
TITLE: Selecting a Consultation Replacement Code when Medicare is the Primary Payor

POLICY/PURPOSE: Effective for dates of service 01/01/2010 and after, Medicare will no longer pay for consultation codes 99241-99245 and 99251-99255. This policy and procedure is designed to assist users with selecting a procedure code to bill in place of a consultation code.

Coders and service providers are to follow these procedures for proper code selection when the patient's primary insurance is a traditional Medicare fee-for-service plan (including Railroad Medicare).

DEFINITIONS:

PROCEDURE:

1. Office/Outpatient Hospital

Apply the following instructions to determine which visit code to use instead of the consultation codes.

Determine the patient's status as New or Established. Follow instructions under Section 1 (A) or 1 (B) based on patient's status.

A. New Patient Office/Outpatient Visits – All 3 Key Components Needed to Determine Level of Care

Crossmap New Patient visits as follows unless coder can determine that the level of care could be coded based on counseling/coordination of care time:

99241 (15) = 99201 (10)

99242 (30) = 99202 (20)

99243 (40) = 99203 (30)

99244 (60) = 99204 (45)

99245 (80) = 99205 (60)

Note: Time in parentheses = total encounter time used for coding based on counseling/coordination of care.

If the level of care can be determined based on counseling/coordination of care time, select the appropriate code based on the time requirements for a New Patient visit.

REMINDER: In order to select a New Patient visit code based on counseling or coordination of care, the counseling/coordination of care time must be more than 50% of the total encounter time. Document total time, counseling time, and counseling topics.

B. Established Patient Office/Outpatient Visits – 2 of 3 Key Components Needed to Determine Level of Care

These visits only require 2 of the 3 key components to determine the level of care. The outpatient consults cannot be crossmapped to established patient visit codes since 2 of the 3 key components may map to more than one code choice. Select established patient visit code based on medical necessity and E&M documentation requirements. If the level of care can be determined based on counseling/coordination of care time, select the appropriate code based on the time requirements for an Established Patient visit. Coders and providers must exercise caution when selecting a code based on counseling/coordination of care time as the total times listed for outpatient consult codes are different than those listed for the established patient office/outpatient visits.

99211 (5)
99212 (10)
99213 (15)
99214 (25)
99215 (40)

Note: Time in parentheses = total encounter time

REMINDER: In order to select an Established patient visit code based on counseling or coordination of care, the counseling/coordination of care time must be more than 50% of the total encounter time. Document total time, counseling time, and counseling topics.

C. Outpatient Hospital Observation Services - All 3 Key Components Needed to Determine Level of Care

1) Initial Observation Care by Principal Provider of Record

In the case of Initial Observation Care, the Principal Provider of Record is considered to be the physician or qualified NPP who ordered hospital outpatient observation services and was responsible for the patient during his/her observation care.

Select appropriate Initial Observation Care code (99218-99220) based on medical necessity and E&M documentation requirements. Do not append the "AP" modifier.

REMINDER: When observation status is initiated in the course of an encounter in another site of service (e.g., emergency department, outpatient hospital clinic, physician's office) all E&M services provided by that provider in conjunction with initiating observation status are considered part of the initial observation care when performed on the same date. The observation care level of service reported by the Principal Provider of Record should include the services related to initiating observation status provided in the other sites as well as in the observation setting.

2) Initial Encounter by Provider OTHER THAN the Principal Provider of Record

Determine the patient's status as New or Established. Follow instructions under Section 1 (A) or 1 (B) based on patient's status.

2. Inpatient Hospital

A. Initial Encounter by Principal Provider of Record

In the case of initial inpatient hospital care, the Principal Provider of Record is the admitting or attending physician or admitting, qualified NPP who oversees the patient's care, as distinct from other physicians or qualified NPPs who may be furnishing specialty care.

Select appropriate initial hospital care code based on medical necessity and E&M documentation requirements. Append the modifier “AI.”

REMINDER: When the patient is admitted to the hospital as an inpatient in the course of an encounter in another site of service (e.g., emergency department, hospital observation status, physician’s office) all E&M services provided by that provider in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the inpatient admission. The inpatient care level of service reported by the principal provider of record should include the services related to the admission that he/she provided in the other sites as well as in the inpatient setting.

Note: Follow Medicare policy for proper code selection when the patient is admitted and discharged from inpatient status on the same calendar day.

B. Initial Encounter by Provider OTHER THAN the Principal Provider of Record

99251 or 99252

The E&M documentation requirements for the lowest level initial hospital care code (99221) are more stringent than the E&M documentation requirements for either 99251 or 99252. View medical record documentation and select the appropriate initial hospital care code (99221-99223). If an initial hospital care code cannot be supported by the documentation, code for a subsequent hospital visit (99231-99233) based on medical necessity and E&M documentation requirements. If a subsequent hospital visit code is selected, append the “CC” modifier.

REMINDER: In order to select a code based on counseling or coordination of care, the counseling/coordination of care time must be more than 50% of the total encounter time. Document total time, counseling time, and counseling topics.

99253 through 99255

Crossmap 99253-99255 as follows unless coder/provider can select the code based on counseling/coordination of care time:

99253 (55) = 99221 (30)

99254 (80) = 99222 (50)

99255 (110) = 99223 (70)

Note: Time in parentheses = total encounter time

REMINDER: In order to select an initial hospital care code based on counseling or coordination of care, the counseling/coordination of care time must be more than 50% of the total encounter time. Document total time, counseling time, and counseling topics.

Coders and providers must exercise caution when selecting a code based on counseling/coordination of care time as the total times listed for inpatient consult codes are different than those listed for the initial hospital care codes.

C. Subsequent Encounters by any Provider:

Select appropriate subsequent hospital visit code (99231-99233) based on medical necessity and E&M documentation requirements.

3. Emergency Department

The Category of “Emergency Department” includes all relevant, internal denotations (e.g., SJ Trauma, SJ ER Fast Track, etc.) that are billed with POS 23.

A. Initial Encounter in Emergency Department by Provider OTHER THAN an Emergency Medicine Department Provider:

- 1) In the ER setting, the Emergency Medicine Department Provider requests that a patient be evaluated by a provider from another medical department (the “*Specialist*”). The Specialist evaluates the patient and the patient is either sent home or admitted by another specialty. The Specialist selects the appropriate emergency department visit code (99281-99285) based on medical necessity and E&M documentation requirements.

- 2) In the ER setting, the Emergency Medicine Department Provider requests that a patient be evaluated by a provider from another medical department (the “*Specialist*”). The Specialist evaluates the patient and decides to admit the patient to either an observation status or an inpatient status. The Specialist would follow the relevant section(s) set forth in this procedure based on the status to which the patient is admitted (i.e. outpatient observation or inpatient hospital).

Due to the complexity of Federal statutes, Nursing Facility Visits will be covered in a separate policy and procedure.

REVISED

REFERENCES:

APPROVED BY: Maryann Palmeter