Coding for hospital admission, consultations, and emergency department visits

by Mark Savarise, MD, FACS

Coding for surgical services can be complicated because it involves numerous rules, guidelines, and exceptions that frequently change. An area of exceptional difficulty is the correct use of codes for evaluation and management (E/M) of patients who require hospitalization. Coding for E/M services has become even more complex due to the Centers for Medicare & Medicaid Services' recent decision to reject the use of consultation codes and institute observation codes. This column provides sample cases that explain how to appropriately code for E/M services for a typical general surgery patient.*

E/M

A 60-year-old male with multiple co-morbidities presents with severe upper abdominal pain and has ultrasound evidence of cholecystitis. The correct E/M code to report in this case depends on several factors:

- The severity of illness and appropriate documentation of elements of the history and physical to determine the level of service
- The hospital admission status of the patient, such as inpatient, observation, emergency, or outpatient
- The disposition of the patient after the evaluation
- Whether the patient is covered by Medicare

Health care professionals examine such factors to determine the appropriate code to use for services provided and how the codes compare for reimbursement. The relative value units (RVUs) of these codes are included here in the scenarios for comparison. RVUs are multiplied by the annual conversion factor to determine reimbursement for a service.

Office consultation

The simplest case involves a patient the surgeon sees in the office and then schedules for surgery through the outpatient surgery department. Consultations for Medicare patients are reported with new patient (99201–99205) or established patient (99212–99215) Current Procedural Terminology (CPT) codes. For non-Medicare patients (unless otherwise instructed by a payor), office or other outpatient consultations are reported with codes 99241–99245. Consultation codes are only appropriate if the patient is referred by another provider for consultation; otherwise, new or established patient codes are used. (See Table 1, page 55, for the 2013 total office/outpatient new, established, and consultation nonfacility RVUs.)

Emergency department (ED) consultation: Patient is admitted

In this example, a patient presents to the ED, general surgery is consulted, and the surgeon determines that the patient requires admission to the hospital through the general surgery service. For Medicare patients, if the patient is admitted to the hospital by the general surgeon, he or she should bill an initial hospital care code (99221–99223) and not an ED visit code. Medicare requires that the admitting physician append modifier AI to the initial hospital visit code (9922X-AI). If the patient is admitted for observation, codes 99218–99220 are reported. For patients receiving hospital outpatient observation services who are then admitted to the hospital as inpatients and who are discharged on the same date, the physician should report CPT codes 99234–99236.

For patients with insurance that follows non-Medicare CPT rules, the instructions are even more obscure. If a patient is admitted after an ED consultation and is not seen on the unit (in the intensive care unit, for example) on the date of admission, only report the outpatient consultation codes (99241–99245). If the surgeon sees the patient on the hospital unit on the date of admission, report all E/M services related to the admission with the initial inpatient admission

*All specific references to CPT codes and descriptions are © 2012 American Medical Association. All rights reserved. CPT and CodeManager are registered trademarks of the American Medical Association.

TABLE 1.
2013 TOTAL OFFICE/OUTPATIENT NEW, ESTABLISHED, AND CONSULTATION NONFACILITY RVUS

2013 TOTAL NONFACILITY RVUS					
CPT	Office/outpatient visit new	CPT	Office/outpatient visit established	CPT	Office/outpatient consultation
99201	1.29	99211	0.60	99241	1.37
99202	2.19	99212	1.29	99242	2.58
99203	3.17	99213	2.13	99243	3.52
99204	4.84	99214	3.13	99244	5.20
99205	5.99	99215	4.20	99245	6.36

TABLE 2.
2013 TOTAL INITIAL OBSERVATION, HOSPITAL, SAME DAY OBSERVATION AND DISCHARGE, AND OUTPATIENT CONSULTATION FACILITY AND NONFACILITY RVUS

2013 TOTAL FACILITY RVUS						2013 TOTAL NONFACILITY RVUS	
CPT	Initial observation care	CPT	Initial hospital care	CPT	Observe/discharge same date	CPT	Outpatient consultation
99218	2.84	99221	2.91	99234	3.86	99241	1.37
99219	3.87	99222	3.95	99235	4.83	99242	2.58
99220	5.30	99223	5.81	99236	6.24	99243	3.52
						99244	5.20
						99245	6.36

service code (99221–99223) or initial observation care code (99221–99223). Do not report both an outpatient consultation and inpatient admission (or observation care) for services on the same day related to the same inpatient stay. (See Table 2, this page, for the 2013 total initial observation, hospital, same day observation and discharge, and outpatient consultation facility and nonfacility RVUs.)

