Dermatology Coding Alert

Consultations: These Tips Clear Your Consultation Coding Confusion

Caution: Confirm with your payer before billing as it may not follow Medicare rules.

Medicare doesn't recognize consultation codes and has not done so for the past several years. However, not all payers reject consultation claims but they do require stringent documentation rules to be followed. Some of these rules may be confusing and this means that every time your provider performs a consultation, you have to do some detective work before you can choose the right code. If you report the wrong type of code to a payer, your practice stands to lose out on deserved reimbursement.

Follow these tips before finalizing your consultation coding claims to ensure you are on the right side of the dollars while reporting a consultation code.

Tip 1: Start By Identifying the Payer

Back in 2010, CMS stopped accepting claims with consultation codes, but some private payers still reimburse for the service. Therefore, you need to check to which payer you are billing before submitting a code.

How it works: If the patient is non-Medicare and the payer has not indicated that it follows Medicare's rules for consultations, you could code from 99241-99245 (Office consultation for a new or established patient ...) for the consultant services in an outpatient setting or 99251-99255 (Inpatient consultation for a new or established patient **...**) for inpatient consultations, says **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC,** president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J. in her audioconference "E&M Documentation: Train the Trainer" for The Coding Institute affiliate Audioeductor.com.

You'll use the inpatient codes when the patient has been admitted to a hospital, a skilled nursing facility, or a partial hospitalization setting, she adds. For both outpatient and inpatient consultations, base the level of consultation on the documentation in the medical record and the documented problem(s) establishing the medical necessity for the consultation.

If the patient is a Medicare beneficiary or is covered by a payer that doesn't recognize consultation codes, report the most appropriate E/M code for the service. For example, if your provider performs a consultation in the hospital for a Medicare patient, you'll report 99221-99223 (Initial hospital care, per day, for the evaluation and management of a patient ...) based on the medical necessity and documentation, Cobuzzi explains.

Tip: If the history is not documented to at least a detailed history and the examination is not at least a detailed examination, "the consult must be coded as a subsequent visit, 99231-99233 (Subsequent hospital care, per day, for the evaluation and management of a patient ...)," Cobuzzi warns.

Tip 2: Define a Consultation

Once you decide that you can bill a consultation code because the payer still recognizes 99241-99245 and 99251-99255, you need to ensure the physician really performed a consultation service.

By definition, according to CPT®, a consult is "a type of evaluation and management service provided at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem."

Because of this definition, there are certain criteria you must be able to find in the provider's documentation, before you

can bill a consultation code. Watch for these five "R's" from Cobuzzi:

1. **Reason** — The consulting physician must include the reason for the consultation in his documentation. The requester's documentation should also indicate the reason (for example, with a narrative within her note as to why she is requesting the consult).

2. **Request** — The consultant must illustrate in his documentation that there was a request for his opinion from the requesting physician (or other appropriate source), along with the need for a consultation. Cobuzzi suggests avoiding the word "refer," and using a statement such as "I have been requested to see patient name in consultation by requesting doctor for state the problem here" or "Requesting doctor is asking my opinion for patient's name's state problem here."

3. **Render** — The consulting provider must perform the service and render his opinion. He must document that opinion, and any services provided, in the patient's record.

4. **Respond** — The consultant must respond back to the requesting provider, sharing his opinion. For outpatient consultations, the consulting provider should send a letter (or a copy of his note) and for inpatient encounters, he would include the opinion in the progress notes.

5. **Return** — Finally, the consulting physician should return or discharge the patient back to the requesting physician either after the consultation or at the conclusion of the suggested course of treatment.

Important: Remember that the consulting physician can treat and care for the patient, as long as he is eventually sending the patient back to the requesting provider. With a consultation the patient "is on loan from the requesting provider," Cobuzzi explains.

Note: When requested by a physician or other appropriate source, a consultation may be provided by a physician or qualified non-physician practitioner (NPP). In order to be a qualified NPP, performing a consultation service must be within the scope of practice and licensure in the state in which the NPP practices and the NPP must bill out the consultation under her own NPI, since incident-to rules require the physician establish the plan of care, meaning that an NPP would not handle a new problem as an incident to service. If the patient is not Medicare, you may be able to bill under the physician's NPI. You will want to check with your payers in order to make that decision for appropriately billing of the consultation.

A consultation requested by a patient or family would not be reported as a consultative service. An appointment the patient schedules to seek a second opinion also does not fit the CPT® definition of a consultation code. However, you can report these visits using another applicable E/M service code such as an office visit code (99201-99205 for a new patient or 99211-99215 for an established patient).