Tulane University Medical Group

Consultations

Read before Proceeding

Physicians and Staff may earn one compliance credit by viewing this presentation, completing the assessment, and faxing the assessment to 504-988-7777

This presentation may be viewed for compliance credit only once in a fiscal year (July 1 - June 30).

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It is the policy of TUMG to provide healthcare services that are in compliance with all state and federal laws governing its operations and consistent with the highest standards of business and professional ethics. Education for all TUMG physicians is an essential step in ensuring the ongoing success of compliance efforts.
This education is Part 5 of a 9-part series on documenting and selecting the level of service for outpatient visits.

Part 1: Overview of Basic Principles
Part 2: Documenting a History
Part 3: Documenting an Exam
Part 4: Documenting Medical Decision Making
Part 5: Documenting Consults
Part 6: Documenting Pre-Operative and Confirmatory Consults
Part 7: Time-Based Codes
Part 8: Linking to Resident Notes
Part 9: Modifiers -24 and -25

The Three R’s of Consults: Request, Recommendation, Report

- The request for a consultation may be made in written or verbal form, but the request for the consultation must be documented in the patient’s medical record.
- If the request for a consult was made, did the consulting physician
  ◦ perform the consultation
  ◦ and, document his or her recommendation in the patient’s medical record
  ◦ and, communicate findings/recommendations by written report to the requesting physician or other appropriate source?
- When all three consult requirements are met (Request, Recommendation, and Report) AND all three E/M Key Components (HX-EX-MDM) are documented AND support the level of consult selected, then the physician may bill a consult code.
- The level of the E/M consult service should be selected based upon the three (3) key components performed and documented:
  ◦ History
  ◦ Examination
  ◦ Medical Decision Making

Documentation Caution:

- If any of the three consult requirements are not met (request, recommendation, or report) then a consult code may not be billed.
- If consult requirements are met, but the three E/M key components are not documented, then a consult may not be billed.
Time-Based Consultations

- Consultations may be billed based on time if the counseling/coordination of care constitutes more than 50 percent of the face-to-face encounter between the physician and the patient and/or family.
- The requirements of “Request”, “Recommendation” and “Report” must also be met.

Is an encounter a consultation if a patient’s “complete care” is transferred?

I would like you to assume all care of my patient

That’s fine. Just have your office send over all records.

Dr. A

Dr. B

Medicare Guidelines state:

“Pay for an initial consultation if all the criteria for a consultation are satisfied. Payment may be made regardless of treatment initiation unless a transfer of care occurs. A transfer of care occurs when the referring physician transfers the responsibility for the patient’s complete care to the receiving physician at the time of referral, and the receiving physician documents approval of care in advance.”

If a “complete transfer of care” occurs, “The receiving physician would report a new or established patient visit depending on the situation and setting (office or inpatient).”

Medicare Carriers Manual 15506
Which of the following scenarios describe a Consult? A Transfer of Care?

1) Dr. GIM, an Internal Medicine physician, recommends that a patient see a neurologist for a sudden onset of numbness and coordination problems.
   a. Consult?  
   b. Transfer of Care?

2) Dr. GIM contacts a patient's OB/GYN physician who agrees to take over as PCP for the patient.
   a. Consult?  
   b. Transfer of Care?

3) Dr. GIM refers a patient to a surgeon because diagnostic tests revealed significant gallstones.
   a. Consult?  
   b. Transfer of Care?

Answers: Scenarios 1 and 3 are consult situations. Scenario 2 is a total transfer of care and the patient would be either a new or establish patient to the OB/GYN physician.

Does initiation of a diagnostic and/or therapeutic service preclude the billing of a consultation service?

- A diagnostic and/or therapeutic service can be initiated during the course of a consultation. This guideline applies to all carriers/payors EXCEPT LA Medicaid.

Same Specialty Consultations:

- 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.
- Medicare says: “Pay for a consultation if one physician in a group practice requests a consultation from another physician in the same group practice as long as all of the requirements for use of the CPT consultation codes are met.”

Medicare Carriers Manual 15506

Can Non-Physicians Request Consults?

