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Clarifying Billing for Consultations

by Roberta L. Buell, M.B.A.

Q: Why am I so confused about when to bill for a consult?

A: Medicare has sent different messages at different times regarding consultations. In early 1999, many of the Medicare carriers distributed information about the inability to bill for a consultation the same day of treatment initiation. A few carriers actually denied or held up claims for consultations when treatment was billed the same day. However, effective August 26, 1999, Medicare published a clarification of the consultation definition in Transmittal Number 1644. The key phrase of this transmittal was "payment may be made regardless of treatment unless a transfer of care occurs. A transfer of care occurs when the referring physician transfers responsibility for *complete* care of the patient at the time of the referral..." This happens rarely in the case of either radiation or medical oncologists.

Q: Does that mean that all *first encounters with cancer patients are consults?*

A: As always, it depends on your documentation. Assuming that the documentation is in order, there is only one instance, I believe, where a consultation should definitely *not* be billed. Sometimes, a patient moves from one area to another and is transferred from one oncologist to another without a change in treatment. I would not consider the first encounter a consult. It should be billed as new patient visit (99201-99205).

Q: What does it take to correctly document a consult?

A: For a new patient, the request by another physician for an oncologist's opinion must be evidenced in the record. The oncologist's opinion about the patient's diagnosis and future treatment plan must also be communicated to the referring physician in a report, letter, or progress note. The key to consultation documentation is two-way communication—from the originating physician to the oncologist and from the oncologist back to the originating physician.

Q: Can you bill only one consult in the life of a patient?

A: Theoretically, you can bill a consult any time the consultant's opinion is sought by the referring physician and the consultant reports his/her findings to the referring physician. However, then the question of medical necessity arises. Medical necessity may be proven when the opinion is for a new problem or one that has not been evaluated for a period of time. For example, the hematologist-oncologist evaluates a patient's anemia. A year later, the patient has colon cancer. Two consults would be medically necessary in this case. It should be noted, however, that some insurance companies have limitations on billing for consults either annually or over the life of the patient.

Q: What if a primary care physician admits a patient, then asks for a consult on one of my ongoing chemotherapy or radiation patients while they are in the hospital?

A: This is a difficult area. If your opinion and treatment plan is necessary for the patient's care in the hospital, then it can be a consult. However, if you are asked to follow the patient in the hospital, then the requirements for billing a consult may not be met. If a patient is transferred to you immediately after admission, it may not meet the requirements for a consult. Again, there are insurance companies that will not allow a consult in this case regardless of the need for it.

Q: What about follow-up consults (99261-99263)?

A: Some oncologists use follow-up consults instead of subsequent hospital visits (99231-99233) because they think that follow-up consults pay more money or that Medicare will pay only one physician for subsequent hospital visits. Neither is true. Since 1995, more than one physician is supposed to be paid for subsequent hospital visits—even if two physicians bill with the same ICD-9-CM code. Recently, we have seen some Medicare carriers start to deny concurrent claims. A possible way to bypass these edits is to use cancer diagnoses.

Q: How should follow-up consults be documented?

A: First, there should be no evidence that the patient is being treated on an ongoing basis by the oncologist. Second, there should be evidence that the oncologist needs to follow-up on the patient (for more diagnostic tests or historical information) or that he/she has been called in again to re-evaluate the patient or patient data.

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