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The Insider News

June 2010

Volume 2, Number 8

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Consultations in 2010

Still using Consultation codes? Consultation codes still appear in the CPT book for 2010. Medicare and other federally funded insurance plans, including Medicaid and Medicare HMOs, do not reimburse the consultation codes in 2010, but a number of commercial carriers are still accepting them.

Here's a few reminders when consultations can be reported:

- CPT guidelines revised this year. Documentation in both the requesting physician's chart and the consultant's chart of the consult request is no longer required to prove the consultation request.

"The written or verbal request for consult may be made by a physician or other appropriate source and documented in the patient's medical record by either the consulting or requesting physician or appropriate source."

- The guidelines now state that "a consultation is a type of evaluation and management service provided by a physician at the request of another physician or appropriate source to either recommend care for a specific condition or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem". This is slightly more liberal than in the past.
- Documentation guidelines have not changed. The requesting provider and the intent of the requesting provider must still be identified, the evaluation and advice documented, and a written report must be sent back to the requesting source.

Here's some additional reminders for those situations when the patient's insurance does not recognize consultation codes:

- In the office, these encounters are reported with office/outpatient codes (99201-99215), depending on whether the patient is new or established. Remember if the patient has previously been seen in the practice by a physician of the same specialty, the patient is considered established, not new. (*exception: California Worker's Comp*)
- When admitting a patient to the hospital, report initial inpatient care codes (99221-99223) accompanied by the modifier "AI".
- If you are asked to see an already admitted patient, either to provide an evaluation/advice or to manage a component of their care, the first encounter is also reported with initial inpatient care codes (99221-99223). No modifier is necessary.

Medicare Conversion Factor

Medicare has just announced that it will continue to hold claims for services on or after June 1, 2010 until June 18th. The hope is that Congress will pass some kind of resolution to the SGR debacle by the end of this week. Otherwise, Medicare claims will begin being processed with the 21% conversion rate reduction.

Workers Comp Corner: WCAB ISSUES GUIDELINES ON RATING PROTOCOLS

In order to provide greater clarity regarding the respective roles of each party in the Formal Rating process, in an En Banc decision, the WCAB has issued the following guidelines:

1. The physician's role is to assess the injured employee's whole person impairment percentage(s) by a report that sets forth facts and reasoning to support its conclusions and that comports with the AMA Guides and case law;
2. In the context of a formal rating, the WCJ's role is to frame instructions, based on substantial medical evidence, that specifically and fully describe the whole person impairment(s) to be rated; in addition, a WCJ's instructions may ask a rater to offer an expert opinion on what whole person impairment(s) should or should not be rated;
3. In the context of a formal rating, the rater's role is to issue a recommended permanent disability rating based solely on the WCJ's formal rating instructions; unless specifically instructed to do so, a rater has no authority to issue a rating based on the rater's own assessment of whether the whole person impairment rating(s) referred to in the WCJ's instructions are based on substantial evidence or are consistent with the AMA Guides;
4. A WCJ is not bound by a rater's recommended permanent disability rating and a WCJ may elect to independently rate an employee's permanent disability; however, a WCJ's rating still must be based on substantial evidence;
5. Potential AMA Guides rating problems may be minimized by the early and proper use of non-formal ratings;
6. In the context of a formal rating, there must be no ex parte communication between the WCJ and the assigned rater.

This decision makes it clear that the WCJ is the ultimate arbiter, and may use his or her discretion as to rely or not rely on information from the physician and the Rater, even after a formal rating is issued. As the ultimate finder of fact, the judge may ignore input from a Rater, as long as he or she decides the case based upon substantial evidence. The judge may elect to independently rate an employee's permanent disability, even after a Rater has recommended a specific permanent disability. Although this decision gives the judges plenty of flexibility, it also requires the WCJ to carefully evaluate a medical report to determine if the physician's impairment rating has been properly supported by underlying medical data. The decision urges judges to not mechanically rely upon physician's conclusions, but to comprehensively analyze the full report before rendering a decision.

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