Coding Consultation E/M Services Correctly

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Incorrect coding of consultative services can cost the healthcare industry and organizations dearly. In March the Office of Inspector General (OIG) announced that approximately 75 percent of evaluation and management (E/M) services billed in 2001 as consultative and allowed by Medicare did not meet all applicable program requirements. This resulted in $1.1 billion in improper payments.

OIG found that consultation services billed to Medicare were not consultations by definition and were reported as the incorrect type of service or with the incorrect level of service or documentation, which did not support consultative services.[1] In response to the OIG consultation service audit findings, the Centers for Medicare and Medicaid Services (CMS) reported a $500 million coding error rate in fiscal year 2005.

This article outlines the guidelines for proper E/M coding, the definition of a consultation, and who can perform one.

E/M Coding and Reporting

Currently coding professionals may assign E/M codes based on the 1995 or 1997 Documentation Guidelines for Evaluation and Management Services with the general multisystem or single organ system examination. Physician offices may report E/M services with either guidelines on a case-by-case basis or choose one for all E/M services provided. The decision of which guidelines to employ may be an important one to the facility's practitioners. For that reason, a comparison of the E/M level achieved based upon one set of guidelines compared to the other, using the same documentation, may be useful in the selection process.

When assigning a particular E/M level, it is important to keep in mind that CMS states, "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted."[2]

Furthermore, CMS states, "The volume of documentation should not be the primary influence upon which a specific level of service is billed."[3] Based upon this information, those assigning E/M codes for professional services performed are encouraged to consider both the E/M level met based upon the provider's documentation as well as the nature of the patient's presenting illness when determining the medical necessity of the encounter.

Time may be the determining factor for the E/M level reported in instances where counseling or coordination of care takes up more than 50 percent of the physician-patient encounter. Some specialty physicians, such as oncologists, may report a fair number of consultative services based upon time, since often their main function is counseling on the various cancer treatments available or coordinating the patient's anticipated care.

In these cases, documentation must include a description of the counseling or coordination of care provided, the total amount of time spent with the patient, and the amount of time spent counseling or coordinating care. The documented time spent counseling or coordinating care must be well delineated from the total time spent with the patient.

What Constitutes a Consultation?

According to CPT 2006, a consultation is a "type of service 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."

CPT further clarified this definition, stating that restrictions have not been set regarding individuals who may be considered an appropriate source, but some examples include a physician assistant, nurse practitioner, doctor of chiropractic, physical therapist, occupational therapist, speech language therapist, psychologist, social worker, lawyer, or insurance company.

A consultation requested by a patient or family would not be reported as a consultative service. However, it may be reported using another applicable E/M service code such as an office visit code.

Who May Perform a Consultation?

When requested by a physician or other appropriate source, a consultation may be provided by a physician or qualified nonphysician practitioner (NPP). In order to be a qualified NPP, performing a consultation service must be within the scope of practice and licensure in the state in which the NPP practices.

It may at times be difficult to discern the appropriateness of consultative services being requested and provided within the same group practice. According to the April 2000 CPT Assistant, "CPT does not limit the use of the consultation codes according to whether or not the physician providing the consult service is of a different specialty field than the physician requesting the advice or opinion. The guidelines for use of the consultation codes simply indicate that use of these codes requires that one physician is responding to a specific request for opinion/advice from another physician regarding evaluation and/or management of a specific problem."[4]

Therefore, even if practitioners are of the same specialty, if the requirements for a consultative service are met, a consultation E/M code may be reported. Documentation, however, must be clear that the advice or opinion of another practitioner is needed and being sought.

What Documentation Is Required?

In order for a service to be considered a consultation, the following criteria must be met and documented:

- A request for a consultation, along with the need for a consultation, must be documented by the consultant in the patient's medical record and included in the patient's medical record of the requesting practitioner.
- An opinion is rendered by the consulting practitioner. This opinion, along with any other service provided, is documented in the patient's health record.
- A written report of the consultant's findings and opinion or recommendation is communicated back to the requesting practitioner.

The question may be raised as to what the connection is between the consultant's and requesting practitioner's documentation. According to chapter 26 of the Medicare Claims Processing Manual, when submitting claims to Medicare using the CMS-1500 form for services or items that are a result of a practitioner's order/referral (i.e., consultative service), the claim form must include the ordering/referring physician's name and unique physician identification number (UPIN), which are located in items 17 and 17a of the form.

Proper completion of these items provides CMS a mechanism for verifying that a consult was requested. From an E/M perspective, CPT outlines that all three key components-history, examination, and medical decision making-must be documented for a consultation unless it is determined that time is the controlling factor for the E/M level assignment.

In the event it is determined that an encounter is a consultative service with time not being applicable as the determining E/M factor and the consultant has not documented any element of a physical examination, even the lowest level consultation E/M codes, 99241 or 99251, would not be met, as both require a problem-focused examination at a minimum. This being the case, one may then need to consider reporting this encounter as an established patient office visit or subsequent hospital care E/M code, if applicable, both of which require documentation of only two of the three key components. One may even consider the unlisted E/M services code, 99499, for a new patient encounter where three of three key components are not documented. However, physician practices are strongly advised to contact their carrier for further guidance in reporting this type of situation.

E/M CPT Code Changes for 2006

A number of code changes took place in CPT 2006 regarding consultation E/M codes. Specifically, the follow-up inpatient consultation code category (99261–99263) was deleted, with instructions to report instead the subsequent hospital care codes (99231–99233) or subsequent nursing facility care codes (99307–99310), whichever is applicable. Additionally, the confirmatory consultation code category (99271–99275) was deleted, with instructions to report the appropriate E/M service code for the setting and type of service being provided. The code categories remaining to report consultations are code 99241–99245 for office or outpatient consults and 99251–99255 for inpatient consults.

Modifier -32

CPT modifier -32 is intended to identify cases in which a consultation was mandated by entities such as a third-party payer, government agency, or regulatory requirement. When deemed appropriate, the modifier would be appended to the basic procedure performed. According to CMS, the use of modifier -32 has no effect on reimbursement.

"Shared/Split" Visits

According to CMS, current payment policy precludes a consultation from being a "shared/split" service. It is felt that a consultation is a unique E/M service not performed jointly or as a team. It may be decided by an NPP and physician to share or split a consultation service; however, this service must then be billed using the NPP's UPIN/PIN, not the physician's UPIN/PIN. The physician may bill the consultation under his or her UPIN only when all components have been performed by the physician.

Notes

1. Department of Health and Human Services, Office of Inspector General. "Consultations in Medicare: Coding and Reimbursement." March 2006. Available online at http://oig.hhs.gov/oei/reports/oei-09-02-00030.pdf.
2. Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual. Chapter 12, sections 30.6 and 30.6.10. Available online at www.cms.hhs.gov/manuals/downloads/clm104c12.pdf.
3. Ibid.
4. American Medical Association. *CPT Assistant* 10, no. 4 (April 2000): 10–11.

References

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