Hot topics in Coding

A collection of articles from Today’s Hospitalist’s Coding Columns
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In response to my May Q&A, I received some comments stating that I had given a wrong answer to a question. The question: whether a hospitalist could bill for time spent evaluating a patient in the ED if the patient was ultimately discharged from the ED to home. I noted in my column that I didn’t think the hospitalist time was billable, and some readers vigorously disagreed.

In this month’s column, we’ll take a look at some ED billing scenarios. As usual, details count: In some scenarios, there are two physicians seeing a patient in the ED and each can bill for services. In others, that’s not the case, or the ED visit by the hospitalist should be bundled into an initial hospital care or observation service.

Who can bill what?
Sometimes, it’s very clear that two doctors can bill for separate services in the ED, or that only one of them should. Take, for instance, a patient who comes in with arm pain and swelling from a fall off a ladder. When the ED physician evaluates the patient, X-rays reveal a closed right forearm fracture of both the ulna and radius.

Because the patient is older and has had a previous fracture in the same extremity, the ED physician contacts an orthopedist to come and evaluate the patient. In the ED, the orthopedist performs that evaluation and applies a temporary splint to keep the fractures stable until the swelling goes down and a cast can be applied.

Clearly, both of these doctors can bill for services. The ED physician should bill an E/M code (ED visits, 99281-99285), while the orthopedist can bill either a visit from that same code range or an office or outpatient service code (99201-99215), depending on whether the orthopedist considers the patient new or established.

But consider another scenario: A patient contacts his outpatient internist’s office complaining of shortness of breath. The physician is at the hospital and agrees to meet the patient in the ED to evaluate his breathing.

Once the patient arrives and is registered, triaged and placed in a room, his primary care physician joins him almost immediately. That doctor evaluates the patient and orders blood work and a chest film, which shows right lower lobe pneumonia.

In this case, the ED doctor doesn’t see the patient and has performed no billable service. The primary care physician, meanwhile, can bill an ED visit (99281-99285). Or, if he or she had seen the patient before the patient registered as an ED patient, another option would be billing an established patient E/M visit instead (99212–99215).
Sometimes, it’s **very clear** that two doctors can bill for separate services in the ED, or that only one of them should.

**Hospitalist scenarios**

Let’s look at other cases a little closer to home: A patient comes to the ED complaining of intermittent blurred vision and a severe headache. The ED doctor evaluates the patient and orders a head CT scan and lab work.

The CT results are inconclusive and the lab results are normal. The patient received an IM injection of pain medication and is being monitored in the ED for a period of time. The patient’s headache improves but does not go away, although the patient doesn’t experience any visual blurriness while in the ED. The ED physician feels uneasy about this patient, so he calls one of the hospitalists on duty to discuss the patient’s symptoms and test results.

The hospitalist walks down to the ED and continues her talk with the ED doctor but does not see the patient face-to-face. The patient ends up being discharged home.

So what can the hospitalist bill? Medicare—as well as most other payers—requires a face-to-face encounter with a patient for a service to be billable. Because the hospitalist had no face-to-face contact with the patient, this service cannot be billed. According to guidance in the CPT Manual, professional services are face-to-face services rendered by a physician or other qualified health care professional.

**Moving out of the ED**

Here’s another scenario: A patient is seen and evaluated for abdominal pain in the ED, and X-rays and lab work are done. The ED physician contacts the hospitalist on duty, asks her to come evaluate the patient and determine if she thinks the patient should be admitted. The hospitalist examines the patient in the ED, reviews all the diagnostic testing done thus far and discusses her findings with the ED physician. The hospitalist then decides to place the patient in observation.

In this scenario, the ED physician can bill an ED service at the appropriate level (99281–99285). Because the hospitalist saw the patient in the ED and is now sending the patient to an observation bed on the same date, the hospitalist should bill an initial observation care code (99218–99220).

**A discharge home**

But let’s change that last scenario up just a bit. Say the hospitalist comes down, examines the patient, reviews the testing and discusses the findings with her ED colleague, but then decides the patient can be discharged home from the ED, rather than being placed in observation or admitted. What can the hospitalist bill?