- Non-physician practitioners, e.g., nurse practitioners, certified nurse-midwives, or physician assistants may request a consultation.

Is it appropriate to code a consultation when the diagnosis is already known by the requesting physician and/or by the consulting physician?

- CPT coding guidelines do not require that the diagnosis be known or unknown at the time of the request for consultation. A consultation may be reported regardless of whether the diagnosis is known or unknown, provided the requirements for a consultation are met.
LA Medicaid and Consults

- Consultation Codes may not be billed to LAMedicaid if ANY of the following scenarios apply to the patient visit:
  
  ◊ If by the end of the visit, the referred to physician knows or suspects that the patient will be seen for further follow-up treatment, the appropriate level of Evaluation and Management code (visit) should be billed rather than the consultation code.
  
  ◊ NOTE: If the documentation reflects that the physician expects to treat the patient again, then the consultation code should not be billed.
  
  ◊ On the day of a procedure, only the procedure can be billed. A consultation/visit code may not be billed.
  
  ◊ If the consulting physician is to perform ANY surgery

  ◊ Global Surgery Period: For procedures defined as having global surgery periods (e.g., bronchoscopies, cardiac caths, laryngoscopies, EGD’s), there is no opportunity to bill an Evaluation and Management service (visit) the day before or the day of the procedure.


What is a confirmatory consultation? What is a Pre-operative consultation?

A separate PowerPoint education that provides information on the requirements for these types of consults is available to all TUMG physicians. To access that presentation, go to the Billing Compliance Webpage: http://tulane.edu/counsel/upco/billing-ed/ and click on the Pre-Op Consults and Confirmatory Consults link.

Documentation Tips

If the request for a consult comes from a TUMG or TUHC physician, be sure to cc that physician in your dictated note.

- Be sure your dictation contains the name of the requesting physician. The dictated note could begin with a statement such as:
  
  “I saw and evaluated this patient at the request of Dr. GIM.”

If the requesting physician is an outside physician, a copy of the report must be in the medical record. Otherwise, a consult code cannot be billed.
Documenting Consultations

Name (Print) __________________________ Date: ______________________
Department/Section: ___________________________ Signature: _____________________

For the following scenarios, indicate if the service would be a Consult, Transfer of Care, or Other E/M service (New or Established patient visit):

1) A PCP requests a consult from an ophthalmologist regarding a patient’s blurred vision and eye pain. The ophthalmologist diagnoses glaucoma and sends a report to the PCP. The PCP then requests that the ophthalmologist assume care for the patient’s condition.
   a. Consult
   b. Transfer of Care
   c. Other E/M Service (New or Established Patient)

2) An 18 year-old high school football player presents to his pediatrician with a sore knee. The pediatrician decides to request an orthopaedic consultation. The orthopaedic physician evaluates the patient and then talks with the pediatrician about recommendations for treatment that consist of rest and OTC pain relievers.
   a. Consult
   b. Transfer of Care
   c. Other E/M Service (New or Established Patient)

3) A General Internist who is relocating out of Louisiana contacts a Family Practice physician about accepting total care for one of his long-term patients. The Family Practice physician accepts the patient.
   a. Consult
   b. Transfer of Care
   c. Other E/M Service (New or Established Patient)

4) What are the three R’s of a Consult?
   a. __________________________
   b. __________________________
   c. __________________________

5) Besides meeting the requirements for a consult, what key component(s) of an E/M service must be documented to support a consult code?
   ______________________________ ________________

6) A consulting physician can initiate treatment (Medicare/Commercial Payors). True False

7) LA Medicaid allows physicians to bill for confirmatory consults. True False

8) Under LA Medicaid guidelines, if a consulting physician is to perform any surgery, a consult code may not be billed. _____True ______False
Name ________________________________  Department ____________________

9) If the requesting physician is an outside physician a copy of the ______________________ must be in the medical record.

10) To bill a consult, the diagnosis for the patient’s condition must be unknown

    _____ True    _____ False

To receive one compliance credit: Complete quiz, be sure to print name (must be legible), the date, and your department at the top of the form.

SIGN the form (no credit will be given without a signature)

Fax to 504-988-7777 (fax information at top of form, no cover sheet required)