

Coding for Medicare consultations



Medicare and some other carriers no longer allow use of the Consult code families. The government made this change to address problems in use of the Consult codes. Other existing codes are to be used in their place. The crosswalk to the other codes is complicated. Prolonged Services codes should be added in some cases. Neurologists need to understand these new rules to be able to code properly for patient care. An overview of rules and a coding crosswalk table are presented here.

Since January 2010, the federal Center for Medicare and Medicaid Services (CMS) has disallowed use of the Consultation evaluation and management (E/M) codes for Medicare patients.¹ This has caused great difficulty for US neurologists. It involves both coding and income problems. This article discusses the coding problems and provides examples of how to use the new coding process.

WHAT HAPPENED AND WHY CMS

responded to problems using the Consult codes. Too often physicians failed to follow all of CMS's required rules for Consult codes. CMS reasoned that many services coded as Consult should not have been coded as consultations; rather they were new or established patient services. An Office of the Inspector General survey found that 75% of services coded as consults did not meet all of CMS's rules for consultation services.²

This coding rule now has spread beyond Medicare. Many contracts with managed care organizations and health insurance carriers specify the use of Medicare guidelines and payment schedule, usually with a different conversion factor for payment rates. Many of these contracts followed Medicare into disallowing the consultation codes. Medicaid is expected to follow this rule in the near future. The no consult code rule now applies to a sizable fraction of a neurologist's practice case mix.

At the same time, CMS increased payments for the new and established patient codes. In their plans, discontinuing use of the Consult codes should be budget neutral. What savings occurred due to use of lower-paying codes should be balanced by increasing the payment for those lower codes. They published their projected crosswalk from Consults to other codes and their budgetary assumptions to keep the system budget neutral.³⁻⁴ CMS increased the office and inpatient code payments by 4%–6%.

A neurologist will end up with increased Medicare income when his or her practice is mainly established office patients and few consultations. Those neurologists who provide mostly consultations will see Medicare payments fall.

The American Academy of Neurology opposed this change, as did most medical associations. Nevertheless, CMS implemented the new rule in January 2010.

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NEW CODING RULES Traditionally a consultation is a request by a referring physician for an opinion from the consulting physician. There are 2 broad groups of Current Procedural Terminology E/M services, one for inpatients and another for outpatients. In place of the Consult codes, CMS directs physicians to crosswalk the service to Office New, Office Established, and Initial Hospital Care families of codes.³ Substantial organizational problems resulted from that directive.

Inpatients. CMS crosswalks the Inpatient Consult codes to Initial Hospital Visit codes. These Initial Hospital Visit codes are the same ones used by the primary attending for the hospital admission day service. In order to identify which is the primary admission note and who is the primary admitting physician, Medicare now advises the primary attending to use modifier code -AI when coding his or her admission note.

Similar rules apply to consultations performed at a nursing home or skilled nursing facility.

Outpatients. The outpatient crosswalk rule is complex. CMS directs physicians to use the New or Established office code families in lieu of consultation codes. The New Office Visit code family uses the same level of service and documentation requirements as in the Consult code family. However, for patients who have been seen in the past 3 years face-to-face by the same or another neurologist in the same practice, an Established Office Visit code is used in lieu of a consult code. For those established patient visits, code at the same level of service as for the consult. For established patients, the documentation requirements are less onerous. A new office visit is distinguished from an established office visit by whether face-to-face services occurred in the past 3 years. E/M is face-to-face and so is EMG. EEG is not face-to-face; reading an EEG does not make the patient established to the practice.

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Taxonomy rule and practice group. Identifying who has been seen in the practice for a face-to-face service in the past 3 years can be complex and onerous. The 3-year rule applies only to services provided by physicians from the same practice group and the same taxonomic specialty. Officially in this formal taxonomy scheme, child neurology is separate from neurology. There also are separate taxonomic codes for clinical neurophysiology, pain medicine, and neuromuscular medi-

cine. Which applies to which physician depends on the primary specialty listed on the provider's Medicare application. Identifying which patients were seen face-to-face in the past 3 years involves having an organized method for querying the practice's billing system, preferably prior to the visit. One also needs to know which physicians were listed as which specialty or subspecialty on their formal Medicare application.

