Coding, Billing & Documentation for the Hospitalist

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Objectives

- Participants will learn appropriate billing guidelines for hospitalist services
- Participants will become familiar with different coding scenarios specific to hospitalists
- Participants will be able to document their services and choose the correct level based on their documentation
- Participants will identify areas of documentation that have potential gaps

Common Codes For Hospitalists

- Initial Hospital Care (99221 -99223)
- Subsequent Hospital Care (99231-99233)
- Observation/Inpatient Care (99234-99236)
- Initial and Subsequent Observation & Discharge (99218-99220, 99224-99226, 99217)
- Hospital Discharge (99238, 99239)
- Critical Care (99291, 99292)

Initial Hospital Care

99221-99223

Initial Hospital Care

	99221 Level I	99222 Level II	99223 Level III
History	Detailed •HPI 4+ •ROS 2-9 •PFSH (2 of 3)	Comp •HPI 4+ •**ROS 10-14** •**PFSH (3 of 3)**	Comp •HPI 4+ •**ROS 10-14** •**PFSH (3 of 3)**
Exam	Detailed	**Comprehensive**	**Comprehensive**
MDM	Straightforward/Low	Moderate	High
Time	Typically 30 min	Typically 50 min	Typically 70 min

Initial Hospital Care

- CPT® Codes 99221-99223
- Documentation must meet 3 of 3 key elements
- Physician order must be for *inpatient*
- Service can be split/shared
  - Both providers must personally document the components personally performed
  - Both providers billing a split/shared visit must be employed by the same group

Hospital Admits ≠ Initial Hospital Care

- Initial hospital care codes should be billed <u>on the date the face-to-face service actually occurs</u> (*Principles of CPT Coding*)
- If physician admits from a different site of service, all other services provided are considered part of the admission (CPT ® 2011)
- **Medicare patients**: Multiple initial hospital care codes can be billed be for the same encounter by multiple providers for the same patient

Initial Hospital Modifier
"Medicare Only"

AI – Principal Physician of Record
- Informational modifier
- Used by "admitting" physician on initial hospital care codes

History
Review of Definitions

- HPI: History of Present Illness *(Chief Complaint Required)*
  - Location, Duration, Quality, Severity, Timing, Context, Modifying Factors, Associated Signs & Symptoms
- *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: ∅ negative or noncontributory*
  - Social: Marital status, Tobacco/Alcohol, Education, Employment, etc

ROS Example

- Review of systems: A 10-point review of systems is otherwise negative. No fever or chills. No chest pain. No other complaints.

- If a complete ROS was medically necessary to be performed and a complete *14 organ system* was reviewed, more appropriate verbiage would be:

  ROS: No chest pain, fever or chills, all other systems reviewed and were negative

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 which precludes obtaining a history
  - History can be obtained from:
    - Family members/friends
    - Chart
    - Nursing or other staff

Family History

Family history: noncontributory
  - Frequently seen with elderly patients.
  - Code 99222 and 99223 require family history
- Non-contributory = family history not documented
- Preferred verbiage
  - Family history: negative for heart disease

Exam "Tips"

- Neck supple ≠ No neck lymphadenopathy
- Extremities are body parts and several different organ systems could be examined, specify what was examined
- HEENT: acronym, need to specify
- 95 DG Comprehensive – 8 organ systems
- 97 DG Comprehensive – 2 bullets in each of 9 body systems
- Look for other medically necessary systems
  - Neuro, Psych, etc.

Initial Hospital Care

- Unit/Floor time includes:
  - Provider present in the hospital unit and/or at the bedside of the patient
  - Reviewing the patient's chart,
  - Examining the patient,
  - Writing notes/orders,
  - Communicating with other professionals and the patient's family on the floor

Split/Shared 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
Non-Qualifying Documentation

- "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

- "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

Split/Shared Care

Non-Qualifying 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 Qualifying Examples

- Upon examination, wound appears to be pinking up well, continue dressing changes as ordered. Agree with NP's history and plan.

