



## How to Bill When You Admit a Patient Seen in the Clinic on the Same Day?



There has been some confusion about how to bill a hospital admission when a patient is also seen in the clinic on the same day. As a rule, only one

Evaluation and Management code is billable for services provided to a patient per day. (There is one exception which we will address later in the article).

CPT, 2005 states that all evaluation and management services provided on the same date of service as the admission by the same physician are considered to be part of the initial hospital care. The level of service reported by the admitting physician for the initial hospital care code should be representative of all services provided by that physician on that day related to the reason for the hospital admission.

It is important to remember that when there are several physicians in a group practice sharing the same specialty, the physicians must bill as though they are a single provider.

**If two physicians from the same practice sharing the same specialty provide an evaluation and management service to the same patient on the same day, only one physician may report the service.**

The physicians may, however, select a level of care based on their combined visits and submit the appropriate code for only one physician.

The following examples illustrate the above guidelines:

### EXAMPLE #1

The physician sees a patient in the clinic for shortness of breath related to COPD and determines that the patient requires admission to the hospital.

The same physician admits the patient to the hospital on the same day as the clinic visit. The initial hospital care code (99221-99223) would be reported based on the work the physician performed for that date of service. The clinic visit would **not** be separately reported.

### EXAMPLE #2

Dr. Jones and Dr. Smith are Physicians in the same practice sharing the same specialty. Dr. Jones sees a patient in the clinic for shortness of breath related to COPD and determines that the patient requires admission to the hospital.

Dr. Smith, his partner, same specialty/division admits the patient to the hospital on the same day. Dr. Jones clinic visit would **not** be reported since the patient is being admitted by Dr. Smith, his partner, on the same date of service. Dr. Smith would report an initial hospital care code based on the combined services of both physicians for that date.



The only exception to the one E&M visit per day rule is related to critical care services **provided after completion of the E&M**. If a patient is seen in the clinic or the hospital and has an E&M service and subsequently needs critical care, critical care services would be billable on the same day as E&M service done earlier that day.

*For questions or additional information regarding the above, contact the Compliance Office at 615-343-7766.*

### Coding Chronic Conditions



We sometimes see coding of chronic conditions even when that condition was not treated on that visit.

There are only 4 diagnoses that you should automatically consider systemic, that do not require current treatment for reporting: diabetes mellitus, Parkinson's, Hypertension and chronic obstructive pulmonary disease. This is according to *Coding Clinic* Second Quarter 1992, pages 16-17.

According to the ICD-9 guidelines, the definition of "other diagnoses" is additional conditions that affect patient care on that visit, requiring one or more of the following: clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, and increased nursing care and/or monitoring. Unless you have documented a chronic condition in accordance with the above guidelines the condition should not be coded. If you have questions or would like additional information contact the compliance office.

### Templates offer Convenience But... Medical Necessity Determines Billing!

Many providers now use templates. Templates are good for helping you to fulfill the documentation requirements. The use of templates can sometimes result in over documentation of services. When selecting the appropriate level of service for billing purposes, medical necessity must support the level of service billed.

When the compliance office reviews your documentation we often will score the note beginning with the medical decision making. If the medical decision making is low we would not expect to see a level four or a level five visit.

While the use of templates may save you time when documenting services, you should not feel compelled to document every element of your template for every patient. Only document those elements that are pertinent to the patient for that visit.

The use of the StarPanel re-use button is to be used with caution. The re-use StarPanel button can quickly lead to "cloned" notes. To avoid "cloning" you should carefully edit any re-used documentation. VUMC regularly receives record requests from patients, third party payers, and Medicare, so documentation must accurately reflect services performed.



The use of electronic macros should also be used with caution. The automatic population of documentation can result in documentation time savings, but information must be accurate and pertinent to the visit or service. It is not the quantity of the documentation that determines the level of service. Unnecessary documentation wastes the time of other providers who must read the note to address the concerns of the patient.

Lastly, the use of templates and electronic macros can result in documentation errors. Contradictions within a note can occur when templates and electronic macros are used without editing. While the compliance office supports the use of these tools, we encourage providers to only document what is medically indicated for the patient and to edit the notes thoughtfully.

