

# Changes to Coding for Medicare Consultations in 2010

**American College of Surgeons  
Division of Advocacy and Health Policy**



# Overview

- How the Medicare Physician Fee Schedule (MPFS) is determined
- Changes in the CY 2010 MPFS regarding use of consultation codes
- How to code inpatient consultations
- How to code outpatient & ER consultations
- Additional resources



# The Medicare Physician Fee Schedule



# Medicare Physician Payment Basics

- Payments are based on Relative Value Units (RVUs) for each code
- The pool of RVUs is fixed – any changes must be budget neutral
- The Medicare conversion factor determines the overall dollar amount of Medicare payment
- A formula (spelled out in law) determines the annual update to the conversion factor



# Physician Fee Schedule Structure

- There are three types of RVUs that make up the total RVU for any procedure
  - Physician work (about 52%)
  - Practice Expense (about 44%)
  - Professional Liability Insurance Expense (about 4%)
- Medical services are ranked according to resources required to provide them
- Services are assigned Work, PE and PLI RVUs
- Total RVUs are multiplied by conversion factor to calculate payment
- Payments are adjusted by Geographic Practice Cost Indices (GPCIs)



# Calculating Payment

- Payment = Total RVU X Conversion Factor
- Total RVU = (Work RVU X Work GPCI) + (PE RVU X PE GPCI) + (PLI RVU X Malpractice GPCI)
- 2009 payment for 99203: *Mid-level Office Visit, New Patient* (assuming GPCI = 1.00)

$$((1.34 \times 1.00) + (1.12 \times 1.00) + (0.09 \times 1.00)) \times \$36.0666 = \$91.97$$

or

$$2.55 \times \$36.0666 = \$91.97$$



# Changes to the Medicare PFS for CY 2010



# CY 2010 CMS Final PFS Rule – Consult coding changes

- Eliminates the use of all consultation codes (inpatient and office/outpatient codes for various places of service except for telehealth consultation G-codes)
- Makes this change “budget neutral” by increasing the work RVUs for new and established office visits, increasing the Work RVUs for initial hospital and initial nursing facility visits, and incorporating the increased use of these visits into PE and Malpractice RVU calculations.
- Increases the value of 10- and 90-day global period procedures based on the average number of post-operative visits.



# CY 2010 CMS Final PFS Rule – Other RVU changes

- Implements revised RVUs for Practice Expense based on the multi-specialty standardized Physician Practice Inputs Survey (PPIS) conducted by the AMA in 2008
- Implements revised RVUs for Professional Liability Insurance based on the PPIS survey, plus other inputs





# 99203: Mid-level Office Visit, new patient

- 2009 Values:

$$1.34 + 1.12 + 0.09 \times \$36.0666 = \$91.97$$

- 2010 Values:

$$1.42 + 1.19 + 0.10 \times \$36.0666 = \$97.74$$

Assumes GPCI = 1.00

Assumes Congress enacts temporary freeze on Medicare payment rates for 2010.



# Consultation Codes

- Consultation Codes that will no longer be paid by Medicare
  - Office or Other Outpatient Consultations **99241 – 99245**
  - Inpatient Consultations **99251 – 99255**



# Please Note:

**These changes apply only to Medicare.** The consultation codes are still in the CPT manual and supported by CPT. Other third-party payers are expected to continue to use the consultation codes for payment.

# Coding for Inpatient Consultations



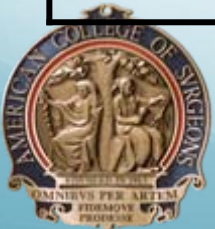
# Coding for Inpatient Consults

- Code an **initial hospital care** or **initial nursing facility care** code for the first visit during a patient's admission to the hospital or nursing facility in lieu of the consultation codes.
- CMS has created a **modifier (-AI)** to identify the admitting physician of record for hospital inpatient and nursing facility admissions.
- Previously only the admitting physician was allowed to code the initial facility care codes.



# Inpatient Consultation Codes

HCPCS Code	History	Physical Exam	Complexity of MDM	Face-to-face Time (mins)
99251	Problem-focused	Problem-focused	Straightforward	20
99252	Expanded Problem-focused	Expanded Problem-focused	Straightforward	40
99253	Detailed	Detailed	Low	55
99254	Comprehensive	Comprehensive	Moderate	80
99255	Comprehensive	Comprehensive	High	110



# Inpatient Visit Codes

<b>HCPCS Code</b>	<b>History</b>	<b>Physical Exam</b>	<b>Complexity of MDM</b>	<b>Face-to-face Time (mins)</b>
99221	Detailed or Comprehensive	Detailed or Comprehensive	Straightforward or Low	30
99222	Comprehensive	Comprehensive	Moderate	50
99223	Comprehensive	Comprehensive	High	70



