

Policies and Procedures - School of Medicine

SECTION: COMPLIANCE	Approved: 05/12/99	Effective Date: 07/01/99	Revised: 7/13/06
CHAPTER: BILLING	Revises Policy Revised: 01/08/04		
POLICY: CONSULTATION	Retired:		
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I. PURPOSE

To provide and ensure proper documentation and billing of outpatient and inpatient consultation services for new and established patients.

II. POLICY

Consultation services billed to all payers shall comply with the standards set forth in the latest edition of the CPT manual, the Medicare Claims Processing Manual, Pub. 100-04, Chapter 12 (for Medicare patients) and any other payer requirements. For Medicare billing purposes, the Medicare Carriers Manual shall prevail over the CPT manual. Medicare HMO and PPO payers, as well as other payers, may have different requirements for payment of consultation services than those set forth in the latest edition of the CPT manual, which shall be met before services are billed to that payer.

III. SCOPE

This policy applies to all employees and agents of Creighton Medical Associates who bill for healthcare items/services under Creighton University's tax ID number.

IV. PROCEDURES

A. Consultations (CPT Code 99241-99255)

A consultation is a "service provided by a physician or qualified non-physician provider (NPP) whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source". (Current Procedural Terminology (CPT), Medicare Claims Processing Manual, Pub. 100-04, Chapter 12). The consultant is being asked for his/her advice, opinion, recommendation, suggestion, direction or counsel in evaluating or treating a patient based on the consultant's expertise in a specific medical area beyond the requestor's knowledge.

B. Consultation Documentation Requirements

- 1. Consultation Request.** The request for consultation from a physician, NPP or other appropriate source **and** the need for the consultation must be documented in the patient's medical record. **NOTE: Some payers may have specific forms that must be completed before a consultation is approved for payment.** The request and need for

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consultation may be documented by a written request from the requesting provider, or by a specific reference to the request in the consultant's medical records. A sample Request for Consultation form is attached as Attachment "A". This format (or a form required by the payer) may be used to document a request for consultation in the office setting.

2. **Consultation Report.** The consultant shall provide a written report of his/her findings and recommendations to the requestor. Note: An appropriate entry in a shared medical record (i.e., inpatient) is sufficient to meet this requirement.

C. Consultation Services

1. **Inpatient Consultation.** Use the initial inpatient consultation codes (99251-99255) for consultations provided in the hospital inpatient setting or nursing facility setting. Only one consultation per consultant, per patient, can be billed per admission (hospital or skilled nursing facility). Any follow-up care provided by the consultant after the initial consultation service shall be billed as either subsequent hospital visits (99231-99233) in the hospital setting or subsequent nursing facility care codes (99307-99310).
2. **Office Consultation.** Use the office or other outpatient consultation codes (99241-99245) for consultations in the office setting. An office consultation may be billed any time there is an appropriate request for consultation from an appropriate source documented in the patient's medical record, even if it is for the same or new problem. Use the appropriate established patient visit codes (99212-99215) for on-going management services provided by the consultant following the initial consultation or for any other services provided in the absence of an appropriate consultation request.

Note: The consultant may initiate diagnostic services and treatment at the initial consultation service and still bill for a consultation service.

3. **Transfer of Care.** A transfer of care occurs when a physician, or qualified NPP requests that another physician or qualified NPP assume management of the patient's condition and does not intend to continue treating or caring for the patient for that condition. In this case, the requesting physician/NPP is not seeking an opinion or advice

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and does not intend to continue treating the patient for that condition transferred to the other physician/NPP. Use the appropriate visit code based on the place of service, i.e., new office patient (999201-99205), established office patient (99211-99215), or subsequent hospital visit (99231-99233).

4. E/M Shared Visits. Medicare does not allow consultation services to be performed as a shared E/M visit by the physician and NPP. If both the physician and NPP participate in the consultation, services must be billed based upon the documentation of one of the providers that provided the level of service to be billed. If neither provider's documentation is sufficient to support a consultation, the services may be billed as a shared E/M service, other than a consultation. You must confirm with other payers whether they will allow shared consultation services provided by the physician and NPP to be billed.

D. Second Opinion

1. Request by Patient and/or Family Member (Office Setting).
 - a. Medicare: A second opinion E/M service provided at the request of a patient and/or family member shall be reported using the appropriate new patient (99201-99215) or established patient (99212-99215) codes.
2. Inpatient Setting (Hospital or Nursing Facility). If a second opinion is requested of another physician or qualified NPP by the attending physician and the other consultation requirements in paragraph B above are met, report the service using the appropriate initial inpatient consultation code (99251-99255).
3. Mandated Consultation (E.g., Third-party Payer). A second opinion requested by a third-party payer is not a Medicare covered service and therefore you must obtain a signed ABN from the patient in order to bill for the consultation service. For all other payers, use CPT modifier – 32 with the consultation code.

