Internal Medicine Coding Alert

Introducing CPT's 'Win-Win' Routine Hospital Care Coding

Higher-paying subsequent care will be your only choice for inpatient follow-up

CPT 2006's deletion of follow-up inpatient consultations gives you more than one reason to celebrate--this change not only eliminates consult coding pitfalls but adds $10 per encounter.

Next year, you'll have only one type of inpatient consultation code. CPT 2006 will delete follow-up inpatient consultations (99261-99263, Follow-up inpatient consultation for an established patient ...) and confirmatory consultation codes (99271-99275, Confirmatory consultation for a new or established patient ...).

Say Goodbye to Consult, Co-Manage Confusion

When the new codes take effect, you won't have to question whether an inpatient consultation is an initial or follow-up consult--a distinction that practitioners have long struggled to comprehend. "Many physicians incorrectly use the current follow-up consultation codes, says **Susan Callaway, CPC, CCS-P,** an independent coding auditor and trainer in North Augusta, S.C

Now, you should report a follow-up inpatient consultation (99261-99263) for visits subsequent to the initial inpatient consult. During these encounters, the internist returns to review lab work, studies obtained or the patient's changed status and does not co-manage the case. But CPT 2006 will eliminate this consult/co-management gray area by removing this coding option.

New method: When the new codes take effect, you will report all inpatient consults with 99251-99255 (Initial inpatient consultation for a new or established patient ...). Beginning in January, you will most likely report follow-up inpatient care with subsequent hospital care codes 99231-99233 (Subsequent hospital care, per day, for the evaluation and management of a patient ...).

Describe Daily Routine Care as 99231-99233

When an internist receives a proper request for a consult in the inpatient setting, you may claim one initial inpatient consult (99251-99255) per hospital admission. These codes won't change for 2006. However, if the internist sees the same patient during the same inpatient stay, you should report subsequent hospital care codes, not follow-up inpatient consult codes (99261-99263, which CPT 2006 will eliminate).

Example: After an internist renders his opinion on an orthopedist patient's diabetes mellitus (250.xx), the internist continues to check on the patient during his hospital stay. Because the internist is managing the patient's subsequent diabetes mellitus care, you should code the subsequent visits with 99231-99233, says **Pat Larabee, CPC, CCP**, a coding specialist at InterMed in South Portland, Maine.

Avoid the temptation to code the above scenario's diabetes mellitus follow-up management as 99261-99263. "Many physicians think that because they have been involved in an initial inpatient consult then any follow-up visit automatically constitutes a follow-up consult," Larabee says. But that is rarely the case.

Better way: If, after the initial consult, the physician continues to treat the patient, you should use subsequent care codes. CPT's deletion of 99261-99263 will leave 99231-99233 as the only coding option.

I think this change "is a blessing," Larabee says. "Ninety-nine percent of the inpatient follow-up consults that I have

audited are actually only subsequent hospital visits." Internists will no longer have the burden of "making sure that the documentation supports the follow-up consult code," she says.

Replace 99261-99263 With Subsequent Care Code

You will, however, have to pay attention to diagnosis coding if you want to avoid denials for two same-day E/M services performed by physicians of different specialties.

Scenario: A cardiologist and an internist are co-managing a patient's care. The cardiologist initially requested the internist's opinion on a heart attack patient's cough, congestion and fever. The internist continues to monitor the patient's upper respiratory infection (URI) and thus each physician is accessing 99231-99233. Therefore, the insurer will receive two subsequent hospital care claims for the same patient on the same date of service.

Key: Each specialist must report the condition(s) he cares for to ensure that the dual charge doesn't trigger a denial. "ICD-9 instructs the physician to list all of the diagnoses he or she addressed during that exam," Callaway says. For the URI/heart attack patient, the internist would report the URI (such as 465.9, Acute upper respiratory infections of unspecified site), and the cardiologist would code the myocardial infarction (for instance 410.01, Acute myocardial infarction; of anterolateral wall; initial episode of care). The different diagnoses and different specialties involved should facilitate payment of both claims.

Earn $10 More for 99231-99233

Barring payment obstacles, 99261-99263's expected deletion will benefit your bottom line. "Level for level, subsequent care codes pay at a higher rate than follow-up consultation codes," Callaway says.

Moneymaker: Codes 99231 and 99233 pay $11.75 more than 99261 and 99263, based on the 2005 National Physician Fee Schedule Relative Value File. Code 99232 reimburses $10.23 more than 99262.

Bottom line: Internists will receive higher reimbursement for the subsequent hospital visits than for the confirmatory consultations, Larabee says. "Looks like a win-win situation to me," she says.