Consultation Service Coding Advice for 2010

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Effective January 1, 2010, we must report consultation services for Medicare patients using the "most applicable" inpatient, outpatient or skilled nursing (SNF) codes from the series 99221-99223 (initial inpatient encounter), 99201-99205 (new office/outpatient), 99211-99215 (established office/outpatient) and initial SNF codes (99304-99306) for evaluation and management (E/M). (footnote 1)

This article provides some guidance about how to report different codes for consultative services. This guidance is provided by the CPT Advisors from your Gastroenterology societies, and is not *per se* legal advice. There is no "official" CMS crosswalk of old codes to 2010 codes (footnote 2).

As of January 1, 2010 *SERVICE DATES*, do NOT report consultation codes (99241-99245, 99251-99255) for any Medicare fee-for-service patient or your claim will be returned without processing. Medicare Advantage plans may choose to follow this policy, or not…most commercial plans are not presently expected to place this restriction on services covered. Consultation services for dates prior to this will still be processed with the consultation codes.

What we suggest here are the closest equivalents based on the key components (history, physical exam and medical decision making) of the codes—what we'll need to report in 2010 instead of the consultation codes.

OUTPATIENT SERVICES

At the most basic level, closest equivalence would appear to be as follows (ignoring for gastroenterology purposes the SNF new patient):

Table 1. Office/outpatient codes to report outpatient consultation services, 2010 (a.)

Prior consultation service	New patient	Established patient (seen within 3 years)(b.)
99241	99201	99212
99242	99202	99212 or 99213
99243	99203	99213 or 99214 (see text)
99244	99204	99214 or 99215 (see text)
99245	99205	99215

a. This would include "additional evaluation" in the emergency department & hospital outpatient, or for patients in observation, where CMS pays a "facility" based fee discounted for the office practice expense component (see text)

b. CMS interprets this to mean face-to-face or E/M visits

INPATIENT

Table 2. Inpatient codes to report inpatient consultation services, 2010

Consultation service level	Hospital inpatient (a.)
99251	99221 or 99499 unlisted E&M or 99231/99232: see text discussion
99252	99221 or 99499 unlisted E&M or 99231/99232:

	see text discussion
99253	99221 (1)
99254	99222 (1)
99255	99223 (1)

(1) Consider add-on 99356 when time required exceeds 30+ minutes beyond usual time of 99221-99223; consider higher level code if counseling/coordination of care exceeds 50 percent of the service and the visit duration meets or exceeds the typical time of a higher code.

OUTPATIENT SERVICES: KEY POINTS

- For **NEW PATIENTS**, (see TABLE 1), key elements are the same at each level, but typical time described as face-to-face is compressed 25-33 percent. This matters if the majority of the visit time is counseling/coordination of care. If the total visit time meets or exceeds the typical time of a more complex service, and if counseling/coordination of care is >50 percent of the visit time, the higher code can be reported as long as the presenting problem justifies spending the time; the general nature of the counseling is described; and the visit time/counseling portion are documented.

- If a consultative service was such that 90+ minutes face to face time was spent, regardless of whether more than half was counseling/coordination of care, in 2010 this could be reported with 99205 **PLUS the add-on** +99354 prolonged service code, since there is no "level 6" code in this series.

- Note that in 2007, gastroenterologists only reported 46 percent and 8 percent respectively at levels 99244 and 99245, so it is quite likely that a significant percent of longer visits in 2010 will be justified as reporting at the 99205 level (often based on counseling) or using prolonged service codes.

- Fee implications: new patient OV codes are 20-30 percent lower than the former consultation code counterparts; national average fees for 99354 prolonged service are: $93.77 (office site of service) and $88.72 (facility site of service).

For **ESTABLISHED PATIENTS**

- The code key components are the same for 99241→99212, and for 99245→99215, except that only 2 of the 3 key components need to be met for the established patient OV codes. 99242 translates closest to 99213.

- The current 99243 mid level consult has no real counterpart in 99212-99215 series; 99214 is most appropriate if the medical decision making level is "moderate," versus "low" for 99243. This translates into requiring a broader differential diagnosis, more records or data to review, prescription meds or invasive procedures of low risk being required, compared to the 99243 currently. History & exam levels are "detailed" for these codes.
- A consultation of this sort though which required more than 20 minutes of counseling and required 40 minutes or more total time face to face would warrant a 99215 code, if time and details were documented.

