Medicare Consultation Services
Payment Policy

Policy Summary

Despite strong objections from organized medicine, the US Centers for Medicare & Medicaid Services (CMS) eliminated payments for inpatient and outpatient consultation codes and now require physicians to bill for new or established patient office visits, initial hospital care codes, or initial nursing facility care codes. Effective, January 1, 2010, consultation codes (99241-99255) are no longer recognized for Medicare Part B payment. Although the payment rule will provide minor increases in payments for some inpatient and outpatient Evaluation and Management (E&M) visits to offset losses that will result from the elimination of these codes, physicians asked to provide expert opinions could see a reduction in reimbursement as a result of this new policy.

CMS’s decision was intended to alleviate confusion that has surrounded the reporting of these codes for years. The new policy will likely cause additional confusion as physicians and billing managers try and make sense of the new rules and are trained on the new coding selections.

Coding Specifics

Effective January 1, 2010, CMS eliminated the use of E&M Consultation CPT codes (99241-99255) for its Medicare physicians and requires them to bill the most appropriate E&M code that represents the location and complexity of the service provided. For office visit and other outpatient E&M services consider 99201-99215. For initial hospital care services consider 99221-99223. For initial nursing facility care services consider 99304-99306.

The principal physician of record will append modifier “AI” – Principal Physician of Record – to the E&M code when billed. 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. Claims that include the AI modifier on codes other than the initial hospital and nursing home visit codes will not be rejected or returned to the physician or other health care provider.

Medicare will no longer recognize the consultation codes for purposes of determining Medicare secondary payments (MSP). In MSP cases, physicians and other health care providers must bill an appropriate E&M code for the services previously paid using the consultation codes. If the primary payer for the service continues to recognize consultation codes, physicians and other health care providers billing for these service may either:

(continued)
• Bill the primary payer an E&M code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with the same E&M code, to Medicare for determination of whether a payment is due; or

• Bill the primary payer using a consultation code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with an E&M code that is appropriate for the service, to Medicare for determination of whether a payment is due

NOTE: The first option may be easier from a billing and claims processing perspective.

Other Payers

MSMS has been gathering information for Michigan payers to see if they plan to follow Medicare’s lead on eliminating reimbursement for CPT consultation codes 99241-99255 effective with their fee update on July 1, 2010.

• Blue Cross Blue Shield of Michigan (BCBSM) regular business and Blue Care Network (BCN) commercial will no longer reimburse CPT codes 99241-99255 effective with their fee update on July 1, 2010

• BCBSM Medicare Plan Blue Private Fee-For-Service and Medicare Plus Blue PPO plans will no longer reimburse CPT codes 99241-99255 effective July 1, 2010

• BCN Advantage will follow Medicare policy and will no longer reimburse CPT codes 99241-99255 effective January 1, 2010

• Michigan Medicaid and BlueCaid will continue reimbursing the consultation codes and will pay for the Telehealth Consultation codes G0425-G0427

• United HealthCare Medicare and Priority Health Medicare plans will follow the Medicare policy and no longer reimburse CPT codes 99241-99255 effective January 1, 2010

Be sure to check with your Medicare carrier regarding billing guidelines in secondary payer situations.

Opposition to Policy

MSMS and the AMA strongly urged CMS to delay the implementation of its new consultations billing policy for a year. Efforts included multiple discussions between Rebecca Patchin, MD, AMA Board of Trustees Chair, and Department of Health and Human Services (HHS) Secretary Kathleen Sebelius. Unfortunately, the General Counsel for HHS determined that CMS can not delay a single section of the final Medicare Physician Fee Schedule Rule (MPFS). Rather, CMS must either delay or move forward with the implementation of the entire rule. Therefore, CMS made a decision to implement the entire MPFS rule, including the new consultations billing policy, on January 1.

In response to CMS’s decision, the AMA has requested that CMS clarify some of the policies raised in two CMS educational pieces on the new policy, Transmittal # 1875 and a MLN Matters article (see Resources below), as well as to undertake additional educational steps to assist physicians with this new policy. We will keep members posted as new information on CMS’s efforts to further educate and answer physicians’ questions on this new policy becomes available.

