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Coding For Consults

by Linda Gledhill, MHA

Q. ***How do you determine if a visit is a consultation or a new patient visit?***

A. A consultation is when a physician or nonphysician practitioner (NPP) is asked by another physician or NPP for an opinion or advice regarding management of a specific problem. A new patient is one who self refers for the initial visit *or* a previously seen patient that has not been seen in the practice for more than three years.

Q. ***Can NPPs perform consultations?***

A. Qualified NPPs may perform consultation services as long as they are within the scope of practice and licensure requirements of the state in which they practice.

Q. ***What documentation is required for a consultation service?***

A. In 2006, both the physician providing the consultation and the physician requesting the consultation must keep documentation of the reason for the consultation request. After the consultation is completed, a written report, including the consultant's opinion for treatment, must be sent to the referring physician and kept in *both* medical records.

Q. ***Can consultations be requested verbally?***

A. Yes, but both the consulting and referring provider must document the request in the patient's medical record. A simple request form is a better way to track and document consult requests.

Q. ***How do I bill when a patient requests a second opinion from my practice?***

A. In 2006, Medicare deleted 'second opinion' Confirmatory Consultation CPT codes 99271-99275. If a patient or family member requests a second opinion, it should be coded as a new patient visit using codes CPT codes 99201-99205.

Q. ***How do I code a second opinion from the patient or family member while the patient is in the hospital and under the care of another provider?***

A. Inpatient consultation requests are tricky. If the request comes from the patient or a family member but the attending physician does *not* request a consultation, the consultation requirements are not met. Instead, for patients or family members requesting a second opinion during a hospital stay, providers should bill using subsequent hospital care CPT codes 99231-99233.

If the attending physician requests a consultation, providers can use the initial inpatient consultation CPT codes 99251-99255. As with all consultation requests, providers must send a report to the physician requesting the consultation.

In 2006, CMS deleted follow-up inpatient consultations CPT codes 99261-99263, as they were difficult to understand and rarely used by providers. After the initial consultation is performed, providers should now charge using subsequent hospital care CPT codes 99231-99233.

Q. ***Can I charge for a consultation when another physician in my group requests that I see one of his or her patients?***

A. According to the Medicare manual, a consultation can be charged by another physician in the same group practice when the consulting physician or qualified NPP has expertise in a specific medical area *beyond* the requesting professional's knowledge. The manual also states that this practice should not become routine.

Q. ***Can I charge a consultation and order diagnostic tests on the same day?***

A. Yes. CMS policy states that "a physician or qualified NPP consultant may initiate diagnostic services and treatment at the initial consultation service."

Q. ***When does transfer of patient care occur?***

A. Transfer of care occurs when the consulting physician takes responsibility for managing the entire course of treatment for the patient. All subsequent visits would be billed as an established patient visit using CPT codes 99212-99215. The point where care is transferred should be documented in the patient progress notes. Consultations *cannot* be charged after a transfer of patient care occurs.

Q. ***Can a consultation be charged when time is used as the basis for the visit charge level?***

A. As with most oncology visits, time can become the deciding factor when counseling and coordination of care are needed. If counseling and coordination of care are required for a period of time that is greater than 50 percent of the CPT-suggested time that the visit would normally require, the visit level can be based on time. An example would be an 80-minute consultation where more than 40 minutes were spent counseling the patient. When using time, documentation should include the amount of time spent in counseling and verification that this time took up more than 50 percent of the visit time.

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