MEDICARE PHYSICIAN CONSULTATION SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF ANALYSIS AND INSPECTIONS

JUNE 1988

OFFICE OF INSPECTOR GENERAL

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THIS REPORT

This report is entitled, "Medicare Physician Consultation Services." It was conducted to ascertain the effectiveness of HCFA policies and procedures in assuring appropriate Medicare reimbursement for physician consultation services provided to patients in a hospital setting.

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OAI88-02-00650

JUNE 1988

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EXECUTIVE SUMMARY

PURPOSE

The purpose of this study was to ascertain the effectiveness of Health Care Financing Administration (HCFA) policies and procedures in assuring appropriate Medicare reimbursement for physician consultation services provided in a hospital setting.

BACKGROUND

A significant amount of Medicare dollars are spent each year for physician consultations. The HCFA reports $404,943,500 in allowed charges to physicians in 1985 for consultations performed in hospitals.

Some of the concerns articulated by HCFA, Medicare carriers and the OIG were:

- Medicare carriers' policies relating to physician consultations appear to vary and may be contributing to wasteful payments;
- Physicians may be misinterpreting the Medicare definition of a consultation when billing the program for services rendered;
- Some billings for consultations may actually reflect ongoing definitive care instead of an advisory-type consultative service; and
- Some physicians may be misrepresenting the intensity of the service provided when submitting claims (upcoding).

The traditional understanding of a consultation in the medical community has been for physicians to provide advice to each other when the patient's condition is beyond the scope of the treating physician's expertise. The Medicare program has recognized this practice of physicians seeking the opinion and advice of other qualified physicians to assist in the diagnosis and treatment of a patient.

Originally, the only Medicare definition of a consultation was contained in the Medicare Carrier's Manual (MCM). Recently, in an effort to establish uniformity, HCFA developed a new system of nomenclature called the HCFA Common Procedure Coding System (HCPCS), which is based upon the Physicians' Current Procedural Terminology Fourth Edition (CPT-4). This listing also defines a consultation and describes five levels of initial consultations.

Although the CPT-4 and MCM definitions have some similarities, there are also some differences, and neither definition addresses some of the areas of concern.

In order to answer some of the concerns expressed by HCFA, Medicare carriers and the OIG, discussions were held with individuals from 15 Medicare carriers, 12 Medicaid State agencies, 12 hospital administrators and 40 physicians representing various specialties.

A random sample of 204 inpatient consultation claims were reviewed with their corresponding medical record and beneficiary claims history. The medical records were reviewed by a registered nurse to determine whether a consultation was performed and whether the level of intensity claimed was accurate according to the CPT-4 definition.

MAJOR FINDINGS

There is a substantial amount of excessive payment for physician consultations.

- The review of records indicated that $92 million was incorrectly allowed in 1985, resulting in $73.6 million in overpayments. By incorporating our recommended changes, we estimate HCFA could save $73 million a year in the future.

- In 157 (77 percent) of the 204 sample cases, the amount allowed for the consultation was incorrect because the CPT-4 definition was not met or because the consultation was allowed at an incorrect level of intensity.

There is no clear understanding as to what constitutes a physician consultation that is reimbursed by Medicare.

- Fifty-three percent of the physicians were not familiar with the Medicare definition of a physician consultation.

- The definition of consultation varies among respondents.

- Distinguishing between concurrent care and a consultation is confusing.

- Seventy-one percent of the respondents felt that the current five levels of CPT-4 reimbursement overlap.

Marked inconsistency and variability exists in the carriers' administration of physician consultations.

- Carriers range from having no controls to having very tight controls for both initial and follow-up consultations.

- The use of follow-up consultations varies with carriers.

RECOMMENDATIONS

The HCFA should:

- *Develop and promulgate a definition of a consultation that will be comprehensive enough to eliminate the present confusion between the two definitions.*

- *Take measures to insure that carriers effectively convey the definition to the medical community.*

- *Adopt specific reimbursement criteria regarding initial and follow-up consultations.*

- *Require all carriers to use CPT-4 procedure codes for consultations.*

- *Group procedures codes and collapse the number of procedures codes for both initial and follow-up consultations to "brief" and "comprehensive."*

INTRODUCTION

BACKGROUND

A significant amount of Medicare dollars is spent for physician consultations. The Health Care Financing Administration (HCFA) reports $404,943,500 in allowed charges to physicians in 1985 for consultations performed in the hospital.