In this situation, she can bill an ED visit (99281–99285) or an E/M visit, but not a discharge code. She would also have to provide documentation that would clearly support the need to re-perform the history, exam and medical decision-making elements. Otherwise, the medical necessity of this second visit could be called into question.

For more information on billing for physician services, see IOM 100-4 (Claims Processing Manual), chapter 12, sections 30.6.7-30.6.10.

Sue A. Lewis, RN, CPC, PCS, is a coding manager for a nonprofit health plan in the Midwest. Send your billing and coding questions to slewis56@q.com, and we may answer them in a future issue.
Billing palliative care services
Invaluable care, big billing challenges

Care delivery models have been evolving for many years, with new types of services introduced regularly. While new services may benefit patients, they can create major billing challenges for the clinicians who provide them. Say hello to palliative care.

Palliative care is one of those emerging specialties, and hospitalists made nearly half (48%) of all palliative care referrals in 2015, according to a recent report.

But contrary to what some believe, palliative care is not the same as hospice. Unlike hospice, palliative care services do not focus on terminal illness and dying. Instead, they emphasize meeting the physical, emotional and spiritual needs of individuals and families facing serious, chronic or life-threatening illness.

But clinicians can run into operational problems when billing for palliative care. That’s because those services are often closely aligned with hospice care, and sometimes, the service lines become blurred. This creates the perfect opportunity for claim denials.

Another problem: Unlike critical care or observation care, palliative care doesn’t come with its own set of specific CPT or HCPCS codes that you can report. How, then, should you bill for these services to give yourself the best chance of being paid?

Numbers to use
First, before you refer a patient to palliative care or provide such services yourself, verify whether or not the patient has elected for hospice. That may affect what services you can bill for and where you need to submit claims. And if a patient has elected hospice and clinicians are managing a condition unrelated to that patient’s terminal illness, Medicare requires them to append a modifier to the service being reported.

When billing for palliative care, make sure the clinicians providing those services are appropriately credentialed in hospice and palliative medicine. (Both the American Board of Medical Specialties and the American Academy of Hospice and Palliative Medicine, for instance, offer certification programs.) In addition to a provider’s NPI number, Medicare has assigned a specialty code (17) for this type of provider.

Further, hospice and palliative care both come with specific taxonomy numbers, depending on the credential of the individual provider (such as an MD, DO or NPP). Using the specialty code and the right taxonomy number helps ensure timely, appropriate adjudication of claims.

Speaking of numbers: Make sure you report the evaluation and management (E/M) service codes that apply to the setting in which you’re providing palliative care. These services can be delivered in many different locations: acute care hospital, skilled nursing facility, nursing home or assisted living, outpatient office, or a patient’s home. Each location has its own set of CPT codes for reporting E/M services.

Spell out who is doing what
If you work as a palliative care consultant, make sure the attending physician or specialist makes a formal written request for you to evaluate the patient. If you are being asked to manage a specific problem, that formal request is not strictly necessary, but it will help support the medical necessity of your services.

You also need to make sure your documentation in the medical record clearly supports the medical necessity for palliative care services. Because these services may be subject to payers’ pre- or post-payment reviews, the medical record needs to demonstrate not only the specific conditions you are managing for the patient, but why.

At the same time, avoid duplicating clinical efforts or producing conflicting treatment plans. Each specialty involved in the care of a patient must make it very clear which condition(s) each is responsible for managing. Further, each provider should submit the diagnosis he or she is managing as the “primary” diagnosis on the claim.

Take, for instance, a patient with COPD, hypertension, and severe peripheral vascular disease (PVD) that causes intractable leg and foot pain. A pulmonologist may be managing the COPD, a hospitalist the
Make sure your documentation clearly supports the medical necessity for palliative care services.

hypertension and the palliative care physician the intractable pain from the PVD.

Also, be sure you understand any billing requirements that Medicare or commercial plans may have for palliative care services. Does the plan even cover these services? Or does the plan require any special certification for providers performing those services?

And if you are part of a hospitalist group that provides these services, make sure everyone in the group reports them in a consistent manner.

