



Consultation Services and Transfer of Care

CMS has finalized its proposal to eliminate Medicare payment for consultations and use the money from these services to increase payments for visits, including visits bundled into global surgical services. In its comments on the proposed rule, the AMA had urged that CMS not finalize it for implementation in January 2010. At the November AMA Interim Meeting, the House of Delegates adopted a resolution which called on the AMA to oppose the elimination of payments consultation service codes. Although the AMA strongly advocated for a delay in implementation, meeting with senior CMS officials, sending a letter to the Director of the Center for Medicare Management , and discussing it with Secretary Sebelius, CMS decided to proceed with the new policy January 1. CMS has released a MedLearn article  describing the consultation payment change. The AMA is continuing to request that CMS clarify a number of outstanding issues surrounding reporting of consultation services and take additional steps to inform and assist physicians. When that information becomes available it will be posted to our web site at www.ama-assn.org/go/regrelief.

The following information is provided as guidance for reporting consultation services for non-Medicare patients following revisions to the CPT codes for CPT® 2010 and due to recent changes to CMS policy in which the CPT codes have been budgetarily eliminated. For Medicare reporting purposes, Medicare contractor's web sites should be referenced for coding guidance.

The CPT Editorial Panel recognized the need to further define evaluation and management (E/M) consultation services to provide clear instructional guidance for the appropriate reporting of these CPT codes, and made substantial revisions to the consultation guidelines which are explained in detail below. Please note, however, that the Centers for Medicare and Medicaid Services (CMS) in the Final Rule has indicated that the consultation guidelines and the associated CPT codes will be invalid for Medicare, effective January 1, 2010. Further guidance by CMS is provided in the following MLN Matters article: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf> Revisions to the CPT® 2010 codebook include: explanation of the appropriate use of office consultation codes 99241-99245 and

inpatient consultation codes 99251-99255; revision of the concurrent care definition in the Definitions of Commonly Used Terms section of the E/M guidelines; and revision of the Outpatient Consultation, Inpatient Consultation, and the overarching Consultation guidelines.

The heading for concurrent care has been revised to include reference to transfer of care. The text for concurrent care has been expanded to include the following definition of transfer of care and its relation to the appropriate use of the consultation codes when an initial consultation evaluation is required:

Transfer of care is the process whereby a physician who is providing management for some or all of a patient's problems relinquishes this responsibility to another physician who explicitly agrees to accept this responsibility, and who, from the initial encounter, is not providing consultative services. The physician transferring care is then no longer providing care for these problems, though he or she may continue providing care for other condition(s) when appropriate.

Consultation codes should not be reported by the physician who has agreed to accept transfer of care before an initial evaluation but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of the site of service.

(CPT 2010 Professional Edition, page 4).

This new definition of referral described above, and in Table 1 below, addresses these "referrals" as explicit transfers of care. The definition indicates that regardless of the site of service, consultation codes **cannot** be reported when the physician accepting the transfer of care of a patient neither performs an initial evaluation nor provides consultative services from the initial encounter, but explicitly accepts the transfer of care.

See Table 1 for a summary of the descriptions of transfer of care services and whether each should be reported as a consultation.

Table 1: Reporting Transfer of Care as Consultation

Transfer of Care Description	Report as Consultation
Physician explicitly agreed to accept responsibility for patient from physician who was managing some or all of the patient's problems	No
Physician accepted transfer of care before an initial evaluation	No
Physician accepted transfer of care after performing an initial consultation evaluation	Yes

The revisions to the overarching consultation guidelines that provided general guidance for the inpatient and outpatient consultation codes are as follows (text new to CPT 2010 is in italics):

Consultations

A consultation is a type of *evaluation and management* service provided by a physician *at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem.*

A physician consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.

A "consultation" initiated by a patient and/or family, and not requested by a physician or other appropriate source (eg, physician assistant, nurse practitioner, doctor of chiropractic, physical therapist, occupational therapist, speech-language pathologist, psychologist, social worker, lawyer, or insurance company), is not reported using the consultation codes but may be reported using the office visit, home service, or domiciliary/rest home care codes *as appropriate*. (Note that Medicare does, and other payers may, restrict what "appropriate sources" are allowed to code a claim as a consultation).