The Medicare carriers, HCFA and the OIG have articulated a number of concerns about the reimbursement for physician consultations, including the following:

- Medicare carriers' policies relating to physician consultations appear to vary widely and may be contributing to wasteful payments;
- physicians in general may be misinterpreting the Medicare definition of a consultation when billing the program for services rendered;
- some billings for consultations may actually reflect ongoing definitive care instead of an advisory-type consultative service;
- some physicians are being reimbursed for certain consultation services that should be included in their global fees for surgery;
- some physicians may be misrepresenting the intensity of the service provided when submitting claims (upcoding);
- some routine medical examinations performed prior to surgery (preoperative clearance) may be billed improperly as consultations;
- some pathologists may be billing for consultations when the services provided are actually evaluations of routine laboratory studies;
- some physicians may be billing for consultations when the services provided are orders for specific procedures, such as biopsies;
- prior medical services by the same physician to the same patient may be present in a high percentage of cases.

The traditional understanding of a consultation in the medical community has been for physicians to provide advice to each other when the patient's condition is beyond the scope of the treating physician's expertise. For example, a patient admitted to the hospital by a family practitioner with a right-sided paresis and lack of speech may need a con-

sultation by a neurologist to give advice to the admitting physician on a definitive diagnosis and treatment, or a patient admitted by an orthopedist for hip surgery could develop chest pains and require a consultation by a cardiologist.

The Medicare program has recognized this practice of physicians seeking the opinion and advice of other qualified physicians to assist in the diagnosis and treatment of a patient. This opinion may be requested by one physician of another from more than 80 specialties recognized by the American Medical Association (AMA). Originally, the only Medicare definition of a consultation was contained in the Medicare Carrier's Manual (MCM), Section 2020D, which defines a consultation as:

> *A professional service furnished by a second physician or consultant at the request of the attending physician. Such a consultation includes the history and examination of the patient as well as the written report, which is furnished to the attending physician for inclusion in the patient's medical record.*

Additionally, Section 4142 of the MCM states:

> *The attending physician may remove himself from the claim and turn the patient over to the person who performed a consultation service. In this situation, the initial examination would be a consultation if the requirements in 2020D were met at that time.*

Recently, in an effort to establish uniformity, HCFA developed a new system of nomenclature called the HCFA Common Procedure Coding System (HCPCS), based upon the Physicians' Current Procedural Terminology Fourth Edition (CPT-4). This listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians, published by the American Medical Association, also defines a consultation as:

> *Services rendered by a physician whose opinion or advice is requested by a physician or other appropriate source for further evaluation and/or management of the patient. When the consulting physician assumes responsibility for the continuing care of the patient, any subsequent service rendered by him will cease to be a consultation. A consultant is expected to render an opinion and/or advice only. If he subsequently assumes responsibility for a portion of patient management, he will be rendering concurrent care. If he has the case transferred or referred to him, he should then use the appropriate codes for services rendered on and subsequent to the date of transfer.*

Five levels of initial consultation are recognized by CPT-4: *limited, intermediate, extended, comprehensive and complex.* These are described in Appendix A. As discussed later in this report, these descriptions may be overlapping and confusing. The amount reimbursed for each level ranges from carrier to carrier. As an example, the reimbursement for an initial consultation by one carrier in the study ranges from $85.00 for a

limited consultation to $125.00 for a complex consultation, with the other levels somewhere in between.

Although the CPT-4 and MCM definitions might appear similar, the following chart reflects some subtle differences.

DIFFERENT FACTORS ADDRESSED BY THE DEFINITIONS

	CPT-4	MCM
Request by Attending for a Consultation	*No*	*Yes*
Request by Physician or Other Source	*Yes*	*No*
History, Examination Done & Written Report to be Completed by Consultant	*No*	*Yes*
Advice or Opinion from Consultant	*Yes*	*No*
When Consultant Assumes Care, Ceases to be a Consultation	*Yes*	*No*
Consultation Only When Attending Removes Himself	*No*	*Yes*
Levels (intensity) of Care Specified	*Yes*	*No*

The following factors are not addressed by either definition:

- prior patient encounters with the consultant;
- the time lapse between consultations; and
- whether the same or new diagnosis creates a new consultation.

