Meeting Questions and Answers:

Subject: Can the GI Practice Survive Without Consultation Codes?
Start Time: Tuesday, December 22, 2009 12:00:00 PM GMT-7:0

Q: On slide number 18, action plan - step 4, when you state the first visit, is that the first visit for a practitioner in the specialty, first visit for a practitioner in the same group, or first visit for an individual practitioner?
A: For the Initial Hospital Visit, it is the first visit by any member of the same group.

Q: Define mid-level provider please
A: Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist who has their own Medicare Provider Number.

Q: What do you do in a group practice when Doctor A sees patient in office for IBD, and presents 6 months later with diarrhea to another physician in the hospital is this a New?
A: If both physicians are of the same specialty and in the same practice, the second physician would bill an Established Patient Visit.

Q: Is there still a chance that CMS will delay this for one year, as I have read?
A: Not likely.

Q: Did you say that in a multi-specialty group a gastro doctor can bill a new patient code if no other gastro doctor has seen the patient in 3 years even though the patient is not new to the group?
A: Yes. The New Patient restriction is for the same specialty designation within the same group.

Q: The Georgia 2010 Physician Fee Schedule for 99203 and 99204 has actually been lowered in Georgia not increased. The payment went from $86 to $77 and 99214 went from $93.05 to 72.40. So the new codes in fact went down in Georgia not up. The RVU went up but the conversion factor went down. So who cares if you get more credit in RVUs if the payment went down?
A: The Fee Schedule probably included the 21% decrease in payment. You will likely see a change in the fee schedule given the two month congressional delay of the 21% cut scheduled for January 1.

Q. What were the part D plans going along with cms again, please
A: We have heard from United Heathcare directly and a few other plans from the webinar participants. See below.

Q: Does elimination of consult codes for Medicare start 1/1/10 for date of service or date of submission?
A: Date of service.

Q: How will this effect a GI who is also Internal Medicine. Single practice.
A: All specialties will be affected in the same way.

Q: Does a colonoscopy or other GI procedure constitute a "face to Face" service for future E & M coding?
A: Yes. (You stole my joke: correction - face-to-any-other-body-part)

Q: Have the internists, PCPs, etc. been properly educated as to using the A1 modifier in their billing? If the A1 modifier is not used, what is the impact on the consultants?
A: Hopefully they have. We are not aware of any impact on specialist if the AI modifier is not used by the admitting physician.

Q: Will the admit codes be reimbursed the same with the ai modifier?
A: Yes.

Q: When Medicare is secondary, earlier I heard Ceclia say to change the code after thr primary pays and then submit to Medicare. Please clarify when Medicare is secondary?

A: Here is the URL for Medicare Secondary Payer information. http://www.cms.hhs.gov/ProviderServices/Downloads/claimsinvestigation.pdf

Q: For services provided prior to 2010 can you bill consult codes for Medicare

A: You can bill the Consultation codes to Medicare for services provided through Dec. 31, 2009.

Q: Would you explain more about "look-back rules"?

A: There is no time restriction for Consultations, so theoretically, you can bill a Consultation multiple times for the same patient as long as the definition is met and supported by the documentation. There is a three year restriction for a New Patient Visit so you can only bill it if the patient has not received any service from any provider in your group of the same specialty designation.

Q: Can you clarify slide number 46 where it states a consult that can be billed as an established patient?

A: If the patient has received any face-to-face service from anyone in your group of the same specialty within the last three years, you must bill the visit as an Established Patient visit.

Q: Please can you elaborate on combined billing for a mid level provider. Is the combined billing total more than the sole physician billing?

A: The “shared services” regulation allows the physician to bill the combination of both the mid-level and his/her own service if the physician sees the patient on the same day in the hospital. For example, if the mid-level documented a level 3 Initial Hospital Service and the physician only documented a level 1 service, the physician could bill a level 3 service under his/her own provider number and receive 100% of the fee schedule amount.

Q: For services provided prior to 2010 can you bill consult codes for Medicare patients?

A: Yes.

Q: Is the billing of th 99221-99223 per admission, per diagnosis or per year?

A: Per admission.

Q: Cecile when you mentioned changing the code if medicare is 2ndary it wont match the primary eob correct?

A: Correct.

Q: How can you change billing codes after the primary insurance has paid and medicare is secondary?

A: See Medicare’s instructions below. You would select the code that is closest in definition to the Consultation code per CMS guiselines.

Q: You discussed billing medicare as a secondary payer. What should be the plan if Medicare primary and a different payer who will continue to recognize consult codes is secondary

A: Good question. CMS did not address this scenario, but I would expect that the service will automatically cross over to the secondary payer with the code billed to Medicare or you would bill the secondary payer with the same code.

Q: Regarding Step #4 of the Action Plan - if we bill a 99223 and see the same patient on a different admission in the future, can we bill a 9922_ again?

A: Yes. The code is per admission.