The written or verbal request for consult may be made by a physician or other appropriate source and documented in the patient's medical record *by either the consulting or requesting physician or appropriate source*. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source.

If a consultation is mandated (eg, by a third-party payer) modifier 32 should also be reported.

Any specifically identifiable procedure (ie, identified with a specific CPT code) performed on or subsequent to the date of the initial consultation should be reported separately.

If, after to the completion of a consultation, the consultant assumes responsibility for management of a portion or all of the patient's condition(s) for subsequent dates of service, the appropriate Evaluation and Management service code for the site of service should be reported. In the hospital or nursing facility setting, the consulting physician should use the appropriate inpatient consultation code for the initial encounter and then subsequent hospital or nursing facility care codes. In the office setting, the physician should use the appropriate office or other outpatient consultation codes and then the established patient office or other outpatient services codes.

To report services provided to a patient who is admitted to a hospital or nursing facility in the course of an encounter in the office or other ambulatory facility, see the notes for Initial Hospital Inpatient Care (pages 14-16, CPT 2010 Professional Edition) or Initial Nursing Facility Care (pages 23-24, CPT 2010 Professional Edition.).

The new definition for consultation specifies that when a consultation code is reported, the result of the consultation service will either be:

- (1) a recommendation for care of a specific problem, or
- (2) a decision to accept responsibility for:
 - (a) the patient's entire care or
 - (b) the care of a specific condition/problem.

Guideline revisions also clarify the requirements for the documentation of a consultation request in the patient's record, from either the consulting or requesting physician or other appropriate source, in addition to the required results and the outcome of the consultation.

In addition to the overarching guidelines, the instructions further stipulate that when a patient is admitted to a hospital or nursing facility by the professional who performed an outpatient consultation on the same day, the outpatient service (eg, outpatient consultation) for that provider does not apply. Only the initial inpatient services codes (99221-99223, 99304-99306) should be reported. This follows current guidelines for admission services when the patient is seen in an office/outpatient setting by a professional other than a consultant. All E/M services provided by that physician in conjunction with that admission are considered part of the initial hospital or nursing care when performed on the same date as the admission. The inpatient care level of service reported by the admitting physician should include the services related to the admission he or she provided in the outpatient and inpatient settings.

Revisions to the Outpatient Consultation Guideline consist of the following:

Office or Other Outpatient Consultations

New or Established Patient

The following codes are used to report consultations provided in the physician's 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). Follow-up visits in the consultant's office or other outpatient facility that are initiated by the physician consultant or patient are reported using the appropriate codes for established patients, office visits (99211-99215), domiciliary, rest home (99334-99337), or home (99347-99350). If an additional request for an opinion or advice regarding the same or a new problem is received from another physician or other appropriate source and documented in the medical record, the office consultation codes may be used again. *Services that constitute transfer of care (ie, are provided for the management of the patient's entire care or for the care of a specific condition or problem) are reported with the appropriate new or established patient codes for office or other outpatient visits, domiciliary, rest home services, or home services (CPT 2010 Professional Edition, page 17).*

This revision includes a reminder that transfer of care services should be reported with the outpatient office codes rather than consultation services.

See **Table 2** for a summary of the descriptions of outpatient consultation services and the appropriate corresponding CPT codes to report for each.

Table 2: Outpatient Consultation Services and Corresponding CPT Codes

Outpatient Consultation Description	CPT Code to Report
Physician explicitly agreed to accept responsibility for patient from physician who was managing some or all of the patient's problems	99201-99215 99324-99337 99341-99350
Physician accepted transfer of care before an initial evaluation	99201-99215 99324-99337 99341-99350
Physician accepted transfer of care after performing an initial consultation evaluation	99241-99245
Follow-up visit in the consulting physician's office, or the patient's residence.	99211-99215 99334-99337 99347-99350

Revisions to the inpatient consultation guidelines consist of the following:

Inpatient Consultations

New or Established Patient

The following codes are used to report physician consultations provided to hospital inpatients, residents of nursing facilities, or patients in a partial hospital setting. Only one consultation should be reported by a consultant per admission. Subsequent services during the same admission are reported using Subsequent Hospital Care codes (99231-99233) or Subsequent Nursing Facility Care codes (99307-99310), including services to complete the initial consultation, monitor progress, revise recommendations, or address a new problem. *Use subsequent hospital care codes (99231-99233) or subsequent nursing facility care codes (99307-99310) to report transfer of care services (see pages 24- 25, CPT 2010 Professional Edition, Concurrent Care and Transfer of Care definitions).*

