

College of Medicine Office of Compliance, Gainesville, Florida
COMPLIANCE TIP – January, 2006

Consultations – New Federal Revisions as of Jan. 17, 2006

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)
Transmittal 788 IMPLEMENTATION DATE: January 17, 2006
<http://www.cms.hhs.gov/transmittals/downloads/R788CP.pdf>

CMS distinguishes a consultation service from other evaluation and management (E/M) visits by the additional aspect that it is provided by a physician or qualified non-physician practitioner (NPP) whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. **The opinion is sought because that individual has expertise in a specific medical area beyond the requesting professional's knowledge.**

IMPORTANT POINTS AND NEW CONDITIONS

- For consultations **requested from outside of our group practice**: The **REQUEST AND REPORT** are **REQUIRED** by federal rules to be **SEPARATE DOCUMENTS** (written) in the medical record of both the requesting and consulting physician.
 - For consultations **within our group practice**, both the request and the response can be documented in the shared medical record.
1. **A WRITTEN REQUEST** for a consultation from an appropriate source and the **NEED** for consultation (i.e., *the reason for a consultation service*) shall be documented by the consultant in the patient's medical record and included in the requesting physician or qualified non-physician practitioner's plan of care in their patient's medical record.

For consultations outside our group practice, the request must be documented in our medical record in a separate document in advance of the service **AND STATE THE REASON FOR THE CONSULTATION SERVICE** .

While CMS permits the initial request may be a verbal interaction between the requesting physician and the consulting physician, CMS does not permit verbal requests to non-providers (clerical staff and nurses), so written requests will now be necessary to support a bill. **A completed consultation form is sufficient – be sure to complete the reason line provided.**

2. After the consultation is provided, the consultant shall prepare a **WRITTEN REPORT** of his/her findings and recommendations, which shall be provided to the referring physician. It is strongly recommended that the **medical record shall have some**

indication of when and how the response was communicated to the requesting physician.

- DELETED CODES: Inpatient Follow-up consultations and Confirmatory Consultations have been deleted. Report these services as Subsequent inpatient visits codes (99231 – 99233).

If an additional request for an opinion or advice, regarding the same or a new problem with the same patient, is received from the same or another physician or qualified NPP and documented in the medical record, the Office or Other Outpatient Consultation (new or established patient) codes (99241 – 99245) may be used again. However, if the consultant continues to care for the patient for the original condition following his/her initial consultation, repeat consultation services shall not be reported by this physician or qualified NPP during his/her ongoing management of this condition.

In the Outpatient setting, for a second opinion evaluation, a physician/qualified NPP shall use new patient codes (99201 – 99205) for new patients and established patient codes (99212 – 99215) for an established patient, as appropriate. The CPT code 99211 is not recognized by Medicare for a consultation service.

- NO COMBINING SERVICES FOR INPATIENT CONSULTATIONS In November, 2002, CMS stated that outpatient consultations could not be a “split/shared” service with a non-physician practitioner (ARNP/PA). This transmittal extends that prohibition to INPATIENT consultations. The service must be supported by either service as it stands alone.

CMS TWEAKS OR REFINES LANGUAGE:

CMS has clarified qualified Non-physician practitioners can perform (and bill) consultations when requirements are met.

Transfer of Care - adds phrase “for the condition” See examples for consultation

A transfer of care occurs when a physician or qualified NPP requests that another physician or qualified NPP take over the responsibility for managing the patients’ complete care for the condition and does not expect to continue treating or caring for the patient for that condition.

When this transfer is arranged, the requesting physician or qualified NPP is not asking for an opinion or advice to personally treat this patient and is not expecting to continue treating the patient for the condition. The receiving physician or qualified NPP shall document this transfer of the patient’s care, to his/her service, in the patient’s medical record or plan of care.

In a transfer of care the receiving physician or qualified NPP would report the appropriate new or established patient visit code according to the place of service and level of service performed and shall not report a consultation service.

CONSULTATION EXAMPLES:

Examples That Do Not Meet the Criteria for Consultation Services

EXAMPLE 1: Standing orders in the medical record for consultations.

EXAMPLE 2: No order for a consultation.

EXAMPLE 3: No written report of a consultation.

EXAMPLE 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.

Examples That Meet the Criteria for Consultation Services

**SAME AS BEFORE – ALL THREE OF THESE EXAMPLES
INCLUDED IN PRIOR CMS TRANSMITTAL EXCEPT**

CMS notes that for brevity, the consultation request and the consultation written report is not repeated in each of these examples.

EXAMPLE 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. 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.

EXAMPLE 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.

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

SAME RULES AS BEFORE:

Initiating Diagnostic Services and treatment still permitted

A physician or qualified NPP consultant may initiate diagnostic services and treatment at the initial consultation service or subsequent visit. Ongoing management, following the initial consultation service by the consultant physician, shall not be reported with consultation service codes. These services shall be reported as subsequent visits for the appropriate place of service and level of service. Payment for a consultation service shall be made regardless of treatment initiation unless a transfer of care occurs.

Billing based on Time and Limitations of consults per consultant per patient

Consultations may be billed based on time if the counseling/coordination of care constitutes more than 50 percent of the face-to-face encounter between the physician or qualified NPP and the patient. The preceding requirements (request, evaluation (or counseling/coordination) and written report) must also be met when the consultation is based on time.

The Initial Inpatient Consultation may be reported only once per consultant per patient per facility admission.

**QUESTIONS?
FOR THE GAINVILLE PRACTICE
CALL THE COLLEGE OF MEDICINE OFFICE OF COMPLIANCE
352-265-8359**