

Inpatient Coding for General Internal Medicine

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WHY ARE WE HERE?

- To EDUCATE and PROTECT our physicians
- To provide your department/practice with every tool you need to maximize compliance and get paid what you deserve
- To update you on the latest CMS/OIG activities related to your specialty

To give you confidence in your coding and documentation!

Nuts and Bolts of E&M Coding:

THE THREE KEY DOCUMENTATION ELEMENTS

MEDICAL DECISION-MAKING

HISTORY

PHYSICAL EXAM

IMPORTANT!

- The Nature of the Presenting Problem determines the level of documentation necessary for the service
- The level of care (**E&M service**) submitted must not exceed the level of care that is **medically necessary**

SO . . .

**Medical Decision-Making and Medical Necessity related to the “NPP” determine the maximum E&M service.
The amount of history and exam alone do NOT.**

MEDICAL DECISION-MAKING

1. Number of Diagnoses or Treatment Options

One or two stable problems?

No further workup required?

Improved from yesterday?

=

LOWER

COMPLEXITY

Multiple active problems?

New problem with additional workup?

Are problems worse?

=

HIGHER

COMPLEXITY

(1)

**Number of Diagnoses or
Amount and/or Complexity
of Management Options**

Problem(s) Status	Number	Point
Self-limited or minor	Max=2	1
Established Problem: stable		1
Established Problem: worsening		2
New Problem: no additional w/u	Max=1	3
New Problem: requiring additional work-up		4
		Total

MEDICAL DECISION-MAKING

2. Amount/Complexity of Data

Were lab/xray ordered or reviewed?

Were other more detailed studies ordered (Echo, PFTs, BMD, EMG/NCV, etc.)?

Did you review old records?

Did you view images yourself?

Discuss the patient with consultant?

(2)

Data to be Reviewed

Review/order lab tests	1
Review/order radiology tests	1
Review/order service in medicine section	1
Discussion of test with performing physician	1
Obtain old records or obtain history from other	1
Review/summarize old records/history from other person and /or discuss case with other provider	2
Independent visualization of image, tracing, specimen	2
Total	

MEDICAL DECISION-MAKING

3. Table of Risk

Is the presenting problem self-limited?

Are procedures required?

Is there exacerbation of chronic illness?

Is surgery or complicated management indicated?

Are prescription medications being managed?

Medical Decision Making *continued*

(3) TABLE OF RISK

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
<i>Minimal</i>	<ul style="list-style-type: none"> • One self-limited or minor problem, e.g., cold, insect bites, tinea corporis 	<ul style="list-style-type: none"> • Laboratory tests requiring venapuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, e.g. echocardiography • KOH prep 	<ul style="list-style-type: none"> • Rest • Gargles • Elastic bandages • Superficial dressings
<i>Low</i>	<ul style="list-style-type: none"> • Two or more self-limited or minor problems • One stable chronic illness, e.g. well controlled hypertension non-insulin dependent diabetes cataract, BPH • Acute uncomplicated illness or injury, e.g. cystitis allergic rhinitis, simple sprain 	<ul style="list-style-type: none"> • Physiologic tests not under stress, e.g. pulmonary function tests • Non-cardiovascular imaging studies with contrast e.g. barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies 	<ul style="list-style-type: none"> • Over the counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
<i>Moderate</i>	<ul style="list-style-type: none"> • One or more chronic illnesses with mild exacerbation progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis e.g. lump in breast • Acute illness with systemic symptoms, e.g. pyelonephritis, pneumonia, colitis • Acute complicated injury, e.g. head injury with brief loss of consciousness 	<ul style="list-style-type: none"> • Physiologic tests under stress, e.g. cardiac stress tests, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, e.g. arteriogram, cardiac cath • Obtain fluid from body cavity, e.g. lumbar puncture, thoracentesis, culdocentesis 	<ul style="list-style-type: none"> • Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
<i>High</i>	<ul style="list-style-type: none"> • One or more chronic illnesses with severe exacerbation, progression, or side effects of Tx. • Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g. multiple trauma acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis. Acute renal failure • An abrupt change in neurologic status, e.g. seizure, TIA, weakness, sensory loss 	<ul style="list-style-type: none"> • Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography 	<ul style="list-style-type: none"> • Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

