Coding for Consultations

In 2006, 2 types of consultation codes were deleted, leaving just one type of valid consultation code. Because both the follow-up inpatient consultation (99261 – 99263) and the confirmatory consultation (99271 – 99275) were rarely used, they were deleted by the CPT Editorial Panel and are no longer valid CPT codes. Use the initial inpatient consult codes (if conditions are met) or another appropriate evaluation and management (E/M) code for services once billed as a follow-up or confirmatory consult. See the Centers for Medicare and Medicaid Services (CMS) Transmittal 788 for further discussion.

The initial inpatient consultation (99251 – 99255) remain in use and are discussed in the remainder of this chapter.

Criteria for Billing a Consultation

A consult is defined by CMS as “a service provided by a physician whose opinion or advice regarding the evaluation and/or management of a specific problem is requested by another physician or appropriate source.” Appendix C of CPT 2009 also provides clinical examples relevant to consults.

For a physician to bill for a consultation, the service provided must be only an opinion or advice that is being sought, and the request and need for the consultation must be documented in the record (Table 14). It is sufficient for an attending physician to document his or her request for a consultation in the progress notes, and a consulting physician’s notation in the record may serve in lieu of a letter sent to the attending physician.

Should the consulting physician initiate treatment at the initial consultation and participate in the patient’s subsequent management, it is now permissible to bill for a consultation and bill separately for the subsequent care. In prior years, the fact that treatment and management was undertaken by the consulting physician meant a consult was no longer appropriate; this is no longer the case.

Additionally medically necessary visits to the patient after providing a consultative service, when necessary to monitor the treatment, should be billed as subsequent hospital visits (99231 – 99233). Cases in which the patient is visited by the consulting physician a second time (with results of a laboratory test needed to identify the problem and for the consulting physician to provide management suggestions) should be billed as subsequent hospital visits (99231 – 99233).
The intention of the physician is the most important factor in choosing the correct code for consultation. In this regard, certain phrases should be avoided to explain the intention, including “to manage,” “to evaluate and treat,” “to follow the patient,” “thank you for this referral,” and “will follow.” An example of a good note that clearly delineates the physician’s intention is: “The patient is seen today at the request of the [surgeon or internist or subspecialist] for possible COPD exacerbation.”

Also, the consulting physician should use different ICD-9 codes for patient care from the codes used by the attending physician, if appropriate. For example, a critical care physician who is handling a case with a pulmonologist could employ a diagnostic code such as sepsis for a consultation, and the pulmonologist may use respiratory failure.

Additional medically necessary visits to the patient after providing a consultative service should not be billed by the consulting physician as follow-up consultations. Such visits are considered to be subsequent hospital visits to monitor the treatment. A follow-up visit would entail seeing the patient initially, then returning after obtaining results of laboratory tests that were needed to identify the problem and to make management suggestions.

Finally, it is legitimate for one member of a group to bill a consultation even if another member requests the consultation (eg, a pulmonologist asking a cardiologist). The CMS confirmed this practice in 2004 during a national conference call, citing the Claims Processing Manual 100-04 (Chapter 12, Section 30.6.10) and the Benefits Policy Manual 100-02 (Chapter 15, Section 30 on concurrent care). As with any consultation, however, the requirements must also be met, which include:

- A request for an opinion that is written and documented in the chart, written as an order, or filled out on a consult sheet;
- Documentation or review of the consultant’s examination of the patient; and
- A written report to the requesting physician stating the consultant’s opinion.
All 3 aspects must be clearly documented. A consultation typically does not encompass standing orders in the chart or the order to see all patients who are admitted to the intensive care unit (ICU). In recent communications with a Contract Medical Director (CMD), the Society was advised that standing orders are not acceptable as evidence of medical necessity. There must be a specific request or “order” for the opinion or advice regarding E/M of a specific patient’s problem.

The claim form should include the name and Unique Physician Identifying Number (UPIN) of the requesting physician.

**Consults and the Surgical Patient**

Surgical care can be confusing with respect to consultations. The key issue is whether the service is truly a consultation service, or whether it qualifies as concurrent care. If the surgeon requests participation in the postoperative care of the patient, management of some aspect of care, or if the consulting physician saw the patient in the preoperative period, the service is considered concurrent care and the consult codes must not be billed. The physician’s services should be billed using the appropriate level visit codes.

CMDs further clarify that a physician must not bill a consultation prior to performing a minor surgical procedure when that patient is referred specifically for the procedure. The initial evaluation is included in the allowance for a minor surgical procedure. 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 services is also performed, documented, and indicated on the claim form with modifier 25 after the E/M code.

