CHAPTER 9 - HOW TO MAXIMIZE REVENUE GENERATION IN THE HOSPITAL FLOOR?

A review of previous chapters, especially chapters 3 and 4, is strongly recommended before reading this chapter, as it lays the foundations for optimal billing and documentation. Maximizing revenue generation is an important consideration for both private practice and academic physicians. There are many ways to maximize revenue generation. We would take a detailed look at each one.

1-AIM FOR THE HIGEST POSSIBLE LEVEL IN AN MDM-BASED CODE SET

The highest-level hospital codes (level 3) are 99223, 99233, and 99236. Outpatient consult codes, which are used in the ER, and inpatient consult codes have the highest level of 5. As explained in Chapter 2, there are 2 ways to reach the highest level. The first one uses total time, and the second uses MDM. You should always look at how much total time you have spent first. If you have spent enough time to meet the requirement for the highest level in a code set, then you should not bother looking at MDM, because, irrespective of MDM, you can report the highest level of code. If the total time you spent with the patient is insufficient for the highest level, you should check whether the MDM is sufficient to reach a higher level. This is the golden rule. Use the pathway that gives you the highest level. You may not be able to turn level 1 into level 3 unless you spend enough time, but turning level 1 into level 2 or turning level 2 into level 3 may not be too difficult.

MDM-based E/M service codes for floor use.

Code Set	CPT code	Code Level	Time	MDM
Admission	99221	Level 1	40 minutes	Straightforward/Low
	99222	Level 2	55 minutes	Moderate
	99223	Level3	**75 minutes**	High
Subsequent	99231	Level 1	25 minutes	Straightforward/Low
	99232	Level 2	35 minutes	Moderate
	99233	Level 3	**50 minutes**	High
Same day	99234	Level 1	45 minutes	Straightforward/Low
	99235	Level 2	70 minutes	Moderate
	99236	Level 3	**85 minutes**	High
Discharge	99238	N/A	<30 minutes	N/A
	99239	N/A	**>30 minutes**	N/A
Consult ER	99242	Level 2	20 minutes	Straightforward
	99243	Level 3	30 minutes	Low
	99244	Level 4	40 minutes	Moderate
	99245	Level 5	**55 minutes**	High
Consult inpatient	99252	Level 2	35 minutes	Straightforward
	99253	Level 3	45 minutes	Low
	99254	Level 4	60 minutes	Moderate
	99255	Level 5	**80 minutes**	high

Almost everything that you do for patient care that is not reported with another CPT code is included in the total time. You don't need to be on the patient floor for the time to count.

1. Preparing to see the patient: **chart review, review of tests or imaging.**
2. Obtaining and/or reviewing separately obtained **history.**
3. Performing a medically appropriate **examination and/or evaluation.**
4. **Ordering** medications, tests, or procedures.
5. **Counseling** and educating the patient/family-caregiver.
6. **Referring and communicating** with other health care professionals.
7. **Coordination** of care.
8. **Documenting** clinical information in the electronic or other health record ~ **writing notes** .
9. Independently **interpreting results** and communicating results to the patient/family.

Example: the highest level on the floor for the subsequent patient has 50 minutes of total time. If you spend 50 minutes on a subsequent patient, then you should bill level 3 (99233) irrespective of complexity/MDM. What if you spend only 35 minutes total time with a subsequent patient, which only qualifies for level 2 (99232)? Can you make it level 3 using MDM? If the answer is yes, *"based on MDM I can report level 3",* then report level 3 based on MDM. If MDM only qualifies level 1, then report level 2 based on total time.

Physicians tend to underestimate their time, but it's important to remember that everything you do for patient care counts toward total time, including writing your note. Time spent in pre-rounding, looking at vitals, labs, imaging, and notes; talking with consultants, radiologists, dietitians, or other team members; and time spent during rounds, including answering questions from patients or caregivers, all count toward time. Time spent on unrelated teaching during the rounds does not count. Time spent looking into textbooks, journal articles, online resources, drug doses, and side effects counts towards time as long as it's done to help with patient management. For example, you had a patient with AKI and looked up all the medications that the patient is on for their side effects on the kidneys. You have a patient with white matter lesions in the brain MRI, and looked in a textbook for what differential labs to send and how to manage this condition.

