

AAOS in the States

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New Medicare Coding for Consultation Services

By Matt Twetten

As of January 1, 2010, Medicare no longer recognizes CPT procedure codes for consultation services (CPT codes 99241-99245 and 99251-99255). This change represents a very significant change in Medicare payment policy; however, as of now, the change is for Medicare only. Commercial payors have not yet adopted similar guidelines when it comes to consultation services and providers should continue to use the consultation codes for all non-Medicare payors. Surgeons should check with each individual commercial payor to determine if that payor is continuing to accept the 99241-99245 and 99251-99255.

When billing Medicare, providers will be required to use other Evaluation and Management (E/M) codes when they provide services that were previously coded as consultations. Specifically, for office or outpatient consultations, Medicare will not recognize codes 99241-99245, but will, instead, require providers to bill these services as new (99201-

99205) or established office/outpatient (99211-99215) visits. For inpatient consultations, Medicare will not recognize codes 99251-99255 but will instead require providers to bill these services as initial inpatient patient visits (99221-99223). For inpatient initial hospital visits, the admitting physician will have to append a modifier, AI, in order for the consulting physician to get reimbursed. For Emergency Department consultations, which would have formerly been coded as outpatient consultations (99241-99245), will now be billed as Emergency Department visits (99281-99285).

In order to offset the decreased compensation for stopping payment for consultation codes, Medicare has also increased the compensation for the new patient E/M visits, established patient E/M visits, and initial inpatient visits. The new and established E/M visits will be paid an additional 6% by Medicare, while the initial inpatient visits will be paid an additional 2% by Medicare. Medicare has also increased payment for all 010 and 090 global period

codes with office visits built into their relative value units (RVU) by .03%.

We have also created a Microsoft excel program which providers can use to calculate the fiscal impact on their practices as a result of this change. The impact will vary from practice to practice depending on the practice's ratio of consultation services to new/established office/outpatient and inpatient patient visits. Roughly speaking, the average orthopaedic surgeon's ratio is 6 Medicare new/established office/outpatient and inpatient patient visits for every 1 Medicare consultation visit. A provider with a higher ratio of new/established and inpatient visits to consultation visits will likely gain revenue as a result of the rule change and a provider with a lower ratio will likely lose revenue as a result of the rule change. We anticipate the impact on all of orthopaedic surgery to be basically even (no net increase or decrease) as a result of the rule change. The tables on Page 2 show the appropriate crosswalks.

(cont'd on Page 2)

Is Outsourcing the Billing Function of My Practice the Right Solution?

Few operational aspects of a medical practice are more critical than billing and collections. And, it is not uncommon for physicians in small to mid-sized groups to feel burdened by the amount of the paperwork required to process their billing. The growing complexities of medical practice billing, coupled with the unrelenting economic pressures, lead many physicians to consider outsourcing their billing functions to a third party billing company. While outsourcing may be a cost-effective option for many practices, there are a number of practical and legal issues that must be considered. And in the end outsourcing this critical function may not be the right choice for your practice.

First determine how well your current in-house billing operation is performing and

what it is costing you. Knowing your own billing costs will help you effectively evaluate whether or not using a third party billing company is right for you. Second, make the decision in the context of your entire operation. If you have high costs and low performance, you may be wise to consider outsourcing. But if you have low costs and low performance, your needs may be best served by spending more on implementing proper processes, training staff and investing in appropriate technology. If your volume of patients is low, it may be hard to reach a deal that will be profitable for you and the billing service company.

When it comes to billing you don't want to take any chances. Keep in mind when you decide to outsource your billing and

collections, you don't relinquish the responsibility of ensuring that your money comes in. Determine whether it is more cost-effective for your practice to utilize an in-house billing department or outsource to a third party billing company with care because your practice depends on it.

Visit the AAOS Practice Management Center (www.aaos.org/pracman) to read the full article. You will also find the following resources:

- Claims processing self-assessment worksheet
- Hire Better Billing Staff
- Cash Controls: Better Safe than Sorry
- Patient-Friendly Billing Checklist

New Medicare Coding for Consultation Services (Cont'd)

Table 1-Crosswalks for Office/Outpatient Consultations

CPT Consultative Services Code	CPT E/M Codes for Crosswalking	Modifier Required
99241	99201 (new patient level 1) or 99211 (established patient level 1)	No
99242	99202 (new patient level 2) or 99212 (established patient level 2)	No
99243	99203 (new patient level 3) or 99213 (established patient level 3)	No
99244	99204 (new patient level 4) or 99214 (established patient level 4)	No
99245	99205 (new patient level 5) or 99215 (established patient level 5)	No

Table 2-Crosswalks for Emergency Department Consultations not requiring admission of patient into inpatient facility

CPT Consultative Services Code	CPT E/M Codes for Crosswalking	Modifier Required
99241	99281 (ER visit level 1)	No
99242	99282 (ER visit level 2)	No
99243	99283 (ER visit level 3)	No
99244	99284 (ER visit level 4)	No
99245	99285 (ER visit level 5)	No

Table 3-Crosswalks for Emergency Department Consultations requiring admission of patient into inpatient facility

CPT Consultative Services Code	CPT E/M Codes for Crosswalking	Modifier Required
99251	99221 (Inpatient Initial Visit, level 1)	Yes, you will need to append Modifier "AI"
99252	99221 (Inpatient Initial Visit, level 1) or 99222 (Inpatient Initial Visit, level 2)	Yes, you will need to append Modifier "AI"
99253	99222 (Inpatient Initial Visit, level 1)	Yes, you will need to append Modifier "AI"
99254	99222 (Inpatient Initial Visit, level 2) or 99222 (Inpatient Initial Visit, level 3)	Yes, you will need to append Modifier "AI"
99255	99223 (Inpatient Initial Visit, level 3)	Yes, you will need to append Modifier "AI"

Table 4-Crosswalks for Inpatient Consultations

CPT Consultative Services Code	CPT E/M Codes for Crosswalking	Modifier Required
99251	99221 (Inpatient Initial Visit, level 1)	Yes, referring physician (not you) will need to append Modifier "AI"
99252	99221 (Inpatient Initial Visit, level 1) or 99222 (Inpatient Initial Visit, level 2)	Yes, referring physician (not you) will need to append Modifier "AI"
99253	99222 (Inpatient Initial Visit, level 1)	Yes, referring physician (not you) will need to append Modifier "AI"
99254	99222 (Inpatient Initial Visit, level 2) or 99222 (Inpatient Initial Visit, level 3)	Yes, referring physician (not you) will need to append Modifier "AI"
99255	99223 (Inpatient Initial Visit, level 3)	Yes, referring physician (not you) will need to append Modifier "AI"

If there are any questions regarding this change, or if you would like to obtain the impact calculator (no charge), feel free to contact Matthew Twetten, AAOS Senior Health Policy Analyst, at 847-384-4338 or by e-mail at Twetten@aaos.org.

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