

(The following text was extracted from pages 33551-33554 of the 2010 Medicare PFS Proposed Rule—**key sections are yellow highlighted**. To view and download the rule in its entirety, go to <http://edocket.access.gpo.gov/2009/pdf/E9-15835.pdf>)

#### 4. Consultation Services

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##### a. Background

The current physician visit and consultation codes were developed by the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel in November 1990. A consultation service is an evaluation and management (E/M) service furnished to evaluate and possibly treat a patient's problem(s). It can involve an opinion, advice, recommendation, suggestion, direction, or counsel from a physician or qualified non-physician provider (NPP) at the request of another physician or appropriate source. (See the Internet-Only Medicare Claims Processing Manual, Pub. 100-04, chapter 12, §30.6.10 A for more information.) A consultation service must be documented and a written report given to the requesting professional. Currently, consultation services are predominantly billed by specialty physicians. Primary care physicians infrequently furnish these services.

The required documentation supports the accuracy and medical necessity of a consultation service that is requested and provided. Medicare pays for a consultation service when the request and report are documented as a consultation service, regardless of whether treatment is initiated during the consultation evaluation service. (See the Internet-Only Medicare Claims Processing Manual, Pub. 100-04, chapter 12, §30.6.10 B.) A consultation request between professionals may be done orally by telephone, face-to-face, or by written prescription brought from one professional to another by the patient. The request must be documented in the medical record.

In the Physician Fee Schedule (PFS) Final Rule issued June 5, 1991, (56 FR 25828) we stated that the agency's goal for the development of the new visit and consultation codes was that they meet two criteria: (1) they should be used reliably and consistently by all physicians and carriers; that is, the same service should be coded the same way by different physicians; and (2) they should be defined in a way that enables us to properly crosswalk the new codes to the relative values for the Harvard vignettes so valid Relative Value Units (RVUs) for work are assigned to the new codes.

Based on requests from the physician community to clarify our consultation payment policy and to provide consultation examples, we convened an internal workgroup of medical officers within CMS (then called the Health Care Financing

Administration, or HCFA) and revised the payment policy instructions in August 1999 in the Medicare Claims Processing Manual (at §30.6.10 as cited above). We provided examples of consultation services and examples of clinical scenarios that did not satisfy Medicare criteria for consultation services. Without explicit instructions for every possible clinical scenario outlined in national policy instructions or in AMA coding definitions or coding instructions, the local policy interpretations by Medicare contractors were not universally equivalent or acceptable to the physician community and resulted in denials in different localities. Some Medicare contractors would consider a consultation service with treatment to be an initial visit rather than a consultation thus resulting in a denial for the billed consultation. We clarified in the 1999 revision that Medicare would pay for a consultation whether treatment was initiated at the consultation visit or not. The physician community has stated that terms such as referral, transfer and consultation, used interchangeably by physicians in clinical settings, confuse the actual meaning of a consultation service and that interpretation of these words varies greatly among members of that community as some label a transfer as a referral and others label a consultation as a referral. Although we clarified the terms referral and consultation in the 1999 revision, there was disagreement with our policy by physicians in the health care community and by AMA CPT staff. We provided our documentation guidance so physicians would be in compliance with

our payment policy. The consultation definition in the AMA CPT simply stated that the consultant's opinion or other information must be communicated to the requesting physician.

Additional manual revisions in both January and September 2001 (at §30.6.10 as cited above) clarified that NPPs can both request and furnish consultation services within their scope of practice and licensure requirements. We continued to explain our documentation requirements to the physician community through our Medicare contractors and in our discussions with the AMA CPT staff. Under our current policy and in the AMA CPT definition, a consultation service must have a request from another physician or other professional and be followed by a report to the requesting professional. The AMA CPT definition does not state the request must be written in the requesting physician's medical record. However, we require the request to be documented in the requesting physician's plan of care in the medical record as a condition for Medicare payment. The E/M documentation guidelines which apply to all E/M visits or consultations ([http://www.cms.hhs.gov/MLNEdWebGuide/25\\_EMDOC.asp](http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp)) clearly state that when referrals are made, consultations are requested, or advice is sought, the medical record should indicate to whom and where the referral or consultation is made or from whom the advice is requested. Our Medicare contractors are responsible for reviewing and paying consultation claims when submitted. When

there is a question that triggers a review of a consultation service, our Medicare contractors will look at both the requesting physician's medical record (where the request should be noted) and the consultant's medical record where the consultation is reported and at the report generated for the requesting physician. Medicare contractors do not look for evidence of documentation on every claim, only when there is a concern raised during random sampling or during a specific audit performed by a contractor. The AMA CPT coding manual, which is not a payment manual, does not specify these requirements, and, therefore, as we understand it, many physicians do not agree with the CMS policy.

