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Pain Management Coding Alert

E/M Coding: Be Ready for Common Observation Scenarios

Remember the 8-hour rule for Medicare.

When your provider performs an observation service for a patient, there's not just one code you can slap on the claim and file worry-free. In fact, there's not even one code set for observations.

You'll have to choose from several coding strategies depending on length of observation, level of service, etc. failure to choose correctly when coding observations will lead to frustrations and denials.

No need to fret, though. Our experts are here to break down some common coding scenarios for observations.

Use 99218-99220 for Different-Day Admit

The first set of observation codes we'll deal with are 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 ...) through 99220 (... A comprehensive history; A comprehensive examination; and Medical decision making of high complexity ...).

According to **Tracey Carl, CCS-P, CEDC**, director of coding and education at CompMed in Newport, Kentucky, you'll use these codes when the provider admits and discharges the patient on different calendar days. This code set represents the first day of those observation services.

Medicare alert: There's a bit of a difference in how you'll use initial observation care codes for Medicare payers. You'll still use these codes when the provider admits and discharges the patient on different calendar days. For Medicare, you'll also use 99218-99220 if the provider treats and releases the patient on the same calendar day, but for less than eight hours of observation care.

"We only follow the eight-hour rule for Medicare patients since the guidelines state that the patient must be in observation for more than 8 hours before we can use the admit and discharge codes [99234-99236]. The CPT® guideline does not state that the observation care must be more than 8 hours," explains Koch.

Example: A patient presents with persistent vomiting, severe headache, and dehydration; she has been unable to hold down liquids for 24 hours. After a dose of Ondansetron the patient is able to tolerate sips of liquid. The patient is placed in observation status to ensure that she can maintain oral intake at 11 p.m. Tuesday and discharged at 4 a.m. Wednesday. Notes indicate a detailed history, comprehensive examination and a low level of medical decision making (MDM). The final diagnosis is dehydration with headache and persistent vomiting.

For the first day of this encounter, you'll report 99218 with E86.0 (Dehydration), R11.10 (Vomiting, unspecified), and R51 (Headache) appended to represent the patient's condition.

Use 99217 for Discharge on Multi-Day Observations

When you're using the 99218-99220 observation codes, you should be able to report 99217 (Observation care discharge day management...) for the next-day discharge.

"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 not only on the first date to bill the 99218 noted above, but also on the date of discharge," explains **Jean Acevedo, LHRM, CPC, CHC, CENTC**, president and senior consultant with Acevedo Consulting Incorporated in Delray Beach, Florida.

So, let's take the earlier example of the patient with dehydration above. If the physician saw the patient face-to-face on the discharge day and noted it in the record, you'd include 99217 with E86.0, R11.10, and R51 appended.

Switch to 99234-99236 for 1-Day Observations

When a patient is in observation for a single calendar day, you'll choose a code from the 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 …) through 99236 (…A comprehensive history; A comprehensive examination; and Medical decision making of high complexity …) code set, Carl says. Private payers have no time constraints on these codes; you can use them for any observation that occurs on a single calendar day.

Medicare, however, is a different story.

For Medicare beneficiaries you would report 99234 through 99236 for any patient admitted to observation status and discharged after more than eight hours of care on the same calendar day, Acevedo says. For Medicare patients the provider treats and releases in less than eight hours on the same date, report 99218-99220 instead.

Example: The PM specialist admits a patient to the hospital at 1 p.m. Saturday for a head injury with loss of consciousness (LOC) and decreased visual acuity. The PM specialist attends to the patient during the observation time. during the observation, the provider orders a consultation with an ophthalmologist who examines the patient with a slit lamp and ophthalmoscope. All test results are normal, so the PM specialist discharges the patient from observation at 9 p.m. Saturday. Notes indicate a comprehensive history and exam, along with high-level MDM.

For this encounter, you'd report 99236 for the entire observation service, regardless of payer.

Remember These Codes for 'Subsequent' Observation Days

In the unlikely (but possible) event that the provider keeps the patient in observation for more than two full calendar days, you'll need to rely on another code set. On these occasions, report the "middle" day with these subsequent observation codes:

- 99224 (Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: problem focused interval history; problem focused examination; medical decision making that is straightforward or of low complexity...)
- 99225 (... an expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity...)
- 99226, (... a detailed interval history; a detailed examination; medical decision making of high complexity ...).

Remember: Unlike the other observation care codes, you can report the subsequent observation codes based on two of the three key components for each code level. So, if notes indicated that the subsequent observation day involved a detailed interval history and exam with moderate-complexity MDM, you could still report 99226.