

2010 Consultation Code Update

Prepared by the APA Office of Healthcare Systems and Financing

Medicare will no longer pay claims using the CPT evaluation and management consultation codes. This does not mean that they will not pay for consultations, but rather that any consultations that take place after January 1, 2010, must be reported using other codes. CMS, which administers Medicare, has advised physicians to use the appropriate new patient or initial evaluation and management (E/M) codes for the designated setting (outpatient, hospital care, nursing facility care or home health care).

What you would formerly have billed as an office consultation should now be billed as an office or other outpatient visit for the evaluation and management of a new patient (99201-99205). An inpatient consult should now be coded using the initial hospital care codes (99221-99223). A consult occurring in a nursing facility should now be coded using the initial nursing facility care codes (99304 – 99306). And, finally, any consultations done as a home service should be coded as a home visit for the evaluation and management of a new patient (99341-99345). It would also be completely appropriate to use 90801 (psychiatric diagnostic interview examination) if it's the first time you've seen the patient. As with all evaluation and management services, the specific code selection should be based on the standard evaluation and management guidelines. The guidelines can be accessed at http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf.

The following are four of the key elements relating to this change in coding policy:

1. A new patient is defined as a patient who has not received any professional services from you (E/M or other face-to-face service) within the past three years. The established patient or subsequent care codes should be used in instances where the patient is not considered a "new patient."
2. The principal physician of record will add modifier "-AI" when submitting claims to distinguish his/her role from that of a consultant physician furnishing specialty care.
3. CMS advises that physicians making a referral document the request to provide care and that physicians accepting a referral continue to communicate the results of their evaluation to the requesting physician per conventional medical practice.
4. Medicare may pay for an inpatient hospital visit or an office or other outpatient visit if one physician or qualified NPP in a group practice requests an evaluation and management service from another physician in the same group practice when the consulting physician or qualified NPP has expertise in a specific medical area beyond the requesting professional's knowledge.

For complete information, CMS has explained the new payment policy and what it means for providers as part of its Medicare Learning Network (MLN Matters #MM6740). This document can be accessed on the CMS website at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf>.

If you have any questions about this change in Medicare policy and how to respond, please contact the Office of Healthcare Systems and Financing's Managed Care Help Line at 1-800-343-4671.

It is important to note that the CPT consultation service codes are not being eliminated, it is just that Medicare will no longer reimburse for these codes. It is unclear as yet if all Medicare Advantage plans and private payers will follow suit.