

February 2010

Lilly Oncology Reimbursement Update

Previous Reimbursement Updates can be found at www.LillyPatientOne.com

Lilly Oncology is pleased to offer this newsletter as part of our commitment to patient access to care. For more information about the topics discussed in this issue, please contact Rick Ford, Director of Reimbursement Consulting for AccessMED, at (913) 744-6001.

© 2010 AccessMED, Inc.

This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of the written law or regulations or local payer guidelines. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Revisions to Consultation Coding Policies Impact Physician Reimbursement in 2010

Changes in Medicare Part B's policy regarding payment for consultation services provided to certain Medicare patients will be of significance to physicians in 2010. The new policy, effective for dates of service January 1, 2010, and after, may lower reimbursement and increase the resources needed to prepare claims and collect accounts receivable for these services.

Medicare's consultation coding policy revisions apply only to original Medicare (the fee-for-service program). Medicare Advantage plans and non-Medicare insurers are not bound by the policy.ⁱ

The policy revisions include (but are not limited to) the following:

- For dates of service beginning January 1, 2010, Medicare Part B carriers and Medicare A/B Administrative Contractors (MACs) no longer recognize the CPT consultation codes 99241 – 99245 (office and other outpatient consultations) and 99251 – 99255 (inpatient consultations).ⁱⁱ However, Medicare contractors will continue to recognize these codes for dates of service prior to January 1, 2010.ⁱⁱⁱ
 - Consultations provided January 1 and after must now be reported to Medicare using other applicable evaluation and management codes. For example, in the office setting, an appropriate new patient visit (CPT codes 99201 – 99205) or an established patient visit code (CPT codes 99211 – 99215) may be reported on the claim form instead of a consultation code.^{iv} The evaluation and management code selected for billing will depend on the physician's documentation of the history, the physical exam, and medical decision making provided during the visit, in accordance with CMS and CPT guidelines.^v
- Likewise, physicians providing consultations in other settings (such as inpatient hospital, nursing facilities, and emergency departments) are required to report evaluation and management services appropriate to those settings instead of consultation codes.^{vi}
- Claims submitted with consultation codes for dates of service on or after January 1 will be returned to the physician for correction and re-billing. Patients may not be billed for a non-covered service.^{vii}

(continues on Page 2)

Why did the CMS make this change? According to CMS, the change was made to eliminate long-standing confusion about the Medicare definition of a “consultation” and to end disagreements about the definition and use of consultation codes that arose between the provider community, the American Medical Association CPT staff, and CMS.^{viii}

How will the change affect Medicare fee-for-service reimbursement? Reimbursement for consultation codes has historically been higher than reimbursement for other types of evaluation and management codes, primarily because documentation requirements associated with the use of the consultation codes were more resource-intensive. For instance, a request for a consultation had to be documented in the patient’s medical records by both the referring and the consulting physicians, and the consulting physician was required to prepare a written report for the referring physician.^{ix}

Because these documentation requirements do not apply to other evaluation and management services, Medicare payment for non-consultation evaluation and management services is lower than the amounts previously paid for consultations. Elimination of the consultation codes will therefore also eliminate the higher reimbursement rates associated with their use. Although CMS has increased reimbursement rates for other evaluation and management services in 2010, the increase only partially offsets the elimination of the consultation codes. Despite the adjustment, physicians may still receive less in 2010 than they did in 2009 for the same service.^x

To facilitate proper billing, physicians will need to verify that they are fully documenting evaluation and management services in accordance with CPT and CMS guidelines, and that all codes that apply to a visit are reported. For example, if a consultation involves lengthy face-to-face time with the patient, then CPT codes describing prolonged physician services may be appropriate to bill in addition to the documented

evaluation and management service.^{xi} A good understanding of CPT and Medicare coding guidelines is important as practices make the transition to the new coding process. CMS makes evaluation and management documentation guidelines available on the CMS Web site at www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp.

