Chapter 8
Basics of Billing and Coding: A Primer for the New Hospitalist Attending

Himati P. Patel and Negin J. Ahadi

Dr. Lane recently finished residency and, despite going to several lectures on billing and coding, she never really paid too much attention. After starting her hospitalist job she received a "crash course" on billing and coding by the hospital. However, she still feels uneasy and is worried she may get into trouble for improper documentation or over/underbilling. If only she had paid more attention to those lectures during residency.

When the words "billing and coding" are mentioned in a room full of physicians, a collective groan is often heard. Simply stated, we became doctors to help people. However, demonstrating the care we provide is necessary and supporting that with documentation is necessary in order to be paid for our services. For some, billing and coding has become the bane of a physician's career. It is viewed by some as a set of time-consuming, irrelevant rules and formalities that add extra time and effort to workflow without providing any actual clinical benefit to the patient. The adage, "if it's not documented, it didn't happen," is relevant to professional billing, since justification is required for the level of care that is being submitted and the associated compensation that is being sought [1].

Complicating the matter is the lack of education that trainees receive during residency, rendering them ineffective once they become independent providers and are responsible for billing for their services while providing excellent patient care [1, 2]. The objectives of this chapter are to introduce the new attending hospitalist to the basics of billing and coding. It will help to establish a common language that will aid in understanding the basic elements of a billable service. It will also demonstrate ways to maximize documentation to reflect the thorough clinical care already being provided in order to maximize reimbursement. Generally speaking, Medicare sets the rules and most other insurance companies follow them. Auditing

H.P. Patel · N.J. Ahadi (✉)
General Internal Medicine, University of Maryland Medical Center,
22 S Greene St, N13W46, Baltimore, MD 21201, USA
e-mail: nahadi@medicine.umaryland.edu

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of Medicare billing is divided by geographic region into Medicare Audit Contractors (MAC). While the rules are unfortunately sometimes subject to interpretation, and there are geographic regional differences in how CMS auditors and insurers expect documentation, there are common unifying threads that are essential to know for the new attending hospitalist. The goal of this chapter is to attempt to deconstruct billing and coding relevant to a hospitalist in a way that demystifies and makes manageable the billing and coding process.

Types of Inpatient Billable Services

Simply put, a billable service is a term that links the performance and documentation of clinical work and the financial compensation that is expected as a result of that work. These services are divided initially based on the location the physician provides the service—loosely speaking, in the hospital versus out of the hospital. That being said, some services located on the hospital campus are considered "outpatient" from a billing standpoint. For the hospitalist, patients seen in the emergency room, consults done in the same-day surgical center, or patients admitted under "observation" status are considered "outpatient" services and require consideration as such. Confused already? The good news is that regardless of the actual code, the fundamental information required for documentation for any type of service is the same.

Once the geographic location is established, the next step is to determine whether this is the first time the provider is seeing the patient (initial visit), or whether it is a follow-up visit by the provider. After completing these two steps, the information in your documentation of that visit will determine what level code can be billed and the subsequent charge that can be submitted. Current procedural terminology (CPT) codes are five digit codes usually starting with 99—that are assigned to different types of services provided to patients located either in or out of the hospital based on the complexity of the clinical care provided and documented in the medical record. In this chapter, the default example will be based on caring for a patient in the inpatient setting as if you were a solo practitioner.

"E/M service" is the umbrella term under which the various patient encounters fall. It stands for "evaluation and management," and refers to the documentation that describes the steps taken to clinically evaluate a problem and then establish a management plan. As such, it incorporates all the things that physicians already do to evaluate patients, manage their problems, and discharge them from the hospital. The common thread to all E/M billable encounters includes documenting: ***history***, ***physical exam***, ***medical decision-making, time required for care, and/or time required to counsel and coordinate care***. What helps determine the actual code, in addition to things like place of service and initial versus subsequent care, are also elements like the time-stamp of the patient; bills are submitted based on the calendar date that the patient is seen rather than on a rolling 24 h period. For instance, if the patient is seen by the hospitalist at 10 p.m. on day one and again at 2 a.m. the

same night, those count as two separate visits on two separate calendar days even though the patient was seen twice within one 24 h period.

