Payment Policy: Outpatient Consultations

Reference Number: LA.PP.039
Product Types: All
Effective Date: 08/2020
Last Review Date: 08/2020

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
The American Medical Association (AMA) Current Procedural Terminology (CPT®) book describes a consultation as a type of evaluation and management (E&M) service provided at the request of another physicians 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.

Furthermore, if subsequent to the completion of the consultation, the consultant assumes responsibility for the management of a portion or all of the patient's condition(s), the appropriate Evaluation and Management (E&M) procedure code for the location of service should be reported.

The purpose of this policy is to outline how Louisiana Healthcare Connections evaluates CPT consultation codes 99241-99245 and HCPS codes G0425-G0427 for reimbursement, particularly identifying those that should have been billed at the appropriate level of office visit, established patient or subsequent hospital care.

CMS no longer recognizes codes 99241-99245 and 99251-99255 for Medicare payment; therefore, providers should never bill these codes for Medicare members. Instead, (for Medicare members) providers should report the appropriate Evaluation and Management code payable under the fee schedule (including for visits that could be described by CPT consultations codes), that identifies where the visit occurred and the complexity of the visit performed.

Application
1. Professional
2. Outpatient Institutional Claims
3. Same member
4. Same Provider

Reimbursement
Claim lines that contain an outpatient consultation, when another outpatient consultation was billed by the same provider within six months, will be denied.

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

CPT guidelines state that only one outpatient consultation should be reported by a consultant per admission. E&M services after the initial consultation during a single admission should be reported using non consultation E&M codes.

Documentation Requirements
The following criteria 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 records
- The consultant's opinion must be communicated by written report to the requesting physician or other appropriate source

Coding and Modifier Information
This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT/HCPCS Code	Descriptor
99241	Office consultation for a new or established patient (15 Min)
99242	Office consultation for a new or established patient (30 Min)
99243	Office consultation for a new or established patient (40 Min)
99244	Office consultation for a new or established patient (60 Min)
99245	Office consultation for a new or established patient (80 Min)
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth

Modifier	Descriptor
NA	Not Applicable

ICD-10 Codes	Descriptor
NA	Not Applicable

Definitions
Not Applicable

Related Policies
Not Applicable

Related Documents or Resources
Not Applicable

References
1. *Current Procedural Terminology (CPT®)*, 2019
2. *HCPCS Level II*, 2019

Revision History	
08/15/2020	Converted corporate to local policy.

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible

for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This clinical policy is the property of LHCC. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.

Senior Director of Network Accounts: _____Electronic Signature on File_

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