ISSUES

This study set out to answer the following key questions:

- *Do varied definitions of physician consultations and their interpretations contribute to inappropriate Medicare reimbursement and related problems?*
- *Do hospital, HCFA and/or carrier policies and procedures contribute to inappropriate reimbursement for physician consultations?*
- *How effective are existing controls to assure proper reimbursement?*

METHODOLOGY

Discussions were held with those who provide the service and those who reimburse it. Fifteen carriers were contacted by either telephone (8) or in person (7). Individuals from their Medicare offices, medical staff and private business departments were interviewed to obtain their perceptions. Twelve hospitals were visited, and discussions held with hospital administrative staff as well as with 40 physicians representing different specialties. Several medical assistants or billing clerks of the physicians interviewed were contacted by telephone.

Medicaid State agencies in the 12 sample States were contacted by telephone to obtain information on their physician consultation policies and procedures. Meetings were also held with medical society representatives and the Peer Review Organizations (PROs).

A random sample of 204 consultation claims processed by 13 carriers (who represent 70 percent of all inpatient consultation charges reported to HCFA's BMAD system) in 1985 was selected for review. The claims were for consultations provided in 88 hospitals in 12 States (one State has two carriers). One of the largest carriers in the country was not included in the sample because it was not using HCPCS procedure codes for consultations. Hospital records and carrier Part B claims histories (all physician services billed to Medicare in 1985) were requested to correspond with each of the 204 claims. The records were reviewed by a registered nurse to determine whether a consultation was performed and whether the level of intensity claimed was accurate according to the CPT-4 definition. No determination as to medical necessity was made as part of the review. The Part B claims histories for each of the patients in the sample were reviewed to see if there were prior, subsequent and same-day services by the physician who billed for the consultation in the sample.

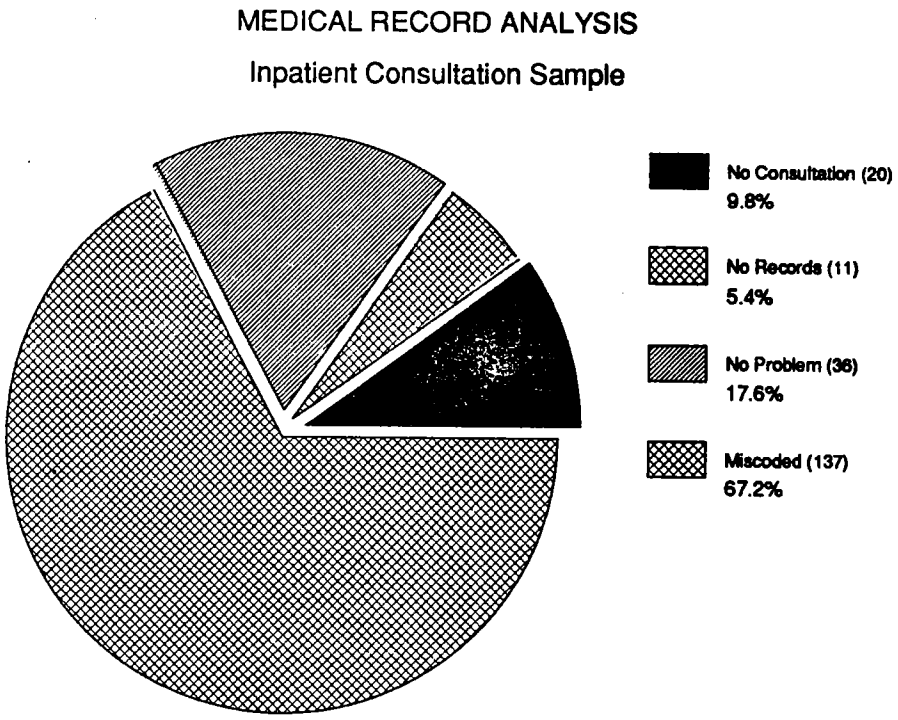
FINDINGS

There is a substantial amount of excessive payment for Physician Consultations

The review of records indicated that $92 million was incorrectly allowed in 1985 for physician consultations performed in the hospital. This resulted in $73.6 million in overpayments (Appendix B).

The records review indicated the following:

a) In 157 of the 204 sample cases, the amount allowed for the consultation was incorrect either because the CPT-4 definition for a consultation was not met, or because the consultation was allowed at an incorrect level of intensity.



1) In 20 (9.8 percent) of the 204 sample cases, the CPT-4 definition of a consultation was not met.

The physicians in 20 cases mentioned above were providing medical care rather than consultative services as defined in the CPT-4. In some of these cases, there were no consultation reports in the record, but only documentation of performed medical procedures such as an electrocardiogram (EKG) or bronchoscopy.

Similarly, claims for consultations by pathologists were actually for interpretation of routine laboratory findings. In other cases, the physicians provided a medical service such as emergency care or a history and physical examination.

