Medicare's Recent Elimination of Consultation Codes—Intended and Unintended Consequences

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The Centers for Medicare & Medicaid Services (CMS) recently eliminated the use of inpatient and office/outpatient consultation codes in the 2010 Medicare Physician Fee Schedule final rule (New Consultation Rule or the Rule).[1] As a result, effective January 1, 2010, the Medicare fee-for-service program[2] no longer recognizes the American Medical Association Current Procedural Terminology (CPT) codes for inpatient and outpatient/office consultations. Consultation codes are now only accepted for telehealth services. The New Consultation Rule has had and will continue to have major effects upon physician billing practices. This article reviews the basic elements of the Rule and some of its practical consequences.

Background

Prior to the New Consultation Rule's enactment, Medicare reimbursed consultations at a higher level than standard evaluation and management (E/M) services. A consultation differs from a similar E/M service in that it is initiated by a specific request for assistance with a particular course of treatment or diagnosis (with the understanding that the patient will be returned to the requesting provider's care following the consultation), while an E/M service does not involve such a specific request of one provider from another provider and can be part of a patient's general/continuous course of care. Prior to the Rule, CMS permitted the use of consultation codes if certain conditions were met. In particular, the request and need for the consultation had to be documented and the physician providing the consultation to the requesting physician was required to provide a written report to the requesting physician. CMS also made the distinction between a consultation and a patient "transfer of care," the latter of which required the use of new or established patient E/M codes as opposed to consultation codes.[3]

In March, 2006, the U.S. Department of Health and Human Services Office of Inspector General issued a report finding that Medicare paid approximately $1.1 billion more in 2001 than it should have for services billed as consultations due to non-conformance with Medicare requirements, including the lack of appropriate documentation.[4] Despite CMS' efforts to educate physicians, particularly with respect to the difference between consultations and other E/M services, CMS indicated that ambiguities and disagreements remained regarding the appropriate use of consultation codes.[5] CMS also stated that over the years, the documentation requirements for consultations have been reduced to such a level that there is no longer a significant difference

between the requirements for consultations and E/M services to justify the payment disparity.[6] These factors led to CMS' enactment of the Rule.

The New Consultation Rule—Basic Requirements

The basic requirements of the Rule are as follows:

- Services that would have previously been billed with CPT codes 99241-99245 (inpatient) and 99251-99255 (outpatient/office) are now to be billed using E/M codes that represent the appropriate location and complexity of the service provided.
- In the inpatient hospital and nursing facility settings, physicians or qualified non-physician practitioners (NPPs) (where permitted) who perform an initial evaluation should bill the initial hospital care codes (99221-99223) or nursing facility care codes (99304-99306). The principal physician of record—who is defined as the physician who oversees the patient's care—should append modifier "-AI" to the appropriate E/M code to distinguish the principal physician from others who provide specialty services to the patient. All others who perform an initial evaluation on the patient should bill only the E/M code appropriate for the service's complexity. Follow-up visits in the facility setting should be billed as subsequent hospital/nursing facility visits, as is the current policy.
- In the office or other outpatient setting, CPT codes 99201-99215 should be used depending on the visit's complexity and whether the patient is new or established.
- In all cases, physicians/practitioners must report the most appropriate available codes for services that were previously billed using CPT consultation codes; existing E/M documentation guidelines must be followed.

CMS issued a Medlearn Matters article (MM6740) outlining the requirements of the New Consultation Rule[7] and a separate Medlearn Matters article (SE1010) responding to specific questions regarding the Rule.[8]

Practical Consequences

The effects of the New Consultation Rule are far reaching and raise multiple questions. CMS addressed several of these questions in its Medlearn Matters article SE1010 and other guidance. Some of CMS' responses, as well as administrative difficulties resulting from the Rule that CMS did not address, are discussed below.

Financial Impact

CMS indicated that the New Consultation Rule is budget neutral due to increases made to the work relative value units for E/M service codes that replace the consultation codes. Therefore, while physicians will no longer receive higher reimbursement amounts associated with consultation codes, they will benefit from an across-the-board increase in payments for E/M services, CMS said. However, CMS acknowledged that the Rule will have a "somewhat differential impact on various groups of providers and/or practitioners."[9] For instance, specialists such as neurologists and endocrinologists are likely to experience a greater negative financial impact as a result of the Rule, while primary care providers may see a boost in their reimbursement. Physician practices should closely track their billing and reimbursement to assess the complete scope of the Rule's financial effects and whether further policy changes in this area are warranted.