Two physicians are considered in the same practice group when they share the same federal tax identification number. That rule is irrespective of whether they practice at the same physical site.

Secondary carriers. When Medicare is a secondary carrier, Consult codes will not be paid by Medicare codes even when the primary accepts the Consult codes. Use the New, Established, and Initial Hospital Care families of codes if you want Medicare to pay as secondary. However, note that Medicare for many years has not paid the secondary amount when the primary carrier's payment exceeds the Medicare allowed charges, as occurs for many privately contracted carriers. Combining both of these rules, it usually makes better sense to code Consults for the primary carrier, and write off the Medicare secondary as not collectable.

Prolonged Service codes and time-based coding. When a service takes greater than 30 minutes more than the base time, the physician can add a separate Prolonged Service code. For outpatients, use code 99354. For inpatients, use code 99356. These are payable by Medicare and most carriers. These Prolonged Service codes should be used more often with the new Medicare no-consults rule. Physicians should familiarize themselves with these codes and use them whenever they are appropriate. In addition to the code 99354 and 99356 for the first hour of prolonged service time, codes 99355 (outpatient) and 99357 (inpatient) are available as additional codes for services that take 75 minutes or more beyond the base code time. For example, an established outpatient service that took 2 hours could be coded as 99215 (40 minutes) plus 99354 (additional hour) plus 99355 (more than 15 minutes into the next hour). Time must be documented, and the reason for the extended time must be described.

When using the Counseling and Care Coordination method to document E/M based on time, use the highest levels of regular E/M before using the Prolonged Services codes. Prolonged Service may be used for established outpatient visits of $40 + 30 = 70$ minutes, which is coded as 99215 plus 99354. When using bullets to document E/M, level 4 or lower codes and base time may be used, e.g., for established outpatient level 4 visits of $25 + 30 = 55$ minutes, code as 99214 + 99354. This requires that time be documented. Only the attending physician's time counts, not the resident's

Table Examples of common crosswalks for Consult codes^a

	Office consults, Hx PX MDM	2010 RVUs	New patient code	Office new, Hx PX MDM	2010 RVUs	Established patient code	Office established, Hx PX MDM	2010 RVUs
Based on work								
Consult code								
99241	PF PF S	1.35	99201	PF PF S	1.08	99212	PF PF S	1.03
99242	E E S	2.54	99202	E E S	1.87	99213	E E L	1.70
99243	D D L	3.47	99203	D D L	2.71	99214	D D M	2.56
99244 ^b	C C M	5.14	99204	C C M	4.20	99214	D D M	2.56
99244 ^b	C C M	5.14	99204	C C M	4.20	99215	C C H	3.46
99245	C C H	6.28	99205	C C H	5.28	99215	C C H	3.46
	Minutes	2010 RVUs	New patient code	Minutes	2010 RVUs	Established patient code	Minutes	2010 RVUs
Based on time^c								
Consult code								
99241	15	1.35	99201	10	1.08	99213	15	1.70
99242	30	2.54	99203	30	1.87	99214	25	2.56
99243	40	3.47	99203	30	2.71	99215	40	3.46
99244	60	5.14	99205	60	4.20	99215	40	3.46
99245	80	6.28	99205	60	5.28	99215 + 99354	70	6.06
	Inpatient consults, Hx PX MDM	2010 RVUs	Inpatient code	Inpatient new, Hx PX MDM	2010 RVUs	Nursing home code	Nursing home new, Hx PX MDM	2010 RVUs
Based on work								
Consult code								
99251	PF PF S	1.37	99231	PF PF S	1.06	99307	PF PF S	1.14
99252	E E S	2.11	99232	E E M	1.91	99308	E E L	1.74
99253	D D L	3.22	99221	D D L	2.61	99304	D D L	2.33
99254	C C M	4.65	99222	C C M	3.53	99305	C C M	3.27
99255	C C H	5.62	99223	C C H	5.18	99306	C C H	4.17
	Minutes	2010 RVUs	Inpatient code	Minutes	2010 RVUs	Nursing home code	Minutes	2010 RVUs
Based on time^c								
Consult code								
99251	20	1.37	99231	15	1.06	99304	25	2.33
99252	40	2.11	99221	30	2.61	99305	35	3.27
99253	55	3.22	99222	50	3.53	99306	45	4.17
99254	80	4.65	99223	70	5.18	99306 + 99356	75	6.55
99255	110	5.62	99223 + 99356	100	7.56	99306 + 99356	75	6.55

