

MLN Matters Number: MM4215

Related Change Request (CR) #: 4215

Related CR Release Date: December 20, 2005

Effective Date: January 1, 2006

Related CR Transmittal #: R788

Implementation Date: January 17, 2006

Consultation Services Current Procedural Terminology (CPT) Codes 99241 – 99255

Note: This article was updated on February 25, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Physicians and qualified non-physician practitioners (NPPs) billing Medicare carriers for Part B services

Provider Action Needed



STOP – Impact to You

This article is based on Change Request (CR) 4215, which 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 2006.

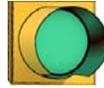


CAUTION – What You Need to Know

CR4215 addresses the Centers for Medicare & Medicaid Services (CMS) 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 non-physician practitioners. It also includes revised and updated consultation examples. Note also that CPT codes 99261 - 99263 (hospital inpatient follow-up consultations) and CPT codes 99271 - 99275 (confirmatory consultations) are deleted effective January 1, 2006.

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GO – What You Need to Do

Please see the *Background* section of this article for further details regarding these changes.

Background

Change Request (CR) 4215 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 non-physician practitioners (NPPs). Physicians and qualified NPPs need these new codes for reporting follow-up visits to a consultation service and for second opinion evaluations beginning January 1, 2006.

CR4215 explains how to report evaluation and management (E/M) services following a consultation service and also second opinion evaluations. In addition, it clarifies:

- The definition of a consultation - when and by whom it may be reported;
- A split/shared visit may not be performed or reported as a consultation service; and
- Qualified NPPs can perform consultations when requirements are met; and

It updates:

- Documentation requirements for the requesting physician/qualified NPP and the consultant, and consultation examples.

Based on the new CPT 2006 coding changes, follow-up visits to a consultation service will be reported with the following Subsequent Hospital Care codes **in the hospital inpatient setting** and with the new Subsequent Nursing Facility (NF) Care codes **in the NF setting**:

Description	CPT Codes
Subsequent Hospital Care codes	99231 – 99233
Subsequent Nursing Facility (NF) Care codes	99307 – 99310

Beginning January 1, 2006, the following 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** will be reported with the following Office or Other Outpatient Established Patient codes.

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Description	CPT Codes
Office or Other Outpatient Established Patient codes	99212 – 99215

Beginning January 1, 2006, **in a facility setting** a second opinion consultation arranged through the attending physician will 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 will be reported.

In the Office or Other Outpatient setting for a second opinion evaluation, a physician/qualified NPP will use new patient codes (99201 – 99205) for new patients and established patient codes (99212 – 99215) for an established patient, as appropriate.

Policy Clarifications/Reminders

Physicians and qualified NPPs should be aware that:

- A consultation service requires a request from an appropriate source, the consultation evaluation service, and a written report;
- Diagnostic and/or therapeutic services may be initiated at the initial consultation service or follow-up visits;
- 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 or qualified NPP and the patient;
- An 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 and the requirements for physician collaboration and physician supervision are met;
- A consultation will not be performed as a split/shared E/M visit;
- Ongoing management following the initial consultation service must be reported using the subsequent care visit codes depending on the setting and type of service; and
- In a transfer of care situation a new patient or established patient visit code must be reported.

In addition, CR4215 instructs physicians and qualified NPPs to report:

- Initial Inpatient Consultation codes (99251 – 99255) for an initial consultation in the inpatient hospital setting and the SNF/NF setting; and

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- Appropriate Office or Other Outpatient Consultation codes (99241 – 99245) for an initial consultation in the office/outpatient setting.

Following the physician's and qualified NPP's initial consultation service, the follow-up visits should be reported using the:

- Subsequent Hospital Care codes (99231 – 99233) for the inpatient hospital setting; and
- Subsequent NF Care codes (99307 – 99310) in the NF setting; and
- Office or Other Outpatient Established Patient codes (99212 – 99215) should be reported for the office/outpatient setting.

Also, physicians and qualified NPPs need to be aware that:

- Medicare does not recognize CPT code 99211, a minimal service, for a consultation service as it would not meet the consultation criteria;
- An initial inpatient consultation will be reported only once per consultant per patient per facility admission;
- In an office or outpatient setting, if an additional request for a consultation, 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 codes may be used again;
- If the consultant continues to care for the patient for the original condition following the initial consultation, repeat consultation services will not be reported by this physician or qualified NPP during his/her ongoing management of this condition;
- For a second opinion evaluation (patient and/or family requested) in the facility setting arranged through the attending physician, the evaluation is reported as an Initial Inpatient Consultation service if the consultation requirements are met;
- If the second opinion evaluation does not meet the consultation requirements, the Subsequent Hospital Care codes for the inpatient setting and Subsequent NF Care codes for the NF setting are reported;
- For a second opinion evaluation, report the Office or Other Outpatient codes (new or established patient as appropriate) for the office/outpatient settings;
- A written report is not required by Medicare to be sent to a physician or qualified NPP when a second opinion evaluation visit has been requested by the patient and/or family;

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- 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;
- Medicare will pay 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 professional's knowledge;
- A consultation service will not be reported on every patient as a routine practice between physicians and qualified NPPs within a group practice setting;
- Include a written request for a consultation in the requesting physician or qualified NPP's plan of care;
- A consultation request may be verbal; however, the verbal interaction identifying the request and reason for a consult must 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;
- A consultation request by the requestor may be written on a physician order form in a shared medical record;
- The reason for the consultation service must be documented by the consultant in the patient's medical record;
- The consultant'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;
- A preoperative consultation at the request of a surgeon is payable if the service is medically necessary and not routine screening;
- Following a preoperative 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 SNF/NF codes or established office/clinic codes should be used and not the consultation codes; and
- Physicians or qualified NPPs who had been treating the patient pre-operatively or who had not seen the patient for a pre-operative consultation and are asked to assume management of an aspect of the patient's care postoperatively, must report subsequent hospital care codes for the inpatient hospital setting, subsequent NF care codes in the SNF/NF setting or the appropriate office or other outpatient visit codes in these settings. The

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surgeon is not asking the physician or qualified NPP for their advice or opinion on the surgeon's care of the patient.

Additional Information

The revised portions of the *Medicare Claims Processing Manual* are attached to CR4215. These revisions include examples of situations that meet the consultation services criteria as well as some examples that do not meet the criteria. CR4215 may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R788CP.pdf> on the CMS website.

If you have any questions, please contact your carrier at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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