In March 2006, the Office of the Inspector General (OIG) published a report entitled, "Consultations in Medicare: Coding and Reimbursement" (OEI-09-02-00030). The purpose of the report was to assess whether Medicare's payments for consultation services were appropriate. While the OIG study was being conducted, we continued our ongoing discussions with the AMA CPT staff for potential changes to the consultation definition and guidance in CPT. The findings in the OIG report (based on claims paid by Medicare in 2001) indicated that Medicare allowed approximately \$1.1 billion more in 2001 than it should have for services that were billed as consultations. Approximately 75 percent of services paid as consultations did not meet all applicable program requirements (per the Medicare instructions) resulting in improper payments. The majority of these errors (47

percent of the claims reviewed) were billed as the wrong type or level of consultation. The second most frequent error was for services that did not meet the definition of a consultation (19 percent of the claims reviewed). The third category of improperly paid claims was a lack of appropriate documentation (9 percent of the claims reviewed). The OIG recommended that CMS, through our Medicare contractors, should educate physicians and other health care practitioners about Medicare criteria and proper billing for all types and levels of consultations with emphasis on the highest levels and follow-up inpatient consultation services.

We agreed with the OIG findings that additional education would help physicians understand the differences in the requirements for a consultation service from those for other E/M services. With each additional revision from 1999 until the OIG study began, we continually educated physicians through the guidance provided by our Medicare contractors. However, there remained discrepancies with unclear and ambiguous terms and instructions in the AMA CPT consultation coding definition, transfer of care and documentation, and the feedback from the physician community indicated they disagreed with Medicare guidance.

Prior to the official publication of the OIG report, we issued a Medlearn Matters article, effective January 2006, to educate the physician community about requirements and proper billing for all types and levels of consultation services as requested by the OIG in their report. The Medlearn Matters article reflected the

manual changes we made in 2006 and the AMA CPT coding changes as noted below.

Our consultation policy revisions continued as a work-in-progress over several years as disagreements were raised by the physician community. We continued to work with AMA CPT coding staff in an attempt to have improved guidance for consultation services in the CPT coding definition. In looking at physician claims data (for example, the low usage of confirmatory consultation services) and in response to concerns from the physician community regarding how to correctly use the follow-up consultation codes, the AMA CPT Editorial Panel chose to delete some of the consultation codes for 2006. The Follow-Up Inpatient Consultation codes (CPT codes 99261 through 99263) and the Confirmatory Consultation codes (CPT codes 99271 through 99275) were deleted. During our ongoing discussions, the AMA CPT staff, maintained that physicians did not fully understand the use of these codes and historically submitted them inappropriately for payment as was reflected in the OIG study.

We issued a manual revision in the Medicare Claims Processing Manual (at §30.6.10 as cited above) simultaneously with the publication of AMA CPT 2006 coding changes removing the follow-up consultation codes, and instructed physicians to use the existing subsequent hospital care code(s) and subsequent nursing facility care codes for visits following a consultation service. The

confirmatory consultation codes (which were typically used for second opinions) were also removed and we instructed physicians to use the existing E/M codes for a second opinion service. We further clarified the documentation requirements by making it easier to document a request for a consultation service from another physician and to submit a consultation report to the requesting professional. Again, physicians stated that a consultant has no control over what a requesting or referring physician writes in a medical record, and that they should not be penalized for the behavior of others. However, our consultation policy instructions apply to all physicians, whether they request a consultation or furnish a consultation. As noted above, documentation by both the requesting physician and the physician who furnishes the consultation, is required under the E/M documentation guidelines. The E/M documentation guidelines have been in use since 1995. In our discussions with the AMA CPT staff and physician groups, and national physician open door conference calls, we have emphasized that the requesting physician medical record is not reviewed unless there is a specific audit or random sampling performed. The physician furnishing the consultation service should document in the medical record from whom a request is received.