You can increase the total time spent on patient care in various ways, including providing counseling or education, coordinating care, calling consultants, etc., as long as it is medically appropriate. For example, you have a patient with asthma exacerbation who is doing well and improving. If you spent only 25 minutes on this patient and the patient has low MDM, the patient only qualifies for level 1 (99231), but you can bill level 3 if you provide an additional 25 minutes of education on asthma prevention and management. 25+25=50 minutes = level 3, 99233.

It is important to note that spending more time to reach a higher level does not work for hospital discharge services when it is already more than 30 minutes, and for normal newborn services. Whether you spend 40 minutes or 4 hours on a discharge doesn't matter; you still bill the same code, 99239.

We have seen above that by spending more time, you could increase the code level and hence revenue generation. Can a similar strategy work in the MDM pathway? The answer is yes, but instead of time, you should identify additional problems, data, or risks to increase the MDM level.

The sicker the patient or the more complex the problem, higher the level you can target. Acute life-threatening illness > complicated acute illness with complication > uncomplicated acute illness > self-limited or minor problem. Severe exacerbation of chronic illness > exacerbation of chronic illness > stable chronic illness.

Consider addressing or uncovering more problems, especially patient comorbidities. Addressing comorbidities and uncovering new problems is not only a good practice but also helps increase the level of MDM and, hence, revenue generation. For example, you have a subsequent patient with soft tissue infection who is doing well and only qualifies for level 1 (99231) based on MDM. Let's assume the patient also had hypothyroidism, and you checked the TSH level, which is elevated, and you changed the levothyroxine dose. By definition, this (unstable chronic disease plus drug prescription) qualifies for moderate MDM and hence level 2 (99232). Another example would be checking a VitD level, if it is low, and you start cholecalciferol, that is level 2 billing.

In many hospitalized patients, it is not difficult to reach the highest level of data element because there are many labs, imaging, or notes to review, and each counts. The high MDM data element has 3 categories, and 2 of them must be fulfilled. The first category only needs 3 items, including any combination of labs, imaging, notes, and an independent historian. Examples of enough items: cbc/bmp/crp or cbc/crp/Ua or CBC/external note review/independent historian. Because in pediatrics, we almost always have an independent historian/caregiver, you practically end up needing 2 more. Category 2 is fulfilled any time you independently interpret a study like CXR, KUB, CT, or EKG. Category 3 is fulfilled any time you have a management discussion with other physicians. You only need 2 out of 3 categories fulfilled. For example, you interpreted the CXR and called the pulmonologist for management, which qualifies as the highest level MDM data. Then you just need to add a sufficiently high problem or risk to reach high-level MDM or the highest-level code. Ordering more tests and imaging (medically appropriate), reviewing more notes, or talking with other physicians all help reach the highest level.

Two risk examples were given for moderate MDM. First one, "prescription drug management" is very useful because when you combine it with unstable chronic disease, then it automatically qualifies for moderate MDM, level 2. For example, you have a subsequent patient with a simple soft-tissue infection that only qualifies for level 1 (99231) based on MDM. If the patient has not well-controlled DM and you continue the patient's insulin, this would automatically make the patient moderate MDM and hence level 2. With a little detail, you generated more revenue. The second risk example is "diagnosis or treatment significantly limited by social determinants of health". You can use this criterion when a patient's social factors significantly complicate evaluation and management, making management more challenging, such as living in a shelter or in a very difficult social situation.

