

Reimbursement Policy	
Subject: Consultations	
Policy Number: G-05006	Policy Section: Evaluation and Management
Last Approval Date: 12/19/2023	Effective Date: 12/19/2023

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to providers.amerigroup.com/DC.****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Amerigroup District of Columbia, Inc. covered the service for the enrollee's benefit plan. The determination that a service, procedure, item, etc. is covered under an enrollee'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 enrollee'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. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional 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.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Amerigroup strives 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. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Amerigroup allows reimbursement for face-to-face medical consultations by physicians or qualified nonphysician practitioners (referred to as *providers* throughout this policy) according to the below 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:

- For non-hospital patients, only one consultation is allowed per member, per provider, per 12 months.
- 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 that 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 Primary Care Physician (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.
- A behavioral health 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 (i.e., history and physical) on a member admitted to an inpatient psychiatric unit for behavioral health treatment. These occurrences usually are billed as evaluation and management (E/M) visits. Medical review may be required to ensure consultation guidelines are met.

Note: A PCP is responsible for the care of his/her own patient and, therefore, does not usually qualify to perform consultations because:

- Such services are considered "evaluations" rather than "consultations."
- 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.

Non-reimbursable

Amerigroup does not allow reimbursement for the following regarding 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
- For both preoperative clearance and postoperative evaluation of the same member by the same consulting provider
- For which the specified guidelines are not met

Related Coding

Standard correct coding applies

Policy History

12/19/2023	Review approved and effective: updated Consultation in Definitions section
04/01/2023	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- American Medical Association Current Procedural Terminology (CPT®) 2023
- CMS
- District contract
- District Medicaid
- Optum EncoderPro 2023

Definitions

Consultation	The opinion or advice of a specialist requested by another physician or other appropriate source regarding evaluation and/or management of a specific problem.
Second Opinion	An opinion obtained from an additional health care 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 and Materials

Modifier Usage

Modifiers 25 and 57

Split Care Surgical Modifiers

©2023-2024 Amerigroup District of Columbia, Inc. All Rights Reserved.