Internal Medicine Coding Alert

Correct Coding for Consults and Referrals: Dont Confuse a Request for an Opinion with a Transfer of Care

Internists are most often their patients primary care physicians, overseeing and coordinating all of their health care. If a patient needs the services of a specialist such as a cardiologist or orthopedist, the internist sends the patient to the other physician and either requests the medical opinion of the specialist about a specific problem or asks the specialist to assume care for that patient.

Depending on the extent of the specialists involvement with the patient, this treatment constitutes either a consultation or a referral. In addition, there are situations where an internist may be called upon to consult on their own patients. For example, a patient is scheduled for surgery by a specialist for a specific problem. The specialist requests that an internist perform a preoperative clearance physical exam to ensure the patient is capable of undergoing surgery. In addition, some internists concentrate on subspecialties of internal medicine, such as endocrinology or gastroenterology. These physicians often perform specialist consults on other physicians patients.

The correct way to bill these scenarios is often confusing for even experienced coders. The terms consult and referral are commonly used by medical personnel to refer to services that may or may not constitute the precise CPT definition of these services. This situation is even more difficult for internal medicine coders because their physicians are often on both sides of the fence: as physicians requesting consultations and as consulting physicians for surgeons and emergency department personnel.

In this article, we will clarify what constitutes a consultation according to CPT and when consultation codes (99243-99245) should and should not be used. We will also outline some problem areas to which internal medicine practices should pay particular attention.

What Is (and Is Not) a Consult?

In the good old days, specialists billed a consultation code every time a primary care physician sent a patient to see them, relates **Barbara J. Cobuzzi, MBA, CPC,** president of Cash Flow Solutions, Inc., a physician practice billing company in Lakewood, NJ.

The reimbursement for the consult codes is significantly higher than that of the normal new patient or established patient office-visit codes (99201-99205, new patient or 99211-99215, established patient) which are used when the patient is referred for treatment not just an opinion, she notes.

However, with the advent of increasing government scrutiny and managed health care, third-party payers are focusing more attention on the proper use of consult codes. A consult should only be billed by a specialist when the service meets the three Rs standard, says Cobuzzi, who also works as a coding and reimbursement consultant to physician practices. The primary care physician must request the opinion of a specialist, the specialist must review the patients condition, and then send a report of his or her findings to the primary care physician who determines follow-up treatment, she explains.

If the primary care physician sends the patient to the specialist with the intention that the specialist will assume treatment for the patienttreating the person for the medical problem specified and then assuming the follow-up carethen that does not constitute a consult, Cobuzzi warns. That is a transfer of care. The specialist should then bill for an office visit by a new patient, or, if the patient has been seen by that specialist in the previous three years, for an established patient.

Billing for consultation codes when the care provided doesnt meet the definition of a consult can land a practice in hot water with the Department of Health and Human Services Office of the Inspector General (OIG) and with their state attorney general.

When the Internist Sees Patients in the ED

For internal medicine practices, coding for consults vs. referrals is a particular concern when the physician is called in to the emergency department (ED) by the ED physician to see a patient.

Many practices bill this as a consult, but it is not, Cobuzzi stresses. The emergency doctor is not expecting to see that patient again. The internist is there to assume care for the patient.

In these situations, the internist should bill the appropriate code for emergency services (99281-99285), she advises. Emergency services codes are not limited to emergency physicians; they are just limited to the emergency room as a place of service.

Note: These codes should only be used by the internist if the patient is not admitted to the hospital. If the patient is admitted, the internist would bill initial hospital care (99221-99223) for the admission.

Many practices will say they will have problems with concurrent care (two physicians billing for care given to the patient on the same day) if they bill an emergency service code and the emergency physician does likewise for the same patient, she admits.

But, this is an error on the part of the payer, Cobuzzi asserts. It is Medicare policy to differentiate physicians by specialty, she notes. If an internist sees a patient in the ER, and the emergency physician sees the same patient, they may both bill the same E/M codes because they saw the same patient but are of different specialtiesso they actually saw the patient for different reasons.

Unfortunately, some private payers do not have the capability to distinguish between specialties in their claims software, or they simply choose not to, Cobuzzi notes. In this case, the practice should appeal to the payer, indicating that the physicians are of different specialties.

If I received concurrent care on the insurance, I would fight it, Cobuzzi says. If you charge your new or established patient office/outpatient visit when you go to the ER, you dont get paid diddly.

Concurrent Care Issues

Another concurrent care dilemma related to the request for consults occurs when an internist asks for a consult for a patient who has been admitted to the hospital, notes Cobuzzi.

For example, an ear, nose and throat (ENT) specialist sees a patient in the hospital at the request of the patients internist, she illustrates. The ENT continues to see the patient for the specific problem, while the primary care physician (the internist) sees the patient for other concerns.

The ENT should bill a consult code for the initial visit and then bill a subsequent inpatient care code (99231-99233) for the other visits. The internist will also bill the subsequent inpatient care codes for his continuing inpatient visits.

There should be no problem with both doctors billing Medicare the 99231-99233 for the subsequent hospital visits because they are different specialties, Cobuzzi says.
Again, however, other payers may have a problem with this. Many third-party payers will want the consultant to bill a follow-up consult code (99261-99263) for the subsequent visits, she says. This is incorrect because the codes for follow-up consult should only be used if the requesting physician makes another request for the consultant to re-examine the patient.

Say the treatment by the internist isnt working or there is a new complication and the internist wants the specialist to see the patient again, she says. That is a follow-up consult. If the specialist is just following the patient for the original problem that should be billed using 99231-99233.

