

Is It A Visit or A Consult?

If you understand these vignettes, you'll know the answer.

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As a "wandering lecturer on coding", I often discuss the rules for appropriate billing of the consultation codes. I usually mention in the beginning of the talk that billing a CPT 99213 (a visit code) rather than a CPT 99242 (a consultation code) - when an encounter qualifies as a consult - can cost a practice \$40.00 based on New Jersey Medicare reimbursement! Now that gets the audience's attention. Invariably, after the talk, some doctors approach me to relate how much they have been utilizing consultations. One important caveat: as tempting as earning an extra \$40.00 for a service might seem, the OIG continues to review consultation services in their work plan. That should not be construed by the medical community as a red flag meant to stop billing consultation codes. Instead, the wise physician will learn the rules for billing consultations and use consult codes appropriately. My personal philosophy on billing was taught to me early in my career from my Carrier Medical Director: provide only medically necessary services, document them thoroughly, and bill properly for everything you do.

Let's start by reviewing the rules for billing consultation codes that appear in the Medicare Carriers Manual (MCM). These rules are defined in the Medicare Carriers Manual Part 3, Chapter 15, Section 15506. According to the MCM: "Consultation Versus Visit.--Pay for a consultation when all of the criteria for the use of a consultation code are met:

- (1) Specifically, a consultation is distinguished from a visit because it is 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 (unless it is a patient-generated confirmatory consultation).
- (2) A request for a consultation from an appropriate source and the need for consultation must be documented in the patient's medical record.
- (3) After the consultation is provided, the consultant prepares a written report of his/her findings which is provided to the referring physician.

Consultations may be billed for time if the counseling/coordination of care constitutes more than 50 percent of the face-to-face encounter between the physician and the patient. The preceding requirements must also be met."

One other point not mentioned here, but commonly understood to be part of the rules for a proper consultation, is that prior to the consultation service being provided, the physician performing the consultation service has not agreed in advance to be taking over complete care of the patient. Note specifically, the words "complete care of the patient", not complete care of the patient's problem. Let's review a number of clinical scenarios for their appropriateness as a consultation.

Case One:

A Medicare patient presents to the office Dr. Malkin's, a podiatrist, stating she has "an ingrown nail." The patient had been seen by Dr. Malkin two years ago for heel pain, and had been discharged from care for that problem. Once in the exam room, the history reveals that the patient called her attending

physician's office about the pain in her toe, and the nurse told her to call Dr. Malkin for an appointment. Dr. Malkin takes a history, completes the examination of the patient, explains the diagnosis and treatment options to the patient, performs a nail avulsion, and writes a written report, which he sends to the patient's attending physician.

Is it a Consultation or a Visit?

Section 15506 of the MCM provides specific examples of evaluation and management encounters which would be billed appropriately as consultations. In each example that is cited, the attending physician requesting the consultation has physically examined the patient before requesting a consultation. Since the patient is a Medicare patient, and had not been examined by the attending physician for this problem, it is improper to bill a consultation code. Simply because a written report was sent to the attending physician and the patient had been recommended to specifically visit, Dr. Malkin does not automatically qualify this encounter as a consultation. Proper billing for this encounter would be a CPT code for an established patient office visit appended with a -25 modifier and the nail avulsion procedure that was performed.

Case Two:

A Medicare patient presents to Dr. Malkin's office, stating she has an ingrown nail. Dr. Malkin had seen this patient two years ago for heel pain, which had resolved, and the patient was discharged from care. Once in the exam room, the history reveals the patient has experienced pain in her toe for a few days and then visited her attending physician. Her doctor told her she probably had an ingrown nail, and to call Dr. Malkin for an appointment. In the meantime, he asked her to soak her foot in salt water and apply Bacitracin. Dr. Malkin takes a history, examines the patient, explains the treatment options to the patient, and performs a nail avulsion. He then writes a report of the encounter, which he sends to the patient's attending physician.

Is it a Consult or a Visit?

Is this really a consult? Is this a request for advice? Some would disagree since a diagnosis was already made by the attending physician. I believe the attending physician made a general diagnosis, and did not specifically instruct the consultant on how to treat this problem. This specific question was asked to an important person, and he agreed this is a consultation because it is up to the consultant to choose the many possible treatment options - anything from oral antibiotics to a matricectomy.