FIGURE 16.11

Sample MDM Risk Template

	1. Minimal (level 2)	2. Low (level 3)	3. Moderate (level 4)	4. High (level 5)
RISK OF COMPLICATIONS &/OR MORBIDITY OR MORTALITY (see examples in Table of Risk)				
Risk of presenting problem(s) (c):	1. Minimal	2. Low	3. Moderate	4. High
Risk of diagnostic procedure(s) ordered or reviewed (c'':	1. Minimal	2. Low	3. Moderate	4. High
Risk of management option(s) (c'':	1. Minimal	2. Low	3. Moderate	4. High

HISTORY

FOUR ELEMENTS

1. Chief Complaint (CC:)
2. History of Present Illness (HPI)
location/quality/severity/duration/timing/context/modifying
factors/associated symptoms
3. Past/Family/Social History (PFSHx)
4. Review of Systems (ROS)

HISTORY

1. Chief Complaint

- Concise statement describing reason for encounter (“stomach pain,” “follow-up diabetes”)
- Can be included in HPI
- **IMPORTANT:**
 - The visit is not billable if Chief Complaint is not somewhere in the note
 - Must be “follow-up” of _____

History - HPI

2. The HPI is a chronological description of the patient's illness or condition. The elements to define the HPI are:
- Location: *Right lower quadrant, at the base of the neck, center of lower back*
 - Quality: *bright red, sharp stabbing, dull*
 - Severity: *Worsening, improving, resolving*
 - Duration: *Since last visit, for the past two months, lasting two hours*
 - Timing: *Seldom, first thing in the morning, recurrent*
 - Context: *When walking, fell down the stairs, patient was in an MVA*
 - Modifying Factors: *Took Tylenol, applied cold compress: with relief/without relief*
 - Associated Signs and Symptoms: *With nausea and vomiting, hot and flushed, red and itching*

TWO TYPES: BRIEF (1-3 COMPONENTS)

EXTENDED (4 OR MORE COMPONENTS)

HISTORY - ROS

4. REVIEW OF SYSTEMS

14 recognized:

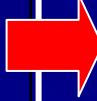


- constitutional
- eyes
- ENT
- CV
- skin
- neuro
- heme/lymph
- psych
- respiratory
- GI
- GU
- MSK
- endocrine
- allergy/Immunology

THREE TYPES:

- PROBLEM PERTINENT (1 SYSTEM)**
- EXTENDED (2-9 SYSTEMS)**
- COMPLETE (10 SYSTEMS)**

History

All three elements in the table must be met to qualify for a given type of history.

History of Present Illness (HPI)	Brief (1-3)	Brief (1-3)	Extended (4 or more) 	Extended (4 or more)
Review of System (ROS)	None	Problem Pertinent (1 system) 	Extended (2-9 systems)	Complete (10+ systems)
Past, Family, Social History (PFSH)	None	None	Pertinent (1 history area) 	Complete (Est: 2 areas New/Consult: 3 areas)
Type of History	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive

HISTORY

■ PEARLS FOR HISTORY DOCUMENTATION:

- Must have PAST/FAMILY/SOCIAL history for comprehensive history (ALL THREE)
- Don't forget **10**-system review!
- Must have comprehensive history and exam to bill higher than 99221 admission

PHYSICAL EXAM

ORGAN SYSTEMS - 12 recognized

Constitution/Eyes/ENMT/Resp/CV/GI/GU/
Heme or Lymph/MSK/Neuro/Psych/Skin

BODY AREAS - 8 recognized

Abdomen/Back/Breast and
Axillae/Chest/Extremity(4)/Genitalia &
Buttocks/Head & Face/Neck

