Each year, we all eagerly await the additions, revisions, and deletions to the various coding systems (ICD-9-CM, CPT, and HCPCS II). But this year, the biggest change to impact professional services was not a deleted code set but rather a category of highly utilized codes not being recognized for payment by one of the United States’ largest and most influential payer: Medicare Part B. Effective January 1, 2010, Medicare will no longer pay for consultation services (except telehealth consultation G codes). In order to see the thought process behind this seemingly bold move, it is important to understand that it wasn’t all that unexpected given the historical background.

Background

In November 1990, the consultation codes were added to the CPT manual (CPT 99241–99255) effective for dates of service beginning January 1, 1991. The intent of these codes was to identify an evaluation and management (E/M) service provided primarily by specialty physicians to evaluate and potentially treat a patient’s problem(s). A consultation service was to be reported when the following criteria were met:

- There was a request for advice, opinion, recommendation, suggestion, or similar such request, documented either as a verbal request or a written request
- A written report of the service was sent back to the requesting physician
- Documentation in both the requesting physician and the consulting physician’s medical records accurately reflected the request for a consultation service

In June 1991, (56 FR, 25828) CMS had two goals for consultation services:
1. To establish reliable and consistent use by all physicians and carriers
2. To establish a valid crosswalk so that valid work relative value units (RVU) could be assigned

Consistency (i.e., different providers reporting the same category of codes for the same service) was a recurrent problem because of the subjectivity and lack of official guidance. Therefore, Medicare received repeated requests from the physician community for specific guidance on when to report a consultation service (with examples). Medicare finally provided guidance in August 1999. This guidance, published within the Medicare Claims Processing Manual (§30.6.10), was accompanied by examples. Although this much sought after guidance was finally available, Medicare could not possibly provide examples.
of every clinical scenario that could be encountered, and it found that the various local Medicare carriers had different interpretations of what a consultation service should be, resulting in a vague and unclear coding concept.

Some felt that if the physician initiated treatment that the service was no longer consultative in nature. Therefore, in 1999, Centers for Medicare & Medicaid Services (CMS) and the AMA clarified in the coding guidelines that consultative services may involve initiation of therapeutic services at the time of or at a subsequent visit. Also within this 1999 time frame, CMS attempted to define what it considered the difference among a referral, a consultation, and transfer of care. Yet this concept is somewhat subjective based on the interpretation of the individual provider and local carriers.

CPT manual revisions were also made in January and September 2001 to identify that non-physician practitioners (NPP) can both request and furnish a consultative service. Around this time frame, it came to CMS’ attention that the AMA CPT definition did not include the directive that the request for the consultation must be documented in the consultant’s medical record and in the requesting physician’s medical record. This inconsistency between CMS and the AMA’s CPT manual was difficult for providers to understand, and therefore was questioned by providers when enforced by CMS.

In March 2006, the Office of Inspector General (OIG) released a report titled Consultations in Medicare: Coding and Reimbursement. The report showed that Medicare had paid approximately $1.1 billion more for consultative services in 2001. The study found that 75% of those claims paid as consultative services did not in fact meet the criteria to be paid as a consultation service. The errors were not solely about selecting a consultation service versus an office/outpatient or inpatient visit, but also the incorrect level of service and deficient documentation resulting in improper payments. The OIG then suggested to CMS that it educate providers on the appropriate use of the codes, and CMS responded to this request by publishing a MedLearn Matters article in January 2006 (prior to the official release of the OIG report) to instruct providers on proper documentation and reporting of consultation services.

In 2006, the AMA ultimately decided to delete some of the consultation codes for confirmatory and follow-up inpatient consultations, which may have been a good thing considering most never understood the proper use anyway. Consequently, the deletion of these codes only partially solved the conundrum of assigning codes for consultation services versus other E/M services.

