Experts: Medicare Is Eyeing Consultation Coding

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PHILADELPHIA — Be careful how you code for consultations, because Medicare contractors will be watching this area carefully, coding experts said at the annual meeting of the American College of Physicians.

In March, the Department of Health and Human Services' Office of the Inspector General (OIG) issued a report highlighting more than $1 billion in estimated overpayments made to physicians in 2001 for consultations under Medicare. In many cases, services were incorrectly billed as consultations, coded for the incorrect type or level of consultation, or were not supported by documentation, according to the OIG report.

"Rest assured there's going to be a focus on consultations," said Dr. Richard W. Whitten, a Medicare Part B carrier medical director for the states of Alaska, Hawaii, and Washington.

OIG officials selected a random sample of 400 consultations allowed by Medicare during 2001, obtained photocopies of portions of patients' medical records, and hired certified professional coders to audit the claims. The results of that audit were extrapolated to produce the $1.1 billion overpayment estimate. Officials found the most problems with consultations billed at the highest billing level and with follow-up inpatient consultations, according to the OIG report.

Pay attention to the definition of and the elements involved in high-level consultation codes, advised Dr. Glenn D. Littenberg, chair of the ACP subcommittee on coding and reimbursement. He urged physicians to keep in mind that a level 5 consultation code involves an extended history of the present illness, a complete system review, a complete family social history, a comprehensive physical exam, and high-complexity decision making.

Complete documentation is essential and should include the request from the referral source, what services were provided by the physician, and the report back to the referral source, Dr. Littenberg said. "It's highly likely that based on [the OIG] report, carriers will be paying a little more attention to consultation coding at the high level," he said.

Officials at the Centers for Medicare and Medicaid Services have already made some changes in consultation coding this year. Beginning this year, CMS has eliminated the CPT codes for follow-up inpatient consultations (99261-99263) and confirmatory consultations or second opinions (99271-99275).

Instead, physicians providing consultations in the hospital setting can use initial inpatient consultation codes (99251-99255) for the initial consultation and subsequent hospital care codes (99231-99233) for follow-up visits, according to CMS. In the office setting, physicians can use the office or other outpatient consultation codes (99241-99245) for initial consults and the office or other established patient codes (99212-99215) for follow-up visits.

Further, consultations that are requested by the family or patient instead of a physician cannot be billed using consultation codes, according to CMS, and instead physicians should rely on existing E/M codes for the setting where the service is provided. ■

The OIG report is available online at www.oig.hhs.gov/oei/reports/oei-09-02-00030.pdf.

Measuring Quality of Care Could Help Reduce Racial Disparities

PHILADELPHIA — Performance measurement is one way to help eliminate racial disparities in health care, Dr. John Z. Ayanian said at the annual meeting of the American College of Physicians.

Public and private payers must also do their part by maintaining accurate and complete data on race and ethnicity to help monitor disparities, said Dr. Ayanian, associate professor of medicine and health care policy at Harvard Medical School in Boston.

There has been some success in narrowing the racial care gap in areas with widespread measurement. For example, a study published last year found both overall quality improvement in the use of β-blockers after acute myocardial infarction among Medicare managed-care beneficiaries and a significant narrowing of the racial gap in treatment. The treatment gap between black and white beneficiaries had been 12% in 1997 and fell to 0.4% in 2002 (N. Engl. J. Med. 2005;353:692-700).

One study found overall quality improvement in use of β-blockers after MI among Medicare beneficiaries, along with a significant narrowing of the racial gap.

But there is still work to do, he said. For example, the same study shows that while overall quality improved in cholesterol control for coronary artery disease, the racial disparity is actually increasing in that measure. The study showed that the gap for cholesterol control, defined as LDL cholesterol below 130 mg/dL after discharge, between black and white patients was 13% in 1999 and widened to 16% in 2002.

Lack of trust and/or communication between minority patients and physicians also are factors in care disparity, Dr. Ayanian said. Many physicians don't recognize that past discrimination in health care, such as the Tuskegee syphilis study, still fuels minorities' mistrust of the health care system, he said.