Medicare Examples of Consultations vs. Visits are listed in Attachment "B"

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E. Consultations Requested by Members of the Same Group

A consultation service may be billed if a CMA physician or qualified NPP requests a consultation from another CMA physician or qualified NPP who has expertise in a specific medical area beyond the requesting professional's knowledge, as long as the consultation requirements in paragraphs B and C above are met. A consultation service shall not be reported on every patient as a routine practice between physicians and qualified NPPs within CMA.

F. Pre-operative Clearance.

A consult may be billed for a pre-operative clearance for a new or established patient performed by any physician at the request of a surgeon as long as all consultation requirements as set forth in paragraphs B and C above are met and the service is medically necessary and not routine screening.

G. Post-Operative Care

1. A physician or qualified NPP who performs a post-operative evaluation of a new or established patient at the request of a surgeon, may bill the appropriate consult code as long as all consultation requirements set forth in paragraphs B and C above are met and that same physician/qualified NPP has not already performed a preoperative consultation.
2. Do not report a consult code(s) if either the pre-operative consultant or another physician assumes responsibility for the management of a portion or all of the patient's condition(s) during the post-operative period. The appropriate codes to use are either the subsequent hospital visit or established office visit codes, depending upon the setting.

V. ADMINISTRATION AND INTERPRETATIONS

Questions regarding this policy may be addressed to your Department Administrator or Billing Supervisor, or the Compliance Director.

VI. AMENDMENTS OR TERMINATION OF THIS POLICY

This policy may be amended or terminated at any time.

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VII. REFERENCES

Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, Section 30.6.10
(<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>) , CPT-4 Coding Manual

REQUEST FOR CONSULTATION

Requested Consultant Name/Dep't: _____
Date of Request: _____

Patient Information:

Name: _____

Address: _____

Street

City

State

Zip

Social Security No.: _____

DOB: _____

Telephone: (_____) _____

Insurance: _____

Primary Care Physician (if other than requesting physician) _____

Consult Appointment date: _____ Time: _____ a.m./p.m.
Day of Week Date

Additional Information:

Requesting Physician: _____

Physician Address: _____

Physician Phone: (_____) _____ Fax: (_____) _____

Emergency

Urgent

Routine

Reason for consultation (please be specific): _____

Tests Performed by Requesting Physician: _____

ATTACHMENT "B"

Medicare Examples of Consultations (Per, Medicare Transmittal 788, Change Request 4215, December 20, 2005, **Bolded information added**)

For brevity, the consultation request and the consultation written report is not repeated in each of these examples. Criteria for consultation services shall always include a request and a written report in the medical record as described above.

1. An internist sees a patient that he has followed for 20 years for mild hypertension and diabetes mellitus. He identifies a questionable skin lesion and asks a dermatologist to evaluate the lesion. The dermatologist examines the patient and decides the lesion is probably malignant and needs to be removed. He removes the lesion which is determined to be an early melanoma. The dermatologist dictates and forwards a report to the internist regarding his evaluation and treatment of the patient. **(The visit to the dermatologist can be billed as a consultation)** Modifier –25 shall be used with the consultation service code in addition to the procedure code. Modifier –25 is required to identify the consultation service as a significant, separately identifiable E/M service in addition to the procedure code reported for the incision/removal of lesion. The internist resumes care of the patient and continues surveillance of the skin on the advice of the dermatologist.
2. A rural family practice physician examines a patient who has been under his care for 20 years and diagnoses a new onset of atrial fibrillation. The family practitioner sends the patient to a cardiologist at an urban cardiology center for advice on his care and management. The cardiologist examines the patient, suggests a cardiac catheterization and other diagnostic tests, which he schedules and then sends a written report to the requesting physician. The cardiologist subsequently periodically sees the patient once a year as follow-up. Subsequent visits provided by the cardiologist should be billed as an established patient visit in the office or other outpatient setting, as appropriate. Following the advice and intervention by the cardiologist the family practice physician resumes the general medical care of the patient. **(The cardiologist can bill the initial visit as a consult, but** subsequent visits provided by the cardiologist should be billed as an established patient visit in the office or other outpatient setting, as appropriate).
3. 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. Other routine care continues to be followed by the family practice physician. **(The surgeon can bill a consult for the initial visit,** but subsequent visits provided by the surgeon should be billed as an established patient visit in the office or other outpatient setting, as appropriate).

Following the advice and intervention by the surgeon the family practice physician resumes the general medical care of the patient.

Examples when a Consult CANNOT be billed

1. Standing orders in the medical record for consultations.
2. No order for a consultation.
3. No written report of a consultation.
4. The emergency room physician treats the patient for a sprained ankle. The patient is discharged and instructed to visit the orthopedic clinic for follow-up. The physician in the orthopedic clinic shall not report a consultation service because advice or opinion is not required by the emergency room physician. The orthopedic physician shall report the appropriate office or other outpatient visit code.