Examination *continued*

<p>1997 Guidelines</p>	<p>any 1-5 elements in one or more organ systems or body areas</p>	<p>any 6+ elements in one or more organ systems or body areas</p>	<p>any 2+ elements of any 6 organ systems or body areas OR any 12+ elements in 2+ organ systems or body areas</p>	<p>Document at least 2 elements of nine organ systems or body areas AND perform all elements of any 9+ organ systems or body areas</p>
<p>1995 Guidelines</p>	<p>OR</p> <p>1 body area/organ system</p>	<p>OR</p> <p>2-7 body areas/organ systems</p> <p><i>limited exam (2-4)</i> of affected body area or organ system and other symptomatic or related organ system(s)</p>	<p>OR</p> <p>2-7 body areas/organ systems</p> <p><i>extended exam (5-7)</i> of affected body area(s) and other symptomatic or related organ system(s) OR 1-2 Detailed System Exams</p>	<p>OR</p> <p>8 or more organ systems</p> <p>OR</p> <p>Comprehensive Single-system exam</p>
<p>Type Of Exam</p>	<p>Problem Focused</p>	<p>Expanded Problem Focused</p>	<p>Detailed</p>	<p>Comprehensive</p>

INPATIENT E&M CODING

■ Initial Hospital Care (First visit)

– Three levels of service: 99221, 99222, 99223

■ Used by admitting physician ONLY

■ 99222 and 223 require comprehensive history and examination (detailed for 221)

■ Distinguishing feature is Medical-Decision Making

– 221 = Low

– 222 = Moderate

– 223 = High

INPATIENT E&M CODING

■ Subsequent Hospital Care

- Three levels of service: 99231, 99232, 99233
- 231 - Stable, recovering, improving
 - **Problem focused** history and exam
- 232 - Not responding, minor complication
 - **Expanded problem focused** history and exam
- 233 - Very unstable, significant complications
 - **Detailed** history and exam

REMEMBER - What is medically necessary to document for that day?

History

All three elements in the table must be met to qualify for a given type of history.

History of Present Illness (HPI)	Brief (1-3)	Brief (1-3)	Extended (4 or more)	Extended (4 or more)
Review of System (ROS)	None	Problem Pertinent (1 system)	Extended (2-9 systems)	Complete (10+ systems)
Past, Family, Social History (PFSH)	None	None	Pertinent (1 history area)	Complete (Est: 2 areas New/Consult: 3 areas)
Type of History	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive

■ Subsequent Hospital Care 99231 – Examples

- 50yo male seen 2 days after MI, pain-free, stable
- 87yo female seen one day after admission for UTI from NH, rehydrated, improving mental status
- 40yo female seen 3 days after asthma exacerbation, tapering steroids, changing to po antibiotics, d/c in am

■ Subsequent Hospital Care 99232 – Examples

- 37 yo female hospitalized for endocarditis, still with low-grade fever
- 63 yo male transferred from CCU after MI, still with multiple PVCs on telemetry
- 73yo female recently diagnosed with lung cancer, now with unsteady gait

■ Subsequent Hospital Care 99233 – Examples

- 56yo male ESRD patient develops chest pain/dypnea while in hospital for cellulitis
- 67yo female in hospital for acute MI develops sudden pulmonary edema
- 46yo male with cirrhosis and peritonitis develops worsening encephalopathy and ascites

SUBSEQUENT HOSPITAL VISITS

Medical Necessity should drive your documentation for each day's visit:

What's wrong with this audit?