# What to code for Inpatient Consultations in 2010

- These codes require documentation of 3 of 3 components: Physical, History & Medical Decision-making, therefore:
  - If you previously coded **99253**, you could now code **99221**
  - If you previously coded **99254**, you could now code **99222**
  - If you previously coded **99255**, you could now code **99223**
  - If you previously coded **99251 or 99252**, you could now code **99499: *Unlisted Evaluation and Management Code***



# Subsequent Care Visits

- Subsequent care visits by all physicians and qualified NPPs will be reported as subsequent hospital care codes and subsequent nursing facility care codes.
- These codes require documentation of **2 of 3 components**: Physical exam, History & Medical Decision-making
- Subsequent inpatient visit codes **99231-99233**
- Subsequent nursing facility visit codes **99307 - 99310**



# Coding for Office/Outpatient Consultations



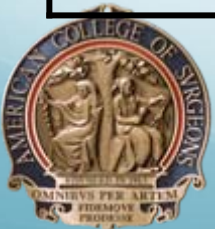
# Coding for Office/Outpatient Consultations

- CMS will only pay for new and established office or other clinic visits under the CY 2010 Physician Fee Schedule.
- A **new patient** is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.
  - New Patient Office/Outpatient Visit Codes **99201 – 99205**
- An **established patient** is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.
  - Established Patient Codes **99211 - 99215**



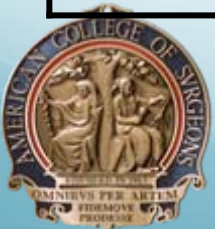
# Office Consultation Codes

HCPCS Code	History	Physical Exam	Complexity of MDM	Face-to-face Time (mins)
99241	Problem-focused	Problem-focused	Straightforward	15
99242	Expanded Problem-focused	Expanded Problem-focused	Straightforward	30
99243	Detailed	Detailed	Low	40
99244	Comprehensive	Comprehensive	Moderate	60
99245	Comprehensive	Comprehensive	High	80



# Office/Outpatient Visit Codes, New Patient

<b>HCPCS Code</b>	<b>History</b>	<b>Physical Exam</b>	<b>Complexity of MDM</b>	<b>Face-to-face Time (mins)</b>
99201	Problem-focused	Problem-focused	Straightforward	10
99202	Expanded Problem-focused	Expanded Problem-focused	Straightforward	20
99203	Detailed	Detailed	Low	30
99204	Comprehensive	Comprehensive	Moderate	45
99205	Comprehensive	Comprehensive	High	60



# What to code for Office/Outpatient Consultations, New Patient

- A **new patient** is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.
- These codes require documentation of **3 of 3 components**: Physical, History & Medical Decision-making, therefore:
  - If you previously coded **99241**, you could now code **99201**
  - If you previously coded **99242**, you could now code **99202**
  - If you previously coded **99243**, you could now code **99203**
  - If you previously coded **99244**, you could now code **99204**
  - If you previously coded **99245**, you could now code **99205**



# Office/Outpatient Visit Codes, Established Patient

HCPCS Code	History	Physical Exam	Complexity of MDM	Face-to-Face Time (mins)
99211				5
99212	Problem-focused	Problem-focused	Straightforward	10
99213	Expanded Problem-Focused	Expanded Problem-Focused	Low	15
99214	Detailed	Detailed	Moderate	25
99215	Comprehensive	Comprehensive	High	40



# What to code for Office/Outpatient Consultations, Established Patient

- A **established patient** is one who has received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years. This applies even if it is a new problem.
- Established patient codes (99211 – 99215) require documentation of **2 of 3 components**: Physical, History & Medical Decision-making.
  - **Example crosswalk**  
If you previously coded **99243**, you could now code **99214**



# ER Consultations

Based on Transmittal 1876 that was release by CMS on 12/14/09

## F. Emergency Department Physician Requests Another Physician to See the Patient in Emergency Department or Office/Outpatient Setting

If the emergency department 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.*



# Emergency Department Visits

<b>HCPCS Code</b>	<b>History</b>	<b>Physical Exam</b>	<b>Complexity of MDM</b>	
99281	Problem- focused	Problem- focused	Straightforward	
99282	Expanded Problem-focused	Expanded Problem-focused	Low Complexity	
99283	Expanded Problem-focused	Expanded Problem-focused	Moderate Complexity	
99284	Detailed	Detail	Moderate	
99285	Comprehensive	Comprehensive	High	



# Consultations during Observation Care

Example according to the new transmittal (1875) from  
CMS

If an internist orders observation services and asks another physician to additionally evaluate the patient, only the internist may bill the initial observation care code. The other physician who evaluated the patient must bill the new or established office or other outpatient visit codes as appropriate.



# CMS Guidelines

- The determination of the appropriate visit code should be made solely on the basis of the existing rules and guidelines for the use of the relevant visit codes (for example, office visit or inpatient visit), without any reference to the guidelines that have been employed for the use of the consultation codes. The guidelines for use of the visit codes are well-established and well-understood.



# CMS Guidelines

## Selection of Level of Evaluation and Management Services:

The duration of the visit is an ancillary factor and does not control the level of the service to be billed unless more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) is spent providing counseling or coordination of care.



