Dermatology Coding Alert

E/M Update: Say Goodbye to Claims for 'Second Opinions' in 2006

CPT consolidates confirmatory consult and inpatient consult coding

You may have fewer choices to make when reporting consult codes in the new year: CPT 2006 has plans to eliminate follow-up inpatient (99261-99263) and confirmatory (99271-99275) consultations.

All Follow-Ups Become Subsequent Care

Beginning Jan. 1, 2006, you should report all facility visits, except the first, during the same inpatient stay, using subsequent care codes 99231-99233 (hospital) or 99311-99313 (nursing facility).

Under current guidelines, the dermatologist may report a follow-up inpatient consultation for subsequent visits during a single inpatient stay, as long as the visit meets the criteria of request with reason, opinion rendered, and report, says **Suzan Hvizdash, BSJ, CPC,** physician education specialist for the department of surgery at UPMC Presbyterian-Shadyside in Pittsburgh.

The elimination of 99261-99263 for 2006 means that come January, you no longer have that option--even if the service meets the requirements of a consult and the surgeon does not assume responsibility for any portion of the patient's care.

Don't Overlook Initial Consult

When these changes take effect, you will still need to report an initial inpatient consult (99251-99255) for the dermatologist's first visit with the patient per inpatient stay, as long as the service meets all the requirements of a consult, says **Susan Callaway, CPC, CCS-P**, an independent coding auditor and trainer in North Augusta, S.C.

Example: On Jan. 2, 2006, the managing physician requests that a dermatologist provide a consultation for a hospital inpatient complaining of a rash. The dermatologist documents the request, examines the patient and shares his findings with the managing physician.

In this case, you would report an initial inpatient consult (for example, 99254, Initial inpatient consultation for a new or established patient ...), as well as any diagnostic tests the dermatologist provides (for example, 11100, Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion).

The next day, Jan. 3, the managing physician once again asks the dermatologist to examine the patient because of new symptoms. Again, the dermatologist documents the managing physician's request, examines the patient and shares his findings.

For the follow-up visit, assign subsequent hospital care codes (for instance, 99232, Subsequent hospital care, per day, for the evaluation and management of a patient ...). This visit looks like a consult, but you will need to report subsequent care, because CPT 2006 makes 99261-99263 invalid.

Remember: A consulting physician may initiate treatment and/or provide diagnostic testing in the absence of a definitive diagnosis, and still report a consult. If, however, the physician accepts primary responsibility for the patient prior to the visit, a transfer of care has occurred, and you should report a new or established patient visit, depending on the situation and setting.

Celebrate the Change

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Some good news: Deletion of 99261-99263 would ease documentation requirements for physicians and headaches for coders trying to choose between follow-up consults and subsequent hospital care, Hvizdash says. You would be able to simply choose 99231-99233 for hospital inpatients or 99311-99313 for nursing facility patients.

And some great news: As a bonus, subsequent hospital care codes generally reimburse better than follow-up inpatient consultations. "Level for level, subsequent care codes pay at a higher rate than follow-up consultation codes," Callaway says.

Forget About 99271-99275

CPT 2006 is also slated to eliminate codes 99271-99275 (Confirmatory consultation for a new or established patient ...). If this happens, you would report either a standard outpatient E/M service (99201-99215) or a consultation (99241-99245)--depending on the circumstances--for so-called "second (or third) opinions." For a confirmatory consult requested by a patient, it would not be appropriate to report a consultation code starting in 2006, experts say.

"With no confirmatory consults in 2006, you'd treat these services like any other E/M service," Hvizdash says. "If the surgeon receives a request from another physician to examine the patient, renders an opinion and provides a response, you have an outpatient consult. If the visit doesn't meet the requirements [such as when a patient 'self-refers'], you'd charge for a standard office visit."

Example: A patient recently diagnosed with skin cancer (172.0-172.8, Malignant melanoma of skin) seeks a second opinion before undergoing Mohs surgery. The dermatologist provides a full workup and discusses possible outcomes with the patient.

By the new guidelines, you would report an appropriate-level new patient visit (such as 99204, Office or other outpatient visit for the evaluation and management of a new patient ...).

Ask for an ABN for Second Opinions

You should obtain an advance beneficiary notice (ABN) from a patient prior to rendering the service if you know that the patient is seeking a second opinion or confirmation of a diagnosis or treatment plan. The ABN lets the patient know that he may be responsible for payment if the insurer deems the service unnecessary, says **Debbie Blondell,** office manager for Park Avenue Dermatology in Coos Bay, Ore.

Why it's worth the effort: In the past, many payers (including Medicare) have not covered confirmatory consultations because the insurers considered such second opinions (especially when generated by the patient or patient's family) a "duplication of services."

This problem may continue to haunt physicians who provide second opinions for patients: Because another physician has already examined the patient and provided an opinion, the payer may deem any attempt to re-examine the patient a duplication of services, even if you bill the care as an office visit or inpatient or outpatient consultation.

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