

CMS Revises Consultation Policy and Issues New In-Patient & Nursing Home “Admissions” Modifier to Mitigate Consultation Policy Change

Effective for services furnished on or after January 1, 2010, instead of coding a consultation, physicians should code a patient evaluation and management visit, using an E/M code that represents where the visit occurs and identifies the complexity or code level of the visit performed.

If a patient is referred to you for what would have been an office consultation and this is the first time you have seen the patient (a new patient), you may submit an Initial Visit.

Keep in mind, however, the parameters that classify a "new patient" to mean a patient who has not received any professional services from the physician within the previous 3 years. That is if the patient has been seen in an Initial Visit setting within the past 3 years, the visit must be coded as an established patient visit depending on the documentation.

Please note these important points:

- **Documentation:** You should continue to follow appropriate documentation standards: (1) Physicians making a referral and physicians accepting a referral should document the request to provide an evaluation of the patient. (2) The physician who has accepted the referral should communicate the results of the evaluation to the requesting physician.
- **New Modifier for Inpatient/nursing home admissions:** As you know, in the past, only the admitting physician has reported initial hospital care codes (99221-99223) and specialists who saw the patient separately often billed inpatient consult codes. But now, as consult codes will no longer be recognized, the following will apply. If you are the “principal physician of record” (the physician who oversees the patient’s care, as opposed to other physicians who furnish specialty care), you should append modifier AI to the E/M code. For example, you should append modifier AI to the initial visit code when you first admit the patient to the hospital or nursing home. If you are not the principal physician of record—e.g., if you are just providing specialty care once the patient has been admitted—do not use modifier AI when you perform your own initial evaluation on the patient. Just bill the E/M code for the complexity level performed.

In summary, and in the inpatient hospital setting and nursing facility setting, any physician who performs an initial evaluation may bill an initial hospital care visit code (CPT code 99221 – 99223) or nursing facility care visit code (CPT 99304 – 99306), where appropriate.

Please be aware that the AAO and AMA are still actively lobbying CMS to postpone this change; we will keep you apprised as the situation develops.

In any event, the value of the higher payment previously allowed by Medicare for consult services supposedly will be transferred to the E&M services for all settings, as well as the post-operative visits that are bundled into all surgical codes.

For guidance on this issue, contact us through the Third Party Insurance Help program.

In addition, there is a detailed MedLearn Matters article on the CMS website at:

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