



m e d i c a l  
m a n a g e m e n t

*We practice  
the business of medicine*

# The Insider News

January 2010

Volume 2, Number 3

## In This Issue

- Consults in 2010
- Changes to Rules for Diagnostic Test Interpretations
- Workers' Compensation Corner

## Contact Us

GR Medical  
Management

*Your billing &  
collections partner*

*A complete revenue  
cycle management  
company*

<http://www.grmed.com>

[info@grmed.com](mailto:info@grmed.com)

877.779.3300 x139

## Consults in 2010

Will you, or won't you, report Consultation codes (99241-99245, 99251-99255) in 2010?

As of January 1, 2010, Medicare will no longer pay for these codes. Neither will Medicare HMO's, MedAdvantage plans, or AARP. However, with other commercial plans, the process is not so clear. United Health Care, for example, says it will continue to pay consult codes, at least for now.

Each medical group where consultation codes have been billed in the past have to decide how they will handle this inconsistency. The options are often based on the size and business office capability of the practice.

Some groups that have enough staff to review each reported consultation are telling their providers to go ahead and report a consult code internally, and meet consult documentation requirements, if they believe they have done a consult. Then the business office will review and convert to a different code if the payer does not accept consult codes.

Some groups are making their providers responsible for knowing who accepts consults and who doesn't and reporting appropriately.

Other groups, especially where there are not enough coders to review each chart note, have decided not to bill consult codes at all.

Practices continuing to report consults must also decide how they will handle the billing if Medicare is the secondary payer

For outpatient/office services, there is a straight crosswalk between the new patient and consult codes. For example, 99203 has the same key component (history, exam, medical decision making) as 99243. The only difference between the two codes is typical time.

In the hospital, the cross walk isn't quite as clean. There is no crosswalk for consult codes 99251-99252. Consult codes 99253-99255 crosswalk directly to initial inpatient codes 99221-99223.

Per Medicare guidelines, if you admit a patient, the initial inpatient code (99221-99223) are reported as appropriate, with a modifier "AI" attached.

If you are not the admitting physician, but are called to see the patient in the hospital, either to evaluate or manage a condition, you would also report your first visit with the initial inpatient code 99221-99223), but no modifier is reported.

All subsequent inpatient visits, either by the admitting physician, or other physicians involved in the patient's care are reported with the subsequent inpatient encounter codes (99231-99233), no modifiers required.

---

## Changes to Rules for Diagnostic Test Interpretations

If your medical group has a contracted source for diagnostic test interpretations (i.e., radiology interpretations), and you bill on behalf of the contracted source (i.e., you bill both the technical and the professional component) and separately reimburse the contractor (i.e., radiologist) for interpretation, this applies to you.

If the diagnostic test interpretations are done internally by a member of your own group practice, this change is not applicable to you.

As of January 4, 2010, Medicare requires that the place of service for the interpretation be accurate. If the technical component of an x-ray occurs in your office, you report the place of service (POS) as 11. However, if the professional component (interpretation) of the x-ray takes place somewhere else (i.e., the radiologist's home), then a different POS (i.e., 99) must be reported. Also, the zip code on the claim form must be accurate to the interpreting physician's location.

As of July 1, 2010, Medicare will require that the interpretation be reported on the day it occurs. If the technical component occurred on July 3<sup>rd</sup>, but final reading didn't take place until July 6<sup>th</sup>, the technical and professional component will need to be reported accurately to represent the correct date for each.

For more information, check out Medicare's Transmittal Memo 1873.

---

## Workers' Compensation Corner:

If QME physicians want to avoid their QME status being threatened by the DWC, they should make sure they get their reports out within 30 days. Although it is true that earlier this year legislation was enacted that created a mechanism for extending the 30-day deadline in certain situations, the evaluators must show good cause for the late reporting, such as family medical emergency, death, natural disaster or similar urgent circumstance. Regulation 38 (i) of Labor Code section 139.2 explicitly states that ongoing problems with late reporting alone may result in non-renewal of QME status. The options that do exist are as follows: Providers are required by Regulation 38 (b) to issue the initial report on time, **unless** a request is filed by the evaluator at least five days prior to the 30-day deadline, and a 15- or 30-day extension is granted by the medical director. When the physician has not received **test results** or the report of a **consulting physician**, necessary to address all disputed medical issues in time to meet the initial 30-day deadline, an extension of up to 30 days shall be granted. However, it should be noted that the statute indicates that, "Extensions will not be granted because relevant medical information/records have not been received. The evaluator shall complete the report based on the information available and state that the opinions and/or conclusions may or may not change after review of the relevant medical information/records." Evaluators requesting time extensions will be monitored and advised by the medical director when such a request appears unreasonable or excessive.

---

GR Medical Management is committed to providing you with the latest information and facts from the industry. Our goal is to keep you up to date and informed in order to streamline your operation.

You can visit us at: [WWW.GRMED.COM](http://WWW.GRMED.COM) for a closer look at who we are & how we can improve your bottom line.

For coding questions, contact Gladys Ross, CPC, CCS-P, ACS-EM at [gross@grmed.com](mailto:gross@grmed.com)

Materials for The Insider News have been prepared by our organization for information purposes only and should not be construed as legal advice or legal opinion on any specific facts or circumstances. These materials do not, and are not, intended to constitute legal advice.

To unsubscribe to this newsletter please contact us at [info@grmed.com](mailto:info@grmed.com)