When an inpatient consultation is performed on a date that a patient is admitted to a hospital or nursing facility, all evaluation and management services provided by the consultant related to the admission are reported with the inpatient consultation service code (99251-99255). If a patient is admitted after an outpatient consultation (office, emergency department, etc), and the patient is not seen on the unit on the date of admission, only report the outpatient consultation code (99241-99245). If the patient is seen by the consultant on the unit on the date of admission, report all evaluation and management services provided by the consultant related to the admission with either the inpatient consultation code (99251-99255) or with the initial inpatient admission service code (99221-99223). Do not report both an outpatient consultation and inpatient consultation for services related to the same inpatient stay. When transfer of care services are provided on a date subsequent to the outpatient consultation, use the subsequent hospital care codes (99231-99233) or subsequent nursing facility care codes (99307-99310)) (CPT 2010 Professional Edition, page 18).

These revisions to the inpatient consultation guidelines stipulate that:

- (1) services provided that are a transfer of care rather than a consultation (refer to previous definitions) and which do not include admission by the same provider should not be reported with these inpatient consultation codes, but rather with the subsequent hospital or nursing facility inpatient codes;
- (2) all outpatient E/M services provided by the consultant related to the admission are included in the inpatient consultation service code (99251-99255), and cannot be separately reported when an inpatient consultation is performed on a date that the patient is admitted to a hospital or nursing facility. This is only true when the patient is seen in the facility on the date of admission. When not seen in the facility, only the outpatient consultation codes can be reported. Subsequent inpatient services can only be reported with the subsequent inpatient service codes (99231-99233, 99307-99310); and
- (3) if an outpatient consultation service results in an agreement to accept responsibility for some or all of the patient's care, and the patient is not seen in the facility on the date of admission, only the subsequent inpatient codes should be reported for services on subsequent dates of service in that facility.

Table 3 below contains a summary of the descriptions of initial inpatient consultation services and the appropriate corresponding CPT codes to report for each.

Table 3: Inpatient Consultations and Corresponding CPT Codes

Inpatient Consultation Description	CPT Code to Report
Physician explicitly agreed to accept responsibility for patient from physician who was managing some or all of the patient's problems	99231-99233 (subsequent care) 99307-99310 (subsequent care)
Physician accepted transfer of care before an initial evaluation	99231-99233 (subsequent care) 99307-99310 (subsequent care)
Physician accepted transfer of care after performing an initial consultation evaluation	99251-99255
Following outpatient consultation other than the date of admission, physician accepted responsibility for some or all of the patient's care when inpatient, and the patient is seen in the facility on a date following admission	99231-99233 (subsequent care) 99307-99310 (subsequent care)

Centers for Medicare & Medicaid Services (CMS) Payment Policy

For Medicare reporting purposes, these instructions regarding consultation services do not apply. Over the years, CMS has implemented a number of payment policies related to the use of consultation codes. As a part of the agency's initial efforts, beginning on January 1, 2008, Medicare no longer accepted Outpatient Prospective Payment System (OPPS) facility claims that included CPT codes for hospital outpatient consultation services. Instead, facility providers were instructed to report the new or established outpatient visit codes 99201-99205, 99211-99215, as appropriate, for all hospital outpatient visits.

The CMS policy for 2010 for consultation services is based on the agency's further observations that consultation services have changed, and that although documentation requirements are similar across all E/M services they believe:

- the consultant's report is no longer the major defining aspect of consultation services, apparently as a result of the CMS' reduction in the required level of formality of consultation reporting and permission for submission of consultation reports in any written form of communication, including a simple copy of the evaluation examination;
- problems persist regarding the education of physicians in the requirements for "dual documentation" (by the referring physician and consulting physician) based on the documentation guidelines; and
- the differentiation of the aspects of care included in the transfer of care versus their consultation policy varies for Medicare patients. CMS plans to publish additional guidance regarding these services and correct reporting.

For these reasons, denial of reimbursement of the CPT inpatient and outpatient consultation codes by CMS became effective on January 1, 2010.