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### **Time - Based Evaluation and Management Billing;**

### **When Time Trumps History, Exam and Medical Decision Making**

Providers may select an E/M code based on time spent on counseling and/or coordination of the patient's care when that time exceeds 50% of the total length of the service. When billing for time based on counseling and/or coordination of care, 'time trumps history, exam, and medical decision-making' precluding the need to follow the usual documentation rules. The physician must document both the total length of the service, and the total length of the time spent specifically on counseling and/or coordination of care and

what was discussed. For quality care reasons you must still document any history, exam and or decision making but the coding can be based on counseling.

When billing for a time-based service in an inpatient setting, the provider has to document in "sufficient detail to justify the selection of the specific code". The physician may count time known as 'floor time' that is spent outside of the presence of the patient. Face-to-Face time refers to time with the physician only. Counseling by other staff is not considered to be part of the physician/patient encounter.

When coding for services based on time remember the following:

- If the patient is not a hospital inpatient, both the total time of the service, as well as the time counted toward counseling and / or coordination of care must be time spent face-to-face with the patient by the specific physician billing the service.
- Time spent with an inpatient by other members of the care team, cannot be used toward the total service time or counseling and coordination of care time.
- Physician must be in the patient's hospital unit for the total service, office time does not count.
- Documentation details: In addition to documenting details toward the code selection, the physician must also document both the total length of the service, and the total length of the time spent specifically on counseling and/or coordination of care and what was discussed.



**EXAMPLE:** Allowable floor time would be time spent discussing an inpatient's progress with other health care professionals involved with the care of the patient or pulling up and reviewing the patient's medical records on the hospital computer.

Time spent on coordination of care with the patient's family in the inpatient setting is also countable only when it is necessary to get information from the family to formulate a plan of care.

**For questions or more information contact the Compliance Office at 615-343-7266.**

## UNAPPROVED ABBREVIATIONS

As of January 1, 2005 JCAHO is demanding 100% compliance with the unapproved abbreviation use. According to the newsletter *'Medical Records Briefing'*, if surveyors from JCAHO find even one unapproved abbreviation in the medical record, the hospital will have to complete an evidence of standards compliance report within forty-five days of the survey. Hospitals are required to have a process in place to effectively manage this unapproved list. The Medical Records Committee has recently made updates to this list which is attached on the following page below.

### Medically Related Abbreviations – **DO NOT USE IN MEDICAL RECORD**

This list of abbreviations which should **NEVER** be used was approved by the Medical Record Committee and will be reviewed for further additions, as needed.

Abbreviation	Meaning	Misinterpretation	Correction
AD	Right Ear	Mistaken for "up to"	Use "right ear"
AS	Left Ear	Mistaken for "as" or "qs"	Use "left ear"
AU	Each Ear	Each Eye	Use "each ear"
IU	International Unit	Mistaken for IV (intravenous) or 10 (ten)	Write "international unit"
MS MSO <sub>4</sub> MgSO <sub>4</sub>		Confused for one another. Can mean morphine sulfate or magnesium sulfate	Write "Morphine Sulfate" or "Magnesium sulfate"
Q.D. or qd	Every day	"QID" or "QOD"	Use "Every Day" or "Daily"
Q.O.D. or QOD	Every other day	Misinterpreted as "q.d." (daily) or "q.i.d." (four times daily) if the "o" is poorly written	Use "Every other day"
U or u	Units	Read as a zero (0) or a four (4), causing a 10 fold overdose or greater, (4 U seen as "40" or 4U seen as 44)	"Unit" has no acceptable abbreviation. Use "unit"
Trailing zero (X.0 mg) Lack of Leading zero (.x mg)		Decimal point is missed.	Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.X mg)

Source: National Coordinating Council for Medication Error Reporting and Prevention, JCAHO (revised 12-12-03).



Please be aware that in addition to JCAHO requirements there are internal penalties for unapproved abbreviations in the medical record.

The Compliance Office conducts routine audits on all physician documentation in which the physician will receive points against him/her for any use of unapproved abbreviations that could potentially contribute to a failed audit.