2) In 137 (67.2 percent) of 204 sample cases,the documentation failed to support the level of intensity that was billed by the consultant.

Illustrative of this is a case where an internist billed for a complex consultation on a patient scheduled for a bunionectomy. The documentation in the medical record did not show the required "in-depth evaluation of a critical problem requiring unusual knowledge, skill and judgment on the part of the consulting physician." Another case involved a 75-year-old patient admitted for anemia who had a complex hematology consultation billed. A review of the medical record revealed a brief note by the hematologist recommending a bone marrow examination, which was done and also billed by the consultant on the same day.

b) In 36 (17.6 percent) of the 204 sample cases, the consultation service was correctly claimed; half of these were billed at the lowest (or limited level) and a quarter at the comprehensive level.

In the remaining 11 (5.4 percent) sample cases, the hospitals did not supply sufficient information for a determination to be made concerning the validity of the consultation claim.

c) The sample indicated that 82 percent of the consultants saw the patient more than once during the hospital stay. Typically the consultant may have provided the initial advice and opinion to the attending, but also continued to provide care throughout the patient's entire hospital stay. In one case, the consultant saw a patient daily for the entire 13-day stay, wrote orders, dictated the discharge summary and charged for a consultation for each visit.

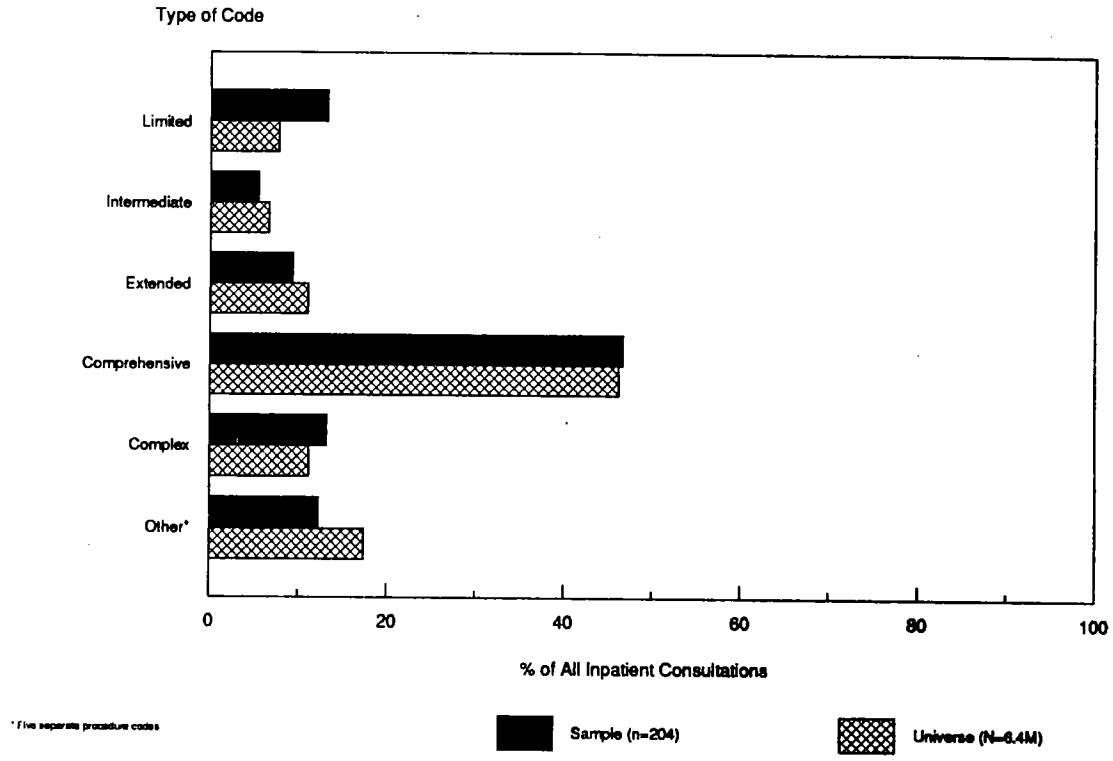
d) The beneficiary history indicated that 26 percent of the physicians in the sample had seen and treated the patient prior to this hospital stay.

On several occasions the consultant indicated in the medical record that patient is "known to me or group." In some instances, the consultant was the admitting physician or the physician of record.

g) The array of procedure codes in the sample shows physicians billed 99 percent of consultations for three reimbursement levels; 47 percent for comprehensive and 26 percent each for limited and complex.