To determine which procedures are “minor surgical,” providers should reference the Medicare Physician Fee Schedule database that lists the postoperative periods applicable to each procedure. The payment rules for surgical procedures apply to codes with entries of 000, 010, 090, and sometimes, YYY. Codes with “090” are considered major surgeries. Codes with “000” or “010” are either minor surgical procedures or endoscopies. Codes with “YYY” are carrier-priced codes, for which individual Medicare carriers determine the global period and the price (the global periods for YYY codes will be 0, 10, or 90 days).

Consultations can be used for a surgical patient if the 3 criteria (“the 3 R’s”) are met, and the physician has not provided a preoperative consultation. For the physician providing any preoperative services, including the preoperative clearance, the appropriate subsequent hospital visit codes (99231 – 99233) are used. The same is true for the physician consultant who assumes responsibility for the management of a portion or all of the patient’s condition(s); the consultation codes must not be used.

**Requests by Patient or Counseling as Consultation**

Requests by families and/or patients for “confirmatory consultations” are no longer valid as of 2006. The codes previously used to document such services (99271 – 99279) have
been deleted. To qualify as a consult, the request must originate with a physician or other appropriate provider. Otherwise, use the appropriate new/ established patient visit codes for these services.

Counseling services or coordination of care do qualify as consultations, provided the services comprise more than 50% face-to-face time, and the remaining criteria for a consult are met.

**Transfer of Care**

Be aware of transfers of care, which automatically disqualify the services as consultations. Such transfers occur when the referring physician transfers the responsibility of complete care at the time of referral, and the receiving physician documents approval for the transfer in advance.

The receiving physician does not qualify as a consulting physician in such instances and must bill services as a new or established patient visit, as appropriate.

**Requesting a Consultation of Colleagues or Partners**

On occasion a physician will consult a partner or another member in a group practice for advice on a specific patient. This is permitted, so long as all requirements for a consultation are met, and the record evidences medical necessity.

CMDs advise that requesting consultations of another physician in the same group practice, on occasion, may even be true when 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 in this scenario is the same for both providers), and the patient record must make this clear.

Similarly, a consult may be sent to a “clinic” or group of physicians, rather than to one and only one physician at the clinic. But be careful. Referral of care does not give rise to a consult, and instead would be billed with a new or established patient visit code, as appropriate. But in the circumstance where 3 cardiologists are in practice together as “Cardiac Partners” and the referring provider seeks advice and/or an opinion (and not referral of care or some aspect of care) from any of the 3 physicians, then a consultation request to “Cardiac Partners” for the specific opinion or advice is appropriate.

**“Incident to” or “Shared Service” Scenarios**

Because consultations are to be provided by the person of whom it is requested, component services of a consultation cannot be provided “incident to” by another physician. The entire consultation service must be provided by the physician of whom it is requested. Similarly, component services cannot be provided by another provider on a
“shared service” basis. That is, in neither instances can nonphysician practitioners (NPPs) provide components of a physician's consultation. This information was clarified by the CMDs for Medicare and is followed by most third-party payors. (See Chapter VII for a full discussion of billing for NPPs.)

Nonphysician Practitioners and Consults

The Society obtained the following information from Medicare’s CMDs regarding the appropriate role of NPPs for consultations. These guidelines were issued specifically to states covered by individual carriers and may not apply in your area. It is always good practice to check with your local contracted Medicare payor, and other third-party payors, when questioning specific policies. Nevertheless, these guidelines are a useful starting point for discussions and should be familiar to your CMD.

A nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS) may perform a consultation, if specifically the NP’s, PA’s or CNS’s opinion or advice regarding E/M of a specific problem is requested by another physician or “other appropriate source.” In other words, an NPP must meet the same criteria for a consultation as required of a physician. It is specifically not acceptable to have a patient referred to a cardiologist, for example, and have an NP, PA, or CNS perform the consult instead. Recall also that a consultation cannot be provided as a “shared service.”

Similarly, an NPP may request a consultation of another provider, so long as the request is made of someone other than the NPP’s supervising physician. The return visit to a supervising physician is an established patient visit. Likewise, the return visit to a physician for whom the NP, PA, or CNS has provided “incident to” services is an established visit.

Finally, if a consultation has been requested of a physician, it could be appropriate for a physician’s NP, PA, or CNS to see the patient (but not to bill the consultation). If the consultation was requested specifically of the NPP’s supervising physician, then the NPP 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 he or she may not bill a consultation. (See also CMS Transmittal 788 for further clarification on NPP consultation services.)

A final note about documentation. Many referrals for consultations are verbal requests made by the primary care provider to the patient after initial treatment proved unsuccessful. For the consulting physician, this raises the question of whether a consultation E/M can be billed, or whether to consider this a new office visit.