Day 1: 223

Day 2: 233

Day 3: 233

Day 4: 233

Day 5: 233

Day 6: 239 (discharge to home)

INPATIENT E&M CODING: Hospital Observation Services

Admission/Discharge on **different** days:

- 99218: *Detailed history/exam, low-complexity MDM*
- 99219: *Comprehensive history/exam, moderate MDM*
- 99220: *Comprehensive history/exam, high MDM*
- 99217: *Observation Discharge*

Admission/Discharge on **same** day:

- 99234: *Detailed history/exam, low-complexity MDM*
- 99235: *Comprehensive history/exam, moderate MDM*
- 99236: *Comprehensive history/exam, high MDM*

INPATIENT E&M CODING:

What is Observation?

1. Evaluating a patient for possible inpatient admission.
2. Treating a patient expected to be stabilized and released in 24 hours (with appropriate documentation, patients can stay in observation more than 24 hours).
3. Extended recovery following a complication of an outpatient procedure, for example:
 - poor pain control
 - intractable vomiting
 - delayed recovery from anesthesia
 - abnormal postoperative bleeding

INPATIENT E&M CODING: What is NOT Observation?

1. A substitute for inpatient admission.
2. For continuous monitoring.
3. For medically stable patients who need diagnostic testing or outpatient procedures.
4. For patients who need therapeutic procedures (e.g., blood transfusion, chemotherapy, dialysis) that are routinely provided in an outpatient setting.
5. Patient awaiting placement in a facility.
6. To be used as a convenience to the patient, his or her family, the hospital, or the attending physician.
7. For routine prep or recovery prior to or following diagnostic or surgical services.
8. A routine “stop” between the Emergency Department and an inpatient admission.

HOSPITAL DISCHARGE

■ IMPORTANT!

- Documentation should include:
 - final examination of patient
 - discharge instructions/follow-up
 - preparation of referrals/prescriptions
 - time spent

If less than 30 minutes: 99238

If more than 30 minutes: 99239

CONSULTS

■ What is a CONSULT? (The Three “R”s)

– Requested by another physician

– Reason for consultation must be documented

– Report must be sent to requesting physician

CONSULTS IMPORTANT !

- Must document reason for consultation and requesting physician
- Coding guidelines for inpatient consults are the same as a NEW or CONSULT Outpatient (99251-99255)
- If you are assuming patient's care, must be billed as a subsequent hospital visit
- CMS IS MONITORING CONSULT SERVICES – overpaid \$1.1 billion in 2001

Consultation Services

Common errors

1. TRANSFER OF CARE (“medical management”) is not a consultation. Must be specific request for your opinion.
2. Treatment and follow-up visits for the problem are allowed and should be billed as subsequent/established care.
3. “Standing order” for your services is inappropriate to bill a consult.
4. Cannot bill for consult and admission on the same day if same provider/billing group.

Critical Care Services

DEFINITION (CPT 2005):

- Direct delivery by a physician of medical care for a critically ill or injured patient. . .
- Illness acutely impairs **one or more vital organ systems** such that there is a high probability of imminent or life-threatening deterioration in patient's condition . . .
- Involves high-complexity decision-making to assess, manipulate, and support vital organ system function to prevent further deterioration

Critical Care Services Documentation Requirements

1. Organ system failure and nature of critical illness

- *Acute respiratory distress*
- *Sepsis*
- *Hypotension*
- *Acute neurologic change*

Critical Care Services Documentation Requirements

2. Attending physician's highly complex decision-making and intervention

(Swan-Ganz interpretation, vent adjustments, lab interpretation, imaging studies, etc.)

Critical Care Services

Documentation Requirements

3. Time spent in critical care of patient

99291 – First 30-74 minutes (\$199.00)

99292 – Each additional 30 minutes (\$99.00)

Must be attending time only in direct care of the patient

CRITICAL CARE SERVICES – What counts?

- Direct patient care
- Time spent on the unit/nurses' station
- Discussion of patient with nurses/consultant
- Writing progress notes/dictating
- Review of labs/imaging studies/etc.
- Time spent with family members when patient is unable to participate – **must be necessary for proper care of patient (not just “daily updates”)**

CRITICAL CARE SERVICES – What does not count?

