Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – Flu Season is upon us! CMS encourages providers to begin taking advantage of each office visit to encourage your patients with Medicare to get a seasonal flu shot; it's their best defense against combating seasonal flu this season. (*Medicare beneficiaries may receive the seasonal influenza vaccine without incurring any out-of-pocket costs. No deductible or copayment/coinsurance applies.*) For more information about Medicare's coverage of the seasonal influenza vaccine and its administration as well as related educational resources for health care professionals, please go to *http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp* on the CMS website.

MLN Matters® Number: MM6740 Revised
Related Change Request (CR) #: 6740
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Effective Date: January 1, 2010
Related CR Transmittal #: R1875CP
Implementation Date: January 4, 2010

Revisions to Consultation Services Payment Policy

Note: This article was revised on November 8, 2011, to add a reference to MM7405 (http://www.cms.gov/MLNMattersArticles/downloads/MM7405.pdf) for additional information regarding the use of consultation codes and the addition of new subsequent observation care codes 99224-99226. All other information remains the same.

Provider Types Affected

This article is for physicians and non-physician practitioners (NPPs) who perform the initial evaluation and management (E/M) consultation for Medicare beneficiaries and submit claims to Medicare Carriers, Fiscal Intermediaries (FIs) and/or Medicare Administrative Contractors (MACs) for those services. It is also intended for Method II critical access hospitals, which bill for the services of those physician and non-physician practitioners who have reassigned their billing rights. This article only applies to billing for physician services under the Medicare fee-for-service program. It does not revise existing policies or rules governing Medicare Advantage or non-Medicare insurers.

Provider Action Needed

This article pertains to Change Request (CR) 6740, which alerts providers that effective January 1, 2010, the Current Procedural Terminology (CPT) consultation codes (ranges 99241-99245 and 99251-99255) are no longer recognized for Medicare Part B payment. Effective for services furnished on or after January 1, 2010, providers should code a patient evaluation and management visit with E/M codes that represents WHERE the visit occurs and that identify the COMPLEXITY of the visit performed. See the *Key Points* section of this article for details.

Background

In the calendar year 2010 Medicare Physician Fee Schedule (MPFS) final rule with comment period (CMS-1413-FC), the Centers for Medicare & Medicaid Services (CMS) eliminated the use of all consultation codes (inpatient and office/outpatient codes) for various places of service except for telehealth consultation HCPCS G-codes. The change will not increase or decrease Medicare payments. 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. All references (both text and code numbers) in the *Medicare Claims Processing Manual*, Chapter 12, Section 30.6 that pertain to the use of the American Medical Association (AMA) Current Procedural Terminology (CPT) consultation codes (ranges 99241-99245 and 99251-99255) are removed by CR 6740. (The Web address for viewing CR 6740 is in the *Additional Information* section of this article.)

Key Points of CR 6740

- Effective January 1, 2010, local Part B carriers and/or A/B MACs will no longer recognize AMA CPT consultation codes (ranges 99241-99245, and 99251-99255) for inpatient facility and office/outpatient settings where consultation codes were previously billed for services in various settings.
- Effective January 1, 2010, local fiscal intermediaries and/or A/B MACs will no longer recognize AMA CPT consultation codes (ranges 99241-99245, and 99251-99255) for Method II CAHs, when billing for the services of those physician and non-physician practitioners who have reassigned their billing rights.

