In-patient E&M Billing

"money on the table"

Rules

- never NOT see a patient when consulted
- never do anything only for the sake of billing
- never NOT do anything due to lack of billing
- never bill when the service has not been rendered

Patient care is always first

having said all that….

- Always maximize billing for services rendered
  - E&M
    - Document to the level of complexity
    - Code appropriately
    - Use modifiers
  - Procedure codes
    - Code for everything you do

Example: PEG

- You're asked by Neurons to place a PEG for feeding access.

Clinical care	**Billing**	**Medicare payment**
See patient today	**initial inpatient consultation note, level 3**	**$191**
PEG	CPT 43246	$225
Post-procedure check the day after	**subsequent hospital care, level 1**	**$ 35**

- E&M portion = $ 226

common E&M vs procedure codes

	Initial hospital care	Subsequent inpatient care	Initial inpatient consult
Level 1	$86	$35	$46
Level 2	$117	$64	$71
Level 3	$172	$91	$109
Level 4	n/a	n/a	$157
Level 5	n/a	n/a	$191

procedure	Medicare payment in KY
Lap cholecystectomy	$609
Open inguinal hernia repair, initial, reducible	$423
Above, incarcerated	$522
Colonoscopy (facility)	$193
Creation AV fistula	$525

Myth

- You can’t bill E&M in the global period

Modifier: 24

- "unrelated evaluation and management service by the same physician during a postoperative period"
  - Has to be tied to an E&M code
  - Same physician (includes same group)
  - Within global period, but not the same day of the procedure
  - Mostly used for underlying disease (diabetes, coronary artery diesese)

-24 modifier example

- 53 year-old male with acute appendicitis. He is on Glucophage, metoprolol, aspirin, and Plavix. His appendix was perforated and required 3 days of hospitalization.

	Service rendered	code	Medicare payment
HD #1	Initial H&P, level 2	99222-57	$117
HD #1	Lap appendectomy	44970	$489
HD #2	Subsequent hospital care, level 2	99232 -24	$64
HD #3	Above, with discharge management, less than 30 min	99238 -24	$63

Other relevant modifiers for E&M

- -25
  - "significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure…"
    - example: central line insertion on the day you bill subsequent hospital care on a post-op patient, you would submit two codes:
      - 99232, -24 & -25 modifier
      - 36556, -79 modifier (unrelated procedure in global period) ($102)

Another relevant modifier

- -57: decision for surgery

On 8/18/09

- Assume we bill on 80% of the patient for E&M billing
- Assume we bill, on average, all level 2 subsequent care for floor patients
- Assume we bill, on average, level 3 for ICU patients (conservative)
- these do not account for all the initial hospital care (conservative)

	Census (ICU/floor)	Collection if 100% billed	Total (E&M)
Gold Surgery	0/4	$0 + $256	$204
Green Surgery	2/17	$182 + 1088	$1016
Red Surgery	5/8	$455 + $512	$773
Blue Surgery	18/42	$1638 + 2688	$3460
Good Samaritan	?		

Total for 8/18/09, if every patient had medicare = $5,453

Let's get more technical

- Total E&M collection = $5,453
- Assume 25% of our patients do not have insurance ➔ $4090
- We work 365 days/year
  - $4,090 x 365 = $1,492,850
  - That is the same as performing 2,451 lap chole