Eli's Rehab Report

Code Confirmatory Consults for Ethically Maximum Return

Physiatrists often code for new or established patient office visits (**CPT 99201** - **99215**) when they are asked to provide a second or even a third opinion concerning a recommended medical treatment or surgical procedure. But these evaluation and management (E/M) sessions should be coded as confirmatory consultations (99271 - 99275) unless the second opinion is requested by another physician. The confirmatory consultation codes normally have a higher relative value unit (RVU) than established patient office visits, and therefore can increase the physiatrists level of reimbursement when used properly.

Who Can Request a Second Opinion?

Many physiatrists believe that they can use confirmatory consult codes if another physician asks them to confirm a diagnosis, but this is actually not true, says **Carol Pohlig, BSN, RN, CPC,** reimbursement analyst in the department of medicine at the Hospital of the University of Pennsylvania in Philadelphia. Physicians and billers are often confused and think that a confirmatory consult should be billed because the nature of the consult request is to confirm their own original opinion. Pohlig says that this is just a matter of semantics because the practices see the word confirmatory and assume that it can be used when confirming another physicians diagnosis. The confirmatory consult, in the billing world, is reserved for a second opinion generated by a non-physician or non-billing provider only, such as a patient, patients family, court or insurance company.

For instance, if a family practice physician is fairly certain that a patient has Bells palsy (351.0) but needs a specialist to confirm the diagnosis, the physical medicine and rehabilitation (PM&R) provider might review the history and testing that the primary care physician (PCP) has performed and see the patient to determine whether the diagnosis was accurate. Code this service as a standard consultation (99241-99245) and document the request for an opinion, the review of the case and the report to the family practice physician.

If a workers compensation insurer or an attorney requests the second opinion, however, use the confirmatory consultation codes. Mandatory second opinion requirements are common in workers compensation or court cases involving medical problems or injuries. When an independent physician is asked to confirm or deny a patients condition, use the confirmatory consultation codes.

Insurers rules vary concerning whether payment will be made for second opinions initiated by anyone other than the patient. For example, Blue Cross and Blue Shield of Alabamas (the Medicare part B carrier for Alabama) policy states, In actual practice, a second or third opinion primarily occurs as a result of a third-party having a mandatory second opinion requirement ... depending on these circumstances, most of these consultations should be billed to the third party and not to Medicare and are subject to medical review.

According to CPT, A physician consultant providing a confirmatory consultation is expected to provide an opinion and/or advice only. Any services subsequent to the opinion are coded at the appropriate level of office visit. With a standard consultation, however, the physician consultant can initiate diagnostic and/or therapeutic services at the same or subsequent visit.

Patient-initiated Second Opinions

Patient-requested second opinions are often more clear-cut. For example, if a patients orthopedist told her that she required arthroscopic surgery (29871-29887) for a torn lateral meniscus in the knee (836.1) and the patient hoped to avoid surgery, she might ask a physiatrist to confirm whether surgery was necessary, or whether therapy and rest might heal the injury. This type of second opinion clearly would fall into the confirmatory consultation codes.

If the patient is requesting a true second opinion, youre usually better off billing it as a confirmatory consult rather than as an office visit, says **Vicki Balistreri,** CPC, a member of the American Academy of Professional Coders (AAPC) national advisory board, and a senior consultant with the Kansas City, Mo., office of Baird, Kurtz and Dobson, a consulting firm that provides healthcare and financial consulting services. The confirmatory consult would pay better than the office visit, so unless your insurer specifically asks you to bill the second opinion as an office visit, it would be advantageous for you to bill it as a confirmatory consult.

For example, the amount that Medicare reimburses for a 99213 standard office visit usually averages between $45 and $55, whereas the 99273 confirmatory consult code usually pays between $85 and $100.

No Set Documentation Guidelines

Whether the second opinion was requested by the patient, a physician or another party, the normal three Rs concept of reporting consultations (request for opinion, review of the patient and report to the requesting physician) does not apply as clearly to confirmatory consultations as it does to traditional consults. There really arent documentation guidelines established for these services because they arent usually covered by third-party payers, says **Brenda Messick, CPC,** senior consultant at Gates, Moore & Co., an Atlanta-based physician healthcare consulting firm.

Many times, in lieu of a report back to the patients physician, the consulting physician may discuss the patients condition with the patients primary care physician, or send a letter to explain his or her opinion, says **Sandy Page, CPC, CCS-P,** co-owner of Medical Practice Support Services Inc., a multispecialty physician practice management consulting firm in Denver.

If the physiatrist providing the second opinion chooses to send a letter to the patient, says Pohlig, the wording of the letter is very important. The physiatrist should acknowledge the request for the second opinion, such as, in regards to your request for a second opinion... If the physiatrist sends a letter back to the primary care physician, the source of the request must be crystal clear so as not to confuse an auditor about who requested the consultation, because this [source of the request] has an effect on which consultation code to choose. Pohlig suggests that a good way to start the letter would be, I saw your patient in consultation for a second opinion...

Payers such as workers compensation insurers and attorneys expect a written report, says Page, and sometimes a request (or subpoena) for medical testimony as an expert witness may follow.

When the confirmatory consultation is required by another party, the consulting physiatrist would add modifier -32 (mandated service) to the consult code, says Page. For example, if a patient injured in an automobile accident suffered from severe, chronic whiplash (847.0), causing her lost wages from missed work, the workers compensation insurer probably would ask several doctors to evaluate the patients condition to confirm or deny whiplash and issue a written report. If the physiatrist performed an expanded, problem-focused exam and confirmed the whiplash diagnosis, the code would be 99272-32.

Transfer of Care Is Different From a Consult

Messick reminds coders not to use consult codes for referrals. She says transfer of care, implied or otherwise, has occurred between the requesting physician and the consulting physician is the determining factor. If a patient transfer occurs, she says, This is a referral and not a consult, and the physiatrist would bill the new (99201-99205) or established (99211-99215) office visit E/M code for the service.

CPT does not establish the length time of a level of confirmatory consultation as it does for other types of E/M services. The difference between a level one confirmatory consult (99271) and a level two (99272) depends on the complexity of the patients history, the examination by the physiatrist, and his or her level of medical decision-making.

Because local Medicare and private insurers may have specific documentation and other requirements for confirmatory consultations, physiatrists should check with their local payers to get specific coding instructions before using these codes.

Codify
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