The meaning of transfer of care has long since been an issue for providers, since the definition varies. Some providers would report an initial visit service, whereas others would report for a consultative service. The CPT manual lacked a specific definition for transfer of care and concurrent care,

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so the AMA added one into the 2010 edition in the E/M services guidelines, which unfortunately may have been a bit late for Medicare patients.

Consultation services were always the E/M category of choice for many specialty providers because the payment was higher than merely reporting for initial or new patient services. This comes as no surprise, considering these services had a financial incentive as well as a desire to be paid accurately for the services provided in the ever-decreasing fee schedules presented from Medicare and CMS as a whole each year.

The debate on whether a service is a referral, transfer of care, consult, consult and treat, evaluate and treat, or other such similar designation is hopefully over now for Medicare patients. But with the simplification of eliminating consultation services as payable by Medicare Part B, it opens up a completely new set of issues that must be considered.

**FY 2010: No CPT consultation services for Medicare**

There are a number of snowball effects from the elimination of consultation services (CPT 99241–99255) by Medicare Part B. Medicare provided guidance in CMS transmittal 1875 (CR 6740) dated December 14, 2009, to update the *Medicare Claims Processing Manual* §30.6.1 instructing on how to assign codes for services that previously would be reported as a consultation service. Some of the highlighted scenarios include:

- Initial consults provided for inpatients
- Consults provided in the emergency department (ED)
- Initial consults provided in an outpatient/office setting

Per the AMA’s CPT guidelines for initial hospital care codes (CPT 99221–99223), only the admitting physician may report one of these codes for the initial face-to-face inpatient encounter with a patient. Other providers are instructed to use inpatient consult codes (CPT 99251–99255), subsequent hospital care codes (CPT 99231–99233), or subsequent nursing facility codes (CPT 99307–99310). Since providers cannot report consult codes to Medicare, providers were instructed to report an initial hospital care code (CPT 99221–99223) for the first face-to-face service provided to an inpatient (even if that provider is not designated as the admitting physician). Medicare has added a new HCPCS II modifier, -AI (Principal Physician of Record), to the 2010 HCPCS II coding manual to document the admitting physician. This modifier shall be appended to the initial hospital care code (CPT 99221–99223) reported by the admitting physician to distinguish that physician from other initial services provided by the non-admitting physicians or those providing specialty care.

Consultation services provided in the ED (previously reported as an office/outpatient consultation in CPT 99241–99245) will be assigned depending on whether the patient was admitted by that same physician.
Consult provided in the ED resulting in admission as an inpatient by the same physician (report only Initial Hospital Care Services CPT 99221–99223)

Consult provided in the ED and patient is discharged home (report only ED visit code (CPT 99281–99285)

Lastly, consultation services provided in an office setting (e.g., physician office), will be reported with the appropriate level office/outpatient visit code (CPT 99201–99215). Don’t forget the rules for new versus established patients, which is a recent addition to at least one of the regional recovery audit contractors’ list of issues for Part B services. According to a recently released CMS-approved RAC issue:

Providers are only allowed to bill the CPT codes for New Patient visits if the patient has not received any professional services from the physician or physician group practice within the previous three years.

This concept can be a bit cloudy when practices have subspecialties. Some payers, including Medicare, may not consider the subspecialty reason enough to report a new patient office visit code when the subspecialty is within the same office and utilizes the same medical record. The AMA has a handy chart in the E/M services guidelines in the CPT manual, but payers are not bound to adhere to this guidance. Check with local payers for specific guidance available regarding this issue.

