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Dermatology Coding Alert

Hospital Coding: Look Out for Observation Services That Change

Experts: Wait until hospital stay is over before coding.

Coders take note: When your physician admits a patient to observation, you need to be sure to select from the proper observation code set for the service.

Also: Patient status might change during the encounter; he might begin his visit in the observation unit, and end up a hospital inpatient before the encounter ends.

Take this advice on when to report observation codes, when to report inpatient codes, and when you might report both for the same patient during the same hospital stay.

Mark First Day With 99218-99220

When a patient is sent to a hospital's observation unit and is considered an outpatient, you'll choose from the following codes for the first day, says **Donelle Holle, RN**, a healthcare, coding, and reimbursement consultant in Fort Wayne, Ind.:

- 99218, Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity...
- 99219, ... a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity...
- 99220, ... a comprehensive history; a comprehensive examination; and medical decision making of high complexity....

"These codes are for the initial admit day," Holle continues. The criteria for these codes is no different than for the actual inpatient admit codes [99221-99223] □ except patients you code with 99218-99220 are outpatients.

Code Hospital E/M Post-Discharge

A common problem when using observation care codes is identifying patient status; until the hospital discharges the patient, there is no way of knowing whether the hospital admitted the patient or kept him in observation, explains **Jean Acevedo, LHRM, CPC, CHC, CENTC**, president and senior consultant with Acevedo Consulting Incorporated in Delray Beach, Fla.

Further, "a patient may have a day or so in observation status and is subsequently admitted to inpatient, resulting in use of both the 99218-99220 codes and inpatient hospital care codes 99221-99223," she continues.

Best bet: Wait until after the patient is discharged from the facility before coding the encounter, if possible. That way, you'll know whether you should code an observation or a hospital admit code □ or both □for your provider's observation services. Further, if you can wait until discharge before filing the claim, your provider might include more documentation that will only strengthen your claim.

Check If Treating Physician Reports Observation

Another coding challenge with observation services lies in Medicare's policy about who can code these services. According to Medicare Carriers Manual, Ch. 12, Section 30.6.8, only the physician who admitted and treated the patient during the observation may report observation codes, confirms **Mary I. Falbo, MBA, CPC**, CEO, Millennium Healthcare

Consulting, Inc. in Lansdale, Pa.

Any other physician who provides an E/M to the patient during her observation stay should use the appropriate E/M code from the 99201 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making...) through 99215 (Office or other outpatient visitfor the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity...) code set, Acevedo explains.

Medicare also recommends including the following notes in your claim documentation to ensure observation services, Acevedo explains:

- Documentation stating the stay for observation care or inpatient hospital care involves at least eight hours, but less than 24 hours;
- Documentation identifying the billing physician was present and personally performed the services; and
- Documentation identifying the order for observation services, progress notes, and discharge notes were written by the billing physician.

Code for Discharge Day With 99217

When a patient is admitted for observation care and then is discharged on a different calendar date, the physician should report 99217 (Observation care discharge day management...) for the discharge day, confirms Falbo.

"Keep in mind that to bill any discharge day code, there must be a face-to-face encounter, so the doctor would need to have seen the patient ... on the date of discharge," reminds Acevedo.

Use These Codes for Longer Single-Day Stays

If the patient is admitted to observation, stays for more than eight but less than 24 hours, and is discharged on the same calendar date, you'll choose from the following codes for Medicare payers, Acevedo confirms:

- 99234, Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity...
- 99235, ... a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity...
- 99236, ... a comprehensive history; a comprehensive examination; and medical decision making of high complexity....

These codes require two face-to-face visits with the patient, and the patient has to be in the observation area for at least eight hours, Holle says.

If a patient is in the observation area for less than eight hours on the same calendar date, you'll choose from the 99218-99220 code set for Medicare payers. This coding convention might not apply to all payers, however.

"Practices need to check with third-party payers to determine if they follow Medicare guidelines for observation care services," says Falbo.