AACE Endocrine Coding Webinar
Welcome to the Brave New World:
Billing for Endocrine E & M Services in 2010

Question and Answer Submissions

Q: If a patient returns after a year or so and takes excessive time including a complex review of either the same diagnosis or a new one, but does not meet the prolonged services description, will Medicare accept the modifier codes such as -22? During the webinar there was no mention of using the Modifier codes along with the CPT® coding.

A: This modifier should not be appended to an E/M service. Modifier -22 Increased Procedural Services is reported when the work required to provide a service is substantially greater than typically required and is appended to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of the procedure, severity of patient’s condition, physical and mental effort required). If the physician spends more than the average time associated with an E/M service, he or she may bill the prolonged service codes in addition to the E/M visit.

Please see the below statement, as provided in the Medicare Claims Processing Manual, Chapter 12, Publication 100-4, section 30.6.15.1 (E), regarding Prolonged Services:

Prolonged services codes can be billed only if the total duration of all physician or qualified NPP direct face-to-face service (including the visit) equals or exceeds the threshold time for the evaluation and management service the physician or qualified NPP provided (typical/average time associated with the CPT® E/M code plus 30 minutes). If the total duration of direct face-to-face time does not equal or exceed the threshold time for the level of evaluation and management service the physician or qualified NPP provided, the physician or qualified NPP may not bill for prolonged services.

Q: I completely understand the issue of a physician being called in to see a patient in the hospital for a consultation and then only being able to charge a follow-up visit in the office later over the next 3 year period of time. My question, however, is, what if a physician goes to the hospital to do a procedure on a patient he/she has never seen, bills only the performance of the procedure, then 6 months down the road, the patient comes to see the physician. Can he or she still bill a new patient visit since he or she never billed an Evaluation and Management (E/M) previously, but only the procedure?

A: No; because the surgical procedure is considered a face-to-face service. Please see the below, as provided in the Medicare Claims Processing Manual, Chapter 12, Publication 100-4, section 30.6.7, regarding the 3-year rule.

30.6.7 - Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99201 - 99215)

A Definition of New Patient for Selection of E/M Visit Code
Interpret the phrase “new patient” to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. For example, if a professional component of a previous procedure is billed in a 3 year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.

Q: My question is in regards for billing counseling and coordination care service which is time based. In this scenario, a provider spends 45 minutes with a patient and over 50% is spent counseling. A consult would be a 99243, but if we need to convert based solely on time, it would be a 99204 new patient or a 99215 established.

My providers feel this is the correct conversion for this type of scenario. Do you feel this is appropriate or should the crosswalk be of the same billing level... 99243, 99203, 99213?

A: If you are not billing based on time, the documentation must support the level of service provided. There is currently not a true 1-to-1 crosswalk. However, if you look at the requirements for 99243, detailed history, detailed examination and medical decision making of low complexity, the requirements are comparable to 99203, 99213 or 99214. Please keep in mind that the documentation must support the level of service provided. Please see the below, as referenced in the Medicare Claims Processing Manual, Chapter 12, Publication 100-4, section 30.6.1C.

C. Selection of Level of Evaluation and Management Service Based On Duration of Coordination of Care and/or Counseling

Advise physicians that when counseling and/or coordination of care dominates (more than 50 percent) the face-to-face physician/patient encounter or the floor time (in the case of inpatient services), time is the key or controlling factor in selecting the level of service. In general, to bill an E/M code, the physician must complete at least 2 out of 3 criteria applicable to the type/level of service provided. However, the physician may document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided. Documentation must be in sufficient detail to support the claim.

EXAMPLE: A cancer patient has had all preliminary studies completed and a medical decision to implement chemotherapy. At an office visit the physician discusses the treatment options and subsequent lifestyle effects of treatment the patient may encounter or is experiencing. The physician need not complete a history and physical examination in order to select the level of service. The time spent in counseling/coordination of care and medical decision-making will determine the level of service billed.

The code selection is based on the total time of the face-to-face encounter or floor time, not just the counseling time. The medical record must be documented in sufficient detail to justify the selection of the specific code if time is the basis for selection of the code. In the office and other outpatient setting, counseling and/or coordination of care must be provided in the presence of the patient if the time spent providing those services is used to determine the level of service reported. Face-to-face time refers to the time with the physician only. Counseling by
other staff is not considered to be part of the face-to-face physician/patient encounter time. Therefore, the time spent by the other staff is not considered in selecting the appropriate level of service. The code used depends upon the physician service provided.

