Objectives

• Participants will be educated on the documentation requirements for Initial and Subsequent Hospital Care, Inpatient Consults, Hospital Discharges, Observation, and Critical Care Services
• Participants will be able to appropriately select the level of service supported by their documentation for all of the above categories
• Participants will be educated on the appropriateness of coding split/share care
Quick Review of Definitions - History

• HPI: History of Present Illness
  – Location, Duration, Quality, Severity, Timing, Context, Modifying Factors, Associated S/S

• ROS: Review of Systems
  – Constitutional, Eyes, ENMT, Cardio, Resp, GI, GU, MS, Integumentary, Neuro, Psych, Endocrine, Heme/Lymph, Allergic/Immunologic

• PFSH: Past Medical, Family and Social History
  – Medical: Current meds, Allergies, Illnesses/Injuries, etc.
  – Family: Ø negative or noncontributory
  – Social: Marital status, Tob/Alcohol, Education, Employment, etc.

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Quick Review of Definitions - History

• DG: If the physician is unable to obtain a history from the patient or other source, the record should describe the patient’s condition or other circumstance that precludes obtaining a history
  – History can be obtained from:
    • Family members/friends
    • Chart
    • Nursing or other staff

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Quick Review – Time and Counseling

• “When counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter, then time may be considered the key or controlling factor to qualify for a particular level of E/M services.”

• When billing based on time, the provider needs to document the total time and either that ‘greater than 50% was spent in counseling’ or the exact number of minutes spent in counseling

• There needs to be a brief summary of the content discussed

Quick Review – Time and Counseling

• Times listed in CPT® should be considered threshold times and should ‘round up’

• Physicians may count only the duration of direct face-to-face contact between the physician and the patient (whether the service was continuous or not) beyond the typical/average time of the visit code billed to determine whether prolonged services can be billed and to determine the prolonged services codes that are allowable
Initial Hospital Care

99221-99223

• Doesn’t recognize new or established status
• Needs 3 of 3 key elements – OR –
• Service can be billed on floor/unit time
• Service can be split/shared
• Physician order to admit to inpatient
Initial Hospital Care

- Initial Hospital Care ≠ Hospital Admission
- Intended to be reported for the first hospital inpatient encounter with the patient by the physician.
- “AI” = Principal Physician of Record (Medicare modifier)

According to Principles of CPT® Coding, “For example, the physician provides an E/M service to the patient in the office on Wednesday and subsequently admits the patient to the hospital on the same day. However, the physician does not have an inpatient encounter with that patient until Thursday morning. The appropriate office E/M service is reported for Wednesday and the date of service for the Initial Hospital Care will be Thursday’s date.”
Initial Hospital Care

• “When the patient is admitted to the hospital as an inpatient in the course of an encounter in another site (ie office), all E/M 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.” (CPT® 2010)

Initial Hospital Care

• If the Initial Hospital Care service is split/shared between two providers, both providers need to personally document what components of service they performed
• It must be clear from the documentation that both providers had a face-to-face encounter with the patient and personally performed at least one of the 3 key elements: history, exam or medical decision-making
Split/Shared Care Documentation

- A split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service.
- The physician and the qualified NPP must be in the same group practice or be employed by the same employer.

Inappropriate Split/Shared Care Documentation

- “I have personally seen and examined the patient independently, reviewed the PA's Hx, exam and MDM and agree with the assessment and plan as written” signed by the physician
- “Patient seen” or “Seen and examined” and signed by the physician
- “Seen and examined and agree with above” (or “agree with plan”), signed by the physician
Inappropriate Split/Shared Care Documentation

- “As above” signed by the physician
- Documentation by the NPP stating “The patient was seen and examined by myself and Dr. X., who agrees with the plan” with a co-sign of the note by Dr. X
- No comment at all by the physician, or only a physician signature at the end of the note