The overriding element that dictates whether a bill will even hold validity is ***medical necessity***. Medical necessity refers to services that are reasonable and necessary for the diagnosis or treatment of a patient. Consider the following case:

Mr. Stevens presents to the emergency department with complaints of left leg pain and is found to have cellulitis requiring IV antibiotics. Dr. Lane orders a chest X-ray and EKG on admission but does not document why in her note. While she may have had a compelling reason, it is not apparent in the documentation that these tests were necessary for the diagnosis or treatment of this patient.

In this example, the patient does not meet medical necessity for these tests. The documentation that is expected for the corresponding bill should reflect the patient's level of illness [1]. The underlying premise is to treat a patient as you normally would according to the severity of his presentation and then document it. Doing more for something that is not supported by medical necessity, even if documented perfectly, will not get paid at a higher level. More importantly, this premise should highlight the fact that clinical care and billing should be in parallel—the physician is being asked to document that which he would have normally done as standard of care commensurate for that problem.

Components of an E/M Service

There are three elements to a typical billable service. They include **history**, **physical exam**, **and medical decision-making**. Each element is graded on its own to determine whether there is enough documentation to support a particular code level. Coders and auditors use a template audit sheet to evaluate the note, quickly check off, and count the various points required within each of these three categories, and ultimately determine the appropriate code. Lack of documentation in any of these three elements can result in a lower level of coding. Terms like "problem-focused," "detailed," "complete," "comprehensive," etc., refer to different levels achievable in each element and are beyond the scope of this chapter. The following will be discussed as if you are coding for a high complexity patient in the inpatient initial visit (i.e., admission H&P). These fundamental points are then just modified for subsequent follow-up visits.

History

The first component that a coder considers is the history. The parts of the history that the coder evaluates are ***chief complaint, history of present illness (HPI), past medical/family/social history (PMFSH), and review of systems (ROS)***. While medications and allergies are critical pieces of the patient history to obtain and

document, they are not considered when determining a level of care. Keeping in mind medical necessity, the more detail documented, the greater likelihood that the bill will reach the threshold for a higher level of care. Each note needs to have a chief complaint or a reason that the patient is being seen again [3]. Even though it may seem counterintuitive to have to specifically write why a patient is being followed-up the next day, as it should seem self-explanatory in the assessment and plan section of the note, even subsequent visits should clearly document the medical necessity for follow-up at the beginning of the note [4]. Notations like "f/u" or "routine visit" should not be used as they do not give import to the level of illness of the patient that is needed to justify their continued hospital stay [5]. For a severely ill patient, a high-level HPI requires four or more HPI elements. These elements are the same ones we are taught to use in medical school when taking a history, including onset, duration, location, timing, and exacerbating/alleviating factors. Modifying and documenting at least four of these descriptors for various complaints in an HPI is the first step to achieve the highest billable level [1]. Alternatively, documenting symptoms and statuses of three chronic medical problems also achieves the same high level bill [6].

You must document ten or more systems in ROS in order to bill for the highest level [6]; anything less automatically downgrades the code [7]. Depending on where you practice, it may be permissible to document the pertinent positive or negative ROS and state "all others reviewed and negative" to equate to greater than ten systems once those systems have been reviewed [3]. Regional practices vary with this and should be verified based on local practice. You must document at least one piece of history in each of the PMFSH sections. Be aware that family history is a commonly omitted component [8]. This simple omission can be the difference between being able to bill for a higher or lower level. Also important is to document if a history was unobtainable and the reason why; you get credit for trying even if unsuccessful [3]. The key is to demonstrate that an effort was made to ask something even if the answer was negative.

To summarize, in order to get the highest level for a documented patient history you must document:

- Chief Complaint
- HPI: four descriptors of the chief complaint or symptoms/ status of three chronic conditions
- PMFSH: at least one piece of information in each category
- ROS: 10 or more.

