Highmark Blue Cross Blue Shield (Highmark BCBS) partners with Wellpoint companies to administer certain services to Medicaid Managed Care (MMC), Health and Recovery Plan (HARP), and Child Health Plus (CHPlus) members. Please note, this information is specific to the MMC, HARP, and CHPlus programs only.

Reimbursement Policy

Subject: **Consultations**	
Policy Number: **G-05006**	Policy Section: **Evaluation and Management**
Last Approval Date: **12/19/2023**	Effective Date: **12/19/2023**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **providerpublic.mybcbswny.com**. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Highmark BCBS covered the service for the member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Highmark BCBS may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

NYHM-CD-RP-052087-24-CPN51474 April 2024

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Highmark BCBS strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Highmark BCBS allows reimbursement for face-to-face medical consultations by physicians or qualified nonphysician practitioners (referred to as *providers* throughout this policy) according to the below guidelines unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise. Reimbursement is based on the fee schedule or contracted/negotiated rate structured on one of the following:

- The appropriate code designating a consultation based on state Medicaid guidelines
- The appropriate code designating a consultation based on CPT guidelines

Consultations

Consultations are reimbursable according to the following guidelines:

- The consultation is requested in writing or orally by the attending provider or appropriate source.
- The consultation is provided within the scope and practice of the consulting provider.
- The consultation includes a personal examination of the patient.
- The consulting provider completes a written report that includes:
    - Member history, including chief diagnosis and/or complaint.
    - Examination.
    - Physical finding(s).
    - Recommendations for future management and/or ordered service(s).
- The member's medical record must contain:
    - The attending provider's request for the consultation.
    - The reason for the consultation.
    - Documentation that indicates the information communicated by the consulting provider to the member's attending provider and the member's authorized representative.
    - The consulting provider's written report.
- Laboratory consultations must relate to test results outside the clinically significant normal or expected range considering the member's condition. During a consultation, the consulting provider may initiate diagnostic and/or therapeutic services:
    - If the consulting provider performs a definitive therapeutic surgical procedure on the same day as the consultation for the same member; the consultation must be reported with Modifier 25 or Modifier 57, whichever is most appropriate:
        - If the appropriate modifier is not reported, the consultation is considered included in the reimbursement for the therapeutic surgical procedure, and therefore not separately reimbursable.

Preoperative clearance and postoperative evaluation
A surgeon may request that a provider perform a consultation as part of either a preoperative clearance or postoperative evaluation, as long as consultation guidelines are met in addition to the following:

- A consulting provider may be reimbursed for a postoperative evaluation only if:
  - The requesting surgeon requires a professional opinion for use in treating the member.
  - The consulting provider has not performed the preoperative clearance.
- Postoperative visits are considered concurrent care and do not qualify for reimbursement as consultations if:
  - A consulting provider performs a preoperative clearance.
  - Subsequent management of all or a portion of the member's postoperative care is transferred to the same consulting provider who performed the preoperative clearance.

Note: The following do not qualify as consultations:

- Routine screenings
- Routine preoperative or postoperative management care including, but not limited to:
  - Member history and physical for the surgical procedure being performed
  - Services applicable to be billed with the surgical procedure code appended with Modifier 56
  - Services applicable to be billed with the surgical procedure code appended with Modifier 55

Consultation by a Primary Care Physician (PCP)
A PCP may perform a consultation for his/her own patient in the following circumstances:

- A surgeon has specifically requested the PCP to perform either a preoperative clearance or a postoperative evaluation, as long as:
  - Consultation, preoperative clearance, and/or postoperative evaluation guidelines are met.
  - Preoperative and/or postoperative consultations rendered by the member's PCP are reimbursable services based on state guidance or the provider's contract.
- The preoperative visit usually is included in the surgeon's global surgical allowance. Medical review may be required if the PCP is reimbursed for a service normally included in the global fee allowance.
- A behavioral health (BH) provider has specifically requested the PCP to perform a consultation to provide either a medical evaluation for a specific condition or a general medical evaluation on a member admitted to an inpatient psychiatric unit for BH treatment. These occurrences usually are billed as evaluation and management (E/M) visits. Medical review may be required to ensure consultation guidelines are met.

Note: A PCP is responsible for the care of his/her own patient and, therefore, does not usually qualify to perform consultations because:

- Such services are considered evaluations rather than consultations.
- The PCP has an established medical record and/or history on the member.

Consultation within the same group practice
A consultation may be considered for reimbursement if the attending provider requests a consultation from another provider of a different specialty or subspecialty within the same group practice, as long as consultation guidelines are met.

Nonreimbursable
Highmark BCBS does not allow reimbursement for the following regarding a consultation:

- Performed by telephone.
  Note: Telephone calls are not considered telemedicine.
- Performed as a split or shared E/M visit.
- Performed in addition to an E/M visit for the same member by the same provider, unless Modifier 25 is appropriate.
- Performed as a second or third opinion requested by the member or member's authorized representative.
- Performed for noncovered services.
- When a transfer of care to the consulting provider occurs.
- For both preoperative clearance and postoperative evaluation of the same member by the same consulting provider.
- For which the specified guidelines are not met.

Related Coding
Standard correct coding applies

Policy History	
12/19/2023	Review approved and effective: updated *Consultation* in Definitions section
09/14/2020	Review approved
04/20/2018	Review approved and effective: policy language updated
06/06/2016	Initial approval 06/06/2016 and effective 01/01/2017

References and Research Materials
This policy has been developed through consideration of the following: • American Medical Association CPT® 2023 • CMS • Optum EncoderPro 2023 • State contract • State Medicaid

Definitions	
Consultation	The opinion or advice of a specialist requested by another physician or other appropriate source regarding evaluation and/or management of a specific problem.

Second Opinion	An opinion obtained from an additional healthcare professional before the performance of a medical service or a surgical procedure; may relate to a formalized process, voluntary or mandatory, that is used to help educate a patient about treatment alternatives or to determine medical necessity.
General Reimbursement Policy Definitions	

Related Policies and Materials
Modifier Usage
Modifiers 25 and 57
Split-Care Surgical Modifiers