Split/Shared Care

- When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's UPIN/PIN number
- If there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient’s medical record) then the service may only be billed under the NPP's UPIN/PIN
### Initial Hospital Care

<table>
<thead>
<tr>
<th></th>
<th>99221-Level I</th>
<th>99222-Level II</th>
<th>99223-Level III</th>
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<tr>
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<tr>
<td>MDM</td>
<td>Straightforward/Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

- **Like family™**

### Initial Hospital Care

- **Time**
  - Typically 30 min
  - Typically 50 min
  - Typically 70 min

- **Unit/floor time includes:**
  - Provider present on patient’s hospital unit and at the bedside rendering services to the patient
  - Reviewing the patient’s chart
  - Examining the patient
  - Writing notes/orders
  - Communicating with other professionals and the patient’s family on the patient’s floor

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Subsequent Hospital Care

99231-99233

- Doesn’t recognize new or established status
- Needs only 2 of 3 key elements – OR –
- Service can be billed on floor/unit time
- Service can be split/shared
- Only need ‘interval’ history
  - It is not necessary to record information about the PFSH
- Need to document CC, pertinent HPI and ROS
- Assessment and Plan should be documented for each service
- Codes are ‘per day’
  - If two or more providers from the same specialty perform a medically necessary visit, the accumulation of both providers’ work can only be billed under one of the providers
Subsequent Hospital Care

<table>
<thead>
<tr>
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<td></td>
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<td>• HPI: 1-3</td>
<td>• HPI 4+</td>
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<tr>
<td></td>
<td>• ROS: n/a</td>
<td>• ROS: 1+</td>
<td>• ROS 2-9</td>
</tr>
<tr>
<td></td>
<td>• PFSH: n/a</td>
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<td>• PFSH (1 of 3)</td>
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<td>Exp Prob Focused</td>
<td>Detailed</td>
</tr>
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<td>2-7 body areas or organ systems</td>
<td>2-7 body areas or organ systems</td>
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<td><strong>MDM</strong></td>
<td>Straightforward/Low</td>
<td>Moderate</td>
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</tr>
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</table>

- **Unit/floor time includes:**
  - Provider present on patient’s hospital unit and at the bedside rendering services to the patient
  - Reviewing the patient’s chart
  - Examining the patient
  - Writing notes/orders
  - Communicating with other professionals and the patient’s family on the patient’s floor
Inpatient Consults

99251-99255

Inpatient Consults…according to Medicare

• Effective January 1, 2010, the consultation codes are no longer recognized for Medicare part B payment
• In the inpatient hospital setting all physicians (and qualified nonphysician practitioners where permitted) who perform an initial evaluation may bill the initial hospital care codes (99221-99223)
Inpatient Consults…according to Medicare

- “The intent of a consultation service is that a physician or qualified NPP or other appropriate source is asking another physician or qualified NPP for advice, opinion, a recommendation, suggestion, direction, or counsel, etc. in evaluating or treating a patient because that individual has expertise in a specific medical area beyond the requesting professional’s knowledge.”

(CMS transmittal 788, Change Request 4215, December 2005)

Inpatient Consults…according to CPT®

- Only one consultation reported by consultant per admission
- If inpatient consult is performed on date that patient is admitted, all E/M services ⇒ 99251-99255
- However, if inpatient consult and admission services are provided on the same date, by the same provider, then may report either ⇒ 99251-99255  - OR - 99221-99223
- If outpatient consult performed and patient subsequently admitted, but physician does not have face-to-face with patient in the hospital ⇒ 99241-99245
Inpatient Consults…according to CPT®

- New verbiage for 2010
  “A consultation is a type of E/M service provided by a physician at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient’s entire care or for the care of a specific condition or problem.”