- Physicians may employ the 2009 consultation service codes, where appropriate, to bill for consultative services furnished up to and including December 31, 2009.
- Providers who bill an E/M service after January 1, 2010 using one of the CPT consultation codes (ranges 99241-99245 and 99251-99255) will have the claim returned with a message indicating that Medicare uses another code for reporting and payment of the service. To receive payment for the E/M service, the claim should be resubmitted using the appropriate E/M code as described in this article. Although CMS has eliminated the use of the CPT consultation codes for payment of E/M services furnished to Medicare fee-for-service patients, those E/M services themselves continue to be covered services if they are medically reasonable and necessary and, therefore, an ABN is not applicable. Furthermore, the patient may not be billed for the E/M service instead of Medicare.
- RHCs and FQHCs will discontinue use of AMA CPT consultation codes 99241-99245 and 99251-99255 and should instead use the E/M codes that most appropriately describe the E/M services that could be described by the CPT consultation codes.
- Conventional medical practice is that physicians making a referral and physicians accepting a referral would document the request to provide an evaluation for the patient. In order to promote proper coordination of care, these physicians should continue to follow appropriate medical documentation standards and communicate the results of an evaluation to the requesting physician. This is not to be confused with the specific documentation requirements that previously applied to the use of the consultation codes.
- 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 code 99221 – 99223) or nursing facility care visit code (CPT 99304 – 99306), where appropriate.
- In all cases, physicians will bill the available code that most appropriately describes the level of the services provided.
- 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. All other physicians who perform an initial evaluation on this patient shall bill only the E/M code for the complexity level performed.
- However, claims that include the "-AI" modifier on codes other than the initial hospital and nursing home visit codes (i.e., subsequent care codes or outpatient codes) will not be rejected and returned to the physician or provider.

- For patients receiving hospital outpatient observation services who are not subsequently admitted to the hospital as inpatients, physicians should report CPT codes 99217-99220. In the event another physician evaluation is necessary, the physician who provides the additional evaluation bills the office or other outpatient visit codes when they provide services to the patient.
    - For example, if an internist orders observation services, furnishes the initial evaluation, and asks another physician to additionally evaluate the patient, only the internist may bill the initial observation care code. The other physician who evaluates the patient must bill the new or established patient office or other outpatient visit codes as appropriate.
- For patients receiving hospital outpatient observation services who are admitted to the hospital as inpatients and who are discharged on the same date, the physician should report CPT codes 99234-99236 (e.g., Code 99234-Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date). If the patient is an inpatient and another physician evaluation is necessary, the physician would bill the initial hospital day code as appropriate (99221-99223). Otherwise, the physician should use the new or established patient office or other outpatient visit codes for a necessary evaluation.
- For patients receiving hospital outpatient observation services who are admitted to the hospital as inpatients on the same date, the physician should report only the initial hospital care services codes (codes 99221 - 99223). Medicare will pay for an initial hospital care service if a physician sees a patient in the emergency room and decides to admit the person to the hospital. 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. Medicare will pay the office visit as billed and the Level 1 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.
- For patients receiving hospital outpatient observation services or inpatient care services (including admission and discharge services) for whom observation services are initiated or the hospital inpatient admission begins on the same date as the patient's discharge, the ordering physician should report CPT codes 99234-99236.
- Emergency department visits (Codes 99281 - 99288)-- physician billing for emergency department services provided to patient by both the patient's personal physician and emergency department (ED) physician. If the ED

physician, based on the advice of the patient's personal physician who came to the emergency department to see the patient, sends the patient home, then the ED physician should bill the appropriate level of emergency department service. The patient's personal physician should also bill the level of emergency department code that describes the service he or she provided in the emergency department. If the patient's personal physician does not come to the hospital to see the patient, but only advises the ED physician by telephone, then the patient's personal physician may not bill.