Four high-risk examples were given for high MDM. The first one: a *decision regarding hospitalization or escalation of hospital-level care*, applies anytime you consider an admission from the ER or a transfer of a patient from the floor to the ICU. The second one, *drug therapy requiring intensive monitoring for toxicity*, applies when you have frequent labs to avoid side effects. Examples include checking daily BMPs while being NPO with IV fluids (to avoid electrolyte derangements), checking daily BMPs while on diuretics, monitoring CBC or LFTs while on drugs that cause neutropenia or hepatotoxicity, or monitoring Cr while on vancomycin. Checking EKGs while on QT-prolonging medications is also in this risk group. The third high-risk example, *parenteral controlled substances*, applies when IV opioids or benzodiazepines are used for pain or comfort. Fourth high-risk example, *decision not to resuscitate or to de-escalate care because of poor prognosis* applies during end-of-life discussions. If you have one of the above high-risk factors, you only need high-level data or a problem to qualify for the highest-level code.

Summary of targeting higher level in a code set.

Time-based higher level code targeting	
Spend more time *(that is medically appropriate)*	Provide counseling, education, address concerns in length
	Coordination of care~ talk with consultants
	More detailed chart review
	More detailed history, examination *(medically appropriate)*
	Writing more detailed notes

MDM-based higher level code targeting	
Problems. *Address more problems or more complex problems*	1 self-limited or minor problem < 2 self-limited or minor problem
	1 stable chronic illness < 2 stable chronic illnesses
	Stable chronic illnesses < chronic illness with exacerbation < chronic illness with severe exacerbation
	Acute, uncomplicated illness < acute illness with systemic symptoms < acute life threatening illness
Data *Order and review more medically appropriate data elements*	Have independent historian
	Order and review more tests, *medically appropriate*
	Review external notes
	Provide independent interpretation of tests or imaging
	Management discussions with other providers
Risks	Prescription drug management *(giving or renewing prescription)*
	Diagnosis or treatment significantly limited by social determinants of health
	Drug therapy requiring intensive monitoring for toxicity
	Decision regarding hospitalization or escalation of hospital-level care
	Decision not to resuscitate or to deescalate care because of poor prognosis
	Parenteral controlled substances

2- USE PROLONGED CARE CODES

Please refer to Chapter 3 for details on prolonged care codes. There are basically 2 different types of prolonged care codes. The first code group consists of 99417 and 99418. Only 99418 is used in an inpatient setting. It is used when you see a patient and then spend too much time with the patient during the same day/date. Second code group 99358 and 993569 is to report extra time for the patient care on the day/date that you have not seen the patient.

99418 represents each 15-minute block. This code exists so you can bill for care beyond the typical. Examples include spending several hours with a socially difficult or medically complex patient, trying to figure out what's wrong, talking with multiple consultants or spending a lot of time at the bedside.

99358 is for the first hour, and 99359 is for each additional 30 minutes. It would be rare for a hospital physician not to see their patient that day. These codes can be used in rare situations when you are involved in the care of a patient while not on service. Hospitalists who take call at home may use these codes more commonly. For example, you were called by your resident at 9pm about a new admission, spent 30 minutes on the phone that night, and saw the patient the next day. Then you can report your time using these prolonged care codes for the night when you didn't see the patient.

Prolonged care codes may be used by the night attending when they are on call and provide care to patients who become active at night. This may be an important source of revenue generation. 99418 involves 15 minutes of care. Most interactions with an active patient at night take at least 15 minutes, which is good enough to bill 99418. If you send 60 minutes, then you can report 4 units of 99418 (4 x 15 = 60). In order to report 9918 at night, though billing in the day should be either time-based 99223 or time-based 99233.

3-CONSULTING ON A PATIENT WITHOUT SEEING THE PATIENT

There are many instances in which a consultant spends a lot of time on the phone with a patient but still does not see the patient that day. In this instance, you can report your time spent on that day with prolonged care codes 99358 and 99359, as long as you see the patient in the following days or have seen the patient in the past.

