



2010
Medicare Part B Consultation
Coding Changes

1/26/2010 & 1/27/2010





Consultations

- The Centers for Medicare/Medicaid Services (CMS) finalized its proposal to require claims for consultation services be submitted with E&M visit codes rather than consultation codes
- Confusion and disagreement on:
 - Referral, transfer and consultation which are used sometimes interchangeably and sometimes inconsistently, by physicians in clinical settings
- Education efforts regarding consultations were not successful
 - January, 2006 MLN Article
 - Manual changes
 - Open forum calls
 - Responded to numerous questions and inquiries



Consultations

- In 2006 OIG published a report titled:
 - “Consultations in Medicare Coding and Reimbursement.”
- OIG report indicated that Medicare allowed:
 - approximately \$1.1 billion more in 2001 than it should have for services that were billed as consultations.



Consultation

- On January 1, 2010, claims for consultation services must be submitted with E&M visit codes rather than consultation codes for Medicare Part B and Part A payment
 - 99241-99245 & 99251-99255
 - Deleted from 2010 Medicare Physician Fee Schedule
 - Final rule (view 10/30/publish 11/25/09)



Federal Register

- <http://www.gpoaccess.gov/fr/index.html>
- 2009 Volume 74 Only
 - Document 1 – Open PDF
 - Wednesday, November 25, 2009, Book 2 of 2
Pages 61737–62206
 - Federal Register Volume 74, Number 226,
Books, 42 CFR Parts 410, 411, 414 et al.
 - Quick Search – Type the word consultations
 - Search document for consultations



Consultations

- Physicians and qualified non-physician practitioners use code evaluation & management visits to report consultation services based on:
 - **where** visit occurred
 - **complexity** of visit performed
- In all cases, physicians non-physician practitioners will bill the available code that most appropriately describes the level of services provided



Inpatient Facility Setting

- E&M initial care codes used instead of initial consultation codes
 - Initial hospital care 99221 – 99223
 - Initial nursing facility care 99304 – 99306
- Beneficiary may now be billed for more than one initial hospital visit per hospital stay



Inpatient Facility Setting

- Admitting physician will use modifier AI
 - Principal Physician of Record
 - Used by the admitting or attending physician who oversees the patient's care
 - Distinct from other specialty physician care
- Initial hospital and nursing facility visit codes may be billed by different physicians/non-physician practitioners (different specialties) on the same day



Inpatient Facility Setting

- Modifier AI is informational
- Follow-up consultations, in the facility setting, should be billed as
 - subsequent hospital visits 99231-99233
 - 99231 and 99232 can be used to bill consultations services when the services provided best fit the documentation requirements in these code descriptions
 - subsequent nursing visits 99307-99310



Office/Other Outpatient Visits

- In office or other outpatient setting when an evaluation is performed, physicians and qualified non-physician practitioners should code:
 - 99201 – 99215
 - **Complexity** of the visit
 - New patient or established patient (to that physician)
 - A new patient is a patient who has not received any professional services (E/M or other face-to-face service) within the previous three years
- Physicians and qualified non-physician practitioners shall follow E/M documentation guidelines for all E/M services
- All rules apply for Medicare Secondary Payer claims and Medicare Primary claims



Medicare Primary or Secondary Payer

- When Medicare is **primary or secondary**:
 - Physicians *must* submit claims with the appropriate E&M visit code in order to receive payment from Medicare
- Please check with other payers to see if they have changed any policies relating to consultations
- Providers may bill primary payers using the consultation codes, but would need to re-code the service to the appropriate E&M visit code to bill Medicare as secondary
- Alternatively, providers may consider billing the appropriate E&M visit code to the primary in order to facilitate the MSP payment



Observation Care

- For Hospital outpatient observation services, provided to patients who are not subsequently admitted to the hospital as inpatients, the primary should report:
 - 99217-99220
- If evaluation is requested of another physician, the physician who provides that additional evaluation should report:
 - 99201 – 99215



Observation Care

- Patients receiving observation services who are admitted to hospital as inpatients and who are discharged on same date, physician should report
 - 99234-99236



