CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 782

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: DECEMBER 16, 2005

Change Request 4215

SUBJECT: Consultation Services (Codes 99241 - 99255)

I. SUMMARY OF CHANGES: This transmittal revises the Medicare Claims Processing Manual, Pub.100-04, Chapter 12, Section 30.6.10 with the correct new CPT codes for 2006 to use for follow-up visits and second opinion evaluations beginning January 1, 2006. The AMA CPT codes 99261 - 99263 (hospital inpatient follow-up consultations) and codes 99271 - 99275 (confirmatory consultations) have been deleted beginning 2006. This transmittal addresses consultation policy clarifications regarding the definition, documentation requirements, when and by whom a consultation may be performed/reported, a split/shared evaluation and management service, and nonphysician practitioners. The consultation examples are revised and updated.

NEW/REVISED MATERIAL
EFFECTIVE DATE: January 1, 2006
IMPLEMENTATION DATE: January 17, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
R	12/30.6.10/Consultation Services (Codes 99241 - 99255)

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 782	Date: December 16, 2005	Change Request 4215

SUBJECT: Consultation Services (Codes 99241 – 99255)

I. GENERAL INFORMATION

A. Background: This transmittal revises the Medicare Claims Processing Manual, Pub.100-04, Chapter 12, Section 30.6.10 with policy clarifications and identifies the new 2006 coding changes made by the American Medical Association (AMA) Current Procedural Terminology (CPT for physicians and qualified nonphysician practitioners (NPP). They need these new codes for reporting follow-up visits to a consultation service and for second opinion evaluations beginning January 1, 2006. It is important to note that the Follow-Up Inpatient Consultation codes (99261 – 99263) and the Confirmatory Consultation codes (99271 – 99275) have been deleted from CPT. This Change Request (CR) explains how to report evaluation and management (E/M) services following a consultation service and also second opinion evaluations.

B. **B. Policy:** This CR clarifies the definition of a consultation; when and by whom the initial consultation may be reported. A split/shared visit may not be performed or reported as a consultation service. This CR clarifies that qualified NPPs can perform consultations when requirements are met. Documentation requirements for the requesting physician/qualified NPP and the consultant physician/qualified NPP are updated. Consultation examples are revised and updated. Based on the new CPT 2006 coding changes, follow-up visits to a consultation service shall be reported with the Subsequent Hospital Care codes (99231 – 99233) in the hospital inpatient setting and with the new Subsequent Nursing Facility (NF) Care codes (99307 – 99310) in the NF setting. As of January 1, 2006, AMA CPT NF codes (99311 – 99313) are deleted and not valid for subsequent nursing facility visits. Follow-up visits to a consultation service in the office or other outpatient settings shall be reported with the Office or Other Outpatient Established Patient codes (99212 – 99215).

C.