Will other payors follow Medicare’s policy? Other payors may choose to follow Medicare’s policy, but they are under no obligation to do so. The AMA has not deleted the consultation codes from the CPT coding system, so they will continue to be recognized by many payors, even if Medicare considers them invalid.^{xii}

How might the billing process change? The revised Medicare policy will require physician practices to implement safeguards in their billing processes to ensure that consultations provided to Medicare patients are billed as evaluation and management services instead. For example, a special software protocol that flags Medicare patients for special handling may need to be created.

In addition, practices will need to decide how to handle claims when Medicare is the secondary payor. If a claim is filed to a primary payor that recognizes and pays for a consultation code, and the claim with the consultation code automatically crosses over to Medicare for secondary payment, Medicare will deny the secondary claim because the consultation code is invalid for Medicare purposes. To address this issue, CMS recommends that practices follow one of two options:

1. Code the primary claim with an appropriate evaluation and management code instead of a consultation code and allow the claim to automatically cross-over to Medicare for secondary payment; or
2. Code the primary claim with an appropriate consultation code and then file the secondary claim to Medicare, changing the consultation code to an appropriate evaluation and management service. If this option is chosen, the practice would also report the

amount paid by the primary payor for the consultation. Medicare secondary payment would be based on the difference between the amount the primary payor paid for the consultation and the amount Medicare would have paid for the other evaluation and management service if Medicare had been primary.^{xiii}

For many billing operations, this will be a manual procedure, although some larger operations may be able to automate the process. The extent of any required manual intervention and the impact of increased accounts receivable follow-up may affect the cost-effectiveness of this approach.

Which physicians will be most affected? All physicians and non-physician practitioners who provide consultations are affected. Specialists, who are the main providers of consultations, will feel the impact to a greater extent than will primary care physicians.^{xiv}

Where can I read more about the new Medicare policy? Further information, including extensive coding detail, can be found on the CMS Web site as follows:

- CMS: Revisions to Consultation Services Payment Policy – Transmittal 1875, Change Request 6740

End Notes

ⁱ CMS. Revisions to Consultation Services Policy – JA6740, Page 1. Accessed January 18, 2010

ⁱⁱ *Ibid.*, Page 2

ⁱⁱⁱ *Ibid.*

^{iv} *Ibid.*, Page 4

^v *Ibid.*, Page 5

^{vi} *Ibid.*, Pages 2-4

^{vii} *Ibid.*, Page 2

^{viii} CMS. *Federal Register*, Vol 7, No. 226; November 25, 2009: Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010, page 61769, column 1, *et.al.* Accessed January 18, 2010.

^{ix} *Ibid.*, Page 61767, column 3

^x CMS. Revisions to Consultation Services Policy – MLN Matters Number MM6740 Revised. Page 2. Accessed January 18, 2010

^{xi} *Ibid.*, Pages 6-8

^{xii} CMS. *Federal Register*, Vol 7, No. 226; November 25, 2009: Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010, pages 61773, column 3

^{xiii} CMS. Revisions to Consultation Services Policy – MLN Matters Number MM6740 Revised. Pages 5 and 6

^{xiv} CMS. *Federal Register*, Vol 7, No. 226; November 25, 2009: Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010, pages 61767, column 3.

<http://www.cms.hhs.gov/transmittals/downloads/R1875CP.pdf>

- CMS: Revisions to Consultation Services Payment Policy – MLN Matters Number MM6740

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf>

- CMS: Revisions to Consultation Services Payment Policy – JA6740.

<http://www.cms.hhs.gov/ContractorLearningResources/downloads/JA6740.pdf>

- CMS: Documentation Guidelines for E&M Services. www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp.

- CMS. *Federal Register*, Vol 7, No. 226; November 25, 2009: Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010, pages 61769 - 61775.

<http://edocket.access.gpo.gov/2009/pdf/E9-26502.pdf>

In addition, the Medicare Administrative Contractors are posting information on their individual Web sites that may be useful in regards to local interpretation of this policy. ♦