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Part B Insider (Multispecialty) Coding Alert

PART B CODING COACH: 3 Expert Answers Can Relieve Your Consultation Coding Fears

Caution: Avoid adding a consultation charge to every surgical procedure that your physician performs.

Consultation coding is a challenge even for veteran coders. But if you know the "three Rs" requirement and what constitutes a transfer of care, you're well on your way to being a consultation guru. Read on to get expert answers to three of the top frequently asked consultation questions.

Question 1: What are the required components for coding a consult?

When you submit a consult claim, you should also include documentation that explains the consultation circumstances. Documentation requirements for consults vary by payer, but experts say your consult documentation should at least include evidence of:

• A written or documented request for the consult

• The consultant's opinion or advice

• Any services the consultant provides or orders

• A written report to the requesting physician or provider.

You need to be sure the visit meets the "three Rs" whether you're reporting an outpatient (99241-99245, Office consultation for a new or established patient ...) or inpatient (99251-99255,Inpatient consultation for a new or established patient ...) consult.

Every consult needs a request (in writing); a reason (again, documented in the record) for the consult; and a report from the consulting physician back to the requesting physician (written) that outlines findings and/or suggests a plan of care, says **Tina Landskroener, CPC, CCS-P, PCS,** business office manager for Blessing Physician Services in Quincy, Ill. In other words, a consultation can establish a diagnosis, confirm a diagnosis, or make suggestions for treatment of the diagnosis.

Physicians in the outpatient setting can code a consultation as often as they are asked to consult. "If the patient has an ongoing problem and the physician is asked to consult on it periodically, he can bill a consult each time the request comes in," says **Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, COBGC, CCC,** manager of compliance education for the University of Washington Physicians andChildren's University Medical Group Compliance Program.

"However, it is important to remember that to bill consultations, all three key components -- history, exam, decision making -- are required," Bucknam adds. "You can't just say 'patient is well known to our service' or something equivalent. You must document all of that history again if you want to bill a consultation."

Example: A primary-care physician (PCP) sends an 87-year-old patient to your urologist for his opinion and advice concerning a slightly elevated prostate-specific antigen (PSA) level. Following a complete evaluation, no further therapy is recommended and your urologist returns the patient to the PCP for follow-up care.

One year later, the PCP performs a repeat PSA that indicates a markedly increased level. The PCP requests another opinion from the same urologist on further management. You can consider this second visit to the urologist another consult, and if the service is provided in the office or outpatient facility, choose a code from the range 99241-99245, says

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Chandra L.Hines, business office manager for NC Urological Associates Inc. in Raleigh, N.C.

Question 2: How important is a documented request?

A documented request is essential if you're coding a consultation. "It is the request that makes a service a consultation,"Bucknam says.

Even if your physician sees a patient and decides not to operate and sends the patient back to the requesting physician for additional care, you cannot bill a consultation if there was no request for opinion or advice. Medicare in particular is very specific about this, Bucknam warns. "It is the request from one physician or other appropriate source to another physician or other appropriate consultant that establishes the service as a consultation," she stresses.

Tip: In place of a written request some payers, such as Highmark Medicare of Pennsylvania, will also accept a specific reference to the request made by a requesting physician or other appropriate source as evidence for a consultation, provided that this reference is documented by the consulting physician in his medical records. The consultant should indicate that "a urological consultation is requested by a specific requesting physician for a particular problem."

Example: If an internist has been managing care for a patient with incontinence and then sends the patient to your specialist for an opinion regarding surgical options, you can bill a consultation (if the documentation requirements are met).

If your physician decides that the patient should have surgery now, the patient agrees, and the urologist performs a surgical procedure and subsequently stays nvolved in the management of the condition, you can still report a consultation because the internist asked for the specialist's opinion, and he provided that opinion, Bucknam explains.

Good news: If your specialist works in a group practice, you can report and be compensated for consultations requested from other physicians in the same group, even if they also are urologists, Hines says. The key is that the consulting physician's knowledge and expertise must go above and beyond that of the requesting physician.

Question 3: What do payers consider a transfer of care?

This question of "transfer of care" often trips up coders. During a consultation, your consulting physician is allowed to perform diagnostic testing or even initiate treatment. However, he must eventually return the patient to the requesting physician for other care. If there is communication between the patient's primary care physician and the specialist,and the primary care physician asks the specialist to take over completely the patient's care, and the specialist accepts, then this upcoming encounter does not meet the criteria for a consult. This would represent a transfer of care, and you should not bill a consultation.

Remember this fact: The "return" does not always occur at the end of the consultative service. "The consultant is permitted to initiate treatment, when appropriate, and still report a consultation," says **Carol Pohlig,BSN, RN, CPC,** senior coding and education specialist in the department of medicine at the University of Pennsylvania in Philadelphia.

When the consultant completes the course of treatment, eventually discharging the patient from his care, a notation in the medical record helps distinguish between ongoing care and future consultation requests, Pohlig explains.

How it works: In the example above of the patient with incontinence,consider if an internal medicine doctor is managing the patient's care and that physician reaches a point where she feels the patient's disease is outside the scope of her practice. She then communicates with the specialist, explains her wishes, and sends him the patient to "evaluate and treat." This would be a transfer of care, even if the urologist decides not to operate and eventually returns the patient to the referring physician or to another provider.

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