Medical Coverage Policy

Consultation Codes

☒ Device/Equipment ☐ Drug ☐ Medical ☐ Surgery ☐ Test ☐ Other

Effective Date:	12/1/2010	Policy Last Updated:	11/06/2012

☐ **Prospective review is recommended/required. Please check the member agreement for preauthorization guidelines.**

☒ **Prospective review is not required.**

Description:
In the 2010 Medicare Fee Schedule the Centers for Medicare and Medicaid Services made Consultation codes not valid for payment. CMS directed use of office and other outpatient codes or initial and subsequent hospital or initial or subsequent nursing facility codes for services previously reported as consults. Adjustments were made to the Medicare Physician Fee Schedule (MFS) to redistribute payments in a payment/cost neutral method across the fee schedule. This redistribution affected different specialties and physicians in different ways so that some gained and some lost payment. CMS also introduced a modifier for the admitting clinicians and provided guidance on various other coding issues.

On December 1, 2010 BCBSRI will be basing payment using the 2010 MFS. Accordingly, BCBSRI will also implement the restriction on the use of CPT® Consultation codes 99241-99245 and 99251-99255. BCBSRI will also consider these codes invalid for payment. These are covered services and may not be billed to the member. The purpose of this policy is to define coding/reporting and payment policy. Please also note additional guidance below, some of which may be at variance with CMS policy. We will use the phrase "consult" to indicate formerly used codes/terms.

Observation Consults: For consultation services in the Observation setting please use either CPT codes 99218-99220 or 99224-99226 based upon the level of service. Subsequent day visits in patients who remain on observation should be reported using 99224-99226.

Traditional Medicare requires Office or Other Outpatient codes (99201-99215) for all these services, but BCBSRI requires the use of a code that is correct for the specific setting, in part to apply correct member cost share. There is no "office co-pay" for Observation setting services.

Emergency Department Consults: Use the appropriate code from the 99281-99285 series (as directed by CMS) or use the 99201-99215 series with the hospital emergency department site of service code. In all cases the service must be face to face and meet CPT coding rules. Applicable specialist office copayment will apply in addition to the Emergency room copayment.

Inpatient Hospital Consults: For the initial encounters in the inpatient hospital setting, the code selection shall be based upon the level of service using CPT definitions for the Subsequent Hospital care codes 99231-99233. This means that services that were formerly coded with lower level consult service codes will now be reported using subsequent hospital

care codes (99231-99233). Do not select the initial hospital care codes (99221-99223) based solely upon the service being the first contact for the stay. **Only the admitting physician is allowed to use initial hospital care codes (99221-99233)**. For initial encounters **by other providers**, services are to be reported using subsequent hospital care codes (99231-99233).

Nursing Facility Consults:
For the initial contact in the nursing facility setting, the code selection shall be based upon the level of service using CPT definitions for codes 99304-99310. This means that services that were formerly coded with lower level consultation codes will be coded using subsequent nursing facility care codes (99307-99310). Do not select codes 99304-99306 based solely upon the service being the first contact for the stay. No physician/professional (or member of the same group who is also in the same subspecialty) may report an Initial Nursing Facility Care service more than once per stay. Nurse Practitioners (RNP), Physician's Assistants (PA) and Clinical Nurse Specialists (CNS) may report 99304-99307 for consultations, so long as a physician in the same clinical field does not report these services. For example, a PA in a surgical practice and the physician surgeon in that practice may not both report a consultation during the stay. Only physicians may perform the actual admission service, per federal regulations, but non-physician professionals may report 99304-99306 for consultations.

AI Modifier:
We ask the admitting physician to use the **AI** modifier, Principal Physician of Record.

Inpatient and outpatient evaluation and management services, same day:
As has always been the case, it is not permissible to report both services on the same date.

Prolonged Services:
Use face-to-face time for outpatient services and unit time for inpatient services when determining code selection and service duration. Time spent on teaching rounds or conferences is not counted.

Coordination of Benefits/Multiple Payers:
BCBSRI will not recognize 99241-99245 and 99251-99255. If BCBSRI is secondary to a payer that does recognize those codes and you wish to use them for the primary payer, we will accept them in the usual manner and crosswalk the submitted codes to the codes we do utilize. Alternatively, you may elect to report services to the primary payer using the methodology BCBSRI uses, if allowed by that payer. The crosswalk was created using key components in CPT.

Medical Criteria:
Not applicable.

Policy:
CPT® Consultation codes 99241-99245 and 99251-99255 are **not separately reimbursed** and the member cannot be billed for the services.

Coding:

Consultations
Not Separately Reimbursed
99241-99245 and 99251-99255

Observation Consultations
99218-99220 or 99224-99226

Emergency Department Consultations
99281-99285

Inpatient Hospital Consultations
99221-99233

Nursing Facility Consultations
99304-99310

Publications:
Provider Update, November 2010
Provider Update, November 2012

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice.