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

News Flash – Version 3.0 of the Measures Groups Specifications Manual released in November 2009 for 2010 PQRI has been revised. Version 3.1 of the 2010 PQRI Measures Groups Specifications Manual and Release Notes reflects a change to the denial remark code note for several Measures Groups. Correct G-codes specific to each Measures Group have been replaced within this document. For further details, the updated "2010 PQRI Measures Groups Specifications Manual and Release Notes" is now available on the CMS PQRI webpage at http://www.cms.hhs.gov/pqri on the CMS website. Click on the "Measures Codes" section page on the left.

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Questions and Answers on Reporting Physician Consultation Services

Provider Types Affected

This article is for physicians and non-physician practitioners (NPPs) who perform initial evaluation and management (E/M) services previously reported by Current Procedural Terminology (CPT) consultation codes for Medicare beneficiaries and submit claims to Medicare Carriers 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 physicians and NPPs who have reassigned their billing rights, and hospices where the hospice bills Part A for the services of physicians on staff or working under arrangement with the hospice. **This article only applies to the services of physicians and NPPs paid under the Medicare Fee-For-Service (FFS) program. It does not revise existing policies or rules governing Medicare Advantage or non-Medicare insurers. Physicians, NPPs, Method II critical access hospitals, and hospices to which the revised policy applies are subsequently referred to as providers throughout this publication.**

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Provider Action Needed

This article pertains to change request (CR) 6740, which alerts providers that effective January 1, 2010, the 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 report each E/M service, including visits that could be described by CPT consultation codes, with an E/M code payable under the Medicare Physician Fee Schedule (MPFS) that represents **WHERE** the visit occurs and that identifies the **COMPLEXITY** of the visit performed.

Background

In the calendar year (CY) 2010 MPFS final rule with comment period (CMS-1413-FC), the Centers for Medicare & Medicaid Services (CMS) eliminated the payment of all CPT consultation codes (inpatient and office/outpatient codes) for various places of service except for telehealth consultation HCPCS G-codes. The change does not increase or decrease Medicare payments. In the case of CPT codes for E/M services that may be reported in CY 2010 for E/M services previously paid by the CPT 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 Publication 100-4, Chapter 12, Section 30.6 of the *Medicare Claims Processing Manual* that pertain to the use of the American Medical Association (AMA) 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.)

Questions (Qs) & Answers (As)

The following Qs and As are offered to address some of the key questions you may have regarding these changes:

Q. When will providers and Medicare contractors stop reporting and paying the CPT consultation codes for consultative E/M services that could be described by the CPT consultation codes?

A. Medicare ceased recognizing the CPT consultation codes for payment effective for services furnished on or after January 1, 2010.

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Q. Does this policy apply to other Medicare products, such as Medicare Advantage?

A. This policy applies to providers billing the Medicare fee-for-service program. If a provider is furnishing an E/M service that could be described by a CPT consultation code to a Medicare Advantage patient, the provider should contact the Medicare Advantage plan for its policy.

Q. Is CMS going to crosswalk the CPT consultation codes that are no longer recognized to the E/M codes for each setting in which an E/M service that could be described by a CPT consultation code can be furnished?

A. No, providers must bill the E/M code (other than a CPT consultation code) that describes the service they provide in order to be paid for the E/M service furnished. The general guideline is that the provider should report the most appropriate available code to bill Medicare for services that were previously billed using the CPT consultation codes. For services that could be described by inpatient consultation CPT codes, CMS has stated that providers may bill the initial hospital care service CPT codes and the initial nursing facility care CPT codes, where those codes appropriately describe the level of service provided. When those codes do not apply, providers should bill the E/M code that most closely describes the service provided.

Q. How should providers bill for services that could be described by CPT inpatient consultation codes 99251 or 99252, the lowest two of five levels of the inpatient consultation CPT codes, when the minimum key component work and/or medical necessity requirements for the initial hospital care codes 99221 through 99223 are not met?