Be Sure to Check Specialty Classification

This can be a particular problem for internal medicine practices that employ subspecialists, Cobuzzi adds. For example, one of her clients is an endocrinologist working with a group of primary care internists.

Endocrinology is within internal medicine, but endocrinology is all that this physician does, she says. When he was called in to see patients in the hospital, he never got paid for his follow-up visits.

Cobuzzi determined that Medicare had this physician listed under the specialty internal medicine and not under endocrinology. He was not getting paid for follow-up visits performed on the same day as his patients primary care internists because Medicare had them listed as the same specialty. After she got this changed, his reimbursement problem was solved.

However, this wont change the attitude of third-party payers who dont differentiate between specialties. In these cases, Cobuzzi acknowledges, doctors are caught between a rock and a hard place. The only alternative is to pursue appeals with the individual carriers.

Appropriate Documentation Is Vital

Internists as primary care physicians must pay particular attention to documentation to ensure that they enable the specialists to whom they send patients to correctly code their consultations and referrals.

Note: This may be particularly important when the consultant is a subspecialist practicing within the same internal medicine practice.

For example, Medicare requires a written request from the primary care physician to the specialist, in order for the consult code to be valid.

Under the best circumstances, a copy of this request should be kept in both the patients chart at the internists office and the patients chart at the specialists office, says Cobuzzi. But, as this is not very realistic, at the very least the request should be provided in writing.

My recommendation for the specialist is that you create a form of some kind, she states. So, when a physician calls the office and says, Id like you to see this patient for this problem. Then, you have a written record of the request and the date and time it was made.

The wording of the request can also be important. Coders and practice managers should advise the internists to avoid using the word referral when they are actually requesting a consultation. Use of this word can imply a transfer of care and be a red flag to auditors.

Specialists should also avoid using that word when they make the report back to the requesting physician, she adds. In many cases you will have the specialist write a note that says, Thank you for referring Nancy Smith to me. I will be following her for such and such a problem.
This can also mean trouble in the event of a post-payment audit. Even if the specialist meant that the primary care physician had requested an opinion originally, and then, he, the specialist, found that he should follow the patient for the problem, thats not what that statement indicates as it is written, she says.

It sounds as though the requesting physician sent the patient over to the specialist, expecting the specialist to assume care, she adds. If that were the case, then a consult code would not be valid.

When Specialists Assume Treatment

Lets say your internist requests the opinion of a specialist, but, after examining the patient, the specialist determines that the problem is so severe that he should follow the patient for this problem instead of the primary care physician. In that case, the specialist often sends a note back with his report indicating that it is his or her opinion that the patient should be followed by the specialist, says Cobuzzi.

However, again, the wording of this statement can make all of the difference. In many cases, the specialist will say something like: Thanks for referring Jane Smith to me. I will follow her for this problem, she says. But, ideally, the note should say, I have evaluated Jane Smith for this problem at your request and, with your approval, will perform the follow-up visits.

Although it sounds nit-picky, it can be very important in the event of a post-payment audit.

This documentation closes the loop and indicates that the service was performed at the request of the primary care physician, that the specialist provided a report of his medical opinion to the original doctor, and asks the primary care physicians permission before assuming care.

It is the internal medicine practices responsibility to keep this information in the patients chart, says Cobuzzi. If an auditor looks, they should find a copy of this information in both the chart at the specialists office and at the primary care physicians office.

The Initiating Treatment Dilemma

Another problem with getting reimbursed for consultations is that many payers consider a consult to be invalid if the second physician initiates treatment for the patient, says **Brett Baker,** third-party relations specialist for the American College of Physicians-American Society of Internal Medicine (ACP-ASIM).

This can be as simple as the second physician prescribing antibiotics to the patient, he notes. Some Medicare carriers also have different interpretations of what constitutes the transfer of care from the primary care physician to the specialist, he notes.

Additionally, many managed care payers have specific referral forms that may actually be used in the event of a consultation, adds Cobuzzi. What managed care calls a referral may actually be a consult or it may not; it is not necessarily the CPT definition of a referral, which means a transfer of care. Their forms often say the physician is requesting a consult, or consult and treat, or referral.

If a request from the original physician says consult and treat, some payers have held that to mean that a transfer of care occurred (i.e., the patient was evaluated and treated) and that the second physician cannot charge for a consultation, says Baker.

The Health Care Financing Administration (HCFA), which administers Medicare, is in the process of rewriting its carrier manual instructions regarding consultations to clarify ambiguities in the definitions of transfer of care, consultation, referral, and follow-up consultation, he says.
We have asked to be a part of the process and we are supposed to meet with them this month [March], notes Baker.

Private Payer Concerns

Even if internal medicine practices are ensuring that their physicians document referrals and requests for consults correctly, and the coders are properly coding these visits, they can still face problems with reimbursement, warns Cobuzzi.

There are insurance companies that expect doctors to break the rules, she states. There are companies that expect internists to charge consultation codes for services performed in the ER even though it does not meet the litmus test of a

consult.

Cobuzzis company does the billing for several practices in her area. One large nationwide private payer has a capitated contract with the emergency department physicians at a local hospital. In the payers computer system, all emergency services codes (99281-99285) are supposed to be covered under the capitated contract, so they have asked all other specialists to use consult codes to get paid for services in the emergency department, she says.

And I cant get this in writing, Cobuzzi adds. They have said, This is what you have to do to get paid. But, I dont have anything in writing to support this.

Its not just Medicare and OIG scrutiny that practices must be careful about, she cautions. Private third-party payers can also go to the state attorney general and allege insurance fraud. If a practice is found to be violating CPT rules and they dont have anything in writing from that specific payer instructing them to code differently from CPT, then they can be held liable.