

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**CONSULTATIONS IN MEDICARE:  
CODING AND REIMBURSEMENT**



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## OBJECTIVE

To determine if services billed to Medicare as consultations were coded correctly and documented adequately.

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## BACKGROUND

Medicare allowed \$3.3 billion for consultations in 2001. The Current Procedural Terminology (CPT) defines a consultation as “. . . a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.” A consultation differs from similar evaluation and management services in that a consultation involves a specific request for help with a particular diagnosis or course of treatment on a limited basis, while an office or inpatient visit lacks such a request and can involve ongoing care of a patient.

The CPT defines four types of consultation: (1) office or other outpatient, (2) initial inpatient, (3) follow-up inpatient, and (4) confirmatory (also called a second opinion). Within each type, three or five levels of complexity exist, with a distinct billing code for each level. The level depends on three key components: (1) the extent of the patient history taken, (2) the thoroughness of the physical examination, and (3) the complexity of the consultant’s medical decisionmaking.

Pursuant to 42 CFR § 411.351 and section 15506 of the Medicare Carriers Manual, Medicare allows reimbursement for consultations if (1) a physician requests the consultation, (2) the request and need for the consultation are documented in the patient’s medical record, and (3) the consultant furnishes a written report to the referring physician. Other provisions of Federal law require that physicians document all Medicare services and bill them with the correct code.

We selected a simple random sample of 400 consultations allowed by Medicare with dates of service in calendar year 2001. For each consultation, we identified the patient, consultant, and referring physician listed on the claim, as well as the provider of any concurrent Part A services. From each of these sources, we requested photocopies of the portion of the patient’s medical record that pertained to the sampled consultation. We contracted with certified professional coders who have extensive experience reviewing Medicare claims to determine

if each service was billed with the correct code and documented adequately.

Because we only reviewed consultation services provided in 2001, our sample results cannot be extrapolated to other periods. Accordingly, we make no inferences to consultation error rates in subsequent years. As noted previously, Medicare reimbursement for consultations increased from \$3.3 billion in 2001 to \$4.1 billion in 2004. To our knowledge, the Centers for Medicare & Medicaid Services (CMS) has made no national policy changes that would affect the incidence of consultation payment errors since 2001, suggesting that at least some of the payment vulnerabilities that we identified still exist.

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## FINDING

### **Medicare allowed approximately \$1.1 billion more in 2001 than it should have for services that were billed as consultations.**

Approximately 75 percent of services billed as consultations and allowed by Medicare in 2001 did not meet all applicable program requirements, resulting in \$1.1 billion in improper payments. Services billed as consultations often did not meet Medicare's definition of a consultation (19 percent—\$191 million), were billed as the wrong type or level of consultation (47 percent—\$613 million), or were not substantiated by documentation (9 percent—\$260 million). Consultations billed at the highest billing level (the most complex services, which generate the highest reimbursements under the physician fee schedule) and follow-up inpatient consultations were particularly problematic; approximately 95 percent of each were miscoded.

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## RECOMMENDATION

Our review showed that services billed to Medicare as consultations often were not actually consultations, were coded as the incorrect type or level of consultation, or were not substantiated by documentation. Although CMS clarified the difference between office visits and consultations in an October 2003 update to section 15506 of the Medicare Carriers Manual, the distinctions among the types and levels of consultations were not addressed. **Therefore, we recommend that, through its Medicare carriers, CMS educate physicians and other health care practitioners about the criteria and proper billing for all types and levels of consultations with emphasis on the highest billing levels and follow-up inpatient consultations.**

## E X E C U T I V E   S U M M A R Y

In addition, we have forwarded information on the miscoded and undocumented services identified in our sample to CMS for appropriate action.

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### **AGENCY COMMENTS**

In its comments to our draft report, CMS noted that the CPT codes for follow-up inpatient consultations and confirmatory consultations were deleted effective January 1, 2006. CMS has revised its policy manuals to reflect these changes. The agency agreed with our recommendation to educate providers about consultations and plans to publish on its Web site a Special Edition article highlighting these changes and providing new coding instructions for consultation services.

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### **OFFICE OF INSPECTOR GENERAL RESPONSE**

We are pleased that CMS has agreed to implement our recommendation and look forward to seeing the Special Edition article when it is published. Also, the elimination of the codes for follow-up inpatient consultations and confirmatory consultations should improve providers' understanding of the proper billing for consultations and reduce the error rate associated with these services.

