Consultations

Wisconsin Physicians Service (WPS) Medicare

Provider Outreach & Education (POE)

November 2007

CMS CENTERS for MEDICARE & MEDICAID SERVICES

WPS® HEALTH INSURANCE

Thank you for spending time with us learning 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.

Reasons for Consultation Education

- A previous Office of Inspector General (OIG) Audit showed the Centers for Medicare & Medicaid Services (CMS) incorrectly paid over 1.1 Billion dollars for Consultation services.
- The Comprehensive Error Rate Testing (CERT) Program shows an increase in the error rate for Consultation services.
- WPS Medicare is responsible for correct payment of Medicare claims.

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You can find the OIG report at the following Website: http://www.oig.hhs.gov/oei/reports/oei-09-02-00030.pdf

The CERT program adjudicates 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 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.

Reasons for Consultation Education (con't)

- Our Medical Review (MR) department is starting a process to verify correct billing of Consultation codes.
- We believe physicians bill correctly when they have accurate information.
- We ask physicians to perform self-audits to verify correct coding.

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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.

Our MR and Provider Outreach & Education (POE) department are working together to provide education. The process starts with education to address CERT errors. We want to ensure the physician community has the correct information for billing 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.

Our MR department continues to monitor billing of Consultations to determine any further action necessary.

References

- The Centers for Medicare and Medicaid Services (CMS) Internet Only Manual (IOM) 100-04 Claims Processing, Chapter 12, Physician/Practitioner Services, Section 30.6.10.
  http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf

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This slide shows the 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.

References (con't)

- CMS IOM 100-02 Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services, Section 30.3.
  http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf
- Wisconsin Physicians Service (WPS) Medicare National Coverage Provision (NCP) PHYS-006 Consultations.
  http://www.wpsmedicare.com/part_B/policy/phys006.pdf

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The WPS Medicare NCP listed here has the information contained in the two CMS references along with coding and billing instructions.

We encourage physicians to look at all the information available when performing self-audits.

Appropriate Providers

- A Physician.
- A Non-Physician Practitioner (NPP) when providing services within their scope of practice.

Note: Consultations may NOT be performed as a shared/split visit.

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A 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.

Definition of a Consultation

- The Common Procedure Terminology (CPT) defines a Consultation as “a type of service provided by a physician whose opinion or advice regarding Evaluation & Management (E&M) of a specific problem is requested by another physician or appropriate source.”

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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 their 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 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.

Consultation Requirements

- There must be a request for the advice or opinion to the performing physician from the originating physician.
- The request must be medically necessary.
- There must be a written report from the performing physician back to the originating physician.

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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.

Intent of the Request

- The documentation must show the intent of the request is for advice and opinion on treatment of the patient.
- The documentation must support both the originating physician and the performing physician’s understanding of the required actions.

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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.

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.

Request Documentation Requirements

Requests can be:

- Written
- Verbal
- In Shared Medicare Records

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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. An example is when 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 a request was 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.

Services that are Not Consultations

- Documentation does not support a request for advice or opinion.
- A request for a transfer of care.
- Documentation does not support the additional expertise or experience of the performing physician.
- A patient initiated second opinion.

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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:

- primary care requesting the 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 a requirement for insurance or hospital requirements.

Counseling/Coordination of Care

- Consultations are not billed based on time.
- The exception is when counseling/ coordination of care is more than 50% of the documented time spent with the patient.
- This time must be face-to-face or time spent on the patient's floor or unit for a facility patient.

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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. The codes are chosen based on the documentation to support the 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 spent after the patient leave 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

- Medicare only allows one Consultation per patient, per physician, per facility admission.
- Bill any additional services using subsequent care codes.

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Facility admission means not only inpatient, but also a skilled nursing facility or nursing home. While a hospital patient generally is a short term stay, a skilled nursing facility or nursing home is longer.

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.

This means Dr. Jones may only bill for one Consultation per facility admission. This also means Dr. Smith, a member of the same group with the same specialty may not bill a Consultation. Dr. Brown, who is a member of the same group but has a different specialty may bill an appropriately documented Consultation.

If Dr. Smith also saw the patient, then he/she bills a subsequent hospital or nursing facility visit.

If Dr. Jones and Dr. Smith have the same specialty but are not in the same group, both can bill a Consultation if appropriate. Documentation is crucial to determine whether the physician performed a Consultation or visit.

Same Group

- A Consultation may be requested from a member of the same group.
- Documentation must support the need for the Consultation and the expertise or knowledge of the performing physician.

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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.

Pre-Operative Consultations

- A surgeon may request a Consultation prior to performing surgery.
- Consultation requirements must be met.
- The service is not routine screening.

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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 that all requirements are met.

Medicare would not expect a surgeon to request a Consultation on all of his/her patients. Medicare does not pay for routine services.

Post Operative Consultations

- Must meet the Consultation criteria.
- Cannot be performed by a physician performing a pre-operative Consultation.

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A physician who performs a pre-operative consultation cannot perform 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.

Global Surgery and Consultations

- Consultations are subject to the Global Surgery Package.
- Modifiers may be appropriate.
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  - 25
  - 57

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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 either 0, 10 or 90 days. 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 not related to the surgery. (The physician can't have performed a pre-operative Consultation.) The diagnosis codes determine whether the service is related 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

Comparison Charts

The next two slides have charts showing both the inpatient and the outpatient Consultation average.

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In addition to the Consultation versus visit issue, we have also identified a concern in whether the documentation supports the level of service billed.

When performing a self-audit, please look at both areas: whether the service is a Consultation or a visit and whether the documentation supports the level of service billed.

The following charts show comparisons in the level of service billed to Medicare.

IL, MI, MN, WI Peer Group 99241 - 99245 All Specialties

Procedure Codes	Peer Group Allowed Services	Percent of Total Allowed Services	Average Allowed Services per Patient
99241	36,555	4.16%	0.99
99242	126,731	14.42%	1.03
99243	296,602	33.75%	1.07
99244	308,985	35.16%	1.10
99245	109,880	12.50%	1.06
	878,753	100.00%	

These charts show billing statistics for Consultation procedure codes.

IL, MI, MN, WI Peer Group 99251 - 99255 All Specialties

Procedure Codes	Peer Group Allowed Services	Percent of Total Allowed Services	Average Allowed Services per Patient
99251	20,347	2.39%	1.04
99252	64,895	7.63%	1.12
99253	210,520	24.75%	1.38
99254	371,319	43.66%	1.70
99255	183,467	21.57%	1.44
	850,548	100.00%	

Clinical Pathology Consultations

- Four Requirements:
  - Requested by the attending physician.
  - Relate to test results outside the normal or expected range.
  - Result in a written narrative.
  - Require the medical judgment of the performing physician.

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You can find more information about Clinical Pathology Consultation codes in our National Coverage Provision (NCP) PHYS-006 – Consultations and

PATH -002 – Pathology Physician Services

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 laboratory medical director 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.

Comparative Billing Reports

- E-Mail the following information to: MEDICAREADMIN@wpsic.com
  - Individual physician name
  - Name of Requester
  - Phone number with extension
  - Best time to contact
- Please include “Consultations” in the subject line to ensure timely response.

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Medicare can formulate a report to show the total number of Consultations versus visits your office submits. This report also shows a comparison between individual and jurisdictional data.

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