Medicare's Decision to Eliminate Payments for Consultation Codes
Frequently Asked Questions

1. **How will Medicare handle claims with the consultation codes for services performed after January 1, 2010?**

   They will be denied.

2. **What modifier will the admitting physician use to designate himself/herself as the principal physician?**

   AI

3. **Can consultants bill an initial hospital care code (without the "AI" modifier) every time a patient is admitted to the hospital regardless of whether the presenting problem is the same or similar?**

   We *think* the answer is yes. While the 3-year rule remains in place for outpatient consultative services, there is no such rule for inpatient consultative services. There is no rule prohibiting a consultant from billing an initial hospital care code (99221-99223) every time a patient is admitted/readmitted to the hospital.

4. **How will billing for the inpatient consultation codes crosswalk to the initial hospital care codes?**

   For the documentation requirements of history, examination, and medical decision making, the 99253 perfectly crosswalks to 99221, 99254 perfectly crosswalks to 99222, and 99255 perfectly crosswalks to 99223. Consultative services that used to be billed using 99251 and 99252 should now be billed using 99499, the unlisted Evaluation and Management (E&M) code, or 99231/32. The level of service is based on the complexity of medical decision making with appropriate history and physician exam documentation to support the code level chosen—it is highly recommended that the appropriate documentation accompany claims for unlisted E&M services (99499).

Suggested Crosswalks of Non-Covered Consultation Codes to Other (Covered) E&M Codes Under Medicare

2009	2010 (Suggested)
99251	99499 (or 99231)
99252	99499 (or 99232)

99253	**99221**
99254	**99222**
99255	**99223**
99241	**99201**
99242	**99202**
99243	**99203**
99244	**99204**
99245	**99205**

5. **Will documentation requirements for billing the consultation codes, including a note back to the referring physician, apply under the new policy?**

   It is still recommended that you continue this practice.

6. **How will application of this policy be handled for claims in which Medicare is the primary and a third party payer (i.e., Medicare Advantage) is the secondary (or vice-versa)?**

   Traditional Medicare will no longer pay for consultation codes as previously noted (but individual Medicare Advantage plans may continue to pay for consultation codes). If Medicare is the primary and a patient has a full secondary insurance policy, you may bill Medicare for the denial and submit a claim to the secondary insurer for the consultation codes. If Medicare is the secondary, you can bill the patient's primary insurance for the consultation codes. *Check with individual Medicare Advantage plans and private payers to determine whether they plan to pay for consultation codes going forward.*

7. **If Medicare denies a consultation, what will that denial message read so that physicians can either bill the secondary payer or bill the patient?**

   Go to the recent MedLearn Matters articles at the following hyperlinks for advice on this topic: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf

   http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1010.pdf

8. **Will Medicare's previous decision not to allow split/billing for the consultation service codes be applied to the new policy?**

   This would assume to be a mute point since their original policy was based on the belief that a consultation was an opinion of one provider. We hope they will state something in writing on this situation.

9. **Which rules will apply for consultations on patients in observation status? Will the consultant bill new or established office visits <u>or</u> will they use the observation admission codes (99218-99220)?**

   Only the admitting physician of record will use the 99218-99220 code. All others will use the outpatient rules and bill a new or established patient (outpatient) visit.

10. **Can the inpatient prolonged services codes be used to account for excess floor or unit time over and above the standard times for the initial hospital visit codes?**

    There will not be a change in the coding requirements or documentation requirements for prolonged services. Apply the same rules you have in the past—remember that prolonged services codes can only be billed using face-to-face time (floor/unit time does not count).

11. **Will consultants be penalized (or denied payment) if the admitting physician does not use the appropriate modifier to designate him/herself as such?**

    It appears that the consulting physician will not be paid unless the admitting physician uses the modifier. Perhaps, this is an internal tracking method for Medicare? There is ongoing discussion regarding this issue.

Submit specific coding questions to IDSA's "Ask the Coder" E-mail Portal or download the Medicare Learning Network (MLN) Matters articles at the following hyperlinks for additional coding guidance related to the Agency's decision to eliminate payments for the consultation codes: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf

http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1010.pdf