Medicare changes coding policy for consultation services

By Matthew Twetten

Change may not affect other providers

As of Jan. 1, 2010, Medicare stopped recognizing Current Procedural Terminology (CPT) codes for consultation services (CPT codes 99241–99245 and 99251–99255). Although this is a significant change in Medicare payment policy, commercial payors have not yet adopted similar guidelines for consultation services.

In December 2009, an informal survey of commercial payors found that most are reviewing their current policies in light of Medicare’s new policy. Several payors indicated they will not follow the Medicare policy and will continue to use the consultation codes. No payors indicated that they will follow the Medicare policy.

In light of this, AAOS advises members to continue to use the consultation CPT codes for all non-Medicare payors. Surgeons should check with each individual commercial payor to determine whether that payor will continue to accept the 99241–99245 and 99251–99255 codes.

Background

An end to payment for consultation codes was included in the proposed regulations to the physician fee schedule issued by the Centers for Medicare and Medicaid Services (CMS) and published in the July 7, 2009 Federal Register.

At that time, the AAOS commented on the proposal and submitted its recommendations to CMS.

The shift away from consultation codes is part of CMS’ efforts to ensure reliable and consistent use and reimbursement of Evaluation and Management (E/M) CPT codes. CMS proposed to make these changes budget-neutral by distributing the generated savings throughout the office visit and initial hospital and facility visit codes.

To offset the decreased compensation that physicians might experience as the result of stopping payment for consultation codes, CMS increased the compensation for the new Medicare patient E/M visits, established Medicare patient E/M visits, and initial Medicare inpatient visits.

Payments by Medicare for new and established E/M visits are 6 percent higher in 2010 than they were in 2009, and payments for initial inpatient visits have increased by 2 percent. Medicare has also increased payment for all 010 and 090 global period codes with office visits built into their relative value units (RVU) by 0.03 percent. Table 1 shows the impact on RVUs as a result of this rule change.

Additionally, for initial hospital and nursing facility visits, CMS proposed requiring the admitting physician to append a modifier to initial care codes, which would allow specialist physicians providing consultative services to also bill the initial care codes.

What the change means

When billing Medicare, providers will be required to use other E/M codes when they provide services that were previously coded as consultations.

Specifically, for office or outpatient consultations, Medicare will not recognize CPT codes 99241–99245 but will instead require providers to bill these services as new (99201–99205) or established (99211–99215) office/outpatient visits.

For inpatient consultations, Medicare will not recognize codes 99251–99255 but will instead require providers to bill these services as initial inpatient patient visits (99221–99223). The following examples show how AAOS members...
should now bill consultation services to Medicare.

**Example 1**—A surgeon sees a Medicare patient in the office for a consultation for another provider in the area. The patient is either new or established, depending on whether he or she has been seen at least once in the previous 36 months by the surgeon or any partner of the surgeon who bills under the same Medicare identification (ID) number.

If the Medicare patient is a new patient (one who has not been seen in the previous 36 months by the surgeon or a billing partner), the surgeon will bill the consultation visit as a new patient visit at the appropriate level (1 through 5) using CPT codes 99201–99205.

If the Medicare patient is an established patient (one who was seen during the previous 36 months by the surgeon or a billing partner), the surgeon will bill the consultation visit as an established patient visit at the appropriate level (1 through 5) using CPT codes 99211–99215.

**Example 2**—A surgeon is called into the emergency department by another provider for a consultation for a Medicare patient.

If the patient doesn't require an admission to the inpatient facility, the surgeon should bill the visit as an emergency department visit using CPT codes 99281-99285 at the appropriate level (1 through 5).

If the patient does require admission to the inpatient facility, the surgeon should bill the visit as an inpatient initial inpatient visit code using CPT codes 99221-99223 at the appropriate level (1 through 3) and add the inpatient admitting modifier "AI".

**Example 3**—A surgeon is called into the hospital by another provider for a consultation for a Medicare patient. In this situation, it doesn’t matter if the surgeon or any partner of the surgeon has ever seen the patient, the surgeon should use the appropriate level of initial inpatient visit codes (level 1, level 2, or level 3) using CPT codes 99221–99223.

The crossover for inpatient consultation services from CPT codes 99251–99255 to CPT Codes 99221–99223 is not direct because initial inpatient visits have only three E/M levels whereas inpatient consultation services have five E/M levels. Surgeons should use the appropriate initial inpatient visit level based on the time and effort of the visit.

In addition, Medicare requires the requesting physician in the hospital to apply an AI modifier to his/her claim for the initial inpatient visit. This will enable Medicare to recognize the separate claim by the consulting physician. If the requesting physician does not apply the AI modifier, the claim will be denied; Medicare will not recognize two initial inpatient visits for the same patient on the same day by two different providers.

The same rules will apply in reverse if a surgeon requests an inpatient consultation from another surgeon. The requesting surgeon must submit his/her claim with the AI modifier for the requested surgeon to get his/her claim paid.

**How will this affect you?**

Many questions on the implications of this change are still unanswered. For example, does the provider bill an office/outpatient visit or an initial inpatient visit if he or she provides a consultation in the emergency department and then admits the patient to the hospital? In example 3 above, if the requesting physician is not the admitting physician, how does the consulting provider ensure that the admitting physician adds the AI modifier? What if a primary care physician requests consultations from an orthopaedic surgeon, a neurosurgeon, and a thoracic surgeon for a trauma patient? Presumably, the primary care physician would use the AI modifier, and each of the surgeons would bill using the initial inpatient visit code. This situation, however, could trigger a carrier review that would delay payment. As these and other questions are answered, the AAOS will update members through **AAOS Now** and **AAOS Headline News Now**.

The AAOS has developed a spreadsheet that AAOS members can use to calculate the fiscal impact on their practices as a result of this change. The impact will vary from practice to practice depending on the practice’s ratio of consultation services to new/established office/outpatient and inpatient patient visits.

The average orthopaedic surgeon has a 6 to 1 ratio of Medicare new/established office/outpatient and inpatient patient visits to Medicare consultation visits. A provider with a higher ratio of new/established and inpatient visits to consultation visits will likely gain revenue as a result of the rule change and a provider with a lower ratio will likely lose revenue as a result of the rule change.

The impact on all of orthopaedic surgery is anticipated to be basically even (no net increase or decrease) as a result...
of the rule change.

View the spreadsheet program (PDF)

If you have questions about the change or about how to use the impact calculator, contact me at (847) 384-4338 or twetten@aaos.org

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E/M guideline changes

Certain definitions in the Evaluation and Management (E/M) guidelines have been changed for 2010 to accommodate the shift from consultation codes to new or established patient codes for Medicare patients.

Concurrent care—Concurrent care occurs when two or more physicians provide care to the same patient. Key to reporting is the documentation of medical necessity of each physicians’ role in the management of the patient’s condition. The orthopaedic surgeon reporting concurrent care services will report the appropriate hospital CPT code and use an orthopaedic diagnosis as the primary diagnosis. Appropriate co-morbid conditions should be listed as secondary or tertiary diagnoses.

Transfer of care—Transfer of care occurs when a physician transfers care of and responsibility for a patient to another physician who agrees to accept responsibility and who, from the beginning, is not providing a consultation service.

A physician should not report a consultation code if he or she accepts the transfer of care before providing an initial E/M service.

With the shift in Medicare payment policy, physicians should report the appropriate new or established patient codes in lieu of using consultation codes. If Medicare is the secondary payor, physicians should report either the new or established patient visit codes to the primary private payor, or take a denial by Medicare when the primary payor crosses over the consultation service.

AAOS Now
January 2010 Issue