CMS Eliminates Medicare Payment for Consultation Codes

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Reasons for Change

- Divergent interpretations
- Lack of proper documentation to support consult code (request, report)
- Continued lack of agreement or understanding of Medicare policy despite numerous educational initiatives
- One of the two goals for development of new codes not panning out
- AMA CPT definition provides no clear definition of transfer of care and is ambiguous and confusing

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Reasons for Change

- Associated physician work for consult is clinically similar to other visits
- Written report not sufficient reason for higher reimbursement as all E/M services require documentation
- Preparation & submission of the consultant's report no longer major defining aspect of consultation but higher payment remains

Effective Date

The changes are effective January 1, 2010



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New Modifier

- New modifier: AI "Principal Physician of Record"
- To be used with inpatient hospital admission codes and initial nursing facility visit code
- In both these settings new modifier will be appended to initial visit code billed by the admitting physician of record

New Modifier

- Admitting physician of record = physician who oversees the patient's care from other physicians who may be furnishing specialty care
- May only be one admitting physician of record per AMA CPT coding rules and Medicare Part B payment policy

Impact on Other Payers

- Concern expressed to CMS by provider community about the effects of this proposal on coordination of payment between CMS and other payers
- CMS basically provided a "non-answer" to this concern by indicating that they have no authority to determine which services will be recognized and paid by other third party payers

Impact on Other Payers

- Medicare will no longer recognize the consultation codes regardless of what other third party payers recognize
- CMS suggests providers consult with the secondary payers in order to receive secondary payment and to determine how those payers want bills to be submitted

Impact on Medicare Secondary Claims

- Medicare will no longer recognize consultation codes submitted on Medicare secondary payer bills
- Per CMS, if the primary payer continues to recognize consult codes, the physician will need to decide whether to bill the primary payer using visit codes (which will preserve the possibility of receiving Medicare secondary payment) or to bill the primary payer with the consult codes which will result in a Medicare secondary payer denial

Code Selection – Office/Outpatient

- Use the appropriate office/outpatient visit code (99201-99205 or 99211-99215)
- Consults were for new <u>and</u> established patients but visit codes are separated into new <u>or</u> established patients
- Refer to definition of new patient for proper code selection
- Visits performed in the OBU by physician other than the physician who admits and is responsible for the patient while in OBU should be coded as office/outpatient visit

Code Selection – Office/Outpatient

- "Preoperative consultations" have been payable for new or established patients performed by a physician or qualified NPP at the request of a surgeon as long as the service was medically necessary and not routine screening
- Use appropriately documented office/outpatient visit code (99201-99205 or 99211-99215) instead of consult codes
- Refer to definition of new patient for proper code selection

Code Selection — Office/Outpatient

Medicare's definition of new patient:

A patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years.

Code Selection – Office/Outpatient

- If an emergency department physician requests that another physician evaluate a given patient in the emergency room, the other or "consulting" physician should bill an emergency department visit unless the patient is admitted to the hospital
- If the patient is admitted to the hospital by the "consulting" physician, the "consulting" physician would bill the appropriate initial hospital care code (OBU or inpatient)

Code Selection – Office/Outpatient

- If there is any silver lining or positive spin on this change it is that Medicare policy did not allow consults to be billed as shared encounters between physicians and NPPs but the shared visit policy can be applied to initial hospital care visits
- Refer to <u>Medicare Claims Processing Manual</u> Internet Manual 100-04, chapter 12, § 30.6.1 (B)

Code Selection – Inpatient Hospital

- Inpatient consult codes (99251-99255) replaced with initial hospital care codes (99221-99223)
- Use prolonged attendance codes to take into account face-to-face times over and above the times specified in the admission codes
- "Consulting" physician would never bill 99234-99236 as not admitting physician of record so could not discharge same day as admit

Code Selection – Inpatient Hospital

- Admitting physician of record bills initial inpatient visit as appropriately documented initial inpatient hospital care code in range of 99221-99223 and appends designated modifier
- "Consultant" bills initial encounter as appropriately documented initial inpatient hospital care code in range of 99221-99223 but does NOT append designated modifier
- Subsequent encounters coded as subsequent hospital visits (99231-99233) by both admitting physician of record and any "consultants"

- Initial visit in a SNF must be furnished by a physician
- Initial visit in a NF may only be furnished by an enrolled NPP, **not** employed by the facility, when state law permits this
- Follow same provider restrictions for readmissions to SNFs or NFs
- Refer to <u>Medicare Claims Processing Manual</u> Internet Manual 100-04, chapter 12, § 30.6.13A