In an inpatient setting, the counseling and/or coordination of care must be provided at the bedside or on the patient’s hospital floor or unit that is associated with an individual patient. Time spent counseling the patient or coordinating the patient’s care after the patient has left the office or the physician has left the patient’s floor or begun to care for another patient on the floor is not considered when selecting the level of service to be reported.

The duration of counseling or coordination of care that is provided face-to-face or on the floor may be estimated but that estimate, along with the total duration of the visit, must be recorded when time is used for the selection of the level of a service that involves predominantly coordination of care or counseling.

**Q:** Please explain the AI modifier and when it should be coded. Is it used by the admitting doctors who are seeing patients only in the hospital?

**A:** The AI modifier is to be used by the admitting or attending physician only. This modifier will identify the physician who oversees the patient’s care from all other physicians who may be furnishing specialty care. All other physicians who perform an initial evaluation on this patient will bill only the E/M code for the complexity level performed.

When a physician is called into the hospital to perform a consultation, they can bill for the initial admission codes (99221-99223) per hospital stay. If they continue to see the patient during the hospital stay, the physician would bill the subsequent inpatient hospital codes (99231-99233).

Claims that include the “-AI” modifier on codes other than the initial hospital and nursing home visit codes (i.e., subsequent care codes or outpatient codes) will not be rejected and returned to the physician or provider.

Please note that your documentation must support the level of care which you are providing to the patient.

**Q:** I was under the impression that the codes 99221 to 99223 were used for admitting physicians only. As a consultant am I allowed to bill one of those codes as an initial visit called in consult by another physician, even though we did not admit?

**A:** Yes, if a physician is called to the hospital for an inpatient consult, the physician can bill 99221-99223. In the inpatient hospital setting and nursing facility setting, physicians and qualified NPPs who perform an initial evaluation may bill an initial hospital care visit code (CPT® codes 99221 – 99223) or nursing facility care visit code (CPT® codes 99304 –99306), where appropriate. In all cases, physicians should bill the available code that most appropriately describes the level of service provided.
Follow-up visits by the physician in the facility setting should be billed as subsequent hospital care visits for hospital inpatients and subsequent nursing facility care visits for patients in nursing facilities, as is the current policy.

Q: Also if we admit the patient we have to use the AI code but cannot bill until the PCP bills?

A: If you are the admitting physician, the AI modifier must be submitted with the appropriate initial hospital visit code (99221-99223). If the PCP provided services to the patient, prior to admission, the PCP would bill for those services. The PCP’s bills would not impact the consulting physician’s bills.

Q: If a patient is seen in the hospital previously, say 6 months ago, and we are called in to consult, is that considered an existing patient?

A: No, because it is a different hospital stay, so you are able to bill the initial admission codes. If you continue to see a patient during a specific hospital stay, then you would bill the subsequent hospital codes.

Q: Should we bill all hospital visits as subsequent hospital codes even first time visits?

A: When a physician is requested for an initial consult, he or she would bill the initial inpatient admission codes. If the medical necessity requirements are not met to report an initial hospital care code, it would be appropriate to bill subsequent hospital care codes.

Q: Should we delay billing Medicare until CMS decides on the RVU increase or just bill regularly and wait for the increase.

A: No, AACE recommends billing your claims routinely in your practice. If CMS revises the conversion factor, making it retroactive, claims will be adjusted.

Q: I would really like to discuss the question everyone was asking during the seminar regarding inpatient consultation. I was pretty much clear on what qualified as inpatient consult until someone mentioned that it was ok to bill inpatient consult even if the patient has been seen in the last three years.

A: The three year rule is only applicable for office or outpatient E/M services. When a consulting physician is requested to see a patient in the hospital (inpatient setting), they should bill the inpatient admission codes (99221-99223). If the consulting physician continues to see the patient during a specific hospital stay, then the physician would bill the subsequent hospital codes (99231-99233).
Q: ER physician calls me as endocrinologist to manage for e.g. DKA, I go to the ER. However, patient is admitted under his primary personal physician. What code do I use?

A: If the physician sees the patient in the ER, and the patient has not been admitted into the hospital, he or she would bill the emergency department codes (99281-99285). If the patient is admitted into the hospital, then the physician would bill the initial inpatient codes (99221-99223).

