

Consultation services carry high values, but rules are changing

L. Neal Freeman, MD, MBA, CCS-P, FACS

Column Editor, "coding.doc"

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Consultative services form an important part of most ophthalmology practices. A somewhat detailed understanding of consultation codes is needed to report these visits appropriately. The necessary knowledge base includes familiarity with the perspectives of payers (especially Medicare).

The CPT codes under discussion here are 99241-99245 (office or outpatient consultations) and 99251-99255 (initial inpatient consultations). The codes for follow-up inpatient consultations and confirmatory consultations have been deleted for 2006.

The comments below will apply to the Medicare program. However, private payers often follow the lead of Medicare. Check with the particular payer for its specific guidelines.

The area is especially significant from financial and compliance perspectives. The Medicare allowables for consultations well exceed those for non-consultative office visits. For example, the 2006 allowable (unadjusted) for a level 3 office consultation (99243) is \$122.79. This greatly exceeds the allowables of \$97.02 for a level 3 non-consultative office visit on a new patient (99203) and \$52.68 for a level 3 office visit on an established patient (99213).

Consultations have traditionally been highly scrutinized. These services have been a focus of interest for the Office of the Inspector General (appearing in the 2004 and prior OIG work plans) and are anticipated to garner great attention from Medicare Program Safeguard Contractors.

There is no distinction in CPT between new and established patients regarding consultations. The level of service is chosen based on the levels of history, examination, and medical decision making. This dependency on all three components is reminiscent of the rules for selecting the level for new "regular" (non-consultative) patients in the office.

Importantly, as discussed below, the rules regarding these visits are changing (although the intent of payers may be the same). The new requirements were presented in Medicare Transmittal 788 (Change Request 4215), issued December 20, 2005 and appear in the Medicare Claims Processing Manual. A Medlearn Matters article on this topic can be accessed at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM4215.pdf>.

Underreporting as well as overreporting of consultative services is common. These problems are minimized when physicians and their staff have a strong grasp of the criteria.

What exactly qualifies as a consultation? I respond with the old storyteller's question, "Do you want the long version or the short version?"

The short version is that a consultation is a service providing an opinion or advice at the request of another provider; the requester expects to continue treating the patient for the condition in question. The long version is that the request must originate from an appropriate source (e.g., another physician with less expertise than the consultant about the problem), and that several specific criteria are met.

Some of the Medicare criteria for consultations follow:

- The request for and need for consultation must appear in both the requester's plan of care and in the consultant's medical record.
- The service must result in an opinion or advice.
- A written report to the appropriate source must be provided.

Elaboration of these criteria is helpful.

The requirement that the request for and need for consultation appear in the requester's chart is new. This requirement insures that consultative service is indeed desired.

An opinion or advice must be provided; indeed the consultant's role must be advisory in nature. If the receiving doctor has become the

managing physician for the condition in question, then a “transfer of care” rather than a consultative service has occurred. It is permissible, however, for a consulting physician to begin diagnostic and/or treatment services on the first visit. This does not negate reporting that visit as a consultation.

A specific example appearing in the Medicare Claims Processing Manual explicitly demonstrates how a transfer of care is distinguished from a consultation. The example is as follows: “The emergency room physician treats the patient for a sprained ankle. The patient is discharged and instructed to visit the orthopedic clinic for follow-up. The physician in the orthopedic clinic shall not report a consultation service because advice or opinion is not required by the emergency room physician. The orthopedic physician shall report the appropriate office or other outpatient visit code.”

Substitute “ophthalmic” for “orthopedic,” and “corneal abrasion” for “sprained ankle” in the above example. You now have an eye care scenario that would be considered a transfer of care and would not qualify for a consultation, at least according to Medicare criteria.

A written report must be provided to the appropriate source. In general, the report will take the form of a letter summarizing the important findings and providing the opinion from the consultant. However, a letter is not always required. There are situations in which the medical record is a shared document between the providers, such as with an Emergency Department Log or a chart in a large group practice. When there is a shared document, the report may simply be the consultant’s entry in the common medical record.

As was at the case before the recent Medicare Transmittal, consultation services within a group are still valid. The criteria for a consultation remain the same as for consultations originating outside the practice. It is required that the consultant has greater expertise in the area in question than does the requesting physician. Medicare specifically points out that provision of consultative services should not be a “routine” on every patient in a group practice setting.

Comfort with the appropriate use of the consultation codes is key for general ophthalmologists as well as for ophthalmic subspecialists. Educate yourself with current information, and your time will be rewarded.

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