4- MEDICAL TEAM CONFERENCE

Please refer to Chapter 3 for details on the medical team conference (team meeting). Hospitalists or consulting physicians may report their time using an appropriate E/M service code, such as 99233, and use prolonged care codes if needed when a family member or patient is present during the meeting. When a family member or caregiver is not present, then code 99367 can be used to report the time.

5- CRITICAL CARE SERVICES

Critical care codes are not reserved for intensivists and may be reported by any other physician. Hospitalists should strongly consider using critical care codes for patient care that meets the definition of critical care. Patients transferred to the ICU are an important group, and hospitalists can report

critical care services for the management of critically ill patients prior to transfer. Only detail is that, because the care is time-based, adult or time-based critical care codes 99291 and 99292 are used, irrespective of the patient's age, and not the pediatric/neonatal critical care codes.

6-OTHER E/M SERVICES

Report other E/M services when you provide them such as, telemedicine codes or online digital E/M services.

7- DO NOT FORGET NON-E/M SERVICES OR PROCEDURES

E/M services or codes only cover evaluation and management. They basically involve examination and talking. If you perform anything other than examination or talking, there can be a separate code for it. For example, an ear exam is part of the physical examination and, hence, part of normal E/M service, but removal of impacted cerumen is not. There is a separate code for impacted cerumen removal; if you perform one, report it separately.

Non-E/M services a hospitalist may report may vary depending on the hospitalist's expertise and comfort level. Hospitalists typically have consulting physicians perform many procedures for them and end up not performing many procedures, but they may still perform procedures such as LP, difficult IV placement, central line placement, intubation, g-tube replacement, and cauterization of a granuloma. It is strongly recommended that physicians scroll through the pages of a CPT code book, find relevant codes for their practice, and use them to generate more revenue. You will be surprised by how many procedures you are already performing that are separately reportable. Chapter 4 provides useful information on common non-E/M service codes that pediatricians may use.

8-APPROPRIATE DOCUMENTATION OF SELECTED CPT CODE

The importance of documentation cannot be overemphasized, as reimbursement doesn’t depend on delivered care but rather on documentation. If a reported CPT code (or a claim) is not supported with appropriate documentation, then the claim may be denied. Please refer to section 6 for guidelines on appropriate documentation.

So, do not just select the highest level of code; also, document in your note that the patient actually qualifies for that level. If you are billing 99233, then either document high-level MDM or 50 minutes of total time.

9- APPROPIATE USE OF ICD CODES

CPT codes are always reported with ICD codes. ICD codes tell the payer about the reason for service, while CPT codes tell the payer about the nature of the service. You should align your CPT codes with ICD codes. If you report a high-level code, then you should list sicker-looking ICD codes, unless time-based billing is used. For example, if the sicket ICD code listed is URI, it may be difficult to justify code 99223, and the claim may be denied; however, it will likely be reimbursed if severe RAD exacerbation is used.

Reported ICD codes should reflect the patient's active problems being addressed, not inactive problems that are not addressed at that encounter. Chronic problems that are not contributing to medical decision-making are not relevant in selecting the level of MDM. Although ICD for unaddressed chronic problems may be listed, they are not as important as the acute problems. If you are reporting higher-level codes, then list the appropriate sick ICD codes first, before ICD codes of other unaddressed chronic problems.

10- DO NOT FORGET TO BILL

Physicians frequently lose revenue when they forget to bill. It's a good idea to have a system that reminds you to bill for every patient that you see. This can be a computer-generated or handwritten patient list, with a check mark for every patient who is seen and billed. If you are a teaching physician, it's a good idea to write down the list of the patients you have seen that day so that if a resident forgets to write a note, you can still detect the missing note and bill for it. If you do not have your own list, then you may not realize when a resident forgets to place a note, especially if you are signing your notes and billing days after being on service.

11- FOLLOW YOUR CLAIMS

Follow your claims (CPT codes) closely to ensure they are submitted appropriately and that denials are addressed. If you do not have a system in place to track your claims, you would have no idea how much revenue you are losing.

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