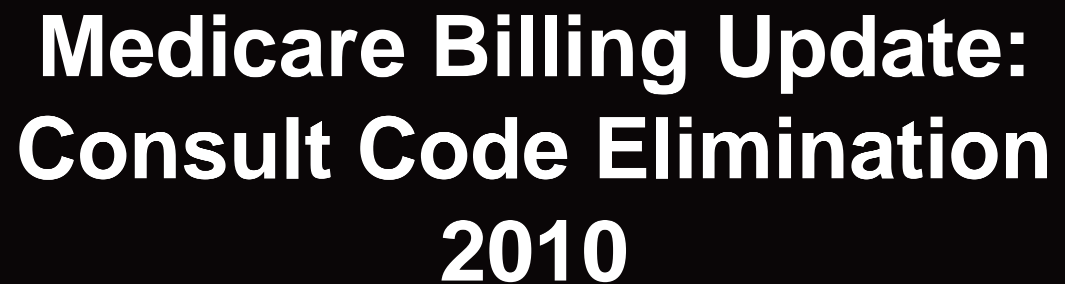

Medicare Billing Update: Consult Code Elimination 2010

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Disclaimer

This material is designed to offer basic information for coding and billing. The information presented here is based on the experience, training, and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, the instructor does not accept any responsibility or liability with regard to errors, omissions, misuse, or misinterpretation. This handout is intended as an educational guide and should not be considered a legal/consulting opinion

E&M SERVICES: GUIDELINES

Concurrent care: the provision of similar services (e.g., hospital visits) to the same patient by more than one physician on the same day.

When concurrent care is provided, no special reporting is required.

E&M SERVICES: GUIDELINES

Transfer of care: the process whereby a physician who is providing management for some or all of a patient's problems relinquishes this responsibility to another physician who *explicitly agrees* to accept this responsibility and who, *from the initial encounter*, is not providing consultative services.

The physician transferring care is then no longer providing care for these problems though he or she may continue providing care for other conditions when appropriate.

E&M SERVICES: GUIDELINES

Consultation codes should not be reported by the physician who has agreed to accept transfer of care before an initial evaluation but are appropriate to report if the decision to accept transfer of care cannot be made until *after the initial* consultation evaluation, regardless of site of service.

You can advise and additionally treat.

Should NOT be reported if the decision to accept was made before the initial evaluation.

CPT 2010

E&M SERVICES: GUIDELINES
Consultations (Review)

-Recommend care for a specific condition or

problem or

-To determine whether to accept responsibility

for ongoing management of the patient's entire care for the care of a specific condition or problems.

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The written or verbal request for consult may be made by a physician or other

appropriate source and still needs to be documented in the patient's medical record by either the consulting or requesting physician or appropriate source.

E&M SERVICES: GUIDELINES
Consultations (Review)

The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source.

for

Office Services - (Previously Consultations)

- Code based on relationship with patient
- New patients (99201-99205)
- Use the 3 year rule regarding New patients
- Established patients (99211-99215)

CMS

Hospital Services – (Previously Consultations)

Admission Codes are now *Initial Encounter Codes*

- 99221-99223

Nursing Care Facility

- 99304-99306

First physician visit with a patient in the hospital is billed with an Initial Encounter Code

Multiple physicians may bill Initial Encounter Codes

- Physician of record appends modifier "AI" to Initial Encounter Codes

Hospital Services – (Previously Consultations)

Request:

–Expectation of "something" in the record asking for additional physician

Report:

–"promote proper coordination of care…follow appropriate medical documentation standards and communicate the results of the evaluation to the requesting physician."

CMS

Hospital Services – (Previously Consultations)

Code based on documentation of E&M

Elements of visit:

–History, Exam and Medical Decision Making*

- Consultation coding had 5 levels (99251-99255)
- Initial Care Codes have 3 levels (99221-99223)

All three components are still required

Hospital Services – (Previously Consultations)

Level 1 Initial Visit

–Detailed ***<u>or</u>*** comprehensive history

–Detailed ***<u>or</u>*** comprehensive examination

–Medical decision making straightforward or low

Level 3 Consultation

–Detailed history

–Detailed examination

–Medical decision making of low complexity

Emergency Department Visits– (Previously Consultations)

"If the emergency department physician requests that another physician evaluate a given patient, the other physician should bill an emergency department visit code."

- No modifier is needed
- No consideration for new or established
- Multiple physicians may bill ED codes for seeing patients.