- Mr. Jones lungs sound better today and he reports less shortness of breath at night. Reviewed and agree with NP's plan.

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Subsequent Hospital Care

99231 - 99233

Subsequent Hospital Care

	99231 Level I	99232 Level II	99233 Level III
History	Prob Focused •HPI: 1-3 •ROS: n/a •PFSH: n/a	Exp Prob Focused •HPI: 1-3 •ROS: 1+ •PFSH: n/a	Detailed •HPI 4+ •ROS 2-9 •PFSH: n/a
Exam	Prob Focused	Exp Prob Focused	Detailed
MDM	Straightforward/Low	Moderate	High
Time	Typically 15 min	Typically 25 min	Typically 35 min

Subsequent Hospital Care

- Requires 2 of the 3 key elements
- 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
  - Service can be split/shared

"Interval History"

DG: A ROS and/or PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. The review and update may be documented by:

- Describing any new ROS and/or PFSH information or noting there has been no change in the information; and
- Noting the *date and location* of the earlier ROS and/or PFSH

Inpatient Consultations

99251-99255

Inpatient Consults: Medicare

- Use the Initial Hospital Care codes
  - 99221-99223
- If documentation doesn't meet lowest level (99221) report the appropriate Subsequent Hospital Care code (99231-99233)

Consultations

- CPT® Guideline - Concurrent Care

> "Concurrent care is the provision of similar
> services (eg, hospital visits) to the same patient
> by more than once physician on the same day.
> When concurrent care is provided, no special
> reporting is required."

Concurrent Care in Global Surgery

The Medicare physician fee schedule payment amount
for surgical procedures includes all services (e.g.,
evaluation and management visits) that are part of the
global surgery payment; therefore, contractors shall
not pay more than that amount when a bill is
fragmented for staged procedures.

IOM 100-04, Chapter 12, 30.6.9.2 (A)

Consultations

- CPT ®Guideline

  "A consultation is a type of evaluation and management 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."

Consultations

- CPT® Guideline
  - Written or verbal request <u>MUST</u> be made by physician or appropriate source and....
    - Documented in patient's medical record by either...
      - Requesting physician or appropriate source; or
      - The consulting physician

Consultations

- CPT® Guidance

  "Consultation codes should not be reported by the physician who has agreed to accept transfer of care **before** an initial evaluation…"

  - Consultation codes may be reported if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service.

Consultations

- CPT® Guidance
  - If the receiving physician agrees to provide management for "some or all" of a patient's condition prior to the initial evaluation, it is not appropriate for the receiving physician to report a consultation code

Observation Services

CPT Codes for Observation

- Initial Observation Care
  - 99218-99220
  - Used when stay is less than 8 hours on the same calendar day or the stay is greater than one calendar day
  - Only billed by admitting physician
- Observation Discharge
  - 99217
- Observation or Inpatient Hospital Care
  - 99234-99236
  - Used when stay is greater than 8 hours on the same calendar day

Observation Services

Same Calendar Day		Two Calendar Days	
Inpatient Care		**Observation Care**	
< 8 hours 99221-99223 ∅ Discharge code	>8 hours 99234-99236 Provider must see twice	Day 1: 99218-99220 Day 2: 99217	
Observation Care		**Documentation Insufficient?**	
< 8 hours 99218-99220 ∅ Discharge code	>8 hours 99234-99236 Provider must see twice	If the documentation doesn't meet the lowest level of service, report 99499	

Observation Documentation

- Dated and timed physician's admitting orders regarding the care the patient is to receive while in observation
  - *Admit to "Observation" & reason*
- Physician should document his/her physical presence
- Physician should document his/her provision of observation care

Observation Documentation

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

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

Subsequent Observation Coding

- CPT® codes 99224-99226
  - New for 2011
- Place of service is outpatient (22)
- **Medicare** vs. CPT® guidelines
  - Billed **ONLY** by the admitting physician
  - All other physicians bill 99201-99215 as appropriate
- Commercial payers
  - Seek guidance

