Part B Insider (Multispecialty) Coding Alert

Documentation Challenge Answers: How Did You Code This 'Consult' Note?

Medicare no longer recognizes consult codes, so you had to put on your thinking cap to code this note.

In the last issue of the Insider, we challenged you to determine how you would code a note that the physician documented as a consult. Did you break through the coding challenges to bill the right codes? Check out the operative note and our expert's advice:

CONSULTING PHYSICIAN: John Q. Sample, MD

ADMIT DATE: 12/01/2010

CONSULTATION DATE: 12/15/2010

CONSULTATION REPORT: This is an 88-year-old female who is in the hospital now for abdominal wall corrective surgery. Saturday this past week she had a hyperbaric chamber run and had hearing change as a result. She says she has had perfectly good hearing up until this point and she said she had a little bleeding from her left ear. The question comes whether hyperbaric is the cause of her ear troubles or whether there is something more dramatic. She has no dizziness. She has no pain right now. She is hearing better from her right ear than the left. She currently is in the ICU. I have been unable to move her to an examining site here in the clinic or office in the hospital.

Bedside exam with a fairly good look with an otoscope shows she has cerumen in both ears. I do not see any blood. She has no percussible pain. I am sure her hearing is diminished as a result of the heavy thick wax in both ears. The exam was confined to her ears today.

IMPRESSION: Hearing loss, cerumen impaction or possible hyperbaric changes. She is not having any trouble breathing through her nose right now and I am not going to put her on any decongestants. We need to get the mechanical wax debris in her ear out before we make any further decisions. She can do that here if she is out and about and up and around or we can do it while she is bedside but there is no equipment to do it at the bedside.

The ENT in her community could also do it if she is discharged soon. I will be happy to follow her. I gave the numbers in the chart to be reached in the office if she is up and about and would like for us to be involved.

Determine How You Fared

Did you code properly? If this is a new patient, you'll report 99221, because the visit meets the three requirements of this inpatient code (Detailed or comprehensive history, detailed or comprehensive exam, and medical decisionmaking of straightforward or low complexity).

Here's why: Since CMS doesn't recognize consultation codes, you should report the appropriate inpatient E/M

code, says **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC,** president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J.

"If the visit does not meet the requirements for a 99221-99223 (Initial hospital care), you are to code as it can be abstracted as follow up inpatient codes, 99231-99233 (Subsequent hospital care)," Cobuzzi says.

Mind your modifiers: If you report the initial hospital care code, remember to append modifier AI (Principal physician of record) to your initial hospital care claim.

"This modifier will identify the physician who oversees the patient's care from all other physicians who may be furnishing specialty care," CMS said in MLN Matters article MM6740. "All other physicians who perform an initial evaluation on this patient shall bill only the E/M code for the complexity level performed."

Congratulations to **Victoria Haney**, who won a free copy of our **CPT 2011 Survival Guide** and a free download of our one-hour audioconference **Collections Best Practices: Bring in Every Dollar Your Practice Deserves, Without Upsetting Patients** for submitting the correct answer to this documentation challenge!