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## OBJECTIVE

To determine if services billed to Medicare as consultations were coded correctly and documented adequately.

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## BACKGROUND

### What Are Consultations?

The Current Procedural Terminology (CPT) defines a consultation as a “. . . type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.”

Appropriate sources include physicians, other health care practitioners, and—in the case of a confirmatory consultation—the patient.<sup>1</sup> A consultation differs from similar evaluation and management services in that it involves a specific request for help with a particular diagnosis or course of treatment on a limited basis, while an office or inpatient visit lacks such a request and can involve ongoing care of a patient.

The CPT, which the Centers for Medicare & Medicaid Services (CMS) uses as the basis for reimbursing physician services, defines four types of consultation according to the place of service and the source of the request:

1. An **office or other outpatient consultation** is a consultation provided in the consultant’s office or other ambulatory facility such as the patient’s residence, a hospital observation unit, or an emergency department. As set forth in the 2001 Physician Fee Schedule, an office or other outpatient consultation has the highest Medicare reimbursement rate of all consultation types.
2. An **initial inpatient consultation** is provided in an inpatient hospital, a skilled nursing facility, or a partial hospital setting. This type of consultation should be billed only once by a particular consultant per inpatient admission. This type of consultation has the second-highest level of Medicare reimbursement.

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<sup>1</sup> Hereinafter, we will use the term “referring physician” as a generic term to designate the source of the consultation, regardless of that individual’s credentials. We will use the term “consultant” to mean the provider of the consultation.

3. A **confirmatory consultation**—also called a second opinion—may be initiated by the patient or third-party insurance payers who require another opinion before approving a medical treatment or surgical procedure. This service can be provided in either an office or inpatient setting. A confirmatory consultation ranks third among the consultation types in terms of Medicare reimbursement rates.
4. A **follow-up inpatient consultation** is a service provided to complete an initial inpatient consultation or a new consultation provided by a consultant who has already performed an initial inpatient consultation for the patient during a single admission. A follow-up consultation can include monitoring progress, recommending treatment modifications, or advising on a new plan of care in response to changes in the patient’s status. A follow-up inpatient consultation has the lowest Medicare reimbursement rate of all consultation types.

The CPT further divides each type of consultation into levels based on the intensity and complexity of three key components. These three key components are patient history, physical examination, and medical decisionmaking. Higher-level codes describe more complex consultations and are reimbursed accordingly. Follow-up inpatient consultations are divided among three levels, while the three other types each have five levels. See Appendix A for a detailed explanation of consultation levels.

#### **Medicare Coverage of and Reimbursement for Consultations**

In 1983, CMS adopted CPT as part of the Healthcare Common Procedure Coding System (HCPCS) and mandated that providers use HCPCS to report consultations and other services to Medicare. Section 1848(c)(5) of the Social Security Act (the Act) required the Secretary of the Department of Health and Human Services to develop a uniform procedure coding system for all physician services, and specifically called for “an appropriate coding structure for . . . consultations.” Section 1848(a)(1) of the Act established the physician fee schedule as the basis for Medicare reimbursement for all physician services, including consultations, beginning in January 1992. In implementing the physician fee schedule, CMS provided new, nationally uniform interpretations of consultation codes.

Pursuant to 42 CFR § 411.351 and section 15506 of the Medicare Carriers Manual (the Manual), Medicare allows reimbursement for

consultations if the following conditions are satisfied (not applicable to confirmatory consultations):

- The referring physician requests the consultant's opinion or advice regarding evaluation and/or management of a specific medical problem.
- The written or verbal request and need for the consultation are documented in the patient's medical record.
- After the consultation is provided, the consultant prepares a written report of his or her findings, which is provided to the referring physician.

In a September 2001 update of the Manual, CMS clarified that physician assistants, nurse practitioners, and certified nurse-midwives can request and perform consultations if the services are within their scope of practice, as defined by State law.

In addition to these requirements, section 1833(e) of the Act states that Medicare will not pay for services, including consultations, unless documentation or other information is furnished to support the claim. Federal regulations at 42 CFR § 424.5(a)(6) require physicians to furnish sufficient documentation (upon request) to Medicare to determine whether payment is due and, if so, the amount to be paid.