Q: I believe I heard a presenter state that on option to Medicare secondary billing might be to bill the primary payer with a consult code and adjust the balance that would go to Medicare. Is this a viable, legal option? And if so, could we potentially be in violation of our primary payer contract by not collecting copays, deductibles, etc…?

A: I agree that writing off the balance is not an option unless you have documentation of financial hardship.

Q: I attended the webinar today and had a question regarding the mc 2ndary's. If we have a patient that has commerical insurance primary and then mc 2nd what do we do with the balance if the primary puts it towards deductible and we had billed consult for the commerical carrier? Since mc considers it a non covered service and we can not bill the patient for it do we have to write off the deductible?

A: According to the CMS transmittal, they expect that you will convert the Consultation code to a payable E/M when sending the secondary claim to Medicare. That will work for the outpatient codes but will be a problem for the inpatient codes as there is no published Medicare crosswalk from an inpatient consultation to the initial hospital care code. I'm sure there will be some glitches at first that CMS will have to address.

Q: We didn't get to ask this question at the end of the webinar. This concerns billing Medicare as secondary for a consult code billed as primary. How can you change the CPT code after primary insurance has already paid for the consult? The code you would change to would have a different charge amount and we were taught never to change a CPT after a primary ins has paid?

A: Your question was echoed numerous times. Here are the instructions from CMS regarding this issue.

Medicare will also no longer recognize the consultation codes for purposes of determining Medicare secondary payments (MSP). In MSP cases, physicians and others must bill an appropriate E/M code for the services previously paid using the consultation codes. If the primary payer for the service continues to recognize consultation codes, physicians and others billing for these services may either:
Bill the primary payer an E/M code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with the same E/M code, to Medicare for determination of whether a payment is due; or

Bill the primary payer using a consultation code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with an E/M code that is appropriate for the service, to Medicare for determination of whether a payment is due.

Note: The first option may be easier from a billing and claims processing perspective.

Q: I need to clarify office visits for MCR patients
99242 consults
if the patient is new we bill 99202
if it is a follow-up is it 99212 or 99213?

99243 consult
if the patient is new 99203
if it is a follow-up 99213 or 99214 ?

A: For the Consultation codes and the New Patient Visits, the documentation requirements are the same for the same level of service so you can cross-walk them. For the Consultations and the Established Patient Visits, the documentation requirements the documentation requirements are different for the same level of service. Select the code based on the documentation.

Q: I just finished listening to the AGA webinar on the elimination of consult codes by CMS and I have a question. You indicated there was a transmittal by CMS that stated when they are secondary to a commercial payer who does accept the consult codes then we are to change the code to what Medicare accepts. Could you please tell me how to get to that transmittal or a document by CMS that says that, so that our office may have that documentation on file when we need to make those changes.

A: Here is the URL: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf

Q: In my practice, we see quite a few patients that have Medicare Part A only and a commercial carrier. We bill Medicare Part A for the denial showing they only have Part A. We send these EOB's to the secondary carriers to show that the Medicare coverage is Part A only… (We found

that when we did not do this we received a high number of denials stating that Medicare needed to be billed as primary…)

So, with that said, now that we have the consultation problem to deal with. If we bill Medicare with a consult code, they will deny it as non-covered, and thus the commercial carrier will follow suit and deny stating they only cover Medicare covered services… If we bill Medicare with a non-consult code, then we are reducing our reimbursement from the commercial payer when the patient does not even have Medicare…

Suggestions? Do you think we would be successful if we do not bill Medicare for the denial, but instead send a copy of the Medicare card or a Medicare electronic eligibility print out with the commercial claim?

A: Try sending a copy of the card. I'm sure some of these problems will be addressed once practices start billing the new codes.

Q: If a patient is admitted and we called in for Bowel Obstruction and a couple of weeks later the patient is still in the hospital with a new problem (esophageal problem) and we are called in again. For the second problem do we bill the initial since it is a new problem or is it follow up since its during the same admission?

A: I agree with part of Dave's answer. As is the current billing guidelines for Inpatient Consultations, they can only be billed once per admission, so too would be the Initial hospital Service, regardless of whether the patient has a new problem. If the patient is discharged and then readmitted, you should bill the Initial Hospital Care for the first visit during the second admission.

C: Just finished the webinar. We have found out from Humana in Florida that they will be doing the same as UHC. Their Medicare products will follow Medicare guidelines while their commercial products will still recognize the consult codes. Aetna is doing the same but BC/BS FL and Cigna are ignoring the rule for now.

Q: I had attended the live webinar Can the GI Practice Survive Without Consultation Codes, unfortunately I had some technical difficulties in the beginning of the course. Will you be holding a similar course or webinar in the near future? I was present for most of the course however, I have 6 GI's and 1 mid level provider I would like to attend.

A: You can purchase a DVD or register for the webinar on-demand from the MGMA. It should be available within the next few days on the MGMA web site at www.mgma.com .

C: In a meeting with Healthspring of AL last week, they stated that as of this time, they will not be following the Medicare guidelines regarding consultation codes. However, it will be evaluated at the beginning of 2010 and once a determination is made, all contracted providers will be notified.