"Principal Physician of Record" Modifier and Use of Initial and Subsequent Hospital Care Codes

CMS said that claims appending modifier -AI to codes other than initial hospital and nursing home visit codes (i.e., subsequent care codes or outpatient codes) will not be rejected. In addition, although CMS expects the CPT code used to accurately reflect the service provided, CMS instructed Medicare contractors to not find fault with the use of a subsequent hospital care code merely because it was actually the provider's first E/M service to an inpatient during a hospital stay. CMS also stated that it has alerted Medicare contractors to expect more initial hospital care E/M codes and a different proportion of such codes; CMS expects Medicare contractors to take this into consideration when deciding whether to pursue medical or other claims review.[10]

No "Crosswalk" Provided—Minimum Components of E/M and Consultation Services Do Not Match

CMS declined to provide a coding crosswalk that would identify each of the eliminated consultation codes and the corresponding replacement E/M codes considered to be equivalent to each of the eliminated codes. CMS expects physicians/practitioners to use an available E/M code that is most appropriate for the service, stating that the Rule "may actually simplify coding because physicians . . . will not have to determine whether the requirements to bill a consult are met."[11] While CMS acknowledged that the code descriptors of E/M codes and consultation codes do not exactly match (for instance, the lowest level inpatient consultation CPT code 99251 requires a "problem focused history," while initial hospital care CPT code 99221 requires a "detailed or comprehensive history"), CMS explained that a particular E/M code may be reported for a service if the requirements for billing that particular code are met in consideration of the service actually provided.[12] Therefore, CMS is essentially directing providers to disregard previous practice for the billing of consultation codes and adjust to the existing requirements for E/M services.

Elimination of Consultation Documentation Requirements and Potential Effect on Coordinated Care

In the preamble to the New Consultation Rule, CMS addressed comments that the elimination of the consultation codes—and, as a result, the elimination of the documentation requirements for a consultation service, such as the written report to a requesting physician—would financially discourage communication and coordination between healthcare providers. In response, CMS stated that it was aware of no evidence that the Rule would have such a result, but that it would be attentive to any concerns that develop with respect to coordination of care.[13] In an apparent further response to this concern, CMS commented in its Medlearn Matters article MM6740 that "conventional medical practice" is to document referrals between physicians for the evaluation of patients and that, in order to promote proper coordination of care, physicians should continue to document requests for evaluations and communicate the results of such evaluations to requesting physicians.[14] Therefore, while there does not appear to be an explicit CMS requirement that such documentation occur, CMS appears to encourage it.

NPPs/Shared Visits

Prior to the New Consultation Rule, Medicare would not pay for consultations if they were "split/shared" with a NPP.[15] In response to a question as to how E/M services that were previously reported with consultation codes and are provided in a split/shared manner should now be billed, CMS stated that the split/shared rules that currently apply to E/M services will continue to apply, including situations where the services were previously reported with consultation codes.[16] With this response, it appears that CMS will now permit consultation services (which now must be billed with an E/M code) to be split/shared, provided that the "incident to" requirements are met in the office setting or that the split/shared requirements are met in the hospital setting (as

applicable).[17] This could provide a significant benefit to physicians who routinely work with NPPs.

New/Established Patient Rules Will Now Apply to Consultation Services

Now that consultation codes will be replaced with E/M codes, CMS has confirmed that the current rules that apply to E/M codes with respect to new and established patient office visits will now apply to consultation services. This means that a consulting physician will receive reimbursement for a consultation service billed as a "new patient" E/M service only if the patient has not received professional services from the consulting physician or a physician in the same group practice and specialty as the consulting physician for the previous three years.[18] This may have significant impacts for multi-specialty group practices that commonly receive cross-specialty consultation referrals. It will present particular difficulties for consultation referrals between group practice specialists in different sub-specialties who would like to use new patient E/M codes; this is due to Medicare contractors' general inability to recognize sub-specialties.