# CMS Guidelines

- In the rare circumstance when a physician (or NPP) provides a service that does not reflect a CPT code description, the service must be reported as an unlisted service with CPT code 99499. A description of the service provided must accompany the claim.

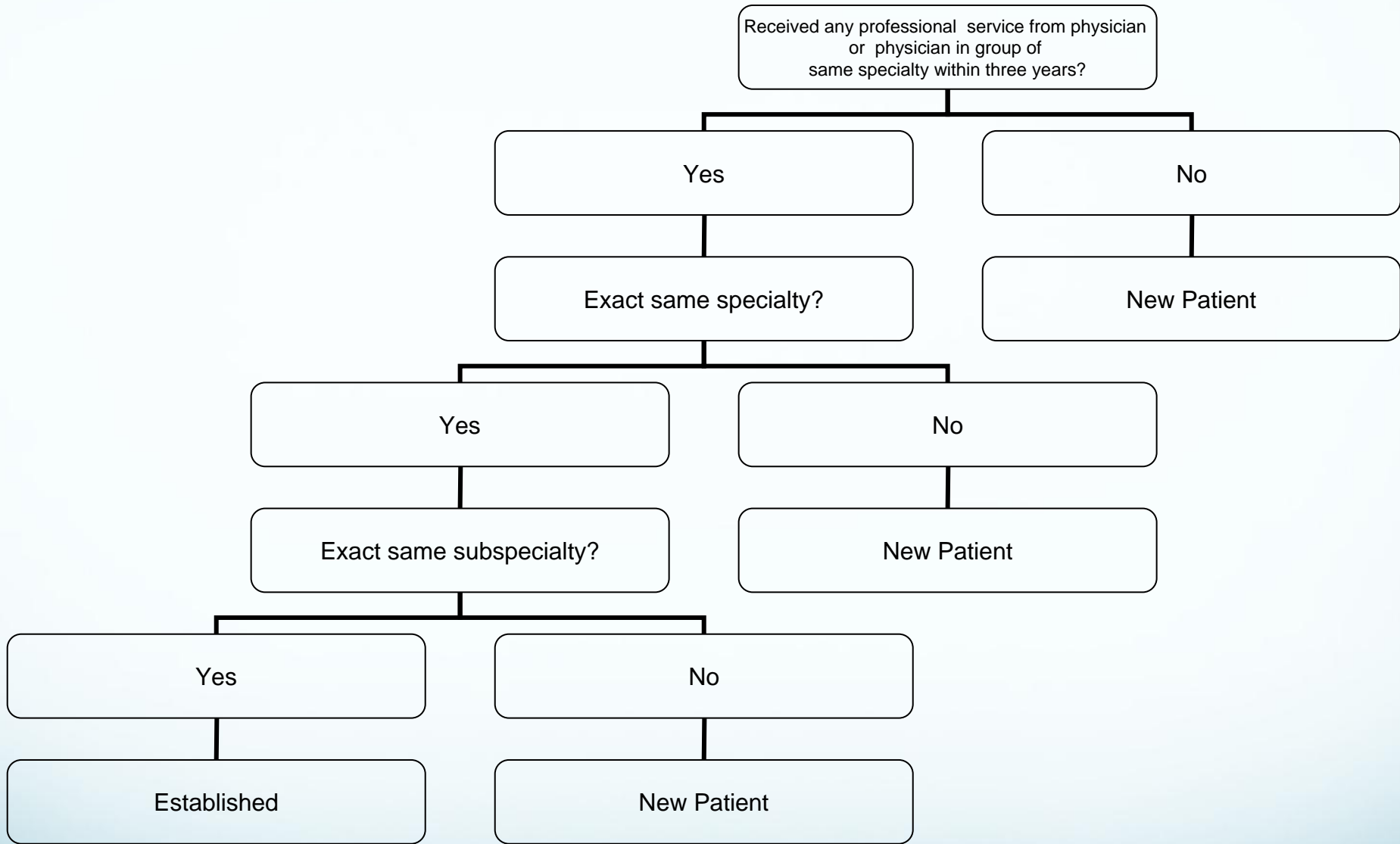


# Decision Tree for New vs. Established Patients

**American Medical Association**

**Current Procedural Terminology: 2010**

**Professional Edition**



# Additional Resources



## Department of Health and Human Services

**Centers for Medicare & Medicaid Services – CMS – 1413- FC**

**Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010.**

**<http://edocket.access.gpo.gov/2009/pdf/E9-26502.pdf>**

## Medicare Claims Processing Manual

**Chapter 12 - Physicians/Nonphysician Practitioners, Section 30**

**AMA CPT Current Procedural Terminology: Professional Edition 2009 and 2010 codebook.**

## Medicare Transmittal

**<http://www.cms.hhs.gov/transmittals/downloads/R1875CP.pdf>**



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# Questions & Answers

