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Frequently Asked Questions about the Elimination of CMS Consultation Codes

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1. **Can I bill for consultation services for Medicare patients in 2010?**
   No, CMS eliminated the use of consultation services as of January 1, 2010 for Medicare Part B patients.

2. **How should a provider bill in 2010 for services that were considered consults in 2009?**
   For visits which were office/outpatient consults in 2009, practices should bill as new or established patient office/outpatient visits. For services considered hospital or facility consults in 2009, practices should bill for initial hospital or facility visits. In the 2010 physician fee schedule, CMS advises practices to use existing rules and guidelines for coding office visits and initial hospital and facility visits.

3. **What documentation is required to bill for an office/outpatient visit or a hospital or facility visit?**
   Physicians must still follow the documentation guidelines for the key components to support the code reported. In the 2010 physician fee schedule, CMS advises practices to use existing rules and guidelines for coding office visits and initial hospital and facility visits.

4. **Is there a direct crosswalk from consults to office/outpatient visits or consults to hospital or facility visits?**
   No, CMS did not design a direct crosswalk. In the 2010 physician fee schedule, CMS states "it is not necessary to develop any complicated coding crosswalk or guidelines for translating the consultation code requirements for purposes of applying the visit codes. The major effects of the provision may actually simplify coding because physicians will use the office and hospital visit codes in place of consultations and will not have to determine whether the requirements to bill a consult are met."

5. **Are the new reimbursement rules for traditional Medicare patients only?**
   Yes, the new rules only apply to Medicare Part B patients.

6. **Are Medicare Advantage plans treated like Medicare Part B?**
   No, Medicare Advantage plans are not treated like Medicare Part B. Contact the Medicare Advantage plan to determine if consultation codes will be eliminated for that plan.

7. **In a hospital setting, how is the admitting physician distinguished from the physicians furnishing care?**
   The admitting physician must use a modifier on his/her claims.

8. **Is the admitting physician always required to attach the modifier to his/her claims?**
   Yes, the admitting physician must always use the modifier to identify himself or herself as the

admitting physician, regardless of whether services are being requested during the hospitalization.

9. **What happens if the admitting physician forgets to put the modifier on the claim?**
   Contractors will suspend all claims associated with the admitting physician's claim, pending the correction, to properly develop the claim in their system.

10. **Rather than billing using initial hospital care codes, can a practice always use the subsequent day codes regardless of the type of visit?**
    Using one code range always, without regard to the carrier instructions or actual documentation, is incorrect and fraudulent.

Primary vs. Secondary

11. **If an office consultation is billed to a private carrier as the primary payer and then the claim is sent to Medicare without any changes, will Medicare deny or appropriately adjust the claim?**
    In this situation, Medicare will deny the claim. CMS advises practices to decide if they will bill for these services as visit codes or consultation codes when Medicare is a primary or secondary payer. If a practice chooses to bill using the visit codes, Medicare will appropriately process the claim; however, if a practice chooses the consultation codes, Medicare will deny the claims. A practice can submit a code to a private plan using the consultation codes and then re-code the claim using a visit code before submitting the secondary claim to Medicare.

12. **If Medicare is the primary payer, how should a practice bill the secondary payer for the visit?**
    Practices need to check with the secondary payer on their policy regarding consultative services. It would be correct to re-code the claim to a consultation code before submitting the secondary claim. Also, practices need to check with the Medigap plans and other major supplemental plans to determine whether they will require the EOMB to match your crossover claim. If the secondary payer requires recoding, practices should:
    - Develop a process to identify the claims in need of recoding.
    - Talk with your system vendor about how to change the code without changing the price on the original charge prior to submitting the claim to the secondary.
    - Develop a process to identify and appeal any secondary claims denied where the CPT code on the EOB does not match the CPT code submitted for secondary insurance payment.

13. **Has CMS eliminated the observation codes?**
    No, CMS has not eliminated the observation codes 99217-99220.

14. **Why do you use the office visit codes instead of the observation codes?**
    You would only use the office or other outpatient codes for days other than the initial and discharge day. For example, patient is admitted to observation status on Monday (99218), seen in follow up on Tuesday (99214) and sent home from observation status on Wednesday (99217).

15. **Will observation services be coded based only on the key components, or can time be used as an alternative to choose the level of service?**
    Observation services can be reported based on either the three key components or, if the time rule is met, time can be the criteria for coding.

Work RVUs

16. **Is the 6% increase to the work RVUs on new and established office/outpatient visits for primary care only?**
    The increase in work RVU's applies to all specialties.

17. **Will there also be an increase in work RVU's for initial inpatient care?**
    Yes, the work RVU's have been updated in the 2010 physician fee schedule by 0.3%.

General Billing

18. **Does the elimination of consultation services apply to the date of service or claim filing date?**
    This rule is date-of-service driven and applies to all services rendered on or after January 1, 2010.

19. **If a specialist sees a patient for the first time in an inpatient setting on day 3 of their hospital stay, how should this visit be coded?**
    This visit would be considered an initial hospital care visit and therefore billed as a 99221-99223 unless the specialist has already seen this patient and the encounter is a follow-up inpatient, which would be reported as a subsequent inpatient encounter (99231-99233).

20. **In a multispecialty practice, if a patient sees providers of different specialties within the 36-month period, how should a practice bill for each of these visits?**
    Under the new 2010 rules, you cannot bill a consult code. The visits would be billed as new patient office visits (99201-99205) if the patient has not been seen by a physician of the same specialty in the group practice during the past 36 months.

21. **Will non-physician practitioners (NPPs) be able to perform the initial hospital care on behalf of specialists?**
    Yes, a qualified NPP can currently perform these services. The "incident to" rules do not apply in the hospital setting, but if the service is provided according to the "split visit" rule with a specialist, then they may be billed under the specialist.