Inpatient Consultation…according to CPT®

- Before: “The written or verbal request for a consult may be made by a physician or other appropriate source and documented in the patient’s medical record.”
- Now: “The written or verbal request for consult may be made by a physician or other appropriate and documented in the patient’s medical record by either the consulting or requesting physician or appropriate source.”
Inpatient Consultation…according to CPT®

• Verbiage that hasn’t changed:
  – “The consultant’s opinion and any services that were ordered or performed must also be documented in the patient’s medical record and communicated by written report to the requesting physician or other appropriate source.”
  • ‘Written report may be part of a common medical record or in a separate letter’ = Medicare verbiage

“‘A physician consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.’

Inpatient Consults

<table>
<thead>
<tr>
<th>History</th>
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<td>PFSH: n/a</td>
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<td>Exp Prob Foc</td>
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<td>HPI 4+</td>
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<td>ROS 2-9</td>
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<td>ROS 10-14</td>
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<td>PFSH (3 of 3)</td>
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</table>

| Exam 1995 DGs    |       |       |       |       |       |
| Prob Foc 1 body area/organ system | Exp Prob Foc 2-7 body areas or organ systems | Detailed 2-7 body areas or organ systems | Comp 8 organ systems |

| MDM              |       |       |       |       |       |
| Straightforward   |       | Low   |       |      Mod | High |

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Inpatient Consults

<table>
<thead>
<tr>
<th></th>
<th>99251</th>
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<th>99254</th>
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<tbody>
<tr>
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<td>40 min</td>
<td>55 min</td>
<td>80 min</td>
<td>110 min</td>
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</table>

• Unit/floor time includes:
  – Provider present on patient’s hospital unit and at the bedside rendering services to the patient.
  – Reviewing the patient’s chart
  – Examining the patient
  – Writing notes/orders
  – Communicating with other professionals and the patient’s family on the patient’s floor

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Hospital Observation Services

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Hospital Observation Services

- Dated and timed physician’s admitting orders regarding the care the patient is to receive while in observation
  - Admit to inpatient care or observation care??
- Physician should document his/her physical presence
- Physician should document his/her provision of observation care

Hospital Observation

- Provider should document the number of hours the patient remained in the observation care status
- Provider should personally document the admission and discharge note

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Observation Billing

<table>
<thead>
<tr>
<th>Same Calendar Day</th>
<th>Two Calendar Days</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Care</strong></td>
<td><strong>Inpatient Care</strong></td>
</tr>
<tr>
<td>&lt; 8 hours 99221-99223</td>
<td>&gt;8 hours 99234-99236</td>
</tr>
<tr>
<td>☐ Discharge code</td>
<td>Provider must see twice</td>
</tr>
<tr>
<td>&gt; Day 1: 99218-99220</td>
<td>Hour 99218-99220</td>
</tr>
<tr>
<td>&lt; 8 hours 99218-99220</td>
<td>&gt;8 hours 99234-99236</td>
</tr>
<tr>
<td>☐ Discharge code</td>
<td>Provider must see twice</td>
</tr>
</tbody>
</table>

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Hospital Observation Services

- **99218-99220**
  - Patients must be admitted as ‘observation status’ in a hospital
  - Used to report initial observation care
  - Do not recognize new or established
  - Must meet 3 of 3 key elements
  - If patient admitted to observation status in the course of an E/M in another site, all E/M services provided by the provider are considered part of the initial observation care when performed on the same date

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Hospital Observation Services

- **99234-99236**
  - Documentation stating the stay for hospital treatment or observation care status involves 8 hours but less than 24 hours on same calendar day
  - Documentation identifying the billing provider was present and personally performed the services
  - Documentation identifying the admission and discharge notes were written by the billing physician

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Hospital Observation Services

• If the documentation does not support the minimum requirements for codes 99218-99220, 9921-99223 or 99234-99236 then report the Unlisted E/M Service code (99499)

• When a physician performs a visit that meets the definition of a Level 5 office visit several days prior to an admission and on the day of admission performs less than a comprehensive history and physical, he or she should report the office visit that reflects the services furnished and also report the lowest level initial hospital care code (i.e., code 99221) for the initial hospital admission – Contractors pay the office visit as billed and the Level 1 initial hospital care code

