Pain Management Coding Alert

E/M Coding: Remember Different Payer Rules for Consults

Medicare doesn't recognize CPT® consult codes.

When the PM specialist performs a consultation service, coders must know the specifics of the encounter before coding.

Why? A consult service has to meet several guidelines, or the payer could reject your claim. Further, Medicare and private payers have some pretty major differences in how to code what you might consider a consultation.

Don't let consult coding confusion cloud your mind. Clear things up with this expert advice on coding consultations.

Check for 3 Rs when Making Consult Decision

For coding purposes, "a consultation is a type of E/M [evaluation and management] service that is provided by a qualified practitioner at the request of another physician or appropriate healthcare provider whose purpose is to either recommend care for a specific condition or problem or to determine whether to accept responsibility for the management of the patient's entire care or a specific condition," explains **Melanie Witt, RN, CPC, MA**, an independent coding expert based in Guadalupita, New Mexico.

Important: In order to qualify as a consultation, Witt says, you need these elements:

- a written or verbal **request** for the consultation in the patient's medical record;
- a clear **reason** in the request that specifies the medical indication for the request; and
- a **reply** to the requesting physician with your provider's opinion about the care.

This is often referred to as the 3 Rs: Request, reason, and reply.

Choose from Inpatient, Outpatient Consult Codes

You'll need to prove the three Rs to affirm that your provider performed a consultation. When you're coding for consult service, however, knowing the payer's preference is vital.

For payers that don't follow Medicare guidelines, you will likely report your consultation with one of the following code sets:

Outpatient consults: Report 99241 (Office consultation for a new or established patient, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making ...) through 99245 (... a comprehensive history; a comprehensive examination; and medical decision making of high complexity ...), depending on encounter specifics.

Inpatient consults: Report 99251 (Inpatient consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making ...) through 99255 (... a comprehensive history; a comprehensive examination; and medical decision making of high complexity ...), depending on encounter specifics.

Quite obviously, the main difference between inpatient and outpatient consults is setting. There are other differences as well, especially when you're counting up consult minutes, according to Witt.

"In the office setting, typical [consult] time is specified as face-to-face time; while, in the inpatient setting, typical [consult] time is specified as unit/floor time," Witt says. This distinction is worth remembering for instances when your

provider is reporting the consult based on counseling or coordination of care rather than the three key components of history, examination, and medical decision making (MDM) - also known as the "counseling exception."

Check Out this Consult Case Study

To make consult coding clearer, consider this clinical example courtesy of **Mary I. Falbo, MBA, CPC**, president and CEO of Millennium Healthcare Consulting Inc. in Lansdale, Pennsylvania:

Scenario Details

Chief Complaint

- Patient seen in the office setting at the request of his primary care physician for etiology of his persistent limited shoulder range of motion (ROM).

History

- 52-year-old female with right shoulder pain; "6" on 1-10 scale. /o; prolonged symptoms after oral non-steroidal challenge. This has been going on for 6 months. Decreased ROM noted. Difficulty with daily activities including carrying briefcase, driving, dressing and cooking noted. Patient states sleep is also being affected.
- Takes NSAID twice daily for pain. Patient reports the medication "helps some."
- History level is detailed.

Exam

- Right shoulder film negative. Tenderness noted.
- Active and passive range of motion remain to right shoulder is significantly decreased.
- Neurological exam normal.
- Exam level is comprehensive.

Assessment and Plan

- Adhesive capsulitis of right shoulder.
- Administered subacromial corticosteroid injection, right shoulder.
- Pain control discussed. Patient declines Rx oral corticosteroid medications.
- Recommended to continue with NSAID, discussed side effects.
- PT therapy for ROM of shoulder.
- Scheduled a follow-up visit in two weeks. If no improvement with physical therapy (PT), then will discuss possible surgical intervention.
- Medical decision making (MDM) is moderate.

Summary of CPT®, ICD-10-CM Impacts

Coding

- 99243 (... a detailed history; a detailed examination; and medical decision making of low complexity ...) for the consult.
- M75.01 (Adhesive capsulitis of right shoulder) appended to 99243 to represent the patient's injury.

Make Use of Other E/M Codes on Medicare Consults

While physicians certainly consult on Medicare patients, "Medicare payers haven't accepted claims for either outpatient (99241-99245) or inpatient (99251-99255) consultations since Jan. 1, 2010," explains **Falbo.**

Do this: "Medicare has indicated that any consultation service would be reported using the appropriate office visit or

inpatient hospital visit codes," says Witt.

According to Falbo, Medicare's consult coding policy consists of these guidelines:

- "Report outpatient E/M services with the appropriate outpatient services code - 99201-99215, or 99281-99285 for patients seen in the emergency department [ED]," she says. "The service must be supported by the key components of history, exam, and medical decision-making - or time, if counseling and/or coordination of care dominates the encounter."
- Report inpatient consultations "using the initial hospital care codes [99221-99223] for the initial evaluation, and a subsequent hospital care code [99231-99233] for subsequent visits," advises Falbo.