



THE AMERICAN GERIATRICS SOCIETY

CMS to Change Coding for Consultations Beginning January 1, 2010

Beginning January 1, 2010, the Centers for Medicare & Medicaid Service (CMS) will eliminate the use of all codes for inpatient and office/outpatient consultations, except for telehealth consultations which may be reported using newly established G-codes. CMS believes for a variety of reasons that there is no longer a difference in physician work between consultation and office visits. The consultation codes were eliminated in a budget-neutral manner using a crosswalk to office visit and initial hospital and nursing home visit codes; therefore, CMS will increase the work relative value units (RVUs) for new and established office visits, for initial hospital visits and for initial nursing facility visits, and incorporate the increased volume of these visits into practice expense and malpractice RVU calculations.

Top-level Summary

Impact of Changes on RVUs and National Payment Amounts

New CMS Coding for an Inpatient Consultation

Background on AMA-CPT

Meaning for Geriatricians

What to do if you are the Attending of Record

Use Specialty Code 38 to Identify Yourself as a Geriatrician

CMS Developing Guidance Documents

Top-level Summary

- Physicians should not use consultation codes 99241-99245 or 99251-99255 when billing Medicare after January 1, 2010.
- For Inpatient Consultations, physicians should use either Hospital Care codes 99221-99223 or Nursing Facility Codes 99304-99306, depending on site of service.
- For Outpatient Consultations, physicians should use Outpatient Services codes 99201-99215. For the home and domiciliary settings, physicians should use 99324-99337 and 99341-99350, respectively.
- Claims with consultation codes will be rejected, but not denied, by Medicare and will be returned to the physician, who will have to resubmit them using the appropriate visit code.
- While this new policy applies to Medicare, it is unclear whether commercial insurers will follow suit; physicians should therefore check with commercial insurers to understand their policies regarding the use of consultation codes.

Impact of Changes on RVUs and National Payment Amounts

See the tables below for impact of changes in the RVUs and national payment amounts (for comparison purposes, we applied the 2009 conversion factor of 36.0666 for 2010; the actual conversion factor for 2010 is currently 28.3895, but this is subject to change pending Congressional intervention to avert the negative 21.2 percent increase that will become effective on January 1, 2010, under current law). The total revenues reflect changes in the practice expense and professional liability RVUs made by CMS for 2010.

Table 1 - Outpatient							
Evaluation & Management Office or Outpatient	2009 Work RVU	2009 Non-Facility Total RVU	National Payment <i>(at conversion factor 36.0666)</i>	2010 Work RVU	2010 Non-Facility Total RVU	National Payment <i>(assuming conversion factor 36.0666)</i>	Percent (%) Difference Between 2009-2010
New Patient							
99201	0.45	1.03	37.15	0.48	1.08	38.95	4.85
99202	0.88	1.78	64.20	0.93	1.87	67.44	5.05
99203	1.34	2.55	91.97	1.42	2.71	97.74	6.27
99204	2.30	3.93	141.74	2.43	4.20	151.48	6.87
99205	3.00	4.96	178.89	3.17	5.28	190.43	6.45
Established Patient							
99211	0.17	0.5	18.03	0.18	0.53	19.12	6.02
99212	0.45	1.03	37.15	0.48	1.08	38.95	4.85
99213	0.92	1.72	62.03	0.97	1.82	65.64	5.82
99214	1.42	2.57	92.69	1.5	2.73	98.46	6.23
99215	2.0	3.48	125.51	2.11	3.68	132.73	5.75
Outpatient consultations (office or outpatient)							
99241	0.64	1.35	48.69	0.64		NA	
99242	1.34	2.54	91.61	1.34		NA	
99243	1.88	3.47	125.15	1.88		NA	
99244	3.02	5.14	185.38	3.02		NA	
99245	3.77	6.28	226.5	3.77		NA	

[\[Back to top\]](#)

Table 2 – Inpatient

	2009 Work RVU	2009 Facility Total RVU	2009 National Payment <i>(at conversion factor 36.0666)</i>	2010 Work RVUs	2010 Facility Total RVU	2010 National Payment <i>(at conversion factor 36.0666)</i>	Percent Difference Between 2009-2010
Initial Hospital Care							
99221	1.88	2.51	90.53	1.89	2.61	94.13	3.98
99222	2.56	3.4	122.63	2.57	3.53	127.32	3.82
99223	3.78	5.02	181.05	3.79	5.18	186.82	3.19

