Dermatology Coding Alert

Bid Goodbye to Medicare Consultation Codes in 2010

Good news:You may see a 3 percent increase to your dermatology practice's bottom line.

You know the lowdown: Medicare is scrapping consultation codes in 2010. While the big buzz is doing its rounds, many coders are still pondering what lies ahead when the new rule is implemented in January.

The CMS proposal calls to end the coverage of consultation codes 99241-99255 (Office consultation for a new or established patient ...) and 99251-99255 (Inpatient consultation for a new or established patient ...) in order to boost payments for primary care services. As a substitute, you should use E/M codes 99201-99215 for office visits or 99221-99223 for initial hospital care.

The Final Rule states that "Beginning January 1, 2010, we will eliminate the use of all consultation codes (inpatient and office/outpatient codes for various places of service except for telehealth consultation G codes) on a budget neutral basis by increasing the work RVUs for new and established office visits and for initial hospital and initial nursing facility visits."

Calculate This E/M Increase

CMS will increase the RVUs associated with new and established office visits, and with initial facility visits for hospitals and nursing homes. For instance, you'll see a 7 percent increase for 99214 (Office or other outpatient visit for the evaluation and management of an established patient ...), with physician work RVUs rising to 1.50 from the 2009 rate of 1.42.

A medical law firm says the elimination of consultation codes would effectively level the playing field for reimbursement advantages between physician specialists providing consultation services --which have historically been paid at a higher rate -- and new and established office visits, initial hospital visits, or initial facility visits.

Example: A primary care physician checks out a patient with a suspicious-looking mole. Since he cannot establish a diagnosis, he sends for a dermatologist to evaluate and examine the patient's mole. The dermatologist decides to perform a biopsy to determine if the mole is malignant or benign (11100, Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion).

Traditionally, you would report the appropriate code from the 99241-99245 series, depending on time spent with the patient, key components, and level of problem severity, in addition to the other procedure codes. In 2010, you will have to report an E/M service code.

Keep an eye on: You'd have to clarify with your private payers what they accept as 99241-99245 and 99251-99255. Private payers that base their fees on Medicare might follow its lead and drop payment for consult codes rather than traditionally higher-paying consult codes. For technicality purposes, however, the proposed rule would apply only to your Medicare Part B coding.

Ditch Consult Codes -- and Consult Coding Questions

A silver lining awaits the proposed rule, which basically ends the confusion surrounding the coding of Medicare claims. You will be able to easily tell what is or isn't a consult, without having to comb your physician's documentation for the three R's of consultations: request, rendering of services, and return of the patient to the requesting physician.

Office consults have always been a gray area; the proposed rule will be a good thing, says **Christine M Liles, CPC,** insurance supervisor at Knoxville Dermatology Group PC in Tennessee. "We won't have to decide if there has been a transfer of care or not. Being able to use just the regular office visit and hospital and nursing home codes will make it

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easier," Liles says.

Anything that makes the job easier and more straightforward is always a welcome idea, she says. In fact, experts predict that the Medicare fee schedule might even help dermatologists by a small overall increase of 3 percent, thanks to changes the RVUs tied to many dermatology codes.

Use Modifier for Cross Over to Hospital Codes

Current guidelines do indicate that hospital visit codes are restricted to use by the admitting physician. In the past, if more than one physician were to submit an initial hospital visit code, the one who submitted it earlier got paid and the others likely got denied. CMS's proposal can change that as physicians who serve as consultants may now use the initial hospital codes.

How will Medicare know what physician admitted a patient? CMS has indicated that your admitting physician will be required to report a modifier appended to the initial hospital visit code on his claim. No word has come from CMS as to what modifier you'd have to use nor what consequences you'd have to face if you failed to report that modifier. Check back with the Dermatology Coding Alert for more updates.

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