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Consultations Script

Thank you for spending time with us to learn more about Consultation services.

We are providing the most up-to-date information available on Consultations. The information provided in this Power Point will help you determine the correct billing of Consultation services.

For any questions you may have on this presentation, please send an e-mail to medicareadmin@wpsic.com and use "Consultations" in the subject line.

We use the following definitions throughout this presentation:

Physician – includes physicians and non-physician practitioners (NPP).

Originating physician – the physician currently treating the patient and the one asking for advice or opinion.

Performing physician – the person performing the service in question – whether a Consultation or a visit.

You can find the Office of the Inspector General (OIG) report at the following Website:
<http://www.oig.hhs.gov/oei/reports/oei-09-02-00030.pdf>

The Comprehensive Error Rate Testing (CERT) program indicates whether WPS Medicare pays claims appropriately. The CERT contractor requests and evaluates documentation from your office. The CERT contractor verifies medical necessity and correct coding of the service. Please respond promptly to requests for documentation from the CERT contractor.

If the CERT contractor does not receive the documentation, then Wisconsin Physicians Service (WPS) is assessed an error and we recoup any monies paid for the service.

If the documentation does not support the medical necessity or the level of service billed, we request a refund. We are required to take further action when the CERT contractor reports a rise in errors for a particular service.

We know most offices are not attempting to defraud Medicare. We also believe most of the errors we see reflect a misunderstanding of the reporting requirements.

We are starting a process of education to address the CERT errors. We want to ensure the physician community has the correct information to bill Consultations.

This presentation includes multiple resources and information for you to determine whether a service is truly a Consultation. We ask your office to evaluate whether you are billing Consultation services correctly. We also ask you to make any changes necessary and refund any incorrect payments.

This slide shows the Centers for Medicare & Medicaid Service (CMS) manual information on Consultations. We encourage physicians to look at the information to see the definition of Consultation and some examples of the correct coding of Consultations.



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A Non Physician Practitioner (NPP) can request and perform Consultations. When the NPP performs the consultation, the documentation must show the additional expertise of the NPP over the originating physician.

A Consultation request from an NPP to their supervising physician is inappropriate.

When both the NPP and physician perform a service on the same date, the service is not a Consultation. These are new or established patient visits as appropriate.

A physician can bill a new patient code when there has been no face-to-face contact for the previous three years.

The following may help in determining whether the service is a Consultation or a visit.

There are three applicable situations.

- The originating physician is unsure of how to treat the problem. The originating physician requests someone with expertise in the patient condition (the performing physician) to look at the patient and provide his/her advice and opinion on treatment. The originating physician then treats the patient condition. In this case, the performing provider may bill a Consultation.
- The originating physician knows the patient has a problem and he/she is not the best choice to treat the problem. The originating physician asks the expert (the performing physician) to treat the patient's condition. The performing provider does not provide a Consultation since he/she assumes responsibility for the problem. He/she has a new or established patient visit.
- The originating physician asks the expert for their advice or opinion on treating the patient. Once the originating physician hears that advice, he/she determines the expert is the better choice to treat the patient condition. In this case, the expert provides a Consultation followed by treatment.

The performing physician may initiate diagnostic tests to determine the patient's condition. This does not preclude billing a Consultation.

The documentation must support all of these bullets.

There must be documentation of the request. The next slide discusses the request documentation requirements.

The documentation must show why the originating physician is asking the advice or opinion of the performing physician. Medicare uses the documentation of the request to determine whether a Consultation (advice or opinion) or a referral (assumption of treatment) is appropriate.

We may request documentation from both the performing and originating physician.

Medicare looks for documentation to support billing a consultation procedure code.

If the documentation shows the originating provider is expecting the performing provider to assume care of the problem, then the service is not a consultation. The request is not asking for advice or opinion.



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A physician chooses those patients they accept. A referral from another provider does not require the performing provider to take over care of a problem. However, if the documentation of the request shows the intent of the service is for the performing provider to treat the patient's condition, Medicare does not consider the service a consultation. A new or established patient care visit is appropriate.

If the documentation show the performing provider understands the request is for assumption of treatment for the patient's condition, this is not a consultation. A new or established patient care visit is appropriate.

In most situations, when one physician refers a patient to another, there is a request and there is a report back. The documentation of the intent of the request is the main factor in Medicare determining whether a service is a consultation or a new or subsequent patient visit code.

The originating physician may send a written request in the form of a letter or e-mail to the performing physician.

The request may be verbal. The originating physician's office staff communicates with the performing provider's staff to take care of the patient's needs. The patient's records document the verbal conversation. This must include the intent of the originating physician.

The request may also be in shared records, for example: facility, hospital or skilled nursing facility. This also includes shared records in large medical groups. There must be a mechanism to determine the request made, the nature of the request and the service performed. A notation of "have Dr. Smith see the patient" does not support a Consultation service.

Please Remember: Documentation must be legible.

If there is no request from the originating physician to the performing physician, the service is not a Consultation.

