Seminars in Colon and Rectal Surgery 30 (2019) 100683

Contents lists available at ScienceDirect

Seminars in Colon and Rectal Surgery

journal homepage: www.elsevier.com/locate/yscrs

Inpatient consults in colorectal surgery

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ARTICLE INFO

Keywords:
Inpatient consult
Colorectal inpatient
Consult billing

ABSTRACT

Surgical consultation is an essential part of colorectal practice. First and foremost, it involves making an urgent assessment as to whether the patient has a colorectal problem that requires immediate intervention. If an intervention is necessary, an appraisal must be made to determine if the patient is fit to undergo a procedure and if the benefits of the intervention outweigh the risk. Communication with patients, families, referring physicians and non-surgical providers is of paramount importance to make sure a coordinated care plan is carried out, and to allay concerns regarding need for surgical interventions. Non-operative inpatient consults can require as close monitoring as those who require operative intervention to minimize risk of complications and to optimize outcomes. Optimal billing and coding can be achieved when the above recommendations are documented and reconciled in a timely manner. Understanding the regulations associated with billing for consults is critical to achieving appropriate compensation and compliance. This chapter focuses on the structural aspects of surgical consultation and billing for inpatient consultation.

Introduction

According to the data of Centers for Disease Control and Prevention (CDC), more than 50 million inpatient surgeries are carried out every year.[1] These statistics are different from figures for outpatient surgeries, or procedures that do not require any hospital stay. The reasons for colorectal consultation may vary and either be the primary problem that requires inpatient stay or be the sequela of other acute or chronic diseases such as cardiovascular, renal or immunologic disease. Similar approaches are undertaken when addressing an inpatient consultation for patients with colorectal disease. Surgical consultations are often of an urgent nature and require timely response from surgical teams to determine if immediate intervention is necessary. Whether the colorectal disease process is of an urgent or non- urgent matter, the goals of surgical evaluation should be the same.

The goals of a colorectal surgery consultation are to:

- Make an assessment as to whether the patient has a colorectal problem that is of an urgent nature.
- Determine if the colorectal disease process requires operative or non-operative management.
- If intervention is necessary, it must be determined if the patient is fit to undergo a procedure and if the benefits of the intervention outweigh the risk.
- Make the patient or surrogates fully aware of the potential risks or complications of the recommended treatment plan.
- Monitor the patient to minimize the risk of complications and if complications occur, confirm that they are managed and addressed in a timely manner.
- Communicate and educate non-surgical providers on the colorectal disease treatment recommendations, alternatives and potential risks to ensure optimal care coordination.

Initial inpatient consultation

Urgent and emergent inpatient consultations often require some form of intervention. Depending on the nature of the disease process, the problem may require operative, endoscopic or percutaneous management. Surgical consultation often requires coordinating efforts between referring physicians and other services. For example, the management of an opioid-induced colonic pseudo-obstruction in a postoperative patient may require simple recommendation for opioid reduction, multimodal analgesia, mobilization, and cathartics. Conversely, for more complex cases where conservative measures have failed, pharmacologic, endoscopic or even operative decompression may be necessary to achieve resolution. In either case, patient and provider education, and close monitoring is the best way to obtain a favorable outcome. Initial evaluation followed by subsequent visits to monitor for uneventful recovery should be appropriately documented and billed, along with a plan for short and long term follow up.

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https://doi.org/10.1016/j.scrs.2019.100683
1043-1489/

Risks, complications, and appropriateness

A surgery consultation does not guarantee the elimination of risks and complications. However, one of the primary objectives of the consultation is to reduce and/or mitigate these risks. Patients, referring doctors and surgeons should work collaboratively to ensure the patient's safety and well-being throughout the decision-making process. This includes careful consideration of the potential risks and benefits from surgical intervention and non-intervention. In the ideal situation, the risks and benefits are understood and considered by patients who can than make an informed decision. In the inpatient setting, consultants are often challenged by cases where patients are unable to make decisions and the responsibility lies in the hands of a surrogate or durable power of attorney. In these cases, advanced directives and realistic expectations for recovery and quality of life are important to communicate and document so that the most appropriate management decisions can be made.

Consideration for "appropriateness" for surgical intervention, along with hospital surgical volume has increasingly become a metric used to evaluate hospitals' quality and safety profile. Hospitals are being asked to report on their implementation of a hospital-wide policy which includes processes aimed at monitoring surgical necessity and preventing overuse of surgical procedures. The Leapfrog Group®, a quality and safety organization use criteria to evaluate hospitals regarding appropriateness of surgical intervention (below). The inquiries are designed to identify the steps hospitals have taken to establish and ensure adherence to their own surgical appropriateness criteria.[2] For these procedures, hospitals are asked about their progress in developing surgical appropriateness criteria based on:

- Published guidelines and input from local surgeons.
- Supporting and monitoring adherence to those criteria.
- Communicating with surgeons, hospital leaders, and board members about adherence to the criteria.

