Part B Insider (Multispecialty) Coding Alert

Part B Coading Coach: Consult Vs. Transfer Of Care - Distinguish The Differences

6 steps to increase your referral reimbursement

With physicians using the word "referral" so freely, billers can have a hard time telling whether they're requesting a consultation or a transfer of care. Use the Three R's -- Request, Render and Report -- to sort out this classic conundrum.

To ensure that you're complying with the consultation rules, watch out for these common consult "myths" among providers, says **Cindy Parman, CPC, CPC-H, RCC**, principal of **Coding Strategies Inc.** in Powder Springs, Ga.:

Myth 1: I'm a specialist, so every new visit is a consultation.

Myth 2: I "consulted" with the patient.

Myth 3: I sent a courtesy copy of the encounter to the primary physician, so it's a consultation.

"The patient may have a 'recommendation' from the attending doctor to see a physician in a particular specialty group," Parman says, but you cannot bill for a consult if "the attending physician did not ask for an opinion or advice from the specialist."

"The providers know what they want - they just don't know what they want in coding terms," says **Marvel Hammer, RN, CPC, CHCO**, a consultant with **MJH Consulting** in Denver. That means it's up to you to figure out the referring physician's true intent.

The essential determining factor is whether a physician intends only an opinion from another provider (in which case you report a consult code, 99241-99245), or whether he intends for that provider to take over care (code new patient visit, 99201-99205). To complicate things a bit more, the 2004 CPT manual tells you: "A physician consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit."

Therefore, be careful not to code a new patient visit just because you see that a consulting physician has initiated services. In some circumstances, a consult includes rendered services and follow-up visits.

For flawless consult coding, follow these six rules:

1. Know the 3 R's. Regardless of what services the physician renders, you can identify a consult every time by checking for three required components.

Many billers rely on the Three R's, Hammer says. "There has to be a Request for an opinion [it must be documented], that opinion needs to be Rendered [it must be performed and documented in the patient's medical record], and there needs to be a written Report sent back to the requesting provider" or other appropriate source, she clarifies.

2. Remember specialists can refer, too. Usually the appropriate source is a general practitioner sending a patient to a specialist for consultation. However, the source can also be a specialist practice sending a patient to a general provider for consultation on overall physical condition or for clearance for surgery, Hammer says. In that case, the general provider gets to bill for a consult.

3. Keep your eyes on the bottom line. Consults reimburse better than new patient visits, so providers have been

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known to go to great lengths to justify their service as a consultation. This is why a pattern of billing consults can spark payer audits and why consults remain on the **HHS Office of Inspector General's** Work Plan for yet another year as a compliance hot spot.

4. Inform your physicians. Improving the communication between providers and front-desk staff is the best way to nip this problem in the bud, Hammer says. "Tell your providers not to say [or write] 'Thanks for referring so-and-so to me' " in the medical record, Hammer says. That only confuses things. The best way to avoid any confusion between a consult and a transfer of care is to use the word "request," e.g., "The patient is being seen today at the request of Dr. Jones."

5. Standardize the referral process. Hammer suggests developing a standard paperwork procedure with your office and the practices you frequently refer patients to or receive referrals from. Create a fax face sheet with boxes to check for "opinion only" or "transfer of care" that front-desk staff can attach when scheduling patients for referrals (be sure to include a disclaimer for HIPAA privacy-rule purposes).

In addition, create a similar sheet with check boxes that providers can give to patients to take with them to their referred appointment. This will leave no doubt as to the sending physician's intent and will become part of the patient's medical chart that will support you in an audit. "It's all about changing habits," Hammer says, and "having improved communication from the get-go allows you to be compliant."

6. Fight for your rights. Many insurance companies that see a consult code alongside a treatment or procedure will automatically downcode the claim to a new patient visit. You should appeal as long as you have proof there was no intent to transfer care on that visit, Hammer says.

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