As an example: Say there is no change in a patient’s condition, and physicians haven’t identified new problems, issues or concerns, so they don’t need to spend more time with the patient and family answering questions. In such a case, one hospitalist providing palliative care shouldn’t report a high level of service while the next hospitalist reports a low-level one. One of your physicians shouldn’t be billing a 99231 while another bills a 99233, unless there’s a documented reason why.

Collaboration and collegiality

If you do experience billing and reimbursement challenges with certain payers, have an administrator in your group set up time to meet with them to discuss the specifics of palliative care services. Establishing a collegial relationship with your payers can be very revenue-friendly.

Until palliative care services are assigned a specific set of codes, collaboration and documentation are the keys to making sure you will be reimbursed for this important and valuable care.

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Switching inpatient to obs: How do you bill?
Plus, coding palliative care consults

Readers have sent in more questions, and it’s no surprise that issues related to how to code for observation services crop up. Here’s what readers want to know.

Changing inpatient status
We are struggling with how to code when the hospital indicates a “patient status” of outpatient vs. observation.

Our hospitalist puts in an order to admit as inpatient, but utilization review the next day determines that the patient should be observation. Because observation cannot be backdated, the hospital enters outpatient on the date of “admission” and observation for the next day (date of determination). On the day the patient arrived, our hospitalist documented an H&P. What can we bill, now that the admit date is entered as outpatient?

This is a challenge that has existed since observation first reared its ugly head! While “observation” is a bed type and a patient status, it’s not a place of service. So you don’t need to worry that your hospital will classify one service as outpatient and another as observation.

When a patient’s status is changed from inpatient to outpatient observation, the physician who performed the initial hospital care (reflected in CPT codes 99221–99223) will need to change the initial care code originally reported to the observation CPT code that best reflects the care provided on the first date the patient arrived.

If that hospitalist is not available—because he or she went off service, for example—another hospitalist may make that code change if they both are in the same group and have agreed to allow each other to make such changes. As for how to bill charges on those two days: If the doctor who first saw the patient is also treating the patient in observation the next day, he or she would bill initial observation care the first day, then subsequent observation care (99224-99226) the next.

But if the hospitalist seeing the patient on the second day is not the original attending, he or she should bill an established patient service (99211-99215) for that second day service.

ED evaluations
When our hospitalists are asked to come evaluate a Medicare patient in the ED to decide whether or not the patient should be admitted, should we bill ED CPT codes 99211-99215 (established patient office visits) or 99201-99205 (new office visits)?

When hospitalists evaluate a patient in the ED, they should roll that time into either their initial care code (99221–99223), if they decide to admit the patient,
While “observation” is a bed type and a patient status, it’s not a place of service.

or an initial observation code (99218-99220) if the patient is placed instead in observation.

But it’s unclear from your question: Are you asking if hospitalists can bill for time spent in the ED evaluating a patient if they ultimately decide to discharge the patient home from the ED, instead of either admitting or placing in observation?

While that situation may come up, I don’t think that hospitalist time is billable. A hospitalist assessing a patient in the ED to see if he or she should be admitted would be duplicating work the ED should already be performing—and billing for.

Palliative consults
When our providers are called in for a palliative consult, they document the appropriate E/M code. But they also want to add 99497 or 99498 for advance care planning, so I need some guidance. Do I apply Z51.5 (encounter for palliative care) on the E/M code and on the 99497? Are these valid encounters if I use both codes?

You can append the Z51.5, which represents the encounter for palliative care, to the E/M service. If the patient has a diagnosis related to a medical condition that necessitates palliative care, that might be a more appropriate diagnosis code to append to the advance care planning service.

Home health certifications
We have been billing home health certifications with G0180 for hospitalists. But during a presentation, our Medicare administrative contractor (MAC) stressed that the community physician/provider who would be managing the patient after discharge should be the one to bill and report the G0180. What’s your take?

Here’s my rule of thumb: Trust your MAC. If they give you guidance on something like this, my advice would be to follow it.

But I’ll also mention two articles issued by the Centers for Medicare and Medicaid Services (CMS) that may be some help. Both are Medicare Learning Network articles. The first is MLN Matters article SE1436, the second is MM9119. Both articles contain a reference that a home health certification can be performed by a physician of a certain specialty in an acute or post-acute care facility, as long as the patient goes directly into a home health stay.