D. In a facility setting, a second opinion consultation arranged through the attending physician shall be reported by a physician/qualified NPP using an appropriate Initial Inpatient Consultation code when the consultation requirements are met. When consultation requirements are not met the Subsequent Hospital Care codes (99231 – 99233) in the hospital setting and the Subsequent NF Care codes (99307 – 99310) in the NF setting shall be reported. In the Office or Other Outpatient setting for a second opinion evaluation, a physician/qualified NPP shall use new patient codes (99201 – 99205) for new patients and established patient codes (99212 – 99215) for an established patient, as appropriate. The CPT code 99211 is not recognized by Medicare for a consultation service since this service typically does not require the presence of a physician or qualified NPP and would not meet the criteria. The CPT modifier -32 (Mandated Services) is not recognized by Medicare as a payment modifier. A second opinion evaluation visit, to satisfy a requirement for a third party payer, is not a covered service in Medicare.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4215.1	Carriers shall instruct physicians and qualified NPPs that a consultation service requires a request from an appropriate source, the consultation evaluation service, and a written report (as identified in Section A).			X						
4215.2	Carriers shall instruct physicians and qualified NPPs that diagnostic services and treatments may be initiated at the initial consultation service or follow-up visits.			X						
4215.3	Carriers shall instruct physicians and qualified NPPs that a consultation service may be based on time when the counseling/coordination of care constitutes more than 50 percent of the face-to-face encounter between the physician and the patient.			X						
4215.4	Carriers shall instruct physicians and qualified NPPs that a qualified NPP may request and/or perform a consultation service within the scope of practice and licensure requirements for the NPP in the State where he/she practices.			X						
4215.5	Carriers shall instruct physicians and qualified NPPs that the qualified NPPs shall meet the collaboration and physician supervision requirements. A physician assistant shall meet the general physician supervision requirement.			X						
4215.6	Carriers shall instruct physicians and qualified NPPs that a consultation service shall not be performed as a split/shared evaluation and management service.			X						
4215.7	Carriers shall instruct physicians and qualified NPPs that ongoing management following the initial consultation service shall be reported using the subsequent care visit codes for the			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	appropriate place of service and level of service.									
4215.8	Carriers shall instruct physicians and qualified NPPs that in a transfer of care situation an appropriate new patient or established patient visit code, according to the place of service and level of service performed, shall be reported.			X						
4215.9	Carriers shall instruct physicians and qualified NPPs to report the Initial Inpatient Consultation codes (99251 – 99255) for an initial consultation in the inpatient hospital setting and the NF setting.			X						
4215.9.1	Carriers shall instruct physicians and qualified NPPs that the initial inpatient consultation may be reported only once per physician/qualified NPP per patient per facility (inpatient and NF) admission. **NOTE:** Editing will be done in the Common Working File. A separate Change Request will be forthcoming with details.			X						
4215.9.2	Carriers shall instruct physicians and qualified NPPs to report the appropriate Office or Other Outpatient Consultation codes (99241 – 99245) for an initial consultation in the office/outpatient setting.			X						
4215.10	Carriers shall instruct physicians and qualified NPPs that following the initial consultation service in the hospital setting, the follow-up visits shall be reported using the Subsequent Hospital Care codes (99231 – 99233) for the inpatient hospital setting.			X						
4215.10.1	Carriers shall instruct physicians and qualified NPPs that following the initial consultation service in the SNF/NF setting, the follow-up visits shall be reported using the new CPT			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	Subsequent NF Care codes (99307 – 99310) in the NF setting.									
4215.10.2	Carriers shall instruct physicians and qualified NPPs that following the initial consultation service in the office or outpatient setting, the Office or Other Outpatient Established Patient codes (99212 – 99215) shall be reported for the office/outpatient setting.			X						
4215.11	Carriers shall instruct physicians and qualified NPPs that Medicare does not recognize CPT code 99211, a minimal service, for a consultation service as it would not meet the consultation criteria.			X						
4215.12	Carriers shall instruct physicians and qualified NPPs that in an office or outpatient setting, another consultation may be requested of the same consultant physician/qualified NPP if the consultant has not been providing ongoing management of the patient for this condition after his/her initial consultation.			X						
4215.12.1	Carriers shall instruct physicians and qualified NPPs that they shall report the Office or Other Outpatient Consultation codes for an additional consultation if the requirement in 4215.12 is met.			X						
4215.13	Carriers shall instruct physicians and qualified NPPs that for a second opinion evaluation (patient and/or family requested) in the facility setting which is arranged through the attending physician, they shall report an Initial Inpatient Consultation service if the consultation requirements are met.			X						
4215.13.1	Carriers shall instruct physicians and qualified NPPs that if the second opinion evaluation does not meet the consultation requirements as identified in Section A, the Subsequent Hospital			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	Care codes for the inpatient hospital setting and Subsequent NF Care codes for the NF setting shall be reported.									
4215.13.2	Carriers shall instruct physicians and qualified NPPs that for a second opinion evaluation in the office or outpatient setting, they shall report the appropriate Office or Other Outpatient codes (new or established patient) for the office/outpatient setting and level of service performed.			X						
4215.13.3	Carriers shall instruct physicians and qualified NPPs that any medically necessary follow-up visits after an initial consultation service shall be reported using the appropriate subsequent visit/established patient E/M visit codes.			X						
4215.14	Carriers shall instruct physicians and qualified NPPs that a written report is not required by Medicare to be sent to a physician or qualified NPP when an evaluation for a second opinion has been requested by the patient and/or family.			X						
4215.15	Carriers shall instruct physicians and qualified NPPs that the CPT modifier -32 (Mandated Services) is not recognized by Medicare as a payment modifier.			X						
4215.15.1	Carriers shall instruct physicians and qualified NPPs that a second opinion evaluation visit, to satisfy a requirement for a third party payer, is not a covered service in Medicare.			X						
4215.16	Carriers shall instruct physicians and qualified NPPs that payment shall be made for a consultation if a physician or qualified NPP in a group practice requests a consultation from another physician or qualified NPP in the same group practice when the consulting physician or qualified NPP has expertise in a specific medical area beyond the requesting			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	professional's knowledge.									
4215.16.1	Carriers shall instruct physicians and qualified NPPs that a consultation service shall not be reported on every patient as a routine practice between physicians and qualified NPPs within a group practice setting.			X						
4215.17	Carriers shall instruct physicians and qualified NPPs that the written request for a consultation shall be included in the requesting physician's or qualified NPP's plan of care.			X						
4215.18	Carriers shall instruct physicians and qualified NPPs that a consultation request may be verbal however the verbal interaction identifying the request and reason for a consult shall be documented in the patient's medical record by the requesting physician or qualified NPP, and also by the consultant physician or qualified NPP in the patient's medical record.			X						
4215.19	Carriers shall instruct physicians and qualified NPPs that a consultation request by the requestor may be written on a physician order form in a shared medical record.			X						
4215.20	Carriers shall instruct physicians and qualified NPPs that the reason for the consultation service shall be documented by the consultant physician or qualified NPP in the patient's medical record.			X						
4215.21	Carriers shall instruct physicians and qualified NPPs that the consultant physician's or qualified NPP's written report may be part of a common medical record or in a separate letter to the requesting physician or qualified NPP and readily available.			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4215.22	Carriers shall instruct physicians and qualified NPPs that a pre-operative consultation at the request of a surgeon is payable if the service is medically necessary and not routine screening.			X						
4215.23	Carriers shall instruct physicians and qualified NPPs that following a pre-operative consultation, if the same physician or qualified NPP assumes responsibility for management of all or part of the patient's care postoperatively, the appropriate subsequent inpatient hospital care codes, subsequent NF codes or established office/clinic codes shall be used and shall not report the consultation codes.			X						
4215.24	Carriers shall instruct physicians and qualified NPPs that physicians or qualified NPPs who are asked to assume management of an aspect of the patient's care postoperatively and who managed the patient's medical care pre-operatively or who are not providing a consultation, shall report the subsequent hospital care codes for inpatient hospital, subsequent NF care codes in the SNF/NF setting or the appropriate office or other outpatient visit codes in these settings.			X						
4215.25	Carriers shall instruct physicians and qualified NPPs regarding the information in this CR via the Medlearn Matters Article and any other viable provider outreach that the carriers deem necessary.			X						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4215.26	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.			X						