Hospital Observation Services

• If a patient is admitted to the hospital after receiving hospital observation care services on the same date, only the initial hospital care code (eg, 99222) is reported

• The initial hospital care code selected to report the services related to both the observation care and initial hospital care should include all of the E/M services provided on that date by the attending physician
Hospital Observation Services

• Currently, there are no CPT® instructions on how to code hospital observation services provided on more than two dates (ie, a patient is admitted to observation status at 8:00 PM on March 1, continues to be observed on March 2, and is discharged from observation status on March 3 at 1:00 PM)

• CPT® Assistant advised using the unlisted E/M service code 99499 for March 2

Hospital Observation Services

• According to Medicare, “In the rare circumstance when a patient is held in observation status for more than two calendar dates, the physician must bill subsequent services furnished before the date of discharge using the outpatient/office visit codes.”
Observation Care Discharge Services

- 99217
  - Final examination of the patient
  - Discussion of the hospital stay
  - Instructions for continuing care
  - Preparation of discharge records

Hospital Discharge Services

99238-99239
Hospital Discharge Services

- Final examination
- Discussion of hospital stay and plan of care to patient and/or all relevant caretakers
- Preparation of discharge records, prescriptions and referral forms
- Must document total time spent performing the above activities

According to WPS, “There must be documentation supporting a face-to-face encounter when billing a discharge service on the date of death. If the provider does not see the patient prior to the time of death or make the pronouncement of death face-to-face, no E/M service may be billed for that date of service.”
Hospital Discharge Services

- According to the AMA from March 1998 CPT Assistant, if a patient dies in the hospital, and the physician is present to pronounce the patient's death, completes the death summary, and talks with the deceased patient's family the appropriate hospital discharge code, 99238-99239 can be reported in the case of a patient death

Providers shall report either 99238 or 99239 for the date the actual visit even if the patient is discharged on a different calendar date:
- 99238: 30 minutes or less
- 99239: more than 30 minutes
- Service can be split/shared
Critical Care Services - Adult

99291-99292

Critical Care Services

- Definition: ‘A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient’s condition; and

- The physician must devote his/her full attention to the patient and, therefore, cannot provide services to any other patient during the same time period.’ (CPT® 2010)
Critical Care Services

- Critical care services do not have to be provided in a critical care unit
- Seeing a patient in the critical care unit does not automatically constitute critical care
- Only one physician can bill for any one minute of critical care provided
- The care of critically ill and unstable patients requires constant physician attention
- Cannot be split/shared with a NPP and a physician

Critical Care Services

- It involves decision making of high complexity to assess, manipulate, and support circulatory, respiratory, central nervous, metabolic, or other vital system function to prevent or treat single or multiple vital organ system failure
- Often also requires extensive interpretation of multiple databases and the application of advanced technology to manage the critically ill patient
Critical Care Services

• Critical care services are time based:
  – Time does not need to be continuous
  – Total time must be documented in the medical record
    • ‘Critical care is a time-based service, and for each date and encounter entry, the physician's progress note(s) shall document the total time that critical care services were provided.’ (Medicare IOM)
  – Critical care can be reported on multiple days

• Definition of Time:
  – Time spent engaged in work directly related to the individual patient’s care whether at the bedside or elsewhere on the floor/unit.
    • Reviewing test results/imaging studies;
    • Discussing the case with other medical staff;
    • Documenting in chart;
    • Counseling with family members, if patient is incompetent to participate in discussions.
Critical Care Services

- Family discussions only if the patient is unable or incompetent to participate in giving history and/or making treatment decisions
- The necessity to have the discussion (e.g., “no other source was available to obtain a history” or “because the patient was deteriorating so rapidly I needed to immediately discuss treatment options with the family”)
- Medically necessary treatment decisions for which the discussion was needed
- A summary in the medical record that supports the medical necessity of the discussion