Abbreviations: C = comprehensive; D = detailed; E = expanded problem focused; H = high complexity; Hx = history; L = low complexity; M = moderate complexity; MDM = medical decision-making; PF = problem focused; PX = examination; RVUs = relative value units; S = straightforward complexity.

^a Codes must meet or exceed these levels based on documented work or time. Minutes in office is face-to-face, minutes in hospital is time on the patient's unit.

^b 99244 crosswalks to more than one established code depending on the work documented.

^c For time-based codes, more than half the time must be documented as spent counseling and/or coordinating care.

time in the teaching setting. Physician assistant or mid-level time can be counted only for inpatients, in which case there must be 2 notes: 1 by the attending physician and 1 by the physician assistant or mid-level. In the latter case, the time and bullets from the 2 notes are aggregated for coding purposes (split-share services). Some carriers (e.g., Maryland's Medicare carrier) require documentation of start and end clock time.

CODING EXAMPLES

1. You provide a consult on a Medicare outpatient who was seen 2 years ago by another neurologist in your group. The consultation took 60 minutes face-to-face. You document a detailed history and moderate medical decision-making, and describe why the service took 60 minutes. You code as 99214 plus a 99354.
2. You next provide a consult on another Medicare patient who was seen 2 years ago by another neurologist in your group. The consult takes 75 minutes. You document that more than

- half of this 75-minute visit was spent counseling and coordinating care and say what that entailed. You code 99215 plus 99354.
3. You provide a consult on a Medicare inpatient for a high decision-making case, i.e., new onset seizures. You document as usual, and code as 99223.
 4. You provide a consult on a Medicare outpatient. Your practice partner performed an inpatient EMG on the patient 2 years ago, but neither of you has performed an E/M visit service. The consult took 60 minutes. You document a detailed history and moderate medical decision-making, and describe why the service took 60 minutes. You code as 99214 plus a 99354. You code as an established because a member of your group performed a face-to-face service 2 years ago—the EMG. Note this would have been a new patient visit, 99204 or 99205, if the test 2 years ago were an EEG because an EEG interpretation is not a face-to-face physician service.

ORGANIZING YOUR CROSSWALKS The base time for services decreases in these crosswalks as shown in the table. For crosswalking outpatient Consults to New Office, the base time decreases by about 1/3: level 4 drops from 60 to 45 minutes, and level 5 from 80 to 60 minutes. For crosswalking outpatient Consults to Established Office, the base time decreases by 1/2: level 4 drops from 60 to 25 minutes and level 5 from 80 to 40 minutes. For crosswalking inpatients to Initial Hospital Visit, the base time for level 4 consult drops from 80 to 70 minutes, and level 5 drops from 110 to 70 minutes.

Office or hospital follow-up visits are not affected by these rules changes. With all these rules to remember, some practices have taken simpler, practical approaches. In one approach the physician codes according to the traditional rules for all patients. The back office crosswalks the codes. This is conservative and may give up some occasional use of Prolonged

Service codes. Another tactic is to have separate superbills for clinic patients—one for patients with carriers who accept the Consult codes, and another for carriers who do not. Such a No-Consult superbill can help walk the physician through the choices when providing a consultation.

DISCLOSURE

Dr. Nuwer serves on a scientific advisory board for and holds stock in CortiCare; serves as Honorary Consulting Editor for *Clinical Neurophysiology*, on the Board of Advisors for *Medical Economics*, and on the editorial boards of the *Journal of Clinical Neurophysiology* and *Practical Neurology*; serves as a consultant for Mattel, Inc. and as Local Medical Director for SleepMed-Digitrace; receives research support from Bristol-Myers Squibb; and has provided occasional depositions and courtroom testimony in medico-legal cases. Ms. McDermott has received funding for travel or speaker honoraria from the American Academy of Neurology.

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