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Consultation Codes Eliminated……New Coding, Documentation and Billing Guidance

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Provider Education   Chart Audits   Coding Certification

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Introduction

After January 1, 2010 CMS will not longer pay for Consultation Services. This change will present significant documentation, coding and billing implications to specialty physicians and primary care physicians providing consultative serves at the request of another healthcare provider.

Problem Statement

The current physician visit and consultation codes were developed by the AMA in November 1990. A consultation is an evaluation and management (E/M) service furnished to evaluate and possibly treat a patient's problem(s). It can involve an opinion, advice, recommendation, suggestion, direction, or counsel from a physician or qualified NPP at the request of another physician or appropriate source. A consultation service must be documented and a written report given to the requesting professional.

A consultation request between professionals may be done orally by telephone, face-to-face, or by written prescription. The request must be documented in the medical record of the requesting physician.

NPP's may request and furnish consultation services within their scope of practice and licensure requirements. They must bill under their own NPI as the consultation services do not meet the criteria for "Incident to" or "Split Visit" billing.

Medicare consistently audited consultations and found that the documentation did not meet the consultation guidelines based on:

1) type of service
2) level of service
3) intent – sent for treatment, not advice

Previous Instructions

Consultation services were required to be documented in the requesting physician's plan of care in the medical record as a condition for Medicare payment. The E/M documentation guidelines which apply to all E/M visits or consultations (http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp) clearly state that when referrals are made, consultations are requested, or advice is sought, the medical record should indicate to whom and where the referral or consultation is made or from whom the advice is requested. Medicare contractors were instructed to look at both the requesting physician's medical record (where the request should be noted) and the consultant's medical record where the consultation is reported, and at the report generated for the requesting physician. In March 2006 the Office of the Inspector General (OIG) published a report entitled "Consultations in Medicare: Coding and Reimbursement" (OEI-09-02-00030). The OIG conducted a study and found approximately $1.1 billion more was paid in 2001 because consultations did not meet the criteria stated above.

CMS Solution

Beginning January 1, 2010 CMS will eliminate the use of all consultation codes (inpatient and office/outpatient codes for various places of service except for telehealth consultation G-codes). CPT ranges 99241-99245 and 99251-99255 should not be reported to "Original" Medicare for consultation services provided to Medicare patients. CMS has increased the work RVU's for initial hospital and initial nursing facility visits, and is incorporating the increased use of these visits into their PE and malpractice RVU calculations.

Implementation

Physicians and practitioners furnishing initial inpatient consultations in a face-to-face encounter to hospital inpatients must utilize initial hospital care codes (as described by CPT codes 99221 through 99223). Practitioners who provide an initial consultation in the SNF setting will report the service with CPT codes 99304 through 99306.

Because of an existing CPT coding rule regarding the admitting physician (previously the only provider allowed to report 99221-99223) the modifier "AI" will distinguish the admitting physician of record who oversees the patient's care from other physicians who may be furnishing specialty care. The admitting physician of record will be required to append the specific modifier to the initial hospital care or initial nursing facility care code which will identify him or her as the admitting physician.

Subsequent care visits by all physicians and qualified NPPs will be reported as subsequent hospital care codes (99231 through 99233 for inpatient, 99217-99220 for Observation) and the subsequent nursing facility care codes (99307-99310) as appropriate.

For office consultations, the physician must crosswalk to the 99201-99205 if the patient has not received professional services from this physician, or another physician of the same specialty within the past 36 months. If the patient is "established" the consultation visit will be reported using 99211-99215.

The use of a hospital card or reference sheet will aid the physician in correctly coding their consultation services.

Summary

This change will bring operational challenges to the billing department. Verification of the primary insurance, and determining if the beneficiary is actually an "Original Medicare" recipient, and not a "Medicare Advantage" enrollee is a critical step, as these changes apply to CMS and do not apply to Medicare Advantage, or any other payer. It will be impossible to correctly code without knowing the correct primary payer.

Processing crossover claims may require re-coding, unless the Medicare Secondary Payer will accept the claim as submitted to the MAC and will pay according to the EOMB. Other questions arise regarding pricing, since the 20% co-payment after Medicare pays their allowed amount on a 99214 may be less than the physician would have received if the Consultation codes 99241-99245 were submitted to the non-Medicare payer.