A cooperative national study that was conducted by Dr. Ayanian and his colleagues looked at new patient preferences for renal transplantation among end-stage renal disease patients ages 18 to 54 in Michigan, Alabama, Southern California, and the Washington metropolitan area in 1996-1997.

The researchers found small differences in the patient preferences for the transplant but larger differences in the referral for evaluation. For example, 86% of white men favored transplantation, and 82% were referred for evaluation. However, 81% of black men favored transplantation but only 58% were referred for evaluation (N. Engl. J. Med. 1999;341:1661-9).

In addition, most patients in the study said they agreed with and trusted their physician. But white patients were more likely to trust and agree with physicians than black patients, and black patients received less information about transplantation.

Physicians, researchers, and policy makers need to work together to help eliminate disparities, Dr. Ayanian said. Expanded research funding is needed to better evaluate the causes of disparities and financial incentives from payers can be used to reward "equitable and high-quality" care, he said. ■

As of July, Part B Drugs Available via CMS Competitive Acquisition Program

Starting next month, physicians will have an alternative to billing for Medicare Part B drugs under the average sales price system.

Officials at the Centers for Medicare and Medicaid Services are launching the Competitive Acquisition Program (CAP) for Part B drugs starting on July 1. The new voluntary program will allow physicians to obtain selected Part B drugs from vendors chosen by CMS through a competitive bidding process.

During the initial phase of the program, CMS has selected one vendor—BioScrip—to provide drugs.

Physicians who participate in CAP will be paid for the administration of the Part B drug or biologic on an assignment-related basis, according to CMS, but will not have to take on the financial risk of purchasing the drugs first.

The program should help to cut down on physician paperwork, according to CMS officials, because CAP vendors are responsible for collecting coinsurance and deductibles from Medicare beneficiaries once drug administration is verified. Physicians who participate in the program will submit claims for drug administration services to their local carrier within 14 days and provide their vendor with beneficiary supplemental insurance information.

But the program may not offer the relief being advertised by CMS, some physicians said. Dr. Alfred Denio, a rheumatologist in Norfolk, Va., said CAP could be an alternative in areas where it has not been financially feasible for physicians to purchase infused therapies on their own. However, even going through a CAP vendor, there will be a significant administrative burden, said Dr. Denio, who serves on the American College of Rheumatology's Committee on Rheumatologic Care.

For example, physicians must submit written orders for drugs to the CAP vendor, notify the vendor when a CAP drug is not administered or the full supply was not administered, and maintain a separate electronic or paper inventory for each CAP drug. "That's added cost to the practice that you will not be reimbursed for," he said.

Although the ACR has not taken an official position on CAP, Dr. Denio said that he believes the administrative burden will be difficult for the office-based physician and that he suspects that few will sign up for the program.

CAP is likely to be a plus for Medicare because it will allow the agency to reduce costs, but there are still not enough details available about the program to ensure that there won't be adverse consequences for physicians, said Dr. Richard Hellman, president-elect of American Association of Clinical Endocrinologists.

Once physicians sign up, they must obtain all drugs on the CAP drug list from their drug vendor, except in certain cases such as emergency administration, according to CMS. This year there are about 180 drugs on the CAP drug list (www.cms.hhs.gov/CompetitiveAcquisforBios/Downloads/CAP_Drugs_List.pdf).

It may make sense to obtain some medicines through the CAP vendor, Dr. Hellman said, but physicians will not be able to pick and choose among drugs on the CAP list.

Dr. Hellman said he is also concerned that CAP will affect access to medications if it makes it unprofitable for physicians to deliver these services in their offices. "[CMS officials] need to be careful that they do not restrict access in their zeal to cut costs."

This year CAP will run from July 1 to Dec. 31. Starting in 2007, the program will run year-round, a 45-day physician election period each fall. Physicians can opt into the CAP program each year and will be required to stay in the program for a full calendar year. More information on the CAP program is available at www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp. ■