We continue to hear from the AMA and from specific national physician specialty representatives that physicians are dissatisfied with Medicare documentation requirements and guidance that distinguish a consultation service

from other E/M services such as transfer of care. CPT has not clarified transfer of care. Therefore, many physician groups disagree with our requirements for documentation of transfer of care. Interpretation differs from one physician to another as to whether transfer of care should be reported as an initial E/M service or as a consultation service.

Despite our efforts, the physician community disagrees with Medicare interpretation and guidance for documentation of transfer of care and consultation. The existing consultation coding definition in the AMA CPT definition remains ambiguous and confusing for certain clinical scenarios and without a clear definition of transfer of care. The CPT consultation codes are used by physicians and qualified NPPs to identify their services for Medicare payment. There is an absence of any guidance in the AMA CPT consultation coding definition that distinguishes a transfer of care service (when a new patient visit is billed) from a consultation service (when a consultation service is billed). Medicare does provide guidance although there is disagreement with our policy from AMA CPT staff and some members of the physician community. Because of the disparity between AMA coding guidance and Medicare policy some physicians state they have difficulty in choosing the appropriate code to bill. The payment for both inpatient consultation and office/outpatient consultation services is higher than for initial hospital care and new patient office/outpatient visits. However, the associated

physician work is clinically similar. Many physicians contend that there is more work involved with a new patient visit than a consultation service because of the post work involvement with a new patient. The payment for a consultation service has been set higher than for initial visits because a written report must be made to the requesting professional. However, all medically necessary Medicare services require documentation in some form in a patient's medical record.

Over the past several years, some physicians have asked CMS to recognize the provision of the consultation report via a different form of communication in lieu of a written letter report to the requesting physician so as to lessen any paperwork burden on physicians. We have eased the consultation reporting requirements by lessening the required level of formality and permitting the report to be made in any written form of communication, (including submission of a copy of the evaluation examination taken directly from the medical record and submitted without a letter format) as long as the identity of the physician who furnished the consultation is evident. Although preparation and submission of the consultant's report is no longer the major defining aspect of consultation services, the higher payment has remained. (See the Internet-Only Medicare Claims Processing Manual, Pub. 100-04, chapter 12, §30.6.10 F.)

Both AMA CPT coding rules and Medicare Part B payment policy have always required that there is only one admitting physician of record for a particular

patient in the hospital or nursing facility setting. (AMA CPT 2009, Hospital Inpatient Services, Initial Hospital Care, p.12) This physician has been the only one permitted to bill the initial hospital care codes or initial nursing facility codes. All other physicians must bill either the subsequent hospital care codes, subsequent nursing facility care codes or consultation codes. (See the Internet-Only Medicare Claims Processing Manual, Pub. 100-04, chapter 12, §30.6.9.1 G.)

Beginning January 1, 2008, we ceased to recognize office/outpatient consultation CPT codes for payment of hospital outpatient visits (72 FR 66790 through 66795). Instead, we instructed hospitals to bill a new or established patient visit CPT code, as appropriate to the particular patient, for all hospital outpatient visits. Regardless of all of our efforts to educate physicians on Medicare guidance for documentation, transfer of care, and consultation policy, disagreement in the physician community prevails.

b. Proposal

Beginning January 1, 2010, we propose to budget neutrally eliminate the use of all consultation codes (inpatient and office/outpatient codes for various places of service except for telehealth consultation G-codes) by increasing the work RVUs for new and established office visits, increasing the work RVUs for initial hospital and initial nursing facility visits, and incorporating the increased use of these visits into our Practice Expense (PE) and malpractice RVU calculations.

We note that section 1834(m) of the Act includes “professional consultations” (including the initial inpatient consultation codes “as subsequently modified by the Secretary”) in the definition of telehealth services. We recognize that consultations furnished via telehealth can facilitate the provision of certain services and/or medical expertise that might not otherwise be available to a patient located at an originating site. Therefore, for CY 2010, if we finalize our proposed policy to eliminate consultations from the PFS, then we propose to create Healthcare Common Procedure Coding System (HCPCS) codes specific to the telehealth delivery of initial inpatient consultations. The purpose of these codes would be solely to preserve the ability for practitioners to provide and bill for initial inpatient consultations delivered via telehealth. These codes are intended for use by practitioners when furnishing services that meet Medicare requirements relating to coverage and payment for telehealth services. Practitioners would use these codes to submit claims to their Medicare contractors for payment of initial inpatient consultations provided via telehealth. The new HCPCS codes would be limited to the range of services included in the scope of the CPT codes for initial inpatient consultations, and the descriptions would be modified to limit the use of such services for telehealth. The HCPCS codes would clearly designate these as initial inpatient consultations provided via telehealth, and not initial hospital care or initial nursing facility care used for inpatient visits. Utilization of these codes

would allow us to provide payment for these services, as well as enable us to monitor whether the codes are used appropriately.

