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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Say Hello to Higher Consultation Payments in 2006 With 6 Easy Steps

Now you can only report 1 initial consult code per admission

Attention coders: You will collect more for some consultation services this year if you know what codes to use.

The 2006 deletion of two consultation code subsections--follow-up inpatient consultations and confirmatory consultations--means you need to use other E/M codes, such as subsequent hospital care and new or established patient visits, to report these services. Be sure to recoup every dollar you deserve by taking these six steps:

1. Report subsequent care codes instead of follow-up consults.

CPT 2006 deletes follow-up inpatient consultation codes 99261-99263 and directs you instead to use subsequent hospital care codes (99231-99233) or subsequent nursing facility care codes (99307-99310), depending on the site of service.

Reason: Follow-up consultation codes "were redundant," and more specific E/M codes are more appropriate to describe these services, explains CPT Changes 2006--An Insider's View.

Codes 99261-99263 were also very confusing to coders and providers, adds **Curt Udell, CPAR, CPC, CMPA**, senior advisor at **Health Care Advisors** in Annandale, VA. These codes were sometimes used for inpatient consultations that started late one day and carried over into the next day before completion, he says. But "misinformation and unclear directives on the appropriate use of these codes" often caused incorrect reporting, he adds. These codes were also used when a physician performed an initial consult and then was asked to perform an additional consultation later in the patient's hospital stay because of unresolved or additional problems.

Example: An endocrinologist performs an initial consult on a diabetic patient and gives the plan of care to the primary physician to execute. The patient's condition doesn't improve, and the primary physician requests another consultation from the endocrinologist.

Old way: In the past, you might have reported an initial inpatient consultation code, such as 99253 (Initial inpatient consultation for a new or established patient...), for the first episode of care and then a follow-up consultation code, such as 99261, for the second episode of care.

New way: Now you would report the initial inpatient consultation code, followed by the appropriate-level subsequent hospital care code, such as **CPT 99231** , for the second episode of care.

Benefit: The new way spells more money for your practice. Subsequent hospital care codes have higher RVU values than did the follow-up consultation codes, Udell says.

2. Double-check documentation for subsequent hospital care.

While there's reason to celebrate the new rules, keep in mind that CMS closely monitors provider use of high-level subsequent hospital care codes, says **Maggie Mac, CMM, CPC, CMSCS**, consulting manager with **Pershing, Yoakley & Associates** in Clearwater, FL.

Physicians in the hospital setting often don't document their services extensively enough to justify level-three subsequent care, yet they report 99233 anyway, Mac says.

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Action: Before you report 99233, make sure to verify documentation of all the necessary code components, which CPT states are at least two of the following: a detailed interval history, a detailed examination and medical decision making of high complexity.

Helpful hint: Be careful of wording in the documentation. Phrases such as "patient stable" are a red flag to auditors that the service does not merit level-three.

3. Remember: Only one initial inpatient consult per admission.

You should continue reporting initial inpatient consults with 99251-99255 (Initial inpatient consultation for a new or established patient...) for the first consultation encounter your physician has with a patient. But remember that if your physician continues to see the patient for multiple follow-up visits during his hospital stay, you must use subsequent hospital care codes for every additional episode of service--even if there are spaces of time between visits.

Caveat: Re-admission wipes the slate clean. If the patient is discharged from the hospital and then re-admitted, and your physician renders a consultation after re-admission, you can bill an initial consult code for this service.

4. Choose the most appropriate E/M for "second opinion" visits.

Many coders are happy to see the 2006 deletion of confirmatory consultation codes 99271-99275. The codes were a hassle because Medicare seldom reimbursed them, Mac notes.

In addition, the codes were confusing because they were the one exception to the consult coding rule that you must always have a documented consult request from another physician, Udell says. With confirmatory consultation codes, the patient and/or a family member could request a "second opinion" from another physician.

New way: When a patient or family member initiates a consultation and there is no documented physician request, you may not use a consultation code to report the visit. Instead, you should choose the most appropriate E/M code to describe the visit.

Example #1: A patient recently diagnosed with cancer comes to see your physician for a second opinion. Your physician performs a history and full exam and discusses his findings and treatment options with the patient. Because the patient is new to your practice, you would bill the appropriate level new patient E/M code, such as 99204.

Example #2: Suppose the same scenario as above with a patient who is an already-established patient. In this case you would report the appropriate established patient E/M code, such as 99214.

Example #3: A physician diagnoses a patient with cancer, but wants your doctor to examine the patient for a second opinion on the best treatment regimen. Because there is documentation of the request for an opinion, you could bill the appropriate office consultation code, such as 99244 (Office consultation for a new or established patient, which requires these three key components...).

Benefit: As with the deletion of follow-up consult codes, the deletion of confirmatory consults also means more money in your pocket. New patient E/M codes, as well as outpatient and inpatient consultation codes, all reimburse higher than confirmatory consults did, Udell says.

5. Be vigilant with "second opinion" visits.

You can take two steps to ensure legitimate payment of your physician's second opinion and consultation services:

1. Instruct front desk staff to ask whether a physician requested a patient's second opinion visit, Udell suggests. If so, staff should contact the referral source to confirm. When there is a request, you may be able to report a consult code for the visit.

2. Have all patients seeking a second opinion fill out an Advance Beneficiary Notice (ABN) to ensure they understand

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they may be responsible for the bill if Medicare considers the service unnecessary. Carriers may still continue their past habit of denying claims for second opinions when they see no medical necessity. And if a carrier requests documentation and sees "second opinion" in the chart, you aren't likely to get paid, Mac adds.

6. Continue using the 3 R's for consults.

The consultations section of CPT may have changed, but the golden rule for coding consults has not. Anytime you report a consultation code, make sure the service meets the requirements of the Three R's:

Request: You must have documentation of a request for consultation from the requesting provider.

Render: Your physician (the consulting provider) must document both the exam and the opinion he renders.

Report: Your physician must send a report of his findings and opinion back to the requesting physician.

Watch out: Be sure your physician is simply performing a consult service and not accepting a transfer of care for the patient, Udell says. A consulting physician can initiate treatment and order diagnostic tests, but if he takes on primary responsibility for even a portion of the patient's care, a transfer of care has occurred and you must report the appropriate E/M code--not a consultation code--for the visit.

Note: If your physician performs an E/M visit because a government authority is requesting a second opinion, be sure to append modifier 32 (Mandated visit).

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