- Time spent off the floor
- Time teaching residents in rounds outside the patient's presence
- Linking to resident's notes
- Time spent on procedures
- Telephone calls to update family members

Teaching Physician
Documentation Requirements
for
Evaluation & Management

Teaching Physician Rules: Latest CMS Revision 11/02

- Applies to Attending Physician supervision of residents and fellows in a GME program
- Includes any physicians **outside the system in a preceptor role** teaching residents
- Does NOT apply to medical students or nurse practitioners

Teaching Physician Rules:

- CMS will pay attending physician for services involving residents only if:
 - Services are personally performed by the attending or
 - Services are jointly furnished by teaching physician and resident or
 - Services are provided under Primary Care Exception
 - Services are appropriately documented

**BOTH RESIDENT AND ATTENDING NOTES ARE COMBINED
FOR PAYMENT!**

Teaching Physician Rules:

HOW MUCH INVOLVEMENT IS REQUIRED?

1. Attending must personally see the patient for each visit
2. Attending must perform the critical/key portion of the service (determined by the physician)
3. Attending must participate in the management

Teaching Physician Rules: HOW MUCH DOCUMENTATION IS REQUIRED?

1. Attending must document:

- a) Physical presence
- b) Evaluation of patient
- c) Involvement in plan

and

2. LINK TO RESIDENT'S NOTE

Teaching Physician Rules:

Correct documentation:

“I saw and evaluated the patient. D/W resident and agree with findings and plan as documented in resident’s note.”

“See resident’s note for details. I saw and evaluated the patient and agree with resident’s findings and plan as written.

Unacceptable Documentation

- **“Agree with above”**
- **“Rounded, Reviewed, Agree”**
- **“Discussed with resident. Agree.”**
- **“Seen and agree.”**
- **“Patient seen and evaluated.”**
- **A legible countersignature or identify alone.**
 - **Note: such documentation is not acceptable because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care.**

Teaching Physician Rules Procedure Supervision

Applies to any billable surgical, high-risk, or complex procedure
(i.e., > 5 minutes)

1. Attending must be present for all **CRITICAL AND KEY** portions (determined by physician)

2. Must be **IMMEDIATELY AVAILABLE** for the entire procedure

NOTE: Different procedures have varying supervision requirements based on Medicare policies

Teaching Physician Rules:

COMMON ISSUES:

1. Can I use a stamp or pre-written statement?

Yes, CMS allows this, as long as the statement meets the criteria. We prefer patient-specific information as well.

2. Can I use this statement for a medical student?

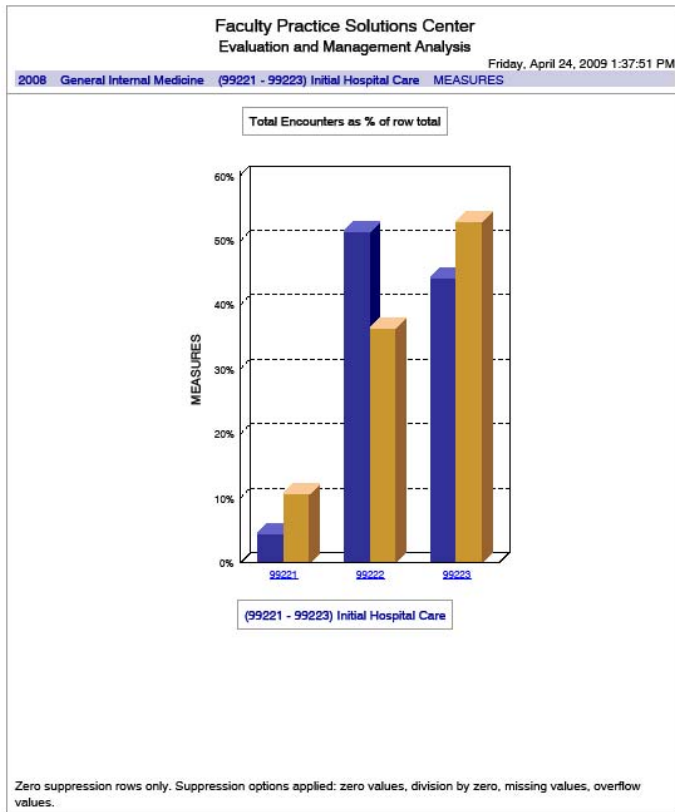
NO! CMS does not pay for medical student services. You cannot bill for a procedure performed by a student.