PHYSICIAN CONSULTATIONS

Distribution by Procedure Code



There is no clear understanding as to what constitutes a Physician Consultation that is reimbursed by Medicare

The results of the record review are not surprising in light of the responses to questions about perceived definitions, such as: "What is your understanding of the Medicare definition of a consultation?"

a) Most physicians know only their own traditional definition.

Twenty-one of the 40 physician respondents (53 percent) were not familiar with the Medicare definitions of a physician consultation. They gave varied answers as to what they believed to be the definition ranging from any first encounter with a patient to a "one shot deal" for advice and opinion. Our sample indicated that 82 percent of the beneficiaries were actually seen more than once by the consultant. When asked what factors cause them to request a consultation, 67 percent of the

physicians gave as the primary reasons: "advice and opinion," "better care of my patient," "for my expertise," or "for expertise I don't have." Although most physicians gave malpractice as a reason, only 19 percent saw it as the primary reason.

b) Other respondents use a variety of definitions.

Some Medicare carriers used the CPT-4 definition, some used the MCM definition and still others used a combination of both. One carrier defined a consultation as "a service rendered by a highly skilled professional advisor whose opinion or advice is requested by the attending physician in the diagnostic evaluation and/or treatment of a patient."

While Medicaid definitions varied from State to State, they all required a request for an opinion or advice. Two of the 12 States said the consultant must be a specialist; some States used the CPT-4 definition.

One State's workers compensation agency developed a definition for a consultation which closely follows CPT-4, but also includes the following requirements: it must be a service rendered by a specialist; it must seek further evaluation or opinion on how to proceed in the management of a patient's illness; the service must be diagnostic; and treatment by the consultant cannot be involved.

Most private insurer respondents said their policies often do not reimburse consultations, but when consultations are a reimbursable service they use the CPT-4 definition. One said: "A consultation is only for opinion and advice to develop and recommend treatment."

Almost all respondents, including physicians, distinguished a consultation from a referral. Most saw a referral as sending a patient to another physician, usually a specialist, for treatment rather than advice or opinion. Some felt a referral only occurred when the referring physician surrendered care to the consultant. Some felt the first visit would always be a consultation; others thought the first visit for a referral should be considered an initial medical visit.

c) Concurrent care: another area of confusion.

The difference between a consultation and concurrent care also appears to be unclear to many. One carrier's medical advisor said, "It's muddy water! Concurrent care is asking for a consultant to assist in the management of a patient. It's difficult to accept concurrent care without an initial consultation to determine if concurrent care is appropriate." Another carrier's medical advisor described a consultation as a one-time identifiable service, with concurrent care occurring when another physician is actually providing treatment. Many respondents felt that concurrent care started after an initial consultation; others felt that the first

visit should be an initial visit when a second or third physician is providing both diagnosis and treatment concurrently, usually for a different diagnosis.

d) The five levels of CPT-4 reimbursement are overlapping.

All but three carriers nationally were using CPT-4 initial consultation procedure codes. Most of the sample carriers were allowing physicians to submit claims using all five of the levels of initial consultations described in the CPT-4 (Appendix A), although some were paying at only three levels.

Seventy-one percent of the respondents did not like the current five levels of care and felt that two or three levels would be more appropriate. Many physician, carrier and Medicaid respondents felt it was difficult to decide where one level ends and another begins. They also indicated that the definitions of the levels are overlapping, somewhat redundant and create an opportunity for "gaming the system."

Marked inconsistency and variability exists in the carriers' administration of Physician Consultations

a) Carriers range from having no controls to having very tight controls for both initial and
follow-up consultations.

HCFA does not require any prepayment screens for physician consultations. Such screens are left to each carrier's discretion. The experience in the sample ranged from some carriers having no screens and perceiving no problems to one carrier who allows one initial consultation per physician per year and two follow-up consultations within 30 days. After that the service becomes a hospital visit and must meet concurrent care screens (see Appendix C).

b) The use of follow-up consultations varies with carriers.

The CPT-4 defines a follow-up consultation as a consultant's reevaluation of a patient on whom he has previously rendered opinion or advice. It provides for no patient management or treatment and describes four levels of follow-up consultations.

Ten of the sample carriers use follow-up consultation codes and five do not. Some do not pay for follow-up consultations; others pay for an unlimited number. When respondents were asked to define a follow-up consultation, their answers ranged from "continuation of an initial consultation" to "any consultation after the first one."

