30 minutes face-to-face (not >50%, all of 30 minutes) and start and stop times documented
Observation begins and ends

- With the physician!
- Physician and facility rules very different
- Economic incentives not aligned
- Physicians don’t understand the issues hospitals face in billing these services

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Observation

- Physician designation
- Stay is expected to be longer than 24 hours
- Not for convenience of patient/family/MD
- Not to be used routinely for pre-op and post op
- Medical necessity always needed

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Observation services

• Admission only 99218-99220
• Discharge 99217
• Admit and discharge in same calendar date 99234-99236
• A day versus a date
• Will use Feb 1 to illustrate examples below

What if: #1

• Patient admitted Feb 1 to observation
• Discharged Feb 2 from observation to home
  • Bill 99218-99220 on Feb 1
  • Bill 99217 on Feb 2
What if #2

- Patient admitted Feb 1 to observation
- Patient in observation Feb 2
- Patient discharged from observation to home on Feb 3
- Bill 99218-99220 on Feb 1
- Bill office visit codes Feb 2 (99211-99215) - Medicare rule. CPT® 99499
- Bill 99217 on Feb 3

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What if #3

- Patient admitted to observation at 6 am on Feb 1
- Patient discharged from observation to home on Feb 1 at 7 pm
- Bill 99234-99236
- CMS requires 8 hour stay
- MD must see patient twice, do two separate notes!

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What if #4

- Patient admitted to observation Feb 1
- Patient status changed and admitted to inpatient unit Feb 1
- *Bill only for inpatient, initial services 99221-99223*

What if #5

- Patient admitted to observation on Feb 1
- Patient transferred to inpatient status on Feb 2
- *Bill 99218-99220 on Feb 1*
- *Bill inpatient visit on Feb 2: whichever was performed 99221-99223 (per CMS) or 99231-99233 (per me)*
- *Discharge from observation not billable Feb 2*
- *Bill hospital d/c on date pt goes home, 99238 or 99239*
Critical Care

- High RVU’s for these services
- Often a target for payers
- If time \textit{is not} documented, \textit{always denied}

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Critical Care

- Provided to a critically ill patient
- The location of the service is not determining factor
- Billed using time units: time MUST be documented in medical record
- Need not be continuous
- Physician does not need to be at the bedside the entire time
Critical Care

• Patient must be critically ill
• Physician must be providing critical care services
• Time must be documented in medical record

Critical care, cont.

• Physician cannot provide service to another patient during critical care time
• If the physician must elicit history from family member or use family member for treatment decisions, can count that time if done on the unit
• Immediately available on the unit
• Includes time for bundled procedures
• Time spent performing procedures not part of critical care cannot be included in critical care time
Critical care, cont.

• If less than 30 minutes of critical care, bill E/M service
• Two MD’s of same specialty, same group should bill as one: only one 99291 per day
• Use 99292 as the add on code

Critical care, cont.

• If E/M done earlier in day, and patient later becomes critically ill, can bill both
  – Bill E/M with -25 modifier
• Notes required, so times must be clear
Include in time

• Time at bedside/on floor
• Discussing case with other professionals
• Review of data, writing notes while on unit
• Discussion with family IF need to get history or IF family is making medical decisions for patient
• Providing bundled procedures

Do not include in time

• Explaining patient’s condition to family
• Phone calls from office, other unit
• Providing service to any other patient
• Performing services not bundled into critical care
99233

- High error rate
- 2 of 3 of history, exam and MDM
- Consider medical necessity

What is required for the history?

- History: 4 HPI elements, 2 systems in ROS
- Physicians often skimp on history
- “Patient eating her lunch”
- Ask physician to document patient’s condition since yesterday, either from nurses or patient
What is required for exam?

- 12 bullets from the 1997 exam
- An extended exam of 2-7 body areas/organ systems

Start with the exam for 99232

- Typical exam is:
  - VSS, Cardio, Respiratory, Abdomen, Extremities, and orientation
- If physician wants to bill a 99233, and exam is one of the components, add to their typical exam!
  - I suggest adding detail that relates to the patient’s illnesses/conditions
High complexity MDM

- A patient with multiple problems, one of which is described as severe
- Or, one is life threatening
- Multiple problems and drug treatment high toxicity
- Acute change in mental status

And, if they really want to bill a 99233

DICTATE IT!
Documentation problems with hospital services

• Subsequent visits
  – Can’t read
  – Can’t verify signature
  – No reason for visit
  – No subjective section at all
  – A/P: Stable, continue

Documentation woes

• Initial hospital services
  – Non contributory, unremarkable
  – WNL = We Never Looked
  – Normal exam findings not described for presenting problem
  – ROS, FH
Short stay forms

- Not enough room to document service at the lowest level of admission
  - Dictate, dictate, dictate

Hospitalists

- Their role in post-op management
- Coverage
- Consult, admission, subsequent care
Called to ED to see your own patient

- Not a consult
- Different rules depending on payer
- For CPT®: Use office/outpatient codes 99201—99215 (probably not new if called to see your own patient)
- For CMS: Use ED codes 99281--99285

Called to ED in consultation

- For Medicare: ED visits, 99281-99285
- For payers still recognizing consults: outpatient consultation codes 99241--99245
Medicare citations

• http://www.cms.hhs.gov/manuals/iom/List.asp
• Publication 100-04, Chapter 12, Section 30

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