

Consultations, New Patients, or Established Patients?

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The New Year started with a flurry of questions and confusion over the status of consultations in 2010. The common question still today is “do we bill consultations or don’t we?”

The answer depends on the payor! Let’s start with a review of the coding rules and reimbursement rules

Coding vs Reimbursement Rules

It is important to understand that services are coded according to CPT rules.

Coding rules are written by the AMA with input from specialty societies and other organizations including Medicare. While the coding rules are written by the AMA, payors have their own reimbursement rules. In the case of consultations, we must take into consideration Medicare fee for service carriers as they will no longer reimburse physicians for consultations.

Consultations codes, 9924x (office or other outpatient) and 9925x (inpatient consultations) remain valid CPT codes. Medicare assigned Relative Value Units (RVU’s) to consultations, but Medicare also assigned an “Invalid” code status to consultations for their reimbursement purposes. So, while Medicare recognizes that consultation codes are still valid CPT codes, they will not reimburse physicians for consultations as they deleted the codes from their payment databases. Medicare calculated the amount of dollars spent each year on consultation services and re-allocated the dollars to other E&M services, thus resulting in an overall 6% increase in dollars allocated to other E&M services for 2010.

Okay, We Have CPT Codes, We Have RVU’s, but Medicare Will Not Reimburse Consultations, So What Do We?

Physicians and coding staff will have to pay attention to the patient’s insurance and report services based on whether the patient has private insurance or if they are covered under Medicare fee for service plans. Physicians will continue to report consultations on non Medicare patients and will report the appropriate new, established, initial hospital care or subsequent care as appropriate for Medicare patients.

CPT Introduces New Consultation Guidelines

2010 CPT brought great, new guidelines explaining terms such as “concurrent care”, “transfer of care”, and “consultations”, but some say the clarifications came too late as Medicare deleted consultations because of previous ambiguity.

- CPT defines **Concurrent Care** as the provision of similar services (e.g., hospital visits) to the same patient by more than one physician on the same day.¹
- **Transfer of care** is the process whereby a physician who is providing management for some or all of a patient’s problems relinquishes this responsibility to another physician who

¹ 2010 CPT Current Procedural Terminology: American Medical Association. AMA Press

explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services.²

- A **consultation** is a type of evaluation and management service provided by a physician at the request of **another** physician or appropriate source to either **recommend** care for a specific condition or problem or to **determine whether to accept responsibility for ongoing management of the patient's entire care** or for the care of a specific condition or **problem**.³

No request, no consult

The instructional guidelines from CPT are important to determine if and when a physician may report a consultation. If there is no request for a recommendation about a specific condition or a request for a physician to evaluate the patient regarding a condition (to accept the transfer of care or not), the consultation codes are not reportable to any private payor.

How to Report According to CPT Rules:

Report the appropriate consultation code (9924x or 9925x) to a private payor according to the CPT rules if the request is present and documented, the evaluation and recommendations documented and a separate report is sent to the requesting physician.

Report 9924x if the service is performed in the office or other outpatient setting .

Report 9924x if the service is performed in the ER and the patient is not admitted or if the patient is admitted and the physician does not perform additional E&M services on the inpatient unit.

How to Report According to Medicare Rules:

Report a new (9920x) or an established patient visit (9921x) to Medicare if the service is provided in the office or other outpatient setting.

Report an Emergency Department service (9928x) if the service is provided in the ER and the patient is not admitted

Report an initial inpatient hospital care (9922x) if the service is provided in the hospital setting.

Report an initial hospital care (9922x-AI) if the patient is admitted to the physicians service.

Action Steps

- Create internal policies and charge capture protocols to ensure the appropriate CPT codes are reported according to CPT rules for private payors and Medicare rules for Medicare fee for service patients.
- Survey private payors to ensure they will continue to recognize and reimburse consultation codes. Medicare has communicated the rules apply to Medicare FFS plans.
- Review the full guideline changes in CPT 2010.
- Review the Medlearn Matters and Medicare Transmittals addressing the change in consultation services.
- Ensure all CPT rules for consultation services are met when reporting a consultation service to a private payor.

² 2010 CPT Current Procedural Terminology: American Medical Association. AMA Press

³ 2010 CPT Current Procedural Terminology: American Medical Association. AMA Press