A. There is not an exact match of the code descriptors of the low level inpatient consultation CPT codes to those of the initial hospital care CPT codes. For example, one element of inpatient consultation CPT codes 99251 and 99252, respectively, requires "a problem focused history" and "an expanded problem focused history." In contrast, initial hospital care CPT code 99221 requires "a detailed or comprehensive history." Providers should consider the following two points in reporting these services. First, CMS reminds providers that CPT code 99221 may be reported for an E/M service if the requirements for billing that code, which are greater than CPT consultation codes 99251 and 99252, are met by the service furnished to the patient. Second, CMS notes that subsequent hospital care CPT codes 99231 and 99232, respectively, require "a

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problem focused interval history" and "an expanded problem focused interval history" and could potentially meet the component work and medical necessity requirements to be reported for an E/M service that could be described by CPT consultation code 99251 or 99252.

Q. How will Medicare contractors handle claims for subsequent hospital care CPT codes that report the provider's first E/M service furnished to a patient during the hospital stay?

A. While CMS expects that the CPT code reported accurately reflects the service provided, CMS has instructed Medicare contractors to not find fault with providers who report a subsequent hospital care CPT code in cases where the medical record appropriately demonstrates that the work and medical necessity requirements are met for reporting a subsequent hospital care code (under the level selected), even though the reported code is for the provider's first E/M service to the inpatient during the hospital stay.

Q. How will more reporting of initial hospital care CPT codes instead of CPT consultation codes affect the review of claims by Medicare contractors?

A. CMS has alerted MAC audit staff as well as Medicare Recovery Audit Contractors of its expectation that physicians may bill more E/M codes for initial hospital care in place of billing inpatient CPT consultation codes. CMS has also alerted contractors to expect a different proportion of various initial hospital care CPT codes under the new policy. CMS expects contractors to consider that these may be appropriate changes when making decisions about whether to pursue medical review and other types of claims review.

Q. How should providers bill for E/M services that cannot be described by any CPT E/M code that is payable by Medicare?

A. These services should be reported with CPT code 99499 (Unlisted evaluation and management service). Reporting CPT code 99499 requires submission of medical records and contractor manual medical review of the service prior to payment, and CMS expects reporting of this E/M code to be unusual.

Q. Because CPT consultation codes are no longer recognized by CMS for payment, is the definition of transfer of care no longer relevant?

A. Yes, CMS agrees that discontinuing recognition of the CPT consultation codes for payment renders the issues regarding the definition of what constitutes a transfer of care no longer relevant.

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Q. When is it appropriate for providers to report critical care services in the context of furnishing an E/M service that could be described by a CPT consultation code?

A. Providers should continue to follow the existing CPT guidelines for reporting critical care codes.

Q. What constitutes a new versus an established patient? Can a provider bill an office/outpatient new patient visit code and/or an initial hospital care service code for a patient seen within the past three years but for a new problem?

A. The rules with respect to new and established patient office visits are unchanged. Providers should follow the guidance in Publication 100-04, Chapter 12, Section 30.6.7 of the *Medicare Claims Processing Manual*:

> Interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. For example, if a professional component of a previous procedure is billed in a 3 year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG, etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.

Q. Will Medicare contractors accept the CPT consultation codes when Medicare is the secondary payer?

A. Medicare will also no longer recognize the CPT consultation codes for purposes of determining Medicare secondary payments (MSP). In MSP cases, providers must bill an appropriate E/M code for the E/M services previously reported and paid using the CPT consultation codes. If the primary payer for the service continues to recognize CPT consultation codes for payment, providers 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 CPT 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

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the service, to Medicare for determination of whether a payment is due.

Q. Can a provider provide an advance beneficiary notice (ABN) to the beneficiary and then bill his or her charge for the consultation after the consultation is billed and denied by Medicare?

A. No, when a CPT consultation code is reported to Medicare, the claim is not denied. Instead, the claim is returned to the provider for a different CPT code because Medicare recognizes another code for payment of E/M services that may be described by CPT consultation codes. Once the claim is resubmitted to report an appropriate, payable E/M code (other than a CPT consultation code) for a medically reasonable and necessary E/M service, the beneficiary can only be billed any applicable Medicare deductible and coinsurance amounts that apply to the covered E/M service.

Q. Can a provider who furnished an E/M service that could be described by a CPT consultation code to a Medicare beneficiary bill the beneficiary for his or her charge for the service after providing an ABN?

A. No, an ABN cannot be employed in these circumstances, because ABNs are applicable only where denial of payment is anticipated on grounds of the medical necessity requirement under section 1862(a)(1)(A) of the Social Security Act. E/M services previously reported using CPT consultation codes may be medically reasonable and necessary. CPT consultation codes 99241-99245 and 99251-99255 are now assigned status indicator "I," which means that these codes are not valid for Medicare purposes, and explicitly provides that "Medicare uses another code for the reporting of, and payment for these services."

