Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Know When You Can Report a Repeat Consultation--and When You Can't

Don't let time-limit myth restrict your options

If you-re a specialist and you use the three-year rule across the board for outpatient services, you-re sacrificing consultation pay.

After you send a patient back to the primary-care physician (PCP) for a completed episode of care, you can perform another consultation. -The three-year rule applies to office visits, not consultations,- said **Barbara J. Cobuzzi, MBA, CPC-OTO, CPC-H, CPC-P, CPC-I, CHCC**, in The Coding Institute-s Otolaryngology Coding and Reimbursement Conference in San Antonio.

Know Status With 99201-99215

You should use the same code for office consultations (99241-99245, Office consultation for a new or established patient -) regardless of the patient's status as new or established.

In contrast, CPT splits office visit codes into those for new patients (99201-99205, Office or other outpatient visit for the E/M of a new patient -) and those for established patients (99211-99215, Office or other outpatient visit for the E/M of an established patient -). E/M service guidelines consider a patient new when, within the past three years, she has not received any face-to-face service from the physician that he reported with a CPT code or from another same-specialty physician within the same group practice.

Zero In on Different Issue

If a physician requests your specialist's opinion on a patient's new problem, you can code another consultation, regardless of how much time has transpired between issues. Suppose the patient comes in for a consult for central vertigo (386.2). Your physician treats the patient for that specific problem and then sends the patient back to her PCP.

A year later when the PCP sends the patient in for a consult from the specialist on a nasal hematoma (920) and epistaxis (784.7), -we would charge out a consult,- says **Candice Ruffing, CPC**, with **Drs. Berghash** and **Lanza PL** in Florida.

Key: Look at the diagnosis to see whether you-re treating the patient for a new problem or the same problem. Try your skill with the following cases.

Compare Problems in Requests

An internist requests a specialist's opinion on the cause and possible treatment of a patient's chronic sinusitis (473.9), which the internist has tried unsuccessfully to treat several times. At this encounter, the specialist performs an E/M and scope (31231, Nasal endoscopy, diagnostic, unilateral or bilateral [separate procedure]) and issues a report on his findings (473.8, Pansinusitis) to the internist.

Catch: The specialist performed radical neck dissection (RND) on the patient nine months ago, and the patient is scheduled for an annual cancer check visit with the surgeon in three months.

The specialist charged 99244 (- requires these three key components: a comprehensive history, a comprehensive examination, and medical decision-making of moderate complexity -) for the initial encounter in which the patient's

internist had asked the specialist's opinion on possible surgical and radiological options for a malignant neck mass (195.0, Malignant neoplasm of other and ill-defined sites; head, face and neck).

Can the specialist code the sinusitis E/M as a consult? Yes, the specialist can again code a consult (such as 99242-25, -an expanded problem-focused history, an ex-panded problem-focused examination, and straightforward MDM -; Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) for the initial E/M because the internist is asking the specialist's opinion on the sinusitis, Cobuzzi says. Modifier 25 indicates that the service is significant and separate and above and beyond that included in the scope's usual pre- and postoperative work.

Reason: There is no time frame on consultation coding. -We have not come across any issues with time restrictions on consult coding,- Ruffing says. If an insurer does question coding another consult, make sure you have documentation that backs up the service's criteria--reason for and request of opinion, rendering of services, report back, and return of patient.

Incorrectly restricting the specialist from using another consult code because she had performed one for the patient within the past three years would cut approximately $56 from the service. The 2008 Medicare Physician Fee Schedule nationally pays roughly $95 for 99242 (2.50 relative value units) compared to $39 for 99212 (1.03 RVUs).

Stick With 9921x for Related Dx

You-ll keep your consultation coding compliant and avoid payback requests if you use office visit codes for patients who come in for follow-up care of a previously consulted upon condition. When a patient's PCP sends the patient back to a specialist who has previously treated him for the same problem, you would not consider the E/M a consult or new patient office visit, Ruffing says. -It would be an established patient office visit.-

Case 2: Suppose the above RND patient returns at the one-year mark for a cancer check (V10.89, Personal history of malignant neoplasm of other sites; other). In this case, the diagnosis is related to the original problem, and the internist is not requesting the specialist's opinion on it.

Do this: Report the encounter as an office visit (99212-99215), not a consultation.