In 2001, Medicare allowed approximately \$3.3 billion for consultations out of a total of \$23 billion for evaluation and management services.<sup>2</sup> By 2004, that figure had grown to \$4.1 billion. In 2001, approximately 45 percent of the allowed claims were for office or other outpatient consultations, and 44 percent were for initial inpatient consultations. The remaining 11 percent were primarily for follow-up inpatient consultations, with a small number of second opinions.

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## METHODOLOGY

### Overview

Certified professional coders reviewed the medical records and supporting documentation for a sample of 400 services billed as consultations and performed in 2001.

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<sup>2</sup> Medicare normally pays 80 percent of allowed charges, and the beneficiary or his or her supplemental insurance pays the remaining 20 percent as coinsurance.

**Sample Selection**

We defined our population as all services allowed with a consultation code (CPT codes 99241 through 99275) appearing in Medicare's National Claims History with service dates in 2001. From this population, we selected a simple random sample of 400 services to be reviewed for documentation and billing accuracy. Because we selected our sample in March 2002, and Medicare may reimburse claims up to 12 months after the date of service, our population actually contained only 16,470,281 services—about two-thirds of the total 25,557,836 consultations allowed with service dates falling in 2001.

After completing the medical review, we compared our population with the set of consultations that were provided in 2001, but did not appear in the National Claims History at the time we selected our sample (and hence were not part of our population). As a result of this comparison, we found that CPT code 99255—Initial inpatient consultation, level five—was underrepresented in our population. We discussed this issue with CMS, but were not able to determine why this code differed from the others. Because nearly all level five codes were upcoded (see Findings), this inconsistency most likely caused us to underestimate the dollars allowed by Medicare for miscoded consultations.

**Sources of Medical Records**

For each service, we identified the patient, the consultant who submitted the claim, the referring physician listed on the claim (if any), and the provider of any concurrent Part A services. We identified the consultant and referring physicians from the unique physician identification number matches. If the claims did not include the unique physician identification numbers, we contacted the appropriate Medicare carrier to identify the provider. From each physician and hospital, we requested photocopies of the portion of each patient's medical record pertaining to the sampled consultation.

Pursuant to Medicare coverage guidelines, documentation for a consultation should contain at least three parts: (1) a request for the consultation from the referring physician, (2) the need for the consultation, and (3) a copy of the written opinion sent by the consultant to the referring physician.<sup>3</sup> For office or other outpatient consultations, the same documentation should be in the medical records for both the

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<sup>3</sup> Centers for Medicare & Medicaid Services, Medicare Part B Physician's & Other Non-Physician Practitioner Manual—Medical Care Section, p. 11.

referring physician and the consultant. For initial inpatient and follow-up inpatient consultations, documentation of the request, the patient history and physical examination, and the written consultation should be contained in the same hospital medical record. For confirmatory consultations completed in an office setting, the consultant is the only source of the record. For confirmatory consultations completed in an inpatient setting, documentation of the patient history and physical examination and the consultant's written report should be included in the hospital medical record. Regardless of the setting, consultants usually keep a copy of the written opinion in their office records.

### **Collecting Medical Records**

We mailed an initial written request to all consultants, referring physicians, and hospitals appearing in our sample. A number of these initial mailings were returned by the post office as undeliverable. We conducted Internet searches using various search engines for alternate addresses for these individuals and facilities. We continued mailing requests to all alternate addresses until we found a valid address or exhausted all possibilities. We sent up to two follow-up requests to each physician or hospital that did not respond. If a hospital did not respond to our second follow-up request, we called the facility to request the records.

Even after repeated attempts, we could not contact any of the sources associated with three consultations in our sample. We removed these services from all subsequent data analyses. Of the 397 consultations for which we were able to contact at least 1 of the sources, we did not receive any records for 2, and counted these as undocumented. Hence, we received a response from at least 1 source of records for 395 of the 400 services in our sample, for an overall response rate of 99 percent. In some cases, we did not receive records from all the sources for a consultation. In these cases, the coders still could complete their record review because most of the information from the various sources is redundant.

### **Record Review**

We contracted with certified professional coders who have extensive experience reviewing Medicare claims to review the medical records.

