Eli's Rehab Report

3 Answers to Your Consult Coding Questions

You can't 'boost' your MDM level, but you can improve your documentation

If your practice frequently reports consultation codes, you should always maintain documentation of the original physician's consult request in your files. But remember, just because another physician sends you a letter asking you to see his patient, consult codes aren't always your best bet. The key is to determine whether the requesting physician asked for your physiatrist's opinion -- and whether your physiatrist sent a report of his findings back to the requesting physician.

We've provided expert answers to the following quest-ions, which were submitted by **Cheryl Brainerd**, coder at Physical Medicine and Rehab of New Haven, Conn.

1. Are the rules the same for inpatient consults as they are for outpatient consults?

No. "You have only one code range choice for outpatient visits (99241-99245)," says **Laureen Jandroep, OTR, CPC, CCS-P, CPC-H, CCS**, director and senior instructor for the CRN Institute, an online coding certification training center. "But CPT includes two sets of inpatient consult codes - one for initial consults (99251-99255) and one for follow-ups (99261-99263)."

The facts. Both inpatient and outpatient consults require a request for the physiatrist's opinion and a review of the patient's condition. Although the request for consult can be either written or verbal, you should always try to acquire a written request, Jandroep says. This way, if your insurer ever audits your practice to determine whether you performed a true consult (versus a standard office visit), the written consult request can help you prove your case.

Outpatient Consults Require Written Reports

You cannot report an outpatient consult code unless your physiatrist sends the requesting physician a report of his findings. "Some physicians customarily send a letter to referring physicians, thanking them for referring a patient and updating them on a patient's condition," Jandroep says. "But just because there's a letter, doesn't mean you performed a consult."

To report a consult, the requesting physician must request your physician's opinion, and shouldn't simply transfer the patient's care to you. You should report transfers of care with the standard office visit codes (99201-99215).

Best bet: It's very good practice to send the requesting physician a report of your findings if you perform an inpatient consultation, but Medicare doesn't specifically require it in every inpatient situation. According to section 15506 of the Medicare Carriers Manual, "In an emergency department or inpatient or outpatient setting in which the medical record is shared between the referring physician and consultant, the request for consult may be documented as part of a plan written in the requesting physician's progress note, an order in the medical record or a specific written request for the consultation. In these settings, the written report required for consult may consist of an appropriate entry in the common medical record."

This guideline applies only if the requesting and consulting physicians share the common medical record, and you should still aspire to send every requesting physician a report of your findings. Documenting an entry in the shared medical record without sending a follow-up report back to the requesting physician should be the rare exception rather than the rule for most practices.

Report Follow-Up Consults for Inpatients Only

According to CPT, follow-up consults "are visits to complete the initial consultation or subsequent consultative visits requested by the attending physician."

Coding example: Suppose an orthopedic surgeon asks your physiatrist to render an opinion on whether a hip replacement patient qualifies for the hospital's rehab unit. The physiatrist tells the orthopedic surgeon that in his opinion, the patient is ready to move to the rehab unit for three to four days of rehabilitation. You should report 99253 for the initial inpatient consultation.

Before the patient transfers to the rehab unit, the nurse reports that the patient's heart rate is steadily dropping. A cardiologist assumes care for four days, after which he alters the patient's prescriptions and releases her from his care. The orthopedic surgeon calls the physiatrist for another opinion regarding the patient's eligibility for the rehab unit. This time, the physiatrist says that the patient has received adequate therapy in her inpatient room and is moving well enough to go home. He prescribes four weeks of physical therapy. You should report 99262 for his follow-up inpatient consultation.

2. We frequently perform inpatient consults to determine whether a patient is a candidate for the rehab unit. We usually fall short in the medical decision-making (MDM) section, even though our doctors are spending the time. How can we boost the MDM level?

Physiatrists often find that their medical decision-making ranks only as "straightforward" or "low" according to CPT's "Complexity of Medical Decision-Making" chart. These MDM levels unfortunately trap physicians in the lower end of the inpatient consult codes. While you can't perform any extra tasks to raise your MDM level, you may be able to find additional factors that could allow you to boost your MDM -- if the physiatrist documents them.

Don't miss: If the physician doesn't document everything related to his medical decision-making, he could be holding back the MDM level, Jandroep says. Scan your physician's documentation for underlying diagnoses. If you see that the patient has diabetes or heart disease, but the physician failed to document that in his review of the patient's hip surgery rehabilitation, you may be able to boost your management options from "limited" to "multiple."

3. If we see the patient for an inpatient consult and a follow-up consult, and then a month later the same requesting physician asks us to see the same patient again, is this a follow-up inpatient consult, an initial consult, or a subsequent visit?

CPT states, "only one initial consultation should be reported by a consultant per admission," which rules out reporting the initial consultation codes for your third visit. To justify billing another follow-up consultation code, most insurers would require you to evaluate a separate condition or a change in the patient's condition or status. The policy of Palmetto GBA (a Part B carrier in South Carolina) states, "A limited number of follow-up consultations are allowed to review new data requested at the initial consultation or upon request of the attending physician if new findings, changes, or worsening in the patient's condition, etc, are encountered."

Smart idea: If the requesting physician calls you a month after your last follow-up consult and asks you to implement the plan you recommended in your consultation report, you should not report another subsequent consult code. After you begin to participate in the patient's management, you should report the appropriate-level subsequent hospital care code (99231-99236).