Codify
BY AAPC

Internal Medicine Coding Alert

Sidestep Concurrent Care Pitfalls With Clear Documentation

Hint: Double-check the diagnosis codes before you submit the claim

If payers are rejecting your concurrent care claims, the denials don't necessarily mean that your internist's services aren't worthy of reimbursement. Your internist's documentation - and how you coded the services - could reveal the real reasons behind your lost payments.

When more than one physician provides services to the same patient during the same time period, coding the concurrent care is appropriate if each physician plays an active and distinct role in the patient's treatment, says **Bruce Rappoport MD, CPC,** a board-certified internist who works with physicians on compliance, documentation, coding and quality issues for Rachlin, Cohen & Holtz LLP, a Fort Lauderdale, Fla.-based accounting firm with healthcare expertise. "This occurs, for example, because of the existence of more than one medical condition requiring diverse, specialized medical services."

Detect Diagnosis Code Problems

Use these helpful solutions and common concurrent care scenarios to make sure that your internist's specialized services don't fall by the wayside. The most common reason for a concurrent care claim denial has to do with your diagnosis codes, experts say.

Example: A cardiologist admits a patient to the hospital for congestive heart failure (428.0, Congestive heart failure, unspecified). The patient develops pneumonia (480.9, Viral pneumonia, unspecified), and the cardiologist calls your internist in to treat it. Your internist's documentation reads: "Patient was admitted for congestive heart failure, and I'm seeing him for pneumonia."

You report a subsequent hospital care code (99231-99233) with 428.0 as the primary diagnosis and 480.9 as the secondary diagnosis and you receive a denial.

Do it this way: Instead, you should use 480.9 as your diagnosis code, because your internist only treated the patient's pneumonia. If both the cardiologist and your internist report the same diagnosis code, you will receive a denial on that claim because your payer will think that both physicians are providing the same services, says **Barbara Cobuzzi, MBA, CPC, CPC-H,** a coding and reimbursement specialist and president of Cash Flow Solutions, a medical billing firm in Brick, N.J.

"The key to concurrent care is your diagnosis code should indicate a different problem" and the documentation should clearly state that the internist is not treating the patient for the same problem as the cardiologist, explains **Suzan Hvizdash,** a physician education specialist for the department of surgery at UPMC Presbyterian-Shadyside in Pittsburgh.

Your internist should document that the cardiologist admitted the patient for congestive heart failure, but during the course of his hospitalization he developed pneumonia, Hvizdash says. At that time, the internist began treating the patient's pneumonia - not the congestive heart failure. "You almost have to overstate your point," because otherwise your internist's notes can be too ambiguous, she says.

Beware of Billing for the Initial Hospital Visit

When both your internist and another specialist want to bill for the initial hospital visit, remember that Medicare will pay for only one initial hospital visit claim per patient, Cobuzzi says. Unfortunately, the physician who receives the reimbursement may not be the one who rightfully deserves it, experts say.

Scenario: Your internist decides to admit a patient, whom he has treated in his office for her diabetes (250.70, Diabetes mellitus; diabetes with peripheral circulatory disorders; type II or unspecified type, not stated as uncontrolled), for gangrene developing in her left foot (785.4, Gangrene). A general surgeon examines the patient later that same day to determine whether he wants to amputate the foot.

You report initial hospital care code 99222 (Initial hospital care, per day, for the evaluation and management of a patient ...), and the general surgeon mistakenly reports 99222 as well. Because the general surgeon's claim went out to the payer faster, Medicare pays the surgeon's claim and denies yours.

Reason: Medicare isn't able to distinguish which initial hospital care claim should get paid, so it pays the first one it receives. "We tell physicians that it might be the first time they see a patient in the hospital, but they can't bill the initial visit unless they admit the patient," Hvizdash explains. Any other physician can then bill a subsequent visit (99231-99233) or a consultation (99251-99255) - if his documentation can support the claim, she adds.

Investigate Your Internist's 'Coordination of Care'

Be careful with submitting concurrent care claims when your internist coordinates a patient's care. Make sure you can identify exactly what billable services the physician provided to the patient, Hvizdash says.

For example: Your internist is coordinating a patient's care in the hospital, making sure that the gastroenterologist evaluates and treats the patient's small bowel obstruction. You report a hospital inpatient code (99221-99223) and 560.9 (Unspecified intestinal obstruction) as your diagnosis code, but Medicare denies your claim because the gastroenterologist used the same diagnosis code for the same service date.

While your internist may provide continuity of care from the patient's perspective, "it's not a billable service," Hvizdash says. The gastroenterologist is the physician who is treating the patient's small bowel obstruction, not the internist. Furthermore, if the internist and the gastroenterologist both bill for the inpatient care using 560.9, the gastroenterologist has a better chance of getting paid on that claim, she says.

What to do: You need to look at your internist's notes to determine whether he performed any other specific services in addition to monitoring the patient's care. Perhaps the internist is monitoring the patient's Coumadin levels or unrelated hypertension (401.9, Essential hypertension, unspecified). Make sure the internist is focusing his documentation on whatever he is doing that the gastroenterologist isn't, Hvizdash says.