Relying on the coders' expertise, we developed a review instrument using Medicare and CPT guidelines for evaluation and management services. The coders used this standardized instrument to perform the

reviews. The coders reviewed each record and determined if the service performed was coded correctly (meaning it met Medicare's definition of a consultation and was billed as the type and level of consultation) and was documented adequately. After completing the instruments, the coders forwarded them for review to our primary contractor, who then returned the instruments to us.

### **Cost Projections**

To calculate the allowed amounts cited in the findings, we first calculated the ratio of the total overpayments for a given category of error (e.g., upcoded consultations) to the total amount allowed for all consultations in our sample. We then applied this ratio to the total amount allowed for consultations in 2001—\$3,290,931,599—to determine the amount allowed in 2001 for each category of improper payment. We used a similar method to estimate the total amount allowed in 2001 for undocumented services. Appendix B shows the point estimates and confidence intervals for these ratios, as well as for other percentages cited in the report. Appendix C gives projections of improperly allowed dollars based strictly on projections to our service universe.

Because we only reviewed consultation services provided in 2001, our sample results cannot be extrapolated to other periods. Accordingly, we make no inferences to consultation error rates in subsequent years. As noted previously, Medicare reimbursement for consultations increased from \$3.3 billion in 2001 to \$4.1 billion in 2004. To our knowledge, CMS has made no national policy changes that would affect the incidence of consultation payment errors since 2001, suggesting that at least some of the payment vulnerabilities that we identified still exist.

### **CERT and This Inspection**

In 2003 and 2004, CMS reported payment error rates for consultations as part of its Comprehensive Error Rate Testing (CERT) program. While its findings were quite similar to the findings in this report, which are based on 2001 data, the Office of Inspector General (OIG) and CMS reviews should not be directly compared because their goals and methodologies are different. The goal of CERT is to measure the performance of CMS's contractors by calculating a paid claims error rate. Our objective, on the other hand, was to determine specifically if consultations billed to Medicare were coded correctly and documented adequately. Hence, CERT reports on nearly every type of service Medicare allows, but does not offer the same depth of information

## I N T R O D U C T I O N

specific to consultations that our narrowly focused inspection provides. This inspection was not designed to reproduce or to review the CERT findings.

This inspection was conducted in accordance with the Quality Standards for Inspections issued by the President's Council on Integrity and Efficiency.

► FINDING

**Medicare allowed approximately \$1.1 billion more than it should have for services that were billed as consultations**

Medicare allowed approximately 26 million services that were billed with a consultation code in 2001.

According to our medical review, approximately 75 percent of these services did not comply with Medicare regulations for reimbursement as a consultation, were billed with an incorrect consultation code, or were documented inadequately. Table 1 shows the types of services improperly paid as consultations, the representation of each type in our sample, and projections to the universe of all services allowed with consultation codes in 2001.<sup>4</sup>

Type of Improper Payment	Sample		Projected	
	Services	Allowed Amount	Services (Proportion)	Allowed Amount (Millions)
<b>Not a Consultation</b>	<b>74</b>	<b>\$2,860.85</b>	<b>0.19</b>	<b>\$191</b>
<b>Incorrect Consultation Code</b>	<b>187</b>	<b>\$9,186.39</b>	<b>0.47</b>	<b>\$613</b>
Incorrect Type	7	\$339.64	0.02	\$23
Incorrect Level	180	\$8,846.75	0.45	\$591
- Upcoded	161	\$9,625.61	0.41	\$643
- Downcoded	19	(\$778.86)	0.05	(\$52)
<b>Undocumented</b>	<b>37</b>	<b>\$3,894.36</b>	<b>0.09</b>	<b>\$260</b>
Nonresponse	2	\$97.06	*	*
Unsubstantiated	35	\$3,797.30	0.09	\$254
<b>Total Improperly Paid</b>	<b>298</b>	<b>\$15,941.60</b>	<b>0.75</b>	<b>\$1,064</b>

Source: Office of Inspector General, Analysis of Record Review Results, 2004. Projected allowed amounts for the different types do not equal total due to rounding. The \* indicates that the *n* for that cell is too small to reliably project.