Observation Care

- When Patients receiving observation services are admitted to hospital as inpatients on the same date, the physician should report only initial hospital care services codes
 - codes 99221 - 99223
- Medicare will pay for an initial hospital care service if a physician sees a patient in emergency room and decides to admit patient to hospital



Observation Care

- Patients receiving observation services or inpatient care services (including admission and discharge services) in whom observation services are initiated or hospital inpatient admission begins on same date as patient's discharge, ordering the physician should report:
 - 99234-99236



Emergency Care

- Emergency Department (ED) Codes
 - 99281 – 99285
 - **where** visit occurred
 - **complexity** of visit performed
- For Patients admitted to hospital by personal physician, bill appropriate level of initial hospital care code
 - 99221 – 99223
 - All evaluation and management services provided by that physician in conjunction with that admission are considered part of initial hospital care when performed on the same date as the admission.



Consultations

- Change in reimbursement will be implemented budget neutral manner
- New and established office or other clinic visits may be billed for outpatient consults
 - Work RVU's for new and established office visits increased
- CMS also increased incremental work RVUs for evaluation & management (E&M) codes that are built into 10-day and 90-day global surgical codes



Consultations

- Initial hospital visits may be billed by physicians doing consults in hospital
 - Work RVUs for initial hospital and facility visits increased
- Admitting physician will append AI modifier to
 - 99221–99223



Telehealth Consultation Codes

- Telehealth follow-up inpatient consultations
 - G0406–G0408
- New initial inpatient hospital telehealth consultations
 - **G0425**, typically 30 minutes communicating with the patient via telehealth.
 - **G0426**, typically 50 minutes communicating with the patient via telehealth
 - **G0427**, typically 70 minutes communicating with the patient via telehealth
 - For Telehealth services CMS will crosswalk the RVUs for initial hospital care (99221-99223)



Reminders

- Physicians and qualified non-physician practitioners may bill 2009 consultation service codes for dates of service up to and including December 31, 2009
- Physicians and qualified non-physician practitioners who bill consultation service codes for dates of service after January 1, 2010, will have claim returned
 - message will indicate Medicare uses another code for service



Reminders

- January 1, 2010
 - Physicians and qualified non-physician practitioners code evaluation & management visit codes
 - Select the code for the service based upon the content of the service
 - Duration of visit is an ancillary factor and does not control level of service to be billed unless more than 50 percent of face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) is spent providing counseling or coordination of care



Reminders

- When counseling and/or coordination of care dominates (more than 50 percent) the face-to-face physician/patient encounter or floor time (in the case of inpatient services), time is key or controlling factor in selecting level of service
 - In general, to bill an E/M code, physician must complete at least 2 out of 3 criteria applicable to type/level of service provided. However, physician may document time spent with patient in conjunction with medical decision-making involved and a description of coordination of care or counseling provided. Documentation must be in sufficient detail to support claim.



Reminders

- **Unlisted code 99499 should not be used to code consultation services**



Educational Resource

- Medicare Claims Processing Manual Pub.100-04, Chapter 12 (Updated every quarter)
 - <http://www.cms.hhs.gov/Manuals/IOM/list.asp>
- Telehealth
 - <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6493.pdf>
- Change Request (CR) 6740
 - <http://www.cms.hhs.gov/MLNMattersArticles/2009MMAN/list.asp#TopOfPage>
- Documentation Guidelines
 - http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp



Educational Resources

- 1995 Documentation Guidelines for Evaluation and Management Services
 - <http://www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf>
- *1997 Documentation Guidelines for Evaluation and Management Services*
 - <http://www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf>
- Medicare Claims Processing Manual
 - <http://www.cms.hhs.gov/Manuals/IOM/list.asp>
- *Current Procedural Terminology (CPT)*
 - American Medical Association (800-621-8335) or <http://www.amapress.org>



Thank You!

- Questions?
- Training Assessment available online:
 - <https://www.surveymonkey.com/s/F39P9V9>