Medicare carriers and some private carriers sometimes audit consults by contacting the requesting physician to clarify the intent in sending the patient to the consulting physician. A justification for this practice can be found in both the 1995 and 1997
documentation guidelines. “If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.” (See Chapter 3 for a complete description of documentation guidelines.)

Because a specialist cannot control what appears in the primary care provider’s notes, there is risk that the referral was never documented, giving auditors a reason to claim the consult is not supported in the medical record. Note, however, that the language in the documentation guidelines does not specify where in the medical record the supporting documentation must be found (ie, in the primary care provider’s note or in the specialist’s notes). Some carriers have suggested that specialists provide a prescription in the specialist’s chart, either via fax from the attending or by hand delivery from the patient that states, “Consult Dr. X for ____.” If the consulting specialist is unable to obtain such a note from the attending physician, a notation in the specialist’s chart can be substituted. This note can be written by the specialist’s staff member after a call to the attending’s office confirming a consult was requested.

As if to emphasize this concern over verbal consult requests, the CMS issued a rules clarification in December 2005 on the topic of verbal requests for consultations. Transmittal 788 requires that verbal consult requests occur in a conversation between the requesting physician and the consulting physician, and not relayed to the consulting physician by a third party. The ruling also requires the request be documented in the written medical records of both physicians. While CMS later backed off this ruling somewhat in a public telephone call (Open Door Forum), the revised interpretation was that while verbal requests may occur between staff and not between physicians, this should be the exception rather than the rule; and the fact that the verbal exchange was not between physicians should be indicated in the medical record.

The bottom line is the need for written documentation indicating both the requesting physician and the consulting physician are part of the consultation, and it is part of the responsibility of providers on each side of the consult to see that such documentation is provided. Because there can be a written request without any verbal interaction, but never a verbal request alone, the written documentation remains paramount.

**Summary**

To use consultation billing codes for critical care, it is essential to have documentation of a request for consultation, the consulting physician’s findings, and a report from the consulting physician to the requesting physician in the chart. The consulting physician also should cite different ICD-9 codes from those cited by the attending physician, if appropriate. A summary of criteria for the consultation codes is provided in Table 15.
Table 15. Consultation Requirements, by CPT Code (99251-99255)

<table>
<thead>
<tr>
<th></th>
<th>History</th>
<th>Exam</th>
<th>Decision Making</th>
<th>Severity</th>
</tr>
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<tbody>
<tr>
<td>99251</td>
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<td>Comprehensive</td>
<td>Moderate complexity</td>
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<tr>
<td>99255</td>
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<td>Comprehensive</td>
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<td>High</td>
</tr>
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Table 15b. High-Level Consultation Claims and Associated Payments

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<th>Critical Care (Intensivists)</th>
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<th>2006</th>
<th>2007</th>
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<tr>
<td>99255</td>
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<tr>
<td>Frequency</td>
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<td>Allowed charges</td>
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<td>Physician Assistants (PAs)</td>
<td>2005</td>
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<td>2007</td>
</tr>
<tr>
<td>99255</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency</td>
<td>7,916</td>
<td>10,499</td>
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<td>Allowed charges</td>
<td>$1,318,416</td>
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<tr>
<td>Nurse Practitioners (NPs)</td>
<td>2005</td>
<td>2006</td>
<td>2007</td>
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<tr>
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<tr>
<td>Frequency</td>
<td>13,752</td>
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<td>$2,301,453</td>
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</table>
Clinical Scenario #8

A patient who was hospitalized with a community-acquired pneumonia developed acute respiratory distress syndrome (ARDS), renal failure, and sepsis. After the patient had been managed by one critical care physician group for 3 weeks in the ICU, the family requests a second opinion. After reviewing the chart, examining the patient, and speaking to the family, you write the consultation and speak to the primary service.

Because the codes for a confirmatory consultation were deleted in 2006, your valid options for coding are to submit a claim for a new or established patient, as appropriate. Of course, all standard requirements for the selected E/M codes apply to this encounter and must be documented accordingly. If the services comprise more than 50% face-to-face time, the encounter may qualify for counseling services or coordination of care. See Chapter IX and the current edition of the CPT handbook for these codes to help determine whether they should be used in particular cases.

Clinical Scenario #9

A 71-year-old patient who has had a stroke and was admitted to the hospital service is receiving mechanical ventilation. He subsequently develops septic shock and the hospitalist requests that you assume total management of the patient while he is in the ICU.

If the patient is transferred to the consultant’s care before he or she writes the consultation, it is considered a transfer of care rather than a consultation. Upon acceptance of the patient, the accepting physician must document the transfer, acceptance of the patient to the service, and the agreement that the new service will provide the rest of the care for the patient.