CMS

Emergency Department Visits– (Previously Consultations)

In the event that the physician performing the evaluation admits the patient, this physician should bill the initial hospital care code, not an ED visit code

- Physician admitting the patient to observation bills observation codes
  - 99217-99220
- All others bill outpatient E&M codes
  - 99201-99215

for

Office Services - (Previously Consultations)

Consider Prolonged Care codes where appropriate

- –Bullet points determine code (99213)
- –Time spent determines prolonged care
- –NOT same concept as “counseling & coordination of care”

for

Prolonged Physician Services – Office

+ 99354 –Prolonged physician service office or other outpatient setting: first hour

+ 99355 -each additional 30 minutes

–Face to Face time (CPT & CMS)

–List separately in addition to code for office or other outpatient Evaluation and Management service

Prolonged Physician Services - Hospital

+ 99356 –Prolonged physician inpatient setting: first hour

+ 99357 -each additional 30 minutes

–Face to Face time (CMS)

–Unit Floor (CPT)

–List separately in addition to code for inpatient Evaluation and Management services

DOCUMENTATION MUST SUPPORT

Prolonged Services

To gain reimbursement for prolonged services, you must document all of the time that the physician spends face-to-face with the patient for outpatient coding and at the unit/floor time that the physician spends treating the patient in the inpatient setting (CPT). *Without an actual minute value stated in the physician notes*, prolonged service codes are **not valid** no matter how much time the physician actually spent.

The time you count need not be continuous, although it should occur on the same date of service.

for

If the dominate service has traditional elements of History, Exam and Medical Decision making

Code	Payment	Prolonged Service (99354)	Total
99213	$53.42	$75.32	$128.74

Bill If the dominant service is counseling and time is the basis of the code selection

–99215 = $107.67

BASED ON DOCUMENTATION

80 Minute Service

If the dominate service has traditional elements of History, Exam and Medical Decision making

Code	Payment	Prolonged Service (99356)	Total
99221	$75.90	$69.00	$144.90
99222	$103.30	$69.00	$172.30

– Time must be face-to-face per CMS and documentation MUST include medical necessity and time.

Prolonged Services

Give a reason.

Don’t Overuse Prolonged Services

– Reserve them for truly time-consuming services, such as when a patient is non-compliant or requires special attention due to a mental or physical handicap, or if the surgeon must explain complex diagnoses, treatment options or substantial lifestyle changes to the patient.

Document and be honest.

30.6.1 – Selection of Level of Evaluation and Management Service

In the rare circumstance when a physician or (NPP) provides a service that does not reflect a CPT Code description, the service must be reported as an unlisted service with CPT code 99499.

A description of the service provided must accompany the claim.

The carrier has the discretion to value the service when the service does not meet the full terms of a CPT code description.

CMS

30.6.9.1 Initial Hospital Care Services & Observation or Inpatient Care Services
(Including Admission and Discharge Services)

When a physician performs a visit that meets the definition of a Level 5 office visit several days prior to an admission and on the day of admission performs *less* than a comprehensive history and physical, he or she should report the **office visit** that reflects the **services furnished and** also report the **lowest level initial hospital care** code (i.e., code 99221) for the initial hospital admission. Contractors pay the office visit as billed and the Level 1 initial hospital care code.

CMS

for

Initial Hospital Care Services & Observation or Inpatient Care Services

According to CMS:

"We follow AMA CPT coding logic and it is not permissible to bill a subsequent prior to an initial. Bottom line, always bill an initial service prior to a subsequent hospital visit."

CMS

Telehealth Consultations 2010

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.

CMS

for

Telehealth Consultations 2010

- 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.

CMS

for

Medicare Primary –Bill initial Care Code (+AI)

–Cross over to ABC insurance

–What can happen?

Medicare Secondary

–Bill Primary with??? Codes

–Cross over to Medicare

for

Bill the primary payer an E/M code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with the same E/M code, to Medicare for determination of whether a payment is due; or

Bill the primary payer using a consultation code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with an E/M code that is appropriate for the service, to Medicare for determination of whether a payment is due.

The Money Side

Bill ABC Insurance for Consult at $300.00

$300.00	$200.00
- $200 allowed	80% $160.00
$100.00 write off	$ 40.00 Co-pay

Recode visit to appropriate code

Medicare Allowed for Visit is $160.00

The Money Side

EXAMPLE 1

A. Actual charge by the physician minus the third party payment: $300 -$160 = $140.

B. The Medicare payment is determined in the usual manner: .80 x $160 = $128.

C. Employer plan's allowable charge of $200 (which is higher than Medicare's fee schedule amount of $160) minus the employer plan's payment of $160 equals $40.

D. Medicare pays $40 (lowest of amounts in steps A, B, or C).

CMS/MSP Manual Ch. 5 Sec. 40.7.3

Caution…

The link that was provided for the so-called CMS consult is ***not*** a crosswalk for billing purposes. CMS used the information to assess how to redistribute the relative values to the new and established E/M outpatient codes (99201-99205, 99211-99215) as well as the initial hospital codes (99221-99223).

This means it has absolutely nothing to do with coding. You need to determine the level of service based on what is documented, not what it might have been had you reported the consult codes (they are no longer in the picture).

Who Is Following Which Rules?

Contact your major payers (e.g., Aetna, United Healthcare, Blue Cross, Blue Shield, etc.)

Also, if you are contracted with any HMO's, contact your IPA's.

The End

- Helpful Websites

http://www.palmettogba.com/PALMETTO/PALMETTO.NSF/DocsCat/Home

http://www.cms.hhs.gov/home/medicare.asp

https://navinet.navimedix.com/Main.asp

Thank you for taking the time to participate in this presentation

Please visit our website at www.scmdservices.com