CONSULTATION SERVICES POLICY

Policy Number: ADMINISTRATIVE 256.2 T0 **Effective Date**: July 1, 2017

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Related Policies

None

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

APPLICATION

This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

OVERVIEW

This policy discusses how Oxford evaluates CPT(®) consultation codes 99241-99245 and 99251-99255 and HCPCS codes G0406-G0408, G0425-G0427, G0508 and G0509 for reimbursement.

REIMBURSEMENT GUIDELINES

Consultation Services

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.

Oxford will consider a claim for a consultation service for reimbursement if the requesting physician or other qualified source is identified on the claim. If the requesting entity is not identified on the claim, the consultation service will be denied because it does not meet basic AMA requirements for reporting such a code.

Services initiated by a patient and/or family and not requested by a physician or other appropriate source should not be reported using CPT consultation codes 99241-99245 or 99251-99255 or HCPCS consultation codes G0406-G0408, G0425-G0427, G0508 or G0509 but may be reported using appropriate office visit, hospital care, home service or domiciliary/rest home care codes.

Note: AMA guidelines state that only one inpatient consultation (99251-99255) should be reported by a consultant per admission. Evaluation and Management (EM) services after the initial consultation during a single admission should be reported using non-consultation EM codes.

DEFINITIONS

Consultation Service: 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. The following criteria also apply:

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

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies may apply.

CPT Code	Description
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 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.

CPT Code	Description
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 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.

HCPCS Code	Description
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth.
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth.

HCPCS Code	Description
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth.
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth.
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth.
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth.
G0508	Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth
G0509	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth

QUESTIONS AND ANSWERS

1	**Q:**	Who are considered "appropriate sources" for a consultation service reported with a consultation code?
	A:	Per the AMA, examples of appropriate sources for a consultation request may include a physician, physician assistant, nurse practitioner, psychologist, social worker, etc.
2	**Q:**	What are examples of sources when it is not appropriate for a physician or other health care professional to report a consultation service code?
	A:	The patient and the patient's family are not considered appropriate sources for reporting a consultation code.
3	**Q:**	If a consultation code is not appropriate to report, or a claim for a consultation code has been denied because an appropriate referring entity has not been identified on the claim, how should the evaluation and management services be reported?
	A:	A claim for evaluation and management services that does not meet the criteria as a consultation may be submitted (or resubmitted) with an appropriate non-consultation evaluation and management code.
4	**Q:**	Where on the claim form or claim submission should the requesting entity be reported? What type of identification is necessary?
	A:	If the requesting entity has a National Provider Identification (NPI) number, that number should be in field 17B of the CMS-1500 form (also known as the 1500 claim form) or its electronic equivalent. If the requesting entity does not have an NPI number, his or her name should be in field 17 of the claim form. As with all claim submissions, all fields should be completed with valid and accurate information.

REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Payment Policy Oversight Committee. [*2017R0129A*]

American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services.

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
07/01/2017	• Updated policy overview; added HCPCS codes G0508 and G0509 (telehealth consultation) to list of services addressed in the policy • Revised reimbursement guidelines: ○ Added langauge to indicate a consultation service will be denied because it does not meet basic AMA requirements if the requesting entity is not identified on the claim ○ Updated list of applicable consultation codes that may be reported using appropriate office visit, hospital care, home service, or domiciliary/rest home care codes; added HCPCS codes G0508 and G0509 • Revised list of applicable HCPCS codes; added G0508 and G0509 • Updated Questions & Answers (Q&A); revised Q&A #3 to indicate: ○ **Q**: If a consultation code is not appropriate to report, *or a claim for a*

Date	Action/Description
	consultation code has been denied because an appropriate referring entity has not been identified on the claim, how should the evaluation and management services be reported? ○ **A**: A claim for evaluation and management services that does not meet the criteria as a consultation may be submitted (or resubmitted) with an appropriate non-consultation evaluation and management code • Archived previous policy version ADMINISTRATIVE 256.1 T0