Education
MSMS offers classes on this and other coding issues in a selection of locations and formats. For a complete listing, visit www.msms.org/eo, click on “Course Listing” classes are titled “Consultations” and “Medicare Update.”

For more information on MSMS educational opportunities, contact Marcie Shattuck, Education Coordinator, at (517) 336-5724 or mshattuck@msms.org.

Questions
For more information on reimbursement and coding issues, contact MSMS Reimbursement Advocate Stacie J. Saylor, CPC, at (517) 336-5722 or ssaylor@msms.org. Also, visit www.msms.org/reimbursement.

Resources (attached)
- CMS MLN Matters article (MM6740)
- AMA Opposition Letter
- MSMS Opposition Letter
News Flash – The newly redesigned MLN Products Catalog is now available and can be viewed at [http://www.cms.hhs.gov/MLNGENINFO](http://www.cms.hhs.gov/MLNGENINFO) on the CMS website. To access the catalog, click on the link MLN Product Catalog. The MLN Products Catalog is an interactive downloadable document that lists all Medicare Learning Network products by media format. The catalog has been revised to provide new customer-friendly links that are embedded within the document, as well as, both subject and provider type indexes. All product titles and the word "download" when selected, will link you to the online version of the product. The word "hard copy" when selected, will automatically link you to the MLN Product Ordering page.

<table>
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<th>MLN Matters® Number: MM6740 Revised</th>
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<td>Related CR Release Date: December 14, 2009</td>
<td>Effective Date: January 1, 2010</td>
</tr>
<tr>
<td>Related CR Transmittal #: R1875CP</td>
<td>Implementation Date: January 4, 2010</td>
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Revisions to Consultation Services Payment Policy

**Note:** This article was revised on December 17, 2009, to correct the "initial hospital day codes" referenced on the top of page 4 (in bold). Those codes should be 99221-99223. The error listed them as 99231-99233. All other information remains the same.

Provider Types Affected

This article is for physicians and non-physician practitioners (NPPs) who perform the initial evaluation and management (E/M) consultation for Medicare beneficiaries and submit claims to Medicare Carriers, Fiscal Intermediaries, and/or Medicare Administrative Contractors (MACs) for those services. It is also intended for Method II critical access hospitals, which bill for the services of those physician and non-physician practitioners who have reassigned their billing rights. This article only applies to physicians billing the Medicare fee-for-service program. It does not apply to Medicare Advantage or non-Medicare insurers.

Provider Action Needed

This article pertains to Change Request (CR) 6740, which alerts providers that effective January 1, 2010, the Current Procedural Terminology (CPT) consultation codes (ranges 99241-99245 and 99251-99255) are no longer recognized for...

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Medicare Part B payment. Effective for services furnished on or after January 1, 2010, providers should code a patient evaluation and management visit with E/M codes that represents WHERE the visit occurs and that identify the COMPLEXITY of the visit performed. See the Key Points section of this article for details.

Background

In the calendar year 2010 Medicare Physician Fee Schedule (MPFS) final rule with comment period (CMS-1413-FC), the Centers for Medicare & Medicaid Services (CMS) eliminated the use of all consultation codes (inpatient and office/outpatient codes) for various places of service except for telehealth consultation G-codes. The change will not increase or decrease Medicare payments. In place of the consultation codes, CMS increased the work relative value units (RVUs) for new and established office visits, increased the work RVUs for initial hospital and initial nursing facility visits, and incorporated the increased use of these visits into the practice expense (PE) and malpractice calculations. CMS also increased the incremental work RVUs for the E/M codes that are built into the 10-day and 90-day global surgical codes. All references (both text and code numbers) in the Medicare Claims Processing Manual, Chapter 12, Section 30.6 that pertain to the use of the American Medical Association (AMA) Current Procedural Terminology (CPT) consultation codes (ranges 99241-99245 and 99251-99255) are removed by CR 6740. (The Web address for viewing CR 6740 is in the Additional Information section of this article.)