The key point is that the attending physician has examined the patient before requesting the consultation. The physician providing the consult has written a report for the attending physician and this encounter is correctly billed as a consult.

Consult Codes

Consult codes differ from visit codes in that the same series of office consultation codes are appropriate for either new or established patients. In this case, an office consult code appended with a -25 modifier and the procedure code (s) would be billed. Prudent documentation requires one to keep a copy of the report sent to the attending physician in the patient's chart and to document in the history that the patient visited his or her attending physician and was then sent to the office. To even further bullet-proof your documentation, it is an excellent idea to call the attending physician's office and ask the office staff to fax a prescription blank with the patient's

name requesting a consultation with Dr. Malkin with the diagnosis of ingrown nail.

Case Three:

A patient with an HMO insurance plan presents to the office of Dr. Malkin with an ingrown nail. The patient is new to Dr. Malkin's office. The patient presents with an insurance form that states "consult and treat." Once in the exam room, the patient reveals that she had symptoms of ingrown nail for a few days and then called her primary care doctor. The nurse at the primary care doctor's office told her to call Dr. Malkin's office for an appointment, and then stop by their office to obtain the necessary insurance paperwork. Dr. Malkin takes a history, which reveals the patient had not seen her attending physician for this problem. He examines the patient, explains the treatment options to the patient, and then performs a nail avulsion. He then writes a report of the encounter, which he sends to the patient's attending physician.

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In this case, a managed care scenario, in which the paperwork reads "consult and treat," a consult code appended with a -25 modifier, in addition to any procedures performed, are properly billed. A written report must also be sent to the attending physician. In fact, a number of insurers will pay only for a consult code and deny a claim with a visit code.

Case Four

A Medicare patient is seen in Dr. Malkin's office. In her initial patient encounter form, she writes she is a newly diagnosed diabetic wanting to get her feet checked. Once in the exam room, her history reveals she has no pedal complaints. Her exam is remarkable for diminished circulation and elongated thickened mycotic nails. Dr. Malkin débrides her nails, prescribes Penlac nail lacquer, provides diabetic foot care education, and then writes a report, which he sends to the patient's attending physician.

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This is clearly a self referred patient, and in spite of a written report being sent to the attending physician this is properly billed with a visit code appended with a -25 modifier in addition to the procedures that were performed.

Case Five:

Medicare patient is seen in Dr. Malkin's office. Her initial patient encounter form states she has no specific complaints. Once in the exam room, the history reveals she is a newly diagnosed diabetic and that her attending physician described the importance of diabetic foot care in addition to eye care and asked her to make an appointment with Dr. Malkin. Dr. Malkin took a history, performed an exam, and provided diabetic foot care and diabetic education. Dr. Malkin recommended that the patient present back to the office in three months. He also dictated a report which was sent to the patient's attending physician describing his findings.

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This encounter meets all the requirements of a consultation. The patient was examined first by the attending physician and a written report was sent back to the attending physician by the consultant. This encounter would be billed with a consult code appended with a -25 modifier, in addition to any procedure codes which were performed.

Case Six

The ward clerk at the local hospital calls the office of Dr. Malkin and states, "I have an order here for Dr. Malkin to take care of Mary Smith's nails. She is in room 423." Dr. Malkin arrives at the hospital and reads the order sheet which states "Consult Dr. Malkin for nail care." The order is signed by the attending physician. Dr. Malkin reviews the chart, takes a history, performs an exam, treats the nails, recommends a prescription antifungal for the nails when she leaves the hospital and completes a consultation form, which is left on the patient's chart.

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This is a consultation, which would be appended with a -25 and billed with the procedures performed. The fact that a common medical record is in place negates the need for a separate written report to the attending physician.

Case Seven:

The nurse at the nursing home calls Dr. Malkin's office and states she noted a blackened area on Mrs. Smith's right heel. She asks him to please come and take of it ASAP. He then asks about her medications, allergies, and medical history and prescribes a treatment protocol. Mrs. Smith is a new Medicare patient to Dr. Malkin. Dr. Malkin arrives at the facility and notes an order that says "Podiatry care prn." Dr. Malkin reviews the chart, takes a history, examines the patient, explains the treatment options, débrides the ulcer, changes the treatment, and completes the consultation form of the nursing home.