Guidance on Admission Decisions

- MLN Matters SE 1037
- http://www.cms.gov/MLNMattersArticles/Downloads/SE1037.pdf
  - The severity of the signs and symptoms exhibited by the patient
  - The medical predictability of something adverse happening to the patient
  - The need for diagnostic studies that appropriately are outpatient services to assist with determination

Observation Discharge

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

Hospital Discharge

99238 - 99239

Hospital Discharge Documentation

- Final examination
  - 99238: < 30 minutes
  - 99239: > 30 minutes
- 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*

Hospital Discharge Documentation

According to Medicare, "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 Documentation

According to the AMA *CPT® Assistant*, March 1998, 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

Additional Documentation Information

- Should be billed on the actual day face to face occurs
- If more than 30 minutes spent on discharge services, time must be documented in the medical record to support billing the 99239 code
- If medically necessary, subsequent visits can be billed on the "actual discharge day"
- Physician must be physically present to pronounce death

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® 2011)

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

Reporting and Documenting Time

- The critical care time you bill can include only the time that is devoted solely to one patient
- Time does not need to be continuous
- Time spent in the following activities can count toward the critical care time:
  - Time spent at the bedside with the patient
  - Time spent on activities that contribute to the patient's care, such as reviewing old records and lab and imaging results, and consulting with other physicians
  - Time spent with family, whether to obtain a history or to discuss treatment options when a patient is unable to participate

Critical Care Inclusions

Below are services included in Critical Care that can not be billed separately

These include:
- Gastric intubation (43752, 43753)
- Interpretation of blood gases
- Interpretation of data stored in computers such as ECG's, blood pressure, hematological data (99090)
- Interpretation of cardiac output (93561-93562)
- Interpretation of chest x-rays (71010-71020)
- Pulse Oximetry (94760-94762)
- Temporary transcutaneous pacing (92953)
- Vascular access procedures (36000, 36410, 36415, 36591, 36600)
- Ventilator management (94002-94004, 94660, 94662)

Critical Care Services

- Cardiopulmonary resuscitation (CPR, code 92950) is reported separately from critical care services, and the time spent performing CPR is not counted in total critical care time
- The time spent performing CPR is subtracted from the total critical care time
- Time spent performing separately reportable procedures needs to be subtracted from the total critical care time

Critical Care Documentation Example

- Please note critical care time: 45 minutes beyond all billable procedure spent entirely focused on this patient's care
- Critical care time began upon arrival at 1306 hours. Time out of the room was 2036 hours. Over the course of the patients ED stay, a total of 120 minutes was spent in critical care delivery. This time does not include time spent performing other billable services.

Documentation Do's

- Additional key elements to include in documentation:
  - Interventions taken to keep the patient from imminent or life threatening deterioration
  - The high complexity of decision-making and thought processes that kept the patient from either deteriorating or further deterioration
  - Specifics of what was done to support vital system functions or to address any organ failure, including labs, x-rays and/or medical tests/procedures
  - Time spent providing critical care services
  - State "excludes" time spent performing separately billable services

Billing Scenarios

www.cms.hhs.gov/manuals

Scenario 1

Dr. Williams, a hospitalist, admits Mrs. Jones to the hospital from the ED at 11:30 am. He performs and documents an initial hospital care code of 99222. At 11:30pm, Dr. Adams another hospitalist in the same group, (same specialty) sees Mrs. Jones and additional medical decision making occurs related to the admitting diagnosis. Can Dr. Adams bill for his visit?

Answer 1

"If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician."

IOM 100-04, Chapter 12, Section 30.6.5

Scenario 2

An orthopedic surgeon admits a Medicare patient from the ER and plans surgery for a hip fracture the next day. He requests that Dr. Smith, the internal medicine hospitalist, see the Medicare patient on the same day for chronic hypertension and pre-operative clearance.

How would this be billed?

