

Coding Policy Policy and Procedure	
SUBJECT: Coding Policy 65.0 Guidelines for Billing Consultations	DEPARTMENT: Coding Compliance
ORIGINAL EFFECTIVE DATE: 03/1991	DATE(S) REVIEWED/REVISED: 01/10, 01/11, 01/12, 01/13, 04/13, 01/14, 01/15, 01/16, 01/17, 01/18, 01/19, 01/20, 01/21
APPROVED BY: Coding Policy Review Committee	NUMBER: MC 65.0 PAGE: 1 of 2

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:

Health Plan Providers
Non-Participating Providers
All Lines of Business

POLICY:

Effective January 1, 2011, Company stopped recognizing CPT consultation codes (99241-99245 and 99251-99255). In 2010, CMS stopped paying consult codes and increased the RVU (relative value unit) for all other Evaluation and Management (E/M) codes. Based on this increased value of E/M codes, Company stopped recognizing consultation codes. For services furnished on or after January 1, 2011, providers may report each E/M service, including visits that could be described by CPT consultation codes, with the E/M code appropriate for the place of service which supports the level of service performed. Claims billed with consultation codes will be denied as provider responsibility and returned to the provider with instructions to rebill with appropriate HCPCS/CPT.

PROCEDURE:

Inpatient and Nursing Facility Services:

- In the inpatient hospital setting and the nursing facility setting, all physicians and qualified non-physician practitioners who perform an initial evaluation may bill the initial hospital care codes (99221-99223) or initial nursing facility care codes (99304-99306).
- When an inpatient hospital service performed by a physician other than the admitting physician of record is necessary, with all the required components performed and appropriately documented, the appropriate level of service (99221-99223) may be billed by the second or subsequent physicians. The principal physician of record shall append modifier "AI" (Principal Physician of Record) to the E/M code for initial hospital care or initial nursing facility care. Modifier AI is not required on follow-up visits in a facility.
- If criteria for 99221 (Initial Hospital Care) are not met by the second or subsequent physicians, but a service was necessary and all of the required components performed and appropriately documented meet the criteria for “Subsequent Hospital Care,” use CPT codes 99231-99232 for billing.
- When a nursing home service performed by a physician other than the admitting physician of record is necessary, with all required components performed and appropriately documented, that level of service (99304-99306) is appropriate for billing by and payment to the second or subsequent physicians.

Coding Policy Policy and Procedure	
SUBJECT: Coding Policy 65.0 Guidelines for Billing Consultations	DEPARTMENT: Coding Compliance
ORIGINAL EFFECTIVE DATE: 03/1991	DATE(S) REVIEWED/REVISED: 01/10, 01/11, 01/12, 01/13, 04/13, 01/14, 01/15, 01/16, 01/17, 01/18, 01/19, 01/20, 01/21
APPROVED BY: Coding Policy Review Committee	NUMBER: MC 65.0 PAGE: 2 of 2

- If criteria for 99304 "Initial Nursing Facility Care" are not met by the second or subsequent physicians but a service was necessary and all of the required components performed and appropriately documented meet criteria for a "Subsequent Nursing Facility Care," use CPT codes 99307, 99308, or 99309 for billing.
- If, in what should be a very **rare** circumstance, an E/M service is necessary, performed and documented that does not meet even the criteria for CPT code 99231 or 99304, then CPT code 99499 may be billed and paid subject to individual adjudication and pricing based on the submitted documentation. In these cases, it is the responsibility of the provider to ensure all necessary information has been documented in the medical record. The service must meet medical necessity and reasonableness standards. Documentation must include the place of service and a brief statement why another E/M code does not apply.

Office or Other Outpatient Setting:

In the office or other outpatient setting where an evaluation is performed, physicians and qualified non-physician practitioners shall use the CPT codes for outpatient E/M visits. For example, a code from the range 99202-99215 may be used for consultations performed in the physician's office, or a code from the range 99218-99220 or 99224-99226 may be used for consultations performed in the observation unit of the hospital.

All physicians and qualified non-physician practitioners shall follow E/M documentation guidelines for E/M services. The CPT definitions for new and established patients apply. A new patient E/M code may be used when the patient has not received any professional or other face-to-face services from the physician or physician group practice (same specialty) within the previous three years.

REFERENCE:

CMS/Medicare Rules and Regulations
Current Procedural Terminology (CPT)
Providence Health Plan Coding Policies