



Weekly Auditing and Compliance Tip

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If It's Not a Consultation, What Is It?

You thought you had a consultation supported in your documentation, and now you find out that you cannot bill the consultation codes (99241-99245, 99251-99255). So, what are the top reasons for a consultation not to be supported?

- If the payer does not support these codes
- If the documentation does not support all the requirements (reason, request, routing back to the requesting providers)
- If the documentation supports a transfer of care

This is a very frustrating situation that many providers, coders, and auditors struggle with. If the consultation codes (99241-99245, 99251-99255) are not supported, what do you bill?

In the Inpatient Hospital and Nursing Facility:

Medicare is actually very clear that in the inpatient (IP) setting, the provider can bill for the initial evaluation and management codes (99221-99223, 99304-99306) for the first time the patient is being evaluated by that specialty, for that admission. If the documentation does not meet the criteria (detailed history and exam), Medicare encourages the use of the subsequent care (99231-99233, 99307-99310) codes. The admitting specialty is to add modifier AI (Not A1), to the initial evaluation and management code.

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What do you do if it is not Medicare?

Empire BlueCross BlueShield states they follow CPT's definition of the transfer of care policy. This states "Use subsequent hospital care codes (99231-99233) or subsequent nursing facility care codes (99307-99310) to report transfer of care services."

However, BlueCross Blue Shield of Oklahoma states "Effective 1/1/2016, BCBSOK eliminated pricing for office consult codes to follow the Center for Medicare & Medicaid Services (CMS) policy."

If two subsidiaries of the same parent company (BlueCross BlueShield) don't handle things the same way, how can you?

The first thing is to find out what are the major payors your hospital handles and find out if they have a documented policy on how to handle their documented policies for whether they pay for consultation codes and, if not, how they expect initial visits and transfers of care to be coded. If they follow CPT, it is a transfer of care. If they follow Medicare, it is an initial admission evaluation.

In the Outpatient Setting:

When consultations are provided in the office or in an outpatient or other ambulatory facility, including hospital observation services, home services, domiciliary, rest home, or emergency department (see the preceding consultation definition above), it is just as complicated.

In some settings, like Observation, Medicare says only the admitting specialty can bill the (observation) codes (99217-99220, 99224-99226), all others are to bill for the appropriate outpatient (99201-99215) codes. This is the same thing that CPT states.

However, United Healthcare states that "Physicians other than the supervising physician providing care to a patient designated as "observation status" should report subsequent observation care".

So how do you figure out how to code the appropriate setting codes when the consultation codes (99241-99245, 99251-99255) are not supported? Since each payor has specific guidelines based on the regional carriers, I would suggest making a list of your top payors, and reaching out to them to find out how they handle each of the



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difference settings. Making a list that shows how to "crosswalk" the codes from a consultation, to the supported alternative would allow consistency within your group. Unfortunately, there is no universal policy for how to bill based on setting for consultations and transfers of care.

This Week's Tip Written by:

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May 9, 2016

2pm EST

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May 16, 2017

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