Q. Can providers count floor/unit time toward the time threshold that must be met to bill a prolonged service with direct (face-to-face) patient contact in the inpatient setting?

A. 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, Section 30.6.15.1.C, provides that providers may count only the duration of direct face-to-face contact between the provider 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.

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Q. Can a new patient office visit CPT code be billed to report an E/M service that could be described by a CPT consultation code when a patient is seen for a pre-operative consultation at the request of a surgeon, even if the consulting provider has provided a professional service to the beneficiary within the past three years?

A. Publication 100-04, Chapter 12, Section 30.6.7 of the *Medicare Claims Processing Manual* states:

> "Interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. For example, if a professional component of a previous procedure is billed in a 3 year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient."

CMS has not adopted any revisions to the previous policies, regarding the billing of E/M codes as a result of the new policy on CPT consultation codes (other than allowing providers who would previously have billed the inpatient CPT consultation codes to bill the initial hospital and nursing home visit CPT codes where those codes appropriately describe the services furnished). Therefore, the requirements of Publication 100-04, Chapter 12, Section 30.6.7.A of the *Medicare Claims Processing Manual* remain in effect. In the situation where a patient is seen for a pre-operative consultation when the consulting provider has furnished a professional service to the beneficiary in the past three years, that provision precludes the provider from billing a new patient office visit CPT code.

Q. When may initial nursing facility (NF) care codes be reported for E/M services that could be described by CPT consultation codes?

A. Physicians may bill an initial NF care CPT code for their first visit during a patient's admission to a NF in lieu of the CPT consultation codes these physicians may have previously reported, when the conditions for billing the initial NF care CPT code are satisfied. The initial visit in a skilled nursing facility (SNF) and nursing facility must be furnished by a physician except as otherwise permitted as specified in CFR Section 483.40(c)(4). The initial NF care CPT codes 99304 through 99306 are used to report the initial E/M visit in a SNF or NF that fulfills federally-mandated requirements under Section 483.40(c).

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Q. *What E/M code should physicians report for an initial E/M service that could be described by a CPT consultation code but that does not meet the requirements for reporting an initial NF care CPT code?*

A. In these cases, physicians and other practitioners may bill a subsequent NF care CPT code in lieu of the CPT consultation codes they may have previously reported. Otherwise, the subsequent NF care CPT codes 99307 through 99310 are used to report either a federally-mandated periodic visit under Section 483.40(c), or any E/M service prior to and after the initial physician visit that is reasonable and medically necessary to meet the medical needs of the individual resident.

Q. *When may NPPs furnish an initial NF E/M service?*

A. In the NF setting, an NPP, who is enrolled in the Medicare program and is not employed by the facility, may perform the initial visit when the state law permits this (See this exception in Publication 100–04, Chapter 12, Section 30.6.13.A of the *Medicare Claims Processing Manual)*. A NPP who is enrolled in the Medicare program is permitted to report the initial hospital care visit or new patient office visit, as appropriate, under current Medicare policy. As discussed in the CY 2010 MPFS proposed rule (74 FR 33543), the long-term care regulations at Section 483.40 require that residents of SNFs receive initial and periodic personal visits. These regulations insure that at least a minimal degree of personal contact between a physician or a qualified NPP and a resident is maintained, both at the point of admission to the facility and periodically during the course of the resident's stay.

Q. *How should E/M services previously reported by CPT consultation codes and provided in a split/shared manner be billed?*

A. The split/shared rules applying to E/M services remain in effect, including those cases where services would previously have been reported by CPT consultation codes.

Q. *Does the policy of no longer recognizing CPT consultation codes for the purposes of Medicare billing apply to billing for physicians' services in hospices, where the hospice bills Part A for the services of physicians on staff or working under arrangement with the hospice?*

A. Yes, when hospices bill Part A for the services of physicians, they must use CPT codes that are paid under the MPFS. Since the CPT consultation codes are no longer recognized for payment under the MPFS, hospices must follow the same guidelines for reporting E/M services as physicians billing Part B. Hospices should use the most appropriate E/M codes to bill

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for E/M services furnished by physicians that could be described by CPT consultation codes.

