Payment Policy: Consultation Services

Reference Number: NH.PP.10
Product Types: New Hampshire Medicaid
Effective Date: 10/01/2019
Last Review Date: n/a

Coding Implications
Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Policy Overview
The purpose of this policy is to define payment criteria for consultation services to be used in making payment decisions and administering benefits.

Application
Physician and other qualified health professionals that perform consultation services.

Policy Description
The American Medical Association (AMA) Current Procedural Terminology (CPT ®) book describes a consultation as a type of evaluation and management service provided at the request of another physician or appropriate source to either recommend care for a specific condition or problem, or to determine whether to accept responsibility for ongoing management of the patient's entire care, or for the care of a specific condition or problem. Consultation codes are found in the 99241-99255 range of the CPT® code book.

In 2006, the Office of Inspector General (OIG) reported that 75 percent of services billed as consultations were improperly paid and did not meet correct coding standards. Specifically, provider documentation did not support that a consultation service had been rendered and in the case where a consultation service was supported by the documentation; many visits were coded at the incorrect type or level of service.

A **consultation** is a request from one physician to another for an advisory opinion. The consultant performs the requested service and makes written recommendations regarding diagnosis and treatment to the requesting physician. The requesting physician utilizes the consultant's opinion combined with his own professional judgment and other considerations (e.g. patient preferences, other consultations, family concerns, and comorbidities) to provide treatment for the patient.

A **referral** is a request from one physician to another to assume responsibility for management of one or more of a patient's specified problems. This may be for a specified period of time, until the problem(s) is resolved, or on an ongoing basis. This represents a temporary or partial transfer of care to another physician for a particular condition. It is the responsibility of the physician accepting the referral to maintain appropriate and timely communication with the referring physician and to seek approval from the referring physician for treating or referring the patient for any other condition that is not part of the original referral.

A **transfer of care** occurs when one physician turns over responsibility for the comprehensive care of a patient to another physician. The transfer may be initiated by either the patient or by the

patient's physician, and it may be either permanent or for a limited period of time until the patient's condition improves or resolves, or based on the patient wishes. When initiated by the patient's physician, the transferring physician should explicitly inform the patient of the transfer, and assist the patient with timely transfer of care consistent with local practice.[i]

Reimbursement

The Health Plan will reimburse consultation codes for the following providers:

- Doctor of Medicine [MD]/ Doctor of Osteopathic Medicine [DO] Specialists
- Dual-Boarded MD/DO Specialists (i.e. Internal Medicine and Endocrinology)
- Mid-Level Specialists (Nurse Practitioner [NP]/Physician's Assistant [PA] within a specialty group)
- Primary Care Providers [PCP] with a pre-operative diagnosis in the first position on the claim

For consultation codes to be considered for reimbursement, the following documentation requirements must be met:

- A written or verbal request for consult must be made by an appropriate source
- The request must be documented in the member's medical record
- The consultant's opinion must be documented in the member's medical record
- The consultant's opinion must be communicated by written report to the requesting physician or other appropriate source

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current 2019 manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT/HCPCS Code	Descriptor
99241	Office consultation for a new or established patient, which requires these 3 key components: - A problem focused history; - A problem focused examination; and - Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99242	Office consultation for a new or established patient, which requires these 3 key components: - An expanded problem focused history; - An expanded problem focused examination; and - Straightforward

CPT/HCPCS Code	Descriptor
	medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99243	Office consultation for a new or established patient, which requires these 3 key components: - A detailed history; - A detailed examination; and - Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family
99244	Office consultation for a new or established patient, which requires these 3 key components: - A comprehensive history; - A comprehensive examination; and - Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
99245	Office consultation for a new or established patient, which requires these 3 key components: - A comprehensive history; - A comprehensive examination; and - Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.
99251	Inpatient consultation for a new or established patient, which requires these 3 key components: - A problem focused history; - A problem focused examination; and - Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 20 minutes are spent at the bedside and on the patient's hospital floor or unit
99252	Inpatient consultation for a new or established patient, which requires these 3 key components: - An expanded problem focused history; - An

CPT/HCPCS Code	Descriptor
	expanded problem focused examination; and - Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.
99253	Inpatient consultation for a new or established patient, which requires these 3 key components: - A detailed history; - A detailed examination; and - Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.
99254	Inpatient consultation for a new or established patient, which requires these 3 key components: - A comprehensive history; - A comprehensive examination; and - Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent at the bedside and on the patient's hospital floor or unit.
99255	Inpatient consultation for a new or established patient, which requires these 3 key components: - A comprehensive history; - A comprehensive examination; and - Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 110 minutes are spent at the bedside and on the patient's hospital floor or unit.

Modifier	Descriptor
NA	Not Applicable

Applicable Diagnosis Codes for Primary Care Providers [PCP]	
ICD-10 Codes	**Descriptor**
Z01.810	Encounter for pre-procedural cardiovascular examination
Z01.811	Encounter for pre-procedural respiratory examination

Z01.812	Encounter for pre-procedural laboratory examination
Z01.818	Encounter for other pre-procedural examination

Additional Information
Not applicable.

Related Documents or Resources

References
1. *Current Procedural Terminology (CPT)*®, 2019
2. *New Hampshire Department of Health and Human Services*
3. *American Academy of Family Physicians (AAFP)*

Revision History	
08/01/2019	Original Policy Draft

Important Reminder
For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.

[i] American Academy of Family Physicians