CMS Proposes Changes to Consultation Reimbursement

The Centers for Medicare and Medicaid Services (CMS) has proposed the elimination of payments to physicians for consultations provided to patients. This has sparked a reaction of horror from many physicians, primarily specialists who routinely provide such consultations. The Practice Management Committee (PMC) and staff of the American College of Chest Physicians (ACCP) have evaluated the financial impact of the elimination of such payments. The ACCP analysis is that the proposed change is not likely to substantially affect the average practice. The actual impact, of course, cannot be known until the final rule from CMS is promulgated, which is expected in early November for a January 1, 2010, effective date.

Much of the outcome for any one practice can be predicated on the coding habits of the individual practice. Those practices that tend to use a greater frequency of higher-level consultation codes may be somewhat negatively impacted by the change, with the converse true for those practices utilizing a greater frequency of lower level consultation codes. However, the "bottom line" for most specialists will likely be "business as usual." Of course, what we do as pulmonary, critical care and sleep specialists is provide advice to our colleagues and guide the care of patients entrusted to our care. There will still be payment to care for patients, but this payment will occur through billing of traditional E/M codes used in both the inpatient and outpatient settings. Just as consultations were reimbursed based on the complexity of the issues dealt with, E/M codes have also been reimbursed in a similar manner.

Consultations, by definition, are patient encounters specifically for the purpose of giving an opinion, as opposed to providing ongoing care to the patient. Most consultations are made at the request of another physician, generally in a primary care field or in a "narrow" specialty, to attempt to answer a specific question. Consultations, for a "second opinion," may also be requested by the patient who will then choose who will actually provide further care. Many consultations result in a procedure being performed by the physicians rendering the opinion. The physician providing a consultation often renders a specific diagnosis or may initiate complex therapies. Consultations have long been a focus of audits based on the finding of high rates of errors in their billing, and this action, if taken by CMS, will reduce the effects of future audits by Medicare Recovery Audit Contractors. In addition, the request for the consultation must be documented in the record, and a report from the consultant to the requesting physician is essential.

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At the present time, there are five levels of consultations based upon the complexity of the history, physical examination, and, most-importantly, the medical decision-making. There can be confusion as to what actually constitutes a consultation, as opposed to E/M services, particularly when being called to render a consultation on one's own patient, or when the physician rendering the consultation assumes care and sees the patient on a regular basis. Accordingly, the elimination of the "formal" consultation and the change to utilization of E/M codes may actually simplify things. Of course, those who routinely perform consultative services should continue to send letters/reports to physicians and midlevel providers who refer patients so as to ensure appropriate communication and good patient care.

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