ED consultation: Patient is not admitted

A patient presents to the ED; general surgery is consulted, but the patient is not admitted to the hospital. If the patient is a Medicare beneficiary, the general surgeon should bill the level of ED code (99281–99285). Non-Medicare patients are considered outpatients until they are admitted to the hospital, and therefore the outpatient consultation codes are reported (99241–99245). If the surgeon does not come to the hospital to see the patient but only advises the ED physician by telephone, then the surgeon may not bill at all for this service. (See Table 3, page 56, for the 2013 total initial hospital and outpatient consultation facility and nonfacility RVUs.)

Inpatient and/or observation consultations

Coding becomes more complicated in the inpatient hospital setting, where health care providers are instructed to bill the initial hospital care codes (99221–99223). As a result, multiple billings of initial hospital visit codes could occur in a single day. However, only one initial visit per specialty can be paid per stay. Follow-up visits in the facility setting may continue to be billed as subsequent hospital care visits (99231–99233). The coding depends on the admission status of the patient when seen and whether the patient is classified as Medicare or non-Medicare.

For Medicare patients, inpatient consultations are reported with the initial hospital visit codes (99221–99223). Do not append modifier AI, which is only used by the admitting physician. If the surgeon is consulted on case involving a Medicare patient who is in observation status, the surgeon should report new patient (99201–99205) or established patient (99211–99215)

TABLE 3.

2013 TOTAL INITIAL HOSPITAL AND OUTPATIENT CONSULTATION FACILITY AND NONFACILITY RVUS

2013 TOTAL FACILITY RVUS				2013 TOTAL NONFACILITY RVUS	
CPT	Initial hospital care	CPT	ED visit	CPT	Outpatient consultation
99221	2.84	99281	0.60	99241	1.37
		99282	1.18	99242	2.58
99222	3.87	99283	1.76	99243	3.52
		99284	3.36	99244	5.20
99223	5.30	99285	4.93	99245	6.36

TABLE 4.

2013 TOTAL INITIAL HOSPITAL, INPATIENT AND OUTPATIENT CONSULTATION FACILITY AND NONFACILITY RVUS

2013 TOTAL FACILITY RVUS				2013 TOTAL NONFACILITY RVUS	
CPT	Initial hospital care	CPT	Inpatient consultation	CPT	Outpatient consultation
99221	2.84	99251	1.39	99241	1.37
		99252	2.14	99242	2.58
99222	3.87	99253	3.26	99243	3.52
		99254	4.70	99244	5.20
99223	5.30	99255	5.85	99245	6.36

office/outpatient codes. For non-Medicare patients, if the consultation is done after the patient is admitted to the hospital, consultation services may be reported with the inpatient consultation codes (99251–99255). Consultation services in observation status are reported with the outpatient consultation codes (99241–99245). (See Table 4, this page, for the 2013 total initial hospital, inpatient and outpatient consultation facility and nonfacility RVUs.)

An important factor for correct coding is to report the service based on the location/status at the time of admission and if the payor is Medicare or follows Medicare rules related to consultation services. In addition, it is important that the surgeon be aware of and/or communicate three things to staff members to accurately report services:

- Is the service a consultation service?
- Where is the service provided?
- What is the disposition of the patient (such as, admitted to observation status; admitted as inpatient to the general surgeon's service or to another physician's service)?

Once this information is determined, the burden of selecting the correct category of CPT E/M codes is minimized.

In summary, there are many ways surgeons are not reimbursed for services. There is very little advantage to "gaming the system" based on the admission status of the patient at the time of the evaluation. Incorrect coding may result in no payment at all.

For additional coding and practice management resources and guidance, visit *www.facs.org/ahp/pubs/tips/index.html.* ◆

Editor's note

Accurate coding is the responsibility of the provider. This summary is only intended as a resource to assist in the billing process.