Physical Exam

The next section a coder considers is the physical exam. There are two sets of guidelines that are used by a coder or auditor to grade the physical exam on a note, the 1995 guidelines and the 1997 guidelines established by CMS. The key

difference is that the 1995 guidelines divide the physical exam into "body areas" while the 1997 guidelines use "organ systems." For the hospitalist, the 1995 guidelines are more reflective of how physical exams are conducted and are a less cumbersome way to document. In order to achieve the highest level physical exam using the 1995 guidelines, you need to document at least one physical exam finding in eight or more organ systems (at the highest level, the 1995 guidelines use organ systems as well). Achieving an equivalent level using the 1997 guidelines requires performing all the exam elements in at least nine systems and then documenting at least two elements in each of the nine or more systems [1]. A single guideline must be used for determining a physical exam level for a patient [6]. As with history-gathering, if you are unable to perform a full physical exam due to a patient-related reason, documenting the attempt and reason for a limited exam is essential.

Medical Decision-Making

Medical decision-making (MDM) is perhaps the most difficult concept to grasp. This is where the complexity and acuity of a patient, coupled with the degree of your thought effort, combine. You must demonstrate that your MDM is at a high level in order to bill as such. Documenting in a way that demonstrates the complexity of a patient and cognitive effort you have put into evaluating that patient is the goal. The three elements that are individually considered for MDM are (1) diagnoses and treatment options, (2) amount and complexity of data, and (3) patient risk. We will examine each of these separately.

Number of Diagnoses or Treatment Options

This part of MDM considers how many medical issues you are addressing, if they are new or established, if they are stable or worsening and if a work-up is planned. A point system is used to account for these factors. You receive the most points for new patient problems with a work-up planned (four points). You received progressively fewer points for new problems without a work-up planned (three points), established problem that is worsening (two points), established problem that is stable/improved (one point), and self-limited or minor problems (one point). The goal is to try to achieve a total of four points for the highest level. Document the actual diagnoses; the auditor will not extrapolate a diagnosis from the separate history and data points for you [8]. Use of "probable" or "rule-out" for unestablished diagnoses is acceptable [9]. Keeping this system in mind will help you to determine whether you need to document more if you are trying to achieve the highest level of billing.

Amount and/or Complexity of Data to Be Reviewed

This section also uses a point system and correlates to some extent on the amount of effort you put into evaluating the patient. Again, four points is needed for the highest level. You receive points if you document that you have reviewed labs, radiology reports, and ECG reports (one point each). Taking the extra step to evaluate the radiographs yourself or actually summarizing the outside records is valued even more [8, 10]. For instance, if you look at and interpret an ECG yourself you get two points. If you discuss test results with the performing physician or decide to obtain records or history from someone other than the patient, you can earn one point for each. For admitted patients, this section is quite easy to obtain four points for most patients.

Patient Risk of Complications and/or Morbidity or Mortality

This section divides patient risk into minimal, low, moderate, and high based on the presenting problem(s), diagnostic procedure(s) ordered, and management options selected. Coders use a table for this. The highest level for presenting problems includes severe exacerbation or progression of a chronic problem, illnesses that put the patient at risk for death or organ injury (e.g., acute renal failure, pulmonary embolism), or acute changes in neurologic status. Essentially, illnesses that if not treated may result in the demise of a patient lend themselves well to the highest level for risk. Diagnostic procedures that carry more risk are considered higher level for coding. For instance, lumbar punctures are moderate risk but cardiac electrophysiology tests are high risk. Finally, management options are also considered for risk. Intravenous fluids with an additive are moderate risk but intravenous narcotics are considered high risk. A decision to change code status to DNR or descalate care also qualifies as high risk.

In order to code for the highest billing level, you need to have achieved the highest level in history, physical exam and medical decision-making.

Consultation

In addition to serving as the primary attending for patients admitted the hospital, hospitalists often serve as medial consultants for various non-medical specialties. Though CMS no longer recognizes consultation codes, private insurers still may. The documentation needed for coding a consult is the same as already described; however, there are some salient documentation features that are specific to consultations. First, the request for the consultation needs to be documented, both on the end of the requesting service as well as the consulting service. Second, a reason

for consultation needs to be documented; this can be stated with phrases like "would like evaluation of _____" or "would like opinion regarding _____." Phrases like "for management of" or "referral for" implies a transfer of care rather than a true consultation. Practically speaking, consultants often help manage the problem on which they are consulting; this means that billing for an initial consultation may not be feasible but your coder may be able to help determine if the documentation meets criteria for a lesser level service like a subsequent follow-up visit code.

