Building Partnerships Between Business and Medicine

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Evaluation and Management CONSULTATIONS (Codes 99241-99245)

When to Code an Evaluation and Management Service as a Consultation

One of the most frequently asked questions is how to determine if an evaluation and management (E/M) service is a consultation. The discreet difference between a consultation and an office visit is that a consultation is provided by a practitioner whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another practitioner. An office visit is deemed a consultation ***only*** when the following criteria for the use of a consultation code are met:

1. Consultation is being performed at the **REQUEST** of another practitioner or appropriate source requesting advice regarding evaluation and/or management of a specific problem
2. The request for the consultation and the reason for the request must be **RECORDED** in the patient's medical record.
3. After the consultation is provided, the practitioner must prepare a written **REPORT** of his or her findings, which is provided to the referring practitioner.

If all the listed requirements are not met then the appropriate office or other outpatient (99201-99215) or hospital inpatient (99221-99223) E/M service should be reported instead of a consultation code.

Some of the confusion in coding consultations begins with the terms used to describe the requested service. The word 'consultation' and the word 'referral' are sometimes incorrectly considered one and the same. When a practitioner refers a patient to another practitioner, it cannot be automatically considered a consultation. The service can only be considered a consultation if the above criteria are met in the service provided. A service provided to a patient who was referred to another practitioner without written or verbal request for a consultation (which is documented in the patient's record) should be coded using one of the office or other outpatient codes or hospital care codes.

The decision to request a consultation is exclusively up to the requesting practitioner. The medical necessity for a consultation is dependent on the clinical judgment of the practitioner. Once the requesting practitioner receives the report from the consulting practitioner, he or she may either continue to manage the patient's condition or request the consulting practitioner to take over the management of the patient's condition from that point forward. If the consulting practitioner chooses to accept management of the patient's condition after the consultation has been completed, the appropriate code from the office or other outpatient or hospital inpatient should be used for any further E/M services provided.

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Examples That Do Not Fulfill the Criteria for Consultations:

- Standing orders in the medical record for consultations
- No order for a consultation
- No written report of a consultation

Which Level to Choose

Once you have determined that the visit meets all the criteria to be considered a consult, the next issue is which level to choose. To select the appropriate level consultation code, all three key components (history, examination and medical decision-making) must meet or exceed the requirements stated in CPT® to qualify for a specific level of E/M service. Refer to the following table:

	Consults				
	If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code				
History	PF	EPF	D	C	C
Examination	PF	EPF	D	C	C
Complexity of Medical Decision	SF	SF	L	M	H
	99241 99251 99271	99242 99252 99272	99243 99253 99373	99244 99254 99274	99245 99255 99275

PF	Problem Focused
EPF	Expanded Problem Focused
D	Detailed
C	Comprehensive
SF	Straightforward Complexity
L	Low Complexity
M	Moderate Complexity
H	High Complexity

Choosing the level using Time as the deciding factor

When is it appropriate to choose the level of E/M Consultation based on time? You may choose the level based on time when you have spent greater than 50% of the total time of the visit in counseling or coordination of care for your patient. The guidelines are very clear as to the proper way to document this occurrence. Your note must show the following:

1. Total time of the visit must be documented.
2. The content of the counseling and/or coordination of care must be documented.
3. The note must clearly state that greater than 50% of the total time was spent in counseling and/or coordination of care.

An example of this documentation is as follows: ***Total visit 30 minutes, 20 minutes spent counseling patient on side effects of medication*** *(99242)*. The times for each level are listed in the table below:

CPT Code	99241	99242	99243	99244	99245	99251	99252	99253	99254	99255
Minutes	15	30	40	60	80	20	40	55	80	110

In Summary

As with any other CPT coding issue, if you have any questions you may refer directly to your current copy of the AMA CPT book.

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