*Not a consultation.* Approximately 19 percent of services allowed as consultations did not meet the definition of a consultation contained in 42 CFR § 411.351. Had providers billed these services correctly, Medicare and its beneficiaries would have saved approximately \$191 million in 2001. Most of these services were actually lower-paying regular office or inpatient visits. Other examples of errors included billing a psychiatric diagnostic interview and a discharge management service as initial inpatient consultations. Nurses (who are not eligible

<sup>4</sup> See the Methodology section for a discussion of our sampling frame as it relates to the universe of services allowed as consultations in 2001.

F I N D I N G

to bill Medicare for consultations) furnished an additional two services in our sample.

*Incorrect consultation code: Incorrect type.* Two percent of the services that were coded as consultations met the regulatory definition of a consultation, but were billed as the wrong type of consultation. Most of these were billed as a type of consultation reimbursed at a higher rate than the one actually performed. Two consultants, however, billed for follow-up inpatient consultations instead of the appropriate, higher-paying initial inpatient consultation codes. Net overpayments for consultations billed as the wrong type totaled \$23 million.

*Incorrect consultation code: Incorrect level.* Nearly 45 percent of the services that were billed as consultations in 2001 were not coded at the proper level. More specifically, 41 percent of all services billed as consultations were upcoded (billed at a higher level than the service actually performed), and 5 percent were downcoded (billed at a lower level). Overall, Medicare and its beneficiaries paid \$643 million too much for upcoded consultations but paid \$52 million too little for downcoded consultations, yielding a net overpayment of \$591 million. Table 2 shows the distribution of downcoded and upcoded services.<sup>5</sup>

Type of Error	Number of Services in Sample	Percentage of Downcoded/Up-coded Services	Mean Under- or Over-Payment	Projected Under- or Over-Allowed Amount (Millions)
Downcoded	19	-	(\$40.99)	(\$52.1)
- By 1 Level	18	95%	(\$37.36)	(\$45.0)
- By 2 Levels	1	5%	(\$106.81)	*
Up-coded	161	-	\$59.79	\$643
- By 1 Level	92	57%	\$39.27	\$241
- By 2 Levels	53	33%	\$77.95	\$276
- By 3 Levels	16	10%	\$117.62	\$126
<b>Total Billed at Incorrect Level</b>	<b>180</b>	<b>-</b>	<b>\$49.15</b>	<b>\$591 (net)</b>

Source: Office of Inspector General, Analysis of Record Review Results, 2004.

The \* indicates that the *n* for that cell is too small to reliably project.

<sup>5</sup> Data are reported in the aggregate for all consultation types. Differences in upcoding among the types of consultation exist, but were not statistically significant.

## F I N D I N G

Physicians billed approximately 2 million services at the highest level of the correct type of consultation, but coded just 5 percent of these correctly. For example: a level five office or other outpatient consultation requires a comprehensive history and evaluation and a high complexity of medical decisionmaking. Nine physicians billed this code instead of the level three office or other outpatient consultation that was supported by the medical record, which showed that the physician took only a detailed history and evaluation and exhibited only a low complexity of medical decisionmaking. Office or other outpatient, initial inpatient, and confirmatory consultations billed at level five were upcoded by 1.9 levels on average, for a mean overpayment of \$93.61 per service.

*Undocumented.* Reviewers found that 9 percent of consultations were not documented in any of the patient's medical records, including those we received from the consultant, the referring physician, and/or the inpatient facility where the patient was staying at the time of the service. Based on this finding, we estimate that Medicare may have allowed approximately \$260 million in 2001 for undocumented services billed as consultations. Besides services that were completely undocumented, medical records for an additional 4 percent were insufficient to determine the correct code to describe the service.

### **Approximately 94 percent of services billed as follow-up inpatient consultations were coded incorrectly**

Excluding undocumented and inadequately documented services, approximately 94 percent of services that were billed as follow-up inpatient consultations should have been billed as another service. In our sample, we found that:

- o 79 percent of these services were actually inpatient visits for daily care, not consultations;
- o 6 percent were actually initial inpatient or outpatient consultations; and
- o 9 percent were upcoded.

As indicated by the Physician Fee Schedule, Medicare reimbursed follow-up inpatient consultations at a lower rate than other types of consultations or regular inpatient visits in 2001. Therefore, it is likely that most of these errors were unintentional.