Answer 2

The orthopedic surgeon will bill for the initial hospital care (99221–99223) and use modifier AI to indicate he is the principal physician of record. The hospitalist will bill another initial hospital code (99221-99223) based on what was performed and documented.

Scenario 3

Following the hip replacement surgery, the orthopedic surgeon requests the consulting hospitalist to manage the hypertension of the patient during the surgical global period while the patient remains in the hospital.

What codes would the hospitalist report?

Answer 3

The hospitalist would need to report the appropriate subsequent hospital codes for the services performed related to the hypertension.

IOM 100-04, Chapter 12, Section 30.6.10 (H)

Scenario 4

Hospitalist is called by the nurse at 6:45 am to pronounce death. The hospitalist is face to face with the patient and pronounces death. A discharge summary is dictated.

Is this billable?

Answer 4

Only the physician who personally performs the pronouncement of death shall bill for the face-to-face Hospital Discharge Day Management Service, CPT code 99238 or 99239. The date of the pronouncement shall reflect the calendar date of service on the day it was performed even if the paperwork is delayed to a subsequent date.

IOM 100-04, Chapter 12, Section 30.6.9.2 (E)

Scenario 5

Patient is admitted by general surgeon for elective surgery on Monday. The surgeon does not have a face to face visit with the patient in the hospital until Tuesday morning. Hospital protocol requires that a hospitalist round all patients on the day of admission. A hospitalist performs a routine visit on the patient during evening rounds.

What can the hospitalist bill?

Answer 5

The answer is nothing. Per CMS, if the hospitalist was called to see the patient due to medical necessity (not protocol), a subsequent visit would be payable.

Scenario 6

Hospitalist admits patient at 9am documenting and performing a 99222. The patient expires at 3pm. The hospitalist is face to face with the patient and pronounces death. A dictated discharge summary is performed.

What can be billed by the hospitalist?

Answer 6

Carriers pay only the initial hospital care code when a patient is admitted as an inpatient and discharged on the same day. They do not pay the hospital discharge management code on the date of admission. Carriers must instruct physicians that they may not bill for both an initial hospital care code and hospital discharge management code on the same date.

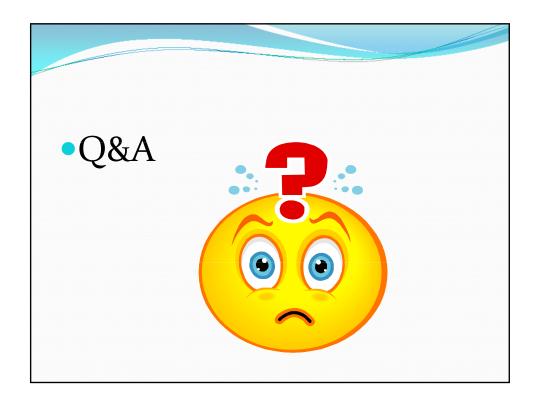**IOM 100-04, Chapter 12, Section 30.6.9.1 (C)**

Scenario 7

Hospitalist A sees the patient on 7/20 and completes the discharge summary. Patient is scheduled for discharge on 7/21 in the morning. Hospitalist B rounds prior to the discharge and sees the patient briefly.

What is billed?

Answer 7

The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified nonphysician practitioner even if the patient is discharged from the facility on a different calendar date.

IOM 100-04, Chapter 12, 30.6.9.2 (B)

7/20 – Bill Hospital Discharge

7/21 – Potentially could bill subsequent visit

- Q&A

Disclaimer

The information presented and responses to the questions posed are not intended to serve as coding or legal advice. Many variables affect coding decisions and any response to the limited information provided in a question is intended only to provide general information that might be considered in resolving coding issues. All coding must be considered on a case-by-case basis and must be supported by appropriate documentation in the medical record. Therefore, the Wisconsin Medical Society recommends consulting directly with payers to determine specific payers' guidance regarding appropriate coding and claim submission. The CPT® codes that are utilized in coding claims are produced and copyrighted by the American Medical Association (AMA). Specific questions regarding the use of CPT® codes may be directed to the AMA.