A CMS update
One final note: The CMS this February released an update on medical student documentation, allowing medical students to document components of an evaluation and management service. This would include documenting the history (history of present illness, review of systems, and past medical, family and social history), physical examination and medical decision-making.

Teaching physicians must not only verify the student documentation in the patient’s medical record, but they must also personally perform (or re-perform) the physical examination and medical decision-making components of the E/M service being billed and indicate that they have done so. But according to the update, teaching physicians do not need to re-document what the medical student has already documented unless they need to add to or correct any of that documentation based on their performance of critical or key components of the encounter.

That revision took effect in March.

Sue A. Lewis, RN, CPC, PCS, is a coding manager for a nonprofit health plan in the Midwest. Send your billing and coding questions to slewis56@q.com, and we may answer them in a future issue.
Billing observation: initial care and consults

My September 2017 column, “The ins and outs of observation billing,” prompted some more questions on how to bill for observation services. In this month’s column, we’ll review two additional queries about observation billing.

Observation codes
Which codes should we use for a patient placed in observation by the night hospitalist at 11 p.m., then discharged at 8 a.m. the next morning?
That’s simple: If a patient is placed in observation on one calendar date and discharged on another, report an initial observation care code (99218–99220) for the first day, then the observation discharge code (99217) on the calendar date of the discharge.

If, however, the night hospitalist had placed that same patient in observation on the same calendar day that the patient is discharged, you should use one of the codes for same day admission and discharge: 99234–99236.

Observation consult
I do coding for a multispecialty practice that employs both hospitalists and specialists. When a patient is placed in observation and a specialist consult is called, what code set do I use to bill the consult: 99201-99205 (new patient office visit) or 99212-99215 (established patient office visit)? I’m under the impression that new patient guidelines do not pertain to observation. But I have had only one claim denied when I billed a 99203—and I believe that denial was due to the fact that I also billed a 99236 (same day admission and discharge).

When a specialist is called in to see a patient in observation, that service should be billed using the new patient E/M codes (99201-99205), as long as that patient has not been seen by anyone in that specialist’s group and of the same specialty within the last three years. Doctors have the same documentation requirements for a 99203 billed for an observation patient as they would in an office or hospital outpatient clinic. And remember:
Only the physician attending in observation can bill observation codes.

Inpatient admissions
Our night hospitalists admit patients between 5 p.m. and 8 a.m. Typically, they see (and bill for) patients who arrive before midnight. But when they do admit someone after midnight, they bill an initial visit (99221-99223). The day hospitalist then sees that patient later that same morning. But when that day visit is on the same calendar day as the admission, we’re not sure what to charge for it.

As you know, Medicare considers physicians from the same group practice and the same specialty as a single physician. If a patient is admitted after midnight and seen later that same day by a second hospitalist, the medical necessity of that second visit could be called into question. If you routinely have hospitalists who work days rounding on these patients, think about how you want to handle this scenario.

Both initial and subsequent visits are paid on a per diem basis. When physicians from the same group and specialty bill two services on the same date, it will be viewed as a single visit. You can combine the documentation of both hospitalists, then select the appropriate level of service for that visit—but only if both visits are medically necessary. That’s a very important caveat.

Make sure the physicians clearly reflect medical necessity in their documentation. You’ll find more about this scenario in the Medicare Claims Processing Manual, chapter 12, section 100.

Attestation dates
Does the date of an attending’s attestation need to be the same as the date the resident saw the patient? Or if the attestation date is different than that of the resident’s service, does the attestation have to specifically state the date on which the teaching physician saw the patient? I’m billing for a service provided by a resident, but the attestation is dated two days later and it is unclear when the attending physician actually saw the patient.

If the supervising physician is not physically present for the key or critical components of the resident’s encounter with the patient, the supervising physician must independently see the patient, perform those elements and document the findings. This information is documented in the Medicare Claims Processing Manual, chapter 12, section 100.

If the teaching physician is physically present for those key or critical components, the teaching physician must still personally document his or her presence and attest to agreeing with the resident’s evaluations and plan of care.

