Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Determine Reason And Place To Help You Classify Consults

Key: Document request and rendering of opinion

Problems differentiating office consultations and confirmatory consultations, or second opinions, can cost your practice up to $12 per patient.

In general, a consultation occurs when a physician, other healthcare practitioner, patient or other third-party requests that your physician render advice on a specific problem a patient is experiencing. Use this strategy to differentiate between some common types of consultations to ensure accurate reimbursement.

Identify These Office Consultation Components

Office consultations occur when a physician requests the opinion of another physician.

You should report office and other outpatient consultation codes (99241-99245) when a physician provides a consultation in the office or other ambulatory facility, such as the patient's residence, a hospital observation unit or an emergency department.

Example: An orthodontist believes his patient suffers from malocclusion severe enough to require orthognathic surgery in order for the patient to chew normally. The orthodontist sends a written request to an oral and maxillofacial surgeon specializing in orthognathic surgery, asking for a consult on the patient's need for surgery. The oral and maxillofacial surgeon determines that the patient's malocclusion will require surgery, specifically, a Le Fort I osteotomy. He sends his findings to the orthodontist in a written report, and notes in his documentation that the orthodonstist requested an opinion on a patient's need for orthognathic surgery.

According to the medical documentation, the oral and maxillofacial surgeon performed an expanded problem-focused history and exam, and straightforward medical decision making. The visit took 35 minutes, so you would report 99242 for the surgeon's service.

While it is not necessary to have the request from the physician in writing, you must be sure that the documentation of the request specifically states that the visit is for a consult, not for an evaluation or treatment, says **Bethany Grizzafi, CPC**, senior coding specialist at the **University of Texas Medical Branch** in Galveston.

Most often, consults are arranged between physicians of different specialties, such as a family practitioner and a cardiologist. However, sometimes a physician may want a consult within his or her specialty. **For example:** An endocrinologist treating a patient for diabetes may request a consult with another endocrinologist who specializes in thyroid disorders.

These intra-specialty consults can be more difficult to obtain reimbursement for, but Medicare guidelines do say that if a consult is within the same specialty and it is medically necessary, they will pay for it, notes **Teresa Thompson, CPC, CEO** of **TM Consulting** and a certified multi-specialty coding specialist in Sequim, WA. **Tip:** To avoid problems, note in the report that the consulting physician is subspecialized in a unique part of their field, says Thompson.

Stop Second Guessing 2nd Opinions

Confirmatory consultations, or "second opinions" take place at the request of a patient to confirm another physician's

diagnosis, or at the request of a third-party insurer before approving coverage for a medical treatment or surgical procedure. The confirmatory consultation codes, 99271-99275, are valid for both inpatient and outpatient confirmatory consults.

Definition: A second opinion occurs when a physician knows what a patient has and the patient wants it confirmed, says Grizzafi.

Most often, the patient, the patient's family, or a third party payer requests a confirmatory consult. If the third party payer requests the confirmatory consult, you should append modifier 32 (Mandated services) to the consult code on the claim.

Example: The insurance carrier for the patient suffering from malocclusion wants to be sure surgery is absolutely necessary and rule out all other treatment options. The carrier requests that a second oral and maxillofacial surgeon examine the patient. The second oral surgeon feels surgery is unnecessary and that braces and splints are capable of solving the patient's malocclusion. In this case, you should report 9927x-32.

Rationale: The orthodontist did not request this consult, the request comes from a third-party payer, and the surgeon only provides his opinion and does not report back his findings or treatment suggestions to the orthodontist.

Potential pitfall: When reporting confirmatory consults, you may not use time as a way to determine visit level. According to CPT: "Typical times have not yet been established for this subcategory of services."

Avoid Foul-Ups With Follow Ups

A third type of consultation that trips up coders is the follow-up consultation: 9926x (Follow up inpatient consultation for an established patient...). These consultations have their own set of requirements or restrictions. First, follow-up consultation codes can only be assigned in an inpatient setting, says **Marvel J Hammer RN, CPC, CHCO**, president of **MJH Consulting** in Denver.

There are two instances when you may assign follow-up consultations, notes Hammer:

1. When the physician sees the patient in the hospital a second time because he was unable to complete his assessment at the first visit, and

2. When an attending physician initially requests a consult from the specialist for an inpatient, but because of the length of the stay and changes in a patient's medical status, the attending requests "a second 'follow-up consult' consult to see if the consulting physician has any more recommendations given the changes in patient status.

Example: An endocrinologist sees an elderly woman with diabetes who was in a car accident at the request of her attending physician to ensure the patient's diabetes is under control. Two weeks later, the patient contracts influenza, and the attending requests a follow-up visit from the endocrinologist because of the complications that may occur when a diabetic patient contracts the flu. For the first visit, you would report 9925x (Initial inpatient consultation for a new or established patient...). For the follow-up visit, you would report 9926x.

Common coding mistake: Doctors who see patients daily after the initial consult are not doing follow-up consults, they are performing follow-up visits, 99231-99233 (Subsequent hospital care, per day, for the evaluation and management of a patient...).

3 Easy Ways to Support All Consultations

Because Medicare has received so many incorrectly coded consultations, you may think reporting these visits with accuracy is a daunting task. But you can code consults with ease if you remember the three R's:

Request: Another physician, provider, patient or private insurer has to request your physician's advice or opinion. You

physician can document this request in his report back to the referring physician, experts say.

Be sure there is documenta-tion somewhere in your chart note that indicates your physician has been asked to render an opinion in regard to the patient's care, advises Thompson.

Review: In addition to a formal request, you must have documentation that the consulting physician has examined the patient and formulated a plan of care.

Report: The consulting physician must give the requesting physician a report of his opinion or advice. This report should include reference to the initial request, the consulting physician's opinion, and possibly a treatment plan.