Consultations, like admissions, have to demonstrate medical necessity and seem "reasonable" that the problem is beyond the scope of the primary service, requiring expert opinion. For instance, consulting infectious diseases for an uncomplicated cellulitis would not pass that litmus test. As such, standing orders like hospital order sets that trigger automatic consultation are not allowed. Each patient needs to be individually evaluated for the need of a consultant's input. Similarly, having routine consultations for a particular group or subspecialty, or co-managing patients with other services, becomes more complicated in terms of billing. Preoperative consultations also require demonstration of necessity and cannot be for routine screening purposes. The diagnosis code for a preoperative evaluation cannot stand by itself but instead needs to be linked to another medical problem that reasonably justifies the consult by a medical specialist [11]. Also, the history component of the consultation can sometimes seem limited. Consider a preoperative consult for a knee surgery in an otherwise healthy man. In those instances, use the history of the problem leading up to the surgery. For example, in the preoperative knee replacement patient, the history would describe elements of the pain and dysfunction leading up to the decision to do surgery [3]. Bottom line-consultations need to be requested to address a specific problem that requires attention in the hospital that was beyond the reasonable scope of the requesting physician [11].

Time-Based Coding

In certain situations, physicians are able to bill based on the time spent with the patient and/or reviewing the patients' information rather than based on the traditional history and physical format. Each of the initial and subsequent encounter codes have specific "time-spent" requirements associated with them; if more than fifty percent of that time was spent in counseling and coordinating care for that patient, billing at that level may be based on the time spent rather than on the history, physical, and decision-making aspect [1]. This is useful when patient encounters are for the purposes of delivering news and coordinating next steps in care. Details about different types of time-based codes are beyond the scope of this chapter but being aware of their existence may become helpful in certain situations.

Common Billing and Coding Pitfalls

Given all the layers and requirements to billing and coding, avoiding common pitfalls is important. As this chapter has emphasized, documentation is critical. Lack of appropriate documentation is the largest pitfall hospitalists make in terms of billing and coding. Data and decision-making will not be extrapolated from nursing notes, medication orders, or other parts of the medical record by coders. Therefore all important decisions need to be documented. If a patient is started on a dilaudid PCA, a high-risk medication and thus high level MDM, it must be documented in the hospitalist's note. Lack of assessment of problems is another pitfall. You should have a descriptive assessment for each problem you are addressing, whether it is worsening, improving, critical, etc. [6, 8]. Similarly, each problem should have a plan. Avoid the use of shorthand as this can lead to confusion for the coder. Use of the acronym "CP" can be meant to convey chest pain but may be misinterpreted to represent cerebral palsy by the coder. Avoid "none" and empty-set symbols in the history and physical. Instead, write "no history of hypertension" or "no cervical or inguinal lymphadenopathy." Do not use the word "non-contributory." This word is ambiguous and is not acceptable for billing. Using general phrases like "remainder of exam within normal limits" lacks specific medical content and is treated as if no medical care was performed [1]. Be as specific as possible. "Diabetes type II with nephropathy and neuropathy" conveys a much more complex patient than just "Diabetes." [8] Avoid words like "normal" or "abnormal," especially for elements pertaining to the presenting problem. For instance, writing that the cardiovascular and lung exams are "normal" without further description in a patient presenting with chest pain is insufficient [6].

Clinically related diagnoses can also be given individual attention in the documentation. For instance, the hypernatremia and acute kidney injury from dehydration are all valid individual diagnoses even though clinically would seem interrelated [9]. Most importantly, be legible in the documentation and sign all notes including date and time. A missing or illegible signature will render your note unbillable [6, 8]. Good documentation accomplishes both the medico-legal and financial goals simultaneously. The physician note should convey a clear story about the patient, his conditions, and the plan to help his issues. It should be able to convey the medical information unambiguously to anyone reviewing the chart so that the other members of the healthcare team can be accurately informed. Therefore, the information needed to be extrapolated for billing purposes should be a natural extension of that, not add additional workload [1, 6].

Medical billing and coding can be a complicated process to learn. Hopefully, this chapter has helped to highlight some of the key terms and concepts pertinent to the new hospitalist physician. The challenge is to document in a way that allows you to receive credit for all the work that you do.

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