Q. Will appending modifier "-A1"(Dressing for one wound) instead of the appropriate modifier "-AI"(Principal physician of record) to the CPT code for an initial hospital or nursing home E/M service furnished by the principal physician of record affect payment to the provider for that service?

A. Because modifier "-AI" (not modifier "-A1") is the appropriate modifier to identify an initial hospital or nursing home E/M service by the patient's principal physician of record, payment to the provider for the E/M service could be affected. Some Medicare contractors may reject an E/M code reported with modifier "-A1" as an invalid procedure code/modifier combination and, therefore, payment for the E/M service would not be made. In that case, the provider should submit a corrected claim reporting modifier "-AI" appended to the E/M code. If an E/M code with modifier "-A1" appended has already been submitted and paid, the provider does not need to submit a corrected claim but should report the appropriate modifier "-AI" on future claims for initial hospital or nursing home E/M services when the E/M service is furnished by the principal physician of record. Providers should contact their Medicare contractor for further assistance if necessary.

Q. Do admitting physicians still get paid if they do not report the modifier "-AI?"

A. Yes, the use of the modifier is for informational purposes only.

Q. The transmittal, "Revisions to Consultation Services Payment Policy" (Transmittal # R1875CP, also referred to as CR 6740), indicates that the CPT consultation codes are 'not valid for Medicare.' It also states Medicare uses a different code to report the service. However, the MLN Matters® article directed to providers states the consult codes are 'non-covered.' When it comes to reporting services, there is a definite difference in these two terms. Please clarify.

A. The question refers to the following passage in the original MLN Matters® article:

> Physicians who bill a consultation after January 1, 2010 will have the claim returned with a message indicating that Medicare uses another code for the service. The physician must bill another code for the service and may not bill the patient for a non-covered service.

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The MLN Matters® article is being reissued to clarify this passage, consistent with the answer to the question that follows.

The provider may not bill the patient in lieu of billing Medicare and may not have the patient sign an ABN to hold the patient personally responsible for the payment. CMS did not intend for this passage to suggest that E/M services that could be described by CPT consultation codes are "non-covered." Rather, CMS intended to indicate that providers may not bill the patient for the E/M service that could be described by a CPT consultation code **as though** the E/M service was non-covered, as is now clarified in the reissued article. However, some people have interpreted the passage to suggest that providers cannot bill for an E/M service that could be described by a CPT consultation code because **it is a non-covered service**. The following language may clarify what CMS was trying to say in the cited passage:

> 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.

Q. Does the new policy violate HIPAA rules by requiring providers to bill for E/M services that could be described by CPT consultation codes using codes other than the ones designated by CPT, which is the adopted code set under the law?

A. The HIPAA regulations place certain requirements on health plans. One of those requirements is that "a health plan may not delay or reject a transaction, or attempt to adversely affect the other entity or the transaction, because the transaction is a standard transaction." In addition, a health plan must "[a]ccept and promptly process any standard transaction that contains code sets that are valid" and CPT-4 has been accepted as the standard medical data code set for, among other things, physician services. However, the regulations also state that "all parties [must] accept these codes within their electronic transactions . . . [but does not require] payment for all of these services."

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As of January 1, 2010, Medicare will no longer recognize for payment CPT consultation codes. Instead, CMS is instructing providers to use the most appropriate office or inpatient E/M code to report E/M services that could be described by CPT consultation codes. This policy change was adopted after going through notice and comment rulemaking and the payment rates for certain E/M services were increased to maintain budget neutrality and to ensure all providers were being paid equivalently for equivalent work. Further, CMS is not changing the definition of any of the existing E/M codes as a result of this policy.

Claims with the CPT consultation codes are not rejected. Instead, Medicare accepts a claim that reports a CPT consultation code, processes it, and returns the claim to the provider to report an E/M code for the service that is recognized by Medicare for payment because CMS does not pay for the CPT consultation codes. In other words, accepting claims with CPT codes (including consultation codes) from the adopted code set, and then processing (paying, denying, or returning the claim to the provider to report a code that is recognized by Medicare for payment) those claims in accordance with the MPFS ensures that Medicare is fulfilling its obligation to "accept" and "process" standard transactions that contain valid code sets.

It is not the intention of CMS to cause confusion or make the Medicare program more administratively complex.

Additional Information

If you have questions, please contact your Medicare MAC 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. The related MLN Matters article may be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf* on the CMS website.

Medicare manuals are available at *http://www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website.

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

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