3. Can this statement be added electronically?

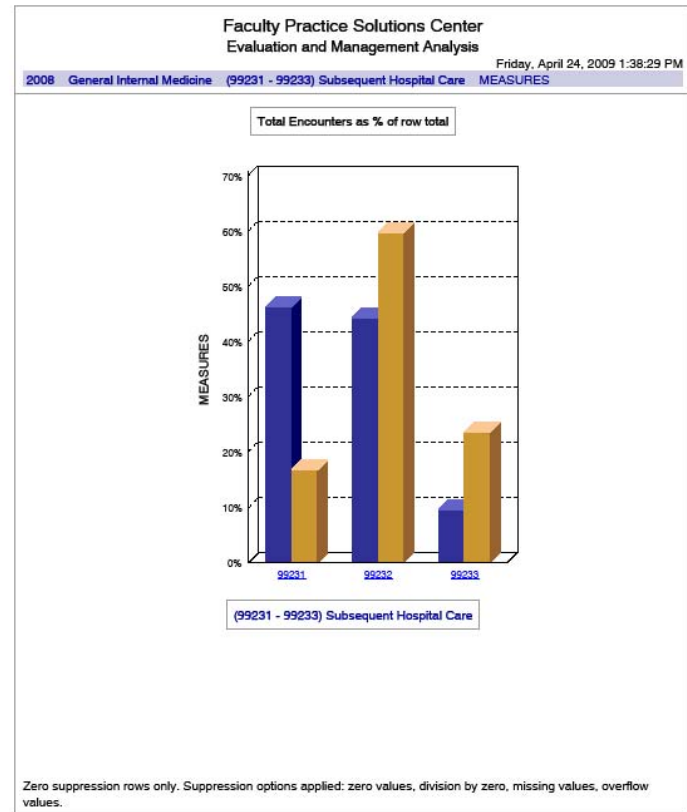
Yes, as long as the statement is triggered in a password-protected field by the attending's keystroke, not the resident's.

