# Part B Insider (Multispecialty) Coding Alert

## CONSULTS: Create Your Own Decision-Making Chart For Consults

**Pay attention to ROS and exam, or your level 5 could turn into a level 3**

Watch out: If your practice bills a lot of high-level consults, you could have an overpayment waiting to happen.

**Problem:** The **HHS Office of Inspector General** found that 41 percent of consults billed in 2001 were upcoded, and almost all level-five consults should have been level-three consults instead.

**Solution:** The key to avoiding upcoding of consults is to look at medical decision-making (MDM), says **Deborah Churchill** with **Churchill Consulting** in Killingworth, CT. Level-four and level-five consults are identical except that the MDM is more complex in a level-five consult, she explains. If your physician reviews 10 or more systems and examines eight or more body systems, then the visit could be a level-four or level-five, depending on the MDM.

**Understand the terminology:** The problem is that Medicare uses subjective terms for MDM, such as "multiple," "moderate" and "extensive," Churchill explains. It's up to you to define for yourself what those terms mean in your physicians' own billing. Defining those terms using numbers gives you a baseline, and "you can show a good faith effort that you've put a lot of thought into it."
You should come up with your own criteria for deciding how many treatments and studies add up to a level-four or level-five E/M, says Churchill. But she's come up with a sample chart that may give you some ideas.

**Note:** The "new patient rule" doesn't apply to consults, says Churchill. In other words, even if you've seen a patient in the past three years, you can bill a new patient consult. The referring physician must send the patient to your doctor for a consult on a new problem, but it can relate to the diagnosis you've seen before.

**Don't Forget ROS And Exam**

Nevertheless, you still can't bill a level-four or -five consult without documenting a "comprehensive" review of systems (ROS) and physical exam, says coder **Heather Stecker** with **Cardiology Consultants of Philadelphia**.

Stecker often sees charts for new patients or consults with an extended history of present illness (HPI) and a complete past family and social history (PFSH)--and only a four-point ROS (instead of 10 or more) or a "detailed" exam instead of a "comprehensive" exam. When coding such visits, note that the condition may have a high degree of complexity, but the ROS and exam don't call for a high-level consult code.

**Challenge:** Many cardiologists in Stecker's practice worried about staying within the scope of their practice while documenting that they reviewed enough systems.

She met with the physicians and the administration, and they came up with a list of complaints, observations and symptoms that the cardiologists could review. Then they delineated the physical findings for those systems that were "cardiology-pertinent" positives or negatives. This helped the cardiologists understand how they could document a "comprehensive" exam and ROS.