

Part B Insider (Multispecialty) Coding Alert

CONSULT CODING QUIZ: Check Your E/M Coding Skills With These Quiz Answers

Hint: Only look to unlisted E/M codes when your MAC specifically tells you to.

How did you fare in our E/M coding quiz on page 10? Check your coding finesse with these four answers to the quiz questions.

Question 1: Consult 'Replacement Codes: If the physician performs a service that you previously would have billed as an inpatient consult, report 99221-99223 in place of 99251-99255, says **Tammie L. Alberts, CPC**, with Rockford Health Systems in Rockford, Ill. For outpatient consults, use either new or established E/M codes 99211-99215 or 99201-99205, she advises.

Question 2: Do Unlisted Codes Apply? Unless the advice comes from a Medicare carrier, "I would be very cautious about using an unlisted E/M code," says **Shelby Davidson, CPC, CMSCS**, coding educator with Ohio Health.

"If the patient is considered an inpatient, you simply report an initial inpatient visit or a subsequent inpatient visit," Davidson says. "Before I would use an unlisted procedure code in place of an E/M code, I would want to see it in writing from CMS." Some MACs have instructed practices to report the unlisted code if the documentation does not support any of the published E/M codes, but other MACs disagree. Therefore, you should only report codes that your MAC instructs you to bill, and be sure to use the MAC's specific published criteria.

Question 3: Who Bills the AI modifier? Not every physician who sees the patient in the hospital should append modifier AI (Principal physician of record).

"The consultant's initial visit should be billed with codes 99221-99223 without the AI modifier," says **Catalina Fischer**, coder with Neurologic Associates in Waukesha, Wisc. "The admitting physician utilizes the same codes but attaches the AI modifier."

"If your physician sees the patient a second, third, fourth time, then he or she would utilize the subsequent inpatient care codes 99231-99233," Fischer says.

To eliminate confusion, you may want to retrain your brain to classify how you define the hospital care codes.

"I think what is making this a bit confusing is that a lot of us are in the habit of calling the codes in the 99221-99223 range 'admit codes,' when they are actually initial hospital care codes," Fischer says. "So if you can retrain your way of thinking, it might become a little easier to understand."

Example: An emergency room (ER) doctor sees a patient who was involved in a motor vehicle accident. He calls in a trauma surgeon because of possible intra-abdominal damage, and the trauma surgeon admits the patient because of possible bleeding. The patient is pregnant, so an ob-gyn comes in for a consultation also. The trauma surgeon would report 99221-99223 with modifier AI appended.

The ob-gyn then bills 99221-99223 with no modifier.

Question 4: Are Level Transfers Appropriate? You should not simply transfer the level from the old consult codes to the office visit codes. Instead, rely on the documentation to guide your code choice.

Example: If a physician follows AMA CPT guidelines for a consult in the office setting and documented (per AMA) a



consult for an established patient that involved a detailed history, detailed examination, and medical decision making of low complexity, it would most likely qualify as a 99243 -- which you can no longer collect for from Medicare.

In 2010, for Medicare patients receiving that same service, you'll probably report 99203 if the consulting physician or another physician of the same group practice and specialty hasn't seen the patient in the last three years.

If the patient was seen within the last three years, in most cases the claim would qualify for a 99214. The key is to match the key components performed to the appropriate E/M code.