Codify by AAPC

# Dermatology Coding Alert

## Consult Update: Work Around Consult Codes When Medicare Is Secondary Payer

**Only shrewd payment calculation can salvage lost pay for dermatology consultations.**

As if it's not confusing enough using consultation codes for one payer and inpatient/outpatient codes for another -- what if one patient has two insurance payers? That's the dilemma you'll face for Medicare Secondary Payer (MSP) claims.

Study our experts' advice to see how you can manage this latest consultation coding quandary for your dermatology practice.

**Know the Extent of Your Problem**

In 2010, CMS ended their coverage of the consultation codes (99241-99255, Office/Inpatient consultation for new or established patient ...), boosting the reimbursement for primary care services to compensate.

Office consults have always been a gray area, and many dermatology coders applauded this change. "We won't have to decide if there has been a transfer of care or not," says **Christine M. Liles, CPC,** insurance supervisor at Knoxville Dermatology Group in Tennessee.

"Being able to use just the regular office visit and hospital and nursing home codes will make it easier."

The catch: If a patient has Medicare as secondary insurance and you bill a consultation (99241-99255), you won't see the supplemental pay because Medicare no longer recognizes the codes, points out **Marvel Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO,** owner of MJH Consulting in Denver.

"The issue becomes somewhat problematic if the primary insurance leaves a patient balance (such as coinsurance or a deductible) and the service needs to be reported to Medicare," Hammer says.

Inventory your major payers: To anticipate when you'll face this dual-consult-pay problem, you need to know how your payers stack up. Some payers that do not base their payments on Medicare's fee schedule may not follow the CMS lead to stop using consultation codes -- while others will. Take a survey of your payers so you'll know what to expect.

For instance: "Blue Cross Blue Shield of Rhode Island will accept either method," said **Peter A. Hollmann, MD,** the AMA CPT editorial panel vice chair, in his presentation at the AMA CPT and RBRVS 2010 Annual Symposium in Chicago.

**Learn 2 Options for MSP Situations**

If the primary payer follows Medicare rules -- no sweat. But "if the primary payer continues to recognize consultation codes," you'll have to decide between the following two billing choices, according to MLN Matters article MM6740.

1. Bill primary payer inpatient/outpatient codes: One option is to bill the primary payer using the outpatient (99201-99215, Office or other outpatient visit...) or inpatient (99221-99233 Initial/subsequent hospital care ...) codes, just as Medicare requires. This choice will preserve the possibility of receiving a secondary Medicare payment, according to the Physician Fee Schedule final rule. The MLN Matters article states that you can bill the primary payer the inpatient or outpatient E/M code. Then you can report the amount actually paid by the primary payer, along with the same E/M code, to Medicare for determination of whether a payment is due.

This option "may be easier from a billing and claims processing perspective," indicates CMS in the MLN Matters article.

*CPT® 2023 American Medical Association. All rights reserved.*

Codify by AAPC

Example: A primary care physician checks out a patient with a suspicious-looking mole. Since he cannot establish a diagnosis, he sends for a dermatologist to evaluate and examine the patient's mole. The dermatologist decides to perform a biopsy to determine if the mole is malignant or benign (11100, Biopsy of skin, subcutaneous tissue and/ or mucous membrane [including simple closure], unless otherwise listed; single lesion).

In 2009, you would report the appropriate code from the 99241-99245 series, depending on time spent with the patient, key components, and level of problem severity, in addition to the other procedure codes. In this case, however, you will have to report an E/M service code.

Sacrifice: A payer that still accepts the consultation codes probably has not adjusted its fee schedule, like Medicare has, to allow higher payment for other E/M codes.

2. Bill primary payer consult codes: Your second choice is to bill the primary payer using the consult codes. If you pass the claim on to the MSP using the consult code, the claim "will result in a denial of payment for invalid codes," according to the final rule. "MSP will not pay for consults," emphasizes **Samantha Daily**, billing specialist with a practice in Portland, Ore. You can bill the primary payer using a consult code, then report a different, Medicare-appropriate E/ M code to the MSP along with the amount paid by the primary insurer. Medicare can use the information to determine whether any payment is due.

Difficulty: This method can be a nightmare from a billing and claims processing perspective.

**Let Calculation Drive Choice**

If you examine your biggest payers and your most common E/M procedures, you might be able to calculate which method will boost your bottom line. "There is essentially no workaround for this situation, so you have to decide whether you will get paid better via payment from the primary insurer with a consult code versus the alternative (billing an E/M to both payers)," says **Robert B. Burleigh, CHBME,** president of Brandywine Healthcare Consulting located in West Chester, Penn.

***CPT® 2023 American Medical Association. All rights reserved.***