

2010 Major Coding Change

Medicare will no longer recognize consultation codes starting 1/1/10.

To avoid denials, it is imperative that your providers and coding/billing staff are aware of the changes and what your process will be to submit claims correctly. When final details are available from CMS, FHC plans to create a tool that will assist providers with this change.

What is the change to consultation codes?

The consultation codes (99241-99245 for office/outpatient and 99251-99255 for inpatient) are still in the CPT manual for 2010, but will **not** be recognized by Medicare starting 1/1/10.

Does that mean we can't perform consultations for Medicare patients anymore?

No. Your providers will still be providing the same service, but it will need to be reported differently to Medicare.

Why did Medicare do this?

CMS has identified that 75% of the claims for consultations received over the past several years did not have documentation supporting the services as consultations, resulting in billions of dollars paid out in error. They point to a general lack of understanding of the use and documentation requirements for consultations.

How will we report the services to Medicare starting 1/1/10?

- **For services previously reported as office/outpatient consultations:**
The applicable codes for new patient visits (99201-99205) or established patient visits (99211-99215) will be reported instead.

At times it is very difficult for a provider to know whether or not the patient is a new patient, but it will be necessary in order to report the appropriate category of service.

- **For services previously reported as inpatient consultations:**
The applicable codes for initial hospital care (99221-99223) or initial nursing facility care (99304-99306) will be reported instead.

The consulting physician will use initial hospital care or initial nursing facility care, regardless of the date of service.

To differentiate between the admitting providers and the consulting providers, it will also be necessary for the admitting providers to add modifier AI to their initial hospital or nursing facility care codes.

Is there a crosswalk we can use to convert the consultation codes to the other codes?

It depends on the code category.

The documentation requirements for office/outpatient consultation codes 99241-99245 mirror those of the new patient visit codes 99201-99205 and **can be directly cross walked.**

The documentation requirements for office/outpatient consultation codes 99241-99245 are different from those of the established patient visit codes 99211-99215 and **cannot be directly cross walked level by level.**

The documentation requirements for the three highest levels of inpatient consultation codes 99253-99255 mirror those of the three initial hospital care codes 99221-99223 and the three initial nursing facility care codes 99304-99306 respectively, **and those levels can be directly cross walked.**

If a provider is performing a service that would normally be reported with one of the two lower levels of inpatient consultation (99251 or 99252), there is no crosswalk available.

Note: *The crosswalks noted above will not work for cases where the level of service is chosen based on time of counseling/coordination of care.*

If providers are no longer billing consultation codes, do they still need to document consultation requests and reports?

That will not be a requirement for Medicare since the services are no longer considered to be consultations. However, FHC recommends that providers still document the reason they are being asked to evaluate the patient. In the event of an audit, that may help show the medical necessity for their services.

What do we do about commercial payers?

Until specific information is available from the individual payers, FHC recommends that you continue using the consultation codes with the usual supporting documentation. Some payers have already indicated they will follow the Medicare policy only for their Medicare products.

Will these changes result in a delay or decrease in reimbursement?

If claims are submitted appropriately to Medicare, one would not expect delays in reimbursement.

Depending upon the volume of consultations normally reported for Medicare patients, decreases in reimbursement are very likely. The RVUs have been increased between 5-6% for new and established office patient visits, and just slightly for initial hospital care, but those increases do not make up the difference between what the reimbursement would have been for consultation codes.

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