## ► R E C O M M E N D A T I O N

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Our review showed that services billed to Medicare as consultations often were not actually consultations, were coded as the incorrect type or level of consultations, or were not substantiated by documentation. Although CMS clarified the difference between office visits and consultations in October 2003, it did not address the distinctions among the types and levels of consultations.

**Therefore, we recommend that, through its Medicare carriers, CMS educate physicians and other health care practitioners about the criteria and proper billing for all types and levels of consultations with emphasis on the highest billing levels and follow-up inpatient consultations.**

In addition, we have forwarded information on the miscoded and undocumented services identified in our sample to CMS for appropriate action.

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### AGENCY COMMENTS

In its comments to our draft report, CMS noted that the CPT codes for follow-up inpatient consultations and confirmatory consultations were deleted effective January 1, 2006. CMS has revised its policy manuals to reflect these changes. The agency agreed with our recommendation to educate providers about consultations and plans to publish on its Web site a Special Edition article highlighting these changes and providing new coding instructions for consultation services. The complete text of CMS's comments is included starting on page 17.

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### OFFICE OF INSPECTOR GENERAL RESPONSE

We are pleased that CMS has agreed to implement our recommendation and look forward to seeing the Special Edition article when it is published. Also, the elimination of the codes for follow-up inpatient consultations and confirmatory consultations should improve providers' understanding of the proper billing for consultations and reduce the error rate associated with these services.

## Coding Levels for Consultations

As defined by CPT, evaluation and management codes include seven basic elements—patient history, physical examination, medical decisionmaking, counseling, coordination of care, the nature of the patient’s presenting problem (or the reason for the visit with the physician), and time.<sup>6</sup> The first three components are key to selecting the correct level for a consultation. To properly code the consultation, the provider must determine, based on these key components, which level of consultation is appropriate. The three key components are:

- The extent of the patient history—consultants use their clinical judgment and the nature of the patient’s presenting problems to determine the depth of the history needed to complete the consultation and provide an opinion to the referring physician. A patient history can be classified into one of four categories:
  - **Problem focused** (brief history of present illness or problem),
  - **Expanded problem focused** (brief history of present illness with problem-pertinent system review),
  - **Detailed** (extended history of present illness with pertinent past, family, and social history directly related to the presenting problem; includes review of a limited number of additional systems), and
  - **Comprehensive** (extended history of present illness with review of body systems directly related to the patient’s problems; complete past, family, and social history).
- The extent of physical examination—based on clinical judgment and the presenting medical problems, the consultant can perform four types of examination:
  - **Problem focused** (limited examination of the affected body area or organ system),
  - **Expanded problem focused** (limited examination of affected area or systems with other symptomatic or related organ systems),

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<sup>6</sup> American Medical Association, Current Procedural Terminology—CPT 2000, 2002, and 2003 versions.

- **Detailed** (extended examination of affected body areas and other related systems), and
  - **Comprehensive** (a general multisystem examination or a complete examination of a single organ system).
- The complexity of the consultant's medical decisionmaking, referring to the factors needed to establish a diagnosis and/or select a management option:
- Selecting the correct level of decisionmaking is based on the number of possible diagnoses or the number of options that must be considered; the amount and/or complexity of medical records, diagnostic tests, and other information that physicians must obtain, review, and analyze; and the risk of significant complications, morbidity, and/or mortality.
  - Four levels of medical decisionmaking are recognized: straightforward, low complexity, moderate complexity, and high complexity.