Q: A patient I follow as outpatient for diabetes is admitted by his PCP for say CHF or pneumonia. The PCP calls me to manage his diabetes. What code do I use?

A: In this scenario, you would bill the initial inpatient codes 99221-99223.

Q: RE Slide 19 and 20: Do we add the prolonged service codes to the usual outpatient code? For e.g. if I have spent 45 minutes with patient in the office, do I bill as: 99213 PLUS 99354 or just bill 99353/54/55? Please clarify.

A: In order to bill for prolonged visit services, the physician must spend at least 30 additional minutes face-to-face with the patient beyond the usual service time indicated in the code descriptor. In this scenario, the physician spent 45 minutes with the patient so level 5 code, 99215, should be billed, if the documentation supports the level of service provided. If the documentation supports 99213, it would be appropriate to bill 99213 and 99354 X 1.

Q: My question is for an established patient seen in the hospital, does the doctor need to dictate a consultation letter or can he just write a follow up note since he can only bill for a follow up hospital code?

A: According to the new CMS requirements, the physician does not have to dictate a letter; however, the physician should document in the patient’s hospital chart that they are consulting for a specific condition.

Q: I’m still very confused about the inpatient “consult.” If we have seen the patient for anything in the past 3 years, we must use Established codes?

A: The three year rule is only applicable for office or outpatient E/M services. When a consulting physician is requested to see a patient in the hospital, they should bill the inpatient admission codes (99221-99223). If the consulting physician continues to see the patient during a specific hospital stay, then the physician would bill the subsequent hospital codes (99231-99233). If the physician is requested for a consult for the same or different diagnosis, during the same hospital stay, the physician would bill the subsequent hospital care codes.

Q: If the ObGyn refers a patient for a prolactinoma, or another internist refers a patient for hyperparathyroidism, I will be unable to bill a Consult or New visit?
A: For Medicare patients, consultation codes are no longer recognized in the office/outpatient and inpatient facility settings. If the physician is requested for an initial consultation, he or she would bill the office/outpatient E/M visits for the office/outpatient setting, 99201-99205; for inpatient consults, 99221-99223 would be billed; and for nursing care facilities, 99304-99306. If follow-up visits are required, the physician would bill the subsequent visit codes based on the place of service (office/outpatient, 99211-99215, inpatient facility, 99231-99233 or nursing care, 99307-99310).

Q: Is there somewhere understandable that I can read more about Observation Care?

A: Yes, please see Medicare Claims Processing Manual, Chapter 12, Publication 100-4, section 30.6.8, regarding Observation Services

30.6.8 - Payment for Hospital Observation Services (Codes 99217 - 99220) and Observation or Inpatient Care Services (Including Admission and Discharge Services – (Codes 99234 – 99236))

(Rev. 1466, Issued: 02-22-08, Effective: 04-01-08, Implementation: 04-07-08)

A. Who May Bill Initial Observation Care

Contractors pay for initial observation care billed by only the physician who admitted the patient to hospital observation and was responsible for the patient during his/her stay in observation. A physician who does not have inpatient admitting privileges but who is authorized to admit a patient to observation status may bill these codes.

For a physician to bill the initial observation care codes, there must be a medical observation record for the patient which contains dated and timed physician’s admitting orders regarding the care the patient is to receive while in observation, nursing notes, and progress notes prepared by the physician while the patient was in observation status. This record must be in addition to any record prepared as a result of an emergency department or outpatient clinic encounter.

Payment for an initial observation care code is for all the care rendered by the admitting physician on the date the patient was admitted to observation. All other physicians who see the patient while he or she is in observation must bill the office and other outpatient service codes or outpatient consultation codes as appropriate when they provide services to the patient. For example, if an internist admits a patient to observation and asks an allergist for a consultation on the patient’s condition, only the internist may bill the initial observation care code. The allergist must bill using the outpatient consultation code that best represents the services he or she provided. The allergist cannot bill an inpatient consultation since the patient was not a hospital inpatient.

B. Physician Billing for Observation Care Following Admission to Observation

When a patient is admitted for observation care for less than 8 hours on the same calendar date, the Initial Observation Care, from CPT® code range 99218 – 99220, shall be reported by the physician. The Observation Care Discharge Service, CPT® code 99217, shall not be reported for this scenario.
When a patient is admitted for observation care and then discharged on a different calendar date, the physician shall report Initial Observation Care, from CPT® code range 99218 – 99220 and CPT® observation care discharge CPT® code 99217.