Key Points of CR 6740

- Effective January 1, 2010, local Part B carriers and/or A/B MACs will no longer recognize AMA CPT consultation codes (ranges 99241-99245, and 99251-99255) for inpatient facility and office/outpatient settings where consultation codes were previously billed for services in various settings.

- Effective January 1, 2010, local FIs and/or A/B MACs will no longer recognize AMA CPT consultation codes (ranges 99241-99245, and 99251-99255) for Method II CAHs, when billing for the services of those physician and non-physician practitioners who have reassigned their billing rights.

- Physicians may employ the 2009 consultation service codes, where appropriate, to bill for consultative services furnished up to and including December 31, 2009.

- Physicians who bill a consultation after January 1, 2010, will have the claim returned with a message indicating that Medicare uses another code for the
service. The physician must bill another code for the service and may not bill the patient for a non-covered service.

- RHCs and FQHCs will discontinue use of AMA CPT consultation codes 99241-99245 and 99251-99255 and should instead use 99201-99215 and 99304-99306.

- Conventional medical practice is that physicians making a referral and physicians accepting a referral would document the request to provide an evaluation for the patient. In order to promote proper coordination of care, these physicians should continue to follow appropriate medical documentation standards and communicate the results of an evaluation to the requesting physician. This is not to be confused with the specific documentation requirements that previously applied to the use of the consultation codes.

- In the inpatient hospital setting and nursing facility setting, any physicians and qualified NPPs who perform an initial evaluation may bill an initial hospital care visit code (CPT code 99221 – 99223) or nursing facility care visit code (CPT 99304 – 99306), where appropriate.

- In all cases, physicians will bill the available code that most appropriately describes the level of the services provided.

- The principal physician of record will append modifier “-AI” Principal Physician of Record, to the E/M code when billed. 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.

- However, 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.

- For patients receiving hospital outpatient observation services who are not subsequently admitted to the hospital as inpatients, physicians should report CPT codes 99217-99220. In the event another physician evaluation is necessary, the physician who provides the additional evaluation bills the office or other outpatient visit codes when they provide services to the patient.
  - For example, if an internist orders observation services, furnishes the initial evaluation, and asks another physician to additionally evaluate the patient, only the internist may bill the initial observation care code. The other physician who evaluates the patient must bill the new or established patient office or other outpatient visit codes as appropriate.
- For patients receiving hospital outpatient observation services who are admitted to the hospital as inpatients and who are discharged on the same date, the physician should report CPT codes 99234-99236 (e.g. code 99234-Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date). If the patient is an inpatient and another physician evaluation is necessary, the physician would bill the initial hospital day code as appropriate (99221-99223). Otherwise, physician should use the new or established patient office or other outpatient visit codes for a necessary evaluation.

- For patients receiving hospital outpatient observation services who are admitted to the hospital as inpatients on the same date, the physician should report only the initial hospital care services codes (codes 99221 - 99223). Medicare will pay for an initial hospital care service if a physician sees a patient in the emergency room and decides to admit the person to the hospital. 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 should report the office visit that reflects the services furnished and also report the lowest level initial hospital care code (i.e., code 99221) for the initial hospital admission. Medicare will pay the office visit as billed and the Level 1 initial hospital care code. The principal physician of record, as previously noted, must append the “-AI” modifier to the claim with the initial hospital care code.

- For patients receiving hospital outpatient observation services or inpatient care services (including admission and discharge services) for whom observation services are initiated or the hospital inpatient admission begins on the same date as the patient’s discharge, the ordering physician should report CPT codes 99234-99236.

- Emergency department visits (codes 99281 - 99288)-- physician billing for emergency department services provided to patient by both patient’s personal physician and emergency department (ED) physician. If the ED physician, based on the advice of the patient’s personal physician who came to the emergency department to see the patient, sends the patient home, then the ED physician should bill the appropriate level of emergency department service. The patient’s personal physician should also bill the level of emergency department code that describes the service he or she provided in the emergency department. If the patient’s personal physician does not come to the hospital to see the patient, but only advises the ED physician by telephone, then the patient’s personal physician may not bill.

