

June 18, 2010

Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Acting Administrator Tavenner,

The undersigned groups are writing to convey our ongoing concerns with the discontinuation of CPT consultation codes in Medicare and to request that the policy be reviewed and revised during the development of the 2011 Medicare physician fee schedule rule.

As you know, in the final physician payment rule for 2010, the Centers for Medicare and Medicaid Services (CMS):

- Predicted that no specialty would see Medicare revenues decline by more than 3%.
- Asserted that there is no longer any significant difference between a consultation and a routine visit because consultants now can send referring physicians the medical record rather than a written report and
- Said concerns that consultation modifications will discourage care coordination are “premature” but CMS will make an “appropriate policy response” if evidence of a deterioration in “effective coordination of care” emerges.

A recent survey by the American Medical Association and 11 medical specialties casts serious doubts on some of the new policy’s underlying assumptions and suggests that it will in fact have a negative effect on care coordination. Revenue losses appear to be considerably higher than projected and physicians report that they have had to compensate by taking a variety of steps to reduce their services to Medicare patients.

Nearly three quarters (72%) of the approximately 5500 physicians who completed the survey estimated that elimination of billing for consultations had decreased their total revenues by more than 5% and 30% have experienced losses of more than 15%. Many practices could not sustain cuts of this size and either have already reduced their services to Medicare patients or are contemplating cost-cutting steps that will impact care. Most notably, 20% of these physicians have already eliminated or reduced appointments for new Medicare patients; 39% will defer the purchase of new equipment and/or information technology; and 34% are eliminating staff, including physicians in some cases.

In addition to these general steps that will affect all Medicare patients, some respondents indicated that they have made or plan to make practice changes that are tied directly to consultation services and are likely to discourage the care coordination improvements that CMS and Congress are seeking. Following CMS's suggestion that they no longer need to provide primary care physicians with a written report, about 6% have stopped providing these reports, another 16% plan to stop providing them and a number of others commented that they will continue providing reports but only very brief ones.

Several other CMS policies have compounded the impact of eliminating Medicare billing for consultations. One such problem involves prolonged services for hospitalized patients, where the issue is whether or not physicians can count time spent on any duties other than their face to face visit with the patient. The CPT system that Medicare codes are built on counts both the face to face time and time spent on the patient's floor or unit. However, CMS only recognizes face to face time and not other services such as establishing and reviewing charts and communicating with families and other health care professionals. In effect, Medicare is denying payment for these services and further discouraging coordination of care between professionals.

Another problem created by Medicare's elimination of consultation codes centers on the identification of new patients, which CPT defines as those who have not been seen by the same physician or another member of the same group and sub-specialty within the last three years. While consultation codes do not distinguish between new and established patients, the office visit codes physicians now must use do make this distinction and Medicare pays more for new patients. The difficulty is that physicians often focus on a narrower range of services than Medicare recognizes in its current list of specialties and sub-specialties. A patient seen by two sub-specialists with very different areas of expertise—such as two different kinds of cancer—will be seen as an established patient, which increases losses associated with elimination of consultation codes in Medicare.

A third issue involves codes for lower level hospital and nursing home consultations. As you know, CMS initially suggested that all inpatient consultations could be billed as an initial hospital visit. However, the lowest level inpatient consultations do not meet the criteria for an initial visit and CMS later suggested that physicians could bill these services using the subsequent inpatient visit codes. The problem is that although CMS redistributed money previously spent on inpatient consultations to initial inpatient visits, it did not increase subsequent visit values. Losses on the lower level consultations are far larger than anticipated.

In addition to leading to larger-than-anticipated revenue losses for some physicians, unexpected issues associated with the new consultation policy also have led to inadequate budget neutrality adjustments and drained money out of Medicare's physician expenditure pool. For example, CMS's assumptions regarding the lower level inpatient consultations appear to have reduced Medicare expenditures on physician services by at least \$50 million more than was redistributed to other E&M services.

A review of CMS's current policies regarding physician consultations is clearly called for. Revenue losses for consultant physicians are larger than projected. Physicians have been forced to reduce services to Medicare patients and care coordination has suffered as a result of the policy. These problems could be mitigated by revising CMS guidelines regarding prolonged visits and new patients and/or by creating some mechanism for reimbursing consultant physicians for a comprehensive report back to a referring physician. We ask that CMS confirm in its proposed Medicare Physician Fee Schedule Rule for 2011 that it will address this issue in the final rule and would welcome a chance to discuss the issue further.

Sincerely,

American Academy of Dermatology Association
American Academy of Neurology Professional Association
American Academy of Otolaryngology- Head and Neck Surgery
American Association of Clinical Endocrinologists
American Association of Neurological Surgeons
American College of Cardiology
American College of Gastroenterology
American College of Osteopathic Internists
American College of Osteopathic Surgeons
American College of Physicians
American College of Radiation Oncology
American College of Rheumatology
American Gastroenterological Association
American Geriatrics Society
American Medical Association
American Medical Group Association
American Osteopathic Academy of Orthopedics
American Psychiatric Association
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society for Reproductive Medicine
American Society of Addiction Medicine
American Society of Clinical Oncology
American Society of Hematology
American Society of Plastic Surgeons
American Thoracic Society
American Urological Association
Congress of Neurological Surgeons
Heart Rhythm Society
Infectious Diseases Society of America
Joint Council of Allergy, Asthma and Immunology
Society for Cardiovascular Angiography and Interventions
The Endocrine Society
The Society of Thoracic Surgeons