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Compliance Hotline

Type: <http://157.21.29.163/Compliance/> and click on Hotline. EVMS Health Services Compliance concerns may also be sent to the EVMS Health Services Compliance Office via phone, mail or e-mail.

Contact Us

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Hospital Stays Lasting Less Than 24 Hours

Because of ongoing confusion CMS has now provided clarification of the existing rules for billing hospital stays lasting less than 24 hours. These guidelines may be found in the Internet-Only Manual on the CMS web site at:

<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

In order to select the correct code several questions must be asked.

- What was the status of the patient? (Was the patient admitted to *observation* status or to *inpatient* status?)
- What was the length of the stay?
- Was the patient admitted and discharged *on the same calendar date*?

PATIENT ADMITTED:	to observation status	to inpatient status
less than 8 hours on same calendar date	99218-99220	99221-99223
at least 8 hours but less than 24 hours on same calendar date	99234-99236	99234-99236
on one calendar date and discharged on a different calendar date	99218-99220 and 99217	99221-99223 and 99238-99239

Note that the admission date is the date the patient was admitted to either observation or inpatient care. It is not necessarily the date of initial observation or hospital care provided by the teaching physician.

CMS requires that "The physician shall satisfy the E/M documentation guidelines for admission to and

discharge from observation care or inpatient hospital care. In addition to meeting the documentation requirements for history, examination and medical decision making, documentation in the medical record shall include:

- *Documentation stating the stay for observation care or inpatient hospital care involves 8 hours, but less than 24 hours;*
- *Documentation identifying the billing physician was present and personally performed the services; and*
- *Documentation identifying the admission and discharge notes were written by the billing physician."*

Coding for Excision of Lesions

Excision is defined as full-thickness (through the dermis) removal of a lesion including margins, and includes simple (non-layered) closure when performed. Codes are selected based on:

- the type of lesion;
 - benign (codes 11400-11446) or
 - malignant (codes 11600-11646)
- the size of the lesion; and
- the location of the lesion.

The size of the lesion is determined by measuring the greatest clinical diameter of the apparent lesion plus that margin required for complete excision (lesion diameter plus the most narrow margins required equals the excised diameter). Margins refer to the most narrow margin required to adequately excise the lesion, based on the physician's judgment. **The measurement of lesion plus margin is made prior to excision.** This measurement must be documented in the record. It is not appropriate to use the pathology report as documentation of the size of the lesion.

Compliance Discussion Groups for May 2008

Topic: Advance Beneficiary Notice (ABN)

Dates: Tuesday, May 20 & Thursday, May 22, 2008

Location: Hofheimer Hall, Room 758 & 755

Time: Noon to 1:00 p.m.

RSVP by email or phone to Leanne Smith (451-6207).
Bring your lunch. Snack & drinks will be provided.