Is it a Consultation or a Visit?

This is not a consult due to the PRN order without a specific consultant being mentioned by name nor a specific problem described to treat. In fact, in some states, just treating a patient in a nursing home (without an order that is specific for your name and a specific problem) can cause problems in an audit. Almost every state has outlawed PRN orders in nursing homes. At best, this could be billed as a CPT 99311 series code (visit) appended with a -25 and the procedures performed. It is critical to have the nursing home rewrite the order using the proper syntax to avoid problems. The order should be written as "Consult Dr. Malkin for black right heel."

Medicare Examples

The MCM provides four specific examples of situations that do not satisfy the criteria for consults, as follows:

1. "Standing orders in the medical record for consultations.
2. No order for a consultation.
3. No written report of a consultation.
4. After hours, an internist receives a call from her patient about a complaint of abdominal pain. The internist believes this requires immediate evaluation and advises the patient to go to the emergency room where she meets the patient and evaluates him. The emergency room physician does not see the patient. The internist should bill for the appropriate level of emergency department service, or if the patient is admitted to the hospital she would bill this visit as an inpatient admission."

Case Eight:

The nurse at the local nursing home calls the office of Dr. Malkin's and states she noted a black area on Mrs. Smith's right heel. The nurse asks that he please come and take of it ASAP. Mrs. Smith is a new Medicare patient to Dr. Malkin. Dr. Malkin arrives at the facility and notes an order that says "Consult Dr. Malkin for evaluation and management of blackened right heel." The order in the chart is signed by the nurse with a notation that it was telephoned in by the attending physician. Dr. Malkin reviews the chart, takes a history,

examines the patient, débrides the ulcer and completes a consult form which he leaves on the chart.

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This would qualify as a consultation in most states and can be appended with a - 25 modifier and billed with any procedures that were performed. Telephone orders are accepted in most states. A few states still insist that consultants in nursing homes, including podiatrists , bill these encounters using the 99311 series, but they are in the minority.

Case Nine:

A Medicare diabetic patient of Dr. Malkin develops a cellulitis that requires admission to the hospital. Dr. Malkin confers with the patient's attending physician, who agrees to admit the patient under his service and have Dr. Malkin manage the pedal component of the admission. An order is written in the chart for Dr. Malkin to evaluate and treat foot infection by the patient's attending physician.

Is it a Visit or a Consult?

Only one physician is allowed to bill the initial patient hospital visit per admission. All other physicians are considered to be consultants. In addition, there are some states in which podiatrists may not admit patients without an MD/DO. This initial hospital encounter with the patient would be properly billed as a consultation by Dr. Malkin and an initial hospital visit by the attending physician.

Lastly, here are a few more pointers on consultation codes:

1. All consult codes require that all three key components: history, exam, and decision making meet or exceed the level of code which is chosen. In an office setting a CPT 99243, consult has the same E/M requirements as a 99203 visit. Both require at least a detailed history, a least a detailed exam, and at least low-decision making.
2. When billing using time, a consult code requires more time spent on face to face counseling and coordinating care than does a visit code. A typical CPT 99203 requires 30 minutes, and to bill on time more than 15 minutes must be spent face to face on counseling. For a 99243 which is typically 40 minutes, more than 20 minutes must be spent face to face counseling.
3. All consult codes may be used for new or established patients. If a Medicare patient is discharged from care for one problem, and then develops a new problem and sees his attending physician for that new problem and he requests your assistance with this problem, a consult is again appropriate.
4. As part of your compliance plan, pull a few consultation encounters, and be certain the request for the consult can be found along with the written report that was sent to the attending physician.

Disclaimer:

The opinions and facts contained herein are not the official position of any organization including, but not limited to, the American College of Podiatric Medical Review, the American Podiatric Medical Association, the New Jersey Podiatric Medical Society, or Podiatry Management magazine. Coding and documentation rules are not simply black and white, and are subject to many interpretations. The various Medicare carriers differ in their medical policies for coding and documentation of the identical patient encounter. Unfortunately, there are many private insurers that maintain unique coding and documentation requirements that are in conflict with the

AMA CPT Manual. The reader is urged to contact his or her local insurance carrier to discuss any statements made in this article considered controversial. In cases where variability exists, the physician must conform to the rules promulgated by the local carrier.