- Both admitting physician of record and "consultant" bill an initial nursing facility care code (99304-99306 range) for their first visit during a patient's admission to the nursing facility
- Admitting physician of record appends designated modifier to initial nursing facility care code
- "Consultant" does NOT append designated modifier
- If "consultant" an NPP, refer to <u>Medicare Claims</u>

 <u>Processing Manual Internet Manual 100-04, chapter</u>
 12, § 30.6.13A

 Use prolonged attendance codes to take into account face-to-face times over and above the times specified in the admission codes

• Subsequent encounters (other than discharge) are to be coded as subsequent nursing facility care codes (99307-99310) by both admitting physician of record and any "consultants"

Impact on Global Surgery Allowance

- CMS agreed to extend the incremental work RVU increase to the E/M codes that are built into procedures with global packages of 10-day and 90-day follow-up periods
- Increases in payments for these services will be small because visits are a small portion of the total global payment

Budget Neutrality & Fee Change Crosswalk

- CMS will make this change budget neutral for the work RVUs by increasing the work RVUs as follows:
 - New and established office visits by @ 6%
 - Initial hospital and nursing facility visits by @ 2%
- Crosswalk developed solely for purposes of making the requisite budget neutrality calculations
- Crosswalk is <u>not</u> for coding
- Estimations used on creating crosswalk based on standard assumptions and utilization data

Telehealth Consults

- HCPCs Level II G-codes to be created for <u>initial</u> inpatient consults delivered via telehealth
- Currently there are only HCPCs Level II codes for inpatient follow-up telehealth consults
- Consults furnished via telehealth can facilitate provision of certain services and/or medical expertise that might not be available to a patient located at an originating site
- RVUs to be crosswalked to initial hospital care codes 99221-99223

Consult Coding Conversion Chart

Consult Code	POS	Code for New Outpatient Visits or Initial Inpatient Visits	Code for Established Outpatient Visits or Subsequent Inpatient Visits		
99241	11	99201-99205	99211-99215	11 =	Office
99242	11	99201-99205	99211-99215	1	
99243	11	99201-99205	99211-99215	1	
99244	11	99201-99205	99211-99215	1	
99245	11	99201-99205	99211-99215	1	
99241	22	99201-99205	99211-99215	22 =	Outpatient
99242	22	99201-99205	99211-99215	1	Hospital
99243	22	99201-99205	99211-99215	1	
99244	22	99201-99205	99211-99215	1	
99245	22	99201-99205	99211-99215	1	
99241	23	99281-99285	99281-99285	23 =	Emergency
99242	23	99281-99285	99281-99285	l	Room
99243	23	99281-99285	99281-99285	1	
99244	23	99281-99285	99281-99285	1	
99245	23	99281-99285	99281-99285		
99251	21	99221-99223	99231-99233	21 =	Inpatient
99252	21	99221-99223	99231-99233	l	Hospital
99253	21	99221-99223	99231-99233	l	
99254	21	99221-99223	99231-99233	l	
99255	21	99221-99223	99231-99233		
99251	31	99304-99306	99307-99310	31 =	Skilled
99252	31	99304-99306	99307-99310	I	Nursing
99253	31	99304-99306	99307-99310	I	Facility
99254	31	99304-99306	99307-99310	I	
99255	31	99304-99306	99307-99310		
99251	32	99304-99306	99307-99310	32 =	Nursing
99252	32	99304-99306	99307-99310	I	Facility
99253	32	99304-99306	99307-99310	I	
99254	32	99304-99306	99307-99310	I	
99255	32	99304-99306	99307-99310		

Q&A

- Q: Will we have to remove consults from our superbills or encounter forms?
- A: No. Payors other than Medicare will still recognize consultation codes.
- Q: Will this have an impact on our current referral process or appointment scheduling process?
- A: No. The only difference is the code selected when a charge is billed to Medicare.
- Q: Why can't we just crosswalk the consult codes to visit codes for Medicare?
- A: Because there are different service and documentation requirements for visits than there are for consultations. The proper visit code must be selected based on the patient's status and the level of care provided and documented.
- Q: What happens if I accidentally bill a consultation code to Medicare?
- A: Medicare would deny the charge. Once the denial was received, the business group could rebill Medicare with the correct procedure code. Compliance is working with the faculty practice plan to initiate a system edit which would prevent the billing of consultation codes to Medicare.

References

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- The American Medical Association. CPT 2009 Professional Edition.
- CMS. Transmittal 808. Change Request 4246. "Nursing Facility Services (Codes 99304 99318)." January 6, 2006.

Questions?

Call the UFJHI Office of Physician Billing Compliance at (904) 244-2158



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