CHAPTER 1
SECTION 8.2

CONSULTATIONS

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I. PROCEDURE CODE RANGE

99241 - 99275

II. DESCRIPTION

A consultation is a type of service provided by an authorized provider whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another authorized provider. The attending provider's request and the need for consultation must be provided in the patient's permanent medical record. The consultant's opinion, along with any services that were ordered or performed, must also be documented in the patient's record and communicated to the requesting provider.

III. POLICY

A. Consultations performed by an authorized individual professional provider at the request of the patient's attending provider are covered.

B. There are four subcategories of consultation: office, inpatient, follow-up inpatient, and confirmatory. The level of services provided within each of these subcategories is based on the following factors:

1. Approach and detail of the medical history;

2. Extent of the examination;

3. Complexity of the decision making process;

4. Severity of the presenting problem; and

5. Time spent with the patient and/or family.

C. Reimbursement for a consultation does not include diagnostic procedures performed by the consultant. Appropriate allowances should be made for such services in addition to the consultation.

IV. EXCEPTIONS

A. A consultation performed within three days of a non-diagnostic surgical procedure by the same provider who performs the surgery is included within the surgical fee. If the consultation and surgery are itemized separately, the consultation will be denied as it is already included in the global surgical charge. In doing so, however, the contractor will total the surgical and the denied consultation charges in determining the allowable charge (i.e., the lower of the billed amount or CMAC amount for the particular surgical procedure).

B. Telephone consultations and telephone toll charges are not covered.

C. Staff consultations required by the policies of a hospital or other institution are not covered.

V. POLICY CONSIDERATIONS

A. Only one initial or confirmatory consultation (99271-99275), inpatient or outpatient, is covered when provided by the same provider during the course of the patient's illness (i.e., for the same diagnosis, or episode of illness). More than one initial or confirmatory consultation for the same patient for the same course of illness will be denied as noncovered. Contractors are required to monitor on a post-payment pattern of review basis any provider who uses a substantial number of the initial or confirmatory consultation codes for possible abusive or fraudulent billing practices.

B. Consultations by providers of the same or different specialties are covered when required because of a complex medical condition. If the Contractor has any doubt about the medical necessity for one or more of the services, consultation reports should be obtained and referred to medical review.

C. A copy of the consultation report is not routinely required, although the Contractor may request the report at any time.

D. The name and address of the attending provider is required on each claim for a consultation. Contractors do not need to develop for the name and address of the attending provider. Providers are to be advised that if the information is not submitted on the claim, the consultation will be reimbursed only up to the allowable charge for CPT procedure code 99202.

E. Consultations will be cost-shared according to the status of the patient, inpatient or outpatient, at the time the service is rendered.

F. If a consultant assumes responsibility for management of a portion or all of the patient's condition(s), appropriate hospital or office setting CPT procedure codes must be used in lieu of the consultation codes.

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