

## 2010 Medicare Consult Changes

This article pertains to Change Request (CR) 6740, which alerts providers that effective January 1, 2020, the CPT consultation codes (ranges Outpatient 99241-99245 and Inpatient 99251-99255) are no longer recognized for Medicare Part B payment.

Providers should code a patient evaluation and management visit with E/M codes that represent WHERE the visit occurs, identifies the COMPLEXITY of the visit performed and in the office/outpatient setting, whether the patient is new or existing.

In place of the consultation codes, CMS increased the work relative value units (RVUs) for new and established office visits, increased the work RVUs for initial hospital and initial nursing facility visits, and incorporated the increased use of these visits into the practice expense (PE) and malpractice calculations. CMS also increased the incremental work RVUs for the E/M codes that are built into the 10-day and 90-day global surgical codes.

Conventional medical practice is that physicians making a referral and physicians accepting a referral would continue to document the request to promote proper coordination of care.

The principal physician of record

will append modifier **-AI (Principal Physician of Record)** to the E/M code when billed. This modifier will identify the physician who oversees the patient's care from all other physicians who may be furnishing specialty care.

In the inpatient hospital setting and nursing facility setting, **any** physicians and qualified NPPs who perform an initial evaluation may bill an initial hospital care visit code (CPT 99221-99223) or nursing facility care visit code (CPT 99303-99306) where appropriate. **This will be different from current billing practice, when only the admitting physician bills the initial visit codes.**

**IMPORTANT: Remember a level 99221 (initial lowest level hospital code) is a detailed level of service. An initial inpatient's evaluation documentation must support that level. If documentation is not met, Medicare requires a 99499 (Unlisted evaluation and management code), which will require documentation sent to Medicare to substantiate what level of payment is made.**

Medicare has stated that claims including the AI modifier on codes other than the initial hospital and nursing home visit codes (i.e., subse-

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quent care codes or outpatient codes) will not be rejected.

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 (ie., code 99221) for the initial hospital care code. The principal physician of record, as previously noted, must append the “-AI” modifier to the claim with the initial hospital care code.

### **MEDICARE SECONDARY**

Other insurances will continue to use the consultations codes. When Medicare is secondary, there are

two options:

- Bill the primary payer an appropriate E/M code (consultation?) and report the amount actually paid by the primary carrier to Medicare along with the acceptable Medicare E/M code to Medicare to determine whether payment is due, or
- Bill consults using the admitting CPT codes (99221-99223) to both carriers.

The first would probably be an administrative nightmare, changing the service based on CPT AND documentation. The second might prove a financial loss to the provider because consults have historically been paid at a higher reimbursement. ■