



Michael D. Maves, MD, MBA, Executive Vice President, CEO

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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](mailto:mari.savickis@ama-assn.org).

Sincerely,

A handwritten signature in black ink, reading "Mike Maves", is written over a thin red vertical line.

Michael D. Maves, MD, MBA