- If the ED physician requests that another physician evaluate a given patient, the other physician should bill an emergency department visit code. If the
patient is admitted to the hospital by the second physician performing the evaluation, he or she should bill an initial hospital care code and not an emergency department visit code.

- 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.

- In the office or other outpatient setting where an evaluation is performed, physicians and qualified NPPs should report the CPT codes (99201 – 99215) depending on the complexity of the visit and whether the patient is a new or established patient to that physician.

- A new patient is a patient who has not received any professional services (E/M or other face-to-face service) within the previous three years. Examples of where a new patient office is not billable:
  - If the consultant furnishes a pre-operative consultation at the request of a surgeon on a beneficiary, the consultant has provided a professional service to the patient within the past three years and would not meet the requirements to bill a new patient office visit.
  - The consultant could not bill for a new patient office visit for a consultation furnished to a known beneficiary for a different diagnosis than he or she has previously treated if the patient was seen by the consultant in the prior three years.
  - The consultant furnishes a consultation to a known beneficiary in an outpatient setting different than the office (e.g. emergency department, observation where the patient was seen in the past three years). As the patient has been seen by the consultant within the past three years, a new patient office visit cannot be billed.

- In order for physicians to bill the highest levels of visit codes, the services furnished must meet the definition of the code (e.g., to bill a Level 5 new patient visit, the history must meet CPT’s definition of a comprehensive history).

- Medicare may pay for an inpatient hospital visit or an office or other outpatient visit if one physician or qualified NPP in a group practice requests an evaluation and management service from another physician in the same group practice when the consulting physician or qualified NPP has expertise in a specific medical area beyond the requesting professional’s knowledge.

- Medicare will also no longer recognize the consultation codes for purposes of determining Medicare secondary payments (MSP). In MSP cases, physicians and others must bill an appropriate E/M code for the services previously paid.

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using the consultation codes. If the primary payer for the service continues to recognize consultation codes, physicians and others billing for these services may either:

- Bill the primary payer an E/M code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with the same E/M code, to Medicare for determination of whether a payment is due; or
- Bill the primary payer using a consultation code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with an E/M code that is appropriate for the service, to Medicare for determination of whether a payment is due.

**Note:** The first option may be easier from a billing and claims processing perspective.

- Medicare contractors will use the following threshold times to determine if the prolonged services codes 99354 and/or 99355 can be billed with the office or other outpatient settings including domiciliary, rest home, or custodial care services and home services codes. Threshold time for prolonged visit codes 99354 and/or 99355 billed with office outpatient visit are as follows (all times in minutes):

<table>
<thead>
<tr>
<th>Code</th>
<th>Typical Time for Code</th>
<th>Threshold Time to Bill Code 99354</th>
<th>Threshold Time to Bill Codes 99354 and 99355</th>
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<td>99201</td>
<td>10</td>
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- Threshold time for prolonged visit codes 99356 and/or 99357 billed with inpatient setting codes are as follows (all times in minutes):

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<th>Typical Time for Code</th>
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- Appropriate documentation is required to support the billing of the prolonged visit codes.
- The existing rules for counting time for purposes of meeting the prolonged care threshold times continue to apply. In particular, the *Medicare Claims Processing Manual*, Chapter 12, 30.6.15.1.C, provides that physicians may count only the duration of direct face-to-face contact between the physician and the patient for these purposes, and may not include time spent reviewing charts or discussion of a patient with house medical staff and not with direct face-to-face contact with the patient.

**Additional Information**

If you have questions, please contact your Medicare MAC, FI, or carrier at their toll-free number, which may be found at [http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip](http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip) on the CMS website.

The official instruction, CR6740, issued to Medicare MACs and carriers regarding this change may be viewed at...
November 25, 2009

Jon Blum
Director
Center for Medicare Management
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Blum:

Thank you and your staff for taking the time to meet with the American Medical Association (AMA) on the Centers for Medicare and Medicaid Services’ (CMS) new consultations billing policy.

