

The three "R's" of consultation codes: request, render and reply

Consult codes tend to focus on advice and opinion and less on action and treatment

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When it comes to deciding when it's appropriate to use a consultation code to describe an inpatient service, physicians face some confusion.

On the surface, it might appear that codes for consults and hospital visit codes are interchangeable. When patients are transferred into your care to continue medical treatment, for example, can you use a consultation code? After all, you've been brought into the case by another physician for your expertise in hospital medicine.

Take a careful look at Medicare's documentation guidelines, and you'll find that the answer is "no." Routine transfer of care or referral is not considered part of a consultation service. It would be appropriate in these situations to refer to the initial hospital visit codes 99221-99223.

The Centers for Medicare and Medicaid Services (CMS) distinguishes consultation services from hospital visit codes,

stating that consults are "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." In other words, consults tend to be more focused on opinion of colleagues and less on action or treatment.

In a simplistic view, payers expect consultation services to be part of a process that starts when a physician requests a consult, a physician renders a service, and the consultant returns to the initial physician to give a reply in the form of opinion or advice.

From this basic process comes the three "Rs" of consultation coding: request, render and reply. Here's an overview of what most payers are looking for in each of those three areas, and some tips to avoid confusion about consultation codes.

Request

First, let's review some basic criteria about requests for consults. The following items can help you make sure you're meeting the criteria for a consult:

- Who is initiating or requesting the consultation? Your docu-

mentation needs to refer to a provider's name (an individual physician, not a medical group) and a unique physician identification number (UPIN). Medicare will not pay a consult code without this information.

- A "consult" initiated by a patient, family member or third-party payer (in other words, a consult not requested by a physician) should not be billed using initial inpatient consultation codes. Medicare rules say this type of consult fits the definition of a confirmatory consult (CPT 99271-99275).

These codes are used for second and third opinions, and they require the advice to be forwarded back to the referring source. Because most third-party payers require opinions or advice be provided before authorizing or paying a particular service, you should use a -32 modifier.

Three types of CPT inpatient consultation codes

Initial inpatient consultations 99251-99255

Follow-up inpatient consults 99261-99263

Confirmatory consultation 99271-99275



An overview of initial inpatient consultation codes

99251
Problem-focused history
Problem-focused exam
Straightforward MDM


99252
Expanded problem-focused history
Expanded problem-focused exam
Straightforward MDM

99253
Detailed history
Detailed exam
Low-complexity MDM

99254
Comprehensive history
Comprehensive exam
Moderate complexity MDM

99255
Comprehensive history
Comprehensive exam
High complexity MDM

Coding and patient care



On the surface, it might appear that codes for consults and hospital visit codes are interchangeable.

■ Does the medical record document a written or verbal request for a consultation? According to Medicare guidelines, in an inpatient setting where the medical record is shared between the referring physician and the consultant, the request may be documented as part of a plan written in the requesting physician's progress note, an order in the medical record or a specific request for consultation.

Rendering

Here are the criteria for rendering care:

■ The medical record needs to contain documentation of the consultant's opinion, advice and (if applicable) any services that may have been ordered or performed. CPT guidelines state that a consultant can initiate diagnostic and/or therapeutic services to help formulate an opinion. CPT instructs that only one initial inpatient consultation should be billed per hospital admission.

■ If the transfer of care will be given to the consultant to treat the problem after an opinion is rendered, each visit after the consult should be reported as a subsequent hospital visit (CPT 99231-99233). If not, care remains with the referring physician for treatment and follow-up.


■ If the consultant can't complete an opinion on the initial consult day, or if the referring physician requests the consultant to return later to provide additional advice, use follow-up inpatient consultation codes (99261-99263). You must thoroughly document additional consult days. Also make sure you describe modifications to management options or advise of a new plan for patient care.

Reply

When consultants reply back to the referring physician, they must provide treatment recommendations or an opinion. In the inpatient setting, this is commonly done through the shared medical record of the hospital.

Red flags

I don't recommend using consultation services unless you have thoroughly documented these three items. While consultation services provide greater reimbursement than initial hospital care codes, payers tend to scrutinize these codes more closely, so you need to make sure you make a solid case when you use them.

That said, the extra reimbursement provided by consult codes does reward you for the additional communication factors required in performing these types of services, so don't sell yourself short. Carefully examine how each of your patients enter the hospital setting to determine whether your services qualify as consult codes. 

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