

Medicare B News Issue 227 April 4, 2006

Heading: Clarification

Title: Consultations

Noridian Administrative Services (NAS) published this article on Consultations in "Medicare B News", Issue 222, which was dated September 7, 2005. This article is being republished and is revised to add questions 11 and 12. The bullets stating the criteria from the Medicare Claims Processing Manual, Chapter 12, Section 30.6.10 that must be met in order for carriers to pay for a consultation have been revised to reflect current wording in the manual.

NAS has received several questions regarding consultations. This article provides clarification for providers, as well as for office coding, billing and managerial staff.

The following instructions are taken directly from the Consultations section of CPT:

"A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.

A physician consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.

The written or verbal request for a consult may be made by a physician or other appropriate source and documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source.

A "consultation" initiated by a patient and/or family, and not requested by a physician, is not reported using the initial consultation codes but may be reported using the codes for confirmatory consultation or office visits, as appropriate.

If a confirmatory consultation is required, eg, by a third party payor, modifier 32, should also be reported." (Note: This single sentence does *not* apply to Medicare).

"Any specifically identifiable procedure (ie, identified with a specific CPT code) performed on or subsequent to the date of the initial consultation should be reported separately.

If subsequent to the completion of a consultation, the consultant assumes responsibility for management of a portion or all of the patient's condition(s), the follow-up consultation codes should not be used. In the hospital setting, the consulting physician should use the appropriate inpatient hospital consultation

code for the initial encounter and then subsequent hospital care codes (not follow-up consultation codes). In the office setting, the appropriate established patient code should be used."

The Medicare Claims Processing Manual, Chapter 12, Section 30.6.10 states all of the following criteria must be met in order for carriers to pay for a consultation:

- • Specifically, a consultation service is distinguished from other evaluation and management (E/M) visits because it is provided by a physician or qualified nonphysician practitioner (NPP) whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. The qualified NPP may perform consultation services within the scope of practice and licensure requirements for NPPs in the State in which he/she practices. Applicable collaboration and general supervision rules apply as well as billing rules;
- • A request for a consultation from an appropriate source and the need for consultation (i.e., the reason for a consultation service) shall be documented by the consultant in the patient's medical record and included in the requesting physician or qualified NPP's plan of care in the patient's medical record; and
- • After the consultation is provided, the consultant shall prepare a written report of his/her findings and recommendations, which shall be provided to the referring physician.

Below are some questions and answers on consultations, which will provide additional clarification on this topic.

Q1. May a Nurse Practitioner (NP), Physician Assistant (PA) or Clinical Nurse Specialist (CNS) perform a consultation?

A1. Yes, *if specifically* the NP's, PA's or CNS' "opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source."

Q2. May a NP, PA or CNS request a consultation of another provider?

A2. Yes. An NP, PA or CNS would *not*, however, request a consultation of his/her supervising physician. The return visit to a supervising physician is an established visit. Likewise, the return visit to a physician for whom the NP, PA or CNS has provided "incident to" services is an established visit.

Q3. May a consult be sent to a "clinic" or group of physicians?

A3. Be careful here! Referral of care does *not* give rise to a consult, and would instead be billed with a new or established patient visit code, as appropriate. But, yes, in the circumstance, for example, where three cardiologists are in practice together as "Bayside Cardiology" and the referring provider is seeking an "&opinion or advice regarding evaluation and/or management of a specific problem&", *rather than* referral for care or some aspect of care, and the referring provider is equally agreeable to having *any* of the three physicians provide the *opinion or advice*, then a consultation request to "Bayside Cardiology" for the specific *opinion or advice* would be appropriate.

Q4. If a consultation has been requested of a physician, could it be appropriate for the physician's NP, PA or CNS to see the patient?

A4. Yes, it could, but if the consultation was requested *of the physician*, then the NP, PA or CNS would bill a new (or established) patient visit using his or her own provider number. If the consultation was *not specifically requested* of the NP, PA or CNS, then the NP, PA or CNS may *not* bill a consultation.

Q5. May a consultation or portions of a consultation be provided "incident to"?

A5. Since "&a consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source," the consultation is to be provided by the person of whom it is requested. Component services of the consultation may *not* be provided by another provider on an "incident to" basis.

Q6. May an inpatient consultation be provided as a "shared service"?