▶ A P P E N D I X ~ B

**Confidence Intervals for Ratios and Percentages**

<b>Statistic</b>	<b>N</b>	<b>Point Estimate</b>	<b>95% Confidence Interval</b>
Ratio of excess allowed amount for services that were miscoded or undocumented to all allowances	397	0.33	0.29 to 0.36
Percentage of services that were miscoded or undocumented	397	0.75	0.71 to 0.79
Percentage of services that were not consultations	397	0.19	0.15 to 0.23
Ratio of excess amount allowed for services that were not consultations to all allowances	397	0.06	0.04 to 0.08
Percentage of services billed as consultations that were coded as the incorrect type or level	397	0.47	0.42 to 0.52
Ratio of excess amount allowed for services coded as the incorrect type or level to all allowances	397	0.19	0.16 to 0.22
Percentage of services billed as the incorrect type of consultation	397	0.02	0.00 to 0.03
Ratio of excess amount allowed for services billed as the incorrect type of consultation to all allowances	397	0.01	≤ 0.01
Percentage of services billed at the incorrect level	397	0.45	0.40 to 0.50
Ratio of excess amount allowed for services billed at the wrong level to all allowances	397	0.18	0.16 to 0.21
Percentage of services that were upcoded	397	0.41	0.36 to 0.45
Ratio of excess amount allowed for upcoded services to all allowances	397	0.20	0.18 to 0.23
Percentage of services that were downcoded	397	0.05	0.03 to 0.07
Ratio of underpayments for downcoded services to all allowances	397	(0.02)	(≤ 0.02) to (0.01)
Percentage of services that were undocumented	397	0.09	0.06 to 0.12
Ratio of the amount allowed for undocumented services to all allowances	397	0.08	0.05 to 0.11
Percentage of services that were documented inadequately	397	0.04	0.02 to 0.06

A P P E N D I X ~ B

**Confidence Intervals for Statistics (continued)**

<b>Statistic</b>	<b>N</b>	<b>Point Estimate</b>	<b>95% Confidence Interval</b>
Percentage of services billed at level five of the correct type that were billed incorrectly	22	0.95	> 0.87
Mean degree of upcoding where the consultation was billed at level five of the correct type	22	1.91 levels	1.58 to 2.24 levels
Mean overpayment due to upcoding where the consultation was billed at level five of the correct type	22	\$92.52	\$77.98 to \$107.06
Ratio of dollars improperly allowed at level five to all allowances	397	0.07	0.04 to 0.09
Percentage of documented services billed as follow-up consultations that were miscoded	34	0.94	> 0.86

▶ A P P E N D I X ~ C

**Inappropriately Allowed Amounts Based Strictly on Our Service Universe**

<b>Statistic</b>	<b>N</b>	<b>Point Estimate</b>	<b>95% Confidence Interval</b>
Excess amount allowed for services that were miscoded or undocumented	397	\$656 million	\$578 million to \$734 million
Excess amount allowed for services that were not actually consultations	397	\$118 million	\$77 million to \$159 million
Excess amount allowed for consultations billed as the incorrect type or level	397	\$378 million	\$317 million to \$439 million
Excess amount allowed for consultations billed as the incorrect type of consultation	397	\$14 million	< \$29 million
Excess amount allowed for consultations billed at the wrong level	397	\$364 million	\$304 million to \$424 million
Excess amount allowed for upcoded services	397	\$396 million	\$340 million to \$452 million
Underpayments for downcoded services	397	(\$32 million)	(\$47 million) to (\$17 million)
Amount allowed for undocumented services	397	\$160 million	\$105 million to \$216 million



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

FEB - 7 2006

200 Independence Avenue SW  
Washington, DC 20201

2006 FEB - 7 PM 1:42  
OFFICE OF INSPECTOR  
GENERAL

TO: Daniel R. Levinson  
Inspector General

FROM: Mark B. McClellan, M.D. Ph.D. *Mark McClellan*  
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General's Draft Report: "Consultations in Medicare: Coding and Reimbursement" (OEI-09-02-00030)

Thank you for the opportunity to review and comment on the Office of Inspector General's (OIG) draft report entitled, "Consultations in Medicare: Coding and Reimbursement." We appreciate the OIG's efforts to ensure Medicare's payments for consultation services are appropriate. The report suggests that over \$1.1 billion was improperly paid in 2001 for claims submitted for consultations.

The Centers for Medicare & Medicaid Services (CMS) is committed to paying all claims correctly and has taken several steps to ensure that all claims for medical services, including consultations, are paid appropriately. CMS measures and publishes its Medicare fee-for-service error rate each year through its Comprehensive Error Rate Testing (CERT) program. CMS is pleased to report that this error rate decreased to 5.2 percent in fiscal year 2005.

As a part of CERT, CMS measured an error rate for consultations in FY 2005 that estimates approximately \$500 million spent in error, with the majority of errors being attributed to incorrect coding. This error rate number is half of that measured by the OIG in 2001; however CMS recognizes that consultation services remain a risk for improper payments. CMS will use the CERT program to continue to look for problems in this area and monitor improvements.