Inpatient Billing – GIM

2008

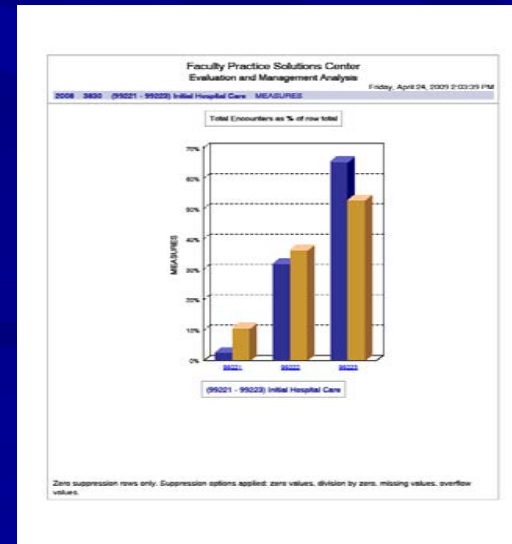
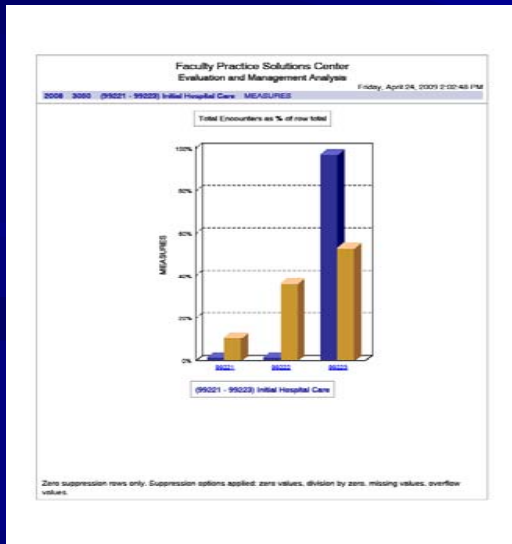
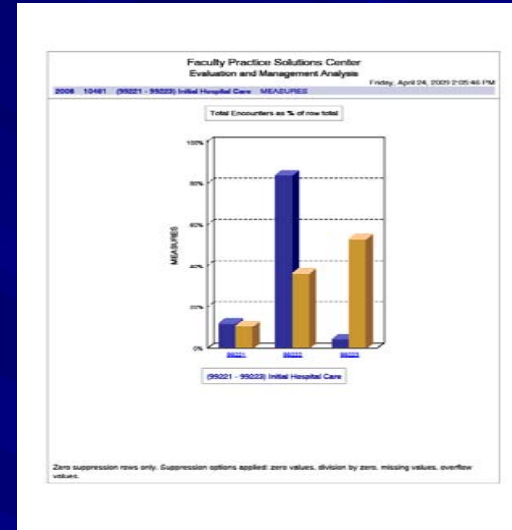
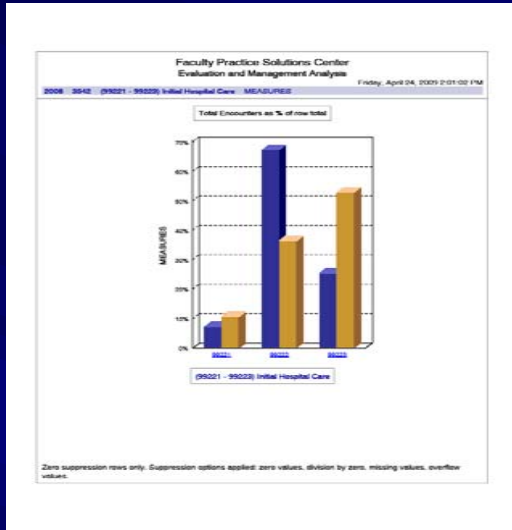