The beneficiary claims histories revealed that 56 percent of the physicians provided medical service subsequent to the hospital stay. Of that 56 percent, 63 percent provided ongoing medical treatment, 20 percent performed procedures and 16 percent provided follow-up consultations.

Eleven of the 15 sample carriers paid for both diagnostic and therapeutic care in addition to a consultation.

Some of the sample carriers include follow-up consultation codes in their concurrent care screens, but most do not.

While there was concern that routine preoperative clearance was a problem, the views of respondents and the results of the medical review both indicate that this is not a significant problem area. Preoperative clearance is a consultation performed prior to surgery to make sure a patient's condition is stable enough to safely undergo the surgery. Hospital administrators revealed no hospital policies requiring routine preoperative consultations. Seven percent of the sample consultations were performed for preoperative clearance and appeared to have supporting documentation. Most respondents said that preoperative consultations, when done, were necessary. One record revealed a consultation performed by a cardiologist in which the surgery was not performed because of the changes revealed in the patient's EKG and because of his unstable condition. Thus, the consultation prevented surgery from being performed that might have compromised the patient.

No new information relating to physician consultations has been disseminated to carriers by HCFA recently. The last issuance was MCM Section 5248 (March 1986), which discusses making reasonable charge determinations for a consultation plus surgery when physicians previously billed global charges for surgery. All of the carriers contacted were aware of this manual section. Most have always paid for a consultation with surgery and thus did not have to make any changes.

RECOMMENDATIONS

The following recommendations were presented to HCFA in the draft report.

1. **Develop and promulgate a definition of a consultation that will be comprehensive enough to eliminate the present confusion between the two definitions. Both definitions should be identical and include the following points:**

   a. Who may request a consultation?
   b. Should a physical examination of the patient always be required?
   c. Is a consultation always for advice and opinion?
   d. Must a consultation be for diagnosis only, or for diagnosis and treatment?
   e. Must a written report always be promulgated?
   f. How should a consultation be distinguished from a referral?
   g. How should a consultation be distinguished from concurrent care?
   h. Should a prior patient/physician relationship remove a patient encounter from the realm of a consultation?
   i. What is the time lapse between initial consultations?
   j. Must a consultation be performed by a specialist?

   HCFA Comment
   We agree that it would be helpful in administering the Medicare program if the Medicare Carriers Manual (MCM) and the CPT-4 definitions of a physician consultation were the same or at least more consistent with one another. In view of the recent enactment of section 4055(a)(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1987, calling for the Secretary to develop (in consultation with appropriate national medical specialty societies) uniform definitions of physicians' services (including consultations), we intend to contribute in every way possible to the Department's completion of that project by July 1, 1989, as mandated by the Congress. We also intend to present this issue to the CPT-4 Editorial Panel for their consideration. We would also point out that we have developed criteria for carriers to assist them in reviewing claims for clinical pathology consultations. (See section 8313.1(c) of the MCM.)

2. **Take measures to insure that carriers effectively convey the definition to the medical community.**

   HCFA Comment
   We are in the process of developing a mandated medical review screen for consultations. More uniform definitions and reimbursement policy will be an outgrowth of the educational work we will be doing with our carriers and they, in turn, will do with the medical community. We anticipate completing this educational effort in early 1989.

3. **Adopt specific reimbursement criteria regarding initial and follow-up consultations.**

HCFA Comment
We disagree with adopting specific reimbursement criteria regarding initial and follow-up consultation. We believe it is within the carrier's discretion to develop criteria regarding initial and follow-up consultations depending on local prevailing practices. Therefore, we plan to limit our immediate activity to ensuring that each carrier follows its existing policy.

4. **Require all carriers to use CPT-4 procedure codes for consultations.**

HCFA Comment
We are reviewing those Medicare carriers that are still using local procedures codes for physician consultations instead of the CPT-4 codes. We will permit continued use of local codes only if there is a compelling need.

5. **Support the Omnibus Budget Reconciliation Act (OBRA) of 1986 (Public Law 99-509) which calls for the collapsing of procedure codes. Collapse the number of procedure codes for both initial and follow-up consultations to brief and comprehensive.**

HCFA Comment
We agree that the collapse of the number of procedures codes may be desirable. We are considering this as part of our review of HCPCS codes as required by OBRA 1986, section 9331(d).