If we create HCPCS G-codes specific to the telehealth delivery of initial inpatient consultations, then we also propose to crosswalk the RVUs for these services from the RVUs for initial hospital care (as described by CPT codes 99221 through 99223). We believe this is appropriate because a physician or practitioner furnishing a telehealth service is paid an amount equal to the amount that would have been paid if the service had been furnished without the use of a telecommunication system. Since physicians and practitioners furnishing initial inpatient consultations in a face-to-face encounter to hospital inpatients must continue to utilize initial hospital care codes (as described by CPT codes 99221 through 99223), we believe it is appropriate to set the RVUs for the proposed inpatient telehealth consultation G-codes at the same level as for the initial hospital care codes.

We considered creating separate G-codes to enable practitioners to bill initial inpatient telehealth consultations when furnished to residents of skilled nursing facilities and crosswalking the RVUs to initial nursing facility care (as described by CPT codes 99304 through 99306). For the sake of administrative simplicity, if we create HCPCS G-codes specific to the telehealth delivery of initial inpatient consultations, they will be defined in §410.78 and in our manuals as

appropriate for use to deliver care to beneficiaries in hospitals or skilled nursing facilities. If we adopt this proposal, then we will make corresponding changes to our regulations at §410.78 and §414.65. In addition, we will add the definition of these codes to the CMS Internet-Only Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, Section 270 and the Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, Section 190.

Outside the context of telehealth services, physicians will bill an initial hospital care or initial nursing facility care code for their first visit during a patient's admission to the hospital or nursing facility in lieu of the consultation codes these physicians may have previously reported. The initial visit in a skilled nursing facility and nursing facility must be furnished by a physician except as otherwise permitted as specified in §483.40(c)(4). In the Nursing Facility setting, an NPP who is enrolled in the Medicare program, and who is not employed by the facility, may perform the initial visit when the State law permits this. (See this exception in the Internet-Only Medicare Claims Processing Manual, Pub. 100-04, chapter 12, §30 .6.13 A). An NPP, who is enrolled in the Medicare program is permitted to report the initial hospital care visit or new patient office visit, as appropriate, under current Medicare policy. Because of an existing CPT coding rule and current Medicare payment policy regarding the admitting physician, we will create a modifier to identify the admitting physician of record for hospital

inpatient and nursing facility admissions. For operational purposes, this modifier will distinguish the admitting physician of record who oversees the patient's care from other physicians who may be furnishing specialty care. The admitting physician of record will be required to append the specific modifier to the initial hospital care or initial nursing facility care code which will identify him or her as the admitting physician of record who is overseeing the patient's care. Subsequent care visits by all physicians and qualified NPPs will be reported as subsequent hospital care codes and subsequent nursing facility care codes.

We believe the rationale for a differential payment for a consultation service is no longer supported because documentation requirements are now similar across all E/M services. To be consistent with Outpatient Prospective Payment System (OPPS) policy, as noted above, we will pay only new and established office or other clinic visits under the PFS.

This proposed change would be implemented in a budget neutral manner, meaning it would not increase or decrease PFS expenditures. We would make this change budget neutral for the work RVUs by increasing the work RVUs for new and established office visits by approximately 6 percent to reflect the elimination of the office consultation codes and the work RVUs for initial hospital and facility visits by approximately 2 percent to reflect the elimination of the facility consultation codes. We have crosswalked the utilization for the office consultation

codes into the office visits and the utilization of the hospital and facility consultation codes into the initial hospital and facility visits. This change would be made budget neutral in the PE and malpractice RVU methodologies through the use of the new work RVUs and the crosswalked utilization. The PE and malpractice RVU methodologies are described elsewhere in this proposed rule.

We are soliciting comments on the proposal, described more fully above, to eliminate payment for all consultation services codes under the PFS and to allow all physicians to bill, in lieu of a consultation service code, an initial hospital care visit or initial nursing facility care visit for their first visit during a patient's admission to the hospital or nursing facility. Additionally, we are soliciting comments on the proposal to create HCPCS G-codes to identify the telehealth delivery of initial inpatient consultations.