Coverage is subject to the terms, conditions, and limitations of an individual member’s programs or products and policy criteria listed below.

Description
A consultation is a type of evaluation and management (E/M) service provided by a physician or other qualified health care professional whose opinion or advice regarding a specific clinical problem is requested by another physician or other appropriate source.

This policy documents UniCare’s documentation and reporting guidelines for consultation E/M services.

Policy
UniCare recognizes consultation services when a physician or other appropriate source is seeking advice, opinion, recommendation, suggestion, direction, counsel, etc. from another physician (usually a specialist) or other qualified health care professional in evaluating or treating a patient because the consulting healthcare provider has expertise in a specific medical area beyond the requesting professional’s knowledge.

Consistent with Current Procedural Terminology (CPT®) guidelines, in addition to physicians, UniCare considers the following examples of “appropriate sources” eligible to request consultations: physician assistant, nurse practitioner, doctor of chiropractic, physical therapist, occupational therapist, speech-language pathologist, psychologist, social worker, lawyer, or insurance company.

I. Types of Consultations
CPT consultation codes are divided into two sections based on place of service:

A. Office or Other Outpatient Consultations:
Office or other outpatient consultations are reported with CPT codes 99241-99245 with no distinction between new and established patients. For office or other outpatient consultative services, UniCare considers outpatient settings to include, but not limited to, the consultant’s office, the emergency or observation department of a hospital, the patient’s home, or domiciliary setting.

B. Inpatient Consultations:
Inpatient consultations are reported with CPT codes 99251-99255 with no distinction between new and established patients. For inpatient consultative services UniCare considers inpatient
settings to include, but not limited to, hospital inpatient, residents of nursing facilities, or patients in a partial hospital setting.

II. Consultation Coding and Documentation Guidelines

Please refer to UniCare’s Reimbursement Policy entitled “Documentation and Reporting Guidelines for Evaluation and Management Services.” This policy contains:

- definitions of terms related to E/M services;
- information on the 1995 and 1997 editions of CMS’ E/M Services Guidelines; and
- documentation required for medical decision making.

UniCare requires that providers document and report both outpatient and inpatient consultation services using the same methodology described in the Documentation and Reporting Guidelines for Evaluation and Management Services reimbursement policy that is used for office or other E/M visits. Key components, along with contributory factors (counseling and coordination of care, nature of the present problem, and time) are used to determine the level of consultation to report.

A. Consistent with CPT guidelines, UniCare requires that the three key components listed below must be documented in the patient’s medical records and used to determine the level of the consultation E/M visit:
- history of present illness
- examination
- medical decision making

B. UniCare follows CPT criteria in determining whether or not an E/M visit is considered a consultation. In order for a service to be properly reported as a consultation, there must be documentation of:

1. A written or verbal request for opinion or advice from another physician or other appropriate source to either recommend care for a specific condition or problem OR to determine whether the consultant should accept responsibility for (a) patient’s entire care or (b) the care of a specific condition or problem. Standing orders in the medical record for consultation do not constitute such a request.

2. A clear explanation as to the reason for the consultation by either the requesting physician or other appropriate source or the consulting physician or other qualified health care professional.

3. A written report to the requesting physician or other appropriate source of the consultant’s finding, opinions, recommendation, and any services that were ordered or performed.
   a. The report should not be a thank you note to the requesting physician or appropriate source for referring the patient, nor should it be a courtesy copy of the history/physical.
   b. The report should provide instruction(s) to the requesting physician or appropriate source to assist in treating the patient or inform the requesting physician or appropriate source that the consulting physician or other qualified health care provider is taking over the partial or total care of the patient.
   c. In a setting where a shared chart is used, the consulting physician or other qualified health care professional is not required to send a written report to the requesting physician or appropriate source because it is expected that the requesting physician or appropriate source will review the consultant’s assessment and recommendations for treatment.

C. During an inpatient admission, after an initial consult, any additional E/M services rendered during the same admission should be reported using subsequent hospital care codes (99231-
99233) or subsequent nursing facility care codes (99307-99310). Such subsequent services include visits performed to complete the initial consultation, monitor progress, revise recommendations, or address a new problem.

D. UniCare follows the CPT coding guideline that a consultation initiated by a patient and/or family, and not requested by a physician or other appropriate source, should not be reported using the consultation codes, but may be reported using, for example, the appropriate office visit, home service, inpatient, or domiciliary/rest home care codes.

