Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Dual-Provider Coding For E/M Services

Here's the difference between 'concurrent,' 'duplicative.'

If your physician performs an evaluation and management (E/M) service for a patient on the same day as another physician, you'll need to know the rules of concurrent care to file your claim correctly.

Nuts and bolts: Concurrent care occurs when two physicians perform separate E/Ms on the same patient on the same date of service. If the patient's condition warrants the care of two (or more) physicians, you'll both be able to code for individual E/Ms based on encounter notes. There are several factors to consider before submitting these claims.

Check out what these experts had to say about averting concurrent care coding confusion.

Separate 'Concurrent' from 'Duplicative' Care

Before diving into the deep end of this compliance issue, you should understand what is and what isn't concurrent care.

"It's important to be able to distinguish concurrent care from duplicative care," explains **Jean Acevedo, LHRM, CPC, CHC, CENTC**, president and senior consultant with Acevedo Consulting Incorporated in Delray Beach, Fla.

CMS definition: "Reasonable and necessary services of each physician rendering concurrent care could be covered where each is required to play an active role in the patient's treatment, for example, because of the existence of more than one medical condition requiring diverse specialized medical services."

Be careful, Acevedo warns, because Medicare's Benefit Policy Manual: Chapter 15, Section 30 E "clearly warns Medicare contractors to 'assure that the services of one physician do not duplicate those provided by another.'"

Once you understand the difference between concurrent and duplicative, you can decide between them by asking these two questions, says Acevedo:

1. Does the patient's condition warrant the services of more than one physician on an attending (rather than consultative) basis?
2. Are the services performed by each provider "reasonable and necessary?"

If you can answer in the affirmative to the above question pair, you've likely got a concurrent care claim on your hands. If you answer "no" to either question, the service likely falls under the scope of duplicative care.

On concurrent care claims, "be diligent in the reporting order of the diagnoses for each claim as well," recommends **Suzan (Berman) Hauptman, MPM, CPC, CEMC, CEDC**, medical coding director at Acusis in Pittsburgh, Pa.

Explanation: Let's say one physician is treating condition A, and the other is treating condition B, but condition C is underlying. When coding for concurrent care, "condition C should not be the primary diagnosis for either service. The documentation should clearly illustrate the physician's involvement with the patient, thus allowing for a clear illustration as to who is treating what [injury or illness]," continues Hauptman.

When Patient Has Multiple Issues, Focus on Dx Codes

Concurrent care can occur when a patient reports to one physician for an E/M, then that physician directs the patient to another physician for a separate issue. "Think about a patient with neoplasm-related colon cancer," Acevedo offers.

So let's say an oncologist performs a level-two initial inpatient hospital service for the patient with colon cancer. The oncologist then contacts an acute care pain specialist to treat the patient's neoplasm-related pain. Documentation indicates a level-three consultation service, and includes a note stating that the specialist received a request for opinion from the oncologist.

Oncologist coding: The oncologist would report 99222 (Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: a **c**omprehensive history; a comprehensive examination; and medical decision making of moderate complexity). Also, the coder should include a diagnosis code to represent the patient's colon cancer, such as C18.9 (Malignant neoplasm of colon, unspecified). Make sure you choose this ICD-10 code based on the specifics of the encounter.

Pain specialist physician coding: The acute pain physician would report 99253 (Inpatient consultation for a new or established patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision making of low complexity). Also, the coder should include a diagnosis code to represent the patient's cancer pain, such as G89.3 (Neoplasm related pain [acute] [chronic]).

"In the above scenario, both physicians are treating the patient concurrently for colon cancer, but with a different symptom focus," Acevedo explains.

While the situation illustrates concurrent care from providers in different specialties, physicians in the same specialty might also provide concurrent care, says Hauptman, who offers this example:

A patient with a fractured wrist and ankle is treated by two orthopedic surgeons in the same practice. Surgeon A treats the patient's wrist injury, and Surgeon B who specializes in ankle injuries treats the ankle fracture.

This is a potential concurrent care situation, despite the fact that the surgeons share both specialty and practice.

Remember, Concurrent Can Feature Only 1 Dx

Though the above example highlights concurrent care for two separately diagnosable conditions, different ICD-10 codes for each concurrent care provider aren't always necessary.

"Two physicians may indeed treat a patient for the same condition and bill the same ICD-10 code with their E/M service," explains Acevedo.

Example: An internist performs an E/M service for a patient with uncomplicated type 2 diabetes. During the encounter, the physician notes that the patient's Hgb A1c has risen to 8. The patient's internist requests the patient see his endocrinologist that day. The endocrinologist performs an E/M to look into the patient's Hgb A1c level.

In this scenario, both physicians should choose an E/M code based on the notes, and submit their claims with E11.9 (Type 2 diabetes mellitus without complications). Concurrent care was necessary because the endocrinologist's expertise was necessary in addition to the internist's to provide complete care for the patient.

Bolster Concurrent Claims with Solid Notes

Good documentation is never a bad thing, but it is a necessity to get concurrent care claims paid especially when both

providers are submitting the same ICD-10 code.

"I always advocate that two physicians treating a patient for the same condition and submitting claims with the same ICD-10 codes fully explain the circumstances in the clinical record," advises Acevedo.

Benefit: If a payer questions whether the care is concurrent or duplicative, "a complete progress note is the best defense," she says.