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: The American Medical Association *Current Procedural Terminology (CPT) 2006* developed new codes for reporting these services beginning January 1, 2006. CMS is currently releasing the HCPCS tape with the codes to be reported for 2006. The new code changes in this CR are on the HCPCS tape.

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2006 **Implementation Date:** January 17, 2005 **Pre-Implementation Contact(s):** Kit Scally (Cathleen.Scally@cms.hhs.gov) **Post-Implementation Contact(s):** Appropriate Regional Office staff	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

30.6.10 – Consultation *Services* (*Codes 99241 - 99255*)

(Rev.782, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-17-06)

A. Consultation *Services* versus *Other Evaluation and Management (E/M) Visits*

Carriers pay for a *reasonable and medically necessary* consultation *service* when all of the *following* criteria for the use of a consultation code are met:

- Specifically, a consultation *service* is distinguished from *other evaluation and management (E/M) visits* because it is provided by a physician *or qualified nonphysician practitioner (NPP)* whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. *The qualified NPP may perform consultation services within the scope of practice and licensure requirements for NPPs in the State in which he/she practices.* Applicable collaboration and general supervision rules apply as well as billing rules;
- A request for a consultation from an appropriate source and the need for consultation *(i.e., the reason for a consultation service) shall* be documented *by the consultant* in the patient's medical record *and included in the requesting physician or qualified NPP's plan of care in the patient's medical record;* and
- After the consultation is provided, the consultant *shall prepare* a written report of his/her findings *and recommendations*, which *shall be* provided to the referring physician.