There is no Consultation if the request indicates the originating physician wants the performing physician to assume an aspect of the patient's care.

Examples:

- A primary care physician requesting a podiatrist to treat the patient's feet
- a primary care physician requesting a cardiologist to treat the patient's heart condition

In order to consider the service a Consultation, the documentation must indicate the additional expertise or knowledge needed for patient care. This becomes even more critical when the physician specialties are the same or similar.

A referral or a patient-initiated visit for a second opinion is not a Consultation. It is not a Consultation when the primary care physician suggests the patient see another physician for a problem. In each of these examples, the performing physician bills a new or established patient as appropriate. Medicare does not pay for mandated requests (Modifier 32.) An example is an insurance or hospital requirements.



The CPT book includes time in the description of E&M services. However, Consultations, just like other E&M services, do not use time to determine the appropriate procedure code. Providers choose the codes based on the documentation to support the level of History, Exam, and Medical Decision making. The documentation must support the level of procedure code billed.

An exception to this rule is when counseling/coordination of care is more than 50% of the documented time spent with the patient. The documentation must show the total time of the visit and the total time spent in counseling/coordination of care. The documentation must also show details of the counseling/coordination of care.

For office or other outpatient codes, the documentation must show the total face-to-face time. Time after the face-to-face encounter does not contribute in choosing the procedure code. For an inpatient, the physician's time spent in counseling/coordination of care must be while the physician is in the patient's room or on the patient's floor.

Facility admission means not only inpatient, but also a skilled nursing facility or nursing home.

Medicare allows one consultation per physician, per patient, per facility admission. This is true even if the patient develops a new problem. Keep in mind, Medicare views physicians with the same specialty in the same group as the same person.

Example: We will assume the documentation meets all consultations requirements.

- Dr. Jones sees the patient for a consultation service during the patient's facility admission.
- Dr. Smith, a member of the same group with the same specialty, is asked to see the patient for a different condition. This is not a consult. Dr. Smith bills a subsequent hospital or nursing facility care visit.
- Dr. Brown, a member of the same group but with a different specialty, is called to see the patient. Dr. Brown may bill a Consultation.
- Dr. Jones and Dr. Smith both see the patient. They have the same specialty but are not in the same group. They both can bill a Consultation if appropriate. Documentation is crucial to determine whether the physician performed a Consultation or visit.

Medicare does not expect to see this type of situation on a frequent basis. Medicare looks at the documentation to determine if the service is a Consultation or a visit. This depends on the intent of the requesting physician.

Consultations within a group also require documentation to support the need for the Consultations service.

Medicare reviews the documentation to determine what expertise or knowledge the patient required that the originating physician could not provide.

A surgeon planning a surgery for a patient may request another physician (whether a new or established patient) to examine the patient to determine the patient's candidacy for the surgery.

The surgeon can determine whether the patient is a good candidate for surgery. However, if the patient has multiple medical problems or has some other type of situation that may affect the decision to perform surgery, then asking another physician for their opinion or advice may be appropriate.



The documentation must support the reason for the Consultation and meet all the requirements. Medicare would not expect a surgeon to request a Consultation on all of his/her patients. Medicare does not pay for routine services.

A physician who performs a pre-operative consultation cannot bill for a consultation during a post-operative period. This is a subsequent visit.

When the performing physician did not provide a pre-operative visit, we determine whether the surgeon is requesting the performing physician to take over a portion of the patient's care. For example: The surgeon provided hip replacement surgery. The surgeon asks another physician to treat the patient's diabetes. This is not a consultation.

The global surgery package indicates all E&M Services (including Consultations) provided during a global period are part of the reimbursement for the surgery itself. Surgical procedures have a global period of 0, 10, or 90 days. The 0-day global period includes only the day of the procedure. The 10-day global period includes the day of the procedure and 10 days after the procedure. The 90-day global period includes the day before the procedure, the day of the procedure and 90 days following the procedure.

There are modifiers to show the documentation supports exceptions to this rule.

- Modifier 24 - indicates the Consultation service provided during the post-operative period is unrelated to the surgery. (The physician can't have performed a pre-operative Consultation.) The diagnosis codes determine the relationship to the surgery.
- Modifier 25 - indicates a Consultation performed on the same day as a procedure is significant and separately identifiable. Documentation must be contained in the records to show the physician performed a great amount of additional work, above and beyond the normal services provided prior to a surgery.
- Modifier 57 - indicates the Consultation provided on the day before or day of a major procedure (90-day global period) was the decision for the surgery.

Documentation must be available to support the use of the Modifiers

The procedure codes for these services are 80500 and 80502. The services require the additional medical interpretation of the test by a physician. The performing physician is rendering a medical opinion.

Service provided by a laboratory technician or a conversation between the medical director of the laboratory and the physician are not Consultations.

Documentation must show the request, the need for the request and the written report just like any other Consultation.

We ask you to perform a self-audit verifying your understanding of the differences in consultations and visits.

The information provided in this presentation show what is and is not a Consultation.

Thank you for your time.