Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Consult or Referral? You Be the Judge

Know the 5 Rs to keep the auditors at bay and collect that extra $50

The feds have consult claims -- which pay about $50 more than an equivalent new patient visit -- under a microscope, so you've got to get your documentation straight.

To report a consultation code (99241-99255), **Barbara Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC,** has extended the 3 Rs into 5 Rs based on what Medicare has been looking for. They are:

1. Reason for consultation
   ;
2. Request for opinion
   ;
3. Render of opinion
   ;
4. Report back of findings: Your physician must provide a written report back to the requesting physician that describes the consulting physician's findings, recommendations, etc.
   ;
6. Return: Discharge patient back to requesting physician.

A Request Comes In

When a doctor or NPP sends your doctor a patient, you have to determine what that provider is asking for. Does she want your physician to advise her in the patient's treatment? Is she transferring the patient to your office to take over care? Or does she simply want your doctor to treat the patient?

If the requesting physician says to your doctor, You have expertise in this area, and I need your opinion on how to proceed with this patient who has this chief complaint, and documents that reason in the patient's chart, that meets the first requirement. In a consultation, the requesting physician loans the patient to the consultant for a specific problem and asks for an opinion.

The best way to back up the request for a consult is to have something in writing in your patient's chart indicating that a physician has requested your opinion, and the problem the physician has requested your opinion on, says **Teresa Thompson, CPC, CMSCS, CCC,** a consultant in Carlsborg, Wash. The main thing Medicare auditors are looking for in consults is whether there is a request for an opinion or a transfer of care between physicians, she says.

The consulting physician may order or perform diagnostic testing, start treating the patient during the consultation visit, or assume care of the patient's problem in a subsequent visit (a transfer of care). Whether or not your physician treats the patient, if the initial visit is to provide the requesting physician with a specialist's advice on how to treat his patient, you can consider that visit a consultation.

A referral, on the other hand, assumes that one physician is handing the patient off to your physician to take over care (which would also qualify as a transfer of care). The first physician is not requesting your doctor's opinion or advice, and there is no requirement that your doctor share his findings or plans for treating the patient with the referring physician. That's true even if your doctor does share his findings in the name of good physician relations; just because the second physician sends the first a letter with findings, it's not necessarily a consultation. To report an E/M visit for a transferred patient, you use the appropriate level initial or subsequent inpatient/new or established outpatient visit code depending on the place of service (99201-99215, 99231-99233).

Not a consult: In a group of ENTs, for instance, one provider specializes in otology. Another ENT sees a new patient who presents with a perforated eardrum. She sees the damage is extensive, so she refers the patient to the otologist in her practice to take over the care of the patient.

This is not a consult, because the original ENT sends the patient to his colleague to care for this problem related to his subspecialty. Instead, you would report an appropriate established outpatient visit code (99211-99215) for the patient's initial visit with the second otolaryngologist.

Yes, a consult: Consider, however, a neurologist who sends a patient who complains of headaches and dizziness to an ENT; the neurologist suspects an inner ear problem, but isn't sure, so she wants an expert opinion. In this case, the requesting physician has exhausted her treatment options and wants the consultant's opinion on further possibilities.

In this latter scenario, if the documentation shows a reason for the consultation, a request for advice and a reply from the second physician, the visit would qualify as a consultation.

It's not always easy to keep up with documentation for consults.

I've never seen a good tracking system, says **Chris Felthauser, CPC, CPC-H, ACS-OH, ACS-OR, PMCC,** medical coding instructor at Orion Medical Services in Eugene, Ore. But as long as your providers are educated as to what is required to be documented, the coders can follow up with random audits to make sure the requirements are met."

Although we have little control over what the requesting physicians' office may or may not have in their chart, one way we can cover ourselves is using a consultation request form that can be faxed to the requestor's office completed and sent back, Felthauser recommends. This way we satisfy the first part of the requirements.

Is the Opinion Documented?

The next step is to verify your doctor has documented his opinion on the patient's condition and recommendations on treatment.

You'll look at the same information on patient history, examination, and medical decision making -- and, of course, the diagnosis code -- that you use to determine the level of E/M service.

Did Your Doctor Report Back?

You must be able to show that your doctor reported his findings to the requesting physician. You'll want a note in the patient's record and a copy of the letter your physician wrote to the requesting physician.

The requesting physician should agree with the treatment plan and authorize the plan of care in a perfect world. Cobuzzi recommends that the consultant' letter finish with a statement that indicates that the consultant will pursue the above plan of care unless she hears from the requesting physician otherwise.