When a patient has been admitted for observation care for a minimum of 8 hours, but less than 24 hours and discharged on the same calendar date, Observation or Inpatient Care Services (Including Admission and Discharge Services) from CPT® code range 99234 – 99236, shall be reported. The observation discharge, CPT® code 99217, cannot also be reported for this scenario.

C. Documentation Requirements for Billing Observation or Inpatient Care Services (Including Admission and Discharge Services (Codes 99234 – 99236))
The physician shall satisfy the E/M documentation guidelines for admission to and discharge from observation care or inpatient hospital care. In addition to meeting the documentation requirements for history, examination, and medical decision making documentation in the medical record shall include:

- Documentation stating the stay for observation care or inpatient hospital care involves 8 hours, but less than 24 hours;
- Documentation identifying the billing physician was present and personally performed the services; and
- Documentation identifying the admission and discharge notes were written by the billing physician.

In the rare circumstance when a patient is held in observation status for more than calendar dates, the physician shall bill a visit furnished before the discharge date using the outpatient/office visit codes. The physician may not use the subsequent hospital care codes since the patient is not an inpatient of the hospital.

D. Admission to Inpatient Status from Observation
If the same physician who admitted a patient to observation status also admits the patient to inpatient status from observation before the end of the date on which the patient was admitted to observation, pay only an initial hospital visit for the evaluation and management services provided on that date. Medicare payment for the initial hospital visit includes all services provided to the patient on the date of admission by that physician, regardless of the site of service. The physician may not bill an initial observation care code for services on the date that he or she admits the patient to inpatient status. If the patient is admitted to inpatient status from observation subsequent to the date of admission to observation, the physician must bill an initial hospital visit for the services provided on that date. The physician may not bill the hospital observation discharge management code (code 99217) or an outpatient/office visit for the care provided in observation on the date of admission to inpatient status.

E. Hospital Observation during Global Surgical Period
The global surgical fee includes payment for hospital observation (codes 99217, 99218, 99219, and 99220, 99234, 99235, 99236) services unless the criteria for use of CPT® modifiers “-24,” “-25,” or “-57” are met. Contractors must pay for these services in addition to the global surgical fee only if both of the following requirements are met:

- The hospital observation service meets the criteria needed to justify billing it with CPT® modifiers “-24,” “-25,” or “-57” (decision for major surgery); and
- The hospital observation service furnished by the surgeon meets all of the criteria for the hospital observation code billed.
Examples of the decision for surgery during a hospital observation period are:
A patient is admitted by an emergency department physician to an observation unit for observation of a head injury. A neurosurgeon is called in to do a consultation on the need for surgery while the patient is in the observation unit and decides that the patient requires surgery. The surgeon would bill an outpatient consultation with the “-57” modifier to indicate that the decision for surgery was made during the consultation. The surgeon must bill an outpatient consultation because the patient in an observation unit is not an inpatient of the hospital. Only the physician who admitted the patient to hospital observation may bill for initial observation care.

A patient is admitted by a neurosurgeon to a hospital observation unit for observation of a head injury. During the observation period, the surgeon makes the decision for surgery. The surgeon would bill the appropriate level of hospital observation code with the “-57” modifier to indicate that the decision for surgery was made while the surgeon was providing hospital observation care.

Examples of hospital observation services during the postoperative period of a surgery are:
A patient at the 80th day following a TURP is admitted to observation with abdominal pain from a kidney stone by the surgeon who performed the procedure. The surgeon decides that the patient does not require surgery. The surgeon would bill the observation code with CPT® modifier “-24” and documentation to support that the observation services are unrelated to the surgery.

A patient at the 80th day following a TURP is admitted to observation with abdominal pain by the surgeon who performed the procedure. While the patient is in hospital observation, the surgeon decides that the patient requires kidney surgery. The surgeon would bill the observation code with HCPCS modifier “-57” to indicate that the decision for surgery was made while the patient was in hospital observation. The subsequent surgical procedure would be reported with modifier “-79.”

A patient at the 20th day following a resection of the colon is admitted to observation for abdominal pain by the surgeon who performed the surgery. The surgeon determines that the patient requires no further colon surgery and discharges the patient. The surgeon may not bill for the observation services furnished during the global period because they were related to the previous surgery.

