A brand new year has begun, and that, as usual, means brand new surprises from our friends at the Centers for Medicare and Medicaid Services.

This year’s big surprise: The CMS has decided that it will no longer pay for consultations in either outpatient (99241-99245) or inpatient (99251-99255) settings.

This decree has caused a great deal of protest, particularly from specialists who depend on consultations for most of their income. After all, we specialists should be appropriately compensated for the special expertise we provide.

It is hard to envision how eliminating consultation payments could be anything but detrimental to patient care. At the least, consulting physicians might feel less inclined to provide reports to referring physicians, which would substantially hurt coordination of care at a time when policymakers continue to place a premium on teamwork.

Further objections abound; nevertheless, the decision has been made, and adjustments must be taken to accommodate it.

For outpatient visits, the CMS expects consultation codes to be replaced with new or established visit codes (that is, 99201-99205 or 99212-99215). They have increased relative value units for those visit codes by 6% to soften the blow, but the difference will be substantially noticeable if a lot of consultations were billed last year.

On the inpatient side, admission codes (99221-99225) are to be used in lieu of consultation codes. The “true” admitting physician will use a new modifier (not yet published at press time) along with the admit code, while all consulting physicians will use the admit code unmodified. Physicians performing a lot of inpatient consultations should anticipate denials, appeals, and confusion as admitting physicians and consultants alike adjust to this change.

As usual, some commercial insurers will follow the CMS lead, while others will continue recognizing the consultation codes (which remain in the 2010 CPT book). This means a decision will need to be made about whether to continue billing consultations for non-Medicare patients whose insurers continue to pay for them. If this route is chosen, Medicare will provide secondary coverage, and will, of course, not pay its portion. So this situation needs to be recognized in advance.

It is probably worth reviewing some past explanation of benefits to determine how Medicare is a secondary payer, and whether any extra revenue will be worth the extra vigilance and work involved.

Discussions on this issue have been widespread and heated, and opinions vary widely. Some specialists contend that they actually welcome the change because they will no longer need to worry about complying with the agency’s confusing and ever-changing consultation rules.

Others are understandably concerned about a potentially significant loss of income. Do not be tempt ed, however, to bill for more services. The CMS is well aware of that tendency (they even have a name for it: “code creep”).

If billing patterns change significantly, an audit can be expected; increased billings must be proved to be medically necessary, not compensatory revenue generation. If increased billings cannot be proved to be medically necessary, abuse or fraud charges will come.

In an audit, remember, everyone is guilty until proven innocent.

Billing patients directly for consultations has been proposed as a way to recover lost revenue. If consultants are no longer covered by the CMS, then physicians have reason to think that they should be able to use a “noncovered service” code (such as 99199-GA) and have Medicare patients sign an Advance Beneficiary Notice (ABN).

This signifies their understanding that Medicare will not pay for the service, the same procedure used for noncovered cosmetic services. It is not clear, however, if this is permissible by the CMS.

Another proposed counterstrategy is to bill Medicare for a new patient visit and add a “surcharge” for consultative care that is billed directly to the patient (again using a National Supplier Clearinghouse (NCS) code and an ABN). This would be considered a “priority service,” analogous to “conierge services” offered by some internists. No one knows whether the CMS (or the patients) would go along with this option, either.

Even proponents of such strategies admit that they are relative and untested; I would not advise attempting them without a careful legal review with an experienced health care attorney.

No matter how individuals choose to deal with the loss of consultation codes, I believe physicians should continue sending reports to referring physicians even though they will not specifically be paid for them. Doctors will continue to work for the good of their patients. I have no doubt that the new system will be interpreted as punitive and counterproductive.

Emphasize that the decision about what to do should be a thoughtful one. An educational specialist, psychologist, or psychiatrist experienced in school placements can make recommendations based on cost, structure, goals, program duration, and professional support.

As a physician, it’s important that you are confident that any potential school or campus has enough professional expertise to ensure the teen’s physical safety and emotional well being.

The long-term goal is for a teenager to establish a firm sense of self. Treatment should continue when teenagers return home and include family therapy that allows for rebuilding of trust and accommodation of revised perceptions of the teen’s new reality.

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