The intent of a consultation service is that a physician or qualified NPP or other appropriate source is asking another physician or qualified NPP for advice, opinion, a recommendation, suggestion, direction, or counsel, etc. in evaluating or treating a patient because that individual has expertise in a specific medical area beyond the requesting professional's knowledge. 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 *or qualified NPP* and the patient. The preceding requirements *(request, evaluation (or counseling/coordination) and written report) shall also be met when the consultation is based on time for counseling/coordination.*

A consultation shall not be performed as a split/shared E/M visit.

B. Consultation Followed by Treatment

A physician *or qualified NPP* consultant may *initiate* diagnostic *services and treatment* at *the* initial *consultation service or subsequent visit. Ongoing management, following the initial consultation service by the consultant physician, shall not be reported with consultation service codes. These services shall be reported as subsequent visits for the appropriate place of service and level of service.* Payment *for a consultation service shall* be made regardless of treatment initiation unless a transfer of care occurs.

Transfer of Care

A transfer of care occurs when a physician *or qualified NPP requests that another physician or qualified NPP take over the responsibility for managing the patients' complete care for the condition and does not expect to continue treating or caring for the patient for that condition.*

When this transfer is arranged, the requesting physician or qualified NPP is not asking for an opinion or advice to personally treat this patient and is not expecting to continue treating the patient for the condition. The receiving physician or qualified NPP shall document this transfer of the patient's care, to his/her service, in the patient's medical record or plan of care.

In a transfer of care the receiving physician or qualified NPP would report the appropriate new or established patient visit code according to the place of service and level of service performed and shall not report a consultation service.

C. Initial and Follow-Up Consultation Services

Initial Consultation Service

In the hospital setting, the consulting physician or qualified NPP shall use the appropriate Initial Inpatient Consultation codes (99251 – 99255) for the initial consultation service.

In the nursing facility setting, the consulting physician or qualified NPP shall use the appropriate Initial Inpatient Consultation codes (99251 – 99255) for the initial consultation service.

The Initial Inpatient Consultation may be reported only once per consultant per patient per facility admission.

In the office or other outpatient setting, the consulting physician or qualified NPP shall use the appropriate Office or Other Outpatient Consultation (new or established patient) codes (99241 – 99245) for the initial consultation service.

If an additional request for an opinion or advice, regarding the same or a new problem with the same patient, is received from the same or another physician or qualified NPP and documented in the medical record, the Office or Other Outpatient Consultation (new or established patient) codes (99241 – 99245) may be used again. However, if the consultant continues to care for the patient for the original condition following his/her initial consultation, repeat consultation services shall not be reported by this physician or qualified NPP during his/her ongoing management of this condition.

Follow-Up Consultation Service

Effective January 1, 2006, the follow-up inpatient consultation codes (99261 – 99263) are deleted.

In the hospital setting, following the initial consultation service, the Subsequent Hospital Care codes (99231 – 99233) shall be reported for additional follow-up visits.

In the nursing facility setting, following the initial consultation service, the Subsequent Nursing Facility (NF) Care codes (new CPT codes 99307 – 99310) shall be reported for additional follow-up visits. Effective January 1, 2006, CPT codes 99311 – 99313 are deleted and not valid for Subsequent NF visits.

In the office or other outpatient setting, following the initial consultation service, the Office or Other Outpatient Established Patient codes (99212 – 99215) shall be reported for additional follow-up visits. The CPT code 99211 shall not be reported as a consultation service. The CPT code 99211 is not included by Medicare for a consultation service since this service typically does not require the presence of a physician or qualified NPP and would not meet the consultation service criteria.

D. Second Opinion E/M Service Requests

Effective January 1, 2006, the Confirmatory Consultation codes (99271 – 99275) are deleted.