Financial impact

Medicare increased the work RVUs for office/outpatient visits (CPT 99201–99215) by 6% as well as increased the work RVUs for initial hospital and nursing facility visits (CPT 99221–99223 and 99304–99306) by 0.3% to make this a budget-neutral change. However, many specialists may find that this supposed increase does have a negative impact on those who report many consultation services each year. Primary care, internists, and other such providers may see an increase in overall reimbursement for FY 2010 since their “bread and butter” codes are the ones targeted for an increase in reimbursement. The discrepancy in payment differentials between primary care and specialists has long since been a battle for equality. This year, the specialists are certainly feeling the pinch. Medicare states that this is not the intention, but specialists may see a negative impact from this change. Although we see the slight increase in payment for some E/M services (e.g., office visits and initial visits), Medicare felt strongly that the work involved with consultation services and the documentation requirements were commensurate since both types of services are assigned based on the CMS Evaluation and Management Documentation Guidelines (1995 or 1997 versions).

Mapping challenges

*Editor’s note: In looking at the codes, there are many different scenarios and combinations of documentation that could impact level assignment. Let’s discuss theoretically how these codes can be compared and potentially mapped. These
One thing that I immediately noticed was that for inpatient services, there are five levels of inpatient consult codes (CPT 99251–99255), but only three levels for initial hospital care (CPT 99221–99223). When assigning E/M codes based off of key components, the elements are history, exam, and medical decision-making. The various elements can be described as being problem focused (PF), expanded problem focused (EPF), detailed (D), comprehensive (C), straightforward (S), low (L), moderate (M), or high (H). The initial hospital care codes (CPT 99221–99223) require that all three key components must be met (or exceeded). Let’s compare the codes and highlight the differences:

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Typical time (mins)</th>
<th>Documentation requirements</th>
<th>CMS map</th>
<th>Typical time (mins)</th>
<th>Documentation requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>99251</td>
<td>20</td>
<td>PF, PF, S</td>
<td>99221</td>
<td>30</td>
<td>D or C, D or C, S or L</td>
</tr>
<tr>
<td>99252</td>
<td>40</td>
<td>EPF, EPF, S</td>
<td>99221</td>
<td>30</td>
<td>D or C, D or C, S or L</td>
</tr>
<tr>
<td>99253</td>
<td>55</td>
<td>D, D, L</td>
<td>99221</td>
<td>30</td>
<td>D or C, D or C, S or L</td>
</tr>
<tr>
<td>99254</td>
<td>80</td>
<td>C, C, M</td>
<td>99222</td>
<td>50</td>
<td>C, C, M</td>
</tr>
<tr>
<td>99255</td>
<td>110</td>
<td>C, C, H</td>
<td>99223</td>
<td>70</td>
<td>C, C, H</td>
</tr>
</tbody>
</table>

Although probably not commonly reported, low levels of inpatient consults (CPT 99251–99252) will require increased documentation to meet the criteria for even the lowest level of initial hospital care. It is recommended to evaluate the prevalence of the reporting of CPT 99251–99252 to determine whether there are opportunities for improved or increased documentation. Another discrepancy notated above is the discrepancy in the typical times. Time can sometimes be considered a factor in code assignment. For services where a minimum of 30 additional minutes is spent with a patient beyond the typical time, many providers look to the prolonged services (face to face) add-on codes (CPT 99356–99357). CPT 99254 and 99255 have at least 30 minutes differential between the typical times for an inpatient consult versus the reporting of initial hospital care. It is important to remember that the automatic assignment of the prolonged services codes would be inappropriate. The documentation must specifically document the total time spent with the patient warranting the reporting of prolonged services.

For outpatient consults provided in the ED, as mentioned above, the codes are assigned depending on whether the patient was admitted to the hospital. ED services similar to the outpatient consults require that all three key components must be met (or exceeded). Let’s look at how CPT 99241–99245 compare to CPT 99281–99285.
CPT 99242 will either map to CPT 99281 or 99282 depending on decision-making. If the documentation qualifies for low MDM, in combination with the history and exam, it will meet the criteria for CPT 99282; otherwise, it will be assigned to CPT 99281. The mid-level outpatient consult codes (CPT 99243–99244) exceed the documentation requirements for the ED services codes (CPT 99283–99284), but since the decision-making is many times the driving factor for ED services, it will not enable the higher level code to be reported because the decision-making element is not met.

