COMMERCIAL REIMBURSEMENT POLICY

Consultation Services

Active

Section: Evaluation and Management
Policy Number: 012
Effective Date: 03/01/24

Description

This policy addresses coding and reimbursement for consultation services.

Definitions

Consultation: A consultation is a type of evaluation and management (E/M) service provided at the request of another physician, other qualified health care professional (QHP), or appropriate source to recommend care for a specific condition or problem.

Policy Statement

Current Procedural Terminology (CPT®) codes 99242-99245 and 99252-99255 apply to new and established patients and are differentiated by place of service. These services may be requested by a physician, other QHP, or appropriate source.

Diagnostic or therapeutic services may be initiated at the time of the consultation or at a subsequent visit.

A consultation requested by a patient and/or the patient's family should be billed with the appropriate E/M service, not as a consultation service.

Office or Other Outpatient Consultations

Subsequent consultation services, initiated by the consultant or patient, are coded as the appropriate established patient E/M service for the setting.

For services provided for the management of the patient's entire care or a specific condition or problem, the appropriate new or established patient E/M service is used for the setting.

Inpatient or Observation Consultations

Only one initial consultation will be reimbursed by a consultant per admission.

Subsequent consultation services, during the same admission, are coded as the appropriate subsequent E/M for the setting.

Documentation Submission

Documentation should identify the request for a consultation by the physician, other QHP, or appropriate source. It should also include a written report from the consultant back to the treating physician, other QHP, or appropriate source. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, the applicable fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	N/A
ICD-10 Diagnosis:	N/A
ICD-10 Procedure:	N/A
CPT/HCPCS:	99242 99243 99244 99245 99252 99253 99254 99255
Revenue Codes:	N/A

Resources

Current Procedural Terminology (CPT®)

Policy History

10/18/2016	Initial Committee Approval
02/28/2023	Revised – replaces EM 001 – Evaluation and Management Services
02/27/2024	Annual Policy Review