In order to identify the specialty of the physicians submitting claims, Medicare contractors generally rely on the broad specialty designations made by physicians/practitioners when they enroll in Medicare; these specialty categories do not provide for a sub-specialty designation (i.e., neuro-ophthalmology). In addition, Medicare contractors generally determine whether physicians are in the same group practice by looking to the tax identification number of the group. Therefore, sub-part National Provider Identifiers (NPIs) established under the same tax identification number would not assist in distinguishing specialties within a group practice for purposes of the "new patient" rule. As a result, Medicare contractors will likely not have a mechanism to validate a claim for a new patient E/M consultation service requested by, for instance, an ophthalmologist and provided by a neuro-ophthalmologist in the same group practice under the same group tax identification number (i.e., the patient was treated by a physician in the same group practice and same broad specialty category as the consulting physician in the previous three years and, therefore, does not qualify as a "new patient"). Certain Medicare contractors have indicated that new patient E/M services billed in such a case will initially be denied, but that on appeal, the claim can be paid if the provider demonstrates that the consulting physician is in fact in a distinct specialty. Even if such a claim is permitted to be reimbursed on appeal, this presents obvious difficulties for consulting physicians who bill new patient E/M codes. These difficulties will continue until or unless Medicare contractors establish explicit policies permitting new patient E/M codes for group practice sub-specialty E/M referrals and implement a mechanism to recognize distinct physician sub-specialties upon initial claim submission.

Medicare Secondary Payer and Private Payor Consultation Policies

Under the Rule, Medicare will no longer recognize CPT consultation codes, even in the case of Medicare secondary payments. Therefore, for purposes of Medicare secondary payment, if a primary payor continues to recognize CPT consultation codes that are eliminated under Medicare and the physician chooses to bill the primary payor with such consultation codes, the physician may not then report the consultation codes to Medicare; the physician must "switch" from the consultation codes reported to the primary payor and report to Medicare an E/M code appropriate for the service.[19] Therefore, physicians have to significantly alter their billing practices to accommodate the differing policies among Medicare and private payors with respect to billing for consultation services.

Conclusion

Complications can be expected as physicians and Medicare contractors transition to the requirements of the New Consultation Rule. If the Rule results in significant negative consequences, further policy changes may be warranted. In the meantime, physician practices—particularly specialty practices that rely heavily on consultation services—must provide appropriate training to their staff regarding the Rule's requirements, closely monitor any policy developments in this area, and keep careful track of their billing activity and reimbursement to assess the full scope of the Rule's impact.

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1 Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010, 74 Fed. Reg. 61,737 (Nov. 25, 2009) (to be codified at 42 C.F.R. pts. 410, 411, 414 et al.).

2 The New Consultation Rule only applies to services paid under the Medicare Fee-For-Service program. It does not revise existing policies or rules governing Medicare Advantage or non-Medicare insurers. Medicare Advantage plans should be contacted with respect to their policy regarding consultations.

3 U.S. Dep't of Health and Human Services, Centers for Medicare & Medicaid Services, Transmittal 788, Medicare Claims Processing Manual (Pub 100-04) (Dec. 20, 2005), *available at* www.cms.hhs.gov/transmittals/downloads/r788cp.pdf.

4 U.S. Dep't of Health and Human Services, Office of Inspector General, Consultations in Medicare: Coding and Reimbursement, OEI-09-02-00030 (Mar. 2006), *available at* http://oig.hhs.gov/oei/reports/oei-09-02-00030.pdf.

5 74 Fed. Reg. at 61,769.

6 74 Fed Reg. at 61,771.

7 U.S. Dep't of Health and Human Services, Centers for Medicare & Medicaid Services, MLN Matters Article MM6740, *Revisions to Consultation Services Payment Policy, available at* www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf.

8 U.S. Dep't of Health and Human Services, Centers for Medicare & Medicaid Services, MLN Matters Article SE1010, *Questions and Answers on Reporting Physician Consultation Services, available at* www.cms.hhs.gov/MLNMattersArticles/downloads/SE1010.pdf.

9 74 Fed. Reg. at 61,772.

10 MLN Matters SE1010, *supra* note 8.

11 74 Fed. Reg. at 61,770-71

12 MLN Matters SE1010, *supra* note 8.

13 74 Fed. Reg. at 61,774.

14 MLN Matters SE1010, *supra* note 8.

15 Transmittal 1875, Medicare Claims Processing Manual (Pub 100-04) (Dec. 20, 2005), available at www.cms.hhs.gov/Transmittals/downloads/R1875CP.pdf.

16 MLN Matters SE1010, *supra* note 8.

17 Claims Processing Manual, *supra* note 3, at Ch. 12, Section 30.6.1(B).

18 MLN Matters SE1010, *supra* note 8.

19 *Id.*