- If the ED physician requests that another physician evaluate a given patient, the other physician should bill an emergency department visit code. If the patient is admitted to the hospital by the second physician performing the evaluation, he or she should bill an initial hospital care code and not an emergency department visit code.
- Follow-up visits by the physician in the facility setting should be billed as subsequent hospital care visits for hospital inpatients and subsequent nursing facility care visits for patients in nursing facilities, as is the current policy.
- In the office or other outpatient setting where an evaluation is performed, physicians and qualified NPPs should report the CPT codes (99201 – 99215) depending on the complexity of the visit and whether the patient is a new or established patient to that physician.
- A new patient is a patient who has not received any professional services (E/M or other face-to-face service) within the previous 3 years. Examples of where a new patient office is not billable:
    - If the consultant furnishes a pre-operative consultation at the request of a surgeon on a beneficiary and the consultant has provided a professional service to the patient within the past three years, then this situation would not meet the requirements to bill a new patient office visit.
    - The consultant could not bill for a new patient office visit for a consultation furnished to a known beneficiary for a different diagnosis than he or she has previously treated if the patient was seen by the consultant in the prior three years.
    - The consultant furnishes a consultation to a known beneficiary in an outpatient setting different than the office (e.g., emergency department) observation where the patient was seen in the past three years. As the patient has been seen by the consultant within the past three years, a new patient office visit cannot be billed.
- In order for physicians to bill the highest levels of visit codes, the services furnished must meet the definition of the code (e.g., to bill a Level 5 new

patient visit, the history must meet CPT's definition of a comprehensive history).

- 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.
- Medicare will also no longer recognize the consultation codes for purposes of determining Medicare secondary payments (MSP). In MSP cases, physicians and others must bill an appropriate E/M code for the services previously paid using the consultation codes. If the primary payer for the service continues to recognize consultation codes, physicians and others billing for these services may either:
  - 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.

  We note that the first option may be easier from a billing and claims processing perspective.
- All physicians and qualified NPPs need to follow the E/M documentation guidelines, which are available at *http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp* on the CMS website.
- Medicare contractors will use the following threshold times to determine if the prolonged services codes 99354 and/or 99355 can be billed with the office or other outpatient settings including domiciliary, rest home, or custodial care services and home services codes. Threshold time for prolonged visit codes 99354 and/or 99355 billed with office outpatient visit are as follows (all times in minutes).

Code	Typical Time for Code	Threshold Time to Bill Code 99354	Threshold Time to Bill Codes 99354 and 99355
99201	10	40	85
99202	20	50	95
99203	30	60	105
99204	45	75	120
99205	60	90	135
99212	10	40	85
99213	15	45	90
99214	25	55	100
99215	40	70	115
99324	20	50	95
99325	30	60	105
99326	45	75	120
99327	60	90	135
99328	75	105	150
99334	15	45	90
99335	25	55	100
99336	40	70	115
99337	60	90	135
99341	20	50	95
99342	30	60	105
99343	45	75	120
99344	60	90	135
99345	75	105	150
99347	15	45	90
99348	25	55	100
99349	40	70	115
99350	60	90	135

- Threshold time for prolonged visit codes 99356 and/or 99357 billed with inpatient setting codes are as follows (all times in minutes).

Code	Typical Time for Code	Threshold Time to Bill Code 99356	Threshold Time to Bill Codes 99356 and 99357
99221	30	60	105
99222	50	80	125
99223	70	100	145
99231	15	45	90
99232	25	55	100
99233	35	65	110
99304	25	55	100
99305	35	65	110
99306	45	75	120
99307	10	40	85
99308	15	45	90
99309	25	55	100
99310	35	65	110
99318	30	60	105

- Appropriate documentation is required to support the billing of the prolonged visit codes.
- The existing rules for counting time for purposes of meeting the prolonged care threshold times continue to apply. In particular, the *Medicare Claims Processing Manual,* Chapter 12, 30.6.15.1.C, provides that physicians may count only the duration of direct face-to-face contact between the physician and the patient for these purposes, and may not include time spent reviewing charts or discussion of a patient with house medical staff and not with direct face-to-face contact with the patient.

Additional Information

If you have questions, please contact your Medicare MAC, FI, or carrier at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

The official instruction, CR6740, issued to Medicare MACs and carriers regarding this change may be viewed at *http://www.cms.hhs.gov/transmittals/downloads/R1875CP.pdf* on the CMS website.

You may also want to review the related article SE1010 (Questions and Answers on Reporting Physician Consultation Services), which may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1010.pdf* on the CMS website.

The E/M documentation guidelines are available at *http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp* on the CMS website.