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CMS Eliminates Consult Codes

In the July 13 Federal Register, CMS announced a proposal to eliminate payment for consultation codes starting on Jan. 1, 2010. The plan includes non-payment for all inpatient (99251-99255, Inpatient consultation for a new or established patient …) and outpatient (99241-99245, Office consultation for a new or established patient …) consultation codes.

Although CMS has halted payment for the in-office consultation codes (99241-99245, Office consultation for a new or established patient …) and inpatient consultation codes (99251-99255, Inpatient consultation for a new or established patient …) in 2010, the AMA chose not to delete them, keeping them in the CPT manual for another year.

Keep in mind: The fact that the consult codes appear in CPT 2010 is no indication of whether payers will actually cover the services this year. Medicare published the final rule on the fee schedule and did adopt the proposal to no longer pay for the consultation codes. Private payers may also follow suit and eliminate consultation payment.

The problem is that the elimination is only a CMS issue and not a private payer elimination. The AMA has kept consultations in the CPT manual and we will have to manage who does and who does not allow consultation. If you think getting a request for opinion was hard before, this will be worse, since no one knows who will require one, with the only surety being that CMS does not.

Instead of reporting consult codes, you will report an initial hospital or an initial nursing home visit or a new or established patient office visit (E/M) code for these services.

In the past, only the admitting physician reported initial hospital care codes (99221-99223, Initial hospital care …), and specialists who saw the patient subsequently and separately often billed inpatient consultation codes.

With the no-pay policy on consult codes, CMS is poised to allow specialists to bill initial hospital care for their first visit with an inpatient. If you perform a consultation in the hospital, you should use an initial hospital visit code (99221-99223) or subsequent hospital visit code (99231-99233), according to Medicare's new consultation guidelines for 2010.

"Stop thinking of 99221-99223 as admit codes," cautioned Peter A. Hollmann, MD, the AMA CPT editorial panel vice chair, at the AMA CPT and RBRVS 2010 Annual Symposium in Chicago. These codes are for initial hospital care that a physician provides. A consultant might see an inpatient who has been in the hospital for several days. If the physician is providing initial hospital care, he can use 99221-99223 even if he provides the care on a day subsequent to the admission day.

Catch: More than one physician can now use an initial hospital care code for the same patient. If two physicians from different specialties are both consulting on a patient for the first time, both physicians will use the initial hospital care code.

Each physician will be able to bill from the 99221- 99223 code range only once, after which he or she will report subsequent hospital care codes (99231-99233, Subsequent hospital care, per day, for the evaluation and management of a patient …) for follow-up hospital visits.

Primary care physicians who perform the majority of admissions are to append modifier AI (Principal physician of record) to the initial hospital care CPT code to indicate their role as the admitting doctor. The physician of record will use the initial code with a modifier, all other submitted claims for initial hospital care codes will presumably be for consultations.

Possible payment delays: If no one uses the modifier, the claim will be subject to medical review. So if the admitting physician does not append modifier AI on a 9922x claim, your initial hospital care code payment could be held up. While it has been said that the AI modifier is informational only and the nonuse by the admitting doctor will not hold up claims, experience would indicate otherwise

Multiple physicians using the same hospital codes sounds like a recipe for denials, but nevertheless that's what Medicare is instructing physician inpatient consultants and care coordinators to do. Whether carriers will then deny these submissions as representing coordination of care or inpatient admission edits, policies and rules will be contractor specific.

Support Multiple Initial Hospital Care With Diagnosis Codes

Proper diagnosis coding is always important, but now that more than one physician can report initial hospital care, your ICD-9 codes better prove why two MDs are necessary for the same patient's hospital care.

Separate ICD-9 codes will help substantiate the medical necessity for providing consultative services. If an auditor reviews your hospital code (99221-99223) documentation, different diagnoses will show why more than one physician's E/M examination was necessary for the same patient. If two physicians from different specialties are treating the same problem, there needs to be a clear medically necessary reason why the additional physician is there, said William J. Mangold, Jr., MD, JD, Noridian Administrative Services' (Arizona, Montana, Utah, Wyoming) Medicare contractor medical director.

Providers should include the reason (s)he needed to see the patient. Separate diagnoses will not make a big difference in the initial claim processing phase, they will, however, help support medical necessity. Plus, different diagnoses will be especially important for follow-up care (99231-99233). As in the past, having unique and different diagnoses on their follow-up codes is still critical for your physicians in order to avoid concurrent care denials.

In conclusion, Providers will have to submit both the consult code and the appropriate E/M code (based on the specificity documented) in order for the proper codes to go out based on insurance payer. If Medicare is secondary, ABI will have to submit consult code to commercial and then change code to corresponding E/M code and file corrected claim upon denial from Medicare.

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