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Part B Insider (Multispecialty) Coding Alert

CONSULTATION ELIMINATION: You Can Report Subsequent Hospital Care Codes for Initial Visits, CMS Says

New CMS policy puzzles many practices, makes others nervous.

CMS has finally cleared up how you should bill initial hospital care when the level of service doesn't meet the requirements to bill 99221 -- and the answer is as clear as mud.

One of the most pressing questions that practices had regarding the elimination of consultation codes was how to bill initial hospital care services that met the requirements for inpatient consult codes (which are no longer payable), but do not meet the criteria to bill the lowest initial hospital care code, 99221.

Initially, MACs offered differing advice, with some saying to bill an unlisted E/M code (99499) and others vaguely suggesting that practices should bill the code "that best meets the documentation," without further clarification. Last week, CMS released MLN Matters article SE1010 to ostensibly clear up the issue. The article noted, "CMS has instructed Medicare contractors to not find fault with providers who report a subsequent hospital care CPT code in cases where the medical record appropriately demonstrates that the work and medical necessity requirements are met for reporting a subsequent hospital care code (under the level selected), even though the reported code is for the provider's first E/M service to the inpatient during the hospital stay."

CMS reps were barraged with questions about the topic during a March 2 Open Door Forum (ODF). "We recognize that there's not an exact match to the code descriptors for the low-level inpatient consult CPT codes to those of the initial hospital care CPT codes," noted CMS's **Rebecca Cole** during the ODF. "For example, 99251 and 99252 require a problem-focused history and an expanded problem-focused history, respectively, while 99221 requires a detailed or comprehensive history."

Clarification: "We'd just like to note that provider can bill 99221 when the requirements for billing that E/M service are met," Cole said. "Second ... subsequent hospital care codes 99231 and 99232 require a problem-focused interval history and an expanded problem-focused interval history. We know that these can potentially meet the component work and medical necessity requirements to be reported for an E/M service that could be described by consult codes 99251 or 99252."

One caller expressed concern about submitting a subsequent care code despite documentation indicating that her physician was visiting the patient in the hospital for the first time, but CMS reps reiterated their position.

"If a subsequent hospital care code visit works with the respect to the intensity of the service and the level of the service, that it's okay to report that if it's an initial hospital visit and the contractors won't have a problem with that," a CMS rep confirmed.

Only if the doesn't meet the lowest level of subsequent hospital care should you report 99499, "and we don't expect that would be very common," she said.

Don't worry about bell curves: CMS has alerted MACs to the fact that practices will be reporting more E/M codes now that consults are eliminated, and that many physicians will be reporting more initial hospital care than in the past, Cole said.

Inpatient documentation example: Suppose a physician performs an inpatient service that would previously have been considered a consult. He documents with an expanded history, moderate medical decision-making (MDM), and a statement saying "Examination of the patient revealed that her condition has not been aggravated."

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Because this physician did not document an adequate exam, only the MDM and history would count toward choosing the level of care. "Because the subsequent visits only require two out of the three components, the visit could be coded appropriately at a 99232," notes **Suzan Berman, CPC, CEMC, CEDC,** senior manager of coding and compliance with the University of Pittsburgh Medical Center. "I would definitely educate the physician that the details of the examination should be notated. But, the fact that the history and the decision-making support the service, it would be billed as a 99232," she advises.

Berman confirms that because initial hospital care requires all three components, this visit would normally not meet the requirements for a 99221 or 99222, since the exam was not appropriately documented.

However, CMS's new regulations indicate that you could report 99232 for the service rather than 99499.

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