2010 changes to Medicare payment for consultation services

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The final rule on 2010 Medicare physician payment contains a significant change in billing practices for consultation codes. This article explains what surgeons and their billing staffs will need to do in order to comply with the rule. Other highlights of the regulation, which was published in the *Federal Register* on November 25, 2009, is summarized in the article on page 18 of this issue.

What did Medicare change about billing for consultation codes?

Beginning January 1, the Centers for Medicare & Medicaid Services (CMS) will eliminate the use of all consultation codes (inpatient and office/outpatient codes for various places of service except for tele-health consultation G-codes) on a budget-neutral basis. To compensate for this change, CMS is increasing the work relative value units (RVUs) for new and established office visits, increasing the work RVUs for initial hospital and initial nursing facility visits, and incorporating the increased use of these visits into practice expense and malpractice RVU calculations.

For inpatient consultations, physicians will bill an initial hospital visit or initial nursing facility visit code for their first visit during a patient's admission to the medical institution. In lieu of outpatient consultation codes, physicians will bill either new or established patient office visit codes, depending on whether the patient has been seen for professional services within the practice in the last three years. You must comply with existing guidelines for coding and billing office visits.

The American College of Surgeons anticipates that most surgeons will do at least as well financially under these rules as under the previous system of consult codes, because of the increase in work RVUs for office and hospital visits and the impact of increases in RVUs for practice expense and medical liability. CMS estimates the combined effect of these changes will be approximately +1 percent in 2010 for general surgeons.

Medicare previously prohibited anyone but the attending physician from billing an initial hospital visit or initial nursing home visit. Has that changed?

Yes. CMS has created a modifier (–AI) 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 be furnishing specialty care. The admitting physician of record will be required to append the –AI 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 inpatient care visits by all physicians will be reported as subsequent hospital care codes and subsequent nursing facility care codes. Additional outpatient care visits will be billed using established patient outpatient/office visit codes.

How do I choose which codes to bill?

Table 1 on page 10 shows the Current Procedural Terminology (CPT)* guidelines for selecting which level of consult code to bill. These are the codes previously used to bill for consultation services that will no longer be paid by Medicare. Table 2 on page 10 shows the guidelines for selecting which level of office visit to bill. These are the codes you will have to select from to bill

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2010 American Medical Association. All rights reserved.

Table 1: CPT Evaluation and Management (E/M) services guidelines for consultations

HCPCS	Description	History	Physical exam	Complexity of medical decision making	CPT estimate of time (minutes)
99241	Office consultation	pf	pf	str	15
99242	Office consultation	epf	epf	str	30
99243	Office consultation	det	det	low	40
99244	Office consultation	comp	comp	mod	60
99245	Office consultation	comp	comp	high	80
99251	Inpatient consultation	pf	pf	str	20
99252	Inpatient consultation	epf	epf	str	40
99253	Inpatient consultation	det	det	low	55
99254	Inpatient consultation	comp	comp	mod	80
99255	Inpatient consultation	comp	comp	high	110

pf = Problem focused
det = Detailed
str = Straightforward decision making
mod = Moderate complexity decision making
epf = Expanded problem focused
comp = Comprehensive
low = Low complexity decision making
high = High complexity decision making

Table 2: CPT E/M services guidelines for office and facility visits

2010 proposed HCPCS	Description	History	Physical exam	Complexity of medical decision making	CPT estimate of time (minutes)
99201	Office/outpatient visit, new	pf	pf	str	10
99202	Office/outpatient visit, new	epf	epf	str	20
99203	Office/outpatient visit, new	det	det	low	30
99204	Office/outpatient visit, new	comp	comp	mod	45
99205	Office/outpatient visit, new	comp	comp	high	60
99211	Office/outpatient visit, established	N/A	N/A	N/A	5
99212	Office/outpatient visit, established	pf	pf	str	10
99213	Office/outpatient visit, established	epf	epf	low	15
99214	Office/outpatient visit, established	det	det	mod	25
99215	Office/outpatient visit, established	comp	comp	high	40
99221	Initial hospital care	det or comp	det or comp	str or low	30
99222	Initial hospital care	comp	comp	mod	50
99223	Initial hospital care	comp	comp	high	70
99304	Nursing facility care, initial	det or comp	det or comp	str or low	25
99305	Nursing facility care, initial	comp	comp	mod	35
99306	Nursing facility care, initial	comp	comp	high	45