As discussed during the meeting, the new policy for billing consultations which CMS adopted in the final physician fee schedule rule, has created significant concern in the physician community. Under the new policy, beginning January 1, 2010, CMS will no longer reimburse physicians for consultations using the CPT consultation codes. The consultation codes comprise 99241-99244 for office or other outpatient consults and 99251-99255 for inpatient consultations. Rather, CMS has instructed physicians to bill using the new or established patient codes instead.

This new policy has caused a combination of panic and confusion among many physicians. A change of this magnitude can not be accomplished under CMS’ expedited time frame without creating havoc for patients and physicians. For the reasons outlined below, the AMA is urging CMS to delay the implementation of this policy for one year.

Background

In December 2005, CMS issued Transmittal #788 describing CMS’ consultations policy. Although CMS considered this a clarification of existing policy, it was perceived by physicians as a significant change and the language in the Transmittal created significant confusion which still persists today. In particular, a number of issues emerged including when a consultation could be billed when there was a transfer of care from one physician to another and the “dual documentation” requirements that call for both the referring and consulting physician to document the consult.

Following the publication of the policy, the AMA discussed these concerns on several occasions with CMS. CMS communicated to the AMA that they hoped to rewrite the policy making it clearer. Meanwhile, the CPT Panel, a multi-stakeholder body with payer representation including Medicare listened to concerns and fielded coding proposal changes during a two-year span from 2006 to 2008. The coding proposal focused on clarifying when a physician can bill for a consult when a transfer of patient care is involved.
from one physician to another. In October 2008, the CPT Panel voted to change the language in the CPT book to help mitigate this confusion. The changes were to go into effect until January 1, 2010.

New Policy Will Create Greater Confusion

Over the summer, we heard from a number of individual physicians, states and specialty societies about their concerns and confusion over the proposal to begin reimbursing consultations using the new or established patient codes instead. Since the final physician fee schedule rule was published by CMS in October, the concerns over the new policy have heightened considerably. Furthermore, during the AMA’s House of Delegates (HOD) meeting in November, the new policy generated significant debate and opposition and resulted in the HOD adopting a resolution that calls for repealing the new policy altogether.

CMS says its goal is to reduce confusion and reduce administrative burden regarding consultation codes but this policy will only increase confusion. We are not convinced that it will ever be possible to resolve all of the issues the new policy has raised and our preference would be to delay its implementation until the effect of the new CPT language can be evaluated. At the very least, the change in consultation billings should be delayed until CMS has worked through a number of technical issues and collaborated with the medical community to ensure that physicians understand and can comply with the new policy. Without such a delay, we anticipate payment denials, re-submissions and appeals that could create claims backlogs, cash flow problems and increased costs that could lead some physicians to avoid Medicare patients—especially if Congress has not acted to prevent a scheduled 21.2% cut in the conversion factor that is also scheduled to take effect on January 1.

Technical

Within each category of E&M service, there are between three to five levels of E&M services available for reporting purposes. In the case of inpatient consult codes there are five levels of codes whereas there are only three initial inpatient visit codes. Many physician organizations requested a crosswalk that would allow physicians to easily discern how to bill for consultations using initial hospital (or nursing facility care codes) in lieu of consultation codes. A number of issues were raised, including several scenarios where following the CMS billing advice could put the physician in violation of current rules for using the visit billing codes and the CPT coding conventions followed by private payers. Many of these issues were raised by commenters and are mentioned in the final rule. However, CMS responded that the visit billing rules are clear and no crosswalk is needed. Without clear coding guidance, we fear that physicians will experience claims denials, audits and repayment demands, and conflicts with secondary payers simply for following the rules that CMS has laid out. Increased frustration and costs for physicians, payers and patients seem sure to follow.

CMS is developing a modifier to distinguish the admitting physician of record who oversees the patient’s care from other physicians furnishing specialty care. This may not be sufficient to address all the issues that could arise when multiple physicians all are billing for an initial hospital visit on the same day. In addition, we do not see how physicians can be expected to begin using this new modifier on January 1 when CMS has not yet told them what the modifier is and how to use it.