Subsequent Hospital Care							
99231	0.76	1.04	37.51	0.76	1.06	38.23	1.92
99232	1.39	1.87	67.44	1.39	1.91	68.89	2.15
99233	2.0	2.68	96.66	2.0	2.74	98.82	2.24
Initial Nursing Facility Care							
99304	1.61	2.25	81.15	1.61	2.43	87.64	8.00
99305	2.3	3.13	112.89	2.31	3.41	122.99	8.94
99306	3	4.03	145.35	3.01	4.33	156.17	7.44
Subsequent Nursing Facility Care							
99307	0.76	1.11	40.03	0.76	1.16	41.84	4.51
99308	1.16	1.68	60.59	1.16	1.79	64.56	6.55
99309	1.55	2.23	80.43	1.55	2.37	85.48	6.28
99310	2.35	3.32	119.74	2.35	3.50	126.23	5.42
Inpatient Consults							
99251	1	1.37	49.41			NA	
99252	1.5	2.11	76.1			NA	
99253	2.27	3.22	116.13			NA	
99254	3.29	4.65	167.71			NA	
99255	4	5.62	202.69			NA	

[\[Back to top\]](#)

New CMS Coding for an Inpatient Consultation

In the CMS Physician Fee Schedule final rule, released in October 2009, CMS said that when performing an inpatient consultation, physicians should bill an initial hospital care or initial nursing facility care code for their first visit during a patient's admission to the hospital or nursing facility. In lieu of outpatient consultation codes, physicians should bill either new or established patient office visit codes, depending on whether the patient has sought professional services at the practice within the last three years.

CMS also applied the RVU increases to the pre- and post- service work for 10-day and 90-day global surgery codes. AGS estimates that the increases in payments for these 10-day and 90-day global services due specifically to this change will be small, approximately \$65 million which is a little more than 0.1% of total Medicare spending for the physician fee schedule.

[\[Back to top\]](#)

Background on AMA-CPT

CMS stated in the final 2010 physician payment rule that the AMA-CPT had not adequately resolved issues regarding the definition of transfer of care as compared to a consultative service

and also indicated that the documentation of a consultation request in CPT was inconsistent with CMS policy. CMS thus explained that the elimination of consultation codes is expected to end the ambiguity and confusion over how to document the request for a consultation as opposed to a transfer of care. Notwithstanding the change in the Medicare policy to eliminate all consultation codes, the revised AMA-CPT for 2010 included new language defining concurrent care and transfer of care, and contains guidance regarding the use consultation codes.

It is not unusual for AMA-CPT to define codes that are not reimbursed by Medicare. However, to be clear, the 2010 revised AMA-CPT language regarding the use of consultation codes does not affect the new policy to eliminate the use of these codes for Medicare purposes as of January 1, 2010. That is, consultation codes will not be used by Medicare beginning in 2010, despite the new AMA-CPT language.

[\[Back to top\]](#)

Meaning for Geriatricians

Geriatricians who did not bill many consultations should see higher payments under the new rules because payments for initial and follow up visits will increase significantly. However, consultations have been paid at a much higher rate than initial patient visits; so even though payments for initial office, hospital and nursing home visits will increase in 2010, the increase will not completely offset lost revenue from a consultation. CMS did not provide a coding crosswalk to assist physicians in choosing which office or hospital code to report in lieu of a consultation code. In choosing which office or hospital code to report, physicians will need to consider what elements are required for the code (e.g., history, physical, medical decision-making) as well as total time spent with the patient. Because the typical time for consultation services is longer than total time for office and hospital visit codes, in some cases it may be appropriate to report a prolonged services code in addition to the visit code. When doing so, it will be important to review CPT and Medicare policy regarding the use of prolonged services codes.

[\[Back to top\]](#)

What to do if you are the Attending of Record

CMS will require physicians who perform the “attending of record” admission services to use a modifier “AI” when reporting the initial services. The rules regarding who may report initial nursing facility care have not changed (see CMS’ MedLearn Matters article SE0418). CMS recognizes that many issues still must be resolved regarding which visit codes to bill in certain circumstances, and is currently developing guidance to address these issues.

Use Specialty Code 38 to Identify Yourself as a Geriatrician

Finally, geriatricians should remember to use the recently created specialty code 38 to designate their geriatric medicine specialty when submitting claims to CMS, rather than the codes for internal medicine (code 11) or for family practice (code 08). Doing so will help CMS and other agencies to compile statistics that allow them to better understand trends in geriatric care, and to compare geriatricians with other geriatricians, rather than comparing them to internal medicine

or family practice physicians. Geriatricians that do not currently use specialty code 38 must update their self-designated specialty information with CMS by updating their provider enrollment application (form CMS-855I), or by updating their enrollment record using CMS' internet-based National Provider Enrollment, Chain and Ownership System (PECOS).

[\[Back to top\]](#)

CMS Developing Guidance Documents

CMS is developing guidance documents, including a new MedLearn Matters article, to provide additional assistance for physicians regarding the elimination of consultation codes beginning January 1. The American Medical Association and many specialty societies are working together and with CMS to ensure that this policy is clear when it becomes effective. In addition, the AGS is continuing to review the new policy in detail and is also developing educational materials to help our members comply with these new requirements.

Please e-mail Caitlin Connolly at CConnolly@americangeriatrics.org if you have any questions. For more detailed information from CMS, [click here](#) to see the MLN Matters article.

[\[Back to top\]](#)