Part B Insider (Multispecialty) Coding Alert

CONSULTATION ELIMINATION: Forget to Append Modifier AI to Inpatient Hospital Visit Claim? This MAC Will Still Reimburse You

Plus: You no longer need to list the ordering/referring physician as item 17 on your claim form when a 'consult' takes place, since CMS doesn't recognize consults.

If you forget to append modifier AI (Principal physician of record) to your initial hospital care claims, you'll still collect your fees, at least from one Medicare payer. That was the word from the Feb. 9 NGS Medicare Part B Consultation Coding Changes conference call. NGS, which is the Part B MAC for four states, offered the seminar to alleviate confusion about the consult code elimination.

Many of the callers expressed concern over accurate use of modifier AI, which you should append to the attending physician's initial hospital care code. Remember that modifier AI is for inpatient use only, not for outpatient E/M codes. "The AI modifier is utilized only by the physician responsible for the overall care of the patient on their initial patient visit code, even if they are not the admitting physician," said **Linda Teti, CPC,** provider outreach and education consultant with NGS. "Remember that AI is a modifier that is informational," Teti noted. Informational modifiers do not influence whether a claim is processed and paid.

One caller asked whether NGS intends to wait for the attending physician's initial hospital care claims (denoted by the AI modifier) before it will pay initial hospital care claims submitted by other specialists, but this MAC does not intend to process claims that way. "No, AI is informational only," Teti responded. "In a perfect world, the doctor following the patient's care will submit with the AI modifier and everyone else wouldn't, but if someone put it on in error or someone forgot to put it on, it won't affect payment," she advised.

Consult Elimination Changes Claims Reporting Rules

Providers frequently ask the NGS Medicare reps whether they must report the referring or ordering physician's name on item 17 of their claim form. That is not a requirement anymore, Teti indicated.

"However, including in your documentation who the patient was referred from and the reason for that visit in the report is simply good medical practice," Teti said.

Remember: "There is no longer an absolute requirement for a consultation request and report, as was previously specified in the consultation documentation requirement." Instead, you should make sure to meet the E/M service documentation coding requirements, since consultation codes are no longer recognized.

Code Pre-Op Clearance Properly

Practices that previously reported consultation codes for pre-operative clearances expressed confusion about which diagnosis codes to use for the visits, now that the exams are no longer considered consults.

In the past, practices used a code from the V72.81-V72.84 series (pre-operative examination) for the consult, but one caller asked which diagnosis she should report going forward for these visits.

The primary diagnosis code should be the V code for the surgical pre-operative exam, and the secondary code should be the diagnosis code representing why the surgery is being performed, said **Karen Drake, RN, CPC,** a provider outreach and clinical education consultant with NGS. "Keep in mind that you want to support the medical necessity for doing that pre-op clearance," Teti said. "For example, the patient comes to you and has a history of heart disease, and that's why a cardiologist is going to be seeing him -- you want to make sure you're going to be using diagnoses that will support the

medical necessity of the visit."