An example of a billable hospital observation service on the same day as a procedure is a patient is admitted to the hospital observation unit for observation of a head injury by a physician who repaired a laceration of the scalp in the emergency department. The physician would bill the observation code with a CPT® modifier 25 and the procedure code.
Q: A question regarding which other doctors might be in the group for the 3 year new patient rule. I am the only endocrinologist in the group; I share an office with one other physician who is a rheumatologist. There are about 20 plus other physician offices in the group, and 80 plus physicians. May I bill a new patient if I have never seen the patient before?

A: Yes; a new patient means a patient who has not received any professional services, i.e. E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. For example, if a professional component of a previous procedure is billed in a 3 year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.

Q: If a Medicare patient is in the hospital and we or a partner had seen them in the office at some time, do we not bill an initial visit code now?

A: Yes; when a physician is called into the hospital to perform a consultation, they can bill for the initial admission codes (99221-99223) per hospital stay. If they continue to see the patient during the same hospital stay, the physician would bill the subsequent inpatient hospital codes (99231-99233).

Please note that your documentation must support the level of care which you are providing to the patient.

Q: If you are the primary physician, should you attach the AI modifier just to your first CPT® code or all of them?

A: The AI modifier is to be used by the admitting or attending physician only. This modifier will identify the physician who oversees the patient’s care from all other physicians who may be furnishing specialty care. The AI modifier should only be used on the initial hospital care and the initial nursing facility care codes.

Claims that include the “-AI” modifier on codes other than the initial hospital and nursing home visit codes (i.e., subsequent care codes or outpatient codes) will not be rejected and returned to the physician or provider.

Q: If you are covering for the primary physician during the weekend, should you append the AI to your CPT® codes for that weekend you are covering for him?

A: No; the AI modifier should only be used on the initial hospital care and the initial nursing facility care codes.
Q: If you have an established patient in the office and he is admitted to the hospital by another physician and he calls you in, do you use the initial hospital visit code or a follow-up code?

A: When a physician is called into the hospital to perform a consultation, they can bill for the initial admission codes (99221-99223) per hospital stay. If they continue to see the patient during the same hospital stay, the physician would bill the subsequent inpatient hospital codes (99231-99233).

Please note that your documentation must support the level of care which you are providing to the patient.

Q: Does the ruling apply only to traditional Medicare?

A: Yes, the ruling only applies to traditional Medicare

Q: Are the MCR advantage plans excluded from this ruling?

A: AACE suggests that you follow-up with your payors to seek clarification.

Q: If so, since these plans pay according to the established CMS fee schedule and there is no fee for a level of consult service, how is the reimbursement determined by the MCR adv plan?

A: Various payors have different guidelines. It is suggested that you contact them directly for additional information regarding their guidelines.

Q: You did not mention any specialists, such as psychiatry, being involved in this effort nor which consultation codes will be eliminated. I have nursing home residents that require psychiatric evaluations and I consult psychiatry and psychology to help manage NH residents. Are these specialists affected as well? And does this affect Medicaid reimbursements?

A: This ruling is for traditional Medicare only. The elimination of consultation codes affects all specialists who bill Medicare. The following consultation codes are no longer recognized by Medicare: office or other outpatient consultations (99241-99245) and inpatient consultations (99251-99255). If a physician is called to the nursing facility to consult, the physician would bill the initial nursing facility care codes 99304-99306. If the physician continues to see the patient during the same nursing facility stay, then they would bill 99307-99310.

Q: Please clarify: Do we need a modifier for prolonged services?

A: No, you do not need a modifier for prolonged service codes.
Q: If I am consulting on a new patient for diabetes and thyroid disorder and do a procedure on the same visit (i.e. ultrasound/biopsy), the whole appointment is 90 to 120 minutes, can I attach a prolonged service code to this - 99205 + 76536 with modifier 25 and a 99354?

A: No, you would bill the appropriate services as time is already factored into the procedures performed, as well as, your E/M service. When additional time is spent counseling and coordinating care with the patient, you may bill prolonged services, if the time requirements have been met.

Q: If an RN which is also a CDE sees the patient under the doctor supervision for education, can we bill for 99211?

A: Yes, you may bill a 99211.

Q: If the medication is adjusted by the RN, which is also a CDE, can we bill for 99212 if the physician did not see the patient?

