



Santa Clara County Medical Association/408-998-8850

Monterey County Medical Society/831-455-1008

### CMS GIVES DETAILS OF CONSULTATION CHANGE

#### Medicare Top Ten Billing Errors

1. Beneficiary enrolled in HMO
2. Services not paid separately
3. Global surgery
4. Service not medically necessary
5. Medicare is secondary payer
6. Service not paid to a chiropractor
7. Provider not certified
8. Routine exams/Related services
9. Non-covered services
10. Timely filing

Effective January 1, 2010, the consultation codes are no longer recognized for Medicare Part B payment. Physicians shall code patient evaluation and management visits with E/M codes that represent where the visit occurs and that identify the complexity of the visit performed. In the inpatient hospital setting and the nursing facility setting, all physicians (and qualified non-physicians where permitted) who perform an initial evaluation and management may bill the initial hospital care codes (99221-99223) or nursing facility care codes (99304-99306). As a result of this change, multiple billings of initial hospital and nursing home visit codes could occur even in a single day. Modifier “-AI,” defined as “Principal Physician of Record,” shall be used by the admitting or attending physician who oversees the patient’s care, as distinct from other physicians who may be furnishing specialty care. The principal physician of record shall append modifier “-AI” in addition to the initial visit code. All other physicians who perform an initial evaluation on this patient shall bill only the E/M code for the complexity level performed. NOTE: the primary purpose of this modifier is to identify the principal physician of record on the initial hospital and nursing home visit codes. Note: The primary purpose of this modifier is to identify the principal physician of record on the initial hospital and nursing home visit codes. Medicare carriers should **not** reject claims when modifier AI is appended to subsequent care or outpatient visit codes. Follow-up visits in the facility setting may be billed as subsequent hospital care visits and subsequent nursing facility care visits, as is the current policy. In all cases, physicians shall bill the available code that most appropriately describes the level of the services provided.

On the Internet:

\*View Program Transmittal 1875:

<http://www.cms.hhs.gov/transmittals/downloads/R1875CP.pdf>

#### Did you know?...

Per United Healthcare (UHC), if you are requesting a reconsideration of a claim that was denied because filing was not timely, you must include confirmation that UHC or one of its affiliates received and accepted your claim. Consistent with UHC’s current policy, as of December 1, 2009, proof of timely filing from an *electronic claim submission* must include confirmation that UHC **accepted** the claim. Although a timely filing denial may have been overturned in the past with only a copy of the EDI submission report, the submission report will no longer be accepted as proof of timely filing beyond December 1, 2009. *For paper claims* – include a copy of a screen print from your accounting software to show the date you submitted the claim. Note: proof of timely filing must include proof that the claim is for the correct patient and the correct visit.

To download a copy of these billing errors and their resolutions, go to:

<http://www.sccma.org>

Click Downloads under the Reimbursement Menu.