Commercial Reimbursement Policy

Subject: Documentation and Reporting Guidelines for Consultation

Policy Number: C-09010  Policy Section: Evaluation and Management

Last Approval Date: 04/06/2018  Effective Date: 04/06/2018

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member’s Anthem Blue Cross and Blue Shield (Anthem) benefit plan. The determination that a service, procedure, item, etc. is covered under a member’s benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member’s state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or Revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and non-participating providers and facilities. This reimbursement policy also applies to Employer Group Retiree Medicare Advantage programs.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim
- Recover and/or recoup claim payment

These policies may be superseded by provider or State contract language, or State, Federal requirements or mandates.

We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. Anthem reserves the right to review and revise its policies periodically when necessary. When there is an update we will publish the most current policy to the website.

Policy

Anthem allows reimbursement for consultation services when a physician or other appropriate source is seeking advice, opinion, recommendation, suggestion, direction, counsel, etc. from another physician (usually a specialist) or other qualified health care professional in evaluating or treating a patient because the consulting healthcare provider has expertise in a specific medical area beyond the requesting professional’s knowledge.

In addition to physicians, Anthem considers the following “appropriate sources” eligible to request consultations: physician assistant, nurse practitioner, doctor of chiropractic, physical therapist, occupational therapist, speech-language pathologist, psychologist, social worker, lawyer, or insurance company.

I. Types of Consultations

CPT consultation codes are divided into two sections based on place of service:

A. Office or Other Outpatient Consultations:

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Office or other outpatient consultations are reported with CPT codes (99241-99245) with no distinction between new and established patients.

B. Inpatient Consultations:
Inpatient consultations are reported with CPT codes (99251-99255) with no distinction between new and established patients.

II. Consultation Coding and Documentation Guidelines
The Health Plan requires that providers document and report both outpatient and inpatient consultation services using the key components, along with contributory factors (counseling and coordination of care, nature of the present problem, and time) are used to determine the level of consultation to report.

III. Transfer of Care
After a transfer of care, the requesting physician or other qualified health care professional will no longer provide care for the specific condition for which care was transferred, but may continue providing care for other conditions when appropriate.

A physician or other qualified health care professional who has agreed to accept transfer of care prior to an initial evaluation should not report consultation codes to Anthem. In such cases, the receiving physician or other qualified health care professional should report the appropriate new or established patient visit code according to the place of service.

If the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service, then it would be appropriate to bill a consultation code.

IV. Initial and Follow-Up Consultation Services
A. Initial Consultation:

1. In the office or outpatient setting, the consultant should use the appropriate office or outpatient consultation CPT codes (99241-99245) for the initial consultation service only.

2. In the hospital and nursing facility setting, the consulting physician or other qualified health care professional shall use the appropriate inpatient consultation CPT codes (99251-99255) for the initial consultation service. The initial inpatient consultation is reported only once per consultant per patient per facility admission.

3. A consulting physician or other qualified health care professional may initiate diagnostic services and treatment at the initial consultation service or may even take over the patient’s care after the initial consultation.
B. Follow-up Services:

1. Ongoing management, following the initial consultation service by the consulting physician or other qualified health care professional should not be reported with consultation service codes.

These services need to be reported as subsequent visits with the appropriate place of service and level of service.

   a. In the outpatient setting, following the initial consultation service, the office or outpatient established patient CPT codes (99212-99215) should be reported for additional follow-up visits.

   b. In the hospital setting, following the initial consultation service, the subsequent hospital care CPT codes (99231-99233) should be reported for additional follow-up visits. In the nursing facility setting, following the initial consultation service, the subsequent nursing facility care CPT codes (99307-99310) should be reported for additional follow-up visits.

2. If an additional request for an opinion regarding the same or new problem for the same patient is received from the same or another physician or other appropriate source and documented in the medical record, the appropriate consultation CPT code may be used again based on the place of service. However, when the consultant continues to care for the patient after any initial consultation service, such follow-up services must be reported with the appropriate follow-up Evaluation and Management (E&M) code.

V. Second Opinion

Anthem requires that a second opinion E&M service requested by a patient and/or family member and performed in the office or other outpatient setting to be reported using the appropriate office or other outpatient new or established patient E&M code and not a consultation code.

In both the inpatient hospital setting and nursing facility setting, a request for a second opinion is usually made by the attending physician or other qualified health care professional and may be reported using a consultation code.

VI. Consultations Requested by Members of Same Group Practice

In the event that one provider requests a consultation from another provider in the same group practice, consultation codes may be reported when the consulting provider has expertise in a specific medical area beyond the requesting provider’s knowledge. Consultations should not be reported on every patient as a routine practice when providers refer patients to each other within a group practice setting.
VII. Consultation for Preoperative Clearance and Postoperative Evaluation

A. Preoperative consultations for new and established patients performed by any physician or other qualified health care professional at the request of a surgeon may be reported with consultation codes, as long as all the requirements for performing and reporting the consultation codes are met and the service is medically necessary and not a routine screening.

B. A physician (primary care or specialist) or other qualified health care professional who performs a postoperative evaluation of a new or established patient at the request of the surgeon may report a consultation code for the E&M service furnished during the postoperative period when all the criteria for the use of the consultation codes are met, and the consulting physician or other qualified health care professional has not performed a preoperative consultation.

C. In the inpatient setting, a physician or other qualified health care professional who has performed a preoperative consultation and assumes responsibility for the management of a portion or all of the patient’s condition(s) during the postoperative period should use the appropriate level of subsequent hospital care codes for E&M services provided. In the outpatient setting, the appropriate level of E&M established patient visit codes are to be used during the postoperative period when the same consulting physician or other qualified health care professional performed a preoperative consultation.

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Comment</th>
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<tbody>
<tr>
<td>99212-99215</td>
<td>E&amp;M Established Patient</td>
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<tr>
<td>99231-99233</td>
<td>Subsequent Hospital Care</td>
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<tr>
<td>99241-99245</td>
<td>Office or Other Outpatient Consultation</td>
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<tr>
<td>99251-99255</td>
<td>Inpatient Consultation</td>
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<tr>
<td>99307-99310</td>
<td>Subsequent Nursing Facility Care</td>
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Exemptions

There are no exemptions to this policy.

Policy History

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<tr>
<th>Date</th>
<th>Description</th>
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<tbody>
<tr>
<td>06/01/19</td>
<td>New policy template; removed description section and added definition section</td>
</tr>
<tr>
<td>04/06/2018</td>
<td>Biennial review approved: Policy language updated; removed examples</td>
</tr>
<tr>
<td>10/04/2016</td>
<td>Annual review: Minor language updates without changes to the policy criteria</td>
</tr>
<tr>
<td>09/01/2015</td>
<td>Annual review approved: No changes to the policy language</td>
</tr>
<tr>
<td>09/02/2014</td>
<td>Annual review approved: Updated policy language; grammatical errors; removed CMS language regarding consultation</td>
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References and Research Materials


Definitions

| Consultation | Type of evaluation and management (E&M) service provided by a physician or other qualified health care professional whose opinion or advice regarding a specific clinical problem is requested by another physician or other appropriate source. |
| Transfer of care | Process whereby a physician or other qualified health care professional who is providing management for some or all of a patient’s problems relinquishes this responsibility to another physician or other qualified health care professional who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services. |

Related Policies and Materials

- Documentation and Reporting Guidelines for Evaluation and Management Services
- Evaluation and Management and Related Modifiers 25 and 57

Use of Reimbursement Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member’s benefits on the date of service. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.

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