# Consultation Coding Questions and Responses

## The proper code must contain the required key components.

**BY HARRY GOLDSMITH, DPM**

*Welcome to Codingline Particulars, a regular feature in Podiatry Management focusing on foot and ankle coding, billing, and practice management issues.*

How would you code the following scenarios?

1) Initial inpatient consult (hospital) for a patient who is not established in our practice

2) Initial inpatient consult (hospital) for a patient established in our practice

3) Follow up inpatient consult

4) Initial ER consult for a patient who is not established in our practice

5) Initial ER consult for a patient established in our practice.

### Response

Prior to giving the responses to the above scenarios, it needs to be understood that hospital E/M coding is not determined by whether the patient is a new patient to you or an established patient in your practice. Inpatient hospital E/M coding is based on the "episode of care"—the time from the patient's admission to the hospital to the time of the patient's discharge. When a hospital E/M service is described as "initial hospital care" or "initial inpatient consultation", the corresponding code reflects the first time you have seen the patient (whether new or established to you and your practice) during this hospital admission. If the patient is discharged and is readmitted, and you are asked to see

the patient again during this second admission, the first encounter will, again, be coded as an "initial hospital care" because…it is based on the re-admission (new episode of care).

You are probably thinking, "I think I've got it. Initial hospital has to do with the first time I have encountered the patient during this admission…ergo, so subsequent hospital care must mean follow-up encounters with the patient during the admission." And, you would be

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about half right. When you check the various E/M coding levels and their descriptors, you will note that

"CPT 99221 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision-making that is straightforward or of low complexity…Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.

CPT 99222 Initial hospital care, per day, for the evaluation and management of a patient, which re-

quires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of moderate complexity…Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit."

CPT 99223 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision-making of high complexity…Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit."

These codes—the only initial hospital care codes—begin at a detailed or comprehensive history/exam level, but get more comprehensive. This could present a problem if your patient's findings do not meet the minimum threshold for CPT 99221 billing. Medicare, in its wisdom, solved the problem by referring the doctor/coder to the "subsequent hos-

pital care" E/M codes.

"CPT 99231 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem-focused examination; medical decision-making that is straightforward or of low complexity…Usually, the patient is stable, recovering, or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.

CPT 99232 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components; an expanded problem-focused interval history; an expanded problem-focused examination; medical decision-making of moderate complexity…Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.

CPT 99233 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision-making of high complexity… Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit."

That's right. If the patient's E/M service does not amount to at least a detailed history and exam with straightforward or low complexity medical decision-making, then the doctor would choose the appropriate subsequent hospital care E/M code even if this is the first time ("initial") the doctor has seen the patient in the hospital during this admission.

If you are the admitting physician (not co-admitting), you would append an "IE" modifier to the initial hospital care E/M code.

There are five levels of inpatient consultation E/M codes that roughly correspond to the code requirements found in the five levels of initial of-

fice patient E/M coding. Inpatient consultation codes range from CPT 99251 to CPT 99255.

**Got it? Good. Let's Respond to the Questions**

Scenario 1: The answer depends on the payer. Medicare does not recognize consultation codes. So, whether this was a true consultation request or a referral to see the patient, for Medicare, the doctor is directed to use an initial or subsequent hospital care code above.

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> **There are five levels of inpatient consultation E/M codes that roughly correspond to the code requirements found in the five levels of initial office patient E/M coding.**

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Again, keep in mind that it does not matter if the patient is new or established to the practice. The choice of E/M code would be dependent only on the relevant level of E/M service performed—using either the initial or subsequent hospital care codes. It is a different story for many non-Medicare payers who continue to recognize the initial inpatient consultation codes. The doctor, for a non-Medicare payer (presuming the payer recognizes consultation codes), would choose the appropriate consultation code for the initial hospital consultation.

Scenario 2: Answered above Scenario 1.

Scenario 3: There are no follow-up inpatient consultation E/M codes. Regardless of payer, you would choose the appropriate subsequent hospital care code.

Scenario 4: The emergency room is considered an outpatient facility. When seeing a non-Medicare patient, to report a consultation provided in an outpatient or ambulatory facility, including emergency department, the doctor would choose the appropriate outpatient consultation E/M code.

"CPT 99241 Office consultation

for a new or established patient, which requires these three key components: a problem-focused history; problem-focused examination; and straightforward medical decision-making.

CPT 99242 Office consultation for a new or established patient, which requires these three key components: an expanded problem-focused history; an expanded problem-focused examination; and straightforward medical decision-making.

CPT 99243 Office consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision-making of low complexity.

CPT 99244 Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision-making of moderate complexity.

CPT 99245 Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; medical decision-making of high complexity."

For Medicare patients, doctors should code the request for a "consultation" using the appropriate level emergency department E/M code, CPT 99281-CPT 99281.

Scenario 5: CPT 99241-99245 (emergency department coding for non-Medicare patient consultations) codes are described "for a new or established patient". Similarly, CPT 99281-99285 (emergency department codes for a requested consultation on a Medicare patient) is described as "no distinction is made between new and established [emergency de-

*Consultation Coding (from page 46)*

partment] patients in the emergency department."

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**Dr. Goldsmith** of Cerritos, CA is editor of Codingline.com and recipient of the Podiatry Management Lifetime Achievement Award.