Table 3: Medicare payments for office and facility visits in 2010

2010 proposed HCPCSMod	Description	2010 proposed total RVUs	2010 proposed pay (CF = 36.0666)†
99201	Office/outpatient visit, new	1.08	$38.95
99202	Office/outpatient visit, new	1.87	67.44
99203	Office/outpatient visit, new	2.71	97.74
99204	Office/outpatient visit, new	4.19	151.12
99205	Office/outpatient visit, new	5.28	190.43
99211	Office/outpatient visit, established	0.53	19.12
99212	Office/outpatient visit, established	1.08	38.95
99213	Office/outpatient visit, established	1.82	65.64
99214	Office/outpatient visit, established	2.73	98.46
99215	Office/outpatient visit, established	3.68	132.73
99221	Initial hospital care	2.72	98.10
99222	Initial hospital care	3.70	133.45
99223	Initial hospital care	5.42	195.48
99304	Nursing facility care, initial	2.33	84.04
99305	Nursing facility care, initial	3.27	117.94
99306	Nursing facility care, initial	4.17	150.40

†This table assumes that Congress will enact a freeze on Medicare payment rates for 2010.

for consultation services beginning January 1. Select the office visit code that most accurately reflects the level of history, physical exam, medical decision making, and time involved in the consultation. In unusual circumstances, when a consultation extends beyond the usual service, you have the option of reporting one of the prolonged physician services codes (99354–99357 with face-to-face contact, or 99358–99359 without face-to-face contact).

How will this affect payment by non-Medicare payors?

CMS does not determine which services other third-party payors will recognize and reimburse. Some payors may choose to adopt the new CMS policy subsequent to this final rule. In cases where other payors 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.

If Medicare is the primary payor, 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 payors in order to determine how to bill those services to receive secondary payment.

If Medicare is the secondary payor, physicians and billing personnel will first need to determine whether the primary payor continues to recognize the consultation codes. If the primary payor does continue to recognize those codes, the physician will need to decide whether to bill the primary payor using visit codes, which will preserve the possibility of receiving a secondary Medicare payment, or to bill the primary payor with the consulta-

tion codes, which will result in a denial of payment for invalid codes by Medicare as the secondary payor.

What are the new payment rates for E/M codes?

As proposed, this change will be implemented in a budget-neutral manner, meaning that it will not increase or decrease aggregate Medicare physician fee schedule expenditures. CMS will make this change budget-neutral for the work RVUs, by increasing the work RVUs for new and established office visits by approximately 6 percent to reflect the elimination of the office consultation codes, and the work RVUs for initial hospital and facility visits by approximately 0.3 percent, to reflect the elimination of the facility consultation codes. CMS is also increasing the incremental work RVUs for the E/M codes that are built into the 10-day and 90-day global surgical codes.

CMS is also implementing changes to practice expense RVUs and medical liability RVUs. Table 3 on page 11 shows the national Medicare payment rates for these services in 2010, taking all these changes into effect.

Why did Medicare make this change?

According to the final rule, CMS is basing this change on the following points:

- The American Medical Association and specific national physician specialty societies have repeatedly claimed that physicians are dissatisfied with CMS documentation requirements and guidance that distinguish a consultation service from other E/M services, such as transfer of care.
- CPT's instructions pertaining to the definitions of a consultation, transfer of care, and documentation requirements are unclear and ambiguous.
- A March 2006 report from the Office of the Inspector General indicated that Medicare allowed approximately $1.1 billion more in 2001 than it should have for services billed as consultations. Approximately 75 percent of services paid as consultations did not meet all applicable program requirements (per the Medicare instructions), resulting in improper payments.
- Beginning January 1, 2008, CMS ceased to recognize office/outpatient consultation CPT codes for payment of hospital outpatient visits under the outpatient prospective payment system. CMS instructed hospitals to bill a new or established patient visit CPT code, as appropriate to the particular patient, for all hospital outpatient visits.
- "The payment for both inpatient consultation and office/outpatient consultation services is higher than for initial hospital care and new patient office/outpatient visits. However, the associated physician work is clinically similar. Many physicians contend that there is more work involved with a new patient visit than a consultation service because of the post work involvement with a new patient."*
- "[T]he rationale for a differential payment for a consultation service is no longer supported because documentation requirements are now similar across all E/M services."*

How will this change affect 10-day and 90-day global payments?

In our response to the proposed regulations, the ACS argued that CMS should increase the bundled payments for postoperative visits occurring over a 10-day or 90-day global period. We argued that arbitrarily changing the work RVUs for some E/M codes without adjusting the E/M components of other procedural codes undermines the relative value scale on which physician payment is based. CMS agreed with this and increased the payments for those services. However, the increases in the payments for these 10-day and 90-day global services due specifically to this change are minor because visits are a relatively small proportion of the total global payment amount. Ω

Federal Register. Available at http://www.federalregister.gov/inspection.aspx#special. Accessed December 8, 2009.