APPENDIX A

LEVELS OF CONSULTATION

A. In a *limited* consultation (90600) the physician confines his service to the examination or evaluation of a single organ system. This procedure includes documentation of the complaint(s), present illness, pertinent examination, review of medical data and establishment of a plan of management relating to the specific problem. An example might be a dermatological opinion about an uncomplicated skin lesion.

B. An *intermediate* consultation (90605) involves examination or evaluation of an organ system, a partial review of the general history, recommendations and preparation of a report. An example would be the evaluation of abdomen for possible surgery that does not proceed to surgery.

C. An *extended* consultation (90610) involves the evaluation of problems that do not require a comprehensive evaluation of the patient as a whole. This procedure includes the documentation of a history of the chief complaint(s), past medical history and pertinent physical examination, review and evaluation of the past medical data establishment of a plan of investigative and/or therapeutic management, and the preparation of an appropriate report. For example: the examination of a cardiac patient who needs assessment before undergoing a major surgical procedure and/or general anesthesia.

D. A *comprehensive* consultation (90620) involves an in-depth evaluation of a patient with a problem requiring the development and documentation of medical data (the chief complaints, present illness, family history, past medical history, personal history, system review and physical examination, review of all diagnostic tests and procedures that have previously been done), the establishment or verification of a plan for further investigative and/or therapeutic management and the preparation of a report. For example: young person with fever, arthritis and anemia; or a comprehensive psychiatric consultation that may include a detailed present illness history, and past history, a mental status examination, exchange of information with primary physician or nursing personnel of family members and other informants and preparation of a report with recommendations.

E. A *complex* consultation (90630) is an uncommonly performed service that involves an in-depth evaluation of a critical problem that requires unusual knowledge, skill and judgment on the part of the consulting physician, and the preparation of a report. An example would be acute myocardial infarction with major complications. Another example would be a young psychotic adult, unresponsive to extensive treatment effort, who is under consideration for residential care.

APPENDIX B

METHODOLOGY FOR ESTIMATING SAVINGS

The variance of the estimate was calculated by the following formula (for ratio estimates):

$$\text{Variance} = \frac{\Sigma(x-ry)2}{n-1}$$
$$= 593.204$$

Where x is the amount originally allowed,
r is the average error rate observed in the sample (0.198),
y is the amount allowed in error, and
n is the total number of cases in the sample (204).

NOTE: Although 11 cases were eliminated from the sample because we were unable to obtain sufficient records from the hospitals, these 11 cases were considered in computing the variance to arrive at the most conservative cost-savings estimate.

The standard error of the estimate was calculated by the following formula:

$$\text{Standard error} = \frac{\sqrt{\frac{\text{Variance}}{n}}}{\bar{x}}$$
$$= 0.022$$

Where $\bar{x}$ is the average amount allowed.

The lower and upper ranges of the 90 percent confidence interval (CI) are 16.1 percent and 23.5 percent, respectively. Precision is 18.7 percent, a reflection of the variability in the errors, of the fact that both over and underpayments were made.

Projections were made by applying these percentages to the total allowed charges for in-patient consultations for the 13 carriers in our sample:

Estimate = $ 64,809,000
$ 52,698,000 = *Lower limit, 90% CI*
$ 76,920,000 = *Upper limit, 90% CI*

The total allowed charges for inpatient consultation for those 13 carriers was $282,420,700.

These carriers represented 70 percent of all charges for inpatient consultations for 1985. If we assume that the remaining 30 percent resembles the majority, projections of amounts allowed in error may be:

Estimate = $ 92,864,000
$ 75,510,000 = *Lower limit, 90 % CI*
$110,217,000 = *Upper limit, 90 % CI*

APPENDIX C

CARRIER CONTROLS

Carrier A Pay for place of service; two levels of care: Routine and Comprehensive. Claims must have name and address of referring physician and statement report must be available. If not, then paid as regular medical care. Comprehensive code requires specialty number. Not all specialties are paid for comprehensive consultation. Must have at least three body systems involved for consultation to be comprehensive. If not, reduced to medical care. More than 2 visits within 60 days, consult is not paid. It is reduced to medical care.

Carrier B Two consults per physician per patient, per diagnosis per hospital admission.

Carrier C One initial consultation within 30 days. Evidence of prior medical care will reduce payment. Medical visit and consultation on the same day will be denied. The level of care will be reduced to the lowest level if code is unspecified on claim. Subsequent medical care is reduced to medical care.

Carrier D NONE, although the second visit after consultation is paid as medical care.