A second opinion E/M service is a request by the patient and/or family or mandated (e.g., by a third-party payer) and is not requested by a physician or qualified NPP. A consultation service requested by a physician, qualified NPP or other appropriate source that meets the requirements stated in Section A shall be reported using the initial consultation service codes as discussed in Section C. A written report is not required by Medicare to be sent to a physician when an evaluation for a second opinion has been requested by the patient and/or family.

A second opinion, for Medicare purposes, is generally performed as a request for a second or third opinion of a previously recommended medical treatment or surgical procedure. A second opinion E/M service initiated by a patient and/or family is not reported using the consultation codes.

In both the inpatient hospital setting and the NF setting, a request for a second opinion would be made through the attending physician or physician of record. If an initial consultation is requested of another physician or qualified NPP by the attending physician and meets the requirements for a consultation service (as identified in Section A) then the appropriate Initial Inpatient Consultation code shall be reported by the consultant. If the service does not meet the consultation requirements, then the E/M service shall be reported using the Subsequent Hospital Care codes (99231 – 99233) in the inpatient hospital setting and the Subsequent NF Care codes (99307 – 99310) in the NF setting.

A second opinion E/M service performed in the office or other outpatient setting shall be reported using the Office or Other Outpatient new patient codes (99201 – 99205) for a new patient and established patient codes (99212 – 99215) for an established patient, as appropriate. The 3 year rule regarding "new patient" status applies. Any medically

necessary follow-up visits shall be reported using the appropriate subsequent visit/established patient E/M visit codes.

The CPT modifier -32 (Mandated Services) is not recognized as a payment modifier in Medicare. A second opinion evaluation service to satisfy a requirement for a third party payer is not a covered service in Medicare.

E. Consultations Requested by Members of Same Group

Carriers pay for a consultation if one physician *or qualified NPP* in a group practice requests a consultation from another physician in the same group practice *when the consulting physician or qualified NPP has expertise in a specific medical area beyond the requesting professional's knowledge. A consultation service shall not be reported on every patient as a routine practice between physicians and qualified NPPs within a group practice setting.*

F. Documentation for Consultation *Services*

Consultation Request

A written request for a consultation from an appropriate source and the need for *a* consultation must be documented in the patient's medical record. *The initial request may be a verbal interaction between the requesting physician and the consulting physician; however, the verbal conversation shall be documented in the patient's medical record, indicating a request for a consultation service was made by the requesting physician or qualified NPP.*

The reason for the consultation service shall be documented by the consultant (physician or qualified NPP) in the patient's medical record and included in the requesting physician or qualified NPP's plan of care. The consultation service request may be written on a physician order form by the requestor in a shared medical record.

Consultation Report

A written report *shall* be furnished to the requesting physician *or qualified NPP*.

In an emergency department or an inpatient or outpatient setting in which the medical record is shared between the referring physician *or qualified NPP* and the consultant, the request may be documented as part of a plan written in the requesting physician *or qualified NPP's* progress note, an order in the medical record, or a specific written request for the consultation. In these settings, the report may consist of an appropriate entry in the common medical record.

In an office setting, the documentation requirement may be met by a specific written request for the consultation from the requesting physician *or qualified NPP* or if the consultant's records show a specific reference to the request. In this setting, the consultation report is a separate document communicated to the requesting physician *or qualified NPP*.

In a large group practice, e.g., an academic department or a large multi-specialty group, in which there is often a shared medical record, it is acceptable to include the consultant's report in the medical record documentation and not require a separate letter from the consulting physician or qualified NPP to the requesting physician or qualified

NPP. The written request and the consultation evaluation, findings and recommendations shall be available in the consultation report.

G. Consultation for Preoperative Clearance

Preoperative consultations are payable for new or established patients performed by any physician *or qualified NPP* at the request of a surgeon, as long as all of the requirements for *performing and reporting* the consultation codes are met *and the service is medically necessary and not routine screening.*

H. Postoperative Care by Physician Who Did Preoperative Clearance Consultation

If subsequent to the completion of a preoperative consultation in the office or hospital, the consultant assumes responsibility for the management of a portion or all of the patient's condition(s) during the postoperative period, the consultation codes should not be used *postoperatively*. In the hospital setting, the physician *or qualified NPP* who has performed a preoperative consultation and assumes responsibility for the management of a portion or all of the patient's condition(s) during the postoperative period should use the appropriate subsequent hospital care codes to bill for the concurrent care he or she is providing. In the office setting, the appropriate established patient visit *codes* should be used during the postoperative period.

