# In compliance...

## with consultation coding requirements

*by the Division of Advocacy and Health Policy*

In March 2006, the U.S. Department of Health and Human Services Office of Inspector General (OIG) released a report indicating that approximately 75 percent of services billed as consultations were incorrectly coded. The inaccuracies cost the Medicare program more than $1.1 billion in 2001, the year for which the data were analyzed. In addition, Medicare reimbursement for consultations has risen without explanation from $3.3 billion in 2001 to $4.1 billion in 2004, fueling speculation that improper coding is growing.

In its report, the OIG listed the three most common problems as follows:

- Services billed as consultations did not meet the definition of a consultation
- Consultations were billed as the wrong type or level of consultation
- Services provided were unsubstantiated by documentation

In addition, effective January 1, Current Procedural Terminology (CPT) eliminated two commonly used types of consultations—follow-up inpatient consultation (codes 99261-99263) and confirmatory consultation (codes 99271-99275).*

### Around the corner

***July***

- Quarterly update to 2006 Medicare fee schedule effective July 1.
- Quarterly update to 2006 Correct Coding Initiative edits effective July 1.
- Economedix will hold a teleconference, Creating an Effective OSHA Compliance Program, on July 12, and another, Practice Valuations…What's Your Practice Worth?, on July 26. For more information, go to *http://www.YourMedPractice.com/ACS* or phone 877/401-9655.
- ACS-sponsored basic and advanced coding workshops for surgeons and office staff will be held July 27–28 in Chicago, IL. For more workshop and registration information, visit the ACS coding workshop Web page at *http://www.facs.org/ahp/workshops/index.html*.

***August***

- Economedix will hold a teleconference, Compensation Formulas of Successful Practices, on August 9, and another, Effective Personnel Management…Hiring, Evaluations, Etc., on August 23. For more information, go to *http://www.YourMedPractice.com/ACS* or phone 877/401-9655.

***What is a consultation?***

CPT defines a consultation as a service provided by a physician when his or her opinion or advice is sought regarding the evaluation and management (E/M) of a specific problem for a specific patient because the consultant has expertise beyond the requesting professional's knowledge of the medical problem. Consultations must be reasonable and necessary and must meet the following criteria:

- Requested by a physician or qualified nonphysician practitioner
- Request must be included in the requesting physician's plan of care in the patient's medical record
- Consultant must document the request in the patient's medical record
- After consultation, consultant must provide a written report with findings and recommendations for the referring physician

Requests for a consultation may be verbal but still must be noted in the patient's medical record and/or plan of care. A written request and opinion and recommendation in a common medical record meet the documentation requirements of a consultation in the hospital setting. Finally, a consulting physician may initiate diagnostic and therapeutic services.

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### *Types of consultations*

Previously, CPT acknowledged four types of consultations: (1) office or other outpatient, (2) initial inpatient, (3) follow-up inpatient, and (4) confirmatory (also called a second opinion). Since January 1, however, CPT only recognizes office or other outpatient and initial inpatient consultations that meet the criteria described previously.

For a consultation in the inpatient setting, the initial consultation should be billed as an initial inpatient consultation (99251-99255), and follow-up visits should be billed as subsequent hospital care codes (99231-99233). The initial inpatient consultation may be reported only once per consultant per facility stay.

In the office or outpatient setting, the consulting physician should use the office or other outpatient consultation code (99241-99245) for the initial consultation and should use office or other outpatient established patient codes (99212-99215) for any additional follow-up visits.

Transfers of care are often miscoded as consultations. A transfer of care occurs when a physician asks another physician to assume responsibility for managing the patient's complete care for the condition and does not expect to continue treating the patient for that condition. The receiving physician should document the transfer of care in the medical record and should code services using the appropriate new, established, or inpatient E/M codes.

A second opinion requested by a patient or family member is not a consultation; rather, it is a second-opinion E/M service. A second opinion performed in an office or outpatient setting should be reported using the office or other outpatient codes for a new patient (99201-99205) or established patient (99212-99215). The three-year rule regarding new patient status applies.

### *Levels of consultations*

The recent OIG report concluded that 95 percent of consultations billed as "high level" did not meet the criteria for that level. To properly code the consultation, the physician must determine the appropriate level of consultation based on patient history, physical examination, and medical decision making. Each of these services is broken down into various categories, including the following:

- History: Patient-focused, expanded problem-focused; detailed problem-focused and comprehensive
- Examination: Problem-focused, expanded problem-focused; detailed exam and comprehensive exam
- Decision making: Straightforward, low complexity, moderate complexity, high complexity

The highest-level codes call for the most complicated levels for the history, exam, and decision-making levels. For example, to bill 99245, the highest level of consultation for an office visit, the physician would have to record a comprehensive history, conduct a comprehensive examination, and make medical decisions of high complexity. Meeting just one requirement does not qualify the service for this high-level code. In addition, the level of consultation may be based on time if counseling and coordination of care constitute more than 50 percent of the face-to-face encounter between the physician and the patient. CPT has provided the following time estimates for office and inpatient consultation codes:

| Office or outpatient | | Inpatient | |
|---|---|---|---|
| 99241 | 15 minutes | 99251 | 20 minutes |
| 99242 | 30 minutes | 99252 | 40 minutes |
| 99243 | 40 minutes | 99253 | 55 minutes |
| 99244 | 60 minutes | 99254 | 80 minutes |
| 99245 | 80 minutes | 92555 | 110 minutes |

When time is the determining factor, the total one-on-one time of the visit and the total face-to-face time spent in counseling and coordination of care should be documented in the medical record.

### *Guidelines for documentation*

When payors analyze claims, one maxim holds true: If it is not documented, it did not happen. The Documentation Guidelines for Evaluation and Management Services (available online at *http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp*) apply to consultation services. The reason for the consultation must be documented in the medical records maintained by the ordering physician and the consultant. The outcome of the consultation also must appear in both

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physicians' medical records. For a consultation, simply retain a copy of the report that is sent to the requesting physician. If there is a common medical record, the required documentation may be maintained in it. In addition, the level of consultation code selected must be supported by the documentation in the medical record. Either the 1995 documentation guidelines or the 1997 documentation guidelines may be used.

E/M services, including consultations, remain a primary focus of program integrity efforts. Local Medicare carriers may audit a claim and request documentation to support the medical necessity of the service and the code level. Medicare providers have a responsibility to provide documentation when requested. If documentation is not provided, the claim will be denied. If the documentation does not support the claim, the claim will be denied or downcoded. Documentation requests may come from a physician's local Medicare carrier or from AdvanceMed, the company charged with administering Medicare's Comprehensive Error Rate Testing program.

In addition to documentation requests, many carriers have offered local provider education and training programs. These programs often compare a physician's use of services with that of other physicians in the same specialty. These programs are for educational purposes only and often request that the physician take some sort of coding training, which is often computer based. Providers are not required to respond to the letter or take the training, although carriers highly recommend the training. The recent OIG report will likely heighten interest in these activities. Ω