Billing Medicare for Consultations is History

On October 30, the Centers for Medicare & Medicaid Services (CMS) released the 2010 final rule on Medicare physician payments. In the absence of Congressional action so far for the 2010 physician update, the final rule not only reduces the conversion factor for services on or after Jan. 1, 2010 by -21.2%, resulting in a conversion factor of $28.4061 it also makes multiple other policy changes that significantly affect oncology.

Elimination of Consultation Codes
Effective January 1, 2010 CMS will eliminate the use of all consultation CPT codes. This includes inpatient codes (99251-99255) and office/outpatient codes (99241-99245) for various places of service, except for telehealth consultation G-codes.

Instead of consultation codes, providers are instructed to bill initial hospital care (99221-99223), initial nursing facility care (99304-99306) or initial office visits (99201-99205 – payable once every 36 months) or established office visits (99211 – 99215), as applicable.

In order to distinguish the admitting physician from others using the initial care codes, CMS will create a modifier the admitting provider will append to the initial care code to identify the admitting provider of record. Others will simply bill the applicable initial care code without a modifier whenever a new patient is seen for the first time.

CMS proposes to implement this rule in a budget-neutral way by ***increasing*** the work RVUs for initial hospital and nursing facility visits by about 0.3%, and increasing the work RVUs for both new and existing office visits by about 6%. In addition, CMS will adjust the practice expense and malpractice expense RVUs for the initial visit codes to recognize the increased use of these visits.

The documentation requirements for consultations will no longer be applicable; physicians will only need to meet the applicable E&M documentation requirements for the initial visit code selected.

Implications for our practices:

*For MEDICARE, you will no longer use the consultation codes for office and hospital consultations.

*For consultations, you will no longer need to document the name of the requesting provider or provide a written consultation report (except as may be medically appropriate).

*For office consultations, you will use a New Patient or Established Patient visit code. (New patient codes can only be used once in 36 months)

*For hospital consultations, you will use an Initial visit code instead of the current consultation code.

*For transfers of care, you will bill an initial visit code instead of the current subsequent visit code.

*Admitting physicians must append a modifier to identify themselves as the "admitting physician of record who is overseeing the patient's care."

*Subsequent visits will still be billed using the subsequent visit codes.

To read the consultation change portion of the "CMS 2010 Final Rule" posted on Federal Register, use the link below and review pages 162 through 206 of the PDF document. The summary is located on pages 201 – 206. http://www.federalregister.gov/OFRUpload/OFRData/2009-26502_PI.pdf

PRIVATE PAYER IMPACT

Since the consultation codes have remained in the 2010 AMA CPT, many are wondering what affect this CMS change will have on private payers. It is unknown at this time but CMS is aware of the potential confusion and clearly advises when they are billed as the secondary payer, they will NOT reimburse the consultation codes even when they are approved by the primary payer.

On page 195 of the PFS Final Rule, CMS states:

"We do not have the authority to determine which services will be recognized and paid by other third party payers. Some payers may choose to adopt this policy subsequent to this final rule. In cases where other payers do not adopt this policy, physicians and their billing personnel will need to take into consideration that Medicare will no longer recognize consultation codes submitted on bills, whether those bills are for primary or secondary payment. In those cases where Medicare is the primary payer, physicians must submit claims with the appropriate visit code in order to receive payment from Medicare for these services. In these cases, physicians should consult with the secondary payers in order to determine how to bill those services in order to receive secondary payment. In those cases where Medicare is the secondary payer, physicians and billing personnel will first need to determine whether the primary payer continues to recognize the consultation codes. If the primary payer does continue to recognize those codes, the physician will need to decide whether to bill the primary payer using visit codes, which will preserve the possibility of receiving a secondary Medicare payment, or to bill the primary payer with the consultation codes, which will result in a denial of payment for invalid codes."

I guess this means…. time will tell and it is something we will have to watch VERY closely. All practices should do an analysis. If reimbursement for the consultation codes is higher than the visit codes for the private payer, offices will most likely continue to submit the consultation codes to the primary payer in 2010.

Change is inevitable. Change is constant.
Benjamin Disraeli

A common truth in healthcare is, "The only constant is change." It appears the consultation changes are being implemented as a method to "make our lives easier" or "clear up the confusion." Well, the jury is still out on this one.