III. Transfer of Care
UniCare has adopted the CPT definition of “transfer of care” which states: “Transfer of care is the process whereby a physician or other qualified health care professional who is providing management for some or all of a patient’s problems relinquishes this responsibility to another physician or other qualified health care professional who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services.”

- After a transfer of care, the requesting physician or appropriate source will no longer provide care for the specific condition for which care was transferred, but may continue providing care for other conditions when appropriate.
- A physician or other qualified health care professional who has agreed to accept transfer of care prior to an initial evaluation should not report consultation codes to Health Plan. In such cases, the receiving physician or other qualified health care professional should report the appropriate new or established patient visit code according to the place of service.
- If the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service, then it would be appropriate to bill a consult.

IV. Initial and Follow-Up Consultation Services
A. Initial Consultation:
1. In the office or outpatient setting, the consultant should use the appropriate office or outpatient consultation CPT codes 99241-99245 for the initial consultation service only.

2. In the hospital and nursing facility setting, the consulting physician or other qualified health care professional shall use the appropriate inpatient consultation CPT codes 99251-99255 for the initial consultation service. The initial inpatient consultation is reported only once per consultant per patient per facility admission.

3. A consulting physician or other qualified health care professional may initiate diagnostic services and treatment at the initial consultation service or may even take over the patient’s care after the initial consultation.

B. Follow-up Services:
1. Ongoing management, following the initial consultation service by the consulting physician or other qualified health care professional should not be reported with consultation service codes. These services need to be reported as subsequent visits with the appropriate place of service and level of service.

a. In the outpatient setting, following the initial consultation service, the office or outpatient established patient CPT codes 99212-99215 should be reported for additional follow-up visits.

b. In the hospital setting, following the initial consultation service, the subsequent hospital care CPT codes 99231-99233 should be reported for additional follow-up visits. In the nursing facility setting, following the initial consultation service, the subsequent nursing facility care CPT codes 99307-99310 should be reported for additional follow-up visits.
2. If an additional request for an opinion regarding the same or new problem for the same patient is received from the same or another physician or other appropriate source and documented in the medical record, the appropriate consultation CPT code may be used again based on the place of service. However, when the consultant continues to care for the patient after any initial consultation service, such follow-up services must be reported with the appropriate follow-up E/M CPT codes.

V. Second Opinion

UniCare requires that a second opinion E/M service requested by a patient and/or family member and performed in the office or other outpatient setting to be reported using the appropriate office or other outpatient new or established patient CPT code and not a consultation code.

In both the inpatient hospital setting and nursing facility setting, a request for a second opinion is usually made by the attending physician or other qualified health care professional and may be reported using consultation service CPT codes.

VI. Consultations Requested by Members of Same Group Practice

In the event that one provider requests a consultation from another provider in the same group practice, consultation codes may be reported when the consulting provider has expertise in a specific medical area beyond the requesting provider's knowledge. Consultations should not be reported on every patient as a routine practice when providers refer patients to each other within a group practice setting.

VII. Consultation for Preoperative Clearance and Postoperative Evaluation

A. Preoperative consultations for new and established patients performed by any physician or other qualified health care professional at the request of a surgeon may be reported with consultation codes, as long as all the requirements for performing and reporting the consultation codes are met and the service is medically necessary and not a routine screening. Please see UniCare's “Evaluation and Management Services and Related Modifiers 25 and 57” Reimbursement Policy for more details.

B. A physician (primary care or specialist) or other qualified health care professional who performs a postoperative evaluation of a new or established patient at the request of the surgeon may report a consultation code for the E/M service furnished during the postoperative period when all the criteria for the use of the consultation codes are met, and the consulting physician or other qualified health care professional has not performed a preoperative consultation.

C. In the inpatient setting, a physician or other qualified health care professional who has performed a preoperative consultation and assumes responsibility for the management of a portion or all of the patient's condition(s) during the postoperative period should use the appropriate level of subsequent hospital care codes for E/M services provided. In the outpatient setting, the appropriate level of established patient visit codes are to be used during the postoperative period when the same consulting physician or other qualified health care professional performed a preoperative consultation.

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**Use of Reimbursement Policy:**
This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member’s benefits on the date of service. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.

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