Policy Concerns

As described earlier, this proposal came as a surprise to the medical community because CMS had never raised it during the ongoing attempt to clarify consult coding. Furthermore, it came at a time when the CPT Panel had just adopted new language that was expected to significantly mitigate confusion over how current Medicare policy on consultations should be applied. CMS apparently is rejecting this effort because there was not “universal agreement” among physicians on what the appropriate policy should be. Yet, CMS’ substitute policy has far less
acceptance among physicians and has not been subjected to the cross-specialty scrutiny that could have identified and avoided some of the confusion and concerns the new policy has engendered among physicians.

Underlying CMS’ decision to eliminate the consultation codes is an assumption that there is no longer a significant difference between consultations and other visits because consultant physicians are no longer required to send the referring physician a report on their findings. A number of organizations, including the AMA and the Medicare Payment Advisory Commission, commented that this decision is inconsistent with Congress’ and the Administration’s desire to encourage coordination among physicians and improve quality of care for the rising numbers of Americans with multiple chronic conditions. There are two potential unintended consequences. First, consulting physicians may stop accepting Medicare patients referred for consults. Second, more and more consultants may stop interpreting the findings in the medical record in a report back to the referring physician. Each scenario presents significant care coordination concerns and while CMS says it will be on the lookout for any unintended impact the new policy could have on care coordination, some real damage to individual patients could occur while CMS is still in monitoring mode.

**Practical Concerns**

The most pressing concern is timing. With only a month remaining before the new billing policy goes into effect, we are extremely concerned about the negative implications this will have on physicians and patients. A change of this magnitude requires much more time to educate physicians. Unless the January deadline is moved back significantly, we do not see how Medicare will have sufficient time to educate physicians about the new modifier or to develop and widely distribute guidance—including a crosswalk—on how to use the visit codes. Time is also needed to educate secondary payers and provide them with enough time to handle impacted crossover claims.

**Conclusion**

We appreciate CMS’ willingness to listen to our concerns. We are hopeful we can continue to be engaged in a constructive dialogue about this critical issue. Should you have any questions, please contact Mari Savickis at mari.savickis@ama-assn.org.

Sincerely,

Michael D. Maves, MD, MBA
December 23, 2009

Acting Administrator Charlene M. Frizzera
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1413-FC
Hubert H. Humphrey Building
200 Independence Avenue, SW
Baltimore, MD 21244-8013

Re: CMS-1413-FC: Medicare Program; Payment Policies Under the Physician Fee Schedule and other revisions to Part B for CY 2010

Dear Acting Administrator Frizzera:

On behalf of the membership of the Michigan State Medical Society, I would like to express concern regarding the scope of the CMS proposed rule currently under consideration to eliminate reimbursement for consultation service performed in the inpatient and outpatient settings.

The timing is not sufficient to educate physicians and billing/coding personnel of the change in policy without creating delay in payments due to incorrect claim submissions for consultation services. This would create unnecessary costs to the physicians and Medicare to have to re-bill and reprocess claims that were submitted with the incorrect CPT codes due to the lack of knowledge of the change in policy.

A consultative service requires greater knowledge and expertise from a physician who has additional education and training in a particular area. The service is usually more complex in nature and may require a more comprehensive exam and medical decision making. The review of the patient’s past medical history and written report take additional time.

(continued)
Acting Administrator Charlene M. Frizzera  
Centers for Medicare & Medicaid Services  
December 23, 2009  
Page 2

We are concerned of the precedent that is being set by eliminating reimbursement for a set of current CPT codes due to a lack of understanding of the meaning of the codes. We would recommend a delay in the implementation of this policy to allow enough time to education appropriately, or until an alternative solution can be discussed. We do not feel eliminating reimbursement for this code set is an appropriate way to resolve this issue. A continued educational approach is preferred. We encourage CMS to continue to work with the American Medical Association through the RUC process to clarify the difference between a consultation and transfer of care as the 2006 OIG report suggests.

Thank you for your consideration and the opportunity to submit these comments.

Sincerely,

Richard E. Smith, MD  
President

C: John E. Billi, MD, MSMS Board of Directors  
Rebecca J. Blake, MSMS Director of Health Care Delivery  
Benjamin J. Louagie, MSMS Director of Operations  
Julie L. Novak, MSMS Executive Director