

Socioeconomic tips of the month

Editor's note: For several years now, the Socioeconomic Affairs Department of the American College of Surgeons has sponsored a coding hotline (800/ACS-7911) and coding and practice management workshops for its Fellows. Through the hotline and the workshops, issues are identified that are of concern to many Fellows and their staffs. In an effort to respond to Fellows' specific inquiries related to coding and practice management issues, we are introducing this new column, which will feature useful tips for surgical practices. Developed by College staff and consultants, this information will be accessible on our Web site for easy retrieval and future access. If there are topics you would like to see addressed in future columns, please contact the Chicago staff of the Socioeconomic Affairs Department via phone at 312/202-5150, via fax at 312/202-5021, or via e-mail at socioecon@facs.org.

Medicare clarifies consultation rules

Q. I hear that Medicare has issued new consultation billing rules for their carrier manual instructions. When is it appropriate to bill a consultation code rather than a referral—a new patient Evaluation and Management CPT code?

A. The distinction between consultation and referral is one of the most problematic coding and reimbursement issues. Medicare payment rules governing when patient encounters qualify as “consultations” vs. “visits” were indeed clarified by revised Medicare carrier instructions issued by the Health Care Financing Administration (HCFA), effective August 26, 1999. According to HCFA officials, the latest billing instructions should not be interpreted as a change in policy; rather, they are intended to clarify ambiguities in previous billing standards.

The instructions clearly outline that a consultation occurs when three criteria are met: (1) the service is provided by a physician whose opinion or advice regarding a specific problem is requested by another physician or other appropriate source, unless it is a patient-generated confirmatory consultation; (2) the request and

its need are documented in writing in the patient's medical record; and (3) the consulting physician prepares a written report of his or her findings that is provided to the referring physician. The instructions also clarify that a consultation followed by treatment, such as a biopsy or operation, does *not* constitute a “transfer of care” unless the responsibility for the patient's complete care is transferred to the receiving physician in advance, and documented as such by the referring physician.

Typically, when a patient is sent to a surgeon, the surgeon's initial encounter with the patient would be billed as a “consultation” rather than a new patient visit if the criteria are met, even if the patient continues to be treated by that surgeon for the specific problem that led to the initial encounter. Later patient encounters outside the global period that occur within three years of the initial visit would be billed as an established patient visit or similar service. Of course, if an additional request for an opinion or advice regarding the same or a new problem is received from the attending physician and documented in the medical record, the consultation codes may be used again.

In its recently issued instructions, HCFA provides several examples of services that would qualify as a consultation. Here is one relevant to surgery: A family practice physician examines a female patient who has been under his care for some time and diagnoses a breast mass. The family practitioner sends the patient to a general surgeon for advice and management of the mass and related patient care. The general surgeon examines the patient and recommends a breast biopsy, which he schedules, and then sends a written report to the requesting physician. The general surgeon subsequently performs a biopsy and then routinely sees the patient once a year as follow-up. Subsequent visits provided by the surgeon should be billed as an established patient visit in the office or other outpatient setting, as appropriate. Other routine care continues to be provided by the family practice physician.

Relevant excerpts from the new instructions may be viewed on the College's Web site at http://www.facs.org/about_college/acsdept/socio_dept/newmedbill.html.

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HCFA's clarified instructions should help surgeons bill appropriately for consultations and may also be useful in dealing with Medicare carrier personnel. Since some private insurers also follow Medicare rules, this latest policy clarification by HCFA may have application beyond Medicare. As a suggestion, in writing letters reporting findings to the physician who requested the consultation, it is helpful to thank the physician for sending the patient for consultation, rather than saying "thank you for the referral of" This minor point in documentation may help avoid a problem in an audit.

Purchase coding resources annually



I have heard that I do not need to purchase a new diagnostic coding book for the year 2000. Is that true?



Yes. ICD-9-CM had no revisions for the year 2000 because of Y2K. So you need not purchase another diagnostic coding book until 2001.

As a rule of thumb, coding resources (that is, CPT and ICD-9-CM) should be purchased annually, and all old copies retained in the event of an audit. So 2000 is a rare exception to the rule for ICD-9-CM. In the case of the Health Care Financing Administration's Common Procedure Coding System (HCPCS), the need to purchase annual updates of the coding manual other than CPT depends upon whether the practice provides services described by these codes. As we understand it, HCPCS will have revisions for 2000. Physicians are responsible for codes reported and should ensure that practice staff and billing companies are using the most current resources available to comply with billing requirements.

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to the IRS that aren't covered, as I did in my first year of ignorance. I have a fax machine and copier now, and I have found them invaluable because every time you change the name on a document or account, along comes a request for a copy of the death certificate—even for frequent flyer miles and other minor documents.

Now is the time to learn French or Italian or another language. It will make the trip to France and Italy more fun if you can say something understandable. I believe I now am about to buy a computer and learn the darned thing before it is too late!

There is an enormous temptation to cling to one's children to escape loneliness. My children are all tremendously supportive and helpful, but I have found that it is not a good idea to depend on them too much. I have come to realize that becoming active is the greatest recovery of widowhood. I think my children often complain that

I am away too much or that I am not a great babysitter because I am too busy.

My house, which Alex and I lived in for 38 years, is my passion. I am "home improving" all the time. I believe gardening is the most serene thing one can do. Digging in the dirt brings great peace of mind. I suppose the choice is either self-improvement or house improvement. A friend told me that Mrs. Jones, a new widow, had her face lifted and liposuction everywhere else, but that her poor friend Irene Walt had done her driveway, built a wine cellar, and installed electric doors on the garage. We all have choices to make.

So my advice to those of you who find yourself a widow or widower—and even to those of you who just find yourself retired—is don't look back and don't have regrets about past mistakes. Rather, keep looking forward, live your life to the fullest, and enjoy every minute of it.