



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/TX>. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state. *****

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 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 both participating and nonparticipating providers and facilities.

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

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

Amerigroup 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 strives to minimize these variations.

Amerigroup 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 allows reimbursement for face-to-face medical consultations by physicians or qualified nonphysician practitioners (referred to as providers 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 one of the following:

- The appropriate code designating a consultation based on state Medicaid guidelines
- The appropriate code designating a consultation based on CPT guidelines

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:
 - Member history, including chief diagnosis and/or complaint.
 - Examination.
 - Physical finding(s).
 - Recommendations for future management and/or ordered service(s).
- The member's medical record must contain:
 - The attending provider's request for the consultation.
 - The reason for the consultation.
 - Documentation that indicates the information communicated by the consulting provider to the member's attending provider and the member's authorized representative.
 - 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 state guidance 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.

	<ul style="list-style-type: none"> • A behavioral health (BH) provider has specifically requested the PCP to perform a consultation to provide either a medical evaluation for a specific condition or a general medical evaluation (e.g., history and physical) on a member admitted to an inpatient psychiatric unit for BH treatment. These occurrences usually are billed as evaluation and management (E/M) visits. Medical review may be required to ensure consultation guidelines are met. <p>Note: A PCP is responsible for the care of his/her own patient and, therefore, does not usually qualify to perform consultations because:</p> <ul style="list-style-type: none"> • Such services are considered evaluations rather than consultations. • The PCP has an established medical record and/or history on the member. <p>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.</p> <p>Nonreimbursable Amerigroup does not allow reimbursement for the following with regard to a consultation:</p> <ul style="list-style-type: none"> • 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 • For both preoperative clearance and postoperative evaluation of the same member by the same consulting provider • For which the specified guidelines are not met
Exemptions	<ul style="list-style-type: none"> • Amerigroup Texas, Inc. and Amerigroup Insurance Company allows one consultation every six months by the same provider for the same diagnosis.
History	<ul style="list-style-type: none"> • Biennial review approved 09/14/20 • Biennial review approved and effective 04/20/18: Texas exemption updated; policy language updated • Biennial review approved 06/06/16

	<ul style="list-style-type: none"> • Biennial review approved 05/12/14: policy template updated; Texas exemptions added • Biennial review approved 08/17/12: policy template updated • Policy definitions updated: 09/15/11 • Biennial review approved 08/16/10 and effective 05/01/05: Consultation definition added; language differentiating Medicaid and CMS appropriate consultation codes added; medical references removed; policy template updated • Review approved 12/01/08: background section/policy template updated • Review approved 04/10/07: consultation guidelines clarified; Preoperative and postoperative consultations clarified; Nonreimbursable section added • Initial approval 03/01/05 and effective 05/01/05
References and Research Materials	<p>This policy has been developed through consideration of the following:</p> <ul style="list-style-type: none"> • CMS • State Medicaid • Amerigroup state contracts • American Medical Association Current Procedural Terminology (CPT), 2018
Definitions	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • None