

March 30, 2011

Mark Miller, Ph.D  
Executive Director  
Medicare Payment Advisory Commission  
601 New Jersey Ave, NW, Suite 9000  
Washington, DC 20001

Dear Dr. Miller:

Our organizations would like to express appreciation for the opportunity to meet with you and other officials from the Medicare Payment Advisory Commission (MedPAC) on Wednesday, March 2<sup>nd</sup> to discuss the negative impact of the Centers for Medicare and Medicaid Services (CMS) 2010 decision to eliminate payments for the consultation codes.

Endocrinologists, Infectious Diseases physicians, Neurologists, Neuro-Ophthalmologists, and Rheumatologists are disproportionately affected by the policy change because of the nature of their predominately cognitive work. Cognitive specialists are physicians with additional training in a specific field of medicine who primarily provide Evaluation & Management (E&M) services to patients with complex medical conditions that require a level of expertise to diagnose and treat that is beyond the training of the referring physician. The nature of their work meant that even before CMS' policy change many cognitive specialists' reimbursements were comparable to that received by primary care physicians<sup>1,2</sup>. The elimination of payments for consultation codes combined with other recent legislative and regulatory initiatives focused on incentivizing primary care means that these specialists are now reimbursed at a level *less* than that of primary care despite their additional training and expertise. This will lead to severe manpower shortages and access problems that will disproportionately impact patients with complex multi-systems diseases.

### **CMS' DECISION IGNORED EFFORTS TO CLARIFY THE DOCUMENTATION REQUIREMENTS AND REDUCDE MISCODING**

CMS' main justification for eliminating payments for the consultation codes was that many physicians failed to provide the necessary documentation or miscoded encounters as consultations when a new or established patient code may have been more appropriate. In so doing, CMS ignored revisions to the Consultations Section of the 2010 Current Procedural Terminology (CPT) Code Book<sup>3</sup> that were designed to address many of the aforementioned concerns. CMS officials, who represent the Agency at the CPT Editorial Panel and participated in multiple meetings of the Consultations Work Group, provided no indication that these revisions would not be acceptable.

Also ignored was an October 2006 letter signed by more than 50 physician groups<sup>4</sup> which urged CMS to clarify a confusing December 2005 policy transmittal that likely perpetuated miscoding

---

<sup>1</sup> J. Paul Leigh et al. [Physician Wages Across Specialties: Informing the Physician Reimbursement Debate](#). Arch. of Intern. Med, Vol. 170 (Oct. 25, 2010).

<sup>2</sup> Bruce Sigsbee. The income gap Specialties vs primary care or procedural vs nonprocedural specialties? Neurology, Vol. 76. (March 8, 2011).

<sup>3</sup> 2010 CPT Code Book. Evaluation and Management Services Guidelines: Consultations. AMA, pages 16-19. 2010

<sup>4</sup> Specialty Sign-on Letter. Medicare Urged to Reconsider Several Policies Surrounding Consultation Services <http://www.idsociety.org/WorkArea/DownloadAsset.aspx?id=4712>. October 2006.

for consultative services.<sup>5</sup> **CMS finalized its policy to eliminate payments for consultation codes in spite of these efforts and, most notably, before the CPT revisions were allowed to take effect in 2010.**

### **CONSULTATIONS INVOLVE ADDITIONAL WORK THAT IS NOT CAPTURED BY OTHER E&M SERVICES**

CMS additionally justified their policy change to eliminate payments for the consultation codes by removing the requirement to generate a written report back to the referring physician, asserting that now the E&M work was similar in value. By no longer requiring a written report, CMS' decision has led to more fragmented care and runs counter to policy-makers focus on greater care coordination, a key principle of the Patient Protection and Affordable Care Act (ACA). That said, **CMS' argument wrongly assumes that all extra work associated with a consultation is related to documentation and fails to recognize that the report is only as good as the quality of cognitive information – manifested as the patient history and diagnostic and treatment plans – contained therein.**

Higher payments for consultations recognize the expertise and work intensity associated with correctly diagnosing patients who have complex medical conditions with whom specialty consultants typically have no previous relationship, synthesizing all relevant data into meaningful treatment recommendations that are individualized to patients needs, and coordinating with the referring physician to ensure that the recommendations are followed or that care is transferred to qualified specialists.<sup>6</sup> In recognition of this additional work, CMS increased the relative values of the consultation codes when it accepted the Five-Year Review recommendations for all E&M service codes in the 2007 Physician Fee Schedule (PFS).<sup>7</sup> **CMS' assertion three-years later that there is no meaningful difference in the work of a consultation service compared to other E&M services is inconsistent with the 2007 decision.**

### **CONSULTATIONS IMPROVE QUALITY AND REDUCE COSTS**

The expertise that cognitive specialty consultants bring to bear in treating complex medical conditions is demonstrated to improve patient outcomes and reduce costs. At our March 2<sup>nd</sup> meeting, we provided numerous clinical examples and cost data that demonstrated and quantified the value of these services.<sup>8</sup>

Moreover, the success of new care delivery models such as the Patient-Centered Medical Home and Accountable Care Organizations, which are centered on the role of the primary care physician, are predicated on a team/consultative approach to medicine that ensures access to appropriate specialty care. **CMS' decision to eliminate payments for the consultation codes contradicts the goals of these models specifically and of health care reform generally to foster greater care coordination.** This suggests that while primary care physicians realized a small short-term

---

<sup>5</sup> CMS Transmittal #788. Change Request 4215: Consultation Services (Codes 99241 - 99255). CMS Manual System, December 2005

<sup>6</sup> Lawrence P. Martinelli et al. [Devaluing a Specialty: The Centers for Medicare and Medicaid Services Proposal to Eliminate Consultation Codes](#). Clin. Infect. Dis, Vol. 49 (Oct. 1, 2009): 995-996.

<sup>7</sup> Medicare 2007 PFS Final Rule. Five-Year Refinement of Relative Value Units Under the Physician Fee Schedule. Federal Register, pages 69726-69727. December 2006.

<sup>8</sup> Case Vignettes and Data Demonstrating the Value of Cognitive Specialists. March 2011

benefit from the policy change, in the long run, a lack of care coordination and access to cognitive specialty care may pose significant challenges for many primary care-centric delivery system reforms and high quality patient care overall.

### **QUESTIONS REMAIN REGARDING CMS' 2010 FINANCIAL IMPACT ESTIMATES**

In the 2010 PFS Final Rule, CMS indicated that the decision to eliminate payments for consultation codes was done in a budget neutral fashion and would have a negligible financial impact on specialty reimbursements. In so doing, the Agency assumed that 50 percent of outpatient consultations would be billed as new patients and 50 percent as established patients and that inpatient consultations would be split between the various codes for an initial hospital or nursing home visit. Questions have been raised about the accuracy of these assumptions.

Our coalition believes that CMS' assumptions may have reduced Medicare expenditure on physician services by at least \$50 million annually more than was redistributed to other E&M services. More troubling than the Agency's budget neutrality assumptions, [AMA survey data](#) suggests that CMS' specialty-specific financial impact estimates<sup>9</sup> were not accurate as many specialists have reported seeing a 10-15% reduction in their revenues due to the decision to eliminate payments for the consultation codes.

The negative consequences of revenue decreases at this magnitude are likely to include reduced access to cognitive specialty care, staff layoffs, mistreatment of complex conditions, deferral of investments in health information technology, and workforce shortages in the affected specialties. As such, **our coalition requests MedPAC's assistance in evaluating the 2010 Medicare claims data to determine the accuracy of CMS' estimates. We also reiterate a request made at the March 2<sup>nd</sup> meeting that MedPAC refine its patient access surveys to recognize that cognitive specialists, while performing consultative work that is more complex and intense, more closely resemble primary care physicians in terms of their services and wages.**

### **NEW PAYMENT MODELS SHOULD RECOGNIZE THE VALUE OF COGNITIVE SPECIALTY CARE**

We recognize that the health care system is transforming and with that, we must also acknowledge that specialty care is essential in this new system. The expertise and availability of cognitive specialists is vital to the successful implementation of any proposed integrative health care delivery model that promotes coordination, provides optimal patient care, and reduces unnecessary spending on duplicate tests, fragmented care, preventable illness and hospitalizations.

Our coalition also believes that service-specific spending targets hold promise as a viable replacement to the Sustainable Growth Rate (SGR) physician payment formula. However, more research needs to be done in this area to ensure that service-specific buckets are crafted fairly and take into account the impact of recent reimbursement changes on various specialties. For example, our coalition is dubious of the need for a primary care services bucket that is separate from other E&M services in light of recent regulatory and legislative actions that have resulted in significant payment increases to primary care physicians. **It is critical that any new payment**

---

<sup>9</sup> Medicare 2010 PFS Final Rule. CY 2010 Total Allowed Charge Impact for Work, Practice Expense, and Malpractice Changes. Federal Register, pages 61981-61984. November 2009.

**policies considered by MedPAC recognize the value of cognitive specialty care for patients with complex medical conditions.**

**CONCLUSION**

While new delivery system reforms and payment models offer some hope that cognitive specialty care will be appropriately recognized in the future, our coalition remains committed to reinstatement of the consultation codes. The negative impact of CMS' decision will not be fully understood for several years but it is increasingly clear that the Agency's assumptions were flawed. Accordingly, **we urge MedPAC to recommend that Congress pass legislation requiring CMS to reinstate and appropriately value the consultation service codes to ensure that patients with complex medical conditions receive necessary care.**

Again, we appreciate you taking the time to meet with us and look forward to continued dialogue with you and the Commission staff.

Sincerely,



Marc Raphaelson, MD  
[Raphaels4@aol.com](mailto:Raphaels4@aol.com)  
American Academy of Neurology



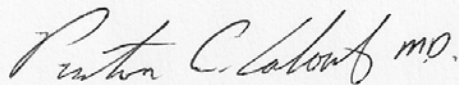
Howard Lando, MD  
[HLando@yahoo.com](mailto:HLando@yahoo.com)  
American Association of Clinical Endocrinologists



David Borenstein, MD  
[dborenstein715@aol.com](mailto:dborenstein715@aol.com)  
American College of Rheumatology



Steven Schmitt, MD  
[schmits@ccf.org](mailto:schmits@ccf.org)  
Infectious Diseases Society of America



Preston Calvert, MD  
[pcalver@gmail.com](mailto:pcalver@gmail.com)  
North American Neuro-Ophthalmology Society



Jason Wexler, MD  
[Jason.a.wexler@medstar.net](mailto:Jason.a.wexler@medstar.net)  
The Endocrine Society

cc:

Kevin Hayes, Ph.D  
MedPAC

Jim Matthews, Ph.D  
MedPAC

Arielle Mir, M.P.A  
MedPAC

Robert Berenson, MD  
Urban Institute