This area of quality development is designed to ensure patients receive the highest quality of care which may or may not include escalation of care. Determinations such as these are important to understand as consultations are often sought in vulnerable populations such as the elderly. A systematic review by Cardona-Morrell et al. found that on average 33–38% of patients near the end of life received non-beneficial treatments during the index hospitalization.[3] As a consultant, taking the time to understand patient and family expectations can help guide appropriate recommendations for the management of colorectal disease.

Billing for inpatient consultations, and emergency department visits

Billing for surgical services is a complicated business. It involves an overwhelming number of rules, guidelines, and exceptions that are subject to constant change. An area of exceptional difficulty is the correct use of codes for evaluation and management (E/M) due to the Centers for Medicare & Medicaid Services' (CMS) 2010 decision to reject the use of consultation codes (99251–99255) and institute observation codes. The standard for E/M coding with inpatient consults includes:

- The severity of illness and appropriate documentation of elements of the history and physical to determine the level of service.
- The hospital admission status of the patient, such as inpatient, observation, or emergency.
- The disposition of the patient after the evaluation.
- Referring doctor information.

Health care professionals use such information to determine the appropriate code to use for services rendered and reimbursement. The relative value units (RVUs) are multiplied by the annual conversion factor to determine reimbursement for a service. In most cases billing is handled by a third-party service, but it is important to understand the basic elements of inpatient coding.

Emergency department (ED) consultation

If a patient presents to the ED, and the colorectal service is consulted, and the surgeon determines that the patient requires admission to the hospital it should be billed as an initial hospital care code (99221–99223) and not an ED visit code. If the patient is admitted for observation, codes (99218–99220) are reported.[5] For patients with insurance that follows non-Medicare CPT® (Common Procedural Terminology) rules, the instructions can be more difficult to understand, and providers may have to refer to specific insurance regulation and compliance to appropriately code. General rules such as if the surgeon sees the patient on the hospital unit on the date of admission, report all E/M services related to the admission with the initial inpatient admission service code (99221–99223) or initial observation care code (99221–99223). Do not bill an outpatient consultation and inpatient admission (or observation care) for services on the same day related to the same inpatient stay.[4]

A patient presents to the ED; and the patient is not admitted to the hospital, the surgeon should bill the level of ED code (99281–99285). If the surgeon does not come to the hospital to see the patient but only advises the ED physician or resident by telephone, then the surgeon may not bill at all for this service.

Inpatient and/or observation consultations

Coding becomes more complicated in the inpatient hospital setting, where health care providers are instructed to bill the initial hospital care codes (99221–99223). As a result, multiple billings of initial hospital visit codes could occur in a single day by different providers. However, only one initial visit per specialty can be paid per stay. Follow-up visits in the facility setting may continue to be billed as subsequent hospital care visits (99231–99233). The coding depends on the admission status of the patient when seen and whether the patient is classified as Medicare or non-Medicare.

For Medicare patients, inpatient consultations are reported with the initial hospital visit codes (99221–99223). For some non-Medicare patients, if the consultation is done after the patient is admitted to the hospital, consultation services may be reported with the inpatient consultation codes (99251–99255).[4]

In conclusion, there are many ways surgeons are reimbursed for services. However, incorrect coding may result in no payment at all or penalties for consistent erroneous coding. For additional coding and practice management resources and guidance the American College of Surgeons or the AMA CPT guide.

Note

This summary is intended as a resource to assist in the billing process. Ultimately, coding is the responsibility of the provider and health system. Members of AMA can look at up to five CPT codes and associated RVUs per day on the AMA website.

*All specific references to CPT codes and descriptions are

References

1. Hall MJ, Schwartzman A, Zhang J, et al. Ambulatory surgery data from hospitals and ambulatory surgery centers: United States, 2010. National Health Statistics Report. 2017. www.cdc.gov.
2. www.leapfroggroup.org/surgeon-volume July, 2019.
3. Cardona-Morrell M, Kim J, Turner R, et al. Non-beneficial treatments in hospital at the end of life: a systematic review on extent of the problem. *Int J Qual*. 2016;28 (4):456–469.
4. Savarise M. Coding for hospital admission, consultations, and emergency department visits. *J Am Coll Surg Bull*. Feb. 2013.