Finally, let’s see how the office consults stack up to new and established office visits. Interestingly, office consult codes (CPT 99241–99245) are not assigned based off of the new and established patient concept. This designation is important in assigning the office visit codes because it will determine which category of codes shall be assigned (CPT 99201–99205 or CPT 99211–99215). One of the key areas to remember is that for established office visits, only two of the three key components must be met (or exceeded), so this can definitely have an impact on code assignment.
Finally, one set of codes where a direct map exists! Even the typical times stay within the less than 30 minutes differential. This map makes it much easier for providers to select the appropriate level of service.

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Typical time (mins)</th>
<th>Documentation requirements</th>
<th>CMS map</th>
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<th>Documentation requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>99241</td>
<td>15</td>
<td>PF, PF, S</td>
<td>99212</td>
<td>10</td>
<td>PF, PF, S</td>
</tr>
<tr>
<td>99242</td>
<td>30</td>
<td>EPF, EPF, S</td>
<td>99213</td>
<td>15</td>
<td>EPF, EPF, L</td>
</tr>
<tr>
<td>99243</td>
<td>40</td>
<td>D, D, L</td>
<td>99214</td>
<td>25</td>
<td>D, D, M</td>
</tr>
<tr>
<td>99244</td>
<td>60</td>
<td>C, C, M</td>
<td>99214 or 99215</td>
<td>40</td>
<td>C, C, M or C, C, H</td>
</tr>
<tr>
<td>99245</td>
<td>80</td>
<td>C, C, H</td>
<td>99215</td>
<td>40</td>
<td>C, C, H</td>
</tr>
</tbody>
</table>

Established patients are not as easy. Since only two of the three key components must be met, as long as the history and exam meet the criteria for the mapped code (or any combination of two of the elements), the code may be assigned. The one thing I notice about this potential mapping is that the assignment of codes seems to primarily rely on the history and exam performed for code assignment. In this day and age of electronic health records and tools to assist in E/M code assignment, these two elements can quite easily be met, rendering the assignment of high levels of established patient visits attainable.

Medical decision-making is a concept that is a difficult component to truly measure using an electronic tool. Most providers would agree that the decision-making can (and maybe should) define the complexity of the patient’s condition and directly affect the level of service reported. Lastly, the only map with a typical time differential that could warrant the prolonged services codes (CPT 99354–99355) is CPT 99215. CPT 99245 typically takes 80 minutes whereas CPT 99215 typically takes only 40 minutes. If the 80 minutes the physician documented were spent with the patient, theoretically CPT 99354 could also be considered as an additional code for the extra time, but only if documented appropriately.

The future of consultation services

Currently, other commercial payers still plan on reimbursing physicians for consultation service codes (CPT 99241–99245 and CPT 99251–99255). This presents problems when patients have Medicare as a Secondary Payer (MSP). Within §30.6.10.A of the Medicare Claims Processing Manual, Medicare specifically states:

> In the office or other outpatient setting where an evaluation is performed, physicians and qualified nonphysician practitioners shall use the CPT codes (99201 – 99215) depending on the complexity of the visit and whether the patient is a new or established patient to that
physician. All physicians and qualified nonphysician practitioners shall follow the E/M documentation guidelines for all E/M services. These rules are applicable for Medicare secondary payer claims, as well as for claims in which Medicare is the primary payer.

This guidance can present operational challenges to providers in deciding whether they will just report the office/outpatient visit codes whenever Medicare is either a primary or secondary insurer or submit the appropriate consultation code to the non-Medicare primary and then map the code to an office/outpatient visit submit to MSP. It seems the latter would present issues for the primary insurer if there is a payment differential for the consult code reported versus the office/outpatient visit code that the visit will be mapped for MSP. Regardless, the provider has to remember that consultation codes are no longer recognized for payment by Medicare Part B. It is recommended to check current policies or guidance from your local payers for guidance.

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