A: No; the services provided by an RN are reported using CPT® code 99211. If the physician instructs the RN to adjust the patient’s medication, these services could be billed as ‘incident to’ under the physician’s or nonphysician practitioner’s provider number. Please refer to the Medicare Benefit Policy Manual, Pub 100-02, Chapter 15, Section 60 for more information regarding ‘incident to’ requirements.

Q: If you are diabetologist (internists) in a group practice managing diabetes, and then the patient develops an endocrine problem (i.e. hypothyroid), and is referred to an endocrinologist in the same practice - can the endocrinologist bill for a new patient visit to manage the hypothyroid?

A: Yes, because the internist and endocrinologist are of different specialties. Make sure the internist and endocrinologist are listed as different specialties with your payers to avoid potential denials.

Q: If a patient is seen in the ER and is consulted by the hospitalist because the patient will be admitted, do you use the ER codes or the inpatient codes if you physically saw them in the ER.

A: You should use the ER codes to bill this visit because the patient was seen in the emergency room and was waiting to be admitted into the hospital.

Q: Can you tell me what the charge range should be for the new codes 99221, 99222, and 99223 for Endocrinologists.

A: On a national average, the codes are reimbursed as follows:
Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

Nonfacility: $89.81 Facility: $89.81

Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

Nonfacility: $122.63 Facility: $122.63

Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

Nonfacility: $180.33 Facility: $180.33

To access specific coding reimbursement in your area, please visit: http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp as fee schedules are based upon your specific locality.

Q: I attended the web-seminar. I am confused about the new rule concerning patients seen in the office and then admitted to the hospital a few days later. We were told to bill a lower level of service for the admission. There was some talk of documentation to be submitted to CMS for the admission. My question is: is it necessary to submit documentation to CMS when admitting a patient to the hospital after the patient has been seen in the office a few days prior, or can we just bill the appropriate level of service?

A: When a Physician performs a visit that meets the definition of a Level 5 office visit several days prior to an admission and on the day of admission performs less than a comprehensive history and physical, he or she must report a Level 1 initial hospital care code. Medicare will pay the office visit that was originally billed and the Level 1 initial hospital care code. If medical necessity requirements are not met to report the Level 1 initial hospital care code, physicians may bill subsequent hospital care codes. When there is no E/M code to describe a given E/M service, it is appropriate to bill CPT® code 99499, unlisted E/M service. Documentation is required when an unlisted code is billed. Please refer to your local Medicare Contractor for specific instructions.
Q: I sometimes cover for IM call and admit patients doing H&P, after that their PCP follow them. I will have to use the AI modifier with those; frequently later during the care I'm consulted as the endocrinologist to take care of the same patient. Will I be able to charge for that using the same code again (w/o AI modifier)? After all, it is the same code used twice.

A: No; Medicare will pay a physician for only one hospital visit per day for the same patient, whether the problems seen during the encounters are related or not. The inpatient hospital visit descriptors contain the phrase “per day” which means that the code and the payment established for the code represent all services provided on that date. The physician should select a code that reflects all services provided during the date of the service.

Q: You mentioned that if you admit a patient the same day that you saw him/her in your office, you can bill for the admission but not for the office visit.

A: Yes, that is correct, you are only able to bill for one E/M service per day. When selecting the level of care for the initial hospital care code, the physician would take into account all of the services provided during the office visit.

Q: How about seeing a patient at the office, coordinate admission by PCP (who will do the H&P) and an endocrinologist consult in the same day? May I be able to charge for the office visit and consult on the same day?

A: No, you are unable to bill the office and consultation (initial hospital care codes) on the same day of service. You are only able to bill the initial admission codes, with no AI modifier. When selecting the level of care for the initial hospital care code, the physician would take into account all of the services provided during the office visit.

Q: Another person asked you about the amounts they will be paying in this new system, you were giving her approximate numbers, can you send me the approximate number too please?

A: On a national average, the codes are reimbursed as follows:

99221 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

Nonfacility: $89.81 Facility: $89.81
99222  Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

Nonfacility:  $122.63  Facility:  $122.63

99223  Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

Nonfacility:  $180.33  Facility:  $180.33

99231  Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

Nonfacility:  $37.15  Facility:  $37.15

99232  Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; an expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

Nonfacility:  $66.72  Facility:  $66.72

99233  Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; a detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

Nonfacility:  $95.58  Facility:  $95.58
To access specific coding reimbursement in your area, please visit:  
http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp as fee schedules are based upon your specific locality.

