CMS Eliminates the Use of Consultation Codes for Medicare Patients – 01/01/2010
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To end the confusion regarding whether a referred patient should be coded as a consultation or transfer of care, CMS has finalized their proposal to stop making payment for consultation codes other than the telehealth consultation "G" codes. This change begins with dates of service on or after January 1, 2010. The resulting savings from this decision have already been redistributed to increase payments for the existing evaluation and management (E/M) services. CMS has also adjusted the payment for the surgical global periods to reflect the higher value of the office visits furnished during the global period. This redistribution will probably result in nominal increases in payment for 2010 surgical procedures.

Although consultation codes are still included in *CPT 2010* as of January 1, 2010, in lieu of reporting 99241-99245 for Medicare patients seen in the office and outpatient settings, physicians will report new and established office or other clinic visits using 99201-99215. In the Emergency Department setting, in lieu of reporting codes 99241-99245 for Medicare patients, physicians will report 99281-99285.

Effective January 1, 2010, outside the context of telehealth services, in lieu of reporting 99251-99255 for Medicare patients, physicians will bill an initial hospital care (99218-99220, 99221-99233) or an initial nursing facility care code (e.g., 99304-99306) for their first visit during a patient's admission to the hospital or nursing facility. Because of an existing *CPT* coding rule and current Medicare payment policy regarding the admitting physician, CMS is creating a modifier to identify the admitting physician of record for hospital inpatient and nursing facility admissions.

For operational purposes, this modifier will distinguish the admitting physician of record who oversees the patient's care from other physicians who may furnish 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 of record who is overseeing the patient's care. Subsequent care visits by all physicians and qualified nonphysician practitioners will be reported as subsequent hospital care codes and subsequent nursing facility care codes.

In the final rule, CMS cautioned physicians against misinterpreting this new coding requirement. While CMS is discontinuing the use of the consultation codes, this decision does not imply discontinuing payment for consultation services. CMS is only discontinuing the payment differential between consultations and visits. These services will continue to be reported, coded, and paid under the Medicare Physician Fee Schedule.

Newby Consulting, Inc. (NCI) has already received the following questions about this new rule

1. What is the modifier admitting physicians of record will be required to use? – We don't know yet! We will write a follow-up article as soon as we know the answer. In the meantime, NCI recommends closely monitoring the Medicare contractor's listserv articles for additional information.

2. Do I have to send a written report to the referring physician? – Physicians must meet the documentation and medical necessity requirements for the code selected as with all other visit services. These E/M codes do not have any requirements for a written report to the referring physician or nonphysician practitioner. Physicians should consider other issues, e.g., continuity of care, coordination of care, the referring physician/nonphysician practitioner's expectation, etc., to decide whether some type of report (written/oral) is necessary.

3. Can/should we continue to use consultation codes for other payers? – CMS responded to this question in one of their response to comments made:

   Comment: A number of commenters expressed concern about the effects of this proposal on coordination of payment between CMS and other payers. The commenters believe that if other payers continue to recognize consultation codes, the result could be confusion, erroneous billings, and serious delays or even denials of payment.

   Response: We *[CMS]* 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**.

4. How do we report initial telehealth consultations? – CMS has developed the following *HCPCS* codes specific to describe initial inpatient consultations approved for telehealth:

   G0425 Initial inpatient telehealth consultation, typically 30 minutes communicating with the patient via telehealth.
   G0426 Initial inpatient telehealth consultation, typically 50 minutes communicating with the patient via telehealth
   G0427 Initial inpatient telehealth consultation, typically 70 minutes or more communicating with the patient via telehealth.

   The purpose of these codes is solely to preserve the ability for practitioners to provide and bill for initial inpatient consultations delivered via telehealth. These codes are intended for use by practitioners when furnishing services that meet Medicare requirements relating to coverage and payment for telehealth services. Practitioners will use these codes to submit claims to their Medicare contractors for payment of initial inpatient consultations provided via telehealth. Physicians should refer to the CMS Internet-Only Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, Section 190.6.1 for instructions for submission of interactive telehealth claims.)

   [As previously stated,] outside the context of telehealth services, physicians will bill an initial hospital care or initial nursing facility care code for their first visit during a patient's admission to the hospital or nursing facility in lieu of the consultation codes these physicians may have previously reported.