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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Nail the New Consultation Rules With These Real-World Examples

Warning: Don't let your newfound in-group consult option get out of hand

You've heard the buzz about the new consultation requirements, but it's a lot to stomach all at once. If you're grimacing each time you code a consultation claim, we'll put you at ease by breaking down the major rule changes into simple scenarios.

1. Make your 3 R's into 4 R's.

For years you've known that in order to report a consultation code, your physician's documentation must satisfy the 3 R's: request, render, and report. Now you'll have one more R requirement to fulfill before you can successfully report a consultation: a **reason.**

Without a documented reason for the consultation, you shouldn't see any money for your physician's service. You must make sure that the requesting physician specifies in the original consultation **request,** which is entered into the patient's medical record, why the patient needs the service, according to Medlearn Matters article MM4215. Likewise, the consulting physician needs to document this reason as well. Then, as always, the consulting provider must document both the exam and the opinion he renders, and he must send a report of his findings and opinion back to the requesting physician.

Example: During a woman's annual physical, her ob-gyn notes that she has elevated blood pressure (401.9, Essential hypertension; unspecified). The ob-gyn decides to send her to a cardiologist for an evaluation because the patient has a family history of hypertension and heart disease. In the consult request, the ob-gyn documents this **reason** and **records** the request in the patient's medical record.

Later, the cardiologist finds that the patient's blood pressure is elevated but does not require medication. So, he gives the patient a "heart healthy" diet plan to follow. The cardiologist documents the **reason** of the ob-gyn's **request** and documents the diet plan he **renders,** then **reports** this to the ob-gyn with a note to continue monitoring the patient's blood pressure.

Watch out: Coding pre-op consults could set you on thin ice. It's not uncommon for a surgeon to get a medical consultation from another physician as a preventative measure due to hospital guidelines or out of good general medical practice, notes **Eric Sandhusen**, director of reimbursement, HIPAA and fiscal compliance for the **Columbia University** department of surgery in New York, NY.

In the past, documentation for the consultation might have just said "surgical clearance." Now if the surgeon doesn't identify some specific reason that the patient needs that surgical clearance (such as diabetes, respiratory or heart conditions) carriers will consider it a screening, and not a consultation.

Don't miss: The **Centers for Medicare and Medicaid Services** (CMS) has also made it clear that your consulting physician needs to have a documented request in the patient's medical record, but the requesting physician now also has to include the request in the patient's medical record. You can't simply make sure the requesting physician's file has the consulting physician's report after the fact. The request for the opinion must be in the requesting physician's chart before the consult happens, experts say.

2. Get ready for NPP changes.

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The new guidelines outline some major changes to what non-physician practitioners (NPPs) can and can't do.

Change #1: One of the most significant changes is that NPPs cannot see patients for hospital shared visit consultations, notes **Terry Fletcher, BS, CPC, CCS-P, CCS, CMSCS, CMC**, healthcare coding consultant in Laguna Beach, CA.

"Doctors were having their NPPs perform all of the work except the plan of care for hospital consults, but now the rules clearly state that if the patient is in the hospital, the initial encounter should be performed by a physician," she says.

Example: A patient fractures her hip, and she's also diabetic, so the orthopedic physician decides to bring in an endocrinologist for a consult on how to manage the diabetes for post-surgical care. Now only the endocrinologist can do the consult--no shared visit or collaboration.

Change #2: Brace yourself for a brand new consultation coding option ...quot; because now, an NPP may both perform and request a consultation in the office, provided she follows her state's scope of practice rules and meets the proper collaboration and supervision requirements, MM4215 explains.

Example: A patient's primary care physician sends him to a neurologist for an opinion on the patient's migraines. An NPP performs the consult, and the coder bills under the NPP's PIN, assuming it falls under the scope of the NPP's state license. Remember that reimbursement will be at 85 percent since the consult does not meet incident-to requirements. (For more on incident-to, see PBI Vol. 7, No. 4).

3. Don't turn your consult into a transfer of care.

Key to these new guidelines is communication between the requesting physician and the consultant--because if the consultant immediately arranges a treatment plan, the visit may be riding a fine line between a new patient E/M and a consult.

Example: CMS Manual 100-04, Transmittal 788 gives the example of a family practice physician who diagnoses a breast mass in his female patient. The family practitioner sends the patient to a general surgeon for advice and management of the mass and related patient care. The general surgeon examines the patient and recommends a biopsy, which he schedules, and then sends a written report to the requesting physician.

However, the family practice physician must resume the medical care of the patient following the advice and intervention by the surgeon in order to keep it a consult, Transmittal 788 asserts. Then, if the general surgeon does the breast biopsy and periodically sees the patient once a year as follow-up, you must code these visits as an established patient visit in the office or other outpatient setting (99212-99215).

4. Know the perks--and limits--of group practice consults.

Now, CMS has clarified that physicians in the same group can provide consultations for other physicians in the group if their knowledge and expertise goes above and beyond the requesting physician's. "This rule was always there, but this clarification actually is one that will alert doctors to make sure they are not performing and billing frivolous consults," Fletcher notes.

Example: An ENT sees a patient who complains of one- sided hearing loss (388.40--Abnormal auditory perception, unspecified). The ENT suspects an acoustic neuroma due to the one-sided nature and requests a consultation with a neuro-otologist in the same practice.

Careful: Don't let your newfound privilege of in-group consults get out of hand. The consulting physician in the group must clearly have a skill set that the requester does not, experts say. And it all goes back to that new fourth R: You must see a **reason** and justification in the chart. In the example above, the problem is a very specific, potentially high-end problem of a tumor, which is far beyond what a general ENT would be qualified to diagnose and treat.

"If doctor #1 can render an opinion and make treatment recommendations, then there is no reason for doctor #2 to

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perform another consult to 'agree' that the patient needs a procedure. Only doctor #2 should bill the treatment and maybe a minimal E/M," Fletcher explains.

If carriers start to see a pattern of practices feeding many patients through generalists and then referring to sub-specialists within their practice, they're going to suspect you're gaming the system. The right way: Schedule the patient for the sub-specialist that is appropriate from the start--the need for a consult should be discovered after the fact.

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