Critical Care Services Includes

- The interpretation of cardiac output (93561, 93562)
- Chest x-rays (71010, 71015, 71020)
- Pulse oximetry (94760, 94761, 94762)
- Blood gases and information data stored in computers (ECGs, BPs, hematologic data (99090))
- Gastric intubation (43752, 91105)
- Temporary transcutaneous pacing (92953)
- Ventilatory management (94002-94004, 94660, 94662)
- Vascular access procedures (36000, 36410, 36415, 36540, 36600) (CPT® 2010)
### Critical Care Services

- Cardiopulmonary resuscitation (CPR, code 92950) is reported separately from critical care services, but the time spent performing CPR is not counted toward determining total critical care time.
- The time spent performing CPR is subtracted from the total critical care time
- Time spent performing separately reportable procedures/services also needs to be subtracted from the total critical care time

### Services Not Supporting Critical Care

- Daily management of a patient on chronic ventilator therapy does not meet the criteria for critical care
- Providing medical care to a critically ill patient should not be automatically deemed to be a critical care service for the sole reason that the patient is critically ill or injured
- Routine daily updates or reports to family members and/or surrogates
Critical Care and E/M

- Which came first…the chicken or the egg?
- Which came first…the E/M or the critical care?
- E/M ⇒ CC ⇒ both billable
- CC ⇒ E/M ⇒ only CC billable

Critical Care Services – Pediatric/Neonatal
Inpatient Pediatric/Neonatal Critical Care

- Same definitions for critical care services apply as for the adult – Codes are reported once per day
- Pediatric: 29 days through 24 months of age
  - 99471: Initial inpatient pediatric critical care
  - 99472: Subsequent inpatient pediatric critical care
- Neonatal: 28 days of age or less
  - 99468: Initial inpatient neonatal critical care
  - 99469: Subsequent inpatient neonatal critical care

Inpatient Pediatric/Neonatal Critical Care

- Pediatric: 2 through 5 years of age
  - 99475: Initial inpatient pediatric critical care
  - 99476: Subsequent inpatient pediatric critical care
Inpatient Pediatric/Neonatal Critical Care

- Services included/bundled
  - Peripheral vessel catheterization (36000)
  - Other arterial catheters (36140, 36620)
  - Umbilical venous catheters (36510)
  - Central vessel catheterization (36555)
  - Vascular access procedures (36400, 36405, 36406)
  - Vascular punctures (36420, 36600)
  - Umbilical arterial catheters (36660)
  - Endotracheal intubation (31500)
  - Ventilatory management (94002-94404)
  - Bedside pulmonary fx testing (94375)

Inpatient Pediatric/Neonatal Critical Care

- Surfactant administration (94610)
- CPAP (94660)
- Monitoring/interpretation of blood gases or oxygen sats (94760-94762)
- Blood transfusion (36430, 36440)
- Oral or nasogastric tube placement (43752)
- Suprapubic bladder aspiration (51100)
- Bladder catheterization (51701, 51702)
- Lumbar puncture (62270)
Continuing Intensive Care Services

- Do not meet the definition of critically ill
- **99477**: Initial hospital care, per day, for E&M of neonate 28 days of age or less, who require intensive observation, frequent interventions, or other intensive care services
- **99478**: Subsequent intensive care, per day, for E&M of the recovering VLBW infant (<1500gm)
- **99479**: Subsequent intensive care, per day, for E&M of the recovering LBW infant (1500-2500 gm)
- **99480**: Subsequent intensive care, per day, for E&M of the recovering infant (2501-5000 gm)

Newborn ‘Admissions’

- **99460**: Initiation of inpatient care normal newborn
- **99221-99223**: Initiation of inpatient care of newborn with medical problem/concern
- **99477**: Initiation of inpatient care of newborn requiring intensive monitoring, but not critically ill
Summary

- Perform only that which is medically necessary
- Document what you do
- Code what you document