Consultation Codes for Medicare Patients

Effective January 1, 2010, CPT consultation codes are no longer recognized by Medicare for part B payment. Other payers are increasingly adopting the same rule. Providers who perform initial evaluation services for Medicare patients should assign evaluation and management (E/M) codes as follows:

1. Outpatient or Other Visits (99201-99215) codes for physician office/outpatient consultations.
2. Inpatient Hospital Visits: Initial and Subsequent (99221-99223) codes for hospital inpatient consultations.

The new rule means that if codes from CPT Consultations subsection (99241-99255) are reported on a CMS-1500 claim (or UB-04 claim or via electronic data interchange), payment will be denied. CMS will not create a crosswalk of Consultation codes to the CPT codes that are to be reported for each type of service.)

OUTPATIENT CONSULTATIONS: Instead of using guidelines for CPT's Consultation subsection codes 99241-99245, providers should use guidelines for Office or Other Outpatient Visit new patient codes 99201-99205 and established patient codes 99211-99215 to determine:

1. Whether the patient is new or established, and
2. Level of history, examination and medical decision making provided.

MEDICARE'S DEFINITION OF NEW PATIENT: *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.*

INPATIENT HOSPITAL VISITS: Instead of using guidelines for CPT's Consultation subsection codes 99241-99255, when providers perform an initial consultation on a hospital inpatient, they should use guidelines for Inpatient Hospital Visits initial hospital care codes 99221-99223.

Providers should report the appropriate E/M code (other than a CPT consultation code) that describes the service provides. The general guideline is that the provider reports the most appropriate available code to bill Medicare for services that were previously billed using the CPT consultation codes. For services that can be described by previously used inpatient consultation CPT codes, CMS has stated that providers may bill the corresponding initial hospital care service codes (where those codes appropriately describe the level of service provided). When the previously used inpatient consultation codes do not apply, providers should report the E/M code that most closely describes the service provided.

NOTE: Low level inpatient consultation codes 99251-99252 do not match any of the initial hospital care codes 99221-99223. For example, inpatient consultation codes 99251 and 99252 require "a problem focused history" and "an expanded problem focused history," respectively. In contrast, initial hospital care code 99221 requires "a detailed or comprehensive history." CMS has stated that providers can report code 99221 for an E/M service if the requirements for billing that code, which are greater than CPT consultation codes 99251and 99252, are met by the service furnished to the patient. CMS also stated that because subsequent hospital care codes 99231 and 99232, respectively, require a problem focused interval history" and "an expanded problem focused interval history," they 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. However, nothing official has been released by CMS that states reporting codes 99231 and 99232 is permitted.

IMPACT ON MEDICARE SECONDARY CLAIMS: If the primary payer continues to recognize consultation codes, the physician will need to decide whether to bill the primary payer using visit codes (which will preserve the possibility of receiving Medicare secondary payment) or to bill the primary payer with the consult codes which will result in a Medicare secondary payer denial.