Medicare uses the Current Procedural Terminology (CPT) coding system of the American Medical Association (AMA) to identify the services or procedures performed by physicians and practitioners. As described in more detail below, the AMA CPT Editorial Panel has revised the consultation codes for 2006 and CMS is hopeful that this will contribute to reducing incorrect coding errors for these services in the future.

CMS' policy regarding consultation services is in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, Section 30.6.10. The revised policy (issued December 20, 2005 in Transmittal 788) in the manual states that Medicare pays for a reasonable and medically necessary consultation service when the following criteria are met:

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- A consultation service is distinguished from other evaluation and management (E/M) visits because it is provided by a physician or qualified nonphysician practitioner (NPP) whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.
- A request for a consultation from an appropriate source and the need for consultation shall be documented by the consultant in the patient's medical record and included in the requesting physician or qualified NPP's plan of care in the patient's medical record; and after the consultation is provided, the consultant shall prepare a written report of his/her findings and recommendations, which shall be provided to the referring physician.

CMS thanks the OIG for their efforts on this report. These findings provide us with valuable information we can use to help us take action towards our commitment to pay claims correctly. We look forward to working together with you in the future as we address the recommendations in this report.

**Office of Inspector General's Draft Report: "Consultations in Medicare: Coding and Reimbursement" (OEI-09-02-00030)**

OIG Recommendation:

Through its Medicare carriers, CMS should educate physicians and other health care practitioners about the criteria and proper billing for all types and levels of consultations with emphasis on the highest levels and follow-up inpatient consultations.

CMS Response:

We agree with the OIG that additional education would help physicians understand the differences in the consultation criteria from other E/M visit services. Therefore, we are developing a Special Edition article to be published on CMS' website. This article will include the Medicare manual revised policy changes and new coding instructions on a consultation service in addition to the consultation information (deleted codes) from the AMA CPT 2006.

Additional Information:

Effective January 1, 2006 the **Follow-Up Inpatient Consultation** codes (99261 – 99263) are deleted from CPT 2006. There are no longer any distinct follow-up consultation codes to report for follow-up visits to an initial consultation visit. As a result of the changes implemented by AMA CPT, CMS has revised the appropriate section of the Internet Only Manual (Transmittal 788, Change Request 4215, dated December 20, 2005) to address the applicable policy and code changes. The manual issuance is available on the CMS website at [www.cms.hhs.gov/transmittals/2005](http://www.cms.hhs.gov/transmittals/2005). The changes include:

- Beginning in 2006, in the hospital setting, the consulting physician or qualified non-physician practitioner (NPP) should use the appropriate **Initial Inpatient Consultation** code (99251 – 99255) for the initial consultation service and thereafter use the *Subsequent Hospital Care* codes (99231 – 99233) for additional follow-up visits. The Initial Inpatient Consultation may be reported only once, per consultant, per facility stay.
- In the nursing facility setting, the consulting physician or qualified NPP should use the appropriate **Initial Inpatient Consultation** code (99251 – 99255) for the initial consultation service and thereafter use the **Subsequent Nursing Facility (NF) Care** codes (**new CPT codes 99307 – 99310**) for additional follow-up visits. CPT codes 99311 – 99313 are deleted for 2006 and will no longer be valid for Subsequent NF visits beginning in 2006.
- In the office/outpatient setting, the consulting physician or qualified NPP should use the appropriate **Office or Other Outpatient Consultation** code (99241 – 99245) for the initial consultation service and thereafter use the **Office or Other Outpatient Established Patient** codes (99212 – 99215) for additional follow-up visits.

- In the office/outpatient setting, if an additional request for a consultation, regarding the same or a new problem with the same patient, is received from the attending physician or qualified NPP and documented in the medical record, the Office or Other Outpatient Consultation codes may be used again.

AMA CPT 2006 has deleted the **Confirmatory Consultation** codes (99271 – 99275). Beginning in 2006, a consultation initiated by a patient and/or family, and not requested by a physician or qualified NPP, is not reported using the consultation codes. Existing E/M codes for the specific setting are to be used.

Section 30.6.10 in Chapter 12 of the Internet Only Manual publication 100-04 includes an update to reflect the code changes and revisions to the consultation definition, the role of qualified NPPs, the split/shared E/M payment policy, medical record documentation requirements, and consultation examples.



## A C K N O W L E D G M E N T S

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