

# A Refresher on CODING CONSULTATIONS

Here's a guide to the  
sometimes confusing documentation requirements  
for consultations.

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If you don't fully understand how to code for consultations, you're not alone. The rules change occasionally, and the documentation requirements can be unclear. However, there are good reasons to understand the codes and to use them, not the least of which are audit risk (if the codes are used inappropriately) and lost income (if the codes aren't used at all). Proper documentation can also improve your patient care.

This article will walk you through coding for a variety of consultations, including inpatient consults, outpatient consults and preoperative clearances. For a refresher on what constitutes a consultation, see "When is a consultation not a consultation?" on page 47.

## Documentation of a consultation

Four things should be documented when a consultation is performed:

- The consultation request,
- The reason for the request,
- The services rendered,
- The report from the consultant physician.

Remember these as the four R's: request, reason, render and report.

The requesting physician should document the request for consultation in the patient record, noting the specific reason for the consultation and how the consultant physi-

cian was contacted (e.g., phone, fax or letter). Likewise, the consultant physician should document that the consultation was requested, by whom and why.

The consultation services rendered should be documented following the established guidelines for evaluation and management (E/M) documentation (1995 or 1997).

The consultant physician should provide a written report of services provided, findings and recommendations or planned follow-up. Where the requesting physician and consultant physician share a common patient record, this documentation can be included in the patient's progress notes. Otherwise, a copy of the consultant's written report should be included in the patient's record.

Whether you are the requesting physician or the consultant physician, documentation is important. Consultations are valued more highly than other office visits or outpatient visits and may become subject to payer scrutiny.

## Preoperative clearance

It's not uncommon for a surgical specialist to request preoperative clearance from the patient's family physician. As with other consultation services, the preoperative clearance consultation should involve a request for opinion or advice. For example, do the comorbid conditions of this patient

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require any special considerations? Can this patient safely undergo this procedure?

When you report a consultation for preoperative clearance, use the appropriate CPT code for the level of service and setting where the consultation services were rendered as well as diagnosis codes that indicate the necessity of the consultation. Select the appropriate ICD-9 code from the V72.81- V72.84 series (V72.81 for preoperative cardiovascular exam, V72.82 for a preoperative respiratory exam, V72.83 for another specified preoperative exam or V72.84 for an unspecified preoperative exam) and a second diagnosis code to indicate the condition for which surgery is intended. Also code any diagnoses that arise during your consultation.

Medicare guidelines state that if, following a preoperative consultation, the consultant assumes responsibility for managing a portion of the patient's condition(s) during the postoperative period, the consultation codes should not be used. In this situation, you should use the appropriate subsequent hospital care codes to bill for the concurrent care in the hospital setting and use the appropriate established patient visit codes for services provided in the office.

If you perform a postoperative evaluation of a new or established patient at the request of the surgeon, then you may bill the appropriate consultation code for E/M services furnished during the postoperative period. The stipulations are that all of the criteria (the four R's) for the use of the consultation codes must be met and you must not have already performed a preoperative consultation.

## About the Author

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You may not bill a consultation if the surgeon asks you simply to manage an aspect of the patient's condition during the postoperative period, because the surgeon is not asking for your opinion or advice in treating the patient. Instead, your services would constitute concurrent care and should be billed using the appropriate subsequent hospital care codes, subsequent nursing facility care codes or office or other outpatient visit codes, depending on the setting. (To learn more about concurrent care coding, see "A Refresher on Medicare and Concurrent Care," *FPM*, November/December 2005.)

## Inpatient/nursing facility settings

You should report an inpatient consultation code (99251-99255) for initial consultation services provided in the hospital, nursing home or partial hospitalization settings only once per admission, according to CPT 2006. If you are consulted more than once during the patient's same admission, your subsequent consultations should be reported with the subsequent hospital care codes (99231-99233) or nursing facility services codes (99307-99310).

## Outpatient settings

In the outpatient setting, if the attending physician requests advice or opinion regarding a problem and documents it in the medical record, the consultant physician can use an office consultation code (99241-99245).

However, if the consultant initiates follow-up services in the office or other outpatient facility, these services are not a consultation; they should be reported using the office or other outpatient services codes (99211-99215).

The documentation requirements for coding consultations are complex but important to learn.

Four things need to be documented for a consultation: the request, the reason, the services rendered and the consultant's report.

It might help you to remember these requirements as the four R's.

## Split/shared consultations

When a qualified nonphysician practitioner (NPP) and a physician each provide a portion of the consultation services, the split/shared services may not be billed as a consultation, according to the *Medicare Claims Processing Manual* (chapter 14, section 30.6.10a). Instead, an appropriate office or hospital code should be reported. If an NPP provides the bulk of the service, the NPP should report the appropriate code under his or her own provider number even if the physician documents examining the patient and reviewing the management plan.

## Get the reimbursement you've earned

Consultations are like other E/M services in that the rules and codes change from time to time and the documentation requirements are hardly black and white. However, where consultation services are medically reasonable and recorded in the patient's chart, these services may reap quality care for patients and reimbursement for the consultant physician. Now that you have reviewed consultation coding and documentation, you should be prepared to request, render, report – and be reimbursed. **FPM**

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### WHEN IS A CONSULTATION NOT A CONSULTATION?

A consultation is a request for advice or opinion regarding evaluation or management of a specific problem. According to CPT 2007, consults may be requested by persons other than physicians (e.g., physician assistants, nurse practitioners, chiropractors, physical therapists, occupational therapists, speech-language pathologists, psychologists, social workers, lawyers or insurance company representatives).

A consultation is *not* a transfer of care. For instance, if a patient who does not have a medical home seeks care at an urgent care facility, the physician at the urgent care facility might recommend that the patient contact a certain family physician to establish ongoing care. This is not a consultation because the physician in the urgent care facility is not requesting advice or an opinion on managing the patient's condition. This also is true when a patient is referred from the emergency department. These scenarios are simply transfers of care or referrals.

#### Here are some other things to keep in mind:

- Consultations requested by a patient or family members, and not requested by a physician or another appropriate source, should be reported using office visit, home service or domiciliary/rest home care codes, not consultation codes.
- Consultations mandated by third-party payers (e.g., a mandatory second opinion) should be reported with modifier -32 appended to the code for the consultation service.
- Consultations can be requested of another physician in your group who has expertise in a specific medical area. For instance, a family physician may consult another family physician in the same group who has expertise in treating patients with attention deficit disorder for advice on revised therapy for a patient who is not tolerating a standard regimen. (Note that Medicare clearly states that consultations within the same group should not be a routine practice.)
- The appropriate level of service for a consultation (e.g., 99243 vs. 99244) will be determined by the three key components of history, exam and medical decision making, in most cases. A consultation may be coded based on time when more than 50 percent of the time spent with the patient is devoted to counseling or coordination of care. (To review time-based coding requirements, see "Time Is of the Essence: Coding on the Basis of Time for Physician Services," *FPM*, June 2003.)

■ If you are asked to consult on a pre-operative clearance, be sure the diagnosis code indicates the consultation's necessity.

■ If you share the work of a consultation with a non-physician practitioner, it cannot be billed as a consultation; an office or hospital code should be used instead.

■ Remember that a consultation is not the same thing as a transfer of care.