A physician (primary care or specialist) *or qualified NPP* who performs a postoperative evaluation of a new or established patient at the request of the surgeon may bill the appropriate consultation code for evaluation and management services furnished during the postoperative period following surgery *when* all of the criteria for the use of the consultation codes are met and that same physician has not already performed a preoperative consultation.

I. Surgeon's Request That Another Physician Participate In Postoperative Care

If the surgeon asks a physician *or qualified NPP who had been treating the patient preoperatively* or who had not seen the patient for a preoperative consultation to take responsibility for the management of an aspect of the patient's condition during the postoperative period, the physician *or qualified NPP* may not bill a consultation because the surgeon is not asking the physician *or qualified NPP's* opinion or advice for the surgeon's use in treating the patient. The physician *or qualified NPP's* services would constitute concurrent care and should be billed using the appropriate *subsequent hospital care codes in the hospital inpatient setting, subsequent NF care codes in the SNF/NF setting or the appropriate office or other outpatient visit codes in the office or outpatient settings.*

J. Examples *That Meet the Criteria for Consultation Services*

For brevity, the consultation request and the consultation written report is not repeated in each of these examples. Criteria for consultation services shall always include a request and a written report in the medical record as described above.

EXAMPLE 1:

An internist sees a patient that he has followed for 20 years for mild hypertension and diabetes mellitus. *He identifies a questionable skin lesion and asks a dermatologist to evaluate the lesion. The dermatologist examines the patient and decides the lesion is probably malignant and needs to be removed.* He removes the lesion which is determined to be an early melanoma. The dermatologist dictates and forwards a report to the internist regarding his evaluation and treatment of the patient. Modifier -25 shall be used with the consultation service code in addition to the procedure code. *Modifier -25 is required to identify the consultation service as a significant, separately identifiable E/M service in addition to the procedure code reported for the incision/removal of lesion. The internist resumes care of the patient and continues surveillance of the skin on the advice of the dermatologist.*

EXAMPLE *2*:

A rural family practice physician examines a patient who has been under his care for 20 years and diagnoses a new onset of atrial fibrillation. The family practitioner sends the patient to a cardiologist at an urban cardiology center for advice on his care and management. The cardiologist examines the patient, suggests a cardiac catheterization and other diagnostic tests which he schedules and then sends a written report to the requesting physician. The cardiologist subsequently periodically sees the patient once a year as follow-up. Subsequent visits provided by the cardiologist should be billed as an established patient visit in the office or other outpatient setting, as appropriate. *Following the advice and intervention by the cardiologist the family practice physician resumes the general medical care of the patient.*

EXAMPLE *3*:

A family practice physician examines a female patient who has been under his care for some time and diagnoses a breast mass. The family practitioner sends the patient to a general surgeon for advice and management of the mass and related patient care. The general surgeon examines the patient and recommends a breast biopsy, which he schedules, and then sends a written report to the requesting physician. The general surgeon subsequently performs a biopsy and then periodically sees the patient once a year as follow-up. Subsequent visits provided by the surgeon should be billed as an established patient visit in the office or other outpatient setting, as appropriate. *Following the advice and intervention by the surgeon the family practice physician resumes the general medical care of the patient.*

I. Examples That Do Not *Meet* the Criteria for *Consultation Services*

EXAMPLE 1: Standing orders in the medical record for consultations.

EXAMPLE 2: No order for a consultation.

EXAMPLE 3: No written report of a consultation.

EXAMPLE 4: *The emergency room physician treats the patient for a sprained ankle. The patient is discharged and instructed to visit the orthopedic clinic for follow-up. The physician in the orthopedic clinic shall not report a consultation service because advice or opinion is not required by the emergency room physician. The orthopedic physician shall report the appropriate office or other outpatient visit code.*