Part B Insider (Multispecialty) Coding Alert

TRANSMITTALS: Don't Bill A Consult Unless Your Documentation Backs It Up

You can't bill a split/shared visit as a consult, but non-physician practitioners can provide consults if you meet all the requirements, the **Centers for Medicare & Medicaid Services** clarifies in Transmittal 788, dated Dec. 20.

The transmittal also updates documentation requirements for both the requesting physician/NPP and the consulting physician/NPP, as well as examples for consults. Example: Verbal requests for consults should be documented in writing in patients' records.

Now that CPT 2006 has deleted follow-up inpatient consult codes 99261-99263 and confirmatory consult codes 99271-99275, CMS agrees with the experts that you should be billing subsequent hospital care codes 99231-99233 and the new subsequent nursing facility care codes 99307-99310 in the nursing facility setting, instead of the deleted codes.

What won't fly: You should also use the appropriate office E/M codes for consults that don't meet the requirements for an initial consult, CMS says. But CMS won't recognize 99211 as a consult service, as it typically does not require a physician or NPP to be present. It doesn't recognize a second opinion visit designed to meet payment requirements for a third-party payor.

In other recent transmittals:

• A physician supplying low-osmolar contrast material (LOCM) in a critical access hospital should use bill type 85X and revenue type 096X, 097X or 098X, CMS clarifies in Transmittal 803, dated Jan. 3. CAHs should also use the same revenue type to bill for physician involvement in providing hydration, therapeutic or diagnostic injections or chemotherapy.

• CMS gives carriers more administrative and financial flexibility in meeting the timeliness requirements for processing enrollment applications in Transmittal 130, dated Dec. 30. The carriers still must process 80 percent of applications within 60 days, 90 percent within 120 days and 99 percent within 180 days. They also have 45 days to process 80 percent of change of information requests, and 90 days to process 99 percent of COI requests.

The Transmittal clarifies that if you fail to respond to two requests for additional information, but then respond a third time, the carrier can't close your application. Instead, the "three strikes" count starts all over again.

• The upper payment limit for rural health clinics will raise to $72.76 per visit, according to Transmittal 796, dated Dec. 30.

• The carriers should manually delete the "G" codes from last year's chemotherapy demonstration project, plus new codes for low vision rehabilitation, from the fee schedule, according to Transmittal 798, dated Dec. 30. Also, CMS incorrectly marked new CT angiography codes 0144T-0154T as non-covered instead of status "C," meaning "carrier-priced." The transmittal also corrects the descriptors for several HCPCS codes.