- If what is now a 99245 highest level consultation were to require 70 minutes or more, such a visit can be reported with both 99215 and code +99354. Again, documenting time and detail of what required time beyond typical (for 99215) is critical to support the coding, and the presenting problem should warrant the extensive time spent.

- Fee implications: payment cuts are 40-50 percent at the 99213-99215 levels versus counterparts of 99243-99245.

When consultation services are provided in the **emergency department,** CMS advises using the emergency department visit codes (99281-99285):

- For a **new patient**, the fees for 99283-99285 and for 99203-99205 (performed in the facility) are quite similar, and the key components are less demanding in the ED code series.

- For **established patients**, the key components for the ED codes are the same as for the 99213-99215 series, yet the reimbursement substantially higher for the ED codes.

When consultation services are provided in an **observation unit:**

- CMS indicates that the physician ordering observation services (furnishes the initial evaluation) should utilize the CPT codes 99217-99220; but a subsequent physician asked to "additionally evaluate the patient" should bill new or established patient office visit codes as appropriate (e.g. 99203-99205 for new patients and 99214-99215 for established patients, if the elements of these codes are met and documented).

INPATIENT SERVICES (see Table 2)

For the inpatient consultation service, coding choices become peculiar at all levels.

- CMS instructs reporting a new modifier "AI" ("Principal Physician of Record") appended to the 99221-99223 code choice indicating the physician is the "quarterback", the traditional admitting/attending physician role.

- The usual consulting role is reported with the same 99221-99223 codes without the modifier.

- There is no real counterpart to 99251/99252, because of the greater detail required in history and physical exam to report 99221. As of 2010, the choices seem to be: provide the greater detail, when medically appropriate; report an unlisted E&M code 99499; or, use 99231-99232 level codes for such situations (subsequent hospital care codes). Unlisted code use is problematic: need for attaching documentation to a claim, slow/uncertain claims processing by contractor; and potential of a practice audit if use of unlisted codes is frequent. Historically though, gastroenterologists report relatively few low level consultation services.

- 99253 has the closest counterpart to 99221 in work components. However, if the time involved on the unit/floor required 60 minutes or more to perform the work elements of 99221, then 99221 + 99356 (prolonged service) reporting would be justified, if the time spent was reasonable for the presenting problem and the reason for the unusual time was clearly documented. Counseling and coordination of care could justify reporting 99222 if counseling consumed more than 25 minutes of a 50+ minute service; or 99223 if consuming more than 35 minutes of a 70+ minute service.

- 99255 and 99223 have the same work elements, with comprehensive level history & physical exam, and high complexity decision making.

- During a single hospital stay, being called back to provide further opinion regarding the same or a different problem would be reported with subsequent hospital care (99231-99233) codes.

- There are no changes for 2010 in the use of critical care (99291-99292) coding, which remains an option for critically ill patient consultative services when the "constant bedside attendance" and other rules are observed and time, details documented.

SHARED/SPLIT SERVICES in 2010

A mid-level practitioner and physician can share the new and established patient visit, initial and subsequent hospital care services. If both see the patient the same day, the physician can select the level of service to reflect the combined work, without needing to duplicate the components performed by the mid-level practitioner, and Medicare reimburses at the physician fee schedule amount. If only the MLP sees the patient, the MLP should bill under their provider number and reimbursement is at 85 percent of the physician fee schedule.

The financial bottom line of these changes to an individual practitioner will depend heavily on the relative volumes of inpatient: outpatient consultative services provided, and in the outpatient side, what the division is between new and established patients. The physician who is conscientious about use of prolonged service codes, or using the counseling exception which allows use of time as the basis of code selection, AND who carefully documents the time and details within the note in these circumstances, will be more fairly compensated for the more complex services despite these new mandated reporting requirements.

Footnotes

1. For background of the issue, see "What's New 2010 CPT, Medicare Reimbursement" on the ASGE Practice Management website (http://www.asge.org/MembersOnlyIndex.aspx?id=4808)

2. In the July 2009 notice of this proposal, CMS published a crosswalk of the code sets, but the purpose of the crosswalk was only to demonstrate budget calculations, not to indicate to physicians which code to report. (http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3469)

References

1. MLN Matters article on consultation code change: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf

2. Related Transmittal #R1875CP instructions to contractors: http://www.cms.hhs.gov/transmittals/downloads/R1875CP.pdf

3. Final 2010 Medicare Physician Fee Schedule: http://www.cms.hhs.gov/PhysicianFeeSched/

4. Evaluation & Management 1995, 1997 guidelines: www.cms.hhs.gov/MLNEDWebGuide/25_EMDOC.asp