The situation you describe—a note generated by the teaching physician that’s dated days after the actual encounter the resident documented—could be risky. It certainly does call into question whether the teaching physician was physically present during the visit. I recommend that you check with your legal department about how to report a service when there is a discrepancy between the date of service the resident provides and the date listed on the attestation statement signed by the supervising physician.

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Patients on the move? Here’s how to bill
Coding advice for when patients move between care settings

Situations that inevitably create billing confusion for hospitalists include how to bill and code for patients who move among different care settings, whether it’s in and out of the ICU, or from observation to inpatient status or vice versa. Here are some questions from readers that delve into billing for these kinds of changes.

Observation to admission
I read your September column ("The ins and outs of billing observation"), and I have these questions: If we originally admit patients to observation but then switch their status to inpatient the next day due to a change in their medical condition, should we bill an observation H&P the first day and then a full inpatient admission H&P the next? Our usual practice has been to just bill a subsequent inpatient visit that second day, not a new H&P.

When patients are admitted from observation on a subsequent date, the hospitalist should bill an initial hospital visit on the date of the inpatient admission. If hospitalists reference any information from the previous day’s initial observation care, they need to indicate the date of that former note as well as confirm that their findings on admission are the same.

Keep in mind that physicians may not bill an observation discharge on the same date as the inpatient admission. And of course, any documentation must support the need for the admission.

However, if patients go from observation to inpatient admission with the same physician on the same date, that hospitalist can bill only one initial visit. Inpatient services are paid on a per diem basis and should include all professional services provided to a patient on that date by one physician. Medicare views doctors from the same group practice and same specialty as a single physician.

Another scenario: A patient is admitted by the night hospitalist as inpatient rehab but then changed to observation status per case management. How do we correct our billing to reflect that change? Should we not bill the 99222 the night hospitalist put in for the admission and instead use an observation code: either 99235 (same day initial observation care and discharge) or 99219 (initial observation care)? But will that then reflect the wrong physician?

First, you may want to review with your hospitalists the criteria that patients must meet to qualify as an inpatient admission. (InterQual criteria are frequently used). That might save you some work on the back end.

When case managers change a patient’s status, you have to change the CPT code you report to get paid. The admitting hospitalist (the night hospitalist in this scenario) should change the inpatient admission code to an outpatient observation code at whatever level his or her documentation supports. Otherwise, if the hospitalist who sees the patient for the first time in observation the next day bills initial observation care, his or her CPT code will not match the hospital’s facility bill—and it will likely be denied.

ICU to the wards
We are now being told that when a patient is transferred from the ICU to the wards under a hospitalist’s care, the receiving hospitalist could potentially bill a new charge that day, even if the critical care physician already charged one. Is that true? We were previously led to believe that because we are all in the same medical group, a hospitalist couldn’t bill on the same day as the critical care physician.

A similar situation: Say the patient was first admitted to the ICU, then transferred to the floor under hospitalist care. Would the hospitalist receiving that patient on the ward bill an initial visit because it is the first time he or she is encounter-
Physicians may not bill an observation discharge on the same date as an inpatient admission.

- a physician who cared for the patient in an acute or post-acute facility from which the patient was directly admitted to home health;
- a nurse practitioner or clinical nurse specialist working in collaboration with the certifying physician or acute/post-acute physician; or
- a certified nurse midwife or physician assistant under the supervision of the certifying physician or acute/post-acute care physician.

Keep in mind that, according to 42 CFR 424.22(d)(2), the face-to-face encounter cannot be performed by any physician or allowed NPP (listed above) who has a financial relationship with the home health agency.

In addition, the patient’s medical record from the certifying physician and/or acute/post-acute care facility must contain information that justifies the referral for Medicare home health services. That includes documentation that substantiates the patient’s homebound status and need for these skilled services.

Further, the clinical note in the medical record from the certifying physician and/or acute/post-acute care facility must demonstrate that the encounter occurred within the required timeframe (within 90 days prior to the start of care or 30 days after the start of care), was related to the primary reason why the patient requires home health services, and was performed by an allowed provider. Typically, this information can be found in clinical and progress notes and discharge summaries.

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