A6. Since "&a consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source," the consultation is to be provided by the person of whom it is requested. Component services of the consultation may *not* be provided by another provider on a "shared service" basis.

Q7. May a consultation be requested by one physician in a group practice of another physician in the same group practice?

A7. It may be appropriate for one physician in a group practice to request a consultation from another physician in the same group practice as long as **all** of the requirements for use of the CPT consultation codes are met and the record evidences medical necessity. This can, *on occasion*, even be true where the physicians are of the same specialty or subspecialty, though the record must clearly evidence the medical necessity of the specific opinion or advice being sought by the referring physician. This specific opinion or advice must be *over and above* the knowledge, experience and skill of usual physicians of the same specialty or subspecialty, (which here is the same for both providers), and the patient record must make this clear.

Q8. May a surgeon request a consultation from another physician to *participate in* postoperative care?

A8. If the surgeon asks a physician who had not seen the patient for a preoperative consultation to take responsibility for the management of an aspect of the patient's condition during the postoperative period, the physician may not bill a consultation. The surgeon, in this case, is not asking the physician's opinion or advice for the surgeon's use in treating the patient. The physician's services would constitute concurrent care and should be billed using the appropriate level visit codes.

Q9. May a consultation arise from a "standing order" such as might occur on admission to a coronary unit?

A9. No. "Standing orders" are not acceptable as evidence of medical necessity. There must be a specific request or "order" for the opinion or advice regarding evaluation and/or management of a specific patient's problem.

Q10. May a physician bill a consultation prior to performing a minor surgical procedure?

A10. No, not when the patient is referred specifically for the procedure. The initial evaluation is included in the allowance for a minor surgical procedure. To determine what procedures are "minor surgical", providers may reference the Medicare Physician Fee Schedule Data Base that lists the postoperative periods that apply to each surgical procedure. The payment rules for surgical procedures apply to codes with entries of 000, 010, 090, and, sometimes, YYY. Codes with "090" are major surgeries. Codes with "000" or "010" are either minor surgical procedures or endoscopies. Codes with "YYY" are carrier-priced codes, for which carriers determine the global period (the global period for these codes will be 0, 10 or 90 days).

Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable, necessary service is also performed and documented (and indicated on the claim form by a modifier 25 after the E&M code). If there are reasons separate from the minor surgery or endoscopy that the physician performs a medically necessary consultation, than that may be billed using a modifier 25.

Q11. May a nurse practitioner (NP), physician's assistant (PA) or clinical nurse specialist (CNS) perform a consultation?

A11. Yes, *if specifically* the NP, PA or CNS' "opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source."

Therefore, for the NP, PA or CNS to perform the consultation, the record must show that: & *specifically* the NP, PA or CNS' "&opinion or advice regarding evaluation and/or management of a specific problem is requested&"

It is specifically *not* acceptable to have a patient referred to the cardiologist(s) (for example), and have an NP, PA or CNS *instead* perform and bill the "consult". Recall also that a consultation cannot be provided as a "*shared service*".

Q12. If the consultant's report, which mentions the request, reason and findings, is the only documentation relating to the consultation in the requesting provider's medical records, does this comply with Medicare guidelines for reimbursement of a consultation?

A12. It may be that this will be the only recoverable evidence should a consultation service be audited. It would be expected that this might occur at times, and the consulting physician has no control of what information is contained in the referring physician's chart. However, this does not alter the requirements for a consultation, and in an audit, were such a question to come up, and there were repetitively *no* such records in any referring physician's notes, then the veracity of the consultant's notes could logically be questioned.

This should not be a major worry or concern to providers who know they've been honestly referred a consultation &but would just not be a protection for physicians who are "creatively interpreting" patients referred for, or self-referring for care, with "consultations".

Applies to the states of: AK, AZ, CO, HI, IA, ND, NV, OR, SD, UT, WA & WY.

Effective Immediately

Sources: Current Procedural Terminology *cpt*[®] 2005, © 2004 American Medical Association

**Medicare Claims Processing Manual, Chapter 12, Section 30.6.10 - Consultations (Codes 99241 - 99275)(Rev. 1, 10-01-03) and Section 40.1-Definition of a Global Surgical Package (Rev. 1, 10-01-03) available at:
www.cms.hhs.gov/manuals/104_claims/clm104index.asp**

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