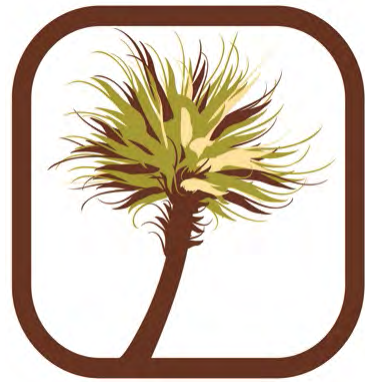


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Palmetto GBASM
PARTNERS IN EXCELLENCESM

Revisions to Consultation Services Payment Policy

OH/WV/SC

January 6, 2010

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Objectives

- Provide background on deletion of consultation services
- Discuss general information affecting these services
- Introduce new HCPCS modifier “AI”
- Review the effects of the deletion for different types of services
 - Initial Hospital
 - Initial Nursing Facility
 - Office/Outpatient Visits
 - Emergency Room Visits
 - Observation Services
- Identify resource locations for the topics listed above

Background

- Problems were detected as far back as the early 90s
- Interpretations and definitions of consultations varied by providers and carriers
- The Centers for Medicare & Medicaid (then called the Health Care Financing Administration, or HCFA) had been working with the provider community by providing:
 - Examples in the manuals
 - More lenient guidelines, i.e., paying for a consultation whether treatment was initiated at the consultation visit or not
 - Manual revisions providing more detailed instructions/information
- Interpretations and definitions of consultations varied by providers and carriers
- AMA CPT code manual, which is not a payment manual, did not specify the requirements in detail, which further confused providers

Background

- In March 2006, the Office of the Inspector General (OIG) published a report, “Consultations in Medicare: Coding and Reimbursement.”
 - Based on claims paid by Medicare in 2001
 - Medicare allowed approximately \$1.1 billion more in consultations than should have been allowed
 - Approximately 75% of services paid did not meet the Medicare requirements
- Medicare continued diligently to educate providers by:
 - Working with the AMA
 - Publishing articles
 - Revising published manuals
 - Reviewing documentation less stringently

General Information

- Effective for dates of service on or after January 1, 2010:
 - CMS is eliminating all consultation CPT codes (inpatient and office/outpatient codes) for various places of services except for telehealth consultation G-codes
 - Work relative value units (RVUs) will increase for new and established office visits, initial hospital visits and initial nursing facility visits
 - Practice expense and malpractice calculations will incorporate increased use of the above visits
 - Incremental work RVUs will increase for evaluation and management (E/M) codes that are built into the 10-day and 90-day global surgical codes

General Information

Select the correct code for E/M visits based on where the visit occurs and the complexity of the visit performed

Inpatient Hospital and Nursing Facility Settings

- All physicians (and qualified nonphysicians where permitted) who perform an initial E/M may submit (depending on place of service):
 - Initial hospital care CPT codes (99221-99223)
 - Initial nursing facility care CPT codes (99304-99306)
- There may be multiple claims for these initial visits for one patient on the same date

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HCPSC Modifier AI

- Defined as “Principal Physician of Record”
- Submitted by the admitting or attending physician who oversees the patient’s care
- Distinguishes admitting/attending physician services from the services of other physicians performing specialty care
- Submit with the initial visit
- All other providers who perform the initial evaluation: submit only the E/M code based on the complexity of the visit (do not submit HCPSC modifier AI)

Office or Other Outpatient Setting

- Submit CPT codes 99201-99215 depending on the complexity of the visit and whether the patient is new or established (within 3 years)

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Emergency Department Visits

Physician	Situation	Submit
ED physician	Sees patient in ED; on advice of patient's personal physician, sends patient home	Appropriate level of emergency department service
Patient's personal physician	Sees patient in ED	Appropriate level of emergency department service
Patient's personal physician	Advises the emergency department physician by telephone, but does not see patient	May not submit a claim
Non-ED physician	Sees patient at the request of the ED physician	Appropriate level of emergency department service
Non-ED physician	Sees patient at the request of the ED physician and admits patient	Appropriate level of initial hospital care (with HPCPCS Modifier AI)

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Hospital Observation

- The initial observation care code is for all the care rendered by the “ordering” physician on the date the patient’s observation service began
- All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient services must submit the appropriate outpatient service codes.

Example: If the Internist orders observation services and asks another physician to additionally evaluate the patient, only the internist may submit the initial observation care code. The other physician who evaluates the patient must submit the new or established office or other outpatient visit codes as appropriate

Frequently Asked Question

Q: How will the deletion of consultation CPT codes affect the submission of secondary claims to Medicare?

A: If the consultation codes are submitted to the primary payer, you must convert the codes to an appropriate E/M code before submitting to Medicare.

Another option is to use the appropriate E/M code when submitting claims to the primary payer. (This option may be easier from a billing perspective.)

Frequently Asked Question

Q: Can I bill a subsequent hospital CPT code (99231-99233) if my documentation does not support one of the three levels of initial hospital services (99221-99223)?

A: Services that do not meet the minimal documentation requirements for the initial hospital services (99221-99223), would not be submitted as a subsequent hospital visit; however, these services may be submitted as the unlisted CPT code 99499.

Resources

- Internet-Only Manuals
 - Pub.100-04 Chapter 12:
<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>
- MLN Matters Article
 - MM6740- Revisions to Consultation Services Payment Policy :
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf>
 - Current Procedural Terminology CPT 2010
- Final rule: www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/list.asp
 - Select the **CMS-1413-FC** link
 - Select **CMS-1413-FC (Published November 25, 2009)** located at bottom of page under “*Related Links Outside CMS*”