Initial Hospital Visit

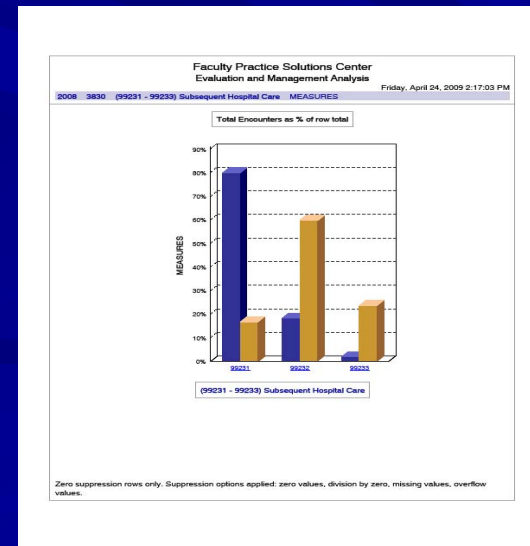
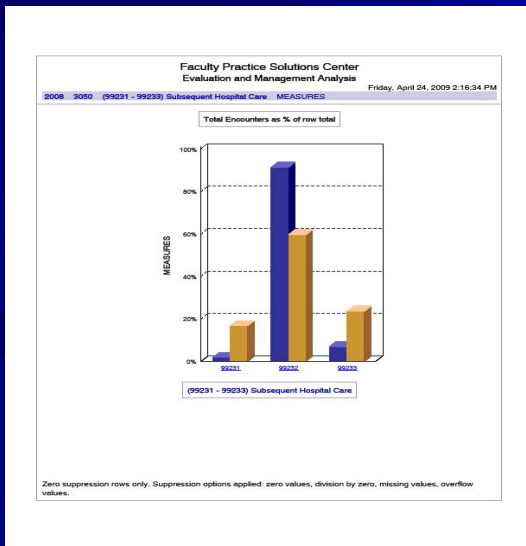
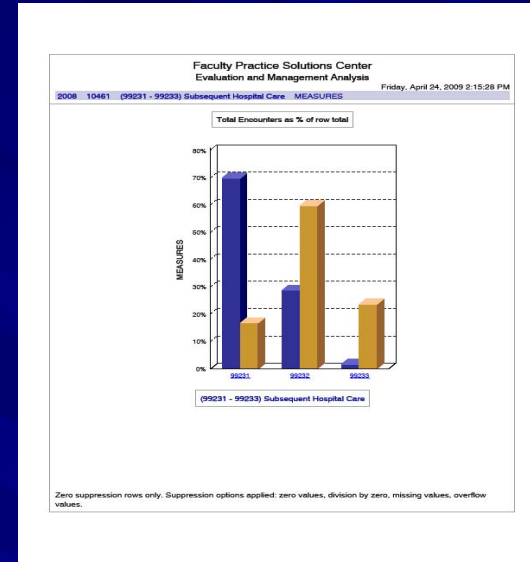
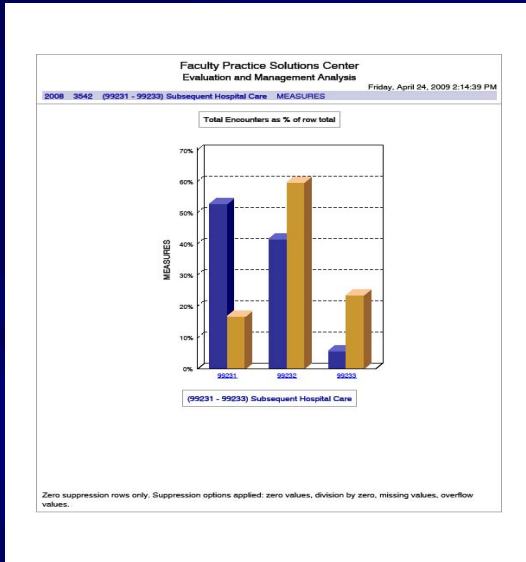


Subsequent Hospital Visit

GIM Variations – Initial Hospital (2008)



GIM Variations – Subsequent Hospital (2008)



Medicare

Hospital-Acquired Conditions

October 1, 2008

Foreign object left post-op

Joint Dislocation

Vas-Cath infection

Air embolism

Head Injury

Manifestations of poor control of blood sugars

Transfusion of wrong blood type

Crushing Injury

Surgical site infection following CABG

Stage III/IV pressure ulcers

Burn

Surgical site infection with certain Ortho procedures

Falls and Trauma

Electric Shock

Surgical site infection following bariatric surgery

Fracture

Cath-associated UTI

DVT following certain Orthopedic procedures

Blue Cross Blue Shield Serious Reportable Events Effective October 1, 2008

**Surgery performed on
the wrong patient**

Joint Dislocation

Vas-Cath infection

**Wrong surgical procedure
performed on a patient**

Head Injury

**Surgery performed on
the wrong body part**

**Object left in the body
after surgery**

Crushing Injury

**Surgical site infection
following CABG**

Stage III/IV pressure ulcers

Burn

Blood incompatibility

Falls and Trauma

Air embolism

Fracture

Cath-associated UTI