EXPERT COMMENTARY

A Farewell to Consultation Codes

The Centers for Medicare and Medicaid Services will no longer pay for consultations in either outpatient (99241-99245) or inpatient (99251-99255) settings.

This decree has caused a great deal of protest, particularly from endocrinologists, neurologists, and other specialists who depend on consultations for a majority of their income. After all, specialists should be appropriately compensated for the expertise they provide.

BY JOSEPH S. EASTERN, M.D.

It is hard to envision how eliminating consultation payments could be anything but detrimental to patient care. At the least, consulting physicians may feel less inclined to provide reports to referring physicians, which will substantially hurt coordination of care at a time when policy makers claim to be looking for ways to improve it.

Further objections abound; nevertheless, the decision has been made, and adjustments must be taken to accommodate it.

For office visits, the CMS expects consultation codes to be replaced with new or established visit codes (99201-99205 or 99212-99215).

The agency has increased relative value units for those visit codes by 6% to soften the blow, but the difference will be substantially noticeable if a lot of consultations were billed last year.

On the inpatient side, admission codes (99221-99223) are to be used in lieu of consultation codes. The "true" admitting physician will use a new modifier (not yet published at press time) along with the admit code, while all consulting physicians will use the admit code unmodified.

Physicians performing a lot of inpatient consultations should anticipate denials, appeals, and confusion as admitting physicians and consultants alike adjust to this change.

As usual, some commercial insurers will follow the CMS lead, while others will continue recognizing the consultation codes (which remain in the 2010 CPT book). This means a decision will need to be made about whether to continue billing consultations for non-Medicare patients whose insurers continue to pay for them. If this route is chosen, Medicare will provide secondary coverage, and will, of course, not pay its portion. So this situation needs to be recognized in advance.

It is probably worth reviewing some past Explanation of Benefits statements to determine how often Medicare is a secondary payer, and whether any extra revenue will be worth the extra vigilance and work involved.

Discussions on this issue have been widespread and heated, and opinions vary widely. Some specialists claim they actually welcome the change because they will no longer need to worry about complying with the CMS's confusing and ever-changing consultation rules.

Others are understandably concerned about a potentially significant loss of income. Do not be tempted, however, to bill for more services as compensation for lost revenue. CMS officials are well aware of that tendency (they even have a name for it: "code creep"), and they will be watching.

If billing patterns change significantly, then an audit can be expected; increased billings must be proved to be of medical necessity, not compensatory revenue generation. If increased billings cannot be proved to be medically necessary, then abuse or fraud charges will come. In an audit, remember, everyone is guilty until proven innocent.

Billing patients directly for consults has been proposed as a way to recover lost revenue. If consults are no longer covered by the CMS, physicians have reasoned that they should be able to use a "noncovered service" code (such as 99199-GA) and have Medicare patients sign an Advance Beneficiary Notice (ABN). This signifies their understanding that Medicare will not pay for the service, the same procedure used for noncovered cosmetic services. It is not clear, however, if this is permissible by the CMS.

Another proposed counterstrategy is to bill Medicare for a new patient visit and add a "surcharge" for consultative care, billed directly to the patient (again using a National Supplier Clearinghouse [NCS] code and an ABN). This would be considered a "priority service," analogous to "concierge services" offered by some internists. No one knows if the CMS (or patients) would go along with this option either.

Even proponents of such strategies admit they are speculative and untested; I would not advise attempting them without a careful legal review with an experienced health care lawyer.

No matter how individuals choose to deal with the loss of consultation codes, I believe physicians should continue sending reports to referring physicians even though they will not specifically be paid for them. Doing what is best for patients should always be the top priority. ■

DR. EASTERN *practices dermatology and dermatologic surgery in Belleville, N.J. To respond to this column, e-mail Dr. Eastern at sknews@elsevier.com.*

Bill Proposes Care of ED 'Frequent Flyers' on Medicaid

BY TERRY RUDD

Some Medicaid patients with chronic illnesses would move out of emergency departments and inpatient beds and into more appropriate community care settings under legislation unveiled in October.

The "Reducing Emergency Department Utilization Through Coordination and Empowerment Demonstration Program Act" (S. 1781) targets frequent ED visits and hospital admissions by Medicaid beneficiaries with chronic conditions such as asthma, chronic obstructive pulmonary disease, severe mental illness, and diabetes. The act would support projects to coordinate care and community support services for those patients.

"Treating people repeatedly in emergency rooms instead of coordinating less costly preventive care … [is a perfect example] of what is wrong with our nation's health care system," said Sen. Jeanne Shaheen (D-N.H.), the legislation's lead sponsor. Sen. Sherrod Brown (D-Ohio), Sen. Dianne Feinstein (D-Calif.), Sen. Frank Lautenberg (D-N.J.), and Sen. Robert Menendez (D-N.J.) are cosponsors.

In the fall of 2010, the Department of Health and Human Services would spend up to $150 million to fund 5-year demonstration projects in up to 10 states. Health care providers would receive a share of any cost savings generated.

Under the bill, multidisciplinary treatment teams of primary care and behavioral health providers would develop individualized care plans for Medicaid enrollees with chronic illnesses. The initiative would fund some services not traditionally covered by Medicaid.

Within a year of the 5-year project's completion, HHS would report results and recommendations to Congress.

The Senate Finance Committee has not acted on S. 1781, however, and no one has introduced companion legislation in the House of Representatives. Rep. Linda Sanchez (D-Calif.) introduced a related bill earlier this year, the "DSH [disproportionate share hospital] Collaborative Care Network Pilot Program Act of 2009" (H.R. 3430). That bill would create a Medicare pilot project to reduce emergency department use by building collaborative care networks for low-income and uninsured patients. It has yet to be acted on by two House committees. ■

To read the bill, visit thomas.loc.gov/cgi-bin/query/z?c111:S.1781:.

Wide Disparity in Care a Cause for Reform, Commonwealth Fund Says

BY ALICIA AULT

A wide disparity in access to and quality of care across the United States argues for a national health reform plan, according to executives at the Commonwealth Fund, who released a state-by-state survey of 38 health indicators.

The survey revealed a fivefold difference in performance on the indicators between the highest-ranked states and the lowest. The differences "translate to real lives and real dollars," Karen Davis, Commonwealth Fund president, said at a press conference.

Health reform legislation would go a long way toward improving access and coverage, Ms. Davis said.

Since 2007, the number of uninsured adults has risen, and the "worst is yet to come," said Cathy Schoen, senior vice president of the Commonwealth Fund.

The top quartile comprises Connecticut, Hawaii, Iowa, Maine, Massachusetts, Minnesota, Nebraska, New Hampshire, North Dakota, Rhode Island, South Dakota, Vermont, and Wisconsin.

Ten of the 13 states in the lowest quartile—Alabama, Arkansas, Florida, Kentucky, Louisiana, Mississippi, Nevada, Oklahoma, Tennessee, and Texas—also ranked at the bottom on the previous 2007 report. Illinois, New Mexico, and North Carolina dropped into the lowest quartile since the last survey, while California, Georgia, and West Virginia moved up out of the last quartile in this most recent report. The lower-performing states had rates of uninsured adults and children that were double those in the top quartile.

According to Ms. Davis and her colleagues, if the lower-performing states were helped to reach the levels of the higher-performing states, 29 million more people would be insured. ■

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