Carrier E Concurrent care screen for follow-up consultations. Attendings and specialists: they look at diagnosis of specialties and allow five follow-up visits for same specialty. For different specialty, allow consult plus 10 follow-up visits. 90620 and 90630 require documentation. Use 5 levels of care and pay at 3 levels: 90600-90605, 90610, 90620-90630.

Carrier F One per month, not to exceed 2 in 3 months. If more, then it is reviewed. Allow 7 follow-up visits per hospital stay. After that, consultant assumes care or is a referral.

Carrier G None specific to consultations, but general controls include 2 medical care claims for same date; 3 visits in 3 months; medical care within 3 days of surgery.

Carrier H One inpatient consultation per 30 days.

Carrier I Will suspend consult within 3 days ofcomprehensive visit or more than 1 consultation claim in 30 days. No inpatient consult by surgeon if surgery done. Follow-up consultation visits paid as medical visits.

Carrier J 90630 must have attachment; more than 1 hospital consultation with same specialty in 1 month is not paid.

Carrier K	1) Routine hospital visits are not paid on same day as consultation; 2) Surgery with consultation within 7 days is not paid; 3) Initial office is not paid on same day as consultation; 4) Radiology is not paid when done with radiological procedure; 5) Level of service is reduced if second consultation is done within 60 days.
Carrier L	1) Suspend concurrent care; 2) Multiple consultations within 3 months; 3) After 10 follow-up visits, visit is reduced to medical care.
Carrier M	1) One initial consultation per year per patient; 2) Follow-up consultation only in hospital andlimited to 2 per 30 days.
Carrier N	One initial consultation plus 2 follow-up visits. The fourth hits the concurrent care screens.
Carrier O	None now. They are looking to downcode after first initial consultation.

APPENDIX D

HCFA COMMENTS ON METHODOLOGY

We are concerned that the subject study might be flawed because it is designed to focus on physician consultations performed in hospitals, while the use of the nine CPT-4 codes for initial and follow-up consultations referred to in the study is not restricted to the hospital setting. According to the American Medical Association, these nine codes may also be used for consultations furnished in a physician's office.

Another concern is that the sampling methodology is not described in enough detail so that it can be determined whether the 204 cases from 13 carriers is a valid sample since the universe is not indicated. Also the projection of a $73.6 million overpayment based on such a small sample seems questionable.

We also are concerned about the qualification of the reviewers who performed the OIG study because a physician was not on the review team. We question whether a nurse is qualified to say what level of consultation was performed.

In the 20 cases in which services provided did not meet the CPT-4 definition of consultation, the claiming of these costs as savings may be questionable as the services may be reimbursable under other CPT-4 codes.

Finally, we note no attempt was made to represent the review findings to the respective carrier staffs to obtain their reaction/comments to these findings. It might be that the reviewers' decisions may have been questionable with respect to some of the claims reviewed.

OIG RESPONSE

1. It is true that consultations are performed in many settings, but the largest portion of the charges (about 74 percent, according to carrier reporting through BMAD) are performed in inpatient hospitals. In conducting this study, we matched all of the Part B sample claims for consultations to Part A hospitalization records, thereby restricting our review to those consultations performed in an inpatient hospital. All monetary projections are based on that portion of the total allowed charges which can be attributed to consultations performed in inpatient settings only.

2. The 204 cases that make up the sample for this study were selected at random from the BMAD beneficiary file, based on the terminal digits of the HICNs. This method is the same method that HCFA uses to create the BMAD sample and various other samples used by its Bureau of Data Management and Strategy and

the Office of the Actuary. The validity of a projection is not dependent on the size of the sample, but rather on the method of selecting cases and the inherent variation of the data being sampled. In keeping with this thinking, we selected a strict random sample and established confidence intervals for all our point estimates.

We agree, however, that the total amount of allowed charges for consultations in inpatient hospitals (the base on which all projections were made) should be included in Appendix B. Although this total can be calculated from the information given in the appendix, projections are easier to understand. We have amended the appendix according to your suggestion.

3. We are satisfied that the use of a Registered Nurse for the purpose of this case review, to determine the level of a consultation, was appropriate. Certainly, if attempts had been made to make judgments as to medical necessity, we would have arranged for the physician support.

4. In those cases where another service (rather than a consultation) should have been billed, we adjusted the potential savings by the allowed amount for the other service. In all cases, we used the reasonable charge for the correct service for the locality and specialty indicated on the original claim to make the adjustment. In some cases, the adjusted amount was actually higher than that billed for the consultation. The composite effect, however, was a net overpayment, which resulted in our projected savings.