Amerigroup An Anthem Company	**Reimbursement Policy**

Subject: Consultations

Effective Date: **04/20/18**	Committee Approval Obtained: **09/14/20**	Section: **Evaluation & Management**

*****The most current version of the reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://providers.amerigroup.com.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup Medicare Advantage 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 CPT® codes, 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 participating providers and facilities; a noncontracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

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

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

Amerigroup Medicare Advantage reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup Medicare Advantage strives to minimize these variations.

Amerigroup Medicare Advantage reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Amerigroup Medicare Advantage allows reimbursement for face-to-face medical consultations by physicians or qualified nonphysician practitioners (referred to as provider[s] throughout this policy) in accordance with specified guidelines unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Reimbursement is based on the fee schedule or contracted/negotiated rate structured on the following: • The appropriate evaluation and management (E/M) code based on CMS guidelines • The appropriate modifier, if applicable **Consultations** Consultations are reimbursable according to the following guidelines: • The consultation is requested in writing or verbally by the attending provider or appropriate source. • The consultation is provided within the scope and practice of the consulting provider. • The consultation includes a personal examination of the patient. • The consulting provider completes a written report that includes: o Member history, including chief diagnosis and/or complaint. o Examination. o Physical finding(s). o Recommendations for future management and/or ordered service(s). • The member's medical record must contain: o The attending provider's request for the consultation. o The reason for the consultation. o Documentation that indicates the information communicated by the consulting provider to the member's attending provider and the member's authorized representative. o The consulting provider's written report. • Laboratory consultations must relate to test results that are outside the clinically significant normal or expected range considering the member's condition. • During a consultation, the consulting provider may initiate diagnostic and/or therapeutic services.

	○ If the consulting provider performs a definitive therapeutic surgical procedure on the same day as the consultation for the same member, the consultation must be reported with Modifier 25 or Modifier 57, whichever is most appropriate. • If the appropriate modifier is not reported, the consultation is considered included in the reimbursement for the therapeutic surgical procedure, and therefore not separately reimbursable. **Preoperative clearance and postoperative evaluation** A surgeon may request a provider perform a consultation as part of either a preoperative clearance **or** postoperative evaluation, as long as consultation guidelines are met in addition to the following: • A consulting provider may be reimbursed for a postoperative evaluation only if: ○ The requesting surgeon requires a professional opinion for use in treating the member. ○ The consulting provider has not performed the preoperative clearance. • Postoperative visits are considered concurrent care and do not qualify for reimbursement as consultations if: ○ A consulting provider performs a preoperative clearance. ○ Subsequent management of all or a portion of the member's postoperative care is transferred to the same consulting provider who performed the preoperative clearance. **Note:** The following do not qualify as consultations: • Routine screenings • Routine preoperative or postoperative management care including, but not limited to: ○ Member history and physical for the surgical procedure being performed ○ Services applicable to be billed with the surgical procedure code appended with Modifier 56 ○ Services applicable to be billed with the surgical procedure code appended with Modifier 55 **Consultation by a PCP**

	A PCP may perform a consultation for his/her own patient in the following circumstances:
	• A surgeon has specifically requested the PCP to perform either a preoperative clearance or a postoperative evaluation, as long as:
	  ○ Consultation, preoperative clearance, and/or postoperative evaluation guidelines are met.
	  ○ Preoperative and/or postoperative consultations rendered by the member's PCP are reimbursable services based on CMS or the provider's contract.
	
	The preoperative visit usually is included in the surgeon's global surgical allowance. Medical review may be required if the PCP is reimbursed for a service normally included in the global fee allowance.
	
	Note: A PCP is responsible for the care of his/her own patient and, therefore, does not usually qualify to perform consultations because the PCP has an established medical record and/or history on the member.
	
	Consultation within the same group practice
	A consultation may be considered for reimbursement if the attending provider requests a consultation from another provider of a different specialty or subspecialty within the same group practice, as long as consultation guidelines are met.
	
	Nonreimbursable
	Amerigroup Medicare Advantage does not recognize office, outpatient or initial inpatient consultation codes. Amerigroup Medicare Advantage does not allow reimbursement for the following with regard to a consultation:
	• Performed by telephone.
	  Note: Telephone calls are not considered telemedicine.
	• Performed as a split or shared E/M visit
	• Performed in addition to an E/M visit for the same member by the same provider, unless Modifier 25 is appropriate
	• Performed as a second or third opinion requested by the member or member's authorized representative
	• Performed for noncovered services
	• When a transfer of care to the consulting provider occurs visits for the same patient by the same consulting provider)

	• For both preoperative clearance and postoperative evaluation of the same member by the same consulting provider • For which the specified guidelines are not met
History	• Biennial review approved 09/14/20 • Biennial review approved and effective 04/20/18: policy language updated • Biennial review approved 06/06/16: policy language updated • Initial approval and effective date 01/01/15
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State contracts • American Medical Association CPT, 2018
Definitions	• **Consultation:** a deliberation by two or more providers with respect to the diagnosis, prognosis and/or treatment in any particular case where the expertise, professional opinion, and medical judgment of the consulting provider are considered necessary • **Second Opinion:** an opinion obtained from an additional healthcare professional prior to the performance of a medical service or a surgical procedure; may relate to a formalized process, either voluntary or mandatory, which is used to help educate a patient regarding treatment alternatives and/or to determine medical necessity • **General Reimbursement Policy Definitions**
Related Policies	• Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service • Modifier 57: Decision for Surgery • Modifier Usage • Split-Care Surgical Modifiers
Related Materials	• None