Q: You said that primary payers should be billed appropriate E/M codes when Medicare is secondary. What if we opted not to bill Medicare at all and just billed the primary an appropriate consultation code? Since we are contracted, but are not accepting new Medicare patients at this time, would this be inappropriate? Obviously, we would not bill the patient any balance.

A: Because you are a Medicare provider, you are required by your participating provider agreement, to submit bills for your Medicare patients. It would be in violation of your Medicare participating provider agreement not to submit your Medicare claims.

Q: Does this also apply to all Medicare Advantage plans and Tricare/Champus?

A: This only applies to traditional Medicare. Please contact your local private and other federal government payers to determine if they are following Medicare’s new policy.

Q: You mentioned CMS had made other changes to offset the loss of revenue from eliminating consult codes. Do you have more specific info regarding how this affects reimbursement rates?

A: In place of the consultation codes, CMS has:
  - Increased the work relative value units (RVUs) for new and established office visits
  - Increased the work RVUs for initial hospital and nursing facility visits
  - Incorporated the increased use of these visits into the practice expense and malpractice calculations
  - Increased the incremental work RVUs for the codes that are built into the 10-day and 90-day global surgical codes

Q: Regarding 99354, we have used time spent to up code in the past, using it when documentation was not sufficient to allow the code used but time was, is this code 99354 another way to code for time or is it to be used instead of using time spent to justify a higher level?

A: If you use time to bill a higher level of service, documentation must support the higher level of service and complexity of the service performed. If medical necessity is not reflected in the documentation, the services could potentially be downcoded even if the time requirements are met.

Q: RN sees the patient for extended time. She starts a specialty test and monitors the patient for 90 minutes. Can we bill the 99211 for the service plus 99354 and 99355 since she’s with
the patient the whole time, or are the prolonged services only eligible for MD, DO, NP and PA?

A: The Prolonged Service Codes are only billed by a physician or nonphysician practitioner.

Q: If I bill in the ICU setting, how does one code and is this affected by the changes?

A: The critical care codes are not affected by this new policy. If you are billing critical care codes 99291-99292, the patient must be critically ill or critically injured. The physician must spend at least 30 minutes evaluating, providing care and managing the patient’s care. This time includes time immediately spent at the patient’s bedside or on the floor unit. The physician must devote his or her full attention to the patient and cannot provide services to another patient during the same period of time.

Q: If a patient in the hospital has been seen by an endocrinologist and there is a request to have a new endocrine evaluation, can the new endocrinologist bill as a new patient?

A: If one endocrinologist has seen the patient and a new endocrinologist is called in, the second endocrinologist can bill the initial inpatient codes, if the second endocrinologist is from a different group. If the same endocrinologist is called back in for a new evaluation (same hospital stay), the physician would bill the subsequent hospital care codes.

Q: When a patient is discharged from the hospital and the patient sees a specialty physician for follow-up visits, what codes should be billed?

A: If the specialty physician saw the patient while they were in the hospital, the specialty physician would bill the established office or other outpatient visit codes, 99211 – 99215, because the physician has seen the patient within three years. If the specialty physician has never seen the patient or has not seen the patient within the past three years, he or she may bill the new patient office or other outpatient visit codes, 99201 – 99205.

Q: I am in a practice with a group of internists. I am practicing both internal medicine and endocrinology here. When they refer a patient for an endocrinology consult, am I able to bill for a new patient visit if I have never seen the patient before? What if I was covering for them and saw their patient for an internal medicine problem before they referred the patient for an endocrine consult?

A: If you are listed with your payer as an internist, you may only bill an established patient visit because of the definition of a new patient visit. A new patient means a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years. If you are listed as an endocrinologist, you may bill a new patient visit.

In a hospital inpatient situation involving one physician covering for another, if physician A sees the patient in the morning and physician B, who is covering for A, sees the same patient in
the evening, Medicare does not pay physician B for the second visit. The hospital visit
descriptors include the phrase “per day” meaning care for the day.

If the physicians are each responsible for a different aspect of the patient’s care, both
physicians are reimbursed